Medicines Information Services

**Information on drug therapy**

Information on any aspect of drug therapy can be obtained from Regional and District Medicines Information Services. Details regarding the local services provided within your region can be obtained by telephoning the following numbers.

<table>
<thead>
<tr>
<th>Region</th>
<th>City</th>
<th>Telephone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>Birmingham:</td>
<td>(0121) 424 7298</td>
</tr>
<tr>
<td></td>
<td>Bristol:</td>
<td>(0117) 342 6655</td>
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<tr>
<td></td>
<td>Ipswich:</td>
<td>(01473) 704 431</td>
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<tr>
<td></td>
<td>Leeds:</td>
<td>(0113) 206 5377</td>
</tr>
<tr>
<td></td>
<td>Leicester:</td>
<td>(0116) 258 6491</td>
</tr>
<tr>
<td></td>
<td>Liverpool:</td>
<td>(0151) 794 8113/7, or (0151) 794 8118</td>
</tr>
<tr>
<td>London:</td>
<td>Guy’s Hospital</td>
<td>(020) 7188 8750, or (020) 7188 3849, or (020) 7188 3855</td>
</tr>
<tr>
<td></td>
<td>Northwick Park Hospital</td>
<td>(020) 8869 2761, or (020) 8869 3973</td>
</tr>
<tr>
<td></td>
<td>Newcastle:</td>
<td>(0191) 282 4631</td>
</tr>
<tr>
<td></td>
<td>Southampton:</td>
<td>(023) 8120 6908/9</td>
</tr>
<tr>
<td>Wales</td>
<td>Cardiff:</td>
<td>(029) 2074 2979, or (029) 2074 2251</td>
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<tr>
<td>Scotland</td>
<td>Aberdeen:</td>
<td>(01224) 552 316</td>
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<td>Dundee:</td>
<td>(01382) 632 351, or (01382) 660 111 Extn 32351</td>
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<td></td>
<td>Edinburgh:</td>
<td>(0131) 242 2920</td>
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<tr>
<td></td>
<td>Glasgow:</td>
<td>(0141) 211 4407</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Belfast</td>
<td>(028) 9504 0558</td>
</tr>
<tr>
<td></td>
<td>Republic of Ireland</td>
<td>Dublin</td>
</tr>
</tbody>
</table>

**United Kingdom Medicines Information (UKMI) website**

www.sps.nhs.uk/

**Manufacturers**

Telephone numbers and email addresses of manufacturers listed in BNF Publications are shown in the Index of manufacturers p. 1102

**UK Teratology Information Service**

Information on drug and chemical exposures in pregnancy.
Tel: 0344 892 0909  
www.uktis.org

**UK Drugs in Lactation Advisory Service (UKDILAS)**

Information on the compatibility of drugs with breastfeeding.
Tel: (0116) 258 6491, or (0121) 424 7298  
Email: ukdilas.enquiries@nhs.net  
www.sps.nhs.uk/ukdilas

**Medicines in Dentistry Specialist Advisory Service**

Information on drug therapy relating to dental treatment.
Liverpool: (0151) 794 8206

**Driver and Vehicle Licensing Agency (DVLA)**

Information on the national medical guidelines of fitness to drive is available from:
www.gov.uk/government/publications/at-a-glance

**Medicines for Children Information Leaflets**

Medicines information for parents and carers.
www.medicinesforchildren.org.uk

**Patient Information Lines**

NHS Urgent Care Services 111

**Poisons Information Services**

UK National Poisons Information Service (for healthcare professionals only)
Tel: 0344 892 0111  
www.toxbase.org

**Sport**

- Information regarding the use of medicines in sport is available from UK Anti-Doping:  
  Tel: (020) 7842 3450  
  ukad@ukad.org.uk  
  UK Anti-Doping  
  Fleetbank House  
  2-6 Salisbury Square  
  London  
  EC4Y 8AE  
- Information about the prohibited status of specific medicines based on the current World Anti-Doping Agency Prohibited List is available from Global Drug Reference Online:  
  www.globaldro.com/UK/search

**Travel Immunisation**

Up-to-date information on travel immunisation requirements may be obtained from:
- National Travel Health Network and Centre (for healthcare professionals only) 0845 602 6712 Monday and Friday: 9–11 a.m. and 1–2 p.m, Tuesday to Thursday: 9–11 a.m. and 1–3:30 p.m.
  travelhealthpro.org.uk/
  Travel Medicine Team, Health Protection Scotland  
  (0141) 300 1100 (2–4 p.m. weekdays)  
  www.travax.nhs.uk (for registered users of the NHS website Travax only)  
  Welsh Government Switchboard English language  
  0300 0603300 (9 a.m.–5:30 p.m. weekdays only)  
  Welsh Government Switchboard Yr Iaith Gymraeg  
  0300 0604400 (9 a.m.–5:30 p.m. weekdays only)  
  Department of Health and Social Services (Belfast)  
  (028) 9052 2118 (weekdays)

**List of Registered Medical Practitioners**

Details on whether doctors are registered and hold a licence to practise medicine in the UK can be obtained from the General Medical Council.
Tel: (0161) 923 6602  
www.gmc-uk.org/register
Since 1949 the British National Formulary (BNF) has been the UK’s most trusted and authoritative healthcare resource, helping to ensure the safe and effective use of medicines at the point of care.

Now, as part of our anniversary celebrations, we want to showcase the rigorous editorial process that goes into creating the content that you rely on for your everyday practice. We will also go behind the scenes at the BNF in our ‘A day in the life’ articles. To find out more visit bnf.org

We really appreciate the support you have given the BNF for our first 70 years - including the launch of the first edition of the BNF for Children in 2005, created to meet the needs of healthcare professionals working with children.

If you have a story to tell about how the BNF has been pivotal in your healthcare journey, we would love to hear about it on social media, just use hashtag #BNF70years

Find out more about the BNF’s first 70 years at bnf.org
Access the BNF your way

The British National Formulary (BNF) and BNF for Children are updated monthly online via MedicinesComplete, ensuring healthcare professionals always have the latest medicines information.

**ONLINE**

**BNF on MedicinesComplete**
Access BNF and BNF for Children on MedicinesComplete and receive the very latest drug information through monthly online updates.

**FormularyComplete**
Create, edit and manage your own local formulary content built upon the trusted prescribing advice of the BNF and BNF for Children.

**BNF on Evidence Search**
Search the BNF and BNF for Children alongside other authoritative clinical and non-clinical evidence and best practice at www.evidence.nhs.uk from NICE.

**PRINT**

Eligible healthcare professionals will now receive one print copy a year – the September issue – to supplement online access. If you are entitled to an NHS copy please refer to page ii for full details on distribution, call 01268 495 609 or email BNF@wilmingtonhealthcare.com.

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Tel: +44 (0) 1256 302 699

For enquiries concerning MedicinesComplete, FormularyComplete, or bulk orders of the print edition, contact pharmpress-support@rpharms.com
Tel: +44 (0) 20 7572 2266

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or via our website www.pharmpress.com

For all bulk orders of more than 20 copies:
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pharmpress-support@rpharms.com

BNFC is available as a mobile app, online (bnf.nice.org.uk) and also through MedicinesComplete; a PDA version is also available. In addition, BNFC content can be integrated into a local formulary by using BNFC on FormularyComplete; see www.bnf.org for details.

Distribution of printed BNFCs
In England, NICE purchases print editions of BNFC for distribution within the NHS. For details of who is eligible to receive a copy and further contact details, please refer to the NICE website: www.nice.org.uk/about/what-we-do/evidence-services/british-national-formulary. If you are entitled to a shared copy of the BNFC, please call (0)1268 495 609 or email: BNF@wilmingtonhealthcare.com.

In Scotland, email: nss.psd-bnf@nhs.net

In Wales, email: nwssp-primarycareservices@wales.nhs.uk

In Northern Ireland, email: ni.bnf@hscni.net

About BNFC content
The BNFC for Children is for rapid reference by UK health professionals engaged in prescribing, dispensing, and best administering medicines to children. BNFC for Children has been constructed using robust procedures for gathering, assessing and assimilating information on paediatric drug treatment, but may not always include all the information necessary for prescribing and dispensing. It is expected that the reader will be relying on appropriate professional knowledge and expertise to interpret the contents in the context of the circumstances of the individual child. BNFC for Children should be used in conjunction with other appropriate and up-to-date literature and, where necessary, supplemented by expert advice. Information is also available from Medicines Information Services.

Special care is required in managing childhood conditions with unlicensed medicines or with licensed medicines for unlicensed uses. Responsibility for the appropriate use of medicines lies solely with the individual health professional.

Please refer to digital versions of BNFC for Children for the most up-to-date content. BNFC for Children is published in print but interim updates are issued and published in the digital versions of BNFC for Children. The publishers work to ensure that the information is as accurate and up-to-date as possible at the date of publication, but knowledge and best practice in this field change regularly. BNFC for Children’s accuracy and currency cannot be guaranteed and neither the publishers nor the authors accept any responsibility for errors or omissions. While considerable efforts have been made to check the material in this publication, it should be treated as a guide only. Prescribers, pharmacists and other healthcare professionals are advised to check www.bnf.org for information about key updates and corrections.

Pharmaid
Numerous requests have been received from developing countries for BNFCs. The Pharmaid scheme of the Commonwealth Pharmacists Association will dispatch old BNFCs to certain Commonwealth countries. For more information on this scheme see commonwealthpharmacy.org/what-we-do/pharmaid/.

If you would like to donate your copy email: admin@commonwealthpharmacy.org
Preface

**BNF for Children** aims to provide prescribers, pharmacists, and other healthcare professionals with sound up-to-date information on the use of medicines for treating children.

A joint publication of the British Medical Association, the Royal Pharmaceutical Society, the Royal College of Paediatrics and Child Health, and the Neonatal and Paediatric Pharmacists Group, **BNF for Children** (‘BNFC’) is published under the authority of a Paediatric Formulary Committee which comprises representatives of these bodies, the Department of Health for England, and the Medicines and Healthcare products Regulatory Agency.

Many areas of paediatric practice have suffered from inadequate information on effective medicines. BNFC addresses this significant knowledge gap by providing practical information on the use of medicines in children of all ages from birth to adolescence. Information in BNFC has been validated against emerging evidence, best-practice guidelines, and crucially, advice from a network of clinical experts.

Drawing information from manufacturers’ literature where appropriate, BNFC also includes a great deal of advice that goes beyond marketing authorisations (product licences). This is necessary because licensed indications frequently do not cover the clinical needs of children; in some cases, products for use in children need to be specially manufactured or imported. Careful consideration has been given to establishing the clinical need for unlicensed interventions with respect to the evidence and experience of their safety and efficacy; local paediatric formularies, clinical literature and national information resources have been invaluable in this process.

BNFC has been designed for rapid reference and the information presented has been carefully selected to aid decisions on prescribing, dispensing and administration of medicines. Less detail is given on areas such as malignant disease and the very specialist use of medicines generally undertaken in tertiary centres. BNFC should be interpreted in the light of professional knowledge and it should be supplemented as necessary by specialised publications. Information is also available from Medicines Information Services (see inside front cover).

It is **important** to use the most recent BNFC information for making clinical decisions. The print edition of **BNF for Children** is updated in September each year. Monthly updates are provided online via the BNF Publications website [www.bnf.org](http://www.bnf.org), MedicinesComplete and the NHS Evidence portal.

The more important changes listed under Changes p. xvii are cumulative (from one print edition to the next), and can be printed off each month to show the main changes since the last print edition as an aide memoire for those using print copies.

The website ([www.bnf.org](http://www.bnf.org)) includes additional information of relevance to healthcare professionals. Other digital formats of BNFC—including versions for mobile devices and integration into local formularies—are also available.

BNF Publications welcomes comments from healthcare professionals. Comments and constructive criticism should be sent to:

British National Formulary,  
Royal Pharmaceutical Society,  
66–68 East Smithfield  
London  
E1W 1AW  
editor@bnf.org

The contact email for manufacturers or pharmaceutical companies wishing to contact BNF Publications is manufacturerinfo@bnf.org
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Contributors for this update were:


Valuable advice has been provided by the following expert groups: Advisory Committee on Malaria Prevention, Association of British Neurologists, British Association of Dermatologists’ Therapy & Guidelines Sub-committee, British Geriatrics Society, British Society of Gastroenterology, British Society of Paediatric Gastroenterology, Hepatology and Nutrition, Faculty of Sexual and Reproductive Healthcare, Neonatal and Paediatric Pharmacists Group, Royal College of Anaesthetists, Royal College of Obstetricians and Gynaecologists, Royal College of Psychiatrists, Vascular Society.

The MHRA have provided valuable assistance.

Correspondents in the pharmaceutical industry have provided information on new products and commented on products in the BNFC.

Numerous doctors, pharmacists, nurses, and others have sent comments and suggestions.

The BNF team are grateful for the support and access to in-house expertise at Pharmaceutical Press and acknowledge the assistance of A. Lourie, J. Macdonald, N. Potter and their teams.

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How BNF Publications are constructed

Overview

The BNF for Children (BNFC) is an independent professional publication that addresses the day-to-day prescribing information needs of healthcare professionals involved in the care of children. Use of this resource throughout the health service helps to ensure that medicines are used safely, effectively, and appropriately. Hundreds of changes are made between print editions, and are published monthly in some digital formats. The most clinically significant updates are listed under Changes p. xvii.

BNFC is unique in bringing together authoritative, independent guidance on best practice with clinically validated drug information.

Information in BNFC has been validated against emerging evidence, best-practice guidelines, and advice from a network of clinical experts. BNFC includes a great deal of advice that goes beyond marketing authorisations (product licences or summaries of product characteristics). This is necessary because licensed indications frequently do not cover the clinical needs of children; in some cases, products for use in children need to be specially manufactured or imported. Careful consideration has been given to establishing the clinical need for unlicensed interventions with respect to the evidence and experience of their safety and efficacy.

Validation of information follows a standardised process. Where the evidence base is weak, further validation is undertaken through a process of peer review. The process and its governance are outlined in greater detail in the sections that follow.

Paediatric Formulary Committee

The Paediatric Formulary Committee (PFC) is responsible for the content of BNFC. The PFC comprises pharmacy, medical and nursing representatives with a paediatric background, and lay representatives who have worked with children or acted as a carer of a paediatric patient; there are also representatives from the Medicines and Healthcare products Regulatory Agency (MHRA) and the Department of Health for England. The PFC decides on matters of policy and reviews amendments to BNFC in the light of evidence and expert advice.

Dental Advisory Group

The Dental Advisory Group oversees the preparation of advice on the drug management of dental and oral conditions; the group includes representatives from the British Dental Association and a representative from the UK Health Departments.

Nurse Prescribers’ Advisory Group

The Nurse Prescribers’ Advisory Group oversees the list of drugs approved for inclusion in the Nurse Prescribers’ Formulary; the group includes representatives from a range of nursing disciplines and stakeholder organisations.

Expert advisers

BNFC uses about 80 expert clinical advisers (including doctors, pharmacists, nurses, and dentists) throughout the UK to help with the clinical content. The role of these expert advisers is to review existing text and to comment on amendments drafted by the clinical writers. These clinical experts help to ensure that BNFC remains reliable by:

- commenting on the relevance of the text in the context of best clinical practice in the UK;
- checking draft amendments for appropriate interpretation of any new evidence;
- providing expert opinion in areas of controversy or when reliable evidence is lacking;
- advising on the use of unlicensed medicines or of licensed medicines for unlicensed uses ('off-label' use);
- providing independent advice on drug interactions, prescribing in hepatic impairment, renal impairment, pregnancy, breast-feeding, neonatal care, palliative care, and the emergency treatment of poisoning.

In addition to consulting with regular advisers, BNFC calls on other clinical specialists for specific developments when particular expertise is required.

BNFC also works closely with a number of expert bodies that produce clinical guidelines. Drafts or pre-publication copies of guidelines are often received for comment and for assimilation into BNFC.

Editorial team

BNFC clinical writers have all worked as pharmacists or possess a pharmacy degree and further, relevant post-graduate qualification, and have a sound understanding of how drugs are used in clinical practice. A number of the clinical writers have specific experience of paediatric practice. As a team, the clinical writers are responsible for editing, maintaining, and updating BNFC content. They follow a systematic prioritisation process in response to updates to the evidence base in order to ensure the most clinically important topics are reviewed as quickly as possible. In parallel the team of clinical writers undertakes a process of rolling revalidation, aiming to review all of the content in the BNFC over a 3- to 4-year period.

Amendments to the text are drafted when the clinical writers are satisfied that any new information is reliable and relevant. A set of standard criteria define when content is referred to expert advisers, the Joint Formulary Committee or other advisory groups, or submitted for peer review.

Clinical writers prepare the text for publication and undertake a number of validation checks on the knowledge at various stages of the production.

Sources of BNFC information

BNFC uses a variety of sources for its information; the main ones are shown below.

Summary of product characteristics

BNFC reviews the summaries of product characteristics (SPCs) of all new products as well as revised SPCs for existing products. The SPCs are a key source of product information and are carefully processed. Such processing involves:

- verifying the approved names of all relevant ingredients including ‘non-active’ ingredients (BNFC is committed to using approved names and descriptions as laid down by the Human Medicines Regulations 2012);
- comparing the indications, cautions, contra-indications, and side-effects with similar existing drugs. Where these are different from the expected pattern, justification is sought for their inclusion or exclusion;
- seeking independent data on the use of drugs in pregnancy and breast-feeding;
- incorporating the information into BNFC using established criteria for the presentation and inclusion of the data;
- checking interpretation of the information by a second clinical writer before submitting to a content manager; changes relating to doses receive a further check;
- identifying potential clinical problems or omissions and seeking further information from manufacturers or from expert advisers;
- constructing, with the help of expert advisers, a comment on the role of the drug in the context of similar drugs.

Much of this processing is applicable to the following sources as well.

Literature

Clinical writers monitor core medical, paediatric, and pharmaceutical journals. Research papers and reviews relating to drug therapy are carefully processed. When a difference between the advice in BNFC and the paper is noted, the new information is assessed for reliability (using tools based on SIGN methodology) and relevance to UK clinical practice. If necessary, new text is drafted and discussed with expert advisers and the Paediatric Formulary Committee. BNFC enjoys a close working relationship with a number of national information providers.

In addition to the routine process, which is used to identify ‘triggers’ for changing the content, systematic literature searches are used to identify the best quality evidence available to inform an update. Clinical writers receive training in critical appraisal, literature evaluation, and search strategies.
Consensus guidelines
The advice in BNFC is checked against consensus guidelines produced by expert bodies. The quality of the guidelines is assessed using adapted versions of the AGREE II tool. A number of bodies make drafts or pre-publication copies of the guidelines available to BNFC; it is therefore possible to ensure that a consistent message is disseminated. BNFC routinely processes guidelines from the National Institute for Health and Care Excellence (NICE), the All Wales Medicines Strategy Group (AWMSG), the Scottish Medicines Consortium (SMC), and the Scottish Intercollegiate Guidelines Network (SIGN).

Reference sources
Paediatric formularies and reference sources are used to provide background information for the review of existing text or for the construction of new text. The BNFC team works closely with the editorial team that produces Martindale: The Complete Drug Reference. BNFC has access to Martindale information resources and each team keeps the other informed of significant developments and shifts in the trends of drug usage.

Peer review
Although every effort is made to identify the most robust data available, inevitably there are areas where the evidence base is weak or contradictory. While the BNF has the valuable support of expert advisers and the Paediatric Formulary Committee, the recommendations made may be subject to a further level of scrutiny through peer review to ensure they reflect best practice. Content for peer review is posted on bnf.org and interested parties are notified via a number of channels, including the BNF e-newsletter.

Statutory information
BNFC routinely processes relevant information from various Government bodies including Statutory Instruments and regulations affecting the Prescription only Medicines Order. Official compendia such as the British Pharmacopoeia and its addenda are processed routinely to ensure that BNFC complies with the relevant sections of the Human Medicines Regulations 2012.

BNFC maintains close links with the Home Office (in relation to controlled drug regulations) and the Medicines and Healthcare products Regulatory Agency (including the British Pharmacopoeia Commission). Safety warnings issued by the Commission on Human Medicines (CHM) and guidelines on drug use issued by the UK health departments are processed as a matter of routine.

Relevant professional statements issued by the Royal Pharmaceutical Society are included in BNFC as are guidelines from bodies such as the Royal College of Paediatrics and Child Health.

Medicines and devices
NHS Prescription Services (from the NHS Business Services Authority) provides non-clinical, categorical information (including prices) on the medicines and devices included in BNFC.

Comments from readers
Readers of BNFC are invited to send in comments. Numerous letters and emails are received by the BNF team. Such feedback helps to ensure that BNFC provides practical and clinically relevant information. Many changes in the presentation and scope of BNFC have resulted from comments sent in by users.

Comments from industry
Close scrutiny of BNFC by the manufacturers provides an additional check and allows them an opportunity to raise issues about BNFC’s presentation of the role of various drugs; this is yet another check on the balance of BNFC advice. All comments are looked at with care and, where necessary, additional information and expert advice are sought.

Market research
Market research is conducted at regular intervals to gather feedback on specific areas of development.

Assessing the evidence
From January 2016, recommendations made in BNFC have been evidence graded to reflect the strength of the recommendation. The addition of evidence grading is to support clinical decision making based on the best available evidence.

The BNFC aims to revalidate all content over a rolling 3- to 4-year period and evidence grading will be applied to recommendations as content goes through the revalidation process. Therefore, initially, only a small number of recommendations will have been graded.

Grading system
The BNFC has adopted a five level grading system from A to E, based on the former SIGN grading system. This grade is displayed next to the recommendation within the text.

Evidence used to make a recommendation is assessed for validity using standardised methodology tools based on AGREE II and assigned a level of evidence. The recommendation is then given a grade that is extrapolated from the level of evidence, and an assessment of the body of evidence and its applicability.

Evidence assigned a level 1- or 2- score has an unacceptable level of bias or confounding and is not used to form recommendations.

Levels of evidence
- **Level 1++**: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias.
- **Level 1+**: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.
- **Level 1**: Meta-analyses, systematic reviews, or RCTs with a high risk of bias.
- **Level 2+++**: High quality systematic reviews of case control or cohort studies; or high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
- **Level 2++**: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
- **Level 2+**: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.
- **Level 3**: Non-analytic studies, e.g. case reports, case series.
- **Level 4**: Expert advice or clinical experience from respected authorities.

Grades of recommendation
- **Grade A: High strength**
  NICE-accredited guidelines; or guidelines that pass AGREE II assessment; or at least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
- **Grade B: Moderate strength**
  A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
- **Grade C: Low strength**
  A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
- **Grade D: Very low strength**
  Evidence level 3; or extrapolated evidence from studies rated as 2+; or tertiary reference source created by a transparent, defined methodology, where the basis for recommendation is clear.
- **Grade E: Practice point**
  Evidence level 4.
How to use the BNFC Publications in print

How to use the BNF for Children in print

This edition of the BNFC (BNFC) continues to display the fundamental change to the structure of the content that was first shown in BNFC 2015-2016. The changes were made to bring consistency and clarity to BNFC content, and to the way that the content is arranged within print and digital products, increasing the ease with which information can be found.

For reference, the most notable changes to the structure of the content include:

— Drug monographs – where possible, all information that relates to a single drug is contained within its drug monograph, moving information previously contained in the prescribing notes. Drug monographs have also changed structurally: additional sections have been added, ensuring greater regularity around where information is located within the publication.

— Drug class monographs – where substantial amounts of information are common to all drugs within a drug class (e.g. macrolides p. 339), a drug class monograph has been created to contain the common information.

— Medicinal forms – categorical information about marketed medicines, such as price and pack size, continues to be sourced directly from the Dictionary of Medicines and Devices provided by the NHS Business Services Authority. However, clinical information curated by the BNF team has been clearly separated from the categorical pricing and pack size information and is included in the relevant section of the drug monograph.

— Section numbering – the BNFC section numbering has been removed. This section numbering tied the content to a rigid structure and enforced the retention of defunct classifications, such as mercurial diuretics, and hindered the relocation of drugs where therapeutic use had altered. It also caused constraints between the BNFC and BNF, where drugs had different therapeutic uses in children.

— Appendix 4 – the content has been moved to individual drug monographs. The introductory notes have been replaced with a new guidance section, Guidance on intravenous infusions p. 17.

Introduction

In order to achieve the safe, effective, and appropriate use of medicines, healthcare professionals must be able to use the BNFC effectively, and keep up to date with significant content changes in each edition, and guidance on various prescribing matters (e.g. prescription writing, the use of intravenous drugs, particular considerations for special patient populations).

 Chapters, containing drug monographs describing the uses, doses, safety issues and other considerations involved in the use of drugs; drug class monographs; and treatment summaries, covering guidance on the selection of drugs. Monographs and treatment summaries are divided into chapters based on specific aspects of medical care, such as Chapter 5, Infections, or Chapter 16, Emergency treatment of poisoning; or drug use related to a particular system of the body, such as Chapter 2, Cardiovascular.

Within each chapter, content is organised alphabetically by therapeutic use (e.g. Airways disease, obstructive), with the treatment summaries first, (e.g. Asthma, acute p. 152), followed by the monographs of the drugs used to manage the conditions discussed in the treatment summary. Within each therapeutic use, the drugs are organised alphabetically by classification (e.g. Antimuscarinics, Beta 2-agonist bronchodilators) and then alphabetically within each classification (e.g. Formoterol fumarate, Salbutamol, Salmeterol, Terbutaline sulfate).

Appendices, covering interactions, borderline substances, and cautionary and advisory labels.

Back matter, covering the lists of medicines approved by the NHS for Dental and Nurse Practitioner prescribing, proprietary and specials manufacturers’ contact details, and the index. Yellow cards are also included, to facilitate the reporting of adverse events, as well as quick reference guides for life support and key drug doses in medical emergencies, for ease of access.

Navigating the BNFC for Children

The contents page provides the high-level layout of information within the BNFC; and in addition, each chapter begins with a small contents section, describing the therapeutic uses covered within that chapter. Once in a chapter, location is guided by the side of the page showing the chapter number (the thumbnail), alongside the chapter title. The top of the page includes the therapeutic use (the running head) alongside the page number.

Once on a page, visual cues aid navigation: treatment summary information is in black type, with therapeutic use titles similarly styled in black, whereas the use of colour indicates drug-related information, including drug classification titles, drug class monographs, and drug monographs.

Although navigation is possible by browsing, primarily access to the information is via the index, which covers the titles of drug class monographs, drug monographs and treatment summaries. The index also includes the names of branded medicines and other topics of relevance, such as abbreviations, guidance sections, tables, and images.

Content types

Treatment summaries

Treatment summaries are of three main types;

• an overview of delivering a drug to a particular body system (e.g. Skin conditions, management p. 736),

• a comparison between a group or groups of drugs (e.g. beta-adrenoceptor blockers (systemic) p. 105),

• an overview of the drug management or prophylaxis of common conditions intended to facilitate rapid appraisal of options (e.g. Hypertension p. 100, or Malaria, prophylaxis p. 401).

In order to select safe and effective medicines for individual children, information in the treatment summaries must be
used in conjunction with other prescribing details about the drugs and knowledge of the child’s medical and drug history.

**Monographs Overview**

In earlier editions (i.e. before BNFC 2015-2016), a systematically administered drug with indications for use in different body systems was split across the chapters relating to those body systems. So, for example, codeine phosphate p. 283 was found in chapter 1, for its antimiotoility effects and chapter 4 for its analgesic effects. However, the monograph in chapter 1 contained only the dose and some selected safety precautions.

Now, all of the information for the systemic use of a drug is contained within one monograph, so codeine phosphate p. 283 is now included in chapter 4. This carries the advantage of providing all of the information in one place, so the user does not need to flick back and forth across several pages to find all of the relevant information for that drug. Cross references are included in chapter 1, where the management of diarrhoea is discussed, to the drug monograph to assist navigation.

Where drugs have systemic and local uses, for example, chloramphenicol p. 368, and the considerations around drug use are markedly different according to the route of administration, the monograph is split, as with earlier editions, into the relevant chapters.

This means that the majority of drugs are still placed in the same chapters and sections as earlier editions, and although there may be some variation in order, all of the relevant information will be easier to locate.

One of the most significant changes to the monograph structure is the increased granularity, with a move from around 9 sections to over 20 sections; sections are only included when relevant information has been identified. The following information describes these sections and their uses in more detail.

**Nomenclature**

Monograph titles follow the convention of recommended international non-proprietary names (rINNs), or, in the absence of a rINN, British Approved Names. Relevant synonyms are included below the title and, in some instances a brief description of the drug action is included. Over future editions these drug action statements will be rolled out for all drugs.

In some monographs, immediately below the nomenclature or drug action, there are a number of cross references used to signpost the user to any additional information they need to consider about a drug. This is most common for drugs formulated in combinations, where users will be signposted to the monographs for the individual ingredients (e.g. senna with ispaghula husk p. 49) or for drugs that are related to a drug class monograph (see Drug class monographs, below).

**Indication and dose**

User feedback has highlighted that one of the main uses of the BNFC is identifying indications and doses of drugs. Therefore, indication and dose information has been promoted to the top of the monograph and highlighted by a coloured panel to aid quick reference.

The indication and dose section is more highly structured than in earlier editions, giving greater clarity around which doses should be used for which indications and by which route. In addition, if the dose varies with a specific preparation or formulation that dosing information has been moved out of the preparations section and in to the indication and dose panel, under a heading of the preparation name.

Doses are either expressed in terms of a definite frequency (e.g. 1 g 4 times daily) or in the total daily dose format (e.g. 6 g daily in 3 divided doses); the total daily dose should be divided into individual doses (in the second example, the child should receive 2 g 3 times daily).

Doses for specific patient groups (e.g. neonates) may be included if they are different to the standard dose. Doses for children can be identified by the relevant age range and may vary according to their age or body-weight.

**Selecting the dose**

The dose of a drug may vary according to different indications, routes of administration, age, body-weight, and body surface area. The right dose should be selected for the right age and body-weight (or body surface area) of the child, as well as for the right indication, route of administration, and preparation.

In earlier editions of the BNFC, age ranges and weight ranges overlapped. For clarity and to aid selection of the correct dose, wherever possible these age and weight ranges now do not overlap. When interpreting age ranges it is important to understand that a child is considered to be 11 up until the point of their 12th birthday, meaning that an age range of child 12 to 17 years is applicable to a child from the day of their 12th birthday until the day before their 18th birthday. All age ranges should be interpreted in this way. Similarly, when interpreting weight ranges, it should be understood that a weight of up to 30 kg is applicable to a child up to, but not including, the point that they tip the scales at 30 kg and a weight range of 35 to 59 kg is applicable to a child as soon as they tip the scales at 35 kg right up until, but not including, the point that they tip the scales at 60 kg. All weight ranges should be interpreted in this way.

A pragmatic approach should be applied to these cut-off points depending on the child’s physiological development, condition, and if weight is appropriate for the child’s age.

For some drugs (e.g. vancomycin p. 335) the neonatal dose varies according to the corrected gestational age of the neonate. Corrected gestational age is the neonate’s total age expressed in weeks from the start of the mother’s last menstrual period. For example, a 3 week old baby born at 27 weeks gestation is treated as having a corrected gestational age of 30 weeks. A term baby has a corrected gestational age of 37–42 weeks when born. For most other drugs, the dose can be based on the child’s actual date of birth irrespective of corrected gestational age. However, the degree of prematurity, the maturity of renal and hepatic function, and the clinical properties of the drug need to be considered on an individual basis.

Many children’s doses in BNFC are standardised by body-weight. To calculate the dose for a given child the weight-standardised dose is multiplied by the child’s weight (or occasionally by the child’s ideal weight for height). The calculated dose should not normally exceed the maximum recommended dose for an adult. For example, if the dose is 8 mg/kg (max. 300 mg), a child of 10 kg body-weight should receive 80 mg, but a child of 40 kg body-weight should receive 300 mg (rather than 320 mg). Calculation by body-weight in the overweight child may result in much higher doses being administered than necessary; in such cases, the dose should be calculated from an ideal weight for height.

Occasionally, some doses in BNFC are standardised by body surface area because many physiological phenomena correlate better with body surface area. In these cases, to calculate the dose for a given child, the body-surface area-standardised dose is multiplied by the child’s body surface area. The child’s body surface area can be estimated from his or her weight using the tables for Body surface area in children (image) p. 1180.

Wherever possible, doses are expressed in terms of a definite frequency (e.g. if the dose is 1 mg/kg twice daily, a child of body-weight 9 kg would receive 9 mg twice daily).
Typical layout of a monograph and associated medicinal forms

1 **Class Monographs and drug monographs**
   In most cases, all information that relates to an individual drug is contained in its drug monograph and there is no symbol. Class monographs have been created where substantial amounts of information are common to all drugs within a drug class, these are indicated by a flag symbol in a circle:

   Drug monographs with a corresponding class monograph are indicated by a tab with a flag symbol:

   The page number of the corresponding class monograph is indicated within the tab. For further information, see How to use BNF Publications

2 **Drug classifications**
   Used to inform users of the class of a drug and to assist in finding other drugs of the same class. May be based on pharmacological class (e.g. opioids) but can also be associated with the use of the drug (e.g. cough suppressants)

3 **Review date**
   The date of last review of the content

4 **Specific preparation name**
   If the dose varies with a specific preparation or formulation it appears under a heading of the preparation name
Pregnancy advice on the use of a drug during pregnancy.

Breast feeding advice on the use of a drug during breast feeding.

Hepatic impairment advice on the use of a drug in hepatic impairment.

Renal impairment advice on the use of a drug in renal impairment.

Pre-treatment screening covers one-off tests required to assess the suitability of a patient for a particular drug.

Monitoring requirements specifies any special monitoring requirements, including information on monitoring the plasma concentration of drugs with a narrow therapeutic index.

Effects on laboratory tests for drugs that can interfere with the accuracy of seemingly unrelated laboratory tests.

Treatment cessation specifies whether further monitoring or precautions are advised when the drug is withdrawn.

Directions for administration practical information on the preparation of intravenous drug infusions; general advice relevant to other routes of administration.

Prescribing and dispensing information practical information around how a drug can be prescribed and dispensed including details of when brand prescribing is necessary.

Handling and storage includes information on drugs that can cause adverse effects to those who handle them before they are taken by, or administered to, a patient; advice on storage conditions.

Patient and carer advice for drugs with a special need for counselling.

Profession specific information provides details of the restrictions certain professions such as dental practitioners or nurse prescribers need to be aware of when prescribing on the NHS.

National funding/access decisions details of NICE Technology Appraisals, SMC advice and AWMSG advice.

Less suitable for prescribing preparations that are considered by the Paediatric Formulary Committee to be less suitable for prescribing.

Exception to legal category advice and information on drugs which may be sold without a prescription under specific conditions.

Medicinal forms

Form

Cautionary and advisory labels if applicable.

Excipients clinically important but not comprehensive [consult manufacturer information for full details].

Electrolytes if clinically significant quantities occur.

Preparation name (Manufacturer/Non-proprietary) Drug name and strength pack sizes. Prices.

Combinations available this indicates a combination preparation is available and a cross reference page number is provided to locate this preparation.

Evidence grading

Evidence grading to reflect the strengths of recommendations will be applied as content goes through the revalidation process. A five level evidence grading system based on the former SIGN grading system has been adopted. The grades A B C D E are displayed next to the recommendations within the text, and are preceded by the symbol: E

For further information, see How BNF Publications are constructed.

Legal categories

This symbol has been placed against those preparations that are available only on a prescription issued by an appropriate practitioner. For more detailed information see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition).

These symbols indicate that the preparations are subject to the prescription requirements of the Misuse of Drugs Act.

For regulations governing prescriptions for such preparations, see Controlled Drugs and Drug Dependence.

Not all monographs include all possible sections; sections are only included when relevant information has been identified.
Occasionally, it is necessary to include doses in the total daily dose format (e.g. 10 mg/kg daily in 3 divided doses); in these cases the total daily dose should be divided into individual doses (in this example a child of body-weight 9 kg would receive 30 mg 3 times daily).

Most drugs can be administered at slightly irregular intervals during the day. Some drugs, e.g. antimicrobials, are best given at regular intervals. Some flexibility should be allowed in children to avoid waking them during the night. For example, the night-time dose may be given at the child’s bedtime.

Special care should be taken when converting doses from one metric unit to another, and when calculating infusion rates or the volume of a preparation to administer. Where possible, doses should be rounded to facilitate administration of suitable volumes of liquid preparations, or an appropriate strength of tablet or capsule.

Other information relevant to Indication and dose
The dose panel also contains, where known, an indication of pharmacokinetic considerations that may affect the choice of dose, and dose equivalence information, which may aid the selection of dose when switching between drugs or preparations.

The BNFC includes unlicensed use of medicines when the clinical need cannot be met by licensed medicines; such use should be supported by appropriate evidence and experience. When the BNFC recommends an unlicensed medicine or the ‘off-label’ use of a licensed medicine, this is shown below the indication and dose panel in the unlicensed use section.

Minimising harm and drug safety
The drug chosen to treat a particular condition should minimise the patient’s susceptibility to adverse effects and, where co-morbidities exist, have minimal detrimental effects on the patient’s other diseases. To achieve this, the Contra-indications, Cautions and Side-effects of the relevant drug should be reviewed.

The information under Cautions can be used to assess the risks of using a drug in a patient who has co-morbidities that are also included in the Cautions for that drug — if a safer alternative cannot be found, the drug may be prescribed while monitoring the patient for adverse-effects or deterioration in the co-morbidity. Contra-indications are far more restrictive than Cautions and mean that the drug should be avoided in a patient with a condition that is contra-indicated.

The impact that potential side-effects may have on a patient’s quality of life should also be assessed. For instance, in a child who has constipation, it may be preferable to avoid a drug that frequently causes constipation.

The Important safety advice section in the BNFC, delineated by a coloured outline box, highlights important safety concerns, often those raised by regulatory authorities or guideline producers. Safety warnings issued by the Commission on Human Medicines (CHM) or Medicines and Healthcare products Regulatory Agency (MHRA) are found here.

Drug selection should aim to minimise drug interactions. If it is necessary to prescribe a potentially serious combination of drugs, patients should be monitored appropriately. The mechanisms underlying drug interactions are explained in Appendix 1, followed by details of drug interactions.

Use of drugs in specific patient populations
Drug selection should aim to minimise the potential for drug accumulation, adverse drug reactions, and exacerbation of pre-existing hepatic or renal disease. If it is necessary to prescribe drugs whose effect is altered by hepatic or renal disease, appropriate drug dose adjustments should be made, and patients should be monitored adequately. The general principles for prescribing are outlined under Prescribing in hepatic impairment p. 18, and Prescribing in renal impairment p. 18. Information about drugs that should be avoided or used with caution in hepatic disease or renal impairment can be found in drug monographs under Hepatic impairment and Renal impairment (e.g. fluconazole p. 389).

Similarly, drug selection should aim to minimise harm to the fetus, nursing infant, and mother. The infant should be monitored for potential side-effects of drugs used by the mother during pregnancy or breast-feeding. The general principles for prescribing are outlined under Prescribing in pregnancy p. 20 and Prescribing in breast-feeding p. 20. The Treatment Summaries provide guidance on the drug treatment of common conditions that can occur during pregnancy and breast-feeding (e.g. Asthma, acute p. 152). Information about the use of specific drugs during pregnancy and breast-feeding can be found in their drug monographs under Pregnancy, and Breast-feeding (e.g. fluconazole p. 389).

A new section, Conception and contraception, containing information around considerations for females of childbearing potential or men who might father a child (e.g. isotretinoin p. 780) has been included.

Administration and monitoring
When selecting the most appropriate drug, it may be necessary to screen the patient for certain genetic markers or metabolic states. This information is included within a section called Pre-treatment screening (e.g. abacavir p. 431). This section covers one-off tests required to assess the suitability of a patient for a particular drug.

Once the drug has been selected, it needs to be given in the most appropriate manner. A Directions for administration section contains the information about intravenous administration previously located in Appendix 4. This provides practical information on the preparation of intravenous drug infusions, including compatibility of drugs with standard intravenous infusion fluids, method of dilution or reconstitution, and administration rates. In addition, general advice relevant to other routes of administration is provided within this section (e.g. fentanyl p. 286) and further details, such as masking the bitter taste of some medicines.

Whenever possible, intramuscular injections should be avoided in children because they are painful.

After selecting and administering the most appropriate drug by the most appropriate route, patients should be monitored to ensure they are achieving the expected benefits from drug treatment without any unwanted side-effects. The Monitoring section specifies any special monitoring requirements, including information on monitoring the plasma concentration of drugs with a narrow therapeutic index (e.g. theophylline p. 171). Monitoring may, in certain cases, be affected by the impact of a drug on laboratory tests (e.g. hydroxocobalamin p. 595), and this information is included in Effects on laboratory tests.

In some cases, when a drug is withdrawn, further monitoring or precautions may be advised (e.g. clonidine hydrochloride p. 103); these are covered under Treatment cessation.

Choice and supply
The prescriber, the child’s carer, and the child (if appropriate) should agree on the health outcomes desired and on the strategy for achieving them (see Taking Medicines to Best Effect). Taking the time to explain to the child (and the child’s carer if appropriate) the rationale and the potential adverse effects of treatment may improve adherence. For some medicines there is a special need for counselling (e.g. appropriate posture during administration of doxycycline p. 364, or recognising signs of blood, liver, or
skin disorders with carbamazepine p. 200); this is shown in Patient and carer advice.

Other information contained in the latter half of the monograph also helps prescribers and those dispensing medicines choose medicinal forms (by indicating information such as flavour or when branded products are not interchangeable e.g. modified-release theophylline p. 171), assess the suitability of a drug for prescribing, understand the NHS funding status for a drug (e.g. sildenafil p. 122), or assess when a patient may be able to purchase a drug without prescription (e.g. loperamide hydrochloride p. 51).

**Medicinal forms**

In the BNFC, preparations follow immediately after the monograph for the drug that is their main ingredient. In earlier editions, when a particular preparation had safety information, dose advice or other clinical information specific to the product, it was contained within the preparations section. This information has been moved to the relevant section in the main body of the monograph under a heading of the name of the specific medicinal form (e.g. peppermint oil p. 37).

The medicinal forms (formerly preparations) section provides information on the type of formulation (e.g. tablet), the amount of active drug in a solid dosage form, and the concentration of active drug in a liquid dosage form. The legal status is shown for prescription-only medicines and controlled drugs, as well as pharmacy medicines and medicines on the general sales list. Practitioners are reminded, by a statement under the heading of ‘Medicinal Form’ that not all products containing a specific drug ingredient may be similarly licensed. To be clear on the precise licensing status of specific medicinal forms, practitioners should check the product literature for the particular product being prescribed or dispensed.

Details of all medicinal forms available on the dm+d for each drug in BNFC Publications appears online on MedicinesComplete. In print editions, due to space constraints, only certain branded products are included in detail. Where medicinal forms are listed they should not be inferred as equivalent to the other brands listed under the same form heading. For example, all the products listed under a heading of “Modified release capsule” will be available as modified release capsules, however, the brands listed under that form heading may have different release profiles, the available strengths may vary and/or the products may have different licensing information. As with earlier editions of the BNFC, practitioners must ensure that the particular product being prescribed or dispensed is appropriate.

As medicinal forms are derived from dm+d data, some drugs may appear under names derived from that data; this may vary slightly from those in earlier BNFC versions, e.g. sodium acid phosphatase, is now sodium dihydrogen phosphate anhydrous.

Children should be prescribed a preparation that complements their daily routine, and that provides the right dose of drug for the right indication and route of administration. When dispensing liquid preparations, a sugar-free preparation should always be used in preference to one containing sugar. Patients receiving medicines containing cariogenic sugars should be advised of appropriate dental hygiene measures to prevent caries.

Earlier editions of the BNFC only included excipients and electrolyte information for proprietary medicines. This information is now covered at the level of the dose form (e.g. tablet). It is not possible to keep abreast of all of the generic products available on the UK market, and so this information serves as a reminder to the healthcare professional that, if

the presence of a particular excipient is of concern, they should check the product literature for the particular product being prescribed or dispensed.

Cautonary and advisory labels that pharmacists are recommended to add when dispensing are included in the medicinal forms section. Details of these labels can be found in Appendix 3, Guidance for cautionary and advisory labels p. 1094. These labels have now been applied at the level of the dose form.

In the case of compound preparations, the prescribing information for all constituents should be taken into account.

**Prices in the BNFC**

Basic NHS net prices are given in the BNFC to provide an indication of relative cost. Where there is a choice of suitable preparations for a particular disease or condition the relative cost may be used in making a selection. Cost-effective prescribing must, however, take into account other factors (such as dose frequency and duration of treatment) that affect the total cost. The use of more expensive drugs is justified if it will result in better treatment of the patient, or a reduction of the length of an illness, or the time spent in hospital.

Prices are regularly updated using the Drug Tariff and proprietary price information published by the NHS dictionary of medicines and devices (dm+d, www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dictionary-medicines-and-devices-dmd). The weekly updated dm+d data (including prices) can be accessed using the dm+d browser of the NHS Business Services Authority (apps.nhsbsa.nhs.uk/DMDBrowser/DMDBrowser.do). Prices have been calculated from the net cost used in pricing NHS prescriptions and generally reflect wholesale dispensing packs. Prices for extemporaneously prepared preparations are not provided in the BNFC as prices vary between different manufacturers.

BNFC prices are not suitable for quoting to patients seeking private prescriptions or contemplating over-the-counter purchases because they do not take into account VAT, professional fees, and other overheads.

A fuller explanation of costs to the NHS may be obtained from the Drug Tariff. Separate drug tariffs are applicable to England and Wales (www.npaa.org.uk/pda/edt_intro.htm), Scotland (www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff/), and Northern Ireland (www.hscbusiness.hscni.net/services/2034.htm); prices in the different tariffs may vary.

**Drug class monographs**

In earlier editions of the BNFC, information relating to a class of drug sharing the same properties (e.g. tetracyclines p. 364), was contained within the prescribing notes. In the updated structure, drug class monographs have been created to contain the common information; this ensures such information is easier to find, and has a more regularised structure.

For consistency and ease of use, the class monograph follows the same structure as a drug monograph. Class monographs are indicated by the presence of a flag (e.g. beta-adrenoceptor blockers (systemic) p. 165). If a drug monograph has a corresponding class monograph, that needs to be considered in tandem, in order to understand the full information about a drug, the monograph is also indicated by a flag (e.g. metoprolol tartrate p. 109). Within this flag, the page number of the drug class monograph is provided (e.g. 1234), to help navigate the user to this information. This is particularly useful where occasionally, due to differences in therapeutic use, the drug monograph may not directly follow the drug class monograph (e.g. sotalol hydrochloride p. 81).
Evidence grading
The BNF has adopted a five level evidence grading system (see How BNF Publications are constructed p. viii). Recommendations that are evidence graded can be identified by a symbol appearing immediately before the recommendation. The evidence grade is displayed at the end of the recommendation.

Other content
Nutrition
Appendix 2 includes tables of ACBS-approved enteral feeds and nutritional supplements based on their energy and protein content. There are separate tables for specialised formulae for specific clinical conditions. Classified sections on foods for special diets and nutritional supplements for metabolic diseases are also included.

Other useful information
Finding significant changes in the BNFC
- Changes, provides a list of significant changes, dose changes, classification changes, new names, and new preparations that have been incorporated into the BNFC, as well as a list of preparations that have been discontinued and removed from the BNFC. Changes listed online are cumulative (from one print edition to the next), and can be printed off each month to show the main changes since the last print edition as an aide memoire for those using print copies. So many changes are made for each update of the BNFC, that not all of them can be accommodated in the Changes section. We encourage healthcare professionals to review regularly the prescribing information on drugs that they encounter frequently;
- Changes to the Dental Practitioners’ Formulary, are located at the end of the Dental List;
- E-newsletter, the BNF & BNFC e-newsletter service is available free of charge. It alerts healthcare professionals to details of significant changes in the clinical content of these publications and to the way that this information is delivered. Newsletters also review clinical case studies, provide tips on using these publications effectively, and highlight forthcoming changes to the publications. To sign up for e-newsletters go to

www.bnf.org.
- An e-learning programme developed in collaboration with the Centre for Pharmacy Postgraduate Education (CPPE), enables pharmacists to identify and assess how significant changes in the BNF affect their clinical practice. The module can be found at

www.cppe.ac.uk.

Using other sources for medicines information
The BNFC is designed as a digest for rapid reference. Less detail is given on areas such as malignant disease and anaesthesia since it is expected that those undertaking treatment will have specialist knowledge and access to specialist literature. The BNFC should be interpreted in the light of professional knowledge and supplemented as necessary by specialised publications and by reference to the product literature. Information is also available from medicines information services.
Changes

Monthly updates are provided online via Medicines Complete and the NHS Evidence portal. The changes listed below are cumulative (from one print edition to the next).

**Significant changes**

Significant changes that appear in the print edition of BNF for Children 2019–2020:

- Side-effects and their further information sections have been reviewed against the current product literature and terms used to define these have been standardised across all drug monographs.
- Attention deficit hyperactivity disorder p. 231: updated guidance on management.
- Carboximazole p. 501: increased risk of congenital malformations; strengthened advice on contraception [MHRA/CHM advice].
- Carboximazole p. 501: risk of acute pancreatitis [MHRA/CHM advice].
- Controlled drugs and drug dependence p. 10: reclassification of gabapentin p. 204 and pregabalin as Class C and Schedule 3 Controlled Drugs.
- Darunavir boosted with cobicistat: avoid use in pregnancy due to risk of treatment failure and maternal-to-child transmission of HIV-1 [MHRA/CHM advice].
- Diabetic complications p. 466: updated guidance.
- Dinutuximab beta p. 547 for treating neuroblastoma [NICE guidance].
- Dolasetravir p. 427 (Tivacox® Triumeq® Juluca®): signal of increased risk of neural tube defects; do not prescribe to women seeking to become pregnant; exclude pregnancy before initiation and advise use of effective contraception [MHRA/CHM advice].
- Doxycline p. 364: license extension into children aged 8 to 11 years.
- Dyslipidaemias p. 130: updated guidance on familial hypercholesterolaemia.
- Eltrombopag p. 602 (Revolade®): reports of interference with bilirubin and creatinine test results [MHRA/CHM advice].
- Elvitegravir boosted with cobicistat: avoid use in pregnancy due to risk of treatment failure and maternal-to-child transmission of HIV-1 [MHRA/CHM advice] (see elvitegravir with cobicistat, emtricitabine and tenofovir alafenamide p. 440).
- Emollients (see Emollient and barrier preparations p. 737): new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients [MHRA/CHM advice].
- Fluoroquinolone antibiotics (ciprofloxacin p. 361): new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects [MHRA/CHM advice].
- Gabapentin p. 204 (Neurontin®): and risk of abuse and dependence: new scheduling requirements from 1 April [MHRA/CHM advice].
- Gentamicin p. 548 for untreated acute myeloid leukaemia [NICE guidance].
- Heavy menstrual bleeding p. 495: updated guidance on management.
- Hydrocortisone p. 456 muco-adhesive buccal tablets: should not be used off-label for adrenal insufficiency in children due to serious risks [MHRA/CHM advice].
- Ipilimumab p. 549 (Yervoy®): reports of cytomegalovirus (CMV) gastrointestinal infection or reactivation [MHRA/CHM advice].
- Lyme disease p. 374: updated guidance on management.
- Meningococcal vaccine p. 808: updated guidance for Meningococcal group B vaccines.
- Nusinersen p. 671 (Spinraza®): reports of communicating hydrocephalus not related to meningitis or bleeding [MHRA/CHM advice].
- Oropharyngeal infections, antibacterial therapy p. 733: updated guidance on sore throat (acute).
- Parenteral amphotericin B p. 387: reminder of risk of potentially fatal adverse reaction if formulations confused [MHRA/CHM advice].
- Prescribing in pregnancy p. 20: Medicines with teratogenic potential, what is effective contraception and how often is pregnancy testing needed? [MHRA/CHM advice].
- Quinolones p. 374: new guidance on management of Cough, acute.
- Respiratory system infections, antibacterial therapy p. 318: new guidance for acute exacerbations of Bronchiectasis (non-cystic fibrosis).
- Respiratory system infections, antibacterial therapy p. 318: new guidance on management of Cough, acute.
- Smoking cessation p. 204: updated guidance.
- Systemic and inhaled fluoroquinolones (ciprofloxacin p. 361): small increased risk of aortic aneurysm and dissection; advice for prescribing in high-risk patients [MHRA/CHM advice].
- Tapentadol p. 295 (Palexia®): risk of seizures and reports of serotonin syndrome when co-administered with other medicines [MHRA/CHM advice].
- Transdermal fentanyl p. 286 patches: life-threatening and fatal opioid toxicity from accidental exposure, particularly in children [MHRA/CHM advice].

Valproate medicines and serious harms in pregnancy: new Annual Risk Acknowledgement Form and clinical guidance from professional bodies to support compliance with the Pregnancy Prevention Programme [MHRA/CHM advice] (see sodium valproate p. 213 and valproic acid p. 219).

Valproate medicines (see sodium valproate p. 213 and valproic acid p. 219): are you in action in compliance with the pregnancy prevention measures? [MHRA/CHM advice].

Venous thromboembolism p. 90: updated guidance on prophylaxis.

Yellow fever vaccine, live p. 829 (Stamaril®) and fatal adverse reactions: extreme caution needed in people who may be immunosuppressed [MHRA/CHM advice].


Dose changes

Changes in dose statements that appear in the print edition of BNF for Children 2019—2020:

- Adalimumab p. 665 [maintenance dosing updated].
- Adenosine p. 80 [dose clarification for neonate and children under 12 years for termination of supraventricular tachycardias and diagnosis of supraventricular arrhythmias].
- Amoxicillin p. 351 [update to indications and doses for Lyme Disease].
- Anakinra p. 662 [dosing in severe renal impairment].
- Azithromycin p. 339 [update to indication and doses for Lyme Disease].
- Budenofalk® [deletion of dosing information for collagenous colitis and update on advice on reducing dose following treatment in Crohn’s disease].
- Caffeine citrate p. 194 [maintenance dosing].
- Canakinumab p. 543.  
- Ceftriaxone p. 332 [update to indications and doses for Lyme Disease].
- Clarithromycin p. 340 [dosing recommendation for Lyme Disease deleted in line with updated guidance].
- Colistimethate sodium p. 358 [dosing recommendations for inhalation ofobilised solution and for intravenous use].
- Doxycycline p. 364 [update to indications and doses for Lyme Disease].
- Erythromycin p. 341 [dosing recommendation for Lyme Disease deleted in line with updated guidance].
- Glycerol phenylbutyrate p. 637 [dose rounding recommendation for children under 2 years].
- Haloperidol p. 252.
- Hexetidine p. 728 [update to age-range].
- Hydroxycobalamin p. 595 [frequency of maintenance dosing for macrocytic anaemia without neurological involvement].
- Imipenem with cilastatin p. 325 [dosing recommendation in renal impairment updated].
- Influenza vaccine p. 825 [update to indication of annual immunisation against seasonal influenza (for children in clinical risk groups who have not received seasonal influenza vaccine previously)].
- Japanese encephalitis vaccine p. 826 [dosing schedule updated].
- Levonorgestrel p. 527 [update to timings of administration of intra-uterine devices and advice on additional contraceptive precautions].
- Malarone® Paediatric (atovaquone with proguanil hydrochloride p. 409) [update to weight ranges for prophylaxis of falciparum malaria].
- Mometasone furoate p. 166 [prophylaxis and treatment of seasonal allergic or perennial rhinitis—age range extended].
-Raltegravir p. 427 [directions for administration for granules for oral suspension deleted as available packs may contain conflicting advice; see individual packs for instructions for reconstitution].
- Rufinamide p. 212 [update to age range for use in children and dosing information for use with valproate].
- Stripectent p. 217 [updated dosing information].
- Vancomycin p. 335 [deletion of the statement recommending the use of ideal body-weight to calculate intravenous doses in obese patients].

New preparations

New preparations that appear in the print edition of BNF for Children 2019—2020:

- Blincyto® [blinatumomab p. 546].
- Cetuxan Plus® [ciprofloxacin with fluocinolone acetonide p. 716].
- Crysvita® [burosumab p. 621].
- FiraPy® [icatibant p. 186].
- Ivenmend® [fosaprepitant p. 270].
- Kineret® [anakinra p. 662].
- MAVIRET® [glecaprevir with pibrentasvir p. 418].
- Nplate® [romiplostim p. 603].
- Nucala® [mepolizumab p. 167].
- Palexia® oral solution [tapentadol p. 295].
- Qarziba® [dinizutumab beta p. 547].
- Silentyo® [melatonin p. 303].
- Sprycl® [dasatinib p. 579].
- Symkevi® [tezacaftor with ivacaftor p. 190].
- Typacil® [tigecycline p. 367].
- Verkaz® eye drops [ciclosporin p. 537].
- Xgeva® [denosumab p. 488].
- Zebinix® [eslicarbazepine acetate p. 202].
- Zemplar® [paricalcitol p. 657].
Guidance on prescribing

General guidance
Medicines should be given to children only when they are necessary, and in all cases the potential benefit of administering the medicine should be considered in relation to the risk involved. This is particularly important during pregnancy, when the risk to both mother and fetus must be considered. It is important to discuss treatment options carefully with the child and the child’s carer. In particular, the child and the child’s carer should be helped to distinguish the adverse effects of prescribed drugs from the effects of the medical disorder. When the beneficial effects of the medicine are likely to be delayed, this should be highlighted.

Prescribing competency framework The Royal Pharmaceutical Society has published a Prescribing Competency Framework that includes a common set of competencies that form the basis for prescribing, regardless of professional background. The competencies have been developed to help healthcare professionals be safe and effective prescribers with the aim of supporting patients to get the best outcomes from their medicines. It is available at www.rpharms.com/resources/frameworks/prescribers-competency-framework.

Multimorbidity
The presence of two or more long-term health conditions in a child (multimorbidity) is generally associated with reduced quality of life, higher mortality, higher rates of adverse drug reactions, greater use of the health service, and a higher treatment burden (due to polypharmacy or multiple appointments). Treatment decisions should involve consideration of the child’s needs, preferences for treatment, health priorities, and lifestyle with the aim of improving quality of life by reducing treatment burden, adverse events, and unplanned or uncoordinated care. All clinicians involved (including primary and secondary care) should work together to minimise the risk of harm. The use of a care plan within a multidisciplinary team with an identified clinical lead, is recommended. Prescribers should consider the risks and benefits of treatments recommended in guidance for single health conditions, when applied to children with multimorbidity; evidence for these recommendations is commonly drawn from children without multimorbidity or who are taking fewer prescribed regular medicines. Treatments intended to relieve symptoms should be reviewed for clinical response, including reducing or stopping treatment that is no longer effective or necessary. Alternatively, non-pharmacological treatments may be offered or treatments of limited benefit can be considered for discontinuation.

Transitional services for chronic conditions
The process of moving from paediatric to adult services can lead to a loss of continuity in care and provoke anxiety in children and their carers. Practitioners should start planning for adult care when the child reaches the age of 13 or 14 at the latest and a child-centred approach should be taken. Consider designating a named practitioner among those providing care to the child to take a coordinating role and to act as an advocate for the child, maintaining a link between the various practitioners involved in care (including a named GP).

Deprescribing
Discontinuing or reducing the dose of medicines, under supervision, should be considered regularly to improve outcomes and reduce burden. Deprescribing should be undertaken as part of routine clinical care involving careful counselling alongside shared decision-making with the child and their carers.

Taking medicines to best effect
Difficulties in adherence to drug treatment occur regardless of age. Factors that contribute to poor compliance with prescribed medicines include:

- difficulty in taking the medicine (e.g. inability to swallow the medicine);
- unattractive formulation (e.g. unpleasant taste);
- prescription not collected or not dispensed;
- purpose of medicine not clear;
- perceived lack of efficacy;
- real or perceived adverse effects;
- carers’ or child’s perception of the risk and severity of side-effects may differ from that of the prescriber;
- instructions for administration not clear.

The prescriber, the child’s carer, and the child (if appropriate) should agree on the health outcomes desired and on the strategy for achieving them (‘concordance’). The prescriber should be sensitive to religious, cultural, and personal beliefs of the child’s family that can affect acceptance of medicines. Taking the time to explain to the child (and carers) the rationale and the potential adverse effects of treatment may improve adherence. Reinforcement and elaboration of the physician’s instructions by the pharmacist and other members of the healthcare team can be important. Giving advice on the management of adverse effects and the possibility of alternative treatments may encourage carers and children to seek advice rather than merely abandon unacceptable treatment.

Simplifying the drug regimen may help; the need for frequent administration may reduce adherence, although there appears to be little difference in adherence between once-daily and twice-daily administration. Combination products reduce the number of drugs taken, but at the expense of the ability to titrate individual doses.

Advanced Pharmacy Services
Advanced Services are provided as part of the NHS Community Pharmacy Contractual Framework, and include services such as the New Medicines Service and Medicines Use Review service. These services are provided by accredited community pharmacists, with the aim of targeting specific children to help manage their medicines more effectively, improve adherence, and reduce medicines wastage.

New Medicines Service The New Medicines Service (NMS) provides education and support to children who are newly prescribed a medicine to manage a long-term condition. The service is split into three stages; patient engagement, intervention and follow-up. As of 2018, this service is available for children living in England who have either been prescribed a new medicine for one of the following conditions – asthma, type 2 diabetes, or hypertension, or have been prescribed a new antiplatelet or anticoagulant. Children can be offered the service by prescriber referral, or opportunistically by the community pharmacy. For further information, see: psnc.org.uk/services-commissioning/advanced-services/nms.
Medicines Use Review  The Medicines Use Review (MUR) service consists of structured adherence-centred reviews with children on multiple medicines, particularly those receiving medicines for long-term conditions. The service is undertaken periodically, or when there is a need to make an adherence-focused intervention due to a problem identified while providing the dispensing service. The pharmacist providing the service is required to ensure that at least 70% of all MURs undertaken in a year are for children who fall into one or more of the national target groups. The national target groups for MURs in England are:

- children taking high-risk medicines (NSAIDs, anticoagulants (including low molecular weight heparin), antiplatelets, or diuretics);
- children recently discharged from hospital who have had changes made to their medicines;
- children prescribed certain respiratory medicines;
- children with, or at risk of cardiovascular disease, and are regularly prescribed at least four medicines.

For further information, see: <www.psc.org.uk/services-commissioning/advanced-services/murs/>

In Wales, Northern Ireland, and Scotland there are variations on this service, including different national target groups. In Wales, see <www.cpwales.org.uk/Contract-support-and-1T/Advanced-Services/Medicines-Use-review-MUR.aspx>

In Northern Ireland, see <www.hscbusiness.hscni.net/services/2427.htm>

In Scotland, see <www.communitypharmacyscotland.org.uk/nhs-care-services/services/chronic-medication-service/>

Drug treatment in children
Children, and particularly neonates, differ from adults in their response to drugs. Special care is needed in the neonatal period (first 28 days of life) and doses should always be calculated with care; the risk of toxicity is increased by a reduced rate of drug clearance and differing target organ sensitivity. The terms infant, child and adolescent are used inconsistently in the literature. However, for reference purposes only, the terms generally used to describe the paediatric stages of development are:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm neonate</td>
<td>Born at &lt; 37 weeks gestation</td>
</tr>
<tr>
<td>Term neonate</td>
<td>Born at 37 to 42 weeks gestation</td>
</tr>
<tr>
<td>Post-term neonate</td>
<td>Born at ≥ 42 weeks gestation</td>
</tr>
<tr>
<td>Neonate</td>
<td>From 0 up to 28 days of age (or first 4 weeks of life)</td>
</tr>
<tr>
<td>Infant</td>
<td>From 28 days up to 24 months of age</td>
</tr>
<tr>
<td>Child</td>
<td>From 2 years up to 12 years of age</td>
</tr>
<tr>
<td>Adolescent</td>
<td>From 12 years up to 18 years of age</td>
</tr>
</tbody>
</table>

In <BNF for Children>, the term neonate is used to describe a newborn infant aged 0–28 days. The terms child or children are used generically to describe the entire range from infant to adolescent (1 month–17 years). An age range is specified when the dose information applies to a narrower age range than a child from 1 month–17 years.

Administration of medicines to children
Children should be involved in decisions about taking medicines and encouraged to take responsibility for using them correctly. The degree of such involvement will depend on the child’s age, understanding, and personal circumstances.

Occasionally a medicine or its taste has to be disguised or masked with small quantities of food. However, unless specifically permitted (e.g. some formulations of pancreatin p. 74), a medicine should not be mixed with large quantities of food because the full dose might not be taken and the child might develop an aversion to food if the medicine imparts an unpleasant taste. Medicines should not be mixed or administered in a baby’s feeding bottle.

Children under 5 years (and some older children) find a liquid formulation more acceptable than tablets or capsules. However, for long-term treatment it may be possible for a child to be taught to take tablets or capsules.

An oral syringe should be used for accurate measurement and controlled administration of an oral liquid medicine. The unpleasant taste of an oral liquid can be disguised by flavouring it or by giving a favourite food or drink immediately afterwards, but the potential for food-drug interactions should be considered.

Advice should be given on dental hygiene to those receiving medicines containing saccharin sugars for long-term treatment; sugar-free medicines should be provided whenever possible.

Children with nasal feeding tubes in place for prolonged periods should be encouraged to take medicines by mouth if possible; enteric feeding should generally be interrupted before the medicine is given (particularly if enteral feeds reduce the absorption of a particular drug). Oral liquids can be given through the tube provided that precautions are taken to guard against blockage; the dose should be washed down with warm water. When a medicine is given through a nasogastric tube to a neonate, sterile water must be used to accompany the medicine or to wash it down.

The intravenous route is generally chosen when a medicine cannot be given by mouth; reliable access, often a central vein, should be used for children whose treatment involves irritant or inotropic drugs or who need to receive the medicine over a long period or for home therapy. The subcutaneous route is used most commonly for insulin administration. Intramuscular injections should preferably be avoided in children, particularly neonates, infants, and young children. However, the intramuscular route may be advantageous for administration of single doses of medicines when intravenous cannulation would be more problematic or painful to the child. Certain drugs, e.g. some vaccines, are only administered intramuscularly.

The intrathecal, epidural and intraosseous routes should be used only by staff specially trained to administer medicines by these routes. Local protocols for the management of intrathecal injections must be in place.

Managing medicines in school
Administration of a medicine during schooltime should be avoided if possible; medicines should be prescribed for once or twice-daily administration whenever practicable. If the medicine needs to be taken in school, this should be discussed with parents or carers and the necessary arrangements made in advance; where appropriate, involvement of a school nurse should be sought. Managing Medicines in Schools and Early Years Settings produced by the Department of Health provides guidance on using medicines in schools (<www.dh.gov.uk>.

Patient information leaflets
Manufacturers’ patient information leaflets that accompany a medicine, cover only the licensed use of the medicine. Therefore, when a medicine is used outside its licence, it may be appropriate to advise the child and the child’s parent or carer that some of the information in the leaflet might not apply to the child’s treatment. Where necessary, inappropriate advice in the patient information leaflet should be identified and reassurance provided about the correct use in the context of the child’s condition.

Biological medicines
Biological medicines are medicines that are made by or derived from a biological source using biotechnology processes, such as recombinant DNA technology. The size and complexity of biological medicines, as well as the way
they are produced, may result in a degree of natural variability in molecules of the same active substance, particularly in different batches of the medicine. This variation is maintained within strict acceptable limits. Examples of biological medicines include insulin and monoclonal antibodies. Biological medicines must be prescribed by brand name and the brand name specified on the prescription should be dispensed in order to avoid inadvertent switching. Automatic substitution of brands at the point of dispensing is not appropriate for biological medicines.

**Biosimilar medicines**

A biosimilar medicine is a biological medicine that is highly similar and clinically equivalent (in terms of quality, safety, and efficacy) to an existing biological medicine that has already been authorised in the European Union (known as the reference biological medicine or originator medicine). The active substance of a biosimilar medicine is similar, but not identical, to the originator biological medicine. Once the patent for a biological medicine has expired, a biosimilar medicine may be authorised by the European Medicines Agency (EMA). A biosimilar medicine is not the same as a generic medicine, which contains a simpler molecular structure that is identical to the originator medicine.

**Therapeutic equivalence**

Biosimilar medicines should be considered to be therapeutically equivalent to the originator biological medicine within their authorised indications. Biosimilar medicines are usually licensed for all the indications of the originator biological medicine, but this depends on the evidence submitted to the EMA for authorisation and must be scientifically justified on the basis of demonstrated or extrapolated equivalence.

**Prescribing and dispensing**

The choice of whether to prescribe a biosimilar medicine or the originator biological medicine rests with the clinician in consultation with the patient. Biological medicines (including biosimilar medicines) must be prescribed by brand name and the brand name specified on the prescription should be dispensed in order to avoid inadvertent switching. Automatic substitution of brands at the point of dispensing is not appropriate for biological medicines.

**Safety monitoring**

Biosimilar medicines are subject to a black triangle status at the time of initial authorisation. It is important to report suspected adverse reactions using the Yellow Card Scheme (see Adverse reactions to new medicines). For all biological medicines, adverse reaction reports should clearly state the brand name and the batch number of the suspected medicine.

**National funding/access decisions**

The Department of Health has confirmed that, in England, NICE can decide to apply the same remit, and the resulting technology appraisal guidance, to relevant biosimilar medicines which appear on the market subsequent to their originator biological medicine. In other circumstances, where a review of the evidence for a particular biosimilar medicine is necessary, NICE will consider producing an evidence summary (see Evidence summary: new medicines, www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/evidence-summaries-new-medicines).

**National information**


**BNF for Children and marketing authorisation**

Where appropriate the doses, indications, cautions, contraindications, and side effects in BNF for Children reflect those in the manufacturers’ Summaries of Product Characteristics (SPCs) which, in turn, reflect those in the corresponding marketing authorisations (formerly known as Product Licences). BNF for Children does not generally include proprietary medicines that are not supported by a valid Summary of Product Characteristics or when the marketing authorisation holder has not been able to supply essential information. When a preparation is available from more than one manufacturer, BNF for Children reflects advice that is the most clinically relevant regardless of any variation in the marketing authorisation. Unlicensed products can be obtained from ‘special-order’ manufacturers or specialist importing companies.

As far as possible, medicines should be prescribed within the terms of the marketing authorisation. However, many children require medicines not specifically licensed for paediatric use. Although medicines cannot be promoted outside the limits of the licence, the Human Medicines Regulations 2012 do not prohibit the use of unlicensed medicines.

**BNF for Children includes advice involving the use of unlicensed medicines or of licensed medicines for unlicensed uses (‘off-label’ use). Such advice reflects careful consideration of the options available to manage a given condition and the weight of evidence and experience of the unlicensed intervention. Where the advice falls outside a drug’s marketing authorisation, BNF for Children shows the licensing status in the drug monograph. However, the limitations of the marketing authorisation should not preclude unlicensed use where clinically appropriate.**

**Prescribing unlicensed medicines**

Prescribing unlicensed medicines or medicines outside the recommendations of their marketing authorisation alters (and probably increases) the prescriber’s professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines, and also inform the...
patient or the patient’s carer that the prescribed medicine is unlicensed.

**Drugs and skilled tasks**

Prescribers and other healthcare professionals should advise children and their carers if treatment is likely to affect their ability to perform skilled tasks (e.g. driving). This applies especially to drugs with sedative effects; patients should be warned that these effects are increased by alcohol. General information about a patient’s fitness to drive is available from the Driver and Vehicle Licensing Agency at www.dvla.gov.uk.

A new offence of driving, attempting to drive, or being in charge of a vehicle, with certain specified controlled drugs in excess of specified limits, came into force on 2nd March 2015. This offence is an addition to the existing rules on drug impaired driving and fitness to drive, and applies to two groups of drugs—commonly abused drugs, including amphetamines, cannabis, cocaine, and ketamine p. 246, and drugs used mainly for medical reasons, such as opioids and benzodiazepines. Anyone found to have any of the drugs (including related drugs, for example, apomorphine hydrochloride) above specified limits in their blood will be guilty of an offence, whether their driving was impaired or not. This also includes prescribed drugs which metabolise to those included in the offence, for example, selegiline hydrochloride. However, the legislation provides a statutory “medical defence” for patients taking drugs for medical reasons in accordance with instructions, if their driving was not impaired—it continues to be an offence to drive if actually impaired. Patients should therefore be advised to continue taking their medicines as prescribed, and when driving, to carry suitable evidence that the drug was prescribed, or sold, to treat a medical or dental problem, and that it was taken according to the instructions given by the prescriber, or information provided with the medicine (e.g. a repeat prescription form or the medicine’s patient information leaflet). Further information is available from the Department for Transport at www.gov.uk/government/collections/driver-driving.

**Oral syringes**

An oral syringe is supplied when oral liquid medicines are prescribed in doses other than multiples of 5 mL. The oral syringe is marked in 0.5- mL divisions from 1 to 5 mL to measure doses of less than 5 mL (other sizes of oral syringe may also be available). It is provided with an adaptor and an instruction leaflet. The 5- mL spoon is used for doses of 5 mL (or multiples thereof).

**Excipients**

Branded oral liquid preparations that do not contain fructose, glucose, or sucrose are described as ‘sugar-free’ in BNF for Children. Preparations containing hydrogenated glucose syrup, mannitol, maltitol, sorbitol, or xylitol are also marked ‘sugar-free’ since they do not cause dental caries. Children receiving medicines containing cariogenic sugars, or their carers, should be advised of dental hygiene measures to prevent caries. Sugar-free preparations should be used whenever possible, particularly if treatment is required for a long period. Where information on the presence of alcohol, aspartame, gluten, sulfites, tartrazine, arachis (peanut) oil or sesame oil is available, this is indicated in BNF for Children against the relevant preparation.

Information is provided on selected excipients in skin preparations, in vaccines, and on selected preservatives and excipients in eye drops and injections. The presence of benzyl alcohol and polyoxyl castor oil (polyethoxylated castor oil) in injections is indicated in BNF for Children. Benzyl alcohol has been associated with a fatal toxic syndrome in preterm neonates, and therefore, parenteral preparations containing the preservative should not be used in neonates. Polyoxyl castor oils, used as vehicles in intravenous injections, have been associated with severe anaphylactoid reactions.

The presence of propylene glycol in oral or parenteral medicines is indicated in BNF for Children; it can cause adverse effects if its elimination is impaired, e.g. in renal failure, in neonates and young children, and in slow metabolisers of the substance. It may interact with metronidazole p. 344.

The lactose content in most medicines is too small to cause problems in most lactose-intolerant children. However in severe lactose intolerance, the lactose content should be determined before prescribing. The amount of lactose varies according to manufacturer, product, formulation, and strength.

**Important** In the absence of information on excipients in BNF for Children and in the product literature (available at www.medicines.org.uk/emc/), contact the manufacturer if it is essential to check details.

**Health and safety**

When handling chemical or biological materials particular attention should be given to the possibility of allergy, fire, explosion, radiation, or poisoning. Care is required to avoid sources of heat (including hair dryers) when flammable substances are used on the skin or hair. Substances, such as corticosteroids, some antimicrobials, phenothiazines, and many cytoxics, are irritant or very potent and should be handled with caution; contact with the skin and inhalation of dust should be avoided. Healthcare professionals and carers should guard against exposure to sensitizing, toxic or irritant substances if it is necessary to crush tablets or open capsules.

**EEA and Swiss prescriptions**

Pharmacists can dispense prescriptions issued by doctors and dentists from the European Economic Area (EEA) or Switzerland (except prescriptions for controlled drugs in Schedules 1, 2, or 3, or for drugs without a UK marketing authorisation). Prescriptions should be written in ink or otherwise so as to be indelible, should be dated, should state the name of the patient, should state the address of the prescriber, should contain particulars indicating whether the prescriber is a doctor or dentist, and should be signed by the prescriber.

**Security and validity of prescriptions**

The Councils of the British Medical Association and the Royal Pharmaceutical Society have issued a joint statement on the security and validity of prescriptions. In particular, prescription forms should:

- not be left unattended at reception desks;
- not be left in a car where they may be visible;
- when not in use, be kept in a locked drawer within the surgery and at home.

Where there is any doubt about the authenticity of a prescription, the pharmacist should contact the prescriber. If this is done by telephone, the number should be obtained from the directory rather than relying on the information on the prescription form, which may be false.

**Patient group direction (PGD)**

In most cases, the most appropriate clinical care will be provided on an individual basis by a prescriber to a specific child. However, a Patient Group Direction for supply and administration of medicines by other healthcare professionals can be used where it would benefit the child’s care without compromising safety.

A Patient Group Direction is a written direction relating to the supply and administration (or administration only) of a licensed prescription-only medicine (including some...
Controlled Drugs in specific circumstances) by certain classes of healthcare professionals; the Direction is signed by a doctor (or dentist) and by a pharmacist. Further information on Patient Group Directions is available in Health Service Circular HSC 2000/026 (England), HDL (2001) 7 (Scotland), and WHC (2000) 116 (Wales); see also the Human Medicines Regulations 2012.

**NICE, Scottish Medicines Consortium and All Wales Medicines Strategy Group**

Advice issued by the National Institute for Health and Care Excellence (NICE), the Scottish Medicines Consortium (SMC) and the All Wales Medicines Strategy Group (AWMSG) is included in *BNF for Children* when relevant. Details of the advice together with updates can be obtained from: www.nice.org.uk, www.scottishmedicines.org.uk and www.awmsg.org.
Prescription writing

Shared care
In its guidelines on responsibility for prescribing (circular EL (91) 127) between hospitals and general practitioners, the Department of Health has advised that legal responsibility for prescribing lies with the doctor who signs the prescription.

Requirements
Prescriptions should be written legibly in ink or otherwise so as to be indelible (it is permissible to issue carbon copies of NHS prescriptions as long as they are signed in ink), should be dated, should state the name and address of the patient, the address of the prescriber, an indication of the type of prescriber, and should be signed in ink by the prescriber (computer-generated facsimile signatures do not meet the legal requirement). The age and the date of birth of the patient should preferably be stated, and it is a legal requirement in the case of prescription-only medicines to state the age for children under 12 years. These recommendations are acceptable for prescription-only medicines. Prescriptions for controlled drugs have additional legal requirements. Wherever appropriate the prescriber should state the current weight of the child to enable the dose prescribed to be checked. Consideration should also be given to including the dose per unit mass e.g. mg/kg or the dose per m² body-surface area e.g. mg/m² where this would reduce error.

The following should be noted:

- The strength or quantity to be contained in capsules, lozenges, tablets etc. should be stated by the prescriber. In particular, strength of liquid preparations should be clearly stated (e.g. 125 mg/5 mL).
- The unnecessary use of decimal points should be avoided, e.g. 3 mg, not 3.0 mg. Quantities of 1 gram or more should be written as 1 g etc. Quantities less than 1 gram should be written in milligrams, e.g. 500 mg, not 0.5 g. Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg. When decimals are unavoidable a zero should be written in front of the decimal point where there is no other zero.
- Micrograms’ and ‘nanograms’ should not be abbreviated. Similarly ‘units’ should not be abbreviated.
- The term ‘millilitre’ (mL or mL) is used in medicine and pharmacy, and cubic centimetre, c.c., or cm³ should not be used. The use of capital ‘L’ in mL is a printing convention throughout the BNF; both ‘mL’ and ‘ml’ are recognised SI abbreviations.
- Dose and dose frequency should be stated; in the case of preparations to be taken ‘as required’ a minimum dose interval should be specified. Care should be taken to ensure children receive the correct dose of the active drug. Therefore, the dose should normally be stated in terms of the mass of the active drug (e.g. ‘125 mg 3 times daily’); terms such as ‘5 mL’ or ‘1 tablet’ should be avoided except for compound preparations. When doses other than multiples of 5 mL are prescribed for oral liquid preparations the dose-volume will be provided by means of an oral syringe, (except for preparations intended to be measured with a pipette). Suitable quantities:
  - Elixirs, Linctuses, and Paediatric Mixtures (5-mL dose), 50, 100, or 150 mL
  - Adult Mixtures (10-mL dose), 200 or 300 mL
  - Ear Drops, Eye drops, and Nasal Drops, 10 mL (or the manufacturer’s pack)
  - Eye Lotions, Gargles, and Mouthwashes, 200 mL
  - The names of drugs and preparations should be written clearly and not abbreviated, using approved titles only; avoid creating generic titles for modified-release preparations.
  - The quantity to be supplied may be stated by indicating the number of days of treatment required in the box provided on NHS forms. In most cases the exact amount will be supplied. This does not apply to items directed to be used as required—if the dose and frequency are not given then the quantity to be supplied needs to be stated. When several items are ordered on one form the box can be marked with the number of days of treatment provided the quantity is added for any item for which the amount cannot be calculated.
  - Although directions should preferably be in English without abbreviation, it is recognised that some Latin abbreviations are used.

Sample prescription

**Pharmacy Stamp**

**Age**

1yr 3mths

**Tel., Forename, Surname & Address**

Master Peter Patient

box 2/4/2010 Flat 1

50 Stanshope Street

Newtown 822 10T

**Amount to be taken per dose**

N.B. Error dose is stated

5

**Number of days’ treatment**

5

**Endings**

Ampicillin oral suspension

125mg/5mL sugar-free

12mg three times daily

Supply 100mL

No more items on this prescription

**Abbreviation of titles**

In general, titles of drugs and preparations should be written in full. Unofficial abbreviations should not be used as they may be misinterpreted.

**Non-proprietary titles**

Where non-proprietary (‘generic’) titles are given, they should be used for prescribing. This will enable any suitable product to be dispensed, thereby saving delay to the patient and sometimes expense to the health service. The only exception is where there is a demonstrable difference in clinical effect between each manufacturer’s version of the formulation, making it important that the child should always receive the same brand; in such cases, the brand name or the manufacturer should be stated.

**Non-proprietary names of compound preparations**

Non-proprietary names of compound preparations which appear in BNF for Children are those that have been compiled...
by the British Pharmacopoeia Commission or another recognised body; whenever possible they reflect the names of the active ingredients. Prescribers should avoid creating their own compound names for the purposes of generic prescribing; such names do not have an approved definition and can be misinterpreted. Special care should be taken to avoid errors when prescribing compound preparations; in particular the hyphen in the prefix ‘co-’ should be retained. Special care should also be taken to avoid creating generic names for modified-release preparations where the use of these names could lead to confusion between formulations with different duration of action.
Supply of medicines

Overview
When supplying a medicine for a child, the pharmacist should ensure that the child and the child’s carer understand the nature and identity of the medicine and how it should be used. The child and the carer should be provided with appropriate information (e.g. how long the medicine should be taken for and what to do if a dose is missed or the child vomits soon after the dose is given).

Safety in the home
Carers and relatives of children must be warned to keep all medicines out of the reach and sight of children. Tablets, capsules and oral and external liquid preparations must be dispensed in a reclosable child-resistant container unless:
- the medicine is in an original pack or patient pack such as to make this inadvisable;
- the child’s carer will have difficulty in opening a child-resistant container;
- a specific request is made that the product shall not be dispensed in a child-resistant container;
- no suitable child-resistant container exists for a particular liquid preparation.

All patients should be advised to dispose of unwanted medicines by returning them to a pharmacy for destruction.

Labelling of prescribed medicines
There is a legal requirement for the following to appear on the label of any prescribed medicine:
- name of the patient;
- name and address of the supplying pharmacy;
- name of the medicine;
- directions for use of the medicine;
- precautions relating to the use of the medicine.

The Royal Pharmaceutical Society recommends that the following also appears on the label:
- the words ‘Keep out of the sight and reach of children’;
- where applicable, the words ‘Use this medicine only on your skin’.

A pharmacist can exercise professional skill and judgement to amend or include more appropriate wording for the name of the medicine, the directions for use, or the precautions relating to the use of the medicine.

Unlicensed medicines
A drug or formulation that is not covered by a marketing authorisation may be obtained from a pharmaceutical company, imported by a specialist importer, manufactured by a commercial or hospital licensed manufacturing unit, or prepared extemporaneously against a prescription.

The safeguards that apply to products with marketing authorisation should be extended, as far as possible, to the use of unlicensed medicines. The safety, efficacy, and quality (including labelling) of unlicensed medicines should be assured by means of clear policies on their prescribing, purchase, supply, and administration. Extra care is required with unlicensed medicines because less information may be available on the drug and any formulation of the drug.

The following should be agreed with the supplier when ordering an unlicensed or extemporaneously prepared medicine:
- the specification of the formulation;
- documentation confirming the specification and quality of the product supplied (e.g. a certificate of conformity or of analysis);
- for imported preparations product and licensing information should be supplied in English.

Extemporaneous preparations
A product should be dispensed extemporaneously only when no product with a marketing authorisation is available. Every effort should be made to ensure that an extemporaneously prepared product is stable and that it delivers the requisite dose reliably; the child should be provided with a consistent formulation regardless of where the medicine is supplied to minimise variations in quality. Where there is doubt about the formulation, advice should be sought from a medicines information centre, the pharmacy at a children’s hospital, a hospital production unit, a hospital quality control department, or the manufacturer.

In many cases it is preferable to give a licensed product by an unlicensed route (e.g. an injection solution given by mouth) than to prepare a special formulation. When tablets or capsules are cut, dispersed, or used for preparing liquids immediately before administration, it is important to confirm uniform dispersal of the active ingredient, especially if only a portion of the solid content (e.g. a tablet segment) is used or if only an aliquot of the liquid is to be administered. In some cases the child’s clinical condition may require a dose to be administered in the absence of full information on the method of administration. It is important to ensure that the appropriate supporting information is available at the earliest opportunity.

Preparation of products that produce harmful dust (e.g. cytotoxic drugs, hormones, or potentially sensitising drugs such as neomycin sulfate p. 714) should be avoided or undertaken with appropriate precautions to protect staff and carers.

The BP direction that a preparation must be freshly prepared indicates that it must be made not more than 24 hours before it is issued for use. The direction that a preparation should be recently prepared indicates that deterioration is likely if the preparation is stored for longer than about 4 weeks at 15–25°C.

The term water used without qualification means either potable water freshly drawn direct from the public supply and suitable for drinking or freshly boiled and cooled purified water. The latter should be used if the public supply is from a local storage tank or if the potable water is unsuitable for a particular preparation.
Emergency supply of medicines

Emergency supply requested by member of the public

Pharmacists are sometimes called upon by members of the public to make an emergency supply of medicines. The Human Medicines Regulations 2012 allows exemptions from the Prescription Only requirements for emergency supply to be made by a person lawfully conducting a retail pharmacy business provided:

- that the pharmacist has interviewed the person requesting the prescription-only medicine and is satisfied:
  - that there is immediate need for the prescription-only medicine and that it is impracticable in the circumstances to obtain a prescription without undue delay;
  - that treatment with the prescription-only medicine has on a previous occasion been prescribed for the person requesting it;
  - as to the dose that it would be appropriate for the person to take;
- that no greater quantity shall be supplied than will provide 5 days’ treatment of phenobarbital p. 223, phenobarbital sodium, or Controlled Drugs in Schedules 4 or 5 (doctors or dentists from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation) or 30 days’ treatment for other prescription-only medicines, except when the prescription-only medicine is:
  - insulin, an ointment or cream, or a preparation for the relief of asthma in an aerosol dispenser when the smallest pack can be supplied;
  - an oral contraceptive when a full cycle may be supplied;
  - an antibiotic in liquid form for oral administration when the smallest quantity that will provide a full course of treatment can be supplied;
- that an entry shall be made by the pharmacist in the prescription book stating:
  - the date of supply;
  - the name, quantity and, where appropriate, the pharmaceutical form and strength;
  - the name and address of the patient;
  - the nature of the emergency;
- that the container or package must be labelled to show:
  - the date of supply;
  - the name, quantity and, where appropriate, the pharmaceutical form and strength;
  - the name of the patient;
  - the name and address of the pharmacy;
  - the words ‘Emergency supply’;
  - the words ‘Keep out of the reach of children’ (or similar warning);
- that the prescription-only medicine is not a substance specifically excluded from the emergency supply provision, and does not contain a Controlled Drug specified in Schedules 1, 2, or 3 to the Misuse of Drugs Regulations 2001 except for phenobarbital p. 223 or phenobarbital sodium for the treatment of epilepsy: for details see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition); (Doctors or dentists from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation).

Emergency supply requested by prescriber

Emergency supply of a prescription-only medicine may also be made at the request of a doctor, a dentist, a supplementary prescriber, a community practitioner nurse prescriber, a nurse, pharmacist, or optometrist independent prescriber, or a doctor or dentist from the European Economic Area or Switzerland, provided:

- that the pharmacist is satisfied that the prescriber by reason of some emergency is unable to furnish a prescription immediately;
- that the prescriber has undertaken to furnish a prescription within 72 hours;
- that the medicine is supplied in accordance with the directions of the prescriber requesting it;
- that the medicine is not a Controlled Drug specified in Schedules 1, 2, or 3 to the Misuse of Drugs Regulations 2001 except for phenobarbital p. 223 or phenobarbital sodium for the treatment of epilepsy: for details see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition); (Doctors or dentists from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation).

Royal Pharmaceutical Society’s guidelines

1. The pharmacist should consider the medical consequences of not supplying a medicine in an emergency.
2. If the pharmacist is unable to make an emergency supply of a medicine the pharmacist should advise the patient how to obtain essential medical care.

For conditions that apply to supplies made at the request of a patient see Medicines, Ethics and Practice, London, Pharmaceutical Press, (always consult latest edition).
Controlled drugs and drug dependence

Regulations and classification
The Misuse of Drugs Act, 1971 as amended prohibits certain activities in relation to ‘Controlled Drugs’, in particular their manufacture, supply, and possession (except where permitted by the 2001 Regulations or under licence from the Secretary of State). The penalties applicable to offences involving the different drugs are graded broadly according to the harmlessness attributable to a drug when it is misused and for this purpose the drugs are defined in the following three classes:


- **Class C** includes: certain drugs related to the amfetamines such as benzphetamine and chlorphentermine, buprenorphine p. 281, mazindol, methyprylon, pemoline, pipiradrol, most benzodiazepines, tramadol hydrochloride p. 296, zaleplon, zolpidem tartrate, zopiclone, androjenic and anabolic steroids, clenbuterol, choric gonadotrophin (HCG), non-human chorionic gonadotrophin, somatropin, somatrem, and somatropin p. 492. Controlled drug prescription requirements do not apply and Schedule 4 Controlled Drugs are subject to the full Controlled Drugs (Safe Custody) Regulations. Records in registers do not need to be kept (except in the case of Sativex®).

Schedule 4 includes in Part I drugs that are subject to minimal control, such as benzodiazepines (except temazepam p. 847 and midazolam p. 229, which are in Schedule 3), non-benzodiazepine hypnotics (zaleplon, zolpidem tartrate, and zopiclone) and Sativex®. Part II includes androjenic and anabolic steroids, clenbuterol, choric gonadotrophin (HCG), non-human chorionic gonadotrophin, somatropin, somatrem, and somatropin p. 492. Controlled drug prescription requirements do not apply and Schedule 4 Controlled Drugs are subject to safe custody requirements. Records in registers do not need to be kept (except in the case of Sativex®).

Schedule 5 includes preparations of certain Controlled Drugs (such as codeine, pholcodine p. 192 or morphine p. 290) which due to their low strength, are exempt from virtually all Controlled Drug requirements other than retention of invoices for two years. Since the Responsible Pharmacist Regulations were published in 2008, standing operation procedures for the management of Controlled Drugs, are required in registered pharmacies. The Health Act 2006 introduced the concept of the ‘accountable officer’ with responsibility for the management of Controlled Drugs and related governance issues in their organisation. Most recently, in 2013 The Controlled Drugs (Supervision of Management and Use) Regulations were published to ensure good governance concerning the safe management and use of Controlled Drugs in England and Scotland.

Prescriptions
Preparations in Schedules 1, 2, 3, 4 and 5 of the Misuse of Drugs Regulations 2001 (and subsequent amendments) are identified throughout the BNF and BNF for children using the following symbols:

<table>
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<tr>
<th>Symbol</th>
<th>For Preparations in Schedule 1</th>
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<td>(04-1)</td>
<td>For Preparations in Schedule 4 (Part I)</td>
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<td>(04-2)</td>
<td>For Preparations in Schedule 4 (Part II)</td>
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<tr>
<td>(05)</td>
<td>For Preparations in Schedule 5</td>
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The principal legal requirements relating to medical prescriptions are listed below (see also Department of Health Guidance at www.gov.uk/dh).

**Prescription requirements**
Prescriptions for Controlled Drugs that are subject to prescription requirements (all preparations in Schedules 2 and 3) must be indelible, must be signed by the prescriber, include the date on which they
were signed, and specify the prescriber’s address (must be within the UK). A machine-written prescription is acceptable, but the prescriber’s signature must be handwritten. Advanced electronic signatures can be accepted for Schedule 2 and 3 Controlled Drugs where the Electronic Prescribing Service (EPS) is used. All prescriptions for Controlled Drugs that are subject to the prescription requirements must always state:

- the name and address of the patient (use of a PO Box is not acceptable);
- in the case of a preparation, the form (the dosage form e.g. tablets must be included on a Controlled Drugs prescription irrespective of whether it is implicit in the proprietary name e.g. MST Continus, or whether only one form is available), and, where appropriate, the strength of the preparation (when more than one strength of a preparation exists the strength required must be specified); to avoid ambiguity, where a prescription requests multiple strengths of a medicine, each strength should be prescribed separately (i.e. separate dose, total quantity, etc);
- for liquids, the total volume in millilitres (in both words and figures) of the preparation to be supplied; for dosage units (tablets, capsules, ampoules), state the total number (in both words and figures) of dosage units to be supplied (e.g. 10 tablets [of 10 mg] rather than 100 mg total quantity);
- the dose, which must be clearly defined (i.e. the instruction ‘one as directed’ constitutes a dose but ‘as directed’ does not); it is not necessary that the dose is stated in both words and figures;
- the words ‘for dental treatment only’ if issued by a dentist.

A pharmacist is not allowed to dispense a Controlled Drug unless all the information required by law is given on the prescription. In the case of a prescription for a Controlled Drug in Schedule 2 or 3, a pharmacist can amend the prescription if it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist (e.g. name, date, signature and GPhC registration number). The prescription should be marked with the date of supply at the time the Controlled Drug supply is made.

The Department of Health and the Scottish Government have issued a strong recommendation that the maximum quantity of Schedule 2, 3 or 4 Controlled Drugs prescribed should not exceed 30 days; exceptionally, to cover a justifiable clinical need and after consideration of any risk, a prescription can be issued for a longer period, but the reasons for the decision should be recorded on the patient’s notes.

A prescription for a Controlled Drug in Schedules 2, 3, or 4 is valid for 28 days from the date stated thereon (the prescriber may forward-date the prescription; the start date may also be specified in the body of the prescription). Schedule 5 prescriptions are valid for 6 months from the appropriate date.

Medicines that are not Controlled Drugs should not be prescribed on the same form as a Schedule 2 or 3 Controlled Drug.

See sample prescription:

![Sample Prescription Image]

**Instalments and repeatable prescriptions** Prescriptions for Schedule 2 or 3 Controlled Drugs can be dispensed by instalments. An instalment prescription must have an instalment direction including both the dose and the instalment amount specified separately on the prescription, and it must also state the interval between each time the medicine can be supplied.

The first instalment must be dispensed within 28 days of the appropriate day (i.e. date of signing unless the prescriber indicates a date before which the Controlled Drug should not be dispensed) and the remainder should be dispensed in accordance with the instructions on the prescription. The prescription must be marked with the date of each supply. The instalment direction is a legal requirement and needs to be complied with, however, for certain situations (e.g. if a pharmacy is closed on the day an instalment is due) the Home Office has approved specific wording which provides pharmacists some flexibility for supply. For details, see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition) or see Home Office approved wording for instalment prescribing (Circular 027/2015), available at www.gov.uk/.

Repeatable prescriptions are prescriptions which contain a direction that they can be dispensed more than once (e.g. repeat × 3). Only Schedule 4 and 5 Controlled Drugs are permitted on repeatable prescriptions.

**Private prescriptions** Private prescriptions for Controlled Drugs in Schedules 2 and 3 must be written on specially designated forms which are provided by local NHS England area teams in England (form FP10PCD), local NHS Health Boards in Scotland (form PPCD) and Wales (form W10PCD); in addition, prescriptions must specify the prescriber’s identification number (or a NHS prescriber code in Scotland).
Prescriptions to be supplied by a pharmacist in hospital are exempt from the requirements for private prescriptions.

**Dependence and misuse**

The most common drugs of addiction are crack cocaine and opioids, particularly diamorphine hydrochloride p. 284 (heroin). For arrangements for prescribing of diamorphine hydrochloride, dipipanone, or cocaine for addicts, see Prescribing of diamorphine (heroin), dipipanone, and cocaine for addicts below.

Along with traditional stimulants, such as amphetamine and cocaine, there has been an emerging use of methamphetamine and a range of psychoactive substances with stimulant, depressant or hallucinogenic properties such as lysergide (lysergic acid diethylamide, LSD), ketamine or gamma-hydroxybutyrate (sodium oxybate, GHB).

**Benzodiazepines and z-drugs** (i.e. zopiclone, zolpidem tartrate) have their own potential for misuse and dependence and are often taken in combination with opiates or stimulants.

Cannabis-based products for medicinal use are Schedule 2 Controlled Drugs and can be prescribed only by clinicians listed on the Specialist Register of the General Medical Council. Cannabis with no approved medicinal use is a Schedule 1 Controlled Drug and cannot be prescribed. It remains the most frequently used illicit drug by young people and dependence can develop in around 10% of users. Cannabis use can exacerbate depression and it may cause an acute short-lived toxic psychosis which resolves with cessation, however paranoid symptoms may persist in chronic users; withdrawal symptoms can occur in some users and these can contribute to sleep problems, agitation and risk of self-harm.

**Supervised consumption**

Supervised consumption is not a legal requirement under the 2001 Regulations. Nevertheless, when supervised consumption is directed on the prescription, the Department of Health recommends that any deviation from the prescriber’s intended method of supply should be documented and the justification for this recorded. Individuals prescribed opioid substitution therapy can take their daily dose under the supervision of a doctor, nurse, or pharmacist during the dose stabilisation phase (usually the first 3 months of treatment), after a relapse or period of instability, or if there is a significant increase in the dose of methadone. Supervised consumption should continue (in accordance with local protocols) until the prescriber is confident that the patient is compliant with their treatment. It is good practice for pharmacists to alert the prescriber when a patient has missed consecutive daily doses.

**Prescribing drugs likely to cause dependence or misuse**

The prescriber has three main responsibilities:

- To avoid creating dependence by introducing drugs to patients without sufficient reason. In this context, the proper use of the morphine-like drugs is well understood. The dangers of other Controlled Drugs are less clear because recognition of dependence is not easy and its effects, and those of withdrawal, are less obvious.
- To see that the patient does not gradually increase the dose of a drug, given for good medical reasons, to the point where dependence becomes more likely. This tendency is seen especially with hypnotics and anxiolytics. The prescriber should keep a close eye on the amount prescribed to prevent patients from accumulating stocks. A minimal amount should be prescribed in the first instance, or when seeing a patient for the first time.
- To avoid being used as an unwitting source of supply for addicts and being vigilant to methods for obtaining medicines. Methods include visiting more than one doctor, fabricating stories, and forging prescriptions.

Patients under temporary care should be given only small supplies of drugs unless they present an unequivocal letter from their own doctor. Doctors should also remember that their own patients may be attempting to collect prescriptions from other prescribers, especially in hospitals. It is sensible to reduce dosages steadily or to issue weekly or even daily prescriptions for small amounts if it is apparent that dependence is occurring.

Prescribers are responsible for the security of prescription forms once issued to them. The stealing and misuse of prescription forms could be minimised by the following precautions:

- records of serial numbers received and issued should be retained for at least three years;
- blank prescriptions should never be pre-signed;
- prescription forms should not be left unattended and should be locked in a secure drawer, cupboard, or carrying case when not in use;
- doctors’, dentists’ and surgery stamps should be kept in a secure location separate from the prescription forms;
- alterations are best avoided but if any are made and the prescription is to be used, best practice is for the prescriber to cross out the error, initial and date the error, then write the correct information;
- if an error made in a prescription cannot be corrected, best practice for the prescriber is to put a line through the script and write ‘spoiled’ on the form, or destroy the form and start writing a new prescription;
- prescribers and pharmacists dispensing drugs prone to abuse should ensure compliance with all relevant legal requirements specially when dealing with prescriptions for Controlled Drugs (see Prescription requirements and Instalments above);
- at the time of dispensing, prescriptions should be stamped with the pharmacy stamp and endorsed by the pharmacist or pharmacy technician with what has been supplied; where loss or theft is suspected, the police should be informed immediately.

**Travelling abroad**

Prescribed drugs listed in Schedule 4 Part II (CD Anab) for self-administration and Schedule 5 of the Misuse of Drugs Regulations 2001 (and subsequent amendments) are not subject to export or import licensing. A personal import/export licence is required for patients travelling abroad with Schedules 2, 3, or 4 Part I (CD Benz) and Part II (CD Anab) Controlled Drugs if, they are carrying more than 3 months’ supply or are travelling for 3 calendar months or more. A Home Office licence is required for any amount of a Schedule 1 Controlled Drug imported into the UK for personal use regardless of the duration of travel. Further details can be obtained at www.gov.uk/guidance/controlled-drugs-licences-fees-and-returns or from the Home Office by contacting DFLU.ie@homeoffice.gsi.gov.uk. In cases of emergency, telephone (020) 7035 6230.

Applications for obtaining a licence must be supported by a cover letter signed by the prescribing doctor or drug worker, which must confirm:

- the patient’s name and address;
- the travel itinerary;
- the names of the prescribed Controlled Drug(s), doses and total amounts to be carried.

Applications for licences should be sent to the Home Office, Drugs & Firearms Licensing Unit, Fry Building, 2 Marsham Street, London, SW1P 4DF. Alternatively, completed application forms can be emailed to DFLU.ie@homeoffice.gsi.gov.uk. A minimum of 10 days should be allowed for processing the application. Patients travelling for less than 3 months or carrying less than 3 months supply of Controlled Drugs do not require a
personal export/import licence, but are advised to carry a
cover letter signed by the prescribing doctor or drug worker.
Those travelling for more than 3 months are advised to make
arrangements to have their medication prescribed by a
practitioner in the country they are visiting.
Doctors who want to take Controlled Drugs abroad while
accompanying patients may similarly be issued with
licences. Licences are not normally issued to doctors who
want to take Controlled Drugs abroad solely in case a family
emergency should arise.
Personal export/import licences do not have any legal status
outside the UK and are issued only to comply with the
Misuse of Drugs Act 2001 and to facilitate passage through
UK Customs and Excise control. For clearance in the country
to be visited it is necessary to approach that country’s
consulate in the UK.

Notification of patients receiving structured
drug treatment for substance dependence
In England, doctors should report cases where they are
providing structured drug treatment for substance
dependence to their local National Drug Treatment
Monitoring System (NDTMS) Team. General information
about NDTMS can be found at www.gov.uk/government/
collections/alcohol-and-drug-misuse-prevention-and-treatment-
guidance.
Enquiries about NDTMS, and how to submit data, should
initially be directed to:
EvidenceApplicationteam@phe.gov.uk
In Scotland, doctors should report cases to the Substance
Drug Misuse Database. General information about the
Scottish Drug Misuse Database can be found in
www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/
Drugs-Misuse/Scottish-Drug-Misuse-Database/. Enquiries about
reporting can be directed to:
nss.isdsubstancemisuse@nhs.net
In Northern Ireland, the Misuse of Drugs (Notification of
and Supply to Addicts) (Northern Ireland) Regulations 1973
require doctors to send particulars of persons whom they
consider to be addicted to certain Controlled Drugs to the
Chief Medical Officer of the Ministry of Health and Social
Services. The Northern Ireland contact is:
Public Health Information & Research Branch
Department of Health
Annexe 2, Castle Buildings, Stormont, Belfast BT4 3SQ
028 9052 2340
phirb@health-ni.gov.uk
Public Health Information & Research Branch also
maintains the Northern Ireland Drug Misuse Database
(NIDMD) which collects detailed information on those
presenting for treatment, on drugs misused and injecting
behaviour; participation is not a statutory requirement.
In Wales, doctors should report cases where they are
providing structured drug treatment for substance
dependence on the Welsh National Database for Substance
Misuse; enquiries should be directed to: substancemisuse-
queries@wales.nhs.uk.

Prescribing of diamorphine (heroin),
dipipanone, and cocaine for addicts
The Misuse of Drugs (Supply to Addicts) Regulations 1997
require that only medical practitioners who hold a special
licence issued by the Home Secretary (or Scottish
Government’s Chief Medical Officer) may prescribe,
administer, or supply diamorphine hydrochloride p. 284,
dipipanone, or cocaine for the treatment of drug addiction.
Medical prescribers, pharmacists independent prescribers,
nurses independent prescribers and supplementary
prescribers do not require a special licence for prescribing
diamorphine hydrochloride p. 284, dipipanone, or cocaine
for patients (including addicts) for relieving pain from
organic disease or injury.
Adverse reactions to drugs

Yellow card scheme
Any drug may produce unwanted or unexpected adverse reactions. Rapid detection and recording of adverse drug reactions is of vital importance so that unrecognised hazards are identified promptly and appropriate regulatory action is taken to ensure that medicines are used safely. Healthcare professionals and coroners are urged to report suspected adverse drug reactions directly to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme using the electronic form at www.mhra.gov.uk/yellowcard. Alternatively, prepaid Yellow Cards for reporting are available from the address below and are also bound in the inside back cover of BNF for Children.

Send Yellow Cards to:
FREEPOST YELLOW CARD
(No other address details required).
Tel: 0800 731 6789

Suspected adverse drug reactions to any therapeutic agent should be reported, including drugs (self-medication as well as those prescribed), blood products, vaccines, radiographic contrast media, complementary and herbal products. For biosimilar medicines and vaccines, adverse reaction reports should clearly state the brand name and the batch number of the suspected medicine or vaccine.

Suspected adverse drug reactions should be reported through the Yellow Card Scheme at www.mhra.gov.uk/yellowcard. Yellow Cards can be used for reporting suspected adverse drug reactions to medicines, vaccines, herbal or complementary products, whether self-medicated or prescribed. This includes suspected adverse drug reactions associated with misuse, overdose, medication errors or from use of unlicensed and off-label medicines. Yellow Cards can also be used to report medical device incidents, defective medicines, and suspected fake medicines.

Report all suspected adverse drug reactions that are:
- serious, medically significant or result in harm.
- serious events are fatal, life-threatening, a congenital abnormality, disabling or incapacitating, or resulting in hospitalisation;
- associated with newer drugs and vaccines; the most up to date list of black triangle medicines is available at: www.mhra.gov.uk/blacktriangle

If in doubt whether to report a suspected adverse drug reaction, please complete a Yellow Card.

The identification and reporting of adverse reactions to drugs in children and neonates is particularly important because:
- the action of the drug and its pharmacokinetics in children (especially in the very young) may be different from that in adults;
- drugs may not have been extensively tested in children;
- many drugs are not specifically licensed for use in children and are used either ‘off-label’ or as unlicensed products;
- drugs may affect the way a child grows and develops or may cause delayed adverse reactions which do not occur in adults;
- suitable formulations may not be available to allow precise dosing in children or they may contain excipients that should be used with caution in children;
- the nature and course of illnesses and adverse drug reactions may differ between adults and children.

Even if reported through the British Paediatric Surveillance Unit’s Orange Card Scheme, any identified suspected adverse drug reactions should also be submitted to the Yellow Card Scheme.

Spontaneous reporting is particularly valuable for recognising possible new hazards rapidly. An adverse reaction should be reported even if it is not certain that the drug has caused it, or if the reaction is well recognised, or if other drugs have been given at the same time. Reports of overdoses (deliberate or accidental) can complicate the assessment of adverse drug reactions, but provide important information on the potential toxicity of drugs. A freephone service is available to all parts of the UK for advice and information on suspected adverse drug reactions; contact the National Yellow Card Information Service at the MHRA on 0800 731 6789. Outside office hours a telephone-answering machine will take messages.

The following Yellow Card Centres can be contacted for further information:

**Yellow Card Centre Northwest**
2nd Floor, 70 Pembroke Place, Liverpool, L69 3GF
Tel: (0151) 794 8122

**Yellow Card Centre Wales**
All Wales Therapeutics and Toxicology Centre, Academic Building, University Hospital Llandough, Penlan Road, Penarth, Vale of Glamorgan, CF64 2XX
Tel: (029) 2074 5831

**Yellow Card Centre Northern & Yorkshire**
Regional Drug and Therapeutics Centre, 16/17 Framlington Place, Newcastle upon Tyne, NE2 4AB
Tel: (0191) 213 7855

**Yellow Card Centre West Midlands**
City Hospital, Dudley Road, Birmingham, B18 7QH
Tel: (0121) 507 5672

**Yellow Card Centre Scotland**
CARDS, Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA
Tel: (0131) 242 2919

**YCCScotland@luht.scot.nhs.uk**

The MHRA’s database facilitates the monitoring of adverse drug reactions. More detailed information on reporting and a list of products currently under additional monitoring can be found on the MHRA website: www.mhra.gov.uk.

**MHRA Drug Safety Update** Drug Safety Update is a monthly newsletter from the MHRA and the Commission on Human Medicines (CHM); it is available at www.gov.uk/drug-safety-update.

**Self-reporting**
Patients and their carers can also report suspected adverse drug reactions to the MHRA. Reports can be submitted directly to the MHRA through the Yellow Card Scheme using the electronic form at www.mhra.gov.uk/yellowcard, by telephone on 0808 100 3352, or by downloading the Yellow Card form from www.mhra.gov.uk. Alternatively, patients can contact the National Yellow Card Information Service at the MHRA on 0800 731 6789. Outside office hours a telephone-answering machine will take messages.

**Prescription-event monitoring**
In addition to the MHRA’s Yellow Card Scheme, an independent scheme monitors the safety of new medicines using a different approach. The Drug Safety Research Unit identifies patients who have been prescribed selected new medicines and collects data on clinical events in these patients. The data are submitted on a voluntary basis by general practitioners on green forms. More information about the scheme and the Unit’s educational material is available from www.dsu.org.

**Newer drugs and vaccines**
Only limited information is available from clinical trials on the safety of new medicines. Further understanding about
the safety of medicines depends on the availability of information from routine clinical practice. The black triangle symbol identifies newly licensed medicines that require additional monitoring by the European Medicines Agency. Such medicines include new active substances, biosimilar medicines, and medicines that the European Medicines Agency consider require additional monitoring. The black triangle symbol also appears in the Patient Information Leaﬂets for relevant medicines, with a brief explanation of what it means. Products usually retain a black triangle for 5 years, but this can be extended if required.

Medication errors
Adverse drug reactions where harm occurs as a result of a medication error are reportable as a Yellow Card or through the local risk management systems into the National Reporting and Learning System (NRLS). If reported to the NRLS, these will be shared with the MHRA. If the NRLS is not available and harm occurs, report using a Yellow Card.

Adverse reactions to medical devices
Suspected adverse reactions to medical devices including dental or surgical materials, intra-uterine devices, and contact lens ﬂuids should be reported. Information on reporting these can be found at: www.mhra.gov.uk.

Side-effects in the BNF for Children
The BNF for Children includes clinically relevant side-effects for most drugs; an exhaustive list is not included for drugs that are used by specialists (e.g. cytotoxic drugs and drugs used in anaesthesia). Where causality has not been established, side-effects in the manufacturers’ literature may be omitted from the BNF for Children. Recognising that hypersensitivity reactions (including anaphylactic and anaphylactoid reactions) can occur with virtually all drugs, this effect is not generally listed, unless the drug carries an increased risk of such reactions or speciﬁc management advice is provided by the manufacturer. Administration site reactions have been omitted from the BNF for Children (e.g. pain at injection site). The BNF for Children also omits effects that are likely to have little clinical consequence (e.g. transient increase in liver enzymes). Drugs that are applied locally or topically carry a theoretical or low risk of systemic absorption and therefore systemic side-effects for these drugs are not listed in the BNF for Children unless they are associated with a high risk to patient safety. Infections are a known complication of treatment with drugs that affect the immune system (e.g. corticosteroids or immunosuppressants); this side-effect is listed in the BNF for Children as ‘increased risk of infection’. Symptoms of drug withdrawal reactions are not individually listed, but are collectively termed ‘withdrawal syndrome’.

### Description of the frequency of side-effects

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very common</td>
<td>greater than 1 in 10</td>
</tr>
<tr>
<td>Common</td>
<td>1 in 100 to 1 in 10</td>
</tr>
<tr>
<td>Uncommon [formerly ‘less commonly’ in BNF publications]</td>
<td>1 in 1000 to 1 in 100</td>
</tr>
<tr>
<td>Rare</td>
<td>1 in 10 000 to 1 in 100</td>
</tr>
<tr>
<td>Very rare</td>
<td>less than 1 in 10 000</td>
</tr>
<tr>
<td>Frequency not known</td>
<td>frequency is not defined by product literature or the side-effect has been reported from post-marketing surveillance data</td>
</tr>
</tbody>
</table>

For consistency, the terms used to describe side-effects are standardised using a deﬁned vocabulary across all of the drug monographs in the BNF for Children (e.g. postural hypotension is used for the term orthostatic hypotension).

### Special problems

**Symptoms** Children may be poor at expressing the symptoms of an adverse drug reaction and parental opinion may be required.

**Delayed drug effects** Some reactions (e.g. cancers and effects on development) may become manifest months or years after exposure. Any suspicion of such an association should be reported directly to the MHRA through the Yellow Card Scheme.

**Congenital abnormalities** When an infant is born with a congenital abnormality or there is a malformed aborted fetus doctors are asked to consider whether this might be an adverse reaction to a drug and to report all drugs (including self-medication) taken during pregnancy.

### Prevention of adverse reactions

Adverse reactions may be prevented as follows:

- never use any drug unless there is a good indication. If the patient is pregnant do not use a drug unless the need for it is imperative;
- allergy and idiosyncrasy are important causes of adverse drug reactions. Ask if the child has had previous reactions to the drug or formulation;
- prescribe as few drugs as possible and give very clear instructions to the child, parent, or carer;
- whenever possible use a familiar drug; with a new drug be particularly alert for adverse reactions or unexpected events;
- consider if excipients (e.g. colouring agents) may be contributing to the adverse reaction. If the reaction is minor, a trial of an alternative formulation of the same drug may be considered before abandoning the drug;
- obtain a full drug history including asking if the child is already taking other drugs including over-the-counter medicines; interactions may occur;
- age and hepatic or renal disease may alter the metabolism or excretion of drugs, particularly in neonates, which can affect the potential for adverse effects. Genetic factors may also be responsible for variations in metabolism, and therefore for the adverse effects of the drug;
- warn the child, parent, or carer if serious adverse reactions are liable to occur.

### Drug allergy (suspected or conﬁrmed)

Suspected drug allergy is any reaction caused by a drug with clinical features compatible with an immunological mechanism. All drugs have the potential to cause adverse drug reactions, but not all of these are allergic in nature. A reaction is more likely to be caused by drug allergy if:

- The reaction occurred while the child was being treated with the drug, or
- The drug is known to cause this pattern of reaction, or
- The child has had a similar reaction to the same drug or drug-class previously.

A suspected reaction is less likely to be caused by a drug allergy if there is a possible non-drug cause or if there are only gastro-intestinal symptoms present. The following signs, allergic patterns and timing of onset can be used to help decide whether to suspect drug allergy:

- **Immediate, rapidly-evolving reactions** (onset usually less than 1 hour after drug exposure)
  - Anaphylaxis, with erythema, urticaria or angioedema, and hypotension and/or bronchospasm. See also Antihistamines, allergen immunotherapy and allergic emergencies p. 174
  - Urticaria or angioedema without systemic features
Exacerbation of asthma e.g. with non-steroidal anti-inflammatory drugs (NSAIDs)

**Non-immediate reactions, without systemic involvement** (onset usually 6–10 days after first drug exposure or 3 days after second exposure)

- Cutaneous reactions, e.g. widespread red macules and/or papules, or, fixed drug eruption (localised inflamed skin)

**Non-immediate reactions, with systemic involvement** (onset may be variable, usually 3 days to 6 weeks after first drug exposure, depending on features, or 3 days after second exposure)

- Cutaneous reactions with systemic features, e.g. drug reaction with eosinophilia and systemic signs (DRESS) or drug hypersensitivity syndrome (DHS), characterised by widespread red macules, papules or erythroderma, fever, lymphadenopathy, liver dysfunction or eosinophilia
- Toxic epidermal necrolysis or Stevens–Johnson syndrome
- Acute generalised exanthematous pustulosis (AGEP)

**Suspected drug allergy information** should be clearly and accurately documented in clinical notes and prescriptions, and shared among all healthcare professionals. Children and parents or carers should be given information about which drugs and drug-classes to avoid and encouraged to share the drug allergy status.

If a drug allergy is suspected, consider stopping the suspected drug and advising the child and parent or carer to avoid this drug in future. Symptoms of the acute reaction should be treated, in hospital if severe. Children presenting with a suspected anaphylactic reaction, or a severe or non-immediate cutaneous reaction, should be referred to a specialist drug allergy service. Children presenting with a suspected drug allergic reaction or anaphylaxis to NSAIDs, and local and general anaesthetics may also need to be referred to a specialist drug allergy service, e.g. in cases of anaphylactoid reactions or to determine future treatment options. Children presenting with a suspected drug allergic reaction or anaphylaxis associated with beta-lactam antibiotics should be referred to a specialist drug allergy service if their disease or condition can only be treated by a beta-lactam antibiotic or they are likely to need beta-lactam antibiotics frequently in the future (e.g. immunodeficient children). For further information see Drug allergy: diagnosis and management. NICE Clinical Guideline 183 (September 2014) www.nice.org.uk/guidance/cg183.

**Defective medicines**

During the manufacture or distribution of a medicine an error or accident may occur whereby the finished product does not conform to its specification. While such a defect may impair the therapeutic effect of the product and could adversely affect the health of a patient, it should not be confused with an Adverse Drug Reaction where the product conforms to its specification.

The Defective Medicines Report Centre assists with the investigation of problems arising from licensed medicinal products thought to be defective and co-ordinates any necessary protective action. Reports on suspect defective medicinal products should include the brand or the non-proprietary name, the name of the manufacturer or supplier, the strength and dosage form of the product, the product licence number, the batch number or numbers of the product, the nature of the defect, and an account of any action already taken in consequence. The Centre can be contacted at:

The Defective Medicines Report Centre
Medicines and Healthcare products Regulatory Agency,
151 Buckingham Palace Road, London, SW1W 9SZ
Tel: (020) 3080 6574
dmrc@mhra.gsi.gov.uk
Guidance on intravenous infusions

Intravenous infusions for neonatal intensive care

Intravenous policy  A local policy on the dilution of drugs with intravenous fluids should be drawn up by a multi-disciplinary team and issued as a document to the members of staff concerned. Centralised additive services are provided in a number of hospital pharmacy departments and should be used in preference to making additions on wards. The information that follows should be read in conjunction with local policy documents.

Guidelines

- Drugs should only be diluted with infusion fluid when constant plasma concentrations are needed or when the administration of a more concentrated solution would be harmful.
- In general, only one drug should be mixed with an infusion fluid in a syringe and the components should be compatible. Ready-prepared solutions should be used whenever possible. Drugs should not normally be added to blood products, mannitol, or sodium bicarbonate. Only specially formulated additives should be used with fat emulsions or amino-acid solutions.
- Solutions should be thoroughly mixed by shaking and checked for absence of particulate matter before use.
- Strict asepsis should be maintained throughout and in general the giving set should not be used for more than 24 hours (for drug admixtures).
- The infusion syringe should be labelled with the neonate’s name and hospital number, the name and quantity of drug, the infusion fluid, and the expiry date and time. If a problem occurs during administration, containers should be retained for a period after use in case they are needed for investigation.
- Administration using a suitable motorised syringe driver is advocated for preparations where strict control over administration is required.
- It is good practice to examine intravenous infusions from time to time while they are running. If cloudiness, crystallisation, change of colour, or any other sign of interaction or contamination is observed the infusion should be discontinued.

Problems

Microbial contamination  The accidental entry and subsequent growth of micro-organisms converts the infusion fluid pathway into a potential vehicle for infection with micro-organisms, particularly species of Candida, Enterobacter, and Klebsiella. Ready-prepared infusions containing the additional drugs, or infusions prepared by an additive service (when available) should therefore be used in preference to making extemporaneous additions to infusion containers on wards etc. However, when this is necessary strict aseptic procedure should be followed.

Incompatibility  Physical and chemical incompatibilities may occur with loss of potency, increase in toxicity, or other adverse effect. The solutions may become opalescent or precipitation may occur, but in many instances there is no visual indication of incompatibility. Interaction may take place at any point in the infusion fluid pathway, and the potential for incompatibility is increased when more than one substance is added to the infusion fluid.

Common incompatibilities  Precipitation reactions are numerous and varied and may occur as a result of pH, concentration changes, ‘salting-out’ effects, complexation or other chemical changes. Precipitation or other particle formation must be avoided since, apart from lack of control of dosage on administration, it may initiate or exacerbate adverse effects. This is particularly important in the case of drugs which have been implicated in either thrombophlebitis (e.g. diazepam) or in skin sloughing or necrosis caused by extravasation (e.g. sodium bicarbonate and parenteral nutrition). It is also especially important to effect solution of colloidal drugs and to prevent their subsequent precipitation in order to avoid a pyrogenic reaction (e.g. amphotericin). It is considered undesirable to mix beta-lactam antibiotics, such as semi-synthetic penicillins and cephalosporins, with proteinaceous materials on the grounds that immunogenic and allergenic conjugates could be formed. A number of preparations undergo significant loss of potency when added singly or in combination to large volume infusions. Examples include ampicillin in infusions that contain glucose or lactates.

Blood  Because of the large number of incompatibilities, drugs should not be added to blood and blood products for infusion purposes. Examples of incompatibility with blood include hypertonic mannitol solutions (irreversible crenation of red cells), dextans (rouleaux formation and interference with cross-matching), glucose (clumping of red cells), and oxytocin (inactivated). If the giving set is not changed after the administration of blood, but used for other infusion fluids, a fibrin clot may form which, apart from blocking the set, increases the likelihood of microbial growth.

Intravenous fat emulsion  These may break down with coalescence of fat globules and separation of phases when additions such as antibacterials or electrolytes are made, thus increasing the possibility of embolism. Only specially formulated products such as Vitlipid N® may be added to appropriate intravenous fat emulsions.

Other infusions  Infusions that frequently give rise to incompatibility include amino acids, mannitol, and sodium bicarbonate.

Method

Ready-prepared infusions should be used whenever available. When dilution of drugs is required to be made extemporaneously, any product reconstitution instructions such as those relating to concentration, vehicle, mixing, and handling precautions should be strictly followed using an aseptic technique throughout. Once the product has been reconstituted, further dilution with the infusion fluid should be made immediately in order to minimise microbial contamination and, with certain products, to prevent degradation or other formulation change which may occur; e.g. reconstituted ampicillin injection degrades rapidly on standing, and also may form polymers which could cause sensitivity reactions. It is also important in certain instances that an infusion fluid of specific pH be used (e.g. furosemide injection requires dilution in infusions of pH greater than 5.5).

When drug dilutions are made it is important to mix thoroughly; additions should not be made to an infusion container that has been connected to a giving set, as mixing is hampered. If the solutions are not thoroughly mixed, a concentrated layer of the drug may form owing to differences in density. Potassium chloride is particularly prone to this ‘layering’ effect when added without adequate mixing to infusions; if such a mixture is administered it may have a serious effect on the heart.

A time limit between dilution and completion of administration must be imposed for certain admixtures to guarantee satisfactory drug potency and compatibility. For admixtures in which degradation occurs without the
formation of toxic substances, an acceptable limit is the time taken for 10% decomposition of the drug. When toxic substances are produced stricter limits may be imposed. Because of the risk of microbial contamination a maximum time limit of 24 hours may be appropriate for additions made elsewhere than in hospital pharmacies offering central additive service. Certain injections must be protected from light during continuous infusion to minimise oxidation, e.g. sodium nitroprusside.

**Drugs given by continuous intravenous infusion to neonates**
The information provided in *BNF for Children* covers dilution with *Glucose intravenous infusion 5%* and *10% Sodium chloride intravenous infusion 0.9%*. Compatibility with glucose 5% and with sodium chloride 0.9% indicates compatibility with *Sodium chloride and glucose intravenous infusion*. Infusion of a large volume of hypotonic solution should be avoided, therefore care should be taken if water for injections is used.

### Prescribing in hepatic impairment

**Overview**
Children have a large reserve of hepatic metabolic capacity and modification of the choice and dosage of drugs is usually unnecessary even in apparently severe liver disease. However, special consideration is required in the following situations:

- liver failure characterised by severe derangement of liver enzymes and profound jaundice; the use of sedative drugs, opioids, and drugs such as diuretics and amphotericin p. 387 which produce hypokalaemia may precipitate hepatic encephalopathy;
- impaired coagulation, which can affect response to oral anticoagulants;
- in cholestatic jaundice elimination may be impaired of drugs such as fusidic acid p. 371 and rifampicin p. 379 which are excreted in the bile;
- in hypoproteinaemia, the effect of highly protein-bound drugs such as phenytoin p. 211, prednisolone p. 458, warfarin sodium p. 99, and benzodiazepines may be increased;
- use of hepatotoxic drugs is more likely to cause toxicity in children with liver disease; such drugs should be avoided if possible;
- in neonates, particularly preterm neonates, and also in infants metabolic pathways may differ from older children and adults because liver enzyme pathways may be immature.

Where care is needed when prescribing in hepatic impairment, this is indicated under the relevant drug in *BNF for Children*.

### Prescribing in renal impairment

**Issues encountered in renal impairment**
The use of drugs in children with reduced renal function can give rise to problems for several reasons:

- reduced renal excretion of a drug or its metabolites may produce toxicity;
- sensitivity to some drugs is increased even if elimination is unimpaired;
- many side-effects are tolerated poorly by children with renal impairment;
- some drugs are not effective when renal function is reduced;
- neonates, particularly preterm, may have immature renal function.

Many of these problems can be avoided by reducing the dose or by using alternative drugs.

**Principles of dose adjustment in renal impairment**
The level of renal function below which the dose of a drug must be reduced depends on the proportion of the drug eliminated by renal excretion and its toxicity. For many drugs with only minor or no dose-related side-effects, very precise modification of the dose regimen is unnecessary and a simple scheme for dose reduction is sufficient. For more toxic drugs with a small safety margin dose regimens based on glomerular filtration rate should be used. When both efficacy and toxicity are closely related to
plasma–drug concentration, recommended regimens should be regarded only as a guide to initial treatment; subsequent doses must be adjusted according to clinical response and plasma–drug concentration. The total daily maintenance dose of a drug can be reduced either by reducing the size of the individual doses or by increasing the interval between doses. For some drugs, although the size of the maintenance dose is reduced it is important to give a loading dose if an immediate effect is required. This is because it takes about five times the half-life of the drug to achieve steady-state plasma concentration. Because the plasma half-life of drugs excreted by the kidney is prolonged in renal impairment, it can take many doses at the reduced dosage to achieve a therapeutic plasma concentration. The loading dose should usually be the same as the initial dose for a child with normal renal function.

Nephrotoxic drugs should, if possible, be avoided in children with renal disease because the consequences of nephrotoxicity are likely to be more serious when the renal reserve is already reduced. Glomerular filtration rate is low at birth and increases rapidly during the first 6 months. Thereafter, glomerular filtration rate increases gradually to reach adult levels by 1–2 years of age, when standardised to a typical adult body surface area (1.73 m²). In the first weeks after birth, serum creatinine falls; a single measure of serum creatinine provides only a crude estimate of renal function and observing the change over days is of more use. In the neonate, a sustained rise in serum creatinine or a lack of the expected postnatal decline, is indicative of a reduced glomerular filtration rate.

Dose recommendations are based on the severity of renal impairment. This is expressed in terms of glomerular filtration rate (mL/minute/1.73 m²).

The following equations provide a guide to glomerular filtration rate.

Child over 1 year:
Estimated glomerular filtration rate (mL/minute/1.73 m²) = 40 × height (cm)/serum creatinine (micromol/litre)

Neonate:
Estimated glomerular filtration rate (mL/minute/1.73 m²) = 30 × height (cm)/serum creatinine (micromol/litre)

The values used in these formulas may differ according to locality or laboratory.

The serum-creatinine concentration is sometimes used as a measure of renal function but is only a rough guide even when corrected for age, weight, and sex.

Important The information on dose adjustment in *BNF for Children* is expressed in terms of estimated glomerular filtration rate. Renal function in adults is increasingly being reported as estimated glomerular filtration rate (eGFR) normalised to a body surface area of 1.73 m²; however, eGFR is derived from the MDRD (Modification of Diet in Renal Disease) formula which is not validated for use in children. eGFR derived from the MDRD formula should not be used to adjust drug doses in children with renal impairment. In *BNF for Children*, values for measures of renal function are included where possible. However, where such values are not available, the *BNF for Children* reflects the terms used in the published information.

### Degrees of renal impairment defined using estimated glomerular filtration rate (eGFR)

<table>
<thead>
<tr>
<th>Degree of impairment</th>
<th>eGFR¹ mL/minute/1.73 m²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal: Stage 1</td>
<td>More than 90 (with other evidence of kidney damage)</td>
</tr>
<tr>
<td>Mild: Stage 2</td>
<td>60–89 (with other evidence of kidney damage)</td>
</tr>
<tr>
<td>Moderate¹: Stage 3</td>
<td>30–59</td>
</tr>
<tr>
<td>Severe: Stage 4</td>
<td>15–29</td>
</tr>
<tr>
<td>Established renal failure: Stage 5</td>
<td>Less than 15</td>
</tr>
</tbody>
</table>

¹. Estimated glomerular filtration rate (eGFR) derived from the Modification of Diet in Renal Disease (MDRD) formula for use in patients over 18 years

Drug prescribing should be kept to the minimum in all children with severe renal disease.
If even mild renal impairment is considered likely on clinical grounds, renal function should be checked before prescribing any drug which requires dose modification.
Where care is needed when prescribing in renal impairment, this is indicated under the relevant drug in *BNF for Children*.

### Dialysis
For prescribing in children on renal replacement therapy consult specialist literature.

### Advanced Pharmacy Services
Children with renal impairment may be eligible for the Medicines Use Review service provided by a community pharmacist. For further information, see *Advanced Pharmacy Services* in Guidance on prescribing p. 1.
Prescribing in pregnancy

Overview
Drugs can have harmful effects on the embryo or fetus at any time during pregnancy. It is important to bear this in mind when prescribing for a woman of childbearing age or for men trying to father a child.

During the first trimester drugs can produce congenital malformations (teratogenesis), and the period of greatest risk is from the third to the eleventh week of pregnancy. During the second and third trimesters drugs can affect the growth or functional development of the fetus, or they can have toxic effects on fetal tissues.

Drugs given shortly before term or during labour can have adverse effects on labour or on the neonate after delivery.

Not all the damaging effects of intra-uterine exposure to drugs are obvious at birth, some may only manifest later in life. Such late-onset effects include malignancy, e.g. adenocarcinoma of the vagina after puberty in females exposed to diethylstilbestrol in the womb, and adverse effects on intellectual, social, and functional development.

The information is based on human data, but information from animal studies has been included for some drugs when its omission might be misleading. Maternal drug doses may from animal

BNF for Children require adjustment during pregnancy due to changes in the nature of the effect of the drug on the infant (pharmacodynamic properties of the drug in the infant).

Important
Drugs should be prescribed in pregnancy only if the expected benefit to the mother is thought to be greater than the risk to the fetus, and all drugs should be avoided if possible during the first trimester. Drugs which have been extensively used in pregnancy and appear to be usually safe should be prescribed in preference to new or untried drugs; and the smallest effective dose should be used. Few drugs have been shown conclusively to be teratogenic in humans, but no drug is safe beyond all doubt in early pregnancy. Screening procedures are available when there is a known risk of certain defects.

Absence of information does not imply safety. It should be noted that the BNF and BNF for Children provide independent advice and may not always agree with the product literature.

Information on drugs and pregnancy is also available from the UK Teratology Information Service. www.uktis.org.

Tel: 0344 892 0909 (09.00–17:00 Monday to Friday; urgent enquiries only outside these hours).

MHRA/CHM advice: Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed? (March 2019)
Guidance is available on contraceptive methods and frequency of pregnancy testing to reduce inadvertent exposures during pregnancy in a woman taking a medicine of teratogenic potential. When using these medicines, a woman should be advised of the risks and encouraged to use the most effective contraceptive method taking into account her personal circumstances. The likelihood of pregnancy should be assessed before each prescription of a medicine with known teratogenic potential, by performing a pregnancy test. If pregnancy cannot be excluded, the decision to start or continue treatment will depend on individual circumstances, such as the urgency for treatment and alternative treatment options. If feasible, treatment with a medicine with teratogenic potential should be delayed until pregnancy has been excluded by a repeat test.


Prescribing in breast-feeding

Overview
Breast-feeding is beneficial; the immunological and nutritional value of breast milk to the infant is greater than that of formula feeds. Although there is concern that drugs taken by the mother might affect the infant, there is very little information on this. In the absence of evidence of an effect, the potential for harm to the infant can be inferred from:

- the amount of drug or active metabolite of the drug delivered to the infant (dependent on the pharmacokinetic characteristics of the drug in the mother);
- the efficiency of absorption, distribution, and elimination of the drug by the infant (infant pharmacokinetics);
- the nature of the effect of the drug on the infant (pharmacodynamic properties of the drug in the infant).

Most medicines given to a mother cause no harm to breast-fed infants and there are few contra-indications to breast-feeding when maternal medicines are necessary. However, administration of some drugs to nursing mothers can harm the infant. In the first week of life, some such as preterm or jaundiced infants are at a slightly higher risk of toxicity. Toxicity to the infant can occur if the drug enters the milk in pharmacologically significant quantities. The concentration in milk of some drugs (e.g. fluvastatin p. 134) may exceed the concentration in maternal plasma so that therapeutic doses in the mother can cause toxicity to the infant. Some drugs inhibit the infant’s sucking reflex (e.g. phenobarbital p. 223) while others can affect lactation (e.g. bromocriptine). Drugs in breast milk may, at least theoretically, cause hypersensitivity in the infant even when concentration is too low for a pharmacological effect. BNF for Children identifies drugs:

- which should be used with caution or which are contra-indicated in breast-feeding for the reasons given above;
- which, on present evidence, may be given to the mother during breast-feeding, because they may appear in milk in amounts which are too small to be harmful to the infant;
- which are not known to be harmful to the infant although they are present in milk in significant amounts.

Where care is needed when prescribing in breast-feeding, this is indicated under the relevant drug in the BNF for Children.

Important
For many drugs insufficient evidence is available to provide guidance and it is advisable to administer only essential drugs to a mother during breast-feeding. Because of the inadequacy of information on drugs in breast-feeding, absence of information does not imply safety.
Prescribing in palliative care

Overview
Palliative care is the active and total approach to the care of children and young adults with life-limiting and life-threatening conditions, embracing physical, emotional, social, and spiritual elements of their care. It focuses on enhancing the quality of life for the child and support for their family, and includes the management of distressing symptoms, provision of respite, and care following death and bereavement.

Effective palliative care requires a broad multidisciplinary approach that includes the whole family, and ideally should start as soon as possible after diagnosis or recognition of a life-threatening condition.

Drug treatment
The number of drugs should be as few as possible. Oral medication is usually appropriate unless there is severe nausea and vomiting, dysphagia, weakness, or coma, when parenteral medication may be necessary. For further information on the use of medicines in paediatric palliative care, see the Association for Paediatric Palliative Medicine (APPM) Master Formulary available at www.appm.org.uk/10.html.

Pain
Pain management in palliative care is focused on achieving control of pain by administering the right drug in the right dose at the right time. Analgesics can be divided into three broad classes: non-opioid (paracetamol p. 278, NSAID), opioid (e.g. codeine phosphate p. 283 ‘weak’, morphine p. 290 ‘strong’) and adjuvant (e.g. antidepressants, antiepileptics). Drugs from the different classes are used alone or in combination according to the type of pain and response to treatment. Analgesics are more effective in preventing pain than in the relief of established pain; it is important that they are given regularly. Paracetamol p. 278 or a NSAID given regularly will often be sufficient to manage mild pain. If non-opioid analgesics alone are not sufficient, then an opioid analgesic alone or in combination with a non-opioid analgesic at an adequate dosage, may be helpful in the control of moderate pain. Codeine phosphate p. 283 or tramadol hydrochloride p. 296 can be considered for moderate pain. If these preparations do not control the pain then morphine p. 290 is the most useful opioid analgesic. Alternatives to morphine p. 290, including transdermal buprenorphine p. 281, transdermal fentanyl p. 286, hydromorphone hydrochloride p. 289, methadone hydrochloride p. 307, or oxycodone hydrochloride p. 292, should be initiated by those with experience in palliative care. Initiation of an opioid analgesic should not be delayed by concern over a theoretical likelihood of psychological dependence (addiction).

Bone metastases
In addition to the above approach, radiotherapy and bisphosphonates may be useful for pain due to bone metastases.

Neuropathic pain
Patients with neuropathic pain may benefit from a trial of a tricyclic antidepressant, most commonly amitriptyline hydrochloride p. 245, for several weeks. An antiepileptic such as carbamazepine p. 200, may be added or substituted if pain persists. Ketamine p. 846 is sometimes used under specialist supervision for neuropathic pain that responds poorly to opioid analgesics. Pain due to nerve compression may be reduced by a corticosteroid such as dexamethasone p. 455, which reduces oedema around the tumour, thus reducing compression. Nerve blocks can be considered when pain is localised to a specific area. Transcutaneous electrical nerve stimulation (TENS) may also help.

Pain management with opioids

Oral route
Treatment with morphine p. 290 is given by mouth as immediate-release or modified-release preparations. During the titration phase the initial dose is based on the previous medication used, the severity of the pain, and other factors such as presence of renal impairment or frailty. The dose is given either as an immediate-release preparation 4-hourly (for starting doses, see Morphine), or as a 12-hourly modified-release preparation, in addition to rescue doses. If replacing a weaker opioid analgesic (such as codeine phosphate p. 283), starting doses are usually higher. If pain occurs between regular doses of morphine p. 290 (‘breakthrough pain’), an additional dose (‘rescue dose’) of immediate-release morphine p. 290 should be given. An additional dose should also be given 30 minutes before an activity that causes pain, such as wound dressing. The standard dose of a strong opioid for breakthrough pain is usually one-tenth to one-sixth of the regular 24-hour dose, repeated every 2–4 hours as required (up to hourly may be needed if pain is severe or in the last days of life). Review pain management if rescue analgesic is required frequently (twice daily or more). Each child should be assessed on an individual basis. Formulations of fentanyl p. 286 that are administered nasally, buccally or sublingually are not licensed for use in children; their usefulness in children is also limited by dose availability.

Children often require a higher dose of morphine p. 290 in proportion to their body-weight compared to adults. Children are more susceptible to certain adverse effects of opioids such as urinary retention (which can be eased by bethanechol chloride), and opioid-induced pruritus.

When adjusting the dose of morphine p. 290, the number of rescue doses required and the response to them should be taken into account; increments of morphine p. 290 should not exceed one-third to one-half of the total daily dose every 24 hours. Thereafter, the dose should be adjusted with careful assessment of the pain, and the use of adjuvant analgesics should also be considered. Upward titration of the dose of morphine p. 290 stops when either the pain is relieved or unacceptable adverse effects occur, after which it is necessary to consider alternative measures.

One of the pain is controlled, children started on 4-hourly immediate-release morphine p. 290 can be transferred to the same total 24-hour dose of morphine p. 290 given as the modified-release preparation for 12-hourly or 24-hourly administration. The first dose of the modified-release preparation is given with, or within 4 hours of the last dose of the immediate-release preparation. For preparations suitable for 12-hourly or 24-hourly administration see modified-release preparations under morphine p. 290. Increments should be made to the dose, not to the frequency of administration. The patient must be monitored closely for efficacy and side-effects, particularly constipation, and nausea and vomiting. A suitable laxative should be prescribed routinely.

Oxycodone hydrochloride p. 292 can be used in children who require an opioid but cannot tolerate morphine p. 290. If the child is already receiving an opioid, oxycodone hydrochloride p. 292 should be started at a dose equivalent to the current analgesic. Oxycodone hydrochloride p. 292 immediate-release preparations can be given for breakthrough pain.
Equivalent doses of opioid analgesics

This table is only an approximate guide (doses may not correspond with those given in clinical practice); children should be carefully monitored after any change in medication and dose titration may be required.

<table>
<thead>
<tr>
<th>Analgesic/Route</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine: PO</td>
<td>100 mg</td>
</tr>
<tr>
<td>Diamorphine: IM, IV, SC</td>
<td>3 mg</td>
</tr>
<tr>
<td>Dihydromorphone: PO</td>
<td>100 mg</td>
</tr>
<tr>
<td>Hydromorphone: PO</td>
<td>2 mg</td>
</tr>
<tr>
<td>Morphine: PO</td>
<td>10 mg</td>
</tr>
<tr>
<td>Morphine: IM, IV, SC</td>
<td>5 mg</td>
</tr>
<tr>
<td>Oxycodone: PO</td>
<td>6.6 mg</td>
</tr>
<tr>
<td>Tramadol: PO</td>
<td>100 mg</td>
</tr>
</tbody>
</table>

PO = by mouth; IM = intramuscular; IV = intravenous; SC = subcutaneous

Parenteral route Diamorphine hydrochloride p. 284 is preferred for injection because, being more soluble, it can be given in a smaller volume. The equivalent subcutaneous dose is approximately a third of the oral dose of morphine p. 290. Subcutaneous infusion of diamorphine hydrochloride p. 284 via a continuous infusion device can be useful (for details, see Continuous Subcutaneous Infusions). If the child can resume taking medicines by mouth, then oral morphine p. 290 may be substituted for subcutaneous infusion of diamorphine hydrochloride p. 284. See the table Approximate Equivalent doses of Morphine and Diamorphine.

Rectal route Morphine p. 290 is also available for rectal administration as suppositories.

Transdermal route Transdermal preparations of fentanyl p. 286 and buprenorphine p. 281 [not licensed for use in children] are available; they are not suitable for acute pain or in those children whose analgesic requirements are changing rapidly because the long time to steady state prevents rapid titration of the dose. Prescribers should ensure that they are familiar with the correct use of transdermal preparations (see under fentanyl p. 286) because inappropriate use has caused fatalities. The following 24-hour oral doses of morphine p. 290 are considered to be approximately equivalent to the buprenorphine and fentanyl p. 286 patches shown, however when switching due to possible opioid-induced hyperalgesia, reduce the calculated equivalent dose of the new opioid by one-quarter to one-half.

Buprenorphine patches are approximately equivalent to the following 24-hour doses of oral morphine

<table>
<thead>
<tr>
<th>Morphine salt (oral)</th>
<th>Equivalent Buprenorphine patch</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 mg daily</td>
<td>Buprenorphine 10 mg patch</td>
</tr>
<tr>
<td>20 mg daily</td>
<td>Buprenorphine 20 mg patch</td>
</tr>
<tr>
<td>30 mg daily</td>
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<td>50 mg daily</td>
<td>Buprenorphine 50 mg patch</td>
</tr>
<tr>
<td>60 mg daily</td>
<td>Buprenorphine 60 mg patch</td>
</tr>
<tr>
<td>70 mg daily</td>
<td>Buprenorphine 70 mg patch</td>
</tr>
</tbody>
</table>

Formulations of transdermal patches are available as 72-hourly, 96-hourly and 7-day patches, for further information see buprenorphine in BNF. Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.

72-hour Fentanyl patches are approximately equivalent to the following 24-hour doses of oral morphine

<table>
<thead>
<tr>
<th>Morphine salt (oral)</th>
<th>Equivalent Fentanyl patch</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 mg daily</td>
<td>Fentanyl 10 mg patch</td>
</tr>
<tr>
<td>20 mg daily</td>
<td>Fentanyl 20 mg patch</td>
</tr>
<tr>
<td>30 mg daily</td>
<td>Fentanyl 30 mg patch</td>
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<td>40 mg daily</td>
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<td>60 mg daily</td>
<td>Fentanyl 60 mg patch</td>
</tr>
<tr>
<td>70 mg daily</td>
<td>Fentanyl 70 mg patch</td>
</tr>
<tr>
<td>80 mg daily</td>
<td>Fentanyl 80 mg patch</td>
</tr>
</tbody>
</table>

Symptom control

Unlicensed indications or routes Several recommendations in this section involve unlicensed indications or routes.

Anorexia Anorexia may be helped by prednisolone p. 458 or dexamethasone p. 455.

Anxiety Anxiety can be treated with a long-acting benzodiazepine such as diazepam p. 226, or a continuous infusion of the short-acting benzodiazepine midazolam p. 229. Interventions for more acute episodes of anxiety (such as panic attacks) include short-acting benzodiazepines such as lorazepam p. 228 given sublingually or midazolam p. 229 given subcutaneously. Temazepam p. 847 provides useful night-time sedation in some children.

Capillary bleeding Capillary bleeding can be treated with tranexamic acid p. 83 by mouth; treatment is usually continued for one week after the bleeding has stopped but it can be continued at a reduced dose if bleeding persists. Alternatively, gauze soaked in tranexamic acid 100 mg/mL p. 83 or adrenaline/epinephrine solution 1 mg/mL (1 in 1000) p. 138 can be applied to the affected area.

Vitamin K Vitamin K may be useful for the treatment and prevention of bleeding associated with prolonged clotting in liver disease. In severe chronic cholestasis, absorption of vitamin K may be impaired; either parenteral or water-soluble oral vitamin K should be considered.

Constipation Constipation is a common cause of distress and is almost invariable after administration of an opioid analgesic. It should be prevented if possible by the regular administration of laxatives. Suitable laxatives include osmotic laxatives (such as lactulose p. 43 or macrogols), stimulant laxatives (such as co-danthramer p. 47 and senna p. 48) or the combination of lactulose p. 43 and a senna p. 48 preparation. Naloxone hydrochloride p. 869 given by mouth may help relieve opioid-induced constipation; it is poorly absorbed but opioid withdrawal reactions have been reported.

Convulsions Convulsions are relatively common in children dying from non-malignant conditions. Phenobarbital p. 223 by mouth or as a continuous subcutaneous infusion may be beneficial; continuous infusion of midazolam p. 229 is an alternative. Both cause drowsiness, but this is rarely a concern in the context of intractable seizures. For breakthrough convulsions diazepam p. 226 given rectally (as a solution), buccal midazolam p. 229, or paraldehyde p. 228 as an enema may be appropriate. See Continuous subcutaneous infusions, below, for the use of midazolam p. 229 by subcutaneous infusion using a continuous infusion device.

Dry mouth Dry mouth may be caused by certain medications including opioid analgesics, antimuscarinic drugs (e.g. hyoscine), antidepressants and some antiemetics;
Prescribing in palliative care

Muscle spasm

The pain of muscle spasm can be helped by a preparation incorporating an antacid with an antiulcent and a prokinetic such as domperidone before meals.

Dysphagia

A corticosteroid such as dexamethasone p. 455 may help, temporarily, if there is an obstruction due to tumour. See also Dry mouth, above.

Dyspnoea

Breathlessness at rest may be relieved by regular oral morphine p. 290 in carefully titrated doses. Diazepam p. 226 may be helpful for dyspnoea associated with anxiety. Sublingual lorazepam p. 228 or subcutaneous or buccal midazolam p. 229 are alternatives. A nebulised short-acting beta, agonist or a corticosteroid, such as dexamethasone p. 455 or prednisolone p. 458, may also be helpful for bronchospasm or partial obstruction.

Excessive respiratory secretion

Excessive respiratory secretion (death rattle) may be reduced by hyoscine hydrobromide p. 273 patches or by subcutaneous or intravenous injection of hyoscine hydrobromide p. 273, however, care must be taken to avoid the discomfort of dry mouth. Alternatively, glycopyrronium bromide p. 838 may be given.

Hyoscine hydrobromide p. 273 can be administered by subcutaneous or intravenous infusion using a continuous infusion device.

Fungating tumours

Fungating tumours can be treated by regular dressing and antibacterial drugs; systemic treatment with metronidazole p. 344 is often required to reduce malodour, but topical metronidazole p. 746 is also used.

Gastro-intestinal pain

The pain of bowel colic may be reduced by loperamide hydrochloride p. 51. Hyoscine hydrobromide p. 273 may also be helpful in reducing the frequency of spasms; it is given sublingually as Kwells® tablets and also by subcutaneous infusion.

Gastric distension pain due to pressure on the stomach may be helped by a preparation incorporating an antacid with an antiflatulent and a prokinetic such as domperidone before meals.

Hiccup

Hiccup due to gastric distension may be helped by a preparation incorporating an antacid with an antiulcent.

Insomnia

Children with advanced cancer may not sleep because of discomfort, cramps, night sweats, joint stiffness, or fear. There should be appropriate treatment of these problems before hypnotics are used. Benzodiazepines, such as temazepam p. 847, may be useful.

Intractable cough

Intractable cough may be relieved by moist inhalations or by regular administration of oral morphine p. 290 every 4 hours. Methadone hydrochloride p. 307 linctus should be avoided because it has a long duration of action and tends to accumulate.

Mucosal bleeding

Mucosal bleeding from the mouth and nose occurs commonly in the terminal phase, particularly in a child suffering from haemopoietic malignancy. Bleeding from the nose caused by a single bleeding point can be arrested by cauterisation or by dressing it. Tranexamic acid p. 83 may be effective applied topically or given systemically.

Muscle spasm

The pain of muscle spasm can be helped by a muscle relaxant such as diazepam p. 226 or baclofen p. 673.

Nausea and vomiting

Nausea and vomiting are common in children with advanced cancer. Ideally, the cause should be determined before treatment with an antiemetic is started. Nausea and vomiting with opioid therapy are less common in children than in adults but may occur particularly in the initial stages and can be prevented by giving an antiemetic. An antiemetic is usually necessary only for the first 4 or 5 days and therefore combined preparations containing an opioid with an antiemetic are not recommended because they lead to unnecessary antiemetic therapy (and associated side-effects when used long-term). Metoclopramide hydrochloride p. 269 has a prokinetic action and is used by mouth for nausea and vomiting associated with gastritis, gastric stasis, and functional bowel obstruction. Drugs with antimuscarinic effects antagonise prokinetic drugs and, if possible, should not therefore be used concurrently.

Haloperidol p. 252 is used by mouth or by continuous intravenous or subcutaneous infusion for most metabolic causes of vomiting (e.g. hypercalcaemia, renal failure). Cyclizine p. 266 is used for nausea and vomiting due to mechanical bowel obstruction, raised intracranial pressure, and motion sickness.

Ondansetron p. 271 is most effective when the vomiting is due to damaged or irritated gut mucosa (e.g. after chemotherapy or radiotherapy). Antiemetic therapy should be reviewed every 24 hours; it may be necessary to substitute the antiemetic or to add another one.

Levomepromazine p. 275 can be used if first-line antiemetics are inadequate. Dexamethasone p. 455 by mouth can be used as an adjunct.

See Continuous subcutaneous infusions, below, for the administration of antiemetics by subcutaneous infusion using a continuous infusion device.

Pruritus

Pruritus, even when associated with obstructive jaundice, often responds to simple measures such as application of emollients. Ondansetron p. 271 may be effective in some children. Where opioid analgesics cause pruritus it may be appropriate to review the dose or to switch to an alternative opioid analgesic. In the case of obstructive jaundice, further measures include administration of colestyramine p. 131.

Raised intracranial pressure

Headache due to raised intracranial pressure often responds to a high dose of a corticosteroid, such as dexamethasone p. 455, for 4 to 5 days, subsequently reduced if possible; dexamethasone p. 455 should be given before 6 p.m. to reduce the risk of insomnia. Treatment of headache and of associated nausea and vomiting should also be considered.

Restlessness and confusion

Restlessness and confusion may require treatment with haloperidol p. 252. Levomepromazine p. 275 is also used occasionally for restlessness.

Continuous subcutaneous infusions

Although drugs can usually be administered by mouth to control symptoms in palliative care, the parenteral route may sometimes be necessary. Repeated administration of intramuscular injections should be avoided in children, particularly if cachectic. This has led to the use of portable continuous infusion devices such as syringe drivers to give a continuous subcutaneous infusion, which can provide good control of symptoms with little discomfort or inconvenience to the patient.

Indications for the parenteral route are:

- inability to take medicines by mouth owing to nausea and vomiting, dysphagia, severe weakness, or coma;
- malignant bowel obstruction for which surgery is inappropriate (avoiding the need for an intravenous infusion or for insertion of a nasogastric tube);
- refusal by the child to take regular medication by mouth.

Syringe driver rate settings

Staff using syringe drivers should be adequately trained and different rate settings should be clearly identified and differentiated; incorrect use of syringe drivers is a common cause of medication errors.
**Bowel colic and excessive respiratory secretions** Hyoscine hydrobromide p. 273 effectively reduces respiratory secretions and is sedative (but occasionally causes paradoxical agitation); it is given in a *subcutaneous* or *intravenous infusion*. Glycopyrronium bromide p. 838 may also be used.

Hyoscine butylbromide p. 64 is effective in bowel colic, is less sedative than hyoscine hydrobromide p. 273, but is not always adequate for the control of respiratory secretions; it is given by *subcutaneous infusion* (**important**: hyoscine butylbromide p. 64 must not be confused with *hyoscine hydrobromide* p. 273, above).

**Confusion and restlessness** Haloperidol p. 252 has little sedative effect. Levomepromazine p. 275 has a sedative effect. Midazolam p. 229 is a sedative and an antiepileptic that may be suitable for a very restless patient.

**Convulsions** If a child has previously been receiving an antiepileptic drug or has a primary or secondary cerebral tumour or is at risk of convulsion (e.g. owing to uraemia) antiepileptic medication should not be stopped. Midazolam p. 229 is the benzodiazepine antiepileptic of choice for *continuous subcutaneous infusion*.

**Nausea and vomiting** Levomepromazine p. 275 causes sedation in about 50% of patients. Haloperidol p. 252 has little sedative effect. Cyclizine p. 266 is particularly likely to precipitate if mixed with diamorphine hydrochloride p. 284 or other drugs (see under *Mixing and compatibility*); it is given by *subcutaneous infusion*.

**Pain control** Diamorphine hydrochloride p. 284 is the preferred opioid since its high solubility permits a large dose to be given in a small volume (see under *Mixing and compatibility*). The table shows approximate equivalent doses of morphine p. 290 and diamorphine hydrochloride p. 284.

**Mixing and compatibility** The general principle that injections should be given into separate sites (and should not be mixed) does not apply to the use of syringe drivers in palliative care. Provided that there is evidence of compatibility, selected injections can be mixed in syringe drivers. Not all types of medication can be used in a subcutaneous infusion. In particular, chlorpromazine hydrochloride p. 251, prochlorperazine p. 275, and diazepam p. 226 are contra-indicated as they cause skin reactions at the injection site; to a lesser extent cyclizine p. 266 and levomepromazine p. 275 also sometimes cause local irritation.

In theory injections dissolved in water for injections are more likely to be associated with pain (possibly owing to their hypotonicity). The use of physiological saline (sodium chloride p. 610 0.9%) however increases the likelihood of precipitation when more than one drug is used; moreover subcutaneous infusion rates are so slow (0.1−0.3 mL/hour) that pain is not usually a problem when water is used as a diluent.

**Compatibility with diamorphine** Diamorphine can be given by *subcutaneous infusion* in a strength of up to 250 mg/mL; up to a strength of 40 mg/mL either *water for injections or physiological saline* (sodium chloride 0.9%) is a suitable diluent—above that strength only *water for injections* is used (to avoid precipitation).

The following can be mixed with diamorphine:
- Cyclizine, may precipitate at concentrations above 10 mg/mL or in the presence of sodium chloride 0.9% or as the concentration of diamorphine relative to cyclizine increases; mixtures of diamorphine and cyclizine are also likely to precipitate after 24 hours.
- Dexamethasone, special care is needed to avoid precipitation of dexamethasone when preparing it.

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**Equivalent doses of morphine sulfate and diamorphine hydrochloride given over 24 hours**

<table>
<thead>
<tr>
<th>ORAL MORPHINE</th>
<th>PARENTERAL MORPHINE</th>
<th>PARENTERAL DIAMORPHINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral morphine</td>
<td>Subcutaneous infusion of morphine sulfate over 24 hours</td>
<td>Subcutaneous infusion of diamorphine hydrochloride over 24 hours</td>
</tr>
<tr>
<td>30 mg</td>
<td>15 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>60 mg</td>
<td>30 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>90 mg</td>
<td>45 mg</td>
<td>30 mg</td>
</tr>
<tr>
<td>120 mg</td>
<td>60 mg</td>
<td>40 mg</td>
</tr>
<tr>
<td>180 mg</td>
<td>90 mg</td>
<td>60 mg</td>
</tr>
<tr>
<td>240 mg</td>
<td>120 mg</td>
<td>80 mg</td>
</tr>
<tr>
<td>360 mg</td>
<td>180 mg</td>
<td>120 mg</td>
</tr>
<tr>
<td>480 mg</td>
<td>240 mg</td>
<td>160 mg</td>
</tr>
<tr>
<td>600 mg</td>
<td>300 mg</td>
<td>200 mg</td>
</tr>
<tr>
<td>780 mg</td>
<td>390 mg</td>
<td>260 mg</td>
</tr>
<tr>
<td>960 mg</td>
<td>480 mg</td>
<td>320 mg</td>
</tr>
<tr>
<td>1200 mg</td>
<td>600 mg</td>
<td>400 mg</td>
</tr>
</tbody>
</table>

If breakthrough pain occurs give a subcutaneous injection equivalent to one-tenth to one-sixth of the total 24-hour subcutaneous infusion dose. With an intermittent subcutaneous injection absorption is smoother so that the risk of adverse effects at peak absorption is avoided (an even better method is to use a subcutaneous butterfly needle). To minimise the risk of infection no individual subcutaneous infusion solution should be used for longer than 24 hours.
Drugs and sport

Anti-doping
UK Anti-Doping, the national body responsible for the UK’s anti-doping policy, advises that athletes are personally responsible should a prohibited substance be detected in their body. Information regarding the use of medicines in sport is available from:
UK Anti-doping
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8AE
(020) 7842 3450
ukad@ukad.org.uk
www.ukad.org.uk

Information about the prohibited status of specific medications based on the current World Anti-Doping Agency Prohibited List is available from Global Drug Reference Online: www.globaldro.com/UK/search

General Medical Council’s advice
Doctors who prescribe or collude in the provision of drugs or treatment with the intention of improperly enhancing an individual’s performance in sport contravene the GMC’s guidance, and such actions would usually raise a question of a doctor’s continued registration. This does not preclude the provision of any care or treatment where the doctor’s intention is to protect or improve the patient’s health.

Prescribing in dental practice

General guidance
Advice on the drug management of dental and oral conditions has been integrated into the main text. For ease of access, guidance on such conditions is usually identified by means of a relevant heading (e.g. Dental and Orofacial Pain) in the appropriate sections.

The following is a list of topics of particular relevance to dentists.

Prescribing by dentists, see Prescription writing p. 6
Oral side-effects of drugs, see Adverse reactions to drugs p. 14
Medical emergencies in dental practice, see BNF
Medical problems in dental practice, see BNF

Drug management of dental and oral conditions

Dental and orofacial pain, see Analgesics p. 276
Neuropathic pain p. 301
Non-opioid analgesics and compound analgesic preparations, see Analgesics p. 276
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Non-steroidal anti-inflammatory drugs p. 674

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Chapter 1
Gastro-intestinal system

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www.nice.org.uk/guidance/ng20

1 Chronic bowel disorders

1.1 Coeliac disease

Coeliac disease

Description of condition

Coeliac disease is an autoimmune condition which is associated with chronic inflammation of the small intestine. Dietary proteins known as gluten, which are present in wheat, barley and rye, activate an abnormal immune response in the intestinal mucosa, which can lead to malabsorption of nutrients.

Aims of treatment

The management of coeliac disease is aimed at eliminating symptoms (such as diarrhoea, bloating and abdominal pain) and reducing the risk of complications, including those resulting from malabsorption.

Non-drug treatment

The only effective treatment for coeliac disease is a strict, life-long, gluten-free diet. A range of gluten-free products is available for prescription (see Borderline substances).

Drug treatment

Children who have coeliac disease are at an increased risk of malabsorption of key nutrients (such as calcium and vitamin D). Supplementation of key nutrients may be required if dietary intake is insufficient.

Carers of children who have coeliac disease should be advised not to medicate with over-the-counter vitamin or mineral supplements. Initiation of supplementation should involve a discussion with a member of the child’s healthcare team in order to identify the individual needs of the patient and to allow for appropriate ongoing monitoring.

Useful Resources

ulceration and fissuring of the mucosa, and the presence of granulomas; affected areas may occur in any part of the gastro-intestinal tract, interspersed with areas of relatively normal tissue. Crohn’s disease may present as recurrent attacks, with acute exacerbations combined with periods of remission or less active disease. Symptoms depend on the site of disease but may include abdominal pain, diarrhoea, fever, weight loss, and rectal bleeding.

Complications of Crohn’s disease include intestinal strictures, abscesses in the wall of the intestine or adjacent structures, fistulae, anaemia, malnutrition, colorectal and small bowel cancers, and growth failure and delayed puberty in children. Crohn’s disease may also be associated with extra-intestinal manifestation: the most common are arthritis and abnormalities of the joints, eyes, liver and skin. Crohn’s disease is also a cause of secondary osteoporosis and those at greatest risk should be monitored for osteopenia and assessed for the risk of fractures.

Up to a third of patients with Crohn’s disease are diagnosed before the age of 21 years but there is a lack of evidence regarding treatment for children. Paediatric practice is often based on extrapolation from adult studies.

**Fistulating Crohn’s disease**

Fistulating Crohn’s disease is a complication that involves the formation of a fistula between the intestine and adjacent structures, such as perianal skin, bladder, and vagina. It occurs in about one quarter of patients, mostly when the disease involves the ileocolonic area.

**Aims of treatment**

Treatment is largely directed at the induction and maintenance of remission and the relief of symptoms. Active treatment of acute Crohn’s disease should be distinguished from preventing relapse. The aims of drug treatment are to reduce symptoms and maintain or improve quality of life, while minimising toxicity related to drugs over both the short and long term. Drug treatment should always be initiated by a paediatric gastroenterologist.

In fistulating Crohn’s disease, surgery and medical treatment aim to close and maintain closure of the fistula.

**Non-drug treatment**

**Drug treatment**

**Treatment of acute disease**

**Monotherapy**

A corticosteroid (either prednisolone p. 458 or methylprednisolone p. 458 or intravenous hydrocortisone p. 456), is used to induce remission in children with a first presentation or a single inflammatory exacerbation of Crohn’s disease in a 12-month period.

Enteral nutrition is an alternative to a corticosteroid when there is concern about growth or side effects.

In children with distal ileal, ileocaecal or right-sided colonic disease, in whom a conventional corticosteroid is unsuitable or contra-indicated, budesonide p. 34 [unlicensed] may be considered. Budesonide is less effective but may cause fewer side-effects than other corticosteroids, as systemic exposure is limited. Aminosalicylates (such as sulfasalazine p. 33 and mesalazine p. 31) are an alternative option in these children. They are less effective than a corticosteroid or budesonide [unlicensed], but may be preferred because they have fewer side-effects. Aminosalicylates and budesonide are not appropriate for severe presentations or exacerbations.

**Add-on treatment**

Add on treatment is prescribed if there are two or more inflammatory exacerbations in a 12-month period, or the corticosteroid dose cannot be reduced.

Azathioprine p. 536 or mercaptopurine p. 562 [unlicensed indications] can be added to a corticosteroid or budesonide to induce remission. In children who cannot tolerate azathioprine or mercaptopurine or in whom thiopurine methyltransferase (TPMT) activity is deficient, methotrexate p. 563 can be added to a corticosteroid.

Under specialist supervision, monoclonal antibody therapies, adalimumab p. 565 and infliximab p. 35, are options for the treatment of severe, active Crohn’s disease, following inadequate response to conventional therapies or in those who are intolerant of or have contra-indications to conventional therapy. See also National funding/access decisions for adalimumab and infliximab.

Adalimumab and infliximab can be used as monotherapy or combined with an immunosuppressant, although there is uncertainty about the comparative effectiveness. There are concerns about the long-term safety of adalimumab and infliximab in children; malignancies, including hepatosplenic T-cell lymphoma, have been reported.

**Maintenance of remission**

Children, and their parents or carers, should be made aware of the risk of relapse with and without drug treatment, and symptoms that may suggest a relapse (most frequently unintended weight loss, abdominal pain, diarrhoea and general ill-health). For those who choose not to receive maintenance treatment during remission, a suitable follow up plan should be agreed upon and information provided on how to access healthcare if a relapse should occur.

Azathioprine or mercaptopurine [unlicensed indications] as monotherapy can be used to maintain remission when previously used with a corticosteroid to induce remission. They may also be used in children who have not previously received these drugs (particularly those with adverse prognostic factors such as early age of onset, perianal disease, corticosteroid use at presentation, and severe presentations). Methotrexate [unlicensed] can be used to maintain remission only in children who required methotrexate to induce remission, or who are intolerant of or are not suitable for azathioprine or mercaptopurine for maintenance. Corticosteroids or budesonide should not be used.

**Maintaining remission following surgery**

Azathioprine or mercaptopurine can be considered to maintain remission after surgery in children with adverse prognostic factors such as more than one resection, or previously complicated or debilitating disease (for example, abscess, involvement of adjacent structures, fistulating or penetrating disease). Aminosalicylates can also be considered as an option, however budesonide or enteral nutrition should not be used.

**Other treatments**

Loperamide hydrochloride p. 51 can be used to manage diarrhoea associated with Crohn’s disease in children who do not have colitis. Colestyramine p. 131 is licensed for the relief of diarrhoea associated with Crohn’s disease. See also Diarrhoea (acute) p. 43.

**Fistulating Crohn’s disease**

Perianal fistulae are the most common occurrence in children with fistulating Crohn’s disease. Treatment may not be necessary for simple, asymptomatic perianal fistulae. When fistulae are symptomatic, local drainage and surgery may be required in conjunction with medical therapy.

Metronidazole p. 344 or ciprofloxacin p. 361 [unlicensed indications], alone or in combination, can improve symptoms of fistulating Crohn’s disease but complete
healing occurs rarely. Metronidazole should be given for at least 6 weeks but no longer than 3 months because of concerns about peripheral neuropathy. Other antibacterials should be given if specifically indicated (e.g. in sepsis associated with fistulare and perianal disease) and for managing bacterial overgrowth in the small bowel.

Either azathioprine p. 538 or mercaptopurine p. 562 (unlicensed indications) is used to control the inflammation in perianal and enterocutaneous fistulating Crohn’s disease and they are continued for maintenance.

Infliximab p. 35 is recommended for children with perianal and enterocutaneous active fistulating Crohn’s disease who have not responded to conventional therapy (including antibacterials, drainage and immunosuppressive treatments), or who are intolerant of or have contraindications to conventional therapy. Infliximab should be used after ensuring that all sepsis is actively draining.

Abscess drainage, fistulotomy, and seton insertion may be appropriate, particularly before infliximab treatment.

Azathioprine, mercaptopurine or infliximab should be continued as maintenance treatment for at least one year.

For the management of non-perianal fistulating Crohn’s disease (including entero-gynaecological and enterovesical fistulae) surgery is the only recommended approach.

**Useful Resources**


www.nice.org.uk/guidance/cg152

**Ulcerative colitis**

**Description of condition**

Ulcerative colitis is a chronic inflammatory condition, characterised by diffuse mucosal inflammation—it has a relapsing–remitting pattern. It is a life-long disease that is associated with significant morbidity. Ulcerative colitis is more common in adults; however, in children it predominately presents between the ages of 5 and 16 years.

The pattern of inflammation is continuous, extending from the rectum upwards to a varying degree. Inflammation of the rectum is referred to as proctitis, and inflammation of the rectum and sigmoid colon as proctosigmoiditis. **Left-sided colitis** refers to disease involving the colon distal to the splenic flexure. **Extensive colitis** affects the colon proximal to the splenic flexure, and includes pan-colitis, where the whole colon is involved. Child–onset ulcerative colitis is classified as extensive in 60–80% of all cases. Common symptoms of active disease or relapse include bloody diarrhoea, an urgent need to defaecate, and abdominal pain.

Ulcerative colitis is classified as **subacute** if it is moderate–to-severe active disease which can be managed in an outpatient setting, and does not require hospitalisation or consideration of urgent surgical intervention.

Complications associated with ulcerative colitis include an increased risk of colorectal cancer, secondary osteoporosis, venous thromboembolism and toxic megacolon. Growth and pubertal development can be affected in children.

**Aims of treatment**

Treatment is focussed on treating active disease to manage symptoms and to induce and maintain remission.

**Drug treatment**

**Overview**

Management of ulcerative colitis is dependent on factors such as clinical severity, extent of disease, and the child’s preference. As limited distal disease is uncommon in children, paediatric treatment strategy depends mainly on disease severity rather than the extent of disease. Clinical and laboratory investigations are used to determine the extent and severity of disease and to guide treatment.

Severity is classified as mild, moderate or severe (or in remission) by using the Paediatric Ulcerative Colitis Activity Index to assess bowel movement, limitations on daily activity and the presence of abdominal pain or melaena—see the NICE guideline for Ulcerative Colitis for further information (Useful resources below).

The extent of disease should be considered when choosing the route of administration for aminosalicylates and corticosteroids; whether oral treatment, topical treatment or both are to be used.

If the inflammation is distal, a rectal preparation is adequate, but if the inflammation is extended, systemic medication is required. Either suppositories or enemas can be offered, taking into account the child’s preferences.

Rectal foam preparations and suppositories can be used when children have difficulty retaining liquid enemas.

Diarrhoea that is associated with active ulcerative colitis is sometimes treated with anti-diarrhoeal drugs (such as loperamide hydrochloride p. 51 [unlicensed under 4 years]) on the advice of a specialist; however their use is contraindicated in acute ulcerative colitis as they can increase the risk of toxic megacolon.

A macrogol-containing osmotic laxative (such as macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride p. 44) may be useful for proximal faecal loading in proctitis.

Oral aminosalicylates for the treatment of ulcerative colitis are available in different preparations and release forms. The preparation and dosing schedule should be chosen taking into account the delivery characteristics and suitability for the patient. When used to maintain remission, single daily doses of oral aminosalicylates can be more effective than multiple daily dosing, but may result in more side-effects.

**Treatment of acute mild-to-moderate ulcerative colitis**

Acute treatment to induce remission generally consists of an aminosalicylate with or without a corticosteroid.

**Aminosalicylates** are recommended as first-line treatment for children at first presentation or with an exacerbation. Oral aminosalicylates (balsalazide sodium p. 31 [unlicensed], mesalazine p. 31 [unlicensed under 6 years], olsalazine sodium p. 33 [unlicensed under 12 years] or sulfasalazine p. 33 [unlicensed under 2 years]) are recommended as first line except in children with proctitis or proctosigmoiditis where a rectal aminosalicylate (mesalazine or sulfasalazine [both unlicensed under 6 years]) is more effective. A rectal corticosteroid (budesonide p. 34 [unlicensed], hydrocortisone p. 456 [unlicensed under 2 years] or prednisolone p. 458) or oral prednisolone [unlicensed under 2 years] alone can be considered in children with proctitis or proctosigmoiditis who are intolerant to or decline treatment with aminosalicylates, or in whom aminosalicylates are contra-indicated.

Addition of oral beclometasone dipropionate [unlicensed] or a rectal aminosalicylate to oral aminosalicylate treatment may also be considered in children with left-sided or extensive disease. Oral prednisolone [unlicensed under 2 years] alone is recommended for children who cannot tolerate or who decline aminosalicylates, or in whom aminosalicylates are contra-indicated.

Oral prednisolone [unlicensed under 2 years] should be considered for the treatment of children with subacute proctitis or proctosigmoiditis.

In all extents of disease, if there are no improvements within four weeks of initial treatment or if symptoms worsen, addition of oral prednisolone to aminosalicylate therapy can be considered (discontinue beclometasone dipropionate if adding oral prednisolone). If there is still no response after 2–4 weeks of treatment with prednisolone,
consider adding oral tacrolimus p. 540 [unlicensed indication] to prednisolone to induce remission. Alternatively, on specialist advice, infliximab p. 35 [unlicensed indication; can be used in children over 6 years] or intravenous tacrolimus [unlicensed indication] can be added, if there is no response after 2–4 weeks of treatment with prednisolone.

Evaluation of response should be done early to allow tapering of corticosteroids and ongoing treatment. Unnecessary corticosteroid exposure is to be avoided to minimise growth retardation and other corticosteroid-related side effects.

Treatment of acute severe ulcerative colitis

Acute severe ulcerative colitis of any extent can be life-threatening and is regarded as a medical emergency. Immediate hospital admission is required for treatment. Intravenous corticosteroids (such as hydrocortisone or methylprednisolone p. 458) should be given to induce remission in children with acute severe ulcerative colitis (whether it is a first presentation or an inflammatory exacerbation) while assessing the need for surgery. If intravenous corticosteroids are contra-indicated, declined or cannot be tolerated, then intravenous ciclosporin p. 537 [unlicensed indication], or surgery should be considered. A combination of intravenous ciclosporin with intravenous corticosteroids, or surgery is second line therapy for children who have little or no improvement within 72 hours of starting intravenous corticosteroids or in children whose symptoms worsen despite treatment with a corticosteroid.

Alternatively, infliximab can be used on specialist advice in children over 6 years. If there is little or no improvement within 72 hours of starting intravenous corticosteroids or in children whose symptoms worsen despite treatment with a corticosteroid.

In patients who experience an initial response to steroids followed by deterioration, stool cultures should be taken to exclude pathogens; cytomegalovirus activation should be considered.

Infliximab for ulcerative colitis

Infliximab p. 35 can be used to treat acute severe active ulcerative colitis in children over 6 years who have had an inadequate response to conventional treatment (including corticosteroids and azathioprine p. 536 or mercaptopurine p. 562) or if conventional treatment is not tolerated or contra-indicated. Treatment with these agents is continued into the maintenance phase if effective and tolerated. See also National funding/access decisions for infliximab.

Infliximab can also be used to treat acute exacerbations of severely active ulcerative colitis in children over 6 years, if ciclosporin p. 537 is contra-indicated or clinically inappropriate.

Maintaining remission in mild, moderate or severe ulcerative colitis

To reduce the chances of relapse occurring, maintenance therapy with an aminosalicylate is recommended in most children. Corticosteroids are not suitable for maintenance treatment because of their side-effects. After a mild-to-moderate inflammatory exacerbation of proctitis or proctosigmoiditis, a rectal aminosalicylate can be started alone or in combination with an oral aminosalicylate, administered daily or as part of an intermittent regimen (such as twice to three times weekly or the first seven days of each month). An oral aminosalicylate can be used alone in children who prefer not to use enemas or suppositories, although, this may not be as effective.

A low dose of oral aminosalicylate is given to maintain remission in children after a mild-to-moderate inflammatory exacerbation of left-sided or extensive ulcerative colitis.

Oral aminosalicylates are available in different preparations and release forms. The preparation and dosing schedule should be chosen taking into account the delivery characteristics and suitability for the child. When used to maintain remission single daily dosing of oral aminosalicylates can be more effective than multiple daily dosing, but may result in more side-effects.

Oral azathioprine or mercaptopurine [unlicensed indications] can be considered to maintain remission, if there has been two or more inflammatory exacerbations in a 12-month period that require treatment with systemic corticosteroids or if remission is not maintained by aminosalicylates, or following a single acute severe episode.

There is no evidence to support the use of methotrexate p. 563 to induce or maintain remission in ulcerative colitis though its use is common in clinical practice.

Non-drug treatment

Surgery may be necessary as emergency treatment for severe ulcerative colitis that does not respond to drug treatment. Patients can also choose to have elective surgery for unresponsive or frequently relapsing disease that is affecting their quality of life.

Useful Resources


Other drugs used for Inflammatory bowel disease

Ustekinumab, p. 771

AMINOSALICYLATES

Aminosalicylates

→ SIDE-EFFECTS

- Common or very common
  - Arthralgia
  - Cough
  - Diarrhoea
  - Dizziness
  - Fever
  - Gastrointestinal discomfort
  - Headache
  - Leucopenia
  - Nausea
  - Skin reactions
  - Vomiting

- Uncommon
  - Alopecia
  - Depression
  - Dyspnkea
  - Myalgia
  - Photosensitivity reaction
  - Thrombocytopenia

- Rare or very rare
  - Agranulocytosis
  - Bone marrow disorders
  - Cardiac inflammation
  - Hepatitis
  - Neutropenia
  - Pancreatitis
  - Peripheral neuropathy
  - Renal impairment
  - Respiratory disorders

- Frequency not known
  - Angioedema
  - Eosinophilia
  - Haemolytic anaemia
  - Neutropenia
  - Urticarial disorders
  - Ulcerative colitis aggravated

SIDE-EFFECTS, FURTHER INFORMATION

A blood count should be performed and the drug stopped immediately if there is suspicion of a blood dyscrasia.

→ ALLERGY AND CROSS-SENSITIVITY

Contra-indicated in salicylate hypersensitivity.

→ RENAL IMPAIRMENT

Monitoring

Renal function should be monitored more frequently in renal impairment.

→ MONITORING REQUIREMENTS

Renal function should be monitored before starting an oral aminosalicylate, at 3 months of treatment, and then annually during treatment.

→ PATIENT AND CARER ADVICE

Blood disorders

Patients receiving aminosalicylates, and their carers, should be advised to report any unexplained bleeding, bruising, purpura, sore throat, fever or malaise that occurs during treatment.
Balsalazide sodium

**INDICATIONS AND DOSE**

Treatment of mild to moderate ulcerative colitis, acute attack

- **BY MOUTH**
  - Child 12-17 years: 2.25 g 3 times a day until remission occurs or for up to maximum of 12 weeks

Maintenance of remission of ulcerative colitis

- **BY MOUTH**
  - Child 12-17 years: 1.5 g twice daily (max. per dose 3 g), adjusted according to response; maximum 6 g per day

**UNLICENSED USE**

Not licensed for use in children under 18 years.

**CAUTIONS**

History of asthma

**INTERACTIONS**

Blood disorder - cholelithiasis - lupus-like syndrome

**SIDE-EFFECTS**

Diarrhoea may develop in the infant.

Manufacturer advises avoid.

**PREGNANCY**

Manufacturer advises caution; avoid in severe impairment (no information available).

**RENAL IMPAIRMENT**

Manufacturer advises avoid in moderate to severe impairment.

**MENICIAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**CAPSULE**

Colazide (Almirall Ltd)

Balsalazide disodium 750 mg Colazide 750mg capsules | 130 capsule | £30.42 DT = £30.42

Mesalazine

**INDICATIONS AND DOSE**

**DOSE EQUIVALENCE AND CONVERSION**

There is no evidence to show that any one oral preparation of mesalazine is more effective than another; however, the delivery characteristics of oral mesalazine preparations may vary.

**ASACOL® MR 400MG TABLETS**

Treatment of mild to moderate ulcerative colitis, acute attack

- **BY MOUTH**
  - Child 12-17 years: 800 mg 3 times a day

Maintenance of remission of ulcerative colitis and Crohn’s ileo-colitis

- **BY MOUTH**
  - Child 12-17 years: 400–800 mg 2–3 times a day

**ASACOL® FOAM ENEMA**

Treatment of acute attack of mild to moderate ulcerative colitis affecting the rectosigmoid region

- **BY RECTUM**
  - Child 12-17 years: 1 g daily for 4–6 weeks, to be administered into the rectum

Treatment of acute attack of mild to moderate ulcerative colitis, affecting the descending colon

- **BY RECTUM**
  - Child 12-17 years: 2 g once daily for 4–6 weeks, to be administered into the rectum

**ASACOL® SUPPOSITORIES**

Treatment and maintenance of remission of ulcerative colitis affecting the rectosigmoid region

- **BY RECTUM**
  - Child 12-17 years: 250–500 mg 3 times a day, last dose to be administered at bedtime

**OCTASA®**

Treatment of mild to moderate ulcerative colitis, acute attack

- **BY MOUTH**
  - Child 6-17 years (body-weight 40 kg and above): 2.4–4 g daily in divided doses

Maintenance of remission of ulcerative colitis and Crohn’s ileo-colitis

- **BY MOUTH**
  - Child 6-17 years (body-weight 40 kg and above): 1.2–2 g once daily, alternatively daily in divided doses

**PENTASA® GRANULES**

Treatment of mild to moderate ulcerative colitis, acute attack

- **BY MOUTH**
  - Child 5-17 years (body-weight up to 40 kg): 10–20 mg/kg 3 times a day
  - Child 5-17 years (body-weight 40 kg and above): 1–2 g twice daily, total daily dose may alternatively be given in 3–4 divided doses

Maintenance of remission of ulcerative colitis

- **BY MOUTH**
  - Child 5-17 years (body-weight up to 40 kg): 7.5–15 mg/kg twice daily, total daily dose may alternatively be given in 3 divided doses
  - Child 5-17 years (body-weight 40 kg and above): 2 g once daily

**PENTASA® RETENTION ENEMA**

Treatment of acute attack of mild to moderate ulcerative colitis affecting the rectosigmoid region

- **BY RECTUM**
  - Child 12-17 years: 1 g once daily, dose to be administered at bedtime

**PENTASA® SUPPOSITORIES**

Treatment of acute attack, ulcerative proctitis

- **BY RECTUM**
  - Child 12-17 years: 1 g daily for 2–4 weeks

Maintenance, ulcerative proctitis

- **BY RECTUM**
  - Child 12-17 years: 1 g daily

**PENTASA® TABLETS**

Treatment of mild to moderate ulcerative colitis, acute attack

- **BY MOUTH**
  - Child 5-17 years (body-weight up to 40 kg): 10–20 mg/kg 3 times a day
  - Child 5-17 years (body-weight 40 kg and above): 1–2 g twice daily, total daily dose may alternatively be given in 3 divided doses

Maintenance of remission of ulcerative colitis

- **BY MOUTH**
  - Child 5-17 years (body-weight up to 40 kg): 7.5–15 mg/kg twice daily, total daily dose may alternatively be given in 3 divided doses
  - Child 5-17 years (body-weight 40 kg and above): 2 g once daily
SALOFALK® ENEMA
Treatment of acute attack of mild to moderate ulcerative colitis or maintenance of remission
▶ BY RECTUM
  • Child 12-17 years: 2 g once daily, dose to be administered at bedtime
SALOFALK® GRANULES
Treatment of mild to moderate ulcerative colitis, acute attack
▶ BY MOUTH
  • Child 5-17 years (body-weight up to 40 kg): 30–50 mg/kg once daily, dose preferably given in the morning, alternatively 10–20 mg/kg 3 times a day
  • Child 5-17 years (body-weight 40 kg and above): 1.5–3 g once daily, dose preferably given in the morning, alternatively 0.5–1 g 3 times a day
Maintenance of remission of ulcerative colitis
▶ BY MOUTH
  • Child 5-17 years (body-weight up to 40 kg): 7.5–15 mg/kg twice daily, total daily dose may alternatively be given in 3 divided doses
  • Child 5-17 years (body-weight 40 kg and above): 500 mg 3 times a day
SALOFALK® RECTAL FOAM
Treatment of mild ulcerative colitis affecting sigmoid colon and rectum
▶ BY RECTUM
  • Child 12-17 years: 2 g once daily, dose to be administered into the rectum at bedtime, alternatively 2 g daily in 2 divided doses
SALOFALK® SUPPOSITORIES
Treatment of acute attack of mild to moderate ulcerative colitis affecting the rectum, sigmoid colon and descending colon
▶ BY RECTUM
  • Child 12-17 years: 0.5–1 g 2–3 times a day, adjusted according to response, dose to be given using 500 mg suppositories
SALOFALK® TABLETS
Treatment of mild to moderate ulcerative colitis, acute attack
▶ BY MOUTH
  • Child 5-17 years (body-weight up to 40 kg): 10–20 mg/kg 3 times a day
  • Child 5-17 years (body-weight 40 kg and above): 0.5–1 g 3 times a day
Maintenance of remission of ulcerative colitis
▶ BY MOUTH
  • Child 5-17 years (body-weight up to 40 kg): 7.5–15 mg/kg twice daily, total daily dose may alternatively be given in 3 divided doses
  • Child 5-17 years (body-weight 40 kg and above): 500 mg 3 times a day

SIDE-EFFECTS
GENERAL SIDE-EFFECTS
▶ Rare or very rare Cheilitis exacerbated · drug fever · flatulence · nephritis
SPECIFIC SIDE-EFFECTS
▶ Rare or very rare
  • With rectal use: Constipation
PREGNANCY
Negligible quantities cross placenta.
BREAST FEEDING
Diarrhoea reported in breast-fed infants, but negligible amounts of mesalazine detected in breast milk.
Monitoring
Monitor breast-fed infant for diarrhoea.
HEPATIC IMPAIRMENT
Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.
RENAL IMPAIRMENT
Use with caution. Avoid if estimated glomerular filtration rate less than 20 mL/minute/1.73 m².

DIRECTIONS FOR ADMINISTRATION
PENTASA® TABLETS
Tablets may be halved, quartered, or dispersed in water, but should not be chewed.
PENTASA® GRANULES
Granules should be placed on tongue and washed down with water or orange juice without chewing.
Contents of one sachet should be weighed and divided immediately before use; discard any remaining granules.
SALOFALK® GRANULES
Granules should be placed on tongue and washed down with water without chewing.

PRESCRIBING AND DISPENSING INFORMATION
There is no evidence to show that any one oral preparation of mesalazine is more effective than another; however, the delivery characteristics of oral mesalazine preparations may vary.
Flavours of granule formulations of Salofalk® may include vanilla.

PATIENT AND CARER ADVICE
If it is necessary to switch a patient to a different brand of mesalazine, the patient should be advised to report any changes in symptoms. Some products may require special administration advice; patients and carers should be informed.

Medicines for Children leaflet: Mesalazine (oral) for inflammatory bowel disease www.medicinesforchildren.org.uk/mesalazine-oral-inflammatory-bowel-disease

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Modified-release tablet
CAUTIONARY AND ADVISORY LABELS 21 (does not apply to Pentasa® tablets), 25 (does not apply to Pentasa® tablets)
Pentasa (Ferring Pharmaceuticals Ltd)
Mesalazine 500 mg Pentasa 500mg modified-release tablets | 100 tablet | £30.74 DT + £30.74
Mesalazine 1 gram Pentasa 1g modified-release tablets | 60 tablet | £36.89 DT + £36.89
Foam
EXCipients: May contain Cetostearyl alcohol (including cetyl) and stearyl alcohol, disodium edetate, hydroxybenzoates (parabens), polysorbates, propylene glycol, sodium metabisulphite
Salofalk (Dr. Falk Pharma UK Ltd)
Mesalazine 1 gram per 1 application Salofalk 1g/application foam enema | 14 dose | £30.17 DT + £30.17
Gastro-resistant tablet

**CAUTIONARY AND ADVISORY LABELS**: (does not apply to Octasa®)

- **Asacol MR** (Allegan Ltd)
  - Mesalazine 400 mg Asacol 400mg MR gastro-resistant tablets | 84 tablet (Pos) £27.45 DT = £27.45 | 168 tablet (Pos) £54.90

- **Octasa MR** (Tillotts Pharma Ltd)
  - Mesalazine 400 mg Octasa 400mg MR gastro-resistant tablets | 90 tablet (Pos) £16.38 DT = £16.38 | 120 tablet (Pos) £22.10
  - Mesalazine 800 mg Octasa 800mg MR gastro-resistant tablets | 90 tablet (Pos) £40.38 | 180 tablet (Pos) £80.75 DT = £80.75

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 250 mg Salofalk 250mg gastro-resistant tablets | 100 tablet (Pos) £16.19 DT = £16.19
  - Mesalazine 500 mg Salofalk 500mg gastro-resistant tablets | 100 tablet (Pos) £32.38 DT = £32.38

**Suppository**

- **Pentasa** (Ferring Pharmaceuticals Ltd)
  - Mesalazine 1 gram Pentasa 1g suppositories | 28 suppository (Pos) £40.01 DT = £40.01

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 500 mg Salofalk 500mg suppositories | 30 suppository (Pos) £14.81 DT = £14.81

- **Mesalazine 1 gram** Pentasa 1g gastro-resistant modified-release granules | 28 sachet (Pos) £30.74 DT = £30.74

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 1 gram Salofalk 1g gastro-resistant modified-release granules sachets sugar-free | 50 sachet (Pos) £30.74 DT = £30.74

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 1 gram Salofalk 1g gastro-resistant modified-release granules sugar-free | 50 sachet (Pos) £30.74 DT = £30.74

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 1 gram Salofalk 1g gastro-resistant modified-release granules sugar-free | 60 sachet (Pos) £48.85 DT = £48.85

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 1 gram Salofalk 1g gastro-resistant modified-release granules sugar-free | 60 sachet (Pos) £97.70 DT = £97.70

**Enema**

- **Pentasa** (Ferring Pharmaceuticals Ltd)
  - Mesalazine 10 mg per 1 ml Pentasa Mesalazine 1g/100ml enema | 7 enema (Pos) £17.73 DT = £17.73

- **Salofalk** (Dr. Falk Pharma UK Ltd)
  - Mesalazine 1.5 mg per 1 ml Salofalk 2g/59ml enema | 7 enema (Pos) £29.92 DT = £29.92

**Sulfasalazine**

(Sulphasalazine)

**INDICATIONS AND DOSE**

- Treatment of acute attack of mild to moderate and severe ulcerative colitis | Active Crohn's disease
  - **BY MOUTH**
    - Child 2-11 years: 10–15 mg/kg 4–6 times a day (max. per dose 1 g) until remission occurs; increased if necessary up to 60 mg/kg daily in divided doses
    - Child 12-17 years: 1–2 g 4 times a day until remission occurs
  - **BY RECTUM**
    - Child 5–7 years: 500 mg twice daily
    - Child 8–11 years: 500 mg, dose to be administered in the morning and 1 g, dose to be administered at night
    - Child 12–17 years: 0.5–1 g twice daily

- Maintenance of remission of mild to moderate and severe ulcerative colitis
  - **BY MOUTH**
    - Child 2-11 years: 5–7.5 mg/kg 4 times a day (max. per dose 500 mg)
    - Child 12-17 years: 500 mg 4 times a day
  - **BY RECTUM**
    - Child 5–7 years: 500 mg twice daily
    - Child 8–11 years: 500 mg, dose to be administered in the morning and 1 g, dose to be administered at night
    - Child 12–17 years: 0.5–1 g twice daily

**Juvenile idiopathic arthritis**

- **BY MOUTH**
  - Child 2-11 years: Initially 5 mg/kg twice daily for 1 week, then 10 mg/kg twice daily for 1 week, then 20 mg/kg twice daily for 1 week; maintenance 20–25 mg/kg twice daily; maximum 2 g per day
  - Child 12–17 years: Initially 5 mg/kg twice daily for 1 week, then 10 mg/kg twice daily for 1 week, then 20 mg/kg twice daily for 1 week; maintenance 20–25 mg/kg twice daily; maximum 3 g per day

**UNLICENSED USE**

- Not licensed for use in children under 12 years.

**INTERACTIONS**

- Appendix 1: olsalazine

**SIDE-EFFECTS**

- Uncommon Paresthesia - tachycardia

**FREQUENCY NOT KNOWN**

- Palpitations - vision blurred

**PREGNANCY**

- Manufacturer advises avoid unless potential benefit outweighs risk.

**BREAST FEEDING**

- Monitoring Monitor breast-fed infants for diarrhoea.

**RENAI IMPAIRMENT**

- Use with caution; manufacturer advises avoid in significant impairment.

**DIRECTIONS FOR ADMINISTRATION**

- Capsules can be opened and contents sprinkled on food.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

- CAUTIONARY AND ADVISORY LABELS
  - Olsalazine sodium (Non-proprietary)
  - Olsalazine sodium 500 mg Olsalazine 500mg tablets | 60 tablet (Pos) £161.00 DT = £161.00

**Capsule**

- CAUTIONARY AND ADVISORY LABELS
  - Olsalazine sodium (Non-proprietary)
  - Olsalazine sodium 250 mg Olsalazine 250mg capsules | 112 capsule (Pos) £144.00 DT = £144.00

**IMPORTANT SAFETY INFORMATION**

**SAFE PRACTICE**

- Sulphasalazine has been confused with sulfadiazine; care must be taken to ensure the correct drug is prescribed and dispensed.

**CONTRA-INDICATIONS**

- Child under 2 years of age

**CAUTIONS**

- Acute porphyrias p. 624 • G6PD deficiency - history of allergy - history of asthma - maintain adequate fluid intake • risk of haematological toxicity • risk of hepatic toxicity • slow acetylator status

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**BNFC 2019–2020**

**Inflammatory bowel disease**

**33**

**Gastro-intestinal system**

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**BNFC 2019–2020**
**Budesonide**

**DRUG ACTION** Budesonide is a glucocorticoid, which exerts significant local anti-inflammatory effects.

**INDICATIONS AND DOSE**

**BUDENOFALK® CAPSULES**
- **Mild to moderate Crohn’s disease affecting the ileum or ascending colon**
  - **BY MOUTH**
    - Child 12-17 years: 3 mg 3 times a day for up to 8 weeks, reduce dose gradually over 2 weeks following treatment

**ENTOCORT® CAPSULES**
- **Mild to moderate Crohn’s disease affecting the ileum or ascending colon**
  - **BY MOUTH**
    - Child 12-17 years: 9 mg once daily for up to 8 weeks; reduce dose for the last 2–4 weeks of treatment, to be taken in the morning

**ENTOCORT® ENEMA**
- **Ulcereative colitis involving rectal and recto-sigmoid disease**
  - **BY RECTUM**
    - Child 12-17 years: 1 enema daily for 4 weeks, to be administered at bedtime

**UNLICENSED USE**
- Not licensed for use in children for Crohn’s disease or ulcerative colitis.

**INTERACTIONS** → Appendix 1: corticosteroids

**SIDE-EFFECTS**
- Common or very common
  - Insomnia • stomatitis • taste altered • tinnitus • urine abnormalities
- Uncommon
  - Face oedema • seizure • vasculitis • vertigo

**FREQUENCY NOT KNOWN**
- Anaemia • appetite decreased • ataxia • cyanosis • encephalopathy • haematuria • hallucination • hepatic failure • hypoprothrombinemia • lymphadenopathy • macrocytosis • meningitis aseptic • methaemoglobinemia • nephrotic syndrome • parotitis • periorbital oedema • pseudomembranous enterocolitis • serum sickness • severe cutaneous adverse reactions (SCARs) • smell disorders • systemic lupus erythematosus (SLE) • yellow discoloration of body fluids

**SIDE-EFFECTS, FURTHER INFORMATION**
- Incidence of side-effects increases with higher doses.
- **Blood disorders** Haematological abnormalities occur usually in the first 3 to 6 months of treatment—discontinue if these occur.

**PREGNANCY**
- Theoretical risk of neonatal haemolysis in third trimester; adequate folate supplements should be given to mother.

**BREAST FEEDING**
- Small amounts in milk (1 report of bloody diarrhoea); theoretical risk of neonatal haemolysis especially in G6PD-deficient infants.

**HEPATIC IMPAIRMENT**
- Manufacturer advises caution.

**RENAL IMPAIRMENT**
- Risk of toxicity, including crystalluria, in moderate impairment—ensure high fluid intake. Avoid in severe impairment.

**MONITORING REQUIREMENTS**
- Blood disorders Close monitoring of full blood counts (including differential white cell count and platelet count) is necessary initially, and at monthly intervals during the first 3 months.
- Renal function Although the manufacturer recommends renal function tests in rheumatic diseases, evidence of practical value is unsatisfactory.
- Liver function Liver function tests should be performed at monthly intervals for first 3 months.

**PATIENT AND CARER ADVICE**
- Contact lenses Some soft contact lenses may be stained.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Oral suspension**

**CAUTIONARY AND ADVISORY LABELS 14**
- EXCEPTED: May contain Alcohol
  - **Sulfasalazine (Non-proprietary)**
    - Sulfasalazine 50 mg per 1 ml Sulfasalazine 250mg/5ml oral suspension sugar free sugar-free | 500 ml (PvB) £44.50–£44.51 DT = £44.51
  - **Sulfasalazine 500 mg** Sulfasalazine 500mg gastro-resistant tablets | 112 tablet (PvB) £8.43 DT = £8.43
  - **Salazopyrin (Pfizer Ltd)**
    - Sulfasalazine 500 mg Salazopyrin EN-Tabs 500mg | 112 tablet (PvB) £8.43 DT = £8.43
  - **Salulazine EC** (Genesis Pharmaceuticals Ltd)
    - Sulfasalazine 500 mg Sululazine EC 500mg tablets | 112 tablet (PvB) £6.74 DT = £8.43

**Gastro-resistant tablet**

**CAUTIONARY AND ADVISORY LABELS 5, 14, 25**
- **Sulfasalazine (Non-proprietary)**
  - Sulfasalazine 500 mg Sulfasalazine 500mg gastro-resistant tablets | 112 tablet (PvB) £8.43 DT = £8.43
  - **Sulazopyrin** (Pfizer Ltd)
    - Sulfasalazine 500 mg Salazopyrin EN-Tabs 500mg | 112 tablet (PvB) £8.43 DT = £8.43
  - **Salulazine EC** (Genesis Pharmaceuticals Ltd)
    - Sulfasalazine 500 mg Sululazine EC 500mg tablets | 112 tablet (PvB) £6.74 DT = £8.43

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 14**
- **Sulfasalazine (Non-proprietary)**
  - Sulfasalazine 500 mg Sulfasalazine 500mg tablets | 112 tablet (PvB) £8.97 DT = £6.40
  - **Salazopyrin** (Pfizer Ltd)
    - Sulfasalazine 500 mg Salazopyrin 500mg tablets | 112 tablet (PvB) £6.97 DT = £6.40

**Suppository**

**CAUTIONARY AND ADVISORY LABELS 14**
- **Salazopyrin** (Pfizer Ltd)
  - Sulfasalazine 500 mg Salazopyrin 500mg suppositories | 10 suppository (PvB) £3.30

**CORTICOSTEROIDS**

**Budesonide**

**DRUG ACTION** Budesonide is a glucocorticoid, which exerts significant local anti-inflammatory effects.

**INDICATIONS AND DOSE**

**BUDENOFALK® CAPSULES**
- Mild to moderate Crohn’s disease affecting the ileum or ascending colon
  - **BY MOUTH**
    - Child 12-17 years: 3 mg 3 times a day for up to 8 weeks, reduce dose gradually over 2 weeks following treatment

**ENTOCORT® CAPSULES**
- Mild to moderate Crohn’s disease affecting the ileum or ascending colon
  - **BY MOUTH**
    - Child 12-17 years: 9 mg once daily for up to 8 weeks; reduce dose for the last 2–4 weeks of treatment, to be taken in the morning

**ENTOCORT® ENEMA**
- Ulcerative colitis involving rectal and recto-sigmoid disease
  - **BY RECTUM**
    - Child 12-17 years: 1 enema daily for 4 weeks, to be administered at bedtime

**UNLICENSED USE**
- Not licensed for use in children for Crohn’s disease or ulcerative colitis.

**INTERACTIONS** → Appendix 1: corticosteroids

**SIDE-EFFECTS**
- Common or very common
  - Insomnia • muscle twitching • oedema
  - With oral use • Muscle twitching • oedema
  - With rectal use • Diarrhoea • gastrointestinal disorders

**HEPATIC IMPAIRMENT**
- For Budenofalk ® manufacturer advises avoid in cirrhosis (risk of increased exposure, limited information available).

**MONITORING REQUIREMENTS**
- Manufacturer advises when used in autoimmune hepatitis, liver function tests should be monitored every 2 weeks for 1 month, then at least every 3 months.

**DIRECTIONS FOR ADMINISTRATION**
- Capsules can be opened and the contents mixed with apple or orange juice.

**PRESCRIBING AND DISPENSING INFORMATION**

**ENTOCORT® CAPSULES**
- Dispense modified-release capsules in original container (contains desiccant).

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Gastro-resistant capsule**

**CAUTIONARY AND ADVISORY LABELS 5, 10, 22, 25**
- **Budenofalk** (Dr. Falk Pharma UK Ltd)
  - Budesonide 3 mg Budenofalk 3mg gastro-resistant capsules | 100 capsule (PvB) £75.05 DT = £75.05

**Modified-release capsule**

**CAUTIONARY AND ADVISORY LABELS 5, 10, 25**
- **Entocort CR** (Tillotts Pharma Ltd)
  - Budesonide 3 mg Entocort CR 3mg capsules | 100 capsule (PvB) £84.15 DT = £84.15

**Enteric coated**
- **Entocort** (Tillotts Pharma Ltd)
  - Budesonide 20 microgram per 1 ml Entocort 2mg/100ml enema | 7 enema (PvB) £33.66
**INFLAMMATORY BOWEL DISEASE**

**INFliximAB**

**Indications and dose**

**Severe active Crohn’s disease**
- **by intravenous infusion**
  - Child <6 months: Initially 5 mg/kg, then 5 mg/kg after 2 weeks, then 5 mg/kg after 4 weeks, then maintenance 5 mg/kg every 8 weeks, interval between maintenance doses adjusted according to response; discontinue if no response within 10 weeks of initial dose

**Fistulating Crohn’s disease**
- **by intravenous infusion**
  - Child 6–17 years: Initially 5 mg/kg, then 5 mg/kg after 2 weeks, followed by 5 mg/kg after 4 weeks, if condition has responded consult product literature for guidance on further doses

**Severe active ulcerative colitis**
- **by intravenous infusion**
  - Child 6–17 years: Initially 5 mg/kg, then 5 mg/kg after 2 weeks, followed by 5 mg/kg after 4 weeks, then 5 mg/kg every 8 weeks, discontinue if no response within 8 weeks of initial dose

**Unlicensed use**
- Not licensed for fistulating Crohn’s disease in children.

**Important Safety Information**

Adequate resuscitation facilities must be available when infliximab is used.

**Contra-indications**

- Moderate or severe heart failure
- Severe infections

**Cautions**

- Demyelinating disorders (risk of exacerbation)
- Dermatomyositis (development of malignancy)
- Hepatitis B virus—monitor for active infection
- History of malignancy
- History of prolonged immunosuppressant or PUVA treatment in patients with psoriasis
- Mild heart failure (discontinue if symptoms develop or worsen)
- Predisposition to infection (discontinue if new serious infection develops)
- Risk of delayed hypersensitivity reactions if drug-free interval exceeds 16 weeks (re-administration after interval exceeding 16 weeks not recommended)

**Caution, further information**

- Infection
  - Manufacturer advises patients should be up-to-date with current immunisation schedule before initiating treatment.
  - Tuberculosis
    - Manufacturer advises patients for active and latent tuberculosis before treatment. Active tuberculosis should be treated with standard treatment for at least 2 months before starting infliximab. If latent tuberculosis is diagnosed, treatment should be started before commencing treatment with infliximab. Patients who have previously received adequate treatment for tuberculosis can start infliximab but should be monitored every 3 months for possible recurrence. In patients without active tuberculosis but who were previously not treated adequately, chemoprophylaxis should ideally be completed before starting infliximab. Patients at high risk of tuberculosis cannot be assessed by tuberculin skin test, chemoprophylaxis can be given concurrently with infliximab. Patients should be advised to seek medical attention if symptoms suggestive of tuberculosis develop (e.g. persistent cough, weight loss and fever).
  - Hypersensitivity reactions
    - Hyper-sensitivity reactions (including fever, chest pain, hypotension, hypertension, dyspnoea, transient visual loss, pruritus, urticaria, serum sickness-like reactions, angioedema, anaphylaxis) reported during or within 1–2 hours after infusion (risk greatest during first or second infusion or in patients who discontinue other immunosuppressants). Manufacturer advises prophylactic antipyretics, antihistamines, or hydrocortisone may be administered.

**Interactions**

- **Appendix 1: monoclonal antibodies**

**Side-effects**

- **Common or very common**
  - Abcess, alopecia, anaemia, arthralgia, chest pain, chills, constipation, decreased leucocytes, depression, diarrhoea, dizziness, dyspnoea, eye inflammation, fatigue, fever, gastrointestinal discomfort, gastrointestinal disorders, haemorrhage, headache, hepatic disorders, hyperhidrosis, hypotension, hypertension, increased risk of infection, infusion related reaction, insomnia, lymphenadenopathy, myalgia, nausea, neutropenia, oedema, pain, palpitations, respiratory disorders, sensation abnormal, sepsis, skin reactions, vasodilatation, vertigo
- **Uncommon**
  - Anxiety, chelitis, cholecystitis, confusion, drowsiness, healing impaired, heart failure, hyperventilation, lupus-like syndrome, lymphocytosis, memory loss, neutropenia, nerve disorders, pancreatitis, peripheral ischaemia, pulmonary oedema, seborrhoea, seizure, syncope, thrombocytopenia, thrombophlebitis
- **Rare or very rare**
  - Agranulocytosis, circulatory collapse, cyanosis, demyelinating disorders, granuloma, haemolytic anaemia, hepatitis B reactivation, meningitis, pneumonia, peripheral effusion, sarcoidosis, severe cutaneous adverse reactions (SCARs), transverse myelitis, vasculitis, vasospasm
- **Frequency not known**
  - Bone fracture, dermatomyositis, exacerabated, hepatosplenic T-cell lymphoma (increased risk in inflammatory bowel disease), myocardial infarction, myocardial ischaemia, ulcerative colitis aggravated, vision loss

**Conception and contraception**

- Manufacturer advises adequate contraception during and for at least 6 months after last dose.

**Pregnancy**

- Use only if essential.

**Breast feeding**

- Amount probably too small to be harmful.

**Pre-treatment screening**

- Tuberculosis
  - Manufacturer advises patients should be evaluated for tuberculosis before treatment.

**Monitoring requirements**

- Monitor for infection before, during, and for 6 months after treatment.
- All patients should be observed carefully for 1–2 hours after infusion and resuscitation equipment should be available for immediate use (risk of hypersensitivity reactions).
- Monitor for symptoms of delayed hypersensitivity if re-administered after a prolonged period.
- Manufacturer advises periodic skin examination for non-melanoma skin cancer, particularly in patients with risk factors.

**Directions for administration**

- For **intravenous infusion** reconstitute each 100-mg vial of powder with 10 mL Water for Injections; to dissolve, gently swirl vial without shaking; allow to stand for 5 minutes; dilute required dose with Sodium Chloride 0.9% to a final volume of 250 mL and give through a low protein-binding filter (1.2 micron or less) over at least 2 hours; start infusion within 3 hours of reconstitution.

**Prescribing and dispensing information**

- Infliximab is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1.
1.3 Irritable bowel syndrome

Irritable bowel syndrome

24-Feb-2016

Description of condition

Irritable bowel syndrome (IBS) is a gastrointestinal disorder characterised by abdominal pain or discomfort that may be relieved by defaecation. It can also be associated with the passage of mucus, bloating, and disordered defaecation; either diarrhoea, constipation, or alternating diarrhoea and constipation. Constipation presents with straining, urgency, and a sensation of incomplete evacuation. Before a diagnosis of IBS is made, the symptoms should be present at least once per week for at least 2 months and other potential pathological causes of the symptoms should be excluded. IBS symptoms are often aggravated by psychological factors, such as anxieties, emotional stress, and fear.

Aims of treatment

Treatment of IBS is focused on symptom control in order to improve quality of life, including minimising abdominal pain and normalising the frequency and consistency of stools.

Non-drug treatment

There is no evidence of the effectiveness of any form of dietary advice or increased fibre intake in children and it is not known whether dietary advice recommended to adult patients is of benefit to children.

Eating regularly, limiting fresh fruit intake, and, reducing intake of ‘resistant starch’ and insoluble fibre (e.g. bran) can be recommended. If an increase in dietary fibre is required, soluble fibre such as oats, ispaghula husk p. 42, or sterculia p. 43 can be recommended. Ensuring a sufficient intake of fluids can also be recommended.

Drug treatment

Clinicians should only prescribe drugs for children with IBS in cases of severe symptoms that have not responded to non-drug approaches. Treatment options include laxatives, antimitotility drugs or antispasmodic drugs.

A laxative can be used to treat abdominal pain if the underlying cause is suspected to be constipation. An osmotic laxative, such as a macrogol or lactulose p. 43, is preferred; lactulose may cause flatulence during the first few days of treatment. Loperamide hydrochloride p. 51 may relieve diarrhoea and antispasmodic drugs may relieve pain.

ANTISPASMODICS

Mebeverine with ispaghula husk

04-Feb-2016

The properties listed below are those particular to the combination only. For the properties of the components please consider, mebeverine hydrochloride p. 65, ispaghula husk p. 42.

• INDICATIONS AND DOSE

Irritable bowel syndrome

• BY MOUTH

• Child 12-17 years: 1 sachet twice daily, in water, morning and evening, 30 minutes before food and 1 sachet daily if required, taken 30 minutes before midday meal

• DIRECTIONS FOR ADMINISTRATION

Contents of one sachet should be stirred into a glass (approx. 150 mL) of cold water and drunk immediately.
ensuring adequate nutrition and drug absorption, thereby

Aims of treatment

Methods of short bowel syndrome focuses on

Short bowel syndrome

Short bowel syndrome

1.4 Short bowel syndrome

Description of condition

Children with a shortened bowel due to large surgical

Aims of treatment

The management of short bowel syndrome focuses on

Drug treatment

Nutritional deficiencies

Children with a short bowel may require replacement of

Diarrhoea and high output stomas

Diarrhoea is a common symptom of short bowel syndrome

Antimotility drugs

Loperamide hydrochloride p. 51 reduces intestinal

Colestyramine

In children with an intact colon and less than

Antisecretory drugs

Use of a proton pump inhibitor alone does not eliminate the

Growth factors

Growth factors can be used to facilitate intestinal adaptation

Drug absorption

For Prescribing in children with stoma see Stoma care p. 75.
Many drugs are incompletely absorbed by children with a short bowel and may need to be prescribed in much higher doses than usual (such as levothyroxine, warfarin, oral contraceptives, and digoxin) or may need to be given intravenously.

Several factors can alter the absorption of drugs taken by mouth in children with a compromised gastrointestinal system. The most important factors are the length of intestine available for drug absorption, and which section system. The most important factors are the length of mouth in children with a compromised gastrointestinal

SIDE-EFFECTS

Colo-rectal polyps

CAUTIONS

CONTRA-INDICATIONS

AMINO ACIDS AND DERIVATIVES

Teduglutide

DRUG ACTION Teduglutide is an analogue of human glucagon-like peptide-2 (GLP-2), which preserves mucosal integrity by promoting growth and repair of the intestine.

INDICATIONS AND DOSE

Short bowel syndrome (initiated under specialist supervision)

BY SUBCUTANEOUS INJECTION

Child 1-17 years: 0.05 mg/kg once daily, dose to be administered to alternating quadrants of the abdomen; alternatively the thigh can be used, for optimal injection volume per body weight, consult product literature. Review treatment after 12 weeks

CONTRA-INDICATIONS Active or suspected malignancy · history of gastro-intestinal malignancy (in previous 5 years)

CAUTIONS Abrupt withdrawal of parental support (reduce gradually with concurrent monitoring of fluid status) · cardiac insufficiency · cardiovascular disease · colo-rectal polyps · hypertension

CAUTIONS, FURTHER INFORMATION

Colo-rectal polyps. Manufacturer recommends faecal occult blood testing in children before initiation of treatment and yearly thereafter. Manufacturer also advises colonoscopy or sigmoidoscopy in children aged 12 years and older before initiation of treatment, after 1 year of treatment and then every 5 years thereafter. Colonoscopy or sigmoidoscopy should be performed in all children with unexplained blood in stool.

SIDE-EFFECTS

Common or very common Anxiety · appetite decreased · congestive heart failure · cough · dyspnoea · fluid imbalance · gallbladder disorders · gastrointestinal discomfort · gastrointestinal disorders · gastrointestinal stoma complication · headache · influenza like illness · insomnia · nausea · pancreatitis · peripheral oedema · respiratory tract infection · vomiting

Uncommon Syncope

ALLERGY AND CROSS-SENSITIVITY Manufacturer advises caution in patients with tetracycline hypersensitivity.

PREGNANCY Specialist sources indicate use if necessary—no human data available.

BREAST FEEDING Manufacturer advises avoid—toxicity in animal studies.

RENAL IMPAIRMENT

Dose adjustments Manufacturer advises use half the daily dose in moderate or severe impairment and end-stage renal disease.

MONITORING REQUIREMENTS Manufacturer advises monitoring of small bowel function, gall bladder, bile ducts and pancreas during treatment.

TREATMENT CESSATION Caution when discontinuing treatment—risk of dehydration.

PATIENT AND CARER ADVICE Patients with cardiovascular disease should seek medical attention if they notice sudden weight gain, swollen ankles or dyspnoea—may indicate increased fluid absorption.

NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

SMC No. 1139/16

The Scottish Medicines Consortium has advised (April 2018) that teduglutide (Revestive®) is accepted for restricted use within NHS Scotland for the treatment of short bowel syndrome, initiated in paediatric patients aged 1 to 17 years. Patients should be stable following a period of intestinal adaptation after surgery. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Powder and solvent for solution for injection

Teduglutide 1.25 mg Revestive 1.25 mg powder and solvent for solution for injection vials | 28 vial £7307.70

Teduglutide 5 mg Revestive 5 mg powder and solvent for solution for injection vials | 28 vial £14615.39

2 Constipation and bowel cleansing

2.1 Bowel cleansing

Other drugs used for Bowel cleansing Bisacodyl, p. 47 · Docusate sodium, p. 46 · Magnesium sulfate, p. 618

DIAGNOSTIC AGENTS > RADIOGRAPHIC CONTRAST MEDIA

Meglumine amidotrizoate with sodium amidotrizoate

(Diatrizoates)

DRUG ACTION Meglumine amidotrizoate with sodium amidotrizoate is a radiological contrast medium with high osmolality.

INDICATIONS AND DOSE

Uncomplicated meconium ileus

BY RECTUM

Neonate: 15–30 mL for 1 dose.
Bowel cleansing

**Distal intestinal obstruction syndrome in children with cystic fibrosis**
- **BY MOUTH, OR BY RECTUM**
  - Child 1-2 months: 15–30 mL for 1 dose
  - Child (body-weight 15-25 kg): 50 mL for 1 dose
  - Child (body-weight 26 kg and above): 100 mL for 1 dose

**Radiological investigations**
- Child: Dose to be recommended by radiologist

**SIDE-EFFECTS**

**SPECIFIC SIDE-EFFECTS**
- With oral use Oral blistering
- **ALLERGY AND CROSS-SENSITIVITY** Hypersensitivity to iodine.
- **PREGNANCY** Manufacturer advises caution.
- **BREAST FEEDING** Amount probably too small to be harmful.
- **DIRECTIONS FOR ADMINISTRATION** Intravenous prehydration is essential in neonates and infants. Fluid intake should be encouraged for 3 hours after administration. By mouth, for child bodyweight under 25 kg, dilute Gastrografin® with 3 times its volume of water or fruit juice; for child bodyweight over 25 kg, dilute Gastrografin® with twice its volume of water or fruit juice. By rectum, administration must be carried out slowly under radiological supervision to ensure required site is reached. For child under 5 years, dilute Gastrografin® with 5 times its volume of water; for child over 5 years dilute Gastrografin® with 4 times its volume of water.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
- **Oral solution**
  - **Excipients:** May contain Disodium edetate
  - **Gastrografin** (Bayer Plc)
    - Sodium amidotrizoate 100 mg per 1 ml, Meglumine amidotrizoate 660 mg per 1 ml Gastrografin oral solution sugar-free | 1000 mL | £175.00

**LAXATIVES** > Osmotic laxatives

**Citric acid with magnesium carbonate**
*Formulated as a bowel cleansing preparation*

**INDICATIONS AND DOSE**
- **Bowel evacuation for surgery, colonoscopy or radiological examination**
  - **BY MOUTH**
  - Child 5-9 years: One-third of a sachet to be given at 8 a.m. the day before the procedure and, one-third of a sachet to be given between 2 and 4 p.m. the day before the procedure
  - Child 10-17 years: 0.5–1 sachet, given at 8 a.m. the day before the procedure and 0.5–1 sachet, given between 2 and 4 p.m. the day before the procedure

**CONTRA-INDICATIONS** Acute severe colitis - gastric retention - gastro-intestinal obstruction - gastro-intestinal perforation - toxic megacolon

**CAUTIONS** Children - colitis (avoid if acute severe colitis) - debilitated - hypovolaemia (should be corrected before administration of bowel cleansing preparations) - impaired gag reflex or possibility of regurgitation or aspiration - patients with fluid and electrolyte disturbances

**CAUTIONS, FURTHER INFORMATION** Adequate hydration should be maintained during treatment.

**INTERACTIONS** > Appendix 1: bowel cleansing preparations

**SIDE-EFFECTS**
- Common or very common Gastrointestinal discomfort - nausea - vomiting
- Uncommon Dehydration - dizziness - electrolyte imbalance - headache

** Specific side-effects, further information** Abdominal pain is usually transient and can be reduced by taking preparation more slowly.

**PREGNANCY** Use with caution.

**BREAST FEEDING** Use with caution.

**RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m² - risk of hypermagnesaemia.

**MONITORING REQUIREMENTS** Renal function should be measured before starting treatment in patients at risk of fluid and electrolyte disturbances.

**DIRECTIONS FOR ADMINISTRATION** One sachet should be reconstituted with 200 mL of hot water; the solution should be allowed to cool for approx. 30 minutes before drinking.

**PRESCRIBING AND DISPENSING INFORMATION**
Reconstitution of one sachet containing 11.57 g magnesium carbonate and 17.79 g anhydrous citric acid produces a solution containing magnesium citrate with 118 mmol Mg²⁺.

Flavours of oral powders may include lemon and lime.

**PATIENT AND CARER ADVICE** Low residue or fluid only diet (e.g. water, fruit squash, clear soup, black tea or coffee) recommended before procedure (according to prescriber’s advice) and copious intake of clear fluids recommended until procedure. Patient or carers should be given advice on how to administer oral powder.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Effervescent powder**
- **CAUTIONARY AND ADVISORY LABELS** 13, 10
- **ELECTROLYTES:** May contain Magnesium
  - Citramag (Sanochemia Diagnostics UK Ltd)
    - Magnesium carbonate heavy 11.57 gram, Citric acid anhydrous 17.79 gram Citramag effervescent powder sachets sugar-free | 10 sachet | £20.50

**BNFC 2019-2020**

Gastro-intestinal system
Macrogol 3350 with anhydrous sodium sulfate, potassium chloride, sodium bicarbonate and sodium chloride
(Formulated as a bowel cleansing preparation)

- **INDICATIONS AND DOSE**
  - Bowel cleansing before radiological examination, colonoscopy, or surgery
    - **INITIALLY BY MOUTH**
    - **Child 12-17 years:** Initially 2 litres daily for 2 doses: first dose of reconstituted solution taken on the evening before procedure and the second dose on the morning of procedure, alternatively (by mouth) initially 250 mL every 10–15 minutes, reconstituted solution to be administered, alternatively (by nasogastric tube) initially 20–30 mL/minute, starting on the day before procedure until 4 litres have been consumed
  - **Distal intestinal obstruction syndrome**
    - **BY MOUTH, OR BY NASOGASTRIC TUBE, OR BY GASTROSTOMY TUBE**
    - **Child 1-17 years:** 10 mL/kilogram/hour for 30 minutes, then increased to 20 mL/kilogram/hour for 30 minutes, then increased if tolerated to 25 mL/kilogram/hour, max. 100 mL/kg (or 4 litres) over 4 hours, repeat 4 hour treatment if necessary

- **UNLICENSED USE** Klean-Prep® not licensed for use in children.
- **CONTRA-INDICATIONS** Acute severe colitis - gastric retention - gastro-intestinal obstruction - gastro-intestinal perforation - gastro-intestinal ulceration - toxic megacolon
- **CAUTIONS** Children - colitis (avoid if acute severe colitis) - debilitated patients - fluid and electrolyte disturbances - heart failure - hypovolaemia (should be corrected before administration of bowel cleansing preparations) - impaired gastro-intestinal disorders - impaired rectal or vaginal absorption - impaired rectal or vaginal absorption - impaired rectal or vaginal absorption - impaired rectal or vaginal absorption
- **INTERACTIONS** → Appendix 1: bowel cleansing preparations
- **SIDE-EFFECTS** Angioedema - arrhythmia - chills - confusion - dehydration - dizziness - dyspnea - electrolyte imbalance - fever - flatulence - gastro-intestinal discomfort - headache - malaise - nausea - palpitations - seizure - skin reactions - thirst - vomiting
- **SIDE-EFFECTS, FURTHER INFORMATION** Abdominal pain is usually transient and can be reduced by taking preparation more slowly.
- **PREGNANCY** Manufacturers advise use only if essential—no information available.
- **BREAST FEEDING** Manufacturers advise use only if essential—no information available.
- **MONITORING REQUIREMENTS** Renal function should be measured before starting treatment in patients at risk of fluid and electrolyte disturbances.
- **DIRECTIONS FOR ADMINISTRATION** 1 sachet should be reconstituted with 1 litre of water. Flavouring such as clear fruit cordials may be added if required. After reconstitution the solution should be kept in a refrigerator and discarded if unused after 24 hours.
- **PRESCRIBING AND DISPENSING INFORMATION** Each Klean-Prep® sachet provides Na+ 125 mmol, K+ 10 mmol, Cl− 35 mmol and HCO3− 20 mmol when reconstituted with 1 litre of water.
- **PATIENT AND CARER ADVICE** Solid food should not be taken for 2 hours before starting treatment. Adequate hydration should be maintained during treatment.

Treatment can be stopped if bowel motions become watery and clear.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Powder**
    - **CAUTIONARY AND ADVISORY LABELS 10, 13**
    - **EXCIPIENTS:** May contain Aspartame
    - **ELECTROLYTES:** May contain Bicarbonate, chloride, potassium, sodium
  - **Klean-Prep** (Forum Health Products Ltd)
    - Potassium chloride 742.5 mg, Sodium chloride 1.465 gram, Sodium bicarbonate 1.685 gram, Sodium sulfate anhydrous 5.685 gram, Polyethylene glycol 3350 59 gram Klean-Prep oral powder 60g sachets sugar-free | 4 sachet £ 110.48

LAXATIVES > STIMULANT LAXATIVES

Magnesium citrate with sodium picosulfate
(Formulated as a bowel cleansing preparation)

- **INDICATIONS AND DOSE**
  - **PICOLAX® SACHETS**
    - Bowel evacuation on day before radiological procedure, endoscopy, or surgery
      - **BY MOUTH**
      - **Child 1 year:** 0.25 sachet taken before 8 a.m, then 0.25 sachet after 6–8 hours
      - **Child 2-3 years:** 0.5 sachet taken before 8 a.m, then 0.5 sachet after 6–8 hours
      - **Child 4-8 years:** 1 sachet taken before 8 a.m, then 0.5 sachet after 6–8 hours
      - **Child 9-17 years:** 1 sachet taken before 8 a.m, then 1 sachet after 6–8 hours

- **CONTRA-INDICATIONS** Acute severe colitis - ascites - congestive cardiac failure - gastric retention - gastro-intestinal obstruction - gastro-intestinal perforation - gastro-intestinal ulceration - toxic megacolon
- **CAUTIONS** Cardiac disease (avoid in congestive cardiac failure) - children - colitis (avoid if acute severe colitis) - debilitated patients - fluid and electrolyte disturbances - hyponatraemia (should be corrected before administration) - impaired rectal or vaginal absorption - impaired rectal or vaginal absorption - impaired rectal or vaginal absorption
- **SIDE-EFFECTS**
  - **Common or very common** Gastrointestinal discomfort - headache - nausea
  - **Uncommon** Confusion - electrolyte imbalance - gastrointestinal disorders - seizures - skin reactions - vomiting
- **PREGNANCY** Caution.
- **BREAST FEEDING** Caution.
- **HEPATIC IMPAIRMENT** Avoid in hepatic coma if risk of renal failure.
- **RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m²—risk of hypermagnesaemia.
- **DIRECTIONS FOR ADMINISTRATION** One sachet of sodium picosulfate with magnesium citrate powder should be reconstituted with 150 mL (approx. half a glass) of cold water; patients should be warned that heat is generated during reconstitution and that the solution should be allowed to cool before drinking.
- **PICOLAX® SACHETS** One sachet should be reconstituted with 150 mL (approx. half a glass) of cold water.
- **PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral powder formulations may include lemon.
Stimulant laxatives include bisacodyl p.

Bulk-forming laxatives include bran, ispaghula husk p.

Laxatives

The child
can occur at any age and is infrequent stools, diffuse stool passage, or seemingly complete defaecation. It can occur at any age and is common in childhood.

Overview

Before prescribing laxatives it is important to be sure that the child is constipated and that the constipation is not secondary to an underlying undiagnosed complaint. Early identification of constipation and effective treatment can improve outcomes for children. Without early diagnosis and treatment, an acute episode of constipation can lead to anal seepage and the risks of granulomatous disease of the gastro-intestinal tract or of lipid pneumonia on aspiration.

Osmotic laxatives

Osmotic laxatives increase the amount of water in the large bowel, either by drawing fluid from the body into the bowel or by retaining the fluid they were administered with. Lactulose p. 43 is a semi-synthetic disaccharide which is not absorbed from the gastro-intestinal tract. It produces an osmotic diarrhoea of low faecal pH and discourages the proliferation of ammonia-producing organisms. It is therefore useful in the treatment of hepatic encephalopathy. Macrogols (such as macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride p. 44) are inert polymers of ethylene glycol which sequester fluid in the bowel; giving fluid with macrogols may reduce the dehydration effect sometimes seen with osmotic laxatives. 

Macrogols are an effective non-traumatic means of evacuation in children with faecal impaction and can be used in the long-term management of chronic constipation.

Bowel cleansing preparations

Bowel cleansing preparations are used before colonic surgery, colonoscopy, or radiological examination to ensure the bowel is free of solid contents; examples include macrogol 3350 with anhydrous sodium sulfate, potassium chloride, sodium bicarbonate and sodium chloride p. 40, citric acid with magnesium carbonate p. 39, magnesium citrate with sodium picosulfate p. 40 and sodium acid phosphate with sodium phosphate p. 45. Bowel cleansing preparations are not treatments for constipation.

Management

The first-line treatment for children with constipation requires the use of a laxative in combination with dietary modification or with behavioural interventions. Diet modification alone is not recommended as first-line treatment.

In children, an increase in dietary fibre, adequate fluid intake and exercise is advised. Diet should be balanced and contain fruits, vegetables, high-fibre bread, baked beans and wholegrain breakfast cereals. Unprocessed bran (which may cause bloating and flatulence and reduces the absorption of micronutrients) is not recommended.

If faecal impaction is not present (or has been treated), the child should be treated promptly with a laxative. A macrogol (such as macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride) is preferred as first-line management. If the response is inadequate, add a stimulant laxative or change to a stimulant laxative if the first-line therapy is not tolerated. If stools remain hard, lactulose or another laxative with softening effects, such as docusate sodium can be added.

In children with chronic constipation, laxatives should be continued for several weeks after a regular pattern of bowel movements or toilet training is established. The dose of laxatives should then be tapered gradually, over a period of months, according to response. Some children may require laxative therapy for several years.

A shorter duration of laxative treatment may be possible in some children with a short history of constipation. Laxatives should be administered at a time that produces an effect that is likely to fit in with the child’s toilet routine.

Faecal softeners

Faecal softeners are claimed to act by decreasing surface tension and increasing penetration of intestinal fluid into the faecal mass. Docusate sodium, and glycerol suppositories p. 48 have softening properties. Enemas containing arachis oil p. 46 (ground-nut oil, peanut oil) lubricate and soften impacted faeces and promote a bowel movement. Liquid paraffin has also been used as a lubricant for the passage of stool but manufacturer advises that it should be used with caution because of its adverse effects, which include anal seepage and the risks of granulomatous disease of the gastro-intestinal tract or of lipid pneumonia on aspiration.
Faecal impaction

Treatment of faecal impaction may initially increase symptoms of soiling and abdominal pain. In children over 1 year of age with faecal impaction, an oral preparation containing a macrogol (such as macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride) is used to clear faecal mass and to establish and maintain soft well-formed stools, using an escalating dose regimen depending on symptoms and response. If disimpaction does not occur after 2 weeks, a stimulant laxative can be added or if stools are hard, used in combination with an osmotic laxative such as lactulose. Long-term regular use of laxatives is essential to maintain well-formed stools and prevent recurrence of faecal impaction; intermittent use may provoke relapses.

Suppositories and enemas should not be used in primary care unless all oral medications have failed and preferably only then following specialist advice. If the impacted mass is not expelled following treatment with macrogols and a stimulant laxative, a sodium citrate enema p. 46 can be administered. Although rectal administration of laxatives may be effective, this route is frequently distressing for the child and may lead to persistence of withholding. A sodium acid phosphate with sodium phosphate enema may be administered under specialist supervision if disimpaction does not occur after a sodium citrate enema. Manual evacuation under anaesthetic may be necessary if disimpaction does not occur after oral and rectal treatment, or if the child is afraid. Children undergoing disimpaction should be reviewed within one week. Maintenance treatment should be started as soon as the bowel is disimpacted.

Useful Resources

www.nice.org.uk/guidance/cg99

LAXATIVES > BULK-FORMING LAXATIVES

Ispaghula husk

24-Feb-2016

DRUG ACTION

Bulk-forming laxatives relieve constipation by increasing faecal mass which stimulates peristalsis.

INDICATIONS AND DOSE

Constipation

BY MOUTH

- Child 1 month–5 years: 2.5–5 mL twice daily, dose to be taken only when prescribed by a doctor, as half or whole level spoonful in water, preferably after meals, morning and evening
- Child 6–11 years: 2.5–5 mL twice daily, dose to be given as a half or whole level spoonful in water, preferably after meals, morning and evening
- Child 12–17 years: 1 sachet twice daily, dose to be given in water preferably after meals, morning and evening

DOSE EQUIVALENCE AND CONVERSION

- 1 sachet equivalent to 2 level 5 mL spoonfuls.

CONTRA-INDICATIONS

Colonic atony · faecal impaction · intestinal obstruction · reduced gut motility

CAUTIONS

Adequate fluid intake should be maintained to avoid intestinal obstruction

SIDE-EFFECTS

Abdominal distension · bronchospasm · conjunctivitis · gastrointestinal disorders · hypersensitivity · rhinitis · skin reactions

DIRECTIONS FOR ADMINISTRATION

Dose to be taken with at least 150 mL liquid.

Methylcellulose

DRUG ACTION

Bulk-forming laxatives relieve constipation by increasing faecal mass which stimulates peristalsis.

INDICATIONS AND DOSE

Constipation | Diarrhoea

BY MOUTH USING TABLETS

- Child 7–11 years: 2 tablets twice daily
- Child 12–17 years: 3–6 tablets twice daily

UNLICENSED USE

No age limit specified by manufacturer.

CONTRA-INDICATIONS

Colonic atony · difficulty in swallowing · faecal impaction · infective bowel disease · intestinal obstruction

CAUTIONS

Adequate fluid intake should be maintained to avoid intestinal obstruction

SIDE-EFFECTS

Abdominal distension · gastrointestinal disorders

DIRECTIONS FOR ADMINISTRATION

In constipation the dose should be taken with at least 300 mL liquid. In diarrhoea, ileostomy, and colostomy control, avoid liquid intake for 30 minutes before and after dose.

PATIENT AND CARER ADVICE

Patients and their carers should be advised that the full effect may take some days to develop. Preparations that swell in contact with liquid

PRESCRIBING AND DISPENSING INFORMATION

Flavours of soluble granules formulations may include plain, lemon, or orange.

HANDLING AND STORAGE

Ispaghula husk contains potent allergens. Individuals exposed to the product (including those handling the product) can develop hypersensitivity reactions such as rhinitis, conjunctivitis, bronchospasm and in some cases, anaphylaxis.

PATIENT AND CARER ADVICE

Manufacturer advises that preparations that swell in contact with liquid should always be carefully swallowed with water and should not be taken immediately before going to bed. Patients and their carers should be advised that the full effect may take some days to develop and should be given advice on how to administer Ispaghula husk.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Effervescent granules

CAUTIONARY AND ADVISORY LABELS

EXCIPIENTS: May contain Aspartame

- Fybogel (Reckitt Benckiser Healthcare (UK) Ltd)
  Ispaghula husk 3.5 gram · Fybogel 3.5 g effervescent granules sachets plain SF sugar-free | 30 sachet (G) £2.83 DT + £2.83
  Fybogel Orange 3.5g effervescent granules sachets SF sugar-free | 30 sachet (G) £2.83 DT + £2.83
  Fybogel Lemon 3.5g effervescent granules sachets SF sugar-free | 30 sachet (G) £2.83 DT + £2.83

- Fybogel Hi-Fibre (Reckitt Benckiser Healthcare (UK) Ltd)
  Ispaghula husk 3.5 gram · Fybogel Hi-Fibre Orange 3.5g effervescent granules sachets sugar-free | 30 sachet (G) £2.26 sugar-free | 30 sachet (G) £4.85 DT + £2.83
  Fybogel Hi-Fibre Lemon 3.5g effervescent granules sachets sugar-free | 10 sachet (G) £2.26

- Ispagel (Bristol Laboratories Ltd)
  Ispaghula husk 3.5 gram · Ispagel Orange 3.5g effervescent granules sachets sugar-free | 10 sachet (G) £2.45 DT + £2.83

Granules

CAUTIONARY AND ADVISORY LABELS

EXCIPIENTS: May contain Aspartame

- Ispaghula husk (Non-proprietary)
  Ispaghula husk 3.5 gram · Ispaghula husk 3.5g granules sachets gluten free | 30 sachet (G) £2.83

Combinations available: Senna with ispaghula husk, p. 49
should always be carefully swallowed with water and should not be taken immediately before going to bed.

● MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Tablet
- Celevac (Advanz Pharma)

Methycellulose "450" 500 mg Celevac 500mg tablets | 112 tablet GSK £3.22 DT + £3.22

Sterculia
19-Feb-2016

● DRUG ACTION Sterculia is a bulk-forming laxative. It relieves constipation by increasing faecal mass which stimulates peristalsis.

● INDICATIONS AND DOSE
  Constipation
  ▶ BY MOUTH
  - Child 6-11 years: 0.5–1 sachet 1–2 times a day, alternatively, half to one heaped 5-ml spoonful once or twice a day; washed down without chewing with plenty of liquid after meals
  - Child 12-17 years: 1–2 sachets 1–2 times a day, alternatively, one to two heaped 5-ml spoonfuls once or twice a day; washed down without chewing with plenty of liquid after meals

● CONTRA-INDICATIONS Colonic atony · difficulty in swallowing · faecal impaction · intestinal obstruction
● CAUTIONS Adequate fluid intake should be maintained to avoid intestinal obstruction
● SIDE-EFFECTS Diarrhoea · gastrointestinal discomfort · gastrointestinal disorders · nausea
● DIRECTIONS FOR ADMINISTRATION May be mixed with soft food (e.g. yoghurt) before swallowing, followed by plenty of liquid.

● PATIENT AND CARER ADVICE Patients and their carers should be advised that the full effect may take some days to develop. Preparations that swell in contact with liquid should always be carefully swallowed with water and should not be taken immediately before going to bed.

● MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Granules
- Normacol Plus (Forum Health Products Ltd)

Fragula 80 mg per 1 gram Sterculia 620 mg per 1 gram Normacol Plus granules 7g sachets | 60 sachet GSK £7.12 DT = £7.12
Normacol Plus granules | 500 gram GSK £8.45 DT + £8.45

Lactulose

● INDICATIONS AND DOSE
  Constipation
  ▶ BY MOUTH
  - Child 1-11 months: 2.5 ml twice daily, adjusted according to response
  - Child 1-4 years: 2.5–10 ml twice daily, adjusted according to response
  - Child 5-17 years: 5–20 ml twice daily, adjusted according to response

Hepatic encephalopathy (portal systemic encephalopathy)
  ▶ BY MOUTH
  - Child 12-17 years: Adjusted according to response to 30–50 mL 3 times a day, subsequently adjusted to produce 2–3 soft stools per day

PHARMACOKINETICS
  - Lactulose may take up to 48 hours to act.

● UNLICENSED USE Not licensed for use in children for hepatic encephalopathy.

● CONTRA-INDICATIONS Galactosaemia · intestinal obstruction

● CAUTIONS Lactose intolerance

● SIDE-EFFECTS
  - Common or very common Abdominal pain · diarrhoea · flatulence · nausea · vomiting
  - Uncommon Electrolyte imbalance

● PREGNANCY Not known to be harmful.

● PATIENT AND CARER ADVICE
  - Medicines for Children leaflet: Lactulose for constipation
  - www.medicinesforchildren.org.uk/lactulose-constipation

● MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Oral solution
  - Lactulose
    - Lactulose 666.667 mg per 1 ml Lactulose 10g/15ml oral solution 15ml sachets sugar free sugar-free | 10 sachet | £2.51 DT + £2.51
    - Lactulose 10g/15ml oral solution 15ml sachets sugar free unflavoured sugar-free | 10 sachet | £2.50 DT + £2.51
    - Lactulose 10g/15ml oral solution 15ml sachets sugar free plum sugar-free | 10 sachet | £2.60 DT + £2.51
    - Lactulose 680 mg per 1 ml Lactulose 3.1-3.7g/5ml oral solution | 300 ml | £1.44–£2.73 | 500 ml | £4.55 DT + £2.40
    - Duphalac (Mylan)
      - Lactulose 680 mg per 1 ml Duphalac 3.35g/5ml oral solution | 200 ml | £1.92 | 300 ml | £2.88 | 500 ml | £4.80 DT + £2.40

Sterculia with frangula

The properties listed below are those particular to the combination only. For the properties of the components please consider, sterulcia above.

● INDICATIONS AND DOSE
  Constipation
  ▶ BY MOUTH
  - Child 6-11 years: 0.5–1 sachet 1–2 times a day, alternatively, 0.5–1 heaped 5-ml spoonful once or twice a day; washed down without chewing with plenty of liquid after meals
  - Child 12-17 years: 1–2 sachets 1–2 times a day, alternatively, 1–2 heaped 5-ml spoonfuls once or twice a day; washed down without chewing with plenty of liquid after meals

● PREGNANCY Manufacturer advises avoid.
● BREAST FEEDING Manufacturer advises avoid.
Macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride

18-Apr-2018

• INDICATIONS AND DOSE

Chronic constipation (dose for 'paediatric' sachets) | Prevention of faecal impaction (dose for 'paediatric' sachets)
▶ BY MOUTH
- Child 1-11 months: 0.5–1 sachet daily
- Child 12-23 months: 1 sachet daily, adjust dose to produce regular soft stools; maximum 4 sachets per day
- Child 2-5 years: 1 sachet daily, adjust dose to produce regular soft stools; maximum 4 sachets per day
- Child 6-11 years: 2 sachets daily, adjust dose to produce regular soft stools; maximum 4 sachets per day

Faecal impaction (dose for 'paediatric' sachets)
▶ BY MOUTH
- Child 1-11 months: 0.5–1 sachet daily
- Child 12-23 months: 2 sachets on first day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily, total daily dose to be taken over a 12-hour period, after disimpaction, switch to maintenance laxative therapy
- Child 2-4 years: 2 sachets on first day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily, total daily dose to be taken over a 12-hour period, after disimpaction, switch to maintenance laxative therapy
- Child 5-11 years: 4 sachets on first day, then increased in steps of 2 sachets daily, total daily dose to be taken over a 12-hour period, after disimpaction, switch to maintenance laxative therapy; maximum 12 sachets per day

Chronic constipation (dose for 'half-strength' sachets)
▶ BY MOUTH
- Child 12-17 years: 2–6 sachets daily in divided doses usually for up to 2 weeks; maintenance 2–4 sachets daily

Faecal impaction (dose for 'half-strength' sachets)
▶ BY MOUTH
- Child 12-17 years: 8 sachets on first day, then increased in steps of 4 sachets daily, total daily dose to be drunk within a 6 hour period, after disimpaction, switch to maintenance laxative therapy if required; maximum 16 sachets per day

Chronic constipation (dose for 'full-strength' sachets)
▶ BY MOUTH
- Child 12-17 years: 1–3 sachets daily in divided doses usually for up to 2 weeks; maintenance 1–2 sachets daily

Faecal impaction (dose for 'full-strength' sachets)
▶ BY MOUTH
- Child 12-17 years: 4 sachets on first day, then increased in steps of 2 sachets daily, total daily dose to be drunk within a 6 hour period, after disimpaction, switch to maintenance laxative therapy if required; maximum 8 sachets per day

DOSE EQUIVALENT AND CONVERSION
- Each 'paediatric' sachet contains 6.563 g of macrogol 3350; each 'half-strength' sachet contains 6.563 g of macrogol 3350; each 'full-strength' sachet contains 13.125 g of macrogol 3350.

MOVICOL ® READY TO TAKE SACHETS
Chronic constipation
▶ BY MOUTH
- Child 12-17 years: 1–3 sachets daily in divided doses usually for up to 2 weeks; maintenance 1–2 sachets daily

Faecal impaction
▶ BY MOUTH
- Child 12-17 years: 4 sachets on first day, then increased in steps of 2 sachets daily, total daily dose to be drunk within a 6 hour period; patients should also take an additional 1 litre of fluid daily, after disimpaction, switch to maintenance laxative therapy if required; maximum 8 sachets per day

MOVICOL ® LIQUID
Chronic constipation
▶ BY MOUTH
- Child 12-17 years: 25 ml 1–3 times a day usually for up to 2 weeks; maintenance 25 ml 1–2 times a day

• UNLICENSED USE

Macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride may be used as detailed below, although these situations are considered outside the scope of its licence:

- Use of 'paediatric' sachets for faecal impaction in impaired cardiovascular function (no information available)
- Use of 'paediatric' sachets for faecal impaction in impaired atulence
- Use of 'paediatric' sachets for faecal impaction in impaired intestinal perforation
- Use of 'paediatric' sachets for faecal impaction in impaired cardiovascular conditions of the intestinal tract (including Crohn’s disease, ulcerative colitis and toxic megacolon)

• CAUTIONS

Cardiovascular impairment (should not take more than 2 'full-strength' sachets or 4 'half-strength' sachets in any one hour) - impaired consciousness (with high doses) - impaired gag reflex (with high doses) - reflux oesophagitis (with high doses)

• SIDE-EFFECTS

Electrolyte imbalance (discontinue if symptoms occur) - flatulence - gastrointestinal discomfort - nausea - vomiting

• PREGNANCY

Manufacturers advise may be used—limited data available.

• RENAL IMPAIRMENT

Manufacturers advise avoid use of 'paediatric' sachets for faecal impaction—no information available.

• DIRECTIONS FOR ADMINISTRATION

Manufacturers advise dissolve contents of each 'half-strength' sachet of oral powder in 62.5 mL of water, and each 'full-strength' sachet of oral powder in 125 mL of water; after reconstitution the solution should be kept in a refrigerator—for further information consult product literature.

Manufacturers advise dissolve contents of each 'paediatric' sachet of oral powder in 62.5 mL of water; after reconstitution the solution should be kept in a refrigerator—for further information consult product literature.

MOVICOL ® LIQUID

Manufacturer advises dilute 25 mL of oral concentrate with 100 mL of water; after dilution the solution should be discarded if unused after 24 hours.

• PATIENT AND CARER ADVICE

Patients or carers should be counselled on how to take the oral powder and oral solution.

Medicines for Children leaflet: Movicol for constipation

www.medicinesforchildren.org.uk/movicol-constipation
Magnesium hydroxide

**INDICATIONS AND DOSE**

**Constipation**
- **By Mouth**
  - Child 3–11 years: 5–10 mL as required, dose to be given mixed with water at bedtime
  - Child 12–17 years: 30–45 mL as required, dose to be given mixed with water at bedtime

**CONTRA-INDICATIONS**
- Acute gastro-intestinal conditions

**INTERACTIONS**
- Appendix 1: magnesium

**HEPATIC IMPAIRMENT**
- Avoid in hepatic coma if risk of renal failure.

**RENAL IMPAIRMENT**
- Increased risk of toxicity in renal impairment.

**Dose adjustments**
- Avoid or reduce dose.

**PRESCRIBING AND DISPENSING INFORMATION**
- When prepared extemporaneously, the BP states Magnesium Hydroxide Mixture, BP consists of an aqueous suspension containing about 8% hydrated magnesium oxide.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

### Oral solution

**CAUTIONARY AND ADVISORY LABELS**
- 13 ELECTROLYTES: May contain Bicarbonate, chloride, potassium, sodium

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Formulation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macrogol 105 mg per litre, Potassium 5.4 mmol per litre</td>
<td>Oral powder</td>
<td>1 litre, Bicarbonate 17 mmol per litre, Chloride 53 mmol per litre</td>
</tr>
<tr>
<td>Macrogol 105 mg per litre, Potassium 5.4 mmol per litre</td>
<td>Oral suspension</td>
<td>1 litre, Sodium 65 mmol per litre</td>
</tr>
<tr>
<td>Macrogol 13.125 mg, Potassium 27 mmol per litre</td>
<td>Oral powder</td>
<td>1 litre, Bicarbonate 85 mmol per litre, Chloride 267 mmol per litre</td>
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<td>Powder</td>
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<tr>
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<tr>
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<tr>
<td>Macrogol 1 litre, Sodium 65 mmol per litre</td>
<td>Powder</td>
<td>1 litre, Sodium 65 mmol per litre</td>
</tr>
</tbody>
</table>

**PRESCRIBING AND DISPENSING INFORMATION**
- When prepared extemporaneously, the BP states Magnesium Hydroxide Mixture, BP consists of an aqueous suspension containing about 8% hydrated magnesium oxide.

**CONTRA-INDICATIONS**
- Conditions associated with increased colonic absorption - gastro-intestinal obstruction - inflammatory bowel disease

**CAUTIONS**
- Ascites - congestive heart failure - electrolyte disturbances - uncontrolled hypertension

**INTERACTIONS**
- Appendix 1: bowel cleansing preparations

Sodium acid phosphate with sodium phosphate

**INDICATIONS AND DOSE**

**Constipation (using Phosphates Enema BP Formula B)**
- **By Rectum**
  - Child 3–6 years: 45–65 mL once daily
  - Child 7–11 years: 65–100 mL once daily
  - Child 12–17 years: 100–128 mL once daily

**FLEET® READY-TO-USE ENEMA**
- **Constitution**
  - Bowel evacuation before abdominal radiological procedures, endoscopy, and surgery (using Phosphates Enema BP Formula B)
  - By Rectum
    - Child 3–6 years: 40–60 mL once daily
    - Child 7–11 years: 60–90 mL once daily
    - Child 12–17 years: 90–118 mL once daily

**CONTRA-INDICATIONS**
- Conditions associated with increased colonic absorption - gastro-intestinal obstruction - inflammatory bowel disease

**CAUTIONS**
- Ascites - congestive heart failure - electrolyte disturbances - uncontrolled hypertension

**INTERACTIONS**
- Appendix 1: bowel cleansing preparations
Gastro-intestinal system

**Medicinal Forms**
- There can be variation in the licensing of different medicines containing the same drug.

**Enema**
- Sodium acid phosphate with sodium phosphate (Non-proprietary)
- Disodium hydrogen phosphate dodecahydrate 80 mg per 1 ml
- Sodium dihydrogen phosphate dihydrate 100 mg per 1 ml
- Phosphates enema (Formula B)

**Indications and Dose**

### Sodium citrate

**MICROLETTE**
- Constipation
  - By Rectum
  - Child 3-17 years: 5–10 mL for 1 dose

**MICRALAX**
- Constipation
  - By Rectum
  - Child 3-17 years: 5 mL for 1 dose

**RELAXIT**
- Constipation
  - By Rectum
  - Child 1 month–2 years: 5 mL for 1 dose, insert only half the nozzle length
  - Child 3-17 years: 5 mL for 1 dose

**Contraindications**
- Acute gastro-intestinal conditions

**Caution**
- Sodium and water retention in susceptible individuals

**Interactions**
- Appendix 1: sodium citrate

**Side-effects**
- Polyuria

**Medicinal Forms**
- There can be variation in the licensing of different medicines containing the same drug.

**Enema**
- Microlette Micro-enema (Pinewood Healthcare)
- Sodium citrate 90 mg per 1 ml
- Micralax Micro-enema (RPH Pharmaceuticals AB)
- Sodium citrate 90 mg per 1 ml
- Relaxit (Supra Enterprises Ltd)
- Sodium citrate 90 mg per 1 ml

## Laxatives

### Softening Laxatives

#### Arachis oil

**Indications and Dose**
- To soften impacted faeces
  - By Rectum
  - Child 3-6 years (under close medical supervision): 45–65 mL as required
  - Child 7-11 years (under close medical supervision): 65–100 mL as required
  - Child 12-17 years (under close medical supervision): 100–130 mL as required

**Unlicensed use**
- Licensed for use in children (age range not specified by manufacturer).

**Contra-indications**
- Inflammatory bowel disease

**Caution**
- Hypersensitivity to soya - intestinal obstruction

**Allergy and Cross-sensitivity**
- Contra-indicated if history of hypersensitivity to arachis oil or peanuts.

**Directions for Administration**
- Warm enema in warm water before use.

**Medicinal Forms**
- There can be variation in the licensing of different medicines containing the same drug.

**Enema**
- Arachis oil (Non-proprietary)
  - Arachis oil 1 ml per 1 ml
  - Arachis oil 130 ml enema

**Side-effects**
- Not known to be harmful—manufacturer advises caution.

#### Docusate sodium

(Dioctyl sodium sulphonate) 20-Apr-2016

**Indications and Dose**
- Chronic constipation
  - By Mouth
  - Child 6 months-1 year: 12.5 mg 3 times a day, adjusted according to response, use paediatric oral solution
  - Child 2-11 years: 12.5–25 mg 3 times a day, adjusted according to response, use paediatric oral solution
  - Child 12-17 years: Up to 500 mg daily in divided doses, adjusted according to response
  - By Rectum
  - Child 12-17 years: 120 mg for 1 dose

**Adjunct in abdominal radiological procedures**
- By Mouth
- Child 12-17 years: 400 mg, to be administered with barium meal
- By Rectum
- Child 12-17 years: 120 mg for 1 dose

**Pharmacokinetics**
- Oral preparations act within 1–2 days; response to rectal administration usually occurs within 20 minutes.

**Unlicensed use**
- Adult oral solution and capsules not licensed for use in children under 12 years.

**Contra-indications**
- Avoid in intestinal obstruction

**Caution**
- Do not give with liquid paraffin - excessive use of stimulant laxatives can cause diarrhoea and related effects such as hypokalaemia - rectal preparations not indicated if haemorrhoids or anal fissure

**Interactions**
- Appendix 1: docusate sodium

**Side-effects**
- Rare or very rare
- With oral use Abdominal cramps - nausea - rash

**Pregnancy**
- Not known to be harmful—manufacturer advises caution.
**LAXATIVES > STIMULANT LAXATIVES**

### Bisacodyl

#### Indications and Dose

**Constipation**
- **By Mouth**
  - Child 4–17 years: 5–20 mg once daily, adjusted according to response, dose to be taken at night
- **By Rectum**
  - Child 2–17 years: 5–10 mg once daily, adjusted according to response

**Bowel clearance before radiological procedures and surgery**
- **Initially by mouth**
  - Child 4–9 years: 5 mg once daily for 2 days before procedure, dose to be taken at bedtime and (by rectum) 5 mg if required, dose to be administered 1 hour before procedure
  - Child 10–17 years: 10 mg once daily for 2 days before procedure, dose to be taken at bedtime and (by rectum) 10 mg if required, dose to be administered 1 hour before procedure

**Pharmacokinetics**
- Tablets act in 10–12 hours; suppositories act in 20–60 minutes.

#### Unlicensed Use

- With rectal use **Bisacodyl** may be used in children aged under 10 years for the management of constipation, **but the higher dose option is not licensed in this age group.**
- With oral use **Bisacodyl** may be used in children for the management of constipation, **but the higher dose option is not licensed.**

#### Contra-indications

- Acute abdominal conditions, acute inflammatory bowel disease, intestinal obstruction, severe dehydration

#### Cautions

- Excessive use of stimulant laxatives can cause diarrhea and related effects such as hypokalaemia, risk of electrolyte imbalance with prolonged use

### Co-danthramer

#### Indications and Dose

**Constipation in palliative care (standard strength capsules)**
- **By Mouth Using Capsules**
  - Child 6–11 years: 1 capsule once daily, dose should be taken at night
  - Child 12–17 years: 1–2 capsules once daily, dose should be taken at night

**Constipation in palliative care (strong capsules)**
- **By Mouth Using Capsules**
  - Child 12–17 years: 1–2 capsules once daily, dose should be given at night

**Constipation in palliative care (standard strength suspension)**
- **By Mouth Using Oral Suspension**
  - Child 2–11 years: 2.5–5 mL once daily, dose should be taken at night
  - Child 12–17 years: 5–10 mL once daily, dose should be taken at night

**Constipation in palliative care (strong suspension)**
- **By Mouth Using Oral Suspension**
  - Child 12–17 years: 5 mL once daily, dose should be taken at night

#### Dose Equivalence and Conversion

- Co-danthramer (standard strength) capsules contain dantron 25 mg with poloxamer 188® 200 mg per capsule.
- Co-danthramer (standard strength) oral suspension contains dantron 25 mg with poloxamer 188® 200 mg per 5 mL.
- Co-danthramer strong capsules contain dantron 37.5 mg with poloxamer 188® 500 mg.
- Co-danthramer strong oral suspension contains dantron 75 mg with poloxamer 188® 1 g per 5 mL.
- Co-danthramer suspension 5 mL = one co-danthramer capsule, **but strong co-danthramer suspension 5 mL = two strong co-danthramer capsules.**
CONTRA-INDICATIONS
Acute abdominal conditions - acute inflammatory bowel disease - intestinal obstruction - severe dehydration.

CAUTIONS
Excessive use of stimulant laxatives can cause diarrhoea and related effects such as hypokalaemia - may cause local irritation - rodent studies indicate potential carcinogenic risk.

CAUTIONS, FURTHER INFORMATION
Local irritation. Avoid prolonged contact with skin (as in incontinent patients or infants wearing nappies - risk of irritation and excoriation).

SIDE-EFFECTS
Abdominal cramps - asthenia - gastrointestinal disorders - hypermagnesaemia - skin reactions - urine red.

PREGNANCY
Manufacturers advise avoid – limited information available.

BREAST FEEDING
Manufacturers advise avoid – no information available.

PRESCRIBING AND DISPENSING INFORMATION
Palliative care. For further information on the use of co-danthramer in palliative care, see www.medicinescomplete.com/#/content/palliative/stimulant-laxatives.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Oral suspension
CAUTIONARY AND ADVISORY LABELS 14 (urine orange)

- Co-danthramer (Non-proprietary)
  - Dantron 10 mg per 1 ml, Docusate sodium 12 mg per 1 ml Co-danthramer 50mg/60mg/5ml oral suspension sugar free sugar-free
  - 200 ml £154.40 DT = £154.40

- Co-danthrusate (Non-proprietary)
  - Dantron 10 mg per 1 ml, Docusate sodium 12 mg per 1 ml Co-danthrusate 50mg/60mg/5ml oral suspension sugar free sugar-free

- Gastrointestinal disorders
- Avoid prolonged contact with skin (as in incontinent patients or infants wearing nappies - risk of irritation and excoriation).

INDICATIONS AND DOSE
Constipation
- By mouth using oral suspension
  - Child 6–11 years: 5 ml once daily, to be taken at night
  - Child 12–17 years: 5–15 ml once daily, to be taken at night

DOSAGE EQUIVALENCE AND CONVERSION
- Co-danthrusate suspension contains dantron 50 mg and docusate sodium 60 mg per 5 ml.

CONTRA-INDICATIONS
Acute abdominal conditions - acute inflammatory bowel disease - intestinal obstruction - severe dehydration.

CAUTIONS
Excessive use of stimulant laxatives can cause diarrhoea and related effects such as hypokalaemia - may cause local irritation - rodent studies indicate potential carcinogenic risk.

CAUTIONS, FURTHER INFORMATION
Local irritation. Avoid prolonged contact with skin (as in incontinent patients or infants wearing nappies - risk of irritation and excoriation).

INTERACTIONS
Appendix 1: docusate sodium

SIDE-EFFECTS
Gastrointestinal disorders - skin reactions - urine orange.

PREGNANCY
Manufacturers advise avoid – limited information available.

BREAST FEEDING
Manufacturers advise avoid – no information available.

UNLICENSED USE
Tablets not licensed for use in children under 6 years. Syrup not licensed for use in children under 2 years.

Doses in BNFC adhere to national guidelines and may differ from those in product literature.
## Sodium picosulfate

(Sodium picosulphate)

**Drug action** Sodium picosulfate is a stimulant laxative. After metabolism in the colon it stimulates the mucosa thereby increasing the motility of the large intestine.

### Indications and dose

**Constitution**

- **By mouth**
  - Child 1 month-3 years: 2.5–10 mg once daily, adjusted according to response
  - Child 4-17 years: 2.5–20 mg once daily, adjusted according to response

**Pharmacokinetics**

- Onset of action 6–12 hours.

### Unlicensed use

Sodium picosulfate doses in BNF Publications adhere to national guidelines and may differ from those in product literature.

### Contra-Indications

Intestinal obstruction - undiagnosed abdominal pain.

### Interactions

† Appendix 1: sodium picosulfate

### Side-effects

- Common or very common: Diarrhoea
- Uncommon: Nausea, vomiting

**Frequency not known** Angioedema - skin reactions - syncope

**Side-effects, Further information** Prolonged or excessive use can cause diarrhoea and related effects such as hypokalaemia.

### Pregnancy

Manufacturer states evidence limited but not known to be harmful.

### Breast feeding

Specialist sources indicate suitable for use in breast-feeding in infants over 1 month.** (b)

### Patient and carer advice

Medicines for Children leaflet: Sodium picosulfate for constipation

www.medicinesforchildren.org.uk/sodium-picosulfate-constipation

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### Senna with ispaghula husk

24-Feb-2016

The properties listed below are those particular to the combination only. For the properties of the components please consider, senna p. 48, ispaghula husk p. 42.

#### Indications and dose

**Constipation**

- **By mouth**
  - Child 12-17 years: 5-10 g once daily, to be taken at night, 5 g equivalent to one level spoonful of granules

**Pregnancy**

Manufacturer advises avoid during first trimester. To be used only intermittently and only if dietary and lifestyle changes fail.

**Directions for administration**

Take at night with at least 150 ml liquid.

### Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

#### Oral solution

- **Senna** (Non-proprietary)
  - Sennoside B (as Sennosides) 1.5 mg per 1 ml
  - Senna 7.5mg/5ml
  - Sennoside B (as Sennosides) 7.5 mg
  - Senna Max Strength 15mg tablets

- **Senokot** (Forum Health Products Ltd, Reckitt Benckiser Healthcare (UK) Ltd)
  - Senna 7.5mg/5ml
  - Sennoside B (as Sennosides) 15 mg

- **Senokot** (Sanofi) 300 mg/100 ml sugar-free oral solution

**Sodium picosulfate**

- **Sodium picosulfate 1 mg per 1 ml**
  - Sodium picosulfate 1 mg per 1 ml
  - Sodium picosulfate 5mg/5ml oral solution sugar free sugar-free
  - Sodium picosulfate 5mg/5ml sugar-free

**Laxoberal** (Sanofi)

**Sodium picosulfate 1 mg per 1 ml**

- Duicolar Pico 5mg/5ml liquid sugar-free

**INDICATIONS AND DOSE**

- Constipation
  - By mouth
  - Child 1 month-3 years: 2.5–10 mg once daily, adjusted according to response
  - Child 4-17 years: 2.5–20 mg once daily, adjusted according to response

**PHARMACOKINETICS**

- Onset of action 6–12 hours.

### Unlicensed use

Sodium picosulfate doses in BNF Publications adhere to national guidelines and may differ from those in product literature.

### Contra-Indications

Intestinal obstruction - undiagnosed abdominal pain.

### Interactions

† Appendix 1: sodium picosulfate

### Side-effects

- Common or very common: Diarrhoea
- Uncommon: Nausea, vomiting

**Frequency not known** Angioedema - skin reactions - syncope

**Side-effects, Further information** Prolonged or excessive use can cause diarrhoea and related effects such as hypokalaemia.

### Pregnancy

Manufacturer states evidence limited but not known to be harmful.

### Breast feeding

Specialist sources indicate suitable for use in breast-feeding in infants over 1 month.** (b)

**Patient and carer advice**

Medicines for Children leaflet: Sodium picosulfate for constipation

www.medicinesforchildren.org.uk/sodium-picosulfate-constipation

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### Diarrhoea

**Diarrhoea (acute)**

01-Aug-2017

**Description of condition**

Diarrhoea is the abnormal passing of loose or liquid stools, with increased frequency, increased volume, or both. Acute diarrhoea is that which lasts less than 14 days, but symptoms usually spontaneously resolve within 2–4 days. It can result from infection, as a side-effect of a drug, or as an acute symptom of a chronic gastro-intestinal disorder (such as Inflammatory bowel disease p. 27 or Irritable bowel syndrome p. 36). It may also occur when intestinal motility or morphology is altered.
Prompt investigation is required to identify or exclude any serious underlying cause if the child has any red flag symptoms as such unexplained weight loss, rectal bleeding, persistent diarrhoea, a systemic illness, has received recent hospital treatment or antibiotic treatment, or following foreign travel (other than to Western Europe, North America, Australia or New Zealand).

**Aims of treatment**
The priority in acute diarrhoea treatment, as in gastro-enteritis, is the prevention or reversal of fluid and electrolyte depletion and the management of dehydration when it is present. This is particularly important in infants, when excessive water and electrolyte loss and dehydration can be life-threatening.

**Treatment**
Most episodes of acute diarrhoea will settle spontaneously without the need for any medical treatment. Oral rehydration therapy (ORT), such as disodium hydrogen, citrate with glucose, potassium chloride and sodium chloride p. 612; potassium chloride with sodium chloride p. 609; potassium chloride with rice powder, sodium chloride and sodium citrate p. 612) is the mainstay of treatment to prevent or correct diarrhoeal dehydration and to maintain the appropriate fluid intake once rehydration is achieved—see Fluids and electrolytes p. 604.

However, in children with severe dehydration and in those unable to drink, immediate admission to hospital and urgent replacement treatment with an intravenous rehydration fluid is recommended—see Fluids and electrolytes p. 604. ORT is recommended for children at increased risk of dehydration and for those with clinical dehydration (including hypernatraemic dehydration). If the child is unable to drink the ORT, or vomits persistently, consider giving the solution via a nasogastric tube.

In infants, after rehydration, encourage breast-feeding, other milk feeds and fluid intake. In older children, after rehydration, give full-strength milk straight away, reintroduce the child’s usual solid food, and avoid giving fruit juices and carbonated drinks until the diarrhoea has stopped.

In children with gastroenteritis, but without clinical dehydration, encourage fluid intake, continue breast-feeding and other milk feeds, and discourage the drinking of fruit juices and carbonated drinks.

In general, antimicrobial drugs have no practical benefit for children with acute or persistent diarrhoea and their use is generally not recommended (side-effects include drowsiness, abdominal distension and ileus).

**Antibacterial drugs for acute diarrhoea**

**Related drugs**
Other drugs used for diarrhoea: codeine phosphate p. 283, co-phenotrope below, methylcellulose p. 42.
## Loperamide hydrochloride

### INDICATIONS AND DOSE

**Symptomatic treatment of acute diarrhoea**

- **By Mouth**
  - Child 4–7 years: 1 mg 3–4 times a day for up to 3 days only
  - Child 8–11 years: 2 mg 4 times a day for up to 5 days
  - Child 12–17 years: Initially 4 mg, followed by 2 mg for up to 5 days, dose to be taken after each loose stool; usual dose 6–8 mg daily; maximum 16 mg per day

### Chronic diarrhoea

- **By Mouth**
  - Child 1–11 months: 100–200 micrograms/kg twice daily, to be given 30 minutes before feeds; increased if necessary up to 2 mg/kg daily in divided doses
  - Child 1–11 years: 100–200 micrograms/kg 3–4 times a day (max. per dose 2 mg), increased if necessary up to 1.25 mg/kg daily in divided doses; maximum 16 mg per day
  - Child 12–17 years: 2–4 mg 2–4 times a day; maximum 16 mg per day

### UNLICENSED USE


### IMPORTANT SAFETY INFORMATION

**MHRA/CHM Advice: Reports of Serious Cardiac Adverse Reactions with High Doses of Loperamide Associated with Abuse or Misuse (September 2017)**

Serious cardiovascular events (such as QT prolongation, torsades de points, and cardiac arrest), including fatalities, have been reported in association with large overdoses of loperamide. Healthcare professionals are reminded that if symptoms of overdose occur, naloxone can be given as an antidote. The duration of action of loperamide is longer than that of naloxone ([an antidote](https://www.medicinesforchildren.org.uk/loperamide-diarrhoea)). The duration of action of loperamide is longer than that of naloxone ([an antidote](https://www.medicinesforchildren.org.uk/loperamide-diarrhoea)). In the event of overdose, treatment with naloxone might be indicated; patients should be monitored closely for at least 48 hours to detect possible CNS depression. Pharmacists should remind patients not to take more than the recommended dose on the label.

### CONTRA-INDICATIONS

Active ulcerative colitis • antibiotic-associated colitis • conditions where abdominal distension develops • conditions where inhibition of peristalsis should be avoided

### CAUTIONS

Not recommended for children under 12 years

### INTERACTIONS

→ Appendix 1: Loperamide

### SIDE-EFFECTS

- **Common or very common**
  - Gastrointestinal disorders • headache • nausea
- **Uncommon**
  - Dizziness • drowsiness • dry mouth • gastrointestinal discomfort • skin reactions • vomiting
- **Rare or very rare**
  - Angioedema • consciousness impaired • coordination abnormal • fatigue • miosis • muscle tone increased • severe cutaneous adverse reactions (SCARs) • urinary retention

### PREGNANCY

Manufacturers advise avoid—no information available.

### BREAST FEEDING

Amount probably too small to be harmful.

### HEPATIC IMPAIRMENT

Manufacturer advises caution—risk of reduced first pass metabolism leading to central nervous system toxicity.

### PATIENT AND CARER ADVICE

Medicines for Children leaflet: Loperamide for diarrhoea

[www.medicinesforchildren.org.uk/loperamide-diarrhoea](http://www.medicinesforchildren.org.uk/loperamide-diarrhoea)

## Loperamide with simeticone

### INDICATIONS AND DOSE

**Acute diarrhoea with abdominal colic**

- **By Mouth**
  - Child 12–17 years: Initially 1 tablet, then 1 tablet, after each loose stool, for up to 2 days; maximum 4 tablets per day

### INTERACTIONS

→ Appendix 1: Loperamide

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

- **Tablet**
  - Loperamide hydrochloride (Non-proprietary) 2 mg Loperamide 2 mg tablets | 30 tablet £2.93 DT = £1.83
  - Norimode (Tillotomed Laboratories Ltd) Loperamide hydrochloride 2 mg Norimode 2 mg tablets | 30 tablet £2.15 DT = £1.83

- **Oral solution**
  - Imodium (Janssen-Cilag Ltd) Loperamide hydrochloride 200 microgram per 1 ml | 100 ml £1.17 DT = £1.17

- **Capsule**
  - Loperamide hydrochloride (Non-proprietary) Loperamide hydrochloride 2 mg Loperamide 2 mg capsules | 30 capsule £2.99 DT = £0.92
  - Norimode (McNeil Products Ltd) Loperamide hydrochloride 2 mg Loperamide 2 mg capsules | 12 capsule £3.55

- **Orodispersible tablet**
  - Imodium (McNeil Products Ltd) Loperamide hydrochloride 2 mg Loperamide 2 mg orodispersible tablets sugar-free | 12 tablet £4.38 sugar-free | 18 tablet £5.85

### Antidiarrhoeals

**Enkephalinase inhibitors**

**Racecadotril**

### INDICATIONS AND DOSE

**Adjunct to rehydration, for the symptomatic treatment of uncomplicated acute diarrhoea**

- **By Mouth Using Granules**
  - Child 3 months–17 years (body-weight up to 9 kg): 10 mg 3 times a day until diarrhoea stops; maximum duration of treatment 7 days
  - Child 3 months–17 years (body-weight 9–12 kg): 20 mg 3 times a day until diarrhoea stops; maximum duration of treatment 7 days
Disorders of gastric acid and ulceration

4 Disorders of gastric acid and ulceration

4.1 Dyspepsia

Dyspepsia

Overview

Dyspepsia covers upper abdominal pain, fullness, early satiety, bloating, and nausea. It can occur with gastric and duodenal ulceration, gastro-oesophageal reflux disease, gastritis, and upper gastrointestinal motility disorders, but most commonly it is of uncertain origin.

Patients with dyspepsia should be advised about lifestyle changes (avoidance of excess alcohol and of aggravating foods such as fats); other measures include weight reduction, Smoking cessation p. 304, and raising the head of the bed. Some medications may cause dyspepsia—these should be stopped, if possible.

A compound alginate preparation may provide relief from dyspepsia; persistent dyspepsia requires investigation. Treatment with a H₂-receptor antagonist or a proton pump inhibitor should be initiated only on the advice of a hospital specialist.

*Helicobacter pylori* may be present in children with dyspepsia. *H. pylori* eradication therapy should be considered for persistent dyspepsia if it is ulcer-like. However, most children with functional (investigated, non-ulcer) dyspepsia do not benefit symptomatically from *H. pylori* eradication.

ANTACIDS

Antacids

Overview

Antacids (usually containing aluminium or magnesium compounds) can often relieve symptoms in *ulcer dyspepsia* and in non-erosive gastro-oesophageal reflux; they are also sometimes used in functional (non-ulcer) dyspepsia but the evidence of benefit is uncertain.

Aluminium- and magnesium-containing antacids, being relatively insoluble in water, are long-acting if retained in the stomach. They are suitable for most antacid purposes. Magnesium-containing antacids tend to be laxative whereas aluminium-containing antacids may be constipating; antacids containing both magnesium and aluminium may reduce these colonic side-effects.

Complexes such as *hydrotalcite* confer no special advantage.

*Calcium-containing* antacids can induce rebound acid secretion; with modest doses the clinical significance of this is doubtful, but prolonged high doses also cause hypercalcaemia and alkalosis.

Simeticone

Simeticone p. 54 (activated dimeticone) is used to treat infantile colic, but the evidence of benefit is uncertain.

Simeticone is added to an antacid as an antifoaming agent to relieve flatulence. These preparations may be useful for the relief of hiccup in palliative care.

Alginates

Alginates taken in combination with an antacid increases the viscosity of stomach contents and can protect the oesophageal mucosa from acid reflux. Some alginate-containing preparations form a viscous gel (‘raft’) that floats on the surface of the stomach contents, thereby reducing symptoms of reflux. Alginate-containing preparations are used in the management of mild symptoms of dyspepsia and gastro-oesophageal reflux disease.

The amount of additional ingredient or antacid in individual preparations varies widely, as does their sodium content, so that preparations may not be freely interchangeable.

ANTACIDS > ALGINATE

Alginic acid

- **INDICATIONS AND DOSE**
  - **GAVISCON INFANT® POWDER SACHETS**
  - **Management of gastro-oesophageal reflux disease**
    - **BY MOUTH**
      - Neonate (body-weight up to 4.5 kg): 1 dose as required, to be mixed with feeds (or water, for breast-fed infants); maximum 6 doses per day.
      - Neonate (body-weight 4.5 kg and above): 2 doses as required, to be mixed with feeds (or water, for breast-fed infants); maximum 12 doses per day.
MEDICINAL FORMS

PRESCRIBING AND DISPENSING INFORMATION

The properties listed below are those particular to the combination only. For the properties of the components please consider, aluminium hydroxide p. 619, magnesium hydroxide p. 45.

Antacids > Aluminium and Magnesium

Co-magaldrox

The properties listed below are those particular to the combination only. For the properties of the components please consider, aluminium hydroxide p. 619, magnesium hydroxide p. 45.

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dyspepsia</strong></td>
</tr>
<tr>
<td>➤ <strong>BY MOUTH</strong></td>
</tr>
<tr>
<td>➤ Child 14-17 years: 10–20 mL, to be taken 20–60 minutes after meals, and at bedtime or when required</td>
</tr>
<tr>
<td><strong>MUCOGEL</strong></td>
</tr>
<tr>
<td><strong>Dyspepsia</strong></td>
</tr>
<tr>
<td>➤ <strong>BY MOUTH</strong></td>
</tr>
<tr>
<td>➤ Child 12-17 years: 10–20 mL 3 times a day, to be taken 20–60 minutes after meals, and at bedtime, or when required</td>
</tr>
</tbody>
</table>

INTERACTIONS ➤ Appendix 1: antacids - magnesium

PRESCRIBING AND DISPENSING INFORMATION

Co-magaldrox is a mixture of aluminium hydroxide and magnesium hydroxide; the proportions are expressed in the form x/y where x and y are the strengths in milligrams per unit dose of magnesium hydroxide and aluminium hydroxide respectively.

**MAALOX** ➤ Maalox® suspension is low in sodium.

**MUCOGEL** ➤ Mucogel® suspension is low in sodium.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

**Oral Suspension**

Maalox (Sanofi)
Aluminium hydroxide 35 mg per 1 mL, Magnesium hydroxide 40 mg per 1 mL
Maalox 150mg/200mg/5ml oral suspension sugar-free | 250 mL (GSK) £2.33 DT + £2.33
Mucogel (Chemidex Pharma Ltd)
Magnesium hydroxide 39 mg per 1 mL, Aluminium hydroxide gel dried 44 mg per 1 mL
Mucogel oral suspension sugar-free | 500 mL (GSK) £2.99 DT + £2.99

**Co-simalcite**

30-Jun-2018

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dyspepsia</strong></td>
</tr>
<tr>
<td>➤ <strong>BY MOUTH</strong></td>
</tr>
<tr>
<td>➤ Child 8-11 years: 5 mL 4 times a day as required, to be taken between meals and at bedtime</td>
</tr>
<tr>
<td>➤ Child 12-17 years: 10 mL 4 times a day as required, to be taken between meals and at bedtime</td>
</tr>
</tbody>
</table>

CONTRA-INDICATIONS

Hypophosphataemia - infants - neonates

CONTRA-INDICATIONS, FURTHER INFORMATION

Aluminium-containing antacids should not be used in neonates and infants because accumulation may lead to increased plasma-aluminium concentrations.

RENAL IMPAIRMENT

Aluminium-containing antacids should not be used in children with renal impairment, because accumulation may lead to increased plasma-aluminium concentrations.

Sodium alginate with potassium bicarbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, alginic acid p. 52.

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management of mild symptoms of dyspepsia and gastro-oesophageal reflux disease</strong></td>
</tr>
<tr>
<td>➤ <strong>BY MOUTH USING CHEWABLE TABLETS</strong></td>
</tr>
<tr>
<td>➤ Child 6-11 years (under medical advice only): 1 tablet, to be chewed after meals and at bedtime</td>
</tr>
<tr>
<td>➤ Child 12-17 years: 1–2 tablets, to be chewed after meals and at bedtime</td>
</tr>
<tr>
<td>➤ <strong>BY MOUTH USING ORAL SUSPENSION</strong></td>
</tr>
<tr>
<td>➤ Child 2-11 years (under medical advice only): 2.5–5 mL, to be taken after meals and at bedtime</td>
</tr>
<tr>
<td>➤ Child 12-17 years: 5–10 mL, to be taken after meals and at bedtime</td>
</tr>
</tbody>
</table>

PRESCRIBING AND DISPENSING INFORMATION

Flavours of oral liquid formulations may include aniseed or peppermint.
Simeticone with aluminium hydroxide and magnesium hydroxide

The properties listed below are those particular to the combination only. For the properties of the components please consider, simeticone below, aluminium hydroxide p. 619.

**INDICATIONS AND DOSE**

**Dyspepsia**
- **BY MOUTH**
  - Child 2-4 years: 5 ml 3 times a day
  - Child 5-11 years: 5–10 mL 3–4 times a day
  - Child 12-17 years: 5–10 mL 4 times a day, to be taken after meals and at bedtime, or when required

**INTERACTIONS** → Appendix 1: antacids

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral suspension**
- **Altacite Plus** (Peckforton Pharmaceuticals Ltd) Simeticone 25 mg per 1 ml, Hydrotalcite 100 mg per 1 ml Altacite Plus oral suspension sugar-free | 100 ml £4.00 sugar-free | 500 ml £5.20 DT + £5.20

**ANTACIDS** > **MAGNESIUM**

Magnesium trisilicate with magnesium carbonate and sodium bicarbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, magnesium trisilicate, magnesium carbonate, sodium bicarbonate p. 607.

**INDICATIONS AND DOSE**

**Dyspepsia**
- **BY MOUTH**
  - Child 5-11 years: 5–10 mL 3 times a day, alternatively as required, dose to be made up with water
  - Child 12-17 years: 10–20 mL 3 times a day, alternatively as required, dose to be made up with water

**CONTRA-INDICATIONS**

- Hypophosphataemia • Severe renal failure

**CAUTIONS**

- Heart failure • hypermagnesaemia • hyperton • metabolic alkalosis • respiratory alkalosis

**INTERACTIONS** → Appendix 1: antacids - sodium bicarbonate

**HEPATIC IMPAIRMENT** In patients with fluid retention avoid antacids containing large amounts of sodium. Avoid antacids containing magnesium salts in hepatic coma if there is a risk of renal failure.

**RENAL IMPAIRMENT**

Magnesium trisilicate and magnesium carbonate mixtures have high sodium content; avoid in patients with fluid retention.

**PRESCRIBING AND DISPENSING INFORMATION**

When prepared extemporaneously, the BP states Magnesium Trisilicate Mixture, BP consists of 5% each of magnesium trisilicate, light magnesium carbonate, and sodium bicarbonate in a suitable vehicle with a peppermint flavour.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral suspension**
- Magnesium trisilicate with magnesium carbonate and sodium bicarbonate (Non-proprietary)
  - Magnesium carbonate light 50 mg per 1 ml, Magnesium trisilicate 50 mg per 1 ml, Sodium bicarbonate 50 mg per 1 ml Magnesium trisilicate oral suspension | 200 ml £1.65 DT + £1.65

**ANTIFOAMING DRUGS**

Simeticone

(Activated dimeticone)

**DRUG ACTION**

Simeticone (activated dimeticone) is an antifoaming agent.

**INDICATIONS AND DOSE**

**DENTINOX®**

Colic | Wind pains
- **BY MOUTH**
  - Neonate: 2.5 mL, to be taken with or after each feed; may be added to bottle feed; maximum 6 doses per day.
  - Child 1 month–1 year: 2.5 mL, to be taken with or after each feed; may be added to bottle feed; maximum 6 doses per day

**INFACOL®**

Colic | Wind pains
- **BY MOUTH**
  - Neonate: 0.5–1 mL, to be taken before feeds.
  - Child 1 month–1 year: 0.5–1 mL, to be taken before feeds

**PRESCRIBING AND DISPENSING INFORMATION**

**DENTINOX®** The brand name Dentinox® is also used for other preparations including teething gel.

**PATIENT AND CARER ADVICE**

**INFACOL®** Patients or carers should be given advice on use of the Infacol® dropper.

**LESS SUITABLE FOR PRESCRIBING**

**INFACOL®** Infacol® is less suitable for prescribing (evidence of benefit in infantile colic uncertain).

**DENTINOX®** Dentinox® colic drops are less suitable for prescribing (evidence of benefit in infantile colic uncertain).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral suspension**
- **Infacol®** (Teva UK Ltd)
  - Infacol 40 mg per 1 ml Infacol 40mg/ml oral suspension sugar-free | 50 mL £2.71 DT + £2.71 sugar-free | 55 mL £3.20 sugar-free | 85 mL £4.66

**Oral drops**
- **Dentinox Infant** (Dendron Ltd)
  - Simeticone 8.4 mg per 1 ml Dentinox Infant colic drops | 100 mL £1.80 DT + £1.80

**Combinations available:** Co-simalcite, p. 53 • Simeticone with aluminium hydroxide and magnesium hydroxide, above
4.2 Gastric and duodenal ulceration

Peptic ulceration

Overview

Peptic ulceration commonly involves the stomach, duodenum, and lower oesophagus; after gastric surgery it involves the gastro-enterostomy stoma. Healing can be promoted by general measures, Smoking cessation p. 304 and taking antacids and by antisecretory drug treatment, but relapse is common when treatment ceases. Nearly all duodenal ulcers and most gastric ulcers not associated with NSAIDs are caused by Helicobacter pylori.

Helicobacter pylori infection

Eradication of Helicobacter pylori reduces the recurrence of gastric and duodenal ulcers and the risk of rebleeding. The presence of H. pylori should be confirmed before starting eradication treatment. If possible, the antibacterial sensitivity of the organism should be established at the time of endoscopy and biopsy. Acid inhibition combined with antibacterial treatment is highly effective in the eradication of H. pylori; reinfection is rare. Antibiotic-associated colitis is an uncommon risk.

Treatment to eradicate H. pylori infection in children should be initiated under specialist supervision. One week triple-therapy regimens that comprise omeprazole p. 60, amoxicillin p. 351, and either clarithromycin p. 340 or metronidazole p. 344 are recommended. Resistance to clarithromycin or to metronidazole is much more common than to amoxicillin and can develop during treatment. A regimen containing amoxicillin and clarithromycin is therefore recommended for initial therapy and one containing amoxicillin and metronidazole is recommended for eradication failure or for a child who has been treated with a macrolide for other infections. There is usually no need to continue antisecretory treatment (with a proton pump inhibitor or H₂-receptor antagonist); however, if the ulcer is large, or complicated by haemorrhage or perforation then antisecretory treatment is continued for a further 3 weeks. Lansoprazole p. 59 may be considered if omeprazole is unsuitable. Treatment failure usually indicates antibacterial resistance or poor compliance.

Two-week triple-therapy regimens offer the possibility of higher eradication rates compared to one-week regimens, but adverse effects are common and poor compliance is likely to offset any possible gain.

Two-week dual-therapy regimens using a proton pump inhibitor and a single antibacterial produce low rates of H. pylori eradication and are not recommended.

See under NSAID-associated ulcers for the role of H. pylori eradication therapy in children starting or taking NSAIDs.

Test for Helicobacter pylori

C-Urea breath test kits are available for confirming the presence of gastro-duodenal infection with Helicobacter pylori. The test involves collection of breath samples before and after ingestion of an oral solution of C-Urea; the samples are sent for analysis by an appropriate laboratory. The test should not be performed within 4 weeks of treatment with an antibacterial or within 2 weeks of treatment with an antisecretory drug. A specific C-Urea breath test kit for children is available (Helicobacter Test INFAl for children of the age 3–11). However the appropriateness of testing for H. pylori infection in children has not been established. Breath, saliva, faecal, and urine tests for H. pylori are frequently unreliable in children; the most accurate method of diagnosis is endoscopy with biopsy.

NSAID-associated ulcers

Gastro-intestinal bleeding and ulceration can occur with NSAID use. Whenever possible, NSAIDs should be withdrawn if an ulcer occurs.

Children at high risk of developing gastro-intestinal complications with a NSAID include those with a history of peptic ulcer disease or serious upper gastro-intestinal complication, those taking other medicines that increase the risk of upper gastro-intestinal side-effects, or those with serious co-morbidity. In children at risk of ulceration, a proton pump inhibitor can be considered for protection against gastric and duodenal ulcers associated with non-selective NSAIDs; high dose ranitidine p. 56 is an alternative. NSAID use and H. pylori infection are independent risk factors for gastro-intestinal bleeding and ulceration. In children already taking a NSAID, eradication of H. pylori is unlikely to reduce the risk of NSAID-induced bleeding or ulceration. However, in children about to start long-term NSAID treatment who are H. pylori positive and have dyspepsia or a history of gastric or duodenal ulcer, eradication of H. pylori may reduce the overall risk of ulceration.

If the NSAID can be discontinued in a child who has developed an ulcer, a proton pump inhibitor usually produces the most rapid healing; alternatively the ulcer can be treated with an H₂-receptor antagonist.

If NSAID treatment needs to continue, the ulcer is treated with a proton pump inhibitor.

GASTROPROTECTIVE COMPLEXES AND CHELATORS

Chelates and complexes

Sucralfate

Sucralfate below is a complex of aluminium hydroxide and sulfated sucrose that appears to act by protecting the mucosa from acid-pepsin attack; it has minimal antacid properties.

<table>
<thead>
<tr>
<th>Sucralfate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDICATIONS AND DOSE</strong></td>
</tr>
<tr>
<td>Benign gastric ulceration</td>
</tr>
<tr>
<td>By Mouth</td>
</tr>
<tr>
<td>Child 1 month–1 year: 250 mg 4–6 times a day</td>
</tr>
<tr>
<td>Child 2–11 years: 500 mg 4–6 times a day</td>
</tr>
<tr>
<td>Child 12–14 years: 1 g 4–6 times a day</td>
</tr>
<tr>
<td>Child 15–17 years: 2 g twice daily, dose to be taken on rising and at bedtime, alternatively 1 g 4 times a day for 4–6 weeks, or in resistant cases up to 12 weeks, dose to be taken 1 hour before meals and at bedtime; maximum 8 g per day</td>
</tr>
<tr>
<td><strong>Prophylaxis of stress ulceration in child under intensive care</strong></td>
</tr>
<tr>
<td>By Mouth</td>
</tr>
<tr>
<td>Child 1 month–1 year: 250 mg 4–6 times a day</td>
</tr>
<tr>
<td>Child 2–11 years: 500 mg 4–6 times a day</td>
</tr>
<tr>
<td>Child 12–14 years: 1 g 4–6 times a day</td>
</tr>
<tr>
<td>Child 15–17 years: 1 g 6 times a day; maximum 8 g per day</td>
</tr>
</tbody>
</table>

| **UNLICENSED USE** |

| **CAUTIONS** |
| Patients under intensive care (Important: reports of bezoar formation) |
Recommended regimen for *Helicobacter pylori* eradication

<table>
<thead>
<tr>
<th>Age range</th>
<th>Acid suppressant</th>
<th>Antibacterial</th>
<th>Metronidazole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1-5 years</td>
<td>Omeprazole 1-2 mg/kg</td>
<td>Amoxicillin</td>
<td>7.5 mg/kg (max. 500 mg)</td>
</tr>
<tr>
<td></td>
<td>once daily (max. per dose 40 mg)</td>
<td>twice daily</td>
<td>twice daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clarithromycin</td>
<td>7.5 mg/kg (max. 500 mg)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100 mg 3 times a day</td>
</tr>
<tr>
<td>Child 6-11 years</td>
<td>Omeprazole 1-2 mg/kg</td>
<td></td>
<td>200 mg 3 times a day</td>
</tr>
<tr>
<td></td>
<td>once daily (max. per dose 40 mg)</td>
<td></td>
<td>200 mg twice daily</td>
</tr>
<tr>
<td>Child 12-17 years</td>
<td>Omeprazole 40 mg once daily</td>
<td>1 g twice daily</td>
<td>400 mg 3 times a day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>500 mg 3 times a day</td>
<td>400 mg twice daily</td>
</tr>
</tbody>
</table>

**CAUTIONS, FURTHER INFORMATION**
- **Bezoar formation** Following reports of bezoar formation associated with sucralfate, caution is advised in seriously ill patients, especially those receiving concomitant enteral feeds or those with predisposing conditions such as delayed gastric emptying.
- **INTERACTIONS** → Appendix 1: sucralfate
- **SIDE-EFFECTS**
  - **Common or very common** Constipation
  - **Uncommon** Dry mouth · nausea
  - **Rare or very rare** Bezoar · rash
  - **Frequency not known** Back pain · bone disorders · diarrhoea · dizziness · drowsiness · encephalopathy · flatulence · headache · vertigo
- **PREGNANCY** No evidence of harm; absorption from gastrointestinal tract negligible.
- **PARENTERAL** Amount probably too small to be harmful.
- **RENAL IMPAIRMENT** Use with caution; aluminium is absorbed and may accumulate.
- **DIRECTIONS FOR ADMINISTRATION** Administration of sucralfate and enteral feeds should be separated by 1 hour and for administration by mouth, sucralfate should be given 1 hour before meals. Oral suspension blocks fine- bore feeding tubes. Crushed tablets may be dispersed in water.
- **PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral liquid formulations may include aniseed and caramel.

**H₂-RECEPTOR ANTAGONISTS**

**H₂-receptor antagonists**

**Overview**

Histamine H₂-receptor antagonists heal gastric and duodenal ulcers by reducing gastric acid output as a result of histamine H₂-receptor blockade; they are also used to relieve symptoms of dyspepsia and *gastric·oesophageal reflux disease*. H₂-receptor antagonists should not normally be used for *Zollinger–Ellison syndrome* because proton pump inhibitors are more effective.

Maintenance treatment with low doses has largely been replaced in *Helicobacter pylori* positive children by eradication regimens. H₂-receptor antagonist therapy can promote healing of *NSAID-associated ulcers*.

**H₂-receptor antagonists**

- **SIDE-EFFECTS**
  - **Common or very common** Constipation · diarrhoea · dizziness · fatigue · headache · myalgia · skin reactions
  - **Uncommon** Confusion · depression · erectile dysfunction · gynaecomastia · hallucination · hepatic disorders · leucopenia · nausea · tachycardia
  - **Rare or very rare** Agranulocytosis · alopecia · arthralgia · atrioventricular block · fever · galactorrhoea · pancreatitis · thrombocytopenia · vasculitis

**Ranitidine**

**INDICATIONS AND DOSE**

**Benign gastric ulceration** | **Duodenal ulceration**
---|---
**BY MOUTH**
- Neonate: 2 mg/kg 3 times a day (max. per dose 3 mg/kg 3 times a day), oral absorption is unreliable.
- Child 1-5 months: 1 mg/kg 3 times a day (max. per dose 3 mg/kg 3 times a day)
- Child 6 months-2 years: 2–4 mg/kg twice daily
- Child 3-11 years: 2–4 mg/kg twice daily (max. per dose 150 mg)
- Child 12-17 years: 150 mg twice daily, alternatively 300 mg once daily, dose to be taken at night

**Prophylaxis of stress ulceration**
- **INITIALLY BY SLOW INTRAVENOUS INJECTION**
- Neonate: 0.5–1 mg/kg every 6–8 hours.
- Child 1 month-11 years: 1 mg/kg every 6–8 hours (max. per dose 50 mg), may be given as an intermittent infusion at a rate of 25 mg/hour
**UNLICENSED USE** Oral preparations not licensed for use in children under 3 years. Injection not licensed for use in children under 6 months.

**INTERACTIONS** → Appendix 1: H2 receptor antagonists

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- Rare or very rare Bone marrow depression - bradycardia - breast conditions - dyskinesia - nethritis acute intestinal - pancreatitis acute - vision blurred
- Frequency not known Dyspnoea

**SPECIFIC SIDE-EFFECTS**

- Rare or very rare
  - With parenteral use Anaphylactic shock - cardiac arrest
- **PREGNANCY**
  - Manufacturer advises avoid unless essential, but not known to be harmful.
- **BREAST FEEDING**
  - Significant amount present in milk, but not known to be harmful.
- **RENAL IMPAIRMENT**
  - Dose adjustments Use half normal dose if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².
- **DIRECTIONS FOR ADMINISTRATION** For slow intravenous injection dilute to a concentration of 2.5 mg/mL with Glucose 5% or Sodium Chloride 0.9%; give over at least 3 minutes.
- **PATIENT AND CARER ADVICE** In fat malabsorption syndrome, give oral doses 1–2 hours before food to enhance effects of pancreatic enzyme replacement. Medicines for Children leaflet: Ranitidine for acid reflux [www.medicinesforchildren.org.uk/ranitidine-acid-reflux](http://www.medicinesforchildren.org.uk/ranitidine-acid-reflux)

**EXCEPTIONS TO LEGAL CATEGORY** Ranitidine can be sold to the public for adults and children over 16 years (provided packs do not contain more than 2 weeks’ supply) for the short-term symptomatic relief of heartburn, dyspepsia, and hyperacidity, and for the prevention of these symptoms when associated with consumption of food or drink (max. single dose 75 mg, max. daily dose 300 mg).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, infusion

**Tablet**

- **Ranitidine (Non-proprietary)**
  - Ranitidine (as Ranitidine hydrochloride) 150 mg Ranitidine 150mg tablets | 60 tablet (£0.72) DT = £0.07
  - Ranitidine (as Ranitidine hydrochloride) 300 mg Ranitidine 300mg tablets | 60 tablet (£0.72) DT = £0.08
  - Zantac (Omega Pharma Ltd, GlaxoSmithKline UK Ltd)
  - Ranitidine (as Ranitidine hydrochloride) 75 mg Zantac 75 tablets | 24 tablet (£0.16) DT = £0.75
  - Ranitidine (as Ranitidine hydrochloride) 150 mg Zantac 150mg tablets | 60 tablet (£1.30 DT + £0.07
  - Ranitidine (as Ranitidine hydrochloride) 300 mg Zantac 300mg tablets | 30 tablet (£0.10 DT + £0.08

**Solution for Injection**

- **Ranitidine (Non-proprietary)**
  - Ranitidine (as Ranitidine hydrochloride) 25 mg per 1 ml Ranitidine 50mg/2ml solution for injection ampoules | 5 amppule (£0.69–£0.050 DT = £0.96
  - Zantac (GlaxoSmithKline UK Ltd)
  - Ranitidine (as Ranitidine hydrochloride) 25 mg per 1 ml Ranitidine 50mg/2ml solution for injection ampoules | 5 amppule (£0.82 DT = £2.96

**Effervescent tablet**

**CAUTIONARY AND ADVISORY LABELS** 13

**ELECTROLYTES**
- May contain Sodium

**PROTON PUMP INHIBITORS**

**Proton pump inhibitors**

**Overview**

Omeprazole p. 60 is an effective short-term treatment for *gastric and duodenal ulcers*; it is also used in combination with antibacterials for the eradication of *Helicobacter pylori*. An initial short course of omeprazole is the treatment of choice in *gastro-oesophageal reflux disease* with severe symptoms; children with endoscopically confirmed erosive, ulcerative, or strictureing *oesophagitis* usually need to be maintained on omeprazole.

Omeprazole is also used for the prevention and treatment of NSAID-associated ulcers. In children who need to continue NSAID treatment after an ulcer has healed, the dose of omeprazole should not normally be reduced because asymptomatic ulcer deterioration may occur.

Omeprazole is effective in the treatment of the *Zollinger–Ellison syndrome* (including cases resistant to other treatment). It is also used to reduce the degradation of pancreatic enzyme supplements in children with cystic fibrosis.

Lansoprazole p. 59 is not licensed for use in children, but may be considered when the available formulations of omeprazole are unsuitable.
Esomeprazole below can be used for the management of gastro-oesophageal reflux disease when the available formulations of omeprazole and lansoprazole are unsuitable.

**Proton pump inhibitors**

- **DRUG ACTION** Proton pump inhibitors inhibit gastric acid secretion by blocking the hydrogen-potassium adenosine triphosphatase enzyme system (the ‘proton pump’) of the gastric parietal cell.

**IMPORTANT SAFETY INFORMATION**

MHRA ADVICE: PROTON PUMP INHIBITORS (PPIs): VERY LOW RISK OF SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS (SEPTEMBER 2015)

Very infrequent cases of subacute cutaneous lupus erythematosus (SCLE) have been reported in patients taking PPIs. Drug-induced SCLE can occur weeks, months or even years after exposure to the drug.

If a patient treated with a PPI develops lesions—especially in sun-exposed areas of the skin—and it is accompanied by arthralgia:
- Advise them to avoid exposing the skin to sunlight.
- Consider SCLE as a possible diagnosis.
- Consider discontinuing PPI treatment if it is imperative for a serious acid-related condition; a patient who develops SCLE with a particular PPI may be at risk of the same reaction with another.
- In most cases, symptoms resolve on PPI withdrawal; topical or systemic steroids might be necessary for treatment of SCLE only if there are no signs of remission after a few weeks or months.

**SIDE-EFFECTS**

- **Common or very common** Abdominal pain, constipation, diarrhoea, dizziness, dry mouth, gastrointestinal disorders, headache, insomnia, nausea, skin reactions, vomiting
- **Rare or very rare** Agranulocytosis, alopecia, gynaecomastia, hallucination, hepatic disorders, hyperhidrosis, hypotension, nephritis tubulointerstitial, pancytopenia, photosensitivity reaction, severe cutaneous adverse reactions (SCARs), stomatitis, taste altered
- **Frequency not known** Hypomagnesaemia (more common after 1 year of treatment, but sometimes after 3 months of treatment), subacute cutaneous lupus erythematosus

**MONITORING REQUIREMENTS** Measurement of serum-magnesium concentrations should be considered before and during prolonged treatment with a proton pump inhibitor, especially when used with other drugs that cause hypomagnesaemia or with digoxin.

**PRESCRIBING AND DISPENSING INFORMATION** A proton pump inhibitor should be prescribed for appropriate indications at the lowest effective dose for the shortest period; the need for long-term treatment should be reviewed periodically.

---

**Esomeprazole**

- **INDICATIONS AND DOSE**
  - **Gastro-oesophageal reflux disease (in the presence of erosive reflux oesophagitis)**
    - **BY MOUTH**
      - Child 1–11 years (body-weight 10–19 kg): 10 mg once daily for 8 weeks
      - Child 1–11 years (body-weight 20 kg and above): 10–20 mg once daily for 8 weeks
      - Child 12–17 years: Initially 40 mg once daily for 4 weeks, continued for further 4 weeks if not fully healed or symptoms persist; maintenance 20 mg daily
    - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
      - Child 1–11 years (body-weight up to 20 kg): 10 mg once daily, injection to be given over at least 3 minutes
      - Child 1–11 years (body-weight 20 kg and above): 10–20 mg once daily, injection to be given over at least 3 minutes
      - Child 12–17 years: 40 mg daily, injection to be given over at least 3 minutes
  - **Symptomatic treatment of gastro-oesophageal reflux disease (in the absence of oesophagitis)**
    - **BY MOUTH**
      - Child 1–11 years (body-weight 10 kg and above): 10 mg once daily for up to 8 weeks
      - Child 12–17 years: 20 mg once daily for up to 4 weeks
    - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
      - Child 1–11 years: 10 mg once daily, injection to be given over at least 3 minutes
      - Child 12–17 years: 20 mg once daily, injection to be given over at least 3 minutes

- **UNLICENSED USE** Tablets and capsules not licensed for use in children 1–11 years.
- **INTERACTIONS** → Appendix 1: proton pump inhibitors
- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - **Uncommon** Encephalopathy
    - **Rare or very rare** Aggression, agitation, bronchospasm, increased risk of infection, muscle weakness
  - **SPECIFIC SIDE-EFFECTS**
    - **Rare or very rare**
      - With parenteral use Renal failure
      - **Frequency not known**
        - With parenteral use Electrolyte imbalance, vitamin B12 deficiency
      - **PREGNANCY** Manufacturer advises caution—no information available.
      - **BREAST FEEDING** Manufacturer advises avoid—no information available.
      - **HEPATIC IMPAIRMENT** Manufacturer advises caution in severe impairment.
  - **Dose adjustments** Manufacturer advises in children 1–11 years, max. 10 mg daily in severe impairment.
  - **RENAL IMPAIRMENT** Manufacturer advises caution in severe renal insufficiency.
- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use For intravenous infusion, dilute reconstituted solution to a concentration not exceeding 800 micrograms/mL with Sodium Chloride 0.9%; give over 10–30 minutes.
  - With oral use Do not chew or crush capsules; swallow whole or mix capsule contents in water and drink within 30 minutes. Do not crush or chew tablets; swallow whole or disperse in water and drink within 30 minutes. Disperse the contents of each sachet of gastro-resistant granules in approx. 15 mL water. Stir and leave to thicken for a few
MEDICINAL FORMS

from special-order manufacturers include: oral suspension

Child (body-weight 30 kg and above):
▶ Lansoprazole

Gastro-resistant granules

▶ Emozul

▶ Esomeprazole (Non-proprietary)

Gastro-resistant capsule

▶ Lansoprazole

▶ Nexium

▶ Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole sodium) 40 mg (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole sodium) 40 mg (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole sodium) 40 mg (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole sodium) 40 mg (Ethypharm UK Ltd)

Esomeprazole (as Esomeprazole sodium) 40 mg (Consilient Health Ltd)

Gastro-resistant tablet

▶ Lansoprazole

▶ Nexium

▶ Nexium

▶ Nexium

Powder for solution for injection

▶ Lansoprazole

▶ Nexium

▶ Nexium

Gastro-resistant granules

CAUTIONARY AND ADVISORY LABELS 25

▶ Nexium

Lansoprazole

INDICATIONS AND DOSE

Benign gastric ulcer

BY MOUTH

Child (body-weight up to 30 kg): 0.5–1 mg/kg once daily (max. per dose 15 mg once daily), doses to be taken in the morning

Child (body-weight 30 kg and above): 15–30 mg once daily, doses to be taken in the morning

PATIENT AND CARER ADVICE

Counselling on administration of gastro-resistant capsules, tablets, and granules advised.

Gastro-resistant capsule

Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole magnesium dihydrate)

20 mg Esomeprazole 20 mg gastro-resistant capsules | 28 capsule (BNF) £11.95 DT + £1.86

Esomeprazole (as Esomeprazole magnesium dihydrate)

40 mg Esomeprazole 40 mg gastro-resistant capsules | 28 capsule (BNF) £17.63 DT + £2.27

Eomeal (Consilent Health Ltd)

Esomeprazole (as Esomeprazole magnesium dihydrate)

20 mg Emozul 20 mg gastro-resistant capsules | 28 capsule (BNF) £12.18 DT + £1.86

Eomesrprazole (as Esomeprazole magnesium dihydrate)

40 mg Emozul 40 mg gastro-resistant capsules | 28 capsule (BNF) £27.82 DT + £2.27

Ventra (Ethylpharm UK Ltd)

Esomeprazole (as Esomeprazole magnesium dihydrate)

20 mg Ventra 20 mg gastro-resistant capsules | 28 capsule (BNF) £15.55 DT + £1.86

Eomesrprazole (as Esomeprazole magnesium dihydrate)

40 mg Ventra 40 mg gastro-resistant capsules | 28 capsule (BNF) £29.97 DT + £2.27

Gastro-resistant tablet

Esomeprazole (Non-proprietary)

Eomesrprazole (as Esomeprazole magnesium trihydrate)

20 mg Esomeprazole 20 mg gastro-resistant tablets | 28 tablet (BNF) £16.50 DT + £2.15

Eomesrprazole (as Esomeprazole magnesium trihydrate)

40 mg Esomeprazole 40 mg gastro-resistant tablets | 28 tablet (BNF) £21.76 DT + £2.83

Nexium (AstraZeneca UK Ltd, Pfizer Consumer Healthcare Ltd)

Eomesrprazole (as Esomeprazole magnesium trihydrate)

20 mg Nexium 20 mg gastro-resistant tablets | 28 tablet (BNF) £18.50 DT + £2.15

Eomesrprazole (as Esomeprazole magnesium trihydrate)

40 mg Nexium 40 mg gastro-resistant tablets | 28 tablet (BNF) £25.19 DT + £2.83

Powder for solution for injection

Eomesrprazole (Non-proprietary)

Eomesrprazole (as Esomeprazole sodium) 40 mg Esomeprazole 40 mg powder for solution for injection vials | 1 vial (BNF) £3.07–£3.13 (Hospital only)

Nexium (AstraZeneca UK Ltd)

Eomesrprazole (as Esomeprazole sodium) 40 mg Nexium IV 40 mg powder for solution for injection vials | 1 vial (BNF) £4.25 (Hospital only)

Gastro-resistant granules

CAUTIONARY AND ADVISORY LABELS 25

Nexium (AstraZeneca UK Ltd)

Eomesrprazole (as Esomeprazole magnesium trihydrate)

10 mg Nexium 10 mg gastro-resistant granules sachets | 28 sachet (BNF) £25.19 DT + £25.19

PATIENT AND CARER ADVICE

Counselling on administration of orodispersible tablet advised.

Medicines for Children leaflet: Lansoprazole for gastro-oesophageal reflux disease (GORD) and ulcers

www.medicinesforchildren.org.uk/lansoprazole-gastrooesophageal-reflux-disease-gord-and-ulcers

Duodenal ulcer

BY MOUTH

Child (body-weight up to 30 kg): 0.5–1 mg/kg once daily (max. per dose 15 mg once daily), doses to be taken in the morning

Child (body-weight 30 kg and above): 15–30 mg once daily, doses to be taken in the morning

NSAID-associated duodenal ulcer / NSAID-associated gastric ulcer

BY MOUTH

Child (body-weight up to 30 kg): 0.5–1 mg/kg once daily (max. per dose 15 mg once daily), doses to be taken in the morning

Child (body-weight 30 kg and above): 15–30 mg once daily, doses to be taken in the morning

Gastro-oesophageal reflux disease

BY MOUTH

Child (body-weight up to 30 kg): 0.5–1 mg/kg once daily (max. per dose 15 mg once daily), doses to be taken in the morning

Child (body-weight 30 kg and above): 15–30 mg once daily, doses to be taken in the morning

Acid-related dyspepsia

BY MOUTH

Child (body-weight up to 30 kg): 0.5–1 mg/kg once daily (max. per dose 15 mg once daily), doses to be taken in the morning

Child (body-weight 30 kg and above): 15–30 mg once daily, doses to be taken in the morning

Fat malabsorption despite pancreatic enzyme replacement therapy in cystic fibrosis

BY MOUTH

Child (body-weight up to 30 kg): 0.5–1 mg/kg once daily (max. per dose 15 mg once daily), doses to be taken in the morning

Child (body-weight 30 kg and above): 15–30 mg once daily, doses to be taken in the morning

UNLICENSED USE

Not licensed for use in children.

INTERACTIONS

Appendix 1: proton pump inhibitors

SIDE-EFFECTS

Common or very common Dry throat - fatigue

Uncommon Anaemia - angioedema - appetite decreased - erectile dysfunction - fever - glossitis - oesophageal candidiasis - pancreatitis - restlessness - tremor

RARE or very RARE Anaemia - angioedema - appetite decreased - erectile dysfunction - fever - glossitis - oesophageal candidiasis - pancreatitis - restlessness - tremor

PREGNANCY

Avoid—present in milk in animal studies.

HEPATIC IMPAIRMENT

Manufacturer advises caution in moderate to severe impairment (risk of increased exposure).

Dose adjustments

Manufacturer advises dose reduction of 50% in moderate to severe impairment.

DIRECTIONS FOR ADMINISTRATION

Orodispersible tablets should be placed on the tongue, allowed to disperse and swallowed, or may be swallowed whole with a glass of water. Alternatively, tablets can be dispersed in a small amount of water and administered by an oral syringe or nasogastric tube.

PATIENT AND CARER ADVICE

Counselling on administration of orodispersible tablet advised.

Medicines for Children leaflet: Lansoprazole for gastro-oesophageal reflux disease (GORD) and ulcers

www.medicinesforchildren.org.uk/lansoprazole-gastrooesophageal-reflux-disease-gord-and-ulcers
Disorders of gastric acid and ulceration

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, powder, gastro-resistant capsule.

**Gastro-resistent capsule**

- Lansoprazole (Non-proprietary)
  - Lansoprazole 15 mg: Lansoprazole 15 mg gastro-resistant capsule 28 capsule (POD) £2.92 DT = £0.76
  - Lansoprazole 30 mg: Lansoprazole 30 mg gastro-resistant capsules 28 capsule (POD) £23.63 DT = £1.01

**Ordispersible tablet**

- Lansoprazole (Non-proprietary)
  - Lansoprazole 15 mg: Lansoprazole 15 mg orodispersible tablets 28 tablet (Pfizer) £2.90 DT = £0.90
  - Lansoprazole 30 mg: Lansoprazole 30 mg orodispersible tablets 28 tablet (Pfizer) £6.99 DT = £4.26
  - Zoton FastTab (Pfizer Ltd)
    - Lansoprazole 15 mg Zoton FastTab 15 mg 28 tablet (POD) £2.99 DT = £0.90
    - Lansoprazole 30 mg Zoton FastTab 30 mg 28 tablet (POD) £5.50 DT = £4.26

**Omeprazole**

**INDICATIONS AND DOSE**

*Helicobacter pylori* eradication in combination with amoxicillin and clarithromycin; or in combination with amoxicillin and metronidazole; or in combination with clarithromycin and metronidazole

- **BY MOUTH**
  - Child 1-5 years: 1–2 mg/kg once daily (max. per dose 40 mg)
  - Child 6–11 years: 1–2 mg/kg once daily (max. per dose 40 mg)
  - Child 12–17 years: 40 mg once daily

**Treatment of duodenal ulcers including those complicating NSAID therapy / Treatment of benign gastric ulcers including those complicating NSAID therapy**

- **BY MOUTH**
  - Neonate: 700 micrograms/kg once daily for 7–14 days, then increased if necessary to 1.4–2.8 mg/kg once daily.
  - Child 1 month-1 year: 700 micrograms/kg once daily, increased if necessary to 3 mg/kg once daily (max. per dose 20 mg)
  - Child 2–7 years (body-weight 10–19 kg): 10 mg once daily, increased if necessary to 20 mg once daily
  - Child 2–7 years (body-weight 20 kg and above): 20 mg once daily, increased if necessary to 40 mg once daily
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child 1 month-1 year: 700 micrograms/kg once daily (max. per dose 20 mg), increased if necessary to 2 mg/kg once daily (max. per dose 40 mg), injection to be given over 5 minutes
    - Child 12–17 years: 40 mg once daily, injection to be given over 5 minutes

**Zollinger-Ellison syndrome**

- **BY MOUTH**
  - Neonate: 700 micrograms/kg once daily for 7–14 days, then increased if necessary to 1.4–2.8 mg/kg once daily.
  - Child 1 month-1 year: 700 micrograms/kg once daily, increased if necessary to 3 mg/kg once daily (max. per dose 20 mg)
  - Child 2–7 years (body-weight 10–19 kg): 10 mg once daily, increased if necessary to 20 mg once daily
  - Child 2–7 years (body-weight 20 kg and above): 20 mg once daily, increased if necessary to 40 mg once daily
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child 1 month-1 year: 700 micrograms/kg once daily (max. per dose 20 mg), increased if necessary to 2 mg/kg once daily (max. per dose 40 mg), injection to be given over 5 minutes
    - Child 12–17 years: 40 mg once daily, injection to be given over 5 minutes

**by intravenous injection, or by intravenous infusion**

- Child 1 month-1 year: Initially 500 micrograms/kg once daily (max. per dose 20 mg), increased if necessary to 2 mg/kg once daily (max. per dose 40 mg), injection to be given over 5 minutes
- Child 12–17 years: 40 mg once daily, injection to be given over 5 minutes

**Gastro-oesophageal reflux disease**

- **BY MOUTH**
  - Neonate: 700 micrograms/kg once daily for 7–14 days, then increased if necessary to 1.4–2.8 mg/kg once daily.
  - Child 1 month-1 year: 700 micrograms/kg once daily, increased if necessary to 3 mg/kg once daily (max. per dose 20 mg)
  - Child 2–7 years (body-weight 10–19 kg): 10 mg once daily, increased if necessary to 20 mg once daily, in severe ulcerating reflux oesophagitis, maximum 12 weeks at higher dose
  - Child 2–7 years (body-weight 20 kg and above): 20 mg once daily, increased if necessary to 40 mg once daily, in severe ulcerating reflux oesophagitis, maximum 12 weeks at higher dose
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child 1 month-1 year: Initially 500 micrograms/kg once daily (max. per dose 20 mg), increased if necessary to 2 mg/kg once daily (max. per dose 40 mg), injection to be given over 5 minutes
    - Child 12–17 years: 40 mg once daily, injection to be given over 5 minutes

**Acid-related dyspepsia**

- **BY MOUTH**
  - Neonate: 700 micrograms/kg once daily for 7–14 days, then increased if necessary to 1.4–2.8 mg/kg once daily.
  - Child 1 month-1 year: 700 micrograms/kg once daily, increased if necessary to 3 mg/kg once daily (max. per dose 20 mg)
  - Child 2–7 years (initiated by a specialist) (body-weight 10–19 kg): 10 mg once daily, increased if necessary to 20 mg once daily
  - Child 2–7 years (initiated by a specialist) (body-weight 20 kg and above): 20 mg once daily, increased if necessary to 40 mg once daily
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child 1 month-1 years: Initially 500 micrograms/kg once daily (max. per dose 20 mg), increased if necessary to 2 mg/kg once daily (max. per dose 40 mg), injection to be given over 5 minutes
    - Child 12–17 years: 40 mg once daily, injection to be given over 5 minutes

**Fat malabsorption despite pancreatic enzyme replacement therapy in cystic fibrosis**

- **BY MOUTH**
  - Neonate: 700 micrograms/kg once daily for 7–14 days, then increased if necessary to 1.4–2.8 mg/kg once daily.
  - Child 1 month-1 year: 700 micrograms/kg once daily, increased if necessary to 3 mg/kg once daily (max. per dose 20 mg)
  - Child 2–7 years (body-weight 10–19 kg): 10 mg once daily, increased if necessary to 20 mg once daily
  - Child 2–7 years (body-weight 20 kg and above): 20 mg once daily, increased if necessary to 40 mg once daily
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child 1 month-1 years: Initially 500 micrograms/kg once daily (max. per dose 20 mg), increased if necessary to 2 mg/kg once daily (max. per dose 40 mg), injection to be given over 5 minutes
    - Child 12–17 years: 40 mg once daily, injection to be given over 5 minutes
● **UNLICENSED USE** Capsules and tablets not licensed for use in children except for severe ulcerating reflux oesophagitis in children over 1 year. Injection not licensed for use in children under 12 years.

● **INTERACTIONS** → Appendix 1: proton pump inhibitors

● **SIDE-EFFECTS**
  ▶ Rare or very rare
  - Aggression - agitation - bronchospasm - encephalopathy - gastrointestinal candidiasis - muscle weakness

● **PREGNANCY** Not known to be harmful.

● **BREAST FEEDING** Present in milk but not known to be harmful.

● **HEPATIC IMPAIRMENT**

  Dose adjustments

  No more than 700 micrograms/kg (max. 20 mg) once daily.

● **DIRECTIONS FOR ADMINISTRATION**

  For administration by mouth, swallow whole, or disperse Losec MUPS® tablets in water, or mix capsule contents or Losec MUPS® tablets with fruit juice or yoghurt. Preparations consisting of an e/c tablet within a capsule should not be opened.

  For administration through an enteral feeding tube, use Losec MUPS® or the contents of a capsule containing omeprazole dispersed in a large volume of water, or in 10 mL Sodium Bicarbonate 8.4% (1 mmol/mL). Allow to stand for 10 minutes before administration.

  For intermittent intravenous infusion, dilute reconstituted solution to a concentration of 400 micrograms/mL with Glucose 5% or Sodium Chloride 0.9%; give over 20–30 minutes.

● **PRESCRIBING AND DISPENSING INFORMATION**

  The RCPCH and NPPG recommend that, when a liquid special of omeprazole is required, the following strength is used: 20 mg/5 mL.

● **PATIENT AND CARER ADVICE**

  ▶ With oral use

  Counselling on administration advised. Medicines for Children leaflet: Omeprazole for gastro-oesophageal reflux disease (GORD) www.medicinesforchildren.org.uk/omeprazole-gastro-oesophageal-reflux-disease-gord

● **PROFESSIONAL SPECIFIC INFORMATION**

  Dental practitioners’ formulary

  Gastro-resistant omeprazole capsules may be prescribed.

● **MEDICINAL FORMS**

  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

  **Gastro-resistant capsule**

  - **Omeprazole (Non-proprietary)**
    - Omeprazole 10 mg: Omeprazole 10 mg gastro-resistant capsules | 28 capsule PACT £9.30 DT + £0.82
    - Omeprazole 20 mg: Omeprazole 20 mg gastro-resistant capsules | 28 capsule PACT £9.86 DT + £0.83
    - Omeprazole 40 mg: Omeprazole 40 mg gastro-resistant capsules | 7 capsule PACT £6.96 DT + £0.62
  - **Losec** (AstraZeneca UK Ltd)
    - Omeprazole 10 mg: Losec 10 mg gastro-resistant capsules | 28 capsule PACT £11.16 DT + £0.82
    - Omeprazole 20 mg: Losec 20 mg gastro-resistant capsules | 28 capsule PACT £11.70 DT + £0.83
    - Omeprazole 40 mg: Losec 40 mg gastro-resistant capsules | 7 capsule PACT £8.35 DT + £0.62
  - **Mepradec** (Discovery Pharmaceuticals)
    - Omeprazole 10 mg: Mepradec 10 mg gastro-resistant capsules | 28 capsule PACT £0.68 DT + £0.82
    - Omeprazole 20 mg: Mepradec 20 mg gastro-resistant capsules | 28 capsule PACT £0.70 DT + £0.83

  **Gastro-resistant tablet**

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  - **Omeprazole (Non-proprietary)**
    - Omeprazole 10 mg: Omeprazole 10 mg gastro-resistant tablets | 28 tablet PACT £18.91 DT + £7.90
    - Omeprazole 20 mg: Omeprazole 20 mg gastro-resistant tablets | 28 tablet PACT £28.56 DT + £5.97

  **Omeprazole 40 mg** Omeprazole 40 mg gastro-resistant tablets | 7 tablet PACT £14.28 DT + £6.17

  - **Losec MUPS** (AstraZeneca UK Ltd)
    - Omeprazole (as Omeprazole magnesium) 10 mg Losec MUPS 10 mg gastro-resistant tablets | 28 tablet PACT £13.30 DT + £9.30
    - Omeprazole (as Omeprazole magnesium) 20 mg Losec MUPS 20 mg gastro-resistant tablets | 28 tablet PACT £13.92 DT + £13.92
    - Omeprazole (as Omeprazole magnesium) 40 mg Losec MUPS 40 mg gastro-resistant tablets | 7 tablet PACT £6.96 DT + £6.96

  - **Mezzopram** (Sanodz Ltd)
    - Omeprazole (as Omeprazole magnesium) 10 mg Mezzopram 10 mg dispersible gastro-resistant tablets | 28 tablet PACT £6.38 DT + £9.30
    - Omeprazole (as Omeprazole magnesium) 20 mg Mezzopram 20 mg dispersible gastro-resistant tablets | 28 tablet PACT £9.86 DT + £13.92
    - Omeprazole (as Omeprazole magnesium) 40 mg Mezzopram 40 mg dispersible gastro-resistant tablets | 7 tablet PACT £4.93 DT + £6.96

  **Powder for solution for infusion**

  - **Omeprazole (Non-proprietary)**
    - Omeprazole (as Omeprazole sodium) 40 mg Omeprazole 40 mg powder for solution for infusion vials | 5 vial PACT £6.00-£32.45 DT + £26.00 (Hospital only)

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**4.3 Gastro-oesophageal reflux disease**

**Gastro-oesophageal reflux disease**

**Management**

Gastro-oesophageal reflux disease includes non-erosive gastro-oesophageal reflux and erosive oesophagitis. Uncomplicated gastro-oesophageal reflux is common in infancy and most symptoms, such as intermittent vomiting or repeated, effortless regurgitation, resolve without treatment between 12 and 18 months of age. Older children with gastro-oesophageal reflux disease may have heartburn, acid regurgitation and dysphagia. Oesophageal inflammation (oesophagitis), ulceration or stricture formation may develop in early childhood; gastro-oesophageal reflux disease may also be associated with chronic respiratory disorders including asthma.

Parents and carers of neonates and infants should be reassured that most symptoms of uncomplicated gastro-oesophageal reflux resolve without treatment. An increase in the frequency and a decrease in the volume of feeds may reduce symptoms. A feed thickener or pre-thickened formula feed can be used on the advice of a dietician. If necessary, a suitable alginate-containing preparation can be used instead of thickened feeds. A thickening agent should be tried for up to 2 weeks before considering other treatment.

**Older children** should be advised about life-style changes such as weight reduction if overweight, Smoking cessation p. 304, and the avoidance of alcohol. An alginate-containing antacid can be used to relieve symptoms.

Children who do not respond to these measures or who have problems such as respiratory disorders or suspected oesophagitis need to be referred to hospital. On the advice of a paediatrician, a histamine H2-receptor antagonist can be used to relieve symptoms of gastro-oesophageal reflux disease, promote mucosal healing and permit reduction in antacid consumption. A proton pump inhibitor can be used for the treatment of moderate, non-erosive oesophagitis that is unresponsive to an H2-receptor antagonist. Endoscopically confirmed erosive, ulcerative, or stricture disease in children is usually treated with a proton pump inhibitor. Reassessment is necessary if symptoms persist despite 4–6 weeks of treatment; long-term use of an H2-receptor antagonist or proton pump inhibitor should not be undertaken without full assessment of the underlying condition. For endoscopically confirmed erosive, ulcerative,
Gastro-intestinal system

PATIENT AND CARER ADVICE

PRESCRIBING AND DISPENSING INFORMATION

please consider, alginic acid p. 607. The properties listed below are those particular to the oesophageal reflux disease.

Pregnancy

If dietary and lifestyle changes fail to control gastro-oesophageal reflux disease in pregnancy, an antacid or an alginate can be used. If this is ineffective, ranitidine p. 56 can be tried. Omeprazole p. 60 is reserved for women with severe or complicated reflux disease.

Other drugs used for Gastro-oesophageal reflux disease

Esomeprazole, p. 58 - Lansoprazole, p. 59

ANTACIDS > ALGINATE

Sodium alginate with calcium carbonate and sodium bicarbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, alginic acid p. 52, sodium bicarbonate p. 607, calcium carbonate p. 613.

INDICATIONS AND DOSE

Mild symptoms of gastro-oesophageal reflux disease

BY MOUTH

Child 6-11 years: 5–10 mL, to be taken after meals and at bedtime

Child 12-17 years: 10–20 mL, to be taken after meals and at bedtime

INTERACTIONS

Appendix 1: calcium salts - sodium bicarbonate

PRESCRIBING AND DISPENSING INFORMATION

Flavours of oral liquid formulations may include aniseed or peppermint.

PATIENT AND CARER ADVICE

Medicines for Children leaflet: Gaviscon for gastro-oesophageal reflux disease www.medicinesforchildren.org.uk/gaviscon-gastro-oesophageal-reflux-disease

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Oral suspension

ELECTROLYTES: May contain Sodium

Acidex (Pinewood Healthcare)

Calcium carbonate 16 mg per 1 ml, Sodium bicarbonate 26.7 mg per 1 ml, Sodium alginate 50 mg per 1 ml Acidex oral suspension anised sugar-free | 500 ml GLS £2.56 DT = £1.95

Acidex oral suspension peppermint sugar-free | 150 ml GLS £1.21 DT = £2.58 sugar-free | 500 ml GLS £2.96 DT = £1.95

Entrocalm Heartburn and Indigestion Relief (Galpharm International Ltd)

Calcium carbonate 16 mg per 1 ml, Sodium bicarbonate 26.7 mg per 1 ml, Sodium alginate 50 mg per 1 ml Entrocalm Heartburn and Indigestion Relief oral suspension sugar-free | 150 ml G 25 mg £1.95

Entrocalm Heartburn and Indigestion Relief (Galpharm International Ltd)

Calcium carbonate 16 mg per 1 ml, Sodium bicarbonate 26.7 mg per 1 ml, Sodium alginate 50 mg per 1 ml Entrocalm Heartburn and Indigestion Relief oral suspension peppermint sugar-free | 150 ml GLS £3.34 DT = £4.33 sugar-free | 300 ml GLS £4.33 DT = £4.33 sugar-free | 600 ml GLS £7.11 DT = £7.11

Gaviscon Liquid Relief (Reckitt Benckiser Healthcare (UK) Ltd)

Calcium carbonate 16 mg per 1 ml, Sodium bicarbonate 26.7 mg per 1 ml, Sodium alginate 50 mg per 1 ml Gaviscon Liquid Relief peppermint sugar-free | 150 ml GLS £2.58 DT = £2.58 sugar-free | 300 ml GLS £4.33 DT = £4.33 sugar-free | 600 ml GLS £7.11 DT = £7.11

Peptac (Teva UK Ltd)

Calcium carbonate 16 mg per 1 ml, Sodium bicarbonate 26.7 mg per 1 ml, Sodium alginate 50 mg per 1 ml Peptac liquid peppermint sugar-free | 500 ml GLS £1.95 DT = £1.95

Peptac liquid anised sugar-free | 500 ml GLS £1.95 DT = £1.95

Rennie (Bayer Pk)

Calcium carbonate 16 mg per 1 ml, Sodium bicarbonate 26.7 mg per 1 ml, Sodium alginate 50 mg per 1 ml Rennie Liquid Heartburn Relief oral suspension sugar-free | 150 ml GLS £2.52 DT = £2.58

Gaviscon Peppermint Liquid Relief sugar-free | 150 ml GLS £2.52 DT = £2.58

4.4 Helicobacter pylori diagnosis

DIAGNOSTIC AGENTS

Urea (13C)

INDICATIONS AND DOSE

Diagnosis of gastro-duodenal Helicobacter pylori infection

BY MOUTH

Child: (consult product literature)

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Soluble tablet

Pylobactell (Torbet Laboratories Ltd)

Urea [13-C] 100 mg Pylobactell breath test kit | 1 kit POM £20.75

DT = £20.75

Powder

Helicobacter Test INFAI (INFAI UK Ltd)

Urea [13-C] 45 mg Helicobacter Test INFAI breath test kit sugar-free | 1 kit POM £10.10 DT = £10.10

Urea [13-C] 75 mg Helicobacter Test INFAI breath test kit sugar-free | 1 kit POM £21.70 DT = £21.70

Tablet

Diabact UBT (HFA Healthcare Products Ltd)

Urea [13-C] 50 mg diabact UBT 50mg tablets | 1 tablet POM £21.25

DT = £21.25

5 Food allergy

Food allergy

Description of condition

Food allergy is an adverse immune response to a food, commonly associated with cutaneous and gastro-intestinal reactions, and less frequently associated with respiratory reactions and anaphylaxis. It is distinct from food intolerance which is non-immunological. Cow’s milk, hen’s eggs, soy, wheat, peanuts, tree nuts, fish, and shellfish are the most common allergens. Cross-reactivity between similar foods can occur (e.g. allergy to other mammalian milk in patients with cow’s milk allergy).

Management of food allergy

Allergy caused by specific foods should be managed by strict avoidance of the causative food. Sodium cromoglicate p. 169 is licensed as an adjunct to dietary avoidance in children with food allergy. Educating the child or their carer about appropriate nutrition, food preparation, and the risks of accidental exposure is recommended, such as food and drinks to avoid, ensuring adequate nutritional intake, and interpreting food labels. For children in whom elimination diets might affect growth, a consultation with a nutritionist is recommended to identify alternative dietary sources.

Drug treatment

There is low quality evidence to support the use of antihistamines to treat acute, non-life-threatening
stimulates gastric emptying and small intestinal transit, and Domperidone is a dopamine receptor antagonist which enhances the strength of oesophageal sphincter contraction. The MHRA/CHM has issued restrictions on its use because domperidone is associated with a small increased risk of serious cardiac side effects.

A low dose of erythromycin p. 341 stimulates gastrointestinal motility and may be used on the advice of a paediatric gastroenterologist to promote tolerance of enteral feeds; erythromycin may be less effective as a prokinetic drug in preterm neonates than in older children.

**6 Gastro-intestinal smooth muscle spasm**

### Antispasmodics

**Antimuscarinics**

The intestinal smooth muscle relaxant properties of antimuscarinic and other antispasmodic drugs may be useful in irritable bowel syndrome. Antimuscarinics (formerly termed ‘anticholinergics’) reduce intestinal motility. They are occasionally used for the management of irritable bowel syndrome.

Antimuscarinics that are used for gastro-intestinal smooth muscle spasm include the tertiary amine dicycloverine hydrochloride below and the quaternary ammonium compounds propantheline bromide p. 64 and hyoscine butylbromide p. 64. The quaternary ammonium compounds are less lipid soluble than atropine and are less likely to cross the blood-brain barrier; they are also less well absorbed from the gastro-intestinal tract.

Dicycloverine hydrochloride, may also have some direct action on smooth muscle. Hyoscine butylbromide is advocated as a gastro-intestinal antispasmodic, but it is poorly absorbed; the injection may be useful in endoscopy and radiology.

Other indications for antimuscarinic drugs include asthma and airways disease, motion sickness, urinary frequency and enuresis, mydriasis and cycloplegia, premedication, palliative care and as an antidote to organophosphorus poisoning.

**Other antispasmodics**

Alverine citrate p. 65, mebeverine hydrochloride p. 65, and peppermint oil p. 37 are believed to be direct relaxants of intestinal smooth muscle and may relieve pain in irritable bowel syndrome, and primary dysmenorrhoea. They have no serious adverse effects but, like all antispasmodics, should be avoided in paralytic ileus.

**Motility stimulants**

Domperidone is a dopamine receptor antagonist which stimulates gastric emptying and small intestinal transit, and
Gastro-intestinal smooth muscle spasms

**Hyoscine butylbromide** 13-Mar-2017

**INDICATIONS AND DOSE**

Symptomatic relief of gastro-intestinal or genito-urinary disorders characterised by smooth muscle spasm

- **BY MOUTH**
  - Child 1 month–1 year: 300–500 micrograms/kg 3–4 times a day (max. per dose 5 mg)
  - Child 2–5 years: 5 mg 3–4 times a day
  - Child 6–11 years: 10 mg 3–4 times a day
  - Child 12–17 years: 10–20 mg 3–4 times a day

Acute spasm | Spasm in diagnostic procedures
---|---
- **INITIALLY BY INTRAMUSCULAR INJECTION, OR BY SLOW INTRAVENOUS INJECTION**
  - Child 2–5 years: 5 mg, then (by intramuscular injection or by slow intravenous injection) 5 mg after 30 minutes if required, dose may be repeated more frequently in endoscopy; maximum 15 mg/day
  - Child 6–11 years: 5–10 mg, then (by intramuscular injection or by intravenous injection) 5–10 mg after 30 minutes if required, dose may be repeated more frequently in endoscopy; maximum 30 mg/day
  - Child 12–17 years: 20 mg, then (by intramuscular injection or by slow intravenous injection) 20 mg after 30 minutes if required, dose may be repeated more frequently in endoscopy; maximum 80 mg/day

**Excessive respiratory secretions in palliative care**

- **BY MOUTH**
  - Child 1 month–1 year: 300–500 micrograms/kg 3–4 times a day (max. per dose 5 mg)
  - Child 2–4 years: 5 mg 3–4 times a day
  - Child 5–11 years: 10 mg 3–4 times a day
  - Child 12–17 years: 10–20 mg 3–4 times a day

**Mydriasis**

- With intramuscular use or intravenous use

- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS** Dyspnoea
  - **SPECIFIC SIDE-EFFECTS**
    - With parenteral use: Mydriasis
  - **PREGNANCY** Manufacturer advises avoid.
  - **BREAST FEEDING** Amount too small to be harmful.

**DIRECTIONS FOR ADMINISTRATION**

- With oral use: For administration by mouth, injection solution may be used; content of ampoule may be stored in a refrigerator for up to 24 hours after opening.
- With intravenous use: For intravenous injection, may be diluted with Glucose 5% or Sodium Chloride 0.9%; give over at least 1 minute.

**PRESCRIBING AND DISPENSING INFORMATION**

Palliative care: For further information on the use of hyoscine butylbromide in palliative care, see www.medicinescomplete.com/#/content/palliative/hyoscine-butylbromide.

**EXCEPTIONS TO LEGAL CATEGORY** Hyoscine butylbromide tablets can be sold to the public for medically confirmed irritable bowel syndrome, provided single dose does not exceed 20 mg, daily dose does not exceed 80 mg, and pack does not contain a total of more than 240 mg.

**MEDIKL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral suspension**
- **Kolanticon** (Peckforton Pharmaceuticals Ltd)
  - Dicycloverine hydrochloride 500 microgram per 1 ml, Simeticone 4 mg per 1 ml, Magnesium oxide light 20 mg per 1 ml, Aluminium hydroxide dried 40 mg per 1 ml Kolanticon gel sugar-free | 200 ml (£4.00 sugar-free | 500 ml (£6.00)

**Propantheline bromide** 13-Mar-2017

**INDICATIONS AND DOSE**

Symptomatic relief of gastro-intestinal disorders characterised by smooth muscle spasm

- **BY MOUTH**
  - Child 1 month–11 years: 300 micrograms/kg 3–4 times a day (max. per dose 15 mg), dose to be taken at least one hour before food
Antispasmodics

**Mebeverine hydrochloride**

**INDICATIONS AND DOSE**
Adjunct in gastrointestinal disorders characterised by smooth muscle spasm

- **By mouth** using immediate-release medicines
  - Child 3 years: 25 mg 3 times a day, dose preferably taken 20 minutes before meals
  - Child 4-7 years: 50 mg 3 times a day, dose preferably taken 20 minutes before meals
  - Child 8-9 years: 100 mg 3 times a day, dose preferably taken 20 minutes before meals
  - Child 10-17 years: 135–150 mg 3 times a day, dose preferably taken 20 minutes before meals

**Irritable bowel syndrome**
- **By mouth** using modified-release medicines
  - Child 12-17 years: 200 mg twice daily

**SIDE-EFFECTS**
- By mouth: Immediate-release capsules
  - Child 12-17 years: 60–120 mg 1–3 times a day

**INTERACTIONS**
- Medicated dosage forms may affect performance on skilled tasks (e.g. driving).

**CONTRA-INDICATIONS**
- Paralytic ileus
- Angioedema – face oedema – skin reactions

**PREGNANCY**
- Not known to be harmful – manufacturers advise avoid.

**BREAST FEEDING**
- Manufacturers advise avoid — no information available.

**PATIENT AND CARER ADVICE**
- Patients or carers should be given advice on the timing of administration of mebeverine hydrochloride tablets and oral suspension.

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- 2019
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**INDICATIONS AND DOSE**
Symptomatic relief of gastrointestinal disorders characterised by smooth muscle spasm | Dysmenorrhoea

- **By mouth**
  - Child 12-17 years: 60–120 mg 1–3 times a day

**SIDE-EFFECTS**
- Intestinal obstruction – paralytic ileus

**PREGNANCY**
- Manufacturer advises avoid — limited information available

**BREAST FEEDING**
- Manufacturer advises avoid — limited information available

**PATIENT AND CARER ADVICE**
- Driving and skilled tasks: Dizziness may affect performance of skilled tasks (e.g. driving).

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Capsule**
- Mebeverine hydrochloride (as Mebeverine pamoate) 10 mg per capsule
  - 60 mg capsules | 100 capsule (Mylan) £0.30 DT + £6.90
  - 120 mg capsules | 60 capsule (Mylan) £0.49 DT + £6.90

**Tablet**
- Mebeverine hydrochloride 200 mg
  - Mebeverine 200 mg modified-release capsules | 60 capsule (Mylan) £8.29
  - Mebeverine 200 mg
  - Mebeverine hydrochloride 315 mg
  - Mebeverine 315 mg tablets | 100 tablet (Mylan) £4.30

**Suspension**
- Mebeverine hydrochloride 10 mg per ml
  - 50 mg/5 ml oral suspension sugar free sugar-free | 300 ml (Mylan) £187.00 DT + £187.00

**Oral suspension**
- Mebeverine hydrochloride (as Mebeverine pamoate) 10 mg per ml
  - 100 mg/5 ml oral suspension sugar free sugar-free | 150 ml (Mylan) £187.00 DT + £187.00

**McNeils Mebeverine hydrochloride 200 mg**
- Mebeverine 200 mg

**Gastro-intestinal system**

**Alverine citrate**

**INDICATIONS AND DOSE**
Symptomatic relief of gastrointestinal disorders characterised by smooth muscle spasm | Dysmenorrhoea

- **By mouth**
  - Child 12-17 years: 60–120 mg 1–3 times a day

**SIDE-EFFECTS**

**PREGNANCY**
- Manufacturer advises avoid — limited information available

**BREAST FEEDING**
- Manufacturer advises avoid — limited information available

**PATIENT AND CARER ADVICE**
- Driving and skilled tasks: Dizziness may affect performance of skilled tasks (e.g. driving).

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Capsule**
- Alverine citrate (Non-proprietary)
  - 60 mg | 100 capsule (Pro-Banthine) £19.49 DT + £3.27
  - 120 mg | 60 capsule (Pro-Banthine) £23.28 DT + £3.27

**Tablet**
- Alverine citrate (Non-proprietary)
  - 120 mg | 112 tablet (Audmonal) £46.50 DT + £20.74

**Suspension**
- Alverine citrate (Non-proprietary)
  - 60 mg | 300 ml oral suspension (Aurobeverine) £1.75 DT + £3.28

**Spasmonal**
- Mebeverine hydrochloride (as Mebeverine pamoate) 10 mg per capsule
  - 60 mg capsules | 100 capsule (Aurobeverine) £0.30 DT + £6.90
  - 120 mg capsules | 60 capsule (Aurobeverine) £0.49 DT + £6.90

**Aurobeverine MR (Milpharm Ltd)**

**Colofac hydrochloride 200 mg**
- Mebeverine MR 200 mg
  - Mebeverine 200 mg modified-release capsules | 60 capsule (Colofac) £8.29

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg
  - Mebeverine 135 mg tablets | 100 tablet (Colofac) £4.30

**Aurobeverine MR (Mylan)**

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg
  - Mebeverine 315 mg tablets | 100 tablet (Colofac) £4.30

**Megazine (Spasmonal) (Medsa Pharmaceuticals Ltd)**

**Lactation**
- May suppress lactation.

**Pro-Banthine**
- Tablet

**Spasmonal (Meda Pharmaceuticals Ltd)**

**Aurobeverine MR 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Aurobeverine MR (Milpharm Ltd)**

**Colofac hydrochloride 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Colofac hydrochloride 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Aurobeverine MR (Mylan)**

**Colofac hydrochloride 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Aurobeverine MR (Milpharm Ltd)**

**Colofac hydrochloride 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Aurobeverine MR (Mylan)**

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- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

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- Mebeverine 315 mg

**Aurobeverine MR (Mylan)**

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**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Aurobeverine MR (Milpharm Ltd)**

**Colofac hydrochloride 200 mg**
- Mebeverine 200 mg

**Colofac hydrochloride 135 mg**
- Mebeverine 135 mg

**Colofac hydrochloride 315 mg**
- Mebeverine 315 mg

**Aurobeverine MR (Mylan)**
7 Liver disorders and related conditions

7.1 Biliary disorders

Cholestasis

Description of condition
Cholestasis is an impairment of bile formation and/or bile flow, which may clinically present with fatigue, pruritus, dark urine, pale stools and, in its most overt form, jaundice and signs of fat soluble vitamin deficiencies.

Treatment
Ursodeoxycholic acid p. 67 [unlicensed] and colestyramine p. 131 [unlicensed under 6 years] are used to relieve cholestatic pruritus in children, even if evidence to support their use is limited.

Colestyramine is an anion-exchange resin that is not absorbed from the gastro-intestinal tract. It relieves pruritus by forming an insoluble complex in the intestine with bile acids and other compounds—the reduction of serum bile acid levels reduces excess deposition in the dermal tissue with a resultant decrease in pruritus.

Under specialist supervision, other drugs which may be used as an alternative treatment for intractable cholestatic pruritus include rifampicin p. 379 [unlicensed indication], phenobarbital p. 223 [unlicensed indication] and opioid antagonists [unlicensed indication]. However, they should be used with caution and under expert guidance as these children usually have severe liver disease—careful monitoring is required.

Inborn errors of primary bile acid synthesis

Description of condition
Inborn errors of primary bile acid synthesis are a group of diseases in which the liver does not produce enough primary bile acids due to enzyme deficiencies. These acids are the main components of the bile, and include cholic acid and chenodeoxycholic acid.

Treatment
Cholic acid p. 67 is licensed for the treatment of inborn errors of primary bile acid synthesis due to an inborn deficiency of two specific liver enzymes. It acts by replacing some of the missing bile acids, therefore relieving the symptoms of the disease.

Chenodeoxycholic acid below is licensed for the treatment of inborn errors of primary bile acid synthesis due to a deficiency of one specific enzyme in the bile acid synthesis pathway when presenting as cerebrotendinous xanthomatosis.

Ursodeoxycholic acid p. 67 [unlicensed indication] has been used to treat inborn errors in primary bile acid synthesis, but there is an absence of evidence to recommend its use.

Primary biliary cholangitis

Description of condition
Primary biliary cholangitis (or primary biliary cirrhosis) is a chronic cholestatic disease which develops due to progressive destruction of small and intermediate bile ducts within the liver, subsequently evolving to fibrosis and cirrhosis.

Treatment
Ursodeoxycholic acid p. 67 is recommended for the management of primary biliary cholangitis, including those with asymptomatic disease. It slows disease progression, but the effect on overall survival is uncertain.

Smith-Lemli-Opitz syndrome

Description of condition
Smith-Lemli-Opitz syndrome is an inborn error of cholesterol synthesis. It is characterised by multiple congenital anomalies, intellectual deficit, growth delay, microcephaly, and behavioural problems. The disease is present at birth, but may be detected in later childhood or adulthood in mild forms. Hypoglycaemia due to adrenal insufficiency can present as an acute manifestation.

Aims of treatment
There is currently no cure for Smith-Lemli-Opitz syndrome. Management is aimed at symptom relief and alleviation of functional disabilities.

Treatment
Children with Smith-Lemli-Opitz syndrome are treated with dietary cholesterol supplementation, including high cholesterol foods (such as egg yolks) or a suspension of pharmaceutical grade cholesterol p. 68 (available from Special-order manufacturers p. 1107 or specialist importing companies) to help improve growth failure and photosensitivity. However, it is not clear who will benefit most from cholesterol treatment or how long it should continue.

In some cases bile acid supplements, such as chenodeoxycholic acid below [unlicensed] and ursodeoxycholic acid p. 67 [unlicensed indication] have been also used for this condition, but their use is not generally recommended.

Bile acids

Chenodeoxycholic acid

† INDICATIONS AND DOSE
Cerebrotendinous xanthomatosis (specialist use only)
† BY MOUTH
Child: Initially 5 mg/kg daily in 3 divided doses, adjusted according to response; maximum 15 mg/kg per day; maximum 1000 mg per day

Defective synthesis of bile acid (specialist use only)
† BY MOUTH
Neonate: Initially 5 mg/kg 3 times a day, reduced to 2.5 mg/kg 3 times a day.

Child: Initially 5 mg/kg 3 times a day, reduced to 2.5 mg/kg 3 times a day

Smith-Lemli-Opitz syndrome (specialist use only)
† BY MOUTH
Neonate: 7 mg/kg once daily, alternatively 7 mg/kg daily in divided doses.

Child: 7 mg/kg once daily, alternatively 7 mg/kg daily in divided doses

† UNLICENSED USE Not licensed for defective synthesis of bile acid. Not licensed for Smith-Lemli-Opitz syndrome.

† CONTRA-INDICATIONS Non-functioning gall bladder - radio-opaque stones
Biliary disorders

**Cholic acid**

**Indications and Dose**

**Cholestasis**
- **By mouth**
  - Child (body-weight up to 10 kg): 50 mg daily, then increased in steps of 50 mg daily in divided doses; usual dose 5–15 mg/kg daily in divided doses, dose to be given with food at the same time each day
  - Child (body-weight 10 kg and above): Usual dose 5–15 mg/kg daily; increased in steps of 50 mg daily in divided doses if required, dose to be given with food at the same time each day; Usual maximum 500 mg/24 hours

**Side-effects**
- Cholelithiasis (long term use), diarrhoea, pruritus

**Interactions**
- Appendix 1: cholic acid
- Appendix 1: ursodeoxycholic acid

**Side-effects, further information**
- Patients presenting with pruritus and/or persistent diarrhoea should be investigated for potential overdose by a serum and/or urine bile acid assay.

**Pregnancy**
- Limited data available—known not to be harmful, manufacturer advises continue treatment.

**Monitoring**
- Manufacturer advises monitor patient parameters more frequently in pregnancy.

**Breast feeding**
- Present in milk but not known to be harmful.

**Hepatic impairment**
- Manufacturer advises caution and stop treatment if there are signs of severe hepatic failure—limited information available (no experience with impairment from causes not related to inborn errors of primary bile acid synthesis).

**Dose adjustments**
- Manufacturer advises adjust dose as the degree of impairment improves during treatment.

**Monitoring requirements**
- Manufacturer advises monitor serum and/or urine bile-acid concentrations every 3 months for the first year, then every 6 months for three years, then annually; monitor liver function tests at the same or greater frequency.

**Directions for administration**
- Manufacturer advises capsules may be opened and the content added to infant formula, juice, fruit compote, or yoghurt for administration.

**Patient and carer advice**
- Counselling advised on administration.

**Medicinal forms**
- There can be variation in the licensing of different medicines containing the same drug.

**Capsule**
- **Chenodeoxycholic acid (non-proprietary)**
  - Chenodeoxycholic acid 250 mg, capsules | 100 capsule (BNF) £14.000

**Ursodeoxycholic acid**

**Indications and dose**

**Cholestasis**
- **By mouth**
  - Neonate: 5 mg/kg 3 times a day (max. per dose 10 mg/kg 3 times a day), adjusted according to response.
  - Child 1–23 months: 5 mg/kg 3 times a day (max. per dose 10 mg/kg 3 times a day), adjusted according to response
  - Child 24 months–7 years: 5 mg/kg 3 times a day, total daily dose may alternatively be given in 3 divided doses

**Cholestasis associated with total parenteral nutrition**
- **By mouth**
  - Neonate: 10 mg/kg 3 times a day.
  - Child: 10 mg/kg 3 times a day

**Sclerosing cholangitis**
- **By mouth**
  - Child: 5–10 mg/kg 2–3 times a day (max. per dose 15 mg/kg 3 times a day), adjusted according to response

**Unlicensed use**
- Not licensed for use in children for the treatment of cholestasis, sclerosing cholangitis, cholestasis associated with total parenteral nutrition or the improvement of hepatic metabolism of essential fatty acids and bile flow in cystic fibrosis.

**Contra-indications**
- Non-functioning gall bladder - radio-opaque stones

**Interactions**
- Appendix 1: ursodeoxycholic acid

**Side-effects**
- Common or very common: Diarrhoea, pale faeces
- Rare or very rare: Cholelithiasis calcification - skin reactions
- Frequency not known: Nausea, vomiting

**Pregnancy**
- No evidence of harm but manufacturer advises avoid.

**Breast feeding**
- Not known to be harmful but manufacturer advises avoid.

**Hepatic impairment**
- Avoid in chronic liver disease (but used in primary biliary cirrhosis).
7.2 Oesophageal varices

Other drugs used for Oesophageal varices Vasopressin, p. 69

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

Terlipressin acetate

INDICATIONS AND DOSE

GLYPRESSIN® INJECTION

Adjunct in acute massive haemorrhage of gastrointestinal tract or oesophageal varices (specialist use only)

BY INTRAVENOUS INJECTION

- Child 12–17 years (body-weight up to 50 kg): Initially 2 mg every 4 hours until bleeding controlled, then reduced to 1 mg every 4 hours if required, maximum duration 48 hours
- Child 12–17 years (body-weight 50 kg and above): Initially 2 mg every 4 hours until bleeding controlled, reduced if not tolerated to 1 mg every 4 hours, maximum duration 48 hours

VARIQUEL® INJECTION

Adjunct in acute massive haemorrhage of gastrointestinal tract or oesophageal varices (specialist use only)

BY INTRAVENOUS INJECTION

- Child 12–17 years (body-weight up to 50 kg): Initially 1 mg, then 1 mg every 4–6 hours for up to 72 hours, to be administered over 1 minute
- Child 12–17 years (body-weight 50–69 kg): Initially 1.5 mg, then 1 mg every 4–6 hours for up to 72 hours, to be administered over 1 minute
- Child 12–17 years (body-weight 70 kg and above): Initially 2 mg, then 1 mg every 4–6 hours for up to 72 hours, to be administered over 1 minute

UNLICENSED USE

Unlicensed for use in children.

CAUTIONS

Arrhythmia · electrolyte and fluid disturbances · heart disease · history of QT-interval prolongation · respiratory disease · septic shock · uncontrolled hypertension · vascular disease

SIDE-EFFECTS

- Common or very common Abdominal cramps · arrhythmias · diarrhoea · headache · hypertension · hypotension · pallor · peripheral ischaemia · vasoconstriction
- Uncommon Chest pain · cyanosis · fluid overload · heart failure · hot flush · hyponatraemia · intestinal ischaemia · ischaemic heart disease · lymphangitis · myocardial infarction · nausea · pulmonary oedema · respiratory disorders · seizure · skin necrosis · uterine disorders · vomiting
- Rare or very rare Dyspnoea · hyperglycaemia · stroke

PREGNANCY

Avoid unless benefits outweigh risk—uterine contractions and increased intra-uterine pressure in early pregnancy, and decreased uterine blood flow reported.

BREAST FEEDING

Avoid unless benefits outweigh risk—no information available.

RENAI IMPAIRMENT

Use with caution in chronic renal failure.

LIPIDS > STEROLS

Cholesterol

INDICATIONS AND DOSE

Smith–Lemli–Opitz syndrome

BY MOUTH

- Neonate: 5–10 mg/kg 3–4 times a day.
- Child: 5–10 mg/kg 3–4 times a day, doses up to 15 mg/kg 4 times daily have been used

UNLICENSED USE

Not licensed.

CONTRA-INDICATIONS

CONTRA-INDICATIONS, FURTHER INFORMATION

For contra-indications, consult product literature.

CAUTIONS

CAUTIONS, FURTHER INFORMATION

For advice on cautions, consult product literature.

DIRECTIONS FOR ADMINISTRATION

Cholesterol powder can be mixed with a vegetable oil before administration.

UNLICENSED USE

Not licensed.

CONTRA-INDICATIONS

CONTRA-INDICATIONS, FURTHER INFORMATION

For contra-indications, consult product literature.

CAUTIONS

CAUTIONS, FURTHER INFORMATION

For advice on cautions, consult product literature.

DIRECTIONS FOR ADMINISTRATION

Cholesterol powder can be mixed with a vegetable oil before administration.

UNLICENSED USE

Not licensed.
Obesity

8  Obesity

Description of condition
Obesity is directly linked to many health problems including cardiovascular disease, type 2 diabetes, and obstructive sleep apnoea syndrome. It can also contribute to psychological and psychiatric morbidities.

In children and adolescents, body mass index (BMI) should be used as a practical estimation of body fat. However, it should be interpreted with caution as it is not a direct measure of adiposity. Assessing the BMI of children is more complicated than for adults because it changes as they grow and mature, with different growth patterns seen between boys and girls.

Public Health England advises that the British 1990 (UK90) growth reference charts should be used to determine the weight status of children. A child ≥ the 91st centile is classified as overweight, and as obese if ≥ the 98th centile. Waist circumference is not recommended as a routine measure, but should be used as an additional predictor for risk of developing other long-term health problems. Children who are overweight or obese and have significant comorbidities or complex needs should be considered for specialist referral.

Aims of treatment
Children who are overweight or obese and are no longer growing taller will ultimately need to lose weight and maintain weight loss to improve their BMI. However, preventing further weight gain while making lifestyle changes, may be an appropriate short-term aim.

Overview
The goals of management of obesity should be agreed together with the child and their parents or carers; parents or carers should be encouraged to take responsibility for lifestyle changes of their children. Referral to a specialist can be considered for children who are overweight or obese and have significant comorbidities or complex needs (e.g. learning disabilities). Children should be assessed for comorbidities such as hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction, and exacerbation of conditions such as asthma.

An initial assessment should consider potential underlying causes (e.g. hypothryoidism) and a review of the appropriateness of current medications, which are known to cause weight gain, e.g. atypical antipsychotics, beta-adrenoceptor blocking drugs, insulin (when used in the treatment of type 2 diabetes), sodium valproate, and tricyclic antidepressants.

Lifestyle changes
Obese children should be encouraged to engage in a sustainable weight management programme which includes strategies to change behaviour, increase physical activity and improve diet and eating behaviour. These changes should be encouraged within the whole family. Any dietary changes should be age appropriate and consistent with healthy eating recommendations. Surgical intervention is not generally recommended in children or adolescents.

Drug treatment
Drug treatment is not generally recommended for children younger than 12 years, unless there are exceptional circumstances, such as if severe comorbidities are present. In children over 12 years, drug treatment is only recommended if physical comorbidities, such as orthopaedic problems or sleep apnoea, or severe psychological comorbidities are present. Drug treatment should never be used as the sole element of treatment and should be used as part of an overall weight management plan. Orlistat p. 70 [unlicensed use] is the only drug currently available in the UK that is recommended specifically for the treatment of obesity; it acts by reducing the absorption of dietary fat. Treatment should be started and monitored in a specialist paediatric setting by experienced multidisciplinary teams. An initial 6–12 month trial is recommended, with regular review to assess effectiveness, adverse effects and adherence.

Treatment may also be used to maintain weight loss rather than to continue to lose weight. A vitamin and mineral supplement may also be considered if there is concern about inadequate micronutrient intake, particularly for younger children who need vitamins and minerals for growth and development.
Rectal and anal disorders

Useful Resources


PERIPHERALLY ACTING ANTI OBESITY PRODUCTS > LIPASE INHIBITORS

Orlistat

- DRUG ACTION Orlistat, a lipase inhibitor, reduces the absorption of dietary fat.

- INDICATIONS AND DOSE
  Adjunct in obesity
  - BY MOUTH
  - Child 12-17 years (initiated by a specialist): 120 mg up to 3 times a day, dose to be taken immediately before, during, or up to 1 hour after each main meal, continue treatment beyond 12 weeks only under specialist supervision, if a meal is missed or contains no fat, the dose of orlistat should be omitted

- UNLICENSED USE Not licensed for use in children.

- CONTRA-INDICATIONS Cholestasis - chronic malabsorption syndrome

- CAUTIONS Chronic kidney disease - may impair absorption of fat-soluble vitamins - volume depletion

- INTERACTIONS → Appendix 1: orlistat

- SIDE-EFFECTS
  - Common or very common Abdominal pain (may be minimised by reduced fat intake) - anxiety - diarrhoea - gastrointestinal disorders
  - Frequency not known Anorectal haemorrhage - bullous dermatitis - cholelithiasis - diverticulitis - hepatitis - oxalate nephropathy - pancreatitis - renal failure

- PREGNANCY Use with caution.

- BREAST FEEDING Avoid—no information available.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.
  Capsule
    - Orlistat (Non-proprietary)
      - Orlistat 120 mg Orlistat 120mg capsules | 84 capsule | £35.43 DT = £26.56
      - Alli (GlaxoSmithKline Consumer Healthcare)
      - Orlistat 60 mg Alli 60mg capsules | 84 capsule | £30.70 DT = £30.70
      - Orlos (Crescent Pharma Ltd)
      - Orlistat 60 mg Orlos 60mg capsules | 84 capsule | £16.95 DT = £30.70
      - Xenical (Cheplapharm Arzneimittel GmbH)
      - Orlistat 120 mg Xenical 120mg capsules | 84 capsule | £31.63 DT = £26.56

9 Rectal and anal disorders

9.1 Anal fissures

Description of condition
An anal fissure is a tear or ulcer in the lining of the anal canal, immediately within the anal margin. Clinical features of anal fissure include bleeding and persistent pain on defecation, and a linear split in the anal mucosa.

Constipation (passage of hard stools) is the most common cause in children. The majority of anal fissures are posterior, and an underlying cause should be considered (secondary anal fissure) if fissures are multiple, occur laterally, and are refractory to treatment.

EGG Suspect sexual abuse if a child has an anal fissure, and if constipation, Crohn’s disease or passing hard stools have been excluded as the cause (see also Useful resources below).

Aims of treatment
The aim of treatment is to relieve pain and promote healing of the fissure.

Drug treatment

EGG Initial management of acute anal fissures should focus on ensuring that stools are soft and easily passed. Osmotic laxatives, such as lactulose p. 43 or macrogols (macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride p. 44), are recommended. A simple analgesic such as paracetamol p. 278 or ibuprofen p. 679, may be offered for prolonged burning pain following defecation.

Children should be referred to a paediatric specialist if the anal fissure has not healed following two weeks of initial management, or earlier if there is significant pain.

Useful Resources


9.2 Haemorrhoids

Haemorrhoids

Description of condition
Haemorrhoids, or piles, are abnormal swellings of the vascular mucosal anal cushions around the anus. Internal haemorrhoids arise above the dentate line and are usually painless unless they become strangulated. External haemorrhoids originate below the dentate line and can be itchy or painful. Haemorrhoids in children are rare but may occur in infants with portal hypertension.

Aims of treatment
The aims of treatment are to reduce the symptoms (pain, bleeding and swelling), promote healing, and prevent recurrence.
Non-drug treatment

Stools should be kept soft and easy to pass (to minimise straining) by increasing dietary fibre and fluid intake. Advice about perianal hygiene is helpful to aid healing and reduce irritation and itching.

Drug treatment

If constipation is present, it should be treated, see Constipation p. 41.

A simple analgesic, such as paracetamol p. 278, can be used for pain relief. NSAIDs should be avoided if rectal bleeding is present.

Symptomatic treatment with a locally applied preparation is appropriate for short periods. Manufacturer advises preparations containing local anaesthetics (lidocaine, cinchocaine, and pramocaine [unlicensed]) should only be used for a few days as they may cause sensitisation of the anal skin—local anaesthetic ointments can be absorbed through the rectal mucosa (with a theoretical risk of systemic effects) and very rarely may cause increased irritation; excessive application should be avoided in infants and children.

Topical preparations combining corticosteroids with local anaesthetics and soothing agents are available for the management of haemorrhoids. Manufacturer advises long-term use of corticosteroid creams can cause ulceration and permanent damage due to thinning of the perianal skin and should be avoided. Continuous or excessive use carries a risk of adrenal suppression and systemic corticosteroid effects (particularly in infants).

Topical preparations containing corticosteroids must not be used if infection is present (such as perianal streptococcal infection, herpes simplex or perianal thrush). Recurrent symptoms, should be referred to secondary care for further investigation and management.

Related drugs

Topical preparations used for haemorrhoids: lidocaine hydrochloride p. 852, benzyl benzoate with bismuth oxide, bismuth subgallate, hydrocortisone acetate, peru balsam and zinc oxide below, cinchocaine hydrochloride with fluocortolone caproate and fluocortolone pivalate below, cinchocaine with hydrocortisone p. 72, cinchocaine with prednisolone p. 72.

CORTICOSTEROIDS

Benzyl benzoate with bismuth oxide, bismuth subgallate, hydrocortisone acetate, peru balsam and zinc oxide

Cinchaconine hydrochloride with fluocortolone caproate and fluocortolone pivalate

Haemorrhoids | Pruritus ani

BY RECTUM USING OINTMENT

Child 12-17 years: Apply twice daily for no longer than 7 days, to be inserted after a bowel movement, then 1 suppository daily on alternate days for 1 week.

Haemorrhoids (severe cases) | Pruritus ani (severe cases)

BY RECTUM USING OINTMENTS

Child 12-17 years: Initially 1 suppository daily for 5–7 days, to be inserted after a bowel movement, then 1 suppository once daily on alternate days for 1 week.

Cautions

Local anaesthetic component can be absorbed through the rectal mucosa (avoid excessive application, particularly in children and infants). Local anaesthetic component may cause sensitisation (use for short periods only—no longer than a few days).

Prescribing and dispensing information

A proprietary brand Anusol Plus HC® (ointment and suppositories) is on sale to the public.

Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

Ointment

Anusol-Hc (Church & Dwight UK Ltd)

Hydrocortisone acetate 2.5 mg per 1 gram, Bismuth oxide 8.75 mg per 1 gram, Benzyl benzoate 12.5 mg per 1 gram, Peru Balsam 18.75 mg per 1 gram, Bismuth subgallate 22.5 mg per 1 gram, Zinc oxide 107.5 mg per 1 gram

Anusol HC ointment 30 grammes £2.49

Suppository

Anusol-Hc (Church & Dwight UK Ltd)

Hydrocortisone acetate 10 mg, Bismuth oxide 24 mg, Benzyl benzoate 33 mg, Peru Balsam 49 mg, Bismuth subgallate 59 mg, Zinc oxide 296 mg

Anusol HC suppositories 12 suppository £1.74

Important safety information

MHRA/CHM advice: CORTICOSTEROIDS; RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

See Corticosteroids, general use p. 450.
Cinchoacaine with hydrocortisone

21-Dec-2017

**INDICATIONS AND DOSE**

**PROCTOSEYL® OINTMENT**

Haemorrhoids | Pruritus ani
---|---
> TO THE SKIN, OR BY RECTUM

- Child: Apply twice daily, to be administered morning and night and after a bowel movement. Apply externally or by rectum. Do not use for longer than 7 days

**PROCTOSEYL® SUPPOSITORIES**

Haemorrhoids | Pruritus ani
---|---
> BY RECTUM

- Child 12-17 years: 1 suppository, insert suppository night and morning and after a bowel movement. Do not use for longer than 7 days

**UNIROID-HC® OINTMENT**

Haemorrhoids | Pruritus ani
---|---
> TO THE SKIN, OR BY RECTUM

- Child 1 month–11 years (under medical advice only): Apply twice daily, and apply after a bowel movement, apply externally or by rectum, do not use for longer than 7 days
- Child 12-17 years: Apply twice daily, and apply after a bowel movement, apply externally or by rectum, do not use for longer than 7 days

**UNIROID-HC® SUPPOSITORIES**

Haemorrhoids | Pruritus ani
---|---
> BY RECTUM

- Child 12-17 years: 1 suppository, insert twice daily and after a bowel movement. Do not use for longer than 7 days

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

See Corticosteroids, general use p. 450.

**CAUTIONS**

Local anaesthetic component can be absorbed through the rectal mucosa (avoid excessive application), local anaesthetic component may cause sensitisation (use for short periods only—no longer than a few days)

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ointment**

- **Proctosedyl** (Sanofi) Cinchocaine hydrochloride 5 mg per 1 gram, Hydrocortisone 5 mg per 1 gram Proctosedyl ointment | 30 gram PDP £10.34 DT = £10.34
- **Uniorid HC** (Chemidex Pharma Ltd) Cinchocaine hydrochloride 5 mg per 1 gram, Hydrocortisone 5 mg per 1 gram Uniorid HC ointment | 30 gram PDP £4.23 DT = £10.34

**Suppository**

- **Proctosedyl** (Sanofi) Cinchocaine hydrochloride 5 mg, Hydrocortisone 5 mg Proctosedyl suppositories | 12 suppository PDP £5.08 DT = £5.08
- **Uniorid HC** (Chemidex Pharma Ltd) Cinchocaine hydrochloride 5 mg, Hydrocortisone 5 mg Uniorid HC suppositories | 12 suppository PDP £1.31 DT = £1.04

Cinchoacaine with prednisolone

21-Dec-2017

**INDICATIONS AND DOSE**

Haemorrhoids | Pruritus ani
---|---
> BY RECTUM USING OINTMENT

- Child: Apply twice daily for 5–7 days, apply 3–4 times a day on the first day if necessary, then apply once daily for a few days after symptoms have cleared

**Haemorrhoids (severe cases) | Pruritus ani (severe cases)**
---|---
> BY RECTUM USING SUPPOSITORIES

- Child 12-17 years: Initially 1 suppository 2–3 times a day, then 1 suppository daily for a total of 5–7 days, to be inserted after a bowel movement

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

See Corticosteroids, general use p. 450.

**CAUTIONS**

Local anaesthetic component can be absorbed through the rectal mucosa (avoid excessive application), local anaesthetic component may cause sensitisation (use for short periods only—no longer than a few days)

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ointment**

- **Scheriproct** (Bayer Plc) Prednisolone hexanoate 1.9 mg per 1 gram, Cinchocaine hydrochloride 5 mg per 1 gram Scheriproct ointment | 30 gram PDP £3.23 DT = £3.23

**Suppository**

- **Scheriproct** (Bayer Plc) Cinchocaine hydrochloride 1 mg, Prednisolone hexanoate 1.3 mg Scheriproct suppositories | 12 suppository PDP £1.52 DT = £1.52

Hydrocortisone with lidocaine

21-Dec-2017

**INDICATIONS AND DOSE**

Haemorrhoids | Pruritus ani
---|---
> BY RECTUM USING AEROSOL SPRAY

- Child 2-13 years (under medical advice only): 1 spray up to 3 times a day, spray once over the affected area
- Child 14-17 years: 1 spray up to 3 times a day for no longer than 7 days without medical advice, spray once over the affected area

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

See Corticosteroids, general use p. 450.

**CAUTIONS**

Local anaesthetic component can be absorbed through the rectal mucosa (avoid excessive application), local anaesthetic component may cause sensitisation (use for short periods only—no longer than a few days)

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ointment**

- **Xyloproct** (Aspen Pharma Trading Ltd) Hydrocortisone acetate 2.75 mg per 1 gram, Lidocaine 50 mg per 1 gram Xyloproct 5%/0.275% ointment | 40 gram PDP £4.19 DT = £4.19
**Hydrocortisone with pramocaine**

**25-Dec-2017**

**INDICATIONS AND DOSE**

Pain and irritation associated with local, non-infected anal or perianal conditions

- **BY RECTUM**
  - Child 12-17 years: 1 applicatorful 2–3 times a day and 1 applicatorful, after a bowel movement, do not use for longer than 7 days; maximum 4 applicatorfuls per day

**CAUTIONS**

Local anaesthetic component can be absorbed through the rectal mucosa (avoid excessive application). Local anaesthetic component may cause sensitisation (use for short periods only—no longer than a few days)

**MEDICINAL FORMS**

No licensed medicines listed.

**Reduced exocrine secretions**

**10 Reduced exocrine secretions**

**Exocrine pancreatic insufficiency**

14-Dec-2016

**Description of condition**

Exocrine pancreatic insufficiency is characterised by reduced secretion of pancreatic enzymes into the duodenum. The main clinical manifestations are malabsorption and malnutrition, associated with low circulating levels of micronutrients, fat-soluble vitamins and lipoproteins. Children also present with gastrointestinal symptoms, such as diarrhoea, abdominal cramps and steatorrhoea.

Exocrine pancreatic insufficiency can result from cystic fibrosis, coeliac disease, Zollinger-Ellison syndrome, and gastrointestinal or pancreatic surgical resection.

**Aims of treatment**

The aim of treatment is to relieve gastrointestinal symptoms and to achieve a normal nutritional status.

**Drug treatment**

Pancreatic enzyme replacement therapy with pancreatin p. 74 is the mainstay of treatment for children with exocrine pancreatic insufficiency.

Pancreatin contains the three main groups of digestive enzymes: lipase, amylase and protease. These enzymes respectively digest fats, carbohydrates and proteins into their basic components so that they can be absorbed and utilised by the body. Pancreatin should be administered with meals and snacks. The dose should be adjusted, as necessary, to the lowest effective dose according to the symptoms of malabsorption and malnutrition.

Fibrosing colonopathy has been reported in children with cystic fibrosis taking high dose pancreatic enzyme replacement therapy (in excess of 10 000 units/kg/day of lipase). Possible risk factors are gender (boys are at greater risk than girls), more severe cystic fibrosis, and concomitant use of laxatives. The peak age for developing fibrosing colonopathy is between 2 and 8 years. Manufacturers of Pancrease HL® and Nutrizym 22® recommend that the total dose of pancreatin used in patients with cystic fibrosis should not usually exceed 10 000 units/kg/day of lipase. Manufacturers recommend that if a patient taking pancreatin develops new abdominal symptoms (or any change in existing abdominal symptoms) the patient should be reviewed to exclude the possibility of colonic damage.

There is limited evidence that acid suppression may improve the effectiveness of pancreatin. Acid-suppressing drugs (proton pump inhibitors or H₂-receptor antagonists) may be trialled in children who continue to experience symptoms despite high doses of pancreatin.

Levels of fat-soluble vitamins and micronutrients (such as zinc and selenium) should be routinely assessed and supplementation recommended whenever necessary.

**Table: Pancreatin preparations**

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Protease units</th>
<th>Amylase units</th>
<th>Lipase units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creon® 10 000 capsule, e/c granules</td>
<td>600</td>
<td>8000</td>
<td>10 000</td>
</tr>
<tr>
<td>Creon® Micro e/c granules (per 100 mg)</td>
<td>200</td>
<td>3600</td>
<td>5000</td>
</tr>
<tr>
<td>Pancrex® granules (per gram)</td>
<td>300</td>
<td>4000</td>
<td>5000</td>
</tr>
<tr>
<td>Pancrex V® capsule, powder</td>
<td>430</td>
<td>9000</td>
<td>8000</td>
</tr>
<tr>
<td>Pancrex V 125® capsule, powder</td>
<td>160</td>
<td>3300</td>
<td>2950</td>
</tr>
<tr>
<td>Pancrex V® e/c tablet</td>
<td>110</td>
<td>1700</td>
<td>1900</td>
</tr>
<tr>
<td>Pancrex V® Forte e/c tablet</td>
<td>330</td>
<td>5000</td>
<td>5600</td>
</tr>
<tr>
<td>Pancrex V® powder (per gram)</td>
<td>1400</td>
<td>30 000</td>
<td>25 000</td>
</tr>
</tbody>
</table>

**Table: Higher-strength pancreatin preparations**

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Protease units</th>
<th>Amylase units</th>
<th>Lipase units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creon® 25 000 capsule, e/c pellets</td>
<td>1000</td>
<td>18 000</td>
<td>25 000</td>
</tr>
<tr>
<td>Creon® 40 000 capsule, e/c granules</td>
<td>1600</td>
<td>25 000</td>
<td>40 000</td>
</tr>
<tr>
<td>Nutrizym 22® capsule, e/c minitablets</td>
<td>1100</td>
<td>19 800</td>
<td>22 000</td>
</tr>
<tr>
<td>Pancrease HL® capsule, e/c minitablets</td>
<td>1250</td>
<td>22 500</td>
<td>25 000</td>
</tr>
</tbody>
</table>

**Non-drug treatment**

Dietary advice should be provided. Food intake should be distributed between three main meals per day, and two or three snacks. Food that is difficult to digest should be avoided, such as legumes (peas, beans, lentils) and high-fibre foods. Alcohol should be avoided completely. Reduced fat diets are not recommended.

Medium-chain triglycerides (see MCT oil, in Borderline substances), which are directly absorbed by the intestinal mucosa, were thought to be useful in some children. However evidence has shown that MCT-enriched preparations offer no advantage over a normal balanced diet.
PANCREATIC ENZYMES

**Pancreatin**

- **Drug Action**: Supplements of pancreatin are given to compensate for reduced or absent exocrine secretion. They assist the digestion of starch, fat, and protein.

- **Indications and Dose**
  - **CREON**: 30000
    - **Pancreatic insufficiency**: by mouth
      - Child 2–17 years: Initially 1–2 capsules, dose to be taken with each meal eaten together with or contents mixed with acidic fluid or soft food (then swallowed immediately without chewing)
  - **CREON**: 25000
    - **Pancreatic insufficiency**: by mouth
      - Child 2–17 years: Initially 1–2 capsules, dose to be taken with each meal eaten together with or contents mixed with acidic fluid or soft food (then swallowed immediately without chewing)
  - **CREON**: 40000
    - **Pancreatic insufficiency**: by mouth
      - Neonate: Initially 100 mg, for administration advice, see Directions for administration.

- **Dose Equivalence and Conversion**
  - For Creon® Micro: 100 mg granules = one measured scoopful (scoop supplied with product).
  
- **Nutrizym 22® Gastro-Resistant Capsules**
  - **Pancreatic insufficiency**: by mouth
    - Child 15–17 years: Initially 1–2 capsules, dose to be taken with meals and 1 capsule as required, dose to be taken with snacks, doses should be swallowed whole or contents taken with water, or mixed with acidic fluid or soft food (then swallowed immediately without chewing)
  
- **Pancrease HL®**
  - **Pancreatic insufficiency**: by mouth
    - Child 15–17 years: Initially 1–2 capsules, dose to be taken during each meal and 1 capsule, to be taken with snacks, all doses or contents mixed with slightly acidic liquid or soft food (then swallowed immediately without chewing)

- **Pancrex® V**
  - **Pancreatic insufficiency**: by mouth
    - Child 1–11 months: 1–2 capsules, contents of capsule to be mixed with feeds
    - Child 1–17 years: 2–6 capsules, dose to be taken with each meal either swallowed whole or sprinkled on food

**CONTRA-INDICATIONS**

- **Pancrease HL®**: Should not be used in children aged 15 years or less with cystic fibrosis
- **Nutrizym 22® Gastro-Resistant Capsules**: Should not be used in children aged 15 years or less with cystic fibrosis
- **Caution**: Can irritate the perioral skin and buccal mucosa if retained in the mouth—excessive doses can cause perianal irritation

**Interactions** → Appendix 1: Pancreatin

**Side-effects**

- Common or very common Abdominal distension · constipation · nausea · vomiting
- Uncommon: Skin reactions
- Frequency not known: Fibrosing colonopathy
- Pregnancy: Not known to be harmful

**Directions for Administration** Pancreatin is inactivated by gastric acid therefore manufacturer advises pancreatin preparations are best taken with food (or immediately before or after food). Since pancreatin is inactivated by heat, excessive heat should be avoided if preparations are mixed with liquids or food; manufacturer advises the resulting mixtures should not be kept for more than one hour and any left-over food or liquid containing pancreatin should be discarded. Enteric-coated preparations deliver a higher enzyme concentration in the duodenum (provided the capsule contents are swallowed whole without chewing). Manufacturer advises gastro-resistant granules should be mixed with slightly acidic soft food or liquid such as apple juice, and then swallowed immediately without chewing. Capsules containing enteric-coated granules can be opened and the granules administered in the same way. For infants, Creon® Micro granules can be mixed with a small amount of milk on a spoon and administered immediately—granules should not be added to the baby’s bottle. Manufacturer advises Pancrex® V powder may be administered via nasogastric tube or gastrostomy tube—consult local and national official guidelines.

**Prescribing and Dispensing Information**

Preparations may contain pork pancreatin—consult product literature.

**Handling and Storage** Hypersensitivity reactions occur occasionally and may affect those handling the powder.

**Patient and Carer Advice**

Patients or carers should be given advice on administration. It is important to ensure
adequate hydration at all times in patients receiving higher-strength pancreatic preparations. Medicines for Children leaflet: Pancreatin for pancreatic insufficiency www.medicinesforchildren.org.uk/pancreatin-pancreatic-insufficiency

> **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Gastro-resistant capsule

- Creon (Mylan)
  - Protease 600 unit, Amylase 8000 unit, Lipase 10000 unit Creon 10000 gastro-resistant capsules | 100 capsule £12.93
  - Protease 1000 unit, Amylase 18000 unit, Lipase 25000 unit Creon 25000 gastro-resistant capsules | 100 capsule £28.25
  - Protease 1600 unit, Amylase 25000 unit, Lipase 40000 unit Creon 40000 gastro-resistant capsules | 100 capsule £47.55
- Nutrizym (Merck-Serono Ltd)
  - Protease 1100 unit, Amylase 19800 unit, Lipase 22000 unit Nutrizym 22 gastro-resistant capsules | 100 capsule £33.33
- Pancrease (Jansen-Cilag Ltd)
  - Protease 1250 unit, Amylase 22500 unit, Lipase 25000 unit Pancrease HL gastro-resistant capsules | 100 capsule £140.38

### Gastro-resistant tablet

**CAUTIONARY AND ADVISORY LABELS 5, 25**

- Pancrex (Essential Pharmaceuticals Ltd)
  - Protease 110 unit, Amylase 1700 unit, Lipase 1900 unit Pancrex V gastro-resistant tablets | 300 tablet £38.79
  - Protease 330 unit, Amylase 5000 unit, Lipase 5600 unit Pancrex V Forte gastro-resistant tablets | 300 tablet £48.11

### Gastro-resistant granules

**CAUTIONARY AND ADVISORY LABELS 25**

- Creon (Mylan)
  - Protease 200 unit, Amylase 3600 unit, Lipase 5000 unit Creon Micro Pancreatin 60.12mg gastro-resistant granules | 20 gram £31.50
- Pancrease (Essential Pharmaceuticals Ltd)
  - Protease 300 unit, Amylase 4000 unit, Lipase 5000 unit Pancrex gastro-resistant granules | 300 gram £57.00

### Powder

- Pancrex (Essential Pharmaceuticals Ltd)
  - Protease 100 unit, Lipase 25000 unit, Amylase 30000 unit Pancrex V oral powder sugar-free | 300 gram £224.00

### Capsule

- Pancrex (Essential Pharmaceuticals Ltd)
  - Protease 160 unit, Lipase 2950 unit, Amylase 3300 unit Pancrex V 125mg capsules | 300 capsule £42.07
  - Protease 430 unit, Lipase 8000 unit, Amylase 9000 unit Pancrex V capsules | 300 capsule £153.20

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11 Stoma care

Stoma care 24-Feb-2016

**Description of condition**

A stoma is an artificial opening on the abdomen to divert flow of faeces or urine into an external pouch located outside of the body. This procedure may be temporary or permanent. Colostomy and ileostomy are the most common forms of stoma but a gastrostomy, jejunostomy, dudodeno-stomy or caecostomy may also be performed. Understanding the type and extent of surgical intervention in each patient is crucial in managing the patient’s pharmaceutical needs correctly.

**Overview**

Prescribing for patients with stoma calls for special care due to modifications in drug delivery, resulting in a higher risk of sub-optimal absorption. The following is a brief account of some of the main points to be borne in mind.

Enteric-coated and modified-release medicines are unsuitable, particularly in patients with an ileostomy, as there may not be sufficient release of active ingredient. Soluble tablets, liquids, capsules or uncoated tablets are more suitable due to their quicker dissolution. When a solid-dose form such as a capsule or a tablet is given, the contents of the ostomy bag should be checked for any remnants. Preparations containing sorbitol as an excipient should be avoided, due to its laxative side effects.

**Analgesics**

Opioid analgesics may cause troublesome constipation in colostomy patients. When a non-opioid analgesic is required, paracetamol is usually suitable. Anti-inflammatory analgesics may cause gastric irritation and bleeding; faecal output should be monitored for traces of blood.

**Antacids**

The tendency to diarrhea from magnesium salts or constipation from aluminium or calcium salts may be increased in patients with stoma.

**Antisecretory drugs**

The gastric acid secretion often increases stoma output. Proton pump inhibitors and somatostatin analogues (octreotide p. 483) are often used to reduce this risk.

**Antidiarrhoeal drugs**

Loperamide hydrochloride p. 51 and codeine phosphate p. 283 reduce intestinal motility and decrease water and sodium output from an ileostomy. Loperamide hydrochloride circulates through the enterohepatic circulation, which is disrupted in patients with a short bowel; high doses of loperamide hydrochloride may be required. Codeine phosphate can be added if response with loperamide hydrochloride alone is inadequate.

**Dignox**

Children with a stoma are particularly susceptible to hypokalaemia. This predisposes children on digoxin p. 82 to digoxin toxicity; potassium supplements or a potassium-sparing diuretic may be advisable.

**Diuretics**

Diuretics should be used with caution in patients with an ileostomy or with urostomy as they may become excessively dehydrated and potassium depletion may easily occur. It is usually advisable to use a potassium-sparing diuretic.

**Iron preparations**

Iron preparations may cause loose stools and sore skin in these patients. If this is troublesome and if iron is definitely indicated, an intramuscular iron preparation should be used. Modified-release preparations should be avoided for the reasons given above.

**Laxatives**

Laxatives should be used in children with stoma only under specialist supervision; they should be prescribed with caution for those with an ileostomy as they may cause rapid and severe loss of water and electrolytes. Colostomy patients may suffer from constipation and whenever possible it should be treated by increasing fluid intake or dietary fibre. If a laxative is required, it should generally be used for short periods only.

**Care of stoma**

Patients and their carers are usually given advice about the use of cleansing agents, protective creams, lotions, deodorants, or sealants whilst in hospital, either by the surgeon or by stoma care nurses. Voluntary organisations offer help and support to patients with stoma.
Chapter 2
Cardiovascular system

1 Arrhythmias

Overview
Management of an arrhythmia requires precise diagnosis of the type of arrhythmia; electrocardiography and referral to a paediatric cardiologist is essential; underlying causes such as heart failure require appropriate treatment.

Bradyarrhythmias
Adrenaline/epinephrine p. 138 is useful in the treatment of symptomatic bradycardia in an infant or child.

Supraventricular tachycardia
In supraventricular tachycardia adenosine p. 80 is given by rapid intravenous injection. If adenosine is ineffective, intravenous amiodarone hydrochloride p. 79, flecainide acetate p. 78, or a beta-blocker (such as esmolol hydrochloride p. 108) can be tried; verapamil hydrochloride p. 111 can also be considered in children over 1 year. Atenolol p. 106, sotalol hydrochloride p. 81 and flecainide acetate are used for the prophylaxis of paroxysmal supraventricular tachycardias.

The use of d.c. shock and vagal stimulation also have a role in the treatment of supraventricular tachycardia.

Syndromes associated with accessory conducting pathways
Amiodarone hydrochloride, flecainide acetate, or a beta-blocker is used to prevent recurrence of supraventricular tachycardia in infants and young children with these syndromes (e.g. Wolff-Parkinson-White syndrome).

Atrial flutter
In atrial flutter without structural heart defects, sinus rhythm is restored with d.c. shock or cardiac pacing; drug treatment is usually not necessary. Amiodarone hydrochloride is used in atrial flutter when structural heart defects are present or after heart surgery. Sotalol hydrochloride may also be considered.

Atrial fibrillation
Atrial fibrillation is very rare in children. To restore sinus rhythm d.c. shock is used; beta-blockers, alone or together with digoxin p. 82 may be useful for ventricular rate control.

Ecotopic tachycardia
Intravenous amiodarone hydrochloride is used in conjunction with body cooling and synchronized pacing in postoperative junctional ecotopic tachycardia. Oral amiodarone hydrochloride or flecainide acetate are used in congenital junctional ecotopic tachycardia.

Amiodarone hydrochloride, flecainide acetate, or a beta-blocker are used in atrial ecotopic tachycardia; amiodarone hydrochloride is preferred in those with poor ventricular function.

Ventricular tachycardia and ventricular fibrillation
Pulseless ventricular tachycardia or ventricular fibrillation require resuscitation, see Paediatric Advanced Life Support algorithm. Amiodarone hydrochloride is used in resuscitation for pulseless ventricular tachycardia or ventricular fibrillation unresponsive to d.c. shock; lidocaine hydrochloride p. 852 can be used as an alternative only if amiodarone hydrochloride is not available.

Amiodarone hydrochloride is also used in a haemodynamically stable child when drug treatment is required; lidocaine hydrochloride can be used as an alternative only if amiodarone hydrochloride is not available.

Torsade de pointes
Torsade de pointes is a form of ventricular tachycardia associated with long QT syndrome, which may be congenital or drug induced. Episodes may be self-limiting, but are frequently recurrent and can cause impairment or loss of consciousness. If not controlled, the arrhythmia can progress to ventricular fibrillation and sometimes death. Intravenous magnesium sulfate can be used to treat torsade de pointes (dose recommendations vary—consult local guidelines). Anti-arrhythmics can further prolong the QT interval, thus worsening the condition.

Anti-arrhythmic drugs
Anti-arrhythmic drugs can be classified clinically into those that act on supraventricular arrhythmias (e.g. verapamil hydrochloride), those that act on both supraventricular and ventricular arrhythmias (e.g. amiodarone hydrochloride), and those that act on ventricular arrhythmias (e.g. lidocaine hydrochloride).

Anti-arrhythmic drugs can also be classified according to their effects on the electrical behaviour of myocardial cells during activity (the Vaughan Williams classification) although this classification is of less clinical significance:
Arrhythmias 77

ANTIARRHYTHMICS › CLASS IB

Lidocaine hydrochloride
(Lignocaine hydrochloride)

INDICATIONS AND DOSE
Ventricular arrhythmias | Pulseless ventricular tachycardia | Ventricular fibrillation

› INITIALLY BY INTRAVENOUS INJECTION, OR BY INTRAOSSEOUS INJECTION

- Neonate: Initially 0.5–1 mg/kg, followed immediately by (by intravenous infusion) 0.6–3 mg/kg/hour, alternatively (by intravenous injection or by intraosseous injection) 0.5–1 mg/kg repeated at intervals of not less than 5 minutes if infusion is not immediately available following initial injection, until infusion can be initiated; maximum 3 mg/kg per course.
- Child 1 month–11 years: Initially 0.5–1 mg/kg, followed immediately by (by intravenous infusion) 0.6–3 mg/kg/hour, alternatively (by intravenous injection or by intraosseous injection) 0.5–1 mg/kg repeated at intervals of not less than 5 minutes if infusion is not immediately available following initial injection, until infusion can be initiated; maximum 3 mg/kg per course.
- Child 12–17 years: Initially 50–100 mg, followed by (by intravenous infusion) 120 mg, dose to be given over 30 minutes, then (by intravenous infusion) 240 mg, dose to be given over 2 hours, then (by intravenous infusion) 60 mg/hour, reduce dose further if infusion is continued beyond 24 hours, if infusion not immediately available following initial injection, the initial injection dose may be repeated at intervals of not less than 5 minutes (to a maximum 300 mg dose in 1 hour) until infusion can be initiated

Neonatal seizures
› BY INTRAVENOUS INFUSION

- Neonate: Initially 2 mg/kg, dose to be given over 10 minutes, followed by 6 mg/kg/hour for 6 hours; reduced to 4 mg/kg/hour for 12 hours, then reduced to 2 mg/kg/hour for a further 12 hours, preterm neonates may require lower doses.

UNLICENSED USE | Not licensed for use in children under 1 year.

CONTRA-INDICATIONS | All grades of atrioventricular block - severe myocardial depression - sino-atrial disorders

CAUTIONS | Acute porphyrias p. 624 (consider infusion with glucose for its anti-porphyrinogenic effects) - congestive cardiac failure (consider lower dose) - post cardiac surgery (consider lower dose)

INTERACTIONS | Appendix 1: antiarrhythmics

SIDE-EFFECTS | Anxiety - arrhythmias - atrioventricular block - cardiac arrest - circulatory collapse - confusion - dizziness - drowsiness - euphoric mood - headache - hypotension (may lead to cardiac arrest) - loss of consciousness - methaemoglobinaemia - muscle twitching - myocardial contractility decreased - nausea - neurological effects - nystagmus - pain - psychosis - respiratory disorders - seizure - sensation abnormal - temperature sensation altered - tinnitus - tremor - vision blurred - vomiting
**Arrhythmias**

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<td>Child 12–17 years: 200 mg daily</td>
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<td>By mouth using immediate-release medicines</td>
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<tr>
<td>Neonate: 2 mg/kg 2–3 times a day, adjusted according to response, also adjust dose according to plasma-flecainide concentration</td>
<td></td>
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<tr>
<td>Child 1 month–11 years: 2 mg/kg 2–3 times a day, adjusted according to response, also adjust dose according to plasma-flecainide concentration; maximum 8 mg/kg per day; maximum 300 mg per day</td>
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<tr>
<td><strong>DOSE ADJUSTMENTS DUE TO INTERACTIONS</strong></td>
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<td><strong>SIDE-EFFECTS</strong></td>
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<td>Common or very common</td>
<td>Arrhythmias - asthenia - dizziness - dyspnoea - fever - oedema - vision disorders</td>
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<td>Alopecia - appetite decreased - constipation - diarrhoea - flatulence - gastrointestinal discomfort - nausea - skin reactions - vomiting</td>
</tr>
<tr>
<td>Rare or very rare</td>
<td>Anxiety - confusion - corneal deposits - depression - drowsiness - flushing - hallucination - headache - hepatic disorders - hyperhidrosis - inflammation - insomnia - memory loss - movement disorders - peripheral neuropathy - photosensitivity reaction - respiratory disorders - seizure - sensation abnormal - syncope - tinnitus - tremor - vertigo</td>
</tr>
<tr>
<td><strong>UNLICENSED USE</strong></td>
<td>Not licensed for use in children under 12 years</td>
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<tr>
<td><strong>RENAI IMPAIRMENT</strong></td>
<td></td>
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<tr>
<td>Possible accumulation of lidocaine and active metabolite; caution in severe impairment</td>
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<tr>
<td><strong>MONITORING REQUIREMENTS</strong></td>
<td>Monitor ECG and have resuscitation facilities available</td>
</tr>
<tr>
<td><strong>DIRECTIONS FOR ADMINISTRATION</strong></td>
<td>For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%</td>
</tr>
<tr>
<td><strong>DOSE EQUIVALENCE AND CONVERSION</strong></td>
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<td>Manufacturer advises reduce dose by half</td>
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<tr>
<td><strong>MONITORING REQUIREMENTS</strong></td>
<td>Monitor plasma-flecainide concentration</td>
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<td><strong>DOSE ADJUSTMENTS DUE TO INTERACTIONS</strong></td>
<td>Reduce dose by 25–50% if estimated glomerular filtration rate is less than 35 ml/minute/1.73 m²</td>
</tr>
<tr>
<td><strong>MONITORING REQUIREMENTS</strong></td>
<td>Monitor plasma-flecainide concentration</td>
</tr>
</tbody>
</table>
PATIENT AND CARER ADVICE
Medicines for Children leaflet: Flecainide for arrhythmias www.medicinesforchildren.org.uk/flecainide-arrhythmias

MEDITCINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

Modified-release capsule
CAUTIONARY AND ADVISORY LABELS 25

Tambocor XL (Teva UK Ltd)
Flecainide acetate 200 mg Tambocor XL 200mg capsules | 30 capsule POM £14.77

Tablet
Flecainide acetate (Non-proprietary)
Flecainide acetate 50 mg Flecainide 50mg tablets | 60 tablet POM £1.68 DT = £4.77
Flecainide acetate 100 mg Flecainide 100mg tablets | 60 tablet POM £8.06 DT = £5.08

Tambocor (Teva UK Ltd)
Flecainide acetate 50 mg Tambocor 50mg tablets | 60 tablet POM £1.57 DT = £4.77
Flecainide acetate 100 mg Tambocor 100mg tablets | 60 tablet POM £16.53 DT = £5.08

ANTIARRHYTHMICS ▶ CLASS III

Amiodarone hydrochloride

INDICATIONS AND DOSE
Supraventricular and ventricular arrhythmias (initiated in hospital or under specialist supervision)

BY MOUTH

Neonate: Initially 5–10 mg/kg twice daily for 7–10 days, then reduced to 5–10 mg/kg daily.

Child 1 month–11 years: Initially 5–10 mg/kg twice daily (max. per dose 200 mg) for 7–10 days, then reduced to 5–10 mg/kg once daily; maximum 200 mg per day

Child 12–17 years: 200 mg 3 times a day for 1 week, then 200 mg twice daily for 1 week, then usually 200mg daily adjusted according to response

INITIALLY BY INTRAVENOUS INFUSION

Neonate: Initially 5 mg/kg, then (by intravenous infusion) 5 mg/kg every 12–24 hours, dose to be given over 30 minutes.

Child: Initially 5–10 mg/kg, dose to be given over 20 minutes to 2 hours, then (by continuous intravenous infusion) 300 micrograms/kg/hour, adjusted according to response; (by continuous intravenous infusion) increased if necessary up to 1.5 mg/kg/hour; maximum 1.2 g per day

Ventricular fibrillation or pulseless ventricular tachycardia refractory to defibrillation (for cardiopulmonary resuscitation)

INITIALLY BY INTRAVENOUS INJECTION

Neonate: 5 mg/kg, dose to be given over at least 3 minutes.

Child: 5 mg/kg (max. per dose 300 mg), dose to be given over at least 3 minutes

UNLICENSED USE
Not licensed for use in children under 3 years.

CONTRA-INDICATIONS
GENERAL CONTRA-INDICATIONS
Avoid in severe conduction disturbances (unless pacemaker fitted) - avoid in sinus node disease (unless pacemaker fitted) - avoid rapid loading after cardiac surgery - iodine sensitivity - sino-atrial heart block (except in cardiac arrest) - sinus bradyarrhythmia (except in cardiac arrest) - thyroid dysfunction

SPECIFIC CONTRA-INDICATIONS
With intravenous use
Avoid bolus injection in cardiomyopathy - avoid bolus injection in congestive heart failure - avoid in circulatory collapse - avoid in severe arterial hypotension - avoid in severe respiratory failure

CAUTIONS
GENERAL CAUTIONS
Acute porphyrias p. 624 - conduction disturbances (in excessive dosage) - heart failure - hypokalaemia - severe bradycardia (in excessive dosage)

SPECIFIC CAUTIONS
With intravenous use
Avoid benzyl alcohol containing injections in neonates - moderate and transient fall in blood pressure (circulatory collapse precipitated by rapid administration or overdosage) - severe hepatocellular toxicity

INTERACTIONS ▶ Appendix 1: antiarrhythmics

SIDE-EFFECTS
GENERAL SIDE-EFFECTS

Common or very common
Arrhythmias - hepatic disorders - hyperthyroidism - nausea - respiratory disorders - skin reactions

Rare or very rare
Bronchospasm (in patients with severe respiratory failure) - headache - idiopathic intracranial hypertension - nerve disorders - SIADH

Frequency not known
Angioedema - confusion - delirium - pancreatitis - severe cutaneous adverse reactions (SCARs)

SIDE-EFFECTS, FURTHER INFORMATION
Corneal microdeposits Patients taking amiodarone may develop corneal microdeposits (reversible on withdrawal of treatment). However, if vision is impaired or if optic neuritis or optic neuropathy occur, amiodarone must be stopped to prevent blindness and expert advice sought.

Thyroid function Amiodarone contains iodine and can cause disorders of thyroid function; both hypothyroidism and hyperthyroidism can occur. Hypothyroidism can be treated with replacement therapy without withdrawing amiodarone if it is essential; careful supervision is required.

Hepatotoxicity Amiodarone is also associated with hepatotoxicity and treatment should be discontinued if severe liver function abnormalities or clinical signs of liver disease develop.

Pulmonary toxicity Pneumonitis should always be suspected if new or progressive shortness of breath or cough develops in a patient taking amiodarone.

PREGNANCY
Possible risk of neonatal goitre; use only if no alternative.
ANTIARRHYTHMICS > OTHER

Adenosine

- INDICATIONS AND DOSE
  Used in conjunction with radionuclide myocardial perfusion imaging in patients who cannot exercise adequately or for whom exercise is inappropriate
  - BY INTRAVENOUS INFUSION
  - Child: (consult product literature)

Termination of supraventricular tachycardias, including those associated with accessory conducting pathways (e.g. Wolff-Parkinson-White syndrome) Diagnosis of supraventricular arrhythmias
  - BY RAPID INTRAVENOUS INJECTION
  - Neonate: Initially 150 micrograms/kg, then increased in steps of 50–100 micrograms/kg every 1–2 minutes if required, dose to be repeated until tachycardia terminated or maximum single dose of 300 micrograms/kg given.
  - Child 1-11 months: Initially 150 micrograms/kg, then increased in steps of 50–100 micrograms/kg every 1–2 minutes if required, dose to be repeated until tachycardia terminated or maximum single dose of 500 micrograms/kg given.
  - Child 1-11 years: Initially 100 micrograms/kg, then increased in steps of 50–100 micrograms/kg every 1–2 minutes if required, dose to be repeated until tachycardia terminated or maximum single dose of 500 micrograms/kg (max.12 mg) given.
  - Child 12-17 years: Initially 3 mg, followed by 6 mg after 1–2 minutes if required, followed by 12 mg after 1–2 minutes if required, in some children over 12 years 3 mg dose ineffective (e.g. if a small peripheral vein is used for administration) and higher initial dose sometimes used; however, those with heart transplant are very sensitive to the effects of adenosine, and should not receive higher initial doses

- UNLICENSED USE Adenocor® licensed for treatment of paroxysmal supraventricular tachycardia in children; not licensed for diagnosis in children; Adenoscan® not licensed in children.

- CONTRA-INDICATIONS Asthma • decompensated heart failure • long QT syndrome • second- or third-degree AV block and sick sinus syndrome (unless pacemaker fitted) • severe hypotension

- CAUTIONS Atrial fibrillation with accessory pathway (conduction down anomalous pathway may increase) • atrial flutter with accessory pathway (conduction down anomalous pathway may increase) • autonomic dysfunction • bundle branch block • first-degree AV block • heart transplant • left main coronary artery stenosis • left to right shunt • pericardial effusion • pericarditis • QT-interval prolongation • recent myocardial infarction • severe heart failure • stenotic carotid artery disease with cerebrovascular insufficiency • stenotic valvular heart disease • uncorrected hypovolaemia

- INTERACTIONS Appendix 1: antiarrhythmics

- SIDE-EFFECTS
  - Common or very common Abdominal discomfort • arrhythmias • atrioventricular block • chest discomfort • chest pain (discontinue) • dizziness • dry mouth • dyspnoea • flushing • headache • hypotension (discontinue if severe) • pain • paraesthesia • thirst • discomfort
  - Uncommon Asthena • back discomfort • bradycardia (discontinue if asystole or severe bradycardia occur) • hyperhidrosis • limb discomfort • nervousness • taste metallic
### Arrhythmias

**Sotalol hydrochloride**

**Indications and Dose**

**Life-threatening arrhythmias including ventricular tachyarrhythmias**
- **By mouth**
- Child 12–17 years: Initially 80 mg once daily, alternatively initially 40 mg twice daily, then increased up to 80–160 mg twice daily, dose to be increased gradually at intervals of 2–3 days.
- Neonate: Initially 1 mg/kg twice daily, increased if necessary up to 4 mg/kg twice daily, dose to be increased at intervals of 3–4 days.

**Atrial flutter, ventricular arrhythmias, life-threatening ventricular tachyarrhythmia and supraventricular arrhythmias (initiated under specialist supervision)**
- **By mouth**
  - Child 1 month–11 years: Initially 1 mg/kg twice daily, then increased if necessary up to 4 mg/kg twice daily (max. per dose 80 mg twice daily), dose to be increased at intervals of 2–3 days.
  - Child 12–17 years: Initially 80 mg once daily, alternatively initially 40 mg twice daily, increased to 80–160 mg twice daily, dose to be increased gradually at intervals of 2–3 days.

**Medicinal Forms**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, infusion, solution for infusion

**Beta-adrenoceptor blockers**

**Non-selective**

**BNFC 2019–2020**

- Rare or very rare: Drowsiness, nasal congestion, nipple tenderness, respiratory disorders, respiratory failure (discontinue), tinnitus, tremor, urinary urgency, vision blurred.
- Frequency not known: Apnoea, cardiac arrest, loss of consciousness, nausea, seizure, syncope, vomiting.
- **Pregnancy**: Large doses may produce fetal toxicity; manufacturer advises use only if potential benefit outweighs risk.
- **Breast feeding**: No information available—unlikely to be present in milk owing to short half-life.
- **Monitoring Requirements**: Monitor ECG and have resuscitation facilities available.
- **Directions for Administration**: For rapid intravenous injection: give over 2 seconds into central or large peripheral vein followed by rapid Sodium Chloride 0.9% flush; injection solution may be diluted with Sodium Chloride 0.9% if required.

**Unlicensed Use**: Not licensed for use in children under 12 years.

**Important Safety Information**

Sotalol may prolong the QT interval, and it occasionally causes life-threatening ventricular arrhythmias. **Important**: particular care is required to avoid hypokalaemia in patients taking sotalol—electrolyte disturbances, particularly hypokalaemia and hypomagnesaemia should be corrected before sotalol started and during use. Reduce dose or discontinue if corrected QT interval exceeds 550 msec.

**Contra-indications**: Long QT syndrome (congenital or acquired) - torsade de pointes.

**Cautions**: Diarrhoea (severe or prolonged).

**Interactions**: + Appendix 1: beta-blockers, non-selective.

**Side-effects**

- Common or very common: Anxiety, arrhythmia, chest pain, dyspepsia, fever, flatulence, hearing impairment, mood altered, muscle spasm, oedema, palpitations, sexual dysfunction, taste altered, torsade de pointes (increased risk in females).

**Breast feeding**: Water soluble beta-blockers such as sotalol are present in breast milk in greater amounts than other beta blockers.

**Renal Impairment**: Avoid if estimated glomerular filtration rate less than 10 mL/minute/1.73 m². Dose adjustments: Halve normal dose if estimated glomerular filtration rate 30–60 mL/minute/1.73 m²; use one-quarter normal dose if estimated glomerular filtration rate 10–30 mL/minute/1.73 m².

**Monitoring Requirements**: Measurement of corrected QT interval, and monitoring of ECG and electrolytes required; correct hypokalaemia, hypomagnesaemia, or other electrolyte disturbances.

**DIRECTIONS FOR ADMINISTRATION**: For administration by mouth, tablets may be crushed and dispersed in water.

**Medicinal Forms**: There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.
CARDIAC GLYCOSIDES

Cardiac glycosides

Digoxin-specific antibody

Serious cases of digoxin toxicity should be discussed with the National Poisons Information Service (see further information, under Poisoning, emergency treatment p. 859). Digoxin-specific antibody p. 868 fragments are indicated for the treatment of known or strongly suspected life-threatening digoxin toxicity associated with ventricular arrhythmias or bradycardia unresponsive to atropine sulfate p. 837 and when measures beyond the withdrawal of digoxin below and correction of any electrolyte abnormalities are considered necessary.

Digoxin

Digoxin is most useful in the treatment of supraventricular tachycardias, especially for controlling ventricular response in persistent atrial fibrillation. Digoxin has a limited role in children with chronic heart failure.

For the management of atrial fibrillation, the maintenance dose of digoxin is determined on the basis of the ventricular rate at rest, which should not be allowed to fall below an acceptable level for the child.

Digoxin is now rarely used for rapid control of heart rate, even with intravenous administration, response may take many hours; persistence of tachycardia is therefore not an indication for exceeding the recommended dose. The intramuscular route is not recommended.

In children with heart failure who are in sinus rhythm, a loading dose may not be required.

Unwanted effects depend both on the concentration of digoxin in the plasma and on the sensitivity of the conducting system or of the myocardium, which is often increased in heart disease. It can sometimes be difficult to distinguish between toxic effects and clinical deterioration because the symptoms of both are similar. The plasma-digoxin concentration alone cannot indicate toxicity reliably, but the likelihood of toxicity increases progressively through the range 1.5 to 3 micrograms/litre for digoxin.

Renal function is very important in determining digoxin dosage.

Hypokalaemia predisposes the child to digitalis toxicity and should be avoided; it is managed by giving a potassium-sparing diuretic or, if necessary, potassium supplements.

If toxicity occurs, digoxin should be withdrawn; serious manifestations require urgent specialist management.

Digoxin-specific antibody fragments are available for reversal of life-threatening overdosage.

Digoxin

**DRUG ACTION** Digoxin is a cardiac glycoside that increases conductivity within the atrioventricular (AV) node.

**INDICATIONS AND DOSE**

**Supraventricular arrhythmias | Chronic heart failure**

**BY MOUTH**

- Neonate (body-weight up to 1.5 kg): Initially 25 micrograms/kg in 3 divided doses for 24 hours, then 4–6 micrograms/kg daily in 1–2 divided doses.

- Neonate (body-weight 1.5–2.5 kg): Initially 30 micrograms/kg in 3 divided doses for 24 hours, then 4–6 micrograms/kg daily in 1–2 divided doses.

**CONTRA-INDICATIONS**

- Constrictive pericarditis (unless to control atrial fibrillation or improve systolic dysfunction— but use with caution) • hypertrophic cardiomyopathy (unless concomitant atrial fibrillation and heart failure— but use with caution) • intermittent complete heart block • myocarditis • second degree AV block • supraventricular arrhythmias associated with accessory conducting pathways e.g. Wolff-Parkinson-White syndrome (although can be used in infancy) • ventricular tachycardia or fibrillation

**CAUTIONS** Avoid hypercalcaemia (risk of digitalis toxicity) • avoid hypokalaemia (risk of digitalis toxicity) • avoid hypomagnesaemia (risk of digitalis toxicity) • avoid hypoxia (risk of digitalis toxicity) • severe respiratory disease • sick sinus syndrome • thyroid disease

DOSE ADJUSTMENTS DUE TO INTERACTIONS

- Manufacturer advises reduce dose by half with concurrent use of amiodarone, dronedarone and quinine.

DOSE EQUIVALENCE AND CONVERSION

- Dose may need to be reduced if digoxin (or another cardiac glycoside) has been given in the preceding 2 weeks.

- When switching from intravenous to oral route may need to increase dose by 20–33% to maintain the same plasma-digoxin concentration.

**UNLICENSED USE** Digoxin is licensed for use in heart failure and supraventricular arrhythmias.

Neonate (body-weight 2.6 kg and above): Initially 45 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

Child 1 month–1 year: Initially 45 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

Child 2–4 years: Initially 35 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

Child 5–9 years: Initially 25 micrograms/kg in 3 divided doses (max. per dose 750 micrograms) for 24 hours, then 6 micrograms/kg daily in 1–2 divided doses; maximum 250 micrograms per day.

Child 10–17 years: Initially 0.75–1.5 mg in 3 divided doses for 24 hours, then 62.5–250 micrograms daily in 1–2 divided doses; higher doses may be necessary.

**BY INTRAVENOUS INFUSION**

- Neonate (body-weight up to 1.5 kg): Initially 20 micrograms/kg in 3 divided doses for 24 hours, then 4–6 micrograms/kg daily in 1–2 divided doses.

- Neonate (body-weight 1.5–2.5 kg): Initially 30 micrograms/kg in 3 divided doses for 24 hours, then 4–6 micrograms/kg daily in 1–2 divided doses.

- Neonate (body-weight 2.6 kg and above): Initially 35 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

- Child 1 month–1 year: Initially 35 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

- Child 2–4 years: Initially 25 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

- Child 5–9 years: Initially 25 micrograms/kg in 3 divided doses (max. per dose 750 micrograms) for 24 hours, then 6 micrograms/kg daily in 1–2 divided doses; maximum 250 micrograms per day.

- Child 10–17 years: Initially 0.5–1 mg in 3 divided doses for 24 hours, then 62.5–250 micrograms daily in 1–2 divided doses; higher doses may be necessary.

- BY MOUTH

- Neonate (body-weight up to 1.5 kg): Initially 20 micrograms/kg in 3 divided doses for 24 hours, then 4–6 micrograms/kg daily in 1–2 divided doses.

- Neonate (body-weight 1.5–2.5 kg): Initially 30 micrograms/kg in 3 divided doses for 24 hours, then 4–6 micrograms/kg daily in 1–2 divided doses.

- Neonate (body-weight 2.6 kg and above): Initially 35 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

- Child 1 month–1 year: Initially 35 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

- Child 2–4 years: Initially 25 micrograms/kg in 3 divided doses for 24 hours, then 10 micrograms/kg daily in 1–2 divided doses.

- Child 5–9 years: Initially 25 micrograms/kg in 3 divided doses (max. per dose 750 micrograms) for 24 hours, then 6 micrograms/kg daily in 1–2 divided doses; maximum 250 micrograms per day.

- Child 10–17 years: Initially 0.5–1 mg in 3 divided doses for 24 hours, then 62.5–250 micrograms daily in 1–2 divided doses; higher doses may be necessary
Bleeding disorders

Antifibrinolytic drugs and haemostatics

Overview
Fibrin dissolution can be impaired by the administration of tranexamic acid below, which inhibits fibrinolysis. It can be used to prevent bleeding or treat bleeding associated with excessive fibrinolysis (e.g. in surgery, dental extraction, obstetric disorders, and traumatic haemorrhage) and in the management of menorrhagia; it may also be used in hereditary angioedema, epistaxis, and thrombolytic overdose. Tranexamic acid can also be used in cardiac surgery to reduce blood loss and to reduce the need for use of blood products. Desmopressin p. 448 is used in the management of mild to moderate haemorrhage and von Willebrand’s disease. It is also used for fibrinolytic response testing.

ANTIHAEMORRHAGICS  🔄 ANTIFIBRINOLYTICS

Tranexamic acid

26-Apr-2017

INDICATIONS AND DOSE

Inhibition of fibrinolysis
- **By mouth**
  - Child: 15–25 mg/kg 2–3 times a day (max. per dose 1.5 g)
  - **By slow intravenous injection**
    - Child: 10 mg/kg 2–3 times a day (max. per dose 1 g), dose to be given over at least 10 minutes
  - **By continuous intravenous infusion**
    - Child: 45 mg/kg, dose to be given over 24 hours

Menorrhagia
- **By mouth**
  - Child 12–17 years: 1 g 3 times a day for up to 4 days, to be initiated when menstruation has started; maximum 4 g per day

Hereditary angioedema
- **By mouth**
  - Child: 15–25 mg/kg 2–3 times a day (max. per dose 1.5 g), for short-term prophylaxis of hereditary angioedema, tranexamic acid is started several days before planned procedures which may trigger an acute attack of hereditary angioedema (e.g. dental work) and continued for 2–5 days afterwards
  - **By slow intravenous injection**
    - Child: 10 mg/kg 2–3 times a day (max. per dose 1 g), dose to be given over at least 10 minutes
  - **By continuous intravenous infusion**
    - Child: 45 mg/kg, dose to be given over 24 hours

Prevention of excessive bleeding after dental procedures (e.g. in haemophilia)
- **By intravenous injection**
  - Child 6–17 years: 10 mg/kg (max. per dose 1.5 g), dose to be given pre-operatively
  - **By mouth**
    - Child 6–17 years: 15–25 mg/kg (max. per dose 1.5 g), dose to be given pre-operatively, then continued →
15–25 mg/kg 2–3 times a day (max. per dose 1.5 g) for up to 8 days, dose to be given postoperatively. 

Prevention of excessive bleeding after dental procedures (e.g. in haemophilia) with mouthwash 5% solution (specialist use only)

▶ BY MOUTH
Child 6-17 years 5–10 mL 4 times a day for 2 days, rinse mouth with solution; the solution should not be swallowed.

Reduction of blood loss during cardiac surgery
▶ BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
Child: (consult local protocol)

UNLICENSED USE Not licensed for reduction of blood loss during cardiac surgery; injection not licensed for use in children under 1 year or for administration by intravenous infusion.

CONTRA-INDICATIONS Fibrinolytic conditions following disseminated intravascular coagulation (unless predominant activation of fibrinolytic system with severe bleeding) - history of convulsions - thromboembolic disease

CAUTIONS Irregular menstrual bleeding (establish cause before initiating therapy) - massive haematuria (avoid if risk of ureteric obstruction) - patients receiving oral contraceptives (increased risk of thrombosis)

CAUTIONS, FURTHER INFORMATION

▪ MENORRHAGIA Before initiating treatment for menorrhagia, exclude structural or histological causes or fibroids causing distortion of uterine cavity.

▪ INTERACTIONS → Appendix 1: tranexamic acid

SIDE-EFFECTS

GENERAL SIDE-EFFECTS
▌ Common or very common Diarrhoea (reduce dose) - nausea - vomiting
▌ Uncommon Allergic dermatitis
▌ Rare or very rare Colour vision change (discontinue) - embolism and thrombosis
▌ Frequency not known Seizure (more common at high doses) - visual impairment (discontinue)

SPECIFIC SIDE-EFFECTS
▌ With intravenous use Hypotension - malaise (on rapid intravenous injection)
▌ PREGNANCY No evidence of teratogenicity in animal studies; manufacturer advises use only if potential benefit outweighs risk—crosses the placenta.
▌ BREAST FEEDING Small amount present in milk—antifibrinolytic effect in infant unlikely.
▌ RENAL IMPAIRMENT Avoid in severe impairment.
Dose adjustments Reduce dose in mild to moderate impairment.
▌ MONITORING REQUIREMENTS Regular liver function tests in long-term treatment of hereditary angioedema.
▌ DIRECTIONS FOR ADMINISTRATION For intravenous administration, dilute with Glucose 5% or Sodium chloride 0.9%.
▌ PATIENT AND CARER ADVICE
Medicines for Children leaflet: Tranexamic acid for heavy bleeding during periods www.medicinesforchildren.org.uk/tranexamic-acid-heavy-bleeding-during-periods
Medicines for Children leaflet: Tranexamic acid for the treatment or prevention of bleeding www.medicinesforchildren.org.uk/tranexamic-acid-treatment-or-prevention-bleeding

▪ MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution
TLab
▌ Tranexamic acid (Non-proprietary)
Tranexamic acid 500 mg Tranexamic acid 500mg tablets | 60 tablet (Hospital) £32.10 DT = £5.42
▌ Cyklokapron (Meda Pharmaceuticals Ltd)
Tranexamic acid 500 mg Cyklokapron 500mg tablets | 60 tablet (Hospital) £14.30 DT = £5.42

Solution for injection
▌ Tranexamic acid (Non-proprietary)
Tranexamic acid 100 mg per 1 ml Tranexamic acid 500mg/5ml solution for injection ampoules | 3 ampoule (Hospital) £7.50 DT = £7.50 (Hospital only) | 10 ampoule (Hospital) £15.47 DT = £15.47 (Hospital only)
▌ Cyklokapron (Pfizer Ltd)
Tranexamic acid 100 mg per 1 ml Cyklokapron 500mg/5ml solution for injection ampoules | 10 ampoule (Hospital) £15.47 DT = £15.47

ANTIHAEMORRHAGICS > HAEMOSTATICS

Emicizumab 09-May-2018
▌ DRUG ACTION Emicizumab is a monoclonal antibody that bridges activated factor IX and factor X to restore function of missing activated factor VIII, which is needed for haemostasis.

▌ INDICATIONS AND DOSE
Prophylaxis of haemorrhage in patients with haemophilia A (initiated by a specialist)
▶ BY SUBCUTANEOUS INJECTION
Child: Initially 3 mg/kg once weekly for 4 weeks, then maintenance 1.5 mg/kg once weekly, administer into the thigh, abdomen or upper arm

▪ CAUTIONS Children under 1 year - concomitant bypassing agent - risk factors for thrombotic microangiopathy

▪ CAUTIONS, FURTHER INFORMATION
Concomitant bypassing agent Manufacturer advises discontinue bypassing agents the day before starting emicizumab; if a bypassing agent is required—consult product literature.

▪ SIDE-EFFECTS
▌ Common or very common Arthralgia - diarrhoea - fever - headache - myalgia - thrombotic microangiopathy
▌ Uncommon Cavernous sinus thrombosis - skin necrosis - thrombophlebitis

▪ CONCEPTION AND CONTRACEPTION Manufacturer advises effective contraception during and for 6 months after treatment in women of childbearing potential.

▪ PREGNANCY Manufacturer advises use only if potential benefit outweighs risk—no information available.

▪ BREAST FEEDING Manufacturer advises avoid—no information available.

▪ EFFECT ON LABORATORY TESTS Manufacturer advises to avoid intrinsic pathway clotting-based laboratory tests or use with caution as results may be misinterpreted—consult product literature.

▪ DIRECTIONS FOR ADMINISTRATION Manufacturer advises max. 2 mL per injection site; rotate injection site and avoid skin that is tender, damaged or scarred. Patients or their caregivers may self-administer Hemlibra® after appropriate training.

▪ PRESCRIBING AND DISPENSING INFORMATION Emicizumab is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1; manufacturer advises to record the brand name and batch number after each administration.
Coagulation factor deficiencies

2.1 Coagulation factor deficiencies

BLOOD AND RELATED PRODUCTS

Dried prothrombin complex

(Human prothrombin complex)

15-Mar-2017

INDICATIONS AND DOSE

Treatment and peri-operative prophylaxis of haemorrhage in patients with congenital deficiency of factors II, VII, IX, or X if purified specific coagulation factors not available

Treatment and peri-operative prophylaxis of haemorrhage in patients with acquired deficiency of factors II, VII, IX, or X (e.g. during warfarin treatment)

BY INTRAVENOUS INFUSION

Child: (consult haematologist)

CONTRA-INDICATIONS

Angina - history of heparin induced thrombocytopenia - recent myocardial infarction (except in life-threatening haemorrhage following overdosage of oral anticoagulants, and before induction of fibrinolytic therapy)

CAUTIONS

Disseminated intravascular coagulation - history of myocardial infarction or coronary heart disease - postoperative use - risk of thrombosis - vaccination against hepatitis A and hepatitis B may be required

SIDE-EFFECTS

Rare or very rare

Fever - headache - hypersensitivity

Frequency not known

Disseminated intravascular coagulation - nephrotic syndrome - thromboembolism

HEPATIC IMPAIRMENT

Manufacturer advises caution (risk of thromboembolic complications).

Monitoring

Monitor closely in hepatic impairment (risk of thromboembolic complications).

PRESCRIBING AND DISPENSING INFORMATION

Dried prothrombin complex is prepared from human plasma by a suitable fractionation technique, and contains factor IX, together with variable amounts of factors II, VII, and X.

Available from CSL Behring (Beriplex® P/N), Octapharma (Octaplex®).

MEDICINAL FORMS

No licensed medicines listed.

Factor VIII fraction, dried

(Human coagulation factor VIII, dried)

INDICATIONS AND DOSE

Treatment and prophylaxis of haemorrhage in congenital factor VIII deficiency (haemophilia A), acquired factor VIII deficiency / Von Willebrand’s disease

BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INFUSION, OR BY CONTINUOUS INTRAVENOUS INFUSION

Child: (consult haematologist)

CAUTIONS

Intravascular haemolysis after large or frequently repeated doses in patients with blood groups A, B, or AB—less likely with high potency concentrates - vaccination against hepatitis A and hepatitis B may be required (not necessary with recombinant preparation)

SIDE-EFFECTS

Uncommon

Angioedema - cardiac discomfort - chills - flushing - headache - hypersensitivity - hypotension - lethargy - nausea - paraesthesia - restlessness - skin reactions - tachycardia - vomiting - wheezing

Rare or very rare

Fever

MONITORING REQUIREMENTS

Monitor for development of factor VIII inhibitors.
PRESCRIBING AND DISPENSING INFORMATION
Dried factor VIII fraction is prepared from human plasma by a suitable fractionation technique; it may also contain varying amounts of von Willebrand factor. Optivate®, Fanhdi®, and Octanate® are not indicated for use in von Willebrand’s disease.

Recombinant human coagulation factor VIII including octocog alfa, moroctocog alfa, and simoctocog alfa are not indicated for use in von Willebrand’s disease.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

**Powder and solution for solution for injection**
- **Factor VIII fraction, dried (Non-proprietary)**
  - Factor VIII 500 unit: Dried Factor VIII Fraction type B 500 unit powder and solvent for solution for injection vials | 1 vial | £210.00
  - Advate (Baxalta UK Ltd)
    - Octocog alfa 250 unit: Advate 250 unit powder and solvent for solution for injection vials | 1 vial | £355.00
  - Octocog alfa 500 unit: Advate 500 unit powder and solvent for solution for injection vials | 1 vial | £710.00
  - Octocog alfa 2000 unit: Advate 2000 unit powder and solvent for solution for injection vials | 1 vial | £1,420.00
- Alphanate (Grifols UK Ltd)
  - Factor VIII high purity 1000 unit, von Willebrand factor
    - 1200 unit: Alphanate 1200 unit powder and solvent for solution for injection vials | 1 vial | £495.00
    - 1500 unit: Alphanate 1500 unit powder and solvent for solution for injection vials | 1 vial | £530.00
  - Electa (Swedish Orphan Biovitrum Ltd)
    - Efmorocog alfa 250 unit: Electa 250 unit powder and solvent for solution for injection vials | 1 vial | £177.50
    - Efmorocog alfa 500 unit: Electa 500 unit powder and solvent for solution for injection vials | 1 vial | £355.00
    - Efmorocog alfa 1000 unit: Electa 1000 unit powder and solvent for solution for injection vials | 1 vial | £710.00
    - Efmorocog alfa 1500 unit: Electa 1500 unit powder and solvent for solution for injection vials | 1 vial | £1,140.00
    - Efmorocog alfa 2000 unit: Electa 2000 unit powder and solvent for solution for injection vials | 1 vial | £1,420.00
    - Efmorocog alfa 3000 unit: Electa 3000 unit powder and solvent for solution for injection vials | 1 vial | £2,000.00
- Fanhdi (Grifols UK Ltd)
  - Factor VIII high purity 500 unit, von Willebrand factor
    - 500 unit: Fanhdi 500 unit powder and solvent for solution for injection vials | 1 vial | £1,165.00
  - Factor VIII high purity 1000 unit, von Willebrand factor
    - 1000 unit: Fanhdi 1000 unit powder and solvent for solution for injection vials | 1 vial | £2,330.00
  - Haemocin (Biotest UK Ltd)
    - Factor VIII high purity 250 unit
      - 250 unit: Haemocin 250 unit powder and solvent for solution for injection vials | 1 vial | £150.00
  - Factor VIII high purity 500 unit, von Willebrand factor
    - 500 unit: Haemocin 500 unit powder and solvent for solution for injection vials | 1 vial | £300.00
  - Factor VIII high purity 1000 unit, von Willebrand factor
    - 1000 unit: Haemocin 1000 unit powder and solvent for solution for injection vials | 1 vial | £600.00
- Kogenate (Bayer Plc)
  - Octocog alfa 2000 unit
    - 2000 unit: Kogenate Bayer 2000 unit powder and solvent for solution for injection vials | 1 vial | £1,260.00
  - Kogenate Bayer (Bayer Plc)
    - Octocog alfa 250 unit
      - 250 unit: Kogenate Bayer 250 unit powder and solvent for solution for injection vials | 1 vial | £157.50
  - Octocog alfa 500 unit
    - 500 unit: Kogenate Bayer 500 unit powder and solvent for solution for injection vials | 1 vial | £315.00
  - Octocog alfa 1000 unit
    - 1000 unit: Kogenate Bayer 1000 unit powder and solvent for solution for injection vials | 1 vial | £630.00
- Nuwiq (Octapharma Ltd)
  - Simoctocog alfa 250 unit
    - 250 unit: Nuwiq 250 unit powder and solvent for solution for injection vials | 1 vial | £130.00
  - Simoctocog alfa 500 unit
    - 500 unit: Nuwiq 500 unit powder and solvent for solution for injection vials | 1 vial | £380.00

Simoctocog alfa 1000 unit: Nuwiq 1000 unit powder and solvent for solution for injection vials | 1 vial | £760.00
Simoctocog alfa 2000 unit: Nuwiq 2000 unit powder and solvent for solution for injection vials | 1 vial | £1,520.00

**Octanate LV (Octapharma Ltd)**
- Factor VIII high purity 500 unit
  - Octanate LV 500 unit powder and solvent for solution for injection vials | 1 vial | £300.00 (Hospital only)

- Factor VIII high purity 1000 unit
  - Octanate LV 1000 unit powder and solvent for solution for injection vials | 1 vial | £600.00 (Hospital only)

- ReFacto (Pfizer Ltd)
  - Moroctocog alfa 250 unit
    - ReFacto AF 250 unit powder and solvent for solution for injection vials | 1 vial | £125.55 (Hospital only)
    - ReFacto AF 500 unit powder and solvent for solution for injection pre-filled syringes | 1 pre-filled disposable injection | £251.10 (Hospital only)
    - ReFacto AF 250 unit powder and solvent for solution for injection pre-filled syringes | 1 pre-filled disposable injection | £502.20 (Hospital only)

Moroctocog alfa 500 unit
- ReFacto AF 500 unit powder and solvent for solution for injection vials | 1 vial | £251.10 (Hospital only)

- Moroctocog alfa 1000 unit
  - ReFacto AF 1000 unit powder and solvent for solution for injection vials | 1 vial | £506.20 (Hospital only)
  - ReFacto AF 1000 unit powder and solvent for solution for injection pre-filled syringes | 1 pre-filled disposable injection | £502.20 (Hospital only)

Moroctocog alfa 2000 unit
- ReFacto AF 2000 unit powder and solvent for solution for injection pre-filled syringes | 1 pre-filled disposable injection | £1,044.40 (Hospital only)
- ReFacto AF 2000 unit powder and solvent for solution for injection vials | 1 vial | £1,044.40 (Hospital only)

Moroctocog alfa 3000 unit
- ReFacto AF 3000 unit powder and solvent for solution for injection pre-filled syringes | 1 pre-filled disposable injection | £1,506.60 (Hospital only)

- Vonceno (CSL Behring UK Ltd)
  - Factor VIII 5000 unit, von Willebrand factor 1200 unit
    - Vonceno 5000 unit powder and solvent for solution for injection vials | 1 vial | £385.00
    - Vonceno 1000 unit powder and solvent for solution for injection vials | 1 vial | £260.00

Factor VIII high purity products
- Factor VIII high purity 1000 unit, von Willebrand factor
  - 1000 unit powder and solvent for solution for injection vials | 1 vial | £506.00 (Hospital only)
  - Factor VIII high purity 1500 unit, von Willebrand factor
  - 1500 unit powder and solvent for solution for injection vials | 1 vial | £506.00 (Hospital only)

Powder and solution for solution for infusion
- Advate (Baxalta UK Ltd)
  - Octocog alfa 1500 unit
    - Advate 1500 unit powder and solvent for solution for infusion vials | 1 vial | £1,065.00
  - Octocog alfa 3000 unit
    - Advate 3000 unit powder and solvent for solution for infusion vials | 1 vial | £2,130.00

- Kogenate (Bayer Plc)
  - Octocog alfa 3000 unit
    - Kogenate Bayer 3000 unit powder and solvent for solution for injection vials | 1 vial | £1,890.00
  - Optivate (Bio Products Laboratory Ltd)
  - Factor VIII 250 unit, von Willebrand factor 430 unit
    - Optivate 250 unit powder and solvent for solution for infusion vials | 1 vial | £385.00

- Wilate 1000 (Octapharma Ltd)
  - Factor VIII 1000 unit, von Willebrand factor 1000 unit
    - Wilate 1000 powder and solvent for solution for infusion vials | 1 vial | £500.00

- Wilate 500 (Octapharma Ltd)
  - Factor VIII 500 unit, von Willebrand factor 500 unit
    - Wilate 500 powder and solvent for solution for infusion vials | 1 vial | £250.00

Factor IX fraction, dried

INDICATIONS AND DOSE
Treatment and prophylaxis of haemorrhage in congenital factor IX deficiency (haemophilia B)
- By intravenous injection, or by continuous intravenous infusion
- Child: (consult haematologist)

CONTRA-INDICATIONS
Disseminated intravascular coagulation

CAUTIONS
Risk of thrombosis—primarily with former low purity products · vaccination against hepatitis A and
Coagulation factor deficiencies

**Fibrinogen, dried**

*Human fibrinogen*

- **INDICATIONS AND DOSE**
  - Treatment of haemorrhage in congenital hypofibrinogenaemia or afibrinogenaemia
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Child: (consult haematologist)

- **CAUTIONS**
  - Risk of thrombosis

- **SIDE-EFFECTS**
  - Common or very common Fever, thromboembolism
  - Rare or very rare Angioedema, headache

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Fibrinogen is prepared from human plasma.

**Protein C concentrate**

- **INDICATIONS AND DOSE**
  - Congenital protein C deficiency
  - **BY INTRAVENOUS INJECTION**
  - Child: (consult haematologist)

- **CAUTIONS**
  - Hypersensitivity to heparins - vaccination against hepatitis A and hepatitis B may be required

- **SIDE-EFFECTS**
  - Rare or very rare Dizziness, fever, skin reactions
  - Frequency not known Haemothorax, hyperhidrosis, restlessness

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Protein C is prepared from human plasma.

**Factor XIII fraction, dried**

*Human fibrin-stabilising factor, dried*

- **INDICATIONS AND DOSE**
  - Congenital factor XIII deficiency
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Child: (consult haematologist)

- **CAUTIONS**
  - Vaccination against hepatitis A and hepatitis B may be required

- **SIDE-EFFECTS**
  - Rare or very rare Anaphylactoid reaction, dyspnoea, skin reactions

- **PRESCRIBING AND DISPENSING INFORMATION**
  - There can be variation in the licensing of different medicines containing the same drug.

**Factor VIII inhibitor bypassing fraction**

- **INDICATIONS AND DOSE**
  - Treatment and prophylaxis of haemorrhage in patients with congenital factor VIII deficiency (haemophilia A) and factor VIII inhibitors
  - **BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
  - Child: (consult haematologist)

- **CONTRA-INDICATIONS**
  - Disseminated intravascular coagulation

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**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for solution for injection**

- **AlphaNine** (Grifols UK Ltd)
  - Factor IX high purity 1000 unit
  - Alphanine 1,000 unit powder and solvent for solution for injection vials | 1 vial (P:R) £130.00

- **Haemonine** (Biotest (UK) Ltd)
  - Factor IX high purity 500 unit
  - Haemonine 500 unit powder and solvent for solution for injection vials | 1 vial (P:R) £100.00 (Hospital only)

- **Replene-VF** (Bio Products Laboratory Ltd)
  - Factor IX high purity 500 unit
  - Replene-VF 500 unit powder and solvent for solution for injection vials | 1 vial (P:R) £64.00 (Hospital only)

**Powder and solvent for solution for infusion**

- **BeneFIX** (Pfizer Ltd)
  - Nonacog alfa 250 unit
  - BeneFit 250 unit powder and solvent for solution for infusion vials | 1 vial (P:R) £131.30 (Hospital only)

- **Nonacog alfa 500 unit**
  - BeneFit 500 unit powder and solvent for solution for infusion vials | 1 vial (P:R) £303.60 (Hospital only)

- **Nonacog alfa 1000 unit**
  - BeneFit 1,000 unit powder and solvent for solution for infusion vials | 1 vial (P:R) £607.20 (Hospital only)

- **Nonacog alfa 2000 unit**
  - BeneFit 2,000 unit powder and solvent for solution for infusion vials | 1 vial (P:R) £1,214.40 (Hospital only)

- **Nonacog alfa 3000 unit**
  - BeneFit 3,000 unit powder and solvent for solution for infusion vials | 1 vial (P:R) £1,821.60 (Hospital only)

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**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for infusion**

- **Ristap** (CSL Behring UK Ltd)
  - Fibrinogen 1 gram
  - Ristap 1g powder for solution for infusion vials | 1 vial (P:R) £400.00

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for solution for injection**

- **Ceprotin** (Baxalta UK Ltd)
  - Protein C 500 unit
  - Ceprocin 500 unit powder and solvent for solution for injection vials | 1 vial (P:R) £2,000.00

- **Protein C 1000 unit**
  - Ceprotin 1000 unit powder and solvent for solution for injection vials | 1 vial (P:R) £1,000.00

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**BREAST FEEDING**

Manufacturers advise avoid—no information available.

**PRESCRIBING AND DISPENSING INFORMATION**

- Haemostatic products

- There can be variation in the licensing of different medicines containing the same drug.
Bleeding disorders

2.2 Subarachnoid haemorrhage

CALCIUM-CANAL BLOCKERS

Nimodipine

07-Feb-2018

- **DRUG ACTION** Nimodipine is a dihydropyridine calcium-channel blocker.

- **INDICATIONS AND DOSE**

  Treatment of vasospasm following subarachnoid haemorrhage (specialist use only)

  - **BY INTRAVENOUS INFUSION**
  - Child 1 month–11 years: Initially 15 micrograms/kg/hour (max. per dose 50 micrograms/hour), increased after 2 hours if no severe decrease in blood pressure; increased to 30 micrograms/kg/hour (max. per dose 2 mg/hour), continue for at least 5 days (max. 14 days), use initial dose of 7.5 micrograms/kg/hour if blood pressure unstable
  - Child 12–17 years (body-weight up to 70 kg): Initially 0.5 mg/hour, increased after 2 hours if no severe decrease in blood pressure; increased to 1–2 mg/hour, continue for at least 5 days (max. 14 days)
  - Child 12–17 years (body-weight 70 kg and above): Initially up to 1 mg/hour, use dose if blood pressure stable; increased after 2 hours if no severe decrease in blood pressure; increased to 1–2 mg/hour, continue for at least 5 days (max. 14 days)

- **Prevention of vasospasm following subarachnoid haemorrhage**

  - **BY MOUTH**
  - Child: 0.9–1.2 mg/kg 6 times a day (max. per dose 60 mg), started within 4 days of haemorrhage and continued for 21 days

- **UNLICENSED USE** Not licensed for use in children.

**IMPORTANT SAFETY INFORMATION**

**SAFE PRACTICE**

Nimodipine has been confused with amlodipine; care must be taken to ensure the correct drug is prescribed and dispensed.

- **CAUTIONS**

  - Cerebral oedema · Hypotension · Severely raised intracranial pressure

- **INTERACTIONS** → Appendix 1: calcium channel blockers

- **SIDE-EFFECTS**

  - Uncommon Thrombocytopenia · Vasodilation

- **PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.

- **BREAST FEEDING** Manufacturer advises avoid—present in milk.

- **RENAI IMPAIRMENT** Monitoring → With intravenous use Manufacturer advises monitor renal function closely in renal impairment.

- **DIRECTIONS FOR ADMINISTRATION** Avoid concomitant administration of nimodipine infusion and tablets.
Blood clots

3.1 Blocked catheters and lines

ANTITHROMBOTIC DRUGS > TISSUE PLASMINOGEN ACTIVATORS

Fibrinolytic drugs

Overview
Alteplase below, streptokinase p. 90 and urokinase p. 90 are used in children to dissolve intravascular thrombi and unblock occluded arteriovenous shunts, catheters, and indwelling central lines blocked with fibrin clots. Treatment should be started as soon as possible after a clot has formed and discontinued once a pulse in the affected limb is detected, or the shunt or catheter unblocked.

The safety and efficacy of treatment remains uncertain, especially in neonates. A fibrinolytic drug is probably only appropriate where arterial occlusion threatens ischaemic and discontinued once a pulse in the affected limb is detected, or the shunt or catheter unblocked.

Alteplase is the preferred fibrinolytic in children and neonates; there is less risk of adverse effects including allergic reactions.

Fibrinolytics

- **DRUG ACTION** Fibrinolytic drugs act as thrombolytics by activating plasminogen to form plasmin, which degrades fibrin and so breaks up thrombi.
- **CONTRA-INDICATIONS** Acute pancreatitis • aneurysm • arteriovenous malformation • bacterial endocarditis • bleeding diatheses • coagulation defects • neoplasm with risk of haemorrhage • pericarditis • recent haemorrhage • recent surgery (including dental extraction) • recent trauma • severe hypertension
- **CAUTIONS** Conditions with an increased risk of haemorrhage • hypertension • risk of bleeding (including that from venepuncture or invasive procedures)
- **SIDE-EFFECTS**
  - **Common or very common** Anaphylactic reaction • angina pectoris • cardiac arrest • cardiogenic shock • chills • CNS haemorrhage • ecchymosis • fever • haemorrhage • haemorrhagic stroke • heart failure • hypotension • ischaemia recurrent (when used in myocardial infarction) • nausea • pericarditis • pulmonary oedema • vomiting
  - **Uncommon** Aphasia • mitral valve incompetence • myocardial rupture • pericardial disorders • reperfusion arrhythmia (when used in myocardial infarction) • seizure

SIDE-EFFECTS, FURTHER INFORMATION
Serious bleeding calls for discontinuation of the thrombolytic and may require administration of coagulation factors and antifibrinolytic drugs.

- **PREGNANCY** Thrombolytic drugs can possibly lead to premature separation of the placenta in the first 18 weeks of pregnancy. There is also a risk of maternal haemorrhage throughout pregnancy and post-partum, and also a theoretical risk of fetal haemorrhage throughout pregnancy.
- **HEPATIC IMPAIRMENT** Manufacturers advise avoid in severe impairment.

Alteplase
(rt-PA; Tissue-type plasminogen activator)

- **INDICATIONS AND DOSE**
  - **Intravascular thrombosis**
    - **BY INTRAVENOUS INFUSION**
      - Neonate: 100–500 micrograms/kg/hour for 3–6 hours, use ultrasound assessment to monitor effect before considering a second course of treatment (consult local protocol).
      - Child: 100–500 micrograms/kg/hour for 3–6 hours, use ultrasound assessment to monitor effect before considering a second course of treatment; maximum 100 mg per day
  - **ACTILYSE CATHTHLO®**
    - Thrombolytic treatment of occluded central venous access devices (including those used for haemodialysis)
      - **BY INTRAVENOUS INJECTION**
      - Child: (consult product literature)
  - **UNLICENSED USE** Actilyse® not licensed for use in children.
  - **CONTRA-INDICATIONS** Oesophageal varices • recent delivery • recent ulcerative gastro-intestinal disease • stroke
  - **INTERACTIONS** → Appendix 1: alteplase
  - **SIDE-EFFECTS**
    - **Uncommon** Haemothorax
    - **Rare or very rare** Agitation • confusion • delirium • depression • epilepsy • psychosis • speech disorder
    - **Frequency not known** Brain oedema (caused by reperfusion)
  - **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated if history of hypersensitivity to gentamicin (residue from manufacturing process).
  - **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion (Actilyse®), dissolve in Water for Injections to a concentration of 1 mg/mL or 2 mg/mL and infuse intravenously; alternatively dilute further in Sodium Chloride 0.9% to a concentration of not less than 200 micrograms/mL; not to be diluted in Glucose.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension
  - **Solution for infusion**
    - Nimotop (Bayer Plc) Nimodipine 200 microgram per 1 ml Nimotop 0.02% solution for infusion 50ml vials | 5 vial [P] £68.00 (Hospital only)
  - **Tablet**
    - Nimotop (Bayer Plc) Nimodipine 30 mg Nimotop 30mg tablets | 100 tablet [P] £40.00

Powder and solvent for solution for injection

- **Actilyse (Boehringer Ingelheim Ltd)**
  - **Alteplase 10 mg** Actilyse 10mg powder and solvent for solution for injection vials | 1 vial [P] £172.80
  - **Alteplase 20 mg** Actilyse 20mg powder and solvent for solution for injection vials | 1 vial [P] £259.20

Powder and solvent for solution for infusion

- **Actilyse (Boehringer Ingelheim Ltd)**
  - **Alteplase 50 mg** Actilyse 50mg powder and solvent for solution for infusion vials | 1 vial [P] £432.00
Streptokinase

- INDICATIONS AND DOSE
  - Intravascular thrombosis
    - Initially by intravenous infusion
    - Child 1 month–11 years: Initially 2500–4000 units/kg, dose to be given over 30 minutes, followed by (by continuous intravenous infusion) 500–1000 units/kg/hour for up to 3 days until reperfusion occurs
    - Child 12–17 years: Initially 250 000 units, dose to be given over 30 minutes, followed by (by continuous intravenous infusion) 100 000 units/hour for up to 3 days until reperfusion occurs

- CONTRA-INDICATIONS
- CAUTIONS
- SIDE-EFFECTS
- ALLERGY AND CROSS-SENSITIVITY

Urokinase

- INDICATIONS AND DOSE
  - Occluded arteriovenous shunts, catheters, and indwelling central lines
    - To the device as a flush
    - Neonate: 5000–25 000 units, inject directly into occluded catheter or central line, dilute dose in sodium chloride 0.9% to fill catheter dead space only. Leave for 20–60 minutes then aspirate the lysate and flush with sodium chloride 0.9%.
    - Child: 5000–25 000 units, inject directly into occluded catheter or central line, dilute dose in sodium chloride 0.9% to fill catheter dead space only. Leave for 20–60 minutes then aspirate the lysate and flush with sodium chloride 0.9%

- CONTRA-INDICATIONS

Venous thromboembolism

### 3.2 Thromboembolism

#### Venous thromboembolism prophylaxis

Low-dose heparin (unfractionated) p. 97 by subcutaneous injection is used to prevent thrombotic episodes in ‘high-risk’ patients; laboratory monitoring of APTT or anti-Factor Xa concentration is also required in prophylactic regimens in children. Low molecular weight heparins, aspirin p. 93 (antiplatelet dose), and warfarin sodium p. 99 can also be used for prophylaxis.

The following guidance on reducing the risk of venous thromboembolism applies to children over 16 years and is based on NICE guideline 89 (www.nice.org.uk/guidance/ng89).

- All children over 16 years old should undergo a risk assessment to identify their risk of venous thromboembolism and bleeding on admission to hospital.
  - Commonly used risk assessment tools can be found at www.nice.org.uk/guidance/ng89/resources. Children over 16 years old considered to be at high risk of venous thromboembolism include those who are anticipated to have a substantial reduction in mobility, those with obesity, malignant disease, history of venous thromboembolism and thrombophilic disorder. Pregnancy and the postpartum period are also risk factors for venous thromboembolism.

There are two methods of thromboprophylaxis: mechanical and pharmacological. Options for mechanical prophylaxis are anti-embolism stockings that provide graduated compression and produce a calf pressure of 14–15 mmHg, and intermittent pneumatic compression.

- Anti-embolism stockings should be worn day and night until the child is sufficiently mobile; they should not be offered to children over 16 years old admitted with conditions such as severe leg oedema, or local conditions (e.g. gangrene, dermatitis). When using pharmacological prophylaxis, in most cases, it should start as soon as possible or within 14 hours of admission. Children over 16 years of age with risk factors for bleeding (e.g. thrombocytopenia, acquired or untreated inherited bleeding disorders) should only receive

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pharmacological prophylaxis when their risk of venous thromboembolism outweighs their risk of bleeding. Children over 16 years of age receiving anticoagulant therapy who are at high risk of venous thromboembolism should be considered for prophylaxis if their anticoagulant therapy is interrupted, for example during the peri-operative period.

**Surgical patients**
- To reduce the risk of venous thromboembolism in surgical patients over 16 years old, regional anaesthesia over general anaesthesia should be used if possible.
- Mechanical prophylaxis (e.g. anti-embolism stockings or intermittent pneumatic compression) should be offered to children over 16 years old with major trauma, or undergoing cranial, abdominal, bariatic, thoracic, maxillofacial, ear, nose, and throat, cardiac or elective spinal surgery.
- Prophylaxis should continue until the child is sufficiently mobile or discharged from hospital (or for 30 days in spinal injury, elective spinal surgery or cranial surgery).
- Choice of mechanical prophylaxis depends on factors such as the type of surgery, suitability for the child, and their condition.
- Pharmacological prophylaxis should be considered in children over 16 years old undergoing general or orthopaedic surgery when the risk of venous thromboembolism outweighs the risk of bleeding.
- The choice of prophylaxis will depend on the type of surgery, suitability for the patient, and local policy.
- A low molecular weight heparin is suitable in all types of general and orthopaedic surgery; heparin (unfractionated) is preferred in patients with renal impairment. Fondaparinux sodium [unlicensed] is an option for children over 16 years old undergoing abdominal, bariatic, thoracic or cardiac surgery, or for patients with lower limb immobilisation or fragility fractures of the pelvis, hip or proximal femur.
- Pharmacological prophylaxis in general surgery should usually continue for at least 7 days post-surgery, or until sufficient mobility has been re-established. Pharmacological prophylaxis should be extended to 28 days after major cancer surgery in the abdomen, and to 30 days in spinal surgery.
- Mechanical prophylaxis with intermittent pneumatic compression should be considered when pharmacological prophylaxis is contra-indicated in children over 16 years old undergoing lower limb amputation, or those with major trauma or fragility fractures of the pelvis, hip or proximal femur.

**Medical patients**
- The choice of prophylaxis will depend on the medical condition, suitability for the patient, and local policy.
- Acutely ill medical patients over 16 years old who are at high risk of venous thromboembolism should be offered pharmacological prophylaxis. Children over 16 years old should be given either a low molecular weight heparin as a first-line option, or fondaparinux sodium [unlicensed] as an alternative, for a minimum of 7 days. Children over 16 years old with renal impairment should be given either a low molecular weight heparin or heparin (unfractionated) and the dose should be adjusted as necessary.
- Mechanical prophylaxis can be considered when pharmacological prophylaxis is contra-indicated; their use should be continued until the child is sufficiently mobile.

**Thromboprophylaxis in pregnancy**
- All pregnant young women over 16 years old (who are not in active labour), or young women over 16 years old who have given birth, had a miscarriage or termination of pregnancy during the past 6 weeks, with a risk of venous thromboembolism that outweighs the risk of bleeding should be considered for pharmacological prophylaxis with a low molecular weight heparin during hospital admission. In pregnant young women over 16 years old, prophylaxis should be continued until there is no longer a risk of venous thromboembolism, or until discharge from hospital. Young women over 16 years old who have given birth, had a miscarriage or termination of pregnancy during the past 6 weeks, should start thromboprophylaxis with a low molecular weight heparin 4–8 hours after the event, unless contra-indicated, and continue for a minimum of 7 days.
- Additional mechanical prophylaxis should be considered for young women over 16 years old who are likely to be immobilised or have significantly reduced mobility and continued until the young woman is sufficiently mobile or discharged from hospital. Intermittent pneumatic compression should be used as the first-line option and antithrombotic stockings as an alternative.

**Treatment of venous thromboembolism**
- For the initial treatment of thrombotic episodes heparin (unfractionated) is given as an intravenous loading dose, followed by continuous intravenous infusion (using an infusion pump) or by intermittent subcutaneous injection; the use of intermittent intravenous injection is no longer recommended. Alternatively, a low molecular weight heparin may be given for initial treatment. If an oral anticoagulant (usually warfarin sodium) is also required, it may be started at the same time as the heparin (the heparin needs to be continued for at least 5 days and until the INR has been in the therapeutic range for 2 consecutive days). Laboratory monitoring of coagulation activity, preferably on a daily basis, involves determination of the activated partial thromboplastin time (APTT) (for heparin (unfractionated) p. 97 only) or of the anti-Factor Xa concentration (for low molecular weight heparins). Local guidelines on recommended APTT for neonates and children should be followed; monitoring of APTT should be discussed with a specialist prior to treatment for thrombotic episodes in neonates.

**Treatment of venous thromboembolism in pregnancy**
- Heparins are used for the management of venous thromboembolism in pregnancy because they do not cross the placenta. Low molecular weight heparins are preferred because they have a lower risk of osteoporosis and of heparin-induced thrombocytopenia. Low molecular weight heparins are eliminated more rapidly in pregnancy, requiring alteration of the dosage regimen for drugs such as dalteparin sodium p. 96, enoxaparin sodium p. 96 and tinzaparin sodium p. 98; see also under individual drugs. Treatment should be stopped at the onset of labour and advice sought from a specialist on continuing therapy after birth.

**Extracorporeal circuits**
- Heparin (unfractionated) is also used in the maintenance of extracorporeal circuits in cardiopulmonary bypass and haemodialysis.

**Haemorrhage**
- If haemorrhage occurs it is usually sufficient to withdraw unfractionated or low molecular weight heparin (unfractionated), but if rapid reversal of the effects of the heparin (unfractionated) is required, protamine sulfate p. 868 is a specific antidote (but only partially reverses the effects of low molecular weight heparin (unfractionated)).

**Advanced Pharmacy Services**
- Children with, or at risk of venous thromboembolism may be eligible for the New Medicines Service / Medicines Use. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.
Oral anticoagulants

Overview

The main use of anticoagulants is to prevent thrombus formation or extension of an existing thrombus in the slower-moving venous side of the circulation, where the thrombus consists of a fibrin web enmeshed with platelets and red cells.

Anticoagulants are of less use in preventing thrombus formation in arteries, for in faster-flowing vessels thrombi are composed mainly of platelets with little fibrin.

Oral anticoagulants antagonise the effects of vitamin K and take at least 48 to 72 hours for the anticoagulant effect to develop fully; if an immediate effect is required, unfractionated or low molecular weight heparin must be given concomitantly.

Uses

Warfarin sodium, p. 99 is the drug of choice for the treatment of systemic thromboembolism in children (not neonates) after initial heparinisation. It may also be used occasionally for the treatment of intravascular or intracardiac thrombi.

Warfarin sodium is used prophylactically in those with chronic atrial fibrillation, dilated cardiomyopathy, certain forms of reconstructive heart surgery, mechanical prosthetic heart valves, and some forms of hereditary thrombophilia (e.g. homozygous protein C deficiency).

Unfractionated or a low molecular weight heparin (see under Parenteral anticoagulants below) is usually preferred for the prophylaxis of venous thromboembolism in children undergoing surgery; alternatively warfarin sodium can be continued in selected children currently taking warfarin sodium and who are at a high risk of thromboembolism (seek expert advice).

Dose

The base-line prothrombin time should be determined but the initial dose should not be delayed whilst awaiting the result.

An induction dose is usually given over 4 days. The subsequent maintenance dose depends on the prothrombin time, reported as INR (international normalised ratio) and should be taken at the same time each day.

Target INR


An INR which is within 0.5 units of the target value is generally satisfactory; larger deviations require dosage adjustment. Target values (rather than ranges) are now recommended.

INR 2.5 for:

- treatment of deep-vein thrombosis or pulmonary embolism (including those associated with antiphospholipid syndrome or for recurrence in patients no longer receiving warfarin sodium)
- atrial fibrillation
- cardioversion—target INR should be achieved at least 3 weeks before cardioversion and anticoagulation should continue for at least 4 weeks after the procedure (higher target values, such as an INR of 3, can be used for up to 4 weeks before the procedure to avoid cancellations due to low INR)
- dilated cardiomyopathy
- mitral stenosis or regurgitation in patients with either atrial fibrillation, a history of systemic embolism, a left atrial thrombus, or an enlarged left atrium
- bioprothetic heart valves in the mitral position (treat for 3 months), or in patients with a history of systemic embolism (treat for at least 3 months), or with a left atrial thrombus at surgery (treat until clot resolves), or with other risk factors (e.g. atrial fibrillation or a low ventricular ejection fraction)
- acute arterial embolism requiring embolectomy (consider long-term treatment)
- myocardial infarction
- INR 3.5 for:
- recurrent deep-vein thrombosis or pulmonary embolism in patients currently receiving anticoagulation and with an INR above 2;
- Mechanical prosthetic heart valves:
- the recommended target INR depends on the type and location of the valve, and patient-related risk factors
- consider increasing the INR target or adding an antiplatelet drug, if an embolic event occurs whilst anticoagulated at the target INR.

Haemorrhage

The main adverse effect of all oral anticoagulants is haemorrhage. Checking the INR and omitting doses when appropriate is essential; if the anticoagulant is stopped but not reversed, the INR should be measured 2–3 days later to ensure that it is falling. The cause of an elevated INR should be investigated. The following recommendations (which take into account the recommendations of the British Society for Haematology Guidelines on Oral Anticoagulation with Warfarin—fourth edition. Br J Haematol 2011; 154: 311–324) are based on the result of the INR and whether there is major or minor bleeding; the recommendations apply to adults taking warfarin:

- Major bleeding—stop warfarin sodium; give phytonadione p. 659 (vitamin K₃) by slow intravenous injection; give dried prothrombin complex p. 85 (factors II, VII, IX, and X); if dried prothrombin complex unavailable, fresh frozen plasma can be given but is less effective; recombinant factor VIIa is not recommended for emergency anticoagulation reversal
- INR >8.0, minor bleeding—stop warfarin sodium; give phytonadione (vitamin K₃) by slow intravenous injection; repeat dose of phytonadione if INR still too high after 24 hours; restart warfarin sodium when INR <5.0
- INR >8.0, no bleeding—stop warfarin sodium; give phytonadione (vitamin K₃) by mouth using the intravenous preparation orally [unlicensed use]; repeat dose of phytonadione if INR still too high after 24 hours; restart warfarin sodium when INR <5.0
- INR 5.0–8.0, minor bleeding—stop warfarin sodium; give phytonadione (vitamin K₃) by slow intravenous injection; restart warfarin sodium when INR <5.0
- INR 5.0–8.0, no bleeding— withhold 1 or 2 doses of warfarin sodium and reduce subsequent maintenance dose
- Unexpected bleeding at therapeutic levels—always investigate possibility of underlying cause e.g. unsuspected renal or gastro-intestinal tract pathology

Advanced Pharmacy Services

Children taking oral anticoagulants may be eligible for the New Medicines Service / Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

Parenteral anticoagulants

Anticoagulants

Although thrombotic episodes are uncommon in childhood, anticoagulants may be required in children with congenital heart disease; in children undergoing haemodialysis; for
preventing thrombosis in children requiring chemotherapy and following surgery; and for systemic venous thrombembolism secondary to inherited thrombophilias, systemic lupus erythematosus, or indwelling central venous catheters.

**Heparin**

Heparin initiates anticoagulation rapidly but has a short duration of action. It is now often referred to as being **standard** or heparin (unfractionated) p. 97 to distinguish it from the **low molecular weight heparins**, which have a longer duration of action. For children at high risk of bleeding, heparin (unfractionated) is more suitable than low molecular weight heparin because its effect can be terminated rapidly by stopping the infusion.

Heparins are used in both the treatment and prophylaxis of thrombembolms, mainly to prevent further clotting rather than to lyse existing clots—surgery or a thrombolytic drug may be necessary if a thrombus obstructs major vessels.

**Low molecular weight heparins**

Dalteparin sodium p. 96, enoxaparin sodium p. 96, and tinzaparin sodium p. 98 are low molecular weight heparins used for treatment and prophylaxis of thrombotic episodes in children. Their duration of action is longer than that of heparin (unfractionated) and in adults and older children **once-daily subcutaneous** dosage is sometimes possible; however, younger children require relatively higher doses (possibly due to larger volume of distribution, altered heparin pharmacokinetics, or lower plasma concentrations of antithrombin) and twice daily dosage is sometimes necessary. Low molecular weight heparins are convenient to use, especially in children with poor venous access.

**Heparinoids**

Danaparoid sodium p. 95 is a heparinoid that has a role in children who develop heparin-induced thrombocytopenia, providing they have no evidence of cross-reactivity.

**Heparin flushes**

The use of heparin flushes should be kept to a minimum. For maintaining patency of peripheral venous catheters, sodium chloride injection 0.9% is as effective as heparin flushes. The role of heparin flushes in maintaining patency of arterial and central venous catheters is unclear.

**Epoprostenol**

Epoprostenol p. 120 (prostacyclin) can be given to inhibit platelet aggregation during renal dialysis when heparins are unsuitable or contra-indicated. It is a potent vasodilator and therefore its side-effects include flushing, headache and hypotension.

**Other drugs used for Thromboembolism**

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**Aspirin**

*(Acetylsalicylic Acid)*

**INDICATIONS AND DOSE**

**Antiplatelet | Prevention of thrombus formation after cardiac surgery**

- **Neonate**: 1–5 mg/kg once daily.
- **Child 1 month-11 years**: 1–5 mg/kg once daily (max. per dose 75 mg)
- **Child 12-17 years**: 75 mg once daily

**Kawasaki disease**

Initial treatment is with high dose aspirin and a single dose of intravenous normal immunoglobulin; this combination has an additive anti-inflammatory effect resulting in faster resolution of fever and a decreased incidence of coronary artery complications. After the acute phase, when the patient is afebrile, aspirin is continued at a lower dose to prevent coronary artery abnormalities.

**Advanced Pharmacy Services**

Children taking antiplatelet drugs may be eligible for the New Medicines Service / Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

**CONTRA-INDICATIONS**

- Active peptic ulceration
- Uncontrolled hypertension
- Severe cardiac failure
- Previous peptic ulceration
- Active bleeding
- Allergic disease
- Anaemia
- Asthma
- Dehydration
- Glyceraldehyde-3-phosphate dehydrogenase deficiency
- Anaemia
- Dehydration
- G6PD deficiency
- Preferably avoid during fever or viral infection in children (risk of Reye’s syndrome)
- Hypertension
- Thrombolytic drug use
- Previous peptic ulceration

**OTHER ANTITHROMBOTIC DRUGS**

- **Dipyridamole p. 94** is also used as an antiplatelet drug to prevent clot formation after cardiac surgery and may be used with specialist advice for treatment of persistent coronary artery aneurysms in Kawasaki disease.

**BNFC 2019 – 2020**

Cardiovascular system

Thromboembolism 93
INTERACTIONS → Appendix 1: aspirin

SIDE-EFFECTS

GENERAL SIDE-EFFECTS
- Rare or very rare Asthmatic attack · bronchospasm

SPECIFIC SIDE-EFFECTS
- Common or very common Dyspepsia · haemorrhage
- Uncommon Dyspnoea · rhinitis · severe cutaneous adverse reactions (SCARs) · skin reactions
- Rare or very rare Aplastic anaemia · erythema nodosum · gastrointestinal haemorrhage · granulocytosis · haemorrhagic vasculitis · intracranial haemorrhage · menorrhagia · nausea · thrombocytopenia · vomiting
- Frequency not known Fluid retention · gastrointestinal disorders · headache · hearing loss · hepatic failure · hyperuricaemia · iron deficiency anaemia · renal impairment · sodium and water retention · deterioration in vitamin K stores low.

Allergy and cross-sensitivity
- Uncommon
- Common or very common

SIDE-EFFECTS

suspension, oral solution

Nu-Seals
- ▶ 5, 25, 32

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

Gastro-resistant tablet

CAUTIONARY AND ADVISORY LABELS 5, 25, 32
- Aspirin (Non-proprietary)
  - Aspirin 75 mg Aspirin 75mg gastro-resistant tablets | 28 tablet £0.71 DT = £0.71 | 56 tablet £1.42 DT = £1.66
  - Aspirin 300 mg Aspirin 300mg gastro-resistant tablets | 100 tablet £25.28 DT = £25.21
- Micropirin (Dexcel-Pharma Ltd)
  - Aspirin 75 mg Micropirin 75mg gastro-resistant tablets | 28 tablet £1.45 DT = £0.71 | 56 tablet £2.87
- Nu-Seals (Alliance Pharmaceuticals Ltd.)
  - Aspirin 75 mg Nu-Seals 75 gastro-resistant tablets | 56 tablet £3.12

Tablet

CAUTIONARY AND ADVISORY LABELS 21, 32
- Aspirin (Non-proprietary)
  - Aspirin 75 mg Aspirin 75mg tablets | 28 tablet £3.50 DT = £1.12
  - Aspirin 300 mg Aspirin 300mg tablets | 100 tablet £12.12 DT = £10.69

Suppository

CAUTIONARY AND ADVISORY LABELS 32
- Aspirin (Non-proprietary)
  - Aspirin 150 mg Aspirin 150mg suppositories | 10 suppository £18.67 DT = £18.67
  - Aspirin 300 mg Aspirin 300mg suppositories | 10 suppository £35.89 DT = £35.89

Dispersible tablet

CAUTIONARY AND ADVISORY LABELS 13, 21, 32
- Aspirin (Non-proprietary)
  - Aspirin 75 mg Aspirin 75mg dispersible tablets | 1000 tablet £18.57–£20.00
  - Aspirin 300 mg Aspirin 300mg dispersible tablets | 100 tablet £5.59 DT = £6.34
- Dananap (ECogen Europe Ltd)
  - Aspirin 75 mg Dananap 75mg dispersible tablets | 28 tablet £0.50 DT = £0.56

Dipyriramole

INDICATIONS AND DOSE

Kawasaki disease (initiated under specialist supervision)
- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
  - Child 1 month–11 years: 1 mg/kg 3 times a day

Prevention of thrombus formation after cardiac surgery
- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
  - Child 1 month–11 years: 2.5 mg/kg twice daily
  - Child 12–17 years: 100–200 mg 3 times a day

UNLICENSED USE
Not licensed for use in children.

CAUTION
Aortic stenosis · coagulation disorders · heart failure · hypotension · left ventricular outflow obstruction · may exacerbate migraine · myasthenia gravis (risk of exacerbation)

INTERACTIONS → Appendix 1: dipyriramole

SIDE-EFFECTS
- Common or very common Angina pectoris · diarrhoea · dizziness · headache · myalgia · nausea · skin reactions · vomiting
- Frequency not known Angioedema · bronchospasm · haemorrhage · hot flush · hypotension · tachycardia · thrombocytopenia
- PREGNANCY
Not known to be harmful.

BREAST FEEDING
Manufacturers advise use only if essential—small amount present in milk.

DIRECTIONS FOR ADMINISTRATION
Injection solution can be given orally.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

Oral suspension
- Dipyriramole (Non-proprietary)
  - Dipyriramole 10 mg per 1 ml Dipyriramole 50mg/5ml oral suspension sugar free sugar-free | 150 ml £39.40 DT = £39.40
  - Dipyriramole 40 mg per 1 ml Dipyriramole 200mg/5ml oral suspension sugar free sugar-free | 150 ml £133.53 DT = £133.53

Tablet

CAUTIONARY AND ADVISORY LABELS 22
- Dipyriramole (Non-proprietary)
  - Dipyriramole 25 mg Dipyriramole 25mg tablets | 84 tablet £9.40 DT = £9.40
  - Dipyriramole 100 mg Dipyriramole 100mg tablets | 84 tablet £12.50 DT = £4.66
ANTITHROMBOTIC DRUGS > HEPARINOIDS

Danaparoid sodium

24-Jul-2018

- INDICATIONS AND DOSE
  Thromboembolic disease in patients with history of heparin-induced thrombocytopenia
  - INITIALLY BY INTRAVENOUS INJECTION
    - Neonate: Initially 30 units/kg, then (by continuous intravenous infusion) 1.2–2 units/kg/hour, infusion dose to be adjusted according to coagulation activity
    - Child 1 month–15 years (body-weight up to 55 kg): Initially 30 units/kg (max. per dose 1250 units), then (by continuous intravenous infusion) 1.2–2 units/kg/hour, infusion dose to be adjusted according to coagulation activity
    - Child 1 month–15 years (body-weight 55 kg and above): Initially 30 units/kg (max. per dose 2500 units), then (by continuous intravenous infusion) 1.2–2 units/kg/hour, infusion dose to be adjusted according to coagulation activity
    - Child 16–17 years (body-weight up to 55 kg): Initially 1250 units, then (by continuous intravenous infusion) 400 units/hour for 2 hours, then (by continuous intravenous infusion) 300 units/hour for 2 hours, then (by continuous intravenous infusion) 200 units/hour for 5 days, infusion dose to be adjusted according to coagulation activity
    - Child 16–17 years (body-weight 55–90 kg): Initially 2500 units, then (by continuous intravenous infusion) 400 units/hour for 2 hours, then (by continuous intravenous infusion) 300 units/hour for 2 hours, then (by continuous intravenous infusion) 200 units/hour for 5 days, infusion dose to be adjusted according to coagulation activity
    - Child 16–17 years (body-weight 91 kg and above): Initially 3750 units, then (by continuous intravenous infusion) 400 units/hour for 2 hours, then (by continuous intravenous infusion) 300 units/hour for 2 hours, then (by continuous intravenous infusion) 200 units/hour for 5 days, infusion dose to be adjusted according to coagulation activity

- UNLICENSED USE
  Not licensed for use in children.

- CONTRA-INDICATIONS
  Active peptic ulcer (unless this is the reason for operation) • acute bacterial endocarditis • diabetic retinopathy • epidural anaesthesia (with treatment doses) • haemophilia and other haemorrhagic disorders • peptic ulcer • recent cerebral haemorrhage • recent surgery to nervous system • severe hypertension • spinal anaesthesia with treatment doses • thrombocytopenia (including history of heparin-induced thrombocytopenia)

- CAUTIONS
  Antibodies to heparins (risk of antibody-induced thrombocytopenia) • body-weight over 90 kg • recent bleeding • risk of bleeding

- INTERACTIONS
  Appendix 1: danaparoid

- SIDE-EFFECTS
  - Common or very common
    - Haemorrhage • heparin-induced thrombocytopenia • skin reactions • thrombocytopenia
  - Uncommon
    - Post procedural haemostasia
  - Rare or very rare
    - Anastomotic haemorrhage

- PREGNANCY
  Manufacturer advises avoid—limited information available but not known to be harmful.

- BREAST FEEDING
  Amount probably too small to be harmful but manufacturer advises avoid.

- HEPATIC IMPAIRMENT
  Manufacturer advises caution in moderate impairment with impaired haemostasis—increased risk of bleeding; avoid in severe hepatic failure unless patient has heparin-induced thrombocytopenia and no alternative available.

- RENAL IMPAIRMENT
  Use with caution in moderate impairment. Avoid in severe impairment unless patient has heparin-induced thrombocytopenia and no alternative available.

  Monitoring
  Increased risk of bleeding in renal impairment, monitor anti-Factor Xa activity.

- MONITORING REQUIREMENTS
  Monitor anti factor Xa activity in patients with body-weight over 90 kg.

- DIRECTIONS FOR ADMINISTRATION
  For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%.

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

  Solution for injection
  - Danaparoid sodium (Non-proprietary)
    - Danaparoid sodium 1250 unit per 1 ml
      - Danaparoid sodium 750 units/0.6ml solution for injection ampoules
      - 10 ampoule £59.99

ANTITHROMBOTIC DRUGS > HEPARINS

Heparins

- CONTRA-INDICATIONS
  Acute bacterial endocarditis • after major trauma • epidural anaesthesia with treatment doses • haemophilia and other haemorrhagic disorders • peptic ulcer • recent cerebral haemorrhage • recent surgery to eye • recent surgery to nervous system • severe hypertension • spinal anaesthesia with treatment doses • thrombocytopenia (including history of heparin-induced thrombocytopenia)

- SIDE-EFFECTS
  - Common or very common
    - Haemorrhage • heparin-induced thrombocytopenia • skin reactions • thrombocytopenia • thrombocytosis
  - Uncommon
    - CNS haemorrhage
  - Rare or very rare
    - Alopecia • hyperkalaemia • osteoporosis • priapism
  - Frequency not known
    - Hypoaldosteronism

SIDE-EFFECTS, FURTHER INFORMATION

Haemorrhage
  If haemorrhage occurs it is usually sufficient to withdraw unfractionated or low molecular weight heparin, but if rapid reversal of the effects of the heparin is required, protamine sulfate is a specific antidote (but only partially reverses the effects of low molecular weight heparins).

Heparin-induced thrombocytopenia
  Clinically important heparin-induced thrombocytopenia is immune-mediated and can be complicated by thrombosis. Signs of heparin-induced thrombocytopenia include a 30% reduction of platelet count, thrombosis, or skin allergy. If heparin-induced thrombocytopenia is strongly suspected or confirmed, the heparin should be stopped and an alternative anticoagulant, such as danaparoid, should be given. Ensure platelet counts return to normal range in those who require warfarin.

Hyperkalaemia
  Inhibition of aldosterone secretion by unfractionated or low molecular weight heparin can result in hyperkalaemia; patients with diabetes mellitus, chronic renal failure, acidosis, raised plasma potassium or those taking potassium-sparing drugs seem to be more susceptible. The risk appears to increase with duration of therapy.

- ALLERGY AND CROSS-SENSITIVITY
  Hypersensitivity to unfractionated or low molecular weight heparin.

- MONITORING REQUIREMENTS
  Heparin-induced thrombocytopenia
    - Platelet counts should be measured just before treatment with unfractionated or low molecular weight heparin, and regular monitoring of platelet counts may be required if given for longer than 4 days. See the British Society for Haematology’s Guidelines on the diagnosis and management of heparin-

> Hyperkalaemia  Plasma-potassium concentration should be measured in patients at risk of hyperkalaemia before starting the heparin and monitored regularly thereafter, particularly if treatment is to be continued for longer than 7 days.

### Dalteparin sodium

#### INDICATIONS AND DOSE

**Treatment of thrombotic episodes**

- **BY SUBCUTANEOUS INJECTION**
  - Neonate: 100 units/kg twice daily.
  - Child 1 month-11 years: 100 units/kg twice daily
  - Child 12-17 years: 200 units/kg once daily (max. per dose 18 000 units); reduced to 100 units/kg twice daily, dose reduced if increased risk of bleeding

**Treatment of venous thromboembolism in pregnancy**

- **BY SUBCUTANEOUS INJECTION**
  - Child 12-17 years (body-weight up to 50 kg): 5000 units twice daily, use body-weight in early pregnancy to calculate the dose
  - Child 12-17 years (body-weight 50–69 kg): 6000 units twice daily, use body-weight in early pregnancy to calculate the dose
  - Child 12-17 years (body-weight 70–89 kg): 8000 units twice daily, use body-weight in early pregnancy to calculate the dose
  - Child 12-17 years (body-weight 90 kg and above): 10 000 units twice daily, use body-weight in early pregnancy to calculate the dose

**Prophylaxis of thrombotic episodes**

- **BY SUBCUTANEOUS INJECTION**
  - Neonate: 100 units/kg once daily.
  - Child 1 month-11 years: 100 units/kg once daily
  - Child 12-17 years: 2500–5000 units twice daily

#### UNLICENSED USE

Not licensed for use in children.

#### INTERACTIONS

→ Appendix 1: low molecular-weight heparins

#### SIDE-EFFECTS

Epidural haematoma - prosthetic cardiac valve thrombosis

#### PREGNANCY

Not known to be harmful, low molecular weight heparins do not cross the placenta. Multidose vial contains benzyl alcohol—manufacturer advises avoid.

#### BREAST FEEDING

Due to the relatively high molecular weight and inactivation in the gastro-intestinal tract, passage into breast-milk and absorption by the nursing infant are likely to be negligible, however manufacturers advise avoid.

#### HEPATIC IMPAIRMENT

Manufacturer advises caution in severe impairment (increased risk of bleeding complications).

- **Dose adjustments**  Manufacturer advises consider dose reduction in severe impairment.

#### RENAL IMPAIRMENT

Use of unfractionated heparin may be preferable.

- **Dose adjustments**  Risk of bleeding may be increased—dose reduction may be required.

#### MONITORING REQUIREMENTS

Routine monitoring of anti-Factor Xa activity is not usually required during treatment with dalteparin, except in neonates; monitoring may also be necessary in severely ill children and those with renal or hepatic impairment.

### Enoxaparin sodium

#### INDICATIONS AND DOSE

**Treatment of thrombotic episodes**

- **BY SUBCUTANEOUS INJECTION**
  - Neonate: 1.5–2 mg/kg twice daily.
  - Child 1 month: 1.5 mg/kg twice daily
  - Child 2 months-17 years: 1 mg/kg twice daily

**Treatment of venous thromboembolism in pregnancy**

- **BY SUBCUTANEOUS INJECTION**
  - Child 12-17 years (body-weight up to 50 kg): 40 mg twice daily, dose based on early pregnancy body-weight
  - Child 12-17 years (body-weight 50–69 kg): 60 mg twice daily, dose based on early pregnancy body-weight
  - Child 12-17 years (body-weight 70–89 kg): 80 mg twice daily, dose based on early pregnancy body-weight
  - Child 12-17 years (body-weight 90 kg and above): 100 mg twice daily, dose based on early pregnancy body-weight

**Prophylaxis of thrombotic episodes**

- **BY SUBCUTANEOUS INJECTION**
  - Neonate: 750 micrograms/kg twice daily.
  - Child 1 month: 750 micrograms/kg twice daily
  - Child 2 months-17 years: 500 micrograms/kg twice daily; maximum 40 mg per day

#### DOSE EQUIVALENCE AND CONVERSION

- 1 mg equivalent to 100 units.

#### UNLICENSED USE

Not licensed for treatment of venous thromboembolism in pregnancy.

Not licensed for use in children.

#### INTERACTIONS

→ Appendix 1: low molecular-weight heparins

#### SIDE-EFFECTS

Common or very common  Hypersensitivity

Frequency not known  Cutaneous vasculitis - eosinophilia - haemorrhagic anaemia - headache - hepatic disorders

#### PREGNANCY

Not known to be harmful, low molecular weight heparins do not cross the placenta. Multidose vial contains benzyl alcohol—avoid.
**MONITORING REQUIREMENTS**

- **RENAL IMPAIRMENT**
  - Risk of bleeding increased; use of unfractionated heparin may be preferable. Consult specialist sources.

**PRESCRIBING AND DISPENSING INFORMATION**

Enoxaparin sodium is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see *Biological medicines and Biosimilar medicines*, under Guidance on prescribing p. 1.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

### Solution for injection

**EXCipients:** May contain Benzyl alcohol

- **Arovi** (ROVI Biotech Ltd)
  - **Enoxaparin sodium 100 mg per 1 ml**
    - **Inhixa** 60mg/0.6ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £15.65 DT = £20.86
    - **Arrovi** 60mg/0.6ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £29.45 DT = £39.26
    - **Arrovi** 40mg/0.4ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £22.79 DT = £30.37
    - **Arrovi** 80mg/0.8ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £41.35 DT = £55.13
    - **Arovi** 100mg/1ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £54.23 DT = £72.30

- **Enoxaparin sodium 150 mg per 1 ml**
  - **Inhixa** 150mg/1ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £18.92 DT = £24.99

**Clexane (Sanofi)**

- **Enoxaparin sodium 100 mg per 1 ml**
  - **Clexane** 60mg/0.6ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £39.26 DT = £52.26
  - **Clexane** 300mg/3ml solution for injection multidose vials | 1 vial (PVS) £21.32 DT = £27.62
  - **Clexane** 80mg/0.8ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £55.13 DT = £72.17
  - **Clexane** 40mg/0.4ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £30.27 DT = £39.67
  - **Clexane** 100mg/1ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £72.30 DT = £90.39
  - **Clexane** 20mg/0.2ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £20.86 DT = £27.82

- **Enoxaparin sodium 150 mg per 1 ml**
  - **Clexane Forte** 120mg/0.8ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £99.91 DT = £122.99
  - **Clexane Forte** 150mg/1ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £99.91 DT = £122.99

- **Inhixa** (Techdow Pharma England Ltd)
  - **Enoxaparin sodium 100 mg per 1 ml**
    - **Inhixa** 40mg/0.4ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £24.22 DT = £30.27
    - **Inhixa** 80mg/0.8ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £44.10 DT = £55.13
    - **Inhixa** 60mg/0.6ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £31.41 DT = £39.26
    - **Inhixa** 100mg/1ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £57.84 DT = £72.30
    - **Inhixa** 20mg/0.2ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £16.69 DT = £21.66

- **Enoxaparin sodium 150 mg per 1 ml**
  - **Inhixa** 120mg/0.8ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (PFS) £79.14 DT = £97.93

### Indications and Dose

- **Prevention of clotting in extracorporeal circuits**
  - **To the device as a flush**
  - **Child:** (consult product literature)

- **Maintenance of neonatal umbilical arterial catheter**
  - **By intravenous infusion**
  - **Neonate:** 0.5 unit/hour.

**Treatment of thrombotic episodes**

- **By intravenous injection**
  - **Neonate up to 35 weeks corrected gestational age:** Initially 50 units/kg, then (by continuous intravenous infusion) 25 units/kg/hour, adjusted according to APTT.
  - **Child 1-11 months:** Initially 75 units/kg, then (by continuous intravenous infusion) 25 units/kg/hour, adjusted according to APTT
  - **Child 1-7 years:** Initially 75 units/kg, then (by continuous intravenous infusion) 20 units/kg/hour, adjusted according to APTT
  - **By subcutaneous injection**
    - **Child:** 250 units/kg twice daily, adjusted according to APTT

**Prophylaxis of thrombotic episodes**

- **By subcutaneous injection**
  - **Child:** 100 units/kg twice daily (max. per dose 5000 units), adjusted according to APTT

**Maintenance of cardiac shunts and critical stents**

- **To the device as a flush**
  - **Child:** (consult local protocol)

### Unlicensed Use

- **Check product literature for licensed use in children.**

### Interactions

- **Appendix 1: heparin (unfractionated)**

### Side-Effects

- **Adrenal insufficiency. hypokalaemia. rebound hyperlipidaemia**

### Pregnancy

- **Does not cross the placenta: maternal osteoporosis reported after prolonged use; multidose vials may contain benzyl alcohol—some manufacturers advise avoid.**

### Breast Feeding

- **Not excreted into milk due to high molecular weight.**

### Heparin Impairment

- **Manufacturer advises caution; consider avoiding in severe impairment (increased risk of bleeding complications).**

### Dose Adjustments

- **Manufacturer advises consider dose reduction if used in severe impairment.**

### Renal Impairment

- **Dose adjustments**
  - **Risk of bleeding increased in severe impairment—dose may need to be reduced.**

### Directions for Administration

- **For continuous intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%.**

- **In neonates**
  - **For maintenance of neonatal umbilical arterial catheter,** dilute 50 units to a final volume of 50 mL with Sodium Chloride 0.45% or use ready-made bag containing 500 units in 500 mL Sodium Chloride 0.9%; infuse at 0.5 mL/hour. **For neonatal intensive care (treatment of thrombosis),** dilute 1250 units/kg body-weight to a final volume of 50 mL with infusion fluid; an intravenous
infusion rate of 1 mL/hour provides a dose of 25 units/kg/hour.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, solution for infusion

  **Solution for injection**

  **EXCIPIENTS:** May contain Benzyl alcohol  
  - Heparin (unfractionated) (Non-proprietary)  
  - Heparin sodium 1000 unit per 1 mL Heparin sodium 1,000 units/mL solution for injection ampoules | 10 ampoule (Pre) £14.85 DT = £14.85  
  - Heparin sodium 5,000 units/mL solution for injection vials | 10 vial (Pre) £16.50–£37.41 DT = £16.50  
  - Heparin sodium 20,000 units/mL solution for injection vials | 10 ampoule (Pre) £70.86 DT = £70.86  
  - Heparin sodium 5,000 units/mL solution for injection ampoules | 10 ampoule (Pre) £37.47 DT = £37.47  
  - Heparin sodium 10,000 units/mL solution for injection ampoules | 10 ampoule (Pre) £65.59 DT = £65.59  
  - Heparin sodium 5000 unit per 1 mL | 10 ampoule (Pre) £29.04 DT = £29.04  
  - Heparin sodium 25,000 units/mL solution for injection vials | 10 vial (Pre) £45.00–£84.60 DT = £45.00  
  - Heparin sodium 25,000 units/mL solution for injection ampoules | 10 ampoule (Pre) £75.76 DT = £75.76  
  - Heparin calcium 2500 unit per 1 mL Heparin calcium 5,000 units/0.2 mL solution for injection ampoules | 10 ampoule (Pre) £44.70 DT = £44.70  
  - Heparin sodium 25,000 units/mL solution for injection ampoules | 10 ampoule (Pre) £76.95 DT = £76.95  
  - Heparin sodium 5,000 units/mL solution for injection ampoules | 10 ampoule (Pre) £37.35 DT = £37.35

- **Intravenous flush**

  **EXCIPIENTS:** May contain Benzyl alcohol  
  - Heparin (unfractionated) (Non-proprietary)  
  - Heparin sodium 10 unit per 1 mL Heparin sodium 50 units/5 mL patency solution ampoules | 10 ampoule (Pre) £14.96 DT = £14.96  
  - Heparin sodium 50 units/5 mL I.V. flush solution ampoules | 10 ampoule (Pre) £14.96 DT = £14.96  
  - Heparin sodium 100 unit per 1 mL Heparin sodium 200 units/2 mL I.V. flush solution ampoules | 10 ampoule (Pre) £15.68 DT = £15.68  
  - Heparin sodium 200 units/2 mL patency solution ampoules | 10 ampoule (Pre) £15.68 DT = £15.68

- **Infusion**

  **EXCIPIENTS:** May contain Benzyl alcohol  
  - Heparin (unfractionated) (Non-proprietary)  
  - Heparin sodium 2 unit per 1 mL Heparin sodium 1,000 units/500 mL infusion Viaflex bags | 1 bag (Pre) £15  
  - Heparin sodium 2,000 units/1 litre infusion Viaflex bags | 1 bag (Pre) £25  
  - Heparin sodium 5 unit per 1 mL Heparin sodium 5,000 units/1 litre infusion Viaflex bags | 1 bag (Pre) £45

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**Tinzaparin sodium**

06-Aug-2018

- **INDICATIONS AND DOSE**

  **Treatment of thrombotic episodes**  
  - **BY SUBCUTANEOUS INJECTION**  
    - Child 1 month: 275 units/kg once daily  
    - Child 2-11 months: 250 units/kg once daily  
    - Child 1-4 years: 240 units/kg once daily  
    - Child 5-9 years: 200 units/kg once daily  
    - Child 10-17 years: 175 units/kg once daily

  **Treatment of venous thromboembolism in pregnancy**  
  - **BY SUBCUTANEOUS INJECTION**  
    - Child 12-17 years: 175 units/kg once daily, dose based on early pregnancy body-weight

- **Prophylaxis of thrombotic episodes**  
  - **BY SUBCUTANEOUS INJECTION**  
    - Child: 50 units/kg once daily


- **INTERACTIONS**  
  → Appendix 1: low molecular-weight heparins

  **SIDE-EFFECTS**

  - Common or very common Anaemia  
  - Rare or very rare Angioedema • Stevens-Johnson syndrome

  **PREGNANCY** Not known to be harmful, low molecular weight heparins do not cross the placenta. Vials contain benzyl alcohol—manufacturer advises avoid.

  **BREAST FEEDING** Due to the relatively high molecular weight of tinzaparin and inactivation in the gastrointestinal tract, passage into breast-milk and absorption by the nursing infant are likely to be negligible; however, manufacturer advise avoid.

  **RENAL IMPAIRMENT** Risk of bleeding may be increased. Unfractionated heparin may be preferable. Manufacturer advises caution if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

  **MONITORING REQUIREMENTS** Routine monitoring of anti-Factor Xa activity is not usually required except in neonates; monitoring may also be necessary in severely ill children and those with renal or hepatic impairment.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  **Solution for injection**

  **EXCIPIENTS:** May contain Benzyl alcohol, sulfites  
  - Tinzaparin sodium (Non-proprietary)  
    - Tinzaparin sodium 10,000 unit per 1 mL Tinzaparin sodium 3,500 units/0.35 mL solution for injection pre-filled syringes | 10 pre-filled disposable injection (Pre) £27.71 DT = £27.71  
    - Tinzaparin sodium 4,500 units/0.45 mL solution for injection pre-filled syringes | 10 pre-filled disposable injection (Pre) £35.63 DT = £35.63  
    - Tinzaparin sodium 2,500 units/0.25 mL solution for injection pre-filled syringes | 10 pre-filled disposable injection (Pre) £19.80 DT = £19.80  
    - Innohep (LEO Pharma)  
      - Tinzaparin sodium 10,000 unit per 1 mL Innohep 20,000 units/2 ml solution for injection vials | 10 vial (Pre) £105.66 DT = £105.66  
      - Tinzaparin sodium 20,000 unit per 1 mL Innohep 18,000 units/0.9 ml solution for injection pre-filled syringes | 10 pre-filled disposable injection (Pre) £64.25 DT = £64.25  
      - Innohep 40,000 units/2 ml solution for injection vials | 1 vial (Pre) £107.08 DT = £107.08  
      - Innohep 8,000 units/0.4 ml solution for injection pre-filled syringes | 6 pre-filled disposable injection (Pre) £28.56 DT = £28.56  
      - Innohep 16,000 units/0.8 ml solution for injection pre-filled syringes | 6 pre-filled disposable injection (Pre) £57.12 DT = £57.12  
      - Innohep 40,000 units/2 ml solution for injection vials | 1 vial (Pre) £34.20 DT = £34.20  
      - Innohep 16,000 units/0.8 ml solution for injection pre-filled syringes | 6 pre-filled disposable injection (Pre) £83.30 DT = £83.30  
      - Innohep 10,000 units/0.5 ml solution for injection pre-filled syringes | 6 pre-filled disposable injection (Pre) £59.50 DT = £59.50

**ANTITHROMBOTIC DRUGS**

**VITAMIN K ANTAGONISTS**

**IMIMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRALS TO TREAT CHRONIC HEPATITIS C: RISK OF INTERACTION WITH VITAMIN K ANTAGONISTS AND CHANGES IN INR (JANUARY 2017)

A EU-wide review has identified that changes in liver function, secondary to hepatitis C treatment with direct-acting antivirals, may affect the efficacy of vitamin K antagonists; the MHRA has advised that INR should be...
monitored closely in patients receiving concomitant treatment.

- **CONTRA-INDICATIONS** Avoid use within 48 hours postpartum · haemorrhagic stroke · significant bleeding
- **CAUTIONS** Bacterial endocarditis (use only if warfarin otherwise indicated) · conditions in which risk of bleeding is increased · history of gastrointestinal bleeding · hyperthyroidism · hypothyroidism · peptic ulcer · postpartum (delay warfarin until risk of haemorrhage is low—usually 5–7 days after delivery) · recent ischaemic stroke · recent surgery · uncontrolled hypertension

- **SIDE-EFFECTS**
  - Common or very common Haemorrhage
  - Rare or very rare Alopecia · nausea · vomiting
  - Frequency not known Blue toe syndrome · CNS haemorrhage · diarrhoea · fever · haemothorax · jaundice · pancreatitis · skin necrosis (increased risk in patients with protein C or protein S deficiency) · skin reactions

- **CONCEPTION AND CONTRA-CONCEPTION** Women of child-bearing age should be warned of the danger of teratogenicity.

- **PREGNANCY** Should not be given in the first trimester of pregnancy. Warfarin, acenocoumarol, and phenindione cross the placenta with risk of congenital malformations, and placental, fetal, or neonatal haemorrhage, especially during the last few weeks of pregnancy and at delivery. Therefore, if at all possible, they should be avoided in pregnancy, especially in the first and third trimesters (difficult decisions may have to be made, particularly in women with prosthetic heart valves, atrial fibrillation, or with a history of recurrent venous thrombosis or pulmonary embolism). Stopping these drugs before the sixth week of gestation may largely avoid the risk of fetal abnormality.

- **HEPATIC IMPAIRMENT** In general, manufacturers advise caution in mild to moderate impairment; avoid in severe impairment.

- **MONITORING REQUIREMENTS**
  - The base-line prothrombin time should be determined but the initial dose should not be delayed whilst awaiting the result.
  - It is essential that the INR be determined daily or on alternate days in early days of treatment, then at longer intervals (depending on response), then up to every 12 weeks.
  - Change in patient’s clinical condition, particularly associated with liver disease, intercurrent illness, or drug administration, necessitates more frequent testing.

- **PATIENT AND CARER ADVICE** Anticoagulant treatment booklets should be issued to all patients or their carers; these booklets include advice for patients on anticoagulant treatment, an alert card to be carried by the patient at all times, and a section for recording of INR results and dosage information. In England, Wales, and Northern Ireland, they are available for purchase from: 3M Security Print and Systems Limited Gorse Street, Chadderton Oldham OL9 9QH Tel: 0845 610 1112 CP practices can obtain supplies through their Local Area Team stores. NHS Trusts can order supplies from www.nhsforms.co.uk or by emailing nhsforms@spsl.uk.com. In Scotland, treatment booklets and starter information packs can be obtained by emailing stockorders.DPPAS@apsgroup.co.uk or by fax on (0131) 6299 967. Electronic copies of the booklets and further advice are also available at www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/anticoagulant.

### Warfarin sodium

#### INDICATIONS AND DOSE

**Treatment and prophylaxis of thrombotic episodes (induction)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
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<tbody>
<tr>
<td><strong>Child</strong></td>
<td>by mouth</td>
<td>Initially 200 micrograms/kg (max. per dose 10 mg) for 1 dose on day 1, then reduced to 100 micrograms/kg once daily (max. per dose 5 mg) for the following 3 days, subsequent doses adjusted according to INR levels, induction dose may need to be altered according to condition (e.g. abnormal liver function tests, cardiac failure), concomitant interacting drugs, and if baseline INR above 1.3.</td>
</tr>
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<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neonate</strong> (initiated under specialist supervision)</td>
<td>by mouth</td>
<td>200 micrograms/kg once daily</td>
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<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
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</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td>by mouth</td>
<td>200 micrograms/kg once daily (max. per dose 10 mg)</td>
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</tbody>
</table>

#### Treatment and prophylaxis of thrombotic episodes following induction dose (if INR still below 1.4)

<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neonate</strong> (under expert supervision)</td>
<td>by mouth</td>
<td>50 micrograms/kg once daily</td>
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<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
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</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td>by mouth</td>
<td>50 micrograms/kg once daily (max. per dose 2.5 mg)</td>
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</table>

#### Treatment and prophylaxis of thrombotic episodes following induction dose (if INR above 3.5)

<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neonate</strong> (under expert supervision)</td>
<td>by mouth</td>
<td>Dose to be omitted.</td>
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<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td>by mouth</td>
<td>Dose to be omitted.</td>
</tr>
</tbody>
</table>

#### Treatment and prophylaxis of thrombotic episodes (usual maintenance)

<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neonate</strong> (under expert supervision)</td>
<td>by mouth</td>
<td>Maintenance 100–300 micrograms/kg once daily, doses up to 400 micrograms/kg once daily may be required especially if bottle fed, to be adjusted according to INR.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type</th>
<th>Method</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td>by mouth</td>
<td>Maintenance 100–300 micrograms/kg once daily, doses up to 400 micrograms/kg once daily may be required especially if bottle fed, to be adjusted according to INR</td>
</tr>
</tbody>
</table>

### IMPORTANT SAFETY INFORMATION

**MHRA/CHM ADVICE: WARFARIN: REPORTS OF CALCIPHYLAXIS (JULY 2016)**

An EU-wide review has concluded that on rare occasions, warfarin use may lead to calciphylaxis—patients should be advised to consult their doctor if they develop a painful skin rash; if calciphylaxis is diagnosed, appropriate treatment should be started and consideration should be given to stopping treatment with warfarin. The MHRA has advised that calciphylaxis is most commonly observed in patients with known risk.
Factors such as end-stage renal disease, however, cases have also been reported in patients with normal renal function.

- **INTERACTIONS** → Appendix 1: coumarins
- **SIDE-EFFECTS** Calciphylaxis - hepatic function abnormal
- **PREGNANCY** Babies of mothers taking warfarin at the time of delivery need to be offered immediate prophylaxis with intramuscular phytonadione (vitamin K₁).
- **BREAST FEEDING** Not present in milk in significant amounts and appears safe. Risk of haemorrhage which is increased by vitamin K deficiency.
- **RENAL IMPAIRMENT** Use with caution in mild to moderate impairment. Monitoring In severe renal impairment, monitor INR more frequently.
- **PRESCRIBING AND DISPENSING INFORMATION** Dietary differences. Infant formula is supplemented with vitamin K₁, which makes formula-fed infants resistant to warfarin; they may therefore need higher doses. In contrast breast milk contains low concentrations of vitamin K making breast-fed infants more sensitive to warfarin.

- **PATIENT AND CARER ADVICE** Anticoagulant card to be provided.


- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

**Oral suspension**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin sodium (Non-proprietary)</td>
<td></td>
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<tr>
<td>Warfarin sodium 1 mg per 1 ml</td>
<td>150 ml</td>
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<th>Tablet</th>
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<tbody>
<tr>
<td>**CAUTIONARY AND ADVISORY LABELS</td>
</tr>
<tr>
<td>Warfarin sodium (Non-proprietary)</td>
</tr>
<tr>
<td>Warfarin sodium 500 microgram</td>
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<tr>
<td>Warfarin sodium 1 mg</td>
</tr>
<tr>
<td>Warfarin sodium 3 mg</td>
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<tr>
<td>Warfarin sodium 4 mg</td>
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<tr>
<td>Warfarin sodium 5 mg</td>
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**Blood pressure conditions**

**4.1 Hypertension**

**Hypertension**

**Overview**

Hypertension in children and adolescents can have a substantial effect on long-term health. Possible causes of hypertension (e.g. congenital heart disease, renal disease and endocrine disorders) and the presence of any complications (e.g. left ventricular hypertrophy) should be established. Treatment should take account of contributory factors and any factors that increase the risk of cardiovascular complications.

Serious hypertension is rare in neonates but it can present with signs of congestive heart failure; the cause is often renal and can follow embolic arterial damage.

Children (or their parents or carers) should be given advice on lifestyle changes to reduce blood pressure or cardiovascular risk; these include weight reduction (in obese children), reduction of dietary salt, reduction of total and saturated fat, increasing exercise, increasing fruit and vegetable intake, and not smoking.

Indications for antihypertensive therapy in children include symptomatic hypertension, secondary hypertension, hypertensive target-organ damage, diabetes mellitus, persistent hypertension despite lifestyle measures, and pulmonary hypertension. The effect of antihypertensive treatment on growth and development is not known; treatment should be started only if benefits are clear.

Antihypertensive therapy should be initiated with a single drug at the lowest recommended dose; the dose can be increased until the target blood pressure is achieved. Once the highest recommended dose is reached, or sooner if the patient begins to experience side effects, a second drug may be added if blood pressure is not controlled. If more than one drug is required, these should be given as separate products to allow dose adjustment of individual drugs, but fixed-dose combination products may be useful in adolescents if compliance is a problem.

Acceptable drug classes for use in children with hypertension include ACE inhibitors, beta-blockers, calcium-channel blockers, and thiazide diuretics. There is limited information on the use of angiotensin-II receptor antagonists in children. Diuretics and beta-blockers have a long history of safety and efficacy in children. The newer classes of antihypertensive drugs, including ACE inhibitors and calcium-channel blockers have been shown to be safe and effective in short-term studies in children. Refractory hypertension may require additional treatment with agents such as minoxidil p. 119 or clonidine hydrochloride p. 103.

**Cardiovascular risk reduction**

Aspirin p. 93 may be used to reduce the risk of cardiovascular events; however, concerns about an increased risk of bleeding and Reye’s syndrome need to be considered.

A statin can be of benefit in older children who have a high risk of cardiovascular disease and have hypercholesterolaemia.

**Hypertension in diabetes**

Hypertension can occur in type 2 diabetes and treatment prevents both macrovascular and microvascular complications. ACE inhibitors may be considered in children with diabetes and microalbuminuria or proteinuric renal disease. Beta-blockers are best avoided in children with, or at a high risk of developing, diabetes, especially when combined with a thiazide diuretic.

**Hypertension in renal disease**

ACE inhibitors may be considered in children with microalbuminuria or proteinuric renal disease. High doses of loop diuretics may be required. Specific cautions apply to the use of ACE inhibitors in renal impairment, but ACE inhibitors may be effective. Dihydropyridine calcium-channel blockers may be added.

**Hypertension in pregnancy**

High blood pressure in pregnancy may usually be due to pre-existing essential hypertension or to pre-eclampsia. Methyl dopa is safe in pregnancy. Beta-blockers are effective and safe in the third trimester. Modified-release preparations of nifedipine p. 111 [unlicensed] are also used for hypertension in pregnancy. Intravenous administration of labetalol hydrochloride p. 105 can be used to control hypertensive crises; alternatively hydralazine hydrochloride p. 118 can be given by the intravenous route.
Hypertensive emergencies

Hypertensive emergencies in children may be accompanied by signs of hypertensive encephalopathy, including seizures. Controlled reduction in blood pressure over 72–96 hours is essential; rapid reduction can cause perfusion leading to organ damage. Treatment should be initiated with intravenous drugs; once blood pressure is controlled, oral therapy can be started. It may be necessary to infuse fluids particularly during the first 12 hours to expand plasma volume should the blood pressure drop too rapidly.

Controlled reduction of blood pressure is achieved by intravenous administration of labetalol hydrochloride or sodium nitroprusside p. 120. Esmolol hydrochloride p. 108 is useful for short-term use and has a short duration of action. Nicardipine hydrochloride p. 110 can be administered as a continuous intravenous infusion for life-threatening hypertension in paediatric intensive care settings. In less severe cases, nifedipine capsules can be used.

Other antihypertensive drugs which can be given intravenously include hydralazine hydrochloride and clonidine hydrochloride.

Hypertension in acute nephritis occurs as a result of sodium and water retention; it should be treated with sodium and fluid restriction, and with furosemide p. 142; antihypertensive drugs may be added if necessary.

Also see advice on short-term management of hypertensive episodes in pheochromocytoma.

Phaeochromocytoma

Long-term management of phaeochromocytoma involves surgery. However, surgery should not take place until there is adequate blockade of both alpha- and beta-adrenoceptors. Alpha-blockers are used in the short-term management of hypertensive episodes in pheochromocytoma. Once alpha blockade is established, tachycardia can be controlled by the cautious addition of a beta-blocker; a cardioselective beta-blocker is preferred. There is no nationwide consensus on the optimal drug regimen or doses used for the management of pheochromocytoma.

Phenoxybenzamine hydrochloride p. 119, a powerful alpha-blocker, is effective in the management of phaeochromocytoma but it has many side-effects.

Pulmonary hypertension

Only pulmonary arterial hypertension is currently suitable for drug treatment. Pulmonary arterial hypertension includes persistent pulmonary hypertension of the newborn, idiopathic pulmonary arterial hypertension in children, and pulmonary hypertension related to congenital heart disease and cardiac surgery.

Some types of pulmonary hypertension are treated with vasodilator antihypertensive therapy and oxygen. Diuretics may also have a role in children with right-sided heart failure.

Initial treatment of persistent pulmonary hypertension of the newborn involves the administration of nitric oxide; epoprostenol p. 120 can be used until nitric oxide is available. Oral sildenafil p. 122 may be helpful in less severe cases. Epoprostenol and sildenafil can cause profound systemic hypotension. In rare circumstances either tolazoline p. 123 or magnesium sulfate p. 618 can be given by intravenous infusion when nitric oxide and epoprostenol have failed.

Treatment of idiopathic pulmonary arterial hypertension is determined by acute vasodilator testing; drugs used for treatment include calcium-channel blockers (usually nifedipine), long-term intravenous epoprostenol, nebulised iloprost p. 121, bosentan p. 121, or sildenafil.

Anticoagulation (usually with warfarin sodium p. 99) may also be required to prevent secondary thrombosis.

Inhaled nitric oxide is a potent and selective pulmonary vasodilator. It acts on cyclic guanosine monophosphate (cGMP) resulting in smooth muscle relaxation. Inhaled nitric oxide is used in the treatment of persistent pulmonary hypertension of the newborn, and may also be useful in other forms of arterial pulmonary hypertension. Dependency can occur with high doses and prolonged use; to avoid rebound pulmonary hypertension the drug should be withdrawn gradually, often with the aid of sildenafil p. 122.

Excess nitric oxide can cause methaemoglobinaemia; therefore, methaemoglobin concentration should be measured regularly, particularly in neonates.

Nitric oxide increases the risk of haemorrhage by inhibiting platelet aggregation, but it does not usually cause bleeding.

Epoprostenol p. 120 (prostacyclin) is a prostaglandin and a potent vasodilator. It is used in the treatment of persistent pulmonary hypertension of the newborn, idiopathic pulmonary arterial hypertension, and in the acute phase following cardiac surgery. It is given by continuous 24-hour intravenous infusion.

Epoprostenol is a powerful inhibitor of platelet aggregation and there is a possible risk of haemorrhage. It is sometimes used as an antiplatelet in renal dialysis when heparins are unsuitable or contra-indicated. It can also cause serious systemic hypotension and, if withdrawn suddenly, can cause pulmonary hypertensive crisis.

Children on prolonged treatment can become tolerant to epoprostenol, and therefore require an increase in dose.

Iloprost p. 121 is a synthetic analogue of epoprostenol and is efficacious when nebulised in adults with pulmonary arterial hypertension, but experience in children is limited. It is more stable than epoprostenol and has a longer half-life.

Bosentan p. 121 is a dual endothelin receptor antagonist used orally in the treatment of pulmonary arterial hypertension. The concentration of endothelin, a potent vasoconstrictor, is raised in sustained pulmonary hypertension.

Sildenafil, a vasodilator developed for the treatment of erectile dysfunction, is also used for pulmonary arterial hypertension. It is used either alone or as an adjunct to other drugs.

Sildenafil is a selective phosphodiesterase type-5 inhibitor. Inhibition of this enzyme in the lungs enhances the vasodilatory effects of nitric oxide and promotes relaxation of vascular smooth muscle.

Sildenafil has also been used in pulmonary hypertension for weaning children off inhaled nitric oxide following cardiac surgery, and less successfully in idiopathic pulmonary arterial hypertension.

Tolazoline p. 123 is now rarely used to correct pulmonary artery vasospasm in pulmonary hypertension of the newborn as better alternatives are available. Tolazoline is an alpha-blocker and produces both pulmonary and systemic vasodilation.

Advanced Pharmacy Services

Children with hypertension may be eligible for the New Medicines Service / Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

Antihypertensive drugs

Vasodilator antihypertensive drugs

Vasodilators have a potent hypotensive effect, especially when used in combination with a beta-blocker and a thiazide. Important: see Hypertension (hypertensive emergencies) for a warning on the hazards of a very rapid fall in blood pressure.

Hydralazine hydrochloride p. 118 is given by mouth as an adjunct to other antihypertensives for the treatment of
resistant hypertension but is rarely used; when used alone it causes tachycardia and fluid retention. Sodium nitroprusside p. 120 is given by intravenous infusion to control severe hypertensive crisis when parental treatment is necessary. At low doses it reduces systemic vascular resistance and increases cardiac output; at high doses it can produce profound systemic hypotension—continuous blood pressure monitoring is therefore essential. Sodium nitroprusside may also be used to control paradoxical hypertension after surgery for coarctation of the aorta.

Minoxidil p. 119 should be reserved for the treatment of severe hypertension resistant to other drugs. Vasodilatation is accompanied by increased cardiac output and tachycardia and children develop fluid retention. For this reason the addition of a beta-blocker and a diuretic (usually furosemide p. 142, in high dosage) are mandatory. Hypertrichosis is troublesome and renders this drug unsuitable for females. Prazosin p. 103 and doxazosin p. 509 have alpha-blocking and vasodilator properties.

**Centrally acting antihypertensive drugs**

Methyldopa, a centrally acting antihypertensive, is of little value in the management of refractory sustained hypertension in infants and children. On prolonged use it is associated with fluid retention (which may be alleviated by concomitant use of diuretics).

Methyldopa is also effective for the management of hypertension in pregnancy.

Clonidine hydrochloride p. 103 is also a centrally acting antihypertensive but has the disadvantage that sudden withdrawal may cause a hypertensive crisis. Clonidine hydrochloride is also used under specialist supervision for pain management, sedation, and opioid withdrawal, attention deficit hyperactivity disorder, and Tourette syndrome.

**Adrenergic neurone blocking drugs**

Adrenergic neurone blocking drugs prevent the release of noradrenaline from postganglionic adrenergic neurones. These drugs do not control supine blood pressure and may cause postural hypotension. For this reason they have largely fallen from use in adults and are rarely used in children.

**Alpha-adrenoceptor blocking drugs**

Doxazosin and prazosin have post-synaptic alpha-blocking and vasodilator properties and rarely cause tachycardia. They can, however, reduce blood pressure rapidly after the first dose and should be introduced with caution. Alpha-blockers can be used with other antihypertensive drugs in the treatment of resistant hypertension.

### Drugs affecting the renin-angiotensin system

#### Angiotensin-converting enzyme inhibitors

Angiotensin-converting enzyme inhibitors (ACE inhibitors) inhibit the conversion of angiotensin I to angiotensin II. The main indications of ACE inhibitors in children are shown below. In infants and young children, captopril p. 114 is often considered first.

**Initiation under specialist supervision**

Treatment with ACE inhibitors should be initiated under specialist supervision and with careful clinical monitoring in children.

**Heart failure**

ACE inhibitors have a valuable role in all grades of heart failure, usually combined with a loop diuretic. Potassium supplements and potassium-sparing diuretics should be discontinued before introducing an ACE inhibitor because of the risk of hyperkalaemia. Profound first-dose hypotension can occur when ACE inhibitors are introduced to children with heart failure who are already taking a high dose of a loop diuretic. Temporary withdrawal of the loop diuretic reduces the risk, but can cause severe rebound pulmonary oedema.

**Hypertension**

ACE inhibitors may be considered for hypertension when thiazides and beta-blockers are contra-indicated, not tolerated, or fail to control blood pressure; they may be considered for hypertension in children with type 1 diabetes with nephropathy. ACE inhibitors can reduce blood pressure very rapidly in some patients particularly in those receiving diuretic therapy.

**Diabetic nephropathy**

ACE inhibitors also have a role in the management of diabetic nephropathy.

**Renal effects**

Renal function and electrolytes should be checked before starting ACE inhibitors (or increasing the dose) and monitored during treatment (more frequently if features mentioned below are present). Hyperkalaemia and other side-effects of ACE inhibitors are more common in children with impaired renal function and the dose may need to be reduced.

Concomitant treatment with NSAIDs increases the risk of renal damage, and potassium-sparing diuretics (or potassium-containing salt substitutes) increase the risk of hyperkalaemia.

In children with severe bilateral renal artery stenosis (or severe stenosis of the artery supplying a single functioning kidney), ACE inhibitors reduce or abolish glomerular filtration and are likely to cause severe and progressive renal failure. They are therefore contra-indicated in children known to have these forms of critical renovascular disease.

ACE inhibitor treatment is unlikely to have an adverse effect on overall renal function in children with severe unilateral renal artery stenosis and a normal contralateral kidney, but glomerular filtration is likely to be reduced (or even abolished) in the affected kidney and the long-term consequences are unknown.

ACE inhibitors are therefore best avoided in those with known or suspected renovascular disease, unless the blood pressure cannot be controlled by other drugs. If they are used in these circumstances renal function needs to be monitored.

ACE inhibitors should also be used with particular caution in children who may have undiagnosed and clinically silent renovascular disease. ACE inhibitors are useful for the management of hypertension and proteinuria in children with nephritis. They are thought to have a beneficial effect by reducing intra-glomerular hypertension and protecting the glomerular capillaries and membrane.

**ACE inhibitors in combination with other drugs**

**Concomitant diuretics**

ACE inhibitors can cause a very rapid fall in blood pressure in volume-depleted children; treatment should therefore be initiated with very low doses. In some children the diuretic dose may need to be reduced or the diuretic discontinued at least 24 hours beforehand (may not be possible in heart failure—risk of pulmonary oedema). If high-dose diuretic therapy cannot be stopped, close observation is recommended after administration of the first dose of ACE inhibitor, for at least 2 hours or until the blood pressure has stabilised.

**Angiotensin-II receptor antagonists**

Candesartan cilostelit p. 117, losartan potassium p. 117 and valsartan p. 118 are specific angiotensin-II receptor blockers.
antagonists with many properties similar to those of the ACE inhibitors. However, unlike ACE inhibitors, they do not inhibit the breakdown of bradykinin and other kinins, and thus are less likely to cause the persistent dry cough which can complicate ACE inhibitor therapy. They are therefore a useful alternative for children who have to discontinue an ACE inhibitor because of persistent cough.

Candesartan cilexetil, losartan potassium or valsartan can be used as an alternative to an ACE inhibitor in the management of hypertension.

Renal effects
Angiotensin-II receptor antagonists should be used with caution in renal artery stenosis (see also Renal effects under ACE Inhibitors, above).

Neonates
The neonatal response to treatment with ACE inhibitors is very variable, and some neonates develop profound hypotension with even small doses; a test-dose should be used initially and increased cautiously. Adverse effects such as apnoea, seizures, renal failure, and severe unpredictable hypotension are very common in the first month of life and it is therefore recommended that ACE inhibitors are avoided whenever possible, particularly in preterm neonates.

Other drugs used for Hypertension

### ALPHA-ADRENOCOCEPTOR BLOCKERS

#### Prazosin

- **INDICATIONS AND DOSE**

  **Hypertension**
  - Child 1 month–11 years: Initially 10–15 micrograms/kg 2–4 times a day, initial dose to be taken at bedtime, then increased to 500 micrograms/kg daily in divided doses, dose to be increased gradually; maximum 20 mg per day
  - Child 12–17 years: Initially 500 micrograms 2–3 times a day for 3–7 days, initial dose to be taken at bedtime, then increased to 1 mg 2–3 times a day for a further 3–7 days, then increased if necessary up to 20 mg daily in divided doses, dose should be increased gradually

  **Congestive heart failure (rarely used)**
  - **BY MOUTH**
    - Child 1 month–11 years: 5 micrograms/kg twice daily, initial dose to be taken at bedtime, then increased to 100 micrograms/kg daily in divided doses, doses should be increased gradually
    - Child 12–17 years: 500 micrograms 2–4 times a day, initial dose to be taken at bedtime, then increased to 4 mg daily in divided doses; maintenance 4–20 mg daily in divided doses

- **UNLICENSED USE** Not licensed for use in children under 12 years.

- **CONTRA-INDICATIONS** History of mitrurition syncope - history of postural hypotension - not recommended for congestive heart failure due to mechanical obstruction (e.g. aortic stenosis)

- **CAUTIONS** Cataract surgery (risk of intra-operative floppy iris syndrome) - first dose hypotension

- **INTERACTIONS** → Appendix 1: alpha blockers

- **SIDE-EFFECTS**
  - Common or very common Asthenia - constipation - depression - diarrhoea - dizziness - dryness - dry mouth - dyspnoea - headache - nasal congestion - nausea - nervousness - oedema - palpitations - postural hypotension - sexual dysfunction - skin reactions - syncope - urinary disorders - vertigo - vision blurred - vomiting
  - Uncommon Angina pectoris - arrhythmias - arthralgia - epistaxis - eye pain - eye redness - gastrointestinal discomfort - hyperhidrosis - paraesthesia - sleep disorders - tinnitus
  - Rare or very rare Alopecia - fever - flushing - gynaecomastia - hallucination - hepatic function abnormal - pain - pancreatitis - vasculitis

- **PREGNANCY** No evidence of teratogenicity; manufacturers advise use only when potential benefit outweighs risk.

- **BREAST FEEDING** Present in milk, amount probably too small to be harmful; manufacturer advises use with caution.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution (no information available).

- **Dose adjustments** In children 12 years and above, manufacturer advises initial dose reduction to 500 micrograms daily; increased with caution.

- **RENAL IMPAIRMENT** Dose adjustments Start with low doses in moderate to severe impairment; increase with caution.

- **DIRECTIONS FOR ADMINISTRATION** For administration by mouth, tablets may be dispersed in water.

- **PATIENT AND CARER ADVICE** First dose effect First dose may cause collapse due to hypotensive effect (therefore should be taken on retiring to bed). Driving and skilled tasks May affect performance of skilled tasks e.g. driving.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral suspension, oral solution

  **Tablet**
  - Prazosin (Non-proprietary)
    - Prazosin (as Prazosin hydrochloride) 2 mg Minipress 2mg tablets
    - 100 tablet [PS](£)
    - Prazosin (as Prazosin hydrochloride) 5 mg Minipress 5mg tablets
    - 100 tablet [PS](£)
    - Hypovase (Pfizer Ltd)
    - Prazosin (as Prazosin hydrochloride) 500 microgram Hypovase 500microgram tablets | 60 tablet [PS](£) £2.69 DT = £2.69
    - Prazosin (as Prazosin hydrochloride) 1 mg Hypovase 1mg tablets
    - 60 tablet [PS](£) £3.46 DT = £3.46

### ANTIHYPERTENSIVES, CENTRALLY ACTING

#### Clonidine hydrochloride

- **INDICATIONS AND DOSE**

  **Severe hypertension**
  - **BY MOUTH**
    - Child 2–7 years: Initially 0.5–1 microgram/kg 3 times a day, then increased if necessary up to 25 micrograms/kg daily in divided doses, increase dose gradually; maximum 1.2 mg per day
    - **BY SLOW INTRAVENOUS INJECTION**
      - Child 2–7 years: 2–6 micrograms/kg (max. per dose 300 micrograms) for 1 dose

- **UNLICENSED USE** Not licensed for use in children.

- **CONTRA-INDICATIONS** Severe bradyarrhythmia secondary to second- or third-degree AV block or sick sinus syndrome

- **CAUTIONS** Cerebrovascular disease - constipation - heart failure - history of depression - mild to moderate bradyarrhythmia - polynuropathy - Raynaud’s syndrome or other occlusive peripheral vascular disease

- **INTERACTIONS** → Appendix 1: clonidine
iali N D S

Common or very common Constipation; depression; dizziness; dry mouth; fatigue; headache; nausea; postural hypotension; salivary gland pain; sedation; sexual dysfunction; sleep disorders; vomiting

Uncommon Delusions; hallucination; malaise - paraesthesia; Raynaud’s phenomenon; skin reactions

Rare or very rare Alopecia; atrioventricular block; dry eye; gynaecomastia; intestinal pseudo-obstruction; nasal dryness

Frequent not known Accommodation disorder; arrhythmias; confusion

Pregnancy May lower fetal heart rate. Avoid oral use unless potential benefit outweighs risk. Avoid using injection.

Breast-feeding Avoid—present in milk.

Renal impairment Use with caution.

Treatment cessation Must be withdrawn gradually to avoid hypertensive crisis.

Directions for administration
- With intravenous use For intravenous injection, give over 10–15 minutes; compatible with Sodium Chloride 0.9% or Glucose 5%.
- With oral use For administration by mouth, tablets may be crushed and dissolved in water.

Patient and carer advice
Medicines for Children leaflet: Clonidine for Tourette’s syndrome, ADHD and sleep-onset disorder
- Driving and skilled tasks Drowsiness may affect performance of skilled tasks (e.g. driving); effects of alcohol may be enhanced.

Less suitable for prescribing Clonidine is less suitable for prescribing.

Medicinal forms There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution for injection

Tablet

Clonidine hydrochloride 10 microgram per 1 ml Catapres 10 microgram tablets | 100 tablet PBN £8.04 DT = £8.04

Solution for injection
- Catapres (Boehringer Ingelheim Ltd)

Clonidine hydrochloride 150 microgram per 1 ml Catapres 150 micrograms/1ml solution for injection ampoules | 5 ampoule PBN £2.09

Oral solution
- Clonidine hydrochloride (Non-proprietary)

Clonidine hydrochloride 10 microgram per 1 ml Clonidine 50 micrograms/5ml oral solution sugar free-sugar-free | 100 ml PBN £66.80 DT = £66.80

Beta-adrenoceptor blockers

Overview
Beta-adrenoceptor blocking drugs (beta-blockers) block the beta-adrenoceptors in the heart, peripheral vasculature, bronchi, pancreas, and liver.

Many beta-blockers are available but experience in children is limited to the use of only a few.

Differences between beta-blockers may affect choice. The water-soluble beta-blockers, atenolol p. 108 and sotalol hydrochloride p. 81, are less likely to enter the brain and may therefore cause less sleep disturbance and nightmares.

Water-soluble beta-blockers are excreted by the kidneys and dosage reduction is often necessary in renal impairment.

Some beta-blockers, such as atenolol, have an intrinsically longer duration of action and need to be given only once daily. Carvedilol p. 127 and labetalol hydrochloride p. 105 are beta-blockers which have, in addition, an arteriolar vasodilating action and thus lower peripheral resistance. Although carvedilol and labetalol hydrochloride possess both alpha- and beta-blocking properties, these drugs have no important advantages over other beta-blockers in the treatment of hypertension.

Beta-blockers slow the heart and can depress the myocardium; they are contra-indicated in children with second- or third-degree heart block.

Beta-blockers can precipitate asthma and should usually be avoided in children with a history of asthma or bronchospasm. If there is no alternative, a child with well-controlled asthma can be treated for a co-existing condition (e.g. arrhythmia) with a cardioselective beta-blocker, which should be initiated with caution at a low dose by a specialist and the child monitored closely for adverse effects. Atenolol and metoprolol tartrate p. 109 have less effect on the beta1 (bronchial) receptors and are, therefore, relatively cardioselective, but they are not cardioselective; they have a lesser effect on airways resistance but are not free of this side-effect.

Beta-blockers are also associated with fatigue, coldness of the extremities, and sleep disturbances with nightmares (may be less common with the water-soluble beta-blockers).

Beta-blockers can affect carbohydrate metabolism causing hypoglycaemia or hyperglycaemia in children with or without diabetes; they can also interfere with metabolic and autonomic responses to hypoglycaemia thereby masking symptoms such as tachycardia. However, beta-blockers are not contra-indicated in diabetes, although the cardioselective beta-blockers (e.g. atenolol and metoprolol tartrate) may be preferred. Beta-blockers should be avoided altogether in those with frequent episodes of hypoglycaemia.

Hypertension
Beta-blockers are effective for reducing blood pressure, but their mode of action is not understood; they reduce cardiac output, alter baroreceptor reflex sensitivity, and block peripheral adrenoceptors. Some beta-blockers depress plasma renin secretion. It is possible that a central effect may also partly explain their mode of action. Blood pressure can usually be controlled with relatively few side-effects. In general the dose of beta-blocker does not have to be high.

Labetalol hydrochloride may be given intravenously for hypertensive emergencies in children; however, care is needed to avoid dangerous hypotension or beta-blockade, particularly in neonates. Esmolol hydrochloride p. 108 is also used intravenously for the treatment of hypertension particularly in the peri-operative period.

Beta-blockers can be used to control the pulse rate in children with phaeochromocytoma. However, they should never be used alone as beta-blockade without concurrent alpha-blockade may lead to a hypertensive crisis; phenoxybenzamine hydrochloride p. 119 should always be used together with the beta-blocker.

Arrhythmias
In arrhythmias, beta-blockers act principally by attenuating the effects of the sympathetic system on automaticity and conductivity within the heart. They can be used alone or in conjunction with digoxin p. 82 to control the ventricular rate in atrial fibrillation. Beta-blockers are also useful in the management of supraventricular tachycardias and ventricular tachycardias particularly to prevent recurrence of the tachycardia.
Esmolol hydrochloride is a relatively cardioselective beta-blocker with a very short duration of action, used intravenously for the short-term treatment of supraventricular arrhythmias and sinus tachycardia, particularly in the peri-operative period.

Sotalol hydrochloride is a non-cardioselective beta-blocker with additional class III anti-arrhythmic activity. Atenolol and sotalol hydrochloride suppress ventricular ectopic beats and non-sustained ventricular tachycardia. However, the pro-arrhythmic effects of sotalol hydrochloride, particularly in children with sick sinus syndrome, may prolong the QT interval and induce torsade de pointes.

Heart failure
Beta-blockers may produce benefit in heart failure by blocking sympathetic activity and the addition of a beta-blocker such as carvedilol to other treatment for heart failure may be beneficial. Treatment should be initiated by those experienced in the management of heart failure.

Thyrotoxicosis
Beta-blockers are used in the management of thyrotoxicosis including neonatal thyrotoxicosis; propranolol hydrochloride p. 106 can reverse clinical symptoms within 4 days. Beta-blockers are also used for the pre-operative preparation for thyroidectomy; the thyroid gland is rendered less vascular, thus facilitating surgery.

Other uses
In tetralogy of Fallot, esmolol hydrochloride or propranolol hydrochloride may be given intravenously in the initial management of cyanotic spells; propranolol hydrochloride is given by mouth for preventing cyanotic spells. If a severe cyanotic spell in a child with congenital heart disease persists despite optimal use of 100% oxygen, propranolol hydrochloride is given by intravenous infusion. If cyanosis is still present after 10 minutes, sodium bicarbonate intravenous infusion p. 607 is given in a dose to correct acidosis (or dose calculated according to arterial blood gas results); sodium bicarbonate 4.2% intravenous infusion is appropriate for a child under 1 year and sodium bicarbonate 8.4% intravenous infusion in children over 1 year. If blood-glucose concentration is less than 3 mmol/litre, glucose 10% intravenous infusion is given, followed by intravenous or intramuscular administration of morphine p. 290.

Beta-blockers are also used in the prophylaxis of migraine. Betaxolol p. 705, levobunolol hydrochloride p. 706, and timolol maleate p. 706 are used topically in glaucoma.

**Beta-adrenoceptor blockers**

**Contra-indications** Asthma - cardiogenic shock - hypotension - marked bradycardia - metabolic acidosis - phaeochromocytoma (apart from specific use with alpha-blockers) - second-degree AV block - severe peripheral arterial disease - sick sinus syndrome - third-degree AV block - uncontrolled heart failure

**Contra-indications, further information**

- Bronchospasm Beta-blockers, including those considered to be cardioselective, should usually be avoided in patients with a history of asthma, bronchospasm or a history of obstructive airways disease. However, when there is no alternative, a cardioselective beta-blocker can be given to these patients with caution and under specialist supervision. In such cases the risk of inducing bronchospasm should be appreciated and appropriate precautions taken.

**Contra-indications** Diabetes - first-degree AV block - history of obstructive airways disease (introduce cautiously) - myasthenia gravis - portal hypertension (risk of deterioration in liver function) - psoriasis - symptoms of thyrotoxicosis may be masked

**Side-effects**

- **Common or very common** Abdominal discomfort - bradycardia - confusion - depression - diarrhoea - dizziness - dry eye (reversible on discontinuation) - dyspnoea - erectile dysfunction - fatigue - headache - heart failure - nausea - paraesthesia - peripheral coldness - peripheral vascular disease - rash (reversible on discontinuation) - sleep disorders - syncope - visual impairment - vomiting
- **Uncommon** Atrialventricular block - bronchospasm
- **Rare or very rare** Hallucination

**Side-effects, further information** With administration by intravenous injection, excessive bradycardia can occur and may be countered with intravenous injection of atropine sulfate.

**Overdose** Therapeutic overdosages with beta-blockers may cause lightheadedness, dizziness, and possibly syncope as a result of bradycardia and hypotension; heart failure may be precipitated or exacerbated. With administration by intravenous injection, excessive bradycardia can occur and may be countered with intravenous injection of atropine sulfate.

For details on the management of poisoning, see Beta-blockers, under Emergency treatment of poisoning p. 859.

**Allergy and cross-sensitivity** Caution is advised in patients with a history of hypersensitivity—may increase sensitivity to allergens and result in more serious hypersensitivity response. Furthermore beta-adrenoceptor blockers may reduce response to adrenaline (epinephrine).

**Pregnancy** Beta-blockers may cause intra-uterine growth restriction, neonatal hypoglycaemia, and bradycardia; the risk is greater in severe hypertension.

**Breast-feeding** With systemic use in the mother, infants should be monitored as there is a risk of possible toxicity due to beta-blockade. However, the amount of most beta-blockers present in milk is too small to affect infants.

**Treatment requirements** Monitor lung function (in patients with a history of obstructive airway disease).

**Treatment cessation** Avoid abrupt withdrawal.

**Beta-adrenoceptor blockers (systemic)**

**Indications and dose**

- **Hypertensive emergencies**
  - **By intravenous infusion**
    - Neonate: Initially 0.5 mg/kg/hour (max. per dose 4 mg/kg/hour), dose to be adjusted according to response at intervals of at least 15 minutes.
    - Child 1 month–11 years: Initially 0.5–1 mg/kg/hour (max. per dose 3 mg/kg/hour), dose to be adjusted according to response at intervals of at least 15 minutes
    - Child 12–17 years: Initially 20–120 mg/hour, dose to be adjusted according to response at intervals of at least 15 minutes

- **Hypertension**
  - **By mouth**
    - Child 1 month–11 years: 1–2 mg/kg 3–4 times a day
    - Child 12–17 years: Initially 50–100 mg twice daily, dose to be increased if required at intervals of 3–14 days; usual dose 200–400 mg twice daily, higher continued
**Blood pressure conditions**

**DIRECTIONS FOR ADMINISTRATION**

**Liver damage**

**REPAIRAL REQUIREMENTS**

**Renal impairment**

**Hepatic impairment**

**With oral use**

**Rare or very rare**

**SIDE-EFFECTS**

**INTERACTIONS**

**Apppendix 1: beta blockers, non-selective**

**INTERACTIONS**

**GENEAL SIDE-EFFECTS**

**Frequency not known**

**Allopoeia - cyanosis - hyperhidrosis - hyperkalaemia - interstitial lung disease - lethargy - muscle cramps - nasal congestion - peripheral oedema - postural hypotension - psychosis - skin reactions - thrombocytopenia**

**Specific side-effects**

**With intravenous use**

**With oral use**

**Photosensitivity reaction**

**Pregnancy**

**Breast feeding**

**Hepatic impairment**

**Manufacturer advises caution (risk of slow metabolism).**

**Dose adjustments**

**Manufacturer advises consider dose reduction.**

**Renal impairment**

**Dose adjustments**

**Dose reduction may be required.**

**Monitoring requirements**

**Liver damage**

**Severe hepatocellular damage reported after both short-term and long-term treatment.**

**Appropriate laboratory testing needed at first symptom of liver dysfunction and if laboratory evidence of damage (or if jaundice) labetalol should be stopped and not restarted.**

**Effect on laboratory tests**

**Interferes with laboratory tests for catecholamines.**

**DIRECTIONS FOR ADMINISTRATION**

**With intravenous use**

**For intravenous infusion, dilute to a concentration of 1 mg/mL in Glucose 5% or Sodium Chloride and Glucose 5%, if fluid restricted may be given undiluted, preferably through a central venous catheter. Avoid upright position during and for 3 hours after intravenous administration.**

**With oral use**

**For administration by mouth, injection may be given orally with squash or juice.**

**106 Unlicensed use**

Not licensed for use in children.

**Important safety information**

**With intravenous use**

**Consult local guidelines.**

In hypertensive encephalopathy reduce blood pressure to normotensive level over 24–48 hours (more rapid reduction may lead to cerebral infarction, blindness, and death). If child fitting, reduce blood pressure rapidly, but not to normal levels.

**Cautions**

Liver damage

**Interactions**

**Appendix 1: beta blockers, non-selective**

**Labetalol hydrochloride (Non-proprietary)**

**Solution for injection**

**Labetalol hydrochloride 5 mg per 1 ml Labetalol 100 mg/20ml solution for injection ampoules | 5 ampoule £78.05 Df = £77.01**

**Tablet CAUTIONARY AND ADVISORY LABELS 8, 21**

**Labetalol hydrochloride (Non-proprietary)**

**Labetalol hydrochloride 100 mg Labetalol 100mg tablets | 56 tablet £1.21 DT = £1.95**

**Labetalol hydrochloride 200 mg Labetalol 200mg tablets | 56 tablet £1.97 DT = £1.15**

**Labetalol hydrochloride 400 mg Labetalol 400mg tablets | 56 tablet £21.12 DT = £15.41**

**Trandate (RPH Pharmaceuticals AB) Labetalol hydrochloride 50 mg Trandate 50mg tablets | 56 tablet £3.79 DT = £3.79**

**Labetalol hydrochloride 100 mg Trandate 100mg tablets | 56 tablet £6.24 DT = £5.98 | 250 tablet £97.64 DT = £95.97**

**Labetalol hydrochloride 200 mg Trandate 200mg tablets | 56 tablet £6.71 DT = £79.13 | 250 tablet £24.76**

**Labetalol hydrochloride 400 mg Trandate 400mg tablets | 56 tablet £10.15 DT = £11.41**

**BETA-ADRENERGIC BLOCKERS NON-SELECTIVE**

**Propranolol hydrochloride 07-Feb-2018**

**INDICATIONS AND DOSE**

**Hyperthyroidism with autonomic symptoms**

**Neonate:**

**Initially 250–500 micrograms/kg every 6–8 hours, adjusted according to response.**

**Child:**

**Initially 250–500 micrograms/kg every 8 hours, adjusted according to response; increased if necessary up to 1 mg/kg every 8 hours (max. per dose 40 mg every 8 hours)**

**By intravenous injection**

**Neonate:**

**Initially 20–50 micrograms/kg every 6–8 hours, adjusted according to response, to be given over 10 minutes.**

**Child:**

**Initially 25–50 micrograms/kg every 6–8 hours (max. per dose 5 mg), adjusted according to response, to be given over 10 minutes**

**Thyrotoxicosis (adjunct)**

**By mouth**

**Neonate:**

**Initially 250–500 micrograms/kg every 6–8 hours, adjusted according to response.**

**Child:**

**Initially 250–500 micrograms/kg every 8 hours, adjusted according to response; increased if necessary up to 1 mg/kg every 8 hours (max. per dose 40 mg every 8 hours)**

**By intravenous injection**

**Neonate:**

**Initially 20–50 micrograms/kg every 6–8 hours, adjusted according to response, to be given over 10 minutes.**

**Child:**

**Initially 25–50 micrograms/kg every 6–8 hours (max. per dose 5 mg), adjusted according to response, to be given over 10 minutes.**

**Unlicensed use**

Not licensed for use in children.
Hypertension 107

**Thyrotoxic crisis**
- **BY MOUTH**
  - Neonate: Initially 250–500 micrograms/kg every 6–8 hours, adjusted according to response.
  - Child: Initially 250–500 micrograms/kg every 6–8 hours, adjusted according to response; increased if necessary up to 1 mg/kg every 8 hours (max. per dose 40 mg every 8 hours).
  - **BY INTRAVENOUS INJECTION**
  - Neonate: Initially 20–50 micrograms/kg every 6–8 hours, adjusted according to response, to be given over 10 minutes.
  - Child: Initially 25–50 micrograms/kg every 6–8 hours (max. per dose 5 mg), adjusted according to response, to be given over 10 minutes.

**Child 1 month**
- **BY MOUTH**
  - Initially 1 mg (max. per dose 3 mg).

**Neonate:**
- **BY MOUTH**
  - Initially 25–50 micrograms/kg every 6–8 hours (max. per dose 5 mg), adjusted according to response, to be given over 10 minutes.

**Child 12**
- **BY INTRAVENOUS INJECTION**
  - Initially 500 micrograms/kg every 6–8 hours (max. per dose 20 mg).

**DIRECTIONS FOR ADMINISTRATION**
- For slow intravenous injection, give over at least 3–5 minutes; rate of administration should not exceed 1 mg/minute. May be diluted with Sodium Chloride 0.9% or Glucose 5%.
- Incompatible with bicarbonate.

**PRESCRIBING AND DISPENSING INFORMATION**
- Modified-release preparations can be used for once daily administration.

**Medication system**
- Includes: oral suspension, oral modified-release capsules.

**Precautions**
- Not licensed for treatment of hypertension in children under 12 years.

**IMPORTANT SAFETY INFORMATION**
- Propranolol has been confused with prednisolone; care must be taken to ensure the correct drug is prescribed and dispensed.

**INTERACTIONS**
- Appendix 1: beta blockers, non-selective

**SIDE-EFFECTS**
- Rare or very rare: Alopecia, memory loss, mood altered, neuromuscular dysfunction, postural hypotension, psychosis, skin reactions, thrombocytopenia
- Frequency not known: Hypoglycaemia

**HEPATIC IMPAIRMENT**
- Reduced oral dose.

**RENAL IMPAIRMENT**
- Reduced oral dose.

**SAFE PRACTICE**
- Care must be taken to ensure the correct drug is prescribed and dispensed.

**Memory loss**
- Mood altered
- Thrombocytopenia

**Migraine prophylaxis**
- **BY MOUTH**
  - Child 2–11 years: Initially 200–500 micrograms/kg twice daily; usual dose 10–20 mg twice daily (max. per dose 2 mg/kg twice daily).
  - Child 12–17 years: Initially 80 mg twice daily; then increased if necessary up to 160–320 mg daily, dose should be increased at weekly intervals, slow-release preparations may be used for once daily administration.

**Arrhythmias**
- **BY MOUTH**
  - Neonate: 250–500 micrograms/kg 3 times a day, then increased if necessary up to 2 mg/kg 3 times a day.

**Child 1 month–11 years**
- Initially 0.25–1 mg/kg 3 times a day, then increased to 5 mg/kg daily in divided doses, dose should be increased at weekly intervals.
- Child 12–17 years: Initially 80 mg twice daily, then increased if necessary up to 160–320 mg daily, dose should be increased at weekly intervals, slow-release preparations may be used for once daily administration.

**Tetralogy of Fallot**
- **BY MOUTH**
  - Neonate: 0.25–1 mg/kg 2–3 times a day (max. per dose 2 mg/kg 3 times a day).
  - Child 1 month–11 years: 0.25–1 mg/kg 3–4 times a day, maximum dose to be given in divided doses; maximum 5 mg/kg per day.

**CAUTIONARY AND ADVISORY LABELS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

**OCTOBER 2011 2019 P**

**Propranolol hydrochloride 80 mg**
- Bedranol SR 80 mg tablets
- Bedranol 160 mg tablets

**Propranolol hydrochloride 160 mg**
- Bedranol 160 mg capsules
- Bedranol SR 160 mg capsules

**Propranolol hydrochloride 2 mg per 1 ml**
- Propranolol hydrochloride 2 mg per 1 ml oral solution sugar-free

**Propranolol hydrochloride 1 mg per 1 ml**
- Propranolol hydrochloride 1 mg per 1 ml oral solution sugar-free

**Propranolol hydrochloride 40 mg per 5 ml**
- Propranolol hydrochloride 40 mg per 5 ml oral solution sugar-free

**Propranolol hydrochloride 10 mg per 1 ml**
- Propranolol hydrochloride 10 mg per 1 ml oral solution sugar-free

**Propranolol hydrochloride 80 mg per 1 ml**
- Propranolol hydrochloride 80 mg per 1 ml oral solution sugar-free

**Modified-release capsule**
- Bedranol SR (Sandoz Ltd, Almus Pharmaceuticals Ltd)
- Bedranol 80 mg capsules
- Bedranol 160 mg capsules
- Bedranol SR 160 mg capsules

**Beta-Propranol (Actavis UK Ltd, Teva UK Ltd, Tillomed Laboratories Ltd)**
- Propranolol hydrochloride 160 mg
- Propranolol hydrochloride 80 mg

**Tablet**
- Propranolol hydrochloride 10 mg
- Propranolol hydrochloride 40 mg
Esmolol hydrochloride

**INDICATIONS AND DOSE**

**Arrhythmias | Hypertensive emergencies**

- **INITIALLY BY INTRAVENOUS INJECTION**
  - Child: Loading dose 500 micrograms/kg, to be given over 1 minute, then (by intravenous infusion) maintenance 50 micrograms/kg/minute for 4 minutes (rate reduced if low blood pressure or low heart rate), if inadequate response, repeat loading dose and increase maintenance infusion, (by intravenous injection) loading dose 500 micrograms/kg, given over 1 minute, then (by intravenous infusion) maintenance 100 micrograms/kg/minute for 4 minutes, if response still inadequate, repeat loading dose and increase maintenance infusion, (by intravenous injection) loading dose 500 micrograms/kg, given over 1 minute, then (by intravenous infusion) maintenance 150 micrograms/kg/minute for 4 minutes, if response still inadequate, repeat loading dose and increase maintenance infusion, (by intravenous injection) loading dose 500 micrograms/kg, given over 1 minute, then (by intravenous infusion) maintenance 200 micrograms/kg/minute for 4 minutes, doses over 300 micrograms/kg/minute not recommended

**Tetralogy of Fallot**

- **INITIALLY BY INTRAVENOUS INJECTION**
  - Neonate: Initially 600 micrograms/kg, dose to be given over 1–2 minutes, then (by intravenous infusion) 300–900 micrograms/kg/minute if required.

**UNLICENSED USE** Not licensed for use in children.

**INTERACTIONS** Appendix 1: beta blockers, selective

**SIDE-EFFECTS**

- **Common or very common** Gastrointestinal disorder
- **Rare or very rare** Alopecia · dry mouth · hepatic disorders · mood altered · postural hypotension · psychosis · skin reactions · thrombocytopenia
- **Frequency not known** Hypersensitivity · lupus-like syndrome

**BREAST FEEDING** Water soluble beta-blockers such as atenolol are present in breast milk in greater amounts than other beta blockers.

**RENAL IMPAIRMENT** Dose adjustments Initially use 50% of usual dose if estimated glomerular filtration rate 10–35 mL/minute/1.73 m², initially use 30–50% of usual dose if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Atenolol for hypertension www.medicinesforchildren.org.uk/atenolol-hypertension-0

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Esmolol hydrochloride (Non-proprietary)**
  - Esmolol hydrochloride 10 mg per 1 mL Esmolol hydrochloride 100mg/10mL solution for injection vials | 10 vial £100.00 (Hospital only)

**INDICATIONS AND DOSE**

**Hypertension**

- **BY MOUTH**
  - Neonate: 0.5–2 mg/kg once daily, dose may be given in 2 divided doses.
  - Child 1 month–11 years: 0.5–2 mg/kg once daily, dose may be given in 2 divided doses, doses higher than 50 mg daily are rarely necessary
  - Child 12–17 years: 25–50 mg once daily, dose may be given in 2 divided doses, higher doses are rarely necessary

**Arrhythmias**

- **BY MOUTH**
  - Neonate: 0.5–2 mg/kg once daily, dose may be given in 2 divided doses.
  - Child 1 month–11 years: 0.5–2 mg/kg once daily, dose may be given in 2 divided doses; maximum 100 mg per day
  - Child 12–17 years: 50–100 mg once daily, dose may be given in 2 divided doses

**UNLICENSED USE** Not licensed for use in children under 12 years.

**IMPORTANT SAFETY INFORMATION**

**SAFE PRACTICE**

Atenolol has been confused with amlodipine; care must be taken to ensure the correct drug is prescribed and dispensed.

**INTERACTIONS** Appendix 1: beta blockers, selective

**SIDE-EFFECTS**

- **Common or very common** Gastrointestinal disorder
- **Rare or very rare** Alopecia · dry mouth · hepatic disorders · mood altered · postural hypotension · psychosis · skin reactions · thrombocytopenia
- **Frequency not known** Hypersensitivity · lupus-like syndrome

**BREAST FEEDING** Water soluble beta-blockers such as atenolol are present in breast milk in greater amounts than other beta blockers.

**RENAL IMPAIRMENT**

Dose adjustments Initially use 50% of usual dose if estimated glomerular filtration rate 10–35 mL/minute/1.73 m², initially use 30–50% of usual dose if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Atenolol for hypertension www.medicinesforchildren.org.uk/atenolol-hypertension-0

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
Metoprolol tartrate

- **INDICATIONS AND DOSE**
  
  **Hypertension**
  - By mouth using immediate-release medicines
  - Child 1 month–11 years: Initially 1 mg/kg twice daily, increased if necessary up to 8 mg/kg daily in 2–4 divided doses (max. per dose 400 mg)
  - Child 12–17 years: Initially 50–100 mg daily, increased if necessary to 200 mg daily in 1–2 divided doses, high doses are rarely necessary; maximum 400 mg per day
  - By mouth using modified-release medicines
  - Child 12–17 years: 200 mg once daily
  
  **Arrhythmias**
  - By mouth using immediate-release medicines
  - Child 12–17 years: Usual dose 50 mg 2–3 times a day, then increased if necessary up to 300 mg daily in divided doses
  
- **SIDE-EFFECTS**
  
  - Common or very common: Postural disorders
  - Rare or very rare: Alertness decreased, alopecia, arrhythmia, arthritis, auditory disorder, chest pain, constipation, drowsiness, dry mouth, dystrophic skin lesion, eye irritation, gangrene, hyperhidrosis, muscle cramps, oedema, palpitations, personality disorder, rhinitis, sexual dysfunction, skin reactions, thrombocytopenia, weight increased
  
- **Hepatic impairment**
  - Reduce dose in severe impairment.
  
- **Medicinal forms**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution
  
  **Tablet**
  - Metoprolol tartrate 50 mg Metoprolol 50mg tablets | 28 tablet (Brand) £6.23 DT = £1.02 | 56 tablet (Brand) £1.56–£1.46
  - Metoprolol tartrate 100 mg Metoprolol 100mg tablets | 28 tablet (Brand) £6.47 DT = £1.17 | 56 tablet (Brand) £2.93

- **Solution for injection**
  - Betacalo (Astrazeneca UK Ltd) Metoprolol tartrate 1 mg per 1 ml Betacalo IV. 5mg/5ml solution for injection ampoules | 5 ampoule (Brand) £5.02 (Hospital only)

**Calcium-channel blockers**

**Calcium-channel blockers**

- **Overview**
  
  Calcium-channel blockers differ in their predilection for the various possible sites of action and, therefore, their therapeutic effects are disparate, with much greater variation than those of beta-blockers. There are important differences between verapamil hydrochloride p. 111, diltiazem hydrochloride p. 146, and the dihydropyridine calcium-channel blockers (amlodipine p. 110, nicardipine hydrochloride p. 110, nifedipine p. 111, and nimodipine p. 88). Verapamil hydrochloride and diltiazem hydrochloride should usually be avoided in heart failure because they may further depress cardiac function and cause clinically significant deterioration.

  Verapamil hydrochloride is used for the treatment of hypertension and arrhythmias. However, it is no longer first-line treatment for arrhythmias in children because it has been associated with fatal collapse especially in infants under 1 year; adenosine p. 80 is now recommended for first-line use.

  Verapamil hydrochloride is a highly negatively inotropic calcium channel-blocker and it reduces cardiac output, slows the heart rate, and may impair atriorentricular conduction. It may precipitate heart failure, exacerbate conduction disorders, and cause hypotension at high doses and should not be used with beta-blockers. Constipation is the most common side-effect.

  Nifedipine relaxes vascular smooth muscle and dilates coronary and peripheral arteries. It has more influence on vessels and less on the myocardium than does verapamil hydrochloride and unlike verapamil hydrochloride has no anti-arrhythmic activity. It rarely precipitates heart failure because any negative inotropic effect is offset by a reduction in left ventricular work. Short-acting formulations of nifedipine may be used if a modified-release preparation delivering the appropriate dose is not available or if a child is unable to swallow (a liquid preparation may be prepared using capsules). Nifedipine may also be used for the management of angina due to coronary artery disease in Kawasaki disease or progeria and in the management of Raynaud’s syndrome.

  Nicardipine hydrochloride has similar effects to those of nifedipine and may produce less reduction of myocardial contractility; it should only be used for the treatment of life-threatening hypertension in paediatric intensive care settings and in postoperative hypertension.

  Amlodipine also resembles nifedipine and nicardipine hydrochloride in its effects and does not reduce myocardial contractility or produce clinical deterioration in heart failure. It has a longer duration of action and can be given once daily. Nifedipine and amlodipine are used for the treatment of hypertension. Side-effects associated with vasodilatation such as flushing and headache (which become less obtrusive after a few days), and ankle swelling (which may respond only partially to diuretics) are common.

  Nimodipine is related to nifedipine but the smooth muscle relaxant effect preferentially acts on cerebral arteries. Its use is confined to prevention and treatment of vascular spasm following aneurysmal subarachnoid haemorrhage.

  Diltiazem hydrochloride is a peripheral vasodilator and also has mild depressor effects on the myocardium. It is used in the treatment of Raynaud’s syndrome.

**Calcium-channel blockers**

- **Drug action**
  
  Calcium-channel blockers (less correctly called ‘calcium-antagonists’) interfere with the inward displacement of calcium ions through the slow channels of active cell membranes. They influence the myocardial cells, the cells within the specialised conducting system of the heart, and the cells of vascular smooth muscle. Thus, myocardial contractility may be reduced, the formation and propagation of electrical impulses within the heart may be depressed, and coronary or systemic vascular tone may be diminished.

- **Side-effects**
  
  - Common or very common: Dizziness, flushing, headache, nausea, palpitations, peripheral oedema, rash, tachycardia, vomiting
  - Uncommon: Gingival hyperplasia
Amlodipine

**INDICATIONS AND DOSE**  
Amlodipine is a dihydropyridine calcium-channel blocker.

- **Hypertension**
  - **BY MOUTH**
    - Child 1 month–11 years: Initially 100–200 micrograms/kg once daily; increased if necessary up to 400 micrograms/kg once daily, adjusted at intervals of 1–2 weeks; maximum 10 mg per day
    - Child 12–17 years: Initially 5 mg once daily, then increased if necessary up to 10 mg once daily, adjusted at intervals of 1–2 weeks

- **DOSE EQUIVALENT AND CONVERSION**
  - Tablets from various suppliers may contain different salts (e.g. amlodipine besilate, amlodipine maleate, and amlodipine mesilate) but the strength is expressed in terms of amlodipine (base); tablets containing different salts are considered interchangeable.

- **UNLICENSED USE**
  - Not licensed for use in children under 6 years.

**IMPORTANT SAFETY INFORMATION**

**SAFE PRACTICE**
Amlodipine has been confused with nimodipine and atenolol; care must be taken to ensure the correct drug is prescribed and dispensed.

**CONTRA-INDICATIONS**
Cardiogenic shock - significant aortic stenosis

**INTERACTIONS**
Appendix 1: calcium channel blockers

**SIDE-EFFECTS**
- **Common or very common**
  - Asthenia
  - Constipation
  - Diarrhoea
  - Drowsiness
  - Dry mouth
  - Erectile dysfunction
  - Gynaecomastia
  - Hyperhidrosis
  - Hypotension
  - Insomnia
  - Malaise
  - Mood alteration
  - Rhinitis
  - Sensation abnormal
  - Skin reactions: Syncope
  - Taste alteration
  - Tinnitus
  - Tremor
  - Urinary disorders
  - Weight changes
- **Rare or very rare**
  - Angioedema
  - Confusion
  - Hepatic disorders
  - Hyperglycaemia
  - Hypersensitivity
  - Leucopenia
  - Muscle tone increased
  - Myocardial infarction
  - Pancreatitis
  - Peripheral neuropathy
  - Photosensitivity reaction
  - Stevens-Johnson syndrome
  - Thrombocytopenia
  - Vasculitis
- **Frequency not known**
  - Extrapyramidal symptoms
  - Pulmonary oedema

**PREGNANCY**
No information available—manufacturer advises avoid, but risk to fetus should be balanced against risk of uncontrolled maternal hypertension.

**SIDE-EFFECTS, FURTHER INFORMATION**
Systemic hypotension and reflex tachycardia with rapid reduction of blood pressure may occur — during intravenous use consider stopping infusion or decreasing dose by half.

Nicardipine hydrochloride

**INDICATIONS AND DOSE**
Nicardipine is a dihydropyridine calcium-channel blocker.

- **Life-threatening hypertension (specialist use only)**
  - **BY CONTINUOUS INTRAVENOUS INFUSION**
    - Neonate: Initially 500 nanograms/kg/minute (max. per dose 5 micrograms/kg/minute), adjusted according to response; maintenance 1–4 micrograms/kg/minute
    - Child: Initially 500 nanograms/kg/minute (max. per dose 5 micrograms/kg/minute), adjusted according to response; maintenance 1–4 micrograms/kg/minute (max. per dose 250 micrograms/minute)

- **CONTRA-INDICATIONS**
  - Acute porphyrias p. 624 - avoid within 8 days of myocardial infarction - cardiogenic shock - compensatory hypertension - significant or advanced aortic stenosis

- **CAUTIONS**
  - Congestive heart failure - elevated intracranial pressure - increased risk of serious hypotension - portal hypertension - pulmonary oedema - significantly impaired left ventricular function - stroke

- **INTERACTIONS**
  - Appendix 1: calcium channel blockers

- **SIDE-EFFECTS**
  - **Common or very common**
    - Hypotension
  - **Frequency not known**
    - Attrioventricular block - erythema - hepatic disorders - ischaemic heart disease - paralytic ileus - pulmonary oedema - thrombocytopenia

**SIDE-EFFECTS, FURTHER INFORMATION**
Systemic hypotension and reflex tachycardia with rapid reduction of blood pressure may occur — during intravenous use consider stopping infusion or decreasing dose by half.
**INDICATIONS AND DOSE**

Hypertensive crisis | Acute angina in Kawasaki disease or progeria

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child: Initially 250–500 micrograms/kg (max. per dose 10 mg), then repeat once if necessary, may cause unpredictable and severe reduction of blood pressure—monitor closely following administration; if ineffective consider alternative treatment and seek specialist advice

Hypertension | Angina in Kawasaki disease or progeria

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 1 month–11 years: 200–300 micrograms/kg (max. per dose 10 mg), then repeat once if necessary, may cause unpredictable and severe reduction of blood pressure—monitor closely following administration; if ineffective consider alternative treatment and seek specialist advice
  - Child 12–17 years: 5–20 mg 3–4 times a day, dose frequency depends on preparation used; maximum 90 mg per day

**Raynaud’s syndrome**

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 2–17 years: 2.5–10 mg 2–4 times a day, start with low doses at night and increase gradually to avoid postural hypotension, dose frequency depends on preparation used

**Persistent hyperinsulinaemic hypoglycaemia**

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Neonate: 100–200 micrograms/kg 4 times a day (max. per dose 600 micrograms/kg).

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral drops

- **Nifedipine hydrochloride (Non-proprietary)**
  - Nifedipine hydrochloride 1 mg per 1 ml
  - Nifedipine hydrochloride 2.5 mg per 1 ml

**Verapamil hydrochloride**

**INDICATIONS AND DOSE**

Treatment of supraventricular arrhythmias

- **BY SLOW INTRAVENOUS INJECTION**
  - Child 1–7 years (administered on expert advice): 100–300 micrograms/kg (max. per dose 5 mg) for 1 dose, to be given over 2–3 minutes (with ECG and blood-pressure monitoring), dose can be repeated after 30 minutes if necessary
## Cardiovascular system

### MEDICINAL FORMS

#### DIRECTIONS FOR ADMINISTRATION

- **Frequency not known**
- **With intravenous use**
  - Uncommon

#### SIDE-EFFECTS

- **Hypotension**
  - Common or very common
- **Bradycardia**
  - Common or very common
- **With intravenous use**
  - Bradyarrhythmias
  - Brachyarrhythmias
- **Frequency not known**
  - Arrhythmias

#### INTERACTIONS

- First-degree AV block
- **SIDE-EFFECTS**
  - Bradycardia
- **Frequency not known**
  - With intravenous use
  - Bradycardia
  - Abdominal pain

#### CAUTIONS

- **CONTRA-INDICATIONS**
  - Acute porphyrinas p. 624.
  - Atrial flutter or fibrillation associated with accessory conducting pathways (e.g. Wolff-Parkinson-White-syndrome).
  - Bradycardia
  - Cardiogenic shock
  - History of heart failure (even if controlled by therapy)
  - History of significantly impaired left ventricular function
  - Hypotension
  - Second- and third-degree AV block
  - Sinus arrhythmias
  - Abdominal pain
  - Abdominal pain

#### CONTRA-INDICATIONS

- Addisons disease
- Hypercalcaemia
- Hypomotriaemia
- Refractory hypokalaemia
- Symptomatic hyperuricaemia

#### CAUTIONS

- Diabetes
- Gout
- Hyperaldosteronism
- Malnourishment
- Nephrotic syndrome
- Systemic lupus erythematosus

#### CAUTIONS,FURTHER INFORMATION

- Potassium loss
- Hypokalaemia can occur with both thiazide and loop diuretics. The risk of hypokalaemia depends on the duration of action as well as the potency and is thus greater with thiazides than with an equipotent dose of a loop diuretic.

#### DIURETICS

### Thiazides and related diuretics

#### CONTRA-INDICATIONS

- Addison’s disease
- Hypercalcaemia
- Hypomotriaemia
- Refractory hypokalaemia
- Symptomatic hyperuricaemia

#### CAUTIONS

- Diabetes
- Gout
- Hyperaldosteronism
- Malnourishment
- Nephrotic syndrome
- Systemic lupus erythematosus

#### CAUTIONS,FURTHER INFORMATION

- Potassium loss
- Hypokalaemia can occur with both thiazide and loop diuretics. The risk of hypokalaemia depends on the duration of action as well as the potency and is thus greater with thiazides than with an equipotent dose of a loop diuretic.

#### MONITORING REQUIREMENTS

- Electrolytes should be monitored in renal impairment.
- Electrolytes should be monitored in renal impairment.
- Electrolytes should be monitored in renal impairment.

#### Solution for injection

- **Securon (Mylan)**
  - Verapamil hydrochloride 2.5 mg per 1 ml
  - Securon IV 5mg/2ml
  - Solution for injection ampoules
  - 5 ampoules £0.84

#### Oral solution

- **Verapamil hydrochloride (Non-proprietary)**
  - Verapamil hydrochloride 8 mg per 1 ml
  - Verapamil 40mg/5ml oral solution sugar free sugar-free
  - 150 ml £41.00 D = £41.00

#### MONITORING REQUIREMENTS

- Electrolytes should be monitored in renal impairment.
- Electrolytes should be monitored in renal impairment.
- Electrolytes should be monitored in renal impairment.

### Cardiovascular system

#### Hypertension

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 12-23 months (administered on expert advice): 20 mg 2–3 times a day
  - Child 2-17 years (administered on expert advice): 40–120 mg 2–3 times a day

#### Prophylaxis of supraventricular arrhythmias (administered on expert advice)

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 12-23 months: 20 mg 2–3 times a day
  - Child 2-17 years: 40–120 mg 2–3 times a day

#### CONTRA-INDICATIONS

- Acute porphyrinas p. 624.
- Atrial flutter or fibrillation associated with accessory conducting pathways (e.g. Wolff-Parkinson-White-syndrome).
- Bradycardia
- Cardiogenic shock
- History of heart failure (even if controlled by therapy)
- History of significantly impaired left ventricular function
- Hypotension
- Second- and third-degree AV block
- Sinus arrhythmias

#### CAUTIONS

- First-degree AV block
- **INTERACTIONS**
  - Appendix 1: calcium channel blockers

#### GENERAL SIDE-EFFECTS

- Common or very common
- Hypotension
- **Frequency not known**
  - Bradycardia
  - Extrapyramidal symptoms
  - Stevens-Johnson syndrome
  - Vertigo

#### SPECIFIC SIDE-EFFECTS

- Common or very common
- Bradycardia
- With intravenous use
- Abdominal pain
- **Frequency not known**
  - Cardiac arrest
  - Drowsiness
  - Erythema
  - Hepatic impairment
  - Hyperhidrosis
  - Myocardial contractility decreased
  - Nervousness
  - Seizure
  - With oral use
  - Alopecia
  - Angioedema
  - Atrioventricular block
  - Bradycardia
  - Constipation
  - Diarrhoea
  - Dizziness
  - Fatigue
  - Galactorrhoea
  - Gastrointestinal discomfort
  - Headache
  - Itch
  - Muscle weakness
  - Myalgia
  - Parasthesia
  - Rigidity
  - Nervousness
  - Palmar plaques
  - Photosensitivity reaction
  - Postural hypotension
  - Tremor
  - Photosensitivity reaction

#### OVERDOSE

- In overdosage, verapamil has a profound cardiac depressant effect causing hypotension and arrhythmias.

#### PREGNANCY

- May reduce uterine blood flow with fetal hypoxia.
- Manufacturer advises avoid in first trimester unless absolutely necessary.
- May inhibit labour.

#### BREAST FEEDING

- Amount too small to be harmful.

#### HEPATIC IMPAIRMENT

- **Dose adjustments**
  - With oral use
  - Manufacturer advises dose reduction.

#### DIRECTIONS FOR ADMINISTRATION

- For intravenous injection, may be diluted with Glucose 5% or Sodium Chloride 0.9.
- Incompatible with solutions of pH greater than 7.

#### MEDICINAL FORMS

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

#### Tablet

<table>
<thead>
<tr>
<th>Verapamil hydrochloride (Non-proprietary)</th>
<th>Verapamil hydrochloride 40 mg</th>
<th>Verapamil 40mg tablets</th>
<th>84 tablet</th>
<th>£2.15 DT = £1.78</th>
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<tbody>
<tr>
<td>Verapamil hydrochloride 80 mg</td>
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<td>£2.54 DT = £2.14</td>
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</tr>
</tbody>
</table>
Bendroflumethiazide *(Bendrofluazide)*

- **INDICATIONS AND DOSE**
  - **Hypertension**
    - By mouth
    - Child 1 month: 0.5–10 micrograms/kg daily, adjusted according to response
    - Child 2–11 years: Initially 0.5–40 micrograms/kg daily (max. per dose 10 mg), then maintenance 0.5–100 micrograms/kg daily, adjusted according to response; maximum 10 mg per day
    - Child 12–17 years: Initially 5–10 mg once daily or on alternate days, adjusted according to response to dose to be taken as a single dose in the morning; maximum 10 mg per day

- **SIDE-EFFECTS**
  - Blood disorder: cholestatic or cholestasis
  - Gastrointestinal disorder: flatulence, constipation, nausea, vomiting, diarrhea, dizziness, and sometimes peritonitis
  - Hypoglycaemia: anaphylactoid reactions
  - Renal disorder: dehydration
  - Cardiovascular disorder: hypotension, palpitations

- **BREAST FEEDING**
  - The amount present in milk is too small to be harmful. Large doses may suppress lactation.

- **INTERACTIONS**
  - Other thiazides: central nervous system depression
  - Potassium-sparing diuretics: increased risk of hypokalaemia
  - NSAIDs: increased risk of haemorrhage
  - Loop diuretics: additive diuretic effect

- **UNLICENSED USE**
  - Not licensed.

- **CONTRA-INDICATIONS**
  - Bilateral renovascular disease
  - Anaemia
  - Renal impairment

- **CAUTIONS**
  - African-Caribbean patients (may respond less well to ACE inhibitors)
  - Concomitant diuretics: Potentiating the glycaemic effect of diazoxide in the management of chronic hypoglycaemia
  - Concomitant diuretics: Nephrogenic and partial pituitary diabetes insipidus

**Oedema in heart failure, renal disease and hepatic disease/ Pulmonary oedema**

- **BY MOUTH**
  - Child 1 month: 0.5–10 micrograms/kg daily, adjusted according to response
  - Child 2–11 years: Initially 0.5–40 micrograms/kg daily (max. per dose 10 mg), then maintenance 0.5–100 micrograms/kg daily, adjusted according to response; maximum 10 mg per day
  - Child 12–17 years: Initially 5–10 mg once daily or on alternate days, adjusted according to response to dose to be taken as a single dose in the morning; maximum 10 mg per day

**CHLOROTHIAZIDE**

- **INDICATIONS AND DOSE**
  - **Heart failure**
  - **Hypertension**
  - **Ascites**
  - **BY MOUTH**
    - Neonate: 10–20 mg/kg twice daily
    - Child 1–5 months: 10–20 mg/kg twice daily
    - Child 6 months–11 years: 10 mg/kg twice daily; maximum 1 g per day
    - Child 12–17 years: 0.25–1 g once daily, alternatively 125–500 mg twice daily

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral suspension, oral solution.

**Tablet**

- **Bendroflumethiazide** (Non-proprietary)
  - Bendroflumethiazide 2.5 mg: Bendroflumethiazide 2.5 mg tablets
  - 28 tablet [PO] £0.75 DT = £0.54
  - 500 tablet [PO] £21.85

- **Bendroflumethiazide 5 mg**
  - 28 tablet [PO] £0.80 DT = £0.60

- **Neo-Naclex (Advanz Pharma)**
  - Bendroflumethiazide 2.5 mg: Neo-Naclex 2.5 mg tablets
  - 28 tablet [PO] £0.33 DT = £0.54
Captopril

INDICATIONS AND DOSE

Hypertension

BY MOUTH

- Preterm neonate (initiated under specialist supervision): Test dose 10 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 300 micrograms/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Neonate (initiated under specialist supervision): Test dose 10–50 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 2 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 months (initiated under specialist supervision): Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 years (initiated under specialist supervision): Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 12-17 years: Test dose 100 micrograms/kg, alternatively test dose 6.25 mg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 2 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Preterm neonate (initiated under specialist supervision): Test dose 10 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 300 micrograms/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Neonate (initiated under specialist supervision): Test dose 10–50 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 2 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 months (initiated under specialist supervision): Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 years (initiated under specialist supervision): Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 12-17 years: Test dose 100 micrograms/kg, alternatively test dose 6.25 mg, monitor blood pressure carefully for 1–2 hours; usual dose 12.5–25 mg 2–3 times a day, then increased if necessary up to 150 mg daily in divided doses, ongoing doses should only be given if test dose tolerated.

Heart failure

BY MOUTH

- Preterm neonate: Test dose 10 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 300 micrograms/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Neonate: Test dose 10–50 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 2 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 months: Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 years (initiated under specialist supervision): Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 12-17 years: Test dose 100 micrograms/kg, alternatively test dose 6.25 mg, monitor blood pressure carefully for 1–2 hours; usual dose 12.5–25 mg 2–3 times a day, then increased if necessary up to 150 mg daily in divided doses, ongoing doses should only be given if test dose tolerated.

Proteinuria in nephritis (under expert supervision)

BY MOUTH

- Preterm neonate: Test dose 10 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 300 micrograms/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Neonate: Test dose 10–50 micrograms/kg, monitor blood pressure carefully for 1–2 hours; usual dose 10–50 micrograms/kg 2–3 times a day, then increased if necessary up to 2 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 months: Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 1-11 years (initiated under specialist supervision): Test dose 100 micrograms/kg (max. per dose 6.25 mg), monitor blood pressure carefully for 1–2 hours; usual dose 100–300 micrograms/kg 2–3 times a day, then increased if necessary up to 4 mg/kg daily in divided doses, ongoing doses should only be given if test dose tolerated.

- Child 12-17 years: Test dose 100 micrograms/kg, alternatively test dose 6.25 mg, monitor blood pressure carefully for 1–2 hours; usual dose 12.5–25 mg 2–3 times a day, then increased if necessary up to 150 mg daily in divided doses, ongoing doses should only be given if test dose tolerated.

SIDE-EFFECTS, FURTHER INFORMATION

In light of reports of cholestatic jaundice, hepatitis, fulminant hepatic necrosis, and hepatic failure, ACE inhibitors should be discontinued if marked elevation of hepatic enzymes or jaundice occur.

- ALLERGY AND CROSS-SENSITIVITY: ACE inhibitors are contra-indicated in patients with hypersensitivity to ACE inhibitors (including angioedema).

- PREGNANCY: ACE inhibitors should be avoided in pregnancy unless essential. They may adversely affect fetal and neonatal blood pressure control and renal function; skull defects and oligohydramnios have also been reported.

- BREAST FEEDING: Information on the use of ACE inhibitors in breast-feeding is limited.

- RENAL IMPAIRMENT

Dose adjustments

Use with caution, starting with low dose, and adjust according to response. Hyperkalaemia and other side-effects of ACE inhibitors are more common in those with impaired renal function and the dose may need to be reduced.

- MONITORING REQUIREMENTS: Renal function and electrolytes should be checked before starting ACE inhibitors (or increasing the dose) and monitored during treatment (more frequently if side effects mentioned are present).

- DIRECTIONS FOR ADMINISTRATION: For hypertension the first dose should preferably be given at bedtime.
### 150 mg daily in divided doses, ongoing doses should only be given if test dose tolerated

**Diabetic nephropathy in type 1 diabetes mellitus**

- Child 12–17 years (under expert supervision): Test dose 100 micrograms/kg, alternatively test dose 6.25 mg, monitor blood pressure carefully for 1–2 hours; usual dose 12.5–25 mg 2–3 times a day, increased if necessary up to 100 mg daily in divided doses, ongoing doses should only be given if test dose tolerated

- **UNLICENSED USE** Not licensed for proteinuria in nephritis. Captopril doses in BNF Publications differ from product licence.

- **CAUTIONS** Children (efficacy and safety not fully established)

- **INTERACTIONS** → Appendix 1: ACE inhibitors

- **SIDE-EFFECTS**
  - Common or very common Insomnia - peptic ulcer
  - Uncommon Appetite decreased - flushing - malaise - pallor - Raynaud’s phenomenon
  - Rare or very rare Anaemia - aplastic anaemia - autoimmune disorder - cardiac arrest - cardiogenic shock - cerebrovascular insufficiency - depression - gynaecomastia - hepatic disorders - hypoglycaemia - lymphadenopathy - nephrotic syndrome - oral disorders - proteinuria - urinary disorders - vision blurred

- **BREAST FEEDING** Avoid in first few weeks after delivery, particularly in preterm infants - risk of profound neonatal hypotension; can be used in mothers breast-feeding older infants if essential but monitor infant’s blood pressure.

- **DIRECTIONS FOR ADMINISTRATION** Administer under close supervision. Give test dose whilst child supine. Tablets can be dispersed in water.

- **PATIENT AND CARER ADVICE**

  Medicines for Children leaflet: Captopril for heart failure
  www.medicinesforchildren.org.uk/captopril-heart-failure-0

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution

#### Tablet

- **Captopril (Non-proprietary)**
  - Captopril 12.5 mg: Captopril 12.5mg tablets | 56 tablet (£0.97 DT + £0.92
  - Captopril 25 mg: Captopril 25mg tablets | 56 tablet (£0.80 DT + £0.80
  - Captopril 50 mg: Captopril 50mg tablets | 56 tablet (£1.52 DT + £1.50

- **Oral solution**

  ELECTROLYTES: May contain Sodium

- **Captopril (Non-proprietary)**
  - Captopril 5 mg per 1 ml Captopril 5mg/5ml oral solution sugar free sugar-free | 100 ml (£93.30–£98.21 DT = £97.23
  - Captopril 5 mg per 1 ml Captopril 25mg/5ml oral solution sugar free sugar-free | 100 ml (£103.49–£108.94 DT = £107.85
  - **Noyada** (Martindale Pharmaceuticals Ltd)
    - Captopril 5 mg per 1 ml Noyada 5mg/5ml oral solution sugar-free | 100 ml (£98.21 DT = £97.23
    - Captopril 5 mg per 1 ml Noyada 25mg/5ml oral solution sugar-free | 100 ml (£108.94 DT = £107.85

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150 micrograms/kg daily in divided doses, limited information.

- Child 1 month-11 years (under expert supervision): Initially 100 micrograms/kg once daily, monitor blood pressure carefully for 1–2 hours, then increased if necessary up to 1 mg/kg/day in 1–2 divided doses
- Child 12–17 years (under expert supervision) (body-weight up to 50 kg): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses
- Child 12–17 years (under expert supervision) (body-weight 50 kg and above): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses; maximum 40 mg per day

**Heart failure**

- **BY MOUTH**

  - Neonate (under expert supervision): Initially 10 micrograms/kg once daily, monitor blood pressure carefully for 1–2 hours, increased if necessary up to 500 micrograms/kg daily in 1–3 divided doses, limited information.

  - Child 1 month-11 years (under expert supervision): Initially 100 micrograms/kg once daily, monitor blood pressure carefully for 1–2 hours, then increased if necessary up to 1 mg/kg/day in 1–2 divided doses
  - Child 12–17 years (under expert supervision) (body-weight up to 50 kg): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses
  - Child 12–17 years (under expert supervision) (body-weight 50 kg and above): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses; maximum 40 mg per day

**Proteinuria in nephritis (under expert supervision)**

- **BY MOUTH**

  - Neonate: Initially 10 micrograms/kg once daily, monitor blood pressure carefully for 1–2 hours, increased if necessary up to 500 micrograms/kg daily in 1–3 divided doses, limited information.

  - Child 1 month-11 years: Initially 100 micrograms/kg once daily, monitor blood pressure carefully for 1–2 hours, then increased if necessary up to 1 mg/kg/day in 1–2 divided doses
  - Child 12–17 years (body-weight up to 50 kg): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses
  - Child 12–17 years (body-weight 50 kg and above): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses; maximum 40 mg per day

**Diabetic nephropathy (expert supervision)**

- **BY MOUTH**

  - Child 12–17 years (body-weight up to 50 kg): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses
  - Child 12–17 years (body-weight 50 kg and above): Initially 2.5 mg once daily, monitor blood pressure carefully for 1–2 hours, maintenance 10–20 mg daily in 1–2 divided doses; maximum 40 mg per day

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**Enalapril maleate**

**INDICATIONS AND DOSE**

**Hypertension**

- **BY MOUTH**

  - Neonate (under expert supervision): Initially 10 micrograms/kg once daily, monitor blood pressure carefully for 1–2 hours, increased if necessary up to 500 micrograms/kg daily in 1–3 divided doses, limited information.

- **UNLICENSED USE** Not licensed for use in children for congestive heart failure, proteinuria in nephritis or diabetic nephropathy; not licensed for use in children less than 20 kg for hypertension.

- **INTERACTIONS** → Appendix 1: ACE inhibitors
Blood pressure conditions

SIDE-EFFECTS
- Common or very common: Depression, hypersensitivity, vision blurred.
- Uncommon: Anaemia, appetite decreased, asthma, bone marrow disorders, flushing, gastrointestinal disorders, hoarseness, hypoglycaemia, malaise, muscle cramps, nervousness, proteinuria, rhinorrhea, sleep disorders, throat pain.
- Rare or very rare: Autoimmune disorder, gynaecomastia, hepatic disorders, lymphopenopathy, oral disorders, Raynaud’s phenomenon, toxic epidermal necrolysis.
- Frequency not known: Arthritis, leucocytosis, myositis, serositis, SIADH, vasculitis.

BREATHE FEEDING
Avoid in first few weeks after delivery, particularly in preterm infants—risk of profound neonatal hypotension; can be used in mothers breast-feeding older infants if essential but monitor infant’s blood pressure.

HEPATIC IMPAIRMENT
Enalapril is a prodrug.

DIRECTIONS FOR ADMINISTRATION
Tablets may be crushed and suspended in water immediately before use.

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Enalapril for high blood pressure
www.medicinesforchildren.org.uk/enalapril-high-blood-pressure

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

Tablet
- Enalapril maleate (Non-proprietary)
  - Enalapril maleate 2.5 mg: Enalapril 2.5mg tablets | 28 tablet [PO]
    - £5.63 DT = £5.15
  - Enalapril maleate 5 mg: Enalapril 5mg tablets | 28 tablet [PO]
    - £4.13 DT = £1.74
  - Enalapril maleate 10 mg: Enalapril 10mg tablets | 28 tablet [PO]
    - £5.64 DT = £1.81
  - Enalapril maleate 20 mg: Enalapril 20mg tablets | 28 tablet [PO]
    - £6.63 DT = £1.76
  - Innovace (Merck Sharp & Dohme Ltd)
    - Enalapril maleate 2.5 mg: Innovace 2.5mg tablets | 28 tablet [PO]
      - £5.35 DT = £5.15
    - Enalapril maleate 5 mg: Innovace 5mg tablets | 28 tablet [PO]
      - £7.51 DT = £1.74
    - Enalapril maleate 10 mg: Innovace 10mg tablets | 28 tablet [PO]
      - £10.53 DT = £1.81
    - Enalapril maleate 20 mg: Innovace 20mg tablets | 28 tablet [PO]
      - £12.51 DT = £1.76

Lisinopril

INDICATIONS AND DOSE
Hypertension
- BY MOUTH
  - Child 6–11 years (under expert supervision): Initially 70 micrograms/kg once daily (max. per dose 5 mg), increased to up to 600 micrograms/kg once daily, alternatively increased to up to 40 mg once daily, dose to be increased in intervals of 1–2 weeks.
  - Child 12–17 years (under expert supervision): Initially 5 mg once daily; usual maintenance 10–20 mg once daily; maximum 80 mg per day.
  - Proteinuria in nephritis (under expert supervision)
    - BY MOUTH
      - Child 6–11 years: Initially 70 micrograms/kg once daily (max. per dose 5 mg), increased to up to 600 micrograms/kg once daily, alternatively increased to up to 40 mg once daily, dose to be increased in intervals of 1–2 weeks.
      - Child 12–17 years: Initially 5 mg once daily; usual maintenance 10–20 mg once daily; maximum 80 mg per day.

Diabetic nephropathy (under expert supervision)
- BY MOUTH
  - Child 12–17 years: Initially 5 mg once daily; usual maintenance 10–20 mg once daily; maximum 80 mg per day.

Heart failure (adjunct) (under close medical supervision)
- BY MOUTH
  - Child 12–17 years: Initially 2.5 mg once daily; increased in steps of up to 10 mg at least every 2 weeks; maximum 35 mg per day.

UNLICENSED USE
Not licensed for use in children.

INTERACTIONS
→ Appendix 1: ACE inhibitors.

SIDE-EFFECTS
- Common or very common: Postural disorders.

UNLICENSED USE
Not recommended; alternative treatment options, with better established safety information during breast-feeding, are available.

PRESCRIBING AND DISPENSING INFORMATION
The RCPCH and NPPG recommend that, when a liquid special of lisinopril is required, the following strength is used: 20 mg/5 mL.

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Lisinopril for high blood pressure
www.medicinesforchildren.org.uk/lisinopril-high-blood-pressure

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

Oral solution
- Lisinopril (Non-proprietary)
  - Lisinopril 1 mg per 1 ml: Lisinopril 1mg/5ml oral solution sugar free
    - 150 ml [PO] £154.11 DT = £154.11

Tablet
- Lisinopril (Non-proprietary)
  - Lisinopril 2.5 mg: Lisinopril 2.5mg tablets | 28 tablet [PO]
    - £4.81 DT = £0.80 | 500 tablet [PO] £11.84
  - Lisinopril 5 mg: Lisinopril 5mg tablets | 28 tablet [PO]
    - £7.54 DT = £0.80 | 500 tablet [PO] £10.93
  - Lisinopril 10 mg: Lisinopril 10mg tablets | 28 tablet [PO]
    - £11.81 DT = £0.80 | 500 tablet [PO] £10.78
  - Lisinopril 20 mg: Lisinopril 20mg tablets | 28 tablet [PO]
    - £10.42 DT = £0.88 | 500 tablet [PO] £12.75
  - Zestril (AstraZeneca UK Ltd)
    - Lisinopril 5 mg: Zestril 5mg tablets | 28 tablet [PO]
      - £3.42 DT = £0.80
    - Lisinopril 10 mg: Zestril 10mg tablets | 28 tablet [PO]
      - £4.76 DT = £0.80
    - Lisinopril 20 mg: Zestril 20mg tablets | 28 tablet [PO]
      - £13.02 DT = £0.88

DRUGS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM
- ANGIOTENSIN II RECEPTOR ANTAGONISTS

Angiotensin II receptor antagonists
- CAUTIONS
  Afro-Caribbean patients—particularly those with left ventricular hypertrophy (may not benefit from an angiotensin-II receptor antagonist) - aortic or mitral valve
stenois · hypertrophic cardiomyopathy · patients with a history of angioedema · patients with primary aldosteronism (may not benefit from an angiotensin-II receptor antagonist) · renal artery stenosis

**SIDE-EFFECTS**
- **Common or very common** Abdominal pain · asthenia · back pain · cough · diarrhoea · dizziness · headache · hyperkalaemia · hypotension · nausea · postural hypotension (more common in patients with intravascular volume depletion, e.g. those taking high-dose diuretics) · renal impairment · skin reactions · vertigo · vomiting
- **Uncommon** Angioedema · hepatic function abnormal · myalgia · thrombocytopenia
- **Rare or very rare** Arthralgia

**PREGNANCY** Angiotensin-II receptor antagonists should be avoided in pregnancy unless essential. They may adversely affect fetal and neonatal blood pressure control and renal function; neonatal skull defects and oligohydramnios have also been reported.

**BREAST FEEDING** Information on the use of angiotensin-II receptor antagonists in breast-feeding is limited. They are not recommended in breast-feeding and alternative treatment options, with better established safety information during breast-feeding, are available.

**HEPATIC IMPAIRMENT** In general, manufacturers advise caution in mild to moderate impairment (limited information available); avoid in severe impairment (no information available).

**RENAI IMPAIRMENT**
- **Dose adjustments** Use with caution, starting with low dose, and adjust according to response.
- **MONITORING REQUIREMENTS** Monitor plasma-potassium concentration, particularly in children with renal impairment.

### Candesartan cilexetil

**INDICATIONS AND DOSE**

**Hypertension**
- **BY MOUTH**
  - Child 6-17 years (under expert supervision) (body-weight up to 50 kg): Initially 4 mg once daily, adjusted according to response, lower dose may be used in intravascular volume depletion; maximum 8 mg per day
  - Child 6-17 years (under expert supervision) (body-weight 50 kg and above): Initially 4 mg once daily, adjusted according to response, lower dose may be used in intravascular volume depletion; maximum 16 mg per day

**CONTRA-INDICATIONS** Cholestaticis

**INTERACTIONS** → Appendix 1: angiotensin-II receptor antagonists

**SIDE-EFFECTS**
- **Common or very common** Fever · increased risk of infection · oropharyngeal pain · sinus arthrythmia
- **Uncommon** Hypoanaemia
- **Rare or very rare** Agranulocytosis · hepatitis · leucopenia · neutropenia

**HEPATIC IMPAIRMENT** Manufacturer advises avoid in severe impairment or cholestasis.

**Dose adjustments** In adults, manufacturer advises dose reduction—consult product literature.

**RENAI IMPAIRMENT** Use with caution if estimated glomerular filtration rate is less than 30 mL/minute/1.73 m²—no information available.

**Dose adjustments** Reduce initial dose.

**INTERACTIONS**
- **Common or very common** Anaemia · hypoglycaemia · postural disorders
- **Uncommon** Angina pectoris · constipation · drowsiness · dysphonia · oedema · palpitations · sleep disorder
- **Rare or very rare** Atrial fibrillation · hepatitis · hypersensitivity · paraesthesia · stroke · syncope · vasculitis
- **Frequency not known** Depression · erectile dysfunction · hypotension · influenza like illness · malaise · migraine · pancreatitis · photosensitivity reaction · rhabdomyolysis · taste altered · tinnitus · urinary tract infection

**HEPATIC IMPAIRMENT** Manufacturer advises avoid in all degrees of impairment (no information available).

**RENAI IMPAIRMENT** Avoid if estimated glomerular filtration rate is less than 30 mL/minute/1.73 m²—no information available.

**PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral liquid formulations may include berry-citrus.
118 Blood pressure conditions

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral suspension**
- **Cozaar** (Merck Sharp & Dohme Ltd)
  - Losartan potassium 2.5 mg per 1 ml Cozaar 2.5 mg/ml oral suspension sugar-free | 200 ml (PO) £53.68 DT = £53.68

**Tablet**
- **Losartan potassium (Non-proprietary)**
  - Losartan potassium 12.5 mg | 28 tablet (PO) £30.00 DT = £3.09
  - Losartan potassium 25 mg | 28 tablet (PO) £16.18 DT = £3.28
  - Losartan potassium 50 mg | 28 tablet (PO) £12.80 DT = £2.07

- **Cozaar** (Merck Sharp & Dohme Ltd)
  - Losartan potassium 12.5 mg | 28 tablet (PO) £37.00 DT = £3.09
  - Losartan potassium 25 mg | 28 tablet (PO) £16.18 DT = £3.28
  - Losartan potassium 50 mg | 28 tablet (PO) £12.80 DT = £2.07

- **Losartan potassium 100 mg** | 28 tablet (PO) £16.18 DT = £1.95

- **Cozaar** (Merck Sharp & Dohme Ltd)
  - Losartan potassium 12.5 mg | 28 tablet (PO) £37.00 DT = £3.09
  - Losartan potassium 25 mg | 28 tablet (PO) £16.18 DT = £3.28
  - Losartan potassium 50 mg | 28 tablet (PO) £12.80 DT = £2.07

- **Losartan potassium 100 mg** | 28 tablet (PO) £16.18 DT = £1.95

**Valsartan**

**INDICATIONS AND DOSE**

**Hypertension**
- **BY MOUTH**
  - Child 6–17 years (under expert supervision) (body-weight 18–34 kg): Initially 40 mg once daily, adjusted according to response; maximum 80 mg per day
  - Child 6–17 years (under expert supervision) (body-weight 35–79 kg): Initially 80 mg once daily, adjusted according to response; maximum 160 mg per day
  - Child 6–17 years (under expert supervision) (body-weight 80 kg and above): Initially 80 mg once daily, adjusted according to response; maximum 320 mg per day

**UNLICENSED USE** Capsules not licensed for use in children.

**CONTRA-INDICATIONS** Biliary cirrhosis • cholestasis

**INTERACTIONS** → Appendix 1: angiotensin-II receptor antagonists

**SIDE-EFFECTS**
- Uncommon Heart failure • syncope
- Frequency not known Neutropenia • serum sickness • vasculitis

**HEPATIC IMPAIRMENT**

Dose adjustments Manufacturer advises maximum 80 mg daily in mild to moderate impairment.

**RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate is less than 30 mL/minute/1.73 m²—no information available.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral solution**
- **Diovan** (Novartis Pharmaceuticals UK Ltd)
  - Valsartan 3 mg per 1 ml Diovan 3mg/ml oral solution | 160 ml (PO) £12.20 DT = £1.20

**Tablet**
- **Valsartan (Non-proprietary)**
  - Valsartan 40 mg | 7 tablet (PO) £7.50 DT = £1.17
  - Valsartan 160 mg | 28 tablet (PO) £14.69 DT = £1.46
  - Valsartan 320 mg | 28 tablet (PO) £20.23 DT = £1.93

**Capsule**
- **Valsartan (Non-proprietary)**
  - Valsartan 40 mg | 28 capsule (PO) £13.97 DT = £4.53
  - Valsartan 80 mg | 28 capsule (PO) £13.97 DT = £6.79
  - Valsartan 160 mg | 28 capsule (PO) £18.41 DT = £7.81

**VASODILATORS** → **VASODILATOR ANTHYPERTENSIVES**

**Hydralazine hydrochloride**

29-Mar-2017

**INDICATIONS AND DOSE**

**Resistant hypertension (adjunct)**
- **BY MOUTH**
  - Neonate: 250–500 micrograms/kg every 8–12 hours, increased if necessary to 2–3 mg/kg every 8 hours.

  - Child 1 month–11 years: 250–500 micrograms/kg every 8–12 hours, increased if necessary to 7.5 mg/kg daily; maximum 200 mg per day

  - Child 12–17 years: 25 mg twice daily, increased to 50–100 mg twice daily

  - BY SLOW INTRAVENOUS INJECTION

  - Neonate: 100–500 micrograms/kg, dose may be repeated if necessary every 4–6 hours; maximum 3 mg/kg per day.

  - Child 1 month–11 years: 100–500 micrograms/kg, dose may be repeated if necessary every 4–6 hours; maximum 3 mg/kg per day; maximum 60 mg per day

  - Child 12–17 years: 5–10 mg, dose may be repeated if necessary every 4–6 hours

  - BY CONTINUOUS INTRAVENOUS INFUSION

  - Neonate: 12.5–50 micrograms/kg/hour, continuous intravenous infusion is the preferred route in cardiac patients; maximum 2 mg/kg per day.

  - Child 1 month–11 years: 12.5–50 micrograms/kg/hour, continuous intravenous infusion is the preferred route in cardiac patients; maximum 3 mg/kg per day

  - Child 12–17 years: 3–9 mg/hour, continuous intravenous infusion is the preferred route in cardiac patients; maximum 3 mg/kg per day

**UNLICENSED USE** Not licensed for use in children.

**CONTRA-INDICATIONS** Acute porphyria p. 624 • cor pulmonale • high output heart failure • idiopathic systemic lupus erythematosus • myoccardial insufficiency due to mechanical obstruction • severe tachycardia

**CAUTIONS** Cerebrovascular disease • occasionally blood pressure reduction too rapid even with low parenteral doses

**INTERACTIONS** → Appendix 1: hydralazine

**SIDE-EFFECTS**
- Common or very common Angina pectoris • diarrhea • dizziness • flushing • gastrointestinal disorders • headache • hypotension • joint disorders • lupus-like syndrome (after long-term therapy (more common in slow acetylator individuals)) • myalgia • nasal congestion • nausea • palpitations • tachycardia • vomiting

  - Rare or very rare Acute kidney injury • agranulocytosis • anaemia • anxiety • appetite decreased • conjunctivitis • depression • dyspnoea • eosinophilia • eye disorders • fever • glomerulonephritis • haematuria • haemolytic anaemia • hallucination • heart failure • hepatic disorders • leucocytosis • leucopenia • lymphadenopathy • malaise • nerve disorders • neutropenia • oedema • pancytopenia • paradoxical pressor response • paraesthesia • pleuritic pain • proteinuria • skin reactions • splenomegaly •
thrombocytopenia • urinary retention • vasculitis • weight decreased

SIDE-EFFECTS, FURTHER INFORMATION The incidence of side-effects is lower if the dose is kept low, but systemic lupus erythematosus should be suspected if there is unexplained weight loss, arthritis, or any other unexplained ill health.

PREGNANCY Neonatal thrombocytopenia reported, but risk should be balanced against uncontrolled maternal hypertension. Manufacturer advises avoid before third trimester.

BREAST FEEDING Present in milk but not known to be harmful. Monitoring Monitor infant in breast-feeding.

HEPATIC IMPAIRMENT Present in milk but not known to be harmful.

BREAST FEEDING Present in milk but not known to be harmful.

RENAL IMPAIRMENT Dose adjustments Manufacturer advises adjust dose or dosing interval according to clinical response.

RENAL IMPAIRMENT Dose adjustments Reduce dose if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

MONITORING REQUIREMENTS Manufacturer advises test for antinuclear factor and for proteinuria every 6 months and check acetylator status before increasing dose, but evidence of clinical value unsatisfactory.

DIRECTIONS FOR ADMINISTRATION

With oral use For administration by mouth, diluted injection may be given orally.

With intravenous use For continuous intravenous infusion, initially reconstitute 20 mg with 1 mL Water for Injections, then dilute with Sodium Chloride 0.9%. Incompatible with Glucose intravenous infusion. For intravenous injection, initially reconstitute 20 mg with 1 mL Water for Injections, then dilute to a concentration of 0.5–1 mg/mL with Sodium Chloride 0.9% and administer over 5–20 minutes.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Table: Lonten (Pfizer Ltd) Minoxidil 2.5 mg Lonten 2.5mg tablets | 60 tablet £8.88 DT £8.88 Minoxidil 5 mg Lonten 5mg tablets | 60 tablet £15.83 DT + £15.83 Minoxidil 10 mg Lonten 10mg tablets | 60 tablet £30.68 DT + £30.68

4.1a Hypertension associated with phaeochromocytoma

Other drugs used for Hypertension associated with phaeochromocytoma Propranolol hydrochloride, p. 106

VASODILATORS > PERIPHERAL VASODILATORS

Phenoxybenzamine hydrochloride

INDICATIONS AND DOSE

Hypertension in phaeochromocytoma

BY MOUTH

• Child: 0.5–1 mg/kg twice daily, adjusted according to response

UNLICENSED USE Not licensed for use in children.

CONTRA-INDICATIONS History of cerebrovascular accident

CAUTIONS Avoid contact with skin (risk of contact sensitisation) - avoid in Acute porphyrias p. 624 - carcinogenic in animals - cerebrovascular disease - congestive heart failure - severe ischaemic heart disease

SIDE-EFFECTS Abdominal distress • dizziness • ejaculation failure • fatigue • miotic • nasal congestion • postural hypotension • reflex tachycardia

PREGNANCY Hypotension may occur in newborn.

BREAST FEEDING May be present in milk.

RENAI IMPAIRMENT Use with caution.

DIRECTIONS FOR ADMINISTRATION For administration by mouth, capsules may be opened.

HANDLING AND STORAGE Owing to risk of contact sensitisation healthcare professionals should avoid contamination of hands.

Phenoxybenzamine hydrochloride

INDICATIONS AND DOSE

Severe hypertension

BY MOUTH

• Child 1 month–11 years: Initially 200 micrograms/kg daily in 1–2 divided doses, then increased in steps of 100–200 micrograms/kg, increased at intervals of at least 3 days; maximum 1 mg/kg per day

• Child 12–17 years: Initially 5 mg daily in 1–2 divided doses, then increased in steps of 5–10 mg daily, increased at intervals of at least 3 days, seldom necessary to exceed 50 mg daily; maximum 100 mg per day

CONTRA-INDICATIONS Phaeochromocytoma

Minoxidil

INDICATIONS AND DOSE

Severe hypertension

BY MOUTH

• Child 1 month–11 years: Initially 200 micrograms/kg daily in 1–2 divided doses, then increased in steps of 100–200 micrograms/kg, increased at intervals of at least 3 days; maximum 1 mg/kg per day

• Child 12–17 years: Initially 5 mg daily in 1–2 divided doses, then increased in steps of 5–10 mg daily, increased at intervals of at least 3 days, seldom necessary to exceed 50 mg daily; maximum 100 mg per day

CONTRA-INDICATIONS Phaeochromocytoma
4.1b Hypertensive crises

Other drugs used for Hypertensive crises: Hydralazine hydrochloride, p. 118 - Labetalol hydrochloride, p. 105

VASODILATORS > VASODILATOR

ANTITHY HYPERTENSIVES

Sodium nitroprusside

- INDICATIONS AND DOSE
  - Hypertensive emergencies
    - BY CONTINUOUS INTRAVENOUS INFUSION
      - Neonate: Initially 500 nanograms/kg/minute, then increased in steps of 200 nanograms/kg/minute (max. per dose 8 micrograms/kg/minute) as required, max. 4 micrograms/kg/minute if used for longer than 24 hours.
      - Child: Initially 500 nanograms/kg/minute, then increased in steps of 200 nanograms/kg/minute (max. per dose 8 micrograms/kg/minute) as required, max. 4 micrograms/kg/minute if used for longer than 24 hours.

- UNLICENSED USE
- CONTRA-INDICATIONS
- CAUTIONS
- INTERACTIONS ➔ Appendix 1: sodium nitroprusside

SIDE-EFFECTS
  - Abdominal pain - anxiety - chest discomfort - diaphoresis - headache - hypertension - nausea - palpitations - vomiting

SIDE-EFFECTS, FURTHER INFORMATION
  Side-effects associated with over rapid reduction in blood pressure: Headache, dizziness, nausea, retching, abdominal pain, perspiration, palpitation, anxiety, retrosternal discomfort—reduce infusion rate if any of these side-effects occur.

Overdose
  Side-effects caused by excessive plasma concentration of the cyanide metabolite include tachycardia, sweating, hyperventilation, arrhythmias, marked metabolic acidosis (discontinue and give antidote, see cyanide in Emergency treatment of poisoning p. 859).

PREGNANCY
  Avoid prolonged use—potential for accumulation of cyanide in fetus.

BREAST FEEDING
  No information available. Caution advised due to thiocyanate metabolite.

HEPATIC IMPAIRMENT
  Use with caution. Avoid in hepatic failure—cyanide or thiocyanate metabolites may accumulate.

RENAL IMPAIRMENT
  Avoid prolonged use—cyanide or thiocyanate metabolites may accumulate.

MONITORING REQUIREMENTS
  Monitor blood pressure (including intra-arterial blood pressure) and blood-cyanide concentration, and if treatment exceeds 3 days, also blood thiocyanate concentration.

TREATMENT CESSATION
  Avoid sudden withdrawal—terminate infusion over 15–30 minutes.

DIRECTIONS FOR ADMINISTRATION
  For continuous intravenous infusion in Glucose 5%, infuse via infusion device to allow precise control. For further details, consult product literature. Protect infusion from light.

MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

Powder and solvent for solution for infusion
  Sodium nitroprusside dihydrate 50 mg
  Sodium nitroprusside 50 mg
  Powder and solvent for solution for infusion vials | 1 vial P6X

4.1c Pulmonary hypertension

ANTITHROMBOTIC DRUGS > PROSTAGLANDINS, CARDIOVASCULAR

Epoprostenol
  (Prostacyclin)

- DRUG ACTION
  Epoprostenol is a prostaglandin and a potent vasodilator. It is also a powerful inhibitor of platelet aggregation.

- INDICATIONS AND DOSE
  Persistent pulmonary hypertension of the newborn
  BY CONTINUOUS INTRAVENOUS INFUSION
  - Neonate: Initially 2 nanograms/kg/minute (max. per dose 20 nanograms/kg/minute), adjusted according to response, rarely doses up to 40 nanograms/kg/minute are used.

Idiopathic pulmonary arterial hypertension
  BY CONTINUOUS INTRAVENOUS INFUSION
  - Child: Initially 2 nanograms/kg/minute, increased if necessary up to 40 nanograms/kg/minute

PHARMACOKINETICS
  - Short half-life of approximately 3 minutes, therefore it must be administered by continuous intravenous infusion.

- UNLICENSED USE
- CONTRA-INDICATIONS
  Pulmonary veno-occlusive disease - severe left ventricular dysfunction

CAUTIONS
  Avoid abrupt withdrawal (risk of rebound pulmonary hypertension/pulmonary hypertensive crisis), haemorrhagic diathesis

INTERACTIONS ➔ Appendix 1: epoprostenol

SIDE-EFFECTS
  - Common or very common
    - Abdominal pain - anxiety - arrhythmias - arthralgia - chest discomfort - diarrhoea - flushing - haemorrhage - headache - intracranial haemorrhage - nausea - pain - rash - sepsis - vomiting
  - Uncommon
    - Dry mouth - hyperhidrosis
  - Rare or very rare
    - Fatigue - hyperthromboid - intravenous catheter occlusion - local infection - pallor
  - Frequency not known
    - Aspites - pulmonary oedema (avoid chronic use if occurs during dose titration), spleen abnormalities

PREGNANCY
  Manufacturer advises caution—no information available.

BREAST FEEDING
  Manufacturer advises avoid—no information available.

MONITORING REQUIREMENTS
  Anticoagulant monitoring required when given with anticoagulants.
  Monitor blood pressure.
**PULMONARY HYPERTENSION**

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**Indications and Dose**

**Idiopathic or familial pulmonary arterial hypertension** (initiated under specialist supervision)

- **By Inhalation of Nebulised Solution**
  - Child 8-17 years: Initially 2.5 micrograms for 1 dose, increased to 5 micrograms for 1 dose, increased if tolerated to 5 micrograms 6–9 times a day, adjusted according to response; reduced if not tolerated to 2.5 micrograms 6–9 times a day, reduce to lower maintenance dose if high dose not tolerated.

**Raynaud’s syndrome**

- **Child 12-17 years:** Initially 30 nanograms/kg/hour, increased to 60–120 nanograms/kg/hour daily for 3–5 days, dose to be given over 6 hours, dose increase should be performed gradually.

**Unlicensed Use**

- Not licensed for use in children.

**Contra-indications**

- Conditions which increase risk of haemorrhage - congenital or acquired valvular defects of the myocardium - decompensated cardiac failure (unless under close medical supervision) - pulmonary veno-occlusive disease - severe arrhythmias - severe coronary heart disease

**Caution**

**General Caution**

- Hypotension (do not initiate if systolic blood pressure below 85 mmHg) - unstable pulmonary hypertension with advanced right heart failure

**Specific Caution**

- When used by inhalation: Acute pulmonary infection - severe asthma

**Interactions**

- Appendix 1: Iloprost

**Side-effects**

- Common or very common: Chest discomfort - cough - diarrhea - dizziness - dyspnoea - haemorrhage - headache - hypotension - nausea - oral disorders - pain - palpitations - rash - syncope - tachycardia - throat complaints - vasodilatation - vomiting

- Frequency not known: Respiratory disorders - taste altered - thrombocytopenia

**Pregnancy**

- When used by inhalation: Use if potential benefit outweighs risk.

**Breast Feeding**

- When used by inhalation: Manufacturer advises avoid—no information available.

**Hepatic Impairment**

- Dose adjustments: When used by inhalation: Initially 2.5 micrograms at intervals of 3–4 hours (max. 6 times daily), adjusted according to response (consult product literature).

- Dose may need to be halved in liver cirrhosis.

**Directions for Administration**

- With intravenous use: For **intravenous infusion** dilute to a concentration of 200 nanograms/mL with Glucose 5% or Sodium Chloride 0.9%; alternatively, may be diluted to a concentration of 2 micrograms/mL and given via syringe driver.

- When used by inhalation: For **inhaled treatment**, to minimise accidental exposure use only with nebulisers listed in Ventavis® product literature in a well ventilated room.

**Prescribing and Dispensing Information**

- When used by inhalation: Delivery characteristics of nebuliser devices may vary—only switch devices under medical supervision.

- With intravenous use: Concentrate for infusion available on a named patient basis from Bayer Schering in 0.5 mL and 1 mL ampoules.

**Medicinal Forms**

- There can be variation in the licensing of different medicines containing the same drug.

**Solution for Infusion**

- **Iloprost (Non-proprietary):**
  - **Iloprost** (as Iloprost trometamol) 100 microgram per 1 ml
  - **Iloprost** (as Iloprost trometamol) 10 microgram per 1 ml

**Nebuliser Liquid**

- **Ventavis** (Bayer Plc)
  - **Iloprost** (as Iloprost trometamol) 10 microgram per 1 ml
  - **Iloprost** (as Iloprost trometamol) 1 microgram per 1 ml

**Endothelin Receptor Antagonists**

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**Boventan**

**Indications and Dose**

**Pulmonary arterial hypertension (initiated under specialist supervision)**

- **By Mouth**
  - Child 2-17 years (body-weight 10–20 kg): Initially 31.25 mg once daily for 4 weeks, then increased to 31.25 mg twice daily.
  - Child 2-17 years (body-weight 20–40 kg): Initially 31.25 mg twice daily for 4 weeks, then increased to 62.5 mg twice daily.
  - Child 12-17 years (body-weight 40 kg and above): Initially 62.5 mg twice daily for 4 weeks, then increased to 125 mg twice daily (max. per dose 250 mg)

**Contra-indications**

- Acute porphyrias p. 624

**Caution**

- Not to be initiated if systemic systolic blood pressure is below 85 mmHg

**Interactions**

- Appendix 1: Boventan
**SIDE-EFFECTS**
- **Common or very common** Anaemia, diarrhoea, flushing, gastroesophageal reflux disease, headache, nasal congestion, palpitations, skin reactions, syncpe
- **Uncommon** Hepatic disorders, leucopenia, neutropenia, thrombocytopenia
- **Rare or very rare** Angioedema
- **Frequency not known** Vision blurred

**CONCEPTION AND CONTRACEPTION** Effective contraception required during administration (hormonal contraception not considered effective). Monthly pregnancy tests advised.

**PREGNANCY** Avoid (teratogenic in animal studies).

**BREAST FEEDING** Manufacturer advises avoid—no information available.

**HEPATIC IMPAIRMENT** Manufacturer advises avoid in moderate-to-severe impairment or if baseline serum transaminases exceed 3 times the upper limit of normal.

**MONITORING REQUIREMENTS**
- Monitor haemoglobin before and during treatment
- Monitor liver function before treatment, at monthly intervals during treatment, and 2 weeks after dose increase (reduce dose or suspend treatment if liver enzymes raised significantly)—discontinue if symptoms of liver impairment.

**TREATMENT CESSATION** Avoid abrupt withdrawal—withdraw treatment gradually.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**
- **Bosentan (Non-proprietary)**
  - Bosentan (as Bosentan monohydrate) 62.5 mg: Bosentan 62.5mg tablets | 56 tablet blister pack £112.50–£1,510.21
  - Bosentan (as Bosentan monohydrate) 125 mg: Bosentan 125mg tablets | 56 tablet blister pack £112.50–£1,510.21
- **Stayveer (Advanz Pharma)**
  - Bosentan (as Bosentan monohydrate) 62.5 mg: Stayveer 62.5mg tablets | 56 tablet blister pack £208.34
  - Bosentan (as Bosentan monohydrate) 125 mg: Stayveer 125mg tablets | 56 tablet blister pack £208.34
- **Tracleer (Actelion Pharmaceuticals UK Ltd)**
  - Bosentan (as Bosentan monohydrate) 62.5 mg: Tracleer 62.5mg tablets | 56 tablet blister pack £1,510.21
  - Bosentan (as Bosentan monohydrate) 125 mg: Tracleer 125mg tablets | 56 tablet blister pack £1,510.21

**PHOSPHODIESTERASE TYPE-5 INHIBITORS**

**Sildenafil**

**INDICATIONS AND DOSE** Pulmonary arterial hypertension (initiated under specialist supervision)

**BY MOUTH**
- Neonate: Initially 250–500 micrograms/kg every 4–8 hours, adjusted according to response, start with the lower dose and frequency, especially if used with other vasodilators; maximum 30 mg per day.
- Child 1–11 months: Initially 250–500 micrograms/kg every 4–8 hours, adjusted according to response, start with the lower dose and frequency, especially if used with other vasodilators; maximum 30 mg per day.
- Child 1–7 years (body-weight up to 20 kg): 10 mg 3 times a day
- Child 1–7 years (body-weight 20 kg and above): 20 mg 3 times a day

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**
- Manufacturer advises reduce dose with concurrent use of moderate and potent inhibitors of CYP3A4 (avoid with ketoconazole, itraconazole and ritonavir)—no specific recommendation made for children.

**UNLICENSED USE** Not licensed for use in children under 1 year.

**CONTRA-INDICATIONS** Hereditary degenerative retinal disorders, history of non-arteritic anterior ischaemic optic neuropathy, recent history of stroke, sickle-cell anaemia

**CAUTIONS** Active peptic ulceration, anatomical deformation of the penis, autonomic dysfunction, bleeding disorders, cardiovascular disease, hypotension (avoid if severe), intravascular volume depletion, left ventricular outflow obstruction, ocular disorders, predisposition to priapism, pulmonary veno-occlusive disease

**INTERACTIONS**
- **Common or very common** Alopecia, anaemia, anxiety, cough, diarrhoea, dizziness, fluid retention, gastrointestinal discomfort, gastrointestinal disorders, headaches, increased risk of infection, insomnia, nasal complaints, nausea, night sweats, pain, skin reactions, tremor, vasodilation, vision disorders
- **Uncommon** Arrhythmias, chest pain, drowsiness, dry eye, dry mouth, eye discomfort, eye disorders, eye inflammation, fatigue, feeling hot, gynaecomastia, haemorrhage, hypertension, hypotension, myalgia, numbness, palpitations, sinus congestion, tinnitus, vertigo, vomiting
- **Rare or very rare** Acute coronary syndrome, arteriosclerotic retinopathy, cerebrovascular insufficiency, glaucoma, haematospermia, hearing impairment, irritability, optic neuropathy (discontinue if sudden visual impairment occurs), oral hypoesthesia, priapism, retinal occlusion, scleral discoulouration, seizure, severe cutaneous adverse reactions (SCARs), sudden cardiac death, syncope, throat tightness

**PREGNANCY** Use only if potential benefit outweighs risk—no evidence of harm in animal studies.

**BREAST FEEDING** Manufacturer advises avoid—no information available.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in mild to moderate impairment, consider dose reduction in mild to moderate impairment (no information available).

**Dose adjustments** Manufacturer advises if not tolerated, consider dose reduction in mild to moderate impairment—consult product literature.

**RENAL IMPAIRMENT** Reduce dose if not tolerated.

**TREATMENT CESSATION** Avoid abrupt withdrawal.

**PATIENT AND CARER ADVICE**
- Medicines for Children leaflet: Sildenafil for pulmonary hypertension www.medicinesforchildren.org.uk/sildenafil-pulmonary-hypertension
- **NATIONAL FUNDING/ACCESS DECISIONS**
  - Scottish Medicines Consortium (SMC) decisions
    - The Scottish Medicines Consortium has advised (December 2012) that sildenafil (Revatio®) is accepted for restricted use within NHS Scotland for pulmonary arterial hypertension in children aged 1–17 years; sildenafil should only be prescribed on the advice of specialists in the Scottish Pulmonary Vascular Unit or the Scottish Adult Congenital Cardiac Service.
### Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, pessary

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<th>Tablet</th>
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<tr>
<td>Sildenafil (non-proprietary)</td>
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<tr>
<td>Sildenafil (as Sildenafil citrate) 20 mg</td>
<td>Silicone 20mg tablets</td>
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<td>Sildenafil (as Sildenafil citrate) 25 mg</td>
<td>Silicone 25mg tablets</td>
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<td>4 tablet [POM]</td>
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<td>Sildenafil (as Sildenafil citrate) 50 mg</td>
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<td>90 tablet [POM]</td>
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<td>Oral suspension</td>
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<td>Revatio 10mg/ml oral suspension sugar-free</td>
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### Sympathomimetics

#### Overview

The properties of sympathomimetics vary according to whether they act on alpha or on beta adrenergic receptors. Response to sympathomimetics can also vary considerably in children, particularly neonates. It is important to titrate the dose to the desired effect and to monitor the child closely.

#### Inotropic sympathomimetics

Dopamine hydrochloride p. 125 has a variable, unpredictable, and dose dependent impact on vascular tone. Low dose infusion normally causes vasodilatation, but there is little evidence that this is clinically beneficial; moderate doses increase myocardial contractility and cardiac output in older children, but in neonates moderate doses may cause a reduction in cardiac output. High doses cause vasoconstriction and increase vascular resistance, and should therefore be used with caution following cardiac surgery, or where there is co-existing neonatal pulmonary hypertension.

In neonates the response to inotropic sympathomimetics varies considerably, particularly in those born prematurely; careful dose titration and monitoring are necessary. Isoprenaline injection is available from ‘special-order’ manufacturers or specialist importing companies.

### Shock

Shock is a medical emergency associated with a high mortality. The underlying causes of shock such as haemorrhage, sepsis or myocardial insufficiency should be corrected. Additional treatment is dependent on the type of shock.

**Septic shock** is associated with severe hypovolaemia (due to vasodilation and capillary leak) which should be corrected with crystalloids or colloids. If hypotension persists despite volume replacement, dopamine hydrochloride should be started. For shock refractory to treatment with dopamine hydrochloride, if cardiac output is high and peripheral vascular resistance is low (warm shock), noradrenaline/norepinephrine p. 126 should be added or if cardiac output is low and peripheral vascular resistance is high (cold shock), adrenaline/epinephrine p. 138 should be added. Additionally, in cold shock, a vasodilator such as milrinone p. 129, glyceryl trinitrate p. 137, or sodium nitroprusside p. 120 (on specialist advice only) can be used to reduce vascular resistance.

If the shock is resistant to volume expansion and catecholamines, and there is suspected or proven adrenal insufficiency, low dose hydrocortisone p. 456 can be used. ACTH-stimulated plasma-cortisol concentration should be measured; however, hydrocortisone can be started without such information. Alternatively, if the child is resistant to catecholamines, and vascular resistance is low, vasopressin p. 69 can be added.

**Neonatal septic shock** can be complicated by the transition from fetal to neonatal circulation. Treatment to reverse right ventricular failure, by decreasing pulmonary artery pressures, is commonly needed in neonates with fluid-refractory shock and persistent pulmonary hypertension of the newborn. Rapid administration of fluid in neonates with patent ductus arteriosus may cause left-to-right shunting and congestive heart failure induced by ventricular overload.

In **cardiogenic shock**, the aim is to improve cardiac output and to reduce the afterload on the heart. If central venous pressure is low, cautious volume expansion with a colloid or crystalloid can be used. An inotrope such as adrenaline/epinephrine or dopamine hydrochloride should...
be given to increase cardiac output. Dobutamine below is a peripheral vasodilator and is an alternative if hypotension is not significant.

Methylxanthines have both inotropic and vasodilatory effects and can be used when vascular resistance is high. Alternatively, glyceryl trinitrate or sodium nitroprusside (on specialist advice only) can be used to reduce vasoconstriction. Hypovolaemic shock should be treated with a crystalloid or colloid solution (or whole or reconstituted blood if source of hypovolaemia is haemorrhage) and further steps to improve cardiac output and decrease vascular resistance can be taken, as in cardiogenic shock.

The use of sympathomimetic inotropes and vasoconstrictors should preferably be confined to the intensive care setting and undertaken with invasive haemodynamic monitoring.

See also advice on the management of anaphylactic shock in Antihistamines, allergen immunotherapy and allergic emergencies p. 174.

Vasoconstrictor sympathomimetics

Vasoconstrictor sympathomimetics raise blood pressure transiently by acting on alpha-adrenergic receptors to cause intense systemic vasoconstriction. Vasoconstrictor sympathomimetics should preferably be confined to the intensive care setting and undertaken with invasive haemodynamic monitoring.

See also advice on the management of anaphylactic shock in Antihistamines, allergen immunotherapy and allergic emergencies p. 174.

SYMPATHOMIMETICS ▶ INOTROPIC

Dobutamine

• **DRUG ACTION** Dobutamine is a cardiac stimulant which acts on beta receptors in cardiac muscle, and increases contractility.

• **INDICATIONS AND DOSE** Inotropic support in low cardiac output states, after cardiac surgery, cardiomyopathies, shock

  ▶ **BY CONTINUOUS INTRAVENOUS INFUSION**

  • **Neonate**: Initially 5 micrograms/kg/minute, then adjusted according to response to 2–20 micrograms/kg/minute, doses as low as 0.5–1 microgram/kg/minute have been used.

  • **Child**: Initially 5 micrograms/kg/minute, then adjusted according to response to 2–20 micrograms/kg/minute, doses as low as 0.5–1 microgram/kg/minute have been used.

• **CONTRA-INDICATIONS** Phaeochromocytoma

• **CAUTIONS** Acute heart failure · acute myocardial infarction · arrhythmias · correct hypercapnia before starting and during treatment · correct hypovolaemia before starting and during treatment · correct hypoxia before starting and during treatment · correct metabolic acidosis before starting and during treatment · diabetes mellitus · extravasation may cause tissue necrosis · extreme caution or avoid in marked obstruction of cardiac ejection (such as idiopathic hypertrophic subaortic stenosis) · hyperthyroidism · ischaemic heart disease · occlusive vascular disease · severe hypotension · susceptibility to angle-closure glaucoma · tachycardia · tolerance may develop with continuous infusions longer than 72 hours

• **INTERACTIONS** → Appendix 1: sympathomimetics, inotropic

• **SIDE-EFFECTS**

  ▶ **Common or very common** Arrhythmias · bronchospasm · chest pain · dyspnoea · eosinophilia · fever · inflammation localised · ischaemic heart disease · nausea · palpitations · platelet aggregation inhibition (on prolonged administration) · skin reactions · urinary urgency · vasoconstriction

  ▶ **Uncommon** Myocardial infarction

  ▶ **Rare or very rare** Atrialventricular block · cardiac arrest · coronary vasospasm · hypertension · hypokalaemia · hypotension

• **FREQUENCY NOT KNOWN** Anxiety · cardiomyopathy · feeling hot · headache · myoclonus · paraesthesia · tremor

• **PREGNANCY** No evidence of harm in animal studies – manufacturers advise use only if potential benefit outweighs risk.

• **BRREST FEEDING** Manufacturers advise avoid—no information available.

• **DIRECTIONS FOR ADMINISTRATION** Dobutamine injection should be diluted before use or given undiluted with syringe pump. Dobutamine concentrate for intravenous infusion should be diluted before use.

  For continuous intravenous infusion, using infusion pump, dilute to a concentration of 0.5–1 mg/mL (max. 5 mg/mL if fluid restricted) with Glucose 5% or Sodium Chloride 0.9%; infuse higher concentration solutions through central venous catheter only. Incompatible with bicarbonate and other strong alkaline solutions.

  In neonates Neonatal intensive care, dilute 30 mg/kg body-weight to a final volume of 50 mL with infusion fluid; an intravenous infusion rate of 0.5 mL/hour provides a dose of 5 micrograms/kg/minute; max. concentration of 5 mg/mL; infuse higher concentration solutions through central venous catheter only. Incompatible with bicarbonate and other strong alkaline solutions.

• **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for infusion

  **Solution for infusion**

  **EXCIPIENTS**: May contain Sulfites

  ▶ Dobutamine (Non-proprietary)

  **Dobutamine (as Dobutamine hydrochloride)** 5 mg per 1 mL Dobutamine 250mg/50mL solution for infusion vials | 1 vial (PST) £7.50

  **Dobutamine (as Dobutamine hydrochloride)** 12.5 mg per 1 mL Dobutamine 250mg/20mL concentrate for solution for infusion ampoules | 5 ampoule (PST) £12.00-£29.25 | 10 ampoule (PST) £52.50

Blood pressure conditions

Cardiovascular system

BNFC 2019-2020
Dopamine hydrochloride

**DRUG ACTION** Dopamine is a cardiac stimulant which acts on beta, receptors in cardiac muscle, and increases contractility with little effect on rate.

**INDICATIONS AND DOSE**
To correct the haemodynamic imbalance due to acute hypotension, shock, cardiac failure, adjunct following cardiac surgery

- **BY CONTINUOUS INTRAVENOUS INFUSION**

- **Neonate:** Initially 3 micrograms/kg/minute (max. per dose 20 micrograms/kg/minute), adjusted according to response.

- **Child:** Initially 5 micrograms/kg/minute (max. per dose 20 micrograms/kg/minute), adjusted according to response.

**UNLICENSED USE** Not licensed for use in children under 12 years.

**CONTRA-INDICATIONS** Phaeochromocytoma - tachyarrhythmia

**CAUTIONS** Correct hypovolaemia - hypertension (may raise blood pressure) - hyperthyroidism

**INTERACTIONS** Appendix 1: sympathomimetics, vasoconstrictor

**SIDE-EFFECTS** Angina pectoris - anxiety - arrhythmias - azotaemia - cardiac conduction disorder - dyspnoea - gangrene - headache - hypertension - mydriasis - nausea - palpitations - piloerection - polyuria - tremor - vasoconstriction - vomiting

**PREGNANCY** No evidence of harm in animal studies—manufacturer advises use only if potential benefit outweighs risk.

**BREAST FEEDING** May suppress lactation—not known to be harmful.

**DIRECTIONS FOR ADMINISTRATION** Dopamine concentrate for intravenous infusion to be diluted before use.

For **continuous intravenous infusion**, dilute to a max. concentration of 3.2 mg/mL with Glucose 5% or Sodium Chloride 0.9%. Infuse higher concentrations through central venous catheter using a syringe pump to avoid extravasation and fluid overload. Incompatible with bicarbonate and other alkaline solutions.

In neonates **Neonatal intensive care**, dilute 30 mg/kg body weight to a final volume of 50 mL with infusion fluid; an intravenous infusion rate of 0.3 mL/hour provides a dose of 3 micrograms/kg/minute; max. concentration of 3.2 mg/mL; infuse higher concentrations through central venous catheter. Incompatible with bicarbonate and other alkaline solutions.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for infusion

- **Dopamine hydrochloride (Non-proprietary)**
  - Dopamine hydrochloride 40 mg per 1 ml Dopamine 200mg/5ml solution for infusion ampoules | 5 ampoule £0.20 (Hospital only) | 5 ampoule £0.20 10 ampoule £0.94
  - Dopamine 200mg/5ml concentrate for solution for infusion ampoules | 10 ampoule £0.34
  - Dopamine hydrochloride 160 mg per 1 ml Dopamine 800mg/5ml solution for infusion ampoules | 10 ampoule £0.34

**SYMPATHOMIMETICS > VASOCONSTRICTOR**

Ephedrine hydrochloride

**INDICATIONS AND DOSE**
Reversal of hypotension from spinal or epidural anaesthesia

- **BY SLOW INTRAVENOUS INJECTION**
  - Child 1-11 years: 500–750 micrograms/kg every 3–4 minutes, adjusted according to response, alternatively 17–25 mg/m² every 3–4 minutes, adjusted according to response, injection solution to contain ephedrine hydrochloride 3 mg/ml; maximum 30 mg per course
  - Child 12-17 years: 3–7.5 mg every 3–4 minutes (max. per dose 9 mg), adjusted according to response, injection solution to contain ephedrine hydrochloride 3 mg/ml; maximum 30 mg per course

**CAUTIONS** Diabetes mellitus - hypertension - hyperthyroidism - susceptibility to angle-closure glaucoma

**INTERACTIONS** Appendix 1: sympathomimetics, vasoconstrictor

**SIDE-EFFECTS**
- **Common or very common** Anxiety - arrhythmias - asthenia - confusion - depression - dyspnoea - headache - hypertension - mydriasis - insomnia - irritability - nausea - palpitations - vomiting
  - **Rare or very rare** Acute urinary retention
  - **Frequency not known** Acute angle closure glaucoma - angina pectoris - appetite decreased - cardiac arrest - dizziness - hypokalaemia - intracranial haemorrhage - psychotic disorder - pulmonary oedema - tremor

**PREGNANCY** Increased fetal heart rate reported with parenteral ephedrine.

**BREAST FEEDING** Present in milk; manufacturer advises avoid—irritability and disturbed sleep reported.

**RENAL IMPAIRMENT** Use with caution.

**DIRECTIONS FOR ADMINISTRATION** For **slow intravenous injection**, give via central venous catheter using a solution containing ephedrine hydrochloride 3 mg/ml.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Ephedrine hydrochloride (Non-proprietary)**
  - Ephedrine hydrochloride 3 mg per 1 ml Ephedrine 30mg/10ml solution for injection ampoules | 10 ampoule (P) £9.32
  - Ephedrine 30mg/10ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £7.59–£9.50 | 12 pre-filled disposable injection £114.00
  - Ephedrine hydrochloride 30 mg per 1 ml Ephedrine 30mg/1ml solution for injection ampoules | 10 ampoule (P) £52.50–£60.28 DT = £60.28

Metaraminol

**INDICATIONS AND DOSE**
**Acute hypotension**

- **BY INTRAVENOUS INJECTION**
  - Child 12-17 years: 15–100 mg, adjusted according to response

**Emergency treatment of acute hypotension**

- **INITIALLY BY INTRAVENOUS INJECTION**
  - Child 12-17 years: Initially 0.5–5 mg, then (by intravenous infusion) 15–100 mg, adjusted according to response

**UNLICENSED USE** Not licensed for use in children.

**CONTRA-INDICATIONS** Hypertension
CAUTIONS Cirrhosis · coronary vascular thrombosis · diabetes mellitus · extravasation at injection site may cause necrosis, following myocardial infarction · hypercapnia · hyperthyroidism · hypoxia · mesenteric vascular thrombosis · peripheral vascular thrombosis · Prinzmetal’s variant angina · susceptibility to angle-closure glaucoma · uncorrected hypovolaemia

CAUTIONS, FURTHER INFORMATION
- Hypertensive response Metaraminol has a longer duration of action than noradrenaline, and an excessive vasopressor response may cause a prolonged rise in blood pressure.

INTERACTIONS → Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
- Common or very common Headache · hypertension
- Rare or very rare Skin exfoliation · soft tissue necrosis
- Frequency not known Abscess · arrhythmias · nausea · palpitations · peripheral ischaemia

PREGNANCY May reduce placental perfusion—manufacturer advises caution—no information available.

BREAST FEEDING Manufacturer advises caution if potential benefit outweighs risk.

DIRECTIONS FOR ADMINISTRATION Monitor blood pressure and rate of flow frequently.

WEBEDRUGS.COM

INTERACTIONS
- Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
- Anxiety · arrhythmias · dyspnoea · extravasation necrosis · headache · hypertension · hypovolaemia · peripheral ischaemia

PREGNANCY Manufacturer advises use if potential benefit outweighs risk—may reduce placental perfusion and induce fetal bradycardia.

ADVERSE REACTIONS
- Hypertension
- Headache
- Anxiety
- Arrhythmias
- Hypovolaemia
- Extravasation, necrosis
- Peripheral ischaemia
- Hypercapnia
- Hypoxia
- Mesenteric vascular thrombosis
- Peripheral vascular thrombosis
- Prinzmetal’s variant angina
- Susceptibility to angle-closure glaucoma

DOSAGE REQUIREMENTS
- Neonate: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose.

- Child: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose

DOSE EQUIVALENT AND CONVERSION
- 1 mg of noradrenaline base is equivalent to 2 mg of noradrenaline acid tartrate. Doses expressed as the base.

UNLICENSED USE Not licensed for use in children.

IMPORTANT SAFETY INFORMATION
- Association of noradrenaline/norepinephrine 0.08 mg/mL (4 mg in 50 mL) solution for infusion with potential risk of medication errors. Healthcare professionals should be aware of the differences in strength and presentation between noradrenaline/norepinephrine products—manufacturer advises noradrenaline 0.08 mg/mL solution for infusion must not be diluted before use and should only be used

for the on-going treatment of patients already established on noradrenaline therapy, whose dose requirements are clinically confirmed to be escalating.

CONTRA-INDICATIONS Hypertension

CAUTIONS Coronary vascular thrombosis · diabetes mellitus · extravasation at injection site may cause necrosis · following myocardial infarction · hypercapnia · hyperthyroidism · hypoxia · mesenteric vascular thrombosis · peripheral vascular thrombosis · Prinzmetal’s variant angina · susceptibility to angle-closure glaucoma · uncorrected hypovolaemia

INTERACTIONS → Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
- Vasoconstrictor action than noradrenaline, and an excessive vasopressor response may cause a prolonged rise in blood pressure.

WEBEDRUGS.COM

INTERACTIONS
- Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
- Vasoconstrictor

PREGNANCY Manufacturer advises use if potential benefit outweighs risk.

ADVERSE REACTIONS
- Hypertension
- Headache
- Anxiety
- Arrhythmias
- Hypovolaemia
- Extravasation, necrosis
- Peripheral ischaemia
- Hypercapnia
- Hypoxia
- Mesenteric vascular thrombosis
- Peripheral vascular thrombosis
- Prinzmetal’s variant angina
- Susceptibility to angle-closure glaucoma

DOSAGE REQUIREMENTS
- Neonate: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose.

- Child: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose

DOSE EQUIVALENT AND CONVERSION
- 1 mg of noradrenaline base is equivalent to 2 mg of noradrenaline acid tartrate. Doses expressed as the base.

UNLICENSED USE Not licensed for use in children.

IMPORTANT SAFETY INFORMATION
- Association of noradrenaline/norepinephrine 0.08 mg/mL (4 mg in 50 mL) solution for infusion with potential risk of medication errors. Healthcare professionals should be aware of the differences in strength and presentation between noradrenaline/norepinephrine products—manufacturer advises noradrenaline 0.08 mg/mL solution for infusion must not be diluted before use and should only be used

for the on-going treatment of patients already established on noradrenaline therapy, whose dose requirements are clinically confirmed to be escalating.

CONTRA-INDICATIONS Hypertension

CAUTIONS Coronary vascular thrombosis · diabetes mellitus · extravasation at injection site may cause necrosis · following myocardial infarction · hypercapnia · hyperthyroidism · hypoxia · mesenteric vascular thrombosis · peripheral vascular thrombosis · Prinzmetal’s variant angina · susceptibility to angle-closure glaucoma · uncorrected hypovolaemia

INTERACTIONS → Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
- Vasoconstrictor

PREGNANCY Manufacturer advises use if potential benefit outweighs risk.

ADVERSE REACTIONS
- Hypertension
- Headache
- Anxiety
- Arrhythmias
- Hypovolaemia
- Extravasation, necrosis
- Peripheral ischaemia
- Hypercapnia
- Hypoxia
- Mesenteric vascular thrombosis
- Peripheral vascular thrombosis
- Prinzmetal’s variant angina
- Susceptibility to angle-closure glaucoma

DOSAGE REQUIREMENTS
- Neonate: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose.

- Child: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose

DOSE EQUIVALENT AND CONVERSION
- 1 mg of noradrenaline base is equivalent to 2 mg of noradrenaline acid tartrate. Doses expressed as the base.

UNLICENSED USE Not licensed for use in children.

IMPORTANT SAFETY INFORMATION
- Association of noradrenaline/norepinephrine 0.08 mg/mL (4 mg in 50 mL) solution for infusion with potential risk of medication errors. Healthcare professionals should be aware of the differences in strength and presentation between noradrenaline/norepinephrine products—manufacturer advises noradrenaline 0.08 mg/mL solution for infusion must not be diluted before use and should only be used

for the on-going treatment of patients already established on noradrenaline therapy, whose dose requirements are clinically confirmed to be escalating.

CONTRA-INDICATIONS Hypertension

CAUTIONS Coronary vascular thrombosis · diabetes mellitus · extravasation at injection site may cause necrosis · following myocardial infarction · hypercapnia · hyperthyroidism · hypoxia · mesenteric vascular thrombosis · peripheral vascular thrombosis · Prinzmetal’s variant angina · susceptibility to angle-closure glaucoma · uncorrected hypovolaemia

INTERACTIONS → Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
- Vasoconstrictor

PREGNANCY Manufacturer advises use if potential benefit outweighs risk.

ADVERSE REACTIONS
- Hypertension
- Headache
- Anxiety
- Arrhythmias
- Hypovolaemia
- Extravasation, necrosis
- Peripheral ischaemia
- Hypercapnia
- Hypoxia
- Mesenteric vascular thrombosis
- Peripheral vascular thrombosis
- Prinzmetal’s variant angina
- Susceptibility to angle-closure glaucoma

DOSAGE REQUIREMENTS
- Neonate: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose.

- Child: 20–100 micrograms/kg/minute (max. per dose 1 microgram/kg/minute), adjusted according to response, dilute the 1 mg/mL concentrate for infusion for this dose

DOSE EQUIVALENT AND CONVERSION
- 1 mg of noradrenaline base is equivalent to 2 mg of noradrenaline acid tartrate. Doses expressed as the base.

UNLICENSED USE Not licensed for use in children.
Phenylephrine hydrochloride

**INDICATIONS AND DOSE**

**Acute hypotension**
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Child 1-11 years: 100 micrograms/kg every 1–2 hours (max. per dose 5 mg) as required
  - Child 12-17 years: Initially 2–5 mg (max. per dose 5 mg), followed by 1–10 mg, after at least 15 minutes if required
- **BY SLOW INTRAVENOUS INJECTION**
  - Child 1-11 years: Initially 5–20 micrograms/kg (max. per dose 500 micrograms), repeated as necessary after at least 15 minutes
  - Child 12-17 years: 100–500 micrograms, repeated as necessary after at least 15 minutes
- **BY INTRAVENOUS INFUSION**
  - Child 1-5 years: Initially 100–500 nanograms/kg/minute, adjusted according to response
  - Child 16-17 years: Initially up to 180 micrograms/minute, reduced to 30–60 micrograms/minute, adjusted according to response

**INTERACTIONS**
- Appendix 1: sympathomimetics, vasoconstrictor

**CAUTIONS**
- Coronary disease • coronary vascular thrombosis • diabetes • extravasation at injection site may cause necrosis • following myocardial infarction • hypercapnia • hyperthyroidism • hypoxia • mesenteric vascular thrombosis • peripheral vascular thrombosis • Prinzmetal’s variant angina • susceptibility to angle-closure glaucoma • uncorrected hypovolaemia

**CAUTIONS, FURTHER INFORMATION**
- Hypertensive response Phenylephrine has a longer duration of action than noradrenaline (norepinephrine), and an increased risk of infection when used in pregnancy is lacking. If carvedilol is used close to delivery, infants should be monitored for signs of alpha-blockade (as well as beta-blockade).

**UNLICENSED USE**
- Not licensed for use in children by intravenous infusion or injection.

**CONTRA-INDICATIONS**
- Hypertension • severe hyperthyroidism

**SIDE-EFFECTS**
- Angina pectoris • arrhythmias • cardiac arrest • dizziness • dyspepsia • flushing • glucose tolerance impaired • headache • hyperhidrosis • hypersalivation • hypotension • intracranial haemorrhage • metabolic change • mydriasis • palpitations • paraesthesia • peripheral coldness • pulmonary oedema • soft tissue necrosis • syncope • urinary disorders • vomiting

**PREGNANCY**
- Avoid if possible; malformations reported following use in first trimester; fetal hypoxia and bradycardia reported in late pregnancy and labour.

**MONITORING REQUIREMENTS**
- Contra-indicated in hypertension—monitor blood pressure and rate of flow frequently.

**DIRECTIONS FOR ADMINISTRATION**
- For **intravenous injection**, dilute to a concentration of 1 mg/mL with Water for Injections and administer slowly. For **intravenous infusion**, dilute to a concentration of 20 micrograms/mL with Glucose 5% or Sodium Chloride 0.9% and administer as a continuous infusion via a central venous catheter using a controlled infusion device.

**PRESCRIBING AND DISPENSING INFORMATION**
- Intraocular pressure

**INTERACTIONS**
- Appendix 1: beta blockers, non-selective

**SIDE-EFFECTS**
- Common or very common • Anaemia • asthma • dyspepsia • eye irritation • fluid imbalance • genital oedema • hypercholesterolaemia • hyperglycaemia • hypoglycaemia • increased risk of infection • oedema • postural hypotension • pulmonary oedema • renal impairment • urinary disorders • weight increased
- Uncommon • Alopecia • angina pectoris • constipation • hyperhidrosis • skin reactions
- Rare or very rare • Dry mouth • hypersensitivity • leucopenia • nasal congestion • severe cutaneous adverse reactions (SCARs) • thrombocytopenia

**PREGNANCY**
- Information on the safety of carvedilol during pregnancy is lacking. If carvedilol is used close to delivery, infants should be monitored for signs of alpha-blockade (as well as beta-blockade).

**BETA-ADRENOCEPTOR BLOCKERS**

**ALPHA- AND BETA-ADRENOCEPTOR BLOCKERS**

**Address**

- **BY INTRAVENOUS INFUSION**
  - Child 1-5 years: 100–500 nanograms/kg/minute, adjusted according to response
  - Child 16-17 years: Initially up to 180 micrograms/minute, reduced to 30–60 micrograms/minute, adjusted according to response

**MEDICINAL FORMS**

**Solution for injection**
- **Phenylephrine hydrochloride (Non-proprietary)**
  - Phenylephrine (as Phenylephrine hydrochloride) 50 microgram per 1 ml Phenylephrine 500micrograms/10ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £5.00 | 10 pre-filled disposable injection 10 ampoule £50.00
  - Phenylephrine hydrochloride 100 microgram per 1 ml Phenylephrine 1mg/10ml solution for injection ampoules | 10 ampoule £99.12

**5 Heart failure**

**Other drugs used for Heart failure**
- Bendroflumethiazide, p. 113 • Candesartan cilexetil, p. 117 • Captopril, p. 114 • Chlorothiazide, p. 113 • Chlortalidone, p. 144 • Digoxin, p. 82 • Enalapril maleate, p. 115 • Glycerol trinitrate, p. 137 • Hydralazine hydrochloride, p. 118 • Lisinopril, p. 116 • Losartan potassium, p. 117 • Metoprolol tartrate, p. 109 • Prazosin, p. 103 • Sodium nitroprusside, p. 120 • Valsartan, p. 118

**Carvedilol**

**INDICATIONS AND DOSE**

**Adjunct in heart failure (limited information available)**
- **BY MOUTH**
  - Child 2-17 years: Initially 50 micrograms/kg twice daily (max. per dose 3.125 mg) for at least 2 weeks, then increased to 100 micrograms/kg twice daily for at least 2 weeks, then increased to 200 micrograms/kg twice daily, then increased if necessary up to 350 micrograms/kg twice daily (max. per dose 25 mg)

**UNLICENSED USE**
- Not licensed for use in children under 18 years.

**CONTRA-INDICATIONS**
- Acute or decompensated heart failure requiring intravenous inotropes

**INTERACTIONS**
- Appendix 1: beta blockers, non-selective

**SIDE-EFFECTS**
- Common or very common • Anaemia • asthma • dyspepsia • eye irritation • fluid imbalance • genital oedema • hypercholesterolaemia • hyperglycaemia • hypoglycaemia • increased risk of infection • oedema • postural hypotension • pulmonary oedema • renal impairment • urinary disorders • weight increased
- Uncommon • Alopecia • angina pectoris • constipation • hyperhidrosis • skin reactions
- Rare or very rare • Dry mouth • hypersensitivity • leucopenia • nasal congestion • severe cutaneous adverse reactions (SCARs) • thrombocytopenia

**PREGNANCY**
- Information on the safety of carvedilol during pregnancy is lacking. If carvedilol is used close to delivery, infants should be monitored for signs of alpha-blockade (as well as beta-blockade).

**BREAST FEEDING**
- Infants should be monitored as there is a risk of possible toxicity due to alpha-blockade (in addition to beta-blockade).

**HEPATIC IMPAIRMENT**
- Manufacturer advises dose adjustment may be required in moderate impairment.
Heart failure

DIRECTIONS FOR ADMINISTRATION
Consult product literature. Intravenous injection to be given over at least 3 minutes.

PRESCRIBING AND DISPENSING INFORMATION
Potassium canrenoate injection is available from 'special-order' manufacturers or specialist importing companies.

Medicines for Children leaflet: Carvedilol for heart failure
www.medicinesforchildren.org.uk/carvedilol-heart-failure-0

Monitoring requirements
Monitor renal function during dose titration in patients with heart failure who also have renal impairment, low blood pressure, ischaemic heart disease, or diffuse vascular disease.

Patient and carer advice
Medicines for Children leaflet: Carvedilol for heart failure
www.medicinesforchildren.org.uk/carvedilol-heart-failure-0

Monitoring requirements
Monitor electrolytes (discontinue if hyperkalaemia occurs).

Indications and dose
Oedema in heart failure and in ascites | Nephrotic syndrome | Reduction of hypokalaemia induced by diuretics or amphotericin

By mouth

Neonate: Initially 1–2 mg/kg daily in 1–2 divided doses; increased if necessary up to 7 mg/kg daily, in resistant ascites.

Child 1 month–11 years: Initially 1–3 mg/kg daily in 1–2 divided doses; increased if necessary up to 9 mg/kg daily, in resistant ascites

Child 12–17 years: Initially 50–100 mg daily in 1–2 divided doses; increased if necessary up to 9 mg/kg daily, in resistant ascites; maximum 400 mg per day

Unlicensed use
Not licensed for reduction of hypokalaemia induced by diuretics or amphotericin.

Contra-indications
Addison’s disease - anuria - hyperkalaemia.

Caution
Acute porphyrias p. 624 - potential metabolic products carcinogenic in rodents.

Interactions
Appendix 1: aldosterone antagonists

Side-effects

Pregnancy
Use only if potential benefit outweighs risk—feminisation of male fetus in animal studies.

Breast feeding
Metabolites present in milk, but amount probably too small to be harmful.

Renal impairment
Avoid in acute renal insufficiency or severe impairment. Monitor Monitor plasma-potassium concentration (high risk of hyperkalaemia in renal impairment).

Monitoring requirements
Monitor electrolytes—discontinue if hyperkalaemia occurs.

Prescribing and dispensing information
The RCPCH and NPPG recommend that, when a liquid special of spironolactone is required, the following strength is used: 50 mg/5 mL.

Patient and carer advice
Medicines for Children leaflet: Spironolactone for heart failure
www.medicinesforchildren.org.uk/spironolactone-heart-failure

Unlicensed use
Not licensed for use in the UK.

Contra-indications
Hyperkalaemia - hypotension - potential metabolic products carcinogenic in rodents.

Interactions
Appendix 1: potassium canrenoate

Side-effects
Common or very common - Ataxia - drowsiness - headache - hyperuricaemia - menstruation irregular.

Uncommon - Electrolyte imbalance - eosinophilia - thrombocytopenia.

Rare or very rare - Agranulocytosis - alopecia - hepatoxicity - hypersensitivity - osteomalacia - skin reactions - voice alteration.

Frequency not known - Acidosis hyperchloraemic - breast pain - confusion (transient; with high doses) - gastrointestinal disorder - gynaecomastia - hirsutism - hypotension.

Pregnancy
Crosses placenta. Feminisation and undescended testes in male fetus in animal studies—manufacturer advises avoid.

Breast feeding
Present in breast milk—manufacturer advises avoid.

Renal impairment
Use with caution if estimated glomerular filtration rate 30–60 mL/minute/1.73 m². Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

Monitoring
Monitor plasma-potassium concentration if estimated glomerular filtration rate 30–60 mL/minute/1.73 m².
PHOSPHODIESTERASE TYPE-3 INHIBITORS

Enoximone

**DRUG ACTION** Enoximone is a phosphodiesterase type-3 inhibitor that exerts most effect on the myocardium; it has positive inotropic properties and vasoactivity.

**INDICATIONS AND DOSE**

**Congestive heart failure, low cardiac output following cardiac surgery**

**INITIALLY BY SLOW INTRAVENOUS INJECTION**

- **Neonate:** Loading dose 500 micrograms/kg, followed by (by continuous intravenous infusion) 5–20 micrograms/kg/minute, adjusted according to response, infusion to be given over 24 hours; maximum 24 mg/kg per day.

- **Child:** Loading dose 500 micrograms/kg, followed by (by continuous intravenous infusion) 5–20 micrograms/kg/minute, adjusted according to response, infusion dose to be given over 24 hours; maximum 24 mg/kg per day.

**SIDE-EFFECTS**

- **Common or very common** Headache · hypotension · insomnia
- **Uncommon** Arrhythmias · diarrhoea · dizziness · nausea · vomiting
- **Rare or very rare** Chills · fever · fluid retention · myalgia · oliguria · urinary retention

**PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.

**CONTRA-INDICATIONS** Severe hypovolaemia

**CAUTIONS** Correct hypokalaemia · heart failure associated with hypertrophic cardiomyopathy, stenotic or obstructive valvular disease or other outlet obstruction

**PRESCRIBING AND DISPENSING INFORMATION** Phosphodiesterase type-3 inhibitors possess positive inotropic and vasoactivity and are useful in infants and children with low cardiac output especially after cardiac surgery. Phosphodiesterase type-3 inhibitors should be limited to short-term use because long-term oral administration has been associated with increased mortality in adults with congestive heart failure.

**PATIENT AND CARER ADVICE** Medicines for Children leaflet: Enoximone for pulmonary hypertension [www.medicinesforchildren.org.uk/enoximone-pulmonary-hypertension](http://www.medicinesforchildren.org.uk/enoximone-pulmonary-hypertension)

**MILRINONE**

**DRUG ACTION** Milrinone is a phosphodiesterase type-3 inhibitor that exerts most effect on the myocardium; it has positive inotropic properties and vasoactivity.

**INDICATIONS AND DOSE**

**Congestive heart failure, low cardiac output following cardiac surgery, shock**

**INITIALLY BY INTRAVENOUS INFUSION**

- **Neonate:** Initially 50–75 micrograms/kg, given over 30–60 minutes, reduce or omit initial dose if at risk of hypotension, then (by continuous intravenous infusion) 30–45 micrograms/kg/hour for 2–3 days (usually for 12 hours after cardiac surgery).

- **Child:** Initially 50–75 micrograms/kg, given over 30–60 minutes, reduce or omit initial dose if at risk of hypotension, then (by continuous intravenous infusion) 30–45 micrograms/kg/hour for 2–3 days (usually for 12 hours after cardiac surgery).

**SIDE-EFFECTS**

- **Common or very common** Arrhythmia supraventricular (increased risk in patients with pre-existing arrhythmias) · arrhythmias · headache · hypotension
- **Uncommon** Angina pectoris · chest pain · hypokalaemia · thrombocytopenia · tremor
- **Rare or very rare** Anaphylactic shock · bronchospasm · skin eruption
- **Frequency not known** Intraventricular haemorrhage · renal failure

**PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.

**CONTRA-INDICATIONS** Severe hypovolaemia

**CAUTIONS** Correct hypokalaemia · heart failure associated with hypertrophic cardiomyopathy, stenotic or obstructive valvular disease or other outlet obstruction

**UNLICENSED USE** Not licensed for use in children under 18 years.

**RENAI IMPAIRMENT**

- Dose adjustments Use half to three-quarters normal dose and monitor response if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².

**MONITORING REQUIREMENTS**

- Monitor blood pressure, heart rate, ECG, central venous pressure, fluid and electrolyte status, renal function, platelet count and hepatic enzymes.
- Monitor renal function.
Dyslipidaemias

Cardiovascular disease risk factors
Atherosclerosis begins in childhood and raised serum cholesterol in children is associated with cardiovascular disease in adulthood. Lowering the cholesterol, without hindering growth and development in children and adolescents, should reduce the risk of cardiovascular disease in later life.

The risk factors for developing cardiovascular disease include raised serum cholesterol concentration, smoking, hypertension, impaired glucose tolerance, male sex, ethnicity, obesity, triglyceride concentration, chronic kidney disease, and a family history of cardiovascular disease.

Heterozygous familial hypercholesterolaemia is the most common cause of raised serum cholesterol in children; homozygous familial hypercholesterolaemia is very rare and its specialised management is not covered in BNF for Children. Familial hypercholesterolaemia can lead to a greater risk of early coronary heart disease and should be managed by a specialist.

Secondary causes of hypercholesterolaemia should be addressed, these include obesity, diet, diabetes mellitus, hypothyroidism, nephrotic syndrome, obstructive biliary disease, glycogen storage disease, and drugs such as corticosteroids.

Management
The aim of management of hypercholesterolaemia is to reduce the risk of atherosclerosis while ensuring adequate growth and development. Children with hypercholesterolaemia (or their carers) should receive advice on appropriate lifestyle changes such as improved diet, increased exercise, weight reduction, and smoking cessation.

Hypothyroidism
Children with hypothyroidism should receive adequate thyroid replacement therapy before their requirement for lipid-regulating treatment is assessed because correction of hypothyroidism itself may resolve the lipid abnormality. Untreated hypothyroidism increases the risk of myositis with lipid-regulating drugs.

Heterozygous familial hypercholesterolaemia
In heterozygous familial hypercholesterolaemia, drug treatment is often required as lifestyle modifications alone are unlikely to sufficiently lower cholesterol concentration.

Treatment with lipid-regulating drugs should be considered by the age of 10 years, although the decision to initiate or defer treatment will depend on the child’s age, the age of onset of coronary heart disease within the family, and the presence of other cardiovascular risk factors. Lipid-regulating drug treatment before the age of 10 years, or a higher dose of statin than licensed for use in the appropriate age group, or a combination of lipid-regulating drugs should be considered in children with a family history of coronary heart disease in early adulthood.

Statins are the lipid-regulating drug of choice and treatment should be lifelong. In children who are intolerant to statins, ezetimibe p. 132, fibrates, or bile acid sequestrants should be considered as alternative options. Vitamins A, D and K, and folic acid supplementation can be given to patients on long-term bile acid sequestrants.

Secondary hypercholesterolaemia
Drug treatment may be indicated in children 10 years and older (rarely necessary in younger children) who are at a high risk of developing cardiovascular disease if 6–12 months of dietary and other lifestyle interventions have failed to lower cholesterol concentration adequately.

Lipid-regulating drugs
Experience in the use of lipid-regulating drugs in children is limited and they should be initiated on specialist advice. Statins are more effective than other classes of drugs in lowering LDL-cholesterol but less effective than the fibrates in reducing triglycerides. Statins also increase concentrations of HDL-cholesterol. Statins reduce cardiovascular disease events and total mortality in adults, irrespective of the initial cholesterol concentration. They are the drugs of first choice in children and are generally well tolerated; atorvastatin p. 134 and simvastatin p. 136 are the preferred statins. Other lipid-regulating drugs can be used if statins are ineffective or are not tolerated.

Ezetimibe can be used alone when statins are not tolerated, or in combination with a statin when a high dose statin fails to control cholesterol concentration adequately. Bile acid sequestrants p. 131 are also available but tolerability of and compliance with these drugs is poor, and their use is declining.

Fibrates may reduce the risk of coronary heart disease in those with low HDL-cholesterol or with raised triglycerides. Evidence for the use of a fibrate (bezafibrate p. 132 or fenofibrate p. 133) in children is limited; fibrates should be considered only if dietary intervention and treatment with a statin and a bile acid sequestran is unsuccessful or contra-indicated.

Evolocumab p. 137 is licensed for the treatment of homozygous familial hypercholesterolaemia; it is used in combination with other lipid-lowering therapies.

In hypertriglyceridaemia which cannot be controlled by very strict diet, omega-3 fatty acid compounds can be considered.

Advanced Pharmacy Services
Children with dyslipidaemia may be eligible for the Medicines Use Review service provided by a community
Colestyramine
(Cholestyramine)

- **INDICATIONS AND DOSE**
  - Familial hypercholesterolaemia
    - **BY MOUTH**
    - Child 6–11 years: Initially 4 g once daily, then increased to 4 g up to 3 times a day, adjusted according to response.
    - Child 12–17 years: Initially 4 g once daily, then increased in steps of 4 g every week; increased to 12–24 g daily in 1–4 divided doses, adjusted according to response; maximum 36 g per day

Pruritus associated with partial biliary obstruction and primary biliary cirrhosis
- **BY MOUTH**
  - Child 1–11 months: 1 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses; maximum 9 g per day.
  - Child 1–5 years: 2 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses; maximum 18 g per day.
  - Child 6–11 years: 4 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses; maximum 24 g per day.
  - Child 12–17 years: 4–8 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses; maximum 36 g per day.

Diarrhoea associated with Crohn’s disease, ileal resection, vagotomy, diabetic vagal neuropathy, and radiation
- **BY MOUTH**
  - Child 1–11 months: 1 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses, if no response within 3 days an alternative therapy should be initiated; maximum 9 g per day.
  - Child 1–5 years: 2 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses, if no response within 3 days an alternative therapy should be initiated; maximum 18 g per day.
  - Child 6–11 years: 4 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses, if no response within 3 days an alternative therapy should be initiated; maximum 24 g per day.
  - Child 12–17 years: 4–8 g once daily, adjusted according to response, total daily dose may alternatively be given in 2–4 divided doses; maximum 36 g per day.

**SIDE-EFFECTS**
- **Common or very common** Constipation, gastrointestinal discomfort, headache, nausea, vomiting
- **Uncommon** Appetite decreased, diarrhoea, gastrointestinal disorders
- **Pregnancy** Bile acid sequestrants should be used with caution as although the drugs are not absorbed, they may cause fat-soluble vitamin deficiency on prolonged use.
- **Breast Feeding** Bile acid sequestrants should be used with caution as although the drugs are not absorbed, they may cause fat-soluble vitamin deficiency on prolonged use.

**MONITORING REQUIREMENTS** A child’s growth and development should be monitored.

### Colespirol hydrochloride

**INDICATIONS AND DOSE**
- Familial hypercholesterolaemia
  - **BY MOUTH**
  - Child 12–17 years: Initially 5 g 1–2 times a day, then increased in steps of 5 g every month, total daily dose may be given in 1–2 divided doses or as a single dose if tolerated; maximum 30 g per day

**UNLICENSED USE** Not licensed for use in children.

**INTERACTIONS** → Appendix 1: colespiroil

**SIDE-EFFECTS**
- Angina pectoris, arthralgia, arthritis, asthenia, burping, chest pain, dizziness, dyspnoea, gallbladder disorders, headaches, inflammation, insomnia, pain, peptic ulcer haemorrhage, tachycardia

**DIRECTIONS FOR ADMINISTRATION** The contents of each sachet should be mixed with at least 100 mL of water or other suitable liquid such as fruit juice or skimmed milk; alternatively it can be mixed with thin soups, cereals, yoghurt, or pulpy fruits ensuring at least 100 mL of liquid is provided.

**PATIENT AND CARER ADVICE** Patient counselling on administration is advised for colespirol hydrochloride granules (avoid other drugs at same time).

**MEDIcINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet

**Granules**
- **CAUTIONARY AND ADVISORY LABELS** 13
  - **Colespital (Pfizer Ltd)**
  - Colespirol hydrochloride 5 gram
    - Colespirol 5g granules sachets plain sugar-free | 30 sachet (PO) £15.05 DT + £15.05
  - Colespital Orange 5g granules sachets sugar-free | 30 sachet (PO) £15.05 DT + £15.05

**Tablet**
- **Colespital (Imported (Canada))**
  - Colespirol hydrochloride 1 gram
    - Colespirol 1g tablets | 120 tablet (PO)

pharmacist. For further information, see **Advanced Pharmacy Services** in Guidance on prescribing p. 1.

**LIPID MODIFYING DRUGS** ➔ **BILE ACID SEQUESTRANTS**

**Bile acid sequestrants**
- **DRUG ACTION** Bile acid sequestrants act by binding bile acids, preventing their reabsorption; this promotes hepatic increased LDL-cholesterol into bile acids; the resultant conversion of LDL-receptor activity of liver cells increases the clearance of LDL-cholesterol from the plasma.
- **CAUTIONS** Interference with the absorption of fat-soluble vitamins (supplements of vitamins A, D, K, and folic acid may be required when treatment is prolonged).
- **SIDE-EFFECTS**
  - **Common or very common** Constipation, gastrointestinal discomfort, headache, nausea, vomiting
  - **Uncommon** Appetite decreased, diarrhoea, gastrointestinal disorders

**PREGNANCY** Bile acid sequestrants should be used with caution as although the drugs are not absorbed, they may cause fat-soluble vitamin deficiency on prolonged use.

**BREAST FEEDING** Bile acid sequestrants should be used with caution as although the drugs are not absorbed, they may cause fat-soluble vitamin deficiency on prolonged use.

**MONITORING REQUIREMENTS** A child’s growth and development should be monitored.

**Colespital hydrochloride**

**INDICATIONS AND DOSE**
- Familial hypercholesterolaemia
  - **BY MOUTH**
  - Child 12–17 years: Initially 5 g 1–2 times a day, then increased in steps of 5 g every month, total daily dose may be given in 1–2 divided doses or as a single dose if tolerated; maximum 30 g per day

**UNLICENSED USE** Not licensed for use in children.

**INTERACTIONS** → Appendix 1: colespital

**SIDE-EFFECTS**
- Angina pectoris, arthralgia, arthritis, asthenia, burping, chest pain, dizziness, dyspnoea, gallbladder disorders, headaches, inflammation, insomnia, pain, peptic ulcer haemorrhage, tachycardia

**DIRECTIONS FOR ADMINISTRATION** The contents of each sachet should be mixed with at least 100 mL of water or other suitable liquid such as fruit juice or skimmed milk; alternatively it can be mixed with thin soups, cereals, yoghurt, or pulpy fruits ensuring at least 100 mL of liquid is provided.

**PATIENT AND CARER ADVICE** Patient counselling on administration is advised for colespital hydrochloride granules (avoid other drugs at same time).

**MEDIcINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet

**Granules**
- **CAUTIONARY AND ADVISORY LABELS** 13
  - Colespital (Pfizer Ltd)
    - Colespital hydrochloride 5 gram
      - Colespital 5g granules sachets plain sugar-free | 30 sachet (PO) £15.05 DT + £15.05
    - Colespital Orange 5g granules sachets sugar-free | 30 sachet (PO) £15.05 DT + £15.05

**Tablet**
- Colespital (Imported (Canada))
  - Colespital hydrochloride 1 gram
    - Colespital 1g tablets | 120 tablet (PO)
**132 Hyperlipidaemia**

**LIPID MODIFYING DRUGS > CHOLESTEROL ABSORPTION INHIBITORS**

**Ezetimibe**

**DRUG ACTION** Ezetimibe inhibits the intestinal absorption of cholesterol.

**INDICATIONS AND DOSE**
- Adjunct to dietary measures and statin treatment in primary hypercholesterolaemia
- Adjunct to dietary measures and statin in homozygous familial hypercholesterolaemia
- Primary hypercholesterolaemia (if statin inappropriate or not tolerated)

**INTERACTIONS** → Appendix 1: ezetimibe

**SIDE-EFFECTS**
- Common or very common: Asthenia, diarrhoea, gastrointestinal discomfort, gastrointestinal disorders
- Uncommon: Appetite decreased, arthralgia, chest pain, cough, hot flush, hypertension, muscle complaints, nausea, pain
- Frequency not known: Constipation, depression, dizziness, dysphoria, hepatitis, myopathy, pancreatitis, paraesthesia, skin reactions, thrombocytopenia
- PREGNANCY: Manufacturer advises avoid—no information available.
- BREAST FEEDING: Manufacturer advises avoid—present in milk in animal studies.
- HEPATIC IMPAIRMENT: Manufacturer advises avoid in moderate to severe impairment.

**MEDICINAL FORMS**
- Tablet
  - Ezetimibe (Non-proprietary)
    - Ezetimibe 10 mg: Ezetimibe 10mg tablets | 28 tablet [Pos] £2.08-£26.31 DT + £2.17
  - Ezetrol (Merrick Sharp & Dohme Ltd)
    - Ezetimibe 10 mg: Ezetrol 10mg tablets | 28 tablet [Pos] £26.31 DT + £2.17
- Combinations available: Simvastatin with ezetimibe, p. 136

**MONITORING REQUIREMENTS**
- Consider monitoring of liver function and creatinine kinase when fibrates used in combination with a statin.

**PRESCRIBING AND DISPENSING INFORMATION**
- Fibrates are mainly used in those whose serum-triglyceride concentration is greater than 10 mmol/litre or in those who cannot tolerate a statin (specialist use).

**MIXED NUTRITION MODIFICATIONS**
- There may be an increase in the likelihood of nutritional deficiency with ezetimibe, particularly if there is also a statin in use. Monitor blood levels of vitamin D and vitamin B12.

**RECOMMENDATIONS FOR THE PATIENT IN THE HOME**
- Exercise regularly
- Avoid obesity
- Avoid high-fat diet

**MEDICAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**
- Cautionary and Advisory Labels 21
  - Bezafibrate (Non-proprietary)
    - Bezafibrate 200 mg: Bezafibrate 200mg tablets | 100 tablet [Pos] £8.50 DT + £5.22
    - Bezalip (Teva UK Ltd)
      - Bezafibrate 200 mg: Bezalip 200mg tablets | 100 tablet [Pos] £8.63 DT + £5.22

**FIBRATES**

**Bezafibrate**

**DRUG ACTION** Fibrates act by decreasing serum triglycerides; they have variable effect on LDL-cholesterol.

**INDICATIONS AND DOSE**
- Hyperlipidaemia including familial hypercholesterolaemia (administered on expert advice)
  - By mouth using immediate-release medicines
    - Child 10-17 years: 200 mg once daily (max. per dose 200 mg 3 times a day), adjusted according to response

**UNLICENSED USE**
- Not licensed for use in children.

**CONTRA-INDICATIONS**
- Gall bladder disease
- Hypoalbuminaemia
- Nephrotic syndrome
- Photosensitivity to fibrates

**CAUTIONS**
- Correct hypothyroidism before initiating treatment

**INTERACTIONS** → Appendix 1: fibrates

**SIDE-EFFECTS**
- Common or very common: Appetite decreased, gastrointestinal disorder
- Uncommon: Acute kidney injury, alopecia, cholestasis, constipation, diarrhoea, dizziness, erectile dysfunction, gastrointestinal discomfort, headache, muscle complaints, muscle weakness, nausea, photosensitivity reaction, skin reactions
- Rare or very rare: Cholelithiasis, depression, insomnia, interstitial lung disease, pancreatitis, pancytopenia, paraesthesia, peripheral neuropathy, rhabdomyolysis (increased risk in renal impairment), severe cutaneous adverse reactions (SCARs), thrombocytopenic purpura

**PREGNANCY**
- Manufacturers advise avoid—no information available.

**BREAST FEEDING**
- Manufacturer advises avoid—no information available.

**HEPATIC IMPAIRMENT**
- Manufacturer advises avoid in significant impairment (except in fatty liver disease).

**RENAL IMPAIRMENT**
- Avoid immediate-release preparations if eGFR less than 15 mL/minute/1.73 m². Avoid modified-release preparations if eGFR less than 60 mL/minute/1.73 m².
  - Myotoxicity: Special care needed in patients with renal disease, as progressive increases in serum creatinine concentration or failure to follow dosage guidelines may result in myotoxicity (rhabdomyolysis); discontinue if myotoxicity suspected or creatine kinase concentration increases significantly.
  - Avoid if estimated glomerular filtration rate less than 15 mL/minute/1.73 m².

**Dose adjustments**
- Reduce dose if estimated glomerular filtration rate 15–60 mL/minute/1.73 m².

**REFERENCES**
- The information here is based on the British National Formulary (BNF) and the British National Formulary for Children (BNFC). Consult the latest edition for the most current information.
Fenofibrate

01-Aug-2018

**DRUG ACTION** Fibrates act by decreasing serum triglycerides; they have variable effect on LDL-cholesterol.

**INDICATIONS AND DOSE**

Hyperlipidaemias including familial hypercholesterolaemia (administered on expert advice)

- **BY MOUTH USING CAPSULES**
  - Child 4-14 years: One 67 mg (micronised) capsule per 20 kg body-weight daily, maximum four 67 mg capsules daily, or max. three 67 mg capsules daily with concomitant statin
  - Child 15-17 years: Initially 3 capsules daily, then increased if necessary to 4 capsules daily, max. 3 capsules daily with concomitant statin, dose relates to 67 mg (micronised) capsules

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- Manufacturer advises max. dose 200 mg daily with concurrent use of a statin—no specific recommendation made for children.

**UNLICENSED USE** 200 mg and 267 mg capsules not licensed in children. Tablets not licensed in children.

**CONTRA-INDICATIONS** Gall bladder disease - pancreatitis (unless due to severe hypertriglyceridaemia) - photosensitivity to ketoprofen

**CAUTIONS** Correct hypothyroidism before initiating treatment

**INTERACTIONS** → Appendix 1: fibrates

**SIDE-EFFECTS**

- **Common or very common** Abdominal pain - diarrhoea - flatulence - nausea - vomiting
- **Uncommon** Cholelithiasis - embolism and thrombosis - headache - muscle complaints - muscle weakness - myopathy - pancreatitis - sexual dysfunction - skin reactions
- **Rare or very rare** Alopecia - hepatic disorders - photosensitivity reaction
- **Frequency not known** Fatigue - interstitial lung disease - rhabdomyolysis (increased risk in renal impairment) - severe cutaneous adverse reactions (SCARs)

**PREGNANCY** Avoid—embryotoxicity in animal studies.

**BREAST FEEDING** Manufacturers advise avoid—no information available.

**HEPATIC IMPAIRMENT** Manufacturer advises avoid—no information available.

**Renal Impairment** Manufacturer advises use with caution in mild-to-moderate impairment; avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- **Myotoxicity** Special care needed in patients with renal disease, as progressive increases in serum creatinine concentration or failure to follow dosage guidelines may result in myotoxicity (rhabdomyolysis); discontinue if myotoxicity suspected or creatine kinase concentration increases significantly.

**Dose adjustments** Manufacturer advises max. 67 mg daily if estimated glomerular filtration rate 30–59 mL/minute/1.73 m².

**MONITORING REQUIREMENTS** Manufacturer advises monitor hepatic transaminases every 3 months during the first 12 months of treatment and periodically thereafter—discontinue treatment if levels increase to more than 3 times the upper limit of normal; monitor serum creatinine levels during the first 3 months of treatment and periodically thereafter—interrupt treatment if creatinine level is 50% above the upper limit of normal.

**PRESCRIBING AND DISPENSING INFORMATION** Fibrates are mainly used in those whose serum-triglyceride concentration is greater than 10 mmol/litre or in those who cannot tolerate a statin (specialist use).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Capsule**

**CAUTIONARY AND ADVISORY LABELS 21**

- Fenofibrate (Non-proprietary)
- Fenofibrate micronised 67 mg
- Fenofibrate micronised 267 mg capsules | 90 capsule (£33.60 + £33.11)
- Fenofibrate micronised 200 mg capsules | 28 capsule (£61.98 DT + £3.00)
- Fenofibrate micronised 267 mg capsules | 28 capsule (£21.75 DT + £3.58)
- Lipantil Micro (Mylan)
  - Fenofibrate micronised 67 mg Lipantil Micro 67 capsules | 90 capsule (£33.60 + £33.11)
  - Fenofibrate micronised 200 mg Lipantil Micro 200 capsules | 28 capsule (£61.98 DT + £3.00)
  - Fenofibrate micronised 267 mg Lipantil Micro 267 capsules | 28 capsule (£21.75 DT + £3.58)

**LIPID MODIFYING DRUGS > STATINS**

**Statins**

**DRUG ACTION** Statins competitively inhibit 3-hydroxy-3-methylglutaryl coenzyme A (HMG CoA) reductase, an enzyme involved in cholesterol synthesis, especially in the liver.

**CAUTIONS** High alcohol intake · history of liver disease · hypothyroidism · patients at increased risk of muscle toxicity, including myopathy or rhabdomyolysis (e.g. those with a personal or family history of muscular disorders, previous history of muscular toxicity and a high alcohol intake)

**CAUTIONS, FURTHER INFORMATION**

- Muscle effects Muscle toxicity can occur with all statins, however the likelihood increases with higher doses and in certain patients (see below). Statins should be used with caution in patients at increased risk of muscle toxicity, including those with a personal or family history of muscular disorders, previous history of muscular toxicity, a high alcohol intake, renal impairment or hypothyroidism.

  - In patients at increased risk of muscle effects, a statin should not usually be started if the baseline creatine kinase concentration is more than 5 times the upper limit of normal (some patients may present with an extremely elevated baseline creatine kinase concentration, for example because of a physical occupation or rigorous exercise—specialist advice should be sought regarding consideration of statin therapy in these patients).

- Hypothyroidism Hypothyroidism should be managed adequately before starting treatment with a statin.

**SIDE-EFFECTS**

- **Common or very common** Asthenia · constipation · diarrhoea · dizziness · flatulence · gastrointestinal discomfort · headache · myalgia · nausea · sleep disorders · thrombocytopenia
- **Uncommon** Alopecia · hepatic disorders · memory loss · pancreatitis · paraesthesia · sexual dysfunction · skin reactions · vomiting
- **Rare or very rare** Myopathy · peripheral neuropathy · tendinopathy

**Frequency not known** Depresssion · diabetes mellitus (in those at risk) · interstitial lung disease

**SIDE-EFFECTS, FURTHER INFORMATION** Muscle effects The risk of myopathy, myositis, and rhabdomyolysis associated with statin use is rare. Although myalgia has been reported commonly in patients receiving statins, muscle toxicity
Hyperlipidaemia

truly attributable to statin use is rare. When a statin is suspected to be the cause of myopathy, and creatine kinase concentration is markedly elevated or if muscular symptoms are severe, treatment should be discontinued. If symptoms resolve and creatine kinase concentrations return to normal, the statin should be reintroduced at a lower dose and the patient monitored closely.

Interstitial lung disease  If patients develop symptoms such as dyspnoea, cough, and weight loss, they should seek medical attention.

CONCEPTION AND CONTRACEPTION  Adequate contraception is required during treatment and for 1 month afterwards.

PREGNANCY  Statins should be avoided in pregnancy (discontinue 3 months before attempting to conceive) as congenital anomalies have been reported and the decreased synthesis of cholesterol possibly affects fetal development.

HEPATIC IMPAIRMENT  In general, manufacturers advise caution (risk of increased exposure); avoid in active disease or unexplained persistent elevations in serum transaminases.

MONITORING REQUIREMENTS

Before starting treatment with statins, at least one full lipid profile (non-fasting) should be measured, including total cholesterol, HDL-cholesterol, non-HDL-cholesterol (calculated as total cholesterol minus HDL-cholesterol), and triglyceride concentrations, thyroid-stimulating hormone, and renal function should also be assessed.

Liver function  There is little information available on a rational approach to liver-function monitoring; however, NICE suggests that liver enzymes should be measured before treatment, and repeated within 3 months and at 12 months of starting treatment, unless indicated at other times by signs or symptoms suggestive of hepatotoxicity (NICE clinical guideline 181 (July 2014). Lipid Modification—Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease). Those with serum transaminases that are raised, but less than 3 times the upper limit of the reference range, should not be routinely excluded from statin therapy. Those with serum transaminases of more than 3 times the upper limit of the reference range should discontinue statin therapy.

Creatine kinase  Creatine kinase concentration should be measured in children before treatment and if unexplained muscle pain occurs.

PATIENT AND CARER ADVICE  Advise patients to report promptly unexplained muscle pain, tenderness, or weakness.

Atorvastatin

INDICATIONS AND DOSE

Hyperlipidaemia including familial hypercholesterolaemia

BY MOUTH  Child 10–17 years: Initially 10 mg once daily, then increased if necessary up to 20 mg once daily, dose to be adjusted at intervals of at least 4 weeks

Homozygous familial hypercholesterolaemia

BY MOUTH  Child 10–17 years: Initially 10 mg once daily, then increased if necessary up to 80 mg once daily, dose to be adjusted at intervals of at least 4 weeks

DOSE ADJUSTMENTS DUE TO INTERACTIONS  Manufacturer advises if concurrent use of ciclosporin is unavoidable, max. dose cannot exceed 10 mg daily.
**INDICATIONS AND DOSE**

Heterozygous familial hypercholesterolaemia (specialist use only)

- **BY MOUTH**
  - Child 6–9 years: Initially 5 mg once daily, then increased if necessary up to 10 mg once daily, dose to be increased gradually at intervals of at least 4 weeks.
  - Child 10–17 years: Initially 5 mg once daily, then increased if necessary up to 20 mg once daily, dose to be increased gradually at intervals of at least 4 weeks, use lower max. dose in children with risk factors for myopathy or rhabdomyolysis (including personal or family history of muscular disorders or toxicity).

Homozygous familial hypercholesterolaemia (specialist use only)

- **BY MOUTH**
  - Child 6–17 years: Initially 5–10 mg once daily, then increased if necessary up to 20 mg once daily, dose to be increased gradually at intervals of at least 4 weeks, use lower max. dose in children with risk factors for myopathy or rhabdomyolysis (including personal or family history of muscular disorders or toxicity).

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- Manufacturer advises max. 5 mg daily with concurrent use of gliclazide or pioglitazone.

**CAUTIONS**

- Known genetic polymorphisms—consult product literature.

**INTERACTIONS → Appendix 1: statins**

**SIDE-EFFECTS**

- Rare or very rare Articular disease, proteinuria.
- Very rare Nephrotic syndrome, gout, myasthenia, myopathy, rhabdomyolysis, proteinuria, rhabdomyolysis.
- Rare Angioedema, glomerulonephritis, proteinuria, vasculitis.

**Breastfeeding**

Manufacturer advises avoiding—small amount of drug present in breast milk.

**Other**

- Pregnancy: Manufacturer advises avoiding.
- Use in patients with renin–angiotensin system dysfunction.
- Use in patients with severe renal impairment.
- Use in patients with severe hepatic impairment.
- Use in patients with concomitant use of cyclosporin (risk of nephrotoxicity).

**INTERACTIONS → Appendix 1: statins**

**SIDE-EFFECTS**

- Uncommon Hair abnormality, scalp abnormality, urinary disorders, vision disorders.

**Medicinal Forms**

- There can be variation in the licensing of different medicines containing the same drug.

**Modified-release tablet**

- Cadaf XL (Torrent Pharma (UK) Ltd)
  - Fluvastatin (as Fluvastatin sodium) 80 mg | 28 tablet £19.20
- Dorisin XL (Aspire Pharma Ltd)
  - Fluvastatin (as Fluvastatin sodium) 80 mg | 28 tablet £19.20
- Lescol XL (Novartis Pharmaceuticals UK Ltd)
  - Fluvastatin (as Fluvastatin sodium) 80 mg | 28 tablet £19.20
- Nandovar XL (Sandoz Ltd)
  - Fluvastatin (as Fluvastatin sodium) 80 mg | 28 tablet £16.32

**Capsule**

- Fluvastatin (Non-proprietary)
  - Fluvastatin (as Fluvastatin sodium) 20 mg | 28 capsule £6.96
  - Fluvastatin (as Fluvastatin sodium) 40 mg | 28 capsule £7.42

**Hepatic Impairment**

- Manufacturer advises initial dose reduction to 10 mg daily; adjust according to response.

**Renal Impairment**

- Start with lower doses in moderate to severe impairment.

**Patient and carer advice**

- Patient counselling is advised for pravastatin tablets (muscle effects).

**Medicinal Forms**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

**Tablet**

- Pravastatin sodium (Non-proprietary)
  - Pravastatin sodium 10 mg | 28 tablet £2.08
  - Pravastatin sodium 20 mg | 28 tablet £3.05

- Pravastatin sodium 40 mg | 28 tablet £3.82

**Interactions → Appendix 1: statins**

**SIDE-EFFECTS**

- Rare or very rare Angioedema, nephrotic syndrome, muscle weakness, sensation abnormal, vasculitis.

**Breastfeeding**

Manufacturer advises avoiding—small amount of drug present in breast milk.

**Other**

- Pregnancy: Manufacturer advises avoiding—no information available.
- Use in patients with renin–angiotensin system dysfunction.
- Use in patients with severe renal impairment.
- Use in patients with severe hepatic impairment.
- Use in patients with concomitant use of cyclosporin (risk of nephrotoxicity).

**Interactions → Appendix 1: statins**

**SIDE-EFFECTS**

- Uncommon Hair abnormality, scalp abnormality, urinary disorders, vision disorders.
Simvastatin

**INDICATIONS AND DOSE**

Hyperlipidaemia including familial hypercholesterolaemia

- **BY MOUTH**
  - Child 5–9 years: Initially 10 mg once daily, then increased if necessary up to 20 mg once daily, dose to be taken at night, increased at intervals of at least 4 weeks
  - Child 10–17 years: Initially 10 mg once daily, then increased if necessary up to 40 mg once daily, dose to be taken at night, increased at intervals of at least 4 weeks

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- Manufacturer advises max. dose 10 mg daily with concurrent use of bezafibrate—no specific recommendation made for children.
- Manufacturer advises max. dose 20 mg daily with concurrent use of amiodarone or amiodipine—no specific recommendation made for children.
- Manufacturer advises reduce dose with concurrent use of some moderate inhibitors of CYP3A4 (max. 20 mg daily with verapamil and diltiazem)—no specific recommendation made for children.

**UNLICENSED USE**

Not licensed for use in children under 10 years.

**INTERACTIONS**

→ Appendix 1: statins

**SIDE-EFFECTS**

- Rare or very rare: Acute kidney injury, anaemia, muscle cramps
- Frequency not known: Cognitive impairment
- **BREAST FEEDING**: Manufacturer advises avoid—no information available.
- **RENAL IMPAIRMENT**: Doses above 10 mg daily should be used with caution if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².
- **PATIENT AND CARER ADVICE**: Patient counselling is advised for simvastatin tablets/oral suspension (muscle effects).

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral suspension**

**EXCipients**: May contain Propylene glycol

- **Simvastatin (Non-proprietary)**
  - Simvastatin 4 mg per 1 ml Simvastatin 20 mg/5 ml oral suspension sugar free sugar free-
    - 150 ml (BNFC) £161.76 DT = £144.32
  - Simvastatin 8 mg per 1 ml Simvastatin 40 mg/5 ml oral suspension sugar free sugar free-
    - 150 ml (BNFC) £152.00–£247.10 DT = £220.45

**Tablet**

- **Simvastatin (Non-proprietary)**
  - Simvastatin 10 mg Simvastatin 10 mg tablets | 28 tablet (BNFC) £14.42 DT = £0.64
  - Simvastatin 20 mg Simvastatin 20 mg tablets | 28 tablet (BNFC) £23.75 DT = £0.75
  - Simvastatin 40 mg Simvastatin 40 mg tablets | 28 tablet (BNFC) £23.75 DT = £0.87
  - Simvastatin 80 mg Simvastatin 80 mg tablets | 28 tablet (BNFC) £6.00 DT = £1.49
  - Simvastatin (with ezetimibe) Simvastatin 10 mg Simvostat 10 mg tablets | 28 tablet (BNFC) £0.52 DT = £0.64
  - Simvastatin 20 mg Simvostat 20 mg tablets | 28 tablet (BNFC) £0.67 DT = £0.75
  - Simvastatin 40 mg Simvostat 40 mg tablets | 28 tablet (BNFC) £0.65 DT = £0.87
  - Simvastatin 80 mg Simvostat 80 mg tablets | 28 tablet (BNFC) £1.31 DT = £1.49
  - **Zocor** (Merck Sharp & Dohme Ltd)
    - Zocor 10 mg Zocor 10 mg tablets | 28 tablet (BNFC) £18.03 DT
    - 10 mg Zocor 20 mg tablets | 28 tablet (BNFC) £29.69 DT
    - 20 mg Zocor 40 mg tablets | 28 tablet (BNFC) £29.69 DT
    - 80 mg Zocor 80 mg tablets | 28 tablet (BNFC) £29.69 DT

**Simvastatin with ezetimibe**

The properties listed below are those particular to the combination only. For the properties of the components please consider, simvastatin above, ezetimibe p. 132.

**INDICATIONS AND DOSE**

Homozygous familial hypercholesterolaemia, primary hypercholesterolaemia, and mixed hyperlipidaemia in patients over 10 years stabilised on the individual components in the same proportions, or for patients not adequately controlled by statin alone

- **BY MOUTH**
  - Child (initiated by a specialist): consult product literature

**INTERACTIONS**

→ Appendix 1: ezetimibe • statins

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

- **Ezetimibe** (Discovery Pharmaceuticals)
  - Ezetimibe 10 mg, Simvastatin 28 mg Ezetimibe 10 mg, Simvastatin 40 mg | 28 tablet (BNFC) £0.87 DT = £0.98
  - Ezetimibe 10 mg, Simvastatin 80 mg Ezetimibe 10 mg, Simvastatin 100 mg | 28 tablet (BNFC) £75.00 DT = £87.00
  - Ezetimibe 10 mg, Simvastatin 20 mg Ezetimibe 10 mg, Simvastatin 40 mg | 28 tablet (BNFC) £64.00 DT = £75.00
  - Ezetimibe 10 mg, Simvastatin 30 mg Ezetimibe 10 mg, Simvastatin 60 mg | 28 tablet (BNFC) £49.00 DT = £64.00
  - Ezetimibe 10 mg, Simvastatin 40 mg Ezetimibe 10 mg, Simvastatin 80 mg | 28 tablet (BNFC) £33.00 DT = £42.00

- **Inegy** (Merck Sharp & Dohme Ltd)
  - Inegy 10 mg, Simvastatin 10 mg tablets | 28 tablet (BNFC) £0.64 DT = £0.87
  - Inegy 10 mg, Simvastatin 20 mg tablets | 28 tablet (BNFC) £0.64 DT = £0.87
  - Inegy 10 mg, Simvastatin 30 mg tablets | 28 tablet (BNFC) £0.64 DT = £0.87

- **Simvastatin** (Discovery Pharmaceuticals)
  - Simvastatin 10 mg Simvastatin 10 mg tablets | 28 tablet (BNFC) £18.03 DT
  - 20 mg Simvastatin 20 mg tablets | 28 tablet (BNFC) £29.69 DT
  - 40 mg Simvastatin 40 mg tablets | 28 tablet (BNFC) £29.69 DT
  - 80 mg Simvastatin 80 mg tablets | 28 tablet (BNFC) £29.69 DT

- **Zocor** (Merck Sharp & Dohme Ltd)
  - Zocor 10 mg Zocor 10 mg tablets | 28 tablet (BNFC) £18.03 DT
  - 20 mg Zocor 20 mg tablets | 28 tablet (BNFC) £29.69 DT
  - 40 mg Zocor 40 mg tablets | 28 tablet (BNFC) £29.69 DT
  - 80 mg Zocor 80 mg tablets | 28 tablet (BNFC) £29.69 DT
Nitrates

**CONTRA-INDICATIONS** Aortic stenosis · cardiac tamponade · constrictive pericarditis · hypertrophic cardiomyopathy · hypotensive conditions · hypovolaemia · marked anaemia · mitral stenosis · raised intracranial pressure due to cerebral haemorrhage · raised intracranial pressure due to head trauma · toxic pulmonary oedema

**CAUTIONS** Heart failure due to obstruction · hypothermia · hypothyroidism · hypoxaemia · malnutrition · metal-containing transdermal systems should be removed before magnetic resonance imaging procedures, cardioversion, or diathermy · recent history of myocardial infarction · susceptibility to angle-closure glaucoma · tolerance · ventilation and perfusion abnormalities

**CAUTIONS, FURTHER INFORMATION**

- **Tolerance** Children receiving nitrates continuously throughout the day can develop tolerance (with reduced therapeutic effects). Reduction of blood-nitrate concentrations to low levels for 4 to 8 hours each day usually maintains effectiveness in such patients.

- **SIDE-EFFECTS**
  - **Common or very common** Arthralgia · back pain · increased risk of infection · nausea · skin reactions
  - **Rare or very rare** Angioedema
  - **PREGNANCY** Manufacturer advises avoid unless essential—limited information available.
  - **BREAST FEEDING** Manufacturer advises avoid—no information available.
  - **HEPATIC IMPAIRMENT** Manufacturer advises caution in moderate to severe impairment (risk of reduced efficacy; no information available in severe impairment).
  - **RENAL IMPAIRMENT** Manufacturer advises caution if estimated glomerular filtration rate less than 30 mL/minute/1.73 m²—no information available.
  - **HANDLING AND STORAGE** Manufacturer advises store in a refrigerator (2–8°C)—consult product literature for further information regarding storage outside refrigerator.
  - **PATIENT AND CARER ADVICE** Patients and their carers should be given training in subcutaneous injection technique.

**INTERACTIONS**

- **Uncommon** Cardiac disorder · cyanosis
- **Rare or very rare** Methaemoglobinaemia · respiratory disorder · restlessness
- **Frequency not known** Hyperhidrosis
- **PREGNANCY** Not known to be harmful.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use For *continuous intravenous infusion*, dilute to max. concentration of 400 micrograms/mL (but continue infusion at the rate of 0.1–0.3 microgram/kg/minute, adjusted according to response, maintenance 1–3 micrograms/kg/minute (max. per dose 10 micrograms/kg/minute)).

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**Glyceryl trinitrate**

**INDICATIONS AND DOSE** Hypertension during and after cardiac surgery · Heart failure after cardiac surgery · Coronary vasoconstriction in myocardial ischaemia · Vasodilatation in shock

- **BY CONTINUOUS INTRAVENOUS INFUSION**
  - **Neonate:** 0.2–0.5 microgram/kg/minute, adjusted according to response, maintenance 1–3 micrograms/kg/minute (max. per dose 10 micrograms/kg/minute).
  - **Child:** Initially 0.2–0.5 microgram/kg/minute, adjusted according to response, maintenance 1–3 micrograms/kg/minute (max. per dose 10 micrograms/kg/minute); maximum 200 micrograms/minute

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**7 Myocardial ischaemia**

**NITRATES**

**Nitrates**

**Overview**

Nitrates are potent coronary vasodilators, but their principal benefit follows from a reduction in venous return which reduces left ventricular work. Unwanted effects such as flushing, headache, and postural hypotension may limit therapy, especially if the child is unusually sensitive to the effects of nitrates or is hypovolaemic. Glyceryl trinitrate below is also used in extravasation.
concentration of 1 mg/ml has been used via a central venous catheter) with Glucose 5% or Sodium Chloride 0.9%. Neonatal intensive care, dilute 3 mg/kg body-weight to a final volume of 50 mL with Glucose 5% or Sodium Chloride 0.9%; an intravenous infusion rate of 1 mL/hour provides a dose of 1 microgram/kg/minute; maximum concentration of 400 micrograms/mL (but concentration of 1 mg/mL has been used via a central venous catheter).

With intravenous use Glass or polyethylene apparatus is preferable; loss of potency will occur if PVC is used. Glycerol trinitrate 1 mg/ml to be diluted before use or given undiluted with syringe pump. Glycerol trinitrate 5 mg/ml to be diluted before use.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  Solution for infusion

  - Excipients: May contain Ethanol, propylene glycol

  - **Glycerol trinitrate (Non-proprietary)**
    - Glycerol trinitrate 1 mg per 1 ml Glycerol trinitrate 50mg/50ml solution for infusion vials | 1 vial £13.90
    - Glycerol trinitrate 5 mg per 1 ml Glycerol trinitrate 50mg/10ml solution for infusion ampoules | 5 ampoule £64.90 (Hospital only)
    - Glycerol trinitrate 25mg/5ml solution for infusion ampoules | 5 ampoule £32.45 (Hospital only)
  - **Nitrocine (Aspire Pharma Ltd)**
    - Glycerol trinitrate 1 mg per 1 ml Nitrocin 10mg/10ml solution for infusion ampoules | 10 ampoule £58.75 (Hospital only)
  - **Nitronal (Intrapharm Laboratories Ltd)**
    - Glycerol trinitrate 1 mg per 1 ml Nitronal 5mg/5ml solution for infusion ampoules | 10 ampoule £18.04
    - Nitronal 50mg/50ml solution for infusion vials | 1 vial £14.76

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### 7.1 Cardiac arrest

#### Cardiopulmonary resuscitation

**Overview**

The algorithms for cardiopulmonary resuscitation (Life support algorithm) (image) p. 1180 reflect the recommendations of the Resuscitation Council (UK); they cover paediatric basic life support, paediatric advanced life support, and newborn life support. The guidelines are available at [www.resus.org.uk](http://www.resus.org.uk).

**Paediatric advanced life support**

Cardiopulmonary (cardiac) arrest in children is rare and frequently represents the terminal event of progressive shock or respiratory failure. During cardiopulmonary arrest in children without intravenous access, the intraosseous route is used ten times the intravenous route. If circulatory access is not possible, the intraosseous route is chosen because it is the endotracheal route is used ten times the intravenous route. If circulatory access is not possible, the intraosseous route is chosen because it is the preferred route. If the endotracheal route is used ten times the intravenous route.

The effects of nebulised adrenaline for the treatment of acute anaphylaxis (for self-administration) | Angioedema (if laryngeal oedema is present) (under expert supervision) | The effects of nebulised adrenaline for the treatment of acute anaphylaxis (under expert supervision)

- **Acute hypotension**
  - By continuous intravenous infusion
    - Neonate: Initially 100 nanograms/kg/minute, adjusted according to response, higher doses up to 1.5 micrograms/kg/minute have been used in acute hypotension.
    - Child: Initially 100 nanograms/kg/minute, adjusted according to response, higher doses up to 1.5 micrograms/kg/minute have been used in acute hypotension.

- **Croup (when not effectively controlled with corticosteroid treatment)**
  - By inhalation of nebulised solution
    - Child 1 month–11 years: 400 micrograms/kg (max. per dose 5 mg), dose to be repeated after 30 minutes if necessary

**PHARMACOKINETICS**

- **Emergency treatment of acute anaphylaxis (under expert supervision)**: Angioedema (if laryngeal oedema is present) (under expert supervision)
  - By intramuscular injection
    - Child 1 month–5 years: 150 micrograms, doses may be repeated several times if necessary at 5 minute intervals according to blood pressure, pulse, and respiratory function, suitable syringe to be used for measuring small volume; injected preferentially into the anterolateral aspect of the middle third of the thigh
    - Child 6–11 years: 300 micrograms, doses may be repeated several times if necessary at 5 minute intervals according to blood pressure, pulse, and respiratory function, into the anterolateral aspect of the middle third of the thigh
    - Child 12–17 years: 500 micrograms, to be injected preferentially into the anterolateral aspect of the middle third of the thigh, doses may be repeated several times if necessary at 5 minute intervals according to blood pressure, pulse, and respiratory function, 300 micrograms (0.3 mL) to be administered if child small or prepubertal

**Acute anaphylaxis when there is doubt as to the adequacy of the circulation (specialist use only)**: Angioedema (if laryngeal oedema is present) (specialist use only)

- **By slow intravenous injection**
  - Child: 1 microgram/kg (max. per dose 50 micrograms), using dilute 1 in 10 000 adrenaline injection, dose to be repeated according to response, if multiple doses required, adrenaline should be given as a slow intravenous infusion stopping when a response has been obtained.

**EMERADE® 150 MICROGRAMS**

**Acute anaphylaxis (for self-administration)**

- For intramuscular injection
  - Child (body-weight up to 15 kg): 150 micrograms, then 150 micrograms after 5–15 minutes as required
  - Child (body-weight 15–30 kg): 150 micrograms, then 150 micrograms after 5–15 minutes as required, on the basis of a dose of 10 micrograms/kg, 300 micrograms may be more appropriate for some children
EMERADE® 300 MICROGRAMS
Acute anaphylaxis (for self-administration)
▶ By intramuscular injection
▶ Child (body-weight 30 kg and above): 300 micrograms, then 300 micrograms after 5–15 minutes as required
EMERADE® 500 MICROGRAMS
Acute anaphylaxis (for self-administration for patients at risk of severe anaphylaxis)
▶ By intramuscular injection
▶ Child 12–17 years: 500 micrograms, then 500 micrograms after 5–15 minutes as required
EPIPEN® AUTO-INJECTOR 0.3MG
Acute anaphylaxis (for self-administration)
▶ By intramuscular injection
▶ Child (body-weight 30 kg and above): 300 micrograms, then 300 micrograms after 5–15 minutes as required
EPIPEN® JR AUTO-INJECTOR 0.15MG
Acute anaphylaxis (for self-administration)
▶ By intramuscular injection
▶ Child (body-weight up to 15 kg): 150 micrograms, then 150 micrograms after 5–15 minutes as required
▶ Child (body-weight 15–30 kg): 150 micrograms, then 150 micrograms after 5–15 minutes as required, on the basis of a dose of 10 micrograms/kg, 300 micrograms may be more appropriate for some children
JEXT® 150 MICROGRAMS
Acute anaphylaxis (for self-administration)
▶ By intramuscular injection
▶ Child (body-weight up to 15 kg): 150 micrograms, then 150 micrograms after 5–15 minutes as required
▶ Child (body-weight 15–30 kg): 150 micrograms, then 150 micrograms after 5–15 minutes as required, on the basis of a dose of 10 micrograms/kg, 300 micrograms may be more appropriate for some children
JEXT® 300 MICROGRAMS
Acute anaphylaxis (for self-administration)
▶ By intramuscular injection
▶ Child (body-weight 30 kg and above): 300 micrograms, then 300 micrograms after 5–15 minutes as required

▶ Unlicensed use
▶ With intramuscular use for acute anaphylaxis Auto-injectors delivering 150-microgram dose of adrenaline may not be licensed for use in children with body-weight under 15 kg.
▶ With intravenous use for acute hypotension Adrenaline 1 in 1000 (1 mg/mL) solution is not licensed for intravenous administration.

Important Safety Information
Safe Practice
▶ With intravenous use
Intravenous route should be used with extreme care by specialists only.
MHRA/CHM Advice: Adrenaline auto-injectors: updated advice after European review (August 2017)
▶ With intramuscular use
Following a European review of all adrenaline auto-injectors approved in the EU, the MHRA recommend that 2 adrenaline auto-injectors are prescribed, which patients should carry at all times. This is particularly important for patients with allergic asthma, who are at increased risk of a severe anaphylactic reaction. Patients with allergies and their carers should be trained to use the particular auto-injector they have been prescribed and encouraged to practise using a trainer device. Patients are advised to check the expiry date of the adrenaline auto-injectors and obtain replacements before they expire.

CAUTIONS
Arrhythmias • cerebrovascular disease • cor pulmonale • diabetes mellitus • hypercalcaemia • hyperreflexia • hypertension • hyperthyroidism • hypokalaemia • ischaemic heart disease • obstructive cardiomyopathy • occlusive vascular disease • organic brain damage • phaeochromocytoma • prostate disorders • psychoneurosis • severe angina • susceptibility to angle-closure glaucoma

CAUTIONS, FURTHER INFORMATION
Cautions listed are only for non-life-threatening situations.

INTERACTIONS
▶ Appendix 1: sympathomimetics, vasoconstrictor

SIDE-EFFECTS
GENERAL SIDE-EFFECTS
▶ Rare or very rare Cardiomyopathy
▶ Frequency not known Angina pectoris • angle closure glaucoma • anxiety • appetite decreased • arrhythmias • asthma • CNS haemorrhage • confusion • dizziness • dry mouth • dyspnoea • headache • hepatic necrosis • hyperglycaemia • hyperhidrosis • hypersalivation • hypertension (increased risk of cerebral haemorrhage) • hypokalaemia • injection site necrosis • insomina • intestinal necrosis • metabolic acidosis • mydriasis • myocardial infarction • nausea • pallor • palpitations • peripheral coldness • psychosis • pulmonary oedema (on excessive dosage or extreme sensitivity) • renal necrosis • soft tissue necrosis • tremor • urinary disorders • vomiting

SPECIFIC SIDE-EFFECTS
▶ With intramuscular use Muscle necrosis • necrotising fasciitis • peripheral ischaemia
▶ With intravenous use Hemiplegia • muscle rigidity

PREGNANCY
▶ With intramuscular use or intravenous use May reduce placental perfusion and cause tachycardia, cardiac irregularities, and extrasystoles in fetus. Can delay second stage of labour. Manufacturers advise use only if benefit outweighs risk.

BREAST FEEDING
▶ With intramuscular use or intravenous use Present in milk but unlikely to be harmful as poor oral bioavailability.

RENAL IMPAIRMENT
Manufacturers advise use with caution in severe impairment.

MONITORING REQUIREMENTS
Monitor blood pressure and ECG.

DIRECTIONS FOR ADMINISTRATION
Acute hypotension
▶ With intravenous use For continuous intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9% and give through a central venous catheter. Incompatible with bicarbonate and alkaline solutions. Neonatal intensive care, dilute 3 mg/kg body-weight to a final volume of 50 mL with infusion fluid; an intravenous infusion rate of 0.1 mL/hour provides a dose of 100 nanograms/kg/minute; infuse through a central venous catheter. Incompatible with bicarbonate and alkaline solutions. These infusions are usually made up with adrenaline 1 in 1000 (1 mg/mL) solution.
▶ When used by inhalation For nebulisation in croup, adrenaline 1 in 1000 solution may be diluted with sterile sodium chloride 0.9% solution.

PRESCRIBING AND DISPENSING INFORMATION
▶ With intramuscular use It is important, in acute anaphylaxis where intramuscular injection might still succeed, time should not be wasted seeking intravenous access. Great vigilance is needed to ensure that the correct strength of adrenaline injection is used; anaphylactic shock kits need to make a very clear distinction between the 1 in 10 000 strength and the 1 in 1000 strength. Patients with severe allergy should be instructed in the self-administration of adrenaline by intramuscular injection. Packs for self-
administration need to be clearly labelled with instructions on how to administer adrenaline (intramuscularly, preferably at the midpoint of the outer thigh, through light clothing if necessary) so that in the case of rapid collapse someone else is able to give it. It is important to ensure individuals at risk and their carers understand that:

- two injection devices should be carried at all times to treat symptoms until medical assistance is available; if, after the first injection, the individual does not start to feel better, the second injection should be given 5 to 15 minutes after the first;
- an ambulance should be called after every administration, even if symptoms improve;
- the individual should lie down with their legs raised.

Adrenaline for administration by intramuscular injection is available in ‘auto-injectors’ (e.g. Emerade®, EpiPen®, or Jext®), pre-assembled syringes fitted with a needle suitable for very rapid administration (if necessary by a bystander or a healthcare provider if it is the only preparation available); injection technique is device specific.

To ensure patients receive the auto-injector device that they have been trained to use, prescribers should specify the brand to be dispensed.

**Patient and carer advice**

- With intramuscular use Individuals at considerable risk of anaphylaxis need to carry (or have available) adrenaline at all times and the patient, or their carers, need to be instructed in advance when and how to inject it.
- With intramuscular use The MHRA has produced an advice sheet on the use of adrenaline auto-injectors, which should be provided to patients and their carers. Medicines for Children leaflet: Adrenaline auto-injector for anaphylaxis www.medicinesforchildren.org.uk/adrenaline-auto-injector-anaphylaxis

**Jext® 300 micrograms** 1.1 ml of the solution remains in the auto–injector device after use.

**Jext® 150 micrograms** 1.25 ml of the solution remains in the auto–injector device after use.

**EpiPen® JR auto-injector 0.15 mg** 1.7 ml of the solution remains in the auto–injector device after use.

**Emerade® 150 micrograms** 0.35 ml of the solution remains in the auto–injector device after use.

**EpiPen® auto-injector 0.3 mg** 1.7 ml of the solution remains in the auto–injector device after use.

**Emerade® 500 micrograms** No solution remains in the auto–injector device after use.

**Emerade® 300 micrograms** 0.2 ml of the solution remains in the auto–injector device after use.

**Exceptions to legal category**

- With intramuscular use POM restriction does not apply to the intramuscular administration of up to 1 mg of adrenaline injection 1 in 1000 (1 mg/ml) for the emergency treatment of anaphylaxis.

**Medicinal forms** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

**Solution for injection**

- **Emerade®/adrenaline/epinephrine (non-proprietary)**
  - Adrenaline 100 microgram per 1 ml Adrenaline (base) 100 micrograms/1 ml (1 in 10,000) dilute solution for injection ampoules | 10 ampoule (PS9) £86.48
  - Adrenaline (base) 500 micrograms/5 ml (1 in 10,000) dilute solution for injection ampoules | 10 ampoule (PS9) £81.33
  - Adrenaline 1 mg per 1 ml Adrenaline (base) 10 mg/10 ml (1 in 1,000) solution for injection ampoules | 10 ampoule (PS9) £96.38
  - Adrenaline (base) for anaphylaxis 1 mg/1 ml (1 in 1,000) solution for injection pre-filled syringes | 1 pre-filled disposable injection (PS9) £11.88 DT + £11.71
  - Adrenaline (as Adrenaline acid tartrate) 1 mg per 1 ml Adrenaline (base) 5 mg/5 ml (1 in 1,000) solution for injection ampoules | 10 ampoule (PS9) £93.58
  - Adrenaline (base) 500 micrograms/0.5 ml (1 in 1,000) solution for injection ampoules | 10 ampoule (PS9) £76.73 DT + £76.73
  - Adrenaline (base) 1 mg/1 ml (1 in 1,000) solution for injection ampoules | 10 ampoule (PS9) £65.95 DT + £65.01
  - **Emerade® (Bausch & Lomb UK Ltd)**
    - Adrenaline 1 mg per 1 ml Emerade 300 micrograms/0.3 ml (1 in 1,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £25.99 DT + £26.45
    - **Adrenaline (as Adrenaline acid tartrate) 1 mg per 1 ml Emerade 150 micrograms/0.15 ml (1 in 1,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £22.99 DT + £22.99**
    - **Emerge 500 micrograms/0.5 ml (1 in 1,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £26.99 DT + £26.99**
  - **EpiPen® (Meda Pharmaceuticals Ltd)**
    - Adrenaline 500 microgram per 1 ml EpiPen Jr 150 micrograms/0.3 ml (1 in 2,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £26.45 DT + £26.45 | 2 pre-filled disposable injection (PS9) £52.90 DT + £52.90
    - **Adrenaline 1 mg per 1 ml EpiPen 300 micrograms/0.3 ml (1 in 1,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £26.45 DT + £26.45 | 2 pre-filled disposable injection (PS9) £52.90**
  - **Jext® (ALK-Abello Ltd)**
    - Adrenaline 1 mg per 1 ml Jext 300 micrograms/0.3 ml (1 in 1,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £23.99 DT + £26.45
    - **Adrenaline (as Adrenaline acid tartrate) 1 mg per 1 ml Jext 150 micrograms/0.15 ml (1 in 1,000) solution for injection auto-injectors | 1 pre-filled disposable injection (PS9) £23.99 DT + £23.99**

**8 Oedema**

**Diuretics**

**Overview**

Diuretics are used for a variety of conditions in children including pulmonary oedema (caused by conditions such as respiratory distress syndrome and bronchopulmonary dysplasia), congestive heart failure, and hypertension. Hypertension in children is often resistant to therapy and may require the use of several drugs in combination. Maintenance of fluid and electrolyte balance can be difficult in children on diuretics, particularly neonates whose renal function may be immature.

**Loop diuretics** are used for pulmonary oedema, congestive heart failure, and in renal disease.

Thiazides are used less commonly than loop diuretics but are often used in combination with loop diuretics or spironolactone p. 128 in the management of pulmonary oedema and, in lower doses, for hypertension associated with cardiac disease.

Aminophylline infusion p. 170 has been used with inhaeuous furosemide p. 142 to relieve fluid overload in critically ill children.

**Heart failure**

Heart failure is less common in children than in adults; it can occur as a result of congenital heart disease (e.g. septal defects), dilated cardiomyopathy, myocarditis, or cardiac surgery. Drug treatment of heart failure due to left
ventricular systolic dysfunction is covered below; optimal management of heart failure with preserved left ventricular function has not been established.

**Acute heart failure** can occur after cardiac surgery or as a complication in severe acute infections with or without myocarditis. Therapy consists of volume loading, vasodilator or inotropic drugs.

**Chronic heart failure** is initially treated with a **loop diuretic**, usually furosemide supplemented with spironolactone, amiloride hydrochloride p. 144, or potassium chloride p. 623.

If diuresis with furosemide is insufficient, the addition of metolazone p. 145 or a **thiazide diuretic** can be considered. With metolazone the resulting diuresis can be profound and care is needed to avoid potentially dangerous electrolyte disturbance.

If diuretics are insufficient an ACE inhibitor, titrated to the maximum tolerated dose, can be used. **ACE inhibitors** are used for the treatment of all grades of heart failure in adults and can also be useful for children with heart failure. Addition of digoxin p. 82 can be considered in children who remain symptomatic despite treatment with a diuretic and an ACE inhibitor.

Some beta-blockers improve outcome in adults with heart failure, but data on beta-blockers in children are limited. Carvedilol p. 127 has vasodilatory properties and therefore (like ACE inhibitors) also lowers afterload.

In children receiving specialist cardiology care, the phosphodiesterase type-3 inhibitor enoximone p. 129 is sometimes used by mouth for its inotropic and vasodilator effects. Spironolactone is usually used as a potassium-sparing diuretic with a loop diuretic; in adults low doses of spironolactone are effective in the treatment of heart failure. Careful monitoring of serum potassium is necessary if spironolactone is used in combination with an ACE inhibitor.

**Thiazides and related diuretics**

Thiazides and related compounds are moderately potent diuretics; they inhibit sodium reabsorption at the beginning of the distal convoluted tubule. They are usually administered early in the day so that the diuresis does not interfere with sleep.

In the management of **hypertension** a low dose of a thiazide produces a maximal or near-maximal blood pressure lowering effect, with very little biochemical disturbance. Higher doses cause more marked changes in plasma potassium, sodium, uric acid, glucose, and lipids, with little advantage in blood pressure control. Thiazides also have a role in chronic heart failure.

Bendroflumethiazide p. 113 is licensed for use in children; chlorothiazide p. 113 is also used. Chlortalidone p. 144, a thiazide-related compound, has a longer duration of action than the thiazides and may be given on alternate days in younger children.

Metolazone is particularly effective when combined with a loop diuretic (even in renal failure) and is most effective when given 30–60 minutes before furosemide profound diuresis can occur and the child should therefore be monitored carefully.

**Loop diuretics**

Loop diuretics inhibit reabsorption of sodium, potassium, and chloride from the ascending limb of the loop of Henlé in the renal tubule and are powerful diuretics.

Furosemide and bumetanide p. 142 are similar in activity; they produce dose-related diuresis. Furosemide is used extensively in children. It can be used for pulmonary oedema (e.g. in respiratory distress syndrome and bronchopulmonary dysplasia), congestive heart failure, and in renal disease.

**Potassium-sparing diuretics and aldosterone antagonists**

Spironolactone is the most commonly used potassium sparing diuretic in children; it is an aldosterone antagonist and enhances potassium retention and sodium excretion in the distal tubule. Spironolactone is combined with other diuretics to reduce urinary potassium loss. It is also used in nephrotic syndrome, the long-term management of Barter’s syndrome, and high doses can help to control ascites in babies with chronic neonatal hepatitis. The clinical value of spironolactone in the management of pulmonary oedema in preterm neonates with chronic lung disease is uncertain.

Potassium canrenoate p. 128 given intravenously, is an alternative aldosterone antagonist that may be useful if a potassium-sparing diuretic is required and the child is unable to take oral medication. It is metabolised to canrenone, which is also a metabolite of spironolactone.

Amiloride hydrochloride on its own is a weak diuretic. It causes retention of potassium and is therefore given with thiazide or loop diuretics as an alternative to giving potassium supplements.

A potassium-sparing diuretic such as spironolactone or amiloride hydrochloride may also be used in the management of amphotericin-induced hypokalaemia. Potassium supplements must not be given with potassium-sparing diuretics. Administration of a potassium-sparing diuretic to a child receiving an ACE inhibitor or an angiotensin-II receptor antagonist can also cause severe hyperkalaemia.

**Potassium-sparing diuretics with other diuretics**

Although it is preferable to prescribe diuretics separately in children, the use of fixed combinations may be justified in older children if compliance is a problem. (Some preparations may not be licensed for use in children—consult product literature).

**Other diuretics**

Mannitol p. 143 is used to treat cerebral oedema, raised intracocular pressure, peripheral oedema, and acites. The carbonic anhydrase inhibitor acetazolamide p. 707 is a weak diuretic although it is little used for its diuretic effect. Eye drops of dorzolamide p. 708 and brinzolamide p. 708 inhibit the formation of aqueous humour and are used in glaucoma. Acetazolamide is used in the treatment of epilepsy, and raised intracranial pressure.

**Diuretics with potassium**

Diuretics and potassium supplements should be prescribed separately.

**Advanced Pharmacy Services**

Children taking diuretics may be eligible for the New Medicines Service / Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

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**Other drugs used for Oedema**

**Diamorphine hydrochloride**, p. 284

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**DIURETICS ▶ LOOP DIURETICS**

**Loop diuretics**

- **DRUG ACTION** Loop diuretics inhibit reabsorption from the ascending limb of the loop of Henlé in the renal tubule and are powerful diuretics.

- **CONTRA-INDICATIONS** Anuria - renal failure due to nephrotic or hepatoxic drugs - severe hypokalaemia - severe hyponatraemia
CAUTIONS
- Can cause acute urinary retention in children with obstruction of urinary outflow, can exacerbate diabetes (but hyperglycaemia less likely than with thiazides), can exacerbate gout, comatose and precomatose states associated with liver cirrhosis, hypokalaemia should be corrected before initiation of treatment, hypovolaemia should be corrected before initiation of treatment.

CAUTIONS, FURTHER INFORMATION
- Potassium loss: Hypokalaemia can occur with both thiazide and loop diuretics. The risk of hypokalaemia depends on the duration of action as well as the potency and is thus greater with thiazides than with an equipotent dose of a loop diuretic.
- Hyperkalaemia: Hypokalaemia is particularly dangerous in children being treated with cardiac glycosides. In hepatic failure hypokalaemia caused by diuretics can precipitate encephalopathy. The use of potassium-sparing diuretics avoids the need to take potassium supplements.
- Urinary retention: Loop diuretics can cause acute urinary retention in children with obstruction of urinary outflow, therefore adequate urinary output should be established before initiating treatment.

SIDE-EFFECTS
- Common or very common: Dizziness, electrolyte imbalance, fatigue, headache, metabolic alkalosis, muscle spasms, nausea
- Uncommon: Diarrhoea
- Rare or very rare: Bone marrow depression, photosensitivity reaction
- Frequency not known: Deafness (more common in renal impairment), leucopenia, paraesthesia, rash, severe cutaneous adverse reactions (SCARs), thrombocytopenia, tinnitus (more common with rapid intravenous administration, and in renal impairment), vomiting

HEPATIC IMPAIRMENT
- Hypokalaemia induced by loop diuretics may precipitate hepatic encephalopathy and coma—potassium-sparing diuretics can be used to prevent this.

RENAL IMPAIRMENT
- High doses or rapid intravenous administration can cause tinnitus and deafness.
- Dose adjustments: High doses of loop diuretics may occasionally be needed in renal impairment.

MONITORING REQUIREMENTS

Bumetanide

INDICATIONS AND DOSE
- Oedema in heart failure, renal disease, and hepatic disease | Pulmonary oedema
  - BY MOUTH
    - Child 1 month-11 years: 15-50 micrograms/kg 1-4 times a day (max. per dose 2 mg); maximum 5 mg per day
    - Child 12-17 years: Initially 1 mg, dose to be taken in the morning, then 1 mg after 6-8 hours if required

- Oedema in heart failure, renal disease, and hepatic disease (severe cases) | Pulmonary oedema (severe cases)
  - BY MOUTH
    - Child 12-17 years: Initially 5 mg daily, increased in steps of 5 mg every 12-24 hours, adjusted according to response

UNLICENSED USE
- Not licensed for use in children under 12 years.

INTERACTIONS
- Appendix 1: loop diuretics

SIDE-EFFECTS
- Common or very common: Dehydration, hypotension, skin reactions
- Uncommon: Breast pain, chest discomfort, ear pain, vertigo
- Rare or very rare: Hearing impairment
- Frequency not known: Arthralgia, encephalopathy, gastrointestinal discomfort, gynaecomastia, hyperglycaemia, hyperuricaemia, muscle cramps, musculoskeletal pain (with high doses in renal failure)

PREGNANCY
- Bumetanide should not be used to treat gestational hypertension because of the maternal hypovolaemia associated with this condition.

MEDIcINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension
  - Oral solution
    - Bumetanide (Non-proprietary)
      - Bumetanide 200 microgram per 1 ml Bumetanide 1mg/5ml oral solution sugar free-sugar-free | 150 ml (PO) £198.00 DT £198.00
  - Tablet
    - Bumetanide (Non-proprietary)
      - Bumetanide 1 mg Bumetanide 1mg tablets | 28 tablet (PO) £7.35 DT £7.31
      - Bumetanide 5 mg Bumetanide 5mg tablets | 28 tablet (PO) £6.98 DT £6.98

Furosemide (Furosemide)

INDICATIONS AND DOSE
- Oedema in heart failure, renal disease, and hepatic disease | Pulmonary oedema
  - BY MOUTH
    - Neonate: 0.5–2 mg/kg every 12–24 hours, alternatively 0.5–2 mg/kg every 24 hours, if corrected gestational age under 31 weeks.
    - Child 1 month-11 years: 0.5–2 mg/kg 2–3 times a day, alternatively 0.5–2 mg/kg every 24 hours, if corrected gestational age of under 31 weeks, higher doses may be required in resistant oedema; maximum 80 mg per day; maximum 12 mg/kg per day
    - Child 12-17 years: 20–40 mg daily; increased to 80–120 mg daily, in resistant oedema
    - BY SLOW INTRAVENOUS INJECTION
    - Neonate: 0.5–1 mg/kg every 12–24 hours, alternatively 0.5–1 mg/kg every 24 hours, if corrected gestational age under 31 weeks.
    - Child 1 month-11 years: 0.5–1 mg/kg every 8 hours (max. per dose 40 mg every 8 hours) as required; maximum 6 mg/kg per day
    - Child 12-17 years: 20–40 mg every 8 hours as required, higher doses may be required in resistant cases
    - BY CONTINUOUS INTRAVENOUS INFUSION
    - Child: 0.1–2 mg/kg/hour

- Oedema in heart failure, renal disease, and hepatic disease following cardiac surgery | Pulmonary oedema following cardiac surgery
  - BY CONTINUOUS INTRAVENOUS INFUSION
    - Child: Initially 100 micrograms/kg/hour, dose to be doubled every 2 hours until urine output exceeds 1 ml/kg/hour
Oliguria

- **BY MOUTH**
  - Child 12-17 years: Initially 250 mg daily, then increased in steps of 250 mg every 4–6 hours (max. per dose 2 g) if required
  - **BY INTRAVENOUS INJECTION**
  - Child 1 month-11 years: 2–5 mg/kg up to 4 times a day; maximum 1 g per day
  - Child 12-17 years: Initially 250 mg, dose to be administered over 1 hour, increased to 500 mg, increased dose is given if satisfactory urinary output not obtained; dose administered over 2 hours, then increased to 1 g, increased dose given if satisfactory response not obtained within subsequent hour; dose to be administered over 4 hours. If no response obtained dialysis probably required.; effective dose of up to 1 g given at a maximum rate of 4 mg/minute can be repeated every 24 hours

- **CAUTIONS**
  Effect may be prolonged in neonates - hepatorenal syndrome - hypoproteinaemia may reduce diuretic effect and increase risk of side-effects

- **INTERACTIONS**

- **SIDE-EFFECTS**

- **GENERAL SIDE-EFFECTS**
  Agranulocytosis - aplastic anaemia - auditory disorder (more common with rapid intravenous administration, and in renal impairment) - diabetes mellitus - eosinophilia - fever - gout - haemolytic anaemia - hepatic encephalopathy - malaise - mucosal reaction - nephritis tubulointerstitial - pancreatitis acute - shock - skin eruption - tetany - urolithiasis - vasculitis

- **SPECIFIC SIDE-EFFECTS**
  - With oral use Acute kidney injury - hepatic disorders - metabolic acidosis - psychiatric disorder - urinary disorders
  - With parenteral use Acute urinary retention - cholestasis

- **PREGNANCY**
  Furosemide should not be used to treat gestational hypertension because of the maternal hypovolaemia associated with this condition.

- **BREAST FEEDING**
  Amount too small to be harmful. May inhibit lactation.

- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use For intravenous injection, give over 5–10 minutes at a usual rate of 100 micrograms/kg/minute (not exceeding 500 micrograms/kg/minute), max. 4 mg/minute; lower rate of infusion may be necessary in renal impairment. For intravenous infusion, dilute with Sodium Chloride 0.9% to a concentration of 1–2 mg/mL. Glucose solutions unsuitable (infusion pH must be above 5.5).
  - With oral use For administration by mouth, tablets can be crushed and mixed with water or injection solution diluted and given by mouth. Risk of ototoxicity may be reduced by giving high oral doses in 2 or more divided doses.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - With oral use Some liquid preparations contain alcohol, caution especially in neonates.

- **MEDICINAL FORMS**
  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

- **Furosemide (Non-proprietary)**
  - Furosemide 20 mg: Furosemide 20mg tablets | 28 tablet [POM] £2.62 DT = £1.48 | 250 tablet [POM] £5.08-£13.21
  - Furosemide 40 mg: Furosemide 40mg tablets | 28 tablet [POM] £2.84 DT = £2.09 | 250 tablet [POM] £3.50-£18.66 | 1000 tablet [POM] £28.21-£92.15
  - Furosemide 50 mg: Furosemide 500mg tablets | 28 tablet [POM] £70.00 DT = £39.04

**Solution for injection**

- **Furosemide (Non-proprietary)**
  - Furosemide 10 mg per 1 ml: Furosemide 250mg/25ml solution for injection ampoules | 10 ampoule [POM] £30.00-£40.00
  - Furosemide 50mg/5ml solution for injection ampoules | 10 ampoule [POM] £2.38-£5.00
  - Furosemide 20mg/2ml solution for injection ampoules | 10 ampoule [POM] £40.00 DT = £13.42

**Oral solution**

- **EXCIPENTS:** May contain Alcohol
  - **Furosemide (Non-proprietary)**
    - Furosemide 4 mg per 1 ml: Furosemide 20mg/5ml oral solution sugar free sugar-free | 150 ml [POM] £14.81 DT = £14.81
    - Furosemide 8 mg per 1 ml: Furosemide 40mg/5ml oral solution sugar free sugar-free | 150 ml [POM] £19.53 DT = £19.53
    - Furosemide 10 mg per 1 ml: Furosemide 50mg/5ml oral solution sugar free sugar-free | 150 ml [POM] £20.21 DT = £20.21
  - Frusil (Rosemont Pharmaceuticals Ltd)
    - Furosemide 4 mg per 1 ml: Frusol 20mg/5ml oral solution sugar-free | 150 ml [POM] £12.07 DT = £14.81
    - Furosemide 8 mg per 1 ml: Frusol 40mg/5ml oral solution sugar-free | 150 ml [POM] £15.58 DT = £19.53
    - Furosemide 10 mg per 1 ml: Frusol 50mg/5ml oral solution sugar-free | 150 ml [POM] £16.84 DT = £20.21

[DIURETICS] [OSMOTIC DIURETICS]

**Mannitol**

- **INDICATIONS AND DOSE**

  **Cerebral oedema**
  - **BY INTRAVENOUS INFUSION**
    - Child 1 month-11 years: 0.25–1.5 g/kg, repeated if necessary, to be administered over 30–60 minutes, dose may be repeated 1–2 times after 4–8 hours
    - Child 12-17 years: 0.25–2 g/kg, repeated if necessary, to be administered over 30–60 minutes, dose may be repeated 1–2 times after 4–8 hours

  **Peripheral oedema and ascites**
  - **BY INTRAVENOUS INFUSION**
    - Child: 1–2 g/kg, to be given over 2–6 hours

- **UNLICENSED USE**
  Not licensed for use in children under 12 years.

- **CONTRA-INDICATIONS**
  Anuria - intracranial bleeding (except during craniotomy) - severe cardiac failure - severe dehydration - severe pulmonary oedema

- **CAUTIONS**
  Extravasation causes inflammation and thrombophlebitis

- **SIDE-EFFECTS**
  - Common or very common
    - Cough - headache - vomiting
  - Uncommon
    - Dizziness - fever - malaise - nausea - pain - skin reactions

- **Frequency not known**

- **PREGNANCY**
  Manufacturer advises avoid unless essential – no information available.

- **BREAST FEEDING**
  Manufacturer advises avoid unless essential – no information available.

- **RENAL IMPAIRMENT**
  Use with caution in severe impairment.
DIURETICS

Amiloride hydrochloride

**Indications and Dose**
Adjunct to thiazide or loop diuretics for oedema in heart failure, and hepatic disease (where potassium conservation desirable)

- **By mouth**
  - Neonate: 100–200 micrograms/kg twice daily.
  - Child 1 month–11 years: 100–200 micrograms/kg twice daily; maximum 20 mg per day.
  - Child 12–17 years: 5–10 mg twice daily.

- **Unlicensed Use** Not licensed for use in children.
- **Contra-Indications** Addison’s disease, anuria, hyperkalaemia
- **Caution** Diabetes mellitus
- **Interactions** Appendix 1: potassium-sparing diuretics
- **Side-Effects** Alopecia, angina pectoris, aplastic anaemia, appetite decreased, arrhythmia, arthralgia, asthenia, atrioventricular block exacerbated, bladder spasm, chest pain, confusion, constipation, cough, depression, diarrhoea, dizziness, drowsiness, dry mouth, dyspnoea, dysuria, electrolyte imbalance, encephalopathy, gastrointestinal discomfort, gastrointestinal disorders, gastrointestinal haemorrhage, gout, headache, insomnia, jaundice, muscle cramps, nasal congestion, nausea, nervousness, neutropenia, pain, palpitations, paraesthesia, postural hypotension, sexual dysfunction, skin reactions, tinnitus, tremor, vertigo, visual impairment, vomiting
- **Pregnancy** Not to be used to treat gestational hypertension.
- **Breast-feeding** Manufacturer advises avoid—no information available.
- **Renal Impairment** Manufacturers advise avoid in severe impairment.
- **Monitoring** Monitor plasma-potassium concentration (high risk of hyperkalaemia in renal impairment).
- **Monitoring Requirements** Monitor electrolytes.

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

- **Oral solution**
  - Excipients: May contain Propylene glycol
  - Amiloride hydrochloride (Non-proprietary)
    - Amiloride hydrochloride 1 mg per 1 ml
    - Amiloride 5 mg/5 ml oral solution sugar-free sugar-free | 150 ml
    - £42.35 DT = £42.33
  - Tablet
    - Amiloride hydrochloride (Non-proprietary)
      - Amiloride hydrochloride 5 mg
      - Amiloride 5 mg tablets | 28 tablet
      - £27.68 DT = £3.29

**Chlortalidone** (Chlorthalidone)

**Indications and Dose**
Ascites | Oedema in nephrotic syndrome

- **By mouth**
  - Child 5–11 years: 0.5–1 mg/kg every 48 hours (max. per dose 1.7 mg/kg every 48 hours), dose to be taken in the morning.
  - Child 12–17 years: Up to 50 mg daily

**Hypertension**

- **By mouth**
  - Child 5–11 years: 0.5–1 mg/kg every 48 hours (max. per dose 1.7 mg/kg every 48 hours), dose to be taken in the morning.
  - Child 12–17 years: 25 mg daily, dose to be taken in the morning, then increased if necessary to 50 mg daily

**Stable Heart Failure**

- **By mouth**
  - Child 5–11 years: 0.5–1 mg/kg every 48 hours (max. per dose 1.7 mg/kg every 48 hours), dose to be taken in the morning.
  - Child 12–17 years: 25–50 mg daily, dose to be taken in the morning, then increased if necessary to 100–200 mg daily, reduce to lowest effective dose for maintenance.

**Interactions** Appendix 1: thiazide diuretics

**Side-Effects**

- Common or very common
  - Appetite decreased, erectile dysfunction, gastrointestinal discomfort, hyperglycaemia, rash

- Uncommon
  - Gout

- Rare or very rare
  - Arrhythmia, diabetes mellitus exacerbated, eosinophilia, glycosuria, hepatic disorders, nephritis tubulointerstitial, paraesthesia, pulmonary oedema, respiratory disorder, vomiting

**Breast-feeding** The amount present in milk is too small to be harmful. Large doses may suppress lactation.

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

- **Tablet**
  - Chlortalidone (Non-proprietary)
    - Chlortalidone 25 mg
    - Chlortalidone 25 mg tablets | 100 tablet
    - £90.55 DT = £88.04
  - Chlortalidone 50 mg
    - Chlortalidone 50 mg tablets | 30 tablet
    - £115.25 DT = £110.36
Patent ductus arteriosus

9 Patent ductus arteriosus

Drugs affecting the ductus arteriosus

Closure of the ductus arteriosus

Patent ductus arteriosus is a frequent problem in premature neonates with respiratory distress syndrome. Substantial left-to-right shunting through the ductus arteriosus may increase the risk of intraventricular haemorrhage, necrotising enterocolitis, bronchopulmonary dysplasia, and possibly death. Indometacin p. 561 or ibuprofen p. 579 can be used to close the ductus arteriosus. Indometacin has been used for many years and is effective but it reduces cerebral blood flow, and causes a transient fall in renal and gastrointestinal blood flow. Ibuprofen may also be used; it has little effect on renal function (there may be a small reduction in sodium excretion) when used in doses for closure of the ductus arteriosus; gastrointestinal problems are uncommon. If drug treatment fails to close the ductus arteriosus, surgery may be indicated.

Maintenance of patency

In the newborn with duct-dependent congenital heart disease it is often necessary to maintain the patency of the ductus arteriosus whilst awaiting surgery. Alprostadil below (prostaglandin E1) and dinoprostone below (prostaglandin E2) are potent vasodilators that are effective for maintaining the patency of the ductus arteriosus. They are usually given by continuous intravenous infusion, but oral dosing of dinoprostone is still used in some centres. During the infusion of a prostaglandin, the newborn requires careful monitoring of heart rate, blood pressure, respiratory rate, and core body temperature. In the event of complications such as apnoea, profound bradycardia, or severe hypotension, the infusion should be temporarily stopped and the complication dealt with; the infusion should be restarted at a lower dose. Recurrent or prolonged apnoea may require ventilatory support in order for the prostaglandin infusion to continue.

PROSTAGLANDIN ANALOGUES AND PROSTAMIDES > PROSTAGLANDINS

Alprostadil

• INDICATIONS AND DOSE
  Maintaining patency of the ductus arteriosus
  ▶ BY CONTINUOUS INTRAVENOUS INFUSION
  • Neonate: Initially 5 nanograms/kg/minute, then increased in steps of 5 nanograms/kg/minute as required; increased to 20 nanograms/kg/minute, doses up to 100 nanogram/kg/minute have been used but are associated with increased side-effects.

Dinoprostone

• INDICATIONS AND DOSE
  Maintaining patency of the ductus arteriosus
  ▶ BY CONTINUOUS INTRAVENOUS INFUSION
  • Neonate: Initially 5 nanograms/kg/minute, then increased in steps of 5 nanograms/kg/minute as required; increased to 20 nanograms/kg/minute, doses up to 100 nanogram/kg/minute have been used but are associated with increased side-effects.
### Cardiovascular System

**Peripheral Vascular Disease**

**Classification and Management**

Raynaud’s syndrome, a vasospastic peripheral vascular disease, consists of recurrent, long-lasting, and episodic vasospasm of the fingers and toes often associated with exposure to cold. Management includes avoidance of exposure to cold and smoking cessation. nifedipine p. 111 and diltiazem hydrochloride below are useful for reducing the frequency and severity of vasospastic attacks. In very severe cases, where digital infarction is likely, intravenous infusion of the prostacyclin analogue iloprost p. 121 may be helpful. Vasoconstrictor therapy is not established as being effective for chilblains.

**Advanced Pharmacy Services**

Children with peripheral vascular disease may be eligible for the Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

### Medicinal Forms

- **Prostin E2** (Pfizer Ltd)
  - Dinoprostone 1 mg per 1 ml Prostin E2 750 micrograms/0.75 ml solution for infusion ampoules. 1 ampoule £8.52 (Hospital only)
  - Dinoprostone 10 mg per 1 ml Prostin E2 5 mg/0.5 ml solution for infusion ampoules. 1 ampoule £18.30 (Hospital only)

### Diltiazem hydrochloride

- **Indications and Dose**
  - Raynaud’s syndrome
  - Child 12-17 years: 30–60 mg 2–3 times a day

- **Side-effects**
  - Common or very common Cardiac conduction disorders - constipation, gastrointestinal discomfort, malaise - skin reactions
  - Uncommon Arrhythmias - diaphoresis, insomnia - nervousness - postural hypotension
  - Rare or very rare Dry mouth

- **Contra-indications**
  - Acute porphyrias p. 624 - cardiogenic shock - left ventricular failure with pulmonary congestion - second or third-degree AV block (unless pacemaker fitted) - severe bradycardia - sick sinus syndrome - significant aortic stenosis

- **Cautionary and advisory labels**
  - Pregnancy Avoid
  - Breast Feeding Significant amount present in milk—no evidence of harm but avoid unless no safer alternative

### Renal Impairment

- Manufacturers advise avoid

### Hepatic Impairment

- Not licensed for use in children.
Chapter 3
Respiratory system

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Respiratory system, drug delivery

Inhalation
This route delivers the drug directly to the Airways; the dose required is smaller than when given by mouth and side-effects are reduced.

Children and their carers should be advised to follow manufacturers' instructions on the care and cleansing of inhaler devices.

Inhaler devices
A pressurised metered-dose inhaler is an effective method of drug administration in mild to moderate chronic asthma; to deliver the drug effectively, particularly in children under 12 years, a spacer device should also be used (see also NICE guidance). By the age of 3 years, a child can usually be taught to use a spacer device without a mask. As soon as a child is able to use the mouthpiece, then this is the preferred delivery system. When a pressurised metered-dose inhaler with a spacer is unsuitable or inconvenient, a dry-powder inhaler or breath-activated inhaler may be used instead if the child is able to use the device effectively.

Dry powder inhalers may be useful in children over 5 years, who are unwilling or unable to use a pressurised metered-dose inhaler with a spacer device; breath-activated inhalers may be useful in older children if they are able to use the device effectively. The child or child's carer should be instructed carefully on the use of the inhaler. It is important to check that the inhaler is being used correctly; poor inhalation technique may be mistaken for a lack of response to the drug.

On changing from a pressurised metered-dose inhaler to a dry powder inhaler, the child may notice a lack of sensation in the mouth and throat previously associated with each actuation; coughing may occur more frequently following use of a dry-powder inhaler.

CFC-free metered-dose inhalers should be cleaned weekly according to the manufacturer's instructions.

MHRA/CHM advice: Pressurised metered dose inhalers (pMDI): risk of airway obstruction from aspiration of loose objects (July 2018)
The MHRA have received reports of patients who have inhaled objects into the back of the throat—in some cases objects were aspirated, causing airway obstruction. Patients should be reminded to remove the mouthpiece cover fully, shake the device and check that both the outside and inside of the mouthpiece are clear and undamaged before inhaling a dose, and to store the inhaler with the mouthpiece cover on.

Spacer devices
Spacer devices are particularly useful for infants, for children with poor inhalation technique, or for nocturnal asthma, because the device reduces the need for coordination between actuation of a pressurised metered-dose inhaler and inhalation. The spacer device reduces the velocity of the aerosol and subsequent impaction on the oropharynx and allows more time for evaporation of the propellant so that a larger proportion of the particles can be inhaled and deposited in the lungs. Smaller-volume spacers may be more manageable for pre-school children and infants. The spacer device used must be compatible with the prescribed metered-dose inhaler.

Use and care of spacer devices
The suitability of the spacer device should be carefully assessed; opening the one-way valve is dependent on the child’s inspiratory flow. Some devices can be tipped to 45° to open the valve during inhaler actuation and inspiration to assist the child.

Inhalation from the spacer device should follow the actuation as soon as possible because the drug aerosol is very short-lived. The total dose (which may be more than a single puff) should be administered as single actuations (with tidal breathing for 10–20 seconds or 5 breaths for each actuation) for children with good inspiratory flow. Larger doses may be necessary for a child with acute bronchospasm.

The device should be cleansed once a month by washing in mild detergent and then allowed to dry in air without rinsing; the mouthpiece should be wiped clean of detergent before use. Some manufacturers recommend more frequent cleaning, but this should be avoided since any electrostatic charge may affect drug delivery. Spacer devices should be replaced every 6–12 months.

Nebulisers
Solutions for nebulisation for use in acute severe asthma are administered over 5–10 minutes from a nebuliser, usually driven by oxygen in hospital.

Children with a severe attack of asthma should preferably have oxygen during nebulisation since beta agonists can increase arterial hypoxaemia.

A nebuliser converts a solution of a drug into an aerosol for inhalation. It is used to deliver higher doses of drug to the Airways than is usual with standard inhalers. The main indications for use of a nebuliser are:

- to deliver a beta, agonist or ipratropium bromide p. 155 to a child with an acute exacerbation of asthma or of airways obstruction;
- to deliver prophylactic medication to a child unable to use other conventional devices;
- to deliver an antibacterial (such as colistimethate sodium p. 358 or tobramycin p. 323) to a child with chronic purulent infection (as in cystic fibrosis or bronchiectasis);
- to deliver budesonide p. 163 to a child with severe croup.

The proportion of a nebuliser solution that reaches the lungs depends on the type of nebuliser and although it can be as high as 30% it is more frequently close to 10% and...
sometimes below 10%. The remaining solution is left in the nebuliser as residual volume or it is deposited in the mouthpiece and tubing. The extent to which the nebulised solution is deposited in the airways or alveoli depends on particle size. Particles with a median diameter of 1–5 microns are deposited in the airways and are therefore appropriate for asthma whereas a particle size of 1–2 microns is needed for alveolar deposition. The type of nebuliser is therefore chosen according to the deposition required and according to the viscosity of the solution.

Nebulised bronchodilators are appropriate for children with chronic persistent asthma or those with severe acute asthma. In chronic asthma, nebulised bronchodilators should only be used to relive persistent daily wheeze, however, with the development of spacers with facemasks, it is now unusual for a child to require long-term nebulised asthma therapy. The use of nebulisers in chronic persistent asthma should be considered only:

- after a review of the diagnosis and use of current inhaler devices;
- if the airflow obstruction is significantly reversible by bronchodilators without unacceptable side-effects;
- if the child does not benefit from use of conventional inhaler device, such as pressurised metered-dose inhaler plus spacer;
- if the child is complying with the prescribed dose and frequency of anti-inflammatory treatment including regular use of high-dose inhaled corticosteroid.

When a nebuliser is prescribed, the child or child’s carer must:

- have clear instructions from a doctor, specialist nurse, physiotherapist, or pharmacist on the use of the nebuliser (and on peak-flow monitoring);
- be instructed not to treat acute attacks without also seeking medical help;
- have regular follow up with doctor or specialist nurse.

**Jet nebulisers**

Jet nebulisers are more widely used than ultrasonic nebulisers. Most jet nebulisers require an optimum flow rate of 6–8 litres/minute and in hospital can be driven by piped air or oxygen; in acute asthma the nebuliser should always be driven by oxygen. Domiciliary oxygen cylinders do not provide an adequate flow rate therefore an electrical compressor is required for domiciliary use. Some jet nebulisers are able to increase drug output during inspiration and hence increase efficiency.

**Safe practice**

The Department of Health has reminded users of the need to use the correct grade of tubing when connecting a nebuliser to a medical gas supply or compressor.

**Nebuliser diluent**

Nebulisation may be carried out using an undiluted nebuliser solution or it may require dilution beforehand. The usual diluent is sterile sodium chloride 0.9% (physiological saline).

In England and Wales nebulisers and compressors are not available on the NHS (but they are free of VAT); some nebulisers (but not compressors) are available on form GP10A in Scotland (for details consult Scottish Drug Tariff).

**Oral**

Systemic side-effects occur more frequently when a drug is given orally rather than by inhalation. Oral corticosteroids, theophylline p. 171, and leukotriene receptor antagonists are sometimes required for the management of asthma. Oral administration of a beta, agonist is generally not recommended for children, but may be necessary in infants and young children who are unable or unwilling to use an inhaler device.

**Parenteral**

Drugs such as beta, agonists, corticosteroids, and aminophylline p. 170 can be given by injection in acute severe asthma when drug administration by nebulisation is inadequate or inappropriate; in these circumstances the child should generally be treated in a high dependency or intensive care unit.

**Peak flow meters**

Peak flow meters may be used to assess lung function in children over 5 years with asthma, but symptom monitoring is the most reliable assessment of asthma control. They are best used for short periods to assess the severity of asthma and to monitor response to treatment; continuous use of peak flow meters may detract from compliance with inhalers.

Peak flow charts should be issued to patients where appropriate, and are available to purchase from: 3M Security Print and Systems Limited. Gorse Street, Chadderton, Oldham, OL9 9QH. Tel: 0845 610 1112

GP practices can obtain supplies through their Area Team stores.

NHS Hospitals can order supplies from www.nhsforms.co.uk/ or by emailing nhsforms@mmm.com.

In Scotland, peak flow charts can be obtained by emailing stockorders.dppas@apsgroup.co.uk.

**NICE decisions**

**Inhaler devices for children under 5 years with chronic asthma**

(August 2000) NICE TA10

When selecting inhaler devices for children under 5 years with chronic asthma, a child’s needs and likelihood of good compliance should govern the choice of inhaler and spacer device; only then should cost be considered.

- corticosteroid and bronchodilator therapy should be delivered by pressurised metered-dose inhaler and spacer device, with a facemask if necessary;
- if this is not effective, and depending on the child’s condition, nebulised therapy may be considered and, in children over 3 years, a dry powder inhaler may also be considered.

www.nice.org.uk/TA10

**Inhaler devices for children 5–15 years with chronic asthma**

(March 2002) NICE TA38

When selecting inhaler devices for children between 5–15 years with chronic asthma, a child’s needs, ability to develop and maintain effective technique, and likelihood of good compliance should govern the choice of inhaler and spacer device; only then should cost be considered.

- corticosteroid therapy should be routinely delivered by a pressurised metered-dose inhaler and spacer device;
- for other inhaled drugs, particularly bronchodilators, a wider range of devices should be considered;
- children and their carers should be trained in the use of the chosen device; suitability of the device should be reviewed at least annually. Inhaler technique and compliance should be monitored.

www.nice.org.uk/TA38

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**1 Airways disease, obstructive**

**Asthma, chronic**

**Description of condition**

Asthma is a common chronic inflammatory condition of the airways, associated with airway hyperresponsiveness and variable airflow obstruction. The most frequent symptoms of
asthma are cough, wheeze, chest tightness, and breathlessness. Asthma symptoms vary over time and in intensity and can gradually or suddenly worsen, provoking an acute asthma attack that, if severe, may require hospitalisation.

**Aims of treatment**

The aim of treatment is to achieve control of asthma. Complete control of asthma is defined as no daytime symptoms, no night-time awakening due to asthma, no asthma attacks, no need for rescue medication, no limitations on activity including exercise, normal lung function (in practical terms forced expiratory volume in 1 second (FEV₁) and/or peak expiratory flow (PEF) > 80% predicted or best), and minimal side-effects from treatment. In clinical practice, patients may choose to balance the aims of asthma management against the potential side-effects or inconvenience of taking medication necessary to achieve perfect control.

**Lifestyle changes**

Weight loss in overweight patients may lead to an improvement in asthma symptoms. Parents with asthma should be advised about the danger of smoking, to themselves and to their children with asthma, and be offered appropriate support to stop smoking. For further information, see Smoking cessation p. 304.

Breathing exercise programmes (including physiotherapist-taught methods) can be offered as an adjuvant to drug treatment to improve quality of life and reduce symptoms.

**Management**

A stepwise approach aims to stop symptoms quickly and to improve peak flow. Treatment should be started at the level most appropriate to initial severity of asthma. The aim is to achieve early control and to maintain it by stepping up treatment as necessary and decreasing treatment when control is good. Before initiating a new drug or adjusting treatment consider whether diagnosis is correct, check adherence and inhaler technique, and eliminate trigger factors for acute attacks.

A self-management programme comprising of a written personalised action plan and education should be offered to all patients with asthma (and/or their family or carers). Recommendations on the management of chronic asthma from the National Institute for Health and Care Excellence (NICE)—Asthma: diagnosis, monitoring and chronic asthma management guidelines (NG80, November 2017), and British Thoracic Society (BTS) and Scottish Intercollegiate Guidelines Network (SIGN)—British guideline on the management of asthma (SIGN 153, September 2016) differ significantly. Recommendations in BNF publications are based on NICE guidelines, and differences with BTS/SIGN (2016) have been highlighted.

**Child over 16 years**

NICE (2017) treatment recommendations for child over 16 years apply to patients aged 17 years and over. BTS/SIGN (2016) treatment recommendations for child over 16 years are the same as those for patients over 12 years (see child over 5 years section).

**Intermittent reliever therapy**

Start an inhaled short-acting beta, agonist (such as salbutamol p. 158 or terbutaline sulfate p. 160), to be used as required, in all patients with asthma. For those with infrequent short-lived wheeze, occasional use of reliever therapy may be the only treatment required. Patients using more than one short-acting beta, agonist inhaler device a month should have their asthma urgently assessed and action taken to improve poorly controlled asthma.

**Regular preventer (maintenance) therapy**

NICE (2017) define inhaled corticosteroid doses for children over 16 years as low, moderate, or high. BTS/SIGN (2016) instead define inhaled corticosteroid doses for children over 16 years as low, medium or high (refer to individual guidelines for inhaled corticosteroid dosing information).

A low dose of inhaled corticosteroid should be started as maintenance therapy in patients who present with any one of the following features: using an inhaled short-acting beta, agonist three times a week or more, symptomatic three times a week or more, or waking at night due to asthma symptoms at least once a week. BTS/SIGN (2016) also recommend initiation in patients who have had an asthma attack in the last 2 years, and starting inhaled corticosteroids at a dose appropriate to the severity of asthma.

BTS/SIGN (2016) recommend that inhaled corticosteroids (except ciclesonide p. 164) should be initially taken twice daily, however, the same total daily dose, taken once a day, can be considered in patients with milder disease if good or complete control of asthma is established. The dose of inhaled corticosteroid should be adjusted over time to the lowest effective dose at which control of asthma is maintained.

BTS/SIGN (2016) recommend the prescribing of inhalers by brand. If asthma is uncontrolled on a low dose of inhaled corticosteroid as maintenance therapy, a leukotriene receptor antagonist (such as montelukast p. 168) should be offered in addition to the inhaled corticosteroid, and the response to treatment reviewed in 4 to 8 weeks.

BTS/SIGN (2016) instead recommend a long-acting beta, agonist (LABA—such as salmeterol p. 157 or formoterol fumarate p. 156) as initial add-on therapy to inhaled corticosteroids if asthma is uncontrolled.

**Additional add-on therapy**

If asthma is uncontrolled on a low dose of inhaled corticosteroid and a leukotriene receptor antagonist as maintenance therapy, a LABA in combination with the inhaled corticosteroid should be offered with or without continued leukotriene receptor antagonist treatment, depending on the response achieved from the leukotriene receptor antagonist.

If asthma remains uncontrolled, offer to change the inhaled corticosteroid and LABA maintenance therapy to a MART regimen (Maintenance And Reliever Therapy—a combination of an inhaled corticosteroid and a fast-acting LABA such as formoterol in a single inhaler), with a low dose of inhaled corticosteroid as maintenance. See budesonide with formoterol p. 164 (not licensed in all age groups).

If asthma remains uncontrolled on a MART regimen with a low dose of inhaled corticosteroid as maintenance with or without a leukotriene antagonist, consider increasing to a moderate dose of inhaled corticosteroid (either continuing a MART regimen or changing to a fixed-dose regimen of an inhaled corticosteroid and a LABA, with a short-acting beta₂ agonist as reliever therapy).

If asthma is still uncontrolled in patients on a moderate dose of inhaled corticosteroid as maintenance with a LABA (either as MART or a fixed-dose regimen), with or without a leukotriene receptor antagonist, consider the following options:

- increasing the inhaled corticosteroid dose to a high-dose as maintenance (this should only be offered as part of a fixed-dose regimen, with a short-acting beta₂ agonist used as a reliever therapy), or
- a trial of an additional drug, for example, a long-acting muscarinic receptor antagonist (such as tiotropium) or modified-release theophylline p. 171, or
- seek advice from an asthma specialist.
BTS/SIGN (2016) instead recommend that if the patient is gaining some benefit from addition of a LABA but control remains inadequate, that the LABA be continued and the dose of inhaled corticosteroid be increased to a medium-dose, if not already on this dose. If increasing the dose of inhaled corticosteroid is ineffective, consider continuing on a low dose of inhaled corticosteroid and a LABA and try adding a leukotriene receptor antagonist, or a long-acting muscarinic receptor antagonist, or modified-release theophylline p. 171.

If there is no response to the LABA, discontinue it and increase the dose of the inhaled corticosteroid to a medium-dose, if not already on this dose. If increasing the dose of inhaled corticosteroid is ineffective, consider continuing on a low dose of inhaled corticosteroid and try adding a leukotriene receptor antagonist or a long-acting muscarinic receptor antagonist. 

High-dose inhaled corticosteroids and further add-on treatment

BTS/SIGN (2016) recommend that if control remains inadequate on a combination of short-acting beta2 agonist as required, a medium dose of inhaled corticosteroid, plus an additional drug, usually a LABA, to consider the following interventions:
- increase the inhaled corticosteroid to a high-dose—with high doses of inhaled corticosteroid via a pressurised metered-dose inhaler (pMDI), a spacer should be used, or
- add a leukotriene receptor antagonist, or
- add modified-release theophylline p. 171, or
- add tiotropium.

If a trial of a further add-on treatment is ineffective, stop the drug (or in the case of increased dose of inhaled corticosteroid, reduce to the original dose) and refer to specialist care.

Continuous or frequent use of oral corticosteroids

BTS/SIGN (2016) recommend adding a regular oral corticosteroid (prednisolone p. 458) at the lowest dose to provide adequate control (under specialist care) in patients with very severe asthma uncontrolled on high-dose inhaled corticosteroids, and who have also tried (or are still receiving) a LABA, a leukotriene receptor antagonist, or modified-release theophylline p. 171.

Monoclonal antibodies and immunosuppressants

BTS/SIGN (2016) recommend, that under specialist initiation, immunosuppressants such as methotrexate p. 563 [unlicensed], and monoclonal antibodies such as omalizumab p. 167 (for severe persistent allergic asthma), and mepolizumab and reslizumab (in adults for severe eosinophilic asthma), may be considered in patients with severe asthma to achieve control and reduce the use of oral corticosteroids. See mepolizumab, omalizumab p. 167, and reslizumab National funding/access decisions.

Child over 5 years

For children over 5 years, NICE (2017) treatment recommendations for children apply to children aged 5–16 years and child over 16 years treatment recommendations apply to those aged 17 years and over. Whereas, for children over 5 years, BTS/SIGN (2016) treatment recommendations for children apply to children aged 5–12 years and child over 16 years treatment recommendations apply to those aged over 12 years.

Intermittent reliever therapy

Start an inhaled short-acting beta2, agonist (such as salbutamol p. 158 or terbutaline sulfate p. 160), to be used as required, in all children with asthma. For those with infrequent short-lived wheeze, occasional use of reliever therapy may be the only treatment required. Children using more than one short-acting beta2, agonist inhaler device a month should have their asthma urgently assessed and action taken to improve poorly controlled asthma.

Regular preventer (maintenance) therapy

NICE (2017) define inhaled corticosteroids doses for children (5–16 years) as paediatric low, moderate, or high. BTS/SIGN (2016) instead define inhaled corticosteroids doses for children (5–12 years) as very low, low, medium, and for children over 12 years as low, medium or high (refer to individual guidelines for inhaled corticosteroid dosing information).

A paediatric low dose of inhaled corticosteroid should be started as maintenance therapy in children who present with any one of the following features: using an inhaled short-acting beta2, agonist three times a week or more, symptomatic three times a week or more, or waking at night due to asthma symptoms at least once a week.

BTS/SIGN (2016) instead recommend starting a very low dose (child 5–12 years) or a low dose (child over 12 years) of inhaled corticosteroid in children presenting with any one of the following features: using an inhaled short-acting beta2, agonist three times a week or more, symptomatic three times a week or more, or waking at night due to asthma symptoms at least once a week, or have had an asthma attack in the last 2 years, and starting inhaled corticosteroids at a dose appropriate to the severity of asthma.

BTS/SIGN (2016) recommend that inhaled corticosteroids (except ciclesonide p. 164) should be initially taken twice daily, however, the same total daily dose, taken once a day, can be considered in patients with milder disease if good or complete control of asthma is established. The dose of inhaled corticosteroid should be adjusted over time, to the lowest effective dose at which control of asthma is maintained.

BTS/SIGN (2016) recommend the prescribing of inhalers by brand.

Initial add-on therapy

If asthma is uncontrolled on a paediatric low dose of inhaled corticosteroid as maintenance therapy, consider a leukotriene receptor antagonist (such as montelukast p. 168) in addition to the inhaled corticosteroid, and review the response to treatment in 4 to 8 weeks.

BTS/SIGN (2016) instead recommend a long-acting beta2 agonist (LABA—such as salmeterol p. 157 or formoterol fumarate p. 156) in children over 12 years, or a LABA or a leukotriene receptor antagonist in children 5–12 years, as initial add-on therapy to inhaled corticosteroids if asthma is uncontrolled.

Additional add-on therapy

If asthma is uncontrolled on a paediatric low dose of inhaled corticosteroid and a leukotriene receptor antagonist as maintenance therapy, consider discontinuation of the leukotriene receptor antagonist and initiation of a LABA in combination with the inhaled corticosteroid.

If asthma remains uncontrolled on a paediatric low dose of inhaled corticosteroid and a LABA as maintenance therapy, consider changing to a MART regimen (Maintenance And Reliever Therapy—a combination of an inhaled corticosteroid and fast-acting LABA such as formoterol in a single inhaler) with a paediatric low dose of inhaled corticosteroid as maintenance. See budesonide with formoterol p. 164 [not licensed in all age groups].

If asthma remains uncontrolled on a MART regimen with a paediatric low dose of inhaled corticosteroid as maintenance, consider increasing to a paediatric moderate dose of inhaled corticosteroid (either continuing a MART regimen or changing to a fixed-dose regimen of an inhaled corticosteroid and a LABA, with a short-acting beta2, agonist as reliever therapy).

If asthma is still uncontrolled on a paediatric moderate dose of inhaled corticosteroid as maintenance with a LABA (either as MART or a fixed-dose regimen), consider seeking advice from an asthma specialist and the following options:
- increasing the inhaled corticosteroid dose to a paediatric high dose as maintenance (this should only be offered as
part of a fixed-dose regimen, with a short-acting beta, agonist as reliever therapy), or

- a trial of an additional drug, such as modified-release theophylline. p. 171.

BTS/SIGN (2016) instead recommend that if the child is gaining some benefit from addition of a LABA but control remains inadequate, continue the LABA and increase the dose of the inhaled corticosteroid to a low-dose (child 5–12 years) or medium-dose (child over 12 years), if not already on this dose. If increasing the dose of inhaled corticosteroid is ineffective, consider continuing on a very low dose (child 5–12 years) or low dose (child over 12 years) of inhaled corticosteroid and a LABA and try adding a leukotriene receptor antagonist, or modified-release theophylline. p. 171, or long-acting muscarinic receptor antagonist (in children over 12 years).

If there is no response to the LABA, discontinue it and increase the dose of inhaled corticosteroid to a low-dose (child 5–12 years) or medium-dose (child over 12 years), if not already on this dose. If increasing the dose of inhaled corticosteroid is ineffective, consider continuing on a very low dose (child 5–12 years) or low dose (child over 12 years) of inhaled corticosteroid and try adding a leukotriene receptor antagonist or long-acting muscarinic receptor antagonist (in children over 12 years).

High-dose inhaled corticosteroids and further add-on treatment

BTS/SIGN (2016) recommend that if control remains inadequate on a combination of a short-acting beta, agonist as required, a low dose (child 5–12 years) or medium dose (child over 12 years) of inhaled corticosteroid, plus an additional drug, usually a LABA, to consider the following interventions:

- increase the inhaled corticosteroid to a medium-dose (child 5–12 years) or high-dose (child over 12 years)—with high doses of inhaled corticosteroid via a pressurised metered dose inhaler (pMDI), a spacer should be used, or
- add a leukotriene receptor antagonist, or
- add modified-release theophylline. p. 171, or
- add tiotropium (in children over 12 years).

If a trial of a further add-on treatment is ineffective, stop the drug (or in the case of increased dose of inhaled corticosteroid, reduce to the original dose) and refer to specialist care.

Continuous or frequent use of oral corticosteroids

BTS/SIGN (2016) recommend adding a regular oral corticosteroid (prednisolone p. 458) at the lowest dose to provide adequate control (under specialist care) in children with very severe asthma uncontrolled on a medium dose (child 5–12 years) or high dose (child over 12 years) of inhaled corticosteroid, and who have also tried (or are still receiving) a LABA, a leukotriene receptor antagonist, or modified-release theophylline. p. 171.

Monoclonal antibodies and immunosuppressants

BTS/SIGN (2016) recommend, that under specialist initiation, immunosuppressants such as methotrexate p. 563 (unlicensed), and monoclonal antibodies such as omalizumab p. 167 (child over 6 years for severe persistent allergic asthma) can be considered in children with severe asthma to achieve control and reduce the use of oral corticosteroids. See omalizumab p. 167 National funding/access decisions.

Child under 5 years

Intermittent reliever therapy

A short-acting beta, agonist (such as salbutamol p. 158) as reliever therapy should be offered to children under 5 years with suspected asthma. A short-acting beta, agonist should be used for symptom relief alongside maintenance treatment.

Children using more than one short-acting beta, agonist inhaler device a month should have their asthma urgently assessed and action taken to improve poorly controlled asthma.

Regular preventer (maintenance) therapy

NICE (2017) define inhaled corticosteroid doses for children under 5 years as paediatric low or moderate. BTS/SIGN (2016) instead define inhaled corticosteroid doses for children under 5 years as very low (refer to individual guidelines for inhaled corticosteroid dosing information).

Consider an 8-week trial of a paediatric moderate dose of inhaled corticosteroid in children presenting with any of the following features: asthma-related symptoms three times a week or more, experiencing night-time awakening at least once a week, or suspected asthma that is uncontrolled with a short-acting beta, agonist alone.

BTS/SIGN (2016) recommend the prescribing of inhalers by brand.

After 8 weeks, stop inhaled corticosteroid treatment and continue to monitor the child’s symptoms:

- if symptoms did not resolve during the trial period, review whether an alternative diagnosis is likely;
- if symptoms resolved then reoccurred within 4 weeks of stopping inhaled corticosteroid treatment, restart the inhaled corticosteroid at a paediatric low-dose as first-line maintenance therapy;
- if symptoms resolved but reoccurred beyond 4 weeks after stopping inhaled corticosteroid treatment, repeat the 8-week trial of a paediatric moderate dose of inhaled corticosteroid.

BTS/SIGN (2016) instead recommend starting a very low dose of inhaled corticosteroid as initial regular preventer therapy in children presenting with any one of the following features: using an inhaled short-acting beta, agonist three times a week or more, symptomatic three times a week or more, or waking at night due to asthma symptoms at least once a week. In children unable to take an inhaled corticosteroid, a leukotriene receptor antagonist (such as montelukast p. 168) may be used as an alternative.

Initial add-on therapy

If suspected asthma is uncontrolled in children under 5 years on a paediatric low dose of inhaled corticosteroid as maintenance therapy, consider a leukotriene receptor antagonist (such as montelukast p. 168) in addition to the inhaled corticosteroid.

If suspected asthma is uncontrolled in children under 5 years on a paediatric low dose of inhaled corticosteroid and a leukotriene receptor antagonist as maintenance therapy, stop the leukotriene receptor antagonist and refer the child to an asthma specialist.

Decreasing treatment

Consider decreasing maintenance therapy when a patient’s asthma has been controlled with their current maintenance therapy for at least three months. When deciding which drug to decrease first and at what rate, the severity of asthma, the side-effects of treatment, duration on current dose, the beneficial effect achieved, and the patient’s preference, should be considered. Patients should be regularly reviewed when decreasing treatment.

Patients should be maintained at the lowest possible dose of inhaled corticosteroid. Reductions should be considered every three months, decreasing the dose by approximately 25–50% each time. Reduce the dose slowly as patients deteriorate at different rates. Only consider stopping inhaled corticosteroid treatment completely for people who are using a paediatric or adult low dose inhaled corticosteroid alone as maintenance therapy and are symptom-free.

Exercise-induced asthma

For most patients, exercise-induced asthma is an illustration of poorly controlled asthma and regular treatment including inhaled corticosteroids should therefore
be reviewed. If exercise is a specific problem in patients already taking inhaled corticosteroids who are otherwise well controlled, consider adding either a leukotriene receptor antagonist, a long-acting beta agonist, an oral beta₂ agonist, sodium cromoglicate p. 169 or nedocromil sodium p. 169, or theophylline p. 171. An inhaled short-acting beta agonists used immediately before exercise is the drug of choice.  

Pregnancy

Women with asthma should be closely monitored during pregnancy. It is particularly important that asthma be well controlled during pregnancy; when this is achieved there is little or no increased risk of adverse maternal or fetal complications.  

Women should be counselled about the importance and safety of taking their asthma medication during pregnancy to maintain good control. Women who smoke should be advised about the dangers to themselves and to their baby and be offered appropriate support to stop smoking.  

For further information, see Smoking cessation p. 304.

Short-acting beta agonists, LABAs, oral and inhaled corticosteroids, sodium cromoglicate p. 169 and nedocromil sodium p. 169, and oral and intravenous theophylline p. 171 (with appropriate monitoring) can be used as normal during pregnancy. There is limited information on use of a leukotriene receptor antagonist during pregnancy, however, where indicated to achieve adequate control, they should not be withheld.  

Advanced Pharmacy Services

Patients with asthma may be eligible for the New Medicines Service / Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

Useful Resources


www.nice.org.uk/guidance/ng80


www.sign.ac.uk/assets/sign153.pdf

Asthma, acute

30-Nov-2016

Life-threatening acute asthma

Any one of the following in a child with a severe asthma:

- SpO₂ < 92%
- Peak flow < 33% best or predicted
- Silent chest
- Cyanosis
- Poor respiratory effort
- Hypotension
- Exhaustion
- Confusion

Management

Following initial assessment, supplementary high flow oxygen should be given to all children with life-threatening acute asthma or SpO₂ < 94% to achieve normal saturations of 94–98%.

First-line treatment for acute asthma is an inhaled short-acting beta agonist, agonist (salbutamol p. 158 or terbutaline sulfate p. 160) given as soon as possible, ideally via a metered dose inhaler and spacer device in mild to moderate acute asthma. Children with severe or life-threatening acute asthma should be transferred to hospital urgently.

In all cases of acute asthma, children should be prescribed an adequate once daily dose of oral prednisolone p. 458.

Treatment for up to 3 days is usually sufficient, but the length of course should be tailored to the number of days necessary to bring about recovery. Intravenous hydrocortisone p. 456 should be reserved for severely affected children who are unable to retain oral medication.

Nebulised ipratropium bromide p. 155 can be combined with beta; agonist treatment for children with severe or life-threatening acute asthma or in those with a poor initial response to beta; agonist therapy to provide greater bronchodilation. Consider adding magnesium sulfate p. 618 to nebulised salbutamol and ipratropium bromide in the first hour in children with a short duration of acute severe asthma symptoms presenting with an oxygen saturation less than 92%.

Children with continuing severe asthma despite frequent nebulised beta, agonists and ipratropium bromide plus oral corticosteroids, and those with life-threatening features, need urgent review by a specialist with a view to transfer to a high dependency unit or paediatric intensive care unit (PICU) to receive second-line intravenous therapies.

In a severe asthma attack where the child has not responded to initial inhaled therapy, early addition of a single bolus dose of intravenous salbutamol may be an option. Continuous intravenous infusion of salbutamol, administered under specialist supervision with continuous ECG and electrolyte monitoring, should be considered in patients with unreliable inhalation or severe refractory asthma. Aminophylline p. 170 may be considered in children with severe or life-threatening acute asthma unresponsive to maximal doses of bronchodilators and corticosteroids. Aminophylline is not recommended in children with mild to moderate acute asthma. Intravenous magnesium sulfate has been used for acute asthma [unlicensed use] although its place in management is not yet established.

Child under 2 years

Inhaled short-acting beta agonists are the initial treatment of choice for acute asthma in children under 2 years. For mild to moderate acute asthma attacks, a metered-dose inhaler with a spacer and mask is the optimal drug delivery device. In a hospital setting, consider oral prednisolone daily for up to 3 days, early in the management of severe asthma attacks. For more severe symptoms, inhaled ipratropium bromide in combination with an inhaled beta, agonist is also an option.

Follow up in all cases

Episodes of acute asthma may be a failure of preventative therapy, review is required to prevent further
episodes. A careful history should be taken to establish the reason for the asthma attack. Inhaler technique should be checked and regular treatment should be reviewed. Children and their carers should be given a written asthma action plan aimed at preventing relapse, optimising treatment, and preventing delay in seeking assistance in future attacks. It is essential that the child’s GP practice is informed within 24 hours of discharge from the emergency department or hospital following an asthma attack. Children who have had a near-fatal asthma attack should be kept under specialist supervision indefinitely. A respiratory specialist should follow up all patients admitted with a severe asthma attack for at least one year after the admission.

Bronchodilators

Adrenoceptor agonists (sympathomimetics)

Selective β2 agonists produce bronchodilation. A short-acting β2 agonist (such as salbutamol p. 158 and terbutaline sulphate p. 160) is used for immediate relief of asthma symptoms while a long-acting β2 agonist is used in addition to an inhaled corticosteroid in children requiring prophylactic treatment. Adrenaline/epinephrine p. 138 (which has both alpha- and beta-adrenoceptor agonist properties) is used in the emergency management of acute allergic and anaphylactic reactions, in angioedema, and in cardiopulmonary resuscitation; it is also used as a nebuliser solution to treat severe croup.

Long-acting β2 agonists

Formoterol fumarate p. 156 and salmeterol p. 157 are longer-acting β2 agonists which are administered by inhalation. They should be used for asthma only in children who regularly use an inhaled corticosteroid.

Vilanterol is a long-acting β2 agonist available in a combination inhaler with fluticasone furoate.

Combination inhalers that contain a long-acting β2 agonist and a corticosteroid ensure that long-acting β2 agonists are not used without concomitant corticosteroids.

Oral

Oral preparations of β2 agonists may be used for children if an inhaler device cannot be used but inhaled β2 agonists are more effective and have fewer side-effects.

Parenteral

β2 agonists can be given intravenously in children with severe or life-threatening acute asthma.

Antimuscarinic bronchodilators

Ipratropium bromide p. 155 by nebulisation can be added to other standard treatment in life-threatening acute asthma or if acute asthma fails to improve with standard therapy. Ipratropium bromide can be used to provide short-term relief in chronic asthma, but short-acting β2 agonists act more quickly and are preferred.

The aerosol inhalation of ipratropium bromide has a maximum effect 30–60 minutes after use; its duration of action is 3 to 6 hours.

Theophylline

Theophylline p. 171 is a xanthine used as a bronchodilator in asthma. It may have an additive effect when used in conjunction with small doses of β2 agonists; the combination may increase the risk of side-effects, including hypokalaemia.

Theophylline is given by injection as aminophylline p. 170, a mixture of theophylline with ethylenediamine, which is 20 times more soluble than theophylline alone. Aminophylline injection is needed rarely for severe acute asthma.

Compound bronchodilator preparations

In general, children are best treated with single-ingredient preparations, such as a selective β2 agonist or ipratropium bromide, so that the dose of each drug can be adjusted.

Oxygen

Overview

Oxygen should be regarded as a drug. It is prescribed for hypoxaemic patients to increase alveolar oxygen tension and decrease the work of breathing. The concentration of oxygen required depends on the condition being treated; administration of an inappropriate concentration of oxygen may have serious or even fatal consequences. High concentrations of oxygen can cause pulmonary epithelial damage (bronchopulmonary dysplasia), convulsions, and retinal damage, especially in preterm neonates.

Oxygen is probably the most common drug used in medical emergencies. It should be prescribed initially to achieve a normal or near-normal oxygen saturation. In most acutely ill children with an expected or known normal or low arterial carbon dioxide (PaCO₂), oxygen saturation should be maintained above 92%; some clinicians may aim for a target of 94–98%. In some clinical situations, such as carbon monoxide poisoning, it is more appropriate to aim for the highest possible oxygen saturation until the child is stable. Hypercapnic respiratory failure is rare in children; in those children at risk, a lower oxygen saturation target of 88–92% is indicated.

High concentration oxygen therapy is safe in uncomplicated cases of conditions such as pneumonia, pulmonary thromboembolism, pulmonary fibrosis, shock, severe trauma, sepsis, or anaphylaxis. In such conditions low arterial oxygen (PaO₂) is usually associated with low or normal arterial carbon dioxide (PaCO₂), and therefore there is little risk of hypoventilation and carbon dioxide retention. In severe acute asthma, the arterial carbon dioxide (PaCO₂) is usually subnormal but as asthma deteriorates it may rise steeply (particularly in children). These patients usually require high concentrations of oxygen and if the arterial carbon dioxide (PaCO₂) remains high despite other treatment, intermittent positive-pressure ventilation needs to be considered urgently.

Oxygen should not be given to neonates except under expert supervision. Particular care is required in preterm neonates because of the risk of hyperoxia.

Low concentration oxygen therapy (controlled oxygen therapy) is reserved for children at risk of hypercapnic respiratory failure, which is more likely in children with:

- advanced cystic fibrosis
- advanced non-cystic fibrosis bronchiectasis
- severe kyphoscoliosis or severe ankylosing spondylitis
- severe lung scarring caused by tuberculosis
- musculoskeletal disorders with respiratory weakness, especially if on home ventilation
- an overdose of opioids, benzodiazepines, or other drugs causing respiratory depression.

Until blood gases can be measured, initial oxygen should be given using a controlled concentration of 28% or less, titrated towards a target concentration of 88–92%. The aim is to provide the child with enough oxygen to achieve an acceptable arterial oxygen tension without worsening carbon dioxide retention and respiratory acidosis.

Domiciliary oxygen

Oxygen should only be prescribed for use in the home after careful evaluation in hospital by a respiratory care specialist. Carers and children who smoke should be advised of the risks of smoking when receiving oxygen, including the risk of fire.
Smoking cessation p. 304 therapy should be recommended before home oxygen prescription.

**Long-term oxygen therapy**

The aim of long-term oxygen therapy is to maintain oxygen saturation of at least 92%. Children (especially those with chronic neonatal lung disease) often require supplemental oxygen, either for 24-hours a day or during periods of sleep; many children are eventually weaned off long-term oxygen therapy as their condition improves.

Long-term oxygen therapy should be considered for children with conditions such as:
- bronchopulmonary dysplasia (chronic neonatal lung disease);
- congenital heart disease with pulmonary hypertension;
- pulmonary hypertension secondary to pulmonary disease;
- idiopathic pulmonary hypertension;
- sickle-cell disease with persistent nocturnal hypoxia;
- interstitial lung disease and obliterator bronchiolitis;
- cystic fibrosis;
- obstructive sleep apnoea syndrome;
- neuromuscular or skeletal disease requiring non-invasive ventilation;
- pulmonary malignancy or other terminal disease with disabling dyspnoea.

Increased respiratory depression is seldom a problem in children with stable respiratory failure treated with low concentrations of oxygen although it may occur during exacerbations; children and their carers should be warned to call for medical help if drowsiness or confusion occurs.

**Short-burst oxygen therapy**

Oxygen is occasionally prescribed for short-burst (intermittent) use for episodes of breathlessness.

**Ambulatory oxygen therapy**

Ambulatory oxygen is prescribed for children on long-term oxygen therapy who need to be away from home on a regular basis.

**Oxygen therapy equipment**

Under the NHS oxygen may be supplied as oxygen cylinders. Oxygen flow can be adjusted as the cylinders are equipped with an oxygen flow meter. Oxygen delivered from a cylinder should be passed through a humidifier if used for long periods.

Oxygen concentrators are more economical for children who require oxygen for long periods, and in England and Wales can be ordered on the NHS on a regional tendering basis. A concentrator is recommended for a child who requires oxygen for more than 8 hours a day (or 21 cylinders per month). Exceptionally, if a higher concentration of oxygen is required the output of 2 oxygen concentrators can be combined using a ‘Y’ connection.

A nasal cannula is usually preferred to a face mask for long-term oxygen therapy from an oxygen concentrator. Nasal cannulas can, however, cause dermatitis and mucosal drying in sensitive individuals.

Giving oxygen by nasal cannula allows the child to talk, eat, and drink, but the concentration of oxygen is not controlled and the method may not be appropriate for acute respiratory failure. When oxygen is given through a nasal cannula at a rate of 1–2 litres/minute the inspiratory oxygen concentration is usually low, but it varies with ventilation and can be high if the patient is underventilating.

**Arrangements for supplying oxygen**

The following oxygen services may be ordered in England and Wales:
- emergency oxygen;
- short-burst (intermittent) oxygen therapy;
- long-term oxygen therapy;
- ambulatory oxygen.

The type of oxygen service (or combination of services) should be ordered on a Home Oxygen Order Form (HOOF); the amount of oxygen required (hours per day) and flow rate should be specified. The clinician will determine the appropriate equipment to be provided. Special needs or preferences should be specified on the HOOF.

The clinician should obtain the consent of the child or carers to pass on the child’s details to the supplier, the fire brigade, and other relevant organisations. The supplier will contact the child or carer to make arrangements for delivery, installation, and maintenance of the equipment. The supplier will also train the child or carer to use the equipment.

The clinician should send the HOOF to the supplier who will continue to provide the service until a revised HOOF is received, or until notified that the child no longer requires the home oxygen service.

HOOF and further instructions are available at www.bhrs.co.uk/oxygen.html.

- East of England, North East: BOC Medical: Tel: 0800 136 603 Fax: 0800 169 9989
- South West: Air Liquide: Tel: 0808 202 2229 Fax: 0191 497 4340
- London East, Midlands, North West: Air Liquide: Tel: 0500 823 773 Fax: 0800 781 4610
- Yorkshire and Humberside, West Midlands, Wales: Air Products: Tel: 0800 373 580 Fax: 0800 214 709
- South East Coast, South Central: Dolby Vivisol: Tel: 08443 814 402 Fax: 0800 781 4610

In Scotland refer the child for assessment by a paediatric respiratory consultant. If the need for a concentrator is confirmed the consultant will arrange for the provision of a concentrator through the Common Services Agency.

Prescribers should complete a Scottish Home Oxygen Order Form (SHOOF) and email it to Health Facilities Scotland. Health Facilities Scotland will then liaise with their contractor to arrange the supply of oxygen. Further information can be obtained at www.dolbyvivisol.com/our-services/healthcare-professionals/home-oxygen-services-scot.aspx.

In Northern Ireland oxygen concentrators and cylinders should be prescribed on form HS21; oxygen concentrators are supplied by a local contractor. Prescriptions for oxygen cylinders and accessories can be dispensed by pharmacists contracted to provide domiciliary oxygen services.

**Croup**

**Management**

Mild croup is largely self-limiting, but treatment with a single dose of a corticosteroid (e.g. dexamethasone p. 455) by mouth may be of benefit.

More severe croup (or mild croup that might cause complications) calls for hospital admission; a single dose of a corticosteroid (e.g. dexamethasone or prednisolone p. 458 by mouth) should be administered before transfer to hospital. In hospital, dexamethasone (by mouth or by injection) or budesonide p. 163 (by nebulisation) will often reduce symptoms; the dose may need to be repeated after 12 hours if necessary.

For severe croup not effectively controlled with corticosteroid treatment, nebulised adrenaline/epinephrine solution 1 in 1000 (1 mg/mL) p. 138 should be given with close clinical monitoring; the effects of nebulised adrenaline/epinephrine last 2–3 hours and the child needs to be monitored carefully for recurrence of the obstruction.
Ipratropium bromide

**INDICATIONS AND DOSE**

Reversible airways obstruction
- **By inhalation of nebulised solution**
  - Child 1-month to 11-years: 250 micrograms every 20–30 minutes for the first 2 hours, then 250 micrograms every 4–6 hours as required
  - Child 12–17 years: 500 micrograms every 4–6 hours as required

Acute bronchospasm
- **By inhalation of nebulised solution**
  - Child 1-month to 11-years: 250 micrograms every 20–30 minutes for the first 2 hours, then 250 micrograms every 4–6 hours as required
  - Child 12–17 years: 500 micrograms every 4–6 hours as required

Severe or life-threatening acute asthma
- **By inhalation of nebulised solution**
  - Child 1-month to 11-years: 250 micrograms every 20–30 minutes for the first 2 hours, then 250 micrograms every 4–6 hours as required
  - Child 12–17 years: 500 micrograms every 4–6 hours as required

**PHARMACOKINETICS**
- The maximal effect of inhaled ipratropium occurs 30–60 minutes after use; its duration of action is 5 to 6 hours and bronchodilation can usually be maintained with treatment 3 times a day.

**UNLICENSED USE**
- The dose of ipratropium for severe or life-threatening acute asthma is unlicensed.
- Ihalvent® not licensed for use in children under 5 years.

**IMPORTANT SAFETY INFORMATION**
- **MHRA/CMH Advice: Pressurised Metered Dose Inhalers (PMDI): Risk of Airway Obstruction From Aspiration of Loose Objects (July 2018)**
- See Respiratory system, drug delivery p. 147.

**CAUTIONS**
- Avoid spraying near eyes - cystic fibrosis
- **Glaucoma** - Acute angle-closure glaucoma has been reported with nebulised ipratropium, particularly when given with nebulised salbutamol (and possibly other beta agonists); care needed to protect the patient’s eyes from nebulised drug or from drug powder.

**INTERACTIONS**
- **Appendix 1: Ipratropium**

**SIDE-EFFECTS**
- **Common or very common**
  - Gastrointestinal motility disorder
  - Throat complaints
- **Uncommon**
  - Corneal oedema, diarrhoea, eye disorders, eye pain, respiratory disorders, vision disorders, vomiting

**ALLERGY AND CROSS-SENSITIVITY**
- Contra-indicated in patients with hypersensitivity to atropine or its derivatives.

**PREGNANCY**
- Manufacturer advises only use if potential benefit outweighs the risk.

**BREAST FEEDING**
- No information available - manufacturer advises only use if potential benefit outweighs risk.

**DIRECTIONS FOR ADMINISTRATION**
- If dilution of ipratropium bromide nebuliser solution is necessary use only sterile sodium chloride 0.9%.

**PATIENT AND CARER ADVICE**
- Patients or carers should be counselled on appropriate administration technique and warned against accidental contact with the eye (due to risk of ocular complications).

**Driving and Skilled Tasks**
- Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks - increased risk of dizziness and vision disorders.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Nebuliser liquid**
- Ipratropium bromide (Non-proprietary)
  - Ipratropium bromide 250 microgram per 1 ml Ipratropium bromide 500 micrograms/2 ml nebuliser liquid unit dose vials | 20 unit dose (PDR) £3.15 DT = £3.00
  - Ipratropium bromide 250 micrograms/1 ml nebuliser liquid unit dose vials | 20 unit dose (PDR) £4.98 DT = £4.90
  - Ipratropium 250 micrograms/1 ml nebuliser liquid Steri-Neb unit dose vials | 20 unit dose (PDR) £6.99 DT = £6.90
  - Ipratropium 500 micrograms/2 ml nebuliser liquid Steri-Neb unit dose vials | 20 unit dose (PDR) £15.99 DT = £15.00

Atrovent UDV (Boehringer Ingelheim Ltd)
- Ipratropium bromide 250 microgram per 1 ml Atrovent 500 micrograms/2 ml nebuliser liquid UDVs | 20 unit dose (PDR) £4.87 DT = £4.00
  - Atrovent 250 micrograms/1 ml nebuliser liquid UDVs | 20 unit dose (PDR) £4.14 DT = £4.90

**Pressurised inhalation**
- Atrovent (Boehringer Ingelheim Ltd)
  - Ipratropium bromide 20 microgram per 1 dose Atrovent 20 micrograms/dose inhaler CFC free | 200 dose (PDR) £5.56 DT = £5.56
  - Inhalevent (Alissa Healthcare Research Ltd)
    - Ipratropium bromide 20 microgram per 1 dose Inhalevent 20 micrograms/dose inhaler | 200 dose (PDR) £5.56 DT = £5.56

Tiotropium
Respiratory system

Beta-2-adrenoceptor agonists, selective

INDICATIONS AND DOSE
Reversible airways obstruction in patients requiring long-term regular bronchodilator therapy | Nocturnal asthma in patients requiring long-term regular bronchodilator therapy | Prophylaxis of exercise-induced bronchospasm in patients requiring long-term regular bronchodilator therapy | Chronic asthma in patients who regularly use an inhaled corticosteroid

BY INHALATION OF POWDER

Child 6-11 years: 12 micrograms twice daily, a daily dose of 24 micrograms of formoterol should be sufficient for the majority of children, particularly for younger age-groups; higher doses should be used rarely, and only when control is not maintained on the lower dose

Child 12-17 years: 12 micrograms twice daily, dose may be increased in more severe airway obstruction; increased to 24 micrograms twice daily, a daily dose of 24 micrograms of formoterol should be sufficient for the majority of children, particularly for younger age-groups; higher doses should be used rarely, and only when control is not maintained on the lower dose

BY INHALATION OF AEROSOL

Child 12-17 years: 12 micrograms twice daily, dose may be increased in more severe airway obstruction; increased to 24 micrograms twice daily, a daily dose of 24 micrograms of formoterol should be sufficient for the majority of children, particularly for younger age-groups; higher doses should be used rarely, and only when control is not maintained on the lower dose

DOSAGE FORMS

There can be variation in the licensing of different medicines containing the same drug.

Pressurised inhalation

Spiriva Respimat (Boehringer Ingelheim Ltd)
Tiotropium (as Tiotropium bromide) 2.5 microgram per
1 dose Spiriva Respimat 2.5 micrograms/dose solution for inhalation cartridge with device | 60 dose pack £23.00 D+ £23.00

156 Airways disease, obstructive

BNFC 2019–2020
**OXIS**

**Chronic asthma**
- BY INHALATION OF POWDER
  - Child 6-17 years: 6–12 micrograms 1–2 times a day (max. per dose 12 micrograms), occasionally doses up to the maximum daily may be needed, reassess treatment if additional doses required on more than 2 days a week; maximum 48 micrograms per day

**Relief of bronchospasm**
- BY INHALATION OF POWDER
  - Child 6-17 years: 6–12 micrograms

**Prophylaxis of exercise-induced bronchospasm**
- BY INHALATION OF POWDER
  - Child 6-17 years: 6–12 micrograms, dose to be taken before exercise

**IMPORTANT SAFETY INFORMATION**

**CHM ADVICE**
To ensure safe use, the CHM has advised that for the management of chronic asthma, long-acting beta₂ agonist (formoterol) should:

- be added only if regular use of standard-dose inhaled corticosteroids has failed to control asthma adequately;
- not be initiated in patients with rapidly deteriorating asthma;
- be introduced at a low dose and the effect properly monitored before considering dose increase;
- not be used for the relief of exercise-induced asthma symptoms unless regular inhaled corticosteroids are also used;
- be reviewed as clinically appropriate: stepping down therapy should be considered when good long-term asthma control has been achieved.

**MHRA/CHM ADVICE: PRESSURISED METERED DOSE INHALERS (PMDI): RISK OF AIRWAY OBSTRUCTION FROM ASPIRATION OF LOOSE OBJECTS (JULY 2018)**
See Respiratory system, drug delivery p. 147.

**MEDICAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Inhalation powder**
- Easyhaler (formoterol) (Orion Pharma (UK) Ltd)
  - Formoterol fumarate dihydrate 12 microgram per 1 dose Easyhaler 12 micrograms/dose dry powder inhaler
  - 120 dose £23.75 DT = £23.75
- Foradil (Novartis Pharmaceuticals UK Ltd)
  - Formoterol fumarate dihydrate 12 microgram Foradil 12 microgram inhalation powder capsules with device
  - 60 capsule £28.06 DT = £28.06
- Oxis Turbohaler (AstraZeneca UK Ltd)
  - Formoterol fumarate dihydrate 6 microgram per 1 dose Oxis 6 Turbohaler
  - 60 dose £24.80 DT = £24.80
- Formoterol fumarate dihydrate 12 microgram per 1 dose Oxis 12 Turbohaler
  - 60 dose £24.80 DT = £24.80

**Pressurised inhalation**

**EXCipients:** May contain Alcohol
- Atimos Modulite (Chiesi Ltd)
  - Formoterol fumarate dihydrate 12 microgram per 1 dose Atimos Modulite 12 micrograms/dose inhaler
  - 100 dose £30.06 DT = £30.06

**Combinations available:** Budesonide with formoterol, p. 164 - Fluticasone with formoterol, p. 165

### Salmeterol

**INDICATIONS AND DOSE**
Reversible airways obstruction in patients requiring long-term regular bronchodilator therapy / Nighttime asthma in patients requiring long-term regular bronchodilator therapy / Prevention of exercise-induced bronchospasm in patients requiring long-term regular bronchodilator therapy / Chronic asthma only in patients who regularly use an inhaled corticosteroid (not for immediate relief of acute asthma)
- BY INHALATION OF AEROSOL, OR BY INHALATION OF POWDER
  - Child 5-11 years: 50 micrograms twice daily
  - Child 12-17 years: 50 micrograms twice daily, dose may be increased in more severe airway obstruction; increased to 100 micrograms twice daily

**PHARMACOKINETICS**
- At recommended inhaled doses, the duration of action of salmeterol is about 12 hours.

**UNLICENSED USE**
Neventor® not licensed for use in children under 12 years.

**IMPORTANT SAFETY INFORMATION**

**CHM ADVICE**
To ensure safe use, the CHM has advised that for the management of chronic asthma, long-acting beta₂ agonist (salmeterol) should:

- be added only if regular use of standard-dose inhaled corticosteroids has failed to control asthma adequately;
- not be initiated in patients with rapidly deteriorating asthma;
- be introduced at a low dose and the effect properly monitored before considering dose increase;
- be discontinued in the absence of benefit;
- not be used for the relief of exercise-induced asthma symptoms unless regular inhaled corticosteroids are also used;
- be reviewed as clinically appropriate: stepping down therapy should be considered when good long-term asthma control has been achieved.

**MHRA/CHM ADVICE: PRESSURISED METERED DOSE INHALERS (PMDI): RISK OF AIRWAY OBSTRUCTION FROM ASPIRATION OF LOOSE OBJECTS (JULY 2018)**
See Respiratory system, drug delivery p. 147.
Respiratory system

MEDICINAL FORMS

PATIENT AND CARER ADVICE

BREAST FEEDING

SIDE-EFFECTS

PATIENT AND CARER ADVICE

Advise patients that inhaled salmeterol should not be used for relief of acute attacks, not to exceed prescribed dose, and to follow manufacturer’s directions; if a previously effective dose of inhaled salmeterol fails to provide adequate relief, a doctor’s advice should be obtained as soon as possible. Patients should be advised to report any deterioration in symptoms following initiation of treatment with a long-acting beta2-agonist.

Medicines for Children leaflet: Salmeterol inhaler for asthma
www.medicinesforchildren.org.uk/salmeterol-inhaler-asthma

MEDICINAL FORMS

Inhalation powder

• Serevent Accuhaler (GlaxoSmithKline UK Ltd)

Salmeterol (as Salmeterol xinafoate) 50 microgram per

1 dose Serevent 50micrograms/dose Accuhaler | 60 dose £29.26 DT + £29.26

Salmeterol (as Salmeterol xinafoate) 25 microgram per

1 dose Serevent 25micrograms/dose inhaler CFC free | 120 dose £29.26 DT + £29.26

Salmeterol (as Salmeterol xinafoate) 50 microgram per

1 dose Serevent 50micrograms/dose Evohaler | 120 dose £29.26 DT + £29.26

Salmeterol (as Salmeterol xinafoate) 25 microgram per

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1 dose Salmeterol (as Salmetero
Respiratory System

Airways disease, obstructive 159

SALBULIN NOVOLIZER®

Acute bronchospasm

- By inhalation of powder
- Child 6-11 years: 100–200 micrograms, up to 400 micrograms daily for persistent symptoms
- Child 12-17 years: Initially 100–200 micrograms, up to 800 micrograms daily for persistent symptoms

Prophylaxis of allergen- or exercise-induced bronchospasm

- By inhalation of powder
- Child 6-11 years: 100–200 micrograms
- Child 12-17 years: 200 micrograms

VENTOLIN ACUHALER®

Acute bronchospasm

- By inhalation of powder
- Child 5-17 years: Initially 200 micrograms, up to 4 times daily for persistent symptoms

Prophylaxis of allergen- or exercise-induced bronchospasm

- By inhalation of powder
- Child 5-17 years: 200 micrograms

PHARMACOKINETICS

- At recommended inhaled doses, the duration of action of salbutamol is about 3 to 5 hours.

- UNLICENSED USE

- Not licensed for use in hyperkalaemia.
- With oral use Syrup and tablets not licensed for use in children under 2 years.
- With intravenous use Injection and solution for intravenous infusion not licensed for use in children under 12 years. Administration of undiluted salbutamol injection through a central venous catheter is not licensed.

IMPORTANT SAFETY INFORMATION

MHRA/CHM ADVICE: PRESSURISED METERED DOSE INHALERS (PMDI): RISK OF AIRWAY OBSTRUCTION FROM ASPIRATION OF LOOSE OBJECTS (JULY 2018)

- When used by inhalation
  See Respiratory system, drug delivery p. 147.

- CAUTIONS

- High doses of beta, agonists can be dangerous in some children

- INTERACTIONS

- Appendix 1: beta; agonists

- SIDE-EFFECTS

  GENERAL SIDE-EFFECTS
  
  - Common or very common Muscle cramps
  - Rare or very rare Akathisia - vasodilatation
  - Frequency not known Metabolic change

  SPECIFIC SIDE-EFFECTS
  
  - Uncommon
    - When used by inhalation Oral irritation - throat irritation
    - With parenteral use Pulmonary oedema
  - Frequency not known
    - With parenteral use Lactic acidosis (with high doses) - vomiting

- BREAST FEEDING

- Inhaled drugs for asthma can be taken as normal during breast-feeding.

- DIRECTIONS FOR ADMINISTRATION

  - For continuous intravenous infusion, dilute to a concentration of 200 micrograms/mL with Glucose 5% or Sodium Chloride 0.9%. If fluid-restricted, can be given undiluted through central venous catheter [unlicensed]. For intravenous injection, dilute to a concentration of 50 micrograms/mL with Glucose 5%, Sodium Chloride 0.9%, or Water for injections.
  - When used by inhalation For nebulisation, dilute nebuliser solution with a suitable volume of sterile Sodium Chloride 0.9% solution according to nebuliser type and duration of administration; salbutamol and ipratropium bromide solutions are compatible and can be mixed for nebulisation.

- PATIENT AND CARER ADVICE

- When used by inhalation For inhalation by aerosol or dry powder, advise patients and carers not to exceed prescribed dose and to follow manufacturer’s directions; if a previously effective dose of inhaled salbutamol fails to provide at least 3 hours relief, a doctor’s advice should be obtained as soon as possible. For inhalation by nebuliser, the dose given by nebuliser is substantially higher than that given by inhaler. Patients should therefore be warned that it is dangerous to exceed the prescribed dose and they should seek medical advice if they fail to respond to the usual dose of the respirator solution.

- Medicines for Children leaflet: Salbutamol inhaler for asthma and wheeze www.medicinesforchildren.org.uk/salbutamol-inhaler-asthma-and-wheeze

- MEDICINAL FORMS

  There can be variation in the licensing of different medicines containing the same drug.

  Tablet

  - Salbutamol (Non-proprietary)
  - Salbutamol (as Salbutamol sulfate) 2 mg Salbutamol 2mg tablets
    | 28 tablet (POM) £11.21 DT = £104.52
  - Salbutamol (as Salbutamol sulfate) 4 mg Salbutamol 4mg tablets
    | 28 tablet (POM) £113.85 DT = £117.00

  Inhalation powder

  - Easyhaler (salbutamol) (Orion Pharma (UK) Ltd)
  - Salbutamol 100 microgram per 1 dose Easyhaler Salbutamol sulfate 100micrograms/dose dry powder inhaler | 200 dose (POM) £3.31 DT = £3.31
  - Salbutamol 200 microgram per 1 dose Easyhaler Salbutamol sulfate 200micrograms/dose dry powder inhaler | 200 dose (POM) £6.63 DT = £6.63
  - Salbutamol Novolizer (Meda Pharmaceuticals Ltd)
  - Salbutamol (as Salbutamol sulfate) 100 microgram per 1 dose Salbutamol Novolizer 100micrograms/dose inhalation powder | 1 dose (POM) £4.95
  - Salbutamol Novolizer 100micrograms/dose inhalation powder refill | 200 dose (POM) £2.75
  - Ventolin Accuhaler (GlaxoSmithKline UK Ltd)
  - Salbutamol 200 microgram per 1 dose Ventolin 200micrograms/dose Accuhaler | 60 dose (POM) £36.60 DT = £3.60

  Solution for injection

  - Ventolin (GlaxoSmithKline UK Ltd)
  - Salbutamol (as Salbutamol sulfate) 500 microgram per 1 ml Ventolin 500micrograms/ml solution for injection ampoules | 5 ampoule (POM) £1.91

  Solution for infusion

  - Ventolin (GlaxoSmithKline UK Ltd)
  - Salbutamol (as Salbutamol sulfate) 1 mg per 1 ml Ventolin 5mg/ml solution for infusion ampoules | 10 ampoule (POM) £24.81

  Oral solution

  - Salbutamol (Non-proprietary)
  - Salbutamol (as Salbutamol sulfate) 400 microgram per 1 ml Salbutamol 2mg/5ml oral solution sugar free sugar-free | 150 ml (POM) £1.15
  - Salbutamol (as Salbutamol sulfate) 400 microgram per 1 ml Salbutamol 2mg/5ml syrup sugar-free | 150 ml (POM) £1.15

  Pressurised inhalation

  - Airomir (Teva UK Ltd)
  - Salbutamol (as Salbutamol sulfate) 100 microgram per 1 dose Airomir 100micrograms/dose inhaler | 200 dose (POM) £1.97 DT = £1.50
  - Airomir Autohaler (Teva UK Ltd)
  - Salbutamol (as Salbutamol sulfate) 100 microgram per 1 dose Airomir 100micrograms/dose Autohaler | 200 dose (POM) £6.02 DT = £6.30
  - Salamon (Teva UK Ltd)
  - Salbutamol (as Salbutamol sulfate) 1 microgram per 1 dose Salamon 100micrograms/dose inhaler CFC free | 200 dose (POM) £1.46 DT = £1.50
Terbutaline sulfate

- **INDICATIONS AND DOSE**
  - **Acute asthma**
    - By subcutaneous injection, or by slow intravenous injection
      - Child 2-14 years: 10 micrograms/kg up to 4 times a day (max. per dose 300 micrograms), reserve intravenous beta, agonists for those in whom inhaled therapy cannot be used reliably or there is no current effect
      - Child 15-17 years: 250–500 micrograms up to 4 times a day, reserve intravenous beta, agonists for those in whom inhaled therapy cannot be used reliably or there is no current effect
    - By continuous intravenous infusion
      - Child: Loading dose 2–4 micrograms/kg, then 1–10 micrograms/kg/hour, dose to be adjusted according to response and heart rate, close monitoring is required for doses above 10 micrograms/kg/hour, reserve intravenous beta, agonists for those in whom inhaled therapy cannot be used reliably or there is no current effect
    - Moderate, severe, or life-threatening acute asthma
      - By inhalation of nebulised solution
        - Child 1 month–4 years: 5 mg, repeat every 20–30 minutes or when required, give via oxygen-driven nebuliser if available
        - Child 5–11 years: 5–10 mg, repeat every 20–30 minutes or when required, give via oxygen-driven nebuliser if available
        - Child 12–17 years: 10 mg, repeat every 20–30 minutes or when required, give via oxygen-driven nebuliser if available
      - Exacerbation of reversible airways obstruction (including nocturnal asthma) Prevention of exercise-induced bronchospasm
        - By inhalation of powder
          - Child 5–17 years: 500 micrograms up to 4 times a day, for occasional use only
        - By mouth
          - Child 1 month–6 years: 75 micrograms/kg 3 times a day (max. per dose 2.5 mg), administration by mouth is not recommended

- **SIDE-EFFECTS**
  - Common or very common
    - Hypotension, muscle spasms
  - Rare or very rare
    - Vasodilatation
  - Frequency not known
    - Angioedema, anxiety, behaviour abnormal, bronchospasm, circulatory collapse, oral irritation, skin reactions, sleep disorder, throat irritation
  - Specific side-effects
  - Uncommon
  - With parenteral use
    - Pulmonary oedema
  - Rare or very rare
    - With parenteral use
      - Lactic acidosis
    - With parenteral use
      - Akathisia, bleeding tendency
  - Pregnancy
    - Inhaled drugs for asthma can be taken as normal during pregnancy.
  - Breast-feeding
    - Inhaled drugs for asthma can be taken as normal during breast-feeding.
  - DIRECTIONS FOR ADMINISTRATION
    - With intravenous use
      - Continuous intravenous infusion
        - Dilute to a concentration of 5 micrograms/mL with Glucose 5% or Sodium Chloride 0.9%; if fluid-restricted, dilute to a concentration of 100 micrograms/mL.
        - When used by inhalation
          - For nebulisation, dilute nebuliser solution with sterile Sodium Chloride 0.9% solution according to nebuliser type and duration of administration; terbutaline and ipratropium bromide solutions are compatible and may be mixed for nebulisation.
  - PATIENT AND CARER ADVICE
    - When used by inhalation
      - For inhalation by dry powder, advise patients and carers not to exceed prescribed dose and to follow manufacturer’s directions; if a previously effective dose of inhaled terbutaline fails to provide at least 3 hours relief, a doctor’s advice should be obtained as soon as possible. For inhalation by nebuliser, the dose given by nebuliser is substantially higher than that given by inhaler. Patients should therefore be warned that it is dangerous to exceed the prescribed dose and they should seek medical advice if they fail to respond to the usual dose of the respirator solution.
  - Medicinal forms
    - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection
  - Solution for injection
    - Bricanyl (AstraZeneca UK Ltd)
      - Terbutaline sulfate 500 micrograms per 1 mL Bricanyl 2.5mg/5ml solution for injection ampoules 10 ampoule (PST) £20.09 DT + £20.09
      - Bricanyl 500micrograms/1ml solution for injection ampoules 5 ampoule (PST) £6.48 DT + £6.48

**BNFC 2019–2020**
Inhalation powder
▶ Bricanyl Turbohaler (AstraZeneca UK Ltd)
Terbutaline sulfate 500 microgram per 1 dose Bricanyl 500 microgram/dose Turbohaler | 120 dose £8.30 DT = £8.30

Nebulis. Liquid
▶ Terbutaline sulfate (Non-proprietary)
Terbutaline sulfate 2.5 mg per 1 ml Terbutaline 5mg/2ml nebuliser liquid unit dose vials | 20 unit dose £4.04 DT = £4.04
▶ Bricanyl Respules (AstraZeneca UK Ltd)
Terbutaline sulfate 2.5 mg per 1 ml Bricanyl 5mg/2ml Respules | 20 unit dose £11.64 DT = £4.04

Tablet
▶ Bricanyl (AstraZeneca UK Ltd)
Terbutaline sulfate 5 mg Bricanyl 5mg tablets | 100 tablet £14.73 DT = £14.73

CORTICOSTEROIDS

Airways disease, use of corticosteroids

30-Nov-2017

Asthma, use of corticosteroids
Inhaled corticosteroids
Corticosteroids are effective in the management of asthma; they reduce airway inflammation.

An inhaled corticosteroid is used regularly for prophylaxis of asthma. Regular use of inhaled corticosteroids reduces the risk of exacerbation of asthma.

Current or previous smoking reduces the effectiveness of inhaled corticosteroids and higher doses may be necessary.

Corticosteroid inhalers must be used regularly for maximum benefit. Beclometasone dipropionate p. 152, budesonide p. 163, fluticasone p. 165, and mometasone furoate p. 165 appear to be equally effective. A spacer device should be used for administering inhaled corticosteroids in children under 15 years; a spacer device is also useful in children over 15 years, particularly if high doses are required.

Oral corticosteroids
Systemic therapy may be required during periods of stress, such as during severe infections, or when airways obstruction or mucus prevent drug access to smaller airways.

An acute attack of asthma should be treated with a short course (3–5 days) of oral corticosteroid. The dose can usually be stopped abruptly but it should be reduced gradually in children under 12 years who have taken corticosteroids for more than 14 days. Tapering is not needed in children 12–18 years provided that the child receives an inhaled corticosteroid in an adequate dose (apart from those on maintenance oral corticosteroid treatment or where oral corticosteroids are required for 3 or more weeks).

In chronic continuing asthma, when the response to other drugs has been inadequate, longer term administration of an oral corticosteroid may be necessary; in such cases high doses of an inhaled corticosteroid should be continued to minimise oral corticosteroid requirements.

An oral corticosteroid should normally be taken as a single dose in the morning to reduce the disturbance to circadian cortisol secretion. Dosage should always be titrated to the lowest dose that controls symptoms. Some clinicians use alternate-day dosing of an oral corticosteroid.

Parenteral corticosteroids
Hydrocortisone injection p. 456 has a role in the emergency treatment of acute severe asthma.

Corticosteroids (inhaled)

IMPORTANT SAFETY INFORMATION

MHRA/CHM ADVICE: CORTICOSTERI OIDS: RARE RISK OF CENTRAL SEROUS CHI ROIRETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

Central serous chorioretinopathy is a retinal disorder that has been linked to the systemic use of corticosteroids. Recently, it has also been reported after local administration of corticosteroids via inhaled and intranasal, epidural, intra-articular, topical dermal, and periocular routes. The MHRA recommends that patients should be advised to report any blurred vision or other visual disturbances with corticosteroid treatment given by any route; consider referral to an ophthalmologist for evaluation of possible causes if a patient presents with vision problems.

▶ SIDE-EFFECTS
- Common or very common Headache · oral candidiasis · taste altered · voice alteration
- Uncommon Anxiety · bronchospasm paradoxical · cataract · vision blurred
- Rare or very rare Adrenal suppression · behaviour abnormal · glaucoma · growth retardation · sleep disorder
- Frequency not known Pneumonia (in patients with COPD)

SIDE-EFFECTS, FURTHER INFORMATION
Systemic absorption may follow inhaled administration particularly if high doses are used or if treatment is prolonged. Therefore also consider the side-effects of systemic corticosteroids.

Candidiasis The risk of oral candidiasis can be reduced by using a spacer device with the corticosteroid inhaler; rinsing the mouth with water after inhalation of a dose may also be helpful. An anti-fungal oral suspension or oral gel can be used to treat oral candidiasis without discontinuing corticosteroid therapy.

Paradoxical bronchospasm The potential for paradoxical bronchospasm (calling for discontinuation and alternative therapy) should be borne in mind. Mild bronchospasm may be prevented by inhalation of a short-acting beta₂ agonist beforehand (or by transfer from an aerosol inhalation to a dry powder inhalation).

PREGNANCY Inhaled drugs for asthma can be taken as normal during pregnancy.

BREAST FEEDING Inhaled corticosteroids for asthma can be taken as normal during breast-feeding.

MONITORING REQUIREMENTS The height and weight of children receiving prolonged treatment with inhaled corticosteroids should be monitored annually; if growth is slowed, referral to a paediatrician should be considered.

NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions
▶ Inhaled corticosteroids for the treatment of chronic asthma in children under 12 years (November 2007) NICE TA131
For children under 12 years with chronic asthma in whom treatment with an inhaled corticosteroid is considered appropriate, the least costly product that is suitable for an individual child (taking into consideration NICE TAs 38 and 10), within its marketing authorisation, is recommended.

For children under 12 years with chronic asthma in whom treatment with an inhaled corticosteroid and a long-acting beta₂ agonist is considered appropriate, the following apply:
- the use of a combination inhaler within its marketing authorisation is recommended as an option;
- the decision to use a combination inhaler or two agents in separate inhalers should be made on an individual basis, taking into consideration therapeutic need and the likelihood of treatment adherence;
Airways disease, obstructive

- If a combination inhaler is chosen, then the least costly inhaler that is suitable for the individual child is recommended. www.nice.org.uk/TA131
- Inhaled corticosteroids for the treatment of chronic asthma in adults and children over 12 years (March 2008) NICE TA138 For adults and children over 12 years with chronic asthma in whom treatment with an inhaled corticosteroid is considered appropriate, the least costly product that is suitable for an individual (taking into consideration NICE TA’s 38 and 10), within its marketing authorisation is recommended.

For adults and children over 12 years with chronic asthma in whom treatment with an inhaled corticosteroid and a long-acting beta agonist is considered appropriate, the following apply:
- The use of a combination inhaler within its marketing authorisation is recommended as an option;
- The decision to use a combination inhaler or two agents in separate inhalers should be made on an individual basis, taking into consideration therapeutic need, and the likelihood of treatment adherence;
- If a combination inhaler is chosen, then the least costly inhaler that is suitable for the individual is recommended. www.nice.org.uk/TA138

**Beclometasone dipropionate**

(Beclometasone dipropionate)

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
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<tr>
<td><strong>Prophylaxis of asthma</strong></td>
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<tr>
<td><strong>By inhalation of powder</strong></td>
</tr>
<tr>
<td>Child 5–11 years: 100–200 micrograms twice daily, dose to be adjusted as necessary</td>
</tr>
<tr>
<td>Child 12–17 years: 200–400 micrograms twice daily; increased if necessary up to 800 micrograms twice daily, dose to be adjusted as necessary</td>
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**CLENIL MODULITE®**

Prophylaxis of asthma
- By inhalation of aerosol
- Child 2–11 years: 100–200 micrograms twice daily
- Child 12–17 years: 200–400 micrograms twice daily, adjusted according to response; increased if necessary up to 1 mg twice daily

**QVAR® PREPARATIONS**

Prophylaxis of asthma
- By inhalation of aerosol
- Child 12–17 years: 50–200 micrograms twice daily; increased if necessary up to 400 micrograms twice daily

**Potency**
- Qvar® has extra-fine particles, is more potent than traditional beclometasone dipropionate CFC-containing inhalers and is approximately twice as potent as Clenil Modulite®.

**SOPROBEC®**

Prophylaxis of asthma
- By inhalation of aerosol
- Child: 100 micrograms twice daily; increased if necessary up to 400 micrograms daily in 2–4 divided doses

**DOSE EQUIVALENCE AND CONVERSION**
- Dose adjustments may be required for some inhaler devices, see under individual preparations.

**Unlicensed use** Easyhaler® Beclometasone Dipropionate is not licensed for use in children under 18 years. Clenil Modulite®-200 and -250 are not licensed for use in children under 12 years.

**Important safety information**

MHRA/CHM Advice (July 2008)
Beclometasone dipropionate CFC-free pressurised metered-dose inhalers (Qvar® and Clenil Modulite®) are not interchangeable and should be prescribed by brand name; Qvar® has extra-fine particles, is more potent than traditional beclometasone dipropionate CFC-containing inhalers, and is approximately twice as potent as Clenil Modulite®.

MHRA/CHM Advice: Pressurised Metered Dose Inhalers (PMDI): Risk of Airway Obstruction from Aspiration of Loose Objects (July 2018)
See Respiratory system, drug delivery p. 147.

**Interactions** → Appendix 1: corticosteroids

**Side-effects**
- Common or very common Throat irritation
- Rare or very rare Wheezing

**Prescribing and dispensing information**
The MHRA has advised (July 2008) that beclometasone dipropionate CFC-free inhalers should be prescribed by brand name.

Soprobec® Soprobec® is not interchangeable with other CFC-free beclometasone dipropionate inhalers.

**QVAR® Preparations**
When switching a patient with well-controlled asthma from another corticosteroid inhaler, initially a 100-microgram metered dose of Qvar® should be prescribed for 200–250 micrograms of beclometasone dipropionate or budesonide and for 100 micrograms of fluticasone propionate. When switching a patient with poorly controlled asthma from another corticosteroid inhaler, initially a 100-microgram metered dose of Qvar® should be prescribed for 100 micrograms of beclometasone dipropionate, budesonide, or fluticasone propionate; the dose of Qvar® should be adjusted according to response.

**Clenil Modulite®** Clenil Modulite® is not interchangeable with other CFC-free beclometasone dipropionate inhalers.

**Patient and carer advice**
Steroid card should be issued with high doses of inhaled beclometasone dipropionate. Medicines for Children leaflet: Beclometasone inhaler for asthma prevention (prophylaxis) www.medicinesforchildren.org.uk/beclometasone-inhaler-asthma-prevention-prophylaxis-0

**Profession specific information**
Dental practitioners’ formulary Clenil Modulite® 50 micrograms/metered inhalation may be prescribed.

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment Inhalation powder

**Cautionary and Advisory labels** 8, 10
- Easyhaler (beclometasone) (Orion Pharma (UK) Ltd)
Beclometasone dipropionate 200 microgram per 1 dose Easyhaler beclometasone 200 micrograms/dose dry powder inhaler | 200 dose £14.93 DT = £14.93

**Pressurised Inhalation**

**Cautionary and Advisory Labels** 8, 10
- Clenil Modulite (Chiesi Ltd)
Beclometasone dipropionate 50 microgram per 1 dose Clenil Modulite 50 micrograms/dose inhaler | 200 dose £3.70 DT = £3.70

Beclometasone dipropionate 100 microgram per 1 dose Clenil Modulite 100 micrograms/dose inhaler | 200 dose £7.42 DT = £7.42

Beclometasone dipropionate 200 microgram per 1 dose Clenil Modulite 200 micrograms/dose inhaler | 200 dose £16.17 DT = £16.17
Budesonide

**INDICATIONS AND DOSE**

**Bronchopulmonary dysplasia with spontaneous respiration**

- **BY INHALATION OF NEBULISED SUSPENSION**
- **Neonate:** 500 micrograms twice daily.
- **Child 1–4 months:** 500 micrograms twice daily

**Bronchopulmonary dysplasia with spontaneous respiration (severe symptoms)**

- **BY INHALATION OF NEBULISED SUSPENSION**
- **Child 1–4 months (body-weight 2.5 kg and above):** 1 mg twice daily

**Prophylaxis of mild to moderate asthma (in patients stabilised on twice daily dose)**

- **BY INHALATION OF POWDER**
- **Child 6–11 years:** 200–400 micrograms once daily, dose to be given in the evening
- **Child 12–17 years:** 200–800 micrograms twice daily, dose to be adjusted as necessary

**Prophylaxis of asthma**

- **BY INHALATION OF POWDER**
- **Child 6–11 years:** 100–400 micrograms twice daily, dose to be adjusted as necessary
- **Child 12–17 years:** 100–450 micrograms twice daily, dose to be adjusted as necessary

- **BY INHALATION OF NEBULISED SUSPENSION**
- **Child 6 months–11 years:** 125–500 micrograms twice daily, adjusted according to response; maximum 2 mg per day
- **Child 12–17 years:** Initially 0.25–1 mg twice daily, adjusted according to response, doses higher than recommended max. may be used in severe disease; maximum 2 mg per day

**BUDELIN® NOVOLIZER®**

**Prophylaxis of asthma**

- **BY INHALATION OF POWDER**
- **Child 6–11 years:** 200–400 micrograms twice daily, dose is adjusted as necessary
- **Child 12–17 years:** 200–800 micrograms twice daily, dose is adjusted as necessary

**Alternative in mild to moderate asthma, for patients previously stabilised on a twice daily dose**

- **BY INHALATION OF POWDER**
- **Child 6–11 years:** 200–400 micrograms once daily, to be taken in the evening
- **Child 12–17 years:** 200–400 micrograms once daily (max. per dose 800 micrograms), to be taken in the evening

**PULMICORT®® RESPULES**

**Prophylaxis of asthma**

- **BY INHALATION OF NEBULISED SUSPENSION**
- **Child 3 months–11 years:** Initially 0.5–1 mg twice daily, reduced to 250–500 micrograms twice daily
- **Child 12–17 years:** Initially 1–2 mg twice daily, reduced to 0.5–1 mg twice daily

**Croup**

- **BY INHALATION OF NEBULISED SUSPENSION**
- **Child:** 2 mg for 1 dose, alternatively 1 mg for 2 doses separated by a 30 minute interval, dose may be repeated every 12 hours until clinical improvement

**PULMICORT®® TURBOHALER**

**Prophylaxis of asthma**

- **BY INHALATION OF POWDER**
- **Child 5–11 years:** 100–400 micrograms twice daily, dose to be adjusted as necessary
- **Child 12–17 years:** 100–800 micrograms twice daily, dose to be adjusted as necessary

**Alternative in mild to moderate asthma, for patients previously stabilised on a twice daily dose**

- **BY INHALATION OF POWDER**
- **Child 5–11 years:** 200–400 micrograms once daily, to be taken in the evening
- **Child 12–17 years:** 200–400 micrograms once daily (max. per dose 800 micrograms), to be taken in the evening

**POTENCY**

- **Dose adjustments may be required for some inhaler devices, see under individual preparations.**

**UNLICENSED USE**

- **Pulmicort®® nebuliser solution** not licensed for use in children under 3 months; not licensed for use in bronchopulmonary dysplasia.

**INTERACTIONS**

- **Appendix 1:** corticosteroids

**DIRECTIONS FOR ADMINISTRATION**

- **Budesonide nebuliser suspension** is not suitable for use in ultrasonic nebulisers.

**PATIENT AND CARER ADVICE**

- **With high doses, a steroid card should be supplied. Patients or carers should be given advice on how to administer budesonide dry powder inhaler and nebuliser suspension.**


**BUDELIN® NOVOLIZER®**

- **Patients or carers should be given advice on administration of Budelin Novolizer®.**

**MEDICINAL FORMS**

- **There can be variation in the licensing of different medicines containing the same drug.**

**Inhalation powder**

**CAUTIONARY AND ADVISORY LABELS ** 8, 10

- **Budelin Novolizer (Meda Pharmaceuticals Ltd)**
- **Budesonide 200 microgram per 1 dose Budelin Novolizer 200micrograms/dose inhalation powder | 100 dose (Port) £14.86 DT = £14.86**
Budesonide with formoterol

The properties listed below are those particular to the combination only. For the properties of the components, please consider, budesonide p. 163, formoterol fumarate p. 156.

- **INDICATIONS AND DOSE**
  - **SYMPLICORT 100/6 TURBOHALER®**
    - **Asthma, maintenance therapy**
      - **By Inhalation of Powder**
        - Child 6-17 years: Initially 1–2 puffs twice daily; reduced to 1 puff daily, dose reduced only if control is maintained
      - **Asthma, maintenance and reliever therapy**
        - **By Inhalation of Powder**
          - Child 12-17 years: Maintenance 2 puffs daily in 1–2 divided doses; 1 puff as required for relief of symptoms, increased if necessary up to 6 puffs as required, max. 8 puffs per day; up to 12 puffs daily can be used for a limited time but medical assessment is recommended
  - **SYMPLICORT 200/6 TURBOHALER®**
    - **Asthma, maintenance therapy**
      - **By Inhalation of Powder**
        - Child 12-17 years: Initially 1–2 puffs twice daily; reduced to 1 puff daily, dose reduced only if control is maintained
      - **Asthma, maintenance and reliever therapy**
        - **By Inhalation of Powder**
          - Child 12-17 years: Maintenance 2 puffs daily in 1–2 divided doses, increased if necessary to 2 puffs twice daily; 1 puff as required for relief of symptoms, increased if necessary up to 6 puffs as required, max. 8 puffs per day; up to 12 puffs daily can be used for a limited time but medical assessment is recommended
  - **SYMPLICORT 400/12 TURBOHALER®**
    - **Asthma, maintenance therapy**
      - **By Inhalation of Powder**
        - Child 12-17 years: Initially 1 puff twice daily; reduced to 1 puff daily, dose reduced only if control is maintained

**INTERACTIONS** → Appendix 1: beta₂ agonists - corticosteroids

**PATIENT AND CARER ADVICE**

- Patient counselling is advised for budesonide with formoterol inhalation (administration).
- With high doses, a steroid card should be supplied.

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (June 2017) that budesonide/formoterol 100 micrograms/6 micrograms and 200 micrograms/6 micrograms (Symbicort® SMART®) is accepted for use within NHS Scotland for regular treatment of asthma where use of a combination (inhaled corticosteroid and a long-acting β₂ adrenoceptor agonist) is appropriate: patients already adequately controlled on both or patients not adequately controlled with inhaled corticosteroids and "as needed" short-acting β₂ adrenoceptor agonists. This advice relates to the extension of the license for Symbicort maintenance and reliever therapy (SMART®) to adolescents aged 12 years and over.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Inhalation powder**

- **Symicort Turbohaler®** (AstraZeneca UK Ltd)
  - Formoterol fumarate dihydrate 6 microgram per 1 dose, Budesonide 100 microgram per 1 dose
    - Symbicort 100/6 Turbohaler | 120 dose [PMD] £28.00 DT + £28.00
  - Formoterol fumarate dihydrate 6 microgram per 1 dose, Budesonide 200 microgram per 1 dose
    - Symbicort 200/6 Turbohaler | 120 dose [PMD] £28.00 DT + £28.00

**Ciclesonide**

- **INDICATIONS AND DOSE**
  - **Prophylaxis of asthma**
    - **By Inhalation of Aerosol**
      - Child 12-17 years: 160 micrograms once daily; reduced to 80 micrograms once daily, if control maintained; increased if necessary up to 320 micrograms twice daily, in severe asthma

**IMPORANT SAFETY INFORMATION**

MHRA/CHM ADVICE: PRESSURISED METERED DOSE INHALERS (PMDI): RISK OF AIRWAY OBSTRUCTION FROM ASPIRATION OF LOOSE OBJECTS (JULY 2018)

See Respiratory system, drug delivery p. 147.

**INTERACTIONS** → Appendix 1: corticosteroids

**SIDE-EFFECTS**

- Cushing’s syndrome

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in severe impairment (risk of increased exposure, no information available).

**PATIENT AND CARER ADVICE**

- Patients or carers should be given advice on how to administer ciclesonide aerosol inhaler.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Pressurised inhalation**

- **Alvesco®** (AstraZeneca UK Ltd)
  - Ciclesonide 80 microgram per 1 dose
    - Alvesco 80 inhaler | 120 dose [PMD] £32.83 DT + £32.83
  - Ciclesonide 160 microgram per 1 dose
    - Alvesco 160 inhaler | 60 dose [PMD] £38.62 DT + £38.62
Fluticasone with formoterol

The properties listed below are those particular to the combination only. For the properties of the components please consider, fluticasone above, formoterol fumarate p. 156.

**INDICATIONS AND DOSE**

**FLUTIFORM® 125**

- Prophylaxis of asthma
  - BY INHALATION OF AEROSOL
    - Child 12-17 years: 2 puffs twice daily

**FLUTIFORM® 50**

- Prophylaxis of asthma
  - BY INHALATION OF AEROSOL
    - Child 12-17 years: 2 puffs twice daily

**INTERACTIONS** → Appendix 1: beta, agonists - corticosteroids

**PATIENT AND CARER ADVICE**

Patients or carers should be given advice on how to administer fluticasone with formoterol aerosol inhalation. With high doses, a steroid card should be provided.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

- **Pressurised inhalation**
  
  **CAUTIONARY AND ADVISORY LABELS** 8, 10 (high doses)
  
  **Flutiform** (Napp Pharmaceuticals Ltd)
  
  Formoterol fumarate dihydrate 5 microgram per 1 dose, Fluticasone propionate 50 microgram per 1 dose Flutiform 50micrograms/dose / 5micrograms/dose inhaler | 120 dose £28.00 DT = £28.00

- **Nebuliser**
  
  **CAUTIONARY AND ADVISORY LABELS** 8, 10
  
  **Flutiform Nebule (GlaxoSmithKline UK Ltd)**
  
  Fluticasone propionate 250 microgram per 1 ml Flutiform 250micrograms/dose Evohaler | 200 dose £36.14 DT = £36.14

Fluticasone with salmeterol

The properties listed below are those particular to the combination only. For the properties of the components please consider, fluticasone above, salmeterol p. 157.

**INDICATIONS AND DOSE**

**SERETIDE 100 ACCUHALER®**

- Prophylaxis of asthma
  - BY INHALATION OF POWDER
    - Child 5-17 years: 1 inhalation twice daily, reduced to 1 inhalation daily, use reduced dose only if control maintained

**SERETIDE 125 EVOHALER®**

- Prophylaxis of asthma
  - BY INHALATION OF AEROSOL
    - Child 12-17 years: 2 puffs twice daily

**SERETIDE 250 ACCUHALER®**

- Prophylaxis of asthma
  - BY INHALATION OF POWDER
    - Child 12-17 years: 1 inhalation twice daily

**SERETIDE 250 EVOHALER®**

- Prophylaxis of asthma
  - BY INHALATION OF AEROSOL
    - Child 12-17 years: 2 puffs twice daily

**SERETIDE 50 EVOHALER®**

- Prophylaxis of asthma
  - INITIALLY BY INHALATION OF AEROSOL
    - Child 5-17 years: 2 puffs twice daily, (by inhalation) reduced to 2 puffs once daily, use reduced dose only if control maintained

**INTERACTIONS**

- Appendix 1: corticosteroids

**DIRECTIONS FOR ADMINISTRATION**

- Fluticasone nebuliser

- BY INHALATION OF NEBULISED SUSPENSION
  - Child 4-15 years: 1 mg twice daily
  - Child 16-17 years: 0.5–2 mg twice daily

**INDICATIONS AND DOSE**

- Prophylaxis of asthma
  - BY INHALATION OF POWDER
    - Child 5-17 years: Initially 50–100 micrograms twice daily (max. per dose 200 micrograms twice daily), dose to be adjusted as necessary
    - Child 16-17 years: Initially 100–500 micrograms twice daily (max. per dose 1 mg twice daily), dose may be increased according to severity of asthma. Doses above 500 micrograms twice daily initiated by a specialist
    - BY INHALATION OF AEROSOL
    - Child 4-15 years: Initially 50–100 micrograms twice daily (max. per dose 200 micrograms twice daily), dose to be adjusted as necessary
    - Child 16-17 years: Initially 100–500 micrograms twice daily (max. per dose 1 mg twice daily), dose may be increased according to severity of asthma. Doses above 500 micrograms twice daily initiated by a specialist
    - BY INHALATION OF NEBULISED SUSPENSION
    - Child 4-15 years: 1 mg twice daily
    - Child 16-17 years: 0.5–2 mg twice daily

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: PRESSURISED METERED DOSE INHALERS (PMDI): RISK OF AIRWAY OBSTRUCTION FROM ASPIRATION OF LOOSE OBJECTS (JULY 2018)

See Respiratory system, drug delivery p. 147.

**INTERACTIONS** → Appendix 1: corticosteroids

**DIRECTIONS FOR ADMINISTRATION**

- Fluticasone nebuliser

- BY INHALATION OF NEBULISED SUSPENSION
  - Child 4-15 years: 1 mg twice daily
  - Child 16-17 years: 0.5–2 mg twice daily

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.
SERETIDE 500 ACCUHALER®

Prophylaxis of asthma

- By Inhalation of Powder
- Child 12-17 years: 1 inhalation twice daily

INTERACTIONS → Appendix 1: beta, agonists • corticosteroids

PRESCRIBING AND DISPENSING INFORMATION

SEREFLO® 125 Manufacturer advises spacer devices are not compatible—if spacer device required, switch to alternative fixed-dose combination preparation.

PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer fluticasone with vilanterol powder for inhalation.

A steroid card should be provided.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Inhalation powder

CAUTIONARY AND ADVISORY LABELS 8, 10
- Relvar Ellipta (GlaxoSmithKline UK Ltd)
  - Vilanterol 22 microgram per 1 dose, Fluticasone furoate 92 microgram per 1 dose
  - Relvar Ellipta 92micrograms/dose / 22micrograms/dose dry powder inhaler | 30 dose (POD) £22.00 DT = £22.00
  - Vilanterol 22 microgram per 1 dose, Fluticasone furoate 184 microgram per 1 dose
  - Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler | 30 dose (POD) £29.50 DT = £29.50

Mometasone furoate

21-Dec-2017

INDICATIONS AND DOSE

Prophylaxis of asthma

- By Inhalation of Powder
- Child 12-17 years: Initially 400 micrograms daily in 1–2 divided doses, single dose to be inhaled in the evening, reduced to 200 micrograms once daily, if control maintained

Prophylaxis of severe asthma

- By Inhalation of Powder
- Child 12-17 years: Increased if necessary up to 400 micrograms twice daily

INTERACTIONS → Appendix 1: corticosteroids

SIDE-EFFECTS
- Common or very common Candida infection

PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer mometasone by inhaler. With high doses, a steroid card should be supplied.

Medicines for Children leaflet: Mometasone furoate inhaler for asthma prevention (prophylaxis) www.medicinesforchildren.org.uk/mometasone-furoate-inhaler-asthma-prevention-prophylaxis

NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (November 2003) that Asmanex® is restricted for use following failure of first-line inhaled corticosteroids.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: ointment

Inhalation powder

CAUTIONARY AND ADVISORY LABELS 8, 10
- Asmanex Twinhaler (Merck Sharp & Dohme Ltd)
  - Mometasone furoate 200 microgram per 1 dose
  - Asmanex 200micrograms/dose Twinhaler | 30 dose (POD) £15.70 DT = £15.70
  - 60 dose (POD) £23.54 DT = £23.54
- Mometasone furoate 400 microgram per 1 dose
  - Asmanex 400micrograms/dose Twinhaler | 30 dose (POD) £21.78 DT = £21.78
  - 60 dose (POD) £36.05 DT = £36.05

Fluticasone with vilanterol

01-Nov-2017

INDICATIONS AND DOSE

Prophylaxis of asthma

- By Inhalation of Powder
- Child 12-17 years: 1 inhalation once daily

INTERACTIONS → Appendix 1: beta, agonists • corticosteroids

SIDE-EFFECTS
- Common or very common Abdominal pain • arthralgia • back pain • bone fracture • cough • dysphonia • fever • increased risk of infection • muscle spasms • oropharyngeal pain
- Uncommon Vision blurred
- Rare or very rare Angioedema • anxiety

PREGNANCY Manufacturer advises use only if potential benefit outweighs risk.
**Mepolizumab**

**DRUG ACTION** Mepolizumab is a humanised anti-interleukin-5 (anti-IL-5) monoclonal antibody; it reduces the production and survival of eosinophils.

**INDICATIONS AND DOSE**

* Add on treatment for severe refractory eosinophilic asthma (under expert supervision)
  - **BY SUBCUTANEOUS INJECTION**
    - Child 6-11 years: 40 mg every 4 weeks
    - Child 12-17 years: 100 mg every 4 weeks

**CAUTIONS** Helminth infection

**SIDE-EFFECTS**

- **Common or very common** Abdominal pain upper - administration related reaction - back pain - eczema - fever - headache - hypersensitivity - increased risk of infection - nasal congestion

**PREGNANCY** Manufacturer advises avoid unless potential benefit outweighs risk—limited data available.

**BREAST FEEDING** Manufacturer advises avoid—present in milk in animal studies.

**PATIENT AND CARER ADVICE**

- Asthma Patients and their carers should be advised to seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment.

**NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**

- **SMC2139**
  - The **Scottish Medicines Consortium** has advised (April 2019) that mepolizumab (Nucala ™) is accepted for restricted use within NHS Scotland as an add-on treatment for severe refractory eosinophilic asthma in patients aged 6 years and older who have eosinophils of at least 150 cells per microlitre (0.15 × 10^9/L) at initiation of treatment and have had at least four asthma exacerbations in the preceding year or are receiving maintenance treatment with oral corticosteroids. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

- **All Wales Medicines Strategy Group (AWMSG) decisions**
  - **AWMSG No. 3750**
    - The **All Wales Medicines Strategy Group** has advised (April 2019) that mepolizumab (Nucala ™) is recommended as an option for restricted use within NHS Wales as an add-on treatment for severe refractory eosinophilic asthma in patients aged 6 years and older. It is restricted for use in a subpopulation of the licensed indication in line with NICE TA431 and is not recommended for use within NHS Wales outside of this subpopulation. This recommendation applies only in circumstances where the approved Patient Access Scheme (PAS) is utilised or where the list/contract price is equivalent or lower than the PAS price.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.
- **Powder for solution for injection**
  - EXCIPIENTS: May contain Polysorbates
  - **Nucala** (GliazoSmithKline UK Ltd) ▼
    - **Mepolizumab 100 mg** Nucala 100mg powder for solution for injection vials 1 vial (PHT) £840.00 (Hospital only)

**Omalizumab**

**INDICATIONS AND DOSE**

- **Prophylaxis of severe persistent allergic asthma**
  - **BY SUBCUTANEOUS INJECTION**
    - Child 6-17 years: Dose according to immunoglobulin E concentration and body-weight (consult product literature)

**ADD-on therapy for chronic spontaneous urticaria in patients who have had an inadequate response to H1 antihistamine treatment**

- **BY SUBCUTANEOUS INJECTION**
  - Child 12-17 years: 300 mg every 4 weeks

**CAUTIONS**

- Autoimmune disease - susceptibility to helminth infection—discontinue if infection does not respond to anthelmintic

**SIDE-EFFECTS**

- **Common or very common** Fever - gastrointestinal discomfort - headache - skin reactions
- **Uncommon** Cough - diarrhoea - dizziness - drowsiness - fatigue - flushing - increased risk of infection - influenza like illness - limb swelling - nausea - paraesthesia - photosensitivity reaction - postural hypotension - respiratory disorders - syncope - weight increased
- **Rare or very rare** Angioedema - hypersensitivity - systemic lupus erythematosus (SLE)
- **Frequency not known** Alopecia - eosinophilic granulomatosis with polyangiitis - immune thrombocytopenic purpura - joint disorders - lymphadenopathy - myalgia

**SIDE-EFFECTS, FURTHER INFORMATION**

Eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome) Churg-Strauss syndrome has occurred rarely in patients given omalizumab; the reaction is usually associated with the reduction of oral corticosteroid therapy. Churg-Strauss syndrome can present as eosinophilia, vasculitic rash, cardiac complications, worsening pulmonary symptoms, or peripheral neuropathy.

**Hypersensitivity reactions** Hypersensitivity reactions can also occur immediately following treatment with omalizumab or sometimes more than 24 hours after the first injection.

**PREGNANCY**

- Manufacturer advises avoid unless essential—crosses the placenta.

**BREAST FEEDING**

- Manufacturer advises avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution (no information available).

**RENAL IMPAIRMENT**

- Manufacturer advises caution—no information available.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

- **Omalizumab for severe persistent allergic asthma**
  - April 2013 NICE TA278

Omalizumab is recommended as an option for treating severe persistent confirmed allergic IgE-mediated asthma as an add-on to optimised standard therapy in patients aged 6 years and over:

- who need continuous or frequent treatment with oral corticosteroids (defined as 4 or more courses in the previous year), and
- only if the manufacturer makes omalizumab available with the discount agreed in the patient access scheme.

Optimised standard therapy is defined as a full trial of and, if tolerated, documented compliance with inhaled high-dose corticosteroids, long-acting beta, agonists, leukotriene receptor antagonists, theophyllines, oral...
corticosteroids, and smoking cessation if clinically appropriate.

Patients currently receiving omalizumab whose disease does not meet the criteria should be able to continue treatment until they and their clinician consider it appropriate to stop. www.nice.org.uk/TA278

- Omalizumab for previously treated chronic spontaneous urticaria (June 2015) NICE TA339

Omalizumab is an option as add-on therapy for the treatment of severe chronic spontaneous urticaria in patients 12 years and over, only if:
- the severity of the condition is assessed objectively, for example, using a weekly urticaria activity score of 26 or more,
- the patient’s condition has not responded to standard treatment with H1-antihistamines and leukotriene receptor antagonists,
- omalizumab is stopped at or before the fourth dose if the condition has not responded,
- omalizumab is stopped at the end of a course of treatment (6 doses) if the condition has responded and is restarted only if the condition relapses,
- omalizumab is administered under the management of a secondary care specialist in dermatology, immunology or allergy,
- the manufacturer provides omalizumab with the discount agreed in the patient access scheme.

Patients currently receiving omalizumab whose disease does not meet the above criteria should have the option to continue treatment until they and their clinician consider it appropriate to stop. www.nice.org.uk/TA339

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (December 2014) that omalizumab (Xolair®) is accepted for restricted use within NHS Scotland for the treatment of chronic spontaneous urticaria in patients aged 12 years and over, who have had an inadequate response to combination therapy with H1-antihistamines, leukotriene receptor antagonists and H2-antihistamines, used according to current treatment guidelines.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Solution for injection
- Xolair (Novartis Pharmaceuticals UK Ltd)
  - Omalizumab 150 mg per 1 ml Xolair 150mg/ml solution for injection pre-filled syringes | 1 pre-filled disposable injection (£53) £326.15
  - Xolair 75mg/0.5ml solution for injection pre-filled syringes | 1 pre-filled disposable injection (£53) £128.07

LEUKOTRIENE RECEPTOR ANTAGONISTS

Leukotriene receptor antagonists

Overview

The leukotriene receptor antagonist montelukast below blocks the effects of cysteinyl leukotrienes in the airways.

Montelukast has not been shown to be more effective than a standard dose of inhaled corticosteroid, but the two drugs appear to have an additive effect. The leukotriene receptor antagonists may be of benefit in exercise-induced asthma and in those with concomitant rhinitis, but they are less effective in children with severe asthma who are also receiving high doses of other drugs.

There is some limited evidence to support the intermittent use of montelukast in children under 12 years with episodic wheeze associated with viral infections [unlicensed use]. Treatment is started at the onset of either asthma symptoms or of corzayl symptoms and continued for 7 days; there is no evidence to support this use in moderate or severe asthma.

Montelukast

- INDICATIONS AND DOSE
  - Prophylaxis of asthma
    - BY MOUTH
      - Child 6 months-5 years: 4 mg once daily, dose to be taken in the evening
      - Child 6-14 years: 5 mg once daily, dose to be taken in the evening
      - Child 15-17 years: 10 mg once daily, dose to be taken in the evening
  - Symptomatic relief of seasonal allergic rhinitis in patients with asthma.
    - BY MOUTH
      - Child 15-17 years: 10 mg once daily, dose to be taken in the evening

- INTERACTIONS → Appendix 1: montelukast
- SIDE-EFFECTS
  - Common or very common Diarrhoea - fever - gastrointestinal discomfort - headache - nausea - skin reactions - upper respiratory tract infection - vomiting
  - Rare or very rare Angioedema - concentration impaired - disorientation - eosinophilic granulomatosis with polyangiitis - erythema nodosum - haullcation - hepatic disorders - memory loss - palpitations - pulmonary eosinophilia - suicidal tendencies - tremor

SIDE-EFFECTS, FURTHER INFORMATION Eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome) has occurred very rarely in association with the use of montelukast; in many of the reported cases the reaction followed the reduction or withdrawal of oral corticosteroid therapy. Prescribers should be alert to the development of eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, or peripheral neuropathy.

- PREGNANCY Manufacturer advises avoid unless essential.
  - There is limited evidence for the safe use of montelukast during pregnancy; however, it can be taken as normal in women who have shown a significant improvement in asthma not achievable with other drugs before becoming pregnant.

- BREAST FEEDING Manufacturer advises avoid unless essential.

- DIRECTIONS FOR ADMINISTRATION Granules may be swallowed or mixed with cold, soft food (not liquid) and taken immediately.

- PRESCRIBING AND DISPENSING INFORMATION Flavours of chewable tablet formulations may include cherry.

- PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer montelukast granules. Medicines for Children leaflet: Montelukast for asthma www.medicinesforchildren.org.uk/montelukast-asthma

- NATIONAL FUNDING/ACCESS DECISIONS SINGULAIR® GRANULES

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (June 2007) that SINGULAIR® granules are restricted for use as an alternative to low-dose inhaled corticosteroids for children 2–14 years with mild persistent asthma who have not recently had serious asthma attacks that required oral
corticosteroid use and who are not capable of using inhaled corticosteroids; Singulair® granules should be initiated by a specialist in paediatric asthma.

**SINGULAIR® CHEWABLE TABLETS**

**Scottish Medicines Consortium (SMC) decisions**
The Scottish Medicines Consortium has advised (June 2007) that Singulair® chewable tablets are restricted for use as an alternative to low-dose inhaled corticosteroids for children 2–14 years with mild persistent asthma who have not recently had serious asthma attacks that required oral corticosteroid use and who are not capable of using inhaled corticosteroids; Singulair® chewable tablets should be initiated by a specialist in paediatric asthma.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Granules**
- **Montelukast** (Non-proprietary)
  - Montelukast (as Montelukast sodium) 4 mg
  - Montelukast 4mg granules sachets sugar-free sugar-free | 28 sachet Pack £4.91–£13.99 DT = £5.25
- **Singulair** (Merck Sharp & Dohme Ltd)
  - Montelukast (as Montelukast sodium) 4 mg
  - Singulair Paediatric 4mg granules sachets sugar-free | 28 sachet Pack £25.69 DT = £5.25

**Tablet**
- **Montelukast** (Non-proprietary)
  - Montelukast (as Montelukast sodium) 10 mg
  - Montelukast 10mg tablets | 28 tablet Pack £26.97 DT = £1.17
- **Singulair** (Merck Sharp & Dohme Ltd)
  - Montelukast (as Montelukast sodium) 10 mg
  - Singulair 10mg tablets | 28 tablet Pack £26.97 DT = £1.17

**Chewable tablet**
- **CAUTIONARY AND ADVISORY LABELS**
  - 23, 24
- **EXCIPIENTS:** May contain Aspartame

- **Montelukast** (Non-proprietary)
  - Montelukast (as Montelukast sodium) 4 mg
  - Montelukast 4mg chewable tablets sugar free sugar-free | 28 tablet Pack £25.69 DT = £1.14
  - Montelukast 5mg chewable tablets sugar free sugar-free | 28 tablet Pack £25.69 DT = £1.26
- **Singulair** (Merck Sharp & Dohme Ltd)
  - Montelukast (as Montelukast sodium) 4 mg
  - Singulair Paediatric 4mg chewable tablets sugar-free | 28 tablet Pack £25.69 DT = £1.26
  - Montelukast (as Montelukast sodium) 5 mg
  - Singulair Paediatric 5mg chewable tablets sugar-free | 28 tablet Pack £25.69 DT = £1.26

**MAST-CELL STABILISERS**

**Cromoglicate and related therapy**

**Overview**
The mode of action of sodium cromoglicate below and nedocromil sodium below is not completely understood; they may be of value as prophylaxis in asthma with an allergic basis, but the evidence for benefit of sodium cromoglicate in children is contentious. Prophylaxis with sodium cromoglicate or nedocromil sodium is less effective than with inhaled corticosteroids.

Nedocromil sodium may be of some benefit in the prophylaxis of exercise-induced asthma.

Sodium cromoglicate and nedocromil sodium may also have a role in allergic conjunctivitis; sodium cromoglicate is used also in allergic rhinitis and allergy-related diarrhoea.
Child 14-17 years: Initially 200 mg 4 times a day for 2–3 weeks, then increased if necessary up to 40 mg/kg daily, then reduced according to response, to be taken before meals

**Severe acute asthma**

- **INDICATIONS AND DOSE**

Severe acute asthma in patients not previously treated with theophylline

- **BY SLOW INTRAVENOUS INJECTION**

Child: 5 mg/kg (max. per dose 500 mg), to be followed by intravenous infusion

**PHARMACOKINETICS**

- Aminophylline is a stable mixture or combination of theophylline and ethylenediamine; the ethylenediamine confers greater solubility in water.
- Theophylline is metabolised in the liver. The plasma-theophylline concentration is increased in heart failure, hepatic impairment, and in viral infections. The plasma-theophylline concentration is decreased in smokers, and by alcohol consumption. Differences in the half-life of aminophylline are important because the toxic dose is close to the therapeutic dose.

**SIDE-EFFECTS**

- Arrhythmias following rapid intravenous injection.
- Cardiac arrhythmias or other cardiac disease.
- Seizure (more common when given too rapidly by intravenous injection).
- Somnolence.
- Nerving.
- Hypotension (more common when given too rapidly by intravenous injection).
- Fever.
- Hyperventilation.
- Electrolyte imbalance.
- Gastrointestinal haemorrhage.
- Gastroesophageal reflux disease.
- Hyperthermia.
- Hyperventilation.
- Hypotension (more common when given too rapidly by intravenous injection).
- Insomnia.
- Mania.
- Metabolic disorder.
- Pain.
- Skin reactions.
- Tachycardia.
- Thirst.
- Tremor.
- Vertigo.
- Visual impairment.
- Vomiting.

**OVERDOSE**

Theophylline and related drugs are often prescribed as modified-release formulations and toxicity

**MEDICATIONS**

- Aminophylline

**INDICATIONS AND DOSE**

Severe acute asthma in patients not previously treated with theophylline

- **BY SLOW INTRAVENOUS INJECTION**

Child: 5 mg/kg (max. per dose 500 mg), to be followed by intravenous infusion

**SIDE-EFFECTS**

- Arrhythmias.
- Central nervous system stimulation.
- Epigastric discomfort.

**INTERACTIONS**

Appendix 1: aminophylline
Theophylline

**INDICATIONS AND DOSE**

**NUELIN SA® 175MG TABLETS**

**Chronic asthma**
- **BY MOUTH USING MODIFIED-RELEASE MEDICINES**
  - Child 6–11 years: 175 mg every 12 hours
  - Child 12–17 years: 175–350 mg every 12 hours

**NUELIN SA® 250 TABLETS**

**Chronic asthma**
- **BY MOUTH USING MODIFIED-RELEASE MEDICINES**
  - Child 6–11 years: 250–500 mg every 12 hours
  - Child 12–17 years: 250–500 mg every 12 hours

**SLO-PHYLLIN®**

**Chronic asthma**
- **BY MOUTH USING MODIFIED-RELEASE MEDICINES**
  - Child 6–11 years: 125–250 mg every 12 hours
  - Child 12–17 years: 250–500 mg every 12 hours

**UNIPHILLY CONTINU®**

**Chronic asthma**
- **BY MOUTH USING MODIFIED-RELEASE MEDICINES**
  - Child 2–5 years: 60–120 mg every 12 hours
  - Child 6–11 years: 125–250 mg every 12 hours
  - Child 12–17 years: 250–500 mg every 12 hours

**Theophylline**

**Measurement of plasma-theophylline concentration** may be increased in heart failure, hepatic impairment, and in viral infections. The plasma-theophylline concentration is increased in heart failure, hepatic impairment, and in viral infections.

**Patients taking oral theophylline or aminophylline should not normally receive a loading dose of intravenous aminophylline.**

**Consider intravenous aminophylline for treatment of severe and life-threatening acute asthma only after consultation with senior medical staff.**

**Modified release** The rate of absorption from modified-release preparations can vary between brands. If a prescription for a modified-release oral aminophylline preparation does not specify a brand name, the pharmacist should contact the prescriber and agree the brand to be dispensed. Additionally, it is essential that a patient discharged from hospital should be maintained on the brand on which that patient was stabilised as an in-patient.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for infusion, suppository

**Solution for injection**
- **Aminophylline (Non-proprietary)**
  - Aminophylline 25 mg per 1 ml
    - Aminophylline 250mg/10ml solution for injection ampoules | 10 ampoule £8.50 DT + £8.50

**Modified-release tablet**

**CAUTIONARY AND ADVISORY LABELS**

**ALLERGY AND CROSS-SENSITIVITY**
- Allergy to ethylenediamine can cause urticaria, erythema, and exfoliative dermatitis.

**PREGNANCY**
- Neonatal irritability and apnoea have been reported. Theophylline can be taken as normal during pregnancy as it is particularly important that asthma should be well controlled during pregnancy.

**BREAST FEEDING**
- Present in milk—irritability in infant reported; modified-release preparations preferable. Theophylline can be taken as normal during breast-feeding.

**HEPATIC IMPAIRMENT**
- Manufacturer advises caution (risk of reduced clearance).

**Dose adjustments**
- With oral use Manufacturer advises consider dose reduction.
- With intravenous use Manufacturer advises maintenance dose reduction—consult product literature.

**MONITORING REQUIREMENTS**
- Aminophylline is monitored therapeutically in terms of plasma-theophylline concentrations.
- Measurement of plasma-theophylline concentration may be helpful and is essential if a loading dose of intravenous aminophylline is to be given to patients who are already taking theophylline, because serious side-effects such as convulsions and arrhythmias can occasionally precede other symptoms of toxicity.
- In most individuals, a plasma-theophylline concentration of 10–20 mg/litre (55–110 micromol/litre) is required for satisfactory bronchodilation, although a lower plasma-theophylline concentration of 5–15 mg/litre may be effective. Adverse effects can occur within the range 10–20 mg/litre and both the frequency and severity increase at concentrations above 20 mg/litre.
- If aminophylline is given intravenously, a blood sample should be taken 4–6 hours after starting treatment.
- With oral use Plasma-theophylline concentration is measured 5 days after starting oral treatment and at least 3 days after any dose adjustment. A blood sample should usually be taken 4–6 hours after an oral dose of a modified-release preparation (sampling times may vary—consult local guidelines).

**DIRECTIONS FOR ADMINISTRATION**
- **With intravenous use** For intravenous injection, give very slowly over at least 20 minutes (with close monitoring).
- For intravenous infusion, dilute to a concentration of 1 mg/ml with Glucose 5% or Sodium Chloride 0.9%.
- With intramuscular use Aminophylline is too irritant for intramuscular use.

**PRESCRIBING AND DISPENSING INFORMATION**
- Patients taking oral theophylline or aminophylline should not normally receive a loading dose of intravenous aminophylline.
- Consider intravenous aminophylline for treatment of severe and life-threatening acute asthma only after consultation with senior medical staff.

Modified release The rate of absorption from modified-release preparations can vary between brands. If a prescription for a modified-release oral aminophylline preparation does not specify a brand name, the pharmacist should contact the prescriber and agree the brand to be dispensed. Additionally, it is essential that a patient discharged from hospital should be maintained on the
Respiratory system

Plasma-theophylline concentration is measured.

BREAST FEEDING

Theophylline can be taken as normal during breast-feeding.

PREGNANCY

Theophylline can be taken as normal during pregnancy as it is particularly important that asthma is well controlled. Neonatal irritability and apnoea have been reported.

SIDE-EFFECTS

Anxiety \textit{\&} arrhythmias \textit{\&} diarrhoea \textit{\&} dizziness \textit{\&} gastrointestinal discomfort \textit{\&} gastrooesophageal reflux disease \textit{\&} headache \textit{\&} hyperuricaemia \textit{\&} nausea \textit{\&} palpitations \textit{\&} seizures \textit{\&} skin reactions \textit{\&} sleep disorders \textit{\&} tremor \textit{\&} urinary disorders \textit{\&} vomiting

SIDE-EFFECTS, FURTHER INFORMATION

Potentially serious hypokalaemia may result from beta-agonist therapy. Particular caution is required in severe asthma, because this effect may be potentiated by concomitant treatment with theophylline and its derivatives, corticosteroids, and diuretics, and by hypoxia. Plasma-potassium concentration should therefore be monitored in severe asthma.

Overdose

Theophylline in overdose can cause vomiting (which may be severe and intractable), agitation, restlessness, dilated pupils, sinus tachycardia, and hyperglycaemia. More serious effects are haematemesis, convulsions, and supraventricular and ventricular arrhythmias. Severe hypokalaemia may develop rapidly.

For details on the management of poisoning, see theophylline, under Emergency treatment of poisoning on p. 859.

UNLICENSED USE

SLO-PHYLlin \textregistered\textsuperscript{\textregistered} Slo-phyllin \textregistered\textsuperscript{\textregistered} capsules not licensed for use in children under 2 years.

CAUTIONS

Cardiac arrhythmias or other cardiac disease \textit{\&} epilepsy \textit{\&} fever \textit{\&} hypertension \textit{\&} hyperthyroidism \textit{\&} peptic ulcer \textit{\&} risk of hypokalaemia

INTERACTIONS

Appendix 1: theophylline

UNLICENSED USE

SLO-PHYLlin \textregistered\textsuperscript{\textregistered} Slo-phyllin \textregistered\textsuperscript{\textregistered} capsules not licensed for use in children under 2 years.

CAUTIONS

Cardiac arrhythmias or other cardiac disease \textit{\&} epilepsy \textit{\&} fever \textit{\&} hypertension \textit{\&} hyperthyroidism \textit{\&} peptic ulcer \textit{\&} risk of hypokalaemia

INTERACTIONS

Appendix 1: theophylline

SIDE-EFFECTS

Anxiety \textit{\&} arrhythmias \textit{\&} diarrhoea \textit{\&} dizziness \textit{\&} gastrointestinal discomfort \textit{\&} gastrooesophageal reflux disease \textit{\&} headache \textit{\&} hyperuricaemia \textit{\&} nausea \textit{\&} palpitations \textit{\&} seizure \textit{\&} skin reactions \textit{\&} sleep disorders \textit{\&} tremor \textit{\&} urinary disorders \textit{\&} vomiting

SIDE-EFFECTS, FURTHER INFORMATION

Potentially serious hypokalaemia may result from beta-agonist therapy. Particular caution is required in severe asthma, because this effect may be potentiated by concomitant treatment with theophylline and its derivatives, corticosteroids, and diuretics, and by hypoxia. Plasma-potassium concentration should therefore be monitored in severe asthma.

Overdose

Theophylline in overdose can cause vomiting (which may be severe and intractable), agitation, restlessness, dilated pupils, sinus tachycardia, and hyperglycaemia. More serious effects are haematemesis, convulsions, and supraventricular and ventricular arrhythmias. Severe hypokalaemia may develop rapidly.

For details on the management of poisoning, see theophylline, under Emergency treatment of poisoning on p. 859.

Pregnancy

Neonatal irritability and apnoea have been reported. Theophylline can be taken as normal during pregnancy as it is particularly important that asthma should be well controlled during pregnancy.

Breastfeeding

Present in milk—irritability in infant reported; modified-release preparations preferable. Theophylline can be taken as normal during breastfeeding.

Hepatic Impairment

Manufacturer advises caution (risk of increased exposure).

Dose Adjustments

Manufacturer advises consider dose reduction.

Monitoring Requirements

In most individuals, a plasma-theophylline concentration of 10–20 mg/litre (65–110 micromol/litre) is required for satisfactory bronchodilation, although a lower plasma-theophylline concentration of 5–15 mg/litre may be effective. Adverse effects can occur within the range 10–20 mg/litre and both the frequency and severity increase at concentrations above 20 mg/litre.

Plasma-theophylline concentration is measured 5 days after starting oral treatment and at least 3 days after any dose adjustment. A blood sample should usually be taken 4–6 hours after an oral dose of a modified-release preparation (sampling times may vary—consult local guidelines).

Directions for Administration

SLO-PHYLlin \textregistered\textsuperscript{\textregistered} Contents of the capsule (enteric-coated granules) may be sprinkled on to a spoonful of soft food (e.g. yoghurt) and swallowed without chewing.

Prescribing and Dispensing Information

The rate of absorption from modified-release preparations can vary between brands. If a prescription for a modified-release oral theophylline preparation does not specify a brand name, the pharmacist should contact the prescriber and agree the brand to be dispensed. Additionally, it is essential that a patient discharged from hospital should be maintained on the brand on which that patient was stabilised as an in-patient.

Patient and Carer Advice

SLO-PHYLlin \textregistered\textsuperscript{\textregistered} Patient or carer should be given advice on how to administer theophylline modified release capsules.

Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug.

Modified-release tablet

CAUTIONARY AND ADVICE LABELS 21, 25

Theophylline 175 mg Nuelin SA 175mg tablets | 60 tablet £6.38 DT = £6.38

Theophylline 250 mg Nuelin SA 250 tablets | 60 tablet £8.92 DT = £8.92

Uniphyllin Continus (Napp Pharmaceuticals Ltd)

Theophylline 200 mg Uniphyllin Continus 200mg tablets | 56 tablet £12.96 DT + £12.96

Theophylline 300 mg Uniphyllin Continus 300mg tablets | 56 tablet £14.77 DT + £14.77

Theophylline 400 mg Uniphyllin Continus 400mg tablets | 56 tablet £16.65 DT + £16.65

Modified-release capsule

CAUTIONARY AND ADVICE LABELS 25

Slo-Phyllin (Merrick Serono Ltd)

Theophylline 60 mg Slo-Phyllin 60mg capsules | 56 capsule £2.76 DT = £2.76

Theophylline 125 mg Slo-Phyllin 125mg capsules | 56 capsule £3.48 DT = £3.48

Theophylline 250 mg Slo-Phyllin 250mg capsules | 56 capsule £4.34 DT = £4.34

Breathe

Theophylline inhaled 20 mg/litre (1 mg/litre) is required for satisfactory bronchodilation, although a lower plasma-theophylline concentration of 5–15 mg/litre may be effective. Adverse effects can occur within the range 10–20 mg/litre and both the frequency and severity increase at concentrations above 20 mg/litre.

INDICATIONS AND DOSE

MUCOCLEAR \textsuperscript{\textregistered} 3%

Mobilise lower respiratory tract secretions in mucous consolidation (e.g. cystic fibrosis) | Mild to moderate acute viral bronchiolitis in infants

BY INHALATION OF NEBULISED SOLUTION

Child: 4 mL 2–4 times a day, temporary irritation, such as coughing, hoarseness, or reversible bronchoconstriction may occur; an inhaled bronchodilator can be used before treatment with hypertonic sodium chloride to reduce the risk of these adverse effects

Mucoclear 3% inhalation solution 4ml ampoules (Pari Medical Ltd) Sodium chloride 30 mg per 1 ml | 20 ampoule - NHS indicative price = £12.98 \textit{\&} Drug Tariff (Part IXa) | 60 ampoule - NHS indicative price = £27.00 \textit{\&} Drug Tariff (Part IXa)

INDICATIONS AND DOSE

MUCOCLEAR \textsuperscript{\textregistered} 6%

Mobilise lower respiratory tract secretions in mucous consolidation (e.g. cystic fibrosis)

BY INHALATION OF NEBULISED SOLUTION

Child: 4 mL twice daily, temporary irritation, such as coughing, hoarseness, or reversible bronchoconstriction may occur; an inhaled bronchodilator can be used before treatment with hypertonic sodium chloride to reduce the risk of these adverse effects

Mucoclear 6% inhalation solution 4ml ampoules (Pari Medical Ltd) Sodium chloride 60 mg per 1 ml | 20 ampoule - NHS indicative price = £12.98 \textit{\&} Drug Tariff (Part IXa) | 60 ampoule - NHS indicative price = £27.00 \textit{\&} Drug Tariff (Part IXa)

Nebuliser solutions
INDICATIONS AND DOSE

NEBUSALE
Mobilise lower respiratory tract secretions in mucous consolidation (e.g. cystic fibrosis)
▶ BY INHALATION OF NEBULISED SOLUTION
▶ Child: 4 mL up to twice daily, temporary irritation, such as coughing, hoarseness, or reversible bronchoconstriction may occur; an inhaled bronchodilator can be used before treatment with hypertonic sodium chloride to reduce the risk of these adverse effects

Resp Ease 6% inhalation solution 4ml vials (Venture Healthcare Ltd) | 60 vial - NHS indicative price = £21.60 - Drug Tariff (Part IXa)
Resp Ease 3% inhalation solution 4ml vials (Venture Healthcare Ltd) | 60 vial - NHS indicative price = £21.60 - Drug Tariff (Part IXa)
Resp Ease 7% inhalation solution 4ml vials (Venture Healthcare Ltd) | 60 vial - NHS indicative price = £21.60 - Drug Tariff (Part IXa)

Resp-Ease mobiliser can be used before treatment with bronchodilators to mobilise lower respiratory tract secretions in mucous consolidation.

PEAK FLOW METERS

Low Range

NEBUSALE 7% inhalation solution 4ml vials (Forest Laboratories UK Ltd) Sodium chloride 70 mg per 1 ml | 60 vial - NHS indicative price = £27.00 - Drug Tariff (Part IXa)

AirZone 7% inhalation solution 4ml vials (Forest Laboratories UK Ltd) Sodium chloride 70 mg per 1 ml | 60 vial - NHS indicative price = £27.00 - Drug Tariff (Part IXa)

MicroPeak 7% inhalation solution 4ml vials (Forest Laboratories UK Ltd) Sodium chloride 70 mg per 1 ml | 60 vial - NHS indicative price = £27.00 - Drug Tariff (Part IXa)

POCKETPEAK 7% inhalation solution 4ml vials (Forest Laboratories UK Ltd) Sodium chloride 70 mg per 1 ml | 60 vial - NHS indicative price = £27.00 - Drug Tariff (Part IXa)

nSpire Pocket Peak peak flow meter low range (nSpire Health Ltd) | 1 device - NHS indicative price = £6.53 - Drug Tariff (Part IXa) price = £4.50

MINI-WRIGHT STANDARD RANGE
Range 60–800 litres/minute.

MicroPeak peak flow meter standard range (Micro Medical Ltd) | 1 device - NHS indicative price = £6.50 - Drug Tariff (Part IXa) price = £4.50

MINI-WRIGHT STANDARD RANGE
Range 60–800 litres/minute.

MicroPeak peak flow meter standard range (Micro Medical Ltd) | 1 device - NHS indicative price = £6.50 - Drug Tariff (Part IXa) price = £4.50

Spacers

A2A SPACER
For use with all pressurised (aerosol) inhalers.

A2A Spacer (Clement Clarke International Ltd) | 1 device - NHS indicative price = £4.15 - Drug Tariff (Part IXa)

A2A Spacer with medium mask (Clement Clarke International Ltd) | 1 device - NHS indicative price = £6.68 - Drug Tariff (Part IXa)

A2A Spacer with small mask (Clement Clarke International Ltd) | 1 device - NHS indicative price = £6.68 - Drug Tariff (Part IXa)

ABLE SPACER
Small-volume device. For use with all pressurised (aerosol) inhalers.

Able Spacer (Clement Clarke International Ltd) | 1 device - NHS indicative price = £4.39 - Drug Tariff (Part IXa)

Able Spacer with medium mask (Clement Clarke International Ltd) | 1 device - NHS indicative price = £7.16 - Drug Tariff (Part IXa)

Able Spacer with small mask (Clement Clarke International Ltd) | 1 device - NHS indicative price = £7.16 - Drug Tariff (Part IXa)

AEROCHAMBER PLUS
Medium-volume device. For use with all pressurised (aerosol) inhalers.

AeroChamber Plus (Trudell Medical UK Ltd) | 1 device - NHS indicative price = £8.24 - Drug Tariff (Part IXa)

AeroChamber Plus with adult mask (Trudell Medical UK Ltd) | 1 device - NHS indicative price = £8.24 - Drug Tariff (Part IXa)
### Allergic conditions

**AeroChamber Plus with infant mask** (Trudell Medical UK Ltd)
1 device - NHS indicative price = £8.24 - Drug Tariff (Part IXa)

**BABYHALER®**
For paediatric use with *Fluixotide®,* and *Ventolin®* inhalers.

**PRESCRIBING AND DISPENSING INFORMATION**
Not available for NHS prescription.

**Babyhaler** (GlaxoSmithKline UK Ltd)
1 device - No NHS indicative price available - Drug Tariff (Part IXa)

**HALERAI D®**
Device to place over pressurised (aerosol) inhalers to aid when strength in hands is impaired (e.g. in arthritis). For use with *Fluixotide*, *Seretide®,* *Serevent®,* and *Ventolin®* inhalers.

**PRESCRIBING AND DISPENSING INFORMATION**
Not available for NHS prescription.

**Haleraid-120** (GlaxoSmithKline UK Ltd)
1 device - No NHS indicative price available - Drug Tariff (Part IXa)

**Haleraid-200** (GlaxoSmithKline UK Ltd)
1 device - No NHS indicative price available - Drug Tariff (Part IXa)

**OPTICHAMBER®**
For use with all pressurised (aerosol) inhalers.

**OptiChamber** (Respironics (UK) Ltd)
1 device - NHS indicative price = £4.28 - Drug Tariff (Part IXa)

**OptiChamber® DI AMOND**
For use with all pressurised (aerosol) inhalers.

**OptiChamber Diamond** (Respironics (UK) Ltd)
1 device - NHS indicative price = £4.49 - Drug Tariff (Part IXa)

**OptiChamber Diamond with large LiteTouch mask 5 years-old** (Respironics (UK) Ltd)
1 device - NHS indicative price = £7.49 - Drug Tariff (Part IXa)

**OptiChamber Diamond with medium LiteTouch mask 1–5 years** (Respironics (UK) Ltd)
1 device - NHS indicative price = £7.49 - Drug Tariff (Part IXa)

**OptiChamber Diamond with small LiteTouch mask 0–18 months** (Respironics (UK) Ltd)
1 device - NHS indicative price = £7.49 - Drug Tariff (Part IXa)

**POCKET CHAMBER®**
Small volume device. For use with all pressurised (aerosol) inhalers.

**Pocket Chamber** (nSpire Health Ltd)
1 device - NHS indicative price = £4.18 - Drug Tariff (Part IXa)

**Pocket Chamber with adult mask** (nSpire Health Ltd)
1 device - NHS indicative price = £9.75 - Drug Tariff (Part IXa)

**Pocket Chamber with child mask** (nSpire Health Ltd)
1 device - NHS indicative price = £9.75 - Drug Tariff (Part IXa)

**Pocket Chamber with infant mask** (nSpire Health Ltd)
1 device - NHS indicative price = £9.75 - Drug Tariff (Part IXa)

**Pocket Chamber with teenager mask** (nSpire Health Ltd)
1 device - NHS indicative price = £9.75 - Drug Tariff (Part IXa)

**SPACE CHAMBER PLUS®**
For use with all pressurised (aerosol) inhalers.

**Space Chamber Plus** (Medical Developments International Ltd)
1 device - NHS indicative price = £4.26 - Drug Tariff (Part IXa)

**Space Chamber Plus with large mask** (Medical Developments International Ltd)
1 device - NHS indicative price = £6.98 - Drug Tariff (Part IXa)

**Space Chamber Plus with medium mask** (Medical Developments International Ltd)
1 device - NHS indicative price = £6.98 - Drug Tariff (Part IXa)

**VOLUMATIC®**
Large-volume device. For use with *Clenil Modulate®,* *Fluixotide®,* *Seretide®,* *Serevent®,* and *Ventolin®* inhalers.

**Volumatic** (GlaxoSmithKline UK Ltd)
1 device - NHS indicative price = £3.88 - Drug Tariff (Part IXa)

**Volumatic with paediatric mask** (GlaxoSmithKline UK Ltd)
1 device - NHS indicative price = £6.63 - Drug Tariff (Part IXa)

**VORTEX®**
Medium-volume device. For use with all pressurised (aerosol) inhalers.

**Vortex Spacer** (Pari Medical Ltd)
1 device - NHS indicative price = £6.28 - Drug Tariff (Part IXa)

**Vortex with baby mask 0–2 years** (Pari Medical Ltd)
1 device - NHS indicative price = £7.29 - Drug Tariff (Part IXa)

**Vortex with child mask 2 years+** (Pari Medical Ltd)
1 device - NHS indicative price = £7.99 - Drug Tariff (Part IXa)

## Antihistamines, allergen immunotherapy and allergic emergencies

### Antihistamines

Antihistamines (histamine H₁-receptor antagonists) are classified as *sedating* or *non-sedating,* according to their relative potential for CNS depression. Antihistamines differ in their duration of action, incidence of drowsiness, and antimuscarinic effects; the response to an antihistamine may vary from child to child. Either a sedating or a non-sedating antihistamine may be used to treat an acute allergic reaction; for conditions with more persistent symptoms which require regular treatment, a non-sedating antihistamine should be used to minimise the risk of sedation and psychomotor impairment associated with sedating antihistamines.

Oral antihistamines are used in the treatment of nasal allergies, particularly seasonal allergic rhinitis (hay fever), and may be of some value in vasomotor rhinitis; rhinorrhoea and sneezing is reduced, but antihistamines are usually less effective for nasal congestion. Antihistamines are used topically to treat allergic reactions in the eye and in the nose. Topical application of antihistamines to the skin is not recommended.

An oral antihistamine may be used to prevent urticaria, and for the treatment of acute urticarial rash, pruritus, insect bites, and stings. Antihistamines are also used in the management of nausea and vomiting, of migraine, and the adjunctive management of anaphylaxis and angioedema.

The *non-sedating* antihistamine cetirizine hydrochloride p. 176 is safe and effective in children. Other non-sedating antihistamines that are used include acrivastine p. 176, bilastine p. 176, desloratadine p. 177 (an active metabolite of loratadine p. 178), fexofenadine hydrochloride p. 178 (an active metabolite of terfenadine), levocetirizine hydrochloride p. 178 (an isomer of cetirizine hydrochloride), loratadine, and mizolastine p. 179. Most non-sedating antihistamines are long-acting (usually 12–24 hours). There is little evidence that desloratadine or levocetirizine hydrochloride confer any additional benefit—they should be reserved for children who cannot tolerate other therapies.

*Sedating* antihistamines are occasionally useful when insomnia is associated with urticaria and pruritus. Most of the sedating antihistamines are relatively short-acting, but promethazine may be effective for up to 12 hours. Alimemazine tartrate p. 180 and *promethazine* have a more sedative effect than chlorphenamine maleate p. 180 and cyclizine p. 266. Chlorphenamine maleate is used as an adjunct to adrenaline/epinephrine p. 138 in the emergency treatment of anaphylaxis and angioedema.

### Allergen immunotherapy

Immunotherapy using allergen vaccines containing house dust mite, animal dander (cat or dog), or extracts of grass and tree pollen can improve symptoms of asthma and...
allergic rhinoconjunctivitis in children. A vaccine containing extracts of wasp and bee venom is used to reduce the risk of severe anaphylaxis and systemic reactions in children with hypersensitivity to wasp and bee stings. An oral preparation of grass pollen extract (Grazax®) is also licensed for disease-modifying treatment of grass pollen-induced rhinitis and conjunctivitis. Children requiring immunotherapy must be referred to a hospital specialist for accurate diagnosis, assessment, and treatment.

Omalizumab p. 167 is a monoclonal antibody that binds to immunoglobulin E (IgE). It is licensed for use as additional therapy in children over 6 years with proven IgE-mediated sensitivity to inhaled allergens, whose severe persistent allergic asthma cannot be controlled adequately with high-dose inhaled corticosteroid together with a long-acting beta agonist. Omalizumab should be initiated by physicians experienced in the treatment of severe persistent asthma. Omalizumab is also indicated as add-on therapy for the treatment of chronic spontaneous urticaria in patients who have had an inadequate response to H₁ antihistamine treatment.

**Anaphylaxis and allergic emergencies**

**Anaphylaxis**

Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction. It is characterised by the rapid onset of respiratory and/or circulatory problems and is usually associated with skin and mucosal changes; prompt treatment is required. Children with pre-existing asthma, especially poorly controlled asthma, are at particular risk of life-threatening reactions. Insect stings are a recognised risk (in particular wasp and bee stings). Latex and certain foods, including eggs, fish, cow’s milk protein, peanuts, sesame, shellfish, soy, and tree nuts may also precipitate anaphylaxis (see Food allergy p. 62). Medicinal products particularly associated with anaphylaxis include blood products, vaccines, allergen immunotherapy preparations, antibacterials, aspirin p. 93 and other NSAIDs, and neuromuscular blocking drugs. In the case of drugs, anaphylaxis is more likely after parenteral administration; resuscitation facilities must always be available for injections associated with special risk. Refined arachis (peanut) oil, which may be present in some medicinal products, is unlikely to cause an allergic reaction—nevertheless it is wise to check the full formula of preparations which may contain allergens.

**Treatment of anaphylaxis**

Adrenaline/epinephrine provides physiological reversal of the immediate symptoms associated with hypersensitivity reactions such as anaphylaxis and angioedema. First-line treatment includes:

- securing the airway, restoration of blood pressure (laying the child flat and raising the legs, or in the recovery position if unconscious or nauseous and at risk of vomiting);
- administering adrenaline/epinephrine by intramuscular injection; the dose should be repeated if necessary at 5-minute intervals according to blood pressure, pulse, and respiratory function;
- administering high-flow oxygen and intravenous fluids;
- administering an antihistamine, such as chlorphenamine maleate, by slow intravenous injection or intramuscular injection as adjunctive treatment given after adrenaline.

Administering an intravenous corticosteroid such as hydrocortisone p. 456 (preferably as sodium succinate) is of secondary value in the initial management of anaphylaxis because the onset of action is delayed for several hours, but should be given to prevent further deterioration in severely affected children. Continuing respiratory deterioration requires further treatment with bronchodilators including inhaled or intravenous salbutamol p. 158, inhaled ipratropium bromide p. 155, intravenous aminophylline p. 150, or intravenous magnesium sulfate p. 618 [unlicensed indication] (as for acute severe asthma); in addition to oxygen, assisted respiration and possibly emergency tracheotomy may be necessary.

When a child is so ill that there is doubt about the adequacy of the circulation, the initial injection of adrenaline/epinephrine may need to be given as a dilute solution by the intravenous route, or by the intramuscular route if venous access is difficult; for details see adrenaline/epinephrine.

On discharge, child should be considered for further treatment with an oral antihistamine and an oral corticosteroid for up to 3 days to reduce the risk of further reaction. The child, or carer, should be instructed to return to hospital if symptoms recur and to contact their general practitioner for follow-up.

Children who are suspected of having had an anaphylactic reaction should be referred to a specialist for specific allergy diagnosis. Avoidance of the allergen is the principal treatment; if appropriate, an adrenaline/epinephrine auto-injector should be given for self-administration or a replacement supplied.

**Intramuscular adrenaline (epinephrine)**

The intramuscular route is the first choice route for the administration of adrenaline/epinephrine p. 138 in the management of anaphylaxis. Adrenaline/epinephrine is best given as an intramuscular injection into the anterolateral aspect of the middle third of the thigh; it has a rapid onset of action after intramuscular administration and in the shocked patient its absorption from the intramuscular site is faster and more reliable than from the subcutaneous site.

Children with severe allergy, and their carers, should ideally be instructed in the self-administration of adrenaline/epinephrine by intramuscular injection.

Prompt injection of adrenaline/epinephrine is of paramount importance. The adrenaline/epinephrine doses recommended for the emergency treatment of anaphylaxis by appropriately trained healthcare professionals are based on the revised recommendations of the Working Group of the Resuscitation Council (UK).

**Intravenous adrenaline (epinephrine)**

Intravenous adrenaline/epinephrine should be given only by those experienced in its use, in a setting where patients can be carefully monitored.

Where the child is severely ill and there is real doubt about adequacy of the circulation and absorption from the intramuscular injection site, adrenaline/epinephrine may be given by slow intravenous injection, repeated according to response; if multiple doses are required consider giving adrenaline by slow intravenous infusion.

It is also important that, where intramuscular injection might still succeed, time should not be wasted seeking intravenous access.

Adrenaline/epinephrine is also given by the intravenous route for acute hypotension.

**Angioedema**

Angioedema is dangerous if laryngeal oedema is present. In this circumstance adrenaline/epinephrine injection, oxygen, antihistamines and corticosteroids should be given as described under Anaphylaxis. Tracheal intubation may be necessary. In some children with laryngeal oedema, adrenaline 1 in 1000 (1 mg/mL) solution may be given by nebuliser. However, nebulised adrenaline/epinephrine cannot be relied upon for a systemic effect—intramuscular adrenaline/epinephrine should be used.

**Hereditary angioedema**

The treatment of hereditary angioedema should be under specialist supervision. Unlike allergic angioedema, adrenaline/epinephrine, corticosteroids, and antihistamines should not be used for the treatment of acute attacks,
including attacks involving laryngeal oedema, as they are ineffective and may delay appropriate treatment—intubation may be necessary. The administration of C1-esterase inhibitor p. 186 (in fresh frozen plasma or in partially purified form) can terminate acute attacks of hereditary angioedema; it can also be used for short-term prophylaxis before dental, medical, or surgical procedures. Tranexamic acid p. 83 is used for short-term or long-term prophylaxis of hereditary angioedema; short-term prophylaxis is started several days before planned procedures which may trigger an acute attack of hereditary angioedema (e.g. dental work) and continued for 2–5 days afterwards. Danazol [unlicensed indication] is best avoided in children because of its androgenic effects, but it can be used for short-term prophylaxis of hereditary angioedema.

**Dose of intramuscular injection of adrenaline (epinephrine) for the emergency treatment of anaphylaxis by healthcare professionals**

<table>
<thead>
<tr>
<th>Age</th>
<th>Dose</th>
<th>Volume of adrenaline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1 month–5 years</td>
<td>150 micrograms</td>
<td>0.15 mL 1 in 1000 (1 mg/mL) adrenaline¹</td>
</tr>
<tr>
<td>Child 6–11 years</td>
<td>300 micrograms</td>
<td>0.3 mL 1 in 1000 (1 mg/mL) adrenaline²</td>
</tr>
<tr>
<td>Child 12–17 years</td>
<td>500 micrograms</td>
<td>0.5 mL 1 in 1000 (1 mg/mL) adrenaline²</td>
</tr>
</tbody>
</table>

These doses may be repeated several times if necessary at 5-minute intervals according to blood pressure, pulse and respiratory function.

1. Use suitable syringe for measuring small volume
2. 300 micrograms (0.3 mL) if child is small or prepubertal

**ANTIHISTAMINES > NON-SEDATING**

**Acrivastine**

- **INDICATIONS AND DOSE**
  Symptomatic relief of allergy such as hay fever, chronic idiopathic urticaria
  - **BY MOUTH**
  - Child 12–17 years: 8 mg 3 times a day

- **CONTRA-INDICATIONS**
  Avoid in Acute porphyrias p. 624

- **INTERACTIONS** → Appendix 1: antihistamines, non-sedating

- **SIDE-EFFECTS**
  - **Common or very common** Drowsiness - dry mouth

SIDE-EFFECTS, FURTHER INFORMATION Non-sedating antihistamines such as acrivastine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

- **PREGNANCY**
  - Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.

- **BREAST FEEDING**
  - Avoid—no information available. Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

- **DIRECTIONS FOR ADMINISTRATION**
  Take tablet 1 hour before or 2 hours after food or fruit juice.

- **PATIENT AND CARER ADVICE**
  Patients or carers should be given advice on how to administer bilastine tablets.

- **Driving and skilled tasks**
  Although drowsiness is rare, nevertheless patients should be advised that it can occur and may affect performance of skilled tasks (e.g. cycling or driving); alcohol should be avoided.

- **MEDICINAL FORMS**
  There can be variation in the licensing of different medicines containing the same drug.

**Capsule**

- **Benadryl Allergy Relief** (McNeil Products Ltd)
  - Acrivastine 8 mg
  - Benadryl Allergy Relief 8mg capsules
  - 24 capsule £5.45 | 48 capsule £9.31

**Bilastine**

- **INDICATIONS AND DOSE**
  Symptomatic relief of allergic rhinoconjunctivitis and urticaria
  - **BY MOUTH**
  - Child 12–17 years: 20 mg once daily

- **CONTRA-INDICATIONS**
  Avoid in Acute porphyrias p. 624

- **INTERACTIONS** → Appendix 1: antihistamines, non-sedating

- **SIDE-EFFECTS**
  - **Common or very common** Drowsiness - headache
  - **Uncommon** Anxiety - appetite increased - asthenia - bundle branch block - diarrhoea - dry mouth - dyspnoea - fever - gastritis - gastrointestinal discomfort - insomnia - nasal complaints - nausea - oral herpes - pre-existing condition improved - pruritus - QT interval prolongation - sinus arrhythmia - thirst - tinnitus - vertigo - weight increased

SIDE-EFFECTS, FURTHER INFORMATION Non-sedating antihistamines such as bilastine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

**Cetirizine hydrochloride**

- **INDICATIONS AND DOSE**
  Symptomatic relief of allergy such as hay fever, chronic idiopathic urticaria, atopic dermatitis
  - **BY MOUTH**
  - Child 1 year: 250 micrograms/kg twice daily
  - Child 2–5 years: 2.5 mg twice daily
  - Child 6–11 years: 5 mg twice daily
  - Child 12–17 years: 10 mg once daily
Desloratadine

INDICATIONS AND DOSE
Symptomatic relief of allergy such as allergic rhinitis, urticaria, chronic idiopathic urticaria

BY MOUTH
Child 1-5 years: 1.25 mg once daily
Child 6-11 years: 2.5 mg once daily
Child 12-17 years: 5 mg once daily

PHARMACOKINETICS
Desloratadine is a metabolite of loratadine.

INTERACTIONS → Appendix 1: antihistamines, non-sedating

SIDE-EFFECTS
Common or very common Asthenia · dry mouth · headache
Rare or very rare Akathisia · arrhythmias · diarrhoea · dizziness · drowsiness · gastrointestinal discomfort · hallucination · hepatic disorders · insomnia · myalgia · nausea · palpitations · seizure · vomiting
Frequency not known Behaviour abnormal · photosensitivity reaction · QT interval prolongation

INTERACTIONS → Appendix 1: antihistamines, non-sedating

SIDE-EFFECTS
Uncommon Agitation · asthenia · diarrhoea · malaise · paraesthesia · skin reactions
Rare or very rare Aggression · angioedema · confusion · depression · hallucination · hepatic function abnormal · insomnia · movement disorders · ocuolgyration · oedema · seizure · syncope · tachycardia · taste altered · thrombocytopenia · tic · tremor · urinary disorders · vision disorders · weight increased

Frequency not known Abdominal pain · appetite increased · dizziness · drowsiness · dry mouth · headache · memory loss · nausea · pharyngitis · suicidal ideation · vertigo

SIDE-EFFECTS, FURTHER INFORMATION
Non-sedating antihistamines such as cetirizine hydrochloride cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

PREGNANCY
Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.

BREAST FEEDING
Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

RARE IMPAIRMENT
Avoid if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

Dose adjustments
Use half normal dose if estimated glomerular filtration rate 30–50 mL/minute/1.73 m².

Use half normal dose and reduce dose frequency to alternate days if estimated glomerular filtration rate 10–30 mL/minute/1.73 m².

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Cetirizine for hay fever

Driving and skilled tasks
Although drowsiness is rare, nevertheless patients should be advised that it can occur and may affect performance of skilled tasks (e.g. cycling or driving); alcohol should be avoided.

PROFESSION SPECIFIC INFORMATION
Dental practitioners’ formulary
Cetirizine Tablets 10 mg may be prescribed.

Cetirizine Oral Solution 5 mg/5 mL may be prescribed.

■ MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Oral solution
EXCIPIENTS: May contain Propylene glycol, sorbitol

■ Desloratadine (Non-proprietary)
Desloratadine 500 microgram per 1 ml
Cetirizine hydrochloride 1 mg per 1 ml
Cetirizine 1mg/ml oral solution sugar-free sugar-free | 200 ml (PO) £1.12 DT = £1.12

■ Tablet
Cetirizine hydrochloride (Non-proprietary)

Cetirizine hydrochloride 10 mg
Cetirizine 10mg tablets | 30 tablet (PO) £0.85–0.86 DT = £0.86

Cetirizine hydrochloride 10 mg
Benadryl Allergy Liquid Release 10mg capsules | 7 capsule (PO) £3.09 DT = £3.09

■ Capsule
Benadryl Allergy (McNeil Products Ltd)
Cetirizine hydrochloride 10 mg
Benadryl Allergy Liquid Release 10mg capsules | 7 capsule (PO) £3.09 DT = £3.09
Fexofenadine hydrochloride 22-May-2017

**INDICATIONS AND DOSE**
Symptomatic relief of seasonal allergic rhinitis
- **BY MOUTH**
  - Child 6-11 years: 30 mg twice daily
  - Child 12-17 years: 120 mg once daily
Symptomatic relief of chronic idiopathic urticaria
- **BY MOUTH**
  - Child 12-17 years: 180 mg once daily

**PHARMAKINETICS**
Fexofenadine is a metabolite of terfenadine.

**INTERACTIONS**
Appendix 1: antihistamines, non-sedating

**SIDE-EFFECTS**
- Common or very common: Dizziness, drowsiness, headache, nausea
- Uncommon: Fatigue
- Frequency not known: Diarrhoea, nervousness
- Palpitations, skin reactions, sleep disorders, tachycardia

**INTERACTIONS, FURTHER INFORMATION**
Non-sedating antihistamines such as fexofenadine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

**PREGNANCY**
Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.

**BREAST FEEDING**
Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

**SIDE-EFFECTS, FURTHER INFORMATION**
Non-sedating antihistamines such as levocetirizine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

**PREGNANCY**
Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.

**BREAST FEEDING**
Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

**RENAI IMPAIRMENT**
Avoid if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

**Dose adjustments**
Reduce dose frequency to every 2 days if estimated glomerular filtration rate 30–50 mL/minute/1.73 m².
Reduce dose frequency to every 3 days if estimated glomerular filtration rate 10–30 mL/minute/1.73 m².

**PATIENT AND CARER ADVICE**
Driving and skilled tasks: Although drowsiness is rare, nevertheless patients should be advised that it can occur and may affect performance of skilled tasks (e.g. cycling or driving); alcohol should be avoided.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

<table>
<thead>
<tr>
<th>Tablet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levocetirizine dihydrochloride 500 microgram per 1 ml Xyzal 0.5mg/ml oral solution sugar-free</td>
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<tr>
<td>Xyzal (UCB Pharma Ltd)</td>
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<tr>
<td>Xypazil (UCB Pharma Ltd)</td>
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<td>Levocetirizine dihydrochloride 500 microgram per 1 ml Xyzal 5mg tablets 60 tablet</td>
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<td>Xypazil (UCB Pharma Ltd)</td>
</tr>
</tbody>
</table>

Levocetirizine dihydrochloride 24-May-2017

**INDICATIONS AND DOSE**
Symptomatic relief of allergy such as hay fever, chronic idiopathic urticaria
- **BY MOUTH**
  - Child 2-11 years (body-weight up to 31 kg): 5 mg once daily
  - Child 2-11 years (body-weight 31 kg and above): 10 mg once daily
  - Child 12-17 years: 10 mg once daily

**INTERACTIONS**
Appendix 1: antihistamines, non-sedating

**SIDE-EFFECTS**
- Common or very common: Drowsiness, fatigue, headache, nervousness
- Uncommon: Appetite increased, insomnia

Loratadine 22-May-2017

**INDICATIONS AND DOSE**
Symptomatic relief of allergy such as hay fever, chronic idiopathic urticaria
- **BY MOUTH**
  - Child 2-11 years (body-weight up to 31 kg): 5 mg once daily
  - Child 2-11 years (body-weight 31 kg and above): 10 mg once daily
  - Child 12-17 years: 10 mg once daily
Rare or very rare Hypersensitivity

Frequency not known Asthma exacerbated - bronchospasm
- QT interval prolongation

SIDE-EFFECTS, FURTHER INFORMATION Non-sedating antihistamines such as mizolastine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

PREGNANCY Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.

BREAST FEEDING Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

HEPATIC IMPAIRMENT Manufacturer advises initial dose adjustment in severe hepatic impairment.

PATIENT AND CARER ADVICE
- Driving and skilled tasks: Although drowsiness is rare, nevertheless patients and their carers should be advised that it can occur and may affect performance of skilled tasks (e.g. cycling or driving); alcohol should be avoided.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Oral solution
- Loratadine (Non-proprietary)
  - Loratadine 1 mg per 1 ml Loratadine 5 mg/5 ml oral solution
  - 100 ml (P30) £1.95 DT + £1.55
  - Loratadine 5 mg/5 ml oral solution sugar free sugar-free
  - 100 ml (P30) N

Tablet
- Loratadine (Non-proprietary)
  - Loratadine 10 mg Loratadine 10 mg tablets | 30 tablet (P) £1.44 DT + £0.71
  - Claritin (Loratadine) (Bayer Plc)
  - Loratadine 10 mg Claritin Allergy 10 mg tablets | 60 tablet (P) £8.85

Oral lycopilisate
- Claritin (Loratadine) (Bayer Plc)
  - Loratadine 10 mg Claritin Rapid Allergy 10 mg tablets sugar-free
  - 10 tablet (G3) £3.24 DT + £3.24

Mizolastine

INDICATIONS AND DOSE
Symptomatic relief of allergy such as hay fever, urticaria
- BY MOUTH
  - Child 12-17 years: 10 mg once daily

CONTRA-INDICATIONS Cardiac disease - hypokalaemia - susceptibility to QT-interval prolongation

INTERACTIONS Appendix 1: antihistamines, non-sedating

SIDE-EFFECTS
Common or very common Appetite increased - asthenia
- diarrhoea - dizziness - drowsiness - dry mouth - gastrointestinal discomfort - headache - nausea - weight increased
- Uncommon Anxiety - arthropathies - arthralgia - depression - myalgia - palpitations

SIDE-EFFECTS, FURTHER INFORMATION Non-sedating antihistamines such as rupatadine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

PREGNANCY Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.

Rupatadine

DRUG ACTION Rupatadine is a second generation non-sedating antihistamine.

INDICATIONS AND DOSE
Symptomatic relief of allergic rhinitis and urticaria
- BY MOUTH USING TABLETS
  - Child 12-17 years: 10 mg once daily
  - BY MOUTH USING ORAL SOLUTION
  - Child 2-11 years (body-weight 10-24 kg): 2.5 mg once daily
  - Child 2-11 years (body-weight 25 kg and above): 5 mg once daily

CAUTIONS History of QT-interval prolongation - predisposition to arrhythmia - uncorrected hypokalaemia

INTERACTIONS Appendix 1: antihistamines, non-sedating

SIDE-EFFECTS
Common or very common Asthenia - dizziness - drowsiness - dry mouth - headache
- Uncommon Appetite increased - arthralgia - back pain - concentration impaired - constipation - cough - diarrhoea - dry throat - eosinophilia - epistaxis - fever - gastrointestinal discomfort - increased risk of infection - irritability - malaise - myalgia - nasal dryness - nausea - neutropenia - night sweats - oropharyngeal pain - skin reactions - thirst - vomiting - weight increased
- Rare or very rare Palpitations - tachycardia

SIDE-EFFECTS, FURTHER INFORMATION Non-sedating antihistamines such as rupatadine cause less sedation and psychomotor impairment than the older antihistamines, but can still occur; sedation is generally minimal. This is because non-sedating antihistamines penetrate the blood brain barrier to a much lesser extent.

PREGNANCY Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity.
BREAST FEEDING  Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

HEPATIC IMPAIRMENT  Manufacturer advises avoid (no information available).

RENAL IMPAIRMENT  Manufacturer advises avoid—no information available.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Oral solution
- Rupatadine (Non-proprietary)
  Rupatadine (as Rupatadine fumarate) 1 mg per 1 ml Rupatadine 1mg/ml oral solution | 120 ml (PO) £17.95

Tablet
- Rupatadine (Non-proprietary)
  Rupatadine (as Rupatadine fumarate) 10 mg  Rupatadine 10mg tablets | 30 tablet (PO) £30.00

SIDE-EFFECTS, FURTHER INFORMATION  Drowsiness may diminish after a few days.

Patients on high dosage may develop photosensitivity and should avoid exposure to direct sunlight.

Children are more susceptible to side-effects.

PREGNANCY  Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity. Use in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitability, and tremor.

BREAST FEEDING  Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

HEPATIC IMPAIRMENT  Manufacturer advises avoid—no information available.

RENAL IMPAIRMENT  Manufacturer advises avoid—no information available.

CAUTIONARY AND ADVISORY LABELS

Driving and skilled tasks  Drowsiness may affect performance of skilled tasks (e.g. cycling or driving); sedating effects enhanced by alcohol.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

Oral solution
- Alimemazine tartrate (Non-proprietary)
  Alimemazine tartrate 1.5 mg per 1 ml
  Alimemazine tartrate 6 mg per 1 ml

Tablet
- Alimemazine tartrate (Non-proprietary)
  Alimemazine tartrate 10 mg Alimemazine 10mg tablets | 28 tablet (PO) £112.85

INDICATIONS AND DOSE  Urticaria | Pruritus

BY MOUTH
- Child 6 months—1 year (specialist use only): 250 micrograms/kg 3–4 times a day (max. per dose 2.5 mg)
- Child 2–4 years: 2.5 mg 3–4 times a day
- Child 5–11 years: 5 mg 3–4 times a day
- Child 12–17 years: 10 mg 2–3 times a day, in severe cases up to maximum daily dose has been used; maximum 100 mg per day

Premedication to anaesthesia

BY MOUTH
- Child 2–6 years: Up to 2 mg/kg, to be given 1–2 hours before operation

UNLICENSED USE  Not licensed for use in children under 2 years.

CONTRA-INDICATIONS  Children under 2 years except on specialist advice (safety of such use has not been established) - epilepsy - hepatic dysfunction - history of narrow angle glaucoma - hypothyroidism - myasthenia gravis - neonate (due to significant antimuscarinic activity) (in neonates) - Parkinson’s disease - phaeochromocytoma - renal dysfunction

CAUTIONS  Cardiovascular diseases (due to tachycardia-inducing and hypotensive effects of phenothiazines) - exposure to sunlight should be avoided during treatment with high doses - pyloroduodenal obstruction - urinary retention - volume depleted patients who are more susceptible to orthostatic hypotension

INTERACTIONS  → Appendix 1: antihistamines, sedating

SIDE-EFFECTS  Agitation - agranulocytosis - amenorrhoea - ativoventricular block - autonomic dysfunction - bile thrombus - consciousness impaired - drug fever - dry mouth - eosinophilia - erectile dysfunction - eye disorder - galactorrhoea - gynaecomastia - hepatic disorders - hyperprolactinaemia - hyperthermia - hypotension - insomnia - leucopenia (on prolonged high dose) - movement disorders - muscle rigidity - nasal congestion - neuroleptic malignant syndrome - pallor - parkinsonism - photosensitivity reaction - postural hypotension (more common in the elderly or in volume depletion) - QT interval prolongation - respiratory depression - seizure - skin reactions - tardive dyskinesia (more common after long term high doses) - tremor - ventricular fibrillation

INCREDIBLE RISK THEMED ON PROLONGED INHALE - HYPOKALAMIA AND CARDIO- DEPRESSANTS

Chlorphenamine maleate

ICHORPHENAMINE MALEATE  (Chlorpheniramine maleate)
Emergency treatment of anaphylactic reactions

- **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
  - Child 1-5 months: 250 micrograms/kg (max. per dose 2.5 mg), repeated if necessary; maximum 4 doses per day
  - Child 6 months-5 years: 2.5 mg, repeated if necessary; maximum 4 doses per day
  - Child 6-11 years: 5 mg, repeated if necessary; maximum 4 doses per day
  - Child 12-17 years: 10 mg, repeated if necessary; maximum 4 doses per day

Driving and skilled tasks  Drowsiness may affect performance of skilled tasks (e.g. cycling or driving); sedating effects enhanced by alcohol.

**PROFESSION SPECIFIC INFORMATION**

Dental practitioners’ formulary  Chlorphenamine tablets may be prescribed. Chlorphenamine oral solution may be prescribed.

**EXCEPTIONS TO LEGAL CATEGORY**

- With intramuscular use or intravenous use Prescription only medicine restriction does not apply to chlorphenamine injection where administration is for saving life in emergency.

**MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

**Solution for injection**

- Chlorphenamine maleate (Non-proprietary)
  - Chlorphenamine maleate 400 microgram per 1 ml Chlorphenamine 10mg/1ml solution for injection ampoules | 5 ampoule £22.48-
  - Allerlie (Crescent Pharma Ltd)
    - Chlorphenamine maleate 400 microgram per 1 ml Allerlie 2mg/5ml oral solution sugar-free | 150 ml £2.78 DT + £2.21
  - Piriton (GlaxoSmithKline Consumer Healthcare)
    - Chlorphenamine maleate 400 microgram per 1 ml Piriton 2mg/5ml syrup | 150 ml £2.78 DT + £2.78

**Oral solution**

**CAUTIONARY AND ADVISORY LABELS 2**

- Chlorphenamine maleate (Non-proprietary)
  - Chlorphenamine maleate 400 microgram per 1 ml Chlorphenamine 2mg/5ml oral solution sugar free sugar-free | 150 ml £2.78 DT + £2.21
  - Allerlie (Crescent Pharma Ltd)
    - Chlorphenamine maleate 400 microgram per 1 ml Allerlie 2mg/5ml oral solution sugar-free | 150 ml £2.21 DT + £2.21
  - Piriton (GlaxoSmithKline Consumer Healthcare)
    - Chlorphenamine maleate 400 microgram per 1 ml Piriton 2mg/5ml syrup | 150 ml £2.78 DT + £2.78

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 2**

- Chlorphenamine maleate (Non-proprietary)
  - Chlorphenamine maleate 4 mg Chlorphenamine 4mg tablets | 28 tablet £1.00 DT + £0.76
  - Allerlie (Crescent Pharma Ltd)
    - Chlorphenamine maleate 4 mg Allerlie 4mg tablets | 28 tablet £1.74 DT + £0.76
  - Hayleve (Genesis Pharmaceuticals Ltd)
    - Chlorphenamine maleate 4 mg Hayleve 4mg tablets | 28 tablet £0.76 DT + £0.76
  - Piriton (GlaxoSmithKline Consumer Healthcare)
    - Chlorphenamine maleate 4 mg Piriton 4mg tablets | 500 tablet £6.96
    - Piriton Allergy 4mg tablets | 30 tablet £2.06 | 60 tablet £3.73
  - Pollenase (chlorphenamine) (EM Pharma)
    - Chlorphenamine maleate 4 mg Pollenase Antihistamine 4mg tablets | 30 tablet £1.00

**Hydroxyzine hydrochloride**

- **INDICATIONS AND DOSE**
  - **Pruritus**
    - **BY MOUTH**
      - Child 6 months–5 years: 5–15 mg daily in divided doses, dose adjusted according to weight; maximum 2 mg/kg per day
      - Child 6-17 years (body-weight up to 40 kg): Initially 15–25 mg daily in divided doses, dose increased as necessary, adjusted according to weight; maximum 2 mg/kg per day
      - Child 6-17 years (body-weight 40 kg and above): Initially 15–25 mg daily in divided doses, increased continued →
Respiratory system

Frequency not known

SIDE-EFFECTS

CAUTIONS

CONTRA-INDICATIONS

Hydroxyzine is contra-indicated in patients with
predisposition to QT interval prolongation — including
atrial fibrillation, valve disease, or prior history of
ventricular arrhythmia. Hydroxyzine is also contra-
indicated in patients with QT prolongation
(>500ms) — include signiﬁcant electrolyte imbalance,
prolongation of the QT interval due to concurrent
administration of other medicines that effect the QT
interval, or signiﬁcant electrolyte imbalance,
especially hypokalaemia or hypomagnesaemia.

Hydroxyzine may also cause QT interval
prolongation and torsade de pointes; these events
are most likely to occur in patients who have risk
factors for QT prolongation, e.g. concomitant use of
drugs that prolong the QT interval, cardiovascular
disease, family history of sudden cardiac death,
signiﬁcant electrolyte imbalance (low plasma-potassium
or plasma-magnesium concentrations), or signiﬁcant
bradycardia.

To minimise the risk of such adverse effects, the
following dose restrictions have been made and new
cautions and contra-indications added:

- Hydroxyzine is contra-indicated in patients with
prolonged QT-interval or who have risk factors for QT-
interval prolongation;
- Consider the risks of QT-interval prolongation and
torsade de points before prescribing to patients
taking drugs that lower heart rate or plasma-
potassium concentration;
- In children with body-weight up to 40 kg, the
maximum daily dose is 2 mg/kg;
- The lowest effective dose for the shortest period of
  time should be prescribed.

CONTRA-INDICATIONS

Acquired or congenital QT interval
prolongation — predisposition to QT interval prolongation

CONTRA-INDICATIONS, FURTHER INFORMATION

QT interval prolongation — Risk factors for QT interval
prolongation include signiﬁcant electrolyte imbalance,
bradycardia, cardiovascular disease, and family history of
sudden cardiac death.

CAUTIONS

Bladder outﬂow obstruction — breathing
problems — cardiovascular disease — children — decreased
gastrointestinal motility — dementia — epilepsy —
hypertension — hyperthyroidism — myasthenia gravis —
yloroduodenal obstruction — stenosing peptic ulcer —
susceptibility to angle-closure glaucoma — urinary
retention.

CAUTIONS, FURTHER INFORMATION

Children have an increased susceptibility to side-effects, particularly CNS
effects.

INTERACTIONS

Rare or very rare — Severe cutaneous adverse reactions
(SCARs) — skin reactions

Frequency not known — Agranulocytosis — alopecia —
anticholinergic syndrome — anxiety — appetite decreased —
arrhythmias — asthma — blood disorder — bronchial
secretion viscosity increased — chest tightness — chills —
coma — concentration impaired — confusion — constipation
— depression — diarrhoea — dizziness — drowsiness — dry mouth —
dry throat — dyskinesia (on discontinuation) — epigastric
pain — fever — flushing — gastrointestinal disorders —
haemolytic anaemia — hallucination — headache — hepatic
function abnormal — hyperhidrosis — hypotension —
irritability — labyrinthitis — leucopenia — malaise —
menstruation irregular — movement disorders — myalgia —
nasal congestion — nausea — palpitations — paraesthesia — QT
interval prolongation — respiratory disorders — respiratory
tract dryness — seizure (with high doses) — sexual
dysfunction — sleep disorders — speech slurred — taste bitter —
thrombocytopenia — tinnitus — tremor (with high doses) —
urinary disorders — vertigo — vision disorders — vomiting

SIDE-EFFECTS, FURTHER INFORMATION

Paradoxical stimulation may occur rarely, especially with high doses.
Drowsiness may diminish after a few days of treatment.

ALLERGY AND CROSS-SENSITIVITY

Hydroxyzine should be avoided in patients with previous
hypersensitivity to cetirizine or other piperazine
derivatives, and aminophylline.

PREGNANCY

Manufacturers advise avoid—toxicity in animal studies with higher doses. Use in the latter part of
the third trimester may cause irritability, paradoxical
excitability, and tremor in the neonate.

BREAST FEEDING

Manufacturers advise avoid—expected to be present in milk but effect unknown.

HEPATIC IMPAIRMENT

Manufacturers advise caution in mild to moderate impairment (increased risk of
accumulation); avoid in severe impairment.

Dose adjustments — Manufacturer advises dose reduction of
33% in mild to moderate impairment.

RENAL IMPAIRMENT

Dose adjustments — Manufacturers advise reduce daily dose
by half in moderate to severe renal impairment.

EFFECT ON LABORATORY TESTS

May interfere with methacholine test — manufacturer advises stop treatment
96 hours prior to test. May interfere with skin testing for
allergy—manufacturer advises stop treatment one week
prior to test.

PATIENT AND CARER ADVISE

Driving and skilled tasks — Drowsiness may affect
performance of skilled tasks (e.g. cycling or driving);
seating effects enhanced by alcohol.

MEDICINAL FORMS

There can be variation in the licensing of
different medicines containing the same drug. Forms available
from special-order manufacturers include: oral suspension, oral
solution

Tablet

CAUTIONARY AND ADVISORY LABELS

Hydroxyzine hydrochloride (Non-proprietary)

Hydroxyzine hydrochloride 10 mg Hydroxyzine 10mg tablets 84 tablet (P) £1.20–£1.65 DT = £1.65

Hydroxyzine hydrochloride 25 mg Hydroxyzine 25mg tablets 28 tablet (P) £0.62–£0.85 DT = £0.85

Atarax (Alliance Pharmaceuticals Ltd)

Hydroxyzine hydrochloride 10 mg Atarax 10mg tablets 84 tablet (P) £1.20 DT = £1.65

Hydroxyzine hydrochloride 25 mg Atarax 25mg tablets 28 tablet (P) £0.62–£0.85

Ketotifen

INDICATIONS AND DOSE

Allergic rhinitis

BY MOUTH

Child 3–17 years: 1 mg twice daily

CONTRA-INDICATIONS

Avoid in Acute porphyrias p. 624—
neonate (due to signiﬁcant antimuscarinic activity)

CAUTIONS

Epilepsy — pyloroduodenal obstruction —
susceptibility to angle-closure glaucoma — urinary
retention

INTERACTIONS

Rare or very rare — Anxiety — insomnia — irritability

Uncommon — Cystitis — dizziness — dry mouth — skin reactions

SIDE-EFFECTS

Common or very common — Antihistamines, sedating

SIDE-EFFECTS, FURTHER INFORMATION

Drowsiness is a significant side-effect with most of the older
antihistamines although paradoxical stimulation may
occurs rarely, especially with high doses. Drowsiness may diminish after a few days of treatment and is considerably less of a problem with the newer antihistamines.

### PREGNANCY
Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity. Use in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitation, and tremor.

### BREAST FEEDING
Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

### PATIENT AND CARER ADVICE
Driving and skilled tasks: Drowsiness may affect performance of skilled tasks (e.g. driving or cycling); sedating effects enhanced by alcohol.

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution.

<table>
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<tr>
<th>Oral solution</th>
<th>CAUTIONARY AND ADVISORY LABELS: 2, 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zaditen (CD Pharma Srl)</td>
<td>Ketotifen (as Ketotifen fumarate) 200 microgram per ml Zaditen 1mg/5ml elixir sugar-free</td>
</tr>
<tr>
<td>Tablet</td>
<td>CAUTIONARY AND ADVISORY LABELS: 2, 21</td>
</tr>
<tr>
<td>Zaditen (CD Pharma Srl)</td>
<td>Ketotifen (as Ketotifen fumarate) 1 mg</td>
</tr>
</tbody>
</table>

### Promethazine hydrochloride

#### INDICATIONS AND DOSE
Symptomatic relief of allergy such as hay fever and urticaria | Insomnia associated with urticaria and pruritus

- **BY MOUTH**
  - Child 2–4 years: 5 mg twice daily, alternatively 5–15 mg once daily, dose to be taken at night
  - Child 5–9 years: 5–10 mg twice daily, alternatively 10–25 mg once daily, dose to be taken at night
  - Child 10–17 years: 10–20 mg 2–3 times a day, alternatively 25 mg once daily, dose to be taken at night, increased if necessary to 25 mg twice daily

**Sedation (short-term use)**

- **BY MOUTH**
  - Child 2–4 years: 15–20 mg
  - Child 5–9 years: 20–25 mg
  - Child 10–17 years: 25–50 mg

**Sedation in intensive care**

- **BY MOUTH, OR BY SLOW INTRAVENOUS INJECTION, OR BY DEEP INTRAMUSCULAR INJECTION**
  - Child 1 month–11 years: 0.5–1 mg/kg 4 times a day (max. per dose 25 mg), adjusted according to response
  - Child 12–17 years: 25–50 mg 4 times a day, adjusted according to response

**Nausea, Vomiting, Vertigo, Labyrinthine disorders, Motion sickness**

- **BY MOUTH**
  - Child 2–4 years: 5 mg, to be taken at bedtime on night before travel, repeat following morning if necessary
  - Child 5–9 years: 10 mg, to be taken at bedtime on night before travel, repeat following morning if necessary
  - Child 10–17 years: 20–25 mg, to be taken at bedtime on night before travel, repeat following morning if necessary

### IMPORTANT SAFETY INFORMATION

**MHRA/CHM ADVICE (MARCH 2008 AND FEBRUARY 2009) OVER-THE-COUNTER COUGH AND COLD MEDICINES FOR CHILDREN**

**Child 6 years** should not be given over-the-counter cough and cold medicines containing promethazine.

**CONTRA-INDICATIONS**
Neonate (due to significant antimuscarinic activity) should not be given to children under 2 years, except on specialist advice, because the safety of such use has not been established.

### CAUTIONS

#### GENERAL CAUTIONS
Epilepsy: pyloroduodenal obstruction; severe coronary artery disease; susceptibility to angle-closure glaucoma; urinary retention

#### SPECIFIC CAUTIONS

- With intravenous use: Avoid extravasation with intravenous injection

### INTERACTIONS
Appendix 1: antihistamines, sedating

### SIDE-EFFECTS

#### GENERAL SIDE-EFFECTS

#### SPECIFIC SIDE-EFFECTS


### PREGNANCY
Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity. Use in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitation, and tremor.

### BREAST FEEDING
Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

### HEPATIC IMPAIRMENT
Manufacturer advises caution.

### RENAL IMPAIRMENT
Use with caution.

### PATIENT AND CARER ADVICE
Driving and skilled tasks: Drowsiness may affect the performance of skilled tasks (e.g. cycling or driving); sedating effects enhanced by alcohol.

### PROFESSIONAL SPECIFIC INFORMATION

**Dental practitioners’ Formulary**

Promethazine Hydrochloride Tablets 10 mg or 25 mg may be prescribed.

Promethazine Hydrochloride Oral Solution (elixir) 5 mg/5 ml may be prescribed.

### LESS SUITABLE FOR PRESCRIBING
Promethazine is less suitable for prescribing for sedation.

### EXCEPTIONS TO LEGAL CATEGORY
Prescription only medicine restriction does not apply to promethazine hydrochloride injection where administration is for saving life in emergency.
**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Solution for injection**

**EXCIPIENTS:** May contain Sulfites
- **Phenergan** (Sanofi)
  - Promethazine hydrochloride 25 mg per 1 ml Phenergan 25mg/1ml solution for injection ampoules | 10 ampoule (P) £6.74

**Oral solution**

**EXCIPIENTS:** May contain Sodium
- **Phenergan** (Sanofi)
  - Promethazine hydrochloride 1 mg per 1 ml Phenergan 5mg/5ml elixir sugar-free | 100 ml (P) £2.85 OT + £2.85

**Tablet**

**EXCIPIENTS AND ADVISORY LABELS** 2
- **Promethazine hydrochloride 10 mg** Promethazine hydrochloride 10mg tablets | 56 tablet (P) £3.56 OT + £3.41
- **Promethazine hydrochloride 25 mg** Promethazine hydrochloride 25mg tablets | 56 tablet (P) £4.65 OT + £4.65
- **Phenergan** (Sanofi)
  - Promethazine hydrochloride 10 mg Promethazine hydrochloride 10mg tablets | 56 tablet (P) £2.96 OT + £3.41
- **Promethazine hydrochloride 25 mg** Promethazine hydrochloride 25mg tablets | 56 tablet (P) £4.65 OT + £4.65
- **Somineic** (Teva UK Ltd)
  - Promethazine hydrochloride 20 mg Somineic 20mg tablets | 8 tablet (P) £1.89 | 16 tablet (P) £2.69

**VACCINES > ALLERGEN-TYPE**

**Grass pollen extract**

**INDICATIONS AND DOSE**
- **Hypersensitivity to bee venom**
  - **BY SUBCUTANEOUS INJECTION**
  - Child: (consult product literature)

**IMPORTANT SAFETY INFORMATION**

**DESENSITISING VACCINES**

In view of concerns about the safety of desensitising vaccines, it is recommended that they are used by specialists and only for the following indications:
- Seasonal allergic hay fever (caused by pollen) that has not responded to anti-allergic drugs;
- Hypersensitivity to wasp and bee venom.

Desensitising vaccines should generally be avoided or used with particular care in patients with asthma.

**CONTRA-INDICATIONS** Children under 5 years - consult product literature

**CAUTIONS** Consult product literature

**INTERACTIONS** → Appendix 1: bee venom extract

**SIDE-EFFECTS**

SIDE-EFFECTS, FURTHER INFORMATION Life-threatening hypersensitivity reactions can occur. Cardiopulmonary resuscitation must be immediately available. Manufacturer advises monitoring for at least 1 hour after injection.

**PREGNANCY** Avoid.

**PRESCRIBING AND DISPENSING INFORMATION** Each set of allergen extracts usually contains vials for the administration of graded amounts of allergen to patients undergoing desensitisation. Maintenance sets containing vials at the highest strength are also available. Product literature must be consulted for details of allergens, vial strengths, and administration.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

- **Pharmalgen®** for the treatment of bee and wasp venom allergy (February 2012) NICE TA246

Pharmalgen® is an option for the treatment of IgE-mediated bee and wasp venom allergy in those who have had:
- A severe systemic reaction to bee or wasp venom, or
- A moderate systemic reaction to bee or wasp venom and who have a raised baseline serum-tryptase concentration, a high risk of future stings, or anxiety about future stings.

Treatment with Pharmalgen® should be initiated and monitored in a specialist centre experienced in venom immunotherapy, www.nice.org.uk/guidance/ta246

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for solution for injection**

- **Bee Venom** (ALK-Abello Ltd)
  - **Bee venom 120 nanogram** Pharmalgen Bee Venom 120nanogram powder and solvent for solution for injection vials | 1 vial (P) £65
  - **Bee venom 1.2 microgram** Pharmalgen Bee Venom 1.2microgram powder and solvent for solution for injection vials | 1 vial (P) £2.65
  - **Bee venom 12 microgram** Pharmalgen Bee Venom 12microgram powder and solvent for solution for injection vials | 1 vial (P) £3.85
  - **Bee venom 120 microgram** Pharmalgen Bee Venom maintenance set 120microgram powder and solvent for solution for injection vials | 4 vial (P) £150.00

**INDICATIONS AND DOSE**

Treatment of seasonal allergic hay fever due to grass pollen in patients who have failed to respond to anti-allergy drugs

- **BY SUBCUTANEOUS INJECTION**
- Child: (consult product literature)

Treatment of seasonal allergic hay fever due to grass pollen in patients who have failed to respond to anti-allergy drugs (initiated under specialist supervision)

- **BY MOUTH**
  - Child 5-17 years: 1 tablet daily, treatment to be started at least 4 months before start of pollen season and continue for up to 3 years

**IMPORTANT SAFETY INFORMATION**

**DESENSITISING VACCINES**

In view of concerns about the safety of desensitising vaccines, it is recommended that they are used by specialists and only for the following indications:
- Seasonal allergic hay fever (caused by pollen) that has not responded to anti-allergic drugs;
- Hypersensitivity to wasp and bee venom.

Desensitising vaccines should generally be avoided or used with particular care in patients with asthma.

**CONTRA-INDICATIONS** Children under 5 years - consult product literature

**CAUTIONS** Consult product literature

**INTERACTIONS** → Appendix 1: grass pollen extract

**SIDE-EFFECTS**

SIDE-EFFECTS, FURTHER INFORMATION Hypersensitivity reactions to immunotherapy can be life-threatening; bronchospasm usually develops within 1 hour and anaphylaxis within 30 minutes of injection. Therefore, cardiopulmonary resuscitation must be immediately available and patients need to be monitored for at least 1 hour after injection. If symptoms or signs of hypersensitivity develop (e.g. rash, urticaria,
bronchospasm, faintness), even when mild, the patient should be observed until these have resolved completely.

- **PREGNANCY** Should be avoided in pregnant women—consult product literature.

- **MONITORING REQUIREMENTS** The first dose of grass pollen extract (Grazax®) should be taken under medical supervision and the patient should be monitored for 20–30 minutes.

- **DIRECTIONS FOR ADMINISTRATION** Oral lyophilisates should be placed under the tongue and allowed to disperse. Advise patient not to swallow for 1 minute, or eat or drink for 5 minutes after taking the tablet. The first should be taken under medical supervision and the patient should be monitored for 20–30 minutes.

- **PRESCRIBING AND DISPENSING INFORMATION** Each set of allergen extracts usually contains vials for the administration of graded amounts of allergen to patients undergoing hyposensitisation. Maintenance sets containing vials at the highest strength are also available. Product literature must be consulted for details of allergens, vial strengths, and administration.

- **PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer oral lyophilisates.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  **Suspension for Injection**
  - Pollinex Trees (Allergy Therapeutics (UK) Ltd)
  - Pollinex Grasses + Rye for injection treatment and extension course vials | 4 vial(£450.00)

  **Oral lyophilisate**
  - Grazax (ALK-Abello Ltd)
  - Phleum pratense 75,000 SQ-T Grazax 75,000 SQ-T oral lyophilisates sugar-free | 30 tablet(£80.12 DT = £80.12)

**Tree pollen extract**

- **INDICATIONS AND DOSE** Treatment of seasonal allergic hay fever due to tree pollen in patients who have failed to respond to anti-allergy drugs
  - **BY SUBCUTANEOUS INJECTION**
  - **Child:** (consult product literature)

**Wasp venom extract**

- **INDICATIONS AND DOSE**
  - Hypersensitivity to wasp venom
  - BY SUBCUTANEOUS INJECTION
  - Child: (consult product literature)

**DESENSITISING VACCINES**

In view of concerns about the safety of desensitising vaccines, it is recommended that they are used by specialists and only for the following indications:
- seasonal allergic hay fever (caused by pollen) that has not responded to anti-allergic drugs;
- hypersensitivity to wasp and bee venom.

Therapy should be observed until these have resolved completely.

- **CONTRA-INDICATIONS** Children under 5 years - consult product literature

- **CAUTIONS** Consult product literature

- **INTERACTIONS** Appendix 1: wasp venom extract

- **SIDE-EFFECTS**

  **FURTHER INFORMATION** Hypersensitivity reactions to wasp venom extracts can be life-threatening; cardiopulmonary resuscitation must be immediately available and patients need to be monitored for at least 1 hour after injection. If symptoms or signs of hypersensitivity develop (e.g. rash, urticaria, bronchospasm, faintness), even when mild, the patient should be observed until these have resolved completely.

- **PREGNANCY** Avoid.

**PRESCRIBING AND DISPENSING INFORMATION** Each set of allergen extracts usually contains vials for the administration of graded amounts of allergen to patients undergoing hyposensitisation. Maintenance sets containing vials at the highest strength are also available. Product literature must be consulted for details of allergens, vial strengths, and administration.

**CONTRA-INDICATIONS** Children under 5 years - consult product literature

**CAUTIONS** Consult product literature

**INTERACTIONS** Appendix 1: wasp venom extract

**SIDE-EFFECTS**

**FURTHER INFORMATION** Hypersensitivity reactions to wasp venom extracts can be life-threatening; cardiopulmonary resuscitation must be immediately available and patients need to be monitored for at least 1 hour after injection. If symptoms or signs of hypersensitivity develop (e.g. rash, urticaria, bronchospasm, faintness), even when mild, the patient should be observed until these have resolved completely.

- **PREGNANCY** Avoid.

**PRESCRIBING AND DISPENSING INFORMATION** Each set of allergen extracts usually contains vials for the administration of graded amounts of allergen to patients undergoing hyposensitisation. Maintenance sets containing vials at the highest strength are also available. Product literature must be consulted for details of allergens, vial strengths, and administration.

**NATIONAL FUNDING/ACCESS DECISIONS**

**Pharmalgen®** for bee and wasp venom allergy (February 2012) NICE TA246

Pharmalgen® is an option for the treatment of IgE-mediated bee and wasp venom allergy in those who have had:
- a severe systemic reaction to bee or wasp venom;
- a moderate systemic reaction to bee or wasp venom and who have a raised baseline serum-tryptase concentration, a high risk of future stings, or anxiety about future stings.
2.1 Angioedema

**DRUGS USED IN HEREDITARY ANGIOEDEMA**

**C1-esterase inhibitor**

**INDICATIONS AND DOSE**

**BERINERT®**

Acute attacks of hereditary angioedema (under expert supervision)
- **By slow intravenous injection, or by intravenous infusion**
  - Child: 20 units/kg

Short-term prophylaxis of hereditary angioedema before dental, medical, or surgical procedures (under expert supervision)
- **By slow intravenous injection, or by intravenous infusion**
  - Child: 15–30 units/kg (max. per dose 1000 units) for 1 dose; to be administered less than 6 hours before procedure

**CINRYZE®**

Acute attacks of hereditary angioedema (under expert supervision)
- **By slow intravenous injection**
  - Child 2–11 years (body-weight 10–25 kg): 500 units for 1 dose, dose may be repeated if necessary after 60 minutes
  - Child 2–11 years (body-weight 26 kg and above): 1000 units for 1 dose, dose may be repeated if necessary after 60 minutes
  - Child 12–17 years: 1000 units for 1 dose, dose may be repeated if necessary after 60 minutes (or sooner for patients experiencing laryngeal attacks if treatment initiation is delayed)

Short-term prophylaxis of hereditary angioedema before dental, medical, or surgical procedures (under expert supervision)
- **By slow intravenous injection**
  - Child 2–11 years (body-weight 10–25 kg): 500 units for 1 dose, to be administered up to 24 hours before procedure

**INTERACTIONS**

- Appendix 1: icatibant

**SIDE-EFFECTS**

- Rare or very rare: Dyspnoea, flushing, headache, hypotension, hypertension, hypotension, nausea, tachycardia, thrombosis (with high doses), urticaria

**PREGNANCY**

Manufacturer advises avoid unless essential.

**NATIONAL FUNDING/ACCESS DECISIONS**

**CINRYZE®**

All Wales Medicines Strategy Group (AWMSG) decisions

The All Wales Medicines Strategy Group has advised (October 2017) that C1-esterase inhibitor (Cinryze®) is recommended as an option for use within NHS Wales for the treatment and pre-procedure prevention of angioedema attacks in patients 2 years old and above, with hereditary angioedema (HAE); routine prevention of angioedema attacks in patients 6 years old and above, with severe and recurrent attacks of HAE, who are intolerant to or insufficiently protected by oral prevention treatments, or patients who are inadequately managed with repeated acute treatment.

**INTERACTIONS**

- Appendix 1: icatibant

**CAUTIONS**

- Vaccination against hepatitis A and hepatitis B may be required.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for solution for injection**

- **Wasp Venom** (ALK-Abello Ltd)
  - Wasp venom 120 nanogram: Pharmalgen Wasp Venom 120 nanogram powder and solvent for solution for injection vials | 1 vial (POM) £150.00
  - Wasp venom 1.2 microgram: Pharmalgen Wasp Venom 1.2 microgram powder and solvent for solution for injection vials | 1 vial (POM) £550.00
  - Wasp venom 12 microgram: Pharmalgen Wasp Venom 12 microgram powder and solvent for solution for injection vials | 1 vial (POM) £550.00
  - Wasp venom 120 microgram: Pharmalgen Wasp Venom 120 microgram powder and solvent for solution for injection vials | 1 vial (POM) £550.00

- **Berinert** (CSL Behring UK Ltd)
  - C1-esterase inhibitor 500 unit: Berinert 500 unit powder and solvent for solution for injection vials | 1 vial (POM) £550.00 DT = £650.00
  - C1-esterase inhibitor 1500 unit: Berinert 1500 unit powder and solvent for solution for injection vials | 1 vial (POM) £1,650.00 DT = £1,650.00

- **Cinryze (Shire Pharmaceuticals Ltd)**
  - C1-esterase inhibitor 500 unit: Cinryze 500 unit powder and solvent for solution for injection vials | 2 vials (POM) £1,336.00

**DRUGS USED IN HEREDITARY ANGIOEDEMA**

**SELECTIVE BRADYKININ B2 ANTAGONISTS**

**ICATIBANT**

**INDICATIONS AND DOSE**

Acute attacks of hereditary angioedema in patients with C1-esterase inhibitor deficiency
- **By subcutaneous injection**
  - Child 2–17 years (body-weight 12 kg and above): (consult product literature)

**INTERACTIONS**

- Appendix 1: icatibant

**CAUTIONS**

- Ischaemic heart disease - stroke
3 Conditions affecting sputum viscosity

MUCOLYTICS

Carbocisteine

• INDICATIONS AND DOSE
  Reduction of sputum viscosity
    • BY MOUTH
      • Child 2–4 years: 62.5–125 mg 4 times a day
      • Child 5–11 years: 250 mg 3 times a day
      • Child 12–17 years: Initially 2.25 g daily in divided doses, then reduced to 1.5 g daily in divided doses, as condition improves

IMPORTANT SAFETY INFORMATION
Mucodyne Paediatric® syrup 250 mg/5 mL has replaced the 125 mg/5 mL formulation—take care to ensure the appropriate dose is administered.

• CONTRA-INDICATIONS
• Active peptic ulceration
• CAUTIONS
• History of peptic ulceration (may disrupt the gastric mucosal barrier)
• SIDE-EFFECTS
• Gastrointestinal haemorrhage • skin reactions • Stevens-Johnson syndrome • vomiting
• PREGNANCY
• Manufacturer advises avoid in first trimester.
• BREAST FEEDING
• No information available.

PRESCRIBING AND DISPENSING INFORMATION
Flavours of oral liquid formulations may include cherry, raspberry, cinnamon, or rum.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Oral solution
- Carbocisteine (Non-proprietary)
  Carbocisteine 50 mg per 1 ml Carbocisteine 250 mg/5 mL oral solution | 300 mL (POS) £18.55 DT = £8.55
  Carbocisteine 75 mg per 1 ml Carbocisteine 750 mg/10 mL oral solution 10 mL sachets sugar free sugar-free | 15 sachet (POS) £3.85 DT = £3.85
- Mucodyne (Sanofi)
  Mucodyne 50 mg per 1 mL Mucodyne Paediatric 250 mg/5 mL syrup | 125 mL (POS) £12.60
  Mucodyne 250 mg/5 mL syrup | 300 mL (POS) £8.39 DT = £8.55

Capsule
- Carbocisteine (Non-proprietary)
  Carbocisteine 375 mg Carbocisteine 375 mg capsules | 120 capsule (POS) £18.96 DT = £4.60
- Mucodyne (Sanofi)
  Mucodyne 375 mg Mucodyne 375 mg capsules | 120 capsule (POS) £18.96 DT = £4.60

3.1 Cystic fibrosis

Cystic fibrosis

Description of condition
Cystic fibrosis is a genetic disorder affecting the lungs, pancreas, liver, intestine, and reproductive organs. The main clinical signs are pulmonary disease, with recurrent infections and the production of copious viscous sputum, and malabsorption due to pancreatic insufficiency. Other complications include hepatobiliary disease, osteoporosis, cystic fibrosis-related diabetes, and distal intestinal obstruction syndrome.

Aims of treatment
The aim of treatment includes preventing and managing lung infections, loosening and removing thick, sticky mucus from the lungs, preventing or treating intestinal obstruction, and providing sufficient nutrition and hydration.

Lung function is a key predictor of life expectancy in people with cystic fibrosis and optimising lung function is a major aim of care.

Non-drug treatment
Specialist physiotherapists should assess patients with cystic fibrosis and provide advice on airway clearance, nebuliser use, musculoskeletal disorders, physical activity, and urinary incontinence. The importance of airway clearance techniques should be discussed with patients and their parents or carers and appropriate training provided. Patients should be advised that regular exercise improves both lung function and overall fitness.

Drug treatment
Treatment for cystic fibrosis lung disease is based on the prevention of lung infection and the maintenance of lung function. In patients with cystic fibrosis, who have clinical evidence of lung disease, the frequency of routine review should be based on their clinical condition, but children should be reviewed at least every 8 weeks. More frequent review is required immediately after diagnosis and during early life.

Mucolytics
Patients with cystic fibrosis who have evidence of lung disease should be offered a mucolytic. Dornase alfa p. 189 is the first choice mucolytic (unlicensed in children under...
Conditions affecting sputum viscosity

Respiratory system

5 years of age. If there is an inadequate response, dornase alfa p. 189 and hypertonic sodium chloride p. 610, or hypertonic sodium chloride p. 610 alone should be considered.

Manitol dry powder for inhalation p. 143 should be considered for children [unlicensed indication] who cannot use dornase alfa p. 189 and hypertonic sodium chloride p. 610 because of ineligibility, intolerance, or inadequate response. 

Lumacaftor with ivacaftor p. 190 is not recommended for treating cystic fibrosis within its marketing authorisation (see lumacaftor with ivacaftor p. 190 National funding/access decisions).

Pulmonary infection

Staphylococcus aureus

Flucloxacillin p. 357 [unlicensed indication] should be offered for prophylaxis against Staphylococcus aureus infection in children from the point of diagnosis up to 3 years of age. Continuing prophylaxis in children up to 6 years of age should also be considered. An alternative oral antibacterial should be given in children allergic to penicillin.

In children who are already taking prophylaxis and have a respiratory sample culture that is positive for Staph. aureus, prophylaxis adherence should be reviewed and antibacterial treatment started. A prophylactic antibacterial should be restarted after treatment (consult local protocol). Patients who are not taking prophylaxis and have a new Staph. aureus infection can be given an oral anti- Staph. aureus antibacterial, if they are clinically well. If they are clinically unwell and have pulmonary disease, oral or intravenous (depending on infection severity) broad-spectrum antibacterials with activity against Staph. aureus should be given (consult local protocol).

A long-term antibacterial should be considered to suppress chronic Staph. aureus respiratory infection in patients whose pulmonary disease is stable. In patients with chronic Staph. aureus respiratory infection who become clinically unwell with pulmonary disease, oral or intravenous (depending on infection severity) broad-spectrum antibacterials with activity against Staph. aureus should be given. In those patients with new evidence of meticillin-resistant Staphylococcus aureus (MRSA) respiratory infection with or without pulmonary exacerbation, specialist microbiological advice should be sought. Antibacterials should not be routinely used to suppress chronic MRSA in patients with stable pulmonary disease.

If a patient with cystic fibrosis and chronic MRSA respiratory infection becomes unwell with a pulmonary exacerbation or shows a decline in pulmonary function, specialist microbiological advice should be sought. 

Pseudomonas aeruginosa

If a patient with cystic fibrosis develops a new Pseudomonas aeruginosa infection, eradication therapy with a course of oral antibacterial should be started (by intravenous injection, if they are clinically unwell), in combination with an inhaled antibacterial. An extended course of oral and inhaled antibacterial should follow (consult local protocol).

If eradication therapy is not successful, sustained treatment with an inhaled antibacterial should be offered. Nebulised colistimethate sodium p. 358 should be considered as first-line treatment (see also colistimethate sodium p. 358 by dry powder inhalation National funding/access decisions).

In patients with chronic Ps. aeruginosa infection (when treatment has not eradicated the infection) who become clinically unwell with pulmonary exacerbations, an oral antibacterial or a combination of two intravenous antibacterial drugs of different classes (depending on infection severity) should be used. Changing antibacterial regimens should be considered to treat exacerbations (consult local protocol).

Nebulised aztreonam p. 343, nebulised tobramycin p. 323, or tobramycin dry powder for inhalation p. 323 [unlicensed indication in child under 6 years] (see tobramycin p. 323 National funding/access decisions) should be considered for those who are deteriorating despite regular inhaled colistimethate sodium p. 358.

Burkholderia cepacia complex

[CGD] Patients who develop a new Burkholderia cepacia complex infection, should be given eradication therapy with a combination of intravenous antibacterial drugs (specialist microbiological advice should be sought on the choice of antibacterials). There is no evidence to support using antibacterials to suppress chronic Burkholderia cepacia complex infection in patients with cystic fibrosis who have stable pulmonary status.

Specialist microbiological advice should be sought for patients with chronic Burkholderia cepacia complex infection (when treatment has not eradicated the infection) and who become clinically unwell with a pulmonary disease exacerbation.

An inhaled antibacterial should be considered for those who have chronic Burkholderia cepacia complex infection and declining pulmonary status; treatment should be stopped if there is no observed benefit.

Haemophilus influenzae

Haemophilus influenzae infection in the absence of clinical evidence of pulmonary infection should be treated with an appropriate oral antibacterial drug. In those who are unwell with clinical evidence of pulmonary infection, an appropriate antibacterial should be given by mouth or intravenously depending on the severity of the illness (consult local protocol).

Non-tuberculous mycobacteria

Non-tuberculous mycobacterial eradication therapy should be considered for patients with cystic fibrosis who are clinically unwell and whose pulmonary disease has not responded to other recommended treatments. Specialist microbiological advice should be sought on the choice of antibacterial and on the duration of treatment.

Aspergillus fumigatus complex

Treatment with an antifungal drug should only be considered to suppress chronic Aspergillus fumigatus complex respiratory infection in patients with declining pulmonary status. Specialist microbiological advice should be sought on the choice of antifungal drug.

Unidentified infections

An oral or intravenous (depending on the exacerbation severity) broad-spectrum antibacterial should be used for patients who have a pulmonary disease exacerbation and no clear cause. If a causative pathogen is identified, an appropriate treatment should be selected (consult local protocol).

Immunomodulatory drugs

Long-term treatment with azithromycin p. 339 [unlicensed indication], at an immunomodulatory dose, should be offered to patients with deteriorating lung function or repeated pulmonary exacerbations. In those patients with continued deterioration in lung function or continuing pulmonary exacerbations, azithromycin p. 339 should be discontinued and the use of an oral corticosteroid considered.

Nutrition and exocrine pancreatic insufficiency

A cystic fibrosis specialist dietitian should offer advice on optimal nutrition.

Pancreatin p. 74 should be offered to patients with exocrine pancreatic insufficiency. Dose should be adjusted as needed to minimise any symptoms or signs of malabsorption (see Exocrine pancreatic insufficiency p. 73). An acid-suppressing drug, such as an H2 receptor antagonist or a
proton pump inhibitor [unlicensed indications] can be considered for patients who have persistent symptoms or signs of malabsorption.  

**Distal intestinal obstruction syndrome**

Oral or intravenous fluids should be offered to ensure adequate hydration for patients with distal intestinal obstruction syndrome. Meglumine amidotrizoate with sodium amidotrizoate solution p. 38 (orally or via an enteral tube) should be considered as first-line treatment for distal intestinal obstruction syndrome. An iso-osmotic polyethylene glycol electrolyte solution (macrogols) (orally or via an enteral tube) can be considered as a second-line treatment. Surgery is a last resort, if prolonged treatment with a polyethylene glycol solution is not effective. Suspected distal intestinal obstruction syndrome should be managed in a specialist cystic fibrosis centre.  

**Liver disease**

If liver function blood tests are abnormal in patients with cystic fibrosis, ursodeoxycholic acid p. 67 [unlicensed indication] can be given until liver function is restored.  

**Bone mineral density**

Patients should be monitored for cystic fibrosis-related low bone mineral density.  

**Cystic fibrosis-related diabetes**

Patients should be monitored for cystic fibrosis-related diabetes.  

**Useful Resources**

Cystic fibrosis: diagnosis and management. National Institute for Health and Care Excellence. NICE guideline 78. October 2017  

www.nice.org.uk/guidance/NG78

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**Dornase alfa**

(Phosphorylated glycosylated recombinant human deoxyribonuclease 1 (rhDNase))

**DRUG ACTION** Dornase alfa is a genetically engineered version of a naturally occurring human enzyme which cleaves extracellular deoxyribonucleic acid (DNA).

**INDICATIONS AND DOSE**

Management of cystic fibrosis patients with a forced vital capacity (FVC) of greater than 40% of predicted to improve pulmonary function

- **BY INHALATION OF NEBULISED SOLUTION**
- **Child 5-17 years: 2500 units once daily, administered by jet nebuliser**

**DOSE EQUIVALENCE AND CONVERSION**

Dornase alfa 1000 units is equivalent to 1 mg

**SIDE-EFFECTS** Chest pain · conjunctivitis · dyspepsia · dysphonia · dysphoena · fever · increased risk of infection · skin reactions

**PREGNANCY** No evidence of teratogenicity; manufacturer advises use only if potential benefit outweighs risk.

**BREAST FEEDING** Amount probably too small to be harmful—manufacturer advises caution.

**DIRECTIONS FOR ADMINISTRATION** Dornase alfa is administered by inhalation using a jet nebuliser, usually once daily at least 1 hour before physiotherapy; however, alternate-day therapy may be as effective as daily treatment. For use undiluted with jet nebulisers only; ultrasonic nebulisers are unsuitable.

**PRESCRIBING AND DISPENSING INFORMATION** Not all children benefit from treatment with dornase alfa; improvement occurs within 2 weeks, but in more severely affected children a trial of 6–12 weeks may be required.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Dornase alfa for cystic fibrosis  

www.medicinesforchildren.org.uk/dornase-alfa-cystic-fibrosis

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**Ivacaftor**

10-Apr-2019

**DRUG ACTION** Ivacaftor is a cystic fibrosis transmembrane conductance regulator (CFTR) protein potentiator that increases chloride transport in the abnormal CFTR protein.

**INDICATIONS AND DOSE**

Cystic fibrosis (specialist use only)

- **BY MOUTH**
  - Child 6–17 years (body-weight 25 kg and above): 150 mg every 12 hours

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- **Manufacturer advises reduce dose to 150 mg twice a week with concurrent use of potent inhibitors of CYP3A4.**
- **Manufacturer advises reduce dose to 150 mg once daily with concurrent use of moderate inhibitors of CYP3A4.**

**CONTRA-INDICATIONS** Organ transplantation (no information available)

**INTERACTIONS** →Appendix 1: ivacaftor

**SIDE-EFFECTS**

- **Common or very common** Breast abnormalities · diarrhoea · dizziness · ear discomfort · headache · ototoxicity · rash · tympanic membrane hyperaemia
- **Uncommon** Gynaecomastia
- **Frequency not known** Cataract · hepatic function abnormal

**SIDE-EFFECTS, FURTHER INFORMATION** Manufacturer advises interrupt treatment if transaminase levels more than 5 times the upper limit of normal or transaminase levels more than 3 times the upper limit of normal and blood bilirubin more than twice the upper limit of normal—consult product literature.

**PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk—limited information available.

**BREAST FEEDING** Manufacturer advises avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in moderate to severe impairment (limited information available).

**DOSE ADJUSTMENTS** Manufacturer advises reduce dose to 150 mg once daily in moderate impairment; in severe impairment reduce starting dose to 150 mg on alternate days, adjust dosing interval according to clinical response and tolerability.

**RENAL IMPAIRMENT** Caution in severe impairment.

**MONITORING REQUIREMENTS**

- Manufacturer advises monitor liver function before treatment, every 3 months during the first year of treatment, then annually thereafter (more frequent monitoring should be considered in patients with a history of transaminase elevations).
- Manufacturer advises baseline and follow-up ophthalmic examinations in children.

**DIRECTIONS FOR ADMINISTRATION** Tablets should be taken with fat-containing food.
PRESCRIBING AND DISPENSING INFORMATION Ivacaftor should be prescribed by a physician experienced in the treatment of cystic fibrosis.

PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer ivacaftor tablets.

Driving and skilled tasks Manufacturer advises that patients and their carers should be counselled on the effects on driving and skilled tasks—increased risk of dizziness.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Tablet CAUTIONARY AND ADVISORY LABELS 25
- Kalydeco (Vertex Pharmaceuticals (UK) Ltd) ▼
- Ivacaftor 150 mg Kalydeco 150mg tablets | 28 tablet [PBN] £7.00.00 | 56 tablet [PBN] £14.00.00

Lumacaftor with ivacaftor The properties listed below are those particular to the combination only. For the properties of the components please consider, ivacaftor p. 189.

INDICATIONS AND DOSE Cystic fibrosis (specialist use only)
- BY MOUTH
  - Child 6–11 years: 200/250 mg every 12 hours
  - Child 12–17 years: 400/250 mg every 12 hours

DOSE ADJUSTMENTS DUE TO INTERACTIONS
- For children aged 6–11 years, manufacturer advises reduce initial dose to 100/125 mg daily for the first week in those also taking a potent inhibitor of CYP3A4.
- For children aged 12–17 years, manufacturer advises reduce initial dose to 200/125 mg daily for the first week in those also taking a potent inhibitor of CYP3A4.

DOSE EQUIVALENCE AND CONVERSION
- Dose expressed as x/y mg of lumacaftor/ivacaftor.

CAUTIONS Forced expiratory volume in 1 second (FEV₁) less than 40% of the predicted normal value—additional monitoring required at initiation of treatment - pulmonary exacerbation—no information available

INTERACTIONS ➔ Appendix 1: Ivacaftor - lumacaftor

SIDE-EFFECTS
- Common or very common Breast abnormalities - diarrhoea - dizziness - ear discomfort - flatulence - headache - menstrual cycle irregularities - nausea - ototoxicity - rash - tympanic membrane hyperaemia - vomiting
- Uncommon Gynaecomastia - hepatic encephalopathy - hepatitis cholestatic - hypertension
- Frequency not known Cataract - chest pain

SIDE-EFFECTS, FURTHER INFORMATION Manufacturer advises interrupt treatment if transaminase levels more than 5 times the upper limit of normal or transaminase levels more than 3 times the upper limit of normal and blood bilirubin more than twice the upper limit of normal—consult product literature.

HEPATIC IMPAIRMENT Manufacturer advises caution in moderate to severe impairment (risk of increased exposure).

Dose adjustments For children aged 6–11 years, manufacturer advises dose reduction of evening dose to 100/125 mg in moderate impairment; in severe impairment, dose reduction to 100/125 mg every 12 hours is advised.

For children aged 12–17 years, manufacturer advises dose reduction of evening dose to 200/125 mg in moderate impairment; in severe impairment, dose reduction to 200/125 mg every 12 hours is advised.

PRE-TREATMENT SCREENING If the patient’s genotype is unknown, a validated genotyping method should be performed to confirm the presence of the F508del mutation on both alleles of the CFTR gene before starting treatment.

MONITORING REQUIREMENTS Manufacturer advises monitor blood pressure periodically during treatment.

EFFECT ON LABORATORY TESTS False positive urine screening tests for tetrahydrocannabinol have been reported—manufacturer advises consider alternative confirmatory method.

DIRECTIONS FOR ADMINISTRATION Tablets should be taken with fat-containing food.

PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer tablets.

Missed doses Manufacturer advises if a dose is more than 6 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions
- Lumacaftor with ivacaftor for treating cystic fibrosis homozygous for the F508del mutation (July 2016) NICE TA398
- Lumacaftor with ivacaftor (Orkambi™) is not recommended, within its marketing authorisation, for treating cystic fibrosis in patients aged 12 years and older who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
- Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they (or their carers) and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/ta398

Scottish Medicines Consortium (SMC) decisions
- SMC No. 1136/16
- The Scottish Medicines Consortium has advised (May 2016) that lumacaftor with ivacaftor (Orkambi™) is not recommended within NHS Scotland for the treatment of cystic fibrosis in patients aged 12 years and older who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene, as the economic case was not demonstrated.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Tablet CAUTIONARY AND ADVISORY LABELS 25
- Excipients: May contain Propylene glycol
- Orkambi (Vertex Pharmaceuticals (UK) Ltd) ▼
- Ivacaftor 125 mg, Lumacaftor 200 mg Orkambi 100mg/125mg tablets | 112 tablet [PBN] £8.00.00 (Hospital only)
- Ivacaftor 125 mg, Lumacaftor 200 mg Orkambi 200mg/125mg tablets | 112 tablet [PBN] £18.00.00 (Hospital only)

Tezacaftor with ivacaftor The properties listed below are those particular to the combination only. For the properties of the components please consider, ivacaftor p. 189.

INDICATIONS AND DOSE Cystic fibrosis (in combination with ivacaftor) (specialist use only)
- BY MOUTH
  - Child 12-17 years: 100/150 mg, to be taken in the morning and, Ivacaftor 150 mg to be taken in the evening

DOSE ADJUSTMENTS DUE TO INTERACTIONS
- With concurrent use of potent CYP3A4 inhibitors, manufacturer advises reduce dose to 100/150 mg
tezacaftor/ivacaftor twice a week, taken approximately 3–4 days apart; the evening dose of ivacaftor should not be taken.

With concurrent use of moderate CYP3A4 inhibitors, manufacturer advises reduce dose to 100/150 mg tezacaftor/ivacaftor every other morning, with ivacaftor 150 mg taken in the mornings alternate to tezacaftor/ivacaftor; the evening dose of ivacaftor should not be taken.

DOSE EQUIVALENCE AND CONVERSION

Combination dose expressed as x/y mg of tezacaftor/ivacaftor.

Cough preparations

Cough suppressants

Cough may be a symptom of an underlying disorder such as asthma, gastro-oesophageal reflux disease, or rhinitis, which should be addressed before prescribing cough suppressants. Cough may be associated with smoking or environmental pollutants. Cough can also result from bronchiectasis including that associated with cystic fibrosis; cough can also have a significant habit component. There is little evidence of any significant benefit from the use of cough suppressants in children with acute cough in ambulatory settings. Cough suppressants may cause sputum retention and this can be harmful in children with bronchiectasis.

The use of cough suppressants containing pholcodine p. 192 or similar opioid analgesics is not generally recommended in children and should be avoided in children under 6 years; the use of over-the-counter cough suppressants containing codeine phosphate p. 283 should be avoided in children under 12 years and in children of any age known to be CYP2D6 ultra-rapid metabolisers.

Sedating antihistamines are used as the cough suppressant component of many compound cough preparations on sale to the public; all tend to cause drowsiness which may reflect their main mode of action.

Demulcent and expectorant cough preparations

Simple linctus and other demulcent cough preparations containing soothing substances, such as syrup or glycerol, may temporarily relieve a dry irritating cough. These preparations have the advantage of being harmless and inexpensive and sugar-free versions are available.

Expectorants are claimed to promote expulsion of bronchial secretions, but there is no evidence that any drug can specifically facilitate expectoration.

An over-the-counter cough medicine containing the expectorant guaifenesin may be used for acute cough in children aged over 12 years; there is some evidence to suggest it may reduce symptoms.

Compound cough preparations for children are on sale to the public but should not be used in children under 6 years; the rationale for some is dubious. Care should be taken to give the correct dose and to not use more than one preparation at a time.

MHRA/CHM advice (March 2008 and February 2009)

Children under 6 years should not be given over-the-counter cough and cold medicines containing the following ingredients:

- brompheniramine, chlorphenamine maleate p. 180, diphenhydramine, doxylamine, promethazine, or tripolidine (antihistamines);
- dextromethorphan or pholcodine (cough suppressants);
- guaifenesin or ipecacuanha (expectorants);

Over-the-counter cough and cold medicines can be considered for children aged 6–12 years after basic principles of best care have been tried, but treatment should be restricted to five days or less. Children should not be given more than 1 cough or cold preparation at a time because different brands may contain the same active ingredient; care should be taken to give the correct dose.

Nasal decongestants, systemic

Nasal congestion in children due to allergic or vasomotor rhinitis should be treated with oral antihistamines, topical nasal preparations containing corticosteroids, or topical decongestants.

There is little evidence to support the use of systemic decongestants in children.
Pseudoephedrine hydrochloride has few sympathomimetic effects, and is commonly combined with other ingredients (including antihistamines) in preparations intended for the relief of cough and cold symptoms.

**COUGH AND COLD PREPARATIONS > COUGH SUPPRESSANTS**

**Pholcodine**

**INDICATIONS AND DOSE**

- **Dry cough**
  - BY MOUTH USING LIINCTUS
  - Child 6-11 years: 2–5 mg 3–4 times a day
  - Child 12-17 years: 5–10 mg 3–4 times a day

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE (MARCH 2008 AND FEBRUARY 2009) OVER-THE-COUNTER COUGH AND COLD MEDICINES FOR CHILDREN**

Children under 6 years should not be given over-the-counter cough and cold medicines containing pholcodine (cough suppressant).

Over-the-counter cough and cold medicines can be considered for children aged 6–12 years after basic principles of best care have been tried, but treatment should be restricted to 5 days or less. Children should not be given more than 1 cough or cold preparation at a time because different brands may contain the same active ingredient; care should be taken to give the correct dose.

- **CONTRA-INDICATIONS** Bronchiectasis - bronchiolitis - chronic bronchitis - patients at risk of respiratory failure
- **CAUTIONS** Asthma - chronic cough - persistent cough - productive cough
- **INTERACTIONS** → Appendix 1: pholcodine
- **SIDE-EFFECTS** Agitation - confusion - constipation - dizziness - drowsiness - gastrointestinal disorder - nausea - skin reactions - sputum retention - vomiting
- **PREGNANCY** Manufacturer advises avoid unless potential benefit outweighs risk.
- **BREAST FEEDING** Manufacturer advises avoid unless potential benefit outweighs risk—no information available.
- **HEPATIC IMPAIRMENT** Manufacturer advises caution; avoid in hepatic failure.
- **RENAL IMPAIRMENT** Use with caution in renal impairment. Avoid in severe renal impairment.
- **PRESCRIBING AND DISPENSING INFORMATION** Pholcodine is not generally recommended for children.

Flavours of oral liquid formulations may include orange. When prepared extemporaneously, the BP states Pholcodine Linctus, Strong, BP consists of pholcodine 10 mg/5 ml linctus sugar-free, BP which contains citric acid monohydrate 1% and Pholcodine Linctus, Strong, BP consists of pholcodine 10 mg/5 ml in a suitable flavoured vehicle, containing citric acid monohydrate 2%.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral solution**

- **Pholcodine (Non-proprietary)**
  - Pholcodine 1 mg per 1 ml Pholcodine 5mg/5ml linctus | 200 ml (P) £1.24+£1.32 DT = £2.21 (CD5)
  - Pholcodine 5mg/5ml linctus sugar-free sugar-free | 200 ml (P) £1.34 DT + £1.34 (CD5) sugar-free | 2000 ml (P) £11.40 (CD5)
  - Pholcodine 2 mg per 1 ml Pholcodine 10mg/5ml linctus strong sugar-free sugar-free | 2000 ml (P) £3.98 DT + £3.88 (CD5)
  - Pholcodine 10mg/5ml linctus strong | 200 ml (P) £1.67 DT = £1.67 (CD5)

**MENTHOL AND DERIVATIVES**

**Eucalyptus with menthol**

**INDICATIONS AND DOSE**

- **BY INHALATION**
  - Child: Add one teaspoonful to a pint of hot, not boiling, water and inhale the vapour

**PRESCRIBING AND DISPENSING INFORMATION** When prepared extemporaneously, the BP states Menthol and Eucalyptus Inhalation, BP 1980 consists of racementhol or levomenthol 2 g, eucalyptus oil 10 ml, light magnesium carbonate 7 g, water to 100 ml. Not recommended (applied as a rub or to pillows) for infants under the age of 3 months.

**PROFESSION SPECIFIC INFORMATION**

Dental practitioners’ formulary

Menthol and Eucalyptus Inhalation BP, 1980 may be prescribed.
Respiratory depression, respiratory distress syndrome and apnoea

Respiratory stimulants

Respiratory stimulants (analeptic drugs), such as caffeine citrate p. 194, reduce the frequency of neonatal apnoea, and the need for mechanical ventilation during the first 7 days of treatment. They are typically used in the management of very preterm neonates, and continued until a corrected gestational age of 24 to 35 weeks is reached (or longer if necessary). They should only be given under expert supervision in hospital; it is important to rule out any underlying disorder, such as seizures, hypoglycaemia, or infection, causing respiratory exhaustion before starting treatment with a respiratory stimulant.

Pulmonary surfactants

Pulmonary surfactants derived from animal lungs, beractant below and poractant alfa below are used to prevent and treat respiratory distress syndrome (hyaline membrane disease) in neonates and preterm neonates. Prophylactic use of a pulmonary surfactant may reduce the need for mechanical ventilation and is more effective than ‘rescue treatment’ in preterm neonates of 29 weeks or less corrected gestational age. Pulmonary surfactants may also be of benefit in neonates with meconium aspiration syndrome or intrapartum streptococcal infection. Pulmonary immaturity with surfactant deficit is the commonest reason for respiratory failure in the neonate, especially in those of less than 30 weeks corrected gestational age. Betamethasone p. 454 given to the mother (at least 12 hours but preferably 48 hours) before delivery substantially enhances pulmonary maturity in the neonate.

### Beractant

#### INDICATIONS AND DOSE
- **Treatment of respiratory distress syndrome in preterm neonates, birth-weight over 700 g (specialist use only)**
  - BY ENDOTRACHEAL TUBE
  - Preterm neonate: 100 mg/kg, preferably administer within 8 hours of birth; dose may be repeated within 48 hours at intervals of at least 6 hours for up to 4 doses.

#### Prophylaxis of respiratory distress syndrome in preterm neonates (specialist use only)
- BY ENDOTRACHEAL TUBE
  - Neonate up to 32 weeks corrected gestational age: 100 mg/kg, preferably administer within 15 minutes of birth; dose may be repeated within 48 hours at intervals of at least 6 hours for up to 4 doses.

#### DOSE EQUIVALENCE AND CONVERSION
- Phospholipid 100 mg/kg is equivalent to a volume of 4 mL/kg.

#### CAUTIONS
- Consult product literature

#### SIDE-EFFECTS
- Uncommon Endotracheal tube obstruction
- Frequency not known Bradycardia - hypoxia

### Poractant alfa

#### INDICATIONS AND DOSE
- **Treatment of respiratory distress syndrome in neonates, birth weight over 700 g (specialist use only)**
  - BY ENDOTRACHEAL TUBE
  - Neonate: 100–200 mg/kg, then 100 mg/kg every 12 hours if required, maximum 300–400 mg/kg per course.

#### Prophylaxis of respiratory distress syndrome (specialist use only)
- BY ENDOTRACHEAL TUBE
  - Neonate 24 weeks to 31 weeks corrected gestational age: 100–200 mg/kg, administer soon after birth, preferably within 15 minutes, then 100 mg/kg after 6–12 hours if required, then 100 mg/kg after 12 hours if required, and if neonate still intubated. Max 300–400 mg/kg per course.

#### CAUTIONS
- Consult product literature

#### SIDE-EFFECTS
- Rare or very rare Bradycardia - hypotension
- Frequency not known Hyperoxia
194 Respiratory depression, respiratory distress syndrome and apnoea

5.1 Neonatal apnoea

**XANTHINES**

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Liquid**
- Curosurf (Chiesi Ltd)
  - Poractant alfa 80 mg per 1 ml Curosurf 240mg/3ml endotracheopulmonary suspension vials | 1 vial £547.40 (Hospital only)
  - Curosurf 120mg/1.5ml endotracheopulmonary suspension vials | 1 vial £281.64 (Hospital only)

**INDICATIONS AND DOSE**

Neonatal apnoea (specialist supervision in hospital)

- **BY MOUTH, OR BY INTRAVENOUS INFUSION**
  - Neonate: Loading dose 20 mg/kg, then maintenance 5 mg/kg once daily, started 24 hours after the loading dose; increased if necessary up to 20 mg/kg daily, a maintenance dose above 20 mg/kg daily can be considered if therapeutic efficacy is not achieved—the plasma-caffeine concentration should be monitored to ensure that a safe level is maintained.

**DOSE EQUIVALENCE AND CONVERSION**
- Caffeine citrate 2 mg ≡ caffeine base 1 mg

**PHARMACOKINETICS**
- Caffeine citrate is well absorbed when given orally.

**UNLICENSED USE** Higher maintenance doses differ from product literature and adhere to national guidelines.

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: SAFE PRACTICE**

From August 2013, all licensed preparations of caffeine are required to be labelled as caffeine citrate. To minimise the risk of dosing errors, always state dose in terms of caffeine citrate when prescribing caffeine.

Some stock packaged as caffeine base.

**CAUTIONS** Cardiovascular disease • gastro-oesophageal reflux • rhythm disorder • seizure disorders

**INTERACTIONS** → Appendix 1: caffeine citrate

**SIDE-EFFECTS**
- Common or very common Arrhythmias • hyperglycaemia
- Uncommon Seizure
- Frequency not known Brain injury • deafness • failure to thrive • feeding intolerance • feeling jittery • gastrointestinal disorders • hypoglycaemia • increased cardiac output • irritability • regurgitation • restless legs

**HEPATIC IMPAIRMENT** Manufacturer advises caution (risk of increased frequency of side-effects).

**Dose adjustments** Manufacturer advises consider dose adjustment according to plasma-caffeine concentration.

**RENAL IMPAIRMENT** Manufacturer advises caution with impaired renal function—potential for accumulation of caffeine.

**Dose adjustments** Reduced daily maintenance dose required—consult product literature.

**MONITORING REQUIREMENTS**
- The therapeutic range for plasma-caffeine concentration is usually 10–20 mg/litre (50–100 micromol/litre), but a concentration of 25–35 mg/litre (130–180 micromol/litre) may be required. Signs of toxicity only normally occur at concentrations greater than 50 mg/litre (260 micromol/litre).
- Monitor for recurrence of apnoea for 1 week after stopping treatment.

**DIRECTIONS FOR ADMINISTRATION** Caffeine citrate injection may be administered by mouth or by intravenous infusion. For intravenous infusion, manufacturer advises giving load dose over 30 minutes and maintenance doses over 10 minutes.

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions
SMC No. B14/12
The Scottish Medicines Consortium has advised (September 2013) that Peyona® is accepted for use within NHS Scotland for the treatment of primary apnoea of premature newborns only whilst Peyona® is available at the price agreed in the patient access scheme.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Solution for injection**
- Caffeine citrate (Non-proprietary)
  - Caffeine citrate 10 mg per 1 ml Caffeine citrate 10mg/1ml solution for injection ampoules | 10 ampoule £48.82

**Solution for infusion**
- Peyona (Chiesi Ltd)
  - Caffeine citrate 20 mg per 1 ml Peyona 20mg/ml solution for infusion ampoules | 10 ampoule £172.50 (Hospital only)

**Oral solution**
- Caffeine citrate (Non-proprietary)
  - Caffeine citrate 10 mg per 1 ml Caffeine citrate 50mg/5ml oral solution | 5 ml £25.99 DT + £25.99

**DOSE EQUIVALENCE AND CONVERSION**
- Caffeine citrate 2 mg ≡ caffeine base 1 mg

**PHARMACOKINETICS**
- Caffeine citrate is well absorbed when given orally.

**UNLICENSED USE** Higher maintenance doses differ from product literature and adhere to national guidelines.

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: SAFE PRACTICE**

From August 2013, all licensed preparations of caffeine are required to be labelled as caffeine citrate. To minimise the risk of dosing errors, always state dose in terms of caffeine citrate when prescribing caffeine.

Some stock packaged as caffeine base.

**CAUTIONS** Cardiovascular disease • gastro-oesophageal reflux • rhythm disorder • seizure disorders

**INTERACTIONS** → Appendix 1: caffeine citrate

**SIDE-EFFECTS**
- Common or very common Arrhythmias • hyperglycaemia
- Uncommon Seizure
- Frequency not known Brain injury • deafness • failure to thrive • feeding intolerance • feeling jittery • gastrointestinal disorders • hypoglycaemia • increased cardiac output • irritability • regurgitation • restless legs

**HEPATIC IMPAIRMENT** Manufacturer advises caution (risk of increased frequency of side-effects).

**Dose adjustments** Manufacturer advises consider dose adjustment according to plasma-caffeine concentration.

**RENAL IMPAIRMENT** Manufacturer advises caution with impaired renal function—potential for accumulation of caffeine.

**Dose adjustments** Reduced daily maintenance dose required—consult product literature.

**MONITORING REQUIREMENTS**
- The therapeutic range for plasma-caffeine concentration is usually 10–20 mg/litre (50–100 micromol/litre), but a concentration of 25–35 mg/litre (130–180 micromol/litre) may be required. Signs of toxicity only normally occur at concentrations greater than 50 mg/litre (260 micromol/litre).
Chapter 4
Nervous system

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1 Epilepsy and other seizure disorders

Epilepsy

Epilepsy control

The object of treatment is to prevent the occurrence of seizures by maintaining an effective dose of one or more antiepileptic drugs. Careful adjustment of doses is necessary, starting with low doses and increasing gradually until seizures are controlled or there are significant adverse effects.

When choosing an antiepileptic drug, the presenting epilepsy syndrome should first be considered. If the syndrome is not clear, the seizure type should determine the choice of treatment. Concomitant medication, co-morbidity, age, and sex should also be taken into account.

The frequency of administration is often determined by the plasma-drug half-life, and should be kept as low as possible to encourage better adherence. Most antiepileptics, the plasma-drug half-life, and should be kept as low as possible to encourage better adherence. Most antiepileptics, the plasma-drug half-life, and should be kept as low as possible to encourage better adherence.

Usual dispensing practice can be followed when a special indication is not stated.

Dispensing pharmacists should ensure the continuity of supply of a particular product when the prescription specifies it. If the prescribed product is unavailable, it may be necessary to dispense a product from a different manufacturer to maintain continuity of treatment of that antiepileptic drug.

Monotherapy with a first-line antiepileptic drug has failed, monotherapy with a second drug should be tried; the diagnosis should be checked before starting an alternative drug if the first drug showed lack of efficacy. The change from one antiepileptic drug to another should be cautious, slowly withdrawing the first drug only when the new regimen has been established. Combination therapy with two or more antiepileptic drugs may be necessary, but the concurrent use of antiepileptic drugs increases the risk of adverse effects and drug interactions. If combination therapy does not bring about worthwhile benefits, revert to the regimen (monotherapy or combination therapy) that provided the best balance between tolerability and efficacy. A single antiepileptic drug should be prescribed wherever possible and will achieve seizure control for the majority of children.

MHRA/CHM advice: Antiepileptic drugs: updated advice on switching between different manufacturers’ products (November 2017)

The CHM has reviewed spontaneous adverse reactions received by the MHRA and publications that reported potential harm arising from switching of antiepileptic drugs in patients previously stabilised on a branded product to a generic. The CHM concluded that reports of loss of seizure control and/or worsening of side-effects around the time of switching between products could be explained as chance associations, but that a causal role of switching could not be ruled out in all cases. The following guidance has been issued to help minimise risk:

- Different antiepileptic drugs vary considerably in their characteristics, which influences the risk of whether switching between different manufacturers’ products of a particular drug may cause adverse effects or loss of seizure control;
- Antiepileptic drugs have been divided into three risk-based categories to help healthcare professionals decide whether it is necessary to maintain continuity of supply of a specific manufacturer’s product. These categories are listed below;
  - If it is felt desirable for a patient to be maintained on a specific manufacturer’s product this should be prescribed either by specifying a brand name, or by using the generic drug name and name of the manufacturer (otherwise known as the Marketing Authorisation Holder);
  - This advice relates only to antiepileptic drug use for treatment of epilepsy; it does not apply to their use in other indications (e.g. mood stabilisation, neuropathic pain);
  - Please report on a Yellow Card any suspected adverse reactions to antiepileptic drugs;
  - Dispensing pharmacists should ensure the continuity of supply of a particular product when the prescription specifies it. If the prescribed product is unavailable, it may be necessary to dispense a product from a different manufacturer to maintain continuity of treatment of that antiepileptic drug. Such cases should be discussed and agreed with both the prescriber and patient (or carer);
- Usual dispensing practice can be followed when a specific product is not stated.

Category 1
Carbamazepine p. 200, phenobarbital, phenytoin, primidone p. 224. For these drugs, doctors are advised to
ensure that their patient is maintained on a specific manufacturer’s product.

**Category 2**

Clobazam p. 225, clonazepam p. 226, eslicarbazepine acetate p. 202, lamotrigine, oscarbazepine p. 209, perampanel, rufinamide p. 212, topiramate p. 218, valproate, zonisamide p. 222. For these drugs, the need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient and/or carer taking into account factors such as seizure frequency, treatment history, and potential implications to the patient of having a breakthrough seizure. Non-clinical factors as for Category 3 drugs should also be considered.

**Category 3**

Brivaracetam p. 200, ethosuximide p. 203, gabapentin p. 204, lacosamide p. 206, levetiracetam p. 208, pregabalin, tiagabine p. 217, vigabatrin p. 221. For these drugs, it is usually unnecessary to ensure that patients are maintained on a specific manufacturer’s product as therapeutic equivalence can be assumed, however, other factors are important when considering whether switching is appropriate. Differences between alternative products (e.g. product name, packaging, appearance, and taste) may be perceived negatively by patients and/or carers, and may lead to dissatisfaction, anxiety, confusion, dosing errors, and reduced adherence. In addition, difficulties for patients with co-morbid autism, mental health problems, or learning disability should also be considered.

**Antiepileptic hypersensitivity syndrome**

Antiepileptic hypersensitivity syndrome is a rare but potentially fatal syndrome associated with some antiepileptic drugs (carbamazepine, lacosamide, lamotrigine, oscarbazepine, phenobarbital, phenytoin, primidone, and rufinamide); rarely cross-sensitivity occurs between some of these antiepileptic drugs. Some other antiepileptics (eslicarbazepine acetate, stiripentol p. 217, and zonisamide) have a theoretical risk. The symptoms usually start between 1 and 8 weeks of exposure; fever, rash, and lymphadenopathy are most commonly seen. Other systemic signs include liver dysfunction, haematological, renal, and pulmonary abnormalities, vasculitis, and multi-organ failure. If signs or symptoms of hypersensitivity syndrome occur, the drug should be withdrawn immediately, the child should not be re-exposed, and expert advice should be sought.

**Risk of suicidal thoughts and behaviour**

The MHRA has advised (August 2008) that all antiepileptic drugs are associated with a small increased risk of suicidal thoughts and behaviour. Symptoms may occur as early as one week after starting treatment. Children and their parents or carers should be advised to seek medical advice if the child develops any mood changes, distressing thoughts, or feelings about suicide or harming themselves, and should be referred for appropriate treatment if necessary.

**Interactions**

Interactions between antiepileptics are complex and may increase toxicity without a corresponding increase in antiepileptic effect. Interactions are usually caused by hepatic enzyme induction or inhibition; displacement from protein binding sites is not usually a problem. These interactions are highly variable and unpredictable.

**Withdrawal**

Antiepileptic drugs should be withdrawn under specialist supervision. Avoid abrupt withdrawal, particularly of barbiturates and benzodiazepines, because this can precipitate severe rebound seizures. Reduction in dosage should be gradual and, in the case of barbiturates, withdrawal of the drug may take months. The decision to withdraw antiepileptic drugs from a seizure-free child, and its timing, is often difficult and depends on individual circumstances. Even in children who have been seizure-free for several years, there is a significant risk of seizure recurrence on drug withdrawal. Drugs should be gradually withdrawn over at least 2–3 months by reducing the daily dose by 10–25% at intervals of 1–2 weeks. Benzodiazepines may need to be withdrawn over 6 months or longer.

In children receiving several antiepileptic drugs, only one drug should be withdrawn at a time.

**Monitoring**

Routine measurement of plasma concentrations of antiepileptic drugs is not usually justified, because the target concentration ranges are arbitrary and often vary between individuals. However, plasma-drug concentrations may be measured in children with worsening seizures, status epilepticus, suspected non-compliance, or suspected toxicity. Similarly, haematological and biochemical monitoring should not be undertaken unless clinically indicated.

Plasma concentration of some medications may change during pregnancy and monitoring may be required (see under *Pregnancy*).

**Driving**

If a driver has a seizure (of any type) they must stop driving immediately and inform the Driver and Vehicle Licensing Agency (DVLA).

Patients who have had a first unprovoked epileptic seizure or a single isolated seizure must not drive for 6 months; driving may then be resumed, provided the patient has been assessed by a specialist as fit to drive and investigations do not suggest a risk of further seizures.

Patients with established epilepsy may drive a motor vehicle provided they are not a danger to the public and are compliant with treatment and follow up. To continue driving, these patients must be seizure-free for at least one year (or have a pattern of seizures established for one year where there is no influence on their level of consciousness or the ability to act); also, they must not have a history of unprovoked seizures.

Patients who have had a seizure while asleep are not permitted to drive for one year from the date of each seizure unless:

- a history or pattern of sleep seizures occurring only ever while asleep has been established over the course of at least one year from the date of the first sleep seizure; or
- an established pattern of purely asleep seizures can be demonstrated over the course of three years if the patient has previously had seizures whilst awake (or awake and asleep).

The DVLA recommends that patients should not drive during medication changes or withdrawal of antiepileptic drugs, and for 6 months after their last dose. If a seizure occurs due to a prescribed change or withdrawal of epilepsy treatment, the patient will have their driving license revoked for 1 year; relicensing may be considered earlier if treatment has been reinstated for 6 months and no further seizures have occurred.

**Pregnancy**

Young women of child-bearing potential should discuss with a specialist the impact of both epilepsy, and its treatment, on the outcome of pregnancy.

There is an increased risk of teratogenicity associated with the use of antiepileptic drugs (especially if used during the first trimester and particularly if the patient takes two or more antiepileptic drugs). Valproate is associated with the highest risk of serious developmental disorders (up to 30–40% risk) and congenital malformations (approx. 10% risk). Valproate must not be used in females of childbearing potential unless the conditions of the Pregnancy Prevention
All infants should be monitored for sedation, feeding difficulties, adequate weight gain, and developmental milestones. Infants should also be monitored for adverse effects associated with the antiepileptic drug particularly with newer antiepileptics, if the antiepileptic is readily transferred into breast-milk causing high infant serum-drug concentrations (e.g. ethosuximide, lamotrigine, primidone, and zonisamide), or if slower metabolism in the infant causes drugs to accumulate (e.g. phenobarbital and lamotrigine). Serum-drug concentration monitoring should be undertaken in breast-fed infants if suspected adverse reactions develop; if toxicity develops it may be necessary to introduce formula feeds to limit the infant’s drug exposure, or to wean the infant off breast-milk altogether. Primidone, phenobarbital, and the benzodiazepines are associated with an established risk of drowsiness in breast-fed babies and caution is required.

Withdrawal effects may occur in infants if a mother suddenly stops breast-feeding, particularly if she is taking phenobarbital, primidone, or lamotrigine.

**Focal seizures with or without secondary generalisation**

Carbamazepine p. 200 and lamotrigine p. 207 are the drugs of choice for focal seizures. Levetiracetam p. 208, oxcarbazepine p. 209 and sodium valproate p. 213 can be considered if these are unsuitable. These drugs may also be used as adjunctive treatment. Other adjunctive options include clobazam p. 225, gabapentin p. 204, and topiramate p. 218. If adjunctive treatment is ineffective or not tolerated, a tertiary specialist should be consulted who may consider eslicarbazepine acetate p. 202, lacosamide p. 206, phenobarbital p. 223, phenytoin p. 211, pregabalin [unlicensed], tiagabine p. 217, vigabatrin p. 221, and zonisamide p. 222.

**Generalised seizures**

**Tonic-clonic seizures**

The drug of choice for newly diagnosed tonic-clonic seizures in children is sodium valproate (except in female patients, see Valproate below), or lamotrigine where sodium valproate is unsuitable (but may exacerbate myoclonic seizures). In children with established epilepsy with generalised tonic-clonic seizures only, lamotrigine may be prescribed as the first-line choice. Carbamazepine or oxcarbazepine can also be considered but may exacerbate myoclonic or absence seizures. Clobazam, lamotrigine, levetiracetam, sodium valproate, or topiramate may be used as adjunctive treatment if monotherapy is ineffective or not tolerated.

**Absence seizures**

Ethosuximide p. 203 and sodium valproate (except in female patients, see Valproate below) are the drugs of choice for absence seizures and syndromes; lamotrigine can be used if these are unsuitable, ineffective or not tolerated. Sodium valproate should be used as the first choice if there is a high risk of generalised tonic-clonic seizures. A combination of any two of these drugs may be used if monotherapy is ineffective. Second-line therapy includes clobazam, clonazepam p. 226, levetiracetam, topiramate or zonisamide which may be considered by a tertiary specialist if adjunctive treatment fails. Carbamazepine, gabapentin, oxcarbazepine, phenytoin, pregabalin, tiagabine, and vigabatrin are not recommended in absence seizures or syndromes.

**Myoclonic seizures**

Myoclonic seizures (myoclonic jerks) occur in a variety of syndromes, and response to treatment varies considerably. Sodium valproate is the drug of choice (except in female patients, see Valproate below); consider levetiracetam or topiramate if sodium valproate is unsuitable (but consider the less favourable side-effect profile of topiramate). A combination of two of these drugs may be used if
monotherapy is ineffective or poorly tolerated. Second-line therapy includes clobazam, clonazepam, piracetam or zonisamide which should be prescribed under the supervision of a tertiary specialist. Carbamazepine, gabapentin, oxcarbazepine, phenytoin, pregabalin, tiagabine, and vigabatrin are not recommended for the treatment of myoclonic seizures.

**Tonic and atonic seizures**

Tonic or atonic seizures are treated with sodium valproate (except in female patients, see Valproate below); lamotrigine can be considered as adjunctive treatment if sodium valproate is ineffective or not tolerated. Adjunctive treatment fails, a tertiary specialist should be consulted who may consider rifinamide p. 212 or topiramate. Carbamazepine, gabapentin, oxcarbazepine, pregabalin, tiagabine, and vigabatrin are not recommended in atonic or tonic seizures.

**Epilepsy syndromes**

**Infantile spasms**

Vigabatrin is the drug of choice for infantile spasms associated with tuberous sclerosis. Corticosteroids, such as prednisolone p. 458 or tetracosactide p. 491, are second-line options if vigabatrin is ineffective. In spasms of other causes, vigabatrin, prednisolone or tetracosactide can be considered as first-line options. A tertiary specialist should be consulted before treating infantile spasms.

**Dravet syndrome**

A tertiary specialist should be involved in decisions regarding treatment of Dravet syndrome. Sodium valproate (except in pregnancy or females of childbearing potential, see Valproate below) or topiramate are first-line treatment options in Dravet syndrome. Clonazepam or stiripentol p. 217 may be considered as adjunctive treatment if first-line treatments are ineffective or not tolerated. Carbamazepine, gabapentin, lamotrigine, oxcarbazepine, phenytoin, pregabalin, tiagabine, and vigabatrin should not be used as they may exacerbate myoclonic seizures.

**Lennox-Gastaut syndrome**

A tertiary specialist should be involved in decisions regarding treatment of Lennox-Gastaut syndrome. Sodium valproate is the first-line drug for treating Lennox-Gastaut syndrome (except in pregnancy or females of childbearing potential, see Valproate below); lamotrigine can be used as adjunctive treatment if sodium valproate is unsuitable, ineffective or not tolerated. Adjunctive treatment is ineffective or not tolerated, rifinamide and topiramate may be considered by tertiary specialists. Carbamazepine, gabapentin, oxcarbazepine, pregabalin, tiagabine, and vigabatrin should not be used. Felbamate [unlicensed] may be used in tertiary specialist centres when all other treatment options have failed.

**Landau-Kleffner syndrome**

Always discuss with or refer to tertiary epilepsy specialists.

**Neonatal seizures**

Seizures can occur before delivery, but they are most common up to 24 hours after birth. Seizures in neonates occur as a result of biochemical disturbances, inborn errors of metabolism, hypoxic ischaemic encephalopathy, drug withdrawal, meningitis, stroke, cerebral haemorrhage or malformation, or severe jaundice (keratitis).

Seizures caused by biochemical imbalance and those in neonates with inherited abnormal pyridoxine or biotin metabolism should be corrected by treating the underlying cause. Seizures caused by drug withdrawal following intrauterine exposure are treated with a drug withdrawal regimen.

Phenobarbital can be used to manage neonatal seizures where there is a risk of recurrence; phenytoin is an alternative. Midazolam p. 229 and rectal paraldehyde p. 228 may also be useful in the management of acute neonatal seizures. Lidocaine hydrochloride p. 852 may be used if other treatments are unsuccessful; lidocaine hydrochloride should not be given to neonates who have received phenytoin infusion because of the risk of cardiac toxicity.

**Antiepileptic drugs**

**Carbamazepine and related antiepileptics**

Carbamazepine p. 200 is a drug of choice for simple and complex focal seizures and is a first-line treatment option for generalised tonic-clonic seizures. It can be used as adjunctive treatment for focal seizures when monotherapy has been ineffective. It is essential to initiate carbamazepine therapy at a low dose and build this up slowly in small increments every 3–7 days. Carbamazepine may exacerbate tonic, atonic, myoclonic and absence seizures and is therefore not recommended if these seizures are present. Oxcarbazepine p. 209 is not recommended in tonic, atonic, absence or myoclonic seizures due to the risk of seizure exacerbation.

**Ethosuximide**

Ethosuximide is a first-line treatment option for absence seizures, and may be used as adjunctive treatment when monotherapy has failed.

**Gabapentin**

Gabapentin p. 204 is used as adjunctive therapy for the treatment of focal seizures with or without secondary generalisation; it is licensed as monotherapy in children over 12 years. It is not recommended if tonic, atonic, absence or myoclonic seizures are present.

**Lamotrigine**

Lamotrigine p. 207 is an antiepileptic drug recommended as a first-line treatment for focal seizures and primary and secondary generalised tonic-clonic seizures. It is also licensed as monotherapy for typical absence seizures in children (but efficacy may not be maintained in all children). It may be tried as an adjunctive treatment for atonic and tonic seizures if first-line treatment has failed [unlicensed]. Myoclonic seizures may be exacerbated by lamotrigine and it can cause serious rashes; dose recommendations should be adhered to closely.

Lamotrigine is used either as sole treatment or as an adjunct to treatment with other antiepileptic drugs. Valproate increases plasma-lamotrigine concentration, whereas the enzyme-inducing antiepileptics reduce it; care is therefore required in choosing the appropriate initial dose and subsequent titration. When the potential for interaction is not known, treatment should be initiated with lower doses, such as those used with valproate.

**Levetiracetam and brivaracetam**

Levetiracetam p. 208 is used for monotherapy and adjunctive treatment of focal seizures with or without secondary generalisation, and for adjunctive treatment of myoclonic seizures in children with juvenile myoclonic epilepsy and primary generalised tonic-clonic seizures. Levetiracetam may be prescribed alone and in combination for the treatment of myoclonic seizures, and under specialist supervision for absence seizures [both unlicensed].

Brivaracetam p. 200 is used as adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalisation.

**Phenobarbital and primidone**

Phenobarbital p. 223 is effective for tonic-clonic, focal seizures and neonatal seizures but may cause behavioural disturbances and hyperkinesia. It may be tried for atypical absence, atonic, and tonic seizures. For therapeutic purposes phenobarbital and phenobarbital sodium should be considered equivalent in effect. Rebound seizures may be a problem on withdrawal.
Primidone p. 224 is largely converted to phenobarbital and this is probably responsible for its antiepileptic action. It is used rarely in children. A low initial dose of primidone is essential.

**Phenytoin**

Phenytoin p. 211 is licensed for tonic–clonic and focal seizures but may exacerbate absence or myoclonic seizures and should be avoided if these seizures are present. It has a narrow therapeutic index and the relationship between dose and plasma-drug concentration is non-linear; small dosage increases in some patients may produce large increases in plasma concentration with acute toxic side-effects. Similarly, a few missed doses or a small change in drug absorption may result in a marked change in plasma-drug concentration. Monitoring of plasma-drug concentration improves dosage adjustment.

When only parenteral administration is possible, fosphenytoin sodium p. 204, a pro-drug of phenytoin, may be convenient to give. Whereas phenytoin should be given intravenously only, fosphenytoin sodium may also be given by intramuscular injection.

**Rufinamide**

Rufinamide p. 212 is licensed for the adjunctive treatment of seizures in Lennox–Gastaut syndrome. It may be considered by a tertiary specialist for the treatment of refractory tonic or atonic seizures [unlicensed].

**Topiramate**

Topiramate p. 218 can be given alone or as an adjunctive treatment in generalised tonic–clonic seizures or focal seizures. It can also be used for absence, tonic and atonic seizures under specialist supervision and as an option in myoclonic seizures [all unlicensed]. Female patients should be fully informed of the risks related to the use of topiramate during pregnancy and the need to use effective contraception—for further information, see *Conception and contraception* and *Pregnancy* in the topiramate drug monograph.

**Valproate**

Valproate (as either sodium valproate p. 213 or valproic acid p. 219) is effective in controlling tonic–clonic seizures, particularly in primary generalised epilepsy. It is a drug of choice in primary generalised tonic–clonic seizures, focal seizures, generalised absences and myoclonic seizures, and can be tried in atypical absence seizures. It is recommended as a first-line option in atonic and tonic seizures. Valproate should generally be avoided in children under 2 years especially with other antiepileptics, but it may be required in infants with continuing epileptic tendency. Sodium valproate has widespread metabolic effects, and monitoring of liver function tests and full blood count is essential. Because of its high teratogenic potential, valproate must not be used in females of childbearing potential unless the conditions of the Pregnancy Prevention Programme are met and alternative treatments are ineffective or not tolerated. During pregnancy, it must not be used for epilepsy unless it is the only possible treatment. For further information see *Important safety information, Conception and contraception, and Pregnancy* in the sodium valproate and valproic acid drug monographs. Plasma-valproate concentrations are not a useful index of efficacy, therefore routine monitoring is unhelpful.

**Zonisamide**

Zonisamide p. 222 can be used as an adjunctive treatment for refractory focal seizures with or without secondary generalisation in children and adolescents aged 6 years and above. It can also be used under the supervision of a specialist for refractory absence and myoclonic seizures [unlicensed indications].

**Benzodiazepines**

Clobazam p. 225 may be used as adjunctive therapy in the treatment of generalised tonic–clonic and refractory focal seizures. It may be prescribed under the care of a specialist for refractory absence and myoclonic seizures. Clonazepam p. 226 may be prescribed by a specialist for refractory absence and myoclonic seizures, but its sedative side-effects may be prominent.

**Other drugs**

Acetazolamide p. 707, a carbonic anhydrase inhibitor, has a specific role in treating epilepsy associated with menstruation. Piracetam is used as adjunctive treatment for cortical myoclonus.

**Status epilepticus**

**Convulsive status epilepticus**

Immediate measures to manage status epilepticus include positioning the child to avoid injury, supporting respiration including the provision of oxygen, maintaining blood pressure, and the correction of any hypoglycaemia. Pyridoxine hydrochloride p. 650 should be administered if the status epilepticus is caused by pyridoxine deficiency.

Seizures lasting 5 minutes should be treated urgently with buccal midazolam p. 229 or intravenous lorazepam p. 228 (repeated once after 10 minutes if seizures recur or fail to respond). Intravenous diazepam p. 226 is effective but it carries a high risk of venous thromboembolitis (reduced by using an emulsion formulation of diazepam injection). Patients should be monitored for respiratory depression and hypotension.

**Important**

If, after initial treatment with benzodiazepines, seizures recur or fail to respond 25 minutes after onset, phenytoin sodium should be used, or if the child is on regular phenytoin p. 211, give phenobarbital sodium intravenously over 5 minutes; the paediatric intensive care unit should be contacted. Paraldehyde p. 228 can be given after starting phenytoin infusion.

If these measures fail to control seizures 45 minutes after onset, anaesthesia with thiopental sodium p. 228 should be instituted with full intensive care support.

**Phenytoin sodium** can be given by intravenous infusion over 20 minutes, followed by the maintenance dosage if appropriate.

Paraldehyde given rectally causes little respiratory depression and is therefore useful where facilities for resuscitation are poor.

**Non-convulsive status epilepticus**

The urgency to treat non-convulsive status epilepticus depends on the severity of the child’s condition. If there is incomplete loss of awareness, oral antiepileptic therapy should be continued or restarted. Children who fail to respond to oral antiepileptic therapy or have complete lack of awareness can be treated in the same way as for convulsive status epilepticus, although anaesthesia is rarely needed.

**Febrile convulsions**

**Brief febrile convulsions** need no specific treatment; antipyretic medication (e.g. paracetamol p. 278), is commonly used to reduce fever and prevent further convulsions but evidence to support this practice is lacking. **Prolonged febrile convulsions** (those lasting 5 minutes or longer), or **recurrent febrile convulsions** without recovery must be treated actively (as for convulsive status epilepticus).

Long-term anticonvulsant prophylaxis for febrile convulsions is rarely indicated.
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ANTIEPILEPTICS

Brivaracetam

19 Jul 2018

● INDICATIONS AND DOSE

Adjuvant therapy of focal seizures with or without secondary generalisation

BY MOUTH, OR BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION

Child 4–17 years (body-weight up to 50 kg): Initially 0.5–1 mg/kg twice daily, adjusted according to response; usual maintenance 1 mg/kg twice daily (max. per dose 2 mg/kg twice daily)

Child 4–17 years (body-weight 50 kg and above): Initially 25–50 mg twice daily, adjusted according to response; usual maintenance 50 mg twice daily (max. per dose 100 mg twice daily)

● INTERACTIONS  ➔ Appendix 1: antiepileptics

● SIDE-EFFECTS

» Common or very common  Anxiety, appetite decreased, constipation, cough, depression, diziness, drowsiness, fatigue, increased risk of infection, insomnia, irritability, nausea, vertigo, vomiting

» Uncommon  Aggression, psychotic disorder

● PREGNANCY

Manufacturer advises avoid unless potential benefit outweighs risks– limited information available. See also Pregnancy in Epilepsy p. 195.

● BREAST FEEDING

Manufacturer advises avoid—present in milk in animal studies.

● HEPATIC IMPAIRMENT

Manufacturer advises caution (risk of increased exposure).

Dose adjustments

Manufacturer advises initial dose of 25 mg twice daily, max. maintenance dose of 75 mg twice daily in children body-weight 50 kg and above.

Manufacturer advises initial dose of 0.5 mg/kg twice daily, max. maintenance dose of 1.5 mg/kg twice daily in children with body-weight up to 50 kg (no information available).

● TREATMENT CESSATION

Manufacturer advises avoid abrupt withdrawal—reduce daily dose in steps of 50 mg at weekly intervals, then reduce to 20 mg daily for a final week.

● DIRECTIONS FOR ADMINISTRATION

» With intravenous use For intermittent intravenous infusion, manufacturer advises dilute in Glucose 5% or Sodium Chloride 0.9% or Lactated Ringer’s solution; give over 15 minutes.

» With oral use Manufacturer advises oral solution can be diluted in water or juice shortly before swallowing.

● PRESCRIBING AND DISPENSING INFORMATION

Manufacturer advises if switching between oral therapy and intravenous therapy (for those temporarily unable to take oral medication), the total daily dose and the frequency of administration should be maintained.

● PATIENT AND CARER ADVICE

Missed doses

Manufacturer advises if one or more doses are missed, a single dose should be taken as soon as possible and the next dose should be taken at the usual time.

Driving and skilled tasks

Manufacturer advises patients and carers should be cautioned on the effects on driving and performance of skilled tasks—increased risk of dizziness.

● NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

SMC No. 1160/16

The Scottish Medicines Consortium has advised (July 2016) that brivaracetam (Briviact®) is accepted for restricted use within NHS Scotland as adjuvative therapy in the treatment of partial-onset seizures with or without secondary generalisation in patients from 16 years of age with refractory epilepsy. Treatment should be initiated by physicians who have appropriate experience in the treatment of epilepsy.

SMC No. SMC2113

The Scottish Medicines Consortium has advised (December 2018) that brivaracetam (Briviact®) is accepted for restricted use within NHS Scotland as adjuvative therapy in the treatment of partial-onset seizures with or without secondary generalisation in patients from 4 to 15 years of age with refractory epilepsy. Treatment should be initiated by physicians who have appropriate experience in the treatment of epilepsy.

All Wales Medicines Strategy Group (AWMSG) decisions

AWMSG No. 3387

The All Wales Medicines Strategy Group has advised (December 2018) that brivaracetam (Briviact®) is recommended as an option for restricted use within NHS Wales. Brivaracetam (Briviact®) should be restricted for use in the treatment of patients with refractory epilepsy, who remain uncontrolled with, or are intolerant to, other adjuvant anti-epileptic medicines, within its licensed indication as adjuvative therapy in the treatment of partial-onset seizures with or without secondary generalisation in patients from 4 years of age with epilepsy. Brivaracetam (Briviact®) is not recommended for use within NHS Wales outside of this subpopulation.

● MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Solution for injection

CAUTIONARY AND ADVISORY LABELS 2

ELECTROLYTES: May contain Sodium

» Briviact (UCB Pharma Ltd)

Brivaracetam 10 mg per 1 ml  Briviact 50 mg/5 ml solution for injection vials 10 vial (Pipp) £222.75

Oral solution

CAUTIONARY AND ADVISORY LABELS 2, 8

EXCIPIENTS: May contain Sorbitol

ELECTROLYTES: May contain Sodium

» Briviact (UCB Pharma Ltd)

Brivaracetam 10 mg per 1 ml  Briviact 10 mg/ml oral solution sugar-free 300 ml (Pipp) £115.83 DT = £115.83

Tablet

CAUTIONARY AND ADVISORY LABELS 2, 8, 25

» Briviact (UCB Pharma Ltd)

Brivaracetam 10 mg  Briviact 10 mg tablets 14 tablet (Pipp) £34.64 DT = £34.64

Brivaracetam 25 mg  Briviact 25 mg tablets 56 tablet (Pipp) £129.64 DT = £129.64

Brivaracetam 50 mg  Briviact 50 mg tablets 56 tablet (Pipp) £129.64 DT = £129.64

Brivaracetam 75 mg  Briviact 75 mg tablets 56 tablet (Pipp) £129.64 DT = £129.64

Brivaracetam 100 mg  Briviact 100 mg tablets 56 tablet (Pipp) £129.64 DT = £129.64

Carbamazepine

26 Jun 2018

● INDICATIONS AND DOSE

Trigeminal neuralgia

» BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child 1 month–11 years: Initially 5 mg/kg once daily, dose to be taken at night, alternatively initially 2.5 mg/kg twice daily, then increased in steps of 2.5–5 mg/kg every 3–7 days as required; maintenance 5 mg/kg 2–3 times a day, increased if necessary up to 20 mg/kg daily

Child 12–17 years: Initially 100–200 mg 1–2 times a day, then increased to 200–400 mg 2–3 times a day, increased if necessary up to 1.8 g daily, dose should be increased slowly
Prophylaxis of bipolar disorder

BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child 1 month-11 years: Initially 5 mg/kg once daily, dose to be taken at night, alternatively initially 2.5 mg/kg twice daily, then increased in steps of 2.5–5 mg/kg every 3–7 days as required; maintenance 5 mg/kg 2–3 times a day, increased if necessary up to 20 mg/kg daily.

Child 12-17 years: Initially 100–200 mg 1–2 times a day, then increased to 200–400 mg 2–3 times a day, increased if necessary up to 1.8 g daily, dose should be increased slowly.

Focal and generalised tonic-clonic seizures | Prophylaxis of bipolar disorder

BY MOUTH

Child 5-11 years: Initially 5 mg/kg daily in 1–2 divided doses, then increased in steps of 2.5–5 mg/kg every 3–7 days as required; maintenance 10–15 mg/kg daily in 1–2 divided doses, increased if necessary up to 20 mg/kg daily in 1–2 divided doses.

Child 12-17 years: Initially 100–400 mg daily in 1–2 divided doses, then increased to 400–1200 mg daily in 1–2 divided doses, increased if necessary up to 1.8 g daily in 1–2 divided doses, dose should be increased slowly.

TEGRETOL® PROLONGED RELEASE

Focal and generalised tonic-clonic seizures | Prophylaxis of bipolar disorder

BY MOUTH

Child 5-11 years: Initially 5 mg/kg daily in 2 divided doses, then increased in steps of 2.5–5 mg/kg every 3–7 days as required; maintenance 10–15 mg/kg daily in 2 divided doses, increased if necessary up to 20 mg/kg daily in 2 divided doses.

Child 12-17 years: Initially 100–400 mg daily in 2 divided doses, increased if necessary up to 20 mg/kg daily in 2 divided doses.

Trigeminal neuralgia

BY MOUTH

Child 5-11 years: Initially 5 mg/kg daily in 2 divided doses, then increased in steps of 2.5–5 mg/kg every 3–7 days as required; maintenance 10–15 mg/kg daily in 2 divided doses, increased if necessary up to 1.8 g daily in 2 divided doses.

Child 12-17 years: Initially 100–400 mg daily in 2 divided doses, increased if necessary up to 1.8 g daily in 2 divided doses, dose should be increased slowly.

UNLICENSED USE Not licensed for use in trigeminal neuralgia or prophylaxis of bipolar disorder.

CONTRA-INDICATIONS Acute porphyrias p. 624. AV conduction abnormalities (unless paced) - history of bone-marrow depression.

CAUTIONS Cardiac disease - history of haematological reactions to other drugs - may exacerbate absence and myoclonic seizures - skin reactions - susceptibility to angle-closure glaucoma.

CAUTIONS, FURTHER INFORMATION Consider vitamin D supplementation in patients who are immobilised for long periods or who have inadequate sun exposure or dietary intake of calcium.

Blood, hepatic, or skin disorders. Carbamazepine should be withdrawn immediately in cases of aggravated liver dysfunction or acute liver disease. Leucopenia that is severe, progressive, or associated with clinical symptoms requires withdrawal (if necessary under cover of a suitable alternative).

INTERACTIONS | Appendix 1: antiepileptics.

SIDE-EFFECTS

Common or very common Dizziness - drowsiness - dry mouth - eosinophilia - fatigue - fluid imbalance - gastrointestinal discomfort - headache - hyponatraemia - leucopenia - movement disorders - nausea - oedema - skin reactions - thrombocytopenia - vision disorders - vomiting - weight increased.

Uncommon Constipation - diarrhoea - eye disorders - tic - tremor.

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erythematous (SLE) - taste altered - tinnitus - urinary disorders - vanishing bile duct syndrome - vasculitis

- Frequency not known Bone fracture - colitis - human herpesvirus 6 infection reactivation - memory loss - nail loss

SIDE-EFFECTS, FURTHER INFORMATION Some side-effects (such as headache, ataxia, drowsiness, nausea, vomiting, blurring of vision, dizziness and allergic skin reactions) are dose-related, and may be dose-limiting. These side-effects are more common at the start of treatment.

Overdose For details on the management of poisoning, see Active elimination techniques, under Emergency treatment of poisoning p. 859.

- ALLERGY AND CROSS-SENSITIVITY Antiepileptic hypersensitivity syndrome associated with carbamazepine. See under Epilepsy p. 195 for more information. Caution—cross-sensitivity reported with oxcarbazepine and with phenytoin.

- PREGNANCY See Pregnancy in Epilepsy p. 195. Monitoring Doses should be adjusted on the basis of plasma-drug concentration monitoring.

- BREATHE FEEDING Amount probably too small to be harmful. Monitoring Monitor infant for possible adverse reactions.

- HEPATIC IMPAIRMENT Manufacturer advises caution and close monitoring—no information available.

- RENAL IMPAIRMENT Use with caution.

- PRE-TREATMENT SCREENING Test for HLA-B*1502 allele in individuals of Han Chinese or Thai origin (avoid unless no alternative—risk of Stevens-Johnson syndrome in presence of HLA-B*1502 allele).

- MONITORING REQUIREMENTS Plasma concentration for optimum response 4–12 mg/litre (20–50 micromol/litre) measured after 1–2 weeks. Manufacturer recommends blood counts and hepatic and renal function tests (but evidence of practical value uncertain).

- TREATMENT CESSATION When stopping treatment with carbamazepine for bipolar disorder, reduce the dose gradually over a period of at least 4 weeks.

- DIRECTIONS FOR ADMINISTRATION Oral liquid has been used rectally—should be retained for at least 2 hours (but may have laxative effect).

TEGRETOL® PROLONGED RELEASE Tegretol® Prolonged Release tablets can be halved but should not be chewed.

- PRESCRIBING AND DISPENSING INFORMATION Switching between formulations Different formulations of oral preparations may vary in bioavailability. Patients being treated for epilepsy should be maintained on a specific manufacturer’s product.

- PATIENT AND CARER ADVICE Blood, hepatic, or skin disorders Patients or their carers should be told how to recognise signs of blood, liver, or skin disorders, and advised to seek immediate medical attention if symptoms such as fever, rash, mouth ulcers, bruising, or bleeding develop.

Medicines for Children leaflet: Carbamazepine (oral) for preventing seizures www.medicinesforchildren.org.uk/carbamazepine-oral-preventing-seizures-0

- PROFESSION SPECIFIC INFORMATION Dental practitioners’ formulary Carbamazepine Tablets may be prescribed.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

Modified-release tablet

CAUTION AND ADVISORY LABELS 3, 8, 25

- Carbagen SR (Mylan) Carbamazepine 200 mg Carbagen SR 200mg tablets | 56 tablet (£8.16 DT = £5.20)
Carbamazepine 400 mg Carbagen SR 400mg tablets | 56 tablet (£8.20 DT = £10.24

- Tegretol Retard (Novartis Pharmaceuticals UK Ltd) Carbamazepine 200 mg Tegretol Prolonged Release 200mg tablets | 56 tablet (£5.20 DT = £5.20)
Carbamazepine 400 mg Tegretol Prolonged Release 400mg tablets | 56 tablet (£10.24 DT = £10.24

Tablet

CAUTION AND ADVISORY LABELS 3, 8

- Carbagen (Mylan) Carbamazepine 100 mg Carbagen 100mg tablets | 28 tablet (£5.74 DT = £2.07 (Hospital only)
Carbamazepine 200 mg Carbagen 200mg tablets | 28 tablet (£4.99 DT = £2.07 (Hospital only)
Carbamazepine 400 mg Carbagen 400mg tablets | 28 tablet (£4.27 DT = £5.02 (Hospital only)

- Tegretol (Novartis Pharmaceuticals UK Ltd) Carbamazepine 100 mg Tegretol 100mg tablets | 84 tablet (£2.07 DT = £2.07
Carbamazepine 200 mg Tegretol 200mg tablets | 84 tablet (£3.83 DT = £3.83
Carbamazepine 400 mg Tegretol 400mg tablets | 56 tablet (£5.02 DT = £5.02

Suppository

CAUTION AND ADVISORY LABELS 3, 8

- Carbamazepine (Non-proprietary) Carbamazepine 125 mg Carbamazepine 125mg suppositories | 5 suppository (£12.20 DT = £12.00
Carbamazepine 250 mg Carbamazepine 250mg suppositories | 5 suppository (£14.00 DT = £14.00

Oral suspension

CAUTION AND ADVISORY LABELS 3, 8

- Carbamazepine (Non-proprietary) Carbamazepine 20 mg per 1 ml Carbamazepine 100mg/5ml oral suspension sugar free sugar-free | 300 ml (£8.25 DT = £8.04

- Tegretol (Novartis Pharmaceuticals UK Ltd) Carbamazepine 20 mg per 1 ml Tegretol 100mg/5ml liquid sugar-free | 300 ml (£6.12 DT = £6.04

Eslicarbazepine acetate

INDICATIONS AND DOSE

Adjunctive therapy of focal seizures with or without secondary generalisation

- BY MOUTH
  - Child 6–17 years (body-weight up to 60 kg): Initially 10 mg/kg once daily, then increased in steps of 10 mg/kg daily, every 1–2 weeks, increased if necessary up to 30 mg/kg daily (max. per dose 1.2 g)
  - Child 6–17 years (body-weight 60 kg and above): Initially 400 mg once daily for 1–2 weeks, then increased to 800 mg once daily (max. per dose 1.2 g)

- CONTRA-INDICATIONS Second- or third-degree AV block
- CAUTIONS Hyponatraemia - PR-interval prolongation
- INTERACTIONS Appendix 1: antiepileptics
- SIDE-EFFECTS
  - Common or very common Anxiety - appetite decreased - asthenia - concentration impaired - diarrhoea - dizziness - drowsiness - gait abnormal - gastrointestinal discomfort - headaches - movement disorders - nausea - skin reactions - sleep disorders - vertigo - vision disorders - vomiting
  - Uncommon Alopecia - anemia - bradycardia - chest pain - chills - confusion - constipation - depression - dry mouth - electrolyte imbalance - eye disorders - flushing - gastritis -
haemorrhage, hearing impairment, hyperhidrosis, hypertension, hypotension, hypothyroidism, increased risk of infection, liver disorder, malaise, mood altered, muscle weakness, myalgia, pain in extremity, palpitations, peripheral coldness, peripheral neuropathy, peripheral oedema, psychomotor retardation, psychotic disorder, sensation abnormal, speech impairment, tinnitus, toothache, weight decreased

- Frequency not known: Angioedema, leucopenia, pancreatitis, severe cutaneous adverse reactions (SCARs), thrombocytopenia

- ALLERGY AND CROSS-SENSITIVITY: Antiepileptic

- hypersensitivity syndrome theoretically associated with eslicarbazepine. See under Epilepsy p. 195 for more information.

- PREGNANCY: Manufacturer advises minimum effective doses and monotherapy if possible—reproductive toxicity in animal studies.

- Monitoring: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

- BREAST FEEDING: Manufacturer advises avoid—present in milk in animal studies.

- HEPATIC IMPAIRMENT: Manufacturer advises caution in mild to moderate impairment—limited information; avoid in severe impairment—no information available.

- RENAL IMPAIRMENT: Manufacturer advises avoid if creatinine creatinine clearance less than 30 mL/minute.

- Dose adjustments: Manufacturer advises reduce initial dose to 5 mg/kg once daily or 10 mg/kg every other day for 2 weeks, then increase to 10 mg/kg once daily if creatinine clearance 30–60 mL/minute. The dose may be further increased based on individual response.

- PRE-TREATMENT SCREENING: Test for HLA-B*1502 allele in individuals of Han Chinese or Thai origin (avoid unless no alternative—risk of Stevens-Johnson syndrome in presence of HLA-B*1502 allele).

- MONITORING REQUIREMENTS: Monitor plasma-sodium concentration in patients at risk of hyponatraemia and discontinue treatment if hyponatraemia occurs.

- PRESCRIBING AND DISPENSING INFORMATION: Switching between formulations Care should be taken when switching between oral formulations. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

- PATIENT AND CARER ADVICE: Driving and skilled tasks: Manufacturer advises patients and carers should be cautioned on the effects on driving and performance of skilled tasks—increased risk of dizziness, somnolence and visual disorders.

- NATIONAL FUNDING/ACCESS DECISIONS: Scottish Medicines Consortium (SMC) decisions

- SMC No. SMC2087: The Scottish Medicines Consortium has advised (February 2019) that eslicarbazepine acetate (Zebinix®) is accepted for restricted use within NHS Scotland as adjunctive therapy in patients aged above 6 years with focal seizures with or without secondary generalisation. It is restricted for use in refractory epilepsy in patients who have been heavily pre-treated and remain uncontrolled with existing anti-epileptic drugs.

- MEDICINAL FORMS: There can be variation in the licensing of different medicines containing the same drug.

- Oral suspension

- Zebinix (Eisai Ltd)

- Eslicarbazepine acetate 50 mg per 1 ml Zebinix 50mg/1ml oral suspension sugar-free 200 ml (PStk) £56.67

- Ethosuximide

- INDICATIONS AND DOSE: Absence seizures / Atypical absence seizures (adjunct) / Myoclonic seizures

- BY MOUTH: Child 1 month-5 years: Initially 5 mg/kg twice daily (max. per dose 125 mg), dose to be increased every 5–7 days; maintenance 10–20 mg/kg twice daily (max. per dose 500 mg), total daily dose may rarely be given in 3 divided doses.

- Child 6-17 years: Initially 250 mg twice daily, then increased in steps of 250 mg every 5–7 days; usual dose 500–750 mg twice daily, increased if necessary up to 1 g twice daily.

- CAUTIONS: Avoid in Acute porphyrias p. 624.

- INTERACTIONS: Appendix 1: antiepileptics

- SIDE-EFFECTS: Aggression, agranulocytosis, appetite decreased, blood disorder, bone marrow disorders, concentration impaired, depression, diarrhoea, dizziness, drowsiness, erythema nodosum, fatigue, gastrointestinal discomfort, generalised tonic-clonic seizure, headache, hiccup, leucopenia, libido increased, lupus-like syndrome, mood altered, movement disorders, nausea, nephrotic syndrome, oral disorders, psychosis, rash, sleep disorders, Stevens-Johnson syndrome, vaginal haemorrhage, vision disorders, vomiting, weight decreased

- SIDE-EFFECTS, FURTHER INFORMATION: Blood counts required if features of fever, sore throat, mouth ulcers, bruising or bleeding.

- PREGNANCY: See also Pregnancy in Epilepsy p. 195.

- Monitoring: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

- BREAST FEEDING: Present in milk. Hyperexcretability and sedation reported.

- HEPATIC IMPAIRMENT: Use with caution.

- RENAL IMPAIRMENT: Use with caution.

- PATIENT AND CARER ADVICE: Blood disorders: Patients or their carers should be told how to recognise signs of blood disorders, and advised to seek immediate medical attention if symptoms such as fever, mouth ulcers, bruising, or bleeding develop.

- Medicines for Children leaflet: ethosuximide for preventing seizures www.medicinesforchildren.org.uk/ethosuximide-preventing-seizures

- MEDICINAL FORMS: There can be variation in the licensing of different medicines containing the same drug.

- Ethosuximide

- CAUTIONARY AND ADVISORY LABELS: 8

- Ethosuximide 50 mg per 1 ml Ethosuximide 250mg/5ml syrup | 200 ml (PStk) £173.00 DT + £173.00

- Ethosuximide 50mg/5ml oral solution sugar free sugar-free | 125 ml (PStk) £108.12–£108.13 sugar-free | 250 ml (PStk) £216.25

- Ethosuximide 250 mg Ethosuximide 250mg capsules | 56 capsule (PStk) £173.00 DT + £173.00
**Fosphenytoin sodium**

*DRUG ACTION*  Fosphenytoin is a pro-drug of phenytoin.

**INDICATIONS AND DOSE**

**Status epilepticus**
- **BY INTRAVENOUS INFUSION**
  - Child 5–17 years: Initially 20 mg(PE)/kg, dose to be administered at a rate of 2–3 mg(PE)/kg/minute, maximum 150 mg(PE)/minute, then 4–5 mg(PE)/kg daily in 1–4 divided doses, dose to be administered at a rate of 1–2 mg(PE)/kg/minute, maximum 100 mg (PE)/minute, dose to be adjusted according to response and trough plasma-phenytoin concentration

**Prophylaxis or treatment of seizures associated with neurosurgery or head injury**
- **BY INTRAVENOUS INFUSION**
  - Child 5–17 years: Same dose and same dosing frequency as oral phenytoin therapy, intravenous infusion to be administered at a rate of 1–2 mg(PE)/kg/minute, maximum 100 mg(PE)/minute

**DOSE EQUIVALENT AND CONVERSION**
- Doses are expressed as phenytoin sodium equivalent (PE); fosphenytoin sodium 1.5 mg = phenytoin sodium 1 mg.

**UNLICENSED USE**  Fosphenytoin sodium doses in BNFC may differ from those in product literature.

**CONTRA-INDICATIONS**  Acute porphyrias p. 624; second-degree heart block; sino-atrial block; sinus bradycardia; Stokes-Adams syndrome; third-degree heart block.

**CAUTIONS**  Heart failure; hypotension; injection solutions alkaline (irritant to tissues); respiratory depression; resuscitation facilities must be available

**INTERACTIONS**  → Appendix 1: anti-epileptics

**SIDE-EFFECTS**
- **Common or very common**  Asthenia; chills; dizziness; drowsiness; dry mouth; dysarthria; euphoric mood; headache; hypotension; movement disorders; nausea; nystagmus; sensation abnormal; skin reactions; stupor; taste altered; tinnitus; tremor; vasodilation; vertigo; vision disorders; vomiting
- **Uncommon**  Cardiac arrest; confusion; hearing impairment; muscle complaints; muscle weakness; nervousness; oral disorders; reflexes abnormal; severe cutaneous adverse reactions (SCARs); systemic lupus erythematosus (SLE); thinking abnormal
- **Frequency not known**  Acute psychosis; agranulocytosis; appetite disorder; atrial conduction depression (more common if injection too rapid); atrioventricular block; bone disorders; bone fracture; bone marrow disorders; bradycardia; cardiac toxicity; cerebrovascular insufficiency; circulatory collapse (more common if injection too rapid); coarsening of the facial features; constipation; delirium; Dupuytren’s contracture; encephalopathy; granulocytopenia; groin tingling; hair changes; hepatic disorders; hyperglycaemia; hypersensitivity; insomnia; leucopenia; lymphadenopathy; nephritis; tubulo-interstitial; Peyronie’s disease; polyarteritis nodosa; polyarthritids; purple glove syndrome; respiratory disorders; sensory peripheral polynuropathy; thrombocytopenia; tonic seizure; ventricular conduction depression (more common if injection too rapid); ventricular fibrillation (more common if injection too rapid)

**SIDE-EFFECTS, FURTHER INFORMATION**  Fosphenytoin has been associated with severe cardiovascular reactions including asystole, ventricular fibrillation, and cardiac arrest. Hypotension, bradycardia, and heart block have also been reported. The following are recommended: monitor heart rate, blood pressure, and respiratory function for duration of infusion; observe patient for at least 30 minutes after infusion; if hypotension occurs, reduce infusion rate or discontinue; reduce dose or infusion rate in renal or hepatic impairment.

**ALLERGY AND CROSS-SENSITIVITY**  Cross-sensitivity reported with carbamazepine.

**PREGNANCY**  See also Pregnancy in Epilepsy p. 195.

**MONITORING**  Changes in plasma-protein binding make interpretation of plasma-phenytoin concentrations difficult—monitor unbound fraction.

The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**  Small amounts present in milk, but not known to be harmful.

**HEPATIC IMPAIRMENT**  Manufacturer advises caution—monitor free plasma-phenytoin concentration (rather than total plasma-phenytoin concentration) in hepatic impairment or hypoalbuminaemia and in hyperbilirubinaemia.

**Dose adjustments**  Manufacturer advises consider a 10–25% reduction in dose or infusion rate (except in the treatment of status epilepticus) in hepatic impairment or hypoalbuminaemia.

**RENAL IMPAIRMENT**  Dose adjustments Consider 10–25% reduction in dose or infusion rate (except initial dose for status epilepticus).

**PRE-TREATMENT SCREENING**  HLA-B*1502 allele in individuals of Han Chinese or Thai origin—avoid unless increased risk (e.g. individual or relative with Stevens-Johnson syndrome).

**MONITORING REQUIREMENTS**
- Manufacturer recommends blood counts (but evidence of practical value uncertain).
- With intravenous use Monitor heart rate, blood pressure, ECG, and respiratory function for during infusion.

**DIRECTIONS FOR ADMINISTRATION**  For intermittent intravenous infusion (Pro-Épanutin®), give in Glucose 5% or Sodium chloride 0.9%, dilute to a concentration of 1.5–25 mg (phenytoin sodium equivalent (PE))/mL.

**PRESCRIBING AND DISPENSING INFORMATION**  Prescriptions for fosphenytoin sodium should state the dose in terms of phenytoin sodium equivalent (PE); fosphenytoin sodium 1.5 mg = phenytoin sodium 1 mg.

**MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

| ELECTROLYTES: May contain Phosphate |
| Pro-Épanutin (Pfizer Ltd) |
| Fosphenytoin sodium 75 mg per 1 ml Pro-Épanutin 750mg/10ml concentrate for solution for injection vials | 10 vial  | £400.00 (Hospital only) |

**Gabapentin**

*INDICATIONS AND DOSE*  Adjunctive treatment of focal seizures with or without secondary generalisation
- **BY MOUTH**
  - Child 2–5 years: 10 mg/kg once daily on day 1, then 10 mg/kg twice daily on day 2, then 10 mg/kg 3 times a
day on day 3, then increased to 30–70 mg/kg daily in 3 divided doses, adjusted according to response, some children may not tolerate daily increments; longer intervals (up to weekly) may be more appropriate

- Child 6-11 years: 10 mg/kg once daily (max. per dose 300 mg) on day 1, then 10 mg/kg twice daily (max. per dose 300 mg) on day 2, then 10 mg/kg 3 times a day (max. per dose 300 mg) on day 3; usual dose 25–35 mg/kg daily in 3 divided doses, some children may not tolerate daily increments; longer intervals (up to weekly) may be more appropriate, daily dose maximum to be given in 3 divided doses; maximum 70 mg/kg per day
- Child 12-17 years: Initially 300 mg once daily on day 1, then 300 mg twice daily on day 2, then 300 mg 3 times a day on day 3, alternatively initially 300 mg 3 times a day on day 1, then increased in steps of 300 mg every 2–3 days in 3 divided doses, adjusted according to response; usual dose 0.9–3.6 g daily in 3 divided doses (max. per dose 1.6 g 3 times a day), some children may not tolerate daily increments; longer intervals (up to weekly) may be more appropriate

### Monotherapy for focal seizures with or without secondary generalisation

- **BY MOUTH**
  - Child 12-17 years: Initially 300 mg once daily on day 1, then 300 mg twice daily on day 2, then 300 mg 3 times a day on day 3, alternatively initially 300 mg 3 times a day on day 1, then increased in steps of 300 mg every 2–3 days in 3 divided doses, adjusted according to response; usual dose 0.9–3.6 g daily in 3 divided doses (max. per dose 1.6 g 3 times a day), some children may not tolerate daily increments; longer intervals (up to weekly) may be more appropriate

### IMPORTANT SAFETY INFORMATION

The levels of propylene glycol, acesulfame K and saccharin sodium may exceed the recommended WHO daily intake limits if high doses of gabapentin oral solution (Rosemont brand) are given to adolescents or adults with low body-weight (39–50 kg)—consult product literature.

**MHRA/CHM ADVICE: GABAPENTIN (NEURONTIN®): RISK OF SEVERE RESPIRATORY DEPRESSION (OCTOBER 2017)**

Gabapentin has been associated with a rare risk of severe respiratory depression even without concomitant opioid medicines. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment, and concomitant use of central nervous system (CNS) depressants might be at higher risk of experiencing severe respiratory depression and dose adjustments may be necessary in these patients.

**MHRA/CHM ADVICE: GABAPENTIN (NEURONTIN®) AND RISK OF ABUSE AND DEPENDENCE: NEW SCHEDULING REQUIREMENTS FROM 1 APRIL (APRIL 2019)**

Following concerns about abuse, gabapentin has been reclassified as a Class C controlled substance and is now a Schedule 3 drug, but is exempt from safe custody requirements. Healthcare professionals should evaluate patients carefully for a history of drug abuse before prescribing gabapentin, and observe patients for signs of abuse and dependence. Patients should be informed of the potentially fatal risks of interactions between gabapentin and alcohol, and with other medicines that cause CNS depression, particularly opioids.

### CAUTIONS

- Diabetes mellitus - high doses of oral solution in adolescents and adults with low body-weight - history of psychotic illness - history of substance abuse - mixed seizures (including absences)

### SIDE-EFFECTS

- **Uncommon** Cognitive impairment - palpitations
- **Frequency not known** Acute kidney injury - alopecia - angioedema - breast enlargement - drug use disorders - gynaecostasia - hallucination - hepatic disorders - hyponatraemia - pancreatitis - pancreatitis - severe cutaneous adverse reactions (SCARs) - thrombocytopenia - tinnitus - urinary incontinence

### PREGNANCY

Manufacturer advises avoid unless benefit outweighs risk — toxicity reported. See also Pregnancy in Epilepsy p. 195.

### BREAST FEEDING

Present in milk—manufacturer advises use only if potential benefit outweighs risk. See also Breast-feeding in Epilepsy p. 195.

### RENAL IMPAIRMENT

Dose adjustments: Reduce dose if estimated glomerular filtration rate less than 80 mL/minute/1.73 m²; consult product literature.

### MONITORING REQUIREMENTS

Monitor for signs of gabapentin abuse.

### EFFECT ON LABORATORY TESTS

False positive readings with some urinary protein tests.

### DIRECTIONS FOR ADMINISTRATION

Capsules can be opened but the bitter taste is difficult to mask.

### PATIENT AND CARER ADVICE

Medicines for Children leaflet: Gabapentin for neuropathic pain
www.medicinesforchildren.org.uk/gabapentin-neuropathic-pain

Medicines for Children leaflet: Gabapentin for preventing seizures
www.medicinesforchildren.org.uk/gabapentin-preventing-seizures

Patient leaflet: NHS England has produced a patient leaflet with information on the reclassification of gabapentin.

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

#### Tablet

**CAUTIONARY AND ADVISORY LABELS 3, 5, 8, 25**

- **Gabapentin (Non-proprietary)**
  - Gabapentin 600 mg Gabapentin 600 mg tablets  | 100 tablet £106.00 DT + £5.99 (3)
  - Gabapentin 800 mg Gabapentin 800 mg tablets  | 100 tablet £78.00 DT + £25.96 (3)
- **Neurontin® (Pfizer Ltd)**
  - Gabapentin 600 mg Neurontin 600 mg tablets  | 100 tablet £84.80 DT + £5.99 (3)
  - Gabapentin 800 mg Neurontin 800 mg tablets  | 100 tablet £98.13 DT + £25.96 (3)

#### Oral solution

**CAUTIONARY AND ADVISORY LABELS 3, 5, 8**

**EXCIPIENTS:** May contain Propylene glycol - ELECTROLYTES: May contain Potassium, sodium

- **Gabapentin (Non-proprietary)**
  - Gabapentin 50 mg per 1 ml Gabapentin 50 mg/ml oral solution sugar free sugar-free | 150 ml £59.00 DT + £66.05 (3)
Lacosamide

**206 Epilepsy and other seizure disorders**

**Capsule**

**CAUTIONARY AND ADVISORY LABELS**

- Gabapentin (Non-proprietary)
- Gabapentin 100 mg: Gabapentin 100 mg capsules | 100 capsule (PO) £18.29 DT + £1.81 (C3)
- Gabapentin 300 mg: Gabapentin 300 mg capsules | 100 capsule (PO) £42.40 DT + £3.15 (C3)
- Gabapentin 400 mg: Gabapentin 400 mg capsules | 100 capsule (PO) £49.06 DT + £3.80 (C3)
- Neurontin (Pfizer Ltd)
- Gabapentin 100 mg: Neurontin 100 mg capsules | 100 capsule (PO) £18.29 DT + £1.81 (C3)
- Gabapentin 300 mg: Neurontin 300 mg capsules | 100 capsule (PO) £42.40 DT + £3.15 (C3)
- Gabapentin 400 mg: Neurontin 400 mg capsules | 100 capsule (PO) £49.06 DT + £3.80 (C3)
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- Gabapentin 400 mg: Neurontin 400 mg capsules | 100 capsule (PO) £49.06 DT + £3.80 (C3)

**INDICATIONS AND DOSE**

**Monotherapy of focal seizures with or without secondary generalisation**

- **BY MOUTH, OR BY INTRAVENOUS INFUSION**
  - Child (body-weight 50 kg and above): Initially 50 mg twice daily, then increased to 100 mg twice daily, after one week; increased in steps of 50 mg twice daily (max. per dose 300 mg twice daily) if necessary and if tolerated, dose to be increased at weekly intervals
  - Child 4-17 years (body-weight up to 50 kg): consult product literature

**Adjunctive treatment of focal seizures with or without secondary generalisation (alternative loading dose regimen when it is necessary to rapidly attain therapeutic plasma concentrations) (under close medical supervision)**

- **BY MOUTH, OR BY INTRAVENOUS INFUSION**
  - Child (body-weight 50 kg and above): Loading dose 200 mg, followed by 100 mg twice daily, to be given 12 hours after initial dose; increased in steps of 50 mg twice daily (max. per dose 300 mg twice daily) if necessary and if tolerated, dose to be increased at weekly intervals
  - Child 4-17 years (body-weight up to 50 kg): consult product literature

**Adjunctive treatment of focal seizures with or without secondary generalisation (alternative loading dose regimen when it is necessary to rapidly attain therapeutic plasma concentrations) (under close medical supervision)**

- **BY MOUTH, OR BY INTRAVENOUS INFUSION**
  - Child (body-weight 50 kg and above): Loading dose 200 mg, followed by 100 mg twice daily, to be given 12 hours after initial dose; increased in steps of 50 mg twice daily (max. per dose 300 mg twice daily) if necessary and if tolerated, dose to be increased at weekly intervals

**CONTRA-INDICATIONS**

- Second- or third-degree AV block

**CAUTIONS**

- Conduction problems • risk of PR-interval prolongation • severe cardiac disease

**INTERACTIONS**

- Appendix 1: antiepileptics

**SIDE-EFFECTS**

- Common or very common: Asthenia, concentration impaired, confusion, constipation, depression, diarrhoea, dizziness, drymouth, dysesthesia, flatulence, gait abnormal, headache, insomnia, mood altered, movement disorders, muscle spasms, nausea, nystagmus, sensation abnormal, skin reactions, tinnitus, vertigo, vision disorders, vomiting
- Uncommon: Agitation, alopecia, angioedema, arrhythmias, atrioventricular block, hallucination, psychotic disorder, suicidal tendencies, syncpe
- Frequency not known: Agranulocytosis

**ALLERGY AND CROSS-SENSITIVITY**

- Antiepileptic hypersensitivity syndrome associated with lacosamide. See under Epilepsy p. 195 for more information.

**PREGNANCY**

- See also Pregnancy in Epilepsy p. 195.

**Monitoring**

- The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**

- Manufacturer advises avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution (risk of increased exposure), particularly in severe impairment (no information available).

**Dose adjustments**

- Manufacturer advises consider dose reduction—consult product literature.

**RENAL IMPAIRMENT**

- Consult product literature.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use: For intermittent intravenous infusion, manufacturer advises give undiluted or dilute with Glucose 5% or Sodium Chloride 0.9% or Lactated Ringer’s Solution; give over 15–60 minutes—doses greater than 200 mg over at least 30 minutes.

**PRESCRIBING AND DISPENSING INFORMATION**

- Flavours of syrup may include strawberry.

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Lacosamide for preventing seizures

**NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**

- SMC No. 532/09
  - The Scottish Medicines Consortium has advised (February 2009) that lacosamide (Vimpat®) is accepted for restricted use within NHS Scotland as adjunctive treatment for focal seizures with or without secondary generalisation in patients from 16 years. It is restricted for specialist use in refractory epilepsy.
  - SMC No. 1301/18
  - The Scottish Medicines Consortium has advised (February 2018) that lacosamide (Vimpat®) is accepted for restricted use within NHS Scotland as adjunctive treatment for focal seizures with or without secondary generalisation in adolescents and children from 4 years of age with epilepsy. It is restricted for specialist use in refractory epilepsy.

**All Wales Medicines Strategy Group (AWMSG) decisions**

- AWMSG No. 3343
  - The All Wales Medicines Strategy Group has advised (March 2018) that lacosamide (Vimpat®) is recommended as an option for use within NHS Wales as adjunctive therapy in the treatment of focal seizures with or without secondary generalisation in children from 4 years of age up to 15 years of age with epilepsy.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Solution for infusion**

- ELECTROLYTES: May contain Sodium
  - Vimpat (UCB Pharma Ltd)

- Lacosamide 10 mg per 1 ml
  - Vimpat 200 mg/20 ml solution for infusion vials | 1 vial (PO) £29.70
**Lamotrigine**

**1. INDICATIONS AND DOSE**

**Monotherapy of focal seizures**
- Monotherapy of primary and secondary generalised tonic-clonic seizures

**Monotherapy of seizures associated with Lennox-Gastaut syndrome**
- **BY MOUTH**
  - Child 12-17 years: Initially 25 mg once daily for 14 days, then increased to 50 mg once daily for further 14 days, then increased in steps of up to 100 mg every 7-14 days; maintenance 100-200 mg daily in 1-2 divided doses; increased if necessary up to 500 mg daily, dose titration should be repeated if restarting after interval of more than 5 days

**Monotherapy of typical absence seizures**
- **BY MOUTH**
  - Child 2-11 years: Initially 300 micrograms/kg daily in 1-2 divided doses, for 14 days, then 600 micrograms/kg daily in 1-2 divided doses, for further 14 days, then increased in steps of up to 600 micrograms/kg every 7-14 days; maintenance 1-10 mg/kg daily in 1-2 divided doses, increased if necessary up to 15 mg/kg daily, dose titration should be repeated if restarting after interval of more than 5 days

**Adjunctive therapy of focal seizures with valproate**
- **Adjunctive therapy of primary and secondary generalised tonic-clonic seizures with valproate**
- **Adjunctive therapy of seizures associated with Lennox-Gastaut syndrome with valproate**
  - **BY MOUTH**
    - Child 2-11 years (body-weight up to 13 kg): Initially 2 mg once daily on alternate days for first 14 days, then 300 micrograms/kg once daily for further 14 days, then increased in steps of up to 300 micrograms/kg every 7-14 days; maintenance 1-5 mg/kg daily in 1-2 divided doses, dose titration should be repeated if restarting after interval of more than 5 days; maximum 200 mg per day
    - Child 2-11 years (body-weight 13 kg and above): Initially 150 micrograms/kg once daily for 14 days, then 300 micrograms/kg once daily for further 14 days, then increased in steps of up to 300 micrograms/kg every 7-14 days; maintenance 1-5 mg/kg daily in 1-2 divided doses, dose titration should be repeated if restarting after interval of more than 5 days; maximum 200 mg per day
    - Child 12-17 years: Initially 25 mg once daily on alternate days for 14 days, then 25 mg once daily for further 14 days, then increased in steps of up to 50 mg every 7-14 days; maintenance 100-200 mg daily in 1-2 divided doses, dose titration should be repeated if restarting after interval of more than 5 days

**Adjunctive therapy of seizures associated with Lennox-Gastaut syndromes (with enzyme inducing drugs) without valproate**
- **BY MOUTH**
  - Child 2-11 years: Initially 300 micrograms/kg twice daily for 14 days, then 600 micrograms/kg twice daily for further 14 days, then increased in steps of up to 1.2 mg/kg every 7-14 days; maintenance 5-15 mg/kg daily in 1-2 divided doses, dose titration should be repeated if restarting after interval of more than 5 days; maximum 400 mg per day
  - Child 12-17 years: Initially 50 mg once daily for 14 days, then 50 mg twice daily for further 14 days, then increased in steps of up to 100 mg every 7-14 days; maintenance 200-400 mg daily in 2 divided doses, increased if necessary up to 700 mg daily, dose titration should be repeated if restarting after interval of more than 5 days

**Adjunctive therapy of seizures associated with Lennox-Gastaut syndromes (without enzyme inducing drugs) without valproate**
- **Adjunctive therapy of primary and secondary generalised tonic-clonic seizures (without enzyme inducing drugs) without valproate**

**CAUTIONS** Myoclonic seizures (may be exacerbated)

**INTERACTIONS** → Appendix 1: antiepileptics

**SIDE-EFFECTS**
- Common or very common
  - Confusion
  - Complaints
  - Convulsions, petit mal
  - Convulsions, grand mal
  - Convulsions, absence
  - Convulsions, myoclonus
  - Convulsions, partial
  - Convulsions, localized
  - Convulsions, focal
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antiepileptic drugs. Consider withdrawal if rash or signs of hypersensitivity syndrome develop. Factors associated with increased risk of serious skin reactions include concomitant use of valproate, initial lamotrigine dosing higher than recommended, and more rapid dose escalation than recommended.

- **ALLERGY AND CROSS-SENSITIVITY** Antiepileptic hypersensitivity syndrome associated with lamotrigine. See under Epilepsy p. 195 for more information.

- **PREGNANCY** See also Pregnancy in Epilepsy p. 195. Monitoring. Doses should be adjusted on the basis of plasma-drug concentration monitoring.

- **BREAST FEEDING** Present in milk, but limited data suggest no harmful effect on infant.

- **HEPATIC IMPAIRMENT** May accumulate. Dose adjustments Consider reducing maintenance dose in significant impairment.

- **TREATMENT CESSATION** Avoid abrupt withdrawal (taper off over 2 weeks or longer) unless serious skin reaction occurs.

- **PRESCRIBING AND DISPENSING INFORMATION** Patients being treated for epilepsy may need to be maintained on a specific manufacturer’s branded or generic lamotrigine product. Switching between formulations should be taken when switching between oral formulations in the treatment of epilepsy. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

- **PATIENT AND CARER ADVICE** Skin react if rash or signs of hypersensitivity syndrome develop. Blood disorders Patients and their carers should be alert for symptoms and signs suggestive of bone-marrow failure, such as anaemia, bruising, or infection. Aplastic anaemia, bone-marrow depression, and pancytopenia have been associated rarely with lamotrigine. Medicines for Children leaflet: Lamotrigine for preventing seizures www.medicinesforchildren.org.uk/lamotrigine-preventing-seizures

- **RENAI IMPAIRMENT** Caution in renal failure; metabolite may accumulate. Dose adjustments Consider reducing maintenance dose in significant impairment.

- **DISCONTINUATION** Avoid abrupt withdrawal (taper off over 2 weeks or longer) unless serious skin reaction occurs.

- **PRESCRIBING AND DISPENSING INFORMATION** Patients being treated for epilepsy may need to be maintained on a specific manufacturer’s branded or generic lamotrigine product. Switching between formulations should be taken when switching between oral formulations in the treatment of epilepsy. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

- **PATIENT AND CARER ADVICE** Skin react if rash or signs of hypersensitivity syndrome develop. Blood disorders Patients and their carers should be alert for symptoms and signs suggestive of bone-marrow failure, such as anaemia, bruising, or infection. Aplastic anaemia, bone-marrow depression, and pancytopenia have been associated rarely with lamotrigine. Medicines for Children leaflet: Lamotrigine for preventing seizures www.medicinesforchildren.org.uk/lamotrigine-preventing-seizures

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

### Dispersible tablet

**CAUTIONARY AND ADVISORY LABELS** 8, 13

- **Lamotrigine (Non-proprietary)**
  - Lamotrigine 5 mg | Lamotrigine 5mg dispersible tablets sugar free | 28 tablet (P) £5.90 DT + £0.86
  - Lamotrigine 25 mg | Lamotrigine 25mg dispersible tablets sugar free | 56 tablet (P) £20.00 DT + £2.20
  - Lamotrigine 100 mg | Lamotrigine 100mg dispersible tablets sugar free | 56 tablet (P) £50.68 DT + £3.99
  - Lamictal (GlaxoSmithKline UK Ltd)
    - Lamotrigine 2 mg | Lamotrigine 2mg dispersible tablets sugar free | 30 tablet (P) £18.81 DT + £18.81
    - Lamotrigine 5 mg | Lamotrigine 5mg dispersible tablets sugar free | 28 tablet (P) £8.38 DT + £6.86
    - Lamotrigine 25 mg | Lamotrigine 25mg dispersible tablets sugar free | 56 tablet (P) £23.53 DT + £2.20
    - Lamotrigine 100 mg | Lamotrigine 100mg dispersible tablets sugar free | 56 tablet (P) £63.04 DT + £3.99

**Levetiracetam**

03-Apr-2018

- **INDICATIONS AND DOSE**

  - **Monotherapy of focal seizures with or without secondary generalisation**
    - **BY MOUTH, OR BY INTRAVENOUS INFUSION**
      - Child 16–17 years: Initially 250 mg once daily for 1 week, then increased to 250 mg twice daily, then increased in steps of 250 mg twice daily (max. per dose 1.5 g twice daily), adjusted according to response, dose to be increased every 2 weeks
      - Child 6 months–17 years (body-weight up to 50 kg): Initially 10 mg/kg once daily, then increased in steps of up to 10 mg/kg twice daily (max. per dose 30 mg/kg twice daily), dose to be increased every 2 weeks
      - Child 12–17 years (body-weight 50 kg and above): Initially 250 mg twice daily, then increased in steps of 500 mg twice daily (max. per dose 1.5 g twice daily), dose to be increased every 2–4 weeks
    - **BY INTRAVENOUS INFUSION**
      - Child 4–17 years (body-weight up to 50 kg): Initially 10 mg/kg once daily, then increased in steps of up to 10 mg/kg twice daily (max. per dose 30 mg/kg twice daily), dose to be increased every 2 weeks
      - Child 12–17 years (body-weight 50 kg and above): Initially 250 mg twice daily, then increased in steps of 500 mg twice daily (max. per dose 1.5 g twice daily), dose to be increased every 2 weeks

- **Adjunctive therapy of myoclonic seizures and tonic-clonic seizures**

  - **BY MOUTH, OR BY INTRAVENOUS INFUSION**
    - Child 12–17 years (body-weight 50 kg and above): Initially 10 mg/kg once daily, then increased in steps of up to 10 mg/kg twice daily (max. per dose 30 mg/kg twice daily), dose to be increased every 2 weeks

- **UNLICENSED USE**

  - **Initial dosing recommendations for levetiracetam**
    - With oral use Manufacturer advises granaules not licensed for use in children under 6 years, for initial treatment in
Epilepsy and other seizure disorders

Levetiracetam 750 mg | Levetiracetam 750mg tablets | 60 tablet P | £84.02 DT = £7.87
Levetiracetam 1 gram | Levetiracetam 1g tablets | 60 tablet P | £93.09 DT = £8.33
Keppra (UCB Pharma Ltd)
Levetiracetam 250 mg | Keppra 250mg tablets | 60 tablet P | £28.01 DT = £3.27
Levetiracetam 500 mg | Keppra 500mg tablets | 60 tablet P | £50.22 DT = £5.50
Levetiracetam 750 mg | Keppra 750mg tablets | 60 tablet P | £84.02 DT = £7.87
Keppra 1 gram | Keppra 1g tablets | 60 tablet P | £95.34 DT = £8.33

Solution for infusion
ELECTROLYTES: May contain Sodium
Levetiracetam (Non-proprietary)
Levetiracetam 500mg/5ml concentrate for solution for infusion vials | 10 vial P | £127.31 DT = £127.31 | 10 vial P | £114.57 £127.31 DT = £127.31 (Hospital only)
Desitrend (Desitin Pharma Ltd)
Levetiracetam 100 mg per 1 ml | Desitrend 500mg/5ml concentrate for solution for infusion ampoules | 10 ampoule P | £127.31 DT = £127.31
Keppra (UCB Pharma Ltd)
Levetiracetam 100 mg per 1 ml | Keppra 500mg/5ml concentrate for solution for infusion vials | 10 vial P | £127.31 DT = £127.31

Oral solution
CAUTIONARY AND ADVISORY LABELS 8
Levetiracetam (Non-proprietary)
Levetiracetam 100 mg per 1 ml | Levetiracetam 100mg/ml oral solution sugar-free sugar-free | 150 ml P | £27.00 sugar-free | 300 ml P | £60.26 DT = £28.94
Keppra (UCB Pharma Ltd)
Levetiracetam 100 mg per 1 ml | Keppra 100mg/ml oral solution sugar-free | 150 ml P | £33.48 sugar-free | 300 ml P | £66.95 DT = £28.94

Oxcarbazepine

INDICATIONS AND DOSE
Monotherapy for the treatment of focal seizures with or without secondary generalised tonic-clonic seizures

BY MOUTH
Child 6-17 years: Initially 4–5 mg/kg twice daily (max. per dose 300 mg), then increased in steps of up to 5 mg/kg twice daily, adjusted according to response, dose to be adjusted at weekly intervals; maximum 46 mg/kg per day

Adjunctive therapy for the treatment of focal seizures with or without secondary generalised tonic-clonic seizures

BY MOUTH
Child 6-17 years: Initially 4–5 mg/kg twice daily (max. per dose 300 mg), then increased in steps of up to 5 mg/kg twice daily, adjusted according to response, dose to be adjusted at weekly intervals; maintenance 15 mg/kg twice daily; maximum 46 mg/kg per day

DOSE ADJUSTMENTS DUE TO INTERACTIONS
In adjunctive therapy, the dose of concomitant antiepileptics may need to be reduced when using high doses of oxcarbazepine.

CAUTIONS
Avoid in Acute porphyrias p. 624 - cardiac conduction disorders, heart failure - hyponatraemia

INTERACTIONS → Appendix 1: antiepileptics

SIDE-EFFECTS
Common or very common Abdominal pain - agitation - alopecia - asthenia - ataxia - concentration impaired - constipation - depression - diarrhoea - dizziness - drowsiness - emotional lability - headache - hyponatraemia - nausea - nyctagmus - skin reactions - vertigo - vision disorders - vomiting

Uncommon Alopecia - concentration impaired - confusion - hallucination - leucopenia - muscle weakness - myalgia - paraesthesia - psychotic disorder - suicidal tendencies - thrombocytopenia - vision disorders - weight changes

Rare or very rare Acute kidney injury - agranulocytosis - hepatic disorders - hyponatraemia - neutropenia - pancreatitis - rhabdomyolysis - severe cutaneous adverse reactions (SCARs) - thinking abnormal

Appendix 1: antiepileptics
210 Epilepsy and other seizure disorders

- Rare or very rare: Angioedema, arthralgia, atrioventricular block, hepatitis, hypothyroidism, pancreatitis, severe cutaneous adverse reactions (SCARs), systemic lupus erythematosus (SLE), thrombocytopenia
- Frequency not known: Agranulocytosis, bone disorders, bone marrow disorders, hypertension, inappropriate antidiuretic hormone secretion like syndrome, neutropenia, speech impairment

**ALLERGY AND CROSS-SENSITIVITY**

Caution in patients with hypersensitivity to carbamazepine. Antiepileptic hypersensitivity syndrome associated with oxcarbazepine. See under Epilepsy p. 195 for more information.

**PREGNANCY**

See also *Pregnancy* in Epilepsy p. 195. Monitoring: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**

Amount probably too small to be harmful but manufacturer advises avoid.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in patients with hepatic impairment.

**RENAL IMPAIRMENT**

Dose adjustments: Halve initial dose if estimated glomerular filtration rate is less than 30 mL/minute/1.73 m², increase according to response at intervals of at least 1 week.

**PRE-TREATMENT SCREENING**

Test for HLA-B*1502 allele in individuals of Han Chinese or Thai origin (avoid unless no alternative—risk of Stevens-Johnson syndrome in presence of HLA-B*1502 allele).

**MONITORING REQUIREMENTS**

- Monitor plasma-sodium concentration in patients at risk of hyponatraemia.
- Monitor body-weight in patients with heart failure.

**PRESCRIBING AND DISPENSING INFORMATION**

Patients may need to be maintained on a specific manufacturer’s branded or generic oxcarbazepine product.

Switching between formulations: Care should be taken when switching between oral formulations. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

**PATIENT AND CARER ADVICE**

Blood, hepatic, or skin disorders: Patients or their carers should be told how to recognise signs of blood, liver, or skin disorders, and advised to seek immediate medical attention if symptoms such as lethargy, confusion, muscular twitching, fever, rash, blistering, mouth ulcers, bruising, or bleeding develop.


**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension
- Oral suspension
  - CAUTIONARY AND ADVISORY LABELS 3, 8
  - EXCIPENTS: May contain Propylene glycol
  - Trileptal (Novartis Pharmaceuticals UK Ltd)
    - Oxcarbazepine 60 mg per 1 ml Trileptal 60mg/ml oral suspension sugar-free | 250 ml (POD) £48.96 DT = £48.96

- Tablet
  - CAUTIONARY AND ADVISORY LABELS 3, 8
  - Oxcarbazepine (Non-proprietary)
    - Oxcarbazepine 150 mg Oxcarbazepine 150mg tablets | 50 tablet (POD) £11.14 DT = £8.37
    - Oxcarbazepine 300 mg Oxcarbazepine 300mg tablets | 50 tablet (POD) £22.32 DT = £15.86
    - Oxcarbazepine 600 mg Oxcarbazepine 600mg tablets | 50 tablet (POD) £45.19 DT = £38.71

**INDICATIONS AND DOSE**

- **Adjunctive treatment of focal seizures with or without secondary generalised seizures**
  - **BY MOUTH**
    - Child 12-17 years: Initially 2 mg once daily, dose to be taken before bedtime, then increased, if tolerated, in steps of 2 mg at intervals of at least every 2 weeks, adjusted according to response; maintenance 4–8 mg once daily; maximum 12 mg per day

- **Adjunctive treatment of primary generalised tonic-clonic seizures**
  - **BY MOUTH**
    - Child 12-17 years: Initially 2 mg once daily, dose to be taken before bedtime, then increased, if tolerated, in steps of 2 mg at intervals of at least every 2 weeks, adjusted according to response, maintenance up to 8 mg once daily; maximum 12 mg per day

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- Titrate at intervals of at least 1 week with concomitant carbamazepine, fosphenytoin, oxcarbazepine, or phenytoin.

**INTERACTIONS**

- Appendix 1: antiepileptics

**SIDE-EFFECTS**

- Common or very common: Anxiety, appetite abnormal, back pain, behaviour abnormal, confusion, dizziness, drowsiness, dysarthria, fatigue, gait abnormal, irritability, movement disorders, nausea, vertigo, vision disorders, weight increased

**PREGNANCY**

Manufacturer advises avoid. See also *Pregnancy* in Epilepsy p. 195. Monitoring: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**

Avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

**Dose adjustments**

Manufacturer advises maximum 8 mg per day in mild to moderate impairment.

**RENAL IMPAIRMENT**

Avoid in moderate or severe impairment.

**PRESCRIBING AND DISPENSING INFORMATION**

Switching between formulations: Care should be taken when switching between oral formulations. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history. Patients may need to be maintained on a specific manufacturer’s branded or generic perampanel product.

**PATIENT AND CARER ADVICE**

- Driving and skilled tasks: Manufacturer advises patients and carers should be cautioned on the effects on driving and performance of skilled tasks—increased risk of dizziness and drowsines.
Phenytoin

19-Apr-2017

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Oral suspension**

**CAUTIONARY AND ADVISORY LABELS** 3, 8
EXCipients: May contain Sorbitol

▶ Fycompa (Eisai Ltd)
Perampanel 500 microgram per 1 ml Fycompa 0.5mg/ml oral suspension sugar-free | 340 ml PHS £12.75

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 3, 8, 25

▶ Fycompa (Eisai Ltd)
Perampanel 2 mg Fycompa 2mg tablets | 7 tablet PHS £35.00 DT + £35.00 | 28 tablet PHS £140.00 DT + £140.00
Perampanel 4 mg Fycompa 4mg tablets | 28 tablet PHS £140.00 DT + £140.00
Perampanel 6 mg Fycompa 6mg tablets | 28 tablet PHS £140.00 DT + £140.00
Perampanel 8 mg Fycompa 8mg tablets | 28 tablet PHS £140.00 DT + £140.00
Perampanel 10 mg Fycompa 10mg tablets | 28 tablet PHS £140.00 DT + £140.00
Perampanel 12 mg Fycompa 12mg tablets | 28 tablet PHS £140.00 DT + £140.00

**Prevention and treatment of seizures during or following neurosurgery or severe head injury**

▶ BY MOUTH
Child: Initially 2.5 mg/kg twice daily, then adjusted according to response to 4–8 mg/kg daily, dose also adjusted according to plasma-phenytoin concentration; maximum 300 mg per day

**Status epilepticus / Acute symptomatic seizures associated with head trauma or neurosurgery**

▶ INITIALLY BY SLOW INTRAVENOUS INJECTION

Neonate: Loading dose 18 mg/kg, dose to be administered over 20–30 minutes, then (by mouth) 2.5–5 mg/kg twice daily (max. per dose 7.5 mg/kg twice daily), adjusted according to response, dose also adjusted according to plasma-phenytoin concentration.

**DOSE EQUIVALENT AND CONVERSION**

Preparations containing phenytoin sodium are not bioequivalent to those containing phenytoin base (such as Epanutin Infatabs® and Epanutin® suspension); 100 mg of phenytoin sodium is approximately equivalent in therapeutic effect to 92 mg phenytoin base. The dose is the same for all phenytoin products when initiating therapy. However, if switching between these products the difference in phenytoin content may be clinically significant. Care is needed when making changes between formulations and plasma-phenytoin concentration monitoring is recommended.

**INDICATIONS AND DOSE**

**Tonic-clonic seizures / Focal seizures**

▶ BY MOUTH
Child 1 month–11 years: Initially 1.5–2.5 mg/kg twice daily, then adjusted according to response to 2.5–5 mg/kg twice daily (max. per dose 7.5 mg/kg twice daily), dose also adjusted according to plasma-phenytoin concentration; maximum 300 mg per day

Child 12–17 years: Initially 75–150 mg twice daily, then adjusted according to response to 150–200 mg twice daily (max. per dose 300 mg twice daily), dose also adjusted according to plasma-phenytoin concentration

▶ INITIALLY BY SLOW INTRAVENOUS INJECTION

Neonate: Loading dose 18 mg/kg, dose to be administered over 20–30 minutes, then (by mouth) 2.5–5 mg/kg twice daily (max. per dose 7.5 mg/kg twice daily), adjusted according to response, dose also adjusted according to plasma-phenytoin concentration.

**INTERACTIONS**

Appendix 1: Antiepileptics

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

**SPECIFIC SIDE-EFFECTS**

With oral use: Electrolyte imbalance - pneumonitis - vitamin D deficiency

With parenteral use: Arrhythmias - atrial conduction depression (more common if injection too rapid) - cardiac

**CONTRA-INDICATIONS**

**GENERAL CONTRA-INDICATIONS**

Acute porphyrias p. 624

**SPECIFIC CONTRA-INDICATIONS**

With intravenous use Second- and third-degree heart block - sino-atrial block - sinus bradycardia - Stokes-Adams syndrome

**CAUTIONS**

**GENERAL CAUTIONS**

Enteral feeding (interrupt feeding for 2 hours before and after dose; more frequent monitoring may be necessary)

**SPECIFIC CAUTIONS**

With intravenous use: Heart failure - hypotension - injection solutions alkaline (irritant to tissues) - respiratory depression - resuscitation facilities must be available

**CAUTIONS, FURTHER INFORMATION**

Consider vitamin D supplementation in patients who are immobilised for long periods or who have inadequate sun exposure or dietary intake of calcium.

Intramuscular phenytoin should not be used (absorption is slow and erratic).

**IMPORTANCE SAFETY INFORMATION**

NHS IMPROVEMENT PATIENT SAFETY ALERT: RISK OF DEATH AND SEVERE HARM FROM ERROR WITH INJECTABLE PHENYTOIN

(NOVEMBER 2016)

Use of injectable phenytoin is error-prone throughout the prescribing, preparation, administration and monitoring processes; all relevant staff should be made aware of appropriate guidance on the safe use of injectable phenytoin to reduce the risk of error.

**UNLICENSED USE**

With oral use: Licensed for use in children (age range not specified by manufacturer).

With intravenous use: Phenytoin doses in BNF publications may differ from those in product literature.

**SPECIFIC SIDE-EFFECTS**

With intravenous use (error-prone throughout the prescribing, preparation, administration and monitoring processes; all relevant staff should be made aware of appropriate guidance on the safe use of injectable phenytoin to reduce the risk of error.)
arrest • extravasation necrosis • hypotension • injection site necrosis • purple glove syndrome • respiratory arrest (more common if injection too rapid) • respiratory disorders • tonic seizure (more common if injection too rapid) • ventricular conduction depression (more common if injection too rapid) • ventricular fibrillation (more common if injection too rapid)•

SIDE-EFFECTS, FURTHER INFORMATION Rash Discontinue; if mild re-introduce cautiously but discontinue immediately if recurrence.

Bradycardia and hypotension With intravenous use; reduce rate of administration if bradycardia or hypotension occurs.

Overdose Symptoms of phenytoin toxicity include nystagmus, diplopia, slurred speech, ataxia, confusion, and hyperglycaemia.

ALLERGY AND CROSS-SENSITIVITY Cross-sensitivity reported with carbamazepine. Antiepileptic hypersensitivity syndrome associated with phenytoin. See under Epilepsy p. 195 for more information.


Doses should be adjusted on the basis of plasma-drug concentration monitoring.

BREAST FEEDING Small amounts present in milk, but not known to be harmful.

HEPATIC IMPAIRMENT Manufacturer advises caution (increased risk of accumulation and toxicity due to decreased protein binding in hepatic impairment, hypalbuminaemia, or hyperbilirubinaemia). Dose adjustments • With oral use Manufacturer advises consider dose reduction.
• With intravenous use Manufacturer advises consider maintenance dose reduction.

PRE-TREATMENT SCREENING HLA* 1502 allele in individuals of Han Chinese or Thai origin—avoid unless essential (increased risk of Stevens-Johnson syndrome).

MONITORING REQUIREMENTS • Therapeutic plasma-phenytoin concentrations reduced in first 3 months of life because of reduced protein binding.
• Trough plasma concentration for optimum response: neonate—3 months, 6–15 mg/litre (25–60 micromol/litre); child 3 months–18 years, 10–20 mg/litre (40–80 micromol/litre).
• Manufacturer recommends blood counts (but evidence of practical value uncertain).
• With intravenous use Monitor ECG and blood pressure.

DIRECTIONS FOR ADMINISTRATION Manufacturer advises each injection or infusion should be preceded and followed by an injection of Sodium Chloride 0.9% through the same needle or catheter to avoid local venous irritation.
• With intravenous use For intravenous injection, give into a large vein at a rate not exceeding 1 mg/minute (max. 50 mg/minute). Manufacturer advises for intravenous infusion, dilute to a concentration not exceeding 10 mg/mL with Sodium Chloride 0.9% and give into a large vein through an in-line filter (0.22–0.50 micron). Give at a rate not exceeding 1 mg/minute (max. 50 mg/minute).
• Complete administration within 1 hour of preparation.

PRESCRIBING AND DISPENSING INFORMATION Switching between formulations Different formulations of oral preparations may vary in bioavailability. Patients being treated for epilepsy should be maintained on a specific manufacturer’s product.

PATIENT AND CARER ADVICE Blood or skin disorders Patients or their carers should be told how to recognise signs of blood or skin disorders, and advised to seek immediate medical attention if symptoms such as fever, rash, mouth ulcers, bruising, or bleeding develop. Leucopenia that is severe, progressive, or associated with clinical symptoms requires withdrawal (if necessary under cover of a suitable alternative).

Medicines for Children leaflet: Phenytoin for preventing seizures www.medicinesforchildren.org.uk/phenytoin-preventing-seizures

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

Tablet
CAUTIONARY AND ADVISORY LABELS 8
• Phenytoin (Non-proprietary) Phenytoin sodium 100 mg solution for injection ampoule | 28 table £30.00 DT = £1.11

Solution for injection
EXCIPIENTS: May contain Alcool, propylene glycol ELECTROLYTES: May contain Sodium
• Phenytoin (Non-proprietary) Phenytoin sodium 50 mg per 1 ml Phenytoin sodium 250mg/5ml solution for injection ampoules | 5 ampoule £24.40 (Hospital only)
• Epanutin (Pfizer Ltd) Phenytoin sodium 50 mg per 1 ml Epanutin Ready-Mixed Parenteral 250mg/5ml solution for injection ampoules | 10 ampoule £48.79 (Hospital only)

Oral suspension
CAUTIONARY AND ADVISORY LABELS 8
• Epanutin (Pfizer Ltd) Phenytoin 6 mg per 1 ml Epanutin 30mg/5ml oral suspension | 500 ml £4.27 DT = £0.87

Chewable tablet
CAUTIONARY AND ADVISORY LABELS 8, 24
• Epanutin (Pfizer Ltd) Phenytoin 50 mg Epanutin Infatabs 50mg chewable tablets | 200 tablet £13.18 DT = £0.65

Capsule
CAUTIONARY AND ADVISORY LABELS 8
• Phenytoin (Non-proprietary) Phenytoin sodium 25 mg Phenytoin sodium 25mg capsules | 28 capsule £7.24 DT = £0.26
• Phenytoin sodium 50 mg Phenytoin sodium 50mg capsules | 28 capsule £7.07 DT = £0.25
• Phenytoin sodium 100 mg Phenytoin sodium 100mg capsules | 84 capsule £67.50 DT = £0.81
• Phenytoin sodium 300 mg Phenytoin sodium 300mg capsules | 28 capsule £9.11 DT = £0.33

Rufinamide

INDICATIONS AND DOSE
Adjuvant treatment of seizures in Lennox-Gastaut syndrome without valproate (initiated by a specialist)
• BY MOUTH
  Child 1-3 years: Initially 5 mg/kg twice daily, then increased in steps of up to 5 mg/kg twice daily (max. per dose 22.5 mg/kg twice daily), adjusted according to response, dose to be increased at intervals of not less than 3 days to the target dose (maximum dose), each dose should be given to the nearest 0.5 mg.
  Child 4-17 years (body-weight up to 30 kg): Initially 100 mg twice daily, then increased in steps of 100 mg twice daily (max. per dose 500 mg twice daily), adjusted according to response, dose to be increased at intervals of not less than 3 days.
  Child 4-17 years (body-weight 30-50 kg): Initially 200 mg twice daily, then increased in steps of 200 mg twice daily (max. per dose 900 mg twice daily), adjusted according to response, dose to be increased at intervals of not less than 2 days.
  Child 4-17 years (body-weight 50.1-70 kg): Initially 200 mg twice daily, then increased in steps of 200 mg twice daily.
Epilepsy and other seizure disorders

Materials for Children leaflet: Rufinamide for preventing seizures
www.medicinesforchildren.org.uk/rufinamide-preventing-seizures

Driving and skilled tasks
Manufacturer advises patients and carers should be cautioned on the effects on driving and performance of skilled tasks—increased risk of dizziness, somnolence and blurred vision.

Scottish Medicines Consortium (SMC) decisions
The Scottish Medicines Consortium has advised (November 2008) that rufinamide (Inovelon®) is accepted for restricted use within NHS Scotland as adjunctive therapy in the treatment of seizures associated with Lennox-Gastaut syndrome in patients 4 years and above. It is restricted for use when alternative traditional antiepileptic drugs are unsatisfactory.

SMC No. 795/12
The Scottish Medicines Consortium has advised (July 2012) that rufinamide 40 mg/mL oral suspension (Inovelon®) is accepted for restricted use within NHS Scotland as adjunctive therapy in the treatment of seizures associated with Lennox-Gastaut syndrome in patients 4 years and above. It is restricted for use when alternative traditional antiepileptic drugs are unsatisfactory.

SMC No. SM2146
The Scottish Medicines Consortium has advised (April 2019) that rufinamide (Inovelon®) is accepted for restricted use within NHS Scotland as adjunctive therapy in the treatment of seizures associated with Lennox-Gastaut syndrome in patients aged 1 year up to 4 years. It is restricted for use when alternative traditional antiepileptic drugs are unsatisfactory.

Sodium valproate

Indications and dose

- Neurontin® 50 mg, 100 mg, 200 mg, 300 mg and 400 mg tablets
- Epilepsy and other seizure disorders

- Epilepsy p. 173
- Allergic and cross-sensitivity

- Antiepileptic

- Hypersensitivity

- Nervous system

- Side-effects
- Common or very common

- Anxiety, appetite decreased, back pain, constipation, diarrhea, dizziness, drowsiness, eating disorder, epistaxis, fatigue, gait abnormal, gastrointestinal discomfort, headache, increased risk of infection, insomnia, movement disorders, nausea, nyctagmus, oligomenorrhea, seizures, skin reactions, tremor, vertigo, vision disorders, vomiting, weight decreased

- Rare

- Drowsiness

- Hypersensitivity

- Allergic and cross-sensitivity

- Antiepileptic

- Hypersensitivity syndrome associated with rufinamide. See under Epilepsy p. 195 for more information.

- Pregnancy

- Breast feeding

- Hepatic impairment

- Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment (no information available).

- Dose adjustments

- Manufacturer advises cautious dose titration in mild to moderate impairment.

- Directions for administration

- Manufacturer advises tablets may be crushed and given in half a glass of water.

- Prescribing and dispensing information

- Switching between formulations. Care should be taken when switching between oral formulations. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

- Patients may need to be maintained on a specific manufacturer’s branded or generic rufinamide product.

- Patient and carer advice

- Counselling on antiepileptic hypersensitivity syndrome is advised.

- Medicines for Children leaflet. Rufinamide for preventing seizures

- Driving and skilled tasks

- Patient and carer advice

- Counselling on antiepileptic hypersensitivity syndrome is advised.

- Medicines for Children leaflet. Rufinamide for preventing seizures

- Nervous system

- Side-effects

- Common or very common

- Anxiety, appetite decreased, back pain, constipation, diarrhea, dizziness, drowsiness, eating disorder, epistaxis, fatigue, gait abnormal, gastrointestinal discomfort, headache, increased risk of infection, insomnia, movement disorders, nausea, nyctagmus, oligomenorrhea, seizures, skin reactions, tremor, vertigo, vision disorders, vomiting, weight decreased

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- Hypersensitivity

- Allergic and cross-sensitivity

- Antiepileptic

- Hypersensitivity syndrome associated with rufinamide. See under Epilepsy p. 195 for more information.

- Pregnancy

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- Directions for administration

- Manufacturer advises tablets may be crushed and given in half a glass of water.
214 Epilepsy and other seizure disorders

Chemistry and haematological parameters if dose exceeds 40 mg/kg daily
- Child 12-17 years: Initially 600 mg daily in 1–2 divided doses, increased in steps of 150–300 mg every 3 days; maintenance 1–2 g daily in 2 divided doses; maximum 2.5 g per day
- **BY MOUTH**
- **BY RECTUM**
- Neonate: Initially 20 mg/kg once daily; maintenance 10 mg/kg twice daily.

- Child 1 month–11 years: Initially 10–15 mg/kg daily in 1–2 divided doses (max. per dose 600 mg); maintenance 25–30 mg/kg daily in 2 divided doses, doses up to 60 mg/kg daily in 2 divided doses may be used in infantile spasms; monitor clinical chemistry and haematological parameters if dose exceeds 40 mg/kg daily
- **BY MOUTH**
- **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION,**
- Neonate: Initially 40 mg/kg daily in 1–2 divided doses, increased in steps of 150–300 mg every 3 days; maintenance 1–2 g daily in 2 divided doses; maximum 2.5 g per day

**Initiation of valproate treatment**
- **INITIALLY BY INTRAVENOUS INJECTION**
- Neonate: 10 mg/kg twice daily.

- Child 1 month–11 years: Initially 10 mg/kg, then (by intravenous infusion or by intravenous injection) increased to 20–40 mg/kg daily in 2–4 divided doses, alternatively (by continuous intravenous infusion) increased to 20–40 mg/kg daily, monitor clinical chemistry and haematological parameters if dose exceeds 40 mg/kg daily
- Child 12-17 years: Initially 10 mg/kg, followed by (by intravenous infusion or by intravenous injection) up to 2.5 g daily in 2–4 divided doses, alternatively (by continuous intravenous infusion) up to 2.5 g daily; (by intravenous injection or by intravenous infusion or by continuous intravenous infusion) usual dose 1–2 g daily, alternatively (by intravenous injection or by intravenous infusion or by continuous intravenous infusion) usual dose 20–30 mg/kg daily, intravenous injection to be administered over 3–5 minutes

**Continuation of valproate treatment**
- **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION,** BY **CONTINUOUS INTRAVENOUS INFUSION**
- Children: If switching from oral therapy to intravenous therapy give the same dose as current oral daily dose, give over 3–5 minutes by intravenous injection or in 2–4 divided doses by intravenous infusion

EPILIM CHRONOSPHERE ®
**All forms of epilepsy**
- **BY MOUTH**
- Child: Total daily dose to be given in 1–2 divided doses (consult product literature)

EPILIM CHRONO ®
**All forms of epilepsy**
- **BY MOUTH**
- **BY RECTUM**
- Child (body-weight 20 kg and above): Total daily dose to be given in 1–2 divided doses (consult product literature)

EPISENTA ® GRANULES
**All forms of epilepsy**
- **BY MOUTH**
- Child: Total daily dose to be given in 1–2 divided doses (consult product literature)

EPIVAL ®
**All forms of epilepsy**
- **BY MOUTH**
- Child: Total daily dose to be given in 1–2 divided doses (consult product literature)

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: VALPROATE MEDICINES: CONTRA-INDICATED IN WOMEN AND GIRLS OF CHILD-BEARING POTENTIAL UNLESS CONDITIONS OF PREGNANCY PREVENTION PROGRAMME ARE MET (APRIL 2018)

Valproate is highly teratogenic and evidence supports that use in pregnancy leads to neurodevelopmental disorders (approx. 30–40% risk) and congenital malformations (approx. 10% risk). Valproate must not be used in women and girls of childbearing potential unless the conditions of the Pregnancy Prevention Programme are met (see Conception and contraception) and only if other treatments are ineffective or not tolerated, as judged by an experienced specialist.

Use of valproate in pregnancy is contra-indicated for migraine prophylaxis [unlicensed] and bipolar disorder; it must only be considered for epilepsy if there is no suitable alternative treatment (see Pregnancy). Women and girls (and their carers) must be fully informed of the risks and the need to avoid exposure to valproate medicines in pregnancy; supporting materials have been provided to use in the implementation of the Pregnancy Prevention Programme; supporting materials have been provided to use in the implementation of the Pregnancy Prevention Programme (see Prescribing and dispensing Information). The MHRA advises that:
- **GP**s must recall all women and girls who may be of childbearing potential, provide the Patient Guide, check they have been reviewed by a specialist in the last year and are on highly effective contraception;
- **Specialists** must book in review appointments at least annually with women and girls under the Pregnancy Prevention Programme, re-evaluate treatment as necessary, explain clearly the conditions as outlined in the supporting materials and complete and sign the Risk Acknowledgement Form—copies of the form must be given to the patient or carer and sent to their GP;
- **Pharmacists** must ensure valproate medicines are dispensed in whole packs whenever possible—all packs dispensed to women and girls of childbearing potential should have a warning label either on the carton or via a sticker. They must also discuss risks in pregnancy with female patients each time valproate medicines are dispensed, ensure they have the Patient Guide and have seen their GP or specialist to discuss their treatment and the need for contraception.

MHRA/CHM ADVICE: VALPROATE MEDICINES: ARE YOU ACTING IN COMPLIANCE WITH THE PREGNANCY PREVENTION MEASURES? (DECEMBER 2018)

The MHRA advises that all healthcare professionals must continue to identify and review all female patients on valproate, including when used outside licensed indications (off-label use) and provide them with the patient information materials every time they attend appointments or receive their medicines. Guidance for psychiatrists on the withdrawal of, and alternatives to, valproate in women of child-bearing potential who have a psychiatric illness is available from the Royal College of Psychiatrists.
MHRA/CHM ADVICE: VALPROATE MEDICINES AND SERIOUS HARMs IN PREGNANCY: NEW ANNUAL RISK ACKNOWLEDGMENT FORM AND CLINICAL GUIDANCE FROM PROFESSIONAL BODIES TO SUPPORT COMPLIANCE WITH THE PREGNANCY PREVENTION PROGRAMME (APRIL 2019)

The Annual Risk Acknowledgement Form has been updated and should be used for all future reviews of female patients on valproate. Specialists should comply with guidance given on the form if they consider the patient is not at risk of pregnancy, including the need for review in case her risk status changes.

Guidance has been published to support healthcare professionals with the use of valproate. These include a summary by NICE of their guidance and safety advice, pan-college guidance by national healthcare bodies, and paediatric guidance by the British Paediatric Neurology Association and the Royal College of Paediatrics and Child Health.

- **CONTRA-INDICATIONS** Acute porphyrias p. 624 • known or suspected mitochondrial disorders (higher rate of acute liver failure and liver-related deaths) • personal or family history of severe hepatic dysfunction

- **CAUTIONS** Systemic lupus erythematosus

**CAUTIONS, FURTHER INFORMATION** Consider vitamin D supplementation in patients that are immobilised for long periods or who have inadequate sun exposure or dietary intake of calcium.

- **Liver toxicity** Liver dysfunction (including fatal hepatic failure) has occurred in association with valproate (especially in children under 3 years and in those with metabolic or degenerative disorders, organic brain disease or severe seizure disorders associated with mental retardation) usually in first 6 months and usually involving multiple antiepileptic therapy. Raised liver enzymes during valproate treatment are usually transient but patients should be reassessed clinically and liver function (including prothrombin time) monitored until return to normal–discontinue if abnormally prolonged prothrombin time (particularly in association with other relevant abnormalities).

- **INTERACTIONS** → Appendix 1: antiepileptics

- **SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **Common or very common** Abdominal pain • agitation • alopecia (regrowth may be curly) • anaemia • behaviour abnormal • confusion • deafness • diarrhoea • drowsiness • hallucination • headache • hepatic disorders • hypoglycaemia • memory loss • mental retardation • irregularities • movement disorders • nail disorder • nausea • oedema • oral disorders • seizures • stupor • thrombocytopenia • tremor • urinary disorders • vomiting • weight increased

- **Uncommon** Androgenetic alopecia • angiodema • bone disorders • bone fracture • bone marrow disorders • coma • encephalopathy • hair changes • hyperammonaemia • hypothyroidism • myelodysplastic syndrome • nephritis tubulointerstitial • polycystic ovaries • red blood cell abnormalities • rhabdomyolysis • severe cutaneous adverse reactions (SCARs) • systemic lupus erythematosus (SLE) • urine abnormalities

- **Frequency not known** Alertness increased

**SPECIFIC SIDE-EFFECTS**

- **Common or very common** With intravenous use Dizziness

**SIDE-EFFECTS, FURTHER INFORMATION**

- **Hepatic dysfunction** Withdraw treatment immediately if persistent vomiting and abdominal pain, anorexia, jaundice, oedema, malaise, drowsiness, or loss of seizure control.

- **Pancreatitis** Discontinue treatment if symptoms of pancreatitis develop.

- **CONCEPTION AND CONTRACEPTION** The MHRA advises that all women and girls of childbearing potential being treated with valproate medicines must be supported on a Pregnancy Prevention Programme—pregnancy should be excluded before treatment initiation and highly effective contraception must be used during treatment.

- **PREGNANCY** For migraine prophylaxis [unlicensed] and bipolar disorder, the MHRA advises that valproate must not be used. For epilepsy, the MHRA advises valproate must not be used unless there is no suitable alternative treatment; in such cases, access to counselling about the risks should be provided (see Healthcare Professional Guide for more information) and a Risk Acknowledgement Form signed by both specialist and patient. If valproate is to be used during pregnancy, the lowest effective dose should be prescribed in divided doses or as modified-release tablets to avoid peaks in plasma-valproate concentrations; doses greater than 1 g daily are associated with an increased risk of teratogenicity. Neonatal bleeding (related to hypofibrininaemia) reported. Neonatal hepatotoxicity also reported. See also Pregnancy in Epilepsy p. 195.

- **Monitoring** Specialist prenatal monitoring should be instigated when valproate has been taken in pregnancy. The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

- **BREAST FEEDING** Present in milk—risk of haematological disorders in breast-fed newborns and infants.

- **HEPATIC IMPAIRMENT** Manufacturer advises avoidance.

- **RENAI IMPAIRMENT** Dose adjustments Reduce dose.

- **MONITORING REQUIREMENTS**

- **Plasma-valproate concentrations** are not a useful index of efficacy, therefore routine monitoring is unhelpful.

- **Monitor liver function before therapy and during treatment; in such cases, access to counselling about the risks should be provided (see Healthcare Professional Guide for more information) and a Risk Acknowledgement Form signed by both specialist and patient. If valproate is to be used during pregnancy, the lowest effective dose should be prescribed in divided doses or as modified-release tablets to avoid peaks in plasma-valproate concentrations; doses greater than 1 g daily are associated with an increased risk of teratogenicity. Neonatal bleeding (related to hypofibrininaemia) reported. Neonatal hepatotoxicity also reported. See also Pregnancy in Epilepsy p. 195.

- **EFFECT ON LABORATORY TESTS** False-positive urine tests for ketones.

- **TREATMENT CESSATION** Avoid abrupt withdrawal; if treatment with valproate is stopped, reduce the dose gradually over at least 4 weeks.

- **DIRECTIONS FOR ADMINISTRATION**

- **Intravenous use** Manufacturer advises for intravenous injection, give over 3–5 minutes. For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%. Reconstitute Epilim® with solvent provided then dilute with infusion fluid if required. Displacement value may be significant, consult local guidelines.

- **Rectal use** For rectal administration, sodium valproate oral solution may be given rectally and retained for 15 minutes (may require dilution with water to prevent rapid expulsion). Epival® Tablets may be halved but not crushed or chewed.

**EPISINTA® CAPSULES** Contents of capsule may be mixed with cold soft food or drink and swallowed immediately without chewing.
Epilepsy and other seizure disorders

**EPILIM® SYRUP** May be diluted, preferably in Syrup BP; use within 14 days.

**EPISENTA® GRANULES** Granules may be mixed with cold soft food or drink and swallowed immediately without chewing.

**EPILIM CHRONOSPHERE®** Granules may be mixed with soft food or drink that is cold or at room temperature, and swallowed immediately without chewing.

### PRESCRIBING AND DISPENSING INFORMATION

The Pregnancy Prevention Programme is supported by the following materials provided by the manufacturer: Patient Guide, Guide for Healthcare Professionals, Risk Acknowledgement Form, and for pharmacists, Patient Cards and Stickers with warning symbols; the MHRA has also produced a patient information sheet providing advice for women and girls taking valproate medicines.

Switching between formulations Care should be taken when switching between oral formulations in the treatment of epilepsy. The need for continued supply of a particular manufacturer’s product should be based on clinical judgment and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

Patients being treated for epilepsy may need to be maintained on a specific manufacturer’s branded or generic oral sodium valproate product.

**EPILIM CHRONOSPHERE®** Prescribe dose to the nearest whole 50-mg sachet.

### PATIENT AND CARER ADVICE

Valproate use by women and girls The MHRA advises women and girls should not stop taking valproate without first discussing it with their doctor.

Blood or hepatic disorders Patients or their carers should be told how to recognise signs and symptoms of blood or liver disorders and advised to seek immediate medical attention if symptoms develop.

Pancreatitis Patients or their carers should be told how to recognise signs and symptoms of pancreatitis and advised to seek immediate medical attention if symptoms such as abdominal pain, nausea, or vomiting develop.

Patients or their carers should be counselled on the administration of granules.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, suppository

### Modified-release tablet

**EPILIM Chrono (Sanofi)**

| Sodium valproate 200 mg | Epilim Chrono 200 tablets | 30 tablet (PST) £1.50 | 100 tablet (PST) £4.50 | £11.35 DT = £11.65 |
| Sodium valproate 300 mg | Epilim Chrono 300 tablets | 30 tablet (PST) £5.24 | 100 tablet (PST) £17.47 DT = £17.47 |

**Epival CR (Chanelle Medical UK Ltd)**

| Sodium valproate 300 mg | Epival CR 300mg tablets | 100 tablet (PST) £17.47 DT = £17.47 |
| Sodium valproate 500 mg | Epival CR 500mg tablets | 100 tablet (PST) £29.10 DT = £29.10 |

**Gastro-resistant tablet**

**CAUTIONARY AND ADVISORY LABELS 5, 8, 10, 25**

### Sodium valproate (non-proproprietary)

| Sodium valproate 200 mg | Sodium valproate 200mg gastro-resistant tablets | 100 tablet (PST) £9.24 DT = £8.36 |
| Sodium valproate 500 mg | Sodium valproate 500mg gastro-resistant tablets | 100 tablet (PST) £18.82 DT = £17.90 |

**Epilim (Sanofi)**

| Sodium valproate 200 mg | Epilim 200 mg gastro-resistant tablets | 30 tablet (PST) £2.32 | 100 tablet (PST) £7.10 DT = £6.36 |
| Sodium valproate 500 mg | Epilim 500 mg gastro-resistant tablets | 30 tablet (PST) £5.78 | 100 tablet (PST) £19.25 DT = £20.12 |

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 8, 10, 21**

| Epilim (Sanofi) ✔️ | Sodium valproate 100 mg | Epilim 100mg tablets | 30 tablet (PST) £1.68 | 100 tablet (PST) £5.60 DT = £5.60 |

### Solution for injection

**CAUTIONARY AND ADVISORY LABELS 5, 8, 10, 21**

| Episenta (Desitin Pharma Ltd) ▼ | Sodium valproate 100 mg per 1 ml | Episenta 100mg/ml solution for injection ampoules | 5 ampoule (PST) £57.90 DT = £57.90 |

**Episenta**

| Sodium valproate 100 mg per 1 ml | Episenta 100mg/ml solution for injection ampoules | 5 ampoule (PST) £35.00 DT = £35.00 |

### Modified-release capsule

**CAUTIONARY AND ADVISORY LABELS 8, 10, 21, 25**

| Episenta (Desitin Pharma Ltd) ▼ | Episenta 150mg modified-release capsules | 100 capsule (PST) £70.00 DT = £70.00 |
| Sodium valproate 300 mg | Episenta 300mg modified-release capsules | 100 capsule (PST) £13.00 DT = £13.00 |

### Oral solution

**CAUTIONARY AND ADVISORY LABELS 8, 10, 21**

| Sodium valproate 40 mg per 1 ml | Sodium valproate 200mg/5ml oral solution sugar free-sugar-free | 300 ml (PST) £7.37 DT = £7.38 |

Epilim 200mg/5ml syrup | 100 ml (PST) £9.33 DT = £9.33 |

**Epilim (Sanofi)**

| Sodium valproate 40 mg per 1 ml | Epilim 200mg/5ml liquid sugar-free | 300 ml (PST) £7.78 DT = £7.80 |

Epilim 200mg/5ml syrup | 100 ml (PST) £9.33 DT = £9.33 |

### Modified-release granules

**CAUTIONARY AND ADVISORY LABELS 8, 10, 21, 25**

| Epilim Chronosphere MR (Sanofi) ▼ | Sodium valproate 50 mg | Epilim Chronosphere MR 50mg granules | 30 sachet (PST) £30.00 DT = £30.00 |

Sodium valproate 100 mg | Epilim Chronosphere MR 100mg granules | 30 sachet (PST) £30.00 DT = £30.00 |

Sodium valproate 250 mg | Epilim Chronosphere MR 250mg granules | 30 sachet (PST) £30.00 DT = £30.00 |

Sodium valproate 500 mg | Epilim Chronosphere MR 500mg granules | 30 sachet (PST) £30.00 DT = £30.00 |

Sodium valproate 1 gram | Epilim Chronosphere MR 1000mg granules | 30 sachet (PST) £30.00 DT = £30.00 |

Episenta (Desitin Pharma Ltd) ▼

| Sodium valproate 500 mg | Episenta 500mg modified-release granules sugar-free | 100 sachet (PST) £21.00 DT = £21.00 |

Episenta 1000mg modified-release granules sugar-free | 100 sachet (PST) £41.00 DT = £41.00 |
Stiripentol

13-Mar-2019

**INDICATIONS AND DOSE**

Adjuvant therapy of refractory generalised tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (Dravet syndrome) in combination with clobazam and valproate (under expert supervision)

- BY MOUTH
  - Child 3-5 years: Initially 20 mg/kg daily in 2–3 divided doses for 1 week, then increased to 30 mg/kg daily in 2–3 divided doses for 1 week, then increased to 50 mg/kg daily in 2–3 divided doses
  - Child 6-11 years: Initially 20 mg/kg daily in 2–3 divided doses for 1 week, then increased in steps of 10 mg/kg daily in 2–3 divided doses, dose to be increased at intervals of 1 week to 50 mg/kg daily in 2–3 divided doses
  - Child 12-17 years: Initially 20 mg/kg daily in 2–3 divided doses for 1 week, then increased to 30 mg/kg daily in 2–3 divided doses for 1 week, then increased in steps of 5 mg/kg daily in 2–3 divided doses, dose to be increased at intervals of 1 week, until the optimum dose is reached based on clinical judgement; maximum 50 mg/kg per day

**DOSE EQUIVALENT AND CONVERSION**

- Stiripentol capsules and oral powder sachets are not bioequivalent. If a switch of formulation is required, manufacturer advises this is done under clinical supervision in case of intolerance.

**CONTRA-INDICATIONS**

History of psychosis in the form of episodes of delirium

**INTERACTIONS**

- Appendix 1: antiepileptics

**SIDE-EFFECTS**

- Common or very common: Agitation, appetite decreased, behaviour abnormal, drowsiness, irritability, movement disorders, muscle tone decreased, nausea, neutropenia, sleep disorders, vomiting, weight decreased
- Uncommon: Diplopia, fatigue, photosensitivity reaction, skin reactions
- Rare or very rare: Thrombocytopenia

**ALLERGY AND CROSS-SENSITIVITY**

Antiepileptic hypersensitivity syndrome theoretically associated with stiripentol. See under Epilepsy p. 195 for more information.

**PREGNANCY**

See also Pregnancy in Epilepsy p. 195.

Monitoring: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**

Present in milk in animal studies.

**HEPATIC IMPAIRMENT**

Manufacturer advises avoid (no information available).

**RENAL IMPAIRMENT**

Avoid—no information available.

**MONITORING REQUIREMENTS**

- Perform full blood count and liver function tests prior to initiating treatment and every 6 months thereafter.
- Manufacturer advises monitor growth.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Stiripentol for preventing seizures www.medicinesforchildren.org.uk/stiripentol-preventing-seizures

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (September 2017) that stiripentol (Diacomit®) is accepted for use within NHS Scotland in conjunction with clobazam and valproate as adjuvantive therapy of refractory generalised tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy whose seizures are not adequately controlled with clobazam and valproate.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Powder**

CAUTIONARY AND ADVISORY LABELS 1, 8, 13, 21

EXCipients: May contain Aspartame

- Diacomit (Alan Pharmaceuticals)
  - Stiripentol 250 mg Diacomit 250mg oral powder sachets 60 sachet £284.00 DT = £284.00
  - Stiripentol 500 mg Diacomit 500mg oral powder sachets 60 sachet £493.00 DT = £493.00

**Capsule**

CAUTIONARY AND ADVISORY LABELS 1, 8, 21

- Diacomit (Alan Pharmaceuticals)
  - Stiripentol 250 mg Diacomit 250mg capsules 60 capsule £284.00 DT = £284.00
  - Stiripentol 500 mg Diacomit 500mg capsules 60 capsule £493.00 DT = £493.00

**Tiagabine**

15-Mar-2019

**INDICATIONS AND DOSE**

Adjuvant treatment for focal seizures with or without secondary generalisation that are not satisfactorily controlled by other antiepileptics (with enzyme-inducing drugs)

- BY MOUTH
  - Child 12-17 years: Initially 5–10 mg daily in 1–2 divided doses, then increased in steps of 5–10 mg/24 hours every week; maintenance 30–45 mg daily in 2–3 divided doses

Adjuvant treatment for focal seizures with or without secondary generalisation that are not satisfactorily controlled by other antiepileptics (without enzyme-inducing drugs)

- BY MOUTH
  - Child 12-17 years: Initially 5–10 mg daily in 1–2 divided doses, then increased in steps of 5–10 mg/24 hours every week; maintenance 15–30 mg daily in 2–3 divided doses

**CAUTIONS**

Avoid in Acute porphyrias p. 624

CAUTIONS, FURTHER INFORMATION: Tiagabine should be avoided in absence, myoclonic, tonic and atonic seizures due to risk of seizure exacerbation.

**INTERACTIONS**

- Appendix 1: antiepileptics

**SIDE-EFFECTS**

- Common or very common: Abdominal pain, behaviour abnormal, concentration impaired, depression, diarrhoea, dizziness, emotional lability, fatigue, gait abnormal, insomnia, nausea, nervousness, speech disorder, tremor, vision disorders, vomiting
- Uncommon: Drowsiness, psychosis, skin reactions
- Rare or very rare: Delusions, hallucination

**PREGNANCY**

See also Pregnancy in Epilepsy p. 195.

Monitoring: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in mild to moderate impairment (risk of increased exposure); avoid in severe impairment.
**218 Epilepsy and other seizure disorders**

**Dose adjustments** Manufacturer advises dose reduction and/or longer dose interval with careful titration in mild to moderate impairment.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Tiagabine for preventing seizures www.medicinesforchildren.org.uk/tiagabine-preventing-seizures

**Driving and skilled tasks** May impair performance of skilled tasks (e.g. driving).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**

**INDICATIONS AND DOSE**

Monotherapy of generalised tonic-clonic seizures or focal seizures with or without secondary generalisation

**BY MOUTH**

- Child 6–17 years: Initially 0.5–1 mg/kg once daily (max. per dose 25 mg) for 1 week, dose to be taken at night, then increased in steps of 25–500 micrograms/kg twice daily, dose to be increased by a maximum of 25 mg twice daily at intervals of 1–2 weeks; usual dose 50 mg twice daily (max. per dose 7.5 mg/kg twice daily), if child cannot tolerate titration regimens recommended above then smaller steps or longer intervals between steps may be used; maximum 500 mg per day

Adjunctive treatment of generalised tonic-clonic seizures or focal seizures with or without secondary generalisation | Adjunctive treatment for seizures associated with Lennox-Gastaut syndrome

**BY MOUTH**

- Child 2–17 years: Initially 1–3 mg/kg once daily (max. per dose 25 mg) for 1 week, dose to be taken at night, then increased in steps of 0.5–1.5 mg/kg twice daily, dose to be increased by a maximum of 25 mg twice daily at intervals of 1–2 weeks; usual dose 2.5–4.5 mg/kg twice daily (max. per dose 7.5 mg/kg twice daily), if child cannot tolerate recommended titration regimens then smaller steps or longer interval between steps may be used; maximum 400 mg per day

**Migraine prophylaxis**

**BY MOUTH**

- Child 16–17 years: Initially 25 mg once daily for 1 week, dose to be taken at night, then increased in steps of 25 mg every week; usual dose 50–100 mg daily in 2 divided doses, if child cannot tolerate recommended titration regimens then smaller steps or longer interval between steps may be used; maximum 200 mg per day

**SIDE-EFFECTS**

- **Common or very common** Alopecia, anaemia, anxiety, appetite abnormal, asthenia, behaviour abnormal, cognitive impairment, concentration impaired, confusion, constipation, cough, depression, diarrhoea, dizziness, dryness, dry mouth, dysphoria, ear discomfort, eye disorders, feeling abnormal, fever, gait abnormal, gastrointestinal discomfort, gastrointestinal disorders, haemorrhage, hypersensitivity, joint disorders, malaise, memory loss, mood altered, movement disorders, muscle complaints, muscle weakness, nasal complaints, nasopharyngitis, nausea, oral disorders, pain, seizures, sensation abnormal, skin reactions, sleep disorders, speech impairment, taste altered, tinnitus, tremor, urinary disorders, urolithiasis, vertigo, vision disorders, vomiting, weight changes

- **Uncommon** Abnormal sensation in eye, ankle/hand, arthralgia, acute myopia, aura, cerebellar syndrome, consciousness impaired, crying, dizziness, dry eye, dysgraphia, dysphoria, eosinophilia, facial swelling, hallucinations, hearing impairment, hyperthermia, hypokalaemia, hypotension, influenza like illness, learning disability, leucopenia, lymphadenopathy, metabolic acidosis, musculoskeletal stiffness, palpitations, pancreatitis, paranasal sinus hyperperfusion, peripheral coldness, peripheral neuropathy, polydipsia, psychotic disorder, renal pain, sexual dysfunction, smell altered, suicidal tendencies, syncope, thinking abnormal, thirst, thrombocytopenia, vasodilation

- **Rare or very rare** Eye inflammation, face oedema, glaucoma, hepatic disorders, limb discomfort, neutropenia, Raynaud’s phenomenon, renal tubular acidosis, severe cutaneous adverse reactions (SCARs), unresponsive to stimuli

**SIDE-EFFECTS, FURTHER INFORMATION**

Topiramate has been associated with acute myopia with secondary angle-closure glaucoma, typically occurring within 1 month of starting treatment. Choroidal effusions resulting in anterior displacement of the lens and iris have also been reported. If raised intraocular pressure occurs: seek specialist ophthalmological advice; use appropriate measures to reduce intraocular pressure and stop topiramate as rapidly as feasible.

**CONCEPTION AND CONTRACEPTION** Manufacturer advises perform pregnancy test before the initiation of treatment—a highly effective contraceptive method is advised in women of child-bearing potential; patients should be fully informed of the risks related to the use of topiramate during pregnancy.

**PREGNANCY** Increased risk of major congenital malformations following exposure during the first trimester. For migraine prophylaxis manufacturer advises avoid. For epilepsy manufacturer advises consider alternative treatment options. See also Pregnancy in Epilepsy p. 195.

**Monitoring** Manufacturer advises in case of administration during first trimester, careful prenatal monitoring should be performed.

It is recommended that the fetal growth should be monitored.

The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING** Manufacturer advises avoid—present in milk.

**HEPATIC IMPAIRMENT** Use with caution in moderate to severe impairment—clearance may be reduced.

**RENAL IMPAIRMENT** Use with caution.

**Dose adjustments** Half usual starting and maintenance dose if estimated glomerular filtration less than

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**Topiramate**

25-Jan-2018

**INDICATIONS AND DOSE**

Monotherapy of generalised tonic-clonic seizures or focal seizures with or without secondary generalisation

**BY MOUTH**

- Child 6–17 years: Initially 0.5–1 mg/kg once daily (max. per dose 25 mg) for 1 week, dose to be taken at night, then increased in steps of 25–500 micrograms/kg twice daily, dose to be increased by a maximum of 25 mg twice daily at intervals of 1–2 weeks; usual dose 50 mg twice daily (max. per dose 7.5 mg/kg twice daily), if child cannot tolerate titration regimens recommended above then smaller steps or longer intervals between steps may be used; maximum 500 mg per day

Adjunctive treatment of generalised tonic-clonic seizures or focal seizures with or without secondary generalisation

**BY MOUTH**

- Child 2–17 years: Initially 1–3 mg/kg once daily (max. per dose 25 mg) for 1 week, dose to be taken at night, then increased in steps of 0.5–1.5 mg/kg twice daily, dose to be increased by a maximum of 25 mg twice daily at intervals of 1–2 weeks; usual dose 2.5–4.5 mg/kg twice daily (max. per dose 7.5 mg/kg twice daily), if child cannot tolerate recommended titration regimens then smaller steps or longer interval between steps may be used; maximum 400 mg per day

**Migraine prophylaxis**

**BY MOUTH**

- Child 16–17 years: Initially 25 mg once daily for 1 week, dose to be taken at night, then increased in steps of 25 mg every week; usual dose 50–100 mg daily in 2 divided doses, if child cannot tolerate recommended titration regimens then smaller steps or longer interval between steps may be used; maximum 200 mg per day

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**UNLICENSED USE** Not licensed for use in children for migraine prophylaxis.

**CAUTIONS** Avoid in Acute porphyrias p. 624 | risk of metabolic acidosis | risk of nephrolithiasis |— ensure adequate hydration (especially in strenuous activity or warm environment)

**INTERACTIONS** Appendix 1: antiepileptics
70 ml/minute/1.73 m²—reduced clearance and longer time to steady-state plasma concentration.

**DIRECTIONS FOR ADMINISTRATION**

**TOPAMAX® Capsules** Swallow whole or sprinkle contents of capsule on soft food and swallow immediately without chewing.

**PRESCRIBING AND DISPENSING INFORMATION**

Switching between formulations. Care should be taken when switching between oral formulations in the treatment of epilepsy. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

Patients being treated for epilepsy may need to be maintained on a specific manufacturer’s branded or generic topiramate product.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Topiramate for preventing seizures www.medicinesforchildren.org.uk/topiramate-preventing-seizures

**TOPAMAX® Capsules** Patients or carers should be given advice on how to administer Topamax® Sprinkle capsules.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral suspension**

- **Topiramate (Non-proprietary)**
  - Topiramate 10 mg per 1 ml Topiramate 50mg/5ml oral suspension sugar free sugar-free | 150 ml (POM) £129.00 DT = £129.00
  - Topiramate 20 mg per 1 ml Topiramate 100mg/5ml oral suspension sugar free sugar-free | 280 ml (POM) £115.69 DT = £115.69

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 3, 8**

- **Topiramate (Non-proprietary)**
  - Topiramate 25 mg Topiramate 25mg tablets | 60 tablet (POM) £10.00 DT = £6.12
  - Topiramate 50 mg Topiramate 50mg tablets | 60 tablet (POM) £36.75 DT = £35.33
  - Topiramate 100 mg Topiramate 100mg tablets | 60 tablet (POM) £37.54 DT = £34.83
  - Topiramate 200 mg Topiramate 200mg tablets | 60 tablet (POM) £57.60 DT = £47.57
  - **Topamax** (Janssen-Cilag Ltd)
    - Topiramate 25 mg Topiramate 25mg tablets | 60 tablet (POM) £19.29 DT = £16.12
    - Topiramate 50 mg Topiramate 50mg tablets | 60 tablet (POM) £31.69 DT = £29.33
    - Topiramate 100 mg Topiramate 100mg tablets | 60 tablet (POM) £56.76 DT = £48.83
    - Topiramate 200 mg Topiramate 200mg tablets | 60 tablet (POM) £110.23 DT = £91.57

**Capsule**

**CAUTIONARY AND ADVISORY LABELS 3, 8**

- **Topiramate (Non-proprietary)**
  - Topiramate 15 mg Topiramate 15mg capsules | 60 capsule (POM) £26.21 DT = £26.21
  - Topiramate 25 mg Topiramate 25mg capsules | 60 capsule (POM) £15.45 DT = £12.21
  - Topiramate 50 mg Topiramate 50mg capsules | 60 capsule (POM) £55.08 DT = £55.08
  - **Topamax** (Janssen-Cilag Ltd)
    - Topiramate 15 mg Topiramate 15mg sprinkle capsules | 60 capsule (POM) £14.79 DT = £12.21
    - Topiramate 25 mg Topiramate 25mg sprinkle capsules | 60 capsule (POM) £22.18 DT = £12.21
    - **Topiramate 50 mg Topiramate 50mg sprinkle capsules | 60 capsule (POM) £36.45 DT = £33.08**

**INDICATIONS AND DOSE**

**CONVULEX®**

**Epilepsy**

- **By Mouth**
  - Child 1 month–11 years: Initially 10–15 mg/kg daily in 2–4 divided doses, max. 600 mg daily; usual maintenance 25–30 mg/kg daily in 2–4 divided doses, doses up to 60 mg/kg daily in 2–4 divided dose in infantile spasms; monitor clinical chemistry and haematological parameters if dose exceeds 40 mg/kg daily
  - Child 12–17 years: Initially 600 mg daily in 2–4 divided doses, increased in steps of 150–300 mg every 3 days; usual maintenance 1–2 g daily in 2–4 divided doses, max. 2.5 g daily in 2–4 divided doses

**DOSE EQUIVALENCE AND CONVERSION**

- **Convulx®** has a 1:1 dose relationship with products containing sodium valproate, but nevertheless care is needed if switching or making changes.

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: VALPROATE MEDICINES: CONTRA-INDICATED IN WOMEN AND GIRLS OF CHILDBEARING POTENTIAL UNLESS CONDITIONS OF PREGNANCY PREVENTION PROGRAMME ARE MET (APRIL 2018)**

Valproate is highly teratogenic and evidence supports that use in pregnancy leads to neurodevelopmental disorders (approx. 30–40% risk) and congenital malformations (approx. 10% risk).

Valproate must not be used in women and girls of childbearing potential unless the conditions of the Pregnancy Prevention Programme are met (see Conception and contraception) and only if other treatments are ineffective or not tolerated, as judged by an experienced specialist.

Use of valproate in pregnancy is contra-indicated for migraine prophylaxis [unlicensed] and bipolar disorder; it must only be considered for epilepsy if there is no suitable alternative treatment (see Pregnancy).

Women and girls (and their carers) must be fully informed of the risks and the need to avoid exposure to valproate medicines in pregnancy; supporting materials have been provided to use in the implementation of the Pregnancy Prevention Programme (see Prescribing and dispensing information). The MHRA advises that:

- GPs must recall all women and girls who may be of childbearing potential, provide the Patient Guide, check they have been reviewed by a specialist in the last year and are on highly effective contraception;
- Specialists must book in review appointments at least annually with women and girls under the Pregnancy Prevention Programme, re-evaluate treatment as necessary, explain clearly the conditions as outlined in the supporting materials and complete and sign the Risk Acknowledgement Form—copies of the form must be given to the patient or carer and sent to their GP;
- Pharmacists must ensure valproate medicines are dispensed in whole packs whenever possible—all packs dispensed to women and girls of childbearing potential should have a warning label either on the carton or via a sticker. They must also discuss risks in pregnancy with female patients each time valproate medicines are dispensed, ensure they have the Patient Guide and have seen their GP or specialist to discuss their treatment and the need for contraception.
Nervous system

INTERACTIONS

Liver toxicity

Hepatic SIDE-EFFECTS, FURTHER INFORMATION.

thrombocytopenia

parkinsonism

menstrual cycle irregularities

diarrhoea

alopecia (regrowth may be curly)

Abdominal pain

Systemic lupus erythematosus

Acute porphyrias p.

retardation) usually in exposure or dietary intake of calcium.

relevant abnormalities).

prothrombin time (particularly in association with other (including prothrombin time) monitored until return to

during valproate treatment are usually transient but

persistent vomiting and abdominal pain, anorexia,

alertness increased

anaemia

seizure

jaundice, oedema, malaise, drowsiness, or loss of seizure control.

Pancreatitis Discontinue treatment if symptoms of pancreatitis develop.

CONCEPTION AND CONCEPTION AND CONCEPTION

The MHRA advises that all women and girls of childbearing potential being treated with valproate medicines must be supported on a Pregnancy Prevention Programme—pregnancy should be excluded before treatment initiation and highly effective contraception must be used during treatment.

PREGNANCY For migraine prophylaxis [unlicensed] and bipolar disorder, the MHRA advises that valproate must not be used. For epilepsy, the MHRA advises valproate must not be used unless there is no suitable alternative treatment; in such cases, access to counselling about the risks should be provided (see Healthcare Professional Guide for more information) and a Risk Acknowledgement Form signed by both specialist and patient. If valproate is to be used during pregnancy, the lowest effective dose should be prescribed in divided doses to avoid peaks in plasma–valproate concentrations; doses greater than 1 g daily are associated with an increased risk of teratogenicity. Neonatal bleeding (related to hypofibrininaemia). Neonatal hepatotoxicity also reported. See also Pregnancy in Epilepsy p. 195.

Monitoring Specialist prenatal monitoring should be instigated when valproate has been taken in pregnancy.

The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

BREAST FEEDING Present in milk—risk of haematological disorders in breast-fed newborns and infants.

HEPATIC IMPAIRMENT Manufacturer advises avoid.

RENNAL IMPAIRMENT Dose adjustment Reduce dose.

MONITORING REQUIREMENTS

Monitor closely if dose greater than 45 mg/kg daily.

Monitor liver function before therapy and during first 6 months especially in patients most at risk.

Measure full blood count and ensure no undue potential for bleeding before starting and before surgery.

EFFECT ON LABORATORY TESTS False-positive urine tests for ketones.

TREATMENT CESSATION In bipolar disorder, avoid abrupt withdrawal; if treatment with valproate is stopped, reduce the dose gradually over at least 4 weeks.

PRESCRIBING AND DISPENSING INFORMATION The Pregnancy Prevention Programme is supported by the following materials provided by the manufacturer: Patient Guide, Guide for Healthcare Professionals, Risk Acknowledgement Form, and for pharmacists, Patient Cards and Stickers with warning symbols; the MHRA has also produced a patient information sheet providing advice for women and girls taking valproate medicines.

CONVULEX Patents being treated for epilepsy may need to be maintained on a specific manufacturer’s branded or generic oral valproic acid product.

PATIENT AND CARER ADVICE Valproate use by women and girls The MHRA advises women and girls should not stop taking valproate without first discussing it with their doctor.

Blood or hepatic disorders Patients or their carers should be told how to recognise signs and symptoms of blood or liver disorders and advised to seek immediate medical attention if symptoms develop.

Pancreatitis Patients or their carers should be told how to recognise signs and symptoms of pancreatitis and advised to seek immediate medical attention if symptoms such as abdominal pain, nausea, or vomiting develop.

CONTRA-INDICATIONS Acute porphyrias p. 624 - known or suspected mitochondrial disorders (higher rate of acute liver failure and liver-related deaths) personal or family history of severe hepatic dysfunction.

CAUTIONS Systemic lupus erythematosus.

CAUTIONS, FURTHER INFORMATION

Liver toxicity Liver dysfunction (including fatal hepatic failure) has occurred in association with valproate (especially in children under 3 years and in those with metabolic or degenerative disorders, organic brain disease or severe seizure disorders associated with mental retardation) usually in first 6 months and usually involving multiple antiepileptic therapy. Raised liver enzymes during valproate treatment are usually transient but patients should be reassessed clinically and liver function (including prothrombin time) monitored until return to normal—discontinue if abnormally prolonged prothrombin time (particularly in association with other relevant abnormalities).

Consider vitamin D supplementation in patients who are immobilised for long periods or who have inadequate sun exposure or dietary intake of calcium.

INTERACTIONS SIDE-EFFECTS, FURTHER INFORMATION Hepatic dysfunction

Withdraw treatment immediately if persistent vomiting and abdominal pain, anorexia,
Vigabatrin

INDICATIONS AND DOSE

Adjuvant treatment of focal seizures with or without secondary generalisation not satisfactorily controlled with other antiepileptics (under expert supervision)

By Mouth

- Neonate: Initially 15–20 mg/kg twice daily, to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 30–40 mg/kg twice daily (max. per dose 75 mg/kg).
- Child 1–3 months: Initially 15–20 mg/kg twice daily (max. per dose 250 mg), to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 30–40 mg/kg twice daily (max. per dose 75 mg/kg).
- Child 2–11 years: Initially 15–20 mg/kg twice daily (max. per dose 250 mg), to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 30–40 mg/kg twice daily (max. per dose 1.5 g).
- Child 12–17 years: Initially 250 mg twice daily, to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 1–1.5 g twice daily.

By Rectum

- Child 1–3 months: Initially 15–20 mg/kg twice daily (max. per dose 250 mg), to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 30–40 mg/kg twice daily (max. per dose 75 mg/kg).
- Child 2–11 years: Initially 15–20 mg/kg twice daily (max. per dose 250 mg), to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 30–40 mg/kg twice daily (max. per dose 1.5 g).
- Child 12–17 years: Initially 250 mg twice daily, to be increased over 2–3 weeks to usual maintenance dose, usual maintenance 1–1.5 g twice daily.

Monotherapy in the management of infantile spasms in West’s syndrome (under expert supervision)

By Mouth

- Neonate: Initially 15–25 mg/kg twice daily, to be adjusted according to response over 7 days to usual maintenance dose; usual maintenance 40–50 mg/kg twice daily (max. per dose 75 mg/kg).
- Child 1 month–1 year: Initially 15–25 mg/kg twice daily, to be adjusted according to response over 7 days to usual maintenance dose; usual maintenance 40–50 mg/kg twice daily (max. per dose 75 mg/kg).

UNLICENSED USE

Granules not licensed for rectal use. Tablets not licensed to be crushed and dispersed in liquid. Vigabatrin doses in BNF publications may differ from those in product literature.

CONTRA-INDICATIONS

Visual field defects

CAUTIONS

History of behavioural problems · history of depression · history of psychosis

FURTHER INFORMATION

Vigabatrin may worsen absence, myoclonic, tonic and atonic seizures.

Visual field defects Vigabatrin is associated with visual field defects. The onset of symptoms varies from 1 month to several years after starting. In most cases, visual field defects have persisted despite discontinuation, and further deterioration after discontinuation cannot be excluded. Product literature advises visual field testing before treatment and at 6-month intervals. Patients and their carers should be warned to report any new visual symptoms that develop and those with symptoms should be referred for an urgent ophthalmological opinion. Gradual withdrawal of vigabatrin should be considered.

INTERACTIONS

Appendix 1: antiepileptics

SIDE-EFFECTS

- Common or very common Abdominal pain · anaemia · anxiety · arthralgia · behaviour abnormal · concentration impaired · depression · dizziness · drowsiness · eye disorders · fatigue · headache · memory loss · mood altered · nausea · oedema · paraesthesia · speech disorder · thinking abnormal · tremor · vision disorders · vomiting · weight increased
- Uncommon Movement disorders · psychotic disorder · seizure (patients with myoclonic seizures at greater risk) · skin reactions
- Rare or very rare Angioedema · encephalopathy · hallucination · hepatitis · optic neuritis · suicide attempt
- Frequency not known Muscle tone increased

SIDE-EFFECTS, FURTHER INFORMATION

Encephalopathic symptoms Encephalopathic symptoms including marked sedation, stupor, and confusion with non-specific slow wave EEG can occur rarely – reduce dose or withdraw.

Visual field defects About one-third of patients treated with vigabatrin have suffered visual field defects; counselling and careful monitoring for this side-effect are required.

PREGNANCY

See also Pregnancy in Epilepsy p. 195.

MONITORING

The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

BREAST FEEDING

Present in milk — manufacturer advises avoid.

RENAL IMPAIRMENT

Dose adjustments Consider reduced dose or increased dose interval if estimated glomerular filtration rate less than 60 mL/minute/1.73 m².

MONITORING REQUIREMENTS

Closely monitor neurological function.

DIRECTIONS FOR ADMINISTRATION

- With oral use: The contents of a sachet should be dissolved in water or a soft drink immediately before taking. Tablets may be crushed and dispersed in liquid.
- With rectal use: Dissolve contents of sachet in small amount of water and administer rectally [unlicensed use].

PATIENT AND CARER ADVICE

Patients and their carers should be warned to report any new visual symptoms that develop.

Medicines for Children leaflet: Vigabatrin for preventing seizures www.medicinesforchildren.org.uk/vigabatrin-preventing-seizures

MEDIeCAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution Powder

CAUTIONARY AND ADVISORY LABELS

- Sabril (Sanofi)
  
  Vigabatrin 500 mg Sabril 500mg oral powder sachets sugar-free | 50 sachets £24.60 DT + £24.60
Zonisamide

**INDICATIONS AND DOSE**
Adjunctive treatment for refractory focal seizures with or without secondary generalisation

- **BY MOUTH**
  - Child 6–17 years (body-weight 20–54 kg): Initially 1 mg/kg once daily for 7 days, then increased in steps of 1 mg/kg every 7 days, usual maintenance 6–8 mg/kg once daily (max. per dose 500 mg once daily), dose to be increased at 2-week intervals in patients who are not receiving concomitant carbamazepine, phenytoin, phenobarbital or other potent inducers of cytochrome P450 enzyme CYP3A4.
  - Child 6–17 years (body-weight 55 kg and above): Initially 1 mg/kg once daily for 7 days, then increased in steps of 1 mg/kg every 7 days, usual maintenance 300–500 mg once daily, dose to be increased at 2-week intervals in patients who are not receiving concomitant carbamazepine, phenytoin, phenobarbital or other potent inducers of cytochrome P450 enzyme CYP3A4.

**CAUTIONS**
Low body-weight or poor appetite—monitor weight throughout treatment (fetal cases of weight loss reported in children) - metabolic acidosis—monitor serum bicarbonate concentration in children and those with other risk factors (consider dose reduction or discontinuation if metabolic acidosis develops) - risk factors for renal stone formation (particularly predisposition to nephrolithiasis).

**CAUTIONS, FURTHER INFORMATION**
Avoid overheating and ensure adequate hydration especially in children, during strenuous activity or if in warm environment (fetal cases of heat stroke reported in children).

**INTERACTIONS**
Appendix 1: antiepileptics.

**SIDE-EFFECTS**
- Common or very common: Alopecia - anxiety - appetite decreased - ataxia - bradynphrenia - concentration impaired - confusion - constipation - depression - diarrhea - diziness - drowsiness - fatigue - fever - gastrointestinal discomfort - hypersensitivity - influenza like illness - insomnia - memory loss - mood altered - nausea - nystagmus - paraesthesia - peripheral oedema - psychosis - rash (consider discontinuation) - skin reactions - speech disorder - tremor - urolithiasis - vision disorders - vomiting - weight decreased
- Uncommon: Behaviour abnormal - gallbladder disorders - hallucination - hypokalaemia - increased risk of infection - leucopenia - respiratory disorders - seizures - suicidal tendencies - thrombocytopenia
- Rare or very rare: Agranulocytosis - angle closure glaucoma - anhidrosis - bone marrow disorders - coma - dysphoria - eye pain - heat stroke - hepatocellular injury - hydrenephrosis - leukocytosis - lymphadenopathy - metabolic acidosis - myasthenic syndrome - neuroleptic malignant syndrome - pancreatitis - renal failure - renal tubular acidosis - rhabdomyolysis - severe cutaneous adverse reactions (SCARs) - urine abnormal
- Frequency not known: Sudden unexplained death in epilepsy

**ALLERGY AND CROSS-SENSITIVITY**
Contra-indicated in sulfonamide hypersensitivity.

Antiepileptic hypersensitivity syndrome theoretically associated with zonisamide. See under Epilepsy p. 195 for more information.

**CONCEPTION AND CONCEPTION**
Manufacturer advises women of childbearing potential should use effective contraception during treatment and for one month after last dose—avoid in women of childbearing potential not using effective contraception unless clearly necessary and the potential benefit outweighs risk; patients should be fully informed of the risks related to the use of zonisamide during pregnancy.

**PREGNANCY**
Manufacturer advises use only if clearly necessary and the potential benefit outweighs risk—tobacco in animal studies; patients should be fully informed of the risks related to the use of zonisamide during pregnancy. See also Pregnancy in Epilepsy p. 195.

**Monitoring**
The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**
Manufacturer advises avoid for 4 weeks after last dose.

**HEPATIC IMPAIRMENT**
Avoid in severe impairment. Dose adjustments: Initially increase dose at 2-week intervals if mild or moderate impairment.

**RENAL IMPAIRMENT**
Dose adjustments: Initially increase dose at 2-week intervals; discontinue if renal function deteriorates.

**TREATMENT CESSATION**
Avoid abrupt withdrawal (consult product literature for recommended withdrawal regimens in children).

**PRESCRIBING AND DISPENSING INFORMATION**
Switching between formulations: Care should be taken when switching between oral formulations. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

Patients may need to be maintained on a specific manufacturer’s branded or generic zonisamide product.

**PATIENT AND CARER ADVICE**
Children and their carers should be made aware of how to prevent and recognise overheating and dehydration. Medicines for Children leaflet: Zonisamide for preventing seizures www.medicinesforchildren.org.uk/zonisamide-preventing-seizures

**NATIONAL FUNDING/ACCESS DECISIONS**
Scottish Medicines Consortium (SMC) decisions
SMC No. 949/14
The Scottish Medicines Consortium has advised (March 2014) that zonisamide (Zonegran®) is accepted for restricted use within NHS Scotland as adjunctive treatment of focal seizures, with or without secondary generalisation, in adolescents and children aged ≥6 years and above. It is restricted to use on advice from specialists in paediatric neurology or epilepsy.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Capsule**

**CAUTIONARY AND ADVISORY LABELS**
- Zonisamide (Non-proprietary)
  - Zonisamide 25 mg Zonisamide 25mg capsules | 14 capsule £44.1
  - Zonisamide 50 mg Zonisamide 50mg capsules | 56 capsule £47.04 DT = £3.60
  - Zonisamide 100 mg Zonisamide 100mg capsules | 56 capsule £62.72 DT = £4.74
  - Zonegran (Eisai Ltd) Zonisamide 25 mg Zonegran 25mg capsules | 14 capsule £44.1
  - Zonisamide 25 mg Zonisamide 25mg capsules | 14 capsule £44.1
Phenobarbital (Phenobarbitone)

**INDICATIONS AND DOSE**

**All forms of epilepsy except typical absence seizures**

- **By mouth**
  - Child 1 month-11 years: Initially 1–1.5 mg/kg twice daily, then increased in steps of 2.5–5 mg/kg as required; maintenance 2.5–4 mg/kg 1–2 times a day
  - Child 12-17 years: 60–180 mg once daily
  - Initially by slow intravenous injection

- Neonate: Initially 20 mg/kg, then (by slow intravenous injection or by mouth) 2.5–5 mg/kg once daily, adjusted according to response.

**Status epilepticus**

- Neonate: Initially 20 mg/kg, dose to be administered at a rate no faster than 1 mg/kg/minute, then 2.5–5 mg/kg 1–2 times a day.

- Child 1 month-11 years: Initially 20 mg/kg, dose to be administered at a rate no faster than 1 mg/kg/minute, then 2.5–5 mg/kg 1–2 times a day.

- Child 12-17 years: Initially 20 mg/kg (max. per dose 1 g), dose to be administered at a rate no faster than 1 mg/kg/minute, then 300 mg twice daily

**DOSE EQUIVALENCE AND CONVERSION**

- For therapeutic purposes phenobarbital and phenobarbital sodium may be considered equivalent in effect.

**CAUTIONS**

- Avoid in Acute porphyrias p. 624.
- Children: debilitated, history of alcohol abuse, history of drug abuse, respiratory depression (avoid if severe).

**CAUTIONS, FURTHER INFORMATION**

- Consider vitamin D supplementation in patients who are immobilised for long periods or who have inadequate sun exposure or dietary intake of calcium.

**INTERACTIONS**

- Appendix 1: antiepileptics

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- Agitation, agranulocytosis, anticonvulsant hypersensitivity syndrome, behaviour abnormal, bone disorders, bone fracture, cognitive impairment, confusion, depression, drowsiness, folate deficiency, hepatic disorders, memory loss, movement disorders, nystagmus, respiratory depression, skin reactions

**SPECIFIC SIDE-EFFECTS**

- With oral use: Hallucination, hypotension, megaloblastic anaemia, severe cutaneous adverse reactions (SCARs), thrombocytopenia

- With parenteral use: Anaemia, aplastic anaemia, Dupuytren’s contracture, hypocalcaemia, irritability, toxic epidermal necrolysis

**Overdose**

- For details on the management of poisoning, see Active elimination techniques, under Emergency treatment of poisoning p. 859.

**ALLERGY AND CROSS-SENSITIVITY**

- Antiepileptic hypersensitivity syndrome associated with phenobarbital. See under Epilepsy p. 195 for more information.

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**PREGNANCY**

- **Monitoring**: The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**BREAST FEEDING**

- Avoid if possible; drowsiness may occur.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

**RENAL IMPAIRMENT**

- Use with caution.

**MONITORING REQUIREMENTS**

- Plasma phenobarbital concentration for optimum response is 15–40 mg/litre (60–180 micromol/litre); however, monitoring the plasma-drug concentration is less useful than with other drugs because tolerance occurs.

**TREATMENT CESSATION**

- Avoid abrupt withdrawal (dependence with prolonged use).

**DIRECTIONS FOR ADMINISTRATION**

- With oral use: For administration by mouth, tablets may be crushed.

- With intravenous use: For intravenous injection, dilute to a concentration of 20 mg/mL with Water for Injections; give over 20 minutes (no faster than 1 mg/kg/minute).

**PRESCRIBING AND DISPENSING INFORMATION**

- Some hospitals supply alcohol-free formulations of varying phenobarbital strengths.

  - The RCPCH and NPPG recommend that, when a liquid special of phenobarbital is required, the following strength is used: 50 mg/5 mL.

  Switching between formulations: Different formulations of oral preparations may vary in bioavailability. Patients should be maintained on a specific manufacturer’s product.

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Phenobarbital for preventing seizures www.medicinesforchildren.org.uk/phenobarbital-preventing-seizures

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution

**Tablet**

- CAUTIONARY AND ADVISORY LABELS 2, 8

  - **Phenobarbital (Non-proprietary)**

  - Phenobarbital 15 mg Phenobarbital 15 mg tablets | 28 tablet £24.95 DT + £16.71

  - Phenobarbital 30 mg Phenobarbital 30 mg tablets | 28 tablet £5.99 DT + £6.69

  - Phenobarbital 60 mg Phenobarbital 60 mg tablets | 28 tablet £7.99 DT + £6.67

**Solution for injection**

- EXCIPIENTS: May contain Propylene glycol

  - **Phenobarbital (Non-proprietary)**

  - Phenobarbital sodium 30 mg per 1 ml Phenobarbital 30 mg/1 ml solution for injection ampoules | 10 ampoule £98.42 DT + £98.42

  - Phenobarbital sodium 60 mg per 1 ml Phenobarbital 60 mg/1 ml solution for injection ampoules | 10 ampoule £103.84 DT + £103.84

  - Phenobarbital sodium 200 mg per 1 ml Phenobarbital 200 mg/1 ml solution for injection ampoules | 10 ampoule £84.66 DT + £84.66

**Oral solution**

- CAUTIONARY AND ADVISORY LABELS 2, 8

  - EXCIPIENTS: May contain Alcohol

  - **Phenobarbital (Non-proprietary)**

  - Phenobarbital 3 mg per 1 ml Phenobarbital 15 mg/5 ml elixir | 500 ml £83.00–£83.01 DT + £83.01

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**Zonisamide 50 mg**  Zonegran capsules | 56 capsule £47.04 DT + £33.60

**Zonisamide 100 mg**  Zonegran 100 mg capsules | 56 capsule £62.72 DT + £4.74
Primidone

**INDICATIONS AND DOSE**

*All forms of epilepsy except typical absence seizures*

- **BY MOUTH**
  - Child 1 month–1 year: Initially 125 mg daily, dose to be taken at bedtime, then increased in steps of 125 mg every 3 days, adjusted according to response; maintenance 250–250 mg twice daily
  - Child 2–4 years: Initially 125 mg once daily, dose to be taken at bedtime, then increased in steps of 125 mg every 3 days, adjusted according to response; maintenance 250–375 mg twice daily
  - Child 5–8 years: Initially 125 mg once daily, dose to be taken at bedtime, then increased in steps of 125 mg every 3 days, adjusted according to response; maintenance 375–500 mg twice daily
  - Child 9–17 years: Initially 125 mg once daily, dose to be taken at bedtime, then increased in steps of 125 mg every 3 days, increased to 250 mg twice daily, then increased in steps of 250 mg every 3 days (max. per dose 750 mg twice daily), adjusted according to response

**CAUTIONS** Avoid in Acute porphyrinas p. 624 - children - debilitated - history of alcohol abuse - history of drug abuse - respiratory depression (avoid if severe)

**SIDE-EFFECTS**

- Common or very common Apathy - ataxia - drowsiness - nausea - nystagmus - visual impairment
- Uncommon Dizziness - headache - hypersensitivity - skin reactions - vomiting
- Rare or very rare Arthralgia - blood disorder - bone disorders - Dupuytren’s contracture - megaloblastic anaemia (may be treated with folic acid) - personality change - psychotic disorder - severe cutaneous adverse reactions (SCARs) - systemic lupus erythematosus (SLE)
- Frequency not known Bone fracture

**ALLERGY AND CROSS-SENSITIVITY** Antiepileptic hypersensitivity syndrome associated with primidone. See under Epilepsy p. 195 for more information.

**PREGNANCY**

Monitoring The dose should be monitored carefully during pregnancy and after birth, and adjustments made on a clinical basis.

**HEPATIC IMPAIRMENT** May precipitate coma.

**RENAI IMPAIRMENT** Use with caution.

**MONITORING REQUIREMENTS**

- Monitor plasma concentrations of derived phenobarbital; plasma concentration for optimum response is 15–40 mg/litre (60–180 micromol/litre).
- **TREATMENT CESSATION** Avoid abrupt withdrawal (dependence with prolonged use).

**PRESCRIBING AND DISPENSING INFORMATION**

Switching between formulations Different formulations of oral preparations may vary in bioavailability. Patients being treated for epilepsy should be maintained on a specific manufacturer’s product.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension

**Tablet**

<table>
<thead>
<tr>
<th>Dosage Form</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primidone 50 mg</td>
<td>100 tablet</td>
<td>£11.00–£12.37 DT</td>
</tr>
<tr>
<td>Primidone 250 mg</td>
<td>100 tablet</td>
<td>£95.65–£121.94 DT</td>
</tr>
</tbody>
</table>

**HYPNOTICS, SEDATIVES AND ANXIOLYSES**

Benzodiazepines

**CONTRA-INDICATIONS** Acute pulmonary insufficiency - marked neuromuscular respiratory weakness - sleep apnoea syndrome - unstable myasthenia gravis

**CAUTIONS** Avoid prolonged use (and abrupt withdrawal thereafter) - history of alcohol dependence or abuse - history of drug dependence or abuse - myasthenia gravis - personality disorder (within the fearful group – dependent, avoidant, obsessive-compulsive) may increase risk of dependence - respiratory disease

**SIDE-EFFECTS**

- Common or very common Alertness decreased - anxiety - ataxia - confusion - depression - dizziness - drowsiness - dysarthria - fatigue - gastrointestinal disorder - headache - hypotension - mood altered - muscle weakness - nausea - respiratory depression (particularly with high dose and intravenous use) – facilities for its treatment are essential – sleep disorders - suicidal ideation - tremor - vertigo - vision disorders - withdrawal syndrome
- Uncommon Agitation (more common in children and elderly) - anterograde amnesia - behaviour abnormal - hallucination - libido disorder - rash - urinary disorders
- Rare or very rare Aggression (more common in children and elderly) - blood disorder - delusions - jaundice - paradoxical drug reaction - psychosis
- Frequency not known Drug dependence

**OVERDOSE** Benzodiazepines taken alone cause drowsiness, ataxia, dysarthria, nystagmus, and occasionally respiratory depression, and coma. For details on the management of poisoning, see Benzodiazepines, under Emergency treatment of poisoning p. 859.

**PREGNANCY** Risk of neonatal withdrawal symptoms when used during pregnancy. Avoid regular use and use only if there is a clear indication such as seizure control. High doses administered during late pregnancy or labour may cause neonatal hypothermia, hypotonia, and respiratory depression.

**HEPATIC IMPAIRMENT** In general, manufacturers advise caution in mild to moderate impairment; avoid in severe impairment. Benzodiazepines with a shorter half-life are considered safer.

**Dose adjustments** In general, manufacturers advise dose reduction in mild to moderate impairment, adjust dose according to response.

**RENAI IMPAIRMENT** Increased cerebral sensitivity to benzodiazepines.
Epilepsy and other seizure disorders

Clobazam

By Mouth
- Child 1 month–5 years: Initially 125 micrograms/kg twice daily, dose to be increased if necessary every 5 days, maintenance 250 micrograms/kg twice daily (max. per dose 500 micrograms/kg twice daily); maximum 30 mg per day
- Child 6–17 years: Initially 5 mg daily, dose to be increased if necessary at intervals of 5 days, maintenance 0.3–1 mg/kg daily, daily doses of up to 30 mg may be given as a single dose at bedtime, higher doses should be divided; maximum 60 mg per day

Monotherapy for cataminal (menstruation) seizures (usually for 7–10 days each month, just before and during menstruation) (under expert supervision)

Cluster seizures
- By Mouth
- Child 1 month–5 years: Initially 125 micrograms/kg twice daily, dose to be increased if necessary every 5 days, maintenance 250 micrograms/kg twice daily (max. per dose 500 micrograms/kg twice daily); maximum 30 mg per day
- Child 6–17 years: Initially 5 mg daily, dose to be increased if necessary at intervals of 5 days, maintenance 0.3–1 mg/kg daily, daily doses of up to 30 mg may be given as a single dose at bedtime, higher doses should be divided; maximum 60 mg per day

Unlicensed Use
- Not licensed for use in children under 6 years. Not licensed as monotherapy.

Important Safety Information

Safe Practice
Clobazam has been confused with clonazepam; care must be taken to ensure the correct drug is prescribed and dispensed.

Contra-Indications
- Hyperkinesis · Obsessional states · Phobic states · Respiratory depression

Caution
- Muscle weakness · Organic brain changes

Contraindications
- The effectiveness of clobazam may decrease significantly after weeks or months of continuous therapy.

Interactions
- Appendix 1: clobazam

Side-Effects
- Appetite decreased · Consciousness impaired · Constipation · Drug abuse · Dry mouth · Fall · Gait unsteady · Libido loss · Movement disorders · Muscle spasms · Nystagmus · Respiratory disorder · Severe cutaneous adverse reactions (SCARs) · Skin reactions · Speech impairment · Weight increased

Breast Feeding
- Benzodiazepines are present in milk, and should be avoided if possible during breast-feeding.

Monitoring
- All infants should be monitored for sedation, feeding difficulties, adequate weight gain, and developmental milestones.

Renal Impairment
- Dose adjustments: Start with small doses in severe impairment.

Monitoring Requirements
- Routine measurement of plasma concentrations of antiepileptic drugs is not usually justified, because the target concentration ranges are arbitrary and often vary between individuals. However, plasma drug concentrations may be measured in children with worsening seizures, status epilepticus, suspected noncompliance, or suspected toxicity. Similarly, haematological and biochemical monitoring should not be undertaken unless clinically indicated.

Prescribing and Dispensing Information
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension.

Oral Suspension
- Clobazam (Non-proprietary)
  - Clobazam 1 mg per 1 ml: Clobazam 5mg/5ml oral suspension sugar free sugar-free | 150 ml (PSt) £90.00 DT = £90.00 (CDE-1) sugar-free | 250 ml (PSt) £150.00 (CDE-1)
  - Clobazam 2 mg per 1 ml: Clobazam 10mg/5ml oral suspension sugar free sugar-free | 150 ml (PSt) £95.00 DT = £95.00 (CDE-1) sugar-free | 250 ml (PSt) £150.33 (CDE-1)
- Perizam (Rosemont Pharmaceuticals Ltd)
  - Clobazam 1 mg per 1 ml: Perizam 1mg/ml oral suspension sugar-free | 150 ml (PSt) £90.00 DT = £90.00 (CDE-1)
  - Clobazam 2 mg per 1 ml: Perizam 2mg/ml oral suspension sugar-free | 150 ml (PSt) £95.00 DT = £95.00 (CDE-1)
- Tapclob (Martinida Pharmaceuticals Ltd)
  - Clobazam 1 mg per 1 ml: Tapclob 5mg/5ml oral suspension sugar-free | 150 ml (PSt) £90.00 DT = £90.00 (CDE-1) sugar-free | 250 ml (PSt) £150.00 (CDE-1)
  - Clobazam 2 mg per 1 ml: Tapclob 10mg/5ml oral suspension sugar-free | 150 ml (PSt) £95.00 DT = £95.00 (CDE-1) sugar-free | 250 ml (PSt) £150.34 (CDE-1)
- Zacco (Thame Laboratories Ltd)
  - Clobazam 1 mg per 1 ml: Zacco 5mg/5ml oral suspension sugar-free | 150 ml (PSt) £82.00 DT = £90.00 (CDE-1)
  - Clobazam 2 mg per 1 ml: Zacco 10mg/5ml oral suspension sugar-free | 150 ml (PSt) £87.00 DT = £95.00 (CDE-1)

Tablet
- Clobazam (Non-proprietary)
  - Clobazam 10 mg: Clobazam 10mg tablets | 30 tablet (PSt) £3.05 DT = £3.25 (CDE-1)
- Frisium (Sanofi)
  - Clobazam 10 mg: Frisium 10mg tablets | 30 tablet (PSt) £2.51 DT = £2.75 (CDE-1)
Clonazepam

**INDICATIONS AND DOSE**

**All forms of epilepsy**
- **BY MOUTH**
  - Child 1-11 months: Initially 250 micrograms once daily for 4 nights, dose to be increased over 2–4 weeks, usual dose 0.5–1 mg daily, dose to be taken at night; may be given in 3 divided doses if necessary
  - Child 1–4 years: Initially 250 micrograms once daily for 4 nights, dose to be increased over 2–4 weeks, usual dose 1–3 mg daily, dose to be taken at night; may be given in 3 divided doses if necessary
  - Child 5–11 years: Initially 500 micrograms once daily for 4 nights, dose to be increased over 2–4 weeks, usual dose 3–6 mg daily, dose to be taken at night; may be given in 3 divided doses if necessary
  - Child 12–17 years: Initially 1 mg once daily for 4 nights, dose to be increased over 2–4 weeks, usual dose 4–8 mg daily, dose usually taken at night; may be given in 3–4 divided doses if necessary

**SIDE-EFFECTS**
- Alopecia
- Bronchial secretion increased
- Concentration impaired
- Coordinated abnormal
- Drooling
- Hypersalivation
- Incomplete precocious puberty
- Muscle tone decreased
- Nystagmus
- Seizures
- Sexual dysfunction
- Skin reactions
- Speech impairment

**BREAST FEEDING**
- Present in milk, and should be avoided if possible during breast-feeding.

**MONITORING**
- All infants should be monitored for sedation, feeding difficulties, adequate weight gain, and developmental milestones.

**RENAI IMPAIRMENT**
- Dose adjustments

**MONITORING REQUIREMENTS**
- Routine measurement of plasma concentration of antiepileptic drugs is not usually justified, because the target concentration ranges are arbitrary and often vary between individuals. However, plasma drug concentrations may be measured in children with worsening seizures, status epilepticus, suspected noncompliance, or suspected toxicity. Similarly, haematological and biochemical monitoring should not be undertaken unless clinically indicated.

**PRESCRIBING AND DISPENSING INFORMATION**
- The RCPCH and NPPG recommend that, when a liquid special of clonazepam is required, the following strength is used:
  - 2 mg/5 mL.
- Switching between formulations should be taken when changing between oral formulations in the treatment of epilepsy. The need for continued supply of a particular manufacturer’s product should be based on clinical judgement and consultation with the patient or their carer, taking into account factors such as seizure frequency and treatment history.

**PATIENT AND CARER ADVICE**
- Medicines for Children leaflet: Clonazepam for preventing seizures.

**UNLICENSED USE**
- Clonazepam doses in BNFC may differ from those in product literature.

**IMPACT SAFETY INFORMATION**

**SAFE PRACTICE**
- Clonazepam has been confused with clonazepam; care must be taken to ensure the correct drug is prescribed and dispensed.

**CONTRA-INDICATIONS**
- Coma
- Current alcohol abuse
- Current drug abuse
- Respiratory depression

**CAUTIONS**
- Acute porphyrias p. 624
- Airways obstruction
- Brain damage
- Cerebellar ataxia
- Depression
- Spinal ataxia
- Suicidal ideation

**CAUTIONS, FURTHER INFORMATION**
- The effectiveness of clonazepam may decrease significantly after weeks or months of continuous therapy.

**INTERACTIONS**
- Appendix 1: clonazepam

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: orodispersible, oral suspension, oral solution.

**TABLET**
- **CAUTIONARY AND ADVISORY LABELS** 2, 8
- **Clonazepam (Non-proprietary)**
  - **Clonazepam 500 microgram**
    - 100 tablet **£30.00 DT = $42.31 (C5-1)
  - **Clonazepam 2 mg**
    - 100 tablet **£30.00 DT = $59.23 (C5-1)

**Oral solution**
- **CAUTIONARY AND ADVISORY LABELS** 2, 8
- **EXCipients**: May contain ethanol.
- **Clonazepam (Non-proprietary)**
  - **Clonazepam 100 microgram per 1 ml**
    - Clonazepam 500micrograms/5ml oral solution sugar free sugar-free **£29.25 DT = $36.42 (C5-1)
  - **Clonazepam 400 microgram per 1 ml**
    - Clonazepam 2mg/5ml oral solution sugar free sugar-free **£108.36 DT = $135.36 (C5-1)

**Diazepam**

**INDICATIONS AND DOSE**

**Tetanus**
- **BY INTRAVENOUS INJECTION**
  - Child: 100–300 micrograms/kg every 1–4 hours
  - **BY INTRAVENOUS INFUSION, OR BY NASOPHARYNGEAL TUBE**
  - Child: 3–10 mg/kg, adjusted according to response, to be given over 24 hours

**Muscle spasm in cerebral spasticity or in postoperative skeletal muscle spasm**
- **BY MOUTH**
  - Child 1–11 months: Initially 250 micrograms/kg twice daily
  - Child 1–4 years: Initially 2.5 mg twice daily
  - Child 5–11 years: Initially 5 mg twice daily
  - Child 12–17 years: Initially 10 mg twice daily; maximum 40 mg per day

**Status epilepticus**
- **Febrile convulsions**
- **Convulsions due to poisoning**
- **BY INTRAVENOUS INJECTION**
- **Neonate**: 300–400 micrograms/kg, then 300–400 micrograms/kg after 10 minutes if required, to be given over 3–5 minutes.
  - Child 1 month–11 years: 300–400 micrograms/kg (max. per dose 10 mg), then 300–400 micrograms/kg after 10 minutes if required, to be given over 3–5 minutes
  - Child 12–17 years: 10 mg, then 10 mg after 10 minutes if required, to be given over 3–5 minutes
  - **BY RECTUM**
  - Neonate: 1.25–2.5 mg, then 1.25–2.5 mg after 10 minutes if required.
  - Child 1 month–1 year: 5 mg, then 5 mg after 10 minutes if required
  - Child 2–11 years: 5–10 mg, then 5–10 mg after 10 minutes if required
**Epilepsy and other seizure disorders**

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use: Diazepam is adsorbed by plastics of infusion bags and giving sets. Emulsion formulation preferred for intravenous injection.
  - For **continuous intravenous infusion** of diazepam emulsion, dilute to a concentration of max. 400 micrograms/mL with Glucose 5% or 10%; max. 6 hours between addition and completion of infusion. For **continuous intravenous infusion** of diazepam solution, dilute to a concentration of max. 50 micrograms/mL with Glucose 5% or Sodium Chloride 0.9%.

- **PATIENT AND CARER ADVICE** Patients or carers should be given advice on how and when to administer rectal diazepam. Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risks of undertaking skilled tasks (e.g. driving) afterwards. For intravenous benzodiazepines the risk extends to **at least 24 hours** after administration. Responsible persons should be available to take patients home afterwards. The dangers of taking alcohol should be emphasised.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, suppository

<table>
<thead>
<tr>
<th>Tablet</th>
<th>CAUTIONARY AND ADVISORY LABELS 2, 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam (Non-proprietary)</td>
<td></td>
</tr>
<tr>
<td>Diazepam 2 mg</td>
<td>Diazepam 2mg tablets</td>
</tr>
<tr>
<td>Diazepam 5 mg</td>
<td>Diazepam 5mg tablets</td>
</tr>
<tr>
<td>Diazepam 10 mg</td>
<td>Diazepam 10mg tablets</td>
</tr>
</tbody>
</table>

  | Emulsion for injection |  |
  | Diazemuls (Accord Healthcare Ltd) |  |
  | Diazepam 5 mg per 1 ml | Diazemuls 10mg/2ml emulsion for injection ampoules | 10 ampoule | £0.05 CD-F-1 |

  | Solution for injection | EXCIPIENTS: May contain Benzyl alcohol, ethanol, propylene glycol |
  | Diazepam (Non-proprietary) |  |
  | Diazepam 5 mg per 1 ml | Diazepam 10mg/2ml solution for injection ampoules | 10 ampoule | £3.50–£7.20 DT = £5.59 CD-F-1 |

  | Oral suspension | CAUTIONARY AND ADVISORY LABELS 2, 19 |
  | Diazepam (Non-proprietary) |  |
  | Diazepam 400 microgram per 1 ml | Diazepam 2mg/5ml oral suspension | 100 ml | £31.75 DT = £31.75 CD-F-1 |

  | Enema | CAUTIONARY AND ADVISORY LABELS 2, 19 |
  | Diazepam (Non-proprietary) |  |
  | Diazepam 2 mg per 1 ml | Diazepam 5mg rectal solution tube | 1 tube | £5.85 DT = £5.85 CD-F-1 |
  | Diazepam 5mg rectal solution tube | 5 tube | £9.65 DT = £9.65 CD-F-1 |
  | Diazepam 10mg rectal solution tube | 5 tube | £13.50 DT = £13.50 CD-F-1 |
  | Diazepam 4 mg per 1 ml | Diazepam 10mg rectal solution tube | 5 tube | £7.35 DT = £7.35 CD-F-1 |
1.1 Status epilepticus

Other drugs used for Status epilepticus Diazepam, p. 226 • Fosphenytoin sodium, p. 204 • Phenobarbital, p. 223 • Phenytoin, p. 211

**ANTIEPILEPTICS**

**Paraldehyde**

**INDICATIONS AND DOSE**

**Status epilepticus**

- **BY RECTUM**
  - Neonate: 0.8 mL/kilogram for 1 dose, the dose is based on the use of a premixed solution of paraldehyde in olive oil in equal volumes.
  - Child: 0.8 mL/kilogram (max. per dose 20 mL) for 1 dose, the dose is based on the use of a premixed solution of paraldehyde in olive oil in equal volumes.

**SIDE-EFFECTS**

- Rash
- →

**UNLICENSED USE**

Not licensed for use in children as an enema.

**CONTRA-INDICATIONS**

Gastric disorders • rectal administration in colitis

**CAUTIONS**

Bronchopulmonary disease

**INTERACTIONS**

→ Appendix 1: antiepileptics

**PREGNANCY**

Avoid unless essential—crosses placenta. See also Pregnancy in Epilepsy p. 195.

**BREAST FEEDING**

Avoid unless essential—present in milk.

**HEPATIC IMPAIRMENT**

Use with caution.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Paraldehyde for seizures www.medicinesforchildren.org.uk/paraldehyde-seizures

**MEDICINAL FORMS**

Forms available from special-order manufacturers include: enema

**ANTIEPILEPTICS › BARBITURATES**

**Thiopental sodium**

(Thiopentone sodium)

**INDICATIONS AND DOSE**

**Prolonged status epilepticus**

- **INITIALLY BY SLOW INTRAVENOUS INJECTION**
  - Neonate: Initially up to 2 mg/kg, then (by continuous intravenous infusion) up to 8 mg/kg/hour, adjusted according to response.
  - Child: Initially up to 4 mg/kg, then (by continuous intravenous infusion) up to 8 mg/kg/hour, adjusted according to response

**Induction of anaesthesia**

- **BY SLOW INTRAVENOUS INJECTION**
  - Neonate: Initially up to 2 mg/kg, then 1 mg/kg, repeated if necessary; maximum 4 mg/kg per course.
  - Child: Initially up to 4 mg/kg, then 1 mg/kg, repeated if necessary; maximum 7 mg/kg per course

**SIDE-EFFECTS**

- Hypotension
- Respiratory disorders
- Skin eruption
- Sneezing
- Myocardial contractility decreased
- Crosses placenta
- May depress neonatal respiration when used during delivery.

**CONTRA-INDICATIONS**

Acute porphyrias p. 624 • myotonic dystrophy

**CAUTIONS**

Acute circulatory failure (shock) • avoid intra-arterial injection • cardiovascular disease • fixed cardiac output • hypovolaemia • reconstituted solution is highly alkaline (extravasation causes tissue necrosis and severe pain)

**INTERACTIONS**

→ Appendix 1: thiopental

**SIDE-EFFECTS**

- Rash
- →

**MEDICINAL FORMS**

Forms available from special-order manufacturers include: enema

**UNLICENSED USE**

Not licensed for use in status epilepticus. Not licensed for use by intravenous infusion.

**IMPORTANT SAFETY INFORMATION**

Thiopental sodium should only be administered by, or under the direct supervision of, personnel experienced in its use, with adequate training in anaesthesia and airway management, and when resuscitation equipment is available.

- **CONTRA-INDICATIONS**
  - Acute porphyrias p. 624 • myotonic dystrophy
- **CAUTIONS**
  - Acute circulatory failure (shock) • avoid intra-arterial injection • cardiovascular disease • fixed cardiac output • hypovolaemia • reconstituted solution is highly alkaline (extravasation causes tissue necrosis and severe pain)
- **INTERACTIONS**
  - Appendix 1: thiopental
- **SIDE-EFFECTS**
  - Rash
  - →

**HYPNOTICS, SEDATIVES AND ANXIOLYTICS › BENZODIAZEPINES**

**Lorazepam**

**INDICATIONS AND DOSE**

**Premedication**

- **BY MOUTH**
  - Child 1 month–11 years: 50–100 micrograms/kg (max. per dose 4 mg), to be given at least 1 hour before procedure, same dose may be given the night before procedure in addition to, or to replace, dose before procedure

**SIDE-EFFECTS**

- Rash
- →

**UNLICENSED USE**

Not licensed for use in status epilepticus. Not licensed for use by intravenous infusion.
BNFC 2019–2020

Status epilepticus 229

Breastfeeding

Benzodiazepines are present in milk, and should be avoided if possible during breast-feeding.

Renal Impairment

Dose adjustments

Start with small doses in severe impairment.

Directions for Administration

With intravenous use For intravenous injection, dilute with an equal volume of Sodium Chloride 0.9% (for neonates, dilute injection solution to a concentration of 100 micrograms/mL). Give over 3–5 minutes; max. rate 50 micrograms/kg over 3 minutes.

Patient and Carer Advice

Driving and skilled tasks Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risks of undertaking skilled tasks (e.g. driving) afterwards. For intravenous benzodiazepines the risk extends to at least 24 hours after administration. Responsible persons should be available to take patients home afterwards. The dangers of taking alcohol should be emphasised.

Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution for injection

Solution for injection

Excipients: May contain Benzyl alcohol, propylene glycol

<table>
<thead>
<tr>
<th>Lorazepam (Non-proprietary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam 2 mg per 1 ml Lorazepam 2mg/1ml solution for injection vials</td>
</tr>
<tr>
<td>Lorazepam 4 mg per 1 ml Ativan 4mg/1ml solution for injection ampoules</td>
</tr>
</tbody>
</table>

Tablet

CAUTIONARY AND ADVISORY LABELS 2, 19

<table>
<thead>
<tr>
<th>Lorazepam (Non-proprietary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam 1 mg Lorazepam 1mg tablets</td>
</tr>
<tr>
<td>Lorazepam 2.5 mg Lorazepam 2.5mg tablets</td>
</tr>
</tbody>
</table>

Midazolam

29-Mar-2018

**Indications and Dose**

**Status epilepticus | Febrile convulsions**

**By Buccal Administration**

- **Neonate:** 300 micrograms/kg, then 300 micrograms/kg after 10 minutes if required.
- Child 1-2 months: 300 micrograms/kg (max. per dose 2.5 mg), then 300 micrograms/kg after 10 minutes (max. per dose 2.5 mg) if required
- Child 3-11 months: 2.5 mg, then 2.5 mg after 10 minutes if required
- Child 1-4 years: 5 mg, then 5 mg after 10 minutes if required
- Child 5-9 years: 7.5 mg, then 7.5 mg after 10 minutes if required
- Child 10-17 years: 10 mg, then 10 mg after 10 minutes if required

**Initially by Intravenous Injection**

- **Neonate:** Initially 150–200 micrograms/kg, followed by (by continuous intravenous infusion) 60 micrograms/kg/hour, (by continuous intravenous infusion) increased in steps of 60 micrograms/kg/hour every 15 minutes (max. per dose 300 micrograms/kg/hour) until seizure controlled.
- Child: Initially 150–200 micrograms/kg, followed by (by continuous intravenous infusion) 60 micrograms/kg/hour, (by continuous intravenous infusion) increased in steps of continued →

**Contraindications**

Avoid injections containing benzyl alcohol in neonates - CNS depression - compromised airway - hyperkinesis - obsessional states - phobic states - respiratory depression

**Caution**

Muscle weakness - organic brain changes - parenteral administration

**Important Safety Information**

**Anaesthesia**

Benzodiazepines should only be administered for anaesthesia by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management.

**Contra-Indications**

Avoid injections containing benzyl alcohol in neonates - CNS depression - compromised airway - hyperkinesis - obsessional states - phobic states - respiratory depression

**Caution**

Muscle weakness - organic brain changes - parenteral administration

**Paradoxical effects**

A paradoxical increase in hostility and aggression may be reported by patients taking benzodiazepines. The effects range from talkativeness and excitement to aggressive and antisocial acts. Adjustment of the dose (up or down) sometimes attenuates the impulses. Increased anxiety and perceptual disorders are other paradoxical effects.

**Special precautions for parenteral administration**

When given parenterally, facilities for managing respiratory depression with mechanical ventilation must be available. Close observation required until full recovery from sedation.

**Interactions**

Appendix 1: lorazepam

**Side-Effects**

**General Side-Effects**

- **Common or very common** Apnoea - asthenia - coma - disinhibition - extrapyramidal symptoms - hypothermia - memory loss - speech slurred - suicide attempt
- **Uncommon** Allergic dermatitis - constipation - sexual dysfunction
- **Rare or very rare** Agranulocytosis - hyponatraemia - pancytopenia - SIAHD - thrombocytopenia

**Specific Side-Effects**

- **Rare or very rare**
  - With oral use Saliva altered
  - Frequency not known
  - With parenteral use Leucopenia
230  Epilepsy and other seizure disorders

Nervous system

60 micrograms/kg/hour every 15 minutes (max. per dose 300 micrograms/kg/hour) until seizure controlled

**Conscious sedation for procedures**

- **BY MOUTH**
  - Child: 500 micrograms/kg (max. per dose 20 mg), to be administered 30–60 minutes before procedure

- **BY BUCAL ADMINISTRATION**
  - Child 6 months–9 years: 200–300 micrograms/kg (max. per dose 5 mg)
  - Child 10–17 years (body-weight up to 70 kg): 6–7 mg (max. per dose 8 mg)

- **BY RECTUM**
  - Child 6 months–11 years: 300–500 micrograms/kg, to be administered 15–30 minutes before procedure

- **BY SLOW INTRAVENOUS INJECTION**
  - Child 1 month–5 years: Initially 25–50 micrograms/kg, to be administered over 2–3 minutes, 5–10 minutes before procedure, dose can be increased if necessary in small steps to maximum total dose per course; maximum 6 mg per course
  - Child 6–11 years: Initially 25–50 micrograms/kg, to be administered over 2–3 minutes, 5–10 minutes before procedure, dose can be increased if necessary in small steps to maximum total dose per course; maximum 10 mg per course
  - Child 12–17 years: Initially 25–50 micrograms/kg, to be administered over 2–3 minutes, 5–10 minutes before procedure, dose can be increased if necessary in small steps to maximum total dose per course; maximum 7.5 mg per course

**Premedication**

- **BY MOUTH**
  - Child: 500 micrograms/kg (max. per dose 20 mg), to be taken 15–30 minutes before the procedure

- **BY RECTUM**
  - Child 6 months–11 years: 300–500 micrograms/kg, to be administered 15–30 minutes before induction

**Induction of anaesthesia (but rarely used)**

- **BY SLOW INTRAVENOUS INJECTION**
  - Child 7–17 years: Initially 150 micrograms/kg (max. per dose 7.5 mg), dose to be given in steps of 50 micrograms/kg (max. 2.5 mg) over 2–5 minutes; wait for 2–5 minutes before subsequent dosing, then 50 micrograms/kg every 2 minutes (max. per dose 2.5 mg) if required; maximum 500 micrograms/kg per course; maximum 25 mg per course

**Sedation of patient receiving intensive care**

- **INITIALLY BY SLOW INTRAVENOUS INJECTION**
  - Child 6 months–11 years: Initially 50–200 micrograms/kg, to be administered over at least 3 minutes, followed by (by continuous intravenous infusion) 30–120 micrograms/kg/hour, adjusted according to response, initial dose may not be required and lower maintenance doses needed if opioid analgesics also used; reduce dose (or reduce or omit initial dose) in hypovolaemia, vasocostriction, or hypothermia
  - Child 12–17 years: Initially 30–300 micrograms/kg, dose to be given in steps of 1–2.5 mg every 2 minutes, followed by (by continuous intravenous infusion) 30–200 micrograms/kg/hour, adjusted according to response, initial dose may not be required and lower maintenance doses needed if opioid analgesics also used; reduce dose (or reduce or omit initial dose) in hypovolaemia, vasocostriction, or hypothermia

**Unlicensed use**

Oromucosal solution not licensed for use in children under 3 months. Unlicensed oromucosal formulations are also available and may have different doses—refer to product literature.

Injection not licensed for use in status epilepticus or febrile convulsions.

Not licensed for use in children under 6 months for premedication and conscious sedation.

Not licensed for use by mouth.

Not licensed for use by buccal administration for conscious sedation.

**Important safety information**

**Anaesthesia**

Benzodiazepines should only be administered for anaesthesia by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management.

**Prescribing of midazolam in palliative care**

The use of high-strength midazolam (5 mg/mL in 2 mL and 10 mL ampoules, or 2 mg/mL in 5 mL ampoules) should be considered in palliative care and other situations where a higher strength may be more appropriate to administer the prescribed dose, and where the risk of overdosage has been assessed. It is advised that flumazenil is available when midazolam is used, to reverse the effects if necessary.

**Contra-indications**

CNS depression - compromised airway - severe respiratory depression

**Caution**

Cardiac disease - children (particularly if cardiovascular impairment) - concentration of midazolam in children under 15 kg not to exceed 1 mg/mL - debilitated patients (reduce dose) - hypothermia - hypovolaemia (risk of severe hypotension) - neonates - risk of airways obstruction and hyperventilation in children under 6 months (monitor respiratory rate and oxygen saturation) - vasoconstriction

**Caution, further information**

Recovery when used for sedation  Midazolam has a fast onset of action, recovery is faster than for other benzodiazepines such as diazepam, but may be significantly longer in the elderly, in patients with a low cardiac output, or after repeated dosing.

**Interactions**

Appendix 1: midazolam

**Side-effects**

**General side-effects**

- **Common or very common**  Level of consciousness decreased - vomiting
- **Uncommon**  Skin reactions
- **Rare or very rare**  Apnoea - bradycardia - cardiac arrest - constipation - dry mouth - dyspnoea - hiccups - movement disorders - physical assault - respiratory disorders - vasodilatation
- **Frequency not known**  Appetite increased - disinhibition (severe; with sedative and peri-operative use) - fall - saliva altered
**SPECIFIC SIDE-EFFECTS**
- With buccal use: Thrombosis
- With parenteral use: Angioedema, drug abuse, drug withdrawal seizure, embolism and thrombosis

**SIDE-EFFECTS, FURTHER INFORMATION**
Higher doses are associated with prolonged sedation and risk of hypoventilation. The co-administration of midazolam with other sedative, hypnotic, or CNS-depressant drugs results in increased sedation. Midazolam accumulates in adipose tissue, which can significantly prolong sedation, especially in patients with obesity, hepatic impairment or renal impairment.

**Overdose**
There have been reports of overdosage when high strength midazolam has been used for conscious sedation. The use of high-strength midazolam (5mg/mL in 2mL and 10mL ampoules, or 2mg/mL in 5mL ampoules) should be restricted to general anaesthesia, intensive care, palliative care, or other situations where the risk has been assessed. It is advised that flumazenil is available when midazolam is used, to reverse the effects if necessary.

**BREAST FEEDING**
Small amount present in milk—avoid breast-feeding for 24 hours after administration (although amount probably too small to be harmful after single doses).

**HEPATIC IMPAIRMENT**
For parenteral preparations, manufacturer advises caution in all degrees of impairment. Dose adjustments for parenteral preparations manufacturer advises consider dose reduction in all degrees of impairment.

**RENAI IMPAIRMENT**
Use with caution in chronic renal failure.

**DIRECTIONS FOR ADMINISTRATION**
- With intravenous use: For intravenous infusion (Hypnovel®), give continuously in Glucose 5% or Sodium Chloride 0.9%. For intravenous injection in status epilepticus and febrile convulsions, dilute with Glucose 5% or Sodium Chloride 0.9%; rapid intravenous injection (less than 2 minutes) may cause seizure-like myoclonus in preterm neonate. For neonate and children under 15 kg dilute to a maximum concentration of 1 mg/mL. Neonatal intensive care, dilute 15 mg/kg body weight to a final volume of 50 mL with infusion fluid; an intravenous infusion rate of 0.1 mL/hour provides a dose of 30 micrograms/kg/hour.
- With oral use: For administration by mouth for sedation and premedication, injection solution may be diluted with apple or black currant juice, chocolate sauce, or cola.

**PRESCRIBING AND DISPENSING INFORMATION**
The RCPCH and NPPG recommend that, when a liquid special of midazolam is required, the following strength is used: 10 mg/5 mL.

**PATIENT AND CARER ADVICE**
Patients or carers should be given advice on how and when to administer midazolam oromucosal solution. Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risks of undertaking skilled tasks (e.g. driving) afterwards. For intravenous benzodiazepines the risk extends to at least 24 hours after administration. Responsible persons should be available to take patients home afterwards. The dangers of taking alcohol should be emphasised.

**MEDITICINAL USES**
- Midazolam is used in conscious sedation, in the treatment of prolonged, acute, convulsive seizures in patients aged 10 years to less than 18 years.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, oromucosal solution, solution for injection, infusion, solution for injection, solution for infusion.

**Solution for injection**
- **Midazolam (Non-proprietary)**
  - Midazolam (as Midazolam hydrochloride) 1 mg per 1 ml
  - Midazolam 5mg/5ml solution for injection ampoules
  - 10 ampoule (PSt) £16.90 DT + £9.63 (PSt)
  - Midazolam 2mg/2ml solution for injection ampoules
  - 10 ampoule (PSt) £4.50–£6.00 DT + £5.00 (C03)

- **Midazolam (as Midazolam hydrochloride) 2 mg per 1 ml**
  - Midazolam 10mg/5ml solution for injection ampoules
  - 10 ampoule (PSt) £6.75 DT + £6.86 (Hospital only) (C03)
  - 10 ampoule (PSt) £7.60 DT + £6.86 (C03)

- **Midazolam (as Midazolam hydrochloride) 5 mg per 1 ml**
  - Midazolam 50mg/10ml solution for injection ampoules
  - 10 ampoule (PSt) £33.77 DT + £27.93 (C03)
  - Midazolam 10mg/2ml solution for injection ampoules
  - 10 ampoule (PSt) £16.65 DT + £6.13 (C03)

- **Midazolam (as Midazolam hydrochloride) 2 mg per 1 ml**
  - Hypnovel (Roche Products Ltd)
  - Midazolam 10mg/2ml solution for injection ampoules
  - 10 ampoule (PSt) £7.11 DT + £6.13 (C03)

**Solution for infusion**
- **Midazolam (Non-proprietary)**
  - Midazolam (as Midazolam hydrochloride) 1 mg per 1 ml
  - Midazolam 50mg/50ml solution for infusion vials
  - 1 vial (PSt) £5.56–£12.00 (C03)

- **Midazolam (as Midazolam hydrochloride) 2 mg per 1 ml**
  - Midazolam 100mg/50ml solution for infusion vials
  - 1 vial (PSt) £9.05–£13.50 (C03)

**Oral solution**
- **Midazolam (Non-proprietary)**
  - Midazolam (as Midazolam hydrochloride) 2 mg per 1 ml
  - Midazolam 2mg/ml oral solution sugar free-sugar-free
  - 118 ml (PSt) N (C01)

**Oromucosal solution**

**CAUTIONARY AND ADVISORY LABELS**
- **2 EXCIPIENTS:** May contain ethanol
- **Buccolam (Shire Pharmaceuticals Ltd)**
  - Midazolam (as Midazolam hydrochloride) 5 mg per 1 ml
  - 2 Buccolam 20mg/2ml oromucosal solution pre-filled oral syringes sugar-free
  - 4 unit dose (PSt) £91.50 DT + £91.50 (C03)
  - Buccolam 7.5mg/1.5ml oromucosal solution pre-filled oral syringes sugar-free
  - 4 unit dose (PSt) £83.00 DT + £83.00 (C03)
  - Buccolam 2.5mg/0.5ml oromucosal solution pre-filled oral syringes sugar-free
  - 4 unit dose (PSt) £85.50 DT + £85.50 (C03)

- **Epistatus (Verloin Pharma Ltd)**
  - Midazolam (as Midazolam maleate) 10 mg per 1 ml
  - Epistatus 10mg/1ml oromucosal solution pre-filled oral syringes sugar-free
  - 1 unit dose (PSt) £45.76 DT + £45.76 (C03)

**2.1 Attention deficit hyperactivity disorder**

**Attention deficit hyperactivity disorder**

**Description of condition**
Attention deficit hyperactivity disorder (ADHD) is a behavioural disorder characterised by hyperactivity, impulsivity and inattention, which can lead to functional impairment such as psychological, social, educational or occupational difficulties. While these symptoms tend to co-

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**NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**
The Scottish Medicines Consortium has advised (November 2017) that midazolam oromucosal solution (Epistatus®) is accepted for use within NHS Scotland for the treatment of...
exist, some patients are predominantly hyperactive and impulsive, while others are principally inattentive. Symptoms typically appear in children aged 3–7 years, but may not be recognised until after 7 years of age, especially if hyperactivity is not present. ADHD is more commonly diagnosed in males than in females. ADHD is usually a persisting disorder and some children continue to have symptoms throughout adolescence and into adulthood, where inattentive symptoms tend to persist, and hyperactive-impulsive symptoms tend to recede over time. ADHD is also associated with an increased risk of disorders such as oppositional defiant disorder (ODD), conduct disorder, and possibly mood disorders such as depression, mania, and anxiety, as well as substance misuse.

Aims of treatment
The aims of treatment are to reduce functional impairment, severity of symptoms, and to improve quality of life.

Non-drug treatment
Children and their parents, or carers should be advised about the importance of a balanced diet, good nutrition and regular exercise. If hyperactivity appears to be influenced by certain foods or drinks, parents or carers should be advised to keep a diary of food or drinks consumed and the associated behaviour. A referral to a dietician should be made where appropriate.

Environmental modifications are changes made to the physical environment that can help reduce the impact of ADHD symptoms on a child’s day-to-day life. The modifications should be specific to the child’s circumstances, and may involve changes to seating arrangements, lighting and noise, reducing distractions, optimising education by having shorter periods of focus with movement breaks, and the appropriate use of teaching assistants at school. These changes should form part of the discussion at the time of diagnosis of ADHD and be trialled and reviewed for effectiveness before drug treatment is started.

In children aged under 5 years, an ADHD-focused parent-training programme that teaches parents or carers behaviour therapy techniques is recommended as first-line treatment. Specialist advice should be sought if symptoms are still causing significant impairment after completion of the programme and implementation of environmental modifications.

In children aged 5 years and over, advice about ADHD and ADHD-focused support should be given to all parents or carers. In children with ADHD and symptoms of oppositional defiant disorder or conduct disorder, a training programme specific for the coexisting condition, involving either the parent or carer with or without the child is also recommended. Drug treatment should be reserved for children whose symptoms are causing persistent and significant impairment of at least one area of function (such as interpersonal relationships, education attainment, and risk awareness) despite environmental modifications.

In adolescents, a course of cognitive behavioural therapy (CBT) in combination with drug treatment should be considered for those who have had some benefit from drug treatment, but still have symptoms causing significant impairment in at least one area of function (such as social skills with peers, problem-solving, self-control, active listening skills, or dealing with and expressing feelings).

Drug treatment
Child aged under 5 years
Drug treatment should only be considered in children under 5 years of age on advice from a specialist ADHD service.

Child aged 5 years and over
Drug treatment should be initiated by a specialist trained in the diagnosis and management of ADHD.

Following dose stabilisation, continuation and monitoring of drug treatment can be undertaken by the child’s general practitioner under a shared care arrangement. Children with ADHD and anxiety disorder, tic disorder, or autism spectrum disorder should be offered the same treatment options as other children with ADHD. Treatment options for ADHD are not licensed for use in children under 6 years of age. Methylphenidate hydrochloride p. 233 is recommended as first-line treatment. If a 6-week trial of methylphenidate hydrochloride p. 233 at the maximum tolerated dose does not reduce symptoms and associated impairment, consider switching to lisdexamfetamine mesilate p. 236. Dexamfetamine sulfate p. 235 can be given to children who are having a beneficial response to lisdexamfetamine mesilate but cannot tolerate its longer duration of effect.

Modified-release preparations of stimulants are preferred because of their pharmacokinetic profile, convenience, improved adherence, reduced risk of drug diversion (drugs being forwarded to others for non-prescription use or misuse), and the lack of need to be taken to school. Immediate-release preparations can be given when more flexible dosing regimens are required, or during initial dose titration. A combination of a modified-release and immediate-release preparation taken at different times of the day can be used to extend the duration of effect. The magnitude, duration of effect, and side-effects of stimulants vary between patients.

Atomoxetine p. 233 or guanfacine p. 237 can be given to children who are intolerant of both methylphenidate hydrochloride p. 233 and lisdexamfetamine mesilate, or if symptoms have not responded to separate 6-week trials of both drugs following adequate dose titration and consideration of alternative preparations. If sustained orthostatic hypotension or fainting episodes occur with guanfacine p. 237 treatment, the dose should be reduced or an alternative treatment offered.

Advice from, or referral to a tertiary specialist ADHD service should be considered if the child is unresponsive to one or more stimulant drugs (e.g. methylphenidate hydrochloride p. 233 and lisdexamfetamine mesilate) and one non-stimulant drug (e.g. atomoxetine p. 233 and guanfacine p. 237). A specialist service should also be consulted for advice before starting clonidine hydrochloride p. 103 [unlicensed] in children with ADHD and sleep disturbances, rages or tics, and before starting atypical antipsychotics in addition to stimulants in children with ADHD and co-existing pervasive aggression, rages or irritability.

Other treatment options such as bupropion hydrochloride, modafinil, and tricyclic antidepressants [all unlicensed] have been used in the management of ADHD, but due to limited evidence their use is not recommended without specialist advice.

Children should be monitored for effectiveness of treatment and side-effects, in addition to changes in sleep pattern, and the potential for stimulant diversion or misuse. If the child develops new, or has worsening of existing seizures, review drug treatment and stop any drug that might be contributing to the seizures; treatment can be cautiously reintroduced if it is unlikely to be the cause. Monitor children for the development of tics associated with stimulant use. If tics are stimulant related, consider a dose reduction, stopping treatment, or changing to a non-stimulant drug. If there is worsening of behaviour, consider adjusting drug treatment and reviewing the diagnosis.

Treatment should be reviewed by a specialist at least once a year and trials of treatment-free periods, or dose reductions considered where appropriate.
Atomoxetine (as Atomoxetine hydrochloride) 60 mg
Atomoxetine (as Atomoxetine hydrochloride) 40 mg
Atomoxetine (as Atomoxetine hydrochloride) 25 mg
Atomoxetine (as Atomoxetine hydrochloride) 18 mg
Atomoxetine (as Atomoxetine hydrochloride) 10 mg
Atomoxetine (as Atomoxetine hydrochloride) 7.5 mg
Atomoxetine (as Atomoxetine hydrochloride) 5 mg

Attention deficit hyperactivity disorder

**INDICATIONS AND DOSE**

Attention deficit hyperactivity disorder (initiated by a specialist)

- **BY MOUTH**
  - Child 6-17 years (body-weight up to 70 kg): Initially 500 micrograms/kg daily for 7 days, dose is increased according to response; maintenance 1.2 mg/kg daily, total daily dose may be given either as a single dose in the morning or in 2 divided doses with last dose no later than early evening, high daily doses to be given under the direction of a specialist; maximum 1.8 mg/kg per day; maximum 120 mg per day.
  - Child 6-17 years (body-weight 70 kg and above): Initially 40 mg daily for 7 days, dose is increased according to response; maintenance 80 mg daily, total daily dose may be given either as a single dose in the morning or in 2 divided doses with last dose no later than early evening, high daily doses to be given under the direction of a specialist; maximum 120 mg per day.

**UNLICENSED USE**

Atomoxetine doses in BNFC may differ from those in product literature. Doses above 100 mg daily not licensed.

**CONTRA-INDICATIONS**

Phaeochromocytoma, severe cardiovascular disease, severe cerebrovascular disease.

**CAUTIONS**

Aggressive behaviour, cardiovascular disease, cerebrovascular disease, emotional lability, history of seizures, hostility, hypertension, mania, psychosis, QT-interval prolongation, structural cardiac abnormalities, susceptibility to angle-closure glaucoma, tachycardia.

**INTERACTIONS**

Appendix 1: atomoxetine

**SIDE-EFFECTS**

- Common or very common: Anxiety, appetite decreased, asthenia, chest pain, constipation, depression, dizziness, drowsiness, gastrointestinal discomfort, headaches, insomnia, mood altered, mydriasis, nausea, reactions, tic, vomiting, weight decreased.
- Uncommon: Behaviour abnormal, dyspnœa, hallucination, hyperhidrosis, hypersensitivity, palpitations, psychosis, QT-interval prolongation, seizure, sensation abnormal, sinus tachycardia, suicidal behaviour, syncope, tremor, vision blurred.
- Rare or very rare: Genital pain, hepatic disorders, priapism, Raynaud’s phenomenon, urinary disorders.
- Frequency not known: Sudden cardiac death.

**PREGNANCY**

Manufacturer advises halve dose in moderate impairment and quarter dose in severe impairment.

**BREAST FEEDING**

Avoid-preserved in milk in animal studies.

**HEPATIC IMPAIRMENT**

Dose adjustments: Manufacturer advises halve dose in moderate impairment and quarter dose in severe impairment.

**MONITORING REQUIREMENTS**

- Monitor for appearance or worsening of anxiety, depression or tics.
- Pulse, blood pressure, psychiatric symptoms, appetite, weight and height should be recorded at initiation of therapy, following each dose adjustment, and at least every 6 months thereafter.

**PATIENT AND CARER ADVICE**

Suicidal ideation: Following reports of suicidal thoughts and behaviour, patients and their carers should be informed about the risk and told to report clinical worsening, suicidal thoughts or behaviour, irritability, agitation, or depression.

Hepatic impairment: Following rare reports of hepatic disorders, patients and carers should be advised of the risk and be told how to recognise symptoms; prompt medical attention should be sought in case of abdominal pain, unexplained nausea, malaise, darkening of the urine, or jaundice.

Medicines for Children leaflet: Atomoxetine for attention deficit hyperactivity disorder (ADHD) www.medicinesforchildren.org.uk/atomoxetine-attention-deficit-hyperactivity-disorder-adhd

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

SMC No. 1107/15
The Scottish Medicines Consortium has advised (December 2015) that atomoxetine oral solution (Strattera®) is accepted for restricted use within NHS Scotland for the treatment of attention deficit hyperactivity disorder (ADHD) in children of 6 years and older, in adolescents and in adults. It is restricted to patients who are unable to swallow capsules.

**Medications**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

**Oral solution**

Cautionary and advisory labels

- **Strattera** (Eli Lilly and Company Ltd)
  - Atomoxetine (as Atomoxetine hydrochloride) 4 mg per 1 ml
  - Strattera 4mg/1ml oral solution sugar-free | 300 ml
  - £85.00 DT = £85.00

- **Capsule**
  - Cautionary and advisory labels
  - **Strattera** (Eli Lilly and Company Ltd)
    - Atomoxetine (as Atomoxetine hydrochloride) 10 mg
      - Strattera 10 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
      - 180 mg capsules | 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 7.5 mg
      - Strattera 7.5 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 5 mg
      - Strattera 5 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
      - 60 mg capsules | 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 4 mg
      - Strattera 4 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 2.5 mg
      - Strattera 2.5 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 1.875 mg
      - Strattera 1.875 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 1.25 mg
      - Strattera 1.25 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09
    - Atomoxetine (as Atomoxetine hydrochloride) 0.75 mg
      - Strattera 0.75 mg capsules | 7 capsule DT = £13.28
      - 28 capsule DT = £53.09

**Methylphenidate hydrochloride**

Attention deficit hyperactivity disorder

**INDICATIONS AND DOSE**

Attention deficit hyperactivity disorder (initiated under specialist supervision)

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 4-5 years: Initially 2.5 mg twice daily, increased in steps of 2.5 mg daily if required, at weekly intervals, increased if necessary up to 1.4 mg/kg daily in 2–3 divided doses, discontinue if no response after 1 month, if effect wears off in evening (with rebound hyperactivity) a dose at bedtime may be appropriate (establish need with trial bedtime dose). Treatment may be started using a modified-release preparation continued →
Child 6-17 years: Initially 5 mg 1–2 times a day, increased in steps of 5–10 mg daily if required, at weekly intervals, increased if necessary up to 60 mg daily in 2–3 divided doses, increased if necessary up to 2.1 mg/kg daily in 2–3 divided doses, the licensed maximum dose is 60 mg daily in 2–3 doses, higher dose (up to a maximum of 90 mg daily) under the direction of a specialist, discontinue if no response after 1 month, if effect wears off in evening (with rebound hyperactivity) a dose at bedtime may be appropriate (establish need with trial bedtime dose). Treatment may be started using a modified-release preparation.

**DOSE EQUIVALENT AND CONVERSION**

- When switching from immediate-release preparations to modified-release preparations—consult product literature.

**CONCERTA® XL**

**Attention deficit hyperactivity disorder**

- **BY MOUTH**
  - Child 6-17 years: Initially 18 mg once daily, dose to be taken in the morning, increased in steps of 18 mg every week, adjusted according to response; increased if necessary up to 2.1 mg/kg daily, licensed max. dose is 54 mg once daily, to be increased to higher dose only under direction of specialist; discontinue if no response after 1 month; maximum 108 mg per day.
  
  **DOSE EQUIVALENT AND CONVERSION**
  - Total daily dose of 15 mg of standard-release formulation is considered equivalent to **Concerta® XL** 18 mg once daily.

**DELMOSART® PROLONGED-RELEASE TABLET**

**Attention deficit hyperactivity disorder (under expert supervision)**

- **BY MOUTH**
  - Child 6-17 years: Initially 18 mg once daily, dose to be taken in the morning, then increased in steps of 18 mg every week if required, discontinue if no response after 1 month; maximum 54 mg per day.
  
  **DOSE EQUIVALENT AND CONVERSION**
  - Total daily dose of 15 mg of standard-release formulation is considered equivalent to **Delmosart®** 18 mg once daily.

**EQUASYM® XL**

**Attention deficit hyperactivity disorder**

- **BY MOUTH**
  - Child 6-17 years: Initially 10 mg once daily, dose to be taken in the morning before breakfast; increased gradually at weekly intervals if necessary; increased if necessary up to 2.1 mg/kg daily, licensed max. dose is 60 mg daily, to be increased to higher dose only under direction of specialist; discontinue if no response after 1 month; maximum 90 mg per day.

**MEDIKINET® XL**

**Attention deficit hyperactivity disorder**

- **BY MOUTH**
  - Child 6-17 years: Initially 10 mg once daily, dose to be taken in the morning with breakfast; adjusted at weekly intervals according to response; increased if necessary up to 2.1 mg/kg daily, licensed max. dose is 60 mg daily, to be increased to higher dose only under direction of specialist; discontinue if no response after 1 month; maximum 90 mg per day.

**XAGGITIN® XL**

**Attention deficit hyperactivity disorder (under expert supervision)**

- **BY MOUTH**
  - Child 6-17 years: Initially 18 mg once daily, dose to be taken in the morning, increased in steps of 18 mg every week, adjusted according to response, discontinue if no response after 1 month; maximum 54 mg per day.

**DOSE EQUIVALENT AND CONVERSION**

- Total daily dose of 15 mg of standard-release formulation is considered equivalent to **Xaggitin® XL** 18 mg once daily.

**UNLICENSED USE**

- Doses over 60 mg daily not licensed.
- Doses of **Concerta XL** over 54 mg daily not licensed. Not licensed for use in children under 6 years.

**CONTRA-INDICATIONS**

- Anorexia nervosa • arrhythmias • cardiomyopathy • cardiovascular disease • cerebrovascular disorders • heart failure • hyperthyroidism • phaeochromocytoma • psychosis • severe depression • severe hypertension • structural cardiac abnormalities • suicidal ideation • uncontrolled bipolar disorder • vasculitis

**CAUTIONS**

- Agitation • alcohol dependence • anxiety • drug dependence • epilepsy (discontinue if increased seizure frequency) • family history of Tourette syndrome • susceptibility to angle-closure glaucoma • tics

**CONCERTA® XL, DELMOSART® PROLONGED-RELEASE TABLET**

- Dysphagia (dose form not appropriate)
- Restricted gastro-intestinal lumen (dose form not appropriate)

**XAGGITIN® XL**

- Dysphagia (dose form not appropriate)

**INTERACTIONS**

- Appendix 1: methylphenidate

**SIDE-EFFECTS**

- Common or very common
  - Alopecia • anxiety • appetite decreased • arrhythmias • arthralgia • behaviour abnormal • cough • depression • diarrhoea • dizziness • drowsiness • dry mouth • fever • gastrointestinal discomfort • growth retardation • headaches • hypertension • laryngeal pain • mood altered • movement disorders • nasopharyngitis • nausea • palpitations • sleep disorders • vomiting • weight decreased

- Uncommon
  - Chest discomfort • constipation • dysphagia • fatigue • haematuria • hallucinations • muscle complaints • psychiatric disorder • suicidal tendencies • tic • tremor • vision disorders

- Rare or very rare
  - Anaemia • angina pectoris • cardiac arrest • cerebrovascular insufficiency • confusion • gynaecomastia • hepatic coma • hyperfocus • hyperhidrosis • leucopenia • mydriasis • myocardial infarction • neuroleptic malignant syndrome • peripheral coldness • Raynaud’s phenomenon • seizures • sexual dysfunction • skin reactions • sudden cardiac death • thinking abnormal • thrombocytopenia

- Frequency not known
  - Delusions • drug dependence • hyperpyrexia • intracranial haemorrhage • logorhoea • pancytopenia • vasculitis

**PREGNANCY**

- Limited experience—avoid unless potential benefit outweighs risk

**BREAST FEEDING**

- Limited information available—avoid.

**MONITORING REQUIREMENTS**

- Monitor for psychiatric disorders.
- Pulse, blood pressure, psychiatric symptoms, appetite, weight and height should be recorded at initiation of therapy, following each dose adjustment, and at least every 6 months thereafter.

**TREATMENT CESSATION**

- Avoid abrupt withdrawal.

**DIRECTIONS FOR ADMINISTRATION**

**MEDIKINET® XL**

- Contents of capsule can be sprinkled on a tablespoon of apple sauce or yoghurt (then swallowed immediately without chewing).

**EQUASYM® XL**

- Contents of capsule can be sprinkled on a tablespoon of apple sauce (then swallowed immediately without chewing).

**PRESCRIBING AND DISPENSING INFORMATION**

- Different versions of modified-release preparations may not have the same clinical effect. To avoid confusion between these
different formulations of methylphenidate, prescribers should specify the brand to be dispensed.

**CONCERTA XL** Consists of an immediate-release component (22% of the dose) and a modified-release component (78% of the dose).

**MEDIKINET XL** Consists of an immediate-release component (50% of the dose) and a modified-release component (50% of the dose).

**EQUASYM XL** Consists of an immediate-release component (30% of the dose) and a modified-release component (70% of the dose).

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Methylphenidate for attention deficit hyperactivity disorder (ADHD) [www.medicinesforchildren.org.uk/methylphenidate-attention-deficit-hyperactivity-disorder](http://www.medicinesforchildren.org.uk/methylphenidate-attention-deficit-hyperactivity-disorder)

**Driving and skilled tasks** Prescribers and other healthcare professionals should advise patients if treatment is likely to affect their ability to perform skilled tasks (e.g. driving). This applies especially to drugs with sedative effects; patients should be warned that these effects are increased by alcohol. General information about a patient’s fitness to drive is available from the Driver and Vehicle Licensing Agency at [www.dvla.gov.uk](http://www.dvla.gov.uk).

2015 legislation regarding driving whilst taking certain drugs, may also apply to methylphenidate, see *Drugs and driving* under Guidance on prescribing p. 1.

**CONCERTA XL** Tablet membrane may pass through gastro-intestinal tract unchanged.

**DELMOSART XL PROLONGED-RELEASE TABLET** Manufacturer advises tablet membrane may pass through gastrointestinal tract unchanged.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: modified-release tablet, oral suspension, oral solution

**Modified-release tablet**

[CAUTIONARY AND ADVISORY LABELS 25]

**CONCERTA XL (Janssen-Cilag Ltd)**

| Methylphenidate hydrochloride 18 mg | Concerta XL 18mg tablets | 30 tablet (Ptd) £31.19 DT + £31.19 (CO) |
| Methylphenidate hydrochloride 27 mg | Concerta XL 27mg tablets | 30 tablet (Ptd) £36.81 DT + £36.81 (CO) |
| Methylphenidate hydrochloride 36 mg | Concerta XL 36mg tablets | 30 tablet (Ptd) £42.45 DT + £42.45 (CO) |
| Methylphenidate hydrochloride 54 mg | Concerta XL 54mg tablets | 30 tablet (Ptd) £73.62 DT + £73.62 (CO) |

**DELMOSART (Actavis UK Ltd)**

| Methylphenidate hydrochloride 18 mg | Delmosart 18mg modified-release tablets | 30 tablet (Ptd) £15.57 DT + £15.57 (CO) |
| Methylphenidate hydrochloride 27 mg | Delmosart 27mg modified-release tablets | 30 tablet (Ptd) £18.39 DT + £18.39 (CO) |
| Methylphenidate hydrochloride 36 mg | Delmosart 36mg modified-release tablets | 30 tablet (Ptd) £21.21 DT + £21.21 (CO) |
| Methylphenidate hydrochloride 54 mg | Delmosart 54mg modified-release tablets | 30 tablet (Ptd) £36.79 DT + £36.79 (CO) |

**XAGGITIN XL (Ethypharm UK Ltd)**

| Methylphenidate hydrochloride 18 mg | Xaggitin XL 18mg tablets | 30 tablet (Ptd) £15.58 DT + £15.58 (CO) |
| Methylphenidate hydrochloride 27 mg | Xaggitin XL 27mg tablets | 30 tablet (Ptd) £18.40 DT + £18.40 (CO) |
| Methylphenidate hydrochloride 36 mg | Xaggitin XL 36mg tablets | 30 tablet (Ptd) £21.22 DT + £21.22 (CO) |
| Methylphenidate hydrochloride 54 mg | Xaggitin XL 54mg tablets | 30 tablet (Ptd) £36.80 DT + £36.80 (CO) |

**Tablet**

| Methylphenidate hydrochloride (Non-proprietary) | Methylphenidate hydrochloride 5 mg | 30 tablet (Ptd) £3.03 DT + £3.03 (CO) |
| Methylphenidate hydrochloride 10 mg | 30 tablet (Ptd) £4.69 DT + £4.69 (CO) |
| Methylphenidate hydrochloride 20 mg | 30 tablet (Ptd) £10.92 DT + £10.92 (CO) |

**Medikinet ( Flynn Pharma Ltd)**

| Methylphenidate hydrochloride 5 mg | Medikinet 5mg tablets | 30 tablet (Ptd) £3.03 DT + £3.03 (CO) |
| Methylphenidate hydrochloride 10 mg | Medikinet 10mg tablets | 30 tablet (Ptd) £4.97 DT + £4.97 (CO) |
| Methylphenidate hydrochloride 20 mg | Medikinet 20mg tablets | 30 tablet (Ptd) £10.92 DT + £10.92 (CO) |

**Ritalin ( Novartis Pharmaceuticals UK Ltd)**

| Methylphenidate hydrochloride 10 mg | Ritalin 10mg tablets | 30 tablet (Ptd) £6.68 DT + £3.57 (CO) |

**Tranquilyn (Genesis Pharmaceuticals Ltd)**

| Methylphenidate hydrochloride 5 mg | Tranquilyn 5mg tablets | 30 tablet (Ptd) £3.03 DT + £3.03 (CO) |
| Methylphenidate hydrochloride 10 mg | Tranquilyn 10mg tablets | 30 tablet (Ptd) £4.27 DT + £3.57 (CO) |

**Modified-release capsule**

[CAUTIONARY AND ADVISORY LABELS 25]

**Equasym XL (Shire Pharmaceuticals Ltd)**

| Methylphenidate hydrochloride 10 mg | Equasym XL 10mg capsules | 30 capsule (Ptd) £25.00 DT + £25.00 (CO) |
| Methylphenidate hydrochloride 20 mg | Equasym XL 20mg capsules | 30 capsule (Ptd) £30.00 DT + £30.00 (CO) |
| Methylphenidate hydrochloride 30 mg | Equasym XL 30mg capsules | 30 capsule (Ptd) £35.00 DT + £35.00 (CO) |

**Medikinet XL ( Flynn Pharma Ltd)**

| Methylphenidate hydrochloride 5 mg | Medikinet XL 5mg capsules | 30 capsule (Ptd) £4.04 DT + £4.04 (CO) |
| Methylphenidate hydrochloride 10 mg | Medikinet XL 10mg capsules | 30 capsule (Ptd) £4.04 DT + £4.04 (CO) |
| Methylphenidate hydrochloride 30 mg | Medikinet XL 30mg capsules | 30 capsule (Ptd) £5.03 DT + £5.03 (CO) |

**CNS STIMULANTS > CENTRALLY ACTING SYMPATHOMIMETICS > AMPHETAMINES**

| Dexamfetamine sulfate (Dexamphetamine sulfate) |

**INDICATIONS AND DOSE**

Refractory attention deficit hyperactivity disorder (initiated under specialist supervision)

**BY MOUTH**

Child 6-17 years: Initially 2.5 mg 2–3 times a day, increased in steps of 5 mg once weekly if required; usual maximum 1 mg/kg daily, up to 20 mg daily (40 mg daily has been required in some children); maintenance dose to be given in 2–4 divided doses

**CONTRA-INDICATIONS** Agitated states, cardiovascular disease, history of alcohol abuse, history of drug abuse, hyperexcitability, hyperthyroidism, moderate hypertension, severe hypertension, structural cardiac abnormalities

**CAUTIONS** Anorexia, bipolar disorder, history of epilepsy (discontinue if seizures occur), mild hypertension, psychosis, susceptibility to angle-closure glaucoma, tics; Tourette syndrome

**CAUTIONS, FURTHER INFORMATION**

Tics and Tourette syndrome: Discontinue use if tics occur.

Growth restriction in children: Monitor height and weight as growth restriction may occur during prolonged therapy (drug-free periods may allow catch-up in growth but withdrawal slowly to avoid inducing depression or renewed hyperactivity).

...
PATIENT AND CARER ADVICE

PRESCRIBING AND DISPENSING INFORMATION

DIRECTIONS FOR ADMINISTRATION

TREATMENT CESSATION

▶ Monitor for aggressive behaviour or hostility during initial treatment.
▶ Monitor growth in children.

MONITORING REQUIREMENTS


▶ PREGNANCY Avoid (retrospective evidence of uncertain significance suggesting possible embryotoxicity).
▶ BREAST FEEDING Significant amount in milk—avoid.
▶ RENAL IMPAIRMENT Use with caution.

INDICATIONS AND DOSE

Attention deficit hyperactivity disorder (initiated by a specialist)

▶ BY MOUTH
  ▶ Child 6–17 years: Initially 30 mg once daily, alternatively initially 20 mg once daily, increased in steps of 10–20 mg every week if required, dose to be taken in the morning, discontinue if response insufficient after 1 month; maximum 70 mg per day

Contra-indications

Advanced arteriosclerosis - agitation states - hyperthyroidism - moderate hypertension - severe hypertension - symptomatic cardiovascular disease

CAUTIONS

Bipolar disorder - history of cardiovascular disease - history of substance abuse - may lower seizure threshold (discontinue if seizures occur) - psychotic disorders - susceptibility to angle-closure glaucoma - tics - Tourette syndrome

CAUTIONS, FURTHER INFORMATION

Cardiovascular disease Manufacturer advises caution in patients with underlying conditions that might be compromised by increases in blood pressure or heart rate; see also Contra-indications.

INTERACTIONS

▶ Appendix 1: amphetamines

SIDE-EFFECTS

▶ Common or very common Abdominal pain - anxiety - appetite decreased - arrhythmias - arthralgia - behaviour abnormal - depression - dry mouth - headache - mood altered - movement disorders - muscle cramps - nausea - palpitations - poor weight gain - sleep disorders - vertigo - vomiting - weight decreased

▶ Rare or very rare Anaemia - angina pectoris - cardiac arrest - cerebrovascular insufficiency - fatigue - growth retardation - hallucination - hepatic coma - hepatic function abnormal - intracranial haemorrhage - leucopenia - mydriasis - psychosis - seizure - skin reactions - suicidal tendencies - thrombocytopenia - tic (in those at risk) - vasculitis cerebral - vision disorders

Frequency not known

Causes wakefulness, excessive activity, paranoia, hallucinations, and hypertension followed by exhaustion, convulsions, hyperthermia, and coma. See Stimulants under Emergency treatment of poisoning p. 859.

Renal impairment

Use with caution.

Tourette syndrome

Dose adjustments

Manufacturer advises max. dose 50 mg daily in severe impairment.

Drug action

Lisdexamfetamine mesilate

23 Jan 2018

DRUG ACTION

Lisdexamfetamine is a prodrug of dexamfetamine.

INTERACTIONS

▶ Appendix 1: amphetamines

SIDE-EFFECTS

▶ Common or very common Abdominal pain upper - anxiety - appetite decreased - arrhythmias - arthralgia - depression - diarrhoea - dizziness - drug dependence - hyperhidrosis - hypermetabolism - hyperpyrexia - kidney injury - myocardial infarction - neuroleptic malignant syndrome - obsessive-compulsive disorder - reflexes increased - rhabdomyolysis - sexual dysfunction - sudden death - taste altered - tremor

Overdose


PREGNANCY

Manufacturer advises use only if potential benefit outweighs risk.

BREAST FEEDING

Manufacturer advises avoid—present in human milk.

RENAI IMPAIRMENT

Manufacturer advises max. dose 50 mg daily in severe impairment.

Dextamfetamine sulfate 10 mg

<table>
<thead>
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<th>100 capsule (PO)</th>
<th>(CD)</th>
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Dextamfetamine sulfate 15 mg

<table>
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<th>100 capsule (PO)</th>
<th>(CD)</th>
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</table>

Tablet

Dextamfetamine sulfate (Non-proprietary)

Dextamfetamine sulfate 5 mg

<table>
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<tr>
<th>28 tablet (PO)</th>
<th>£24.75 DT + £24.62 (OT)</th>
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Amfexa (Flynn Pharma Ltd)

Dextamfetamine sulfate 5 mg

<table>
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<tr>
<th>Amfexa 5mg tablets</th>
<th>30 tablet (PO)</th>
<th>£19.89 (CD)</th>
</tr>
</thead>
</table>

Lisdexamfetamine mesilate

23 Jan 2018

DRUG ACTION

Lisdexamfetamine is a prodrug of dexamfetamine.

INTERACTIONS

▶ Appendix 1: amphetamines

SIDE-EFFECTS

▶ Common or very common Abdominal pain upper - anxiety - appetite decreased - arrhythmias - arthralgia - depression - diarrhoea - dizziness - drug dependence - hyperhidrosis - hypermetabolism - hyperpyrexia - kidney injury - myocardial infarction - neuroleptic malignant syndrome - obsessive-compulsive disorder - reflexes increased - rhabdomyolysis - sexual dysfunction - sudden death - taste altered - tremor

Overdose


PREGNANCY

Manufacturer advises use only if potential benefit outweighs risk.

BREAST FEEDING

Manufacturer advises avoid—present in human milk.

RENAI IMPAIRMENT

Manufacturer advises max. dose 50 mg daily in severe impairment.
Attention deficit hyperactivity disorder 237

**SYMPATHOMIMETICS 》 ALPHÀ-2-ADRENOCEPTOR AGONISTS**

Guanfacine

14-Jul-2018

**INDICATIONS AND DOSE**

Attention deficit hyperactivity disorder in children for whom stimulants are not suitable, not tolerated or ineffective (initiated under specialist supervision)

- **BY MOUTH**
  - Child 6-12 years (body-weight 25 kg and above): Initially 1 mg once daily; adjusted in steps of 1 mg every week if necessary and if tolerated; maintenance 0.05–0.12 mg/kg once daily (max. per dose 4 mg), for optimal weight-adjusted dose titrations, consult product literature
  - Child 13–17 years (body-weight 41.5–49.4 kg): Initially 1 mg once daily; adjusted in steps of 1 mg every week if necessary and if tolerated; maintenance 0.05–0.12 mg/kg once daily (max. per dose 4 mg), for optimal weight-adjusted dose titrations, consult product literature
  - Child 13–17 years (body-weight 49.5–58.4 kg): Initially 1 mg once daily; adjusted in steps of 1 mg every week if necessary and if tolerated; maintenance 0.05–0.12 mg/kg once daily (max. per dose 6 mg), for optimal weight-adjusted dose titrations, consult product literature
  - Child 13–17 years (body-weight 58.5 kg and above): Initially 1 mg once daily; adjusted in steps of 1 mg every week if necessary and if tolerated; maintenance 0.05–0.12 mg/kg once daily (max. per dose 7 mg), for optimal weight-adjusted dose titrations, consult product literature

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- Manufacturer advises reduce dose by half with concurrent use of moderate and potent inhibitors of CYP3A4.
- Manufacturer advises increase dose up to max. 7 mg daily with concurrent use of potent inducers of CYP3A4—no specific recommendation made for children.

**CAUTIONS**

- Bradycardia (risk of torsade de pointes) - heart block (risk of torsade de pointes) - history of cardiovascular disease - history of QT-interval prolongation - hypokalaemia (risk of torsade de pointes)

**INTERACTIONS** 》 Appendix 1: guanfacine

**SIDE-EFFECTS**

- Common or very common
  - Anxiety
  - Appetite decreased
  - Arrhythmias
  - Asthenia
  - Constipation
  - Depression
  - Diarrhoea
  - Dizziness
  - Drowsiness
  - Dry mouth
  - Gastrointestinal discomfort
  - Headache
  - Hypotension
  - Mood altered
  - Nausea
  - Skin reactions
  - Sleep disorders
  - Urinary disorders
  - Vomiting
  - Weight increased

- Uncommon
  - Asthma
  - Atrioventricular block
  - Chest pain
  - Hallucination
  - Loss of consciousness
  - Pallor
  - Seizure
  - Syncope

- Rare or very rare
  - Hypertension
  - Hypertensive encephalopathy
  - Malaise

- Frequency not known
  - Erectile dysfunction

**SIDE-EFFECTS, FURTHER INFORMATION**

Somnolence and sedation may occur, predominantly during the first 2–3 weeks of treatment and with dose increases; manufacturer advises to consider dose reduction or

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Capsule**

- **CAUTIONARY AND ADVISORY LABELS 》 3, 25**
  - **Elvanse (Shire Pharmaceuticals Ltd)**
    - Lisdexamfetamine dimesylate 20 mg: Elvanse 20 mg capsules
      - 28 capsule P38.54 DT + £54.62 CT
    - Lisdexamfetamine dimesylate 30 mg: Elvanse Adult 30 mg capsules
      - 28 capsule P38.58 DT + £58.24 CE
    - Lisdexamfetamine dimesylate 40 mg: Elvanse 40 mg capsules
      - 28 capsule P38.62 DT + £62.82 CT
    - Lisdexamfetamine dimesylate 50 mg: Elvanse Adult 50 mg capsules
      - 28 capsule P38.68 DT + £68.60 CE
    - Lisdexamfetamine dimesylate 70 mg: Elvanse Adult 70 mg capsules
      - 28 capsule P38.83 DT + £83.16 CE
discontinuation of treatment if symptoms are clinically significant or persistent.

**Overdose** Features may include hypotension, initial hypertension, bradycardia, lethargy, and respiratory depression. Manufacturer advises that patients who develop lethargy should be observed for development of more serious toxicity for up to 24 hours.

- **CONCEPTION AND CONTRACEPTION** Manufacturer recommends effective contraception in females of childbearing potential.
- **PREGNANCY** Manufacturer advises avoid—tooxity in animal studies.
- **BREAST FEEDING** Manufacturer advises avoid—present in milk in animal studies.
- **HEPATIC IMPAIRMENT** Manufacturer advises caution (pharmacokinetics have not been assessed in paediatric patients with hepatic impairment).
- **DOSE ADJUSTMENTS** Manufacturer advises consider dose reduction.
- **RENAL IMPAIRMENT** Manufacturer advises consider dose reduction in severe impairment and end-stage renal disease.

- **MONITORING REQUIREMENTS**
  - Manufacturer advises to conduct a baseline evaluation to identify patients at risk of somnolence, sedation, hypotension, bradycardia, QT-prolongation, and arrhythmia; this should include assessment of cardiovascular status. Monitor for signs of these adverse effects weekly during dose titration and then every 3 months during the first year of treatment, and every 6 months thereafter. Monitor BMI prior to treatment and 6 months thereafter. More frequent monitoring is advised following dose adjustments.
  - Monitor blood pressure and pulse during dose downward titration and following discontinuation of treatment.
  - **TREATMENT CESSATION** Manufacturer advises avoid abrupt withdrawal; consider dose tapering to minimise potential withdrawal effects.

- **DIRECTIONS FOR ADMINISTRATION** Manufacturer advises avoid administration with high fat meals (may increase absorption).

- **PATIENT AND CARER ADVICE** Patients or carers should be counselled on administration of guanfacine modified-release tablets.
  - **Missed doses** Manufacturer advises that patients and carers should inform their prescriber if more than one dose is missed; consider dose re-titration.
  - **Driving and skilled tasks** Manufacturer advises patients and carers should be counselled about the effects on driving and performance of skilled tasks—increased risk of dizziness and syncope.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Modified-release tablet**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS</th>
<th>2, 25</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intuniv (Shire Pharmaceuticals Ltd)</strong></td>
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<tr>
<td>Guanfacine (as Guanfacine hydrochloride) 1 mg</td>
<td>Intuniv 1mg modified-release tablets</td>
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<tr>
<td>Guanfacine (as Guanfacine hydrochloride) 2 mg</td>
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<tr>
<td>Guanfacine (as Guanfacine hydrochloride) 4 mg</td>
<td>Intuniv 4mg modified-release tablets</td>
</tr>
</tbody>
</table>

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### 2.2 Bipolar disorder and mania

#### Mania and hypomania

**Overview**

Antimanic drugs are used to control acute attacks and to prevent recurrence of episodes of mania or hypomania. Long-term treatment of bipolar disorder should continue for at least two years from the last manic episode and up to five years if the patient has risk factors for relapse.

An antidepressant drug may also be required for the treatment of co-existing depression, but should be avoided in patients with rapid-cycling bipolar disorder, a recent history of hypomania, or with rapid mood fluctuations.

**Benzodiazepines**

Use of benzodiazepines may be helpful in the initial stages of treatment for behavioural disturbance or agitation; they should not be used for long periods because of the risk of dependence.

**Antipsychotic drugs**

Antipsychotic drugs (normally olanzapine p. 257, quetiapine p. 258, or risperidone p. 260) are useful in acute episodes of mania and hypomania; if the response to antipsychotic drugs is inadequate, lithium or valproate may be added. An antipsychotic drug may be used concomitantly with lithium or valproate in the initial treatment of severe acute mania.

See **Important safety information, Conception and contraception, and Pregnancy** in the valproic acid p. 219 and sodium valproate p. 213 monographs.

Atypical antipsychotics are the treatment of choice for the long-term management of bipolar disorder in children and adolescents; if the patient has frequent relapses or continuing functional impairment, consider concomitant therapy with lithium or valproate. An atypical antipsychotic that causes less weight gain and does not increase prolactin levels is preferred.

When discontinuing antipsychotics, the dose should be reduced gradually over at least 4 weeks if the child is continuing on other antimanic drugs; if the child is not continuing on other antimanic drugs, or has a history of manic relapse, a withdrawal period of up to 3 months is required.

**Carbamazepine**

Carbamazepine p. 200 may be used under specialist supervision for the prophylaxis of bipolar disorder (manic-depressive disorder) in children unresponsive to a combination of other prophylactic drugs; it is used in patients with rapid-cycling manic-depressive illness (4 or more affective episodes per year). The dose of carbamazepine should not normally be increased if an acute episode of mania occurs.

**Valproate**

Valproic acid (as the semisodium salt) is licensed in adults for the treatment of manic episodes associated with bipolar disorder. Sodium valproate is unlicensed for the treatment of bipolar disorder. Valproate (valproic acid and sodium valproate) can also be used for the prophylaxis of bipolar disorder [unlicensed use]. It must be started and supervised by a specialist experienced in managing bipolar disorder.

Because of its teratogenic risk, valproate must not be used in females of childbearing potential unless the conditions of the Pregnancy Prevention Programme are met and alternative treatments are ineffective or not tolerated.

Valproic acid and sodium valproate must not be used during pregnancy in bipolar disorder. The benefit and risk of valproate therapy should be carefully reconsidered at regular treatment reviews. For further information, see **Important safety information, Conception and contraception, and**
Pregnancy in the valproic acid and sodium valproate monographs.

In patients with frequent relapse or continuing functional impairment, consider switching therapy to lithium or an atypical antipsychotic, or adding lithium or an atypical antipsychotic to valproate. If a patient taking valproate experiences an acute episode of mania that is not ameliorated by increasing the valproate dose, consider concomitant therapy with olanzapine, quetiapine, or risperidone.

**Lithium**

Lithium salts are used in the prophylaxis and treatment of mania, in the prophylaxis of bipolar disorder (manic-depressive disorder), and bipolar depression, and as concomitant therapy with antidepressant medication in children who have had an incomplete response to treatment for acute depression in bipolar disorder [unlicensed indication]. It is also used for the treatment of aggressive or self-harming behaviour [unlicensed indication].

The decision to give prophylactic lithium requires specialist advice, and must be based on careful consideration of the likelihood of recurrence in the individual child, and the benefit of treatment weighed against the risks. The full prophylactic effect of lithium may not occur for six to twelve months after the initiation of therapy. An atypical antipsychotic or valproate (given alone or as adjunctive therapy with lithium) are alternative prophylactic treatments in patients who experience frequent relapses or continued functional impairment.

**CONTRA-INDICATIONS**

- Addison’s disease
- cardiac insufficiency
- dehydration
- family history of Brugada syndrome
- rhythm disorder
- untreated hypothyroidism

**CAUTIONS**

- Avoid abrupt withdrawal
- cardiac disease
- concurrent ECT (may lower seizure threshold)
- diuretic treatment (risk of toxicity)
- epilepsy (may lower seizure threshold)
- myasthenia gravis
- psoriasis (risk of exacerbation)
- QT interval prolongation
- review dose as necessary in intercurrent infection (especially if sweating profusely)
- review dose as necessary in vomiting
- surgery

**CAUTIONS, FURTHER INFORMATION**

- Long-term use
- Long-term use of lithium has been associated with thyroid disorders and mild cognitive and memory impairment. Long-term treatment should therefore be undertaken only with careful assessment of risk and benefit, and with monitoring of thyroid function every 6 months (more often if there is evidence of deterioration).

The need for continued therapy should be assessed regularly and patients should be maintained on lithium after 3–5 years only if benefit persists.

**SIDE-EFFECTS**

- Rare or very rare
  - Nephropathy
- **Frequency not known**
  - Abdominal discomfort
  - alopecia
  - angioedema
  - appetite decreased
  - arthralgias
  - atrioventricular block
  - cardiomyopathy
  - cerebellar syndrome
  - circulatory collapse
  - coma
  - delirium
  - diarrhoea
  - dizziness
  - dry mouth
  - electrolyte imbalance
  - encephalopathy
  - folliculitis
  - gastritis
  - goitre
  - hyperglycaemia
  - hyperparathyroidism
  - hypersalivation
  - hypotension
  - hypothyroidism
  - idiopathic intracranial hypertension
  - leucocytosis
  - memory loss
  - movement disorders
  - muscle weakness
  - myasthenia gravis
  - nausea
  - neoplasms
  - nystagmus
  - peripheral neuropathy
  - peripheral oedema
  - polycystic ovarian syndrome
  - QT interval prolongation
  - reflexes abnormal
  - renal disorders
  - renal impairment
  - rhabdomyolysis
  - sexual dysfunction
  - skin reactions
  - skin ulcer
  - speech impairment
  - taste altered
  - thyrotoxicosis
  - tremor
  - vertigo
  - vision disorders
  - vomiting
  - weight increased

**Overdose**

Signs of intoxication require withdrawal of treatment and include increasing gastrointestinal disturbances (vomiting, diarrhoea), visual disturbances, polynuria, muscle weakness, fine tremor increasing to coarse tremor, CNS disturbances (confusion and drowsiness increasing to lack of coordination, restlessness, stupor); abnormal reflexes, myoclonus, incontinence, hyperpnea.

With severe intoxication, cardiac arhythmias (including sino-atrial block, bradycardia and first-degree heart block), blood pressure changes, circulatory failure, renal failure, coma and sudden death reported.

For details on the management of poisoning, see Lithium, under Emergency treatment of poisoning p. 859.

**CONCEPTION AND CONTRACEPTION**

Manufacturer advises effective contraception during treatment for women of childbearing potential.

**PREGNANCY**

Avoid if possible, particularly in the first trimester (risk of teratogenicity, including cardiac abnormalities).

**Dose adjustments**

Dose requirements increased during the second and third trimesters (but on delivery return abruptly to normal).

**Monitoring**

Close monitoring of serum-lithium concentration advised in pregnancy (risk of toxicity in neonate).

**BREAST FEEDING**

Present in milk and risk of toxicity in infant—avoid.

**RENAL IMPAIRMENT**

Caution in mild to moderate impairment. Avoid in severe impairment.

**Monitoring**

In renal impairment monitor serum-lithium concentration closely and adjust dose accordingly.

**MONITORING REQUIREMENTS**

- Serum concentrations
  - Lithium salts have a narrow therapeutic/toxic ratio and should therefore not be prescribed unless facilities for monitoring serum-lithium concentrations are available.
  - Samples should be taken 12 hours after the dose to achieve a serum-lithium concentration of 0.4–1 mmol/litre (lower end of the range for maintenance therapy and elderly patients).
  - A target serum-lithium concentration of 0.8–1 mmol/litre is recommended for acute episodes of mania, and for patients who have previously relapsed or have sub-syndromal symptoms. It is important to determine the optimum range for each individual patient.
  - Routine serum-lithium monitoring should be performed weekly after initiation and after each dose change until concentrations are stable, then every 3 months thereafter. Additional serum-lithium measurements should be made if a patient develops significant intercurrent disease or if there is a significant change in a patient’s sodium or fluid intake.
  - Manufacturer advises to assess renal, cardiac, and thyroid function before treatment initiation.
  - An ECG is recommended in patients with cardiovascular disease or risk factors for it. Body-weight or BMI, serum electrolytes, and a full blood count should also be measured before treatment initiation.
  - Monitor body-weight or BMI, serum electrolytes, eGFR, and thyroid function every 6 months during...
treatment, and more often if there is evidence of impaired renal or thyroid function, or raised calcium levels. Manufacturer also advises to monitor cardiac function regularly.

**TREATMENT CESSATION** While there is no clear evidence of withdrawal or rebound psychosis, abrupt discontinuation of lithium increases the risk of relapse. If lithium is to be discontinued, the dose should be reduced gradually over a period of at least 4 weeks (preferably over a period of up to 3 months). Patients and their carers should be warned of the risk of relapse if lithium is discontinued abruptly. If lithium is stopped or is to be discontinued abruptly, consider changing therapy to an atypical antipsychotic or valproate.

**PATIENT AND CARER ADVICE** Patients should be advised to report signs and symptoms of lithium toxicity, hypothyroidism, renal dysfunction (including polyuria and polydipsia), and benign intracranial hypertension (persistent headache and visual disturbance). Maintain adequate fluid intake and avoid dietary changes which reduce or increase sodium intake.

**Lithium treatment packs** A lithium treatment pack should be given to patients on initiation of treatment with lithium. The pack consists of a patient information booklet, lithium alert card, and a record book for tracking serum-lithium concentration. Packs may be purchased from 3M 0845 610 1112

Driving and skilled tasks May impair performance of skilled tasks (e.g. driving, operating machinery).

## Lithium carbonate

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and prophylaxis of mania</td>
</tr>
<tr>
<td><strong>BY MOUTH</strong></td>
</tr>
<tr>
<td>Child 12–17 years: Dose adjusted according to serum-lithium concentration, doses are initially divided throughout the day, but once daily administration is preferred when serum-lithium concentration stabilised</td>
</tr>
</tbody>
</table>

DOSE EQUIVALENCE AND CONVERSION

- Preparations vary widely in bioavailability; changing the preparation requires the same precautions as initiation of treatment.

**CAMCOLIT® MODIFIED-RELEASE TABLET**

| Treatment of mania | Treatment of bipolar disorder | Treatment of recurrent depression | Treatment of prophylaxis of aggressive or self-harming behaviour |
| --- |
| **BY MOUTH** |
| Child 12–17 years: Initially 225–675 mg twice daily, dose adjusted according to serum-lithium concentration, doses are initially divided throughout the day, but once daily administration is preferred when serum-lithium concentration stabilised |

**LISKONUM®**

| Treatment of mania | Treatment of bipolar disorder | Treatment of recurrent depression | Treatment of prophylaxis of aggressive or self-harming behaviour |
| --- |
| **BY MOUTH** |
| Child 12–17 years: Initially 225–450 mg twice daily, dose adjusted according to serum-lithium concentration, doses are initially divided throughout the day, but once daily administration is preferred when serum-lithium concentration stabilised |

**UNLICENSED USE** Not licensed for aggressive or self-harming behaviour. Not licensed for concomitant therapy with antidepressant medication in children who have had an incomplete response to treatment for acute depression in bipolar disorder. Camcolit® brand not licensed for use in children.

**INTERACTIONS** → Appendix 1: lithium

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Modified-release tablet**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS 10, 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camcolit (Essential Pharma Ltd) Lithium carbonate 400 mg Camcolit 400 modified-release tablets</td>
</tr>
<tr>
<td>Liskonum (TeFarma) Lithium carbonate 450 mg Liskonum 450mg modified-release tablets</td>
</tr>
<tr>
<td>Priadel (lithium carbonate) (Essential Pharma M) Lithium carbonate 200 mg Priadel 200mg modified-release tablets</td>
</tr>
<tr>
<td>Priadel 400mg modified-release tablets</td>
</tr>
</tbody>
</table>

**Tablet**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium carbonate (Non-proprietary) Lithium carbonate 250 mg</td>
</tr>
</tbody>
</table>
**Lithium citrate**

- **INDICATIONS AND DOSE**
  - Treatment and prophylaxis of mania
  - Treatment and prophylaxis of bipolar disorder
  - Treatment and prophylaxis of recurrent depression
  - Treatment and prophylaxis of aggressive or self-harming behaviour
    - BY MOUTH
    - Child: Dose adjusted according to serum-lithium concentration; doses are initially divided throughout the day, but once daily administration is preferred when serum-lithium concentration stabilised

**DOSE EQUIVALENCE AND CONVERSION**
- Preparations vary widely in bioavailability; changing the preparation requires the same precautions as initiation of treatment.

**LI- LIQUID**

- Treatment and prophylaxis of mania
- Treatment and prophylaxis of bipolar disorder
- Treatment and prophylaxis of recurrent depression
- Treatment and prophylaxis of aggressive or self-harming behaviour
  - BY MOUTH
  - Child: Dose adjusted according to serum-lithium concentration

**DOSE EQUIVALENCE AND CONVERSION**
- For Li-Liquid®: Lithium citrate tetrahydrate 509 mg is equivalent to lithium carbonate 200 mg.

**PRIADEL® LIQUID**

- Treatment and prophylaxis of mania
- Treatment and prophylaxis of bipolar disorder
- Treatment and prophylaxis of recurrent depression
- Treatment and prophylaxis of aggressive or self-harming behaviour
  - BY MOUTH
  - Child: Dose adjusted according to serum-lithium concentration, doses are initially divided throughout the day, but once daily administration is preferred when serum-lithium concentration stabilised

**DOSE EQUIVALENCE AND CONVERSION**
- For Priadel® liquid: Lithium citrate tetrahydrate 520 mg is equivalent to lithium carbonate 204 mg.

- **UNLICENSED USE** Not licensed for use in children.
- **INTERACTIONS** Appendix 1: lithium
- **SIDE-EFFECTS** Polydipsia

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral solution**

| CAUTIONARY AND ADVISORY LABELS | 10 |
| Li-Liquid (Rosemont Pharmaceuticals Ltd) |  |
| Lithium citrate 101.8 mg per 1 ml Li-Liquid 509mg/5ml oral solution | 150 ml (P) | £5.79 DT + £5.79 |
| Lithium citrate 203.6 mg per 1 ml Li-Liquid 1018mg/5ml oral solution | 150 ml (P) | £11.58 DT + £11.58 |
| Priadel (lithium citrate) (Essential Pharma M) |  |
| Lithium citrate 104 mg per 1 ml Priadel 520mg/5ml liquid sugar-free | 150 ml (P) | £6.73 DT + £6.73 |

**2.3 Depression**

**Antidepressant drugs**

**Overview**
Depression in children should be managed by an appropriate specialist and treatment should involve psychological therapy.

**Choice**
The major classes of antidepressant drugs include the tricyclics and related antidepressant drugs, the selective serotonin re-uptake inhibitors (SSRIs), and the monoamine oxidase inhibitors (MAOIs).

Antidepressant drugs should not be used routinely in mild depression, and psychological therapy should be considered initially; however, a trial of antidepressant therapy may be considered in cases refractory to psychological treatments or in those associated with psychosocial or medical problems. Drug treatment of mild depression may also be considered in children with a history of moderate or severe depression.

Choice of antidepressant drug should be based on the individual child’s requirements, including the presence of concomitant disease, existing therapy, suicide risk, and previous response to antidepressant therapy.

When drug treatment of depression is considered necessary in children, the SSRIs should be considered first-line treatment; following a safety and efficacy review, fluoxetine p. 243 is licensed to treat depression in children.

Tricyclic antidepressant drugs should be avoided for the treatment of depression in children.

**St John’s wort** *(Hypericum perforatum)* is a popular herbal remedy on sale to the public for treating mild depression in adults. It should not be used for the treatment of depression in children because St John’s wort can induce drug metabolising enzymes and a number of important interactions with conventional drugs, including conventional antidepressants, have been identified.

Furthermore, the amount of active ingredient varies between different preparations of St John’s wort and switching from one to another can change the degree of enzyme induction. If a child stops taking St John’s wort, the concentration of interacting drugs may increase, leading to toxicity.

**Management**
Children should be reviewed every 1–2 weeks at the start of antidepressant treatment. Treatment should be continued for at least 4 weeks before considering whether to switch antidepressant due to lack of efficacy. In cases of partial response, continue for a further 2–4 weeks. Following remission, antidepressant treatment should be continued at the same dose for at least 6 months. Children with a history of recurrent depression should continue treatment for at least 2 years.

**Hyponatraemia and antidepressant therapy**

Hyponatraemia (possibly due to inappropriate secretion of antidiuretic hormone) has been associated with all types of antidepressants; however, it has been reported more frequently with SSRIs than with other antidepressant drugs. Hyponatraemia should be considered in all children who develop drowsiness, confusion, or convulsions while taking an antidepressant.

**Suicidal behaviour and antidepressant therapy**
The use of antidepressant drugs has been linked with suicidal thoughts and behaviour. Where necessary, children should be monitored for suicidal behaviour, self-harm, and hostility, particularly at the beginning of treatment or if the dose is changed.

**Serotonin syndrome**
Serotonin syndrome or serotonin toxicity is a relatively uncommon adverse drug reaction caused by excessive central and peripheral serotonergic activity. Onset of symptoms, which range from mild to life-threatening, can occur within hours or days following the initiation, dose escalation, or overdose of a serotonergic drug, the addition of a new serotonergic drug, or the replacement of one serotonergic drug by another without allowing a long enough washout period in-between, particularly when the first drug is an irreversible MAOI or a drug with a long half-life. Severe toxicity, which is a medical emergency, usually
UPTAKE INHIBITORS (such as tremor, hyperreflexia, clonus, myoclonus, rigidity), autonomic dysfunction (tachycardia, blood pressure changes, hyperthermia, diaphoresis, shivering, diaphoresis), and altered mental state (agitation, confusion, mania).

Treatment consists of withdrawal of the serotoninergic medication and supportive care; specialist advice should be sought.

Important safety information: Depressive illness in children and adolescents
The balance of risks and benefits for the treatment of depressive illness in individuals under 18 years is considered unfavourable for the SSRIs citalopram, escitalopram, paroxetine, and sertraline, and for mirtazapine and venlafaxine. Clinical trials have failed to show efficacy and have shown an increase in harmful outcomes. However, it is recognised that specialists may sometimes decide to use these drugs in response to individual clinical need; children and adolescents should be monitored carefully for suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment. Only fluoxetine has been shown in clinical trials to be effective for treating depressive illness in children and adolescents. However, it is possible that, in common with the other SSRIs, it is associated with a small risk of self-harm and suicidal thoughts. Overall, the balance of risks and benefits for fluoxetine in the treatment of depressive illness in individuals under 18 years is considered favourable, but children and adolescents must be carefully monitored as above.

Anxiety
Management of acute anxiety in children with drug treatment is contentious. For chronic anxiety (of longer than 4 weeks’ duration), it may be appropriate to use an antidepressant drug before a benzodiazepine.

Tricyclic antidepressants are not effective for treating depression in children.

Some tricyclic antidepressant drugs may have a role in some forms of neuralgia, and in nocturnal enuresis in children.

Dosage
It is important to use doses that are sufficiently high for effective treatment but not so high as to cause toxic effects. Low doses should be used for initial treatment. In most children the long half-life of tricyclic antidepressant drugs allows once-daily administration, usually at night; the use of modified-release preparations is therefore unnecessary.

Other drugs used for Depression
- Lithium carbonate, p. 240
- Lithium Citrate, p. 241

ANTIDEPRESSANTS > SELECTIVE SEROTONIN RE-UPTAKE INHIBITORS

Selective serotonin re-uptake inhibitors

- **Drug Action** Selectively inhibit the re-uptake of serotonin (5-hydroxytryptamine, 5-HT).
- **Contra-Indications** Poorly controlled epilepsy. SSRIs should not be used if the patient enters a manic phase.
- **Caution** Cardiac disease. concurrent electroconvulsive therapy, diabetes mellitus, epilepsy (discontinue if convulsions develop). History of bleeding disorders (especially gastro-intestinal bleeding) - history of mania - susceptibility to angle-closure glaucoma

**Side-Effects**
- **Common or Very Common** Anxiety, appetite abnormal - arrhythmias, arthralgia, asthenia, concentration impaired, confusion, constipation, depersonalisation, diarrhoea, dizziness, drowsiness, dry mouth, fever, gastrointestinal discomfort, haemorrhage, headache, hyperhidrosis, malaise, mania, memory loss, menstrual cycle irregularities, myalgia, mydriasis, nausea (dose-related), palpitations, paraesthesia, QT interval prolongation, sexual dysfunction, skin reactions, sleep disorders, taste altered, tinnitus, tremor, urinary disorders, visual impairment, vomiting, weight changes, yawning.
- **Uncommon** Alopecia, angioedema, behaviour abnormal, hallucination, movement disorders, photosensitivity reaction, postural hypotension, seizure, suicidal tendencies, syncope.
- **Rare or Very Rare** Galactorrhoea, hepatitis, hyperprolactinaemia, hypoglycaemia, serotonin syndrome, severe cutaneous adverse reactions (SCARs), SIADH, thrombocytopenia.
- **Frequency Not Known** Withdrawal syndrome

**Overdose** Symptoms of poisoning by selective serotonin re-uptake inhibitors include nausea, vomiting, agitation, tremor, nyctagmus, drowsiness, and sinus tachycardia; convulsions may occur. Rarely, severe poisoning results in the serotonin syndrome, with marked neuropsychiatric effects, neuromuscular hyperactivity, and autonomic instability; hyperthermia, rhabdomyolysis, renal failure, and coagulopathies may develop.

For details on the management of poisoning, see Selective serotonin re-uptake inhibitors, under Emergency treatment of poisoning p. 859.

**Pregnancy** Manufacturers advise avoid during pregnancy unless the potential benefit outweighs the risk. There is a small increased risk of congenital heart defects when taken during early pregnancy. If used during the third trimester there is a risk of neonatal withdrawal symptoms, and persistent pulmonary hypertension in the newborn has been reported.

**Hepatic Impairment** In general, manufacturers advise caution (prolonged half-life).

**Treatment Cessation** Gastro-intestinal disturbances, headache, anxiety, dizziness, paraesthesia, electric shock sensation in the head, neck, and spine, tinnitus, sleep disturbances, fatigue, influenza-like symptoms, and sweating are the most common features of abrupt withdrawal of an SSRI or marked reduction of the dose; palpitation and visual disturbances can occur less commonly. The dose should be tapered over at least a few weeks to avoid these effects. For some patients, it may be necessary to withdraw treatment over a longer period; consider obtaining specialist advice if symptoms persist.

Withdrawal effects may occur within 5 days of stopping treatment with antidepressant drugs; they are usually mild and self-limiting, but in some cases may be severe. The risk of withdrawal symptoms is increased if the antidepressant is stopped suddenly after regular administration for 8 weeks or more.

**Patient and Carer Advice**
- Driving and skilled tasks May also impair performance of skilled tasks (e.g. driving, operating machinery).
Citalopram

**INDICATIONS AND DOSE**

**Major depression**
- **BY MOUTH USING TABLETS**
  - Child 12-17 years: Initially 10 mg once daily, increased if necessary to 20 mg once daily, dose to be increased over 2–4 weeks; maximum 40 mg per day
  - **BY MOUTH USING ORAL DROPS**
  - Child 12-17 years: Initially 8 mg once daily, increased if necessary to 16 mg once daily, dose to be increased over 2–4 weeks; maximum 32 mg per day

**DOSE EQUIVALENCE AND CONVERSION**
- 4 oral drops (8 mg) is equivalent in therapeutic effect to 10 mg tablet.

**SIDE-EFFECTS**
- **Common or very common** Acute angle closure glaucoma.
- **Rare or very rare** Cough.

**CAUTIONS**
- **SUSCEPTIBILITY TO QT-INTERVAL PROLONGATION**
- **SIDE-EFFECTS**
  - **Common or very common** Acute angle closure glaucoma.
  - **Rare or very rare** Cough.
  - **Frequency not known** Hypokalaemia

**INTERACTIONS**
- **Appendix 1: SSRIs**
- **CONTRA-INDICATIONS**
- **Dose adjustments** For tablets manufacturer advises lower initial doses, may be increased to max. 20 mg daily; use with extra caution and careful dose titration in severe impairment.
- **Renal impairment** No information available for estimated glomerular filtration rate less than 20 ml/minute/1.73 m².
- **Treatment cessation** The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment).

**DIRECTIONS FOR ADMINISTRATION**

- **Cipramil®** oral drops should be mixed with water, orange juice, or apple juice before taking.
- **Patient and carer advice** Counselling on administration of oral drops is advised. Patients should be advised of the effects of citalopram on driving and skilled tasks.

**Medicinal forms**
- There can be variation in the licensing of different medicines containing the same drug.
- **Oral drops**
  - **Excipients:** May contain alcohol
  - **Citalopram (non-proprietary)**
    - Citalopram (as Citalopram hydrochloride) 40 mg per 1 ml Citalopram 40mg/ml oral drops sugar-free sugar-free | 15 ml (POS) £14.09 DT = £5.21
    - **Cipramil** (Lundbeck Ltd)
    - Citalopram (as Citalopram hydrochloride) 40 mg per 1 ml Cipramil 40mg/ml drops sugar-free | 15 ml (POS) £11.08 DT = £5.21
- **Tablet**
  - **Citalopram (non-proprietary)**
    - Citalopram (as Citalopram hydrobromide) 10 mg Citalopram 10mg tablets | 28 tablet (POS) £6.00 DT = £0.89
    - Citalopram (as Citalopram hydrobromide) 20 mg Citalopram 20mg tablets | 28 tablet (POS) £9.00 DT = £0.88
    - Citalopram (as Citalopram hydrobromide) 40 mg Citalopram 40mg tablets | 28 tablet (POS) £15.12 DT = £0.96

**Fluoxetine**

**INDICATIONS AND DOSE**

**Major depression**
- **BY MOUTH**
  - Child 8–17 years: Initially 10 mg daily, increased if necessary up to 20 mg daily, dose to be increased after 1–2 weeks of initial dose, daily dose may be administered as a single or divided dose
- **Pharmacokinetics**
  - **Consider the long half-life of fluoxetine when adjusting dosage (or in overdosage).**

**Side-effects**
- **Common or very common** Chills, feeling abnormal, postmenopausal haemorrhage, uterine disorder, vasodilation, vision blurred
- **Uncommon** Cold sweat, dysphagia, dyspnoea, hypotension, mood altered, muscle twitching, self-injurious behaviour, temperature sensation altered, thinking abnormal
- **Rare or very rare** Bucconglossal syndrome, leucopenia, neutropenia, oesophageal pain, pharyngitis, respiratory disorders, serum sickness, speech disorder, vasculitis
- **Frequency not known** Growth retardation

**Breast feeding** Present in milk—use with caution.

**Hepatic impairment**
- **Dose adjustments** Manufacturer advises dose reduction or increasing dose interval.

**Directions for administration**
- **Dispersible tablets** can be dispersed in water for administration or swallowed whole with plenty of water.
- **Patient and carer advice** Patients and carers should be counselled on the administration of dispersible tablets.

**Medicinal forms**
- There can be variation in the licensing of different medicines containing the same drug.
- **Oral suspension**
  - **Fluoxetine (as Fluoxetine hydrochloride) 10 mg** Fluoxetine 10mg tablets | 30 tablet (POS) £44.00 DT = £44.00
  - **Dispersible tablet**
  - **Olena (Advanz Pharma)**
    - Fluoxetine (as Fluoxetine hydrochloride) 20 mg Olena 20mg dispersible tablets sugar-free | 28 tablet (POS) £3.44 DT = £3.44
  - **Oral solution**
    - **Fluoxetine (non-proprietary)**
      - Fluoxetine (as Fluoxetine hydrochloride) 4 mg per 1 ml Fluoxetine 20mg/5ml oral solution | 70 ml (POS) £12.75 DT = £2.93
      - Fluoxetine 20mg/5ml oral solution sugar-free | 70 ml (POS) £12.95 DT = £12.95
    - **Prozac (Es Lilly and Company Ltd)**
      - Fluoxetine (as Fluoxetine hydrochloride) 4 mg per 1 ml Prozac 20mg/5ml liquid | 70 ml (POS) £11.12 DT = £2.93
    - **Prozep (Chemidex Pharma Ltd)**
      - Fluoxetine (as Fluoxetine hydrochloride) 4 mg per 1 ml Prozep 20mg/5ml oral solution sugar-free | 70 ml (POS) £12.95 DT = £12.95
Fluvoxamine maleate

**INDICATIONS AND DOSE**

**Obsessive-compulsive disorder**

- **BY MOUTH**
  - Child 8-17 years: Initially 25 mg daily, then increased in steps of 25 mg every 4-7 days (max. per dose 100 mg twice daily) if required, dose to be increased according to response, doses above 50 mg should be given in 2 divided doses, if no improvement in obsessive-compulsive disorder within 10 weeks, treatment should be reconsidered

- **SIDE-EFFECTS**
  - Rare or very rare: Hepatic function abnormal (discontinue)
  - Frequency not known: Bone fracture - glaucoma - hypomania - neuroleptic malignant-like syndrome - withdrawal syndrome neonatal

- **BREAST FEEDING**
  - Present in milk—avoid.

- **HEPATIC IMPAIRMENT**
  - Dose adjustments: Manufacturer advises low initial dose.

- **RENAL IMPAIRMENT**
  - Dose adjustments: Start with low dose.

- **TREATMENT CESSATION**
  - The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment).

- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks: Patients should be counselled about the effects on driving and skilled tasks.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**

- Fluvoxamine maleate (Non-proprietary)
  - Fluvoxamine maleate 50 mg Fluvoxamine 50mg tablets | 60 tablet [PST] £20.98 DT + £17.54
  - Fluvoxamine maleate 100 mg Fluvoxamine 100mg tablets | 30 tablet [PST] £20.98 DT + £17.69
  - Prozac (Eli Lilly and Company Ltd)
  - Fluvoxamine maleate 20 mg Prozac 20mg capsules | 30 capsule [PST] £1.50 DT + £0.93

Sertraline

**INDICATIONS AND DOSE**

**Obsessive-compulsive disorder**

- **BY MOUTH**
  - Child 6-11 years: Initially 25 mg daily for 1 week, then increased to 50 mg daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day
  - Child 12-17 years: Initially 50 mg daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day

**Major depression**

- **BY MOUTH**
  - Child 12-17 years: Initially 50 mg once daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day

**UNLICENSED USE**

Not licensed for use in children for depression.

- **INTERACTIONS** → Appendix 1: SSRIs

- **SIDE-EFFECTS**
  - Common or very common: Chest pain - depression - gastrointestinal disorders - increased risk of infection - mood altered - neuromuscular dysfunction - vasodilatation
  - Rare or very rare: Balanoposthitis - bone disorder - cardiac disorder - coma - conversion disorder - diabetes mellitus - drug dependence - dysphonia - eye disorders - gait abnormal - genital discharge - glaucoma - hair texture abnormal - hepatic disorders - hiccup - hypercholesterolaemia - hypoglycaemia - injury - lymphadenopathy - myocardial infarction - neoplasms - oliguria - peripheral ischaemia - psychotic disorder - vasodilatation procedure - vision disorders - vulvovaginal atrophy
  - Frequency not known: Cerebrovascular insufficiency - gynaecomastia - hyperglycaemia - leucopenia - neuroleptic malignant syndrome - pancreatitis

- **BREAST FEEDING**
  - Not known to be harmful but consider discontinuing breast-feeding.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises avoid in severe impairment (no information available).

- **Dose adjustments**
  - Manufacturer advises dose reduction or increasing dose interval in mild to moderate impairment.

- **RENAL IMPAIRMENT**
  - Use with caution.

- **TREATMENT CESSATION**
  - The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment).

- **PRESCRIBING AND DISPENSING INFORMATION**
  - The RCPCH and NPPG recommend that, when a liquid special of sertraline is required, the following strength is used: 50 mg/5 mL.

- **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: Sertraline for OCD (obsessive compulsive disorder) and depression www.medicinesforchildren.org.uk-sertraline-ocd-obsessive-compulsive-disorder-and-depression

**Driving and skilled tasks**

Patients should be counselled on the effects on driving and skilled tasks.
ANTIDEPRESSANTS

TRICYCLIC ANTIDEPRESSANTS

Amitriptyline hydrochloride

- **INDICATIONS AND DOSE**

  **Neuropathic pain**
  - **BY MOUTH**
  - Child 2-11 years: Initially 200–500 micrograms/kg once daily (max. per dose 10 mg), dose to be taken at night, increased if necessary; maximum 1 mg/kg twice daily on specialist advice
  - Child 12-17 years: Initially 10 mg once daily, increased if necessary to 75 mg once daily, dose to be taken at night, dose to be increased gradually, higher doses to be given on specialist advice

- **UNLICENSED USE**
  - Not licensed for use in neuropathic pain.

- **CONTRA-INDICATIONS**
  - Arrhythmias - during manic phase of bipolar disorder - heart block

- **CAUTIONS**
  - Cardiovascular disease - chronic constipation - diabetes - epilepsy - history of bipolar disorder - history of psychosis - hyperthyroidism (risk of arrhythmias) - patients with a significant risk of suicide - phaeochromocytoma (risk of arrhythmias) - susceptibility to angle-closure glaucoma - urinary retention

- **CAUTIONS, FURTHER INFORMATION**
  - Treatment should be stopped if the patient enters a manic phase.

- **INTERACTIONS**
  - Appendix 1: tricyclic antidepressants

- **SIDE-EFFECTS**
  - Common or very common
    - Anticholinergic syndrome
    - Drowsiness
    - QT interval prolongation
  - **Frequency not known**
    - Agranulocytosis
    - Alopecia
    - Anxiety
    - Appetite abnormal
    - Arthralgia
    - Asthenia
    - Bone marrow depression
    - Breast enlargement
    - Cardiac conduction disorders
    - Coma
    - Concentration impaired
    - Confusion
    - Constipation
    - Delirium
    - Delusions
    - Diarrhoea
    - Dizziness
    - Dry mouth
    - Dysarthria
    - Eosinophilia
    - Epigastric distress
    - Face oedema
    - Galactorrhoea
    - Gynaecomastia
    - Hallucination
    - Headache
    - Hepatic disorders
    - Hyperhidrosis
    - Hyperpyrexia
    - Hypertension
    - Hypnotics
    - Leucopenia
    - Mood altered
    - Movement disorders
    - Mydriasis
    - Myocardial infarction
    - Nausea
    - Neuroleptic malignant syndrome
    - Oral disorders
    - Palpitations
    - Paralytic ileus
    - Peripheral neuropathy
    - Photosensitivity reaction
    - Seizure
    - Sensation abnormal
    - Sexual dysfunction
    - SIADH
    - Skin reactions
    - Sleep disorders
    - Stroke
    - Sudden cardiac death
    - Suicidal tendencies
    - Syncope
    - Taste altered
    - Testicular swelling
    - Thrombocytopenia
    - Tinnitus
    - Tremor
    - Urinary disorders
    - Urinary tract dilation
    - Vision disorders
    - Vomiting
    - Weight changes
    - Withdrawal syndrome

- **OVERDOSE**

  Overdose with amitriptyline is associated with a relatively high rate of mortality. Symptoms of overdose may include dry mouth, coma of varying degree, hypotension, hypothermia, hyperreflexia, extensor plantar responses, convulsions, respiratory failure, cardiac conduction defects, and arrhythmias. Dilated pupils and urinary retention also occur. For details on the management of poisoning, see Tricyclic and related antidepressants, under Emergency treatment of poisoning p. 859.

- **PREGNANCY**
  - Use only if potential benefit outweighs risk.

- **BREAST FEEDING**
  - The amount secreted into breast milk is too small to be harmful.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises use with caution in mild-to-moderate impairment; avoid in severe impairment.

- **TREATMENT CESSATION**
  - Withdrawal effects may occur within 5 days of stopping treatment with antidepressant drugs; they are usually mild and self-limiting, but in some cases may be severe. The risk of withdrawal symptoms is increased if the antidepressant is stopped suddenly after regular administration for 8 weeks or more. The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment). If possible tricyclic and related antidepressants should be withdrawn slowly.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Limited quantities of tricyclic antidepressants should be prescribed at any one time because their cardiovascular and epileptogenic effects are dangerous in overdose.

- **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: Amitriptyline for neuropathic pain
  - www.medicinesforchildren.org.uk/amitriptyline-neuropathic-pain-0

  - Driving and skilled tasks
    - Drowsiness may affect the performance of skilled tasks (e.g. driving).
    - Effects of alcohol enhanced.

  - **LESS SUITABLE FOR PRESCRIBING**
  - Amitriptyline hydrochloride is less suitable for prescribing, see Tricyclic and related antidepressant drugs in Antidepressant drugs p. 241.

- **MEDICINAL FORMS**

  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

  **Oral solution**

  **CAUTIONARY AND ADVISORY LABELS**

  - **Amitriptyline hydrochloride (Non-proprietary)**
    - Amitriptyline hydrochloride 2 mg per 1 ml Amitriptyline 10 mg/5ml oral solution sugar free sugar-free | 150 ml [POD] £131.90 DT = £131.90
    - Amitriptyline hydrochloride 5 mg per 1 ml Amitriptyline 25 mg/5ml oral solution sugar free sugar-free | 150 ml [POD] £18.00 DT = £18.00
    - Amitriptyline hydrochloride 10 mg per 1 ml Amitriptyline 50mg/5ml oral solution sugar free sugar-free | 150 ml [POD] £24.00 DT = £19.20

  **Tablet**

  **CAUTIONARY AND ADVISORY LABELS**

  - **Amitriptyline hydrochloride (Non-proprietary)**
    - Amitriptyline hydrochloride 10 mg Amitriptyline 10 mg tablets | 28 tablet [POD] £1.00 DT = £0.87
    - Amitriptyline hydrochloride 25 mg Amitriptyline 25 mg tablets | 28 tablet [POD] £1.75 DT = £0.72
    - Amitriptyline hydrochloride 50 mg Amitriptyline 50 mg tablets | 28 tablet [POD] £5.99 DT = £2.04
Doxepin

- **INDICATIONS AND DOSE**
  - Depressive illness (particularly where sedation is required)
  - BY MOUTH
    - Child 12-17 years: Initially 75 mg daily in divided doses, alternatively 75 mg once daily, adjusted according to response, dose to taken at bedtime; maintenance 25–300 mg daily, doses above 100 mg given in 3 divided doses

- **CONTRA-INDICATIONS**
  - Acute porphyrias p. 624
  - arrhythmias - during manic phase of bipolar disorder - heart block

- **CAUTIONS**
  - Cardiovascular disease - chronic constipation - diabetes - epilepsy - history of bipolar disorder - history of psychosis - hyperthyroidism (risk of arrhythmias) - patients with significant risk of suicide - pheochromocytoma (risk of arrhythmias) - susceptibility to angle-closure glaucoma - urinary retention

  **CAUTIONS, FURTHER INFORMATION**
  - Treatment should be stopped if the patient enters a manic phase.

- **INTERACTIONS**
  - Appendix 1: tricyclic antidepressants

- **SIDE-EFFECTS**

- **Overdose**
  - Tricyclic and related antidepressants cause dry mouth, coma of varying degree, hypertension, hyperthermia, hyperreflexia, extensor plantar responses, convulsions, respiratory failure, cardiac conduction defects, and arrhythmias. Dilated pupils and urinary retention also occur. For details on the management of poisoning see Tricyclic and related antidepressants under Emergency treatment of poisoning p. 859

- **PREGNANCY**
  - Use with caution—limited information available.

- **BREAST FEEDING**
  - The amount secreted into breast milk is too small to be harmful. Accumulation of metabolite may cause sedation and respiratory depression in neonate.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

- **Dose adjustments**
  - Manufacturer advises consider dose reduction in mild to moderate impairment.

- **RENA L IMPAIRMENT**
  - Use with caution.

- **TREATMENT CESSATION**
  - Withdrawal effects may occur within 5 days of stopping treatment with antidepressant drugs; they are usually mild and self-limiting, but in some cases may be severe. The risk of withdrawal symptoms is increased if the antidepressant is stopped suddenly after regular administration for 8 weeks or more. The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment). If possible tricyclic and related antidepressants should be withdrawn slowly.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Limited quantities of tricyclic antidepressants should be prescribed at any one time because their cardiovascular and epileptogenic effects are dangerous in overdose.

- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks Drowsiness may affect performance of skilled tasks (e.g. driving). Effects of alcohol enhanced.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

  **Capsule**
  - DOXEPIN HYDROCHLORIDE (Generic)
  - 25 mg capsules
  - £97.00 DT + £97.00
  - 50 mg capsules
  - £154.00 DT + £154.00

- **Imipramine hydrochloride**

  - **INDICATIONS AND DOSE**
    - Nocturnal enuresis
    - BY MOUTH
      - Child 6–7 years: 25 mg once daily, to be taken at bedtime, initial period of treatment (including gradual withdrawal) 3 months—full physical examination before further course
      - Child 8–10 years: 25–50 mg once daily, to be taken at bedtime, initial period of treatment (including gradual withdrawal) 3 months—full physical examination before further course
      - Child 11–17 years: 50–75 mg once daily, to be taken at bedtime, initial period of treatment (including gradual withdrawal) 3 months—full physical examination before further course

  - **Attention deficit hyperactivity disorder (under expert supervision)**
    - BY MOUTH
    - Child 6–17 years: 10–30 mg twice daily

  - **UNLICENSED USE**
    - Not licensed for use for attention deficit hyperactivity disorder.

  - **CONTRA-INDICATIONS**
    - Acute porphyrias p. 624
    - arrhythmia - during the manic phase of bipolar disorder - heart block

  - **CAUTIONS**
    - Cardiovascular disease - chronic constipation - diabetes - epilepsy - history of bipolar disorder - history of psychosis - hyperthyroidism (risk of arrhythmias) - patients with a significant risk of suicide - pheochromocytoma (risk of arrhythmias) - susceptibility to angle-closure glaucoma - urinary retention

  **CAUTIONS, FURTHER INFORMATION**
  - Treatment should be stopped if the patient enters a manic phase.

  - **INTERACTIONS**
    - Appendix 1: tricyclic antidepressants

  - **SIDE-EFFECTS**
    - **Common or very common**
      - Anxiety - appetite decreased - arrhythmias - asthenia - cardiac conduction disorders - confusion - delirium - depression - dizziness - drowsiness - epilepsy - hallucination - headache - hepatic disorders - hypotension - mood altered - nausea - palpitations - paraesthesia - sexual dysfunction - skin reactions - sleep disorder - tremor - vomiting - weight changes

    - **Rare**
Nortriptyline

- **INDICATIONS AND DOSE**
  - **Depressive illness**
    - **BY MOUTH**
      - Child 12-17 years: To be initiated at a low dose, then increased if necessary to 30–50 mg daily in divided doses, alternatively increased if necessary to 30–50 mg once daily; maximum 150 mg per day

- **CONTRA-INDICATIONS**
  - Arrhythmias · during the manic phase of bipolar disorder · heart block

- **CAUTIONS**
  - Cardiovascular disease · chronic constipation · diabetes · epilepsy · history of bipolar disorder · history of psychosis · hyperthyroidism (risk of arrhythmias) · patients with a significant risk of suicide · phaeochromocytoma (risk of arrhythmias) · susceptibility to angle-closure glaucoma · urinary retention

- **CAUTIONS, FURTHER INFORMATION**
  - Treatment should be stopped if the patient enters a manic phase.

- **INTERACTIONS**
  - Appendix 1: tricyclic antidepressants

- **SIDE-EFFECTS**
  - Agranulocytosis · alopecia · anxiety · appetite decreased · arrhythmias · ataxia · atrioventricular block · bone marrow disorders · breast enlargement · confusion · constipation · delusions · diarthrosis · dizziness · drowsiness · drug cross-reactivity · drug fever · dry mouth · eosinophilia · fever · flushing · galactorrhoea · gastrointestinal discomfort · gynaecomastia · hallucination · headache · hepatic disorders · hyperhidrosis · hypertension · hypomania · hypotension · increased risk of fracture · increased risk of infection · malaise · movement disorders · mydriasis · myocardial infarction · nausea · oedema · oral disorders · palpitations · paralytic ileus · peripheral neuropathy · photosensitivity reaction · psychosis exacerbated · seizure · sensation abnormal · sexual dysfunction · SIADH · skin reactions · sleep disorders · stroke · suicidal tendencies · taste altered · testicular swelling · thrombocytopenia · tinnitus · tremor · urinary disorders · uric acid · vasomotor disorders · vomiting · weight changes

- **OVERDOSE**
  - Tricyclic and related antidepressants cause dry mouth, coma of varying degree, hypotension, hypothermia, hyperreflexia, extensor plantar responses, convulsions, respiratory failure, cardiac conduction defects, and arrhythmias. Dilated pupils and urinary retention also occur. For details on the management of poisoning see Tricyclic and related antidepressants under Emergency treatment of poisoning p. 859.
  - **PREGNANCY**
    - Use only if potential benefit outweighs risk.
  - **BREAST FEEDING**
    - The amount secreted into breast milk is too small to be harmful.
  - **HEPATIC IMPAIRMENT**
    - Manufacturer advises avoid in severe impairment.
  - **RENAL IMPAIRMENT**
    - Use with caution in severe impairment.

- **TREATMENT CESSATION**
  - Withdrawal effects may occur within 5 days of stopping treatment with antidepressant drugs; they are usually mild and self-limiting, but in some cases may be severe. The risk of withdrawal symptoms is increased if the antidepressant is stopped suddenly after regular administration for 8 weeks or more. The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment). If possible tricyclic and related antidepressants should be withdrawn slowly.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Limited quantities of tricyclic antidepressants should be prescribed at any one time because their cardiovascular and epileptogenic effects are dangerous in overdosage.

- **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: imipramine for various conditions www.medicinesforchildren.org.uk/imipramine-various-conditions
  - Driving and skilled tasks: Drowsiness may affect the performance of skilled tasks (e.g. driving).
  - Effects of alcohol enhanced.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

- **Oral solution**
  - CAUTIONARY AND ADVISORY LABELS 2
  - Imipramine hydrochloride (Non-proprietary)
    - Imipramine hydrochloride 5 mg per 1 ml
      - Imipramine 25mg/5ml oral solution sugar free sugar-free | 150 ml [Pod]  £45.00 DT = £45.00

- **Tablet**
  - CAUTIONARY AND ADVISORY LABELS 2
  - Imipramine hydrochloride (Non-proprietary)
    - Imipramine hydrochloride 10 mg
      - Imipramine 10mg tablets | 28 tablet [Pod] 0.81 DT = 0.80
  - Imipramine hydrochloride 25 mg
      - Imipramine 25mg tablets | 28 tablet [Pod] 0.63 DT = 0.63
at any one time because their cardiovascular and epileptogenic effects are dangerous in overdose.

**PATIENT AND CARER ADVICE** Drowsiness may affect the performance of skilled tasks (e.g. driving). Effects of alcohol enhanced.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution.

**Nervous system**

(Misleadingly) as managed under the close supervision of an appropriate effects of antipsychotic drugs on the developing nervous system have been extrapolated from adult antipsychotic drugs in children and adolescents and much of the information available has been gathered from studies in adults.

There is little information on the efficacy and safety of antipsychotic drugs in children and adolescents and much of the information available has been extrapolated from adult data; in particular, little is known about the long-term effects of antipsychotic drugs on the developing nervous system. Antipsychotic drugs should be initiated and managed under the close supervision of an appropriate specialist.

Antipsychotic drugs are also known as ‘neuroleptics’ and (misleadingly) as ‘major tranquilisers’.

In the short term they are used to calm disturbed children whatever the underlying psychopathology, which may be schizophrenia, brain damage, mania, toxic delirium, or agitated depression. Antipsychotic drugs are used to alleviate severe anxiety but this too should be a short-term measure.

**Schizophrenia**

The aim of treatment is to alleviate the suffering of the child (and carer) and to improve social and cognitive functioning. Many children require life-long treatment with antipsychotic medication. Antipsychotic drugs relieve positive psychotic symptoms such as thought disorder, hallucinations, and delusions, and prevent relapse; they are usually less effective on negative symptoms such as apathy and social withdrawal. In many patients, negative symptoms persist between episodes of treated positive symptoms, but earlier treatment of psychotic illness may protect against the development of negative symptoms over time. Children with acute schizophrenia generally respond better than those with chronic symptoms.

Long-term treatment of a child with a definitive diagnosis of schizophrenia is usually required after the first episode of illness in order to prevent relapses. Doses that are effective in acute episodes should generally be continued as prophylaxis.

**First-generation antipsychotic drugs**

The first-generation antipsychotic drugs act predominantly by blocking dopamine D_2 receptors in the brain. First-generation antipsychotic drugs are not selective for any of the four dopamine pathways in the brain and so can cause a range of side-effects, particularly extrapyramidal symptoms and elevated prolactin. The phenothiazine derivatives can be divided into 3 main groups:

- **Group 1**: chlorpromazine hydrochloride p. 251, levomepromazine p. 275, and promazine hydrochloride, generally characterised by pronounced sedative effects and moderate antimuscarinic and extrapyramidal side-effects.
- **Group 2**: pericyazine p. 253, generally characterised by moderate sedative effects, but fewer extrapyramidal side-effects than groups 1 or 3.
- **Group 3**: perphenazine, prochlorperazine p. 275, and trifluoperazine p. 254, generally characterised by fewer sedative and antimuscarinic effects, but more pronounced extrapyramidal side-effects than groups 1 and 2.

**Butyrophenones** (e.g. haloperidol p. 252) resemble the group 3 phenothiazines in their clinical properties.

**Diphenylbutylpiperidines** (pimozide p. 253) and the substituted benzamides (sulpiride p. 253) have reduced sedative, antimuscarinic, and extrapyramidal effects.

**Second-generation antipsychotic drugs**

The second-generation antipsychotic drugs (also referred to as atypical antipsychotic drugs) act on a range of receptors in comparison to first-generation antipsychotic drugs and have more distinct clinical profiles, particularly with regard to side-effects.

**Prescribing of antipsychotic drugs in children with learning disabilities**

When prescribing for children with learning disabilities who are prescribed antipsychotic drugs and who are not experiencing psychotic symptoms, the following considerations should be taken into account:

- a reduction in dose or the discontinuation of long-term antipsychotic treatment;
- review of the child’s condition after dose reduction or discontinuation of an antipsychotic agent;
- referral to a psychiatrist experienced in working with children who have learning disabilities and mental health problems;
- annual documentation of the reasons for continuing a prescription if the antipsychotic is not reduced in dose or discontinued.

**2.4 Psychoses and schizophrenia**

**Psychoses and related disorders**

06-Mar-2017

**Advice on doses of antipsychotic drugs above BNF for Children upper limit**

- Consider alternative approaches including adjuvant therapy.
- Bear in mind risk factors, including obesity. Consider potential for drug interactions—see interactions: Appendix 1 (antipsychotics).
- Carry out ECG to exclude untoward abnormalities such as prolonged QT interval; repeat ECG periodically and reduce dose if prolonged QT interval or other adverse abnormality develops.
- Increase dose slowly and not more often than once weekly.
- Carry out regular pulse, blood pressure, and temperature checks; ensure that patient maintains adequate fluid intake.
- Consider high-dose therapy to be for limited period and review regularly; abandon if no improvement after 3 months (return to standard dosage).

**Important**: When prescribing an antipsychotic for administration on an emergency basis, the intramuscular dose should be lower than the corresponding oral dose (owing to absence of first-pass effect), particularly if the child is very active (increased blood flow to muscle considerably increases the rate of absorption). The prescription should specify the dose for each route and not imply that the same dose can be given by mouth or by intramuscular injection. The dose of antipsychotic for emergency use should be reviewed at least daily.

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BNFC 2019–2020
Side effects of antipsychotic drugs

Side-effects caused by antipsychotic drugs are common and contribute significantly to non-adherence to therapy.

*Extrapyramidal symptoms*

Extrapyramidal symptoms occur most frequently with the piperazine phenothiazines (Iphuphenazine, perphenazine, prochlorperazine, and trifluoperazine), the butyrophphenones (benperidol and haloperidol), and the first-generation depot preparations. They are easy to recognise but cannot be predicted accurately because they depend on the dose, the type of drug, and on individual susceptibility. Extrapyramidal symptoms consist of:

- *parkinsonian symptoms* (including tremor), which may occur more commonly in adults or the elderly and may appear gradually;
- *dystonia* (abnormal face and body movements) and dyskinesia, which occur more commonly in children or young adults and appear after only a few doses;
- *akathisia* (restlessness), which characteristically occurs after large initial doses and may resemble an exacerbation of the condition being treated;
- *tardive dyskinesia* (rhythmic, involuntary movements of tongue, face, and jaw), which usually develops on long-term therapy or with high dosage, but it may develop on short-term treatment with low doses—short-lived tardive dyskinesia may occur after withdrawal of the drug.

*Parkinsonian symptoms* remit if the drug is withdrawn and may be suppressed by the administration of antimuscarinic drugs. However, routine administration of such drugs is not justified because not all patients are affected and they may mask or worsen tardive dyskinesia.

*Tardive dyskinesia* is the most serious manifestation of extrapyramidal symptoms; it is of particular concern because it may be irreversible on withdrawing therapy and treatment is usually ineffective. In children, tardive dyskinesia is more likely to occur when the antipsychotic drug is withdrawn. However, some manufacturers suggest that drug withdrawal at the earliest signs of tardive dyskinesia (fine vermicular movements of the tongue) may halt its full development. Tardive dyskinesia occurs fairly frequently, especially in the elderly, and treatment must be carefully and regularly reviewed.

*Hyperprolactinaemia*

Most antipsychotic drugs, both first- and second-generation, increase prolactin concentration to some extent because dopamine inhibits prolactin release. Aripiprazole reduces prolactin because it is a dopamine-receptor partial agonist. Risperidone, amisulpride, and first-generation antipsychotic drugs are most likely to cause symptomatic hyperprolactinaemia. The clinical symptoms of hyperprolactinaemia include sexual dysfunction, reduced bone mineral density, menstrual disturbances, breast enlargement, and galactorrhoea.

*Sexual dysfunction*

Sexual dysfunction is one of the main causes of non-adherence to antipsychotic medication; physical illness, psychiatric illness, and substance misuse are contributing factors. Antipsychotic-induced sexual dysfunction is caused by more than one mechanism. Reduced dopamine transmission and hyperprolactinaemia decrease libido; antimuscarinic effects can cause disorders of arousal; and alpha-2-adrenoceptor antagonists are associated with erection and ejaculation problems in men. Risperidone and haloperidol commonly cause sexual dysfunction. If sexual dysfunction is thought to be antipsychotic-induced, dose reduction or switching medication should be considered.

*Cardiovascular side-effects*

Antipsychotic drugs have been associated with cardiovascular side-effects such as tachycardia, arrhythmias, and hypotension. QT-interval prolongation is a particular concern with pimozide and haloperidol. There is also a higher probability of QT-interval prolongation in patients using any intravenous antipsychotic drug, or any antipsychotic drug or combination of antipsychotic drugs with doses exceeding the recommended maximum. Cases of sudden death have occurred.

*Hyperglycaemia and weight gain*

Hyperglycaemia, and sometimes diabetes, can occur with antipsychotic drugs, particularly clozapine, olanzapine, quetiapine, and risperidone. All antipsychotic drugs may cause weight gain, but the risk and extent varies. Clozapine and olanzapine commonly cause weight gain. Olanzapine is associated with more weight gain than other second generation antipsychotic drugs. Weight gain happens soon after treatment with olanzapine has started.

*Hypotension and interference with temperature regulation*

Hypotension and interference with temperature regulation are dose-related side-effects. Clozapine, chlorpromazine, and quetiapine can cause postural hypotension (especially during initial dose titration) which may be associated with syncope or reflex tachycardia in some children.

*Neuroleptic malignant syndrome*

Neuroleptic malignant syndrome (hyperthermia, fluctuating level of consciousness, muscle rigidity, and autonomic dysfunction with pallor, tachycardia, labile blood pressure, sweating, and urinary incontinence) is a rare but potentially fatal side-effect of all antipsychotic drugs. Discontinuation of the antipsychotic drug is essential because there is no proven effective treatment, but bromocriptine and dantrolene have been used. The syndrome, which usually lasts for 5–7 days after drug discontinuation, may be unduly prolonged if depot preparations have been used.

*Blood dyscrasias*

Perform blood counts if unexplained infection or fever develops.

*Choice*

The antipsychotic drugs most commonly used in children are haloperidol p. 252, risperidone p. 260, and olanzapine p. 257. There is little meaningful difference in efficacy between each of the antipsychotic drugs (other than clozapine p. 256), and response and tolerability to each antipsychotic drug varies. There is no first-line antipsychotic drug which is suitable for all children. Choice of antipsychotic medication is influenced by the child’s medication history, the degree of sedation required (although tolerance to this usually develops), and consideration of individual patient factors such as risk of extrapyramidal side-effects, weight gain, impaired glucose tolerance, QT-interval prolongation, or the presence of negative symptoms.

*Negative symptoms*

Second generation antipsychotic drugs may be better at treating the negative symptoms of schizophrenia.

*Extrapyramidal side-effects*

Second-generation antipsychotic drugs may be prescribed if extrapyramidal side-effects are a particular concern. Of these, aripiprazole p. 255, clozapine, olanzapine, and quetiapine p. 258 are least likely to cause extrapyramidal side-effects. Although amisulpride p. 254 is a dopamine-receptor antagonist, extrapyramidal side-effects are less common than with the first-generation antipsychotic drugs because amisulpride selectively blocks mesolimbic dopamine receptors, and extrapyramidal symptoms are caused by blockade of the striatal dopamine pathway.

*QT interval*

Aripiprazole has negligible effect on the QT interval. Other antipsychotic drugs with a reduced tendency to prolong QT interval include amisulpride, clozapine, olanzapine, perphenazine, risperidone, and sulphiride p. 253.

*Diabetes*

Schizophrenia is associated with insulin resistance and diabetes; the risk of diabetes is increased in children with...
schizophrenia who take antipsychotic drugs. First-
generation antipsychotic drugs are less likely to cause
diabetes than second-generation antipsychotic drugs, and of
the first-generation antipsychotic drugs, haloperidol has the
lowest risk. A amisulpride and aripiprazole have the lowest
risk of diabetes of the second-generation antipsychotic
drugs. A amisulpride, aripiprazole, haloperidol, sulpiride, and
trifluoperazine p. 254 are least likely to cause weight gain.

Sexual dysfunction and prolactin
The antipsychotic drugs with the lowest risk of sexual
dysfunction are aripiprazole and quetiapine. Olanzapine may be
considered if sexual dysfunction is judged to be
secondary to hyperprolactinaemia. Hyperprolactinaemia is
usually not clinically significant with aripiprazole, clozapine,
olanzapine, and quetiapine treatment. When changing from
other antipsychotic drugs, a reduction in prolactin
concentration may increase fertility.

Children should receive an antipsychotic drug for
4–6 weeks before it is deemed ineffective. Prescribing more
than one antipsychotic drug at a time should be avoided
except in exceptional circumstances (e.g. clozapine
augmentation or when changing medication during
titration) because of the increased risk of adverse effects
such as extrapyramidal symptoms, QT-interval
prolongation, and sudden cardiac death.

Clozapine is used for the treatment of schizophrenia in
children unresponsive to, or intolerant of, other
antipsychotic drugs. Clozapine should be introduced if
schizophrenia is not controlled despite the sequential use of
two or more antipsychotic drugs (one of which should be a
second-generation antipsychotic drug), each for at least
6–8 weeks. If symptoms do not respond adequately to an
optimised dose of clozapine, plasma-clozapine
concentration should be checked before adding a second
antipsychotic drug to augment clozapine; allow 8–10 weeks’
treatment to assess response. Children must be registered
with a clozapine patient monitoring service.

Monitoring
Full blood count, urea and electrolytes, and liver function
test monitoring is required at the start of therapy with
antipsychotic drugs, and then annually thereafter.

Blood lipids and weight should be measured at baseline, at
3 months (weight should be measured at frequent intervals
during the first 3 months), and then yearly.

Fasting blood glucose should be measured at baseline, at
4–6 months, and then yearly.

Before initiating antipsychotic drugs, an ECG may be
required, particularly if physical examination identifies
cardiovascular risk factors, if there is a personal history of
cardiovascular disease, or if the child is being admitted as an
inpatient.

Blood pressure monitoring is advised before starting
therapy and frequently during dose titration of antipsychotic
drugs.

Other uses
Nausea and vomiting, chorea, motor tics, and intractable
hiccup.

Equivalent doses of oral antipsychotics
These equivalences are intended only as an approximate
guide; individual dosage instructions should also be
checked; children should be carefully monitored after any
change in medication. Equivalent daily dose of antipsychotic
drug:

- Chlorpromazine 100 mg
- Clozapine 50 mg
- Haloperidol 2–3 mg
- Pimozide 2 mg
- Risperidone 0.5–1 mg
- Sulpiride 200 mg
- Trifluoperazine 5 mg

Important: These equivalences must not be extrapolated
beyond the maximum dose for the drug. Higher doses require
careful titration in specialist units and the equivalences
shown here may not be appropriate.

Dosage
After an initial period of stabilisation, the total daily oral
dose of antipsychotic drugs can be given as a single dose in
most children.

Antipsychotic depot injections
There is limited information on the use of antipsychotic
depot injections in children and use should be restricted to
specialist centres.

ANTIPSYCHOTICS

Antipsychotic drugs

- **CAUTIONS** Blood dyscrasias - cardiovascular disease -
  conditions predisposing to seizures - depression - diabetes
  (may raise blood glucose) - epilepsy - history of jaundice -
  myasthenia gravis - photosensitisation (may occur with
  higher doses) - severe respiratory disease - susceptibility
  to angle-closure glaucoma

- **CAUTIONS, FURTHER INFORMATION**
  Cardiovascular disease  An ECG may be required, particularly
  if physical examination identifies cardiovascular risk
  factors, personal history of cardiovascular disease, or if the
  patient is being admitted as an inpatient.

- **SIDE-EFFECTS**
  - Common or very common  Agitation - amenorrhoea -
    arrhythmias - constipation - dizziness - drowsiness - dry
    mouth - erectile dysfunction - galactorrhoea -
    gynaecomastia - hyperprolactinaemia - hypotension (dose-
    related) - insomnia - leucopenia - movement disorders -
    neutropenia - parkinsonism - QT interval prolongation -
    rash - seizure - tremor - urinary retention - vomiting -
    weight increased

  - Uncommon  Agranulocytosis - embolism and thrombosis -
    neuroleptic malignant syndrome (discontinue—potentially
    fatal)

  - Rare or very rare  Sudden death - withdrawal syndrome
    neonatal

  - **OVERDOSE** Phenothiazines cause less depression of
    consciousness and respiration than other sedatives.
    Hypotension, hyperthermia, sinus tachycardia, and
    arrhythmias may complicate poisoning. For details on the
    management of poisoning see Antipsychotics under
    Emergency treatment of poisoning p. 829.

  - **PREGNANCY** Extrapyramidal effects and withdrawal
    syndrome have been reported occasionally in the neonate
    when antipsychotic drugs are taken during the third
    trimester of pregnancy. Following maternal use of
    antipsychotic drugs in the third trimester, neonates should
    be monitored for symptoms including agitation, hypotonia
    hypotension, hyperthermia, tremor, drowsiness, feeding
    problems, and respiratory distress.

  - **BREAST FEEDING** There is limited information available on
    the short- and long-term effects of antipsychotic drugs on
    the breast-fed infant. Animal studies indicate possible
    adverse effects of antipsychotic medicines on the
    developing nervous system. Chronic treatment with
    antipsychotic drugs whilst breast-feeding should be
    avoided unless absolutely necessary.

  - **MONITORING REQUIREMENTS**
    - It is advisable to monitor prolactin concentration at the
      start of therapy, at 6 months, and then yearly. Patients
      taking antipsychotic drugs not normally associated with
      symptomatic hyperprolactinaemia should be considered
for prolactin monitoring if they show symptoms of hyperprolactinaemia (such as breast enlargement and galactorrhoea).

- Patients with schizophrenia should have physical health monitoring (including cardiovascular disease risk assessment) at least once per year.
- Regular clinical monitoring of endocrine function should be considered when children are taking an antipsychotic drug known to increase prolactin levels; this includes measuring weight and height, assessing sexual maturation, and monitoring menstrual function.

**TREATMENT CESSATION** There is a high risk of relapse if medication is stopped after 1–2 years. Withdrawal of antipsychotic drugs after long-term therapy should always be gradual and closely monitored to avoid the risk of acute withdrawal syndromes or rapid relapse. Patients should be monitored for 2 years after withdrawal of antipsychotic medication for signs and symptoms of relapse.

**PATIENT AND CARER ADVICE** As photosensitisation may occur with higher dosages, patients should avoid direct sunlight.

- **Driving and skilled tasks** Drowsiness may affect performance of skilled tasks (e.g. driving or operating machinery), especially at start of treatment; effects of alcohol are enhanced.

**ANTIPSYCHOTICS > FIRST-GENERATION**

| Chlorpromazine hydrochloride | 09-Jul-2018 |

**INDICATIONS AND DOSE**

**Childhood schizophrenia and other psychoses (under expert supervision)**

- **BY MOUTH**
  - Child 1–5 years: 500 micrograms/kg every 4–6 hours, adjusted according to response; maximum 40 mg per day
  - Child 6–11 years: 10 mg 3 times a day, adjusted according to response; maximum 75 mg per day
  - Child 12–17 years: Initially 25 mg 3 times a day, adjusted according to response, alternatively initially 75 mg once daily, adjusted according to response, dose to be taken at night; maintenance 75–300 mg daily, increased if necessary up to 1 g daily

**Relief of acute symptoms of psychoses (under expert supervision)**

- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child 1–5 years: 500 micrograms/kg every 6–8 hours; maximum 40 mg per day
  - Child 6–11 years: 500 micrograms/kg every 6–8 hours; maximum 75 mg per day
  - Child 12–17 years: 25–50 mg every 6–8 hours

**Nausea and vomiting in palliative care (where other drugs have failed or are not available)**

- **BY MOUTH**
  - Child 1–5 years: 500 micrograms/kg every 4–6 hours; maximum 40 mg per day
  - Child 6–11 years: 500 micrograms/kg every 4–6 hours; maximum 75 mg per day
  - Child 12–17 years: 10–25 mg every 4–6 hours

- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child 1–5 years: 500 micrograms/kg every 6–8 hours; maximum 40 mg per day
  - Child 6–11 years: 500 micrograms/kg every 6–8 hours; maximum 75 mg per day
  - Child 12–17 years: Initially 25 mg, then 25–50 mg every 3–4 hours until vomiting stops

**DOSE EQUIVALENCE AND CONVERSION**

- For equivalent therapeutic effect 100 mg chlorpromazine base given rectally as a suppository

**CONTRA-INDICATIONS** CNS depression - comatose states - hypothyroidism - phaeochromocytoma

**INTERACTIONS** > Appendix 1: phenothiazines

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **Common or very common** Anxiety; glucose tolerance impaired; mood altered; muscle tone increased

- **Frequency not known** Accommodation disorder - angioedema - atrioventricular block - cardiac arrest - eye deposit - eye disorders - gastrointestinal disorders - hepatic disorders - hyperglycaemia - hypertriglyceridaemia - hypopituitarism - photosensitivity reaction - respiratory disorders - sexual dysfunction - SIADH - skin reactions - systemic lupus erythematosus (SLE) - temperature regulation disorder - trismus

**SPECIFIC SIDE-EFFECTS**

- With intramuscular use Muscle rigidity; nasal congestion

**SIDE-EFFECTS, FURTHER INFORMATION** Acute dystonic reactions may occur; children are particularly susceptible.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in severe hepatic failure (increased risk of accumulation).

**RENAL IMPAIRMENT**

- **Dose adjustments** Start with small doses in severe renal impairment because of increased cerebral sensitivity.

**MONITORING REQUIREMENTS**

- With intramuscular use Patients should remain supine, with blood pressure monitoring for 30 minutes after intramuscular injection.

**PRESCRIBING AND DISPENSING INFORMATION**

- **Palliative care** For further information on the use of chlorpromazine hydrochloride in palliative care, see www.medicinescomplete.com/#/content/palliative/antipsychotics.

**HANDLING AND STORAGE** Owing to the risk of contact sensitisation, pharmacists, nurses, and other health workers should avoid direct contact with chlorpromazine; tablets should not be crushed and solutions should be handled with care.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution.

**Tablet**

| CAUTIONARY AND ADVISORY LABELS | 2, 11 |
| chlorpromazine hydrochloride (Non-proprietary) | 251 |
| Chlorpromazine hydrochloride 25 mg Chlorpromazine 25 mg tablets | 28 tablet | £44.78 DT = £41.72 |
| Chlorpromazine hydrochloride 50 mg Chlorpromazine 50 mg tablets | 28 tablet | £48.00 DT = £41.81 |
| Chlorpromazine hydrochloride 100 mg Chlorpromazine 100 mg tablets | 28 tablet | £46.25 DT = £41.56 |

**Solution for injection**

- **Largactil (Sanofi)**
  - Chlorpromazine hydrochloride 25 mg per 1 ml Largactil 50mg/2ml solution for injection ampoules | 10 ampoule | £7.51 |

**Oral solution**

| CAUTIONARY AND ADVISORY LABELS | 2, 11 |
| chlorpromazine hydrochloride (Non-proprietary) | 251 |
| Chlorpromazine hydrochloride 5 mg per 1 ml Chlorpromazine 25 mg/5ml syrup | 150 ml | £2.35 DT = £2.35 |
| Chlorpromazine hydrochloride 10 mg per 1 ml Chlorpromazine 25 mg/5ml oral solution sugar free | 50 ml | £2.35 DT = £2.35 |
| Chlorpromazine hydrochloride 20 mg per 1 ml Chlorpromazine 50 mg/5ml oral solution | 150 ml | £2.35 DT = £2.35 |
| Chlorpromazine hydrochloride 20 mg per 1 ml Chlorpromazine 100 mg/5ml oral solution | 150 ml | £5.50 DT = £5.50 |
Haloperidol

INDICATIONS AND DOSE

Nausea and vomiting in palliative care

BY MOUTH
- Child 12-17 years: 1.5 mg once daily, dose to be taken at night, increased if necessary to 1.5 mg twice daily (max. per dose 5 mg twice daily)
- BY CONTINUOUS INTRAVENOUS INFUSION, OR BY CONTINUOUS SUBCUTANEOUS INFUSION
  - Child 1 month-11 years: 25–85 micrograms/kg, to be administered over 24 hours
  - Child 12–17 years: 1.5–5 mg, to be administered over 24 hours

Schizophrenia (when alternatives ineffective or not tolerated) (under expert supervision)

BY MOUTH
- Child 13-17 years: 0.25–1.5 mg twice daily, alternatively 0.16–1 mg 3 times a day, individual benefit-risk should be assessed when considering doses above 3 mg daily; maximum 5 mg per day

Persistent, severe aggression in autism or pervasive developmental disorders (when other treatments ineffective or not tolerated) (under expert supervision)

BY MOUTH
- Child 6–11 years: 0.25–1.5 mg twice daily, alternatively 0.16–1 mg 3 times a day, the need for continued treatment must be reassessed after a maximum of 6 weeks and regularly thereafter
- Child 12-17 years: 0.25–2.5 mg twice daily, alternatively 0.16–1.6 mg 3 times a day, the need for continued treatment must be reassessed after a maximum of 6 weeks and regularly thereafter

Severe tic disorders, including Tourette’s syndrome (when educational, psychological and other pharmacological treatments ineffective) (under expert supervision)

BY MOUTH
- Child 10–17: 0.25–1.5 mg twice daily, alternatively 0.16–1 mg 3 times a day, the need for continued treatment must be reassessed every 6–12 months

Restlessness and confusion in palliative care

BY MOUTH
- Child 1-17 years: 10–20 micrograms/kg every 8–12 hours

Unlicensed Use

Not licensed for use in palliative care.

Contra-indications

CNS depression - comatose states - congenital long QT syndrome - history of torsade de pointes - history of ventricular arrhythmia - QTc-interval prolongation - recent acute myocardial infarction - uncompensated heart failure - uncorrected hypokalaemia

Cautionary

Bradyarrhythmia - electrolyte disturbances (correct before treatment initiation) - family history of QTc-interval prolongation - history of heavy alcohol exposure - hyperthyroidism - hypotension (including orthostatic hypotension) - prolactin-dependent tumours - prolactinaemia

INTERACTIONS

Appendix 1: haloperidol

SIDE-EFFECTS

General Side-effects

- Common or very common: Depression - eye disorders - headache - hypersalivation - nausea - neuromuscular dysfunction - psychotic disorder - vision disorders - weight decreased
- Rare or very rare: Hypoglycaemia - respiratory disorders - SIADH - trismus
- Frequency not known: Hypersensitivity vasculitis - pancytopenia - rhabdomyolysis - thrombocytopenia

Specific Side-effects

- With oral use: Antiepileptics
- With parenteral use: Severe cutaneous adverse reactions (SCARs)

Side-effects, Further Information

Haloperidol is a less sedating antipsychotic.

Pregnancy

Manufacturer advises it is preferable to avoid—moderate amount of data indicate no malformative or fetal/neonatal toxicity, however there are isolated case reports of birth defects following fetal exposure, mostly in combination with other drugs; reproductive toxicity shown in animal studies.

Hepatic Impairment

Manufacturer advises caution.

Dose adjustments

Manufacturer advises halve initial dose and then adjust if necessary with smaller increments and at longer intervals.

Renal Impairment

Manufacturer advises use with caution.

Dose adjustments

Manufacturer advises consider lower initial dose in severe impairment and then adjust if necessary with smaller increments and at longer intervals.

Monitoring Requirements

Manufacturer advises monitor electrolytes before treatment initiation and periodically during treatment.

Manufacturer advises perform ECG before treatment initiation and assess need for further ECGs during treatment on an individual basis.

Prescribing and Dispensing Information

Palliative care

For further information on the use of haloperidol in palliative care, see www.medicinescomplete.com/#/content/palliative/haloperidol.

Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

Tablet

Cautionary and Advisory Labels 2

Haloperidol (Non-proprietary)

Haloperidol 500 microgram | Haloperidol 500 microgram tablets | 28 tablet (PO) £22.95-£30.00 + DT = £29.59
Haloperidol 1.5 mg | Haloperidol 1.5 mg tablets | 28 tablet (PO) £15.10 DT + £15.10
Haloperidol 5 mg | Haloperidol 5 mg tablets | 28 tablet (PO) £16.58 DT + £16.50
Haloperidol 10 mg | Haloperidol 10 mg tablets | 28 tablet (PO) £19.85 DT + £19.36

Solution for injection

Haloperidol (Non-proprietary)

Haloperidol 5 mg per 1 ml | Haloperidol 5 mg/mL solution for injection ampoules | 10 ampoule (PO) £35.00 + DT = £35.00

Oral solution

Cautionary and Advisory Labels 2

Haloperidol (Non-proprietary)

Haloperidol 1 mg per 1 ml | Haloperidol 5 mg/mL oral solution sugar free: 100 ml (PO) £35.99 + DT = £6.47 sugar-free | 500 ml (PO) £22.35
Haloperidol 2 mg per 1 ml | Haloperidol 10 mg/mL oral solution sugar free: 100 ml (PO) £46.75 DT + £7.10 sugar-free | 500 ml (PO) £35.50

Haldol (Janssen-Cilag Ltd)

Haloperidol 2 mg per 1 ml | Haldol 2 mg/mL oral solution sugar-free | 100 ml (PO) £4.45 DT + £7.10

Halikid (Thame Laboratories Ltd)

Haloperidol 200 microgram per 1 ml | Halikid 200 micrograms/mL oral solution sugar-free | 100 ml (PO) £8.90

BNFC 2019-2020
PERICYZINE (PERICAZINE)

**INDICATIONS AND DOSE**

**Schizophrenia (under expert supervision) / Psychoses (severe mental or behavioural disorders only) (under expert supervision)**

- **BY MOUTH**
  - Child 1-11 years: Initially 500 micrograms daily for 10-kg child, increased by 1 mg for each additional 5 kg; dose may be gradually increased according to response but maintenance should not exceed twice initial dose; maximum 10 mg per day.
  - Child 12-17 years: Initially 25 mg 3 times a day, increased in steps of 25 mg every week, adjusted according to response, increased if necessary up to 100 mg 3 times a day; total daily dose may alternatively be given in 2 divided doses.

**UNLICENSED USE** Tablets not licensed for use in children.

**CONTRA-INDICATIONS** CNS depression, comatose states, history of arrhythmias, history of congenital QT prolongation, hypothyroidism, CNS depression.

**CAUTIONS**

- **Hepatic impairment** Can precipitate coma; phenothiazines are hepatotoxic.
- **Renal impairment** Avoid in renal impairment.

**SIDE-EFFECTS**

- Atioventricular block, cardiac arrest, consciousness impaired, contact dermatitis, glucose tolerance impaired, hepatic disorders, hyperglycaemia, hyperthermia, nasal congestion, priapism, respiratory depression.
- Hyperhidrosis.
- Hypertension.
- Libido decreased.
- Nausea.
- Tachycardia.
- Tachypnoea.
- Vision blurred.

**INTERACTIONS**

- Pimozide should not be given with other antipsychotic drugs (including depot preparations), tricyclic antidepressants or other drugs which prolong the QT interval, such as certain antimalarials, antiarrhythmic drugs and certain antihistamines and should not be given with drugs which cause electrolyte disturbances (especially diuretics).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral solution**

- Pericyazine 2 mg per 1 ml
  - Pericyazine 10 mg/5ml oral solution
  - 100 ml £18.80 DT = £28.80

**Tablet**

- Pericyazine 2.5 mg
  - Pericyazine 2.5 mg tablets
  - 84 tablet £13.79 DT = £22.90
  - Pericyazine 10 mg
  - 84 tablet £13.79 DT = £22.90

**SULPIRIDE**

**INDICATIONS AND DOSE**

**Psychoses and schizophrenia**

- **BY MOUTH**
  - Child 14-17 years (under expert supervision): 200–400 mg twice daily; maximum 800 mg per day.

**Psychoses**

- **BY MOUTH**
  - Child 14-17 years (under expert supervision): 200–400 mg twice daily; maximum 2.4 g per day.

**Tourette syndrome (under expert supervision)**

- **BY MOUTH**
  - Child 2-11 years: 50-400 mg twice daily
  - Child 12-17 years: 100–400 mg twice daily.

**UNLICENSED USE** Not licensed for use in Tourette syndrome.

**CONTRA-INDICATIONS** CNS depression, comatose states, phaeochromocytoma.

**CAUTIONS** Aggressive patients (even low doses may aggravate symptoms), agitated patients (even low doses may aggravate symptoms), excited patients (even low doses may aggravate symptoms).
INTERACTIONS → Appendix 1: sulpiride

SIDE-EFFECTS
- Common or very common
  - Breast abnormalities
- Uncommon
  - Hyponatraemia - SIADH - trismus - urticaria
- Rare or very rare
  - Oculogyric crisis
- Frequency not known
  - Cardiac arrest - confusion - dyspnoea

RENAL IMPAIRMENT
- Dose adjustments
  - Start with small doses in severe renal impairment because of increased cerebral sensitivity.

MONITORING REQUIREMENTS
- Sulpiride does not affect blood pressure to the same extent as other antipsychotic drugs and so blood pressure monitoring is not mandatory for this drug.
- PRESCRIBING AND DISPENSING INFORMATION
  - Flavours of oral liquid formulations may include lemon and aniseed.
- PATIENT AND CARER ADVICE

MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution
  - Oral solution
    - CAUTIONARY AND ADVISORY LABELS 2
      - Sulpiride (Non-proprietary)
        - Sulpiride 40 mg per 1 ml Sulpiride 200mg/5ml oral solution sugar-free 150 ml £31.00 DT = £31.00
      - Tablet
        - CAUTIONARY AND ADVISORY LABELS 2
          - Sulpiride (Non-proprietary)
            - Sulpiride 200 mg Sulpiride 200mg tablets | 30 tablet £8.70 DT + £4.40
            - Sulpiride 400 mg Sulpiride 400mg tablets | 30 tablet £23.50 DT + £18.80
          - Dolmatil (Sandﬁ)
            - Sulpiride 200 mg Dolmatil 200mg tablets | 100 tablet £6.00
            - Sulpiride 400 mg Dolmatil 400mg tablets | 100 tablet £19.00

Trifluoperazine

INDICATIONS AND DOSE
- Schizophrenia and other psychoses: Short-term adjunctive management of psychomotor agitation, excitement, and violent or dangerously impulsive behaviour
  - BY MOUTH
    - Child 12–17 years (under expert supervision): Initially 5 mg twice daily, dose may be increased by 5 mg after 1 week. If necessary, dose may be further increased in steps of 5 mg at intervals of 3 days. When satisfactory control has been achieved, reduce gradually until an effective maintenance level has been established

Short-term adjunctive management of severe anxiety
- BY MOUTH
  - Child 3–5 years (under expert supervision): Up to 500 micrograms twice daily
  - Child 6–11 years (under expert supervision): Up to 2 mg twice daily
  - Child 12–17 years (under expert supervision): 1–2 mg twice daily, increased if necessary to 3 mg twice daily

Severe nausea and vomiting unresponsive to other antiemetics
- BY MOUTH
  - Child 3–5 years: Up to 500 micrograms twice daily
  - Child 6–11 years: Up to 2 mg twice daily
  - Child 12–17 years: 1–2 mg twice daily (max. per dose 3 mg twice daily)

CONTRA-INDICATIONS
- CNS depression - comatose states - phaeochromocytoma

SIDE-EFFECTS → Appendix 1: phenothiazines

INTERACTIONS
- Alertness decreased - anxiety - appetite decreased - blood disorder - cardiac arrest - confusion - fatigue - hyponatraemia - jaundice cholestatic - lens opacity - muscle weakness - oedema - pancytopenia - photosensitivity reaction - postural hypotension (dose-related) - skin reactions - thrombocytopenia - urinary hesitation - vision blurred - withdrawal syndrome

SIDE-EFFECTS, FURTHER INFORMATION
- Extrapyramidal symptoms are more frequent at doses exceeding 6mg daily.
- Acute dystonias are more common with potent first generation antipsychotics. The risk is increased in men, young adults, children, antipsychotic-naïve patients, rapid dose escalation, and abrupt treatment discontinuation.
- HEPATIC IMPAIRMENT
  - Manufacturer advises avoid.

RENAL IMPAIRMENT
- Dose adjustments
  - Start with small doses in severe renal impairment because of increased cerebral sensitivity.

MONITORING REQUIREMENTS
- Trifluoperazine does not affect blood pressure to the same extent as other antipsychotic drugs and so blood pressure monitoring is not mandatory for this drug.

MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug.
  - Oral solution
    - CAUTIONARY AND ADVISORY LABELS 2
      - Trifluoperazine (as Trifluoperazine hydrochloride)
        - 200 microgram per 1 ml Trifluoperazine 1mg/5ml oral solution sugar-free £112.25 DT + £112.25
      - Trifluoperazine (as Trifluoperazine hydrochloride) 1 mg per 1 ml Trifluoperazine 5mg/5ml oral solution sugar-free £25.50–£27.00 DT + £27.00
    - Table
      - CAUTIONARY AND ADVISORY LABELS 2
        - Trifluoperazine (as Trifluoperazine hydrochloride)
          - 1 mg Trifluoperazine 1mg tablets | 112 tablet £59.12–£99.80 DT + £59.12
          - 5 mg Trifluoperazine 5mg tablets | 112 tablet £134.89–£165.00 DT + £134.89

ANTIPSYCHOTICS → SECOND-GENERATION

Amisulpride

DRUG ACTION
- Amisulpride is a selective dopamine receptor antagonist with high affinity for mesolimbic D2 and D3 receptors.

INDICATIONS AND DOSE
- Acute psychotic episode in schizophrenia
  - BY MOUTH
    - Child 15–17 years (under expert supervision): 200–400 mg twice daily, adjusted according to response; maximum 1.2 g per day

Schizophrenia with predominantly negative symptoms
- BY MOUTH
  - Child 15–17 years (under expert supervision): 50–300 mg daily

UNLICENSED USE
- Not licensed for use in children under 18 years.

CONTRA-INDICATIONS
- CNS depression - comatose states - phaeochromocytoma - pre-pubertal children - prolactin-dependent tumours

INTERACTIONS → Appendix 1: amisulpride
Aripiprazole

**DRUG ACTION** Aripiprazole is a dopamine D₂ partial agonist with weak 5-HT₁A partial agonism and 5-HT₂A receptor antagonism.

**INDICATIONS AND DOSE**

**Schizophrenia**

- **BY MOUTH**
  - Child 15-17 years (under expert supervision): Initially 2 mg once daily for 2 days, increased to 5 mg once daily for 2 days, then increased to 10 mg once daily, then increased in steps of 5 mg if required; maximum 30 mg per day

- For mania (under expert supervision)
  - **BY MOUTH**
    - Child 13-17 years: Initially 2 mg once daily for 2 days, increased to 5 mg once daily for 2 days, then increased to 10 mg once daily, increased in steps of 5 mg if required, maximum duration of treatment 12 weeks, doses above 10 mg daily should only be used in exceptional cases; maximum 36 mg per day

**SIDE-EFFECTS**

- **Common or very common** Anxiety, breast pain, hypersalivation, muscle rigidity, nausea, oculogyric crisis, orgasm abnormal, trismus
- **Uncommon** Hyperglycaemia
- **Frequency not known** Angiokeratoma, bone disorders, cardiomyopathy, confusion, dizziness, dyslipidaemia, hyponatraemia, nasal congestion, neoplasms, SIADH–urticaria–vision blurred

**PREGNANCY** Avoid.

**BREAST FEEDING** Avoid—no information available.

**RENAL IMPAIRMENT** No information available if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

**DOSE ADJUSTMENTS** Halve dose if estimated glomerular filtration rate 30–60 mL/minute/1.73 m². Use one-third dose if estimated glomerular filtration rate 10–30 mL/minute/1.73 m².

**MONITORING REQUIREMENTS** Amisulpride does not affect blood pressure to the same extent as other antipsychotic drugs and so blood pressure monitoring is not mandatory for this drug.

**INTERACTIONS**

- **CAUTIONS**
  - **CONTRA-INDICATIONS** CNS depression, comatose state, phaeochromocytoma
  - **CAUTIONS** Cerebrovascular disease
  - **INTERACTIONS** + Appendix 1: aripiprazole

**SIDE-EFFECTS**

- **Common or very common** Anxiety, appetite abnormal, diabetes mellitus, fatigue, gastrointestinal discomfort, headache, hyponatraemia, nausea, vision disorders
- **Uncommon** Depression, hiccup, hyperglycaemia, sexual dysfunction
- **Frequency not known** Aggression, alopecia, cardiomyopathy, chest pain, diabetic hyperosmolar coma, diabetic ketoacidosis, diarrhoea, dysphagia, generalised tonic-clonic seizure, hepatic disorders, hyperhidrosis, hypertension, hyponatraemia, laryngospasm, musculoskeletal stiffness, myalgia, oropharyngeal spasm, pancreatitis, pathological gambling, peripheral oedema, photosensitivity reaction, pneumonia aspiration, rhombomylitis, serotonin syndrome, speech disorder, suicidal tendencies, syncope, temperature regulation disorder, thrombocytopenia, urinary incontinence, weight decreased

**SIDE-EFFECTS, FURTHER INFORMATION** Increased incidence of side-effects associated with doses of 30 mg daily; doses above 10 mg daily should only be used in exceptional cases and with close clinical monitoring.

**PREGNANCY** Use only if potential benefit outweighs risk.

**BREAST FEEDING** Manufacturer advises avoid—present in milk.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in severe impairment (oral treatment preferred to intramuscular administration; limited information available).

**MONITORING REQUIREMENTS** Aripiprazole does not affect blood pressure to the same extent as other antipsychotic drugs and so blood pressure monitoring is not mandatory for this drug.

**DIRECTIONS FOR ADMINISTRATION** Orodispersible tablets should be placed on the tongue and allowed to dissolve, or be dispersed in water and swallowed.

**PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer aripiprazole orodispersible tablets.

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**DOSAGE**

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**IMPORTANT SAFETY INFORMATION**

When prescribing, dispensing, or administering, check that the correct preparation is used—the preparation usually used in hospital for the rapid control of an acute episode (solution for injection containing aripiprazole 7.5 mg/mL) should not be confused with depot preparations (aripiprazole 400-mg vial with solvent), which are usually used in the community or clinics for maintenance treatment.
Nervous system

**Mental health disorders**

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**
- Aripiprazole for the treatment of schizophrenia in people aged 15 to 17 years (January 2011) NICE TA23
- Aripiprazole is recommended as an option for the treatment of schizophrenia in adolescents aged 15 to 17 years who have not responded adequately to, or who are intolerant of, risperidone, or for whom risperidone is contra-indicated.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/ta223

- Aripiprazole for treating moderate to severe manic episodes in adolescents with bipolar I disorder (July 2013) NICE TA292
- Aripiprazole is recommended as an option for the treatment of moderate to severe manic episodes for up to 12 weeks in adolescents aged 13 years and older with bipolar I disorder.

www.nice.org.uk/guidance/ta292

**ABILIFY® ORAL SOLUTION**

Scottish Medicines Consortium (SMC) decisions
- With oral use The Scottish Medicines Consortium, has advised (August 2013) that oral aripiprazole (Abilify®) is accepted for restricted use within NHS Scotland for the treatment of moderate to severe manic episodes in Bipolar I Disorder in adolescents aged 13 years and older for a period of up to 12 weeks. It is restricted to initiation and management under the supervision of a child/adolescent psychiatrist.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

**Tablet**

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<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS</th>
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<tr>
<td>Aripiprazole (Non-proprietary)</td>
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**Oral solution**

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<tr>
<td>Aripiprazole 1 mg per 1 ml</td>
<td>Aripiprazole 1mg/ml oral solution</td>
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</table>

**Orodispersible tablet**

| CAUTIONARY AND ADVISORY LABELS | 2 |
| EXCIPIENTS: May contain Aspartame |  |
| Aripiprazole (Non-proprietary) |  |
| Aripiprazole 10 mg | Aripiprazole 10mg orodispersible tablets sugar free sugar-free | 28 tablet [POM] £96.04 DT = £79.22 |
| Aripiprazole 15 mg | Aripiprazole 15mg orodispersible tablets sugar free sugar-free | 28 tablet [POM] £96.04 DT = £79.22 |

**Clozapine**

**DRUG ACTION**

Clozapine is a dopamine D2, dopamine D1, 5-HT2A, alpha1-adrenoceptor, and muscarinic-receptor antagonist.

**INDICATIONS AND DOSE**

Schizophrenia in patients unresponsive to, or intolerant of, conventional antipsychotic drugs

- **BY MOUTH**
  - Child 12-17 years (under expert supervision): 12.5 mg 1–2 times a day for day 1, then 25–50 mg for day 2, then increased, if tolerated, in steps of 25–50 mg daily, to be increased gradually over 14–21 days, increased to up to 300 mg daily in divided doses, larger dose to be taken at night, up to 200 mg daily may be taken as a single dose at bedtime; increased in steps of 50–100 mg 1–2 times a week if required, it is preferable to increase once a week; usual dose 200–450 mg daily, max. 900 mg per day, if restarting after interval of more than 48 hours, 12.5 mg once or twice on first day (but may be feasible to increase more quickly than on initiation)—extreme caution if previous respiratory or cardiac arrest with initial dosing

**LICENSED USE**

Not licensed for use in children under 16 years.

**IMPORTANT SAFETY INFORMATION**


Clozapine has been associated with varying degrees of impairment of intestinal peristalsis—see Cautions and Contra-indications for further information. Patients and their carers should be advised to seek immediate medical advice before taking the next dose of clozapine if constipation develops.

**CONTRA-INDICATIONS**

Alcoholic and toxic psychoses - bone-marrow disorders - coma - drug intoxication - history of agranulocytosis - history of circulatory collapse - history of neutropenia - paralytic ileus - severe cardiac disorders (e.g. myocarditis) - severe CNS depression - uncontrolled epilepsy.

**CAUTIONS**

Susceptibility to angle-closure glaucoma - taper off other antipsychotics before starting

**CAUTIONS, FURTHER INFORMATION**

- Agranulocytosis Neutropenia and potentially fatal agranulocytosis reported. Leucocyte and differential blood counts must be normal before starting; monitor counts every week for 18 weeks then at least every 2 weeks and if clozapine continued and blood count stable after 1 year at least every 4 weeks (and 4 weeks after discontinuation); if leucocyte count below 3000/mm3 or if absolute neutrophil count below 1500/mm3 discontinue permanently and refer to haematologist. Patients who have a low white blood cell count because of benign ethnic neutropenia may be started on clozapine with the agreement of a haematologist. Avoid drugs which depress leucopoiesis; patients should report immediately symptoms of infection, especially influenza-like illness.

- Myocarditis and cardiomyopathy Fatal myocardis (most commonly in first 2 months) and cardiomyopathy reported. Perform physical examination and take full medical history before starting

Specialist examination required if cardiac abnormalities or history of heart disease found—clozapine initiated only in absence of severe heart disease and if benefit outweighs risk
Persistent tachycardia especially in first 2 months should prompt observation for other indicators for myocarditis or cardiomyopathy
If myocarditis or cardiomyopathy suspected clozapine should be stopped and patient evaluated urgently by cardiologist
Discontinue permanently in clozapine-induced myocarditis or cardiomyopathy
- Intestinal obstruction Impairment of intestinal peristalsis, including constipation, intestinal obstruction, faecal impaction, and paralytic ileus, (including fatal cases) reported. Clozapine should be used with caution in patients receiving drugs that may cause constipation (e.g. antimuscarinic drugs) or in those with a history of colonic disease or lower abdominal surgery. It is essential that constipation is recognised and actively treated.

**INTERACTIONS** → Appendix 1: clozapine

**SIDE-EFFECTS**
- Common or very common Appetite decreased - eosinophilia - fatigue - fever - headache - hypertension - leucocytosis - muscle complaints - nausea - oral disorders - postural hypotension (dose-related) - speech impairment - sweating abnormal - syncope - temperature regulation disorders - urinary disorders - vision blurred
- Rare or very rare Anaemia - cardiac arrest - cardiac inflammation - cardiomyopathy - circulatory collapse - confusion - delirium - diabetes mellitus - dyslipidaemia - dysphagia - gastrointestinal disorders - glucose tolerance impaired - hepatic disorders - hyperglycaemia - increased risk of infection - intestinal obstruction (including fatal cases) - ketoacidosis - nephritis tubulointerstitial - obsessive-compulsive disorder - pancreatitis - pericardial effusion - respiratory disorders - restlessness - sexual dysfunction - skin reactions - thrombocytopena - thrombocytosis

**SIDE-EFFECTS, FURTHER INFORMATION** Hypersalivation associated with clozapine therapy can be treated with hyoscine hydrobromide [unlicensed indication], provided that the patient is not at particular risk from the additive antimuscarinic side-effects of hyoscine and clozapine.

**PREGNANCY** Use with caution.

**BREAST FEEDING** Avoid.

**HEPATIC IMPAIRMENT** Manufacturer advises caution—monitor liver function (discontinue if liver enzymes are greater than 3 times the upper limit of normal or jaundice occurs); avoid in symptomatic or progressive impairment and in hepatic failure.

**RENAL IMPAIRMENT** Avoid in severe impairment.

**MONITORING REQUIREMENTS** Monitor leucocyte and differential blood counts. Clozapine requires differential white blood cell monitoring weekly for 18 weeks, then fortnightly for up to one year, and then monthly as part of the clozapine patient monitoring service.
- Close medical supervision during initiation (risk of collapse because of hypotension and convulsions).
- Blood lipids and weight should be measured at baseline, at 3 months (weight should be measured at frequent intervals during the first 3 months), and then yearly with antipsychotics. Patients taking clozapine require more frequent monitoring of these parameters: every 3 months for the first year, then yearly.
- Fasting blood glucose should be measured at baseline, at 4–6 months, and then yearly. Patients taking clozapine should have fasting blood glucose tested at baseline, after one months’ treatment, then every 4–6 months.
- Patient, prescriber, and supplying pharmacist must be registered with the appropriate Patient Monitoring Service—it takes several days to do this.

**TREATMENT CESSATION** On planned withdrawal reduce dose over 1–2 weeks to avoid risk of rebound psychosis. If abrupt withdrawal necessary observe patient carefully.

**DIRECTIONS FOR ADMINISTRATION** Shake oral suspension well for 90 seconds when dispensing or if visibly settled and stand for 24 hours before use; otherwise shake well for 10 seconds before use. May be diluted with water.

**PRESCRIBING AND DISPENSING INFORMATION** Clozapine has been used for psychosis in Parkinson’s disease in children aged 16 years and over.

**PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer clozapine oral suspension.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral suspension** CAUTIONARY AND ADVISORY LABELS 2, 10
- **Denzapine** (Britannia Pharmaceuticals Ltd)
  - Clozapine 50 mg per 1 ml Denzapine 50mg/ml oral suspension sugar-free | 100 ml | £39.60

**Tablet** CAUTIONARY AND ADVISORY LABELS 2, 10
- **Clozaril** (Mylan)
  - **Clozapine 25 mg**
    - Clozari 25mg tablets | 84 tablet | £3.02
    - (Hospital only) | 84 tablet | £1.80 (Hospital only)
    - 100 tablet | £10.00 (Hospital only)
  - **Clozapine 100 mg**
    - Clozari 100mg tablets | 28 tablet | £12.07
    - (Hospital only) | 84 tablet | £33.60 (Hospital only)
    - 100 tablet | £39.00 (Hospital only)
  - **Denzapine** (Britannia Pharmaceuticals Ltd)
  - **Clozapine 25 mg**
    - Denzapine 25mg tablets | 84 tablet | £16.64
    - 100 tablet | £19.80
  - **Clozapine 50 mg**
    - Denzapine 50mg tablets | 100 tablet | £39.60
  - **Clozapine 100 mg**
    - Denzapine 100mg tablets | 84 tablet | £66.53
  - **Clozapine 200 mg**
    - Denzapine 200mg tablets | 100 tablet | £158.40
  - **Zapone** (Leyden Delta B.V.)
    - **Zapone 25 mg**
      - Zapone 25mg tablets | 84 tablet | £8.28
      - 500 tablet | £48.39
    - **Zapone 100 mg**
      - Zapone 100mg tablets | 84 tablet | £33.88
      - 500 tablet | £196.43

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**Olanzapine**

**DRUG ACTION** Olanzapine is a dopamine D\(_2\), D\(_3\), D\(_4\), 5-HT\(_2\), histamine-1-, and muscarinic-receptor antagonist.

**INDICATIONS AND DOSE**

**Schizophrenia** | **Combination therapy for mania**
- **BY MOUTH**
  - Child 12–17 years (under expert supervision): Initially 5–10 mg daily, adjusted according to response, usual dose 5–20 mg daily, doses greater than 10 mg daily only after reassessment, when one or more factors present that might result in slower metabolism (e.g. female gender, non-smoker) consider lower initial dose and more gradual dose increase; maximum 20 mg per day

**Monotherapy for mania**
- **BY MOUTH**
  - Child 12–17 years (under expert supervision): 15 mg daily, adjusted according to response, usual dose 5–20 mg daily, doses greater than 15 mg daily only after reassessment, when one or more factors continued →
Fasting blood glucose should be measured at baseline, and more gradual dose increase; maximum 20 mg per day.

Blood lipids and weight should be measured at baseline, at 1 month for the

INTERACTIONS

▶ Appendix 1: olanzapine

SIDE-EFFECTS

▶ Common or very common Anticholinergic syndrome - appetite increased - arthralgia - asthenia - eosinophilia - fever - glycosuria - hypersonmia - oedema - sexual dysfunction


▶ Rare or very rare Hepatic disorders - hypothermia - pancreatitis - rhabdomyolysis - thrombocytopenia

PREGNANCY

Use only if potential benefit outweighs risk; neonatal lethargy, tremor, and hypertonia reported when used in third trimester.

BREAST FEEDING

Avoid — present in milk.

HEPATIC IMPAIRMENT

Manufacturer advises caution.

Dose adjustments

In adults, manufacturer advises consider initial dose reduction — consult product literature.

RENAI IMPAIRMENT

Dose adjustments

Consider initial dose of 5 mg daily.

MONITORING REQUIREMENTS

Blood lipids and weight should be measured at baseline, at 3 months (weight should be measured at frequent intervals during the first 3 months), and then yearly with antipsychotic drugs. Patients taking olanzapine require more frequent monitoring of these parameters: every 3 months for the first year, then yearly.

Fasting blood glucose should be measured at baseline, at 4–6 months, and then yearly. Patients taking olanzapine should have fasting blood glucose tested at baseline, after one month’s treatment, then every 4–6 months.

DIRECTIONS FOR ADMINISTRATION

Olanzapine orodispersible tablet may be placed on the tongue and allowed to dissolve, or dispersed in water, orange juice, apple juice, milk, or coffee.

PATIENT AND CARER ADVICE

Patients or carers should be given advice on how to administer orodispersible tablets. Medicines for Children leaflet: Olanzapine for schizophrenia, bipolar disorder, mania and agitation www.medicinesforchildren.org.uk/olanzapine-schizophrenia-bipolar-disorder-mania-and-agitation

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

Tablet

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<td>Zalasta (Consilient Health Ltd) Olanzapine 20 mg Zalasta 20mg tablets</td>
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Quetiapine

DRUG ACTION

Quetiapine is a dopamine D2, dopamine D3, 5-HT2, α1-adrenoceptor, and histamine-1 receptor antagonist.

INDICATIONS AND DOSE

Schizophrenia

▶ BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child 12-17 years (under expert supervision): Initially 25 mg twice daily, adjusted according to response.
### Medicinal Forms

- **HEPATIC IMPAIRMENT**
  - Dose adjustments should be made cautiously in patients with hepatic impairment.
- **PREGNANCY**
  - Use only if benefit outweighs risks.
- **BREAST FEEDING**
  - Use with caution.
- **UNLICENSED USE**
  - Use only if potential benefit outweighs risks.

### Treatment of mania in bipolar disorder

- **CHILD 12-17 years (under expert supervision):** Initially 50 mg once daily, adjusted according to response. Adjusted in steps of 50 mg daily, usual dose 400–600 mg daily in 2 divided doses.

### Dose equivalence and conversion

- Patients can be switched from immediate-release to modified-release tablets at the equivalent daily dose.
- To maintain clinical response, dose titration may be required.

### Nervous system

- **Antipsychotics**
  - Use with caution.
- **Psychoses and schizophrenia**
  - Use with caution.
- **Dystonia**
  - Use with caution.
- **Dyskinesia**
  - Use with caution.
- **SIADH**
  - Use with caution.

### Appendix 1: quetiapine

- **Seroquel (as Quetiapine fumarate) 25 mg**
  - Brand: Seroquel (as Quetiapine fumarate) 25 mg (AstraZeneca UK Ltd)
  - Dose: 150 mg once daily for day 1, then 200 mg twice daily for days 2, 3, and 4.

### Nervous system

- **Side-effects**
  - Common or very common: Appetite increased, asthenia, dysarthria, dyspepsia, dyspnoea, fever, headache, hyperglycaemia, irritability, palpitations, peripheral oedema, rhinitis, sleep disorders, suicidal behaviour (particularly on initiation), suicidal ideation (particularly on initiation), syncope, vision blurred, withdrawal syndrome.
  - Uncommon: Anaemia, diabetes mellitus, dysphagia, hyponatraemia, hypothyroidism, sexual dysfunction, skin reactions, thrombocytopenia.

### Nervous system

- **Rare or very rare**
  - Angioedema, breast swelling, gastrointestinal disorders, hepatic disorders, hypothyria, mental disorder, metabolic syndrome, pancreatitis, rhabdomyolysis, severe cutaneous adverse reactions (SCARs), SIADH.

### Nervous system

- **Pregnancy**
  - Use only if benefit outweighs risks.

### Nervous system

- **Breast feeding**
  - Use with caution.

### Nervous system

- **Unlicensed use**
  - Not licensed for use in children.

### Nervous system

- **Cautions**
  - Cerebrovascular disease, patients at risk of aspiration pneumonia.
  - Treatment of depression in patients under 25 years (increased risk of suicide).

### Nervous system

- **Interactions**
  - Add to recommendations from other sources.

### Nervous system

- **Adverse reactions**
  - Dyspepsia, dysphagia, hyperglycaemia, irritability, palpitations, peripheral oedema, rhinitis, sleep disorders, suicidal behaviour (particularly on initiation), suicidal ideation (particularly on initiation), syncope, vision blurred, withdrawal syndrome.

### Nervous system

- **Medicinal forms**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, powder.

### Nervous system

- **Modified-release tablets**
  - CAUTIONARY AND ADVISORY LABELS 2, 23, 25

### Nervous system

- **Tablet**
  - CAUTIONARY AND ADVISORY LABELS 2

### Nervous system

- **Quetiapine (as Quetiapine fumarate) 200 mg**
  - Brand: Sondate XL 200 mg (Mintreleq XL 200 mg [Aristo Pharma Ltd])
  - Use: 200 mg once daily for day 1, then 200 mg twice daily for days 2, 3, and 4.

### Nervous system

- **Quetiapine (as Quetiapine fumarate) 400 mg**
  - Brand: Brancico XL 400 mg (Atrolak XL 400 mg [Aspire Pharma Ltd])
  - Use: 400 mg once daily, maximum 800 mg per day.
**Risperidone**

**DRUG ACTION** Risperidone is a dopamine D₂, 5-HT₂A, alpha₁-adrenoceptor, and histamine-1 receptor antagonist.

**INDICATIONS AND DOSE**

**Acute and chronic psychosis**

- **BY MOUTH**
  - Child 12-17 years (under expert supervision): 2 mg daily in 1–2 divided doses for day 1, then 4 mg daily in 1–2 divided doses for day 2, slower tita...
Movement disorders

Cerebral palsy and spasticity

Description of condition

Cerebral palsy is a group of permanent, non-progressive abnormalities of the developing fetal or neonatal brain that lead to movement and posture disorders, causing activity limitation and functional impact. There can be accompanying clinical and developmental comorbidities. These include disturbances of sensation, perception, cognition, communication and behaviour; epilepsy; and secondary musculoskeletal problems (such as muscle contracture and abnormal torsion). Cerebral palsy is not curable and the comorbidities can impact on many areas of participation and quality of life, particularly eating, drinking, comfort, and sleep.

Spasticity

Spasticity in children is most commonly associated with cerebral palsy, but can also be associated with other non-progressive brain disorders.

Aims of treatment

Treatment involves managing spasticity to optimise movement and posture, while minimising potential secondary musculoskeletal deformity, as well as managing developmental and clinical comorbidities.

Drug treatment

Spasticity

Oral diazepam p. 226 or oral baclofen p. 573 can be used to treat discomfort, pain, muscle spasm and functional disability. If oral diazepam is initially used because of its rapid onset of action, consider changing to oral baclofen if a sustained, longer duration of effect is required or if long-term treatment is necessary. If the response to diazepam or baclofen after 4–6 weeks is unsatisfactory, a trial of combined treatment using both drugs can be considered. Consider reducing the dose if adverse effects such as drowsiness occur. Treatment cessation should be considered when management is reviewed and at least every six months.

If dystonia is considered to contribute significantly to problems with posture, function and pain, a trial of treatment with oral trihexyphenidyl hydrochloride p. 263, levodopa, or baclofen [unlicensed indications] can be considered.

Treatment with botulinum toxin type A p. 265 [unlicensed under 2 years] should be considered for those in whom focal spasticity of the upper or lower limbs is inhibiting fine motor function, affecting care and hygiene, causing pain or disturbing sleep, impeding tolerance of other treatments (such as orthoses), or causing cosmetic concerns. A trial of botulinum toxin type A treatment can also be considered in those with spasticity when focal dystonia is causing problems, such as postural or functional difficulties or pain. Ongoing assessment of muscle tone, range of movement and motor function is required. Botulinum toxin type A treatment should not be offered to children receiving treatment with Aminoglycosides p. 320.

Treatment with intrathecal baclofen [unlicensed under 4 years] (administered by continuous pump) can be considered in children with spasticity if (despite the use of non-invasive treatments) spasticity or dystonia are causing difficulties with pain, muscle spasm, posture, function or self-care. Before deciding to implant the intrathecal baclofen pump, an intrathecal baclofen test should be performed to assess the therapeutic effect and to check for adverse effects.

Developmental and clinical comorbidities

Regular assessment and appropriate nutritional support should be provided, especially if there are concerns about oral intake, growth or nutritional status. Enteral tube feeding can be provided if oral intake is insufficient to provide adequate nutrition.

Children with cerebral palsy are likely to have risk factors for low bone mineral density and can have an increased risk of low-impact fractures. Calcium and vitamin D supplementation (such as colecalciferol with calcium carbonate p. 655) may be required. Children with reduced bone density and a history of low-impact fracture can be considered for bisphosphonate therapy (under specialist guidance).

Pain is common in children with cerebral palsy, especially those with more severe motor impairment. Condition-specific causes of pain and discomfort include musculoskeletal problems (for example, scoliosis, hip subluxation and dislocation), increased muscle tone (including dystonia and spasticity), muscle fatigue and immobility, constipation, vomiting, and gastro-oesophageal reflux disease. Reversible causes of pain should be treated as appropriate, see Spasticity (above), Constipation p. 41, Gastro-oesophageal reflux disease p. 61, Urinary frequency, enuresis and incontinence p. 506, Nocturnal enuresis in children p. 506 and Urinary tract infections.

Other types of pain include non-specific back pain, headache, non-specific abdominal pain, dental pain and dysmenorrhea. Initially, a ‘stepped approach’ trial of

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Oral solution

**CAUTIONARY AND ADVISORY LABELS**

Risperidone 1 mg (Non-proprietary) per 1 ml Risperidone 1mg/ml oral solution sugar-free sugar-free 100 ml | £58.22 DT | £3.43 |

Risperidone 2 mg (Non-proprietary) per 1 ml Risperidone 2mg/ml oral solution sugar-free sugar-free 100 ml | £37.01 DT | £3.43 |

Oral dispersible tablet

**CAUTIONARY AND ADVISORY LABELS**

Risperidone 1 mg (Non-proprietary) per 1 mg Risperidone 1mg/ml oral solution sugar-free sugar-free 100 ml | £18.64 DT | £14.79 |

Risperidone 2 mg (Non-proprietary) per 1 mg Risperidone 2mg/ml oral solution sugar-free sugar-free 100 ml | £39.05 DT | £39.99 |

Risperidone 3 mg (Non-proprietary) per 1 mg Risperidone 3mg/ml oral solution sugar-free sugar-free 100 ml | £50.27 DT | £50.27 |
simple analgesia (such as paracetamol p. 278, ibuprofen p. 679, or both) for mild-to-moderate pain can be considered. If such a trial is unsuccessful, the child should be referred to a specialist pain team. 

In children with cerebral palsy, sleep disturbances are common. ECG If no treatable cause is found, a trial of melatonin p. 303 [unlicensed] can be considered to manage sleep disturbances, particularly for problems with falling asleep. Regular sedative medication should not be used to manage primary sleep disorders in children with cerebral palsy without seeking specialist advice. 

Epilepsy can be associated with cerebral palsy; for its management, see Epilepsy p. 195.

Children with cerebral palsy are at greater risk of mental health problems, in comparison with the general age comparison population. For management of these conditions, see Depression (Antidepressant drugs p. 241), Anxiety (Hypnotics and anxiolytics p. 302), and Attention deficit hyperactivity disorder p. 231.

Drooling: Drooling can be managed with an antimuscarinic drug, such as glycopyrronium bromide p. 774 [unlicensed in under 3 years] (oral or by enteral tube) or hyoscine hydrobromide p. 273 [unlicensed] (transdermal). For children with dyskinetic cerebral palsy, trihexyphenidyl hydrochloride [unlicensed] can be used (on specialist advice). If antimuscarinic drugs provide insufficient benefit or are not tolerated, botulinum toxin type A [unlicensed indication] injections to the salivary glands can be considered. High-dose botulinum toxin type A [unlicensed indication] injections to the salivary glands can, rarely, cause breathing and swallowing difficulties, which requires urgent hospital admission. Surgery can be an option in cases resistant to drug treatment.

Non-drug treatment: All children with spasticity should be offered physiotherapy and, where necessary, occupational therapy. They can also benefit from orthoses. Orthopaedic surgery can be used, as an adjunct to other interventions, to prevent deterioration and improve function.

Related drugs: Other drugs used for Cerebral palsy and spasticity: co-careldopa p. 264, dantrolene sodium p. 848.

Useful Resources:


Dystonias and related disorders

Dystonias:

Dystonias may result from conditions such as cerebral palsy or may be related to a deficiency of the neurotransmitter dopamine as in Segawa syndrome.

Dopaminergic drugs used in dystonias:

Levodopa, the amino-acid precursor of dopamine, acts by replenishing depleted striatal dopamine. It is given with an extracerebral dopa-decarboxylase inhibitor, which reduces the peripheral conversion of levodopa to dopamine, thereby limiting side-effects such as nausea, vomiting, and cardiovascular effects; additionally, effective brain-dopamine concentrations are achieved with lower doses of levodopa. The extracerebral dopa-decarboxylase inhibitor most commonly used in children is carbidopa (in co-careldopa p. 264).

Levodopa therapy should be initiated at a low dose and increased in small steps; the final dose should be as low as possible. Intervals between doses should be chosen to suit the needs of the individual child.

In severe dystonias related to cerebral palsy, improvement can be expected within 2 weeks. Children with Segawa syndrome are particularly sensitive to levodopa; they may even become symptom free on small doses. Levodopa also has a role in treating metabolic disorders such as defects in tetrahydrobiopterin synthesis and dihydrobiopterin reductase deficiency. Tetrahydrobiopterin may have a role in metabolic disorders.

Children may experience nausea within 2 hours of taking a dose; nausea and vomiting with co-careldopa is rarely dose-limiting.

In dystonic cerebral palsy, treatment with larger doses of levodopa is associated with the development of potentially troublesome motor complications (including response fluctuations and dyskinesias). Response fluctuations are characterised by large variations in motor performance, with normal function during the ‘on’ period, and weakness and restricted mobility during the ‘off’ period.

Antimuscarinic drugs used in dystonias:

The antimuscarinic drugs procyclidine hydrochloride p. 263 and trihexyphenidyl hydrochloride p. 263 reduce the symptoms of dystonias, including those induced by antipsychotic drugs; there is no justification for giving them routinely in the absence of dystonic symptoms. Tardive dyskinesia is not improved by antimuscarinic drugs and may be made worse.

There are no important differences between the antimuscarinic drugs, but some children tolerate one better than another.

Procyclidine hydrochloride can be given parenterally and is effective emergency treatment for acute drug-induced dystonic reactions.

If treatment with an antimuscarinic is ineffective, intravenous diazepam p. 226 can be given for life-threatening acute drug-induced dystonic reactions.

Drugs used in essential tremor, chorea, tics, and related disorders:

Haloperidol p. 252 can also improve motor tics and symptoms of Tourette syndrome and related choreas. Other treatments for Tourette syndrome include pimozone p. 253 [unlicensed indication] (important: ECG monitoring required), and sulphpride p. 253 [unlicensed indication].

Propranolol hydrochloride p. 106 or another beta-adrenoceptor blocking drug may be useful in treating essential tremor or tremor associated with anxiety or thyrotoxicosis.

Botulinum toxin type A p. 265 should be used under specialist supervision. Treatment with botulinum toxin type A can be considered after an acquired non-progressive brain injury if rapid-onset spasticity causes postural or functional difficulties, and in children with spasticity in whom focal dystonia causes postural or functional difficulties or pain.
Dystonias and other involuntary movements

**Other drugs used for Dystonias and other involuntary movements**  Chlorpropramide hydrochloride, p. 251 - Clonidine hydrochloride, p. 103 - Clozapine, p. 256 - Perisycaine, p. 253 - Prochlorperazine, p. 275 - Trifluoperazine, p. 254

**Antimuscarinics**

**Procyclidine hydrochloride**

- **Drug action** Procyclidine exerts its antiparkinsonian action by reducing the effects of the relative central cholinergic excess that occurs as a result of dopamine deficiency.

- **Indications and dose**
  - **Acute dystonia**
    - **By intramuscular injection, or by intravenous injection**
    - Child 1 month-1 year: 0.5–2 mg for 1 dose, dose usually effective in 5–10 minutes but may need 30 minutes for relief.
    - Child 2-9 years: 2–5 mg for 1 dose, dose usually effective in 5–10 minutes but may need 30 minutes for relief.
    - Child 10-17 years: 5–10 mg, occasionally, more than 10 mg, dose usually effective in 5–10 minutes but may need 30 minutes for relief.

- **Dystonia**
  - **By mouth**
    - Child 7-11 years: 1.25 mg 3 times a day.
    - Child 12-17 years: 2.5 mg 3 times a day.

- **Unlicenced use** Not licensed for use in children.

- **Contra-indications**
  - Gastro-intestinal obstruction - myasthenia gravis

- **Caution**
  - Cardiovascular disease - hypertension - liable to abuse - psychotic disorders - pyrexia - those susceptible to angle-closure glaucoma

- **Interactions**
  - Appendix 1: procyclidine

- **Side-effects**
  - Common or very common: Constipation - dry mouth - urinary retention - vision blurred
  - Uncommon: Anxiety - cognitive impairment - confusion - dizziness - gingivitis - hallucination - memory loss - nausea - rash - vomiting
  - Rare or very rare: Psychotic disorder

- **Pregnancy** Use only if potential benefit outweighs risk.

- **Breast feeding** Avoid.

- **Hepatic impairment** Manufacturer advises caution.

- **Renal impairment** Use with caution.

- **Treatment cessation** Avoid abrupt withdrawal in patients taking long-term treatment.

- **Patient and carer advice**
  - Driving and skilled tasks: May affect performance of skilled tasks (e.g. driving).

- **Medicinal forms**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Solution for injection**

- Procyclidine hydrochloride (Non-proprietary) Procyclidine hydrochloride 5 mg per 1 ml Procyclidine 10mg/2ml solution for injection ampoules | 5-ampoule POM £60.00–£78.75 DT = £72.50

**Oral solution**

- Procyclidine hydrochloride (Non-proprietary) Procyclidine hydrochloride 500 microgram per 1 ml Procyclidine 2.5mg/5ml oral solution sugar free sugar-free | 150 ml POM £11.00–£14.03 DT = £14.01

**Trihexyphenidyl hydrochloride**

**(Benzhexol hydrochloride)**

- **Drug action** Trihexyphenidyl exerts its effects by reducing the effects of the relative central cholinergic excess that occurs as a result of dopamine deficiency.

- **Indications and dose**
  - **Dystonia**
    - **By mouth**
      - Child 3 months-17 years: Initially 1–2 mg daily in 1–2 divided doses, then increased in steps of 1 mg every 3–7 days, dose to be adjusted according to response and side-effects; maximum 2 mg/kg per day.

- **Unlicenced use** Not licensed for use in children.

- **Contra-indications**
  - Gastro-intestinal obstruction - myasthenia gravis

- **Caution**
  - Cardiovascular disease - hypertension - liable to abuse - psychotic disorders - pyrexia - those susceptible to angle-closure glaucoma

- **Interactions**
  - Appendix 1: trihexyphenidyl

- **Side-effects**

- **Pregnancy** Use only if potential benefit outweighs risk.

- **Breast feeding** Avoid.

- **Hepatic impairment** Manufacturer advises caution.

- **Renal impairment** Use with caution.

- **Treatment cessation** Avoid abrupt withdrawal in patients taking long-term treatment.

- **Directions for administration** Tablets should be taken with or after food.

- **Patient and carer advice**
  - Medicines for Children leaflet: Trihexyphenidyl hydrochloride for dystonia www.medicinesforchildren.org.uk/trihexyphenidyl

- **Driving and skilled tasks** May affect performance of skilled tasks (e.g. driving).

- **Medicinal forms**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral solution**

- Exciipients: May contain Propylene glycol
  - Trihexyphenidyl hydrochloride (Non-proprietary) Trihexyphenidyl hydrochloride 1 mg per 1 ml Trihexyphenidyl 5mg/5ml oral solution | 200 ml POM £24.00–£28.37 DT = £26.40

**Tablet**

- Trihexyphenidyl hydrochloride (Non-proprietary) Trihexyphenidyl hydrochloride 2 mg Trihexyphenidyl 2mg tablets | 84 tablet POM £4.20 DT = £3.46
  - Trihexyphenidyl hydrochloride 5 mg Trihexyphenidyl 5mg tablets | 84 tablet POM £17.01 DT = £17.01
DOPAMINERGIC DRUGS > DOPAMINE PRECURSORS

Co-careldopa

INDICATIONS AND DOSE

Dopamine-sensitive dystonias including Segawa syndrome and dystonias related to cerebral palsy (dose expressed as levodopa)

BY MOUTH

- Child: Initially 250–500 micrograms/kg 4 times a day, dose to be increased every 4–5 days according to response, a preparation containing 1:4 carbidopa:levodopa to be administered; maintenance 2.5–3 mg/kg 4 times a day, at higher doses consider preparation containing 1:10 carbidopa:levodopa, review regularly (every 3–6 months).

BY MOUTH

- Neonate: Initially 250–500 micrograms/kg 4 times a day, dose to be increased every 4–5 days according to response, a preparation containing 1:4 carbidopa:levodopa to be administered; maintenance 2.5–3 mg/kg 4 times a day, at higher doses consider preparation containing 1:10 carbidopa:levodopa, review regularly (every 3–6 months).

DOSE EQUIVALENT AND CONVERSION

- The proportions are expressed in the form x/y where x and y are the strengths in milligrams of carbidopa and levodopa respectively.
- 2 tablets Sinemet® 12.5 mg/50 mg is equivalent to 1 tablet Sinemet® Plus 25 mg/100 mg.

UNLICENSED USE

- Not licensed for use in children.

CAUTIONS

- Cardiovascular disease.
- Diabetes mellitus.
- History of myocardial infarction with residual arrhythmia.
- History of peptic ulcer.
- History of myocardial infarction with residual arrhythmia.
- Pulmonary disease.
- Susceptibility to angle-closure glaucoma.

INTERACTIONS

- Appendix 3: carbidopa - levodopa.

SIDE-EFFECTS

- Rare or very rare Drowsiness, seizure, sleep disorders.
- Frequency not known Agranulocytosis, Alertness decreased, Alopecia, Anaemia, Angioedema, Anxiety, Appetite decreased, Asthenia, Cardiac disorders, Chest pain, Compulsions, Confusion, Constipation, Delusions, Depression, Diarrhoea, Dizziness, Dry mouth, Dyskinesia, Hypnotic (may be dose-limiting), Dysphagia, Dysphoa, Eating disorders, Euphoric mood, Eye disorders, Faint, Focal tremor, Gait abnormal, Gastrointestinal discomfort, Gastrointestinal disorders, Gastrointestinal haemorrhage, Haemolytic anaemia, Hallucination, Headache, Henoch-Schönlein purpura, Hiccups, Hoarseness, Horner’s syndrome exacerbated, Hypertension, Hypotension, Leucopenia, Malaise, Malignant melanoma, Movement disorders, Muscle complaints, Nausea, Neuroleptic malignant syndrome (on abrupt discontinuation), Oedema, Oral disorders, Palpitations, Pathological gambling, Postural disorders, Psychotic disorders, Respiration abnormal, Sensation abnormal, Sexual dysfunction, Skin reactions, Suicidal ideation, Sweat changes, Syncope, Taste bitter, Teeth grinding, Thrombocytopenia, Trismus, urinary disorders, Urine dark, Vasodilation, Vision disorders, Vomiting, Weight changes.

PREGNANCY

- Use with caution — toxicity has occurred in animal studies.

BREAST FEEDING

- May suppress lactation; present in milk — avoid.

HEPATIC IMPAIRMENT

- Manufacturer advises use with caution in hepatic disease.

DUODOPA® Dose adjustments

- Manufacturer advises titrate dose with caution in severe impairment.

MONITORING REQUIREMENTS

- In prolonged therapy, psychiatric, hepatic, haematological, renal, and cardiovascular monitoring is advisable; warn patients to resume normal activities gradually.

EFFECT ON LABORATORY TESTS

- False positive tests for urinary ketones have been reported.

TREATMENT CESSATION

- Avoid abrupt withdrawal.

PRESCRIBING AND DISPENSING INFORMATION

- Co-careldopa is a mixture of carbidopa and levodopa; the proportions are expressed in the form x/y where x and y are the strengths in milligrams of carbidopa and levodopa respectively.

PATIENT AND CARER ADVICE

- Warn patients to resume normal activity gradually.

Driving and skilled tasks

- Sudden onset of sleep Excessive daytime sleepiness and sudden onset of sleep can occur with co-careldopa.

- Patients starting treatment with these drugs should be warned of the risk and of the need to exercise caution when driving or operating machinery.

- Those who have experienced excessive sedation or sudden onset of sleep should refrain from driving or operating machines until these effects have stopped occurring.

- Management of excessive daytime sleepiness should focus on the identification of an underlying cause, such as depression or concomitant medication.

- Patients should be counselled on improving sleep behaviour.

MEDICINAL FORMS

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

TABLET

CAUTIONARY AND ADVISORY LABELS 10, 14

- Co-careldopa (Non-proprietary)

| Carbidopa (as Carbidopa monohydrate) 12.5 mg, Levodopa 250 mg | 90 tablet blister pack | £6.28 – £8.25 DT = £8.13 |
| Carbidopa (as Carbidopa monohydrate) 10 mg, Levodopa 100 mg | 100 tablet blister pack | £11.50 DT = £11.20 |
| Carbidopa (as Carbidopa monohydrate) 25 mg, Levodopa 100 mg | 100 tablet blister pack | £5.71 – £6.99 DT = £6.02 |
| Carbidopa (as Carbidopa monohydrate) 50 mg | 100 tablet blister pack | £35.00 DT = £34.98 |
| Sinemet 110 (Merck Sharp & Dohme Ltd) | 100 mg Sinemet 10mg/100mg tablets | 100 tablet blister pack | £7.50 DT = £7.20 |
| Sinemet 275 (Merck Sharp & Dohme Ltd) | 250 mg Carbidopa 25mg/250mg tablets | 200 tablet blister pack | £4.98 |
| Sinemet Plus 50 (Merck Sharp & Dohme Ltd) | 12.5 mg, Levodopa 50 mg | 90 tablet blister pack | £6.28 DT = £6.13 |
| Sinemet Plus 62.5 (Merck Sharp & Dohme Ltd) | 12.5 mg, Levodopa 75 mg | 90 tablet blister pack | £11.88 DT = £11.40 |
**Nausea and labyrinth disorders**

**Drug treatment**

Antiemetics should be prescribed only when the cause of vomiting is known because otherwise they may delay diagnosis, particularly in children. Antiemetics are unnecessary and sometimes harmful when the cause can be treated, such as in diabetic ketoadsisis, or in digoxin p. 82 or antiepileptic overdose.

If antiemetic drug treatment is indicated, the drug is chosen according to the aetiology of vomiting. Antihistamines are effective against nausea and vomiting resulting from many underlying conditions. There is no evidence that any one antihistamine is superior to another but their duration of action and incidence of adverse effects (drowsiness and antimuscarinic effects) differ.

The phenothiazines are dopamine antagonists and act centrally by blocking the chemoreceptor trigger zone. They are of considerable value for the prophylaxis and treatment of nausea and vomiting associated with diffuse neoplastic disease, radiation sickness, and the emesis caused by drugs resulting from many underlying conditions. There is no evidence that any one antihistamine is superior to another but their duration of action and incidence of adverse effects (drowsiness and antimuscarinic effects) differ.

The phenothiazines are dopamine antagonists and act centrally by blocking the chemoreceptor trigger zone. They are of considerable value for the prophylaxis and treatment of nausea and vomiting associated with diffuse neoplastic disease, radiation sickness, and the emesis caused by drugs such as opioids, general anaesthetics, and cytotoxics.

Prochlorperazine p. 275, perphenazine, and trifluperazine p. 254 are less sedating than chlorpromazine hydrochloride p. 251; severe dystonic reactions sometimes occur with phenothiazines. Some phenothiazines are available as rectal suppositories, which can be useful in children with persistent vomiting or with severe nausea; for children over 12 years prochlorperazine can also be administered as a buccal tablet which is placed between the upper lip and the gum.

Other antipsychotic drugs including haloperidol p. 252 and levomepromazine p. 275 are used for the relief of nausea in palliative care.

**Metoclopramide hydrochloride p. 269 is an effective antiemetic and its activity closely resembles that of**
phenothiazines. Metoclopramide hydrochloride also acts directly on the gastro-intestinal tract and it may be superior to the phenothiazines for emesis associated with gastroduodenal, hepatic, and biliary disease. Due to the risk of neurological side effects, metoclopramide hydrochloride should only be used in children as second line therapy in postoperative and cytotoxic induced nausea and vomiting. Domperidone p. 268 acts at the chemoreceptor trigger zone; it has the advantage over metoclopramide hydrochloride and the phenothiazines of being less likely to cause central effects such as sedation and dystonic reactions because it does not readily cross the blood–brain barrier.

Granisetron p. 271 and ondansetron p. 271 are specific 5HT₃-receptor antagonists which block 5HT₃ receptors in the gastro-intestinal tract and in the CNS. They are of value in the management of nausea and vomiting in children receiving cytotoxics and in postoperative nausea and vomiting.

Aprepitant p. 269 is a neurokinin 1-receptor antagonist, licensed for the prevention of nausea and vomiting associated with highly and moderately emetogenic cancer chemotherapy; it is given in combination with a 5HT₃-receptor antagonist (with or without a corticosteroid).

Nabilone is a synthetic cannabinoid with antiemetic properties. It may be used for nausea and vomiting caused by cytotoxic chemotherapy that is unresponsive to conventional antiemetics.

Dexamethasone p. 455 has antiemetic effects. Dexamethasone may also have a role in cytotoxic-induced nausea and vomiting.

**Vomiting during pregnancy**

Nausea in the first trimester of pregnancy is generally mild and does not require drug therapy. On rare occasions if vomiting is severe, short-term treatment with an antihistamine, such as promethazine, may be required. Promethazine hydrochloride or metoclopramide hydrochloride are alternatives. If symptoms do not settle in 24 to 48 hours then specialist opinion should be sought. Hyperemesis gravidarum is a more serious condition, which requires regular antiemetic therapy, intravenous fluid and electrolyte replacement and sometimes nutritional support. Supplementation with thiamine p. 650 must be considered in order to reduce the risk of Wernicke’s encephalopathy.

**Postoperative nausea and vomiting**

The incidence of postoperative nausea and vomiting depends on many factors including the anaesthetic used, and the type and duration of surgery. Other risk factors include female sex, non-smokers, a history of postoperative nausea and vomiting or motion sickness, and intraoperative and postoperative use of opioids. Therapy to prevent postoperative nausea and vomiting should be based on the assessed risk. Drugs used include 5HT₃-receptor antagonists, droperidol p. 275, dexamethasone, some phenothiazines (e.g. prochlorperazine), and antihistamines (e.g. cyclizine below). A combination of two or more antiemetic drugs that have different mechanisms of action is often indicated in those at high risk of postoperative nausea and vomiting or where postoperative vomiting presents a particular danger (e.g. in some types of surgery). When a prophylactic antiemetic drug has failed, postoperative nausea and vomiting should be treated with one or more drugs from a different class.

**Opioid-induced nausea and vomiting**

Cyclizine, ondansetron, and prochlorperazine are used to relieve opioid-induced nausea and vomiting; ondansetron has the advantage of not producing sedation.

**Motion sickness**

Antiemetics should be given to prevent motion sickness rather than after nausea or vomiting develops. The most effective drug for the prevention of motion sickness is hyoscine hydrobromide p. 273. For children over 10 years old, a transdermal hyoscine patch provides prolonged activity but it needs to be applied several hours before travelling. The sedating antihistamines are slightly less effective against motion sickness, but are generally better tolerated than hyoscine. If a sedative effect is desired promethazine is useful, but generally a slightly less sedating antihistamine such as cyclizine or cinnarizine p. 272 is preferred. Domperidone, metoclopramide hydrochloride, 5HT₃-receptor antagonists, and the phenothiazines (except the antihistamine phenothiazine promethazine) are ineffective in motion sickness.

**Other vestibular disorders**

Management of vestibular diseases is aimed at treating the underlying cause as well as treating symptoms of the balance disturbance and associated nausea and vomiting. Antihistamines (such as cinnarizine), and phenothiazines (such as prochlorperazine) are effective for prophylaxis and treatment of nausea and vertigo resulting from vestibular disorders; however, when nausea and vertigo are associated with middle ear surgery, treatment can be difficult.

**Nausea caused by cytotoxic chemotherapy, palliative care, and migraine**

Antiemetics have a role in the management of nausea and vomiting induced by cytotoxic chemotherapy, in palliative care, and associated with migraine.

**Other drugs used for Nausea and labyrinth disorders**

Promethazine hydrochloride, p. 183

### ANTIEMETICS AND ANTINAUSEANTS

#### ANTIHISTAMINES

**Cyclizine**

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea and vomiting of known cause</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>BY MOUTH, OR BY INTRAVENOUS INJECTION</strong></td>
</tr>
<tr>
<td>Child 1 month–5 years: 0.5–1 mg/kg up to 3 times a day (max. per dose 25 mg), intravenous injection to be given over 3–5 minutes, for motion sickness, take 1–2 hours before departure</td>
</tr>
<tr>
<td>Child 6–11 years: 25 mg up to 3 times a day, intravenous injection to be given over 3–5 minutes, for motion sickness, take 1–2 hours before departure</td>
</tr>
<tr>
<td>Child 12-17 years: 50 mg up to 3 times a day, intravenous injection to be given over 3–5 minutes, for motion sickness, take 1–2 hours before departure</td>
</tr>
<tr>
<td><strong>BY RECTUM</strong></td>
</tr>
<tr>
<td>Child 2-5 years: 12.5 mg up to 3 times a day</td>
</tr>
<tr>
<td>Child 6-11 years: 25 mg up to 3 times a day</td>
</tr>
<tr>
<td>Child 12-17 years: 50 mg up to 3 times a day</td>
</tr>
<tr>
<td><strong>BY CONTINUOUS INTRAVENOUS INFUSION, OR BY SUBCUTANEOUS INFUSION</strong></td>
</tr>
<tr>
<td>Child 1–23 months: 3 mg/kg, dose to be given over 24 hours</td>
</tr>
<tr>
<td>Child 2-5 years: 50 mg, dose to be given over 24 hours</td>
</tr>
<tr>
<td>Child 6-11 years: 75 mg, dose to be given over 24 hours</td>
</tr>
<tr>
<td>Child 12-17 years: 150 mg, dose to be given over 24 hours</td>
</tr>
</tbody>
</table>
Nausea and vomiting in palliative care

- **BY SUBCUTANEOUS INFUSION**
  - Child 1-23 months: 3 mg/kg, dose to be given over 24 hours
  - Child 2-5 years: 50 mg, dose to be given over 24 hours
  - Child 6-11 years: 75 mg, dose to be given over 24 hours
  - Child 12-17 years: 150 mg, dose to be given over 24 hours
- **BY MOUTH**
  - Child 1 month-5 years: 0.5–1 mg/kg up to 3 times a day (max. per dose 25 mg)
  - Child 6-11 years: 25 mg up to 3 times a day
  - Child 12-17 years: 50 mg up to 3 times a day
- **BY INTRAVENOUS INJECTION**
  - Child 1 month-5 years: 0.5–1 mg/kg up to 3 times a day (max. per dose 25 mg), intravenous injection to be given over 3–5 minutes
  - Child 6-11 years: 25 mg up to 3 times a day, intravenous injection to be given over 3–5 minutes
  - Child 12-17 years: 50 mg up to 3 times a day, intravenous injection to be given over 3–5 minutes
- **BY CONTINUOUS INTRAVENOUS INFUSION**
  - Child 1-23 months: 3 mg/kg, dose to be given over 24 hours
  - Child 2-5 years: 50 mg, dose to be given over 24 hours
  - Child 6-11 years: 75 mg, dose to be given over 24 hours
  - Child 12-17 years: 150 mg, dose to be given over 24 hours
- **BY RECTUM**
  - Child 1-23 months: 3 mg/kg, dose to be given over 24 hours
  - Child 2-5 years: 50 mg, dose to be given over 24 hours
  - Child 6-11 years: 75 mg, dose to be given over 24 hours
  - Child 12-17 years: 150 mg, dose to be given over 24 hours
- **BY SUBCUTANEOUS INFUSION**
  - Child 1 month-5 years: 12.5 mg up to 3 times a day
  - Child 6-11 years: 25 mg up to 3 times a day
  - Child 12-17 years: 50 mg up to 3 times a day

- **UNLICENSED USE** Tablets not licensed for use in children under 6 years. Injection not licensed for use in children.

- **CONTRA-INDICATIONS** Neonate (due to significant antimuscarinic activity) (in neonates)

- **CAUTIONS** Epilepsy - glaucoma - may counteract haemodynamic benefits of opioids - neuromuscular disorders - increased risk of transient paralysis with intravenous use - pyloroduodenal obstruction - severe heart failure - may cause fall in cardiac output and associated increase in heart rate, mean arterial pressure and pulmonary wedge pressure - urinary retention

- **INTERACTIONS** Appendix 1: antihistamines, sedating

- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Agitation (more common at high doses) - angle closure glaucoma - depression
  - **FREQUENCY NOT KNOWN**

- **SPECIFIC SIDE-EFFECTS**
  - With oral use: Level of consciousness decreased
  - With parenteral use: Chills - consciousness impaired - injection site necrosis - pain - paralysis - sensation of pressure - thrombophlebitis

- **PREGNANCY**
  - Manufacturer advises avoid; however, there is no evidence of teratogenicity. The use of sedating antihistamines in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitability, and tremor.

- **BREAST FEEDING**
  - No information available. Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution.

- **DIRECTIONS FOR ADMINISTRATION** For administration by mouth, tablets may be crushed.
  - Mixing and compatibility for the use of syringe drivers in palliative care: Cyclizine may precipitate at concentrations above 10 mg/mL or in the presence of sodium chloride 0.9% or as the concentration of diamorphine relative to cyclizine increases; mixtures of diamorphine and cyclizine are also likely to precipitate after 24 hours.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - **Palliative care** For further information on the use of cyclizine in palliative care, see www.medicinescomplete.com/#/content/palliative/antihistaminic-antimuscarinic-antiemetics.

- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks: Drowsiness may affect performance of skilled tasks (e.g. cycling, driving); effects of alcohol enhanced.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, suppository

  - **Tablet**
    - Cautionary and advisory labels 2
    - Cyclizine (Non-proprietary)
      - Cyclizine hydrochloride 50 mg
    - Cyclizine 50mg tablets | 30 tablet £2.04–4.50 | 100 tablet £13.64 DT = £6.81

  - **Solution for injection**
    - Cyclizine (Non-proprietary)
      - Cyclizine lactate 50 mg per 1 mL
      - Cyclizine 50mg/1ml solution for injection ampoules | 5 ampoule (POs) £16.25–17.78 DT = £16.25 | 10 ampoule (POs) £25.00

- **ANTIEMETICS AND ANTINAUSEANTS**

<table>
<thead>
<tr>
<th>Cannabinoids</th>
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<tbody>
<tr>
<td>Nabilone</td>
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</table>

- **INDICATIONS AND DOSE**
  - Nausea and vomiting caused by cytotoxic chemotherapy, unresponsive to conventional antiemetics (preferably in hospital setting) (under close medical supervision)
    - By mouth
      - Child: (consult local protocol)

- **UNLICENSED USE**
  - Not licensed for use in children.

- **CAUTIONS**
  - Adverse effects on mental state can persist for 48–72 hours after stopping - heart disease - history of psychiatric disorder - hypertension

- **INTERACTIONS** Appendix 1: nabilone

- **SIDE-EFFECTS**

- **SIDE-EFFECTS, FURTHER INFORMATION**
  - Drowsiness and diziness occur frequently with standard doses.

- **PREGNANCY**
  - Avoid unless essential.

- **BREAST FEEDING**
  - Avoid—no information available.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises avoid in severe impairment (primarily biliary excretion).
● PATIENT AND CARER ADVICE

Behavioural effects Patients should be made aware of possible changes of mood and other adverse behavioural effects.

Driving and skilled tasks Drowsiness may affect performance of skilled tasks (e.g. driving).

Effects of alcohol enhanced.

For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including nabilone, see Drugs and skilled tasks under Guidance on prescribing p. 1.

● MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule

Capsule

CAUTIONARY AND ADVISORY LABELS 2

Nabilone (Non-proprietary)

Nabilone 250 microgram | 20 capsule | £150.00 DT + £150.00 COT

Nabilone 1 mg | 20 capsule | £100.00 DT + £150.00 COT

Nabilone 250 microgram capsules | 2 capsule | £100.00 DT + £150.00 COT

ANTIMETICS AND ANTINAUSEANTS ▶

DOPAMINE RECEPTOR ANTAGONISTS

Domperidone 10-Mar-2017

● INDICATIONS AND DOSE

Relief of nausea and vomiting

▶ BY MOUTH

Child (body-weight up to 35 kg): 250 micrograms/kg up to 3 times a day; maximum 750 micrograms/kg per day

Child 12-17 years (body-weight 35 kg and above): 10 mg up to 3 times a day; maximum 30 mg per day

Gastro-oesophageal reflux disease (but efficacy not proven)

▶ BY MOUTH

Neonate: 250 micrograms/kg 3 times a day, dose can be increased if response inadequate, increased if necessary up to 400 micrograms/kg 3 times a day, interrupt treatment occasionally to assess recurrence—consider restarting if symptoms recur, discontinue if response inadequate at higher dose

Child: 250 micrograms/kg 3 times a day (max. per dose 10 mg), dose can be increased if response inadequate, increased if necessary up to 400 micrograms/kg 3 times a day (max. per dose 20 mg), interrupt treatment occasionally to assess recurrence—consider restarting if symptoms recur, discontinue if response inadequate at higher dose

● UNLICENSED USE

Not licensed for use in children for gastro-oesophageal reflux disease.

IMPORTANT SAFETY INFORMATION

MHRA/CHM ADVICE—DOMPERIDONE: RISK OF CARDIAC SIDE-EFFECTS—RESTRICTED INDICATION, NEW CONTRA-INDICATIONS, REDUCED DOSE AND DURATION OF USE

The benefits and risks of domperidone have been reviewed. As domperidone is associated with a small increased risk of serious cardiac side-effects, the following restrictions to indication, dose and duration of treatment have been made, and new contra-indications added:

● Domperidone should only be used for the relief of the symptoms of nausea and vomiting;

● Domperidone should be used at the lowest effective dose for the shortest possible duration (max. treatment duration should not normally exceed 1 week);

● Domperidone is contra-indicated for use in conditions where cardiac conduction is, or could be, impaired, or where there is underlying cardiac disease, when administered concomitantly with drugs that prolong the QT interval or potent CYP3A4 inhibitors, and in severe hepatic impairment;

The recommended dose in adults and adolescents over 12 years and over 35 kg is 10 mg up to 3 times daily;

The recommended dose in children under 35 kg is 250 micrograms/kg up to 3 times daily;

Oral liquid formulations should be given via an appropriately designed, graduated oral syringe to ensure dose accuracy.

This advice does not apply to unlicensed uses of domperidone (e.g. palliative care).

● CONTRA-INDICATIONS

Cardiac disease · gastro-intestinal haemorrhage · mechanical obstruction · mechanical perforation · predisposition to cardiac conduction disorders · prolactinoma

● CAUTIONS

Children · if there are cardiac concerns, obtain ECG before and during treatment

● INTERACTIONS

Children → Appendix 1: domperidone

● SIDE-EFFECTS

Common or very common Dry mouth

Uncommon Anxiety · asthenia · breast abnormalities · diarrhoea · drowsiness · headache · lactation disorders · libido loss

Frequency not known Arrhythmias · depression · gynaecomastia · menstrual cycle irregularities · movement disorders · ocuolygic crisis · QT interval prolongation · seizure · sudden cardiac death · urinary retention

● PREGNANCY

Use only if potential benefit outweighs risk.

● BREAST FEEDING

Amount too small to be harmful.

● HEPATIC IMPAIRMENT

Manufacturer advises avoid in moderate to severe impairment.

● RENAL IMPAIRMENT

Dose adjustments Reduce frequency.

● PATIENT AND CARER ADVICE

Arrhythmia Patients and their carers should be told how to recognise signs of arrhythmia and advised to seek medical attention if symptoms such as palpitation or syncope develop.

Medicines for Children leaflet: Domperidone for gastro-oesophageal reflux www.medicinesforchildren.org.uk/domperidone-gastro-oesophageal-reflux

● MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

Oral suspension

CAUTIONARY AND ADVISORY LABELS 22

Domperidone (Non-proprietary)

Domperidone 1 mg per 1 ml Domperidone 1mg/ml oral suspension sugar free sugar-free | 200 ml | £25.67 DT + £21.52

Tablet

CAUTIONARY AND ADVISORY LABELS 22

Domperidone (Non-proprietary)

Domperidone (as Domperidone maleate) 10 mg Domperidone 10mg tablets | 30 tablet | £2.71 DT + £0.94 | 100 tablet | £9.04 DT + £3.13

Domperidone (as Domperidone maleate) 10 mg Modilium 10mg tablets | 30 tablet | £2.71 DT + £0.94 | 100 tablet | £9.04 DT + £3.13
Nausea and labyrinth disorders 269

Metoclopramide hydrochloride 10-Aug-2018

INDICATIONS AND DOSE
Second-line option for treatment of established postoperative nausea and vomiting | Prevention of delayed chemotherapy-induced nausea and vomiting

- BY MOUTH, OR BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION
- Child: 100–150 micrograms/kg up to 3 times a day (max. per dose 10 mg), when administered by slow intravenous injection, to be given over at least 3 minutes

- UNLICENSED USE Maxolon® tablets not licensed for use in children.

IMPORTANT SAFETY INFORMATION
MHRA/CHM ADVICE—METOCLOPRAMIDE: RISK OF NEUROLOGICAL ADVERSE EFFECTS—RESTRICTED DOSE AND DURATION OF USE (AUGUST 2013)
The benefits and risks of metoclopramide have been reviewed by the European Medicines Agency’s Committee on Medicinal Products for Human Use, which concluded that the risk of neurological effects such as extrapyramidal disorders and tardive dyskinesia outweigh the benefits in long-term or high-dose treatment. To help minimise the risk of potentially serious neurological adverse effects, the following restrictions to indications, dose and duration of use have been made:

- In children aged 1–18 years, metoclopramide should only be used as a second-line option for prevention of delayed chemotherapy-induced nausea and vomiting and for treatment of established postoperative nausea and vomiting;
- Use of metoclopramide is contra-indicated in children aged under 1 year;
- Metoclopramide should only be prescribed for short-term use (up to 5 days);
- Recommended dose is 100–150 micrograms/kg (max. 10 mg), repeated up to 3 times daily;
- Intravenous doses should be administered as a slow bolus over at least 3 minutes;
- Oral liquid formulations should be given via an appropriately designed, graduated oral syringe to ensure dose accuracy.

This advice does not apply to unlicensed uses of metoclopramide (e.g. palliative care).

- CONTRA-INDICATIONS 3–4 days after gastrointestinal surgery | gastro-intestinal haemorrhage | gastro-intestinal obstruction | gastro-intestinal perforation | phaeochromocytoma
- CAUTIONS Asthma | atopic allergy | bradycardia | cardiac conduction disturbances | epilepsy | may mask underlying disorders such as cerebral irritation | uncorrected electrolyte imbalance
- INTERACTIONS → Appendix 1: metoclopramide
- SIDE-EFFECTS
  - COMMON OR VERY COMMON Asthenia | depression | diarrhoea | drowsiness | hypotension | menstrual cycle irregularities | movement disorders | parkinsonism
  - UNCOMMON Arrhythmias | hallucination | hyperprolactinaemia | level of consciousness decreased
  - RARE OR VERY RARE Confusion | galactorrhoea | seizure
  - FREQUENCY NOT KNOWN Atrophic ventricular block | blood disorders | cardiac arrest | gynaecostasia | hypertension | neurolepetic malignant syndrome | QT interval prolongation | shock | syncope | tremor

SPECIFIC SIDE-EFFECTS
- With parenteral use Anxiety | dizziness | dyspnoea | oedema | skin reactions | visual impairment

SIDE-EFFECTS, FURTHER INFORMATION
Metoclopramide can induce acute dystonic reactions involving facial and skeletal muscle spasms and oculogyric crises. These dystonic effects are more common in the young, especially girls and young women; they usually occur shortly after starting treatment with metoclopramide and subside within 24 hours of stopping it. Use of an antimuscarinic drug such as procyclidine will abort dystonic attacks.

- PREGNANCY Not known to be harmful.
- BREAST FEEDING Small amount present in milk; avoid.
- HEPATIC IMPAIRMENT Manufacturer advises caution in severe impairment (risk of accumulation).
- Dose adjustments Manufacturer advises dose reduction of 50% in severe impairment.
- RENAL IMPAIRMENT Dose adjustments Avoid or use small dose in severe impairment; increased risk of extrapyramidal reactions.
- DIRECTIONS FOR ADMINISTRATION Oral liquid preparation to be given via a graduated oral dosing syringe.
- PATIENT AND CARER ADVICE Counselling on use of pipette advised with oral solution.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

Solution for Injection
- Metoclopramide hydrochloride (Non-proprietary)
  Metoclopramide hydrochloride 5 mg per 1 ml Metoclopramide 10mg/2ml solution for injection ampoules | 5 ampoule [PST ] £1.31-£15.00 | 10 ampoule [PST ] £25.00 DT = £2.65
  Maxolon (Advanz Pharma)
  Metoclopramide hydrochloride 5 mg per 1 ml Maxolon 10mg/2ml solution for injection ampoules | 12 ampoule [PST ] £3.21
  Maxolon High Dose 100mg/20ml solution for injection ampoules | 10 ampoule [PST ] £26.68
- Oral solution
  Metoclopramide hydrochloride (Non-proprietary)
  Metoclopramide hydrochloride 1 mg per 1 ml Metoclopramide 5mg/5ml oral solution sugar free sugar-free | 150 ml [PST ] £19.77 DT = £15.77
  Tablet
  Metoclopramide hydrochloride (Non-proprietary)
  Metoclopramide hydrochloride 10 mg Metoclopramide 10mg tablets | 28 tablet [PST ] £1.40 DT = £0.61
  Maxolon (Advanz Pharma)
  Metoclopramide hydrochloride 10 mg Maxolon 10mg tablets | 84 tablet [PST ] £5.24

ANTIMETICS AND ANTINAUSEANTS

NEUROKININ RECEPTOR ANTAGONISTS

Aprepitant

INDICATIONS AND DOSE
Adjunct treatment to prevent nausea and vomiting associated with moderately and highly emetogenic chemotherapy

- BY MOUTH
- Child 6 months–11 years (body-weight 6 kg and above): (consult product literature)
- Child 12–17 years: Initially 125 mg, dose to be taken 1 hour before chemotherapy, then 80 mg once daily for 2 days, dose to be taken 1 hour before chemotherapy or in the morning if no chemotherapy is given, consult product literature for dose of concomitant 5HT3- antagonist (and corticosteroid if required)

- CONTRA-INDICATIONS Acute porphyrias p. 624
- INTERACTIONS → Appendix 1: aprepitant
270 Nausea and labyrinth disorders

- **SIDE-EFFECTS**
  - Common or very common: Appetite decreased, asthenia, constipation, gastrointestinal discomfort, headache, hiccup.
  - Uncommon: Anaemia, anxiety, burping, dizziness, drowsiness, dry mouth, febrile neutropenia, gastrointestinal disorders, hot flush, malaise, nausea, palpitations, skin reactions, urinary disorders, vomiting.
  - Rare or very rare: Bradycardia, cardiovascular disorder, chest discomfort, cognitive disorder, conjunctivitis, cough, disorientation, euphoric mood, gait abnormal, hyperhidrosis, increased risk of infection, muscle spasms, muscle weakness, oedema, oropharyngeal pain, photosensitivity reaction, polydipsia, seborrhoea, severe cutaneous adverse reactions (SCARs), sneezing, stomatitis, taste altered, throat irritation, tinnitus, weight decreased.
  - Frequency not known: Dysarthria, dyspnoea, insomnia, miosis, sensation abnormal, visual acuity decreased, wheezing.

- **CONCEPTION AND CONTRACEPTION** Manufacturer advises effectiveness of hormonal contraceptives may be reduced—alternative non-hormonal methods of contraception necessary during treatment and for 2 months after stopping aprepitant.

- **PREGNANCY** Manufacturer advises avoid unless clearly necessary—no information available.

- **BREAST FEEDING** Manufacturer advises avoid—present in milk in animal studies.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in moderate to severe impairment—limited information available.

- **NATIONAL FUNDING/ACCESS DECISIONS**

  **Scottish Medicines Consortium (SMC) decisions**
  The Scottish Medicines Consortium has advised (June 2017) that aprepitant (Emend®) is accepted for use within NHS Scotland as part of combination therapy, for the prevention of nausea and vomiting associated with moderately emetogenic cancer chemotherapy in infants, toddlers and children from the age of six months to less than 12 years (powder for oral suspension) and adolescents from the age of 12 years to 17 years (hard capsules). The Scottish Medicines Consortium has advised (July 2017) that aprepitant (Emend®) is accepted for use within NHS Scotland as part of combination therapy, for the prevention of nausea and vomiting associated with highly emetogenic cancer chemotherapy in children from the age of six months to under 12 years (powder for oral suspension), and adolescents from the age of 12 years to 17 years (hard capsules).

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension
  - Powder: Emend (Merck Sharp & Dohme Ltd).
    - Aprepitant 125 mg: Emend 125mg oral powder sachets | 1 sachet £15.81
  - Capsule: Emend (Merck Sharp & Dohme Ltd).
    - Aprepitant 80 mg: Emend 80mg capsules | 2 capsule £31.61
    - Aprepitant 125 mg: Emend 125mg capsules | 5 capsule £79.03

- **INDICATIONS AND DOSE**
  **Adjuvant to 5HT_3-receptor antagonist (with or without dexamethasone) in preventing nausea and vomiting associated with moderately and highly emetogenic chemotherapy**
  - By intravenous infusion:
    - Child 6 months-11 years (body-weight 6 kg and above): Initially 3 mg/kg (max. per dose 115 mg) on day 1 of cycle, then 2 mg/kg (max. per dose 80 mg) on days 2 and 3 of cycle, dose to be administered over 60 minutes and completed 30 minutes before chemotherapy, consult product literature for dose of concomitant corticosteroid and 5HT_3-receptor antagonist and for information on alternative dosing for single and multi-day regimens.
    - Child 12-17 years: Initially 115 mg on day 1 of cycle, then 80 mg on days 2 and 3 of cycle, dose to be administered over 30 minutes and completed 30 minutes before chemotherapy, consult product literature for dose of concomitant corticosteroid and 5HT_3-receptor antagonist and for information on alternative dosing for single and multi-day regimens.

- **DRUG ACTION** Aprepitant is a prodrug of aprepitant.

- **CONTRA-INDICATIONS** Acute porphyrias p. 624

- **INTERACTIONS** → Appendix 1: fosaprepitant

- **SIDE-EFFECTS**
  - Common or very common: Appetite decreased, asthenia, constipation, flushing, gastrointestinal discomfort, headache, hiccup.
  - Uncommon: Anaemia, anxiety, burping, dizziness, drowsiness, dry mouth, febrile neutropenia, gastrointestinal disorders, malaise, nausea, palpitations, skin reactions, thrombophlebitis, urinary disorders, vomiting.
  - Rare or very rare: Bradycardia, cardiovascular disorder, chest discomfort, cognitive disorder, conjunctivitis, cough, disorientation, euphoric mood, gait abnormal, hyperhidrosis, increased risk of infection, muscle spasms, muscle weakness, oedema, oropharyngeal pain, photosensitivity reaction, polydipsia, seborrhoea, severe cutaneous adverse reactions (SCARs), sneezing, stomatitis, taste altered, throat irritation, tinnitus, weight decreased.
  - Frequency not known: Dysarthria, dyspnoea, insomnia, miosis, sensation abnormal, visual acuity decreased, wheezing.

- **CONCEPTION AND CONTRACEPTION** Effectiveness of hormonal contraceptives reduced—effective non-hormonal methods of contraception necessary during treatment and for 2 months after stopping fosaprepitant.

- **PREGNANCY** Avoid unless potential benefit outweighs risk—no information available.

- **BREAST FEEDING** Avoid—present in milk in animal studies.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in moderate to severe impairment—limited information available.

- **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion (Ivemend®), manufacturer advises give intermittently in Sodium chloride 0.9%; reconstitute each 150 mg vial with 5 mL sodium chloride 0.9% gently without shaking to avoid foaming, then dilute in 145 mL infusion fluid; for volumes less than 150 mL, transfer the required volume to a bag or syringe prior to infusion; infuse through central venous catheter.

Fosaprepitant

**29-Aug-2018**

- **DRUG ACTION** Fosaprepitant is a prodrug of aprepitant.
Nausea and labyrinth disorders 271

**Ondansetron**

**DRUG ACTION** Ondansetron is a specific 5HT3-receptor antagonist which blocks 5HT3 receptors in the gastrointestinal tract and in the CNS.

**INDICATIONS AND DOSE**

**Prevention of postoperative nausea and vomiting**
- **BY SLOW INTRAVENOUS INJECTION**
  - Child: 100 micrograms/kg (max. per dose 4 mg) for 1 dose, dose to be given over at least 30 seconds before, during, or after induction of anaesthesia

**Treatment of postoperative nausea and vomiting**
- **BY SLOW INTRAVENOUS INJECTION**
  - Child: 100 micrograms/kg (max. per dose 4 mg) for 1 dose, dose to be given over at least 30 seconds

**Prevention and treatment of chemotherapy- and radiotherapy-induced nausea and vomiting—initial dose**
- **BY INTRAVENOUS INFUSION**
  - Child 6 months–17 years (body surface area up to 1.3 m²): 5 mg/m² for 1 dose then give orally, alternatively 150 micrograms/kg (max. per dose 8 mg), dose to be administered immediately before chemotherapy, then 150 micrograms/kg every 4 hours (max. per dose 8 mg) for 2 further doses then give orally; maximum 32 mg per day
  - Child 6 months–17 years (body surface area 1.3 m² and above): 8 mg for 1 dose then give orally, alternatively 150 micrograms/kg (max. per dose 8 mg), dose to be administered immediately before chemotherapy, then 150 micrograms/kg every 4 hours (max. per dose 8 mg) for 2 further doses then give orally, intravenous infusion to be administered over at least 15 minutes; maximum 32 mg per day

**Prevention and treatment of chemotherapy- and radiotherapy-induced nausea and vomiting—(follow-on dose based on body surface area)**
- **BY MOUTH**
  - Child 6 months–17 years (body surface area up to 0.6 m²): 2 mg every 12 hours for up to 5 days (dose can be started 12 hours after intravenous administration); maximum 32 mg per day
  - Child 6 months–17 years (body surface area 0.6–1.2 m²): 4 mg every 12 hours for up to 5 days (dose can be started 12 hours after intravenous administration); maximum 32 mg per day
  - Child 6 months–17 years (body surface area 1.3 m² and above): 8 mg every 12 hours for up to 5 days (dose can be started 12 hours after intravenous administration); maximum 32 mg per day
Prevention and treatment of chemotherapy- and radiotherapy-induced nausea and vomiting—(follow-on dose based on body weight)

▶ By mouth

Child 6 months–17 years (body-weight up to 10.1 kg): 2 mg every 12 hours for up to 5 days (dose can be started 12 hours after intravenous administration); maximum 32 mg per day.

Child 6 months–17 years (body-weight 10.1–40 kg): 4 mg every 12 hours for up to 5 days (dose can be started 12 hours after intravenous administration); maximum 32 mg per day.

Child 6 months–17 years (body-weight 41 kg and above): 8 mg every 12 hours for up to 5 days (dose can be started 12 hours after intravenous administration); maximum 32 mg per day.

• UNLICENSED USE Not licensed for radiotherapy-induced nausea and vomiting in children.

• CONTRA-INDICATIONS Congenital long QT syndrome

• CAUTIONS Adenotonsillar surgery • subacute intestinal obstruction • susceptibility to QT-interval prolongation (including electrolyte disturbances)

• INTERACTIONS ▶ Appendix 1: ondansetron

• SIDE-EFFECTS

▶ Common or very common

Constipation • feeling hot • headache • sensation abnormal

▶ Uncommon

Arrhythmias • chest pain • hiccups • hypotension • movement disorders • oculogyric crisis • seizure

▶ Rare or very rare

Dizziness • QT interval prolongation • vision disorders

• PREGNANCY No information available; avoid unless potential benefit outweighs risks.

• BREAST FEEDING Present in milk in animal studies—avoid.

• HEPATIC IMPAIRMENT Manufacturer advises caution in moderate to severe impairment (decreased clearance).

Dose adjustments Manufacturer advises a reduced maximum daily dose in moderate to severe impairment—consult product literature.

• DIRECTIONS FOR ADMINISTRATION

With intravenous use For intravenous infusion, dilute to a concentration of 320–640 micrograms/mL with glucose 5% or Sodium Chloride 0.9%; give over at least 15 minutes.

With oral use Ondansetron hydrochloride syrup contains 43 micrograms/mL. Ondansetron 8 mg film coated tablets contain 8 mg ondansetron hydrochloride.

• PRESCRIBING AND DISPENSING INFORMATION Flavours of oral liquid formulations may include strawberry.

• PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer orodispersible films and lyophilisates.

• MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

Tablet

▶ Ondansetron (Non-proprietary)

Ondansetron (as Ondansetron hydrochloride) 4 mg Ondansetron 4 mg tablets | 10 tablet (Pack) £0.81–£25.46 DT = £9.94 | 30 tablet (Pack) £3.15–£76.38

Ondansetron (as Ondansetron hydrochloride) 8 mg Ondansetron 8 mg tablets | 10 tablet (Pack) £4.71–£99.95 DT = £10.31

Ondansetron (as Ondansetron hydrochloride) 8 mg Ondansetron 8 mg tablets | 10 tablet (Pack) £4.71–£99.95 DT = £10.31

Ondansetron (as Ondansetron hydrochloride) 8 mg Zofran 8 mg tablets | 10 tablet (Pack) £17.91

Ondansetron (as Ondansetron hydrochloride) 8 mg Zofran 8 mg tablets | 10 tablet (Pack) £17.91

Solution for injection

▶ Ondansetron (Non-proprietary)

Ondansetron (as Ondansetron hydrochloride) 2 mg per 1 ml Ondansetron 8 mg/4 ml solution for injection ampoules | 5 ampoule (Pack) £11.80–£38.45 DT = £59.95

Ondansetron 4 mg/2 ml solution for injection ampoules | 5 ampoule (Pack) £5.00–£29.97 DT = £29.97 | 1 ampoule (Pack) £15.00 DT = £15.00

Zofran Flexi-amp (Novartis Pharmaceuticals UK Ltd)

Ondansetron (as Ondansetron hydrochloride) 2 mg per 1 ml Zofran Flexi-amp 8 mg/4 ml solution for injection | 5 ampoule (Pack) £39.95 DT = £39.95

Zofran Flexi-amp 4 mg/2 ml solution for injection | 5 ampoule (Pack) £29.97 DT = £29.97

Oral solution

▶ Ondansetron (Non-proprietary)

Ondansetron (as Ondansetron hydrochloride) 800 microgram per 1 ml Ondansetron 4 mg/5 ml oral solution sugar free sugar-free | 50 ml (Pack) £38.11 DT = £38.10

Zofran (Novartis Pharmaceuticals UK Ltd)

Ondansetron (as Ondansetron hydrochloride) 800 microgram per 1 ml Zofran 4 mg/5 ml syrup sugar-free | 50 ml (Pack) £35.97 DT = £38.10

Orodispersible film

▶ Setofilm (Norgine Pharmaceuticals Ltd)

Ondansetron 4 mg Setofilm 4 mg orodispersible films sugar-free | 10 film (Pack) £28.50 DT = £28.50

Ondansetron 8 mg Setofilm 8 mg orodispersible films sugar-free | 10 film (Pack) £57.00 DT = £57.00

Oral lyophilisate

EXCIPIENTS: May contain Aspartame

Zofran Melt (Novartis Pharmaceuticals UK Ltd)

Ondansetron 4 mg Zofran Melt 4 mg oral lyophilisates sugar-free | 10 tablet (Pack) £35.97 DT = £35.97

Ondansetron 8 mg Zofran Melt 8 mg oral lyophilisates sugar-free | 10 tablet (Pack) £71.94 DT = £71.94

Orodispersible tablet

▶ Ondansetron (Non-proprietary)

Ondansetron 4 mg Ondansetron 4 mg orodispersible tablets | 10 tablet (Pack) £43.46 DT = £43.46

Ondansetron 8 mg Ondansetron 8 mg orodispersible tablets | 10 tablet (Pack) £85.43 DT = £85.43

ANTIHISTAMINES ▶ SEDATING

Cinnarizine

09-Jul-2018

▶ INDICATIONS AND DOSE

Relief of symptoms of vestibular disorders, such as vertigo, tinnitus, nausea, and vomiting in Ménière’s disease

▶ BY MOUTH

Child 5–11 years: 15 mg 3 times a day

Child 12–17 years: 30 mg 3 times a day

Motion sickness

▶ BY MOUTH

Child 5–11 years: Initially 15 mg, dose to be taken 2 hours before travel, then 7.5 mg every 8 hours if required, dose to be taken during journey

Child 12–17 years: Initially 30 mg, dose to be taken 2 hours before travel, then 15 mg every 8 hours if required, dose to be taken during journey

• CONTRA-INDICATIONS Avoid in Acute porphyrias p. 624 (due to significant antimuscarinic activity) (in neonates)

• CAUTIONS

Epilepsy • glaucoma • pyloroduodenal obstruction • urinary retention

• INTERACTIONS ▶ Appendix 1: antihistamines, sedating

• SIDE-EFFECTS

▶ Common or very common

Drowsiness • gastrointestinal discomfort • nausea • weight increased

▶ Uncommon

Fatigue • hyperhidrosis • vomiting

Frequency not known

Dry mouth • gastrointestinal disorder • headache • jaundice cholestatic • movement disorders

BNFC 2019–2020
Promazine teoclate

- **INDICATIONS AND DOSE**
  - **Nausea | Vomiting | Labyrinthine disorders**
    - **BY MOUTH**
    - Child 5–9 years: 12.5–37.5 mg daily
    - Child 10–17 years: 25–75 mg daily; maximum 100 mg per day
  - **Motion sickness prevention (acts longer than promethazine hydrochloride)**
    - **BY MOUTH**
    - Child 5–9 years: 12.5 mg once daily, dose to be taken at bedtime on night before travel or 1–2 hours before travel
    - Child 10–17 years: 25 mg once daily, dose to be taken at bedtime on night before travel or 1–2 hours before travel
  - **Motion sickness treatment (acts longer than promethazine hydrochloride)**
    - **BY MOUTH**
    - Child 5–9 years: 12.5 mg, dose to be taken at onset of motion sickness, then 12.5 mg daily for 2 days, dose to be taken at bedtime
    - Child 10–17 years: 25 mg, dose to be taken at onset of motion sickness, then 25 mg once daily for 2 days, dose to be taken at bedtime

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM advice (March 2008 and February 2009) over-the-counter cough and cold medicines for children

Children under 6 years should not be given over-the-counter cough and cold medicines containing promazine.

- **CONTRA-INDICATIONS**
  - Neonate (due to significant antimuscarinic activity) (in neonates) · should not be given to children under 2 years, except on specialist advice, because the safety of such use has not been established

**CAUTIONS**

- Asthma · bronchiectasis · bronchitis · epilepsy · pyloroduodenal obstruction · Reye’s syndrome · severe coronary artery disease · susceptibility to angle-closure glaucoma · urinary retention

**INTERACTIONS**

- **Appendix 1: antihistamines, sedating**
- **Anticholinergic syndrome**
- **Avoid:** sedating antihistamines in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitation, and tremor.

**SIDE-EFFECTS**

- **Anticholinergic syndrome** · anxiety · appetite decreased · arrhythmia · blood disorder · bronchial secretion viscosity increased · confusion · dizziness · drowsiness · dry mouth · epigastric discomfort · fatigue · haemolytic anaemia · headache · hypotension · jaundice · movement disorders · muscle spasms · nightmare · palpitations · photosensitivity reaction · urinary retention · vision blurred

**SIDE-EFFECTS, FURTHER INFORMATION**

Paradoxical stimulation may occur, especially with high doses.

**INTERACTIONS**

- Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity. Use in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitability, and tremor.

**BEST USAGE**

- Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution in hepatic insufficiency — no information available.

**RENAL IMPAIRMENT**

- Use with caution — no information available.

**PATIENT AND CARER ADVICE**

- Driving and skilled tasks: Drowsiness may affect performance of skilled tasks (e.g., cycling, driving); sedating effects enhanced by alcohol.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**

- **CAUTIONARY AND ADVISORY LABELS 2**
  - Cinnarizine (Non-proprietary)
    - Cinnarizine 15 mg Cinnarizine 15 mg tablets | 84 tablet | £15.40
  - **Stugeron** (Johnson & Johnson Ltd; Janssen-Cilag Ltd)
    - Cinnarizine 15 mg Stugeron 15 mg tablets | 15 tablet | £2.21 | 100 tablet | £4.18

**ANTIMUSCARINICS**

**Hyoscine hydrobromide**

(Scopolamine hydrobromide)

**30-Mar-2017**

- **INDICATIONS AND DOSE**
  - **Motion sickness**
    - **BY MOUTH**
    - Child 4–9 years: 75–150 micrograms, dose to be taken up to 30 minutes before the start of journey, then 75–150 micrograms every 6 hours if required; maximum 450 micrograms per day
    - Child 10–17 years: 150–300 micrograms, dose to be taken up to 30 minutes before the start of journey, then 150–300 micrograms every 6 hours if required; maximum 900 micrograms per day
    - **BY TRANSDERMAL APPLICATION**
    - Child 10–17 years: Apply 1 patch, apply behind ear 5–6 hours before journey, then apply 1 patch after 72 hours if required, remove old patch and site replacement patch behind the other ear
  - **Hypersalivation associated with clozapine therapy**
    - **BY MOUTH**
    - Child 12-17 years: 300 micrograms up to 3 times a day; maximum 900 micrograms per day

**CAUTIONS**

- Asthma · bronchiectasis · bronchitis · epilepsy · pyloroduodenal obstruction · Reye’s syndrome · severe coronary artery disease · susceptibility to angle-closure glaucoma · urinary retention

**INTERACTIONS**

- **Appendix 1: antihistamines, sedating**
- **Anticholinergic syndrome**
- **Avoid:** sedating antihistamines in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitation, and tremor.

**SIDE-EFFECTS**

- **Anticholinergic syndrome** · anxiety · appetite decreased · arrhythmia · blood disorder · bronchial secretion viscosity increased · confusion · dizziness · drowsiness · dry mouth · epigastric discomfort · fatigue · haemolytic anaemia · headache · hypotension · jaundice · movement disorders · muscle spasms · nightmare · palpitations · photosensitivity reaction · urinary retention · vision blurred

**SIDE-EFFECTS, FURTHER INFORMATION**

Paradoxical stimulation may occur, especially with high doses.

**INTERACTIONS**

- Most manufacturers of antihistamines advise avoiding their use during pregnancy; however, there is no evidence of teratogenicity. Use in the latter part of the third trimester may cause adverse effects in neonates such as irritability, paradoxical excitability, and tremor.

**BEST USAGE**

- Most antihistamines are present in breast milk in varying amounts; although not known to be harmful, most manufacturers advise avoiding their use in mothers who are breast-feeding.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution.

**RENAL IMPAIRMENT**

- Use with caution.

**PATIENT AND CARER ADVICE**

- Driving and skilled tasks: Drowsiness may affect performance of skilled tasks (e.g., cycling, driving); sedating effects enhanced by alcohol.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**

- **CAUTIONARY AND ADVISORY LABELS 2**
  - Avomine (Max Healthcare Ltd)
    - Promethazine teoclate 25 mg Avomine 25 mg tablets | 10 tablet | £1.13 | 28 tablet | £3.13
  - **Vertigon** (Manx Healthcare Ltd)
    - Promethazine teoclate 25 mg Vertigon 25 mg tablets | 28 tablet | £3.13
Nausea and labyrinth disorders  

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Excessive respiratory secretions
- **BY MOUTH, OR BY SUBLINGUAL ADMINISTRATION**
  - Child 2-11 years: 10 micrograms/kg 4 times a day (max. per dose 300 micrograms)
  - Child 12-17 years: 300 micrograms 4 times a day
- **BY TRANSDERMAL APPLICATION**
  - Child 1-month-2 years: 250 micrograms every 72 hours, dose equates to a quarter patch
  - Child 3-9 years: 500 micrograms every 72 hours, dose equates to a half patch
  - Child 10-17 years: 1 mg every 72 hours, dose equates to one patch

Excessive respiratory secretion in palliative care
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAVENOUS INJECTION**
  - Child: 10 micrograms/kg every 4–8 hours (max. per dose 600 micrograms)
- **BY CONTINUOUS SUBCUTANEOUS INFUSION, OR BY INTRAVENOUS INFUSION**
  - Child: 40–60 micrograms/kg over 24 hours

Bowel colic pain in palliative care
- **BY MOUTH USING SUBLINGUAL TABLETS**
  - Child: 10 micrograms/kg 3 times a day (max. per dose 300 micrograms), as Kwells®

Premedication
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Child 1-11 years: 15 micrograms/kg (max. per dose 600 micrograms), to be administered 30–60 minutes before induction of anaesthesia
  - Child 12-17 years: 200–600 micrograms, to be administered 30–60 minutes before induction of anaesthesia
- **BY INTRAVENOUS INJECTION**
  - Child 1-11 years: 15 micrograms/kg (max. per dose 600 micrograms), to be administered immediately before induction of anaesthesia
  - Child 12-17 years: 200–600 micrograms, to be administered immediately before induction of anaesthesia

**SIDE-EFFECTS**
- With transdermal use: Balance impaired
- **PREGNANCY** Use only if potential benefit outweighs risk. Injection may depress neonatal respiration.
- **BREAST FEEDING** Amount too small to be harmful.
- **HEPATIC IMPAIRMENT** Manufacturer advises caution.
- **RENAL IMPAIRMENT** Use with caution.
- **DIRECTIONS FOR ADMINISTRATION**
  - With transdermal use: Patch applied to hairless area of skin behind ear; if less than whole patch required either cut with scissors along full thickness ensuring membrane is not peeled away or cover portion to prevent contact with skin.
  - With oral use: For administration by mouth, injection solution may be given orally.

**PRESCRIBING AND DISPENSING INFORMATION** Flavours of chewable tablet formulations may include raspberry.

**Palliative care** For further information on the use of hyoscine hydrobromide in palliative care, see www.medicinescomplete.com/#/content/palliative/hyoscine-hydrobromide.

**PATIENT AND CARER ADVICE**
- With transdermal use: Explain accompanying instructions to patient and in particular emphasise advice to wash hands after handling and to wash application site after removing, and to use one patch at a time.
- Driving and skilled tasks: Use with transdermal use: Drowsiness may persist for up to 24 hours or longer after removal of patch; effects of alcohol enhanced.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 2
- **Kwells** (Bayer Plc)
  - Hyoscine hydrobromide 150 microgram
  - Kwells Kids 150 microgram tablets | 12 tablet | £1.84 DT = £1.84
  - Hyoscine hydrobromide 300 microgram
  - Kwells 300 microgram tablets | 12 tablet | £1.84 DT = £1.84
- **Travel Calm** (The Boots Company Plc)
  - Hyoscine hydrobromide 300 microgram
  - Travel Calm 300 microgram tablets | 12 tablet | £1.84 DT = £1.84

**Solution for injection**
- **Hyoscine hydrobromide (Non-proprietary)**
  - Hyoscine hydrobromide 400 microgram per 1 ml
  - Hyoscine hydrobromide 400 micrograms/1ml solution for injection ampoules | 10 ampoule | £0.50–£47.21
  - Hyoscine hydrobromide 600 microgram per 1 ml
  - Hyoscine hydrobromide 600 micrograms/1ml solution for injection ampoules | 10 ampoule | £53.93 DT = £53.93

**Transdermal patch**

**CAUTIONARY AND ADVISORY LABELS** 19
- **Scopoderm** (GlaxoSmithKline Consumer Healthcare)
  - Hyoscine 1 mg per 72 hour
  - Scopoderm 1.5 mg patches | 2 patch | £2.87 DT = £2.87

**Chewable tablet**

**CAUTIONARY AND ADVISORY LABELS** 2, 24
- **Joy-Rides** (Teva UK Ltd)
  - Hyoscine hydrobromide 150 microgram
  - Joy-rides 150 microgram chewable sugar-free | 12 tablet | £1.55 DT = £1.55

**IMPORTANT SAFETY INFORMATION**

Antimuscarinic drugs used for premedication to general anaesthesia should only be administered by, or under the direct supervision of, personnel experienced in their use.

**UNLICENSED USE** Not licensed for use in excessive respiratory secretions or hypersalivation associated with clozapine therapy.

**CAUTIONS**

**Epilepsy**

**CAUTIONS, FURTHER INFORMATION**

**Anticholinergic syndrome**

**With systemic use** In some children hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness).

**INTERACTIONS** → Appendix 1: hyoscine

**SIDE-EFFECTS**

**Common or very common**

**With transdermal use** Eye disorders - eyelid irritation

**Rare or very rare**

**With transdermal use** Concentration impaired - glaucoma - hallucinations - memory loss - restlessness

**Frequency not known**

**With oral use** Asthma - cardiovascular disorders - central nervous system stimulation - gastrointestinal disorder - hallucination - hypersensitivity - hyperthermia - hypohidrosis - mydriasis - oedema - respiratory tract reaction - restlessness - seizure

**With parenteral use** Agitation - angle closure glaucoma - arrhythmias - delirium - dysphagia - dysepsia - epilepsy exacerbated - hallucination - hypersensitivity - idiosyncratic drug reaction - loss of consciousness - mydriasis - neuroleptic malignant syndrome - psychotic disorders - thirst

**With transdermal use** Balance impaired
**ANTIPSYCHOTICS > FIRST-GENERATION**

**Droperidol**

15-Mar-2017

**DRUG ACTION** Droperidol is a butyrophenone, structurally related to haloperidol, which blocks dopamine receptors in the chemoreceptor trigger zone.

**INDICATIONS AND DOSE**

Prevention and treatment of postoperative nausea and vomiting

- **BY INTRAVENOUS INJECTION**
  - Child 2-17 years: 20–50 micrograms/kg (max. per dose 1.25 mg), dose to be given 30 minutes before end of surgery, then 20–50 micrograms/kg every 6 hours (max. per dose 1.25 mg) if required

**CONTRA-INDICATIONS** Bradycardia · CNS depression · comatose states · hypokalaemia · hypomagnesaemia · phaeochromocytoma · QT-interval prolongation

**CAUTIONS** Chronic obstructive pulmonary disease · electrolyte disturbances · history of alcohol abuse · respiratory failure

**INTERACTIONS** → Appendix 1: droperidol

**SIDE-EFFECTS**

- Uncommon Anxiety · oculogyration
- Rare or very rare Blood disorder · cardiac arrest · confusion · dysphoria
- Frequency not known Coma · epilepsy · hallucination · oligomenorrhoea · respiratory disorders · SIADH · syncope

**BREAST FEEDING** Limited information available—avoid repeated administration.

**HEPATIC IMPAIRMENT** Manufacturer advises caution.

Dose adjustments Manufacturer advises maximum 625 micrograms repeated every 6 hours as required.

**RENAL IMPAIRMENT** Dose adjustments In postoperative nausea and vomiting, max. 625 micrograms repeated every 6 hours as required.

**MONITORING REQUIREMENTS** Continuous pulse oximetry required if risk of ventricular arrhythmia—continue for 30 minutes following administration.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Droperidol (Non-proprietary)**
  - 2.5 mg per 1 ml Droperidol 2.5 mg/ml solution for injection ampoules | 10 ampoule £35.40
  - **Xomolix** (Kyowa Kirin Ltd)
    - Droperidol 2.5 mg per 1 ml Xomolix 2.5mg/ml solution for injection ampoules | 10 ampoule £39.40

**Levomepromazine**

(Methotrimeprazine)

12-Dec-2016

**INDICATIONS AND DOSE**

Restlessness and confusion in palliative care

- **BY CONTINUOUS SUBCUTANEOUS INFUSION**
  - Child 1-11 years: 0.35–3 mg/kg, to be administered over 24 hours
  - Child 12-17 years: 12.5–200 mg, to be administered over 24 hours

Nausea and vomiting in palliative care

- **BY CONTINUOUS INTRAVENOUS INFUSION, OR BY SUBCUTANEOUS INFUSION**
  - Child 1 month-11 years: 100–400 micrograms/kg, to be administered over 24 hours
  - Child 12-17 years: 5–25 mg, to be administered over 24 hours

**CONTRA-INDICATIONS** CNS depression · comatose states · phaeochromocytoma

**CAUTIONS** Patients receiving large initial doses should remain supine

**INTERACTIONS** → Appendix 1: phenothiazines

**SIDE-EFFECTS**

- Common or very common Asthenia · heat stroke
- Rare or very rare Cardiac arrest · hepatic disorders
- Frequency not known Allergic dermatitis · confusion · delirium · gastrointestinal disorders · glucose tolerance impaired · hyperglycaemia · hypoaesthesia · photosensitivity reaction · priapism · SIADH

**HEPATIC IMPAIRMENT** Manufacturer advises consider avoiding.

**RENAL IMPAIRMENT**

Dose adjustments Start with small doses in severe renal impairment because of increased cerebral sensitivity.

**DIRECTIONS FOR ADMINISTRATION** For administration by subcutaneous infusion dilute with a suitable volume of Sodium Chloride 0.9%.

**PRESCRIBING AND DISPENSING INFORMATION**

Palliative care For further information on the use of levomepromazine in palliative care, see www.medicinescomplete.com/#/content/palliative/levomepromazine.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Levomepromazine (Non-proprietary)**
  - Levomepromazine hydrochloride 25 mg per 1 ml Levomepromazine 25mg/1ml solution for injection ampoules | 10 ampoule £20.13 DT = £20.13
  - **Noziman** (Sanofi)
    - Levomepromazine hydrochloride 25 mg per 1 ml Noziman 25mg/1ml solution for injection ampoules | 10 ampoule £20.13 DT = £20.13

**Prochlorperazine**

**INDICATIONS AND DOSE**

Prevention and treatment of nausea and vomiting

- **BY MOUTH**
  - Child 1-11 years (body-weight 10 kg and above): 250 micrograms/kg 2–3 times a day
  - Child 12-17 years: 5–10 mg up to 3 times a day if required
  - **BY INTRAMUSCULAR INJECTION**
    - Child 2–4 years: 1.25–2.5 mg up to 3 times a day if required
    - Child 5–11 years: 5–6.25 mg up to 3 times a day if required
    - Child 12–17 years: 12.5 mg up to 3 times a day if required

**Nausea and vomiting in previously diagnosed migraine**

- **BY MOUTH USING BUCAL TABLET**
  - Child 12-17 years: 3–6 mg twice daily, tablets to be placed high between upper lip and gum and left to dissolve

**DOSE EQUIVALENCE AND CONVERSION**

- Doses are expressed as prochlorperazine maleate or prochlorperazine mesilate.
  - 1 mg prochlorperazine maleate = 1 mg prochlorperazine mesilate.

**UNLICENSED USE**

- With intramuscular use Injection not licensed for use in children.
- With buccal use Buccastem M® tablets not licensed for use in children.
CONTRA-INDICATIONS Avoid oral route in child under 10 kg
- children (in psychotic disorders) - CNS depression - comatose states - phaeochromocytoma

CAUTIONS Hypotension (more likely after intramuscular injection)

INTERACTIONS Appendix 1: phenothiazines

DIRECTIONS FOR ADMINISTRATION

RENAL IMPAIRMENT
- Frequency not known
- Rare or very rare
- With buccal use
- Oral disorders
- With intramuscular use
- Atroventricular block - cardiac arrest - eye disorders - jaundice - muscle rigidity - nasal congestion - respiratory depression
- With oral use
- Atroventricular block - autonomic dysfunction - cardiac arrest - consciousness impaired - hyperthermia - jaundice - muscle rigidity - nasal congestion - oculogyric crisis - respiratory depression

SIDE-EFFECTS

GENERAL SIDE-EFFECTS
- Rare or very rare
- With buccal use
- Blood disorder - hepatic disorders
- Frequency not known
- With buccal use
- Oral disorders
- With intramuscular use
- Atroventricular block - cardiac arrest - eye disorders - jaundice - muscle rigidity - nasal congestion - respiratory depression
- With oral use
- Atroventricular block - autonomic dysfunction - cardiac arrest - consciousness impaired - hyperthermia - jaundice - muscle rigidity - nasal congestion - oculogyric crisis - respiratory depression

SIDE-EFFECTS, FURTHER INFORMATION

Acute dystonias are more common with first-generation antipsychotics. The risk is increased in men, young adults, children, antipsychotic-naïve patients, rapid dose escalation, and abrupt treatment discontinuation.

Hepatic Impairment

Manufacturer advises avoid.

Renal Impairment

Dose adjustments
- Start with small doses in severe renal impairment because of increased cerebral sensitivity.

DIRECTIONS FOR ADMINISTRATION
- With buccal use
- Buccal tablets are placed high between upper lip and gum and left to dissolve.

PATIENT AND CARER ADVICE
- With buccal use
- Patients or carers should be given advice on how to administer prochlorperazine buccal tablets.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS 2
- Prochlorperazine (Non-proprietary)
- Prochlorperazine maleate 5 mg
  - Prochlorperazine maleate 5 mg tablets | 28 tablet (£0.98) £0.73 | 84 tablet (£2.10–£2.58
- Stemetil (Sanofi)
- Prochlorperazine maleate 5 mg
  - Stemetil 5 mg tablets | 28 tablet (£1.98) £0.73 | 84 tablet (£5.94

Solution for injection
- Stemetil (Sanofi)
- Prochlorperazine mesilate 12.5 mg per 1 ml
  - Prochlorperazine mesilate 12.5 mg/1 ml solution for injection ampoules | 10 ampoule (£0.23) £0.23

Buccal tablet

CAUTIONARY AND ADVISORY LABELS 2
- Prochlorperazine (Non-proprietary)
- Prochlorperazine maleate 3 mg
  - Prochlorperazine maleate 3 mg buccal tablets | 50 tablet (£5.00–£37.23
- Buccastem (Alliance Pharmaceuticals Ltd)
- Prochlorperazine maleate 3 mg
  - Buccastem 3 mg tablets | 8 tablet (£4.01

Oral solution

CAUTIONARY AND ADVISORY LABELS 2
- Stemetil (Sanofi)
- Prochlorperazine mesilate 1 mg per 1 ml
  - Stemetil 1 mg/5 ml syrup | 100 ml (£3.34) £3.34

5 Pain

Analgescics

Pain relief

The non-opioid drugs, paracetamol p 278 and ibuprofen p 679 (and other NSAIDs), are particularly suitable for pain in musculoskeletal conditions, whereas the opioid analgesics are more suitable for moderate to severe pain, particularly of visceral origin.

Pain in sickle-cell disease

The pain of mild sickle-cell crises is managed with paracetamol, an NSAID, codeine phosphate p 283, or dihydrocodeine tartrate p 285. Severe crises may require the use of morphine p 290 or diamorphine hydrochloride p 284; concomitant use of an NSAID may potentiate analgesia and allow lower doses of the opioid to be used. A mixture of nitrous oxide and oxygen (Entonox® , Equanox®) may also be used.

Dental and orooral pain

Analgesics should be used judiciously in dental care as a temporary measure until the cause of the pain has been dealt with.

Dental pain of inflammatory origin, such as that associated with pulpitis, apical infection, localised osteitis or pericoronitis is usually best managed by treating the infection, providing drainage, restorative procedures, and other local measures. Analgesics provide temporary relief of pain (usually for about 1 to 7 days) until the causative factors have been brought under control. In the case of pulpitis, intra-ossseous infection or abscess, reliance on analgesics alone is usually inappropriate. Similarly the pain and discomfort associated with acute problems of the oral mucosa (e.g. acute herpetic gingivostomatitis, erythema multiforme) may be relieved by benzoylamine hydrochloride p 731 or topical anaesthetics until the cause of the mucosal disorder has been dealt with. However, where a child is febrile, the antipyretic action of paracetamol or ibuprofen is often helpful.

The choice of an analgesic for dental purposes should be based on its suitability for the child. Most dental pain is relieved effectively by non-steroidal anti-inflammatory drugs (NSAIDs) e.g. ibuprofen. Paracetamol has analgesic and antipyretic effects but no anti-inflammatory effect. Opioid analgesics such as dihydrocodeine tartrate act on the central nervous system and are traditionally used for moderate to severe pain. However, opioid analgesics are relatively ineffective in dental pain and their side-effects can be unpleasant.

Combining a non-opioid with an opioid analgesic can provide greater relief of pain than either analgesic given alone. However, this applies only when an adequate dose of each analgesic is used. Most combination analgesic preparations have not been shown to provide greater relief of pain than an adequate dose of the non-opioid component given alone. Moreover, combination preparations have the disadvantage of an increased number of side-effects.

Any analgesic given before a dental procedure should have a low risk of increasing postoperative bleeding. In the case of pain after the dental procedure, taking an analgesic before the effect of the local anaesthetic has worn off can improve control. Postoperative analgesia with ibuprofen is usually continued for about 24 to 72 hours.

Dysmenorrhoea

Paracetamol or a NSAID will generally provide adequate relief of pain from dysmenorrhoea. Alternatively use of a combined hormonal contraceptive in adolescent girls may prevent the pain.
Non-opioid analgesics and compound analgesic preparations

Paracetamol has analgesic and antipyretic properties but no demonstrable anti-inflammatory activity; unlike opioid analgesics, it does not cause respiratory depression and is less irritant to the stomach than the NSAIDs. Overdosage with paracetamol is particularly dangerous as it may cause hepatic damage which is sometimes not apparent for 4 to 6 days.

Non-steroidal anti-inflammatory analgesics (NSAIDs) are particularly useful for the treatment of children with chronic disease accompanied by pain and in children under 16 years except in Kawasaki disease or for its antiplatelet action. Several NSAIDs are also used for postoperative analgesia.

Compound analgesic preparations

Compound analgesic preparations that contain a simple analgesic (such as paracetamol) with an opioid component reduce the scope for effective titration of the individual components in the management of pain of varying intensity.

Compound analgesic preparations containing paracetamol with a low dose of an opioid analgesic (e.g. 8 mg of codeine phosphate per compound tablet) may be used in older children but the advantages have not been substantiated. The low dose of the opioid may be enough to cause opioid side-effects (in particular, constipation) and can complicate the treatment of overdosage yet may not provide significant additional relief of pain. A full dose of the opioid component (e.g. 60 mg codeine phosphate) in compound analgesic preparations effectively augments the analgesic activity but is associated with the full range of opioid side-effects (including nausea, vomiting, severe constipation, drowsiness, respiratory depression, and risk of dependence on long-term administration).

In general, when assessing pain, it is necessary to weigh up carefully whether there is a need for a non-opioid and an opioid analgesic to be taken simultaneously.

Opioid analgesics and dependence

Opioid analgesics are usually used to relieve moderate to severe pain particularly of visceral origin. Repeated administration may cause tolerance, but this is no deterrent in the control of pain in terminal illness. Regular use of a potent opioid may be appropriate for certain cases of chronic non-malignant pain; treatment should be supervised by a specialist and the child should be assessed at regular intervals.

Strong opioids

Morphine remains the most valuable opioid analgesic for severe pain although it frequently causes nausea and vomiting. It is the standard against which other opioid analgesics are compared. In addition to relief of pain, morphine also confers a state of euphoria and mental detachment.

Morphine is the opioid of choice for the oral treatment of severe pain in palliative care. It is given regularly every 4 hours (or every 12 or 24 hours as modified-release preparations).

Buprenorphine p. 281 has both opioid agonist and antagonist properties and may precipitate withdrawal symptoms, including pain, in children dependent on other opioids. It has abuse potential and may itself cause dependence. It has a much longer duration of action than morphine and sublingually is an effective analgesic for 6 to 8 hours. Unlike most opioid analgesics, the effects of buprenorphine are only partially reversed by naloxone hydrochloride p. 869. It is rarely used in children.

Diamorphine hydrochloride p. 284 (heroin) is a powerful opioid analgesic. It may cause less nausea and hypotension than morphine p. 290. In palliative care the greater solubility of diamorphine hydrochloride allows effective doses to be injected in smaller volumes and this is important in the emaciated child. Diamorphine hydrochloride is sometimes given by the intranasal route to treat acute pain in children and is available as a nasal spray; intranasal administration of diamorphine injection has been [unlicensed].

Alfentanil p. 845, fentanyl p. 296 and remifentanil p. 845 are used by injection for intra-operative analgesia. Fentanyl is available in a transdermal drug delivery system as a self-adhesive patch which is changed every 72 hours.

Methadone hydrochloride p. 307 is less sedating than morphine and acts for longer periods. In prolonged use, methadone hydrochloride should not be administered more often than twice daily to avoid the risk of accumulation and opioid overdosage. Methadone hydrochloride may be used instead of morphine when excitation (or exacerbation of pain) occurs with morphine. Methadone hydrochloride may also be used to treat children with neonatal abstinence syndrome.

Papaveretum p. 294 should not be used in children; morphine is easier to prescribe and less prone to error with regard to the strength and dose.

Pethidine hydrochloride p. 295 produces prompt but short-lasting analgesia; it is less constipating than morphine, but even in high doses is a less potent analgesic. Its use in children is not recommended. Pethidine hydrochloride is used for analgesia in labour; however, other opioids, such as morphine or diamorphine hydrochloride, are often preferred for obstetric pain.

Tramadol hydrochloride p. 296 is used in older children and produces analgesia by two mechanisms: an opioid effect and an enhancement of serotonergic and adrenergic pathways. It has fewer of the typical opioid side-effects (notably, less respiratory depression, less constipation and less addiction potential); psychiatric reactions have been reported.

Weak opioids

Codeine phosphate p. 283 can be used for the relief of short-term acute moderate pain in children older than 12 years where other painkillers such as paracetamol p. 278 or ibuprofen p. 679 have proved ineffective. Dihydrocodeine tartrate p. 285 has an analgesic efficacy similar to that of codeine phosphate.

Postoperative analgesia

A combination of opioid and non-opioid analgesics is used to treat postoperative pain. The use of intra-operative opioids affects the prescribing of postoperative analgesics. A postoperative opioid analgesic should be given with care since it may potentiate any residual respiratory depression. Morphine is used most widely. Tramadol hydrochloride is not as effective in severe pain as other opioid analgesics. Buprenorphine p. 281 may antagonise the analgesic effect of previously administered opioids and is generally not recommended. Pethidine hydrochloride is generally not recommended for postoperative pain because it is metabolised to norpethidine which may accumulate, particularly in neonates and in renal impairment; norpethidine stimulates the central nervous system and may cause convulsions.

Opioids are also given epidurally [unlicensed route] in the postoperative period but are associated with side-effects such as pruritus, urinary retention, nausea and vomiting; respiratory depression can be delayed, particularly with morphine.
Patient-controlled analgesia (PCA) and nurse-controlled analgesia (NCA) can be used to relieve postoperative pain—consult hospital protocols.

**Pain management and opioid dependence**

Although caution is necessary, patients who are dependent on opioids or have a history of drug dependence may be treated with opioid analgesics when there is a clinical need. Treatment with opioid analgesics in this patient group should normally be carried out with the advice of specialists. However, doctors do not require a special licence to prescribe opioid analgesics to patients with opioid dependence for relief of pain due to organic disease or injury.

**Other drugs used for Pain**

Diclofenac potassium, p. 275
Levomepromazine, p. 275
Mefenamic acid, p. 682

### ANALGESICS > NON-OPIOID

**Paracetamol**

(Paracetamol)

**INDICATIONS AND DOSE**

**Pain | Pyrexia with discomfort**

- **BY MOUTH**

  - **Neonate 28 weeks to 32 weeks corrected gestational age:**
    - 20 mg/kg for 1 dose, then 10–15 mg/kg every 6–12 hours as required, maximum daily dose to be given in divided doses; maximum 30 mg/kg per day.
  - **Neonate 32 weeks corrected gestational age and above:**
    - 20 mg/kg for 1 dose, then 10–15 mg/kg every 6–8 hours as required, maximum daily dose to be given in divided doses; maximum 60 mg/kg per day.
  - **Child 1–2 months:**
    - 30–60 mg every 8 hours as required, maximum daily dose to be given in divided doses; maximum 60 mg/kg per day
  - **Child 3–5 months:**
    - 60 mg every 4–6 hours; maximum 4 doses per day
  - **Child 6–23 months:**
    - 120 mg every 4–6 hours; maximum 4 doses per day
  - **Child 2–3 years:**
    - 180 mg every 4–6 hours; maximum 4 doses per day
  - **Child 4–5 years:**
    - 240 mg every 4–6 hours; maximum 4 doses per day
  - **Child 6–7 years:**
    - 240–250 mg every 4–6 hours; maximum 4 doses per day
  - **Child 8–9 years:**
    - 360–375 mg every 4–6 hours; maximum 4 doses per day
  - **Child 10–11 years:**
    - 480–500 mg every 4–6 hours; maximum 4 doses per day
  - **Child 12–15 years:**
    - 480–750 mg every 4–6 hours; maximum 4 doses per day
  - **Child 16–17 years:**
    - 0.5–1 g every 4–6 hours; maximum 4 doses per day
  - **BY RECTUM**

  - **Neonate 28 weeks to 32 weeks corrected gestational age:**
    - 20 mg/kg for 1 dose, then 10–15 mg/kg every 12 hours as required, maximum daily dose to be given in divided doses; maximum 30 mg/kg per day.
  - **Neonate 32 weeks corrected gestational age and above:**
    - 30 mg/kg for 1 dose, then 15–20 mg/kg every 8 hours as required, maximum daily dose to be given in divided doses; maximum 60 mg/kg per day.
  - **Child 1–2 months:**
    - 30–60 mg every 8 hours as required, maximum daily dose to be given in divided doses; maximum 60 mg/kg per day.

**Pain in children with risk factors for hepatotoxicity | Pyrexia with discomfort in children with risk factors for hepatotoxicity**

- **BY INTRAVENOUS INFUSION**

  - **Neonate 32 weeks corrected gestational age and above:**
    - 7.5 mg/kg every 8 hours, dose to be administered over 15 minutes.
  - **Neonate:**
    - 10 mg/kg every 4–6 hours, dose to be administered over 15 minutes; maximum 30 mg/kg per day.
  - **Child (body-weight up to 10 kg):**
    - 10 mg/kg every 4–6 hours, dose to be administered over 15 minutes; maximum 30 mg/kg per day
  - **Child (body-weight 10–50 kg):**
    - 15 mg/kg every 4–6 hours, dose to be administered over 15 minutes; maximum 60 mg/kg per day
  - **Child (body-weight 50 kg and above):**
    - 1 g every 4–6 hours, dose to be administered over 15 minutes; maximum 4 g per day

**Post-operative pain**

- **BY MOUTH**

  - **Child 1 month–5 years:**
    - 20–30 mg/kg for 1 dose, then 15–20 mg/kg every 4–6 hours, maximum daily dose to be given in divided doses; maximum 75 mg/kg per day
  - **Child 6–11 years:**
    - 20–30 mg/kg (max. per dose 1 g) for 1 dose, then 15–20 mg/kg every 4–6 hours, maximum daily dose to be given in divided doses; maximum 75 mg/kg per day; maximum 4 g per day
  - **Child 12–17 years:**
    - 1 g every 4–6 hours; maximum 4 doses per day
  - **BY RECTUM**

  - **Child 1–2 months:**
    - 30 mg/kg for 1 dose, then 15–20 mg/kg every 4–6 hours, maximum daily dose to be given in divided doses; maximum 75 mg/kg per day
  - **Child 3 months–5 years:**
    - 30–40 mg/kg for 1 dose, then 15–20 mg/kg every 4–6 hours, maximum daily dose to be given in divided doses; maximum 75 mg/kg per day; maximum 4 g per day
  - **Child 6–11 years:**
    - 30–40 mg/kg (max. per dose 1 g) for 1 dose, then 15–20 mg/kg every 4–6 hours, maximum daily dose to be given in divided doses; maximum 75 mg/kg per day; maximum 4 g per day
  - **Child 12–17 years:**
    - 1 g every 4–6 hours; maximum 4 doses per day
Prophylaxis of post-immunisation pyrexia following immunisation with meningococcal group B vaccine (Bexsero®) given as part of the routine immunisation schedule

- **By mouth**
  - Child 2 months: 60 mg, first dose to be given at the time of vaccination, then 60 mg after 4–6 hours, then 60 mg after 4–6 hours, use weight-based doses for preterm infants born at less than 32 weeks gestation and currently weighing less than 4 kg—see oral doses for pain and pyrexia with discomfort
  - Child 4 months: 60 mg, first dose to be given at the time of vaccination, then 60 mg after 4–6 hours, then 60 mg after 4–6 hours, use weight-based doses for preterm infants born at less than 32 weeks gestation and currently weighing less than 4 kg—see oral doses for pain and pyrexia with discomfort

Post-immunisation pyrexia in infants

- **By mouth**
  - Child 2–3 months: 60 mg for 1 dose, then 60 mg after 4–6 hours if required
  - Child 4 months: 60 mg for 1 dose, then 60 mg after 4–6 hours; maximum 4 doses per day

- **Unlicensed use** Paracetamol oral suspension 500 mg/5 mL not licenced for use in children under 16 years. Not licenced for use in children under 2 months by mouth; under 3 months by rectum. Not licenced for use as prophylaxis of post-immunisation pyrexia following immunisation with meningococcal group B vaccine. 

- **Caution** Before administering, check when paracetamol last administered and cumulative paracetamol dose over previous 24 hours · body-weight under 50 kg · chronic alcohol consumption · chronic dehydration · chronic malnutrition · hepatocellular insufficiency · long-term use (especially in those who are malnourished)

- **Caution, further information** Some patients may be at increased risk of experiencing toxicity at therapeutic doses, particularly those with a body-weight under 50 kg and those with risk factors for hepatotoxicity. Clinical judgement should be used to adjust the dose of oral and intravenous paracetamol in these patients.

- **Co-administration of enzyme-inducing antiepileptic medications may increase toxicity; doses should be reduced.**

- **Interactions** → Appendix 1: paracetamol

- **Side-effects**
  - **General side-effects**
  - Rare or very rare
  - Thrombocytopenia

  - **Specific side-effects**
  - Common or very common
  - With rectal use: Anorectal erythema
  - Rare or very rare
  - With intravenous use: Hypersensitivity · Hypotension · Leucopenia · Malaise · Neutropenia
  - With rectal use: Angioedema · Liver injury · Skin reactions
  - Frequency not known
  - With intravenous use: Flushing · Skin reactions · Tachycardia
  - With oral use: Agranulocytosis · Bronchospasm · Hepatic function abnormal · Rash · Severe cutaneous adverse reactions (SCARs)
  - With rectal use: Agranulocytosis · Blood disorder · Severe cutaneous adverse reactions (SCARs)

- **Overdose** Liver damage and less frequently renal damage can occur following overdose.

  - Nausea and vomiting, the only early features of poisoning, usually settle within 24 hours. Persistence beyond this time, often associated with the onset of right subcostal pain and tenderness, usually indicates development of hepatic necrosis.

  - **Pregnancy** Not known to be harmful.
  - **Breast feeding** Amount too small to be harmful.
  - **Hepatic impairment** Dose-related toxicity—avoid large doses.
  - **Renal impairment** Dose adjustments. Increase infusion dose interval to every 6 hours if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- **Directions for administration**
  - With intravenous use: For intravenous infusion (Perfalgan®), give in Glucose 5% or Sodium Chloride 0.9%; dilute to a concentration of not less than 1 mg/mL and use within an hour; may also be given undiluted. For children under 33 kg, use 50 mL-vial.
  - **Prescribing and dispensing information** BP directs that when Paediatric Paracetamol Oral Suspension or Paediatric Paracetamol mixture is prescribed Paracetamol Oral Suspension 120 mg/5 mL should be dispensed.

- **Patient and carer advice**
  - Medicines for Children leaflet: Paracetamol for mild-to-moderate pain www.medicinesforchildren.org.uk/paracetamol-mild-moderate-pain

- **Profession specific information**
  - Dental practitioners’ formulary
  - Paracetamol Tablets may be prescribed.
  - Paracetamol Soluble Tablets 500 mg may be prescribed.
  - Paracetamol Oral Suspension may be prescribed.

- **Exceptions to legal category**
  - Paracetamol capsules or tablets can be sold to the public provided packs contain no more than 32 capsules or tablets; pharmacists can sell multiple packs up to a total quantity of 100 capsules or tablets in justifiable circumstances.

- **Medicinal forms** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, suppository, powder

**Tablet**

- **Cautionary and advisory labels** 29, 30
  - Paracetamol (Non-proprietary)
  - Paracetamol 500 mg Paracetamol 500 mg caplets | 100 tablet (PST) £3.05 DT = £1.81
  - Paracetamol 500 mg tablets | 100 tablet (PST) £2.13 DT = £1.81
  - 1000 tablet (PST) £15.94–£18.10
  - Paracetamol 1 gram Paracetamol 1 g tablets | 100 tablet (PST) £2.49
  - Mandanol (M & A Pharmachen Ltd)
  - Paracetamol 500 mg Mandanol 500 mg caplets | 100 tablet (PST) £1.17 DT = £1.81
  - Mandanol 500 mg tablets | 100 tablet (PST) £1.17 DT = £1.81
  - Paravict (Ecogen Europe Ltd)
  - Paracetamol 500 mg Paravict 500 mg tablets | 100 tablet (PST) £1.62 DT = £1.81

**Suppository**

- **Cautionary and advisory labels** 30
  - Paracetamol (Non-proprietary)
  - Paracetamol 80 mg Paracetamol 80 mg suppositories | 10 suppository (PST) £0.00
  - Paracetamol 120 mg Paracetamol 120 mg suppositories | 10 suppository (PST) £12.39 DT = £12.39
  - Paracetamol 125 mg Paracetamol 125 mg suppositories | 10 suppository (PST) £15.00 DT = £13.80
  - Paracetamol 240 mg Paracetamol 240 mg suppositories | 10 suppository (PST) £22.01 DT = £22.01
  - Paracetamol 250 mg Paracetamol 250 mg suppositories | 10 suppository (PST) £27.60 DT = £27.60
  - Paracetamol 500 mg Paracetamol 500 mg suppositories | 10 suppository (PST) £36.50 DT = £36.50
Paracetamol 1 gram Paracetamol 1g suppositories | 10 suppository £60.00 DT = £59.50

- **Alvedon** (Intrapharm Laboratories Ltd)
  - Paracetamol 60 mg Alvedon 60mg suppositories | 10 suppository £11.00 DT = £11.05
  - Paracetamol 125 mg Alvedon 125mg suppositories | 10 suppository £13.80 DT = £13.80
  - Paracetamol 250 mg Alvedon 250mg suppositories | 10 suppository £27.60 DT = £27.60

Oral suspension

**CAUTIONARY AND ADVISORY LABELS 30**

- **Paracetamol (Non-proprietary)**
  - Paracetamol 24 mg per 1 ml Paracetamol 120mg/5ml oral suspension paediatric | 100 ml £1.23-£1.50 | 500 ml £5.75-£6.13 DT = £6.13
  - Paracetamol 120mg/5ml oral suspension paediatric sugar free-sugar free | 100 ml £1.19 DT = £1.19 sugar-free | 200 ml (P) £2.38 sugar-free | 500 ml (P) £5.95 sugar-free | 1000 ml (P) £11.90
  - Paracetamol 50 mg per 1 ml Paracetamol 250mg/5ml oral suspension | 100 ml £1.40-£1.75 DT = £1.75 | 500 ml £7.00-£8.75
  - Paracetamol 250mg/5ml oral suspension sugar free-sugar-free | 100 ml £1.17-£1.19 sugar-free | 200 ml £2.33 DT = £2.34 sugar-free | 500 ml £5.83-£5.85 sugar-free | 1000 ml £11.65
  - Paracetamol 100 mg per 1 ml Paracetamol 500mg/5ml oral suspension sugar free-sugar-free | 150 ml (P) £24.00 DT = £24.00

**Effervescent tablet**

**CAUTIONARY AND ADVISORY LABELS 29, 30**

- **Paracetamol (Non-proprietary)**
  - Paracetamol 500 mg Paracetamol 500mg soluble tablets | 100 tablet D8 (P) DT = £6.79
  - Paracetamol 500mg effervescent tablets | 24 tablet (P81) £1.72 | 60 tablet (P82) £4.30 | 100 tablet (P83) £1.59-£1.77 DT = £1.77

- **Altridexal** (Trion Pharma Ltd)
  - Paracetamol 1 gram Altridexal 1000mg effervescent tablets sugar-free | 50 tablet (P81) £6.59

**Solution for infusion**

- **Paracetamol (Non-proprietary)**
  - Paracetamol 10 mg per 1 ml Paracetamol 500mg/50ml solution for infusion bottles | 10 bottle (P) £11.00 (Hospital only)
  - Paracetamol 500mg/50ml solution for infusion vials | 10 vial (P) £14.40
  - Paracetamol 1g/100ml solution for infusion bottles | 10 bottle (P) £14.00
  - Paracetamol 1g/100ml solution for infusion vials | 10 vial (P) £12.00-£15.60 DT = £12.00 | 20 vial (P) £24.00
  - Paracetamol 100mg/10ml solution for infusion ampoules | 20 ampoule (P) £12.00

- **Perfalan** (Bristol-Myers Squibb Pharmaceuticals Ltd)
  - Paracetamol 10 mg per 1 ml Perfalan 1g/100ml solution for infusion vials | 12 vial (P) £14.96
  - Perfalan 500mg/50ml solution for infusion vials | 12 vial (P) £13.60

**Oral solution**

**CAUTIONARY AND ADVISORY LABELS 30**

- **Paracetamol (Non-proprietary)**
  - Paracetamol 24 mg per 1 ml Paracetamol 120mg/5ml oral solution paediatric sugar free-sugar free | 2000 ml (P) £23.80 DT = £23.80
  - Paracetamol 100 mg per 1 ml Paracetamol 500mg/5ml oral solution sugar free-sugar free | 150 ml (P) £24.00 sugar-free | 200 ml (P) £18.00 DT = £18.00

**Powder**

- **Paracetamol (Non-proprietary)**
  - Paracetamol 650 mg Paracetamol 650mg oral powder sachets | 10 sachet (P) 15 sachet (P)

**Capsule**

**CAUTIONARY AND ADVISORY LABELS 29, 30**

- **Paracetamol (Non-proprietary)**
  - Paracetamol 500 mg Paracetamol 500mg capsules | 100 capsule (P) £3.06 DT = £3.06

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### Opioids

- **CONTRA-INDICATIONS** Acute respiratory depression - comatose patients - head injury (opioid analgesics interfere with pupillary responses vital for neurological assessment) - raised intracranial pressure (opioid analgesics interfere with pupillary responses vital for neurological assessment) - risk of paralytic ileus

- **CAUTIONS** Adrenocortical insufficiency (reduced dose is recommended) - asthma (avoid during an acute attack) - convulsive disorders - diseases of the biliary tract - hypotension - hypothroidism (reduced dose is recommended) - impaired respiratory function (avoid in chronic obstructive pulmonary disease) - inflammatory bowel disorders - myasthenia gravis - obstructive bowel disorders - shock

**CAUTIONS, FURTHER INFORMATION**

- Dependence Repeated use of opioid analgesics is associated with the development of psychological and physical dependence; although this is rarely a problem with therapeutic use, caution is advised if prescribing for patients with a history of drug dependence.
- Palliative care In the control of pain in terminal illness, the cautions listed should not necessarily be a deterrent to the use of opioid analgesics.

- **SIDE-EFFECTS**
  - Common or very common Arrhythmias - confusion - constipation - dizziness - drowsiness - dry mouth - euphoric mood - flushing - hallucination - headache - hyperhidrosis - hypotension (with high doses) - miosis - nausea (more common on initiation) - palpitations - respiratory depression (with high doses) - skin reactions - urinary retention - vertigo - visual impairment - vomiting (more common on initiation)
  - Uncommon Drug dependence - dysphoria - withdrawal syndrome

**SIDE-EFFECTS, FURTHER INFORMATION**

- **Respiratory depression** Respiratory depression is a major concern with opioid analgesics and it may be treated by artificial ventilation or be reversed by naloxone. Neonates (particularly if pre-term) may be more susceptible.

**Dependence and withdrawal** Psychological dependence rarely occurs when opioids are used therapeutically (e.g. for pain relief), but tolerance can develop during long-term treatment.

- **Overdose** Opioids (narcotic analgesics) cause coma, respiratory depression, and pinpoint pupils. For details on the management of poisoning, see Opioids, under Emergency treatment of poisoning p. 859 and consider the specific antidote, naloxone hydrochloride.

- **PREGNANCY** Respiratory depression and withdrawal symptoms can occur in the neonate if opioid analgesics are used during delivery; also gastric stasis and inhalation pneumonia has been reported in the mother if opioid analgesics are used during labour.

- **TREATMENT CESSATION** Avoid abrupt withdrawal after long-term treatment; they should be withdrawn gradually to avoid abstinence symptoms.

- **PRESCRIBING AND DISPENSING INFORMATION** The Faculty of Pain Medicine has produced resources for healthcare
Buprenorphine

**Indications and Dose**

Moderate to severe pain

- **By Sublingual Administration**
  - Child (body-weight 16–25 kg): 100 micrograms every 6–8 hours
  - Child (body-weight 25–37.5 kg): 100–200 micrograms every 6–8 hours
  - Child (body-weight 37.5–50 kg): 200–300 micrograms every 6–8 hours
  - Child (body-weight 50 kg and above): 200–400 micrograms every 6–8 hours

- **By Intramuscular Injection, or by Slow Intravenous Injection**
  - Child 6 months–11 years: 3–6 micrograms/kg every 6–8 hours (max. per dose 9 micrograms/kg)
  - Child 12–17 years: 300–600 micrograms every 6–8 hours

**Unlicensed Use**

- With oral use: Sublingual tablets not licensed for use in children under 6 years.
- With intramuscular use or intravenous use: Injection not licensed for use in children under 6 months.

**Caution**

- Impaired consciousness

**Buvidal**

- Susceptibility to QT-interval prolongation

**Interactions**

- Appendix 1: opioids

**Side-effects**

- **General Side-effects**
  - Rare or very rare: Angioedema, bronchospasm
  - Frequency not known: Hepatic disorders

- **Specific Side-effects**
  - Common or very common
  - With parenteral use: Hypersensitivity, withdrawal syndrome, neonatal
  - With sublingual use: Fatigue, sleep disorders
  - Uncommon
  - With sublingual use: Anxiety, apnoea, appetite decreased, atrioventricular block, coma, conjunctivitis, coordination abnormal, cyanosis, depersonalisation, depression, diarrhoea, diplopia, dyspepsia, dysphonia, hypertension, pallor, paraesthesia, psychosis, seizure, speech slurred, tinnitus, tremor, urinary disorder
  - Frequency not known
  - With parenteral use: Psychotic disorder, vision blurred
  - With sublingual use: Cerebrospinal fluid pressure increased, circulation impaired, haemorrhagic diathesis, oral disorders, syncope

**Overdose**

- The effects of buprenorphine are only partially reversed by naloxone.

**Breast Feeding**

- Present in low levels in breast milk.

**Monitoring**

- Neonates should be monitored for drowsiness, adequate weight gain, and developmental milestones.

**Hepatic Impairment**

- Manufacturer advises caution; avoid in severe impairment (limited information available).

**Renal Impairment**

- Avoid use or reduce dose; opioid effects increased and prolonged; increased cerebral sensitivity.

**Pre-treatment Screening**

- Documentation of viral hepatitis status is recommended before commencing therapy for opioid dependence.

**Monitoring Requirements**

- Monitor liver function; when used in opioid dependence baseline liver function test is recommended before commencing therapy, and regular liver function tests should be performed throughout treatment.

**Directions for Administration**

- Sublingual tablets may be halved.

**Patient and Carer Advice**

- Patients or carers should be given advice on how to administer buprenorphine products.
Co-codamol

The properties listed below are those particular to the combination only. For the properties of the components please consider, paracetamol p. 278.

**INDICATIONS AND DOSE**

**Short-term treatment of acute moderate pain (using co-codamol 8/500 preparations only)**

- **BY MOUTH**
  - Child 12–15 years: 8/500 mg every 6 hours as required for maximum 3 days; maximum 32/2000 mg per day
  - Child 16–17 years: 8/500–16/1000 mg every 6 hours as required for maximum 3 days; maximum 64/4000 mg per day

**Short-term treatment of acute moderate pain (using co-codamol 15/500 preparations only)**

- **BY MOUTH**
  - Child 12–15 years: 15/500 mg every 6 hours as required for maximum 3 days; maximum 60/2000 mg per day
  - Child 16–17 years: 15/500–30/1000 mg every 6 hours as required for maximum 3 days; maximum 120/4000 mg per day

**Short-term treatment of acute moderate pain (using co-codamol 30/500 preparations only)**

- **BY MOUTH**
  - Child 12–15 years: 30/500 mg every 6 hours as required for maximum 3 days; maximum 120/2000 mg per day
  - Child 16–17 years: 30/500–60/1000 mg every 6 hours as required for maximum 3 days; maximum 240/4000 mg per day

**KAPAKE® 15/500**

**Short-term treatment of acute pain**

- **BY MOUTH**
  - Child 12–15 years: 1 tablet every 6 hours as required for maximum 3 days; maximum 4 tablets per day
  - Child 16–17 years: 2 tablets every 6 hours as required for maximum 3 days; maximum 8 tablets per day

**IMPORTANT SAFETY INFORMATION**

See codeine phosphate p. 283 for MHRA/CHM advice for restrictions on the use of codeine as an analgesic in children.

**CONTRA-INDICATIONS**  Acute ulcerative colitis · antibiotic-associated colitis · children who undergo the removal of tonsils or adenoids for the treatment of obstructive sleep apnoea · conditions where abdominal distention develops · conditions where inhibition of peristalsis should be avoided · known ultra-rapid codeine metabolisers

**CAUTIONS**  Acute abdomen · alcohol dependence · avoid abrupt withdrawal after long-term treatment · cardiac arrhythmias · chronic alcoholism · chronic dehydration · chronic malnutrition · convulsive disorders · gallstones · hepatic cellular insufficiency

**CAUTIONS, FURTHER INFORMATION**

- Variation in metabolism  The capacity to metabolise codeine to morphine can vary considerably between individuals; there is a marked increase in morphine toxicity in patients who are ultra-rapid codeine metabolisers (CYP2D6 ultra-rapid metabolisers) and a reduced therapeutic effect in poor codeine metabolisers.

**INTERACTIONS**  → Appendix 1: opioids · paracetamol

**SIDE-EFFECTS**  Abdominal pain · addiction · agranulocytosis · blood disorder · irritability · pancreatitis · restlessness · severe cutaneous adverse reactions (SCARs) · thrombocytopenia

**Overdose**  Liver damage (and less frequently renal damage) following overdosage with paracetamol.

**BREAST FEEDING**  Avoid — although amount of codeine usually too small to be harmful, mothers vary considerably in their capacity to metabolise codeine — risk of morphine overdose in infant.

**HEPATIC IMPAIRMENT**  Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment. Dose adjustments  Manufacturer advises consider dose reduction in mild to moderate impairment.

**RENAL IMPAIRMENT**  Reduce dose or avoid codeine; increased and prolonged effect; increased cerebral sensitivity.

**PRESCRIBING AND DISPENSING INFORMATION**

Co-codamol is a mixture of codeine phosphate and paracetamol; the proportions are expressed in the form x/y, where x and y are the strengths in milligrams of codeine phosphate and paracetamol respectively.

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and no strength is stated, tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate 8 mg and paracetamol 500 mg should be dispensed.

The Drug Tariff allows tablets of co-codamol labelled ‘dispersible’ to be dispensed against an order for ‘effervescent’ and vice versa.

**LESS SUITABLE FOR PRESCRIBING**  Co-codamol is less suitable for prescribing.

**EXCEPTIONS TO LEGAL CATEGORY**  Co-codamol 8/500 can be sold to the public in certain circumstances; for exemptions see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition).

**MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

CAUTIONARY AND ADVISORY LABELS  (2 does not apply to the 8/500 tablet), 29, 30

- Co-codamol (Non-proprietary)
  - Codeine phosphate 8 mg, Paracetamol 500 mg
  - Co-codamol 8mg/500mg tablets | 100 tablet [PSt] £2.70 DT + £2.70 [DSt] | 500 tablet [PSt] £13.50 [DSt] | 1000 tablet [PSt] £27.00 [DSt]
  - Co-codamol 8mg/500mg caplets | 32 tablet [PSt] £0.81–10.95 [DSt]
  - Codeine phosphate 15 mg, Paracetamol 500 mg
  - Co-codamol 15mg/500mg tablets | 100 tablet [PSt] £15.00 DT + £4.12 [DSt]
  - Co-codamol 30 mg, Paracetamol 500 mg
  - Co-codamol 30mg/500mg caplets | 100 tablet [PSt] £3.90 DT + £3.63 [DSt]
  - Co-codamol 30mg/500mg tablets | 100 tablet [PSt] £1.17 DT + £1.09 [DSt] | 100 tablet [PSt] £7.53 DT + £3.63 [DSt]
  - Codeine phosphate 60 mg, Paracetamol 1 gram
  - Codeine phosphate 60mg/1000mg tablets | 100 tablet [PSt] £1.85 [DSt]
  - Codipar (Advanz Pharma)
  - Codeine phosphate 15 mg, Paracetamol 500 mg
  - Codipar 15mg/500mg tablets | 100 tablet [PSt] £8.25 DT + £4.12 [DSt]
  - Emcozin (M & A Pharmachen Ltd)
  - Codeine phosphate 30 mg, Paracetamol 500 mg
  - Emcozin 30mg/500mg tablets | 100 tablet [PSt] £2.55 DT + £3.63 [DSt]
  - Kapake (Galen Ltd)
  - Codeine phosphate 30 mg, Paracetamol 500 mg
  - Kapake 30mg/500mg tablets | 100 tablet [PSt] £7.10 DT + £3.63 [DSt]
  - Migraleve Yellow (McNeil Products Ltd)
  - Codeine phosphate 8 mg, Paracetamol 500 mg
  - Migraleve Yellow 16 tablet [PSt] £0.70 [DSt]
  - Panadol Ultra (GlaxoSmithKline Consumer Healthcare)
  - Codeine phosphate 12.8 mg, Paracetamol 500 mg
  - Panadol Ultra 12.8mg/500mg tablets | 20 tablet [PSt] £2.61 DT + £3.61 [DSt]
**BNFC 2019–2020**

**Pain 283**

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**Codeine phosphate**

- **INDICATIONS AND DOSE**
  - **Acute diarrhoea**
    - **BY MOUTH**
      - Child 12–17 years: 30 mg 3–4 times a day; usual dose 15–60 mg 3–4 times a day

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**Short-term treatment of acute moderate pain**

- **BY MOUTH, OR BY INTRAMUSCULAR INJECTION**
- **Child 12–17 years**: 30–60 mg every 6 hours if required for maximum 3 days; maximum 240 mg per day

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**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE (JULY 2013) CODEINE FOR ANALGESIA: RESTRICTED USE IN CHILDREN DUE TO REPORTS OF MORPHINE TOXICITY**

Codine should only be used to relieve acute moderate pain in children older than 12 years and only if it cannot be relieved by other painkillers such as paracetamol or ibuprofen alone. A significant risk of serious and life-threatening adverse reactions has been identified in children with obstructive sleep apnoea who received codeine after tonsillectomy or adenoidectomy:

- In children aged 12–18 years, the maximum daily dose of codeine should not exceed 240 mg. Doses may be taken up to four times a day at intervals of no less than 6 hours. The lowest effective dose should be used and duration of treatment should be limited to 3 days.
- Codeine is contraindicated in all children (under 18 years) who undergo the removal of tonsils or adenoids for the treatment of obstructive sleep apnoea.
- Codeine is not recommended for use in children whose breathing may be compromised, including those with neuromuscular disorders, severe cardiac or respiratory conditions, respiratory infections, multiple trauma or extensive surgical procedures.
- Codeine is contraindicated in patients of any age who are known to be ultra-rapid metabolisers of codeine (CYP2D6 ultra-rapid metabolisers).
- Codeine should not be used in breast-feeding mothers because it can pass to the baby through breast milk.
- Parents and carers should be advised on how to recognise signs and symptoms of morphine toxicity, and to stop treatment and seek medical attention if signs or symptoms of toxicity occur (including reduced consciousness, lack of appetite, somnolence, constipation, respiratory depression, ‘pin-point’ pupils, nausea, vomiting).

**MHRA/CHM ADVICE (APRIL 2015) CODEINE FOR COUGH AND COLD: RESTRICTED USE IN CHILDREN**

Do not use codeine in children under 12 years as it is associated with a risk of respiratory side effects. Codeine is not recommended for adolescents (12–18 years) who have problems with breathing. When prescribing or dispensing codeine-containing medicines for cough and cold, consider that codeine is contraindicated in:

- Children younger than 12 years old
- Patients of any age known to be CYP2D6 ultra-rapid metabolisers
- Breastfeeding mothers

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**CONTRA-INDICATIONS**

- Acute ulcerative colitis - anti-biotic-associated colitis - children under 18 years who undergo the removal of tonsils or adenoids for the treatment of obstructive sleep apnoea - conditions where abdominal distension develops - conditions where inhibition of peristalsis should be avoided - known ultra-rapid codeine metabolisers

**CAUTIONS**

- Acute abdomen - cardiac arrhythmias - gallstones - not recommended for adolescents aged 12–18 years with breathing problems

**CAUTIONS, FURTHER INFORMATION**

- Variation in metabolism The capacity to metabolise codeine to morphine can vary considerably between individuals; there is a marked increase in morphine toxicity in patients who are ultra-rapid codeine metabolisers (CYP2D6 ultra-rapid metabolisers) and a reduced therapeutic effect in poor codeine metabolisers.
**INTERACTIONS** → Appendix 1: opioids

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**
- Biliary spasm - hyperthermia - mood altered - sexual dysfunction - ureteral spasm

**SPECIFIC SIDE-EFFECTS**
- With oral use: Abdominal cramps - addiction - appetite decreased - depression - drug reaction with eosinophilia and systemic symptoms (DRESS) - dyskinesia - dyspnoea - face oedema - fatigue - fever - hyperglycaemia - hypersensitivity - intracranial pressure increased - lymphadenopathy - malaise - muscle rigidity (with high doses) - nightmare - pancreatitis - restlessness - seizure - splenomegaly - urinary disorders - vision disorders
- With parenteral use: Dysuria
- **HEPATIC IMPAIRMENT**
  - Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.
- **RENAL IMPAIRMENT**
  - Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

**PRESCRIBING AND DISPENSING INFORMATION**
BP directs that when Diabetic Codeine Linctus is prescribed, Codeine Linctus formulated with a vehicle appropriate for administration to diabetics, whether or not labelled 'Diabetic Codeine Linctus', shall be dispensed or supplied.

**PATIENT AND CARER ADVICE**
Medicines for Children leaflet: Codeine phosphate for pain
[www.medicinesforchildren.org.uk/codeine-phosphate-pain-0](http://www.medicinesforchildren.org.uk/codeine-phosphate-pain-0)

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution for injection.

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 2**
- Codeine phosphate (Non-proprietary)
  - Codeine phosphate 15 mg: Codeine 15mg tablets | 2 tablet [P](£1.40 DT = £0.83 [DD]) | 10 tablet [P](£2.96 DT = £2.96 [DD])
  - Codeine phosphate 30 mg: Codeine 30mg tablets | 2 tablet [P](£1.59 DT = £0.93 [DD]) | 10 tablet [P](£5.68 DT = £3.32 [DD]) | 500 tablet [P](£16.60 [DD])
  - Codeine phosphate 60 mg: Codeine 60mg tablets | 2 tablet [P](£1.89 DT = £1.53 [DD])

**Solution for injection**
- Codeine phosphate (Non-proprietary)
  - Codeine phosphate 60 mg per 1 ml: Codeine 60mg/1ml solution for injection ampoules | 10 ampoule [P](£24.10-£24.19 DT = £24.19 [DD])

**Oral solution**

**CAUTIONARY AND ADVISORY LABELS 2**
- Codeine phosphate (Non-proprietary)
  - Codeine phosphate 3 mg per 1 ml: Codeine 15mg/5ml linctus sugar free sugar-free | 200 ml [P](£1.90 DT = £1.62 [DD]) sugar-free | 2000 ml [P](£16.20 [DD])
  - Codeine phosphate 5 mg per 1 ml: Codeine 25mg/5ml linctus | 200 ml [P](£1.73-£1.90 DT = £1.90 [DD]) | 500 ml [P](£6.64 DT = £6.64 [DD])
  - Galcodeine (Thornton & Ross Ltd)
    - Codeine phosphate 3 mg per 1 ml: Galcodeine 15mg/5ml linctus sugar-free | 2000 ml [P](£9.90 [DD])

**Diamorphine hydrochloride**
(Heroin hydrochloride)

**INDICATIONS AND DOSE**

**Acute or chronic pain**
- **BY MOUTH**
  - Child 1 month-11 years: 100–200 micrograms/kg every 4 hours (max. per dose 10 mg), adjusted according to response.
  - Child 12-17 years: 5–10 mg every 4 hours, adjusted according to response.
- **BY CONTINUOUS INTRAVENOUS INFUSION**
  - Child 1 month-11 years: 12.5–25 micrograms/kg/hour, adjusted according to response.
  - Child 1 month-11 years: 20 micrograms/kg/hour, adjusted according to response.
- **BY INTRAVENOUS INJECTION**
  - Child 1-2 months: 20 micrograms/kg every 6 hours, adjusted according to response.
  - Child 3-5 months: 25–50 micrograms/kg every 6 hours, adjusted according to response.
  - Child 6-11 months: 75 micrograms/kg every 4 hours, adjusted according to response.
  - Child 11-17 years: 75–100 micrograms/kg every 4 hours (max. per dose 5 mg), adjusted according to response.
  - Child 12-17 years: 2.5–5 mg every 4 hours, adjusted according to response.
- **BY INTRAMUSCULAR INJECTION, OR BY SUBCUTANEOUS INJECTION**
  - Child 12-17 years: 5 mg every 4 hours, adjusted according to response.

**Acute or chronic pain in ventilated neonates**
- **INITIALLY BY INTRAVENOUS INJECTION**
  - Neonate: Initially 50 micrograms/kg, dose to be administered over 30 minutes, followed by (by continuous intravenous infusion) 15 micrograms/kg/hour, adjusted according to response.

**Acute or chronic pain in non-ventilated neonates**
- **BY CONTINUOUS INTRAVENOUS INFUSION**
  - Neonate: 2.5–7 micrograms/kg/hour, adjusted according to response.

**Acute severe nociceptive pain in an emergency setting (specialist supervision in hospital)**
- **BY INTRANASAL ADMINISTRATION**
  - Child 2-5 years (body-weight 12-17 kg): 1.44 mg for 1 dose, spray into alternate nostrils.
  - Child 2-5 years (body-weight 18-23 kg): 2.16 mg for 1 dose, spray into alternate nostrils.
  - Child 2-5 years (body-weight 24-29 kg): 2.88 mg for 1 dose, spray into alternate nostrils.
  - Child 2-5 years (body-weight 30-39 kg): 3.2 mg for 1 dose, spray into alternate nostrils.
  - Child 2-5 years (body-weight 40-50 kg): 4.8 mg for 1 dose, spray into alternate nostrils.

**CONTRA-INDICATIONS**
- Delayed gastric emptying - phaeochromocytoma.

**CAUTIONS**
- CNS depression - severe cor pulmonale - severe diarrhoea - toxic psychosis.

**INTERACTIONS** → Appendix 1: opioids

**SIDE-EFFECTS**
- **Common or very common**
  - **Uncommon**
Dihydrocodeine tartrate

- **INDICATIONS AND DOSE**
  - **Moderate to severe pain**
    - **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
      - Child 1-3 years: 500 micrograms/kg every 4–6 hours
      - Child 4-11 years: 0.5–1 mg/kg every 4–6 hours (max. per dose 30 mg)

- **UNLICENSED USE**
  - Most preparations not licensed for use in children under 4 years.

- **CAUTIONS**
  - Pancreatitis • severe cor pulmonale

- **INTERACTIONS**
  - Appendix 1: opioids

- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Dysuria • mood altered
  - **SPECIFIC SIDE-EFFECTS**
    - With oral use Biliary spasm • bronchospasm • hypothermia • sexual dysfunction • ureteral spasm
  - **BREAST FEEDING**
    - Use only if potential benefit outweighs risk.
  - **HEPATIC IMPAIRMENT**
    - Manufacturer advises caution; consider avoiding.
    - Dose adjustments Manufacturer advises dose reduction, if used.
  - **RENAL IMPAIRMENT**
    - Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

- **PROFESSION SPECIFIC INFORMATION**
  - Dental practitioners’ formulary

Dihydrocodeine tablets 30 mg may be prescribed.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral solution, solution for injection, powder for solution for injection

Tablet

**CAUTIONARY AND ADVISORY LABELS** 2

- **Diamorphine hydrochloride (Non-proprietary)**
  - Diamorphine hydrochloride 10 mg: Diamorphine 10 mg tablets 100 tablet (P99) £37.13 DT = £37.13 (07)

**Powder for solution for injection**

- **Diamorphine hydrochloride (Non-proprietary)**
  - Diamorphine hydrochloride 5 mg: Diamorphine 5 mg powder for solution for injection ampoules 5 ampoule (P99) £11.36–£14.95 DT = £13.76 (07)
  - Diamorphine hydrochloride 10 mg: Diamorphine 10 mg powder for solution for injection ampoules 5 ampoule (P99) £16.56–£16.95 DT = £14.39 (07)
  - Diamorphine hydrochloride 30 mg: Diamorphine 30 mg powder for solution for injection ampoules 5 ampoule (P99) £16.52–£17.95 DT = £15.05 (07)
  - Diamorphine hydrochloride 100 mg: Diamorphine 100 mg powder for solution for injection ampoules 5 ampoule (P99) £42.39–£57.95 DT = £50.17 (07)
  - Diamorphine hydrochloride 500 mg: Diamorphine 500 mg powder for solution for injection ampoules 5 ampoule (P99) £187.70–£213.95 DT = £201.83 (07)

**Spray**

- EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate
  - Ayendi (Wockhardt Ltd)
    - Diamorphine (as Diamorphine hydrochloride) 720 microgram per 1 dose Ayendi 720 micrograms/actuation nasal spray 68 dose (P99) £107.90 (Hospital only) (07) | 160 dose (P99) £112.90 (Hospital only) (07)
    - Diamorphine (as Diamorphine hydrochloride) 1.6 mg per 1 dose Ayendi 1600 micrograms/actuation nasal spray 68 dose (P99) £113.52 (Hospital only) (07) | 160 dose (P99) £123.75 (Hospital only) (07)

Dihydrocodeine tartrate

- **Child 12-17 years**: 30 mg every 4–6 hours
- **BY INTRAMUSCULAR INJECTION, OR BY SUBCUTANEOUS INJECTION**
  - Child 1-3 years: 500 micrograms/kg every 4–6 hours
  - Child 4-11 years: 0.5–1 mg/kg every 4–6 hours (max. per dose 30 mg)
  - Child 12-17 years: 30 mg every 4–6 hours (max. per dose 50 mg)

**Chronic severe pain**

- **BY MOUTH USING MODIFIED-RELEASE MEDICINES**
  - Child 12-17 years: 60–120 mg every 12 hours
  - DF118 FORTE®

**Severe pain**

- **BY MOUTH**
  - Child 12-17 years: 40–80 mg 3 times a day; maximum dose 240 mg per day

- **UNLICENSED USE**
  - Most preparations not licensed for use in children under 4 years.

- **CAUTIONS**
  - Pancreatitis • severe cor pulmonale

- **INTERACTIONS**
  - Appendix 1: opioids

- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Dysuria • mood altered
  - **SPECIFIC SIDE-EFFECTS**
    - With oral use Biliary spasm • bronchospasm • hypothermia • sexual dysfunction • ureteral spasm
  - **BREAST FEEDING**
    - Use only if potential benefit outweighs risk.
  - **HEPATIC IMPAIRMENT**
    - Manufacturer advises caution; consider avoiding.
    - Dose adjustments Manufacturer advises dose reduction, if used.
  - **RENAL IMPAIRMENT**
    - Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

- **PROFESSION SPECIFIC INFORMATION**
  - Dental practitioners’ formulary

Dihydrocodeine tablets 30 mg may be prescribed.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral solution, solution for injection, powder for solution for injection
Dihydrocodeine with paracetamol

The properties listed below are those particular to the combination only. For the properties of the components please consider, paracetamol p. 278.

**INDICATIONS AND DOSE**

**Mild to moderate pain (using 10/500 preparations only)**
- **By mouth**
  - Child 12-17 years: 10/500–20/1000 mg every 4–6 hours as required; maximum 80/4000 mg per day

**Severe pain (using 20/500 preparations only)**
- **By mouth**
  - Child 12-17 years: 20/500–40/1000 mg every 4–6 hours as required; maximum 160/4000 mg per day

**Severe pain (using 30/500 preparations only)**
- **By mouth**
  - Child 12-17 years: 30/500–60/1000 mg every 4–6 hours as required; maximum 240/4000 mg per day

**DOSE EQUIVALENT AND CONVERSION**
- A mixture of dihydrocodeine tartrate and paracetamol; the proportions are expressed in the form x/y, where x and y are the strengths in milligrams of dihydrocodeine and paracetamol respectively.

**IMPORANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: Dihydrocodeine with paracetamol (Co-dydramol): prescribe and dispense by strength to minimise risk of medication error (January 2018)**
- The MHRA has advised that dihydrocodeine with paracetamol preparations are prescribed and dispensed by strength to minimise dispensing errors and the risk of accidental opioid overdose—see Prescribing and dispensing information.

**CAUTIONS**
- Alcohol dependence • before administering, check when paracetamol last administered and cumulative paracetamol dose over previous 24 hours • chronic alcoholism • chronic dehydration • chronic malnutrition • hepatocellular insufficiency • pancreatitis • severe cor pulmonale

**INTERACTIONS**
- Appendix 1: opioids • paracetamol

**SIDE-EFFECTS**
- Abdominal pain • blood disorder • leucopenia • malaise • neutropenia • pancreatitis • paraesthesia • paralytic ileus • severe cutaneous adverse reactions (SCARs) • thrombocytopenia

**Overdose**
- Liver damage (and less frequently renal damage) following overdosage with paracetamol.

**BREAST FEEDING**
- Amount of dihydrocodeine too small to be harmful but use only if potential benefit outweighs risk.

**HEPATIC IMPAIRMENT**
- Manufacturer advises consider avoiding in mild to moderate impairment; avoid in severe impairment.

**Dose adjustments**
- Manufacturer advises dose reduction in mild to moderate impairment, if used.

**RENAL IMPAIRMENT**
- Reduce dose or avoid dihydrocodeine; increased and prolonged effect; increased cerebral sensitivity.

**PRESCRIBING AND DISPENSING INFORMATION**
- The MHRA advises when prescribing dihydrocodeine with paracetamol, the tablet strength and dose must be clearly indicated; when dispensing dihydrocodeine with paracetamol, ensure the prescribed strength is supplied—contact the prescriber if in doubt.
- The BP defines Co-dydramol Tablets as containing dihydrocodeine tartrate 10 mg and paracetamol 500 mg.

**LESS SUITABLE FOR PRESCRIBING**
- Dihydrocodeine with paracetamol is less suitable for prescribing.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 2, 29, 30**
- Dihydrocodeine with paracetamol (Non-proprietary)
  - Dihydrocodeine tartrate 10 mg, Paracetamol 500 mg
  - Co-dydramol 20mg/500mg tablets (30 tablet (P)) £1.14 DT + £0.79 (C5) | 100 tablet (P) £3.00 DT + £2.63 (C5) | 500 tablet (P) £13.15 (C5)
  - Dihydrocodeine tartrate 20 mg, Paracetamol 500 mg
  - Co-dydramol 20mg/500mg tablets | 56 tablet (P) £5.57–£5.87 (C5) | 112 tablet (P) £11.13 DT + £11.13 (C5)
  - Dihydrocodeine tartrate 30 mg, Paracetamol 500 mg
  - Co-dydramol 30mg/500mg tablets | 56 tablet (P) £6.82 DT + £6.82 (C5)
- Eroset (M & A Pharmachem Ltd)
  - Dihydrocodeine tartrate 10 mg, Paracetamol 500 mg | Eroset 500mg/10mg tablets | 30 tablet (P) £0.68 DT + £0.79 (C5) | 100 tablet (P) £1.48 DT + £2.63 (C5)
- Paramol (SSL International Plc)
  - Dihydrocodeine tartrate 7.46 mg, Paracetamol 500 mg
  - Paramol tablets | 12 tablet (P) £2.26 (C5) | 24 tablet (P) £3.86 (C5) | 32 tablet £4.52 (C5)
- Remedeine (Crescent Pharma Ltd)
  - Dihydrocodeine tartrate 20 mg, Paracetamol 500 mg
  - Remedeine tablets | 56 tablet (P) £5.87 (C5) | 112 tablet (P) £11.13 DT + £11.13 (C5)
  - Dihydrocodeine tartrate 30 mg, Paracetamol 500 mg
  - Remedeine Forte tablets | 56 tablet (P) £6.82 DT + £6.82 (C5)

**Fentanyl**

**INDICATIONS AND DOSE**

**Chronic intractable pain not currently treated with a strong opioid analgesic**
- **By transdermal application**
  - Child 16-17 years: Initially 12 micrograms/hour every 72 hours, alternatively initially 25 micrograms/hour every 72 hours, when starting, evaluation of the analgesic effect should not be made before the system has been worn for 72 hours or more for the plasma-fentanyl concentration)—previous analgesic therapy should be phased out gradually from time of first patch application, dose should be adjusted at 48–72 hour intervals in steps of 12–25 micrograms/hour if necessary, more than one patch may be used at a time (but applied at the same time to avoid confusion)—consider additional or alternative analgesic therapy if dose required exceeds 300 micrograms/hour (important: it takes 17 hours or more for the plasma-fentanyl concentration to decrease by 50%—replacement opioid therapy should be initiated at a low dose and increased gradually)

**Chronic intractable pain currently treated with a strong opioid analgesic**
- **By transdermal application**
  - Child 2-17 years: Initial dose based on previous 24-hour opioid requirement (consult product literature), for conversion from long term oral morphine to transdermal fentanyl, see Pain management with opioids under Prescribing in palliative care p. 22.
Spontaneous respiration: analgesia and enhancement of anaesthesia, during operation

- By intravenous injection
  - Child 1 month–11 years: Initially 1–3 micrograms/kg, then 1 microgram/kg as required, dose to be administered over at least 30 seconds
  - Child 12–17 years: Initially 50–100 micrograms (max. per dose 200 micrograms), dose maximum on specialist advice, then 25–50 micrograms as required, dose to be administered over at least 30 seconds

Assisted ventilation: analgesia and enhancement of anaesthesia during operation

- By intravenous injection
  - Neonate: Initially 1–5 micrograms/kg, then 1–3 micrograms/kg as required, dose to be administered over at least 30 seconds.

- Child 1 month–11 years: Initially 1–5 micrograms/kg, then 1–3 micrograms/kg as required, dose to be administered over at least 30 seconds.
- Child 12–17 years: Initially 1–5 micrograms/kg, then 50–200 micrograms as required, dose to be administered over at least 30 seconds.

Assisted ventilation: analgesia and respiratory depression in intensive care

- Initially by intravenous injection
  - Neonate: Initially 1–5 micrograms/kg, then (by intravenous infusion) 1.5 micrograms/kg/hour, adjusted according to response.
  - Child: Initially 1–5 micrograms/kg, then (by intravenous infusion) 1–6 micrograms/kg/hour, adjusted according to response.

Breakthrough pain in patients receiving opioid therapy for chronic cancer pain

- By buccal administration using lozenges

  - Child 16–17 years: Initially 200 micrograms, dose to be given over 15 minutes, then 200 micrograms after 15 minutes if required, no more than 2 dose units for each pain episode; if adequate pain relief not achieved with 1 dose unit for consecutive breakthrough pain episodes, increase the strength of the dose unit until adequate pain relief achieved with 4 lozenges or less daily, if more than 4 episodes of breakthrough pain each day, adjust background analgesia.

Dose equivalence and conversion

- Fentanyl films are not bioequivalent to other fentanyl preparations.
- Fentanyl preparations for the treatment of breakthrough pain are not interchangeable; if patients are switched from another fentanyl-containing preparation, a new dose titration is required.

Doses at extremes of body-weight

- To avoid excessive dosage in obese patients, weight-based doses may need to be calculated on the basis of ideal bodyweight.

Unlicensed use

- With intravenous use Not licensed for use in children under 2 years; infusion not licensed for use in children under 12 years.

### IMPORTANT SAFETY INFORMATION

MHRA/CHM advice: Transdermal Fentanyl patches: Life-threatening and fatal opioid toxicity from accidental exposure, particularly in children (October 2018)

Accidental exposure to transdermal fentanyl can occur if a patch is swallowed or transferred to another individual. Always fully inform patients and their carers about directions for safe use of fentanyl patches, including the importance of:
- Not exceeding the prescribed dose;
- Following the correct frequency of patch application, avoiding touching the adhesive side of patches, and washing hands after application;
- Not cutting patches and avoiding exposure of patches to heat including via hot water;
- Ensuring that old patches are removed before applying a new one;
- Following instructions for safe storage and properly disposing of used patches or those which are not needed.

Patients and carers should be advised to seek immediate medical attention if overdose is suspected—see Side-effects and Patient and carer advice for further information.

### CAUTIONS

- Cerebral tumour - diabetes mellitus (with Actiq® and Cyonil® lozenges) - impaired consciousness

### CAUTIONS, FURTHER INFORMATION

- With transdermal use Transdermal fentanyl patches are not suitable for acute pain or in those patients whose analgesic requirements are changing rapidly because the long time to steady state prevents rapid titration of the dose. Risk of fatal respiratory depression, particularly in patients not previously treated with a strong opioid analgesic; manufacturer recommends use only in opioid tolerant patients.
- With intravenous use Repeated intra-operative doses should be given with care since the resulting respiratory depression can persist postoperatively and occasionally it may become apparent for the first time postoperatively when monitoring of the patient might be less intensive.

### INTERACTIONS

- Appendices: opioids

### SIDE-EFFECTS

- Common or very common
  - With transdermal use Anxiety - appetite decreased - asthenia - depression - diarrhoea - dyspnoea - gastrointestinal discomfort - hypertension - insomnia - malaise - muscle complaints - peripheral oedema - sensation abnormal - temperature sensation altered - tremor
  - Uncommon
  - With parental use Airway complication of anaesthesia - chills - hiccups - hypothermia 
  - With transdermal use Consciousness impaired - cyanosis - fever - gastrointestinal disorders - influenza like illness - memory loss - respiratory disorders - seizures - sexual dysfunction - vision blurred
  - Rare or very rare
  - With transdermal use Apnoea
  - Frequency not known
  - With parental use Biliary spasm - cardiac arrest - cough - hyperalgesia - loss of consciousness - seizure
  - With transdermal use Myoclonus - withdrawal syndrome neonatal

### SIDE-EFFECTS, FURTHER INFORMATION

- Muscle rigidity

Intravenous administration of fentanyl can cause muscle rigidity, which may involve the thoracic muscles. Manufacturer advises administration by slow intravenous
injection to avoid; higher doses may require premedication with benzodiazepines and muscle relaxants.

**Transdermal use** Monitor patients using patches for increased side-effects if fever is present (increased absorption possible); avoid exposing application site to external heat, for example a hot bath or sauna (may also increase absorption).

- **BREAST FEEDING**
  - With buccal use Manufacturer advises avoid during treatment and for 5 days after last administration—present in milk.
  - With intravenous use Manufacturer advises avoid during treatment and for 24 hours after last administration—present in milk.
  - With transdermal use Manufacturer advises avoid during treatment and for 72 hours after removal of patch—present in milk.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution (risk of accumulation).
- **RENAL IMPAIRMENT** Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

- **DIRECTIONS FOR ADMINISTRATION**
  - With transdermal use For patches, apply to dry, non-irritated, non-irradiated, non-hairy skin on torso or upper arm, removing after 72 hours and sitting replacement patch on a different area (avoid using the same area for several days).
  - With intravenous use For intravenous infusion, injection solution may be diluted in Glucose 5% or Sodium Chloride 0.9%.
  - With buccal use Patients should be advised to place the lozenge in the mouth against the cheek and move it around the mouth using the applicator; each lozenge should be sucked over a 15 minute period. In patients with a dry mouth, water may be used to moisten the buccal mucosa. Patients with diabetes should be advised each lozenge contains approximately 2 g glucose.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - With transdermal use Prescriptions for fentanyl patches can be written to show the strength in terms of the release rate and it is acceptable to write ‘Fentanyl 25 patches’ to prescribe patches that release fentanyl 25 micrograms per hour. The dosage should be expressed in terms of the interval between applying a patch and replacing it with a new one, e.g. ‘one patch to be applied every 72 hours’. The total quantity of patches to be supplied should be written in words and figures.

- **PATIENT AND CARER ADVICE**
  - With transdermal use Patients and carers should be informed about safe use, including correct administration and disposal, strict adherence to dosage instructions, and the symptoms and signs of opioid overdose. Patches should be removed immediately in case of breathing difficulties, marked drowsiness, confusion, dizziness, or impaired speech, and patients and carers should seek prompt medical attention.


**EFFENTORA** Patients or carers should be given advice on how to administer Effentora® buccal tablets.

Patients should be advised not to eat or drink until the tablet is completely dissolved; after 30 minutes, if any remnants remain, they may be swallowed with a glass of water. Patients with a dry mouth should be advised to drink water to moisten the buccal mucosa before administration of the tablets; if appropriate effervescence does not occur, a switch of therapy may be advised.

**NATIONAL FUNDING/ACCESS DECISIONS**

- **Scottish Medicines Consortium (SMC) decisions**
  - The Scottish Medicines Consortium has advised (September 2008) that PecFent® nasal spray should be restricted for use within NHS Scotland for the management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain, when other short-acting opioids are unsuitable.

- **Instanyl®**
  - The Scottish Medicines Consortium has advised that Instanyl® nasal spray should be restricted for use within NHS Scotland for the management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain, when other short-acting opioids are unsuitable.

- **EFFENTORA**
  - The Scottish Medicines Consortium has advised that Effentora® buccal tablets should be restricted for the management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain, when other short acting opioids are unsuitable.

- **Scottish Medicines Consortium (SMC) decisions**
  - The Scottish Medicines Consortium has advised (January 2009) that Abstral® sublingual tablets should be restricted for the management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain, when other short acting opioids are unsuitable.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, infusion, solution for infusion

**Solution for injection**

- **Fentanyl (Non-proprietary)**
  - Fentanyl (as Fentanyl citrate) 50 microgram per 1 ml
  - Fentanyl 100 micrograms/2ml solution for injection ampoules | 10 ampoule (P) £7.00–£14.33 DT = £14.32 (Q)
  - Fentanyl 500 micrograms/10ml solution for injection ampoules | 10 ampoule (P) £15.00–£16.15 (Q)
  - Sublimaze (Piramal Critical Care Ltd)
  - Fentanyl (as Fentanyl citrate) 50 microgram per 1 ml
  - Sublimaze 500 micrograms/10ml solution for injection ampoules | 5 ampoule (P) £6.53 (Q)

**Solution for infusion**

- **Fentanyl (Non-proprietary)**
  - Fentanyl (as Fentanyl citrate) 50 microgram per 1 ml
  - Fentanyl 2.5mg/50ml solution for infusion vials | 1 vial (P) £3.50 (Q)

**Transdermal patch**

**CAUTIONARY AND ADVISORY LABELS 2**

- **Durogesic DTrans (Janssen-Cilag Ltd)**
  - Fentanyl 12 microgram per 1 hour
  - Durogesic DTrans 12micrograms/hour transdermal patches | 5 patch (P) £12.59 DT = £12.59 (Q)
  - Fentanyl 25 microgram per 1 hour
  - Durogesic DTrans 25 micrograms/hour transdermal patches | 5 patch (P) £17.99 DT = £17.99 (Q)
  - Fentanyl 50 microgram per 1 hour
  - Durogesic DTrans 50 micrograms/hour transdermal patches | 5 patch (P) £33.66 DT = £33.66 (Q)
  - Fentanyl 75 microgram per 1 hour
  - Durogesic DTrans 75 micrograms/hour transdermal patches | 5 patch (P) £46.99 DT = £46.99 (Q)
  - Fentanyl 100 microgram per 1 hour
  - Durogesic DTrans 100 micrograms/hour transdermal patches | 5 patch (P) £57.86 DT = £57.86 (Q)
  - Fencino (Ethpharm UK Ltd)
  - Fentanyl 12 microgram per 1 hour
  - Fencino 12 micrograms/hour transdermal patches | 5 patch (P) £8.46 DT = £12.59 (Q)
  - Fentanyl 25 microgram per 1 hour
  - Fencino 25 micrograms/hour transdermal patches | 5 patch (P) £12.10 DT = £17.99 (Q)
<table>
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<tr>
<td>Fentanyl 50 microgram per 1 hour</td>
<td>£38.88 DT = £57.86</td>
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</tr>
<tr>
<td>Fentanyl 5 microgram per 1 hour</td>
<td>£8.05 DT = £12.05</td>
<td>Tegus (Teva Ltd)</td>
</tr>
</tbody>
</table>

**Contraindications**: Acute abdomen

**Cautions**: Pancreatitis, toxic psychosis

**Interactions**: Appendix 1: opioids

**Side-effects**: Common or very common - Abdominal pain, anxiety, appetite decreased, asthenia, sleep disorders.

**Uncommon**: Depression, diarrhoea, dysphoria, erectile dysfunction, malaise, movement disorders, paraesthesia, peripheral oedema, taste altered, tremor.

**Frequency not known**: Hyperalgesia, paralytic ileus, seizure, withdrawal syndrome neonatal.

**Breast feeding**: Avoid - no information available.

**Renal impairment**: Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

**Directions for administration**: For immediate-release capsules, swallow whole capsule or sprinkle contents on soft food. For modified-release capsules, swallow whole or open capsule and sprinkle contents on soft cold food (swallow the pellets within the capsule whole; do not crush or chew).
Palladone SR

CAUTIONARY AND ADVISORY LABELS

1. There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

2. Modified-release capsule

3. There are changes in the licensing of Palladone SR capsules. Palladone SR modified-release capsules were not licensed to treat children with cancer pain (age-range not specified by manufacturer).

Morphine

INICATIONS AND DOSE

Pain

- BY SUBCUTANEOUS INJECTION
  - Neonate: Initially 100 micrograms/kg every 6 hours, adjusted according to response.
  - Child 1–5 months: Initially 100–200 micrograms/kg every 6 hours, adjusted according to response
  - Child 6 months–1 year: Initially 100–200 micrograms/kg every 4 hours, adjusted according to response
  - Child 2–11 years: Initially 200 micrograms/kg every 4 hours, adjusted according to response
  - Child 12–17 years: Initially 2.5–10 mg every 4 hours, adjusted according to response
  - INITIALLY BY INTRAVENOUS INJECTION
  - Neonate: 50 micrograms/kg every 6 hours, adjusted according to response, dose to be administered over at least 5 minutes, alternatively (by intravenous injection) initially 50 micrograms/kg, dose to be administered over at least 5 minutes, followed by (by continuous intravenous infusion) 5–20 micrograms/kg/hour, adjusted according to response
  - Child 1–5 months: 100 micrograms/kg every 6 hours, adjusted according to response, dose to be administered over at least 5 minutes, alternatively (by intravenous injection) initially 100 micrograms/kg, dose to be administered over at least 5 minutes, followed by (by continuous intravenous infusion) 10–30 micrograms/kg/hour, adjusted according to response
  - Child 6 months–11 years: 100 micrograms/kg every 4 hours, adjusted according to response, dose to be administered over at least 5 minutes, alternatively (by intravenous injection) initially 100 micrograms/kg, dose to be administered over at least 5 minutes, followed by (by continuous intravenous infusion) 20–30 micrograms/kg/hour, adjusted according to response
  - Child 12–17 years: 5 mg every 4 hours, adjusted according to response, dose to be administered over at least 5 minutes, alternatively (by intravenous injection) initially 5 mg, dose to be administered over at least 5 minutes, alternatively (by intravenous injection) initially 5 mg, dose to be administered over at least 5 minutes, followed by (by continuous intravenous infusion) 20–30 micrograms/kg/hour, adjusted according to response
  - Pain (with modified-release 12-hourly preparations)
    - BY MOUTH USING MODIFIED-RELEASE MEDICINES
      - Child: Every 12 hours, dose adjusted according to daily morphine requirements, dosage requirements should be reviewed if the brand is altered
  - Pain (with modified-release 24-hourly preparations)
    - BY MOUTH USING MODIFIED-RELEASE MEDICINES
      - Child: Every 24 hours, dose adjusted according to daily morphine requirements, dosage requirements should be reviewed if the brand is altered
  - Neonatal opioid withdrawal (under expert supervision)
    - BY MOUTH
      - Neonate: Initially 40 micrograms/kg every 4 hours until symptoms controlled, dose to be increased if necessary; reduce frequency gradually over 6–10 days, stop when 40 micrograms/kg once daily achieved, dose may vary—consult local guidelines.
  - Persistent cyanosis in congenital heart disease when blood glucose less than 3 mmol/litre (following glucose)
    - BY INTRAVENOUS INJECTION, OR BY INTRAMUSCULAR INJECTION
      - Child: 100 micrograms/kg
  - DOSE EQUIVALENCE AND CONVERSION
    - The doses stated refer equally to morphine hydrochloride and sulfate.

UNLICENSED USE

- With oral use Oramorph® solution and MXL® capsules not licensed for use in children under 3 years. Oramorph® unit dose vials and Filnarine® SR tablets not licensed for use in children under 6 years. MST Continus® preparations licensed to treat children with cancer pain (age-range not specified by manufacturer).
- With rectal use Suppositories are not licensed for use in children.

IMPORTANT SAFETY INFORMATION

Do not confuse modified-release 12-hourly preparations with 24-hourly preparations, see Prescribing and dispensing information.

CONTRA-INDICATIONS

- Acute abdomen - delayed gastric emptying - heart failure secondary to chronic lung disease - phaeochromocytoma

CAUTIONS

- Cardiac arrhythmias - pancreatitis - severe cor pulmonale

INTERACTIONS

- Appendix 1: opioids
**SIDE-EFFECTS**
- Common or very common
- With oral use: Appetite decreased, asthenic conditions, gastrointestinal discomfort, insomnia, neuromuscular dysfunction
- Uncommon
- With oral use: Agitation, bronchospasm, ileus, mood altered, myoclonus, peripheral oedema, pulmonary oedema, seizure, sensation abnormal, syncope, taste altered
- Frequency not known
- With oral use: Amenorrhoea, biliary pain, cough decreased, hyperalgesia, hypertension, pancreatitis exacerbated, sexual dysfunction, thinking abnormal, urethral spasm
- With parental use: Alertness decreased, bile duct disorders, mood altered, myoclonus, sexual dysfunction, urethral spasm, urinary disorders, vision disorders

**BREAST FEEDING** Therapeutic doses unlikely to affect infant.

**HEPATIC IMPAIRMENT** Manufacturer advises caution. Avoid oral preparations in acute impairment; for injectable preparations—consult product literature.

**RENAI IMPAIRMENT** Avoid use or reduce dose; opioid effects increased and prolonged; increased cerebral sensitivity.

**MONITORING REQUIREMENTS** Possible association between acute chest syndrome in patients with sickle cell disease treated with morphine during a vaso-occlusive crisis—manufacturer advises close monitoring for acute chest syndrome symptoms during treatment.

**DIRECTIONS FOR ADMINISTRATION**
- With intravenous use For continuous intravenous infusion, dilute with Glucose 5% or 10% or Sodium Chloride 0.9%.
- With intravenous use in neonates Neonatal intensive care, dilute 2.5 mg/kg body-weight to a final volume of 50 mL with infusion fluid; an intravenous infusion rate of 0.1 mL/hour provides a dose of 5 micrograms/kg/hour.
- With oral use For modified release capsules—swallow whole or open capsule and sprinkle contents on soft food.

**PRESCRIBING AND DISPENSING INFORMATION** Modified-release preparations are available as 12-hourly or 24-hourly formulations; prescribers must ensure that the correct preparation is prescribed. Preparations that should be given 12-hourly include Filmarine® SR, MST Continus®, Morphgesic® SR and Zomorph®. Preparations that should be given 24-hourly include MXL®. Prescriptions must specify the ‘form’.
- With rectal use Both the strength of the suppositories and the morphine salt contained in them must be specified by the prescriber.

**PATIENT AND CARER ADVICE**
- With oral use Patients or carers should be given advice on how to administer morphine modified-release capsules. Medicines for Children leaflet: Morphine for pain www.medicinesforchildren.org.uk/morphine-pain

**EXCEPTIONS TO LEGAL CATEGORY**
- Morphine Oral Solutions Prescription—only medicines or schedule 2 controlled drug. The proportion of morphine hydrochloride may be altered when specified by the prescriber; if above 13 mg per 5 mL the solution becomes a schedule 2 controlled drug. It is usual to adjust the strength so that the dose volume is 5 or 10 mL.
- Oral solutions of morphine can be prescribed by writing the formula:

  Morphine hydrochloride 5 mg 
  Chloroform water to 5 mL 

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral solution, solution for injection, infusion, solution for infusion, suppository.

**Modified-release tablet**

**CAUTIONARY AND ADVISORY LABELS 2, 25**
- **MST Continus** (Napp Pharmaceuticals Ltd)
  - Morphine sulfate 5 mg MST Continus 5mg tablets | 60 tablet (£12.29 DT = £3.29 COD)
  - Morphine sulfate 10 mg MST Continus 10mg tablets | 60 tablet (£5.20 DT = £3.00 COD)
  - Morphine sulfate 15 mg MST Continus 15mg tablets | 60 tablet (£9.10 DT = £3.10 COD)
  - Morphine sulfate 20 mg MST Continus 20mg tablets | 60 tablet (£12.47 DT = £4.72 COD)
  - Morphine sulfate 30 mg MST Continus 30mg tablets | 60 tablet (£18.65 DT = £4.23 COD)
  - Morphine sulfate 60 mg MST Continus 60mg tablets | 60 tablet (£24.32 DT = £4.32 COD)
  - Morphine sulfate 100 mg MST Continus 100mg tablets | 60 tablet (£38.50 DT = £6.50 COD)
  - Morphine sulfate 200 mg MST Continus 200mg tablets | 60 tablet (£61.34 DT = £10.22 COD)
  - **Morphgesic SR** (Advanz Pharma)
  - Morphine sulfate 10 mg Morphgesic SR 10mg tablets | 60 tablet (£9.65 DT = £3.20 COD)
  - Morphine sulfate 30 mg Morphgesic SR 30mg tablets | 60 tablet (£9.24 DT = £3.12 COD)
  - Morphine sulfate 60 mg Morphgesic SR 60mg tablets | 60 tablet (£18.04 DT = £3.04 COD)
  - Morphine sulfate 100 mg Morphgesic SR 100mg tablets | 60 tablet (£28.54 DT = £4.76 COD)

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 2**
- **Sevredol** (Napp Pharmaceuticals Ltd)
  - Morphine sulfate 10 mg Sevredol 10mg tablets | 56 tablet (£5.31 DT = £5.31 COD)
  - Morphine sulfate 20 mg Sevredol 20mg tablets | 56 tablet (£10.61 DT = £10.61 COD)
  - Morphine sulfate 50 mg Sevredol 50mg tablets | 56 tablet (£28.02 DT = £28.02 COD)

**Suppository**

**CAUTIONARY AND ADVISORY LABELS 2**
- **Morphine (Non-proprietary)**
  - Morphine sulfate 10 mg Morphine sulfate 10mg suppositories | 12 suppository (£13.45 DT = £13.45 COD)

**Solution for injection**

**Morphine (Non-proprietary)**
- Morphine sulfate 1 mg per 1 ml Morphine sulfate 1mg/1ml solution for injection ampoules | 10 ampoule (£44.00 DT = £44.00 COD)
- Morphine sulfate 1mg/1ml solution for injection ampoules | 10 ampoule (£31.90 DT)
- Morphine sulfate 10mg/1ml solution for injection ampoules | 10 ampoule (£15.00 DT)
- Morphine sulfate 10 mg per 1 ml Morphine sulfate 10mg/1ml solution for injection ampoules | 10 ampoule (£12.36 DT = £10.46 COD)
- Morphine sulfate 15 mg per 1 ml Morphine sulfate 15mg/1ml solution for injection ampoules | 10 ampoule (£10.74–£13.10 DT = £10.74 COD)
- Morphine sulfate 20 mg per 1 ml Morphine sulfate 20mg/1ml solution for injection ampoules | 10 ampoule (£65.67 DT = £65.67 COD)
- Morphine sulfate 30 mg per 1 ml Morphine sulfate 30mg/1ml solution for injection ampoules | 10 ampoule (£14.02 DT = £11.49 COD)
- Morphine sulfate 60mg/2ml solution for injection ampoules | 5 ampoule (£29.15 DT = £29.15 COD)

**Modified-release capsule**

**CAUTIONARY AND ADVISORY LABELS 2**
- **MXL** (Napp Pharmaceuticals Ltd)
  - Morphine sulfate 30 mg MXL 30mg capsules | 28 capsule (£10.31 COD)
  - Morphine sulfate 60 mg MXL 60mg capsules | 28 capsule (£14.95 COD)
  - Morphine sulfate 90 mg MXL 90mg capsules | 28 capsule (£22.04 DT = £22.04 COD)
  - Morphine sulfate 120 mg MXL 120mg capsules | 28 capsule (£29.15 DT = £29.15 COD)
**Morphine with cyclizine**

The properties listed below are those particular to the combination only. For the properties of the components please consider, morphine p. 290, cyclizine p. 266.

### Indications and dose

#### Cyclimorph-10

- **Moderate to severe pain (short-term use only)**
  - **By subcutaneous injection, or by intramuscular injection, or by intravenous injection**
  - Child 12-17 years: 1 mL, do not repeat dose more often than every 4 hours; maximum 3 doses per day

#### Cyclimorph-15

- **Moderate to severe pain (short-term use only)**
  - **By subcutaneous injection, or by intramuscular injection, or by intravenous injection**
  - Child 12-17 years: 1 mL, do not repeat dose more often than every 4 hours; maximum 3 doses per day

**Caution:** Myocardial infarction (cyclizine may aggravate severe heart failure and counteract the haemodynamic benefits of opioids). Not recommended in palliative care

**Interactions:** Appendix 1: antihistamines, sedating opioids

### Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

#### Solution for injection

- **Cyclimorph (AdvancPharma)**
  - Morphine tartrate 15 mg per 1 mL, Cyclizine tartrate 50 mg per 1 mL
  - Cyclimorph 15 solution for injection 1 mL ampoules
    - 5 ampoules | £9.12 (CD)
  - Morphine tartrate 10 mg per 1 mL, Cyclizine tartrate 50 mg per 1 mL
  - Cyclimorph 10 solution for injection 1 mL ampoules
    - 5 ampoules | £8.77 (CD)

### Oxycodone hydrochloride

#### Indications and dose

**Moderate to severe pain in palliative care**

- **By mouth using immediate-release medicines**
  - Child 1 month–11 years: Initially 200 micrograms/kg every 4–6 hours (max. per dose 5 mg), dose to be increased if necessary according to severity of pain
  - Child 12–17 years: Initially 5 mg every 4–6 hours, dose to be increased if necessary according to severity of pain

- **By mouth using modified-release medicines**
  - Child 8–11 years: Initially 5 mg every 12 hours, dose to be increased if necessary according to severity of pain, use 12-hourly modified-release preparations for this dose; see Prescribing and dispensing information
  - Child 12–17 years: Initially 10 mg every 12 hours, dose to be increased if necessary according to severity of pain, use 12-hourly modified-release preparations for this dose; see Prescribing and dispensing information

**Dose equivalence and conversion**

- 2 mg oral oxycodone is approximately equivalent to 1 mg parenteral oxycodone.

**Oxenila XL**

#### Severe pain

- **By mouth**
  - Child 12–17 years: Initially 10 mg every 24 hours, dose to be increased if necessary according to severity of pain, some patients may require higher doses than the maximum daily dose; maximum 400 mg per day

**Unlicensed use**

Oxycodone preparations are not licensed for use in children under 12 years and some may not be licensed for use in children—further information can be found in the product literature of the individual preparations.

#### Important safety information

Do not confuse modified-release 12-hourly preparations with 24-hourly preparations, see Prescribing and dispensing information.
Rare or very rare
- Haemorrhage
- Lymphadenopathy
- Muscle spasms
- Photosensitivity reaction
- Tooth discoloration
- Weight changes

Frequency known
- Aggression
- Amnorrhoea
- Cholestasis

Breast feeding
- Present in milk—avoid.

Hepatic impairment
- Manufacturer advises caution in mild impairment; avoid in moderate to severe impairment.

Dose adjustments
- In adults, manufacturer advises initial dose reduction in mild impairment—consult product literature.

Renal impairment
- Opioid effects increased and prolonged and increased cerebral sensitivity occurs. Avoid if estimated glomerular filtration rate less than 10 ml/min/1.73 m².

Dose
- Initial dose 2.5 mg every 6 hours in patients not currently treated with an opioid with mild to moderate impairment.

Prescribing and dispensing information
- Modified-release preparations are available as 12-hourly or 24-hourly formulations. Preparations that should be given 12-hourly include Abtard™, Carexil™, Infosys™, Leveraxo™, Longtec™, Oceltra™, OxyContin™, Oxypro™, Oxylan™, Relubon™, and Renocontin®. Preparations that should be given 24-hourly include Onexila™ XL.

Palliative care
- For further information on the use of oxycodone in palliative care, see www.medicinescomplete.com/#/content/palliative/oxycodone.

Medicinal forms
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution, solution for infusion.

Modified-release tablet
- CAUTIONARY AND ADVISORY LABELS 2, 25

- Abtard (Ethypaln UK Ltd)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £6.26 DT + £15.25 (C02)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £12.52 DT + £25.04 (C02)
  - Oxycodone hydrochloride 15 mg
  - 28 tablet (PsO) £19.06 DT + £38.12 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £38.11 DT + £76.23 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)
  - Oxycodone hydrochloride 60 mg
  - 28 tablet (PsO) £65.70 DT + £115.24 (C02)
  - Carexil (Sandob Ltd)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £6.26 DT + £15.25 (C02)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £12.52 DT + £25.04 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £38.11 DT + £76.23 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)

- OxyContin (AstraZeneca Ltd)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £11.52 DT + £23.04 (C02)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £19.06 DT + £38.12 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £38.11 DT + £76.23 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)
  - Oxycodone hydrochloride 80 mg
  - 28 tablet (PsO) £65.70 DT + £115.24 (C02)
  - Oxycodone hydrochloride 120 mg
  - 28 tablet (PsO) £93.70 DT + £175.40 (C02)

- OxyContin (Mann Pharmaceuticals Ltd)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £19.06 DT + £38.12 (C02)

- Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £38.11 DT + £76.23 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)
  - Oxycodone hydrochloride 60 mg
  - 28 tablet (PsO) £65.70 DT + £115.24 (C02)

- Leveraxo (Mylan)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £12.39 DT + £25.52 (C02)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £24.79 DT + £50.04 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £49.58 DT + £99.08 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £70.60 DT + £140.30 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £99.19 DT + £198.39 (C02)
  - Oxycodone hydrochloride 60 mg
  - 28 tablet (PsO) £110.97 DT + £215.49 (C02)
  - Oxycodone hydrochloride 80 mg
  - 28 tablet (PsO) £138.39 DT + £280.39 (C02)

- Oxeltra (Gilead Sciences UK Ltd)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £12.52 DT + £25.04 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)
  - Oxycodone hydrochloride 60 mg
  - 28 tablet (PsO) £65.70 DT + £115.24 (C02)

- Onexila XL (Aspire Pharma Ltd)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £12.52 DT + £25.04 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)
  - Oxycodone hydrochloride 60 mg
  - 28 tablet (PsO) £65.70 DT + £115.24 (C02)

- Oxeltra (Wockhardt UK Ltd)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £12.52 DT + £25.04 (C02)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £19.06 DT + £38.12 (C02)
  - Oxycodone hydrochloride 15 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £31.57 DT + £63.14 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £40.10 DT + £80.20 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £52.51 DT + £105.02 (C02)

- OxyContin (Mann Pharmaceuticals Ltd)
  - Oxycodone hydrochloride 5 mg
  - 28 tablet (PsO) £12.52 DT + £25.04 (C02)
  - Oxycodone hydrochloride 10 mg
  - 28 tablet (PsO) £25.04 DT + £50.08 (C02)
  - Oxycodone hydrochloride 15 mg
  - 28 tablet (PsO) £38.12 DT + £76.23 (C02)
  - Oxycodone hydrochloride 20 mg
  - 28 tablet (PsO) £50.09 DT + £100.19 (C02)
  - Oxycodone hydrochloride 30 mg
  - 28 tablet (PsO) £65.70 DT + £115.24 (C02)
  - Oxycodone hydrochloride 40 mg
  - 28 tablet (PsO) £83.28 DT + £166.56 (C02)
  - Oxycodone hydrochloride 60 mg
  - 28 tablet (PsO) £110.97 DT + £215.49 (C02)
  - Oxycodone hydrochloride 80 mg
  - 28 tablet (PsO) £138.39 DT + £280.39 (C02)
**Indications and Dose**

**Postoperative Analgesia** | Severe Chronic Pain

- **By Subcutaneous Injection, or by Intramuscular Injection**
- **Neonate:** 115 micrograms/kg every 4 hours if required.
- **Child 1-11 months:** 154 micrograms/kg every 4 hours if required.
- **Child 1-5 years:** 1.93–3.85 mg every 4 hours if required.
- **Child 6-11 years:** 3.85–7.7 mg every 4 hours if required.
- **By Intravenous Injection**
- **Neonate:** Use 25 to 50% of the corresponding subcutaneous/intramuscular dose.
- **Child:** Use 25 to 50% of the corresponding subcutaneous/intramuscular dose.
Pethidine hydrochloride  
(Meperidine)

**INDICATIONS AND DOSE**

**Obstetric analgesia**
- By subcutaneous injection, or by intramuscular injection
  - Child 12-17 years: 1 mg/kg (max. per dose 100 mg), then 1 mg/kg after 1–3 hours if required; maximum 400 mg per day

**CONTRA-INDICATIONS**
Phaeochromocytoma

**CAUTIONS**
Accumulation of metabolites may result in neurotoxicity - cardiac arrhythmias - not suitable for severe continuing pain - severe cor pulmonale

**INTERACTIONS** → Appendix 1: opioids

**SIDE-EFFECTS**
Anxiety - asthenia - biliary spasm - coordination abnormal - delirium - dysuria - hypothermia - seizure - syncope - tremor

**Overdose**
Convulsions reported in overdosage.

**BREAST FEEDING**
Present in milk but not known to be harmful.

**HEPATIC IMPAIRMENT**
Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

**Dose adjustments**
Manufacturer advises dose reduction in mild to moderate impairment.

**RENAL IMPAIRMENT**
Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

**Solution for injection**
- Pethidine hydrochloride (Non-proprietary)
  - Pethidine hydrochloride 50 mg per 1 ml
  - Pethidine 50mg/1ml solution for injection ampoules | 10 ampoule [P] £5.11 DT + £5.11 [D]

- Pethidine 100mg/2ml solution for injection ampoules | 10 ampoule [P] £4.66 DT + £4.66 [D]

**TAPENTADOL**

**INDICATIONS AND DOSE**
Moderate to severe acute pain which can be managed only with opioid analgesics
- By mouth using oral solution
  - Child 2–17 years (specialist supervision in hospital): 1.25 mg/kg every 4 hours (max. per dose 100 mg) for up to 3 days, the dose for children with a high BMI must not exceed the calculated dose for a body-weight at the 97.5 percentile for the given age

**IMPORTANT SAFETY INFORMATION**
MHRA/CHM ADVICE: TAPENTADOL (PALEXIA®): RISK OF SEIZURES AND REPORTS OF SEROTONIN SYNDROME WHEN CO-ADMINISTERED WITH OTHER MEDICINES (JANUARY 2019)

Tapentadol can induce seizures and should be prescribed with caution in patients with a history of seizure disorders or epilepsy. Seizure risk may be increased in patients taking other medicines that lower seizure threshold, for example, antidepressants such as selective serotonin reuptake inhibitors (SSRIs), serotonin-noradrenaline reuptake inhibitors (SNRIs), tricyclic antidepressants, and antipsychotics.

Serotonin syndrome has been reported when tapentadol is used in combination with serotonergic antidepressants—withdrawal of the serotonergic medicine, together with supportive symptomatic care, usually brings about a rapid improvement in serotonin syndrome.

**CAUTIONS**
Obesity

**INTERACTIONS** → Appendix 1: opioids

**SIDE-EFFECTS**
Common or very common Anxiety · appetite decreased · asthenia · diarrhoea · feeling of body temperature change · gastrointestinal discomfort · muscle spasms · sleep disorders · tremor

Uncommon Concentration impaired · depressed mood · dysarthria · dyspnoea · feeling abnormal · irritability · memory loss · movement disorders · muscle contractions involuntary · oedema · sensation abnormal · urinary disorders

Rare or very rare Angioedema · impaired gastric emptying · level of consciousness decreased · seizure · thinking abnormal

**BREAST FEEDING**
Avoid—no information available.

**HEPATIC IMPAIRMENT**
Manufacturer advises avoid (no information available).

**RENAL IMPAIRMENT**
Manufacturer advises avoid (no information available).
Nervous system

MEDICATION FORMS

NATIONAL FUNDING/ACCESS DECISIONS

There can be variation in the licensing of different medicines containing the same drug.

Oral solution

CAUTIONARY AND ADVISORY LABELS 2

EXCIPIENTS: May contain Propylene glycol

Palexia (Grunenthal Ltd)

Tramadol hydrochloride

07-Sep-2018

Tramadol hydrochloride

07-Sep-2018

Palexia

CAUTIONARY AND ADVISORY LABELS

2

Oral solution

24

Tapentadol (as Tapentadol hydrochloride) 20 mg per 1 ml Palexia

20mg/ml oral solution sugar-free | 100 ml (Pax) £17.80 DT = £17.80 (SR) sugar-free | 200 ml (Pax) £35.60 (SR)

CONTRA-INDICATIONS

Acute intoxication with alcohol - acute intoxication with analgesics - acute intoxication with hypnotics - acute intoxication with opioids - compromised respiratory function - not suitable for narcotic withdrawal treatment - uncontrolled epilepsy

CAUTIONS

Excessive bronchial secretions - history of epilepsy — use tramadol only if compelling reasons - impaired consciousness - not suitable as a substitute in opioid-dependent patients - not suitable in some types of general anaesthesia - postoperative use - susceptibility to seizures — use tramadol only if compelling reasons - variation in metabolism

CAUTIONS, FURTHER INFORMATION

General anaesthesia

Not recommended for analgesia during potentially light planes of general anaesthesia (possibly increased intra-operative recall reported).

Variation in metabolism

The capacity to metabolise tramadol can vary considerably between individuals; there is a risk of developing side-effects of opioid toxicity in patients who are ultra-rapid tramadol metabolisers (CYP 2D6 ultra-rapid metabolisers) and the therapeutic effect may be reduced in poor tramadol metabolisers.

Postoperative use

Manufacturer advises extreme caution when used for postoperative pain relief in children— reports of rare, but life threatening adverse events after tonsillectomy and/or adenoidectomy for obstructive sleep apnoea; if used, monitor closely for symptoms of opioid toxicity.

INTERACTIONS

Appendix 1: opioids

SIDE-EFFECTS

GENERAL SIDE-EFFECTS

Common or very common

Fatigue

Rare or very rare

Dyspnoea - epileptiform seizure - respiratory disorders - sleep disorders - vision blurred

Frequency not known

Asthma exacerbated - hypoglycaemia

SPECIFIC SIDE-EFFECTS

Uncommon

With parenteral use

Circulatory collapse - gastrointestinal discomfort

Rare or very rare

With parenteral use

Angioedema - appetite change - behaviour abnormal - cognitive disorder - dystonia - hypersensitivity - mood altered - movement disorders - muscle weakness - perception disorders - psychiatric disorder - sensation abnormal

Frequency not known

With oral use

Anxiety - blood disorder - gastrointestinal disorder - hyperkinesia - hypertension - paraesthesia - syncope - tremor - urinary disorder

PREGNANCY

Embryotoxic in animal studies — manufacturers advise avoid.

BREAST FEEDING

Amount probably too small to be harmful, but manufacturer advises avoid.

HEPATIC IMPAIRMENT

Manufacturers advise caution (risk of delayed elimination); some oral preparations should be avoided in severe impairment—consult product literature.

Dose adjustments

Manufacturers advise consider increasing dosage interval.

RENAL IMPAIRMENT

Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs. Caution (avoid for oral drops) in severe impairment.

TREATMENT CESSATION

Manufacturer advises consider tapering the dose gradually to prevent withdrawal symptoms.

DIRECTIONS FOR ADMINISTRATION

Tramadol hydrochloride orodispersible tablets should be sucked and then swallowed. May also be dispersed in water. Some tramadol hydrochloride modified-release capsule preparations may be opened and the contents swallowed.

NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

SMC No. 654/10

The Scottish Medicines Consortium has advised (June 2011) that tapentadol (Palexia® SR) is accepted for restricted use within NHS Scotland for the management of severe chronic pain in adult patients, which can be adequately managed only with opioid analgesics, when morphine sulfate modified-release has failed to provide adequate pain control or is not tolerated.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Oral solution

CAUTIONARY AND ADVISORY LABELS 2

EXCIPIENTS: May contain Propylene glycol

Palexia (Grunenthal Ltd)

Tramadol hydrochloride

07-Sep-2018

Tramadol hydrochloride

07-Sep-2018

Palexia

CAUTIONARY AND ADVISORY LABELS

2

Oral solution

24

Tapentadol (as Tapentadol hydrochloride) 20 mg per 1 ml Palexia

20mg/ml oral solution sugar-free | 100 ml (Pax) £17.80 DT = £17.80 (SR) sugar-free | 200 ml (Pax) £35.60 (SR)

CONTRA-INDICATIONS

Acute intoxication with alcohol - acute intoxication with analgesics - acute intoxication with hypnotics - acute intoxication with opioids - compromised respiratory function - not suitable for narcotic withdrawal treatment - uncontrolled epilepsy

CAUTIONS

Excessive bronchial secretions - history of epilepsy — use tramadol only if compelling reasons - impaired consciousness - not suitable as a substitute in opioid-dependent patients - not suitable in some types of general anaesthesia - postoperative use - susceptibility to seizures — use tramadol only if compelling reasons - variation in metabolism

CAUTIONS, FURTHER INFORMATION

General anaesthesia

Not recommended for analgesia during potentially light planes of general anaesthesia (possibly increased intra-operative recall reported).

Variation in metabolism

The capacity to metabolise tramadol can vary considerably between individuals; there is a risk of developing side-effects of opioid toxicity in patients who are ultra-rapid tramadol metabolisers (CYP 2D6 ultra-rapid metabolisers) and the therapeutic effect may be reduced in poor tramadol metabolisers.

Postoperative use

Manufacturer advises extreme caution when used for postoperative pain relief in children— reports of rare, but life threatening adverse events after tonsillectomy and/or adenoidectomy for obstructive sleep apnoea; if used, monitor closely for symptoms of opioid toxicity.

INTERACTIONS

Appendix 1: opioids

SIDE-EFFECTS

GENERAL SIDE-EFFECTS

Common or very common

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Rare or very rare

Dyspnoea - epileptiform seizure - respiratory disorders - sleep disorders - vision blurred

Frequency not known

Asthma exacerbated - hypoglycaemia

SPECIFIC SIDE-EFFECTS

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With parenteral use

Circulatory collapse - gastrointestinal discomfort

Rare or very rare

With parenteral use

Angioedema - appetite change - behaviour abnormal - cognitive disorder - dystonia - hypersensitivity - mood altered - movement disorders - muscle weakness - perception disorders - psychiatric disorder - sensation abnormal

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PREGNANCY

Embryotoxic in animal studies — manufacturers advise avoid.

BREAST FEEDING

Amount probably too small to be harmful, but manufacturer advises avoid.

HEPATIC IMPAIRMENT

Manufacturers advise caution (risk of delayed elimination); some oral preparations should be avoided in severe impairment—consult product literature.

Dose adjustments

Manufacturers advise consider increasing dosage interval.

RENAL IMPAIRMENT

Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs. Caution (avoid for oral drops) in severe impairment.

TREATMENT CESSATION

Manufacturer advises consider tapering the dose gradually to prevent withdrawal symptoms.

DIRECTIONS FOR ADMINISTRATION

Tramadol hydrochloride orodispersible tablets should be sucked and then swallowed. May also be dispersed in water. Some tramadol hydrochloride modified-release capsule preparations may be opened and the contents swallowed.
immediately without chewing—check individual preparations.

For intravenous infusion, dilute in Glucose 5% or Sodium Chloride 0.9%.

**Prescribing and dispensing information**
Modified-release preparations are available as 12-hourly or 24-hourly formulations. Non-proprietary preparations of modified-release tramadol may be available as either 12-hourly or 24-hourly formulations; prescribers and dispensers must ensure that the correct formulation is prescribed and dispensed. Branded preparations that should be given 12-hourly include **Invodol SR**, **Mabron**, **Maneo**®, **Marol**®, **Maxitram SR**, **Oldaram**, **Tilodol SR**, **Tramulief SR**, **Tramel SR**, **Zamirol SR**, **Zeridame SR**, **Zytramol SR**, **Zydol SR** and **Zydot SR**. Preparations that should be given 24-hourly include **Tradorec XL®**, **Zamadol® 24hr**, and **Zydot XL®**.

**Patient and carer advice**
Patients or carers should be given advice on how to administer tramadol hydrochloride orodispersible tablets. Medicines for Children leaflet: Tramadol for pain

www.medicinesforchildren.org.uk/tramadol-pain

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

<table>
<thead>
<tr>
<th>Modified-release tablet CAUTIONARY AND ADVISORY LABELS</th>
<th>2, 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol hydrochloride 100 mg Brimisol PR 100mg tablets</td>
<td>60 tablet £18.00 (C03)</td>
</tr>
<tr>
<td><strong>Invodol SR</strong> (Ennogen Healthcare Ltd) Tramadol hydrochloride 100 mg Invodol SR 100mg tablets</td>
<td>60 tablet £9.55 (C03)</td>
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<tr>
<td>Tramadol hydrochloride 150 mg Invodol SR 150mg tablets</td>
<td>60 tablet £8.31 (C03)</td>
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<tr>
<td>Tramadol hydrochloride 200 mg Invodol SR 200mg tablets</td>
<td>60 tablet £11.35 (C03)</td>
</tr>
<tr>
<td><strong>Mabron</strong> (Morningside Healthcare Ltd, Teva UK Ltd) Tramadol hydrochloride 100 mg Mabron 100mg modified-release tablets</td>
<td>60 tablet £11.52 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 150 mg Mabron 150mg modified-release tablets</td>
<td>60 tablet £23.28 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 200 mg Mabron 200mg modified-release tablets</td>
<td>60 tablet £31.04 (C03)</td>
</tr>
<tr>
<td><strong>Maneo</strong> (Mylan) Tramadol hydrochloride 100 mg Maneo 100mg modified-release tablets</td>
<td>60 tablet £6.39 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 150 mg Maneo 150mg modified-release tablets</td>
<td>60 tablet £10.40 (C03)</td>
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<tr>
<td>Tramadol hydrochloride 200 mg Maneo 200mg modified-release tablets</td>
<td>60 tablet £14.20 (C03)</td>
</tr>
<tr>
<td><strong>Marol</strong> (Teva UK Ltd) Marol hydrochloride 100 mg Marol 100mg modified-release tablets</td>
<td>60 tablet £6.94 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 150 mg Marol 150mg modified-release tablets</td>
<td>60 tablet £10.39 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 200 mg Marol 200mg modified-release tablets</td>
<td>60 tablet £14.19 (C03)</td>
</tr>
</tbody>
</table>

| Tilodol SR (Sandoz Ltd) Tilodol hydrochloride 100 mg Tilodol SR 100mg tablets | 60 tablet £15.52 (C03) |
| Tramadol hydrochloride 150 mg Tilodol SR 150mg tablets | 60 tablet £23.28 (C03) |
| Tramadol hydrochloride 200 mg Tilodol SR 200mg tablets | 60 tablet £33.01 (C03) |
| **Tradorec XL** (Endo Ventures Ltd) Tramadol hydrochloride 100 mg Tradorec XL 100mg tablets | 30 tablet £14.10 (C03) |
| Tramadol hydrochloride 150 mg Tradorec XL 150mg tablets | 30 tablet £14.98 (C03) |
| Tramadol hydrochloride 200 mg Tradorec XL 200mg tablets | 30 tablet £22.47 (C03) |
| **Tramel SR** (Advancis Pharma) Tramulief SR 100mg tablets | 60 tablet £6.98 (C03) |
| Tramulief SR 100mg tablets | 60 tablet £10.48 (C03) |
| Tramulief SR 200mg tablets | 60 tablet £14.28 (C03) |
| **Zamadol 24hr** (Mega Pharmaceuticals Ltd) Tramadol hydrochloride 150 mg Zamadol 24hr 150mg modified-release tablets | 28 tablet £10.70 (C03) |
| Tramadol hydrochloride 200 mg Zamadol 24hr 200mg modified-release tablets | 28 tablet £14.26 (C03) |
| Tramadol hydrochloride 300 mg Zamadol 24hr 300mg modified-release tablets | 28 tablet £21.39 (C03) |
| Tramadol hydrochloride 400 mg Zamadol 24hr 400mg modified-release tablets | 28 tablet £28.51 DT = £28.51 (C03) |
| **Zeridame SR** (Actavis UK Ltd) Tramadol hydrochloride 100 mg Zeridame SR 100mg tablets | 60 tablet £17.21 (C03) |
| Tramadol hydrochloride 150 mg Zeridame SR 150mg tablets | 60 tablet £25.82 (C03) |
| Tramadol hydrochloride 200 mg Zeridame SR 200mg tablets | 60 tablet £34.43 (C03) |
| **Zydot XL** (Grunenthal Ltd) Tramadol hydrochloride 50 mg Zydot XL 50mg tablets | 30 tablet £6.60 DT = £4.60 (C03) |
| Tramadol hydrochloride 100 mg Zydot XL 100mg tablets | 30 tablet £11.72 (C03) |
| Tramadol hydrochloride 150 mg Zydot XL 150mg tablets | 30 tablet £25.83 (C03) |
| Tramadol hydrochloride 200 mg Zydot XL 200mg tablets | 30 tablet £34.40 (C03) |
| **Zydot XL** (Grunenthal Ltd) Tramadol hydrochloride 150 mg Zydot XL 150mg tablets | 30 tablet £17.98 (C03) |
| Tramadol hydrochloride 200 mg Zydot XL 200mg tablets | 30 tablet £31.04 (C03) |
| **Zydot** (Grunenthal Ltd) Tramadol hydrochloride 100 mg Zydot 100mg tablets | 60 tablet £34.43 (C03) |
| Tramadol hydrochloride 150 mg Zydot 150mg tablets | 60 tablet £34.43 (C03) |
| Tramadol hydrochloride 200 mg Zydot 200mg tablets | 60 tablet £34.43 (C03) |
| **Zydot** (Grunenthal Ltd) Tramadol hydrochloride 100 mg Zydot 100mg tablets | 30 tablet £13.35 DT = £13.33 (C03) |
| Tramadol hydrochloride 150 mg Zydot 150mg tablets | 30 tablet £20.49 (C03) |
| Tramadol hydrochloride 200 mg Zydot 200mg tablets | 30 tablet £28.60 (C03) |
| **Zydot** (Grunenthal Ltd) Tramadol hydrochloride 100 mg Zydot 100mg tablets | 10 tablet £6.94 (C03) |
| Tramadol hydrochloride 150 mg Zydot 150mg tablets | 10 tablet £10.39 (C03) |
| Tramadol hydrochloride 200 mg Zydot 200mg tablets | 10 tablet £14.19 (C03) |

<table>
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<tr>
<th>Soluble tablet CAUTIONARY AND ADVISORY LABELS</th>
<th>2, 13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zydot</strong> (Grunenthal Ltd) Tramadol hydrochloride 50 mg Zydot 50mg soluble tablets sugar-free</td>
<td>1 tablet £13.33 DT = £13.33 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 100 mg per 1 ml Tramadol 100mg/2ml solution for injection ampoules</td>
<td>5 ampoule £4.90 DT = £4.90 (C03)</td>
</tr>
<tr>
<td><strong>Zamadol</strong> (Mega Pharmaceuticals Ltd) Tramadol hydrochloride 50 mg per 1 ml Zamadol 100mg/2ml solution for injection ampoules</td>
<td>5 ampoule £15.49 DT = £15.49 (C03)</td>
</tr>
<tr>
<td><strong>Zydot</strong> (Grunenthal Ltd) Tramadol hydrochloride 50 mg per 1 ml Zydot 50mg/2ml solution for injection ampoules</td>
<td>5 ampoule £4.00 DT = £4.00 (C03)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modified-release capsule CAUTIONARY AND ADVISORY LABELS</th>
<th>2, 13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maxitram SR</strong> (Chiesi Ltd) Tramadol hydrochloride 50 mg Maxitram SR 50mg capsules</td>
<td>60 capsule £4.55 DT = £4.72 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 100 mg Maxitram SR 100mg capsules</td>
<td>60 capsule £11.14 DT = £11.47 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 150 mg Maxitram SR 150mg capsules</td>
<td>60 capsule £18.21 DT = £18.71 (C03)</td>
</tr>
<tr>
<td>Tramadol hydrochloride 200 mg Maxitram SR 200mg capsules</td>
<td>60 capsule £24.28 DT = £24.93 (C03)</td>
</tr>
<tr>
<td><strong>Tramequ SR</strong> (Beecham Pharmaceuticals Ltd) Tramulief SR 50mg capsules</td>
<td>60 capsule £7.24 DT = £7.24 (C03)</td>
</tr>
<tr>
<td>Tramulief SR 100mg capsules</td>
<td>60 capsule £14.47 DT = £14.47 (C03)</td>
</tr>
</tbody>
</table>
Tramadol hydrochloride 150 mg Tramquil SR 150mg capsules | 60 capsule [Pax] £21.71 DT + £21.71 [CO]
Tramadol hydrochloride 200 mg Tramquil SR 200mg capsules | 60 capsule [Pax] £28.93 DT + £28.93 [CO]
Zamadol SR (Meta Pharmaceuticals Ltd) Trapadol hydrochloride 50 mg Zamadol SR 50mg capsules | 60 capsule [Pax] £7.24 DT + £7.24 [CO]
Tramadol hydrochloride 100 mg Zamadol SR 100mg capsules | 60 capsule [Pax] £14.47 DT + £14.47 [CO]
Tramadol hydrochloride 150 mg Zamadol SR 150mg capsules | 60 capsule [Pax] £21.71 DT + £21.71 [CO]
Tramadol hydrochloride 200 mg Zamadol SR 200mg capsules | 60 capsule [Pax] £28.93 DT + £28.93 [CO]

Oral drops
CAUTIONARY AND ADVISORY LABELS 2, 13
- Tramadol hydrochloride (non-proprietary)
  - Tramadol (as Tramadol hydrochloride) 100 mg per 1 ml Tramadol 100mg/ml oral drops | 10 ml [Pax] £3.50 DT + £3.50 [CO]

Capsule
CAUTIONARY AND ADVISORY LABELS 2
- Tramadol hydrochloride (non-proprietary)
  - Tramadol hydrochloride 50 mg, Tramadol 50mg capsules | 30 capsule [Pax] £1.99 DT + £0.73 [CO] | 100 capsule [Pax] £14.40 DT + £2.43 [CO]
  - Zamadol (Meta Pharmaceuticals Ltd) Trapadol hydrochloride 50 mg, Zamadol 50mg capsules | 100 capsule [Pax] £8.00 DT + £2.43 [CO]
  - Zyldol (Grunenthal Ltd) Trapadol hydrochloride 50 mg, Zyrol 50mg capsules | 30 capsule [Pax] £2.29 DT + £0.75 [CO] | 100 capsule [Pax] £7.63 DT + £2.43 [CO]

Orodispersible tablet
CAUTIONARY AND ADVISORY LABELS 2
- Zamadol Melt (Meta Pharmaceuticals Ltd) Trapadol hydrochloride 50 mg, Zamadol Melt 50mg tablets sugar-free | 60 tablet [Pax] £7.12 DT + £7.12 [CO]

Combinations available: Tramadol with paracetamol, below

Tramadol with paracetamol
22-Feb-2018
The properties listed below are those particular to the combination only. For the properties of the components please consider, paracetamol p. 278, tramadol hydrochloride p. 296.

- INDICATIONS AND DOSE
  - Moderate to severe pain
    - BY MOUTH
      - Child 12-17 years: 75/650 mg every 6 hours as required

- DOSE EQUIVALENCE AND CONVERSION
  - The proportions are expressed in the form x/y, where x and y are the strengths in milligrams of tramadol and paracetamol respectively.

- INTERACTIONS
  - Appendix 1: opioids - paracetamol

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.

  Effervescent tablet
  CAUTIONARY AND ADVISORY LABELS 2, 13, 29, 30 ELECTROLYTES: May contain Sodium
  - Tramacet (Grunenthal Ltd) Trapadol hydrochloride 37.5 mg, Paracetamol 325 mg Trapadex 37.5mg/325mg effervescent tablets sugar-free | 60 tablet [Pax] £9.68 DT + £9.68 [CO]

  Tablet
  CAUTIONARY AND ADVISORY LABELS 2, 25, 29, 30
  - Tramadol with paracetamol (non-proprietary)
    - Tramadol hydrochloride 37.5 mg, Paracetamol 325 mg Trapadex 37.5mg/325mg tablets | 60 tablet [Pax] £2.27-£9.68 DT + £2.35 [CO]

  - Tramadol hydrochloride 75 mg, Paracetamol 650 mg Trapadex 75mg/650mg tablets | 30 tablet [Pax] £19.50 DT + £19.50 [CO]

5.1 Migraine

Migraine

Treatment of acute migraine

Treatment of a migraine attack should be guided by response to previous treatment and the severity of the attacks. A simple analgesia such as paracetamol p. 278 (preferably in a soluble or dispersible form) or an NSAID, usually ibuprofen p. 679, is often effective; concomitant antiemetic treatment may be required. If treatment with an analgesic is inadequate, an attack may be treated with a specific antimigraine compound such as the 5HT1-receptor agonist sumatriptan p. 299. Ergot alkaloids are associated with many side-effects and should be avoided.

Excessive use of acute treatments for migraine (opioid and non-opioid analgesics, 5HT1-receptor agonists, and ergotamine) is associated with medication-overuse headache (analgesic-induced headache); therefore, increasing consumption of these medicines needs careful management.

5HT1-receptor agonists

5HT1-receptor agonists are used in the treatment of acute migraine attacks; treatment of children should be initiated by a specialist. A 5HT1-receptor agonist may be used during the established headache phase of an attack and is the preferred treatment in those who fail to respond to conventional analgesics. 5HT1-receptor agonists are not indicated for the treatment of hemiplegic, basilar, or ophthalmoplegic migraine.

If a child does not respond to one 5HT1-receptor agonist, an alternative 5HT1-receptor agonist should be tried. For children who have prolonged attacks that frequently recur despite treatment with a 5HT1-receptor agonist, combination therapy with an NSAID such as naproxen p. 683 can be considered. Sumatriptan and zolmitriptan p. 309 are used for migraine in children. They may also be of value in cluster headache.

Antiemetics

Antiemetics, including domperidone p. 268, phenothiazines, and antihistamines, relieve the nausea associated with migraine attacks. Antiemetics may be given by intramuscular injection or rectally if vomiting is a problem. Domperidone has the added advantage of promoting gastric emptying and normal peristalsis; a single dose should be given at the onset of symptoms.

Prophylaxis of migraine

Where migraine attacks are frequent, possible provoking factors such as stress should be sought; combined oral contraceptives may also provoke migraine. Preventive treatment should be considered if migraine attacks interfere with school and social life, particularly for children who:

- suffer at least two attacks a month;
- suffer an increasing frequency of headaches;
- suffer significant disability despite suitable treatment for migraine attacks;
- cannot take suitable treatment for migraine attacks.

In children it is often possible to stop prophylaxis after a period of treatment. Propranolol hydrochloride p. 106 may be effective in preventing migraine in children but it is contra-indicated in
those with asthma. Side-effects such as depression and postural hypotension can further limit its use.

Pizotifen below, an antihistamine and a serotonin-receptor antagonist, may also be used but its efficacy in children has not been clearly established. Common side-effects include drowsiness and weight gain.

Topiramate p. 218 is licensed for migraine prophylaxis; see Conception and contraception, and Pregnancy in the topiramate drug monograph for information on use in females of childbearing potential and pregnancy.

Cluster headache and the trigeminal autonomic cephalalgias

Cluster headache rarely responds to standard analgesics. Sumatriptan given by subcutaneous injection is the drug of choice for the treatment of cluster headache. If an injection is unsuitable, sumatriptan nasal spray or zolmitriptan nasal spray may be used. Treatment should be initiated by a specialist. Alternatively, 100% oxygen at a rate of 10–15 litres/minute for 10–20 minutes is useful in aborting an attack.

The other trigeminal autonomic cephalalgias, paroxysmal hemicrania (sensitive to indometacin p. 681), and short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing, are seen rarely and are best managed by a specialist.

Other drugs used for Migraine

Antihistamines

Paracetamol with buclizine hydrochloride and codeine phosphate

The properties listed below are those particular to the combination only. For the properties of the components please consider, paracetamol p. 278, codeine phosphate p. 283.

● INDICATIONS AND DOSE

Migraleve®

Acute migraine

▷ BY MOUTH

Child 12-14 years: Initially 1 tablet, (pink tablet) to be taken at onset of attack, or if it is imminent, followed by 1 tablet every 4 hours if required, (yellow tablet) to be taken following initial dose; maximum 1 pink and 3 yellow tablets in 24 hours

Child 15-17 years: Initially 2 tablets, (pink tablets) to be taken at onset of attack or if it is imminent, followed by 2 tablets every 4 hours if required, (yellow tablets) to be taken following initial dose; maximum 2 pink and 6 yellow tablets in 24 hours

● INTERACTIONS → Appendix 1: antihistamines, sedating.

● PRESCRIBING AND DISPENSING INFORMATION See co-codemol p. 282 for Migraleve Yellow preparations.

LESS SUITABLE FOR PRESCRIBING

Migraleve® Migraleve® is less suitable for prescribing.

● MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Tablet

Cautionary and Advisory Labels 2, 17, 30

Migraleve Pink (McNeil Products Ltd) Buclizine hydrochloride 6.25 mg, Codeine phosphate 8 mg, Paracetamol 500 mg. Migraleve Pink tablets 12 tablet (P) £3.79 (C01) 24 tablet (P) £6.08 (C01) 48 tablet (P) £3.97 (C01)

TRIPTANS

Sumatriptan

● INDICATIONS AND DOSE

Treatment of acute migraine

▷ BY MOUTH

Child 6-9 years: Initially 25 mg for 1 dose, followed by 25 mg after at least 2 hours if required, to be taken only if migraine recurs (patient not responding to initial dose should not take second dose for same attack)

Child 10-11 years: Initially 50 mg for 1 dose, followed by 50 mg after at least 2 hours, to be taken only continued →
Nervous system

With intranasal use

Rare or very rare

Common or very common

CONTRA-INDICATIONS

Coronary vasospasm

Previous cerebrovascular accident

Prinzmetal

Tablets and injection not licensed for

Child 12–17 years: Initially 10–20 mg for dose, followed by 10–20 mg after at least 2 hours if required, to be taken only if migraine recurs (patient not responding to initial dose should not take second dose for same attack); maximum 40 mg per day

Treatment of acute cluster headache

BY SUBCUTANEOUS INJECTION

Child 10–17 years: Initially 6 mg for 1 dose, followed by 6 mg after at least 1 hour if required, to be taken only if migraine recurs (patient not responding to initial dose should not take second dose for same attack), dose to be administered using an auto-injector; maximum 12 mg per day

BY INTRANASAL ADMINISTRATION

Child 12–17 years: Initially 10–20 mg for 1 dose, followed by 10–20 mg after at least 2 hours if required, to be taken only if migraine recurs (patient not responding to initial dose should not take second dose for same attack); maximum 40 mg per day

TREATMENT OF ACUTE CLUSTER HEADACHE

BY SUBCUTANEOUS INJECTION

Child 10–17 years (under expert supervision): Initially 6 mg for 1 dose, followed by 6 mg after at least 1 hour if required, to be taken only if headache recurs (patient not responding to initial dose should not take second dose for same attack), dose to be administered using auto-injector; maximum 12 mg per day

BY INTRANASAL ADMINISTRATION

Child 12–17 years (under expert supervision): Initially 10–20 mg for 1 dose, followed by 10–20 mg after at least 2 hours if required, to be taken only if headache recurs (patient not responding to initial dose should not take second dose for same attack); maximum 40 mg per day

UNLICENSED USE


CONTRA-INDICATIONS

Coronary vasospasm - ischaemic heart disease - mild uncontrolled hypertension - moderate and severe hypertension - peripheral vascular disease - previous cerebrovascular accident - previous myocardial infarction - previous transient ischaemic attack - Prinzmetal's angina

CAUTIONS

Conditions which predispose to coronary artery disease - history of seizures - mild, controlled hypertension - pre-existing cardiac disease - risk factors for seizures

INTERACTIONS → Appendix 1: sumatriptan

SIDE-EFFECTS

GENERAL SIDE-EFFECTS

Common or very common - Asthma - dizziness - drowsiness - dyspnoea - feeling abnormal - flushing - malaise - nausea - pain - sensation abnormal - skin reactions - temperature sensation altered - vomiting

Rare or very rare - Hypersensitivity - Frequency not known - Angina pectoris - anxiety - arrhythmias - arthralgia - colitis ischaemic - coronary vasospasm - diarrhoea - dystonia - hyperhidrosis - hypotension - myocardial infarction - myalgia - palpitations - Raynaud's phenomenon - seizure - tremor - vision disorders

SPECIFIC SIDE-EFFECTS

Common or very common - With intranasal use - Epistaxis - nasal irritation - taste altered - throat irritation - With subcutaneous use - Haemorrhage - swelling

SIDE-EFFECTS, FURTHER INFORMATION

Discontinue if symptoms of heat, heaviness, pressure or tightness (including throat and chest) occur.

ALLERGY AND CROSS-SENSITIVITY

Caution in patients with sensitivity to sulfonamides.

PREGNANCY

There is limited experience of using 5HT1-receptor agonists during pregnancy; manufacturers advise that they should be avoided unless the potential benefit outweighs the risk.

BREAST FEEDING

Present in milk but amount probably too small to be harmful; withhold breast-feeding for 12 hours after treatment.

HEPATIC IMPAIRMENT

Manufacturer advises caution (reduced pre-systemic clearance increases exposure); avoid in severe impairment (no information available).

Dose adjustments → With oral use - In adults, manufacturer advises consider dose reduction—consult product literature.

RENAL IMPAIRMENT

Use with caution.

PATIENT AND CARER ADVICE

Medicines for Children leaflet: Sumatriptan for migraine headaches www.medicinesforchildren.org.uk/sumatriptan-migraine-headaches

Driving and skilled tasks - Drowsiness may affect performance of skilled tasks (e.g. driving).

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

SOLUTION FOR INJECTION

CAUTIONARY AND ADVISORY LABELS 3, 10

Sumatriptan (as Sumatriptan succinate) 12 mg per 1 ml

Sumatriptan (as Sumatriptan succinate) 12 mg per 1 ml

Imigran Subject 6mg/0.5ml solution for injection pre-filled syringe refill pack → 2 pre-filled disposable injection $50.96 DT + $50.96

Spray

CAUTIONARY AND ADVISORY LABELS 3, 10

Imigran (GlaxoSmithKline UK Ltd)

Imigran 100 mg per 1 ml

Imigran 200 mg per 1 ml

Imigran Subject 6mg/0.5ml solution for injection pre-filled syringe with device → 2 pre-filled disposable injection $50.96 DT + $50.96

Tablet

CAUTIONARY AND ADVISORY LABELS 3, 10

Sumatriptan (as Sumatriptan succinate) 50 mg

Sumatriptan 100 mg per 1 ml

Sumatriptan 200 mg per 1 ml

Imigran (GlaxoSmithKline UK Ltd)

Imigran 50mg tablets → 1 unit dose $33.00 DT + $2.90

Imigran 50mg tablets → 6 tablet $39.27 DT + $2.90

Imigran 200mg tablets → 1 unit dose $42.47 DT + $42.47

Migraitan (Bristol Laboratories Ltd)

Migraitan (as Sumatriptan succinate) 50 mg

Migraitan 50mg tablets → 2 tablet $4.44

Zolmitriptan

INDICATIONS AND DOSE

Treatment of acute migraine

BY MOUTH

Child 12–17 years: 2.5 mg, followed by 2.5 mg after at least 2 hours if required, dose to be taken only if migraine recurs, if response unsatisfactory after 3 attacks consider increasing dose to 5 mg or switching to alternative treatment; maximum 10 mg per day

BNFC 2019–2020

300 Pain
Neuropathic pain

Overview and management

Neuropathic pain, which occurs as a result of damage to neural tissue, includes compression neuropathies, peripheral neuropathies (e.g. due to Diabetic complications p. 466, HIV infection p. 425, chemotherapy), trauma, idiopathic neuropathy, central pain (e.g. pain following spinal cord injury and syringomyelia), postherpetic neuralgia, and phantom limb pain. The pain may occur in an area of sensory deficit and may be described as burning, shooting or scalding; it may be accompanied by pain that is evoked by a nonnoxious stimulus (allodynia).

Children with chronic neuropathic pain require multidisciplinary management, which may include physiotherapy and psychological support. Neuropathic pain is generally managed with a tricyclic antidepressant such as amitriptyline hydrochloride p. 245 or antiepileptic drugs such as carbamazepine p. 200. Children with localised pain may benefit from topical local anaesthetic preparations, particularly while awaiting specialist review. Neuropathic pain may respond only partially to opioid analgesics. A corticosteroid may help to relieve pressure in compression neuropathy and thereby reduce pain.

Chronic facial pain

Chronic oral and facial pain including persistent idiopathic facial pain (also termed ‘atypical facial pain’) and temporo mandibular dysfunction (previously termed temporomandibular joint pain dysfunction syndrome) may call for prolonged use of analgesics or for other drugs. Tricyclic antidepressants may be useful for facial pain (unlicensed indication), but are not on the Dental Practitioners’ List. Disorders of this type require specialist referral and psychological support to accompany drug treatment. Children on long-term therapy need to be monitored both for progress and for side-effects.
6 Sleep disorders

6.1 Insomnia

Hypnotics and anxiolytics

Overview

Most anxiolytics (‘sedatives’) will induce sleep when given at night and most hypnotics will sedate when given during the day. Hypnotics and anxiolytics should be reserved for short courses to alleviate acute conditions after causal factors have been established.

The role of drug therapy in the management of anxiety disorders in children and adolescents is uncertain; drug therapy should be initiated only by specialists after psychosocial interventions have failed. Benzodiazepines and tricyclic antidepressants have been used but adverse effects may be problematic.

Hypnotics

The prescribing of hypnotics to children, except for occasional use such as for sedation for procedures is not justified. There is a risk of habituation with prolonged use. Problems settling children at night should be managed with behavioural therapy.

Dental procedures

Some anxious children may benefit from the use of a hypnotic the night before a dental appointment.

Chloral and derivatives

Chloral hydrate below and derivatives were formerly popular hypnotics for children. Chloral hydrate is now mainly used for sedation during diagnostic procedures.

Antihistamines

Some antihistamines such as promethazine hydrochloride p. 183 are used for occasional insomnia in adults; their prolonged duration of action can often cause drowsiness the following day. The sedative effect of antihistamines may diminish after a few days of continued treatment; antihistamines are associated with headache, psychomotor impairment and antimuscarinic effects. The use of hypnotics in children is not usually justified.

Melatonin

Melatonin p. 303 is a pineal hormone that may affect sleep pattern. Clinical experience suggests that when appropriate behavioural sleep interventions fail, melatonin may be of value for treating sleep onset insomnia and delayed sleep phase syndrome in children with conditions such as visual impairment, cerebral palsy, autism, and learning difficulties. It is also sometimes used before magnetic resonance imaging (MRI), computed tomography (CT), or EEG investigations. Little is known about its long-term effects in children, and there is uncertainty as to the effect on other circadian rhythms including endocrine or reproductive hormone secretion. The need to continue melatonin therapy should be reviewed every 6 months.

Anxiolytics

Anxiolytic treatment should be used in children only to relieve acute anxiety (and related insomnia) caused by fear (e.g. before surgery). Anxiolytic treatment should be limited to the lowest possible dose for the shortest possible time.

Buspirone

Buspironone hydrochloride is thought to act at specific serotonin (SHT1a) receptors; safety and efficacy in children have yet to be determined.
**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, suppository, enema

**Tablet**
- **Chloralhydrate (Non-proprietary)**
  - Cloral betaine 707 mg: Cloral betaine 707mg tablets | 30 tablet (PBN) £138.59 DT + £138.59
- **Oral solution**
  - CAUTIONARY AND ADVISORY LABELS (1 paediatric solution only), 19 (solution other than paediatric only), 27
  - Choral hydrate (Non-proprietary)
    - Choral hydrate 28.66 mg per 1 ml: Choral hydrate 143.3mg/5ml oral solution BP | 150 ml (PBN) £24.25 DT + £24.25

**SIDE-EFFECTS**
- Rare or very rare
  - Angina pectoris
  - Arthritis
  - Concentration impaired
  - Crying
  - Depression
  - Disorientation
  - Electrolyte imbalance
  - Excessive tearing
  - Gastrointestinal disorders
  - Haemorrhage
  - Hot flush
  - Hypertiglyceridaemia
  - Leucopenia
  - Memory loss
  - Muscle complaints
  - Nail disorder
  - Palpitations
  - Parasthesia
  - Prostatitis
  - Seizures
  - Sexual dysfunction
  - Syncope
  - Thirst
  - Thrombocytopenia
  - Urinary disorders
  - Vertigo
  - Vision disorders
  - Vomiting
- Frequency not known
  - Angiodema
  - Appetite decreased
  - Constipation
  - Dry mouth
  - Excessive tearing
  - Gastrointestinal discomfort
  - Hyperthirubinaemia
  - Hypertension
  - Menopausal symptoms
  - Movement disorders
  - Nausea
  - Night sweats
  - Oral disorders
  - Skin reactions
  - Urine abnormalities
  - Weight increased
- Uncommon
  - Anxiety
  - Asthma
  - Chest pain
  - Dizziness
  - Dry mouth
  - Gastrointestinal discomfort
  - Hypertension
  - Menopausal symptoms
  - Movement disorders
  - Memory loss
- Rare or very rare
  - Angina pectoris
  - Arthritis
  - Concentration impaired
  - Crying
  - Depression
  - Disorientation
  - Electrolyte imbalance
  - Excessive tearing
  - Gastrointestinal disorders
  - Haemorrhage
  - Hot flush
  - Hypertiglyceridaemia
  - Leucopenia
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  - Muscle complaints
  - Nail disorder
  - Palpitations
  - Parasthesia
  - Prostatitis
  - Seizures
  - Sexual dysfunction
  - Syncope
  - Thirst
  - Thrombocytopenia
  - Urinary disorders
  - Vertigo
  - Vision disorders
  - Vomiting
- Frequency not known
  - Angiodema
  - Appetite decreased
  - Constipation
  - Dry mouth

**CAUTIONS**

**UNLICENSED USE** Melatonin is used for sleep onset insomnia and delayed sleep phase syndrome, but is not licensed for these indications.

**INTERACTIONS**

**SIDE-EFFECTS**
- Common or very common
  - Arthralgia
  - Behaviour abnormal
  - Drowsiness
  - Feeling abnormal
  - Headaches
  - Increased risk of infection
  - Mood altered
  - Pain
  - Sleep disorders
- Uncommon
  - Anxiety
  - Asthenia
  - Chest pain
  - Dizziness
  - Dry mouth
  - Gastrointestinal discomfort
  - Hyperthirubinaemia
  - Hypertension
  - Menopausal symptoms
  - Movement disorders
  - Nausea
  - Night sweats
  - Oral disorders
  - Skin reactions
  - Urine abnormalities
  - Weight increased

**PREGNANCY**

**BREAST FEEDING**

**HEPATIC IMPAIRMENT**

**RENAL IMPAIRMENT**

**PRESCRIBING AND DISPENSING INFORMATION**

**TREATMENT** with melatonin should be initiated and supervised by a specialist, but may be continued by general practitioners. The need to continue melatonin therapy should be reviewed every 6 months.

Melatonin is available as a modified-release tablet (**Circadin** and **Slenyto**) and also as unlicensed formulations. **Circadin** is licensed for the short-term treatment of primary insomnia in adults over 55 years. Unlicensed immediate-release preparations are available, however, there is variability in clinical effect of unlicensed formulations.

The RCPCH and NPPG recommend that, when a liquid special of melatonin is required, the following strength is used: 1 mg/mL.

**PATIENT AND CARER ADVICE**

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: modified-release tablet

**Modified-release tablet**
- **Circadin (Fyln Pharma Ltd)**
  - Melatonin 3 mg: Melatonin 3mg modified-release tablets | 120 tablet (PBN) £41.20
- **Circadin (Fyln Pharma Ltd)**
  - Melatonin 2 mg: Melatonin 2mg modified-release tablets | 30 tablet (PBN) £15.39 DT + £15.39
- **Slenyto (Fyln Pharma Ltd)**
  - Melatonin 1 mg: Melatonin 1mg modified-release tablets | 60 tablet (PBN) £103.00

**7 Substance dependence**

**Substance dependence**

**Guidance on treatment of drug misuse**


**Nicotine dependence**

See Smoking cessation p. 304.

**Neonatal abstinence syndrome**

Neonatal abstinence syndrome occurs at birth as a result of intra-uterine exposure to opioids or high-dose benzodiazepines. Treatment is usually initiated if:

- Feeding becomes a problem and tube feeding is required;
- There is profound vomiting or watery diarrhoea;
- The baby remains very unsettled after two consecutive feeds despite gentle swaddling and the use of a pacifier.

Treatment involves weaning the baby from the drug on which it is dependent. Morphine p. 290 or methadone hydrochloride p. 307 can be used in babies of mothers who have been taking opioids. Morphine p. 290 is widely used because the dose can be easily adjusted, but methadone hydrochloride p. 307 may provide smoother control of symptoms. Weaning babies from opioids usually takes 7–10 days.

Weaning babies from benzodiazepines that have a long half-life is difficult to manage; chlorpromazine hydrochloride p. 251 may be used in these situations but
excessive sedation may occur. For babies who are dependent on barbiturates, phenobarbital p. 223 may be tried, although it does not control gastro-intestinal symptoms.

### 7.1 Nicotine dependence

#### Smoking cessation

**Overview**

Smoking tobacco is the main cause of preventable illness and premature death in the UK. It is linked to a number of diseases such as cancer (primarily lung cancer), chronic obstructive pulmonary disease, and cardiovascular disease, and can lead to complications during pregnancy. Smoking cessation reduces the risk of developing or worsening of smoking-related illnesses, and the benefits begin as soon as a person stops smoking.

Smoking cessation may be associated with temporary withdrawal symptoms caused by nicotine dependence, making it difficult for people to stop. These symptoms include nicotine cravings, irritability, depression, restlessness, poor concentration, light-headedness, sleep disturbances, and increased appetite. Weight gain is a concern for many people who stop smoking, however it is less likely to occur when drug treatment is used to aid smoking cessation.

**Non-drug treatment**

All smokers, including those who smoke e-cigarettes, should be advised to stop smoking and be offered support to facilitate smoking cessation. They should also be advised that stopping in one step (‘abrupt quitting’) offers the best chance of lasting success, and that a combination of drug treatment and behavioural support is likely to be the most effective approach. Abrupt quitting is when a smoker makes a commitment to stop smoking on or before a particular date (the quit date), rather than by gradually reducing their smoking.

Smokers who wish to stop smoking should be referred to their local NHS Stop Smoking Services, where they will be provided with advice, drug treatment, and behavioural support options such as individual counselling or group meetings. Smokers who decline to attend their local NHS Stop Smoking Services should be referred to a suitable healthcare professional who can also offer drug treatment and practical advice.

**Child aged over 12 years**

Nicotine replacement therapy (NRT) is the only drug treatment recommended to aid smoking cessation in children over 12 years of age. A combination of long-acting NRT (transdermal patch) and short-acting NRT (lozenges, gum, sublingual tablets, inhalator, nasal spray and oral spray) may be beneficial in children with a high-level of nicotine dependence, or in those who have previously failed to stop smoking despite NRT treatment. Nicotine transdermal patches are generally applied for 16 hours, with the patch removed overnight; if the child experiences strong nicotine cravings upon waking, a 24 hour patch can be used instead. Short-acting nicotine preparations are used whenever the urge to smoke occurs or to prevent cravings.

As all NRT preparations appear to be equally effective, the choice of preparation for each child should take into consideration the child’s likely adherence, preferences, and previous experience of smoking-cessation aids, as well as contra-indications, side-effects, and license of each preparation. Some preparations are not licensed in children under 18 years of age.

A quit date should be agreed when NRT is prescribed for smoking cessation, and treatment should be available before the child stops smoking. Children should be prescribed enough treatment to last 2 weeks after their agreed quit date, and be re-assessed shortly before the prescription ends.

Children who are unwilling or not ready to stop smoking may also benefit from the use of NRT as part of a ‘harm reduction approach’, because the amount of nicotine in NRT is much lower and less addictive than in smoking tobacco. Harm reduction approaches include stopping smoking whilst using NRT to prevent relapse, and smoking reduction or temporary abstinence, with or without the use of NRT. These children should be advised that NRT will make it easier to reduce how much they smoke and improve their chance of stopping in the long-term. In the UK, sale of e-cigarettes is prohibited in children under 18 years of age.

**Pregnancy**

Pregnant females should be advised to stop smoking completely, and be informed about the risks to the unborn child of smoking during pregnancy, and the harmful effects of exposure to second-hand smoke for both mother and baby. All pregnant females who smoke or have stopped smoking in the last 2 weeks should be referred to their local NHS Stop Smoking Services, and ongoing support should be offered during and following pregnancy. Smoking cessation should also be encouraged for all members of the household. Pregnant females who smoke should be advised to contact the NHS Pregnancy Smoking Helpline for further information (Tel: 0800 169 9169).

NRT should only be used in pregnant females if non-drug treatment options have failed. Clinical judgement should be used when deciding whether to prescribe NRT following a discussion about its risks and benefits. Subsequent prescriptions should only be given to pregnant females who have demonstrated they are still not smoking.

**Concomitant drugs**

Polycyclic aromatic hydrocarbons found in tobacco smoke increase the metabolism of some drugs by inducing hepatic enzymes, often requiring an increase in dose. Information about drugs interacting with tobacco smoke can be found under Interactions of the relevant drug monograph.

**Useful Resources**


National Centre for Smoking Cessation and Training. [www.ncsct.co.uk](http://www.ncsct.co.uk)

### NICOTINIC RECEPTOR AGONISTS

**Nicotine**

- **INDICATIONS AND DOSE**
  - Nicotine replacement therapy in individuals who smoke fewer than 20 cigarettes each day
    - Child 12-17 years: 2 mg as required, chew 1 piece of gum when the urge to smoke occurs or to prevent cravings, if attempting smoking cessation, treatment should continue for 3 months before reducing the dose
    - By sublingual administration using sublingual tablets
      - Child 12-17 years: 1 tablet every 1 hour, increased to 2 tablets every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - Child aged 12 years
      - 1 tablet every 1 hour, increased to 2 tablets every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - By mouth using chewing gum
      - Child aged 12 years
        - 1 piece of gum every 1 hour, increased to 2 pieces of gum every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - By inhalation
      - Child aged 12 years
        - 1 inhalator every 1 hour, increased to 2 inhalators every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - By nasal spray
      - Child aged 12 years
        - 1 spray every 1 hour, increased to 2 sprays every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - By oral inhalator
      - Child aged 12 years
        - 1 capsule every 1 hour, increased to 2 capsules every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - By oral inhalator using aerosol propellant
      - Child aged 12 years
        - 1 inhalator every 1 hour, increased to 2 inhalators every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.

    - By sublingual tablets
      - Child aged 12 years
        - 1 tablet every 1 hour, increased to 2 tablets every 1 hour if required, if attempting smoking cessation, treatment should continue for up to 12 weeks.
to 3 months before reducing the dose; maximum 40 tablets per day

**Nicotine replacement therapy in individuals who smoke more than 20 cigarettes each day or who require more than 15 pieces of 2-mg strength gum each day**
- **BY INHALATION USING INHALATOR**
  - Child 12-17 years: As required, the cartridges can be used when the urge to smoke occurs or to prevent cravings; individuals should not exceed 12 cartridges of the 10-mg strength daily, or 6 cartridges of the 15-mg strength daily
- **BY MOUTH USING LOZENGES**
  - Child 12-17 years: 1 lozenge every 1–2 hours as required, one lozenge should be used when the urge to smoke occurs, individuals who smoke less than 20 cigarettes each day should usually use the lower-strength lozenges; individuals who smoke more than 20 cigarettes each day and those who fail to stop smoking with the low-strength lozenges should use the higher-strength lozenges; if attempting smoking cessation, treatment should continue for 6–12 weeks before attempting a reduction in dose; maximum 15 lozenges per day
- **BY MOUTH USING OROMUCOSAL SPRAY**
  - Child 12-17 years: 1–2 sprays as required, individuals can spray in the mouth when the urge to smoke occurs or to prevent cravings, individuals should not exceed 2 sprays per episode (up to 4 sprays every hour); maximum 64 sprays per day
- **BY INTRanasAL ADMINISTRATION USING NASAL SPRAY**
  - Child 12-17 years: 1 spray as required, individuals can spray into each nostril when the urge to smoke occurs, up to twice every hour for 16 hours daily, if attempting smoking cessation, treatment should continue for 8 weeks before reducing the dose; maximum 64 sprays per day
- **BY TRANSdermal APPLICATION USING PATCHES**
  - Child 12-17 years: Individuals who smoke more than 10 cigarettes daily should apply a high-strength patch daily for 6–8 weeks, followed by the medium-strength patch for 2 weeks, and then the low-strength patch for the final 2 weeks; individuals who smoke fewer than 10 cigarettes daily can usually start with the medium-strength patch for 6–8 weeks, followed by the low-strength patch for 2–4 weeks; a slower titration schedule can be used in individuals who are not ready to quit but want to reduce cigarette consumption before a quit attempt; if abstinence is not achieved, or if withdrawal symptoms are experienced, the strength of the patch used should be maintained or increased until the patient is stabilised; individuals using the high-strength patch who experience excessive side-effects, that do not resolve within a few days, should change to a medium-strength patch for the remainder of the initial period and then use the low-strength patch for 2–4 weeks

**UNLICENSED USE** All preparations are licensed for children over 12 years (with the exception of Nicotinell® lozenges which are licensed for children under 18 years only when recommended by a doctor).

**CAUTIONS**

**GENERAL CAUTIONS** Diabetes mellitus—blood-glucose concentration should be monitored closely when initiating treatment - haemodynamically unstable patients hospitalised with cerebrovascular accident - haemodynamically unstable patients hospitalised with myocardial infarction - haemodynamically unstable patients hospitalised with severe arrhythmias - phaeochromocytoma - uncontrolled hyperthyroidism

**SPECIFIC CAUTIONS**
- When used by inhalation Bronchospastic disease - chronic throat disease - obstructive lung disease
- With intranasal use Bronchial asthma (may exacerbate)
- With oral use Gastritis (can be aggravated by swallowed nicotine) - gum may also stick to and damage dentures - oesophagitis (can be aggravated by swallowed nicotine) - peptic ulcers (can be aggravated by swallowed nicotine)
- With transdermal use patches should not be placed on broken skin - patients with skin disorders

**CAUTIONS, FURTHER INFORMATION** Most warnings for nicotine replacement therapy also apply to continued cigarette smoking, but the risk of continued smoking outweighs any risks of using nicotine preparations.

Specific cautions for individual preparations are usually related to the local effect of nicotine.

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**
- Common or very common Dizziness - headache - hyperhidrosis - nausea - palpitations - skin reactions - vomiting
- Uncommon Flushing

**SPECIFIC SIDE-EFFECTS**
- Common or very common
  - When used by inhalation Asthenia - cough - dry mouth - flatulence - gastrointestinal discomfort - hiccups - hypersensitivity - nasal complaints - oral disorders - taste altered - throat complaints
  - With intranasal use Chest discomfort - cough - dyspnoea - epistaxis - nasal complaints - paraesthesia - throat irritation
  - With oral use Anxiety - appetite abnormal - burping - diarrhoea - dyspepsia (may be caused by swallowed nicotine) - gastrointestinal disorders - hiccups - increased risk of infection - mood altered - oral disorders - sleep disorders
  - With sublingual use Asthenia - cough - dry mouth - flatulence - gastrointestinal discomfort - hiccups - hypersensitivity - oral disorders - rhinitis - taste altered - throat complaints
- Uncommon
  - When used by inhalation Abnormal dreams - arrhythmias - bronchospasm - burping - chest discomfort - dysphonia - dyspnoea - hypertension - malaise
  - With intranasal use Abnormal dreams - asthenia - hypertension - malaise
  - With sublingual use Abnormal dreams - arrhythmias - bronchospasm - burping - chest discomfort - dysphonia - dyspnoea - hypertension - malaise - nasal complaints
  - With transdermal use Arrhythmias - asthenia - chest discomfort - dyspnoea - hypertension - malaise - myalgia - paraesthesia
- Rare or very rare
  - When used by inhalation Dysphagia

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**Nervous System** 4

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**Side-effects**

**General side-effects**
- Common or very common Dizziness - headache - hyperhidrosis - nausea - palpitations - skin reactions - vomiting
- Uncommon Flushing

**Specific side-effects**
- Common or very common
  - When used by inhalation Asthenia - cough - dry mouth - flatulence - gastrointestinal discomfort - hiccups - hypersensitivity - nasal complaints - oral disorders - taste altered - throat complaints
  - With intranasal use Chest discomfort - cough - dyspnoea - epistaxis - nasal complaints - paraesthesia - throat irritation
  - With oral use Anxiety - appetite abnormal - burping - diarrhoea - dyspepsia (may be caused by swallowed nicotine) - gastrointestinal disorders - hiccups - increased risk of infection - mood altered - oral disorders - sleep disorders
  - With sublingual use Asthenia - cough - dry mouth - flatulence - gastrointestinal discomfort - hiccups - hypersensitivity - oral disorders - rhinitis - taste altered - throat complaints
  - Uncommon
  - When used by inhalation Abnormal dreams - arrhythmias - bronchospasm - burping - chest discomfort - dysphonia - dyspnoea - hypertension - malaise
  - With intranasal use Abnormal dreams - asthenia - hypertension - malaise
  - With sublingual use Abnormal dreams - arrhythmias - bronchospasm - burping - chest discomfort - dysphonia - dyspnoea - hypertension - malaise - nasal complaints
  - With transdermal use Arrhythmias - asthenia - chest discomfort - dyspnoea - hypertension - malaise - myalgia - paraesthesia
  - Rare or very rare
  - When used by inhalation Dysphagia
BREAST FEEDING

When used by inhalation

▶

With sublingual use

▶

▶

With transdermal use

Abdominal discomfort - angioedema - pain in extremity

▶

Frequency not known

When used by inhalation

Angioedema - excessive tearing - vision blurred

▶

With transdermal use

Abdominal discomfort - angioedema - excessive tearing - oropharyngeal complaints

▶

With sublingual use

Excessive tearing - muscle tightness - vision blurred

SIDE EFFECTS, FURTHER INFORMATION

Some systemic effects occur on initiation of therapy, particularly if the patient is using high-strength preparations; however, the patient may confuse side-effects of the nicotine-replacement preparation with nicotine withdrawal symptoms. Common symptoms of nicotine withdrawal include malaise, headache, dizziness, sleep disturbance, coughing, influenza-like symptoms, depression, irritability, increased appetite, weight gain, restlessness, anxiety, drowsiness, aphthous ulcers, decreased heart rate, and impaired concentration.

PREGNANCY

The use of nicotine replacement therapy in pregnancy is preferable to the continuation of smoking, but should be used only if smoking cessation without pregnancy is preferable to the continuation of smoking, and impaired concentration.

HEPATIC IMPAIRMENT

Manufacturer advises caution in moderate to severe impairment (risk of decreased clearance).

RENAL IMPAIRMENT

Use with caution in severe renal impairment.

DIRECTIONS FOR ADMINISTRATION

Acidic beverages, such as coffee or fruit juice, may decrease the absorption of nicotine through the buccal mucosa and should be avoided for 15 minutes before the use of oral nicotine replacement therapy.

Administration by transdermal patch. Patches should be applied to a dry, non-hairy skin on the hip, trunk, or upper arm and held in position for 10–20 seconds to ensure adhesion; place next patch on a different area and avoid using the same site for several days.

Administration by nasal spray. Initially 1 spray should be used in both nostrils but when withdrawing from therapy, the dose can be gradually reduced to 1 spray in 1 nostril.

Administration by oral spray. The oral spray should be released into the mouth, holding the spray as close to the mouth as possible and avoiding the lips. The patient should not inhale while spraying and avoid swallowing for a few seconds after use. If using the oral spray for the first time, or if unit not used for 2 or more days, prime the unit before administration.

Administration by sublingual tablet. Each tablet should be placed under the tongue and allowed to dissolve.

Administration by lozenge. Slowly allow each lozenge to dissolve in the mouth; periodically move the lozenge from one side of the mouth to the other. Lozenges last for 10–30 minutes, depending on their size.

Administration by inhalation. Insert the cartridge into the device and draw in air through the mouthpiece; each session can last for approximately 5 minutes. The amount of nicotine from 1 puff of the cartridge is less than that from a cigarette, therefore it is necessary to inhale more often than when smoking a cigarette. A single 10 mg cartridge lasts for approximately 20 minutes of intense use; a single 15 mg cartridge lasts for approximately 40 minutes of intense use.

Administration by medicated chewing gum. Chew the gum until the taste becomes strong, then rest it between the cheek and gum; when the taste starts to fade, repeat this process. One piece of gum lasts for approximately 30 minutes.

PRESCRIBING AND DISPENCING INFORMATION

Flavours of chewing gum and lozenges may include mint, freshfruit, freshmint, icy white, or cherry.

PATIENT AND CARER ADVICE

Patient or carers should be given advice on how to administer nicotine chewing gum, inhalators, lozenges, sublingual tablets, oral spray, nasal spray and patches.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Spray

EXCIPIENTS: May contain Ethanol

▶

Nicorette (McNeil Products Ltd)

Nicotine 500 microgram per 1 actuation Nicorette 500 micrograms/dose nasal spray | 10 ml GSK | £16.18 DT | £16.18

▶

Nicorette QuickMist (McNeil Products Ltd)

Nicotine 1 mg per 1 actuation Nicorette QuickMist 1mg/dose mouth spray freshmint sugar-free | 3.2 ml GSK | £11.03 DT | £11.03

▶

spray and patches.

Sublingual tablet

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▶

Nicorette Microtab (McNeil Products Ltd)

Nicotine (as Nicotine cyclodextrin complex) 2 mg Nicorette Microtab 2mg sublingual tablets sugar-free | 100 tablet GSK | £15.23 DT | £15.23

Transdermal patch

▶

Nicotine 7 mg per 24 hour Nicotin 7mg patches | 7 patch GSK £9.97 DT | £9.12

▶

Nicotine 14 mg per 24 hour Nicotin 14mg patches | 7 patch GSK £9.97 DT | £9.40

▶

Nicotine 21 mg per 24 hour Nicotin 21mg patches | 7 patch GSK £9.97 DT | £9.79

▶

Nicotine 21 mg per 24 hour Nicotin 21mg patches | 7 patch GSK £9.97 DT | £9.79

▶

Nicotin Pre-Quit Clear (Omega Pharma Ltd)

Nicotin 10 mg per 24 hour Nicotin 10mg/16hour patches | 7 patch GSK £9.97 DT | £9.97

▶

Nicotin Pre-Quit Clear (Omega Pharma Ltd)

Nicotin 10 mg per 24 hour Nicotin 10mg/16hour patches | 7 patch GSK £10.99 DT | £10.99

▶

Nicotin 21 mg per 24 hour Nicotin 21mg patches | 7 patch GSK £11.15 DT | £11.15

▶

Nicotin 21 mg per 24 hour Nicotin 21mg patches | 7 patch GSK £11.15 DT | £11.15

▶

Nicotin 25 mg per 24 hour Nicotin 25mg/16hour patches | 7 patch GSK £11.15 DT | £11.15

▶

Nicotin TTS (GlaxoSmithKline Consumer Healthcare)

Nicotine 7 mg per 24 hour Nicotin TTS 10 patches | 7 patch GSK £9.12 DT | £9.12

▶

Nicotine 7 mg per 24 hour Nicotin TTS 10 patches | 7 patch GSK £9.12 DT | £9.12

▶

Nicotine 14 mg per 24 hour Nicotin TTS 20 patches | 7 patch GSK £13.43 DT | £13.43

▶

Nicotine 21 mg per 24 hour Nicotin TTS 30 patches | 7 patch GSK £13.43 DT | £13.43

Medicated chewing-gum

▶

Nicotin (Omega Pharma Ltd)

Nicotine 2 mg Nicotin Fresh Mint 2mg medicated chewing gum sugar-free | 12 piece GSK £1.71 sugar-free | 24 piece GSK £2.85 sugar-free | 96 piece GSK £8.55 DT | £8.26

▶

Nicotin Extra Fresh Mint 2mg medicated chewing gum sugar-free | 30 piece GSK £5.16 sugar-free | 100 piece GSK £11.82 sugar-free | 200 piece GSK £20.69

▶

Nicotine 4 mg Nicotin Extra Fresh Mint 4mg medicated chewing gum sugar-free | 30 piece GSK £9.15 sugar-free | 100 piece GSK £11.82 sugar-free | 200 piece GSK £20.69
7.2 Opioid dependence

**ANALGESICS > OPIOIDS**

**Methadone hydrochloride**

- **INDICATIONS AND DOSE**

  **Neonatal opioid withdrawal**

  **BY MOUTH**

  - Neonate: Initially 100 micrograms/kg, then increased in steps of 50 micrograms/kg every 6 hours until symptoms are controlled, doses may vary, consult local guidelines, for maintenance, total daily dose that controls symptoms to be given in 2 divided doses.

- **DOSE EQUIVALENCE AND CONVERSION**

  - See buprenorphine p. 281 for dose adjustments in opioid substitution therapy, for patients taking methadone who want to switch to buprenorphine.

- **UNLICENSED USE**

  - Not licensed for use in children.

**IMPORTANT SAFETY INFORMATION**

Methadone oral solution 1 mg/mL is 2½ times the strength of Methadone Linctus (2 mg/5mL). Many preparations of Methadone oral solution are licensed for opioid drug addiction only but some are also licensed for analgesia in severe pain.

- **CONTRA-INDICATIONS**

  - Phaeochromocytoma

- **CAUTIONS**

  - Family history of sudden death (ECG monitoring recommended) - history of cardiac conduction abnormalities.

- **CAUTIONS, FURTHER INFORMATION**

  - QT-interval prolongation: Patients with the following risk factors for QT-interval prolongation should be carefully monitored while taking methadone: heart or liver disease, electrolyte abnormalities, or concomitant treatment with drugs that can prolong QT interval; patients requiring more than 100 mg daily should also be monitored.

- **INTERACTIONS**

  - Appendix 1: opioids

- **SIDE-EFFECTS**

  - Dry eye - dysuria - hyperprolactinaemia - hypothermia - intracranial pressure increased - mood altered - nasal dryness - QT interval prolongation

- **SIDE-EFFETS, FURTHER INFORMATION**

  - Methadone is a long-acting opioid therefore effects may be cumulative.

  - Methadone, even in low doses is a special hazard for children; non-dependent adults are also at risk of toxicity; dependent adults are at risk if tolerance is incorrectly assessed during induction.

- **Overdose**

  - Methadone has a very long duration of action; patients may need to be monitored for long periods following large overdoses.

- **BREAST FEEDING**

  - Withdrawal symptoms in infant; breastfeeding permissible during maintenance but dose should be as low as possible and infant monitored to avoid sedation (high doses of methadone carry an increased risk of sedation and respiratory depression in the neonate).

- **HEPATIC IMPAIRMENT**

  - Manufacturer advises caution; consider avoiding in severe impairment (risk of increased exposure).

- **Dose adjustments**

  - Manufacturer advises consider dose reduction.
RENAL IMPAIRMENT
Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

TREATMENT CESSATION
Avoid abrupt withdrawal.
- In neonates When used for neonatal opioid withdrawal, reduce dose over 7–10 days.

DIRECTIONS FOR ADMINISTRATION
Syrup preserved with hydroxybenzoate (parabens) esters may be incompatible with methadone hydrochloride.

PRESCRIBING AND DISPENSING INFORMATION
Flavours of oral liquid formulations may include tolu.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution

Tablet

CAUTIONARY AND ADVISORY LABELS 2
- Physeptone (Martindale Pharmaceuticals Ltd)
  Methadone hydrochloride 5 mg Physeptone 5mg tablets | 50 tablet £2.84 DT = £2.84

Oral solution

CAUTIONARY AND ADVISORY LABELS 2
- Methadose (Rosemont Pharmaceuticals Ltd)
  Methadone hydrochloride 10 mg per 1 ml Methadose 10mg/ml oral solution concentrate sugar-free | 150 ml £12.01 DT = £12.01
  Methadone hydrochloride 20 mg per 1 ml Methadose 20mg/ml oral solution concentrate sugar-free | 150 ml £24.02 DT = £24.02
- Metharose (Rosemont Pharmaceuticals Ltd)
  Methadone hydrochloride 1 mg per 1 ml Metharose 1mg/ml oral solution sugar-free | 500 ml £6.82 DT = £4.45
- Physeptone (Martindale Pharmaceuticals Ltd)
  Methadone hydrochloride 1 mg per 1 ml Physeptone 1mg/ml oral solution sugar-free | 100 ml £1.27 DT = £0.90
  Methadone hydrochloride 1 mg per 1 ml Physeptone 1mg/ml mixture | 100 ml £1.27 DT = £0.90 | 500 ml £6.42 DT = £4.50

308 Substance dependence
Chapter 5
Infection

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1 Bacterial infection

Antibacterials, principles of therapy
07-Mar-2017

Antibacterial drug choice
Before selecting an antibacterial the clinician must first consider three factors—the patient, the known or likely causative organism, and the risk of bacterial resistance with repeated courses.

Factors related to the patient which must be considered include history of allergy, renal and hepatic function, susceptibility to infection (i.e. whether immunocompromised), ability to tolerate drugs by mouth, severity of illness, risk of complications, ethnic origin, age, whether taking other medication and, if female, whether pregnant, breast-feeding or taking an oral contraceptive.

The known or likely organism and its antibacterial sensitivity, in association with the factors above, will provide one or more antibacterial option. In children receiving antibacterial prophylaxis, an antibacterial from a different class should be used.

Some children may be at higher risk of treatment failure. They include those who have had repeated antibacterial courses, a previous or current culture with resistant bacteria, or those at higher risk of developing complications.

Antibacterial policies
Local policies often limit the antibacterials that may be used to achieve reasonable economy consistent with adequate cover, and to reduce the development of resistant organisms. A policy may indicate a range of drugs for general use, and permit other drugs only on the advice of the microbiologist or paediatric infectious diseases specialist.

Antibacterials, considerations before starting therapy
The following precepts should be considered before starting:

- Viral infections should not be treated with antibacterials. However, antibacterials may be used to treat secondary bacterial infection (e.g. bacterial pneumonia secondary to influenza);

- Samples should be taken for culture and sensitivity testing; ‘blind’ antibacterial prescribing for unexplained pyrexia usually leads to further difficulty in establishing the diagnosis;

- Knowledge of prevalent organisms and their current sensitivity is of great help in choosing an antibacterial before bacteriological confirmation is available. Generally, narrow-spectrum antibacterials are preferred to broad-spectrum antibacterials unless there is a clear clinical indication (e.g. life-threatening sepsis);

- The dose of an antibacterial varies according to a number of factors including age, weight, hepatic function, renal function, and severity of infection. The prescribing of the so-called ‘standard’ dose in serious infections may result in failure of treatment or even death of the patient; therefore it is important to prescribe a dose appropriate to the condition. An inadequate dose may also increase the likelihood of antibacterial resistance. On the other hand, for an antibacterial with a narrow margin between the toxic and therapeutic dose (e.g. an aminoglycoside) it is also important to avoid an excessive dose and the concentration of the drug in the plasma may need to be monitored;

- The route of administration of an antibacterial often depends on the severity of the infection. Life-threatening infections often require intravenous therapy. Antibacterials that are well absorbed may be given by mouth even for some serious infections. Parenteral administration is also appropriate when the oral route cannot be used (e.g. because of vomiting) or if absorption is inadequate (e.g. in neonates and young children). Whenever possible, painful intramuscular injections should be avoided in children;

- Duration of therapy depends on the nature of the infection and the response to treatment. Courses should not be unduly prolonged because they encourage resistance, they may lead to side-effects and they are costly. However, in certain infections such as tuberculosis or osteomyelitis it may be necessary to treat for prolonged periods. Conversely a single dose of an antibacterial may cure uncomplicated urinary-tract infections. The prescription for an antibacterial should specify the duration of treatment or the date when treatment is to be reviewed.
Advice to be given to children and their parents, or carers

If an antibacterial is given, advice should be given about:

- Possible adverse effects e.g. diarrhoea;
- An antibiotic not being needed currently;
- Seeking medical help if symptoms worsen rapidly or significantly at any time, if symptoms do not start to improve within an agreed time, or if the child becomes systemically very unwell.  
- Seeking medical help if symptoms worsen rapidly or significantly at any time, if symptoms do not start to improve within an agreed time, or if the child becomes systemically very unwell.  

Antibacterials, considerations during therapy

Review choice of antibacterial if susceptibility results indicate bacterial resistance and symptoms are not improving—consult local microbiologist as needed.  

Antibacterials, switching from parenteral to oral treatment

The ongoing parenteral administration of an antibacterial should be reviewed within 48 hours of treatment initiation and a switch to oral treatment considered if appropriate.  

Antibacterials for prophylaxis

In most situations, only a short course of prophylactic antibacterial is needed. Longer-term antibacterial prophylaxis is appropriate in specific indications such as vesico-ureteric reflux.

Notifiable diseases

Doctors must notify the Proper Officer of the local authority (usually the consultant in communicable disease control) or local health protection unit when attending a patient suspected of suffering from any of the diseases listed below; a form is available from the Proper Officer.

Antibacterials for children

<table>
<thead>
<tr>
<th>Notifiable diseases</th>
<th>BNFC 2019–2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrax</td>
<td>Mumps</td>
</tr>
<tr>
<td>Botulism</td>
<td>Paratyphoid fever</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>Plague</td>
</tr>
<tr>
<td>Cholera</td>
<td>Poliomyelitis, acute</td>
</tr>
<tr>
<td>Diarrhoea (infectious bloody)</td>
<td>Rubies</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Rubella</td>
</tr>
<tr>
<td>Encephalitis, acute</td>
<td>SARS</td>
</tr>
<tr>
<td>Food poisoning</td>
<td>Scarlet fever</td>
</tr>
<tr>
<td>Haemolytic uraemic syndrome</td>
<td>Smallpox</td>
</tr>
<tr>
<td>Haemorrhagic fever (viral)</td>
<td>Streptococcal disease (Group A, invasive)</td>
</tr>
<tr>
<td>Hepatitis, viral</td>
<td>Tetanus</td>
</tr>
<tr>
<td>Legionnaires’ disease</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Leprosy</td>
<td>Typhoid fever</td>
</tr>
<tr>
<td>Malaria</td>
<td>Typhus</td>
</tr>
<tr>
<td>Measles</td>
<td>Whooping cough</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Yellow fever</td>
</tr>
</tbody>
</table>

Note: It is good practice for doctors to also inform the consultant in communicable disease control of instances of other infections (e.g. psittacosis) where there could be a public health risk.

Sepsis, early management

Children identified as being at high risk of severe illness or death due to suspected sepsis should be given a broad-spectrum antibacterial at the maximum recommended dose without delay (ideally within one hour). Microbiological samples and blood cultures must be taken prior to administration of antibiotics; the prescription should be adjusted subsequently according to susceptibility results. A thorough clinical examination should be carried out to identify sources of infection. If the cause of infection is identified, treat in line with local antibacterial guidance or susceptibility results.

Children aged up to 17 years with suspected community-acquired sepsis of any cause should be treated with ceftriaxone p. 332. If the child is already in hospital or is known to have previously been infected or colonised with ceftriaxone-resistant bacteria, an alternative antibiotic should be chosen following local guidelines. Children younger than 3 months should also receive an additional antibiotic that is active against listeria (such as ampicillin p. 353 or amoxicillin p. 351).

Neonates who are in hospital with suspected sepsis within 72 hours of birth, should be treated with intravenous benzylpenicillin sodium p. 349 and gentamicin p. 322. Community-acquired sepsis in neonates (who are more than 40 weeks corrected gestational age) should be treated with ceftriaxone, unless already receiving an intravenous calcium infusion. Neonates aged 40 weeks corrected gestational age or below, or receiving an intravenous calcium infusion, should receive cefotaxime p. 330, dosed according to age.

The need for intravenous fluids, inotropes, vasopressors and oxygen should also be assessed without delay, taking into consideration the child’s lactate concentration, systolic blood pressure (in children over 12 years) and their risk of severe illness or death. Children at high risk should be monitored continuously if possible, and no less than every 30 minutes.

Children with suspected sepsis who are not immediately deemed to be at high risk of severe illness or death, should be re-assessed regularly for the need for empirical treatment, taking into consideration all risk factors including lactate concentration and evidence of acute kidney injury.
Antibacterials, use for prophylaxis

**Rheumatic fever: prevention of recurrence**
- Phenoxyethylpenicillin p. 350 by mouth or erythromycin p. 341 by mouth.

**Invasive group A streptococcal infection: prevention of secondary cases**
- Phenoxyethylpenicillin by mouth.
  - If child penicillin allergic, either erythromycin by mouth or azithromycin p. 339 by mouth [unlicensed indication].
  - For details of those who should receive chemoprophylaxis contact a consultant in communicable disease control (or a consultant in infectious diseases or the local Public Health England Laboratory).

**Meningococcal meningitis: prevention of secondary cases**
- Ciprofloxacin p. 361 by mouth [unlicensed indication] or rifampicin p. 379 by mouth or ceftriaxone p. 332 by intramuscular injection [unlicensed indication].
  - For details of those who should receive chemoprophylaxis contact a consultant in communicable disease control (or a consultant in infectious diseases or the local Public Health England Laboratory). Unless there has been direct exposure of the mouth or nose to infectious droplets from a patient with meningococcal disease who has received less than 24 hours of antibacterial treatment, healthcare workers do not generally require chemoprophylaxis.

**Haemophilus influenzae type b disease: prevention of secondary cases**
- Rifampicin by mouth or (if rifampicin cannot be used) ceftriaxone by intramuscular injection, or by intravenous injection, or by intravenous infusion [unlicensed indication].
  - For details of those who should receive chemoprophylaxis contact a consultant in communicable disease control (or a consultant in infectious diseases or the local Public Health England Laboratory). Unless there has been direct exposure of the mouth or nose to infectious droplets from a patient with meningococcal disease who has received less than 24 hours of antibacterial treatment, healthcare workers do not generally require chemoprophylaxis.

**Haemophilus influenzae type b disease**

**Pertussis, antibacterial prophylaxis**
- Clarithromycin (or azithromycin or erythromycin) by mouth.
  - Within 3 weeks of onset of cough in the index case, give antibacterial prophylaxis to all close contacts if amongst them there is at least one unimmunised or partially immunised child under 1 year of age, or if there is at least one individual who has not received a pertussis-containing vaccine more than 1 week and less than 5 years ago (so long as that individual lives or works with children under 4 months of age, is pregnant at over 32 weeks gestation, or is a healthcare worker who works with children under 1 year of age or with pregnant women).

**Pneumococcal infection in asplenia or in patients with sickle-cell disease, antibacterial prophylaxis**
- Phenoxyethylpenicillin by mouth.
  - If cover also needed for H. influenzae in child give amoxicillin p. 351 instead.
  - If penicillin-allergic, erythromycin by mouth.
  - Antibacterial prophylaxis is not fully reliable. Antibacterial prophylaxis may be discontinued in children over 5 years of age with sickle-cell disease who have received pneumococcal immunisation and who do not have a history of severe pneumococcal infection.

**Staphylococcus aureus lung infection in cystic fibrosis, antibacterial prophylaxis**
- Primary prevention, flucloxacillin p. 357 by mouth. Secondary prevention, flucloxacillin by mouth.

**Tuberculosis antibacterial prophylaxis in susceptible close contacts or those who have become tuberculin positive**
- See Close contacts and Chemoprophylaxis for latent tuberculosis under Tuberculosis p. 375.

**Urinary-tract infection, antibacterial prophylaxis**
- Trimethoprim p. 373 by mouth or nitrofurantoin p. 384 by mouth.
  - Antibacterial prophylaxis may be considered in children with recurrent symptomatic urinary-tract infection, vesicoureteric reflux, or those awaiting imaging investigations.

**Animal and human bites, antibacterial prophylaxis**
- Co-amoxiclav p. 354 alone (or clindamycin p. 337 if penicillin-allergic).

  - Cleanse wound thoroughly. For tetanus-prone wound, give human tetanus immunoglobulin p. 798 (with a tetanus-containing vaccine if necessary, according to immunisation history and risk of infection).

  - Consider rabies prophylaxis for bites from animals in endemic countries. Assess risk of blood-borne viruses (including HIV, hepatitis B and C) and give appropriate prophylaxis to prevent viral spread. Antibacterial prophylaxis recommended for wounds less than 48–72 hours old when the risk of infection is high (e.g. bites from humans or cats; bites to the hand, foot, face, or genital area; bites involving oedema, crush or puncture injury, or other moderate to severe injury; wounds that cannot be debrided adequately; patients with diabetes mellitus, cirrhosis, asplenia, prosthetic joints or valves, or those who are immunocompromised). Give antibacterial prophylaxis for up to 5 days.
**Gastro-intestinal procedures, antibacterial prophylaxis**

**Operations on stomach or oesophagus**
- Single dose of i/v gentamicin p. 322 or i/v cefuroxime p. 329 or i/v co-amoxiclav (additional intra-operative or postoperative doses may be given for prolonged procedures or if there is major blood loss).

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

Add i/v teicoplanin p. 334 (or vancomycin p. 335) if high risk of meticillin-resistant *Staphylococcus aureus*.

**Open biliary surgery**
- Single dose of i/v cefuroxime + i/v metronidazole p. 344 or i/v gentamicin + i/v metronidazole or i/v co-amoxiclav alone (additional intra-operative or postoperative doses may be given for prolonged procedures or if there is major blood loss).

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

Where i/v metronidazole is suggested, it may alternatively be given by suppository but to allow adequate absorption, it should be given 2 hours before surgery.

Add i/v teicoplanin (or vancomycin) if high risk of meticillin-resistant *Staphylococcus aureus*.

**Resections of colon and rectum, and resections in inflammatory bowel disease, and appendicectomy**
- Single dose of i/v gentamicin + i/v metronidazole or i/v cefuroxime + i/v metronidazole or i/v co-amoxiclav alone (additional intra-operative or postoperative doses may be given for prolonged procedures or if there is major blood loss).

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

Where i/v metronidazole is suggested, it may alternatively be given by suppository but to allow adequate absorption, it should be given 2 hours before surgery.

Add i/v teicoplanin (or vancomycin) p. 334 (or vancomycin p. 335) if high risk of meticillin-resistant *Staphylococcus aureus*.

**Endoscopic retrograde cholangiopancreatography**
- Single dose of i/v gentamicin p. 322 or oral or i/v ciprofloxacin p. 361.

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

Prophylaxis recommended if pancreatic pseudocyst, immunocompromised, history of liver transplantation, or risk of incomplete biliary drainage. For biliary complications following liver transplantation, add i/v amoxicillin p. 351 or i/v teicoplanin (or vancomycin).

**Percutaneous endoscopic gastrostomy or jejunostomy**
- Single dose of i/v co-amoxiclav p. 354 or i/v cefuroxime p. 329.

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

Use single dose of i/v teicoplanin (or vancomycin) if history of allergy to penicillins or cephalosporins, or if high risk of meticillin-resistant *Staphylococcus aureus*.

**Orthopaedic surgery, antibacterial prophylaxis**

**Closed fractures**
- Single dose of i/v cefuroxime or i/v flucloxacillin p. 357 (additional intra-operative or postoperative doses may be given for prolonged procedures or if there is major blood loss).

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

If history of allergy to penicillins or to cephalosporins or if high risk of meticillin-resistant *Staphylococcus aureus*, use single dose of i/v teicoplanin (or vancomycin) (additional intra-operative or postoperative doses may be given for prolonged procedures or if there is major blood loss).

**Open fractures**
- Use i/v co-amoxiclav alone or i/v cefuroxime + i/v metronidazole p. 344 (or i/v clindamycin p. 337 alone if history of allergy to penicillins or to cephalosporins).

Add i/v teicoplanin (or vancomycin) if high risk of meticillin-resistant *Staphylococcus aureus*. Start prophylaxis within 3 hours of injury and continue until soft tissue closure (max. 72 hours).

At first debridement also use a single dose of i/v cefuroxime + i/v metronidazole + i/v gentamicin or i/v co-amoxiclav + i/v gentamicin (or i/v clindamycin + i/v gentamicin if history of allergy to penicillins or to cephalosporins).

At time of skeletal stabilisation and definitive soft tissue closure use a single dose of i/v gentamicin and i/v teicoplanin (or vancomycin) (intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

**High lower-limb amputation**
- Use i/v co-amoxiclav alone or i/v cefuroxime + i/v metronidazole.

Intravenous antibacterial prophylaxis should be given up to 30 minutes before the procedure.

Continue antibacterial prophylaxis for at least 2 doses after procedure (max. duration of prophylaxis 5 days).

If history of allergy to penicillin or to cephalosporins, or if high risk of meticillin-resistant *Staphylococcus aureus*, use i/v teicoplanin (or vancomycin) + i/v gentamicin + i/v metronidazole.

Where i/v metronidazole is suggested, it may alternatively be given by suppository but to allow adequate absorption, it should be given 2 hours before surgery.

**Obstetric surgery, antibacterial prophylaxis**

**Termination of pregnancy**
- Single dose of oral metronidazole (additional intra-operative or postoperative doses may be given for prolonged procedures or if there is major blood loss).

If genital chlamydial infection cannot be ruled out, give doxycycline p. 364 postoperatively.

**Infective endocarditis, antibacterial prophylaxis**

**NICE guidance: Antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures** (March 2008, updated 2016)

- Chlorhexidine mouthwash is not recommended for the prevention of infective endocarditis in adult patients undergoing dental procedures.

Antibacterial prophylaxis is not routinely recommended for the prevention of infective endocarditis in children undergoing the following procedures:
- dental;
- upper and lower respiratory tract (including ear, nose, and throat procedures and bronchoscopy);
- genito-urinary tract (including urological, gynaecological, and obstetric procedures);
- upper and lower gastro-intestinal tract.

While these procedures can cause bacteraemia, there is no clear association with the development of infective endocarditis. Prophylaxis may expose children to the adverse effects of antimicrobials when the evidence of benefit has not been proven.

Any infection in children at risk of endocarditis should be investigated promptly and treated appropriately to reduce the risk of endocarditis.

If children at risk of infective endocarditis are undergoing a gastro-intestinal or genito-urinary tract procedure at a site where infection is suspected, they should receive...
appropriate antibacterial therapy that includes cover against organisms that cause endocarditis. Children at risk of infective endocarditis should:
- advised to maintain good oral hygiene;
- told how to recognise signs of infective endocarditis, and
- advised when to seek expert advice.

Patients at risk of infective endocarditis include those with valve replacement, acquired valvular heart disease with stenosis or regurgitation, structural congenital heart disease (including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect, fully repaired patent ductus arteriosus, and closure devices considered to be endothelialised), hypertrophic cardiomyopathy, or a previous episode of infective endocarditis.

**Dermatological procedures**
Advice of a Working Party of the British Society for Antimicrobial Chemotherapy is that patients who undergo dermatological procedures do not require antibacterial prophylaxis against endocarditis. The British Association of Dermatologists Therapy Guidelines and Audit Subcommittee advise that such dermatological procedures include skin biopsies and excision of moles or of malignant lesions.

**Joint prostheses and dental treatment, antibacterial prophylaxis**
Advice of a Working Party of the British Society for Antimicrobial Chemotherapy is that patients with prosthetic joint implants (including total hip replacements) do not require antibacterial prophylaxis for dental treatment. The Working Party considers that it is unacceptable to expose patients to the adverse effects of antibacterials when there is no evidence that such prophylaxis is of any benefit, but that those who develop any intercurrent infection require prompt treatment with antibacterials to which the infecting organisms are sensitive.

The Working Party has commented that joint infections have rarely been shown to follow dental procedures and are even more rarely caused by oral streptococci.

**Immunosuppression and indwelling intraperitoneal catheters**
Advice of a Working Party of the British Society for Antimicrobial Chemotherapy is that patients who are immunosuppressed (including transplant patients) and patients with indwelling intraperitoneal catheters do not require antibacterial prophylaxis for dental treatment provided there is no other indication for prophylaxis.

The Working Party has commented that there is little evidence that dental treatment is followed by infection in immunosuppressed and immunodeficient patients nor is there evidence that dental treatment is followed by infection in patients with indwelling intraperitoneal catheters.

**Blood infections, antibacterial therapy**

**Septicaemia (community-acquired)**
- Child 1 month–18 years, aminoglycoside + amoxicillin p. 351 (or ampicillin p. 353) or cefotaxime p. 330 (or ceftriaxone p. 332) alone
- If pseudomonas or resistant micro-organisms suspected, use a broad-spectrum antipseudomonal beta-lactam antibacterial.
- If anaerobic infection suspected, add metronidazole p. 344.
- If Gram-positive infection suspected, add flucloxacillin p. 357 or vancomycin p. 335 (or teicoplanin p. 334).
- Suggested duration of treatment at least 5 days.

**Septicaemia (hospital-acquired)**
- Child 1 month–18 years, a broad-spectrum antipseudomonal beta-lactam antibacterial (e.g. piperacillin with tazobactam p. 348, ticarcillin with clavulanic acid p. 348, imipenem with cilastatin p. 325, or meropenem p. 326)
- If pseudomonas suspected, or if multiple-resistant organisms suspected, or if severe sepsis, add aminoglycoside.
- If meticillin-resistant *Staphylococcus aureus* suspected, add vancomycin (or teicoplanin).
- If anaerobic infection suspected, add metronidazole to a broad-spectrum cephalosporin.
- Suggested duration of treatment at least 5 days.

**Septicaemia related to vascular catheter**
- Vancomycin (or teicoplanin)
- If Gram-negative sepsis suspected, especially in the immunocompromised, add a broad-spectrum antipseudomonal beta-lactam.
- Consider removing vascular catheter, particularly if infection caused by *Staphylococcus aureus*, pseudomonas, or *Candida* species.

**Meningococcal septicaemia**
If meningococcal disease suspected, a single dose of benzylpenicillin sodium p. 349 should be given before urgent transfer to hospital, so long as this does not delay the transfer; cefotaxime may be an alternative in penicillin allergy; chloramphenicol p. 368 may be used if history of immediate hypersensitivity reaction to penicillin or to cephalosporins.

- Benzylpenicillin sodium or cefotaxime (or ceftriaxone)
- If history of immediate hypersensitivity reaction to penicillin or to cephalosporins, chloramphenicol
To eliminate nasopharyngeal carriage, ciprofloxacin p. 361, or rifampicin p. 379, or ceftriaxone may be used.

**Septicaemia in neonates**
- Neonate less than 72 hours old, benzylpenicillin sodium + gentamicin p. 322
- If Gram-negative septicaemia suspected, use benzylpenicillin sodium + gentamicin + cefotaxime; stop benzylpenicillin sodium if Gram-negative infection confirmed.
- Suggested duration of treatment usually 7 days.
- Neonate more than 72 hours old, flucloxacillin + gentamicin or amoxicillin (or ampicillin) + cefotaxime
- Suggested duration of treatment usually 7 days.

**Cardiovascular system infections, antibacterial therapy**

**Endocarditis: initial ‘blind’ therapy**
- Flucloxacillin p. 357 (or benzylpenicillin sodium p. 349 if symptoms less severe) + gentamicin p. 322
- If cardiac prostheses present, or if penicillin-allergic, or if meticillin-resistant *Staphylococcus aureus* suspected, vancomycin p. 335 + rifampicin p. 379 + gentamicin

**Endocarditis caused by staphylococci**
- Flucloxacillin
- Add rifampicin for at least 2 weeks in prosthetic valve endocarditis
- Suggested duration of treatment at least 4 weeks (at least 6 weeks for prosthetic valve endocarditis)
Endocarditis (native valve) caused by fully-sensitive streptococci e.g. viridans streptococci

- Benzylpenicillin sodium
- Suggested duration of treatment 4 weeks
- Alternative if a large vegetation, intracardial abscess, or infected emboli are absent, benzylpenicillin sodium + gentamicin
- Suggested duration of treatment 2 weeks
- If penicillin-allergic, vancomycin
- Suggested duration of treatment 4 weeks

Endocarditis (native valve) caused by less-sensitive streptococci

- Benzylpenicillin sodium + gentamicin
- Suggested duration of treatment 4–6 weeks (stop gentamicin after 2 weeks if micro-organisms moderately sensitive to penicillin)
- If aminoglycoside cannot be used and if streptococci moderately sensitive to penicillin, benzylpenicillin sodium
- Suggested duration of treatment 4 weeks
- If penicillin-allergic or highly penicillin-resistant, vancomycin (or teicoplanin p. 334) + gentamicin
- Suggested duration of treatment 4–6 weeks (stop gentamicin after 2 weeks if micro-organisms moderately sensitive to penicillin)

Endocarditis (prosthetic valve) caused by streptococci

- Benzylpenicillin sodium + gentamicin
- Suggested duration of treatment at least 6 weeks (stop gentamicin after 2 weeks if micro-organisms fully sensitive to penicillin)
- If penicillin-allergic or highly penicillin-resistant, vancomycin (or teicoplanin) + gentamicin
- Suggested duration of treatment at least 6 weeks (stop gentamicin after 2 weeks if micro-organisms fully sensitive to penicillin)

Endocarditis caused by enterococci (e.g. Enterococcus faecalis)

- Amoxicillin p. 351 (or ampicillin p. 353) + gentamicin
- If gentamicin-resistant, substitute gentamicin with streptomycin p. 323
- Suggested duration of treatment at least 4 weeks (at least 6 weeks for prosthetic valve endocarditis)
- If penicillin-allergic or penicillin-resistant, vancomycin (or teicoplanin) + gentamicin
- If gentamicin-resistant, substitute gentamicin with streptomycin
- Suggested duration of treatment at least 4 weeks (at least 6 weeks for prosthetic valve endocarditis)

Endocarditis caused by Haemophilus, Actinobacillus, Cardiobacterium, Eikenella, and Kingiellaspecies ('HACEK' micro-organisms)

- Amoxicillin (or ampicillin) + gentamicin
- Suggested duration of treatment 4 weeks (6 weeks for prosthetic valve endocarditis); stop gentamicin after 2 weeks
- Suggested duration of treatment 4 weeks (6 weeks for prosthetic valve endocarditis); stop gentamicin after 2 weeks

Central nervous system infections, antibacterial therapy

Meningitis: initial empirical therapy

- Transfer patient to hospital urgently.
- If meningococcal disease (meningitis with non-blanching rash or meningococcal septicaemia) suspected, benzylpenicillin sodium p. 349 should be given before transfer to hospital, so long as this does not delay the transfer. If a patient with suspected bacterial meningitis without non-blanching rash cannot be transferred to hospital urgently, benzylpenicillin sodium should be given before the transfer. Cefotaxime p. 330 may be an alternative in penicillin allergy; chloramphenicol p. 368 may be used if history of immediate hypersensitivity reaction to penicillin or to cephalosporins.
- In hospital, consider adjunctive treatment with dexamethasone p. 455, preferably starting before or with first dose of antibacterial, but no later than 12 hours after starting antibacterial; avoid dexamethasone in septic shock, meningococcal septicaemia, or if immunocompromised, or in meningitis following surgery. In hospital, if aetiology unknown:
  - Neonate and child 1–3 months, cefotaxime (or ceftriaxone p. 332) + amoxicillin p. 351 (or ampicillin p. 353)
  - Consider adding vancomycin p. 335 if prolonged or multiple use of other antibacterials in the last 3 months, or if travelled, in the last 3 months, to areas outside the UK with highly penicillin- and cephalosporin-resistant pneumococci
  - Suggested duration of treatment at least 14 days
  - Child 3 months–18 years cefotaxime (or ceftriaxone)
  - Consider adding vancomycin if prolonged or multiple use of other antibacterials in the last 3 months, or if travelled, in the last 3 months, to areas outside the UK with highly penicillin- and cephalosporin-resistant pneumococci
  - Suggested duration of treatment at least 10 days

Meningitis caused by group B streptococcus

- Benzylpenicillin sodium + gentamicin p. 322 or cefotaxime (or ceftriaxone) alone
- Suggested duration of treatment at least 14 days; stop gentamicin after 5 days

Meningitis caused by meningococci

- Benzylpenicillin sodium or cefotaxime (or ceftriaxone)
- Suggested duration of treatment 7 days.
- If history of immediate hypersensitivity reaction to penicillin or to cephalosporins, chloramphenicol
- Suggested duration of treatment 7 days.

Meningitis caused by pneumococci

- Cefotaxime (or ceftriaxone)
- Consider adjunctive treatment with dexamethasone, preferably starting before or with first dose of antibacterial, but no later than 12 hours after starting antibacterial (may reduce penetration of vancomycin into cerebrospinal fluid).
- If micro-organism penicillin-sensitive, replace cefotaxime with benzylpenicillin sodium.
- If micro-organism highly penicillin- and cephalosporin-resistant, add vancomycin and if necessary rifampicin p. 379.
- Suggested duration of antibacterial treatment 14 days.
Meningitis caused by *Haemophilus influenzae*
- Cefotaxime (or ceftriaxone)
  - Consider adjunctive treatment with dexamethasone, preferably starting before or with first dose of antibacterial, but no later than 12 hours after starting antibiotic.
  - **Suggested duration of antibacterial treatment** 10 days.
  - For *H. influenzae* type b give rifampicin for 4 days before hospital discharge to those under 10 years of age or to those in contact with vulnerable household contacts.
  - If history of immediate hypersensitivity reaction to penicillin or to cephalosporins, or if micro-organism resistant to cefotaxime, chloramphenicol
  - Consider adjunctive treatment with dexamethasone, preferably starting before or with first dose of antibacterial, but no later than 12 hours after starting antibiotic.
  - **Suggested duration of antibacterial treatment** 10 days.
  - For *H. influenzae* type b give rifampicin for 4 days before hospital discharge to those under 10 years of age or to those in contact with vulnerable household contacts.

Meningitis caused by *Listeria*
- Amoxicillin (or ampicillin) + gentamicin
  - **Suggested duration of treatment** 21 days.
  - Consider stopping gentamicin after 7 days.
  - If history of immediate hypersensitivity reaction to penicillin, co-trimoxazole p. 362
  - **Suggested duration of treatment** 21 days.

Ear infections, antibacterial therapy
**Otitis externa**
Otitis externa can be triggered by a bacterial infection caused by *Pseudomonas aeruginosa* or *Staphylococcus aureus*. Consider systemic antibacterial if spreading cellulitis or patient systemically unwell.

**Choice of antibacterial therapy**

**No penicillin allergy**
- Fluclouxacinil p. 357

**Penicillin allergy or intolerance**
- Clarithromycin p. 340 (or azithromycin p. 339 or erythromycin p. 341)

If *Pseudomonas* suspected
- Ciprofloxacin p. 361 (or an aminoglycoside)
  - For topical treatments, see *Otitis externa*, under Ear p. 712.

**Otitis media**
Acute otitis media is an inflammation in the middle ear associated with effusion and accompanied by an ear infection. Acute otitis media is commonly seen in children and is generally caused by viruses (respiratory syncytial virus and rhinovirus) or bacteria (*Haemophilus influenzae*, *Streptococcus pneumoniae*, *Streptococcus pyogenes*, and *Moraxella catarrhalis*); both virus and bacteria often co-exist. For further information see *Acute otitis media* in Ear p. 712.

Antibacterial therapy should be offered to children with acute otitis media who are systemically very unwell, have signs and symptoms of a more serious illness, or those who are at high-risk of serious complications due to pre-existing comorbidities. Antibacterial therapy should also be considered if otorrhoea (discharge following perforation of the eardrum) is present, or in children under 2 years of age with bilateral otitis media.

Eye infections, antibacterial therapy

**Purulent conjunctivitis**
- Chloramphenicol p. 368 eye drops.

**Congenital chlamydial conjunctivitis**
- Erythromycin p. 341 (by mouth)
  - **Suggested duration of treatment** 14 days

**Congenital gonococcal conjunctivitis**
- Cefotaxime p. 330 (or ceftriaxone p. 332)
  - **Suggested duration of treatment** single dose.

Gastro-intestinal system infections, antibacterial therapy

**Gastro-enteritis**
Frequently self-limiting and may not be bacterial.
- Antibacterial not usually indicated.

**Campylobacter enteritis**
Frequently self-limiting; treat if immunocompromised or if severe infection.
- Clarithromycin p. 340 (or azithromycin p. 339 or erythromycin p. 341)
- Alternative, ciprofloxacin p. 361
- Strains with decreased sensitivity to ciprofloxacin isolated frequently

**Salmonella (non-typhoid)**
- Treatment for invasive or severe infection. Do not treat less severe infection unless there is a risk of developing invasive infection (e.g. immunocompromised children, those with haemoglobininopathy, or children under 6 months of age).
- Ciprofloxacin or cefotaxime p. 330

**Shigellosis**
- Antibacterial not indicated for mild cases.
- Azithromycin or ciprofloxacin
- Alternatives if micro-organism sensitive, amoxicillin p. 351 or trimethoprim p. 373

**Typhoid fever**
Infections from Middle-East, South Asia, and South-East Asia may be multiple-antibacterial-resistant and sensitivity should be tested.
- Cefotaxime (or ceftriaxone p. 332)
- Azithromycin may be an alternative in mild or moderate disease caused by multiple-antibacterial-resistant micro-organisms
- Alternative if micro-organism sensitive, ciprofloxacin or chloramphenicol p. 368
Clostridium difficile infection
Clostridium difficile infection is caused by colonisation of the colon with Clostridium difficile and production of toxin. It often follows antibiotic therapy and is usually of acute onset, but may become chronic. It is a particular hazard of ampicillin p. 353, amoxicillin, co-amoxiclav p. 354, second-and third-generation cephalosporins, clindamycin p. 337, and quinolones, but few antibacterials are free of this side-effect. Oral metronidazole p. 344 or oral vancomycin p. 335 are used as specific treatment; vancomycin may be preferred for very sick patients. Metronidazole can be given by intravenous infusion if oral treatment is inappropriate.

- For first episode of mild to moderate infection, oral metronidazole
  - Suggested duration of treatment 10–14 days
- For second or subsequent episode of infection, for severe infection, for infection not responding to metronidazole, or in children intolerant of metronidazole, oral vancomycin
- Suggested duration of treatment 10–14 days
- For infection not responding to vancomycin, or for life-threatening infection, or in patients with ileus, oral vancomycin + i/v metronidazole
  - Suggested duration of treatment 10–14 days

Peritonitis
- A cephalosporin + metronidazole or amoxicillin + gentamicin p. 322+ metronidazole or piperacillin with tazobactam p. 348 alone

Peritonitis: peritoneal dialysis-associated
- Vancomycin (or teicoplanin p. 334) + ceftriaxone p. 331 added to dialysis fluid or vancomycin added to dialysis fluid + ciprofloxacin by mouth
  - Suggested duration of treatment 14 days or longer

Necrotising enterocolitis in neonates
- Benzylpenicillin sodium p. 349+ gentamicin + metronidazole or amoxicillin (or ampicillin) + gentamicin + metronidazole or amoxicillin (or ampicillin) + cefotaxime + metronidazole

Pelvic inflammatory disease
Contact tracing recommended.
- Child 2–11 years, erythromycin + metronidazole p. 344+ single-dose of i/m ceftriaxone
  - Suggested duration of treatment 14 days (except i/m ceftriaxone)
- Child 12–17 years, doxycycline + metronidazole + single-dose of i/m ceftriaxone
  - If severely ill, seek specialist advice.
  - Suggested duration of treatment 14 days (except i/m ceftriaxone)

Syphilis
Contact tracing recommended.
- Child under 12 years, benzylpenicillin sodium p. 349 or procaine benzylpenicillin [unlicensed]
  - Suggested duration of treatment 10 days

Early syphilis (infection of less than 2 years)
- Child 12–17 years, benzathine benzylpenicillin [unlicensed]
  - Suggested duration of treatment single-dose (repeat dose after 7 days for females in the third trimester of pregnancy)
  - Alternatively, doxycycline or erythromycin
  - Suggested duration of treatment 14 days

Late latent syphilis (asymptomatic infection of more than 2 years)
- Child 12–17 years, benzathine benzylpenicillin [unlicensed]
  - Suggested duration of treatment once weekly for 2 weeks
  - Alternatively, doxycycline
  - Suggested duration of treatment 28 days

Asymptomatic contacts of patients with infectious syphilis
- Child 12–17 years, doxycycline
  - Suggested duration of treatment 14 days

Neonatal congenital syphilis
- Benzylpenicillin sodium
  - Also consider treating neonates with suspected congenital syphilis whose mothers were treated inadequately for syphilis, or whose mothers were treated for syphilis in the 4 weeks before delivery, or whose mothers were treated with non-penicillin antibacterials for syphilis.
  - Suggested duration of treatment 10 days.

Genital system infections, antibacterial therapy
Uncomplicated genital chlamydial infection, non-gonococcal urethritis, and non-specific genital infection
Contact tracing recommended.
- Child under 12 years, erythromycin p. 341
  - Suggested duration of treatment 14 days
- Child 12–17 years, azithromycin p. 339 as a single dose or doxycycline p. 364 for 7 days
  - Alternatively, erythromycin for 14 days

Gonorrhoea: uncomplicated
Contact tracing recommended. Consider chlamydia co-infection. Choice of antibacterial depends on locality where infection acquired.
- Child under 12 years, single-dose of ceftriaxone p. 332
- Child 12–17 years, single-dose of cefixime p. 330
  - Alternatively, if micro-organism sensitive, single-dose of ciprofloxacin p. 361
- Child 12–17 years with pharyngeal infection, single-dose of ceftriaxone

Pelvic inflammatory disease
Contact tracing recommended.
- Child 2–11 years, erythromycin + metronidazole p. 344+ single-dose of i/m ceftriaxone
  - Suggested duration of treatment 14 days (except i/m ceftriaxone)
- Child 12–17 years, doxycycline + metronidazole + single-dose of i/m ceftriaxone
  - If severely ill, seek specialist advice.
  - Suggested duration of treatment 14 days (except i/m ceftriaxone)

Syphilis
Contact tracing recommended.
- Child under 12 years, benzylpenicillin sodium p. 349 or procaine benzylpenicillin [unlicensed]
  - Suggested duration of treatment 10 days

Early syphilis (infection of less than 2 years)
- Child 12–17 years, benzathine benzylpenicillin [unlicensed]
  - Suggested duration of treatment single-dose (repeat dose after 7 days for females in the third trimester of pregnancy)
  - Alternatively, doxycycline or erythromycin
  - Suggested duration of treatment 14 days

Late latent syphilis (asymptomatic infection of more than 2 years)
- Child 12–17 years, benzathine benzylpenicillin [unlicensed]
  - Suggested duration of treatment once weekly for 2 weeks
  - Alternatively, doxycycline
  - Suggested duration of treatment 28 days

Asymptomatic contacts of patients with infectious syphilis
- Child 12–17 years, doxycycline
  - Suggested duration of treatment 14 days

Neonatal congenital syphilis
- Benzylpenicillin sodium
  - Also consider treating neonates with suspected congenital syphilis whose mothers were treated inadequately for syphilis, or whose mothers were treated for syphilis in the 4 weeks before delivery, or whose mothers were treated with non-penicillin antibacterials for syphilis.
  - Suggested duration of treatment 10 days.

Genital system infections, antibacterial therapy
Uncomplicated genital chlamydial infection, non-gonococcal urethritis, and non-specific genital infection
Contact tracing recommended.
- Child under 12 years, erythromycin p. 341
  - Suggested duration of treatment 14 days
- Child 12–17 years, azithromycin p. 339 as a single dose or doxycycline p. 364 for 7 days
  - Alternatively, erythromycin for 14 days

Gonorrhoea: uncomplicated
Contact tracing recommended. Consider chlamydia co-infection. Choice of antibacterial depends on locality where infection acquired.
- Child under 12 years, single-dose of ceftriaxone p. 332
- Child 12–17 years, single-dose of cefixime p. 330
  - Alternatively, if micro-organism sensitive, single-dose of ciprofloxacin p. 361
- Child 12–17 years with pharyngeal infection, single-dose of ceftriaxone

Musculoskeletal system infections, antibacterial therapy
Osteomyelitis
Seek specialist advice if chronic infection or prostheses present.
- Flucloxacillin p. 357
  - Consider adding fusidic acid p. 371 or rifampicin p. 379 for initial 2 weeks.
  - Suggested duration of treatment 6 weeks for acute infection
  - If penicillin–allergic, clindamycin p. 337
  - Consider adding fusidic acid or rifampicin for initial 2 weeks.
  - Suggested duration of treatment 6 weeks for acute infection
  - If meticillin–resistant Staphylococcus aureus suspected, vancomycin p. 335 (or teicoplanin p. 334)
Consider adding fusidic acid or rifampicin for initial 2 weeks.
- **Suggested duration of treatment** 6 weeks for acute infection

### Septic arthritis
Seek specialist advice if prostheses present.
- Flucloxacillin
- **Suggested duration of treatment** 4–6 weeks (longer if infection complicated).
- If penicillin-allergic, clindamycin
- **Suggested duration of treatment** 4–6 weeks (longer if infection complicated).
- If meticillin-resistant *Staphylococcus aureus* suspected, vancomycin (or teicoplanin)
- **Suggested duration of treatment** 4–6 weeks (longer if infection complicated).
- If gonococcal arthritis or Gram-negative infection suspected, cefotaxime p. 330 (or ceftriaxone p. 332)
- **Suggested duration of treatment** 4–6 weeks (longer if infection complicated; treat gonococcal infection for 2 weeks).

### Nose infections, antibacterial therapy

#### Sinusitis (acute)
Acute sinusitis is generally triggered by a viral infection, although occasionally it may become complicated by a bacterial infection caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catharrhalis*, or *Staphylococcus aureus*. For further information see Sinusitis (acute) p. 721.

#### Treatment
- **Antibacterial therapy should only be offered to children with acute sinusitis who are systemically very unwell, have signs and symptoms of a more serious illness, those who are at high-risk of complications due to pre-existing comorbidities, or whenever bacterial sinusitis is suspected.**
- For further information see Sinusitis (acute) p. 721.

#### Choice of antibacterial therapy

**No penicillin allergy**
- **First line:** Non-life threatening symptoms: phenoxymethylpenicillin p. 350.
  - Systemically very unwell, signs and symptoms of a more serious illness, or at high-risk of complications: co-amoxiclav p. 354.
- **Second line** (worsening symptoms despite 2 or 3 days of antibiotic treatment):
  - Non-life threatening symptoms: co-amoxiclav.
  - Systemically very unwell, signs and symptoms of a more serious illness or at high-risk of complications: consult local microbiologist.

**Penicillin allergy or intolerance**
- **First line:** clarithromycin p. 340, or doxycycline p. 364 (for children above 12 years old).
- **Second line** (worsening symptoms despite 2 or 3 days of antibiotic treatment): Consult local microbiologist.

### Use of nasal drops
- Local decongestant nasal drops can be useful in both acute and chronic sinusitis, especially in children or those with atopic sensitivities.
- Do not use as chronic treatment.

### Coagulase-negative staphylococci
- More common from nasal carriage, it is less likely to be associated with serious complications than *S. aureus*.
- Usually treated with vancomycin or rifampicin.

### Septic arthritis
- **Suggested duration of treatment** 6 weeks for acute infection

### Oral bacterial infections

#### Antimicrobial drugs
- Antibacterial drugs should only be prescribed for the treatment of oral infections on the basis of defined need. They may be used in conjunction with (but not as an alternative to) other appropriate measures, such as providing drainage or extracting a tooth.
- The ‘blind’ prescribing of an antibiotic for unexplained pyrexia, cervical lymphadenopathy, or facial swelling can lead to difficulty in establishing the diagnosis. In severe oral infections, a sample should always be taken for bacteriology.
- Oral infections which may require antibacterial treatment include acute periapical or periodontal abscesses, cellulitis, acutely created oral-antral communication (and acute sinusitis), severe pericoronitis, localised osteitis, acute necrotising ulcerative gingivitis, and destructive forms of chronic periodontal disease. Most of these infections are readily resolved by the early establishment of drainage and removal of the cause (typically an infected necrotic pulp).
- Antibacterials may be required if treatment has to be delayed, in immunocompromised patients, or in those with conditions such as diabetes. Certain rarer infections including bacterial sialadenitis, osteomyelitis, actinomycosis, and infections involving fascial spaces such as Ludwig’s angina, require antibiotics and specialist hospital care.
- Antibacterial drugs may also be useful after dental surgery in some cases of spreading infection. Infection may spread to involve local lymph nodes, to fascial spaces (where it can cause airway obstruction), or into the bloodstream (where it can lead to cavernous sinus thrombosis and other serious complications). Extension of an infection can also lead to maxillary sinusitis; osteomyelitis is a complication, which usually arises when host resistance is reduced.
- If the oral infection fails to respond to antibacterial treatment within 48 hours the antibacterial should be changed, preferably on the basis of bacteriological investigation. Failure to respond may also suggest an incorrect diagnosis, lack of essential additional measures (such as drainage), poor host resistance, or poor patient compliance.
- Combination of a penicillin (or a macrolide) with metronidazole p. 344 may sometimes be helpful for the treatment of severe oral infections or oral infections.

#### Penicillins
- Phenoxymethylpenicillin p. 350 is effective for dentoalveolar abscess.

#### Broad-spectrum penicillins
- Amoxicillin p. 351 is as effective as phenoxymethylpenicillin but is better absorbed; however, it may encourage emergence of resistant organisms.
- Like phenoxymethylpenicillin, amoxicillin is ineffective against bacteria that produce beta-lactamases.
- Co-amoxiclav p. 354 is active against beta-lactamase-producing bacteria that are resistant to amoxicillin. Co-amoxiclav may be used for severe dental infection with spreading cellulitis or dental infection not responding to first-line antibacterial treatment.

#### Cephalosporins
- The cephalosporins offer little advantage over the penicillins in dental infections, often being less active against anaerobes. Infections due to oral streptococci (often termed viridans streptococci) which become resistant to penicillin are usually also resistant to cephalosporins. This is of importance in the case of patients who have had rheumatic fever and are on long-term penicillin therapy. Cefadroxil p. 327 and cefadroxil p. 328 have been used in the treatment of oral infections.
Tetracyclines
In children over 12 years of age, tetracyclines can be effective against oral anaerobes but the development of resistance (especially by oral streptococci) has reduced their usefulness for the treatment of acute oral infections; they may still have a role in the treatment of destructive (refractory) forms of periodontal disease. Doxycycline p. 364 has a longer duration of action than tetracycline p. 367 or oxytetracycline p. 367 and need only be given once daily; it is reported to be more active against anaerobes than some other tetracyclines.
Doxycycline may have a role in the treatment of recurrent aphthous ulceration, or as an adjunct to gingival scaling and root planing for periodontitis.

Macrolides
The macrolides are an alternative for oral infections in penicillin-allergic patients or where a beta-lactamase producing organism is involved. However, many organisms are now resistant to macrolides or rapidly develop resistance; their use should therefore be limited to short courses.

Clindamycin
Clindamycin p. 337 should not be used routinely for the treatment of oral infections because it may be no more effective than penicillins against anaerobes and there may be cross-resistance with erythromycin-resistant bacteria. Clindamycin can be used for the treatment of dental/veolar abscess that has not responded to penicillin or to metronidazole.

Metronidazole and tinidazole
Metronidazole is an alternative to a penicillin for the treatment of many oral infections where the patient is allergic to penicillin or the infection is due to beta-lactamase-producing anaerobes. It is the drug of first choice for the treatment of acute necrotising ulcerative gingivitis (Vincent’s infection) and pericoronitis; amoxicillin is a suitable alternative. For these purposes metronidazole for 3 days is sufficient, but the duration of treatment may need to be longer in pericoronitis. Tinidazole p. 346 is licensed for the treatment of acute ulcerative gingivitis.

Respiratory system infections, antibacterial therapy
Epiglottitis (Haemophilus influenzae)
- Cefotaxime p. 330 (or ceftriaxone p. 332)
- If history of immediate hypersensitivity reaction to penicillin or to cephalosporins, chloramphenicol p. 368

Bronchiectasis (non-cystic fibrosis), acute exacerbation
Bronchiectasis is a persistent or progressive condition, caused by chronic inflammatory damage to the airways and is characterised by thick-walled, dilated bronchi. Signs and symptoms may range from intermittent expectoration and infection, to chronic cough, persistent daily production of sputum, bacterial colonisation, and recurrent infections. An acute exacerbation is defined as sustained deterioration of the child’s signs and symptoms from their baseline and presents with worsening local symptoms, with or without increased wheeze, breathlessness or haemoptysis and may be accompanied by fever or pleurisy.

Treatment
Obtain a sputum sample and send for culture and susceptibility testing. Antibacterial therapy should be given to all children with an acute exacerbation.

For children receiving prophylactic antibacterial therapy, switching from intravenous to oral antibacterials, and for advice to be given to children and their parents, or carers, see Antibacterials, principles of therapy p. 309.

Reassessment
- Other diagnoses such as pneumonia, or signs and symptoms of a more serious illness such as cardiorespiratory failure, or sepsis;
- Previous antibacterial use that may have led to resistance.

Choice of antibacterial therapy

Oral first line:
- Amoxicillin p. 351, clarithromycin p. 340, or doxycycline p. 364 (child over 12 years).
- Alternative if at high risk of treatment failure (repeated courses of antibacterials, previous culture with resistant or atypical bacteria, or high risk of complications): co-amoxiclav p. 354, or ciprofloxacin p. 361 (on specialist advice).

Intravenous first line (severely unwell or unable to take oral treatment):
- Amoxiclav, piperacillin with tazobactam p. 348, or ciprofloxacin (on specialist advice).

Antibacterial prophylaxis
For children with repeated acute exacerbations, a trial of antibacterial prophylaxis may be given on specialist advice only.

Cough, acute
Acute cough is usually self-limiting and often resolves within 3–4 weeks without antibacterials. It is most commonly caused by a viral upper respiratory tract infection, but can have other infective causes such as acute bronchitis or pneumonia, or non-infective causes such as interstitial lung disease or gastro-oesophageal reflux disease.

Treatment
Children and their parents, or carers should be advised that an acute cough is usually self-limiting and to manage symptoms using self-care treatments. These include honey (for children under the age of 1 year) and over-the-counter cough medicines containing expectorants or cough suppressants, however there is limited evidence to support the use of such products. For more information, see Aromatic inhalations, cough preparations and systemic nasal decongestants p. 191.

Children with an acute cough who are systemically very unwell should be offered immediate antibacterial treatment.

Do not routinely offer an antibacterial to treat an acute cough associated with an upper respiratory tract infection or acute bronchitis in children who are not systemically very unwell or at higher risk of complications.

Children with a pre-existing co-morbidity or young children who were born prematurity are considered to be at a higher risk of complications if they present with an acute cough. In these patients, the need for immediate
antibacterial treatment should be considered based on the face-to-face clinical examination. A

For general advice to give to children and their parents, or carers, see Antibiocin, principles of therapy p. 309. B

Seek specialist advice, or refer children with an acute cough to hospital if they have signs or symptoms of a more serious illness or condition. A

Reassessment

B

Reassess if symptoms worsen rapidly or significantly taking into account alternative diagnoses, symptoms suggestive of a more serious condition, and previous antibacterial use which may have led to resistant bacteria. A

Choice of antibacterial therapy

- First line
  - Amoxicillin.
  - Alternative first line choices: clarithromycin, erythromycin p. 341, or doxycycline (child over 12 years). A

Choice during pregnancy:

- Amoxicillin or erythromycin. A

Community-acquired pneumonia

Children under 2 years with mild symptoms of lower respiratory tract infection (particularly those vaccinated with pneumococcal polysaccharide conjugate vaccine (adsorbed) p. 819 and haemophilus type b conjugate vaccine) are unlikely to have pneumonia; antibacterial treatment may be considered if symptoms persist.

- Neonate, benzylpenicillin sodium p. 349 + gentamicin p. 322
- Child 1 month–18 years, amoxicillin (or ampicillin p. 353) by mouth
- Pneumococci with decreased penicillin sensitivity have been isolated in the UK, but are not common.
- If no response to treatment, add clarithromycin (or azithromycin p. 339 or erythromycin)
- If staphylococci suspected (e.g. in influenza or measles), give by mouth amoxicillin + flucloxacillin p. 357 or co-amoxiclav alone
- If septicaemia, complicated pneumonia, or if oral administration not possible, initiate treatment with i/v amoxicillin or i/v co-amoxiclav or i/v ceftriaxone p. 329 or i/v cefotaxime (or ceftiraxone)
- Suggested duration of treatment 7 days (may extend treatment to 14 days in some cases e.g. if staphylococci suspected)
- Child 1 month–18 years, if penicillin-allergic, clarithromycin (or azithromycin or erythromycin)
- Suggested duration of treatment 7 days (may extend treatment to 14 days in some cases e.g. if staphylococci suspected)

Pneumonia possibly caused by atypical pathogens

- Clarithromycin (or azithromycin or erythromycin)
- Suggested duration of treatment 10–14 days
- Alternative for chlamydia or mycoplasma infections in children over 12 years, doxycycline
- Suggested duration of treatment 10–14 days

Hospital-acquired pneumonia

- Early-onset infection (less than 5 days after admission to hospital), treat as for severe community-acquired pneumonia of unknown aetiology; if life-threatening infection, or if recent history of antibacterial treatment, or if resistant organisms suspected, treat as for late-onset hospital-acquired pneumonia
- Late-onset infection (more than 5 days after admission to hospital), an antipseudomonal penicillin (e.g. piperacillin with tazobactam) or another antipseudomonal beta-lactam

- If meticillin-resistant Staphylococcus aureus suspected, add vancomycin p. 335.
- If severe illness caused by Pseudomonas aeruginosa, add an aminoglycoside.
- Suggested duration of treatment 7 days (longer if Pseudomonas aeruginosa confirmed)

Lung infection in cystic fibrosis (Staphylococcus spp.)

- Flucloxacillin
- If child already taking flucloxacillin prophylaxis or if severe exacerbation, add fusidic acid p. 371 or rifampicin p. 379; use flucloxacillin at treatment dose
- If penicillin-allergic, clarithromycin p. 340 (or azithromycin p. 339 or erythromycin p. 341) or clindamycin p. 337
- Use clarithromycin only if micro-organism sensitive

Lung infection in cystic fibrosis (Haemophilus influenzae)

- Amoxicillin p. 351 or a broad-spectrum cephalosporin
- In severe exacerbation use a third-generation cephalosporin (e.g. cefotaxime p. 330)

Lung infection in cystic fibrosis (Pseudomonas spp.)

- Ciprofloxacin p. 361 + nebulised colistimethate sodium p. 358
- For severe exacerbation, an antipseudomonal beta-lactam antibiotic + parenteral tobramycin p. 323

Skin infections, antibacterial therapy

Impetigo: small areas of skin infected

Seek local microbiology advice before using topical treatment in hospital.

- Topical fusidic acid p. 371
- Suggested duration of treatment 7 days is usually adequate (max. 10 days).
- Alternatively, if meticillin-resistant Staphylococcus aureus, topical mupirocin p. 748
- Suggested duration of treatment 7 days is usually adequate (max. 10 days).

Impetigo: widespread infection

- Oral flucloxacillin p. 357
- If streptococci suspected in severe infection, add phenoxybenzyl penicillin p. 350
- Suggested duration of treatment 7 days.
- If penicillin-allergic, oral clarithromycin p. 340 (or azithromycin p. 339 or erythromycin p. 341)
- Suggested duration of treatment 7 days.

Erysipelas

- Phenoxybenzyl penicillin or benzylpenicillin sodium p. 349
- If severe infection, replace phenoxybenzyl penicillin or benzylpenicillin sodium with high-dose flucloxacillin
- Suggested duration of treatment at least 7 days
- If penicillin-allergic, clindamycin p. 337 or clarithromycin (or azithromycin or erythromycin)
- Suggested duration of treatment at least 7 days.
Cellulitis
- Flucloxacillin (high dose)
  - If streptococcal infection confirmed, replace flucloxacillin with phenoxybenzylpenicillin or benzylpenicillin sodium
  - If Gram-negative bacteria or anaerobes suspected (e.g. facial infection, orbital infection, or infection caused by animal or human bites), use broad-spectrum antibacterials; if periumbilical cellulitis, use flucloxacillin + gentamicin p. 322
- If penicillin-allergic, clindamycin or clarithromycin (or azithromycin or erythromycin)
- If Gram-negative bacteria suspected, use broad-spectrum antibacterials.

Staphylococcal scalded skin syndrome
- Flucloxacillin
  - Suggested duration of treatment 7–10 days.
- If penicillin-allergic, clarithromycin (or azithromycin or erythromycin)
  - Suggested duration of treatment 7–10 days.

Animal and human bites
Cleanse wound thoroughly. For tetanus-prone wound, give appropriate prophylaxis to prevent viral spread.
- For tetanus-prone wound, give with a tetanus-containing vaccine if necessary, according to immunisation history and risk of infection. Consider rabies prophylaxis for animal or human bites), use broad-spectrum antibacterials; if periumbilical cellulitis, use flucloxacillin + gentamicin p. 322
- Co-amoxiclav p. 354
  - If penicillin-allergic, clindamycin

Surgical wound infection
- Flucloxacillin or co-amoxiclav

Paronychia or ‘septic spots’ in neonate
- Flucloxacillin
  - If systemically unwell, add an aminoglycoside.

ANTIBACTERIALS > AMINOGLYCOSIDES

Aminoglycosides

Overview
These include amikacin p. 321, gentamicin p. 322, neomycin sulfate p. 714, streptomycin p. 323, and tobramycin p. 323. All are bactericidal and active against some Gram-positive and many Gram-negative organisms. Amikacin, gentamicin, and tobramycin are also active against *Pseudomonas aeruginosa*; streptomycin is active against *Mycobacterium tuberculosis* and is now almost entirely reserved for tuberculosis.

The aminoglycosides are not absorbed from the gut (although there is a risk of absorption in inflammatory bowel disease and liver failure) and must therefore be given by injection for systemic infections.

Gentamicin is the aminoglycoside of choice in the UK and is used widely for the treatment of serious infections. It has a broad spectrum but is inactive against anaerobes and has poor activity against haemolytic streptococci and pneumococci. When used for the ‘blind’ therapy of undiagnosed serious infections it is usually given in conjunction with a penicillin or metronidazole p. 344 (or both). Gentamicin is used together with another antibiotic for the treatment of endocarditis. Streptomycin may be used as an alternative in gentamicin-resistant enterococcal endocarditis.

Loading and maintenance doses of gentamicin may be calculated on the basis of the patient’s weight and renal function (e.g. using a nomogram); adjustments are then made according to serum-gentamicin concentrations. High doses are occasionally indicated for serious infections, especially in the neonate, in the patient with cystic fibrosis, or in the immunocompromised patient. Whenever possible treatment should not exceed 7 days.

Amikacin is more stable than gentamicin to enzyme inactivation. Amikacin is used in the treatment of serious infections caused by gentamicin-resistant Gram-negative bacilli.

Tobramycin has similar activity to gentamicin. It is slightly more active against *Ps. aeruginosa* but shows less activity against certain other Gram-negative bacteria.

Neomycin sulfate is too toxic for parenteral administration and can only be used for infections of the skin or mucous membranes or to reduce the bacterial population of the colon prior to bowel surgery or in hepatic failure. Oral administration may lead to malabsorption. Small amounts of neomycin sulfate may be absorbed from the gut in patients with hepatic failure and, as these patients may also be uraemic, cumulation may occur with resultant ototoxicity.

Cystic fibrosis
A higher dose of parenteral aminoglycoside is often required in children with cystic fibrosis because renal clearance of the aminoglycoside is increased. Aminoglycosides have a role in the treatment of pseudomonal lung infections in cystic fibrosis. Tobramycin can be administered by nebuliser or by inhalation of powder on a cyclical basis (28 days of tobramycin followed by a 28-day tobramycin-free interval) for the treatment of chronic pulmonary *Ps. aeruginosa* infection in cystic fibrosis; however, resistance may develop and some patients do not respond to treatment.

Once daily dosage
*Once daily administration* of aminoglycosides is more convenient, provides adequate serum concentrations, and has largely superseded *multiple-daily dose regimens* (given in 2–3 divided doses during the 24 hours). Local guidelines on dosage and serum concentrations should be consulted. A once–daily, high-dose regimen of an aminoglycoside should be avoided in children with endocarditis or burns of more than 20% of the total body surface area. There is insufficient evidence to recommend a once daily, high-dose regimen of an aminoglycoside in pregnancy.

Serum concentrations
Serum concentration monitoring avoids both excessive and subtherapeutic concentrations thus preventing toxicity and ensuring efficacy. Serum-aminoglycoside concentrations should be monitored in patients receiving parenteral aminoglycosides and *must* be determined in obesity, and in cystic fibrosis, or if high doses are being given, or if there is renal impairment.

Neonates
As aminoglycosides are eliminated principally via the kidney, neonatal treatment must reflect the changes in glomerular filtration that occur with increasing gestational and postnatal age. The *extended interval dose regimen* is used in neonates, and serum-aminoglycoside concentrations *must* be measured. In patients on single daily dose regimens it may become necessary to prolong the dose interval to more than 24 hours if the trough concentration is high.
Aminoglycosides (by injection)

- **CONTRAINDICATIONS** Myasthenia gravis (aminoglycosides may impair neuromuscular transmission)
- **CAUTIONS** Care must be taken with dosage (the main side-effects of the aminoglycosides are dose-related) - conditions characterised by muscular weakness (aminoglycosides may impair neuromuscular transmission) - if possible, dehydration should be corrected before starting an aminoglycoside - whenever possible, parenteral treatment should not exceed 7 days
- **SIDE-EFFECTS**
  - **Common or very common** Skin reactions - tinnitus
  - **Uncommon** Nausea - vomiting
  - **Rare or very rare** Anaemia - bronchospasm - eosinophilia - fever - headache - hearing loss - hypomagnesaemia - paraesthesia - renal impairment
  - **Frequency not known** Confusion - lethargy - nephrotoxicity

**SIDE-EFFECTS, FURTHER INFORMATION**
Otootoxicity and nephrotoxicity are important side-effects to consider with aminoglycoside therapy. Nephrotoxicity occurs most commonly in patients with renal impairment.

- **PREGNANCY** There is a risk of auditory or vestibular nerve damage in the infant when aminoglycosides are used in the second and third trimesters of pregnancy. The risk is greatest with streptomycin. The risk is probably very small with gentamicin and tobramycin, but their use should be avoided unless essential.

**MONITORING** If given during pregnancy, serum-aminoglycoside concentration monitoring is essential.

- **RENAL IMPAIRMENT** Excretion of aminoglycosides is principally via the kidney and accumulation occurs in renal impairment. Otootoxicity and nephrotoxicity occur commonly in patients with renal failure. A once-daily, high-dose regimen of an aminoglycoside should be avoided in children over 1 month of age with a creatinine clearance less than 20 mL/minute/1.73 m².

**Dose adjustments** If there is impairment of renal function, the interval between doses must be increased; if the renal impairment is severe, the dose itself should be reduced as well.

**Monitoring** Serum-aminoglycoside concentrations must be monitored in patients with renal impairment; earlier and more frequent measurement of aminoglycoside concentration may be required.

**MONITORING REQUIREMENTS**
- Serum concentrations Serum concentration monitoring avoids both excessive and subtherapeutic concentrations thus preventing toxicity and ensuring efficacy.
- Serum-aminoglycoside concentrations should be measured in all patients receiving parenteral aminoglycosides and must be determined in obesity, if high doses are being given and in cystic fibrosis.
- Serum aminoglycoside concentrations must be determined in neonates.
- In children with normal renal function, aminoglycoside concentrations should be measured after 3 or 4 doses of a multiple daily dose regimen.
- Blood samples should be taken just before the next dose is administered (‘trough’ concentration). If the pre-dose (‘trough’) concentration is high, the interval between doses must be increased. For multiple daily dose regimens, blood samples should also be taken approximately 1 hour after intramuscular or intravenous administration (‘peak’ concentration). If the post-dose (‘peak’) concentration is high, the dose must be decreased.
- Renal function should be assessed before starting an aminoglycoside and during treatment.
- Auditory and vestibular function should also be monitored during treatment.

Amikacin

- **INDICATIONS AND DOSE**
  - **Serious Gram-negative infections resistant to gentamicin (multiple daily dose regimen)**
    - **BY SLOW INTRAVENOUS INJECTION**
      - Child 1 month–11 years: 7.5 mg/kg every 12 hours, to be administered over 3–5 minutes
      - Child 12–17 years: 7.5 mg/kg every 12 hours; increased to 7.5 mg/kg every 8 hours (max. per dose 500 mg every 8 hours) for up to 10 days, higher dose to be used in severe infection, to be administered over 3–5 minutes; maximum 15 g per course
  - **Serious Gram-negative infections resistant to gentamicin (once daily dose regimen)**
    - **BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
      - Neonate: 15 mg/kg every 24 hours, intravenous injection to be administered over 3–5 minutes.
      - **Neonatal sepsis (extended interval dose regimen)**
        - **BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
      - Neonate: Loading dose 10 mg/kg, then 7.5 mg/kg every 12 hours, intravenous injection to be administered over 3–5 minutes.
  - **Pseudomonal lung infection in cystic fibrosis**
    - **BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child: 10 mg/kg every 8 hours (max. per dose 500 mg every 8 hours), intravenous injection to be administered over 3–5 minutes
  - **DOSES AT EXTREMES OF BODY-WEIGHT**
    - **To avoid excessive dosage in obese patients, use ideal weight for height to calculate dose and monitor serum-amikacin concentration closely**

- **UNLICENSED USE**
  - With intravenous use. Dose for cystic fibrosis not licensed.

- **INTERACTIONS** → Appendix 1: aminoglycosides

- **SIDE-EFFECTS**
  - **Uncommon** Superinfection
  - **Rare or very rare** Albuminuria - arthralgia - azotaemia - balance impaired - hearing impairment - hypotension - muscle twitching - tremor
  - **Frequency not known** Apnoea - neuromuscular blockade - paralysis

- **MONITORING REQUIREMENTS**
  - With intravenous use. Multiple daily dose regimen: one-hour (‘peak’) serum concentration should not exceed 30 mg/litre; pre-dose (‘trough’) concentration should be less than 10 mg/litre. **Once daily dose regimen**: pre-dose (‘trough’) concentration should be less than 5 mg/litre.

- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use. For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%; give over 30–60 minutes.

- **PRESCRIBING AND DISPENSING INFORMATION** Local guidelines may vary in the dosing advice provided.
Infection

322 Bacterial infection

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

Solution for injection

- **Amikacin (Non-proprietary)**
  - Amikacin (as Amikacin sulfate) 250 mg per 1 ml
  - Amikacin 500mg/2ml solution for injection vials | 5 vial | £60.00 (Hospital only)
- **Aminikin** (Bristol-Myers Squibb Pharmaceuticals Ltd)
  - Amikacin (as Amikacin sulfate) 50 mg per 1 ml
  - Amikin 100mg/2ml solution for injection vials | 5 vial | £10.33

INTERACTIONS → Appendix 1: aminoglycosides

SIDE-EFFECTS Antibiotic associated colitis - blood disorder - depression - encephalopathy - hallucination - hepatic reaction - neurotoxicity - peripheral neuropathy - seizure - stomatitis - vestibular damage

MONITORING REQUIREMENTS

- With intravenous use in neonates. Extended interval dose regimen in neonates: pre-dose (‘trough’) concentration should be less than 2 mg/litre (less than 1 mg/litre if more than 3 doses administered); consider monitoring one hour (‘peak’) concentration in neonates with poor response to treatment, with oedema, with Gram-negative infection, or with birth-weight greater than 4.5 kg (consider increasing dose if ‘peak’ concentration less than 8 mg/litre in severe sepsis).
- With intravenous use. Once daily dose regimen: pre-dose (‘trough’) concentration should be less than 1 mg/litre.
- With intramuscular or intravenous use. Multiple daily dose regimen: one hour (‘peak’) serum concentration should be 5–10 mg/litre; pre-dose (‘trough’) concentration should be less than 2 mg/litre. Multiple daily dose regimen for endocarditis: one hour (‘peak’) serum concentration should be 3–5 mg/litre; pre-dose (‘trough’) concentration should be less than 1 mg/litre. Serum-gentamicin concentration should be determined twice each week (more often in renal impairment). Multiple daily dose regimen for cystic fibrosis: one hour (‘peak’) serum concentration should be 8–12 mg/litre; pre-dose (‘trough’) concentration should be less than 2 mg/litre.
- With intrathecal use or intraventricular use Intrathecal/ intraventricular injection: cerebrospinal fluid concentration should not exceed 10 mg/litre.

DIRECTIONS FOR ADMINISTRATION

- With intrathecal or intraventricular use. For intrathecal or intraventricular injection, use preservative-free intrathecal preparations only.
- With intravenous use. For intravenous infusion, dilute in Glucose 5% or Sodium Chloride 0.9%; give over 30 minutes.

PRESCRIBING AND DISPENSING INFORMATION

Local guidelines may vary in the dosing advice provided.

- With intrathecal use. Only preservative-free intrathecal preparation should be used.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Solution for injection

- **Gentamicin (Non-proprietary)**
  - Gentamicin (as Gentamicin sulfate) 5 mg per 1 ml Gentamicin Intrathecal 5mg/1ml solution for injection ampoules | 5 ampoule | £36.28 DT + £36.28 (Hospital only)
- **Gentamicin (as Gentamicin sulfate)** 10 mg per 1 ml Gentamicin 20mg/2ml solution for injection ampoules | 5 ampoule | £11.25 DT + £11.25
- **Gentamicin Paediatric** 20mg/2ml solution for injection vials | 5 vial | £11.25 DT + £11.25
- **Gentamicin (as Gentamicin sulfate)** 40 mg per 1 ml Gentamicin 80mg/2ml solution for injection vials | 5 vial | £6.88 DT + £6.88
- **Gentamicin (as Gentamicin sulfate)** 10 mg per 1 ml Gentamicin 20mg/2ml solution for injection vials | 5 ampoule | £6.88 DT + £6.88
- **Gentamicin Adult Injection** 80mg/2ml solution for injection vials | 5 vial | £12.00
- **Cidomycin (Sanofi)**
  - Gentamicin (as Gentamicin sulfate) 40 mg per 1 ml Cidomycin Adult Injectable 80mg/2ml solution for injection vials | 5 vial | £6.88 DT + £6.88
  - Cidomycin Adult Injectable 80mg/2ml solution for injection ampoules | 5 ampoule | £6.88 DT + £6.88

IMPORTANT SAFETY INFORMATION

MHRA/CHM ADVICE: POTENTIAL FOR HISTAMINE-RELATED ADVERSE DRUG REACTIONS WITH SOME BATCHES (NOVEMBER 2017)

Following reports that some batches of gentamicin sulphate active pharmaceutical ingredient (API) used to manufacture gentamicin may contain higher than expected levels of histamine, which is a residual from the manufacturing process, the MHRA advise to monitor patients for signs of histamine-related adverse reactions; particular caution is required in patients taking concomitant drugs known to cause histamine release, in children, and in patients with severe renal impairment.

INDICATIONS AND DOSE

Septicaemia | Meningitis and other CNS infections | Biliary-tract infection | Acute pyelonephritis | Endocarditis | Pneumonia in hospital patients | Adjunct in listerial meningitis

- **BY INTRAVENOUS INFUSION**
  - Child: Initially 7 mg/kg, to be given in a once daily regimen (not suitable for endocarditis or meningitis), subsequent doses adjusted according to serum-gentamicin concentration.
  - **BY INTRAMUSCULAR INJECTION, OR BY SLOW INTRAVENOUS INJECTION**
  - Child 1 month–11 years: 2.5 mg/kg every 8 hours, to be given in a multiple daily dose regimen, intravenous injection to be administered over at least 3 minutes
  - Child 12–17 years: 2.5 mg/kg every 8 hours, to be given in a multiple daily dose regimen, intravenous injection to be administered over at least 3 minutes

Neonatal sepsis

- **BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Neonate up to 7 days: 5 mg/kg every 36 hours, to be given in an extended interval dose regimen.
  - Neonate 7 days to 28 days: 5 mg/kg every 24 hours, to be given in an extended interval dose regimen.

Pseudomonal lung infection in cystic fibrosis

- **BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Child: 3 mg/kg every 8 hours, to be given in a multiple daily dose regimen, intravenous injection to be administered over at least 3 minutes

Bacterial ventriculitis and CNS infection (supplement to systemic therapy) (administered on expert advice)

- **BY INTRATHecal INJECTION, OR BY INTRAVENTRICULAR INJECTION**
  - Neonate: (consult local protocol).

Neonate: Initially 1 mg daily, then increased if necessary to 5 mg daily, seek specialist advice

DOSES AT EXTREMES OF BODY-WEIGHT

- With intramuscular use or intravenous use To avoid excessive dosage in obese patients, use ideal weight for height to calculate parenteral dose and monitor serum-gentamicin concentration closely.
**Bacterial infection** 323

### Streptomycin

**INDICATIONS AND DOSE**

Tuberculosis, resistant to other treatment, in combination with other drugs

- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child: 15 mg/kg once daily (max. per dose 1 g)

Adjunct to doxycycline in brucellosis (administered on expert advice)

- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child: 5–10 mg/kg every 6 hours, total daily dose may alternatively be given in 2–3 divided doses

**UNLICENSED USE** Not licensed for use in children.

**IMPORTANT SAFETY INFORMATION**

Side-effects increase after a cumulative dose of 100 g, which should only be exceeded in exceptional circumstances.

**INTERACTIONS** → Appendix 1: aminoglycosides

**SIDE-EFFECTS**

- Hypersensitivity - oral paraesthesia

**RENAI IMPAIRMENT**

Dose adjustments Should preferably be avoided. If essential, use with great care and consider dose reduction.

**MONITORING REQUIREMENTS**

- One-hour (‘peak’) concentration should be 15–40 mg/litre; pre-dose (‘trough’) concentration should be less than 5 mg/litre (less than 1 mg/litre in renal impairment).

**MEDICINAL FORMS**

Forms available from special-order manufacturers include: powder for solution for injection

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### Tobramycin

**INDICATIONS AND DOSE**

Chronic *Pseudomonas aeruginosa* infection in patients with cystic fibrosis

- **BY INHALATION OF NEBULISED SOLUTION**
  - Child 6-17 years: 170 mg every 12 hours for 28 days, subsequent courses repeated after 28-day interval without tobramycin nebuliser solution

**Pseudomonal lung infection in cystic fibrosis**

- **BY SLOW INTRAVENOUS INJECTION**
  - Child: 8–10 mg/kg daily in 3 divided doses, to be given as a multiple daily dose regimen over 3–5 minutes

**SEPTICAEMIA | MENINGITIS AND OTHER CNS INFECTIONS | BILIARY-TRACT INFECTION | ACUTE PYLEONEPHRITIS | PNEUMONIA IN HOSPITAL PATIENTS**

- **BY SLOW INTRAVENOUS INJECTION**
  - Child 1 month-11 years: 2–2.5 mg/kg every 8 hours, to be given as a multiple daily dose regimen over 3–5 minutes

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**CAUTIONS**

- When used by inhalation conditions characterised by muscular weakness—may impair neuromuscular transmission - history of prolonged previous or concomitant intravenous aminoglycosides—increased risk of otoxicity - renal impairment—limited information available - severe haemoptysis—risk of further haemorrhage

**INTERACTIONS** → Appendix 1: aminoglycosides

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- Rare or very rare: Diarrhoea - dizziness

**SPECIFIC SIDE-EFFECTS**

- Common or very common
  - When used by inhalation: Dysphonia - malaise - respiratory disorder - sputum discolouration

- Uncommon
  - When used by inhalation: Cough

- Rare or very rare
  - When used by inhalation: Abdominal pain - aphony - appetite decreased - asthenia - asthma - chest discomfort - drowsiness - ear disorder - ear pain - haemorrhage - hypoxia - increased risk of infection - lymphadenopathy - oral ulceration - pain - taste altered

- Frequency not known
  - When used by inhalation: Oropharyngeal pain
With parenteral use: 
- Granulocytopenia
- Leucocytosis
- Leucopenia
- Nerve disorders
- Thrombocytopenia
- Urine abnormalities
- Vertigo

**SIDE-EFFECTS, FURTHER INFORMATION**

Manufacturer advises to monitor serum-tobramycin concentration in patients with known or suspected signs of auditory dysfunction; if ototoxicity develops — discontinue treatment until serum concentration falls below 2 mg/litre.

**RENAL IMPAIRMENT**

- When used by inhalation: Manufacturer advises monitor serum-tobramycin concentration; if nephrotoxicity develops — discontinue treatment until serum concentration falls below 2 mg/litre.

**MONITORING REQUIREMENTS**

- With intravenous use: Extended interval dose regimen in neonates: pre-dose (‘trough’) concentration should be less than 2 mg/litre.
- With intravenous use: Once daily dose regimen: pre-dose (‘trough’) concentration should be less than 1 mg/litre.
- Multiple daily dose regimen: one-hour (‘peak’) serum concentration should not exceed 10 mg/litre in cystic fibrosis; pre-dose (‘trough’) concentration should be less than 2 mg/litre.
- When used by inhalation: Measure lung function before and after initial dose of tobramycin and monitor for bronchospasm; if bronchospasm occurs in a patient not using a bronchodilator, repeat test using bronchodilator. Manufacturer advises monitor renal function before treatment and then annually.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use: For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%; give over 20–60 minutes.
- When used by inhalation: Other inhaled drugs should be administered before tobramycin.

**PRESCRIBING AND DISPENSING INFORMATION**

- With intravenous use or when used by inhalation: Local guidelines may vary in dosing advice provided.

**PATIENT AND CARER ADVICE**

- When used by inhalation: Patient counselling is advised for tobramycin dry powder for inhalation (administration).

**NEBULISER SOLUTION**

- When used by inhalation: Manufacturer advises monitor concentration in serum.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

- Tobramycin by dry powder inhalation for pseudomonal lung infection in cystic fibrosis (March 2013) NICE TA276
- When used by inhalation: Tobramycin dry powder for inhalation is recommended for chronic pulmonary infection caused by *Pseudomonas aeruginosa* in patients with cystic fibrosis only if there is an inadequate response to colistimethate sodium, or if colistimethate sodium cannot be used because of contra-indications or intolerance. The manufacturer must provide tobramycin dry powder for inhalation at the discount agreed as part of the patient access scheme to primary, secondary and tertiary care in the NHS. Patients currently receiving tobramycin dry powder for inhalation can continue treatment until they and their clinician consider it appropriate to stop. [www.nice.org.uk/TA276](http://www.nice.org.uk/TA276)

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

**Solution for injection**

- **Tobramycin (Non-proprietary)**
  - Tobramycin 40 mg per 1 ml: Tobramycin 80mg/2ml solution for injection vials: 5 vial ([PMS]) £20.80 DT + £20.80
  - Tobramycin 240mg/6ml solution for injection vials: 1 vial ([PMS]) £19.20 DT + £19.20
  - Nebcin (Flynn Pharma Ltd): Tobramycin 40 mg per 1 ml Nebcin 80mg/2ml solution for injection vials: 1 vial ([PMS]) £5.37 DT + £5.37

**Inhalation powder**

- Tobin Podhaler (Novartis Pharmaceuticals UK Ltd): Tobramycin 28 mg Tobin Podhaler 28mg inhalation powder capsules with device: 224 capsule ([PMS]) £1,790.00 DT + £1,790.00

**Nebuliser liquid**

- **Tobramycin (Non-proprietary)**
  - Tobramycin 60 mg per 1 ml: Tobramycin 300mg/5ml nebuliser liquid ampoules: 56 ampoule ([PMS]) £1,187.00 DT + £780.00
  - Bramitob (Chiesi Ltd): Tobramycin 75 mg per 1 ml Bramitob 300mg/4ml nebuliser solution 4ml ampoules: 56 ampoule ([PMS]) £1,187.00 DT + £1,187.00
  - TOBI (Novartis Pharmaceuticals UK Ltd): Tobramycin 60 mg per 1 ml Tobi 300mg/5ml nebuliser solution 5ml ampoules: 56 ampoule ([PMS]) £1,305.92 DT + £780.00
  - Tymbrineb (Teva UK Ltd): Tobramycin 60 mg per 1 ml Tymbrineb 300mg/5ml nebuliser solution 5ml ampoules: 56 ampoule ([PMS]) £780.00 DT + £780.00
  - Vantobra (Pari Medical Ltd): Tobramycin 100 mg per 1 ml Vantobra 170mg/1.7ml nebuliser solution 1.7ml ampoules: 56 ampoule ([PMS]) £1,305.00

**ANTIBACTERIALS**

**Carbenapens**

**Overview**

The carbenapens are beta-lactam antibacterials with a broad-spectrum of activity which includes many Gram-positive and Gram-negative bacteria, and anaerobes; *imipenem* (imipenem with cilastatin p. 325) and meropenem p. 326 have good activity against *Pseudomonas aeruginosa*. The carbenapens are not active against meticillin-resistant *Staphylococcus aureus* and *Enterococcus faecium*.

Imipenem (imipenem with cilastatin) and meropenem are used for the treatment of severe hospital-acquired infections and polymicrobial infections caused by multiple-antibacterial resistant organisms (including septicaemia, hospital-acquired pneumonia, intra-abdominal infections, skin and soft-tissue infections, and complicated urinary-tract infections).

Ertapenem p. 325 is licensed for treating abdominal and gynaecological infections and for community-acquired pneumonia, but it is not active against atypical respiratory pathogens and it has limited activity against penicillin-resistant pneumococci. Unlike the other carbenapens, ertapenem is not active against *Pseudomonas* or against *Acinetobacter spp*.

Imipenem is partially inactivated in the kidney by enzymatic activity and is therefore administered in combination with *cilastatin* (imipenem with cilastatin), a specific enzyme inhibitor, which blocks its renal metabolism. Meropenem and ertapenem are stable to the renal enzyme which inactivates imipenem and therefore can be given without cilastatin.

Side-effects of imipenem with cilastatin are similar to those of other beta-lactam antibiotics. Meropenem has less seizure-inducing potential and can be used to treat central nervous system infection.
Ertapenem

**INDICATIONS AND DOSE**

- **Abdominal infections** | **Acute gynaecological infections** | **Community-acquired pneumonia**
  - By intravenous infusion
  - Child 3 months-12 years: 15 mg/kg every 12 hours; maximum 1 g per day
  - Child 13-17 years: 1 g once daily
- **Diabetic foot infections of the skin and soft-tissue**
  - By intravenous infusion
  - Child 13-17 years: 1 g once daily

**CAUTIONS**
- CNS disorders—risk of seizures
- Interaction → Appendix 1: carbapenems
- Side-effects
  - Common or very common: Diarrhoea, skin reactions
  - Uncommon: Faeces discoloured, headache, hot flush, hypertension, melaena
  - Frequency not known: Aggression, hallucinations, psychiatric disorder

**ALLERGY AND CROSS-SENSITIVITY**
- Avoid if history of immediate hypersensitivity reaction to beta-lactam antibacterials.
- Use with caution in patients with sensitivity to beta-lactam antibacterials.

**PREGNANCY**
- Manufacturer advises avoid unless potential benefit outweighs risk.

**BREAST FEEDING**
- Present in milk—manufacturer advises avoid.

**RENAL IMPAIRMENT**
- Use with caution (risk of seizures); avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

**DIRECTIONS FOR ADMINISTRATION**
- For intravenous infusion (Invanz®), give intermittently in Sodium chloride 0.9%.
  - Reconstitute 1 g with 10 mL Water for injections or Sodium chloride 0.9%; dilute requisite dose in infusion fluid to a final concentration not exceeding 20 mg/mL; give over 30 minutes; incompatible with glucose solutions.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.
- **Powder for solution for infusion**
  - Ertapenem (Non-proprietary)
    - Ertapenem (as Ertapenem sodium) 1 g
    - Ertapenem (as Ertapenem sodium) 1 g
  - **Powder for solution for infusion vials**
    - Invanz (Merck Sharp & Dohme Ltd)
    - Ertapenem (as Ertapenem sodium) 1 g

Imipenem with cilastatin

**INDICATIONS AND DOSE**

- **Aerobic and anaerobic Gram-positive and Gram-negative infections (not indicated for CNS infections)** | **Hospital-acquired sepsicaemia**
  - By intravenous infusion
  - Neonate up to 7 days: 20 mg/kg every 12 hours.
  - Neonate 7 days to 20 days: 20 mg/kg every 8 hours.
  - Neonate 21 days to 28 days: 20 mg/kg every 6 hours.
  - Child 1-2 months: 20 mg/kg every 6 hours.
  - Child 3 months-17 years: 15 mg/kg every 6 hours (max. per dose 500 mg)

**UNLICENSED USE**
- Not licensed for use in children under 1 year.

**CAUTIONS**
- CNS disorders—epilepsy
- Interaction → Appendix 1: carbapenems

**SIDE-EFFECTS**
- Common or very common: Diarrhoea, eosinophilia, nausea, skin reactions, thrombophlebitis, vomiting
- Uncommon: Bone marrow disorders, confusion, dizziness, drowsiness, hallucinations, hypotension, leucopenia, movement disorders, psychiatric disorder, seizure, thrombocytopenia, thrombocytosis
- Rare or very rare: Agranulocytosis, anaphylactic reaction, angioedema, chest discomfort, colitis haemorrhagic, cyanosis, dyspnoea, encephalopathy, flushing, focal tremor, gastrointestinal discomfort, haemolytic anaemia, headache, hearing loss, hepatic disorders, hyperhidrosis, hyperventilation, increased risk of infection, myasthenia gravis aggravated, oral disorders, palpitations, paraesthesia, polynephritis, polynia, pseudomembranous enterocolitis, renal impairment, severe cutaneous adverse reactions (SCARs), spinal pain, tachycardia, taste altered, tinnitus, tongue discolouration, tooth discoloration, urine discolouration, vertigo
- Frequency not known: Agitation

**ALLERGY AND CROSS-SENSITIVITY**
- Avoid if history of immediate hypersensitivity reaction to beta-lactam antibacterials.
- Use with caution in patients with sensitivity to beta-lactam antibacterials.

**PREGNANCY**
- Manufacturer advises avoid unless potential benefit outweighs risk (toxicity in animal studies).

**BREAST FEEDING**
- Present in milk but unlikely to be absorbed.

**RENAL IMPAIRMENT**
- Clinical data are insufficient to recommend dosing for children with impairment (serum creatinine greater than 2 mg/dL)—in adults, manufacturer advises reduce dose (consult product literature).

**EFFECT ON LABORATORY TESTS**
- Positive Coombs’ test.

**DIRECTIONS FOR ADMINISTRATION**
- For intravenous infusion dilute to a concentration of 5 mg (as imipenem)/mL in Sodium chloride 0.9%; give up to 500 mg (as imipenem) over 20–30 minutes, give dose greater than 500 mg (as imipenem) over 40–60 minutes.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.
- **Powder for solution for infusion**
  - Imipenem with cilastatin (Non-proprietary)
    - Cilastatin (as Cilastatin sodium) 500 mg, imipenem (as imipenem monohydrate) 500 mg Imipenem 500mg / Cilastatin 500mg powder for solution for infusion vials | 10 vial (£24.10)
    - Primaxin IV (Merck Sharp & Dohme Ltd)
      - Cilastatin (as Cilastatin sodium) 500 mg, imipenem (as imipenem monohydrate) 500 mg Primaxin IV 500mg powder for solution for infusion vials | 1 vial (£12.00)
Meropenem

06-Aug-2018

● INDICATIONS AND DOSE

Aerobic and anaerobic Gram-positive and Gram-negative infections: Hospital-acquired septicaemia

▶ By intravenous infusion, or by intravenous injection

Neonate up to 7 days: 20 mg/kg every 12 hours.

Neonate 7 days to 28 days: 20 mg/kg every 8 hours.

Child 1 month–11 years (body-weight up to 50 kg): 10–20 mg/kg every 8 hours.

Child 1 month–11 years (body-weight 50 kg and above): 0.5–1 g every 8 hours.

Child 12–17 years: 0.5–1 g every 8 hours.

Severe aerobic and anaerobic Gram-positive and Gram-negative infections

▶ By intravenous infusion, or by intravenous injection

Neonate up to 7 days: 40 mg/kg every 12 hours.

Neonate 7 days to 28 days: 40 mg/kg every 8 hours.

Child 12–17 years: 2 g every 8 hours.

Exacerbations of chronic lower respiratory-tract infection in cystic fibrosis

▶ By intravenous infusion

Child 1 month–11 years (body-weight up to 50 kg): 40 mg/kg every 8 hours.

Child 1 month–11 years (body-weight 50 kg and above): 2 g every 8 hours.

Child 12–17 years: 2 g every 8 hours.

Meningitis

▶ By intravenous infusion

Neonate up to 7 days: 40 mg/kg every 12 hours.

Neonate 7 days to 28 days: 40 mg/kg every 8 hours.

Child 1 month–11 years (body-weight up to 50 kg): 40 mg/kg every 8 hours.

Child 1 month–11 years (body-weight 50 kg and above): 2 g every 8 hours.

Child 12–17 years: 2 g every 8 hours.

● UNLICENSED USE

Not licensed for use in children under 3 months.

● INTERACTIONS ➔ Appendix 1: carbapenems

● SIDE-EFFECTS

▶ Common or very common

Abdominal pain, diarrhoea, headache, inflammation, nausea, pain, skin reactions, thrombocytopenia, vomiting

▶ Uncommon

Agranulocytosis, antibiotic associated colitis, eosinophilia, haemolytic anaemia, increased risk of infection, leucopenia, neutropenia, paraesthesia, severe cutaneous adverse reactions (SCARs), thrombocytopenia, thrombophlebitis

▶ Rare or very rare

Seizure

● ALLERGY AND CROSS-SENSITIVITY

Avoid if history of immediate hypersensitivity reaction to beta-lactam antibacterials.

Use with caution in patients with sensitivity to beta-lactam antibacterials.

● PREGNANCY

Use only if potential benefit outweighs risk—no information available.

● BREASTFEEDING

Unlikely to be absorbed (however, manufacturer advises avoid).

● RENAL IMPAIRMENT

Dose adjustments

Use normal dose every 12 hours if estimated glomerular filtration rate 26–50 mL/minute/1.73 m².

Use half normal dose every 12 hours if estimated glomerular filtration rate 10–25 mL/minute/1.73 m².

Use half normal dose every 24 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

● MONITORING REQUIREMENTS

Monitor liver function—risk of hepatotoxicity.

● EFFECT ON LABORATORY TESTS

Positive Coombs’ test.

● DIRECTIONS FOR ADMINISTRATION

Intravenous injection to be administered over 5 minutes.

Displacement value may be significant when reconstituting injection, consult local guidelines. For intravenous infusion, dilute reconstituted solution further to a concentration of 1–20 mg/mL in Glucose 5% or Sodium Chloride 0.9%; give over 15–30 minutes.

● MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for injection

ELECTROLYTES: May contain Sodium

Meropenem (non-proprietary)

Meropenem (as Meropenem trihydrate) 500 mg Meropenem 500 mg powder for solution for injection vials | 10 vial POM £83.00–£103.14 DT + £88.90 (Hospital only) | 10 vial POM £88.90–£103.14 DT + £88.90

Meropenem (as Meropenem trihydrate) 1 gram Meropenem 1 g powder for solution for injection vials | 10 vial POM £117.80–£206.28 DT = £177.80 (Hospital only) | 10 vial POM £177.80–£206.30 DT = £177.80

Meropenem (Pfizer Ltd)

Meropenem (as Meropenem trihydrate) 500 mg Meropenem 500 mg powder for solution for injection vials | 10 vial POM £103.14 DT = £88.90

Meropenem (as Meropenem trihydrate) 1 gram Meropenem 1 g powder for solution for injection vials | 10 vial POM £206.28 DT = £177.80

ANTIBACTERIALS ➔ CEPHALOSPORINS

Cephalosporins

Overview

The cephalosporins are broad-spectrum antibiotics which are used for the treatment of septicaemia, pneumonia, meningitis, biliary-tract infections, peritonitis, and urinary-tract infections. The pharmacology of the cephalosporins is similar to that of the penicillins, excretion being principally renal. Cephalosporins penetrate the cerebrospinal fluid poorly unless the meninges are inflamed; cefotaxime p. 330 and ceftriaxone p. 332 are suitable cephalosporins for infections of the CNS (e.g. meningitis).

The principal side-effect of the cephalosporins is hypersensitivity and about 0.5–6.5% of penicillin-sensitive patients will also be allergic to the cephalosporins. If a cephalosporin is essential in patients with a history of immediate hypersensitivity to penicillin, because a suitable alternative antibacterial is not available, then cefixime p. 330, cefotaxime, ceftriaxone p. 331, ceftriaxone, or cefuroxime p. 329 can be used with caution; cefaclor p. 328, cefadroxil p. 327, cefalexin p. 327, and cefadroxil p. 328 should be avoided.

The orally active ‘first generation’ cephalosporins, cefalexin, cefadine, and cefadroxil and the ‘second generation’ cephalosporin, cefaclor have a similar antimicrobial spectrum. They are useful for urinary-tract infections which do not respond to other drugs or which occur in pregnancy, respiratory-tract infections, otitis media, and skin and soft-tissue infections. Cefaclor has good activity against H. influenzae. Cefadroxil has a long duration of action and can be given twice daily; it has poor activity against H. influenzae. Cefuroxime axetil, an ester of the ‘second generation’ cephalosporin cefuroxime, has the same antibacterial spectrum as the parent compound; it is poorly absorbed and needs to be given with food to maximise absorption.
Cefixime is an orally active ‘third generation’ cephalosporin. It has a longer duration of action than the other cephalosporins that are active by mouth. It is only licensed for acute infections.

Cefuroxime is a ‘second generation’ cephalosporin that is less susceptible than the earlier cephalosporins to inactivation by beta-lactamases. It is, therefore, active against certain bacteria which are resistant to the other drugs and has greater activity against *Haemophilus influenzae*.

Cefotaxime, ceftriaxone and ceftriaxone are ‘third generation’ cephalosporins with greater activity than the ‘second generation’ cephalosporins against certain Gram-negative bacteria. However, they are less active than cefuroxime against Gram-positive bacteria, most notably *Staphylococcus aureus*. Their broad antibacterial spectrum may encourage superinfection with resistant bacteria or fungi.

Ceftazidime has good activity against pseudomonas. It is also active against other Gram-negative bacteria. Ceftriaxone has a longer half-life and therefore needs to be given only once daily. Indications include serious infections also active against other Gram-negative bacteria. However, they are less active than cephalosporins against certain Gram-negative bacteria which may rarely cause symptoms but these usually resolve when the antibacterial is stopped. In neonates, ceftriaxone may displace bilirubin from plasma-albumin and resolve when the antibacterial is stopped. In neonates, bladder which may rarely cause symptoms but these usually resolve when the antibacterial is stopped. In neonates, ceftriaxone may displace bilirubin from plasma-albumin and resolve when the antibacterial is stopped.

### Cephalosporins

- **DRUG ACTION** Cephalosporins are antibacterials that attach to penicillin binding proteins to interrupt cell wall biosynthesis, leading to bacterial cell lysis and death.

- **SIDE-EFFECTS**
  - **Common or very common** Abdominal pain - diarrhoea - dizziness - eosinophilia - headache - increased risk of infection - leucopenia - nausea - neutropenia - skin reactions - thrombocytopena - vomiting
  - **Uncommon** Anaphylactic reaction - antibiotic associated colitis
  - **Rare or very rare** Agranulocytosis - angioedema - nephritis tubulointerstitial (reversible) - severe cutaneous adverse reactions (SCARs)

- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with cefixime hypersensitivity. Cross-sensitivity with other beta-lactam antibacterials. About 0.5–6.5% of penicillin-sensitive patients will also be allergic to the cephalosporins. Patients with a history of immediate hypersensitivity to penicillin and other beta-lactams should not receive a cephalosporin.

- **EFFECT ON LABORATORY TESTS** False positive urinary glucose (if tested for reducing substances). False positive Coombs’ test.

### ANTIBACTERIALS > CEPHALOSPORINS, FIRST-GENERATION

#### Cefadroxil

- **INDICATIONS AND DOSE**
  - Susceptible infections due to sensitive Gram-positive and Gram-negative bacteria
    - **BY MOUTH**
      - Child 6–17 years (body-weight up to 40 kg): 0.5 g twice daily
      - Child 6–17 years (body-weight 40 kg and above): 0.5–1 g twice daily

- **SIDE-EFFECTS**
  - **Common or very common** Dyspepsia - glossitis
  - **Rare or very rare** Arthralgia - drug fever - fatigue - hepatic disorders - insomnia - nervousness - serum sickness-like reaction

- **PREGNANCY** Not known to be harmful.

- **BREAST FEEDING** Present in milk in low concentration, but appropriate to use.

- **RENAL IMPAIRMENT** Reduce dose if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

#### Cefalexin (Cephalexin)

- **INDICATIONS AND DOSE**
  - Susceptible infections due to sensitive Gram-positive and Gram-negative bacteria
    - **BY MOUTH**
      - Neonate up to 7 days: 25 mg/kg twice daily (max. per dose 125 mg).
      - Neonate 7 days to 20 days: 25 mg/kg 3 times a day (max. per dose 125 mg).
      - Neonate 21 days to 28 days: 25 mg/kg 4 times a day (max. per dose 125 mg).
      - Child 1–11 months: 12.5 mg/kg twice daily, alternatively 125 mg twice daily
      - Child 1–4 years: 12.5 mg/kg twice daily, alternatively 125 mg 3 times a day
      - Child 5–11 years: 12.5 mg/kg twice daily, alternatively 250 mg 3 times a day
      - Child 12–17 years: 500 mg 2–3 times a day

- **SERIOUS SUSCEPTIBLE INFECTIONS**
  - **BY MOUTH**
    - Child 1 month–11 years: 25 mg/kg 2–4 times a day (max. per dose 1 g 4 times a day)
    - Child 12–17 years: 1–1.5 g 3–4 times a day
Prophylaxis of recurrent urinary-tract infection

- BY MOUTH
  - Child: 12.5 mg/kg once daily (max. per dose 125 mg), dose to be taken at night

- INTERACTIONS → Appendix 1: cephalosporins
- SIDE-EFFECTS Agitation - arthritis - confusion - fatigue - gastrointestinal discomfort - genitai pruritus - hallucination - hepatitis (transient) - hypersensitivity - jaundice cholestatic (transient) - joint disorders - vaginal discharge
- PREGNANCY Not known to be harmful.
- BREAST FEEDING Present in milk in low concentration, but appropriate to use.
- RENAL IMPAIRMENT Dose adjustments Reduce dose in moderate impairment.
- PATIENT AND CARER ADVICE Medicines for Children leaflet: Cefalexin for bacterial infections www.medicinesforchildren.org.uk/cefalexin-bacterial-infections-0

- PROFESSION SPECIFIC INFORMATION
  Dental practitioners’ formulary
  Cefalexin Capsules may be prescribed. Cefalexin Tablets may be prescribed. Cefalexin Oral Suspension may be prescribed.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

### Oral suspension

**CAUTIONARY AND ADVISORY LABELS**

- Cefalexin (Non-proprietary)
  - Cefalexin 25 mg per 1 ml Cefalexin 125mg/5ml oral suspension sugar free sugar-free | 100 ml (POD) £0.84–£1.65
  - Cefalexin 125mg/5ml oral suspension | 100 ml (POD) £1.64 DT = £0.84
  - Cefalexin 50 mg per 1 ml Cefalexin 250mg/5ml oral suspension sugar free sugar-free | 100 ml (POD) £1.72–£2.03
  - Keflex (Flynn Pharma Ltd) Keflex 125mg/5ml oral suspension | 100 ml (POD) £0.84 DT = £0.84
  - Cefalexin 50 mg per 1 ml Keflex 250mg/5ml oral suspension | 100 ml (POD) £1.40 DT = £1.40

#### Tablet

**CAUTIONARY AND ADVISORY LABELS**

- Cefalexin (Non-proprietary)
  - Cefalexin 250 mg Cefalexin 250mg tablets | 28 tablet (POD) £2.55 DT = £1.69
  - Cefalexin 500 mg Cefalexin 500mg tablets | 21 tablet (POD) £5.35 DT = £2.15
  - Keflex (Flynn Pharma Ltd) Keflex 250mg tablets | 28 tablet (POD) £1.60 DT = £1.69
  - Cefalexin 500 mg Keflex 500mg tablets | 21 tablet (POD) £2.08 DT = £2.15

#### Capsule

**CAUTIONARY AND ADVISORY LABELS**

- Cefalexin (Non-proprietary)
  - Cefalexin 250 mg Cefalexin 250mg capsules | 28 capsule (POD) £1.82 DT = £1.82
  - Cefalexin 500 mg Cefalexin 500mg capsules | 21 capsule (POD) £2.04 DT = £1.99
  - Keflex (Flynn Pharma Ltd) Keflex 250mg capsules | 28 capsule (POD) £1.46 DT = £1.82
  - Cefalexin 500 mg Keflex 500mg capsules | 21 capsule (POD) £1.98 DT = £1.99

### Cefradine (Cephadrine)

- **INDICATIONS AND DOSE**
  - Susceptible infections due to sensitive Gram-positive and Gram-negative bacteria | Surgical prophylaxis
    - BY MOUTH
      - Child 7-11 years: 25–50 mg/kg daily in 2-4 divided doses
      - Child 12-17 years: 250–500 mg 4 times a day, alternatively 0.5–1 g twice daily; increased if necessary up to 1 g 4 times a day, increased dose may be used in severe infections
  - Prevention of *Staphylococcus aureus* lung infection in cystic fibrosis
    - BY MOUTH
      - Child 7-17 years: 2 g twice daily

- **UNLICENSED USE** Not licensed for use in children for prevention of *Staphylococcus aureus* lung infection in cystic fibrosis.
- **INTERACTIONS** → Appendix 1: cephalosporins
- **SIDE-EFFECTS** Akathisia - aplastic anaemia - arthralgia - blood disorder - chest tightness - confusion - gastrointestinal discomfort - glossitis - hepatitis (transient) - hypersensitivity - jaundice cholestatic - muscle tone increased - nervousness - oedema - sleep disorder
- **PREGNANCY** Not known to be harmful.
- **BREAST FEEDING** Present in milk in low concentration, but appropriate to use.
- **RENAI IMPAIRMENT** Dose adjustments Reduce dose if estimated glomerular filtration rate less than 20 mL/minute/1.73 m².
- **PROFESSION SPECIFIC INFORMATION**
  Dental practitioners’ formulary
  Cefradine Capsules may be prescribed.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Capsule

**CAUTIONARY AND ADVISORY LABELS**

- Cefradine (Non-proprietary)
  - Cefradine 250 mg Cefradine 250mg capsules | 20 capsule (POD) £6.00 DT = £2.86
  - Cefradine 500 mg Cefradine 500mg capsules | 20 capsule (POD) £8.75 DT = £4.04

### ANTIBACTERIALS > CEPHALOSPORINS, SECOND-GENERATION

### Cefaclor

- **INDICATIONS AND DOSE**
  - Susceptible infections due to sensitive Gram-positive and Gram-negative bacteria
    - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 1-11 months: 20 mg/kg daily divided doses, usually 62.5 mg 3 times a day
      - Child 1-4 years: 20 mg/kg daily divided doses, alternatively 125 mg 3 times a day
      - Child 5-11 years: 20 mg/kg daily in 3 divided doses, usual max. 1 g daily, alternatively 250 mg 3 times a day
      - Child 12-17 years: 250 mg 3 times a day; maximum 4 g per day
    - BY MOUTH USING MODIFIED-RELEASE MEDICINES
      - Child 12-17 years: 375 mg every 12 hours, dose to be taken with food
Severe susceptible infections due to sensitive Gram-positive and Gram-negative bacteria

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 1-11 months: 40 mg/kg daily in 3 divided doses, usual max. 1 g daily, alternatively 125 mg 3 times a day
  - Child 1-4 years: 40 mg/kg daily in 3 divided doses, usual max. 1 g daily, alternatively 250 mg 3 times a day
  - Child 5-11 years: 40 mg/kg daily in 3 divided doses, usual max. 1 g daily
  - Child 12-17 years: 500 mg 3 times a day; maximum 4 g per day

**Pneumonia**

- **BY MOUTH USING MODIFIED-RELEASE TABLETS**
  - Child 12-17 years: 750 mg every 12 hours, dose to be taken with food

**Lower urinary-tract infections**

- **BY MOUTH USING MODIFIED-RELEASE MEDICINES**
  - Child 12-17 years: 375 mg every 12 hours, dose to be taken with food

Asymptomatic carriage of *Haemophilus influenzae* or mild exacerbations in cystic fibrosis

- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
  - Child 1-11 months: 125 mg every 8 hours
  - Child 1-6 years: 250 mg 3 times a day
  - Child 7-17 years: 500 mg 3 times a day

**INTERACTIONS**

- **Appendix 1: cephalosporins**

**SIDE-EFFECTS**

- Akathisia
- Anxiety
- Aplastic anaemia
- Arthralgia
- Arthritis
- Asthenia
- Colitis
- Confusion
- Drowsiness
- Dyspnoea
- Fever
- Genital pruritus
- Hallucination
- Hepatitis (transient)
- Hypersensitivity
- Insomnia
- Jaundice
- Cholestatic (transient)
- Lymphadenopathy
- Lymphocytosis
- Muscle tone increased
- Nausea
- Paraesthesia
- Proteinuria
- Syncope
- Vasodilatation

**SIDE-EFFECTS, FURTHER INFORMATION**

- Cefaclor is associated with protracted skin reactions, especially in children.

**PREGNANCY**

- Not known to be harmful.

**BREAST FEEDING**

- Present in milk in low concentration, but not known to be harmful.

**GENERAL SIDE-EFFECTS**

- Frequency not known

**Drug fever**

- **Surgical prophylaxis**

- **INITIALLY BY INTRAVENOUS INJECTION**
  - Child: 50 mg/kg (max. per dose 1.5 g), to be administered up to 30 minutes before the procedure, then (by intravenous injection or by intramuscular injection) 30 mg/kg every 8 hours (max. per dose 750 mg) if required for up to 3 doses (for high-risk procedures)

**INDICATIONS AND DOSE**

Susceptible infections due to Gram-positive and Gram-negative bacteria

- **BY MOUTH**
  - Child 3 months-1 year: 10 mg/kg twice daily (max. per dose 125 mg)
  - Child 2-11 years: 15 mg/kg twice daily (max. per dose 250 mg)
  - Child 12-17 years: 250 mg twice daily, dose may be doubled in severe lower respiratory-tract infections or if pneumonia is suspected

- **BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
  - Neonate up to 7 days: 25 mg/kg every 12 hours, increased if necessary to 50 mg/kg every 12 hours, increased dose used in severe infection.

- **Neonate 7 days to 28 days**: 25 mg/kg every 6 hours, increased if necessary to 50 mg/kg every 8 hours, increased dose used in severe infection.

- **Neonate 28 days to 1 month**: 25 mg/kg every 6 hours, increased if necessary to 50 mg/kg every 8 hours, increased dose used in severe infection.

- **Neonate 1 month to 11 years**: 50 mg/kg (max. per dose 750 mg) for up to 3 days in Lyme disease (for high-risk procedures)

- **11 years to 17 years**: 15 mg/kg twice daily (max. per dose 500 mg) for 14–21 days (for 28 days in Lyme arthritis)

- **Child 12-17 years**: 500 mg twice daily for 14–21 days (for 28 days in Lyme arthritis)

**Lower urinary-tract infection**

- **BY MOUTH**
  - Child 3 months-11 years: 15 mg/kg twice daily (max. per dose 500 mg) for 14–21 days (for 28 days in Lyme arthritis)
  - Child 12-17 years: 500 mg twice daily for 14–21 days (for 28 days in Lyme arthritis)

**Surgical prophylaxis**

- **INITIALLY BY INTRAVENOUS INJECTION**
  - Child: 50 mg/kg (max. per dose 1.5 g), to be administered up to 30 minutes before the procedure, then (by intravenous injection or by intramuscular injection) 30 mg/kg every 8 hours (max. per dose 750 mg) if required for up to 3 doses (for high-risk procedures)

**UNLICENSED USE**

- With oral use
  - Not licensed for treatment of Lyme disease in children under 12 years. Duration of treatment in Lyme disease is unlicensed.

**INTERACTIONS**

- **Appendix 1: cephalosporins**

**SIDE-EFFECTS**

- Frequency not known
  - Drug fever

**SPECIFIC SIDE-EFFECTS**

- **Uncommon**
  - With parenteral use
    - Gastrointestinal disorder
  - Frequency not known
  - With oral use
    - Hepatic disorders
    - Jarisch-Herxheimer reaction
    - Serum sickness
  - With parenteral use
    - Cutaneous vasculitis

**PREGNANCY**

- Not known to be harmful.

**BREAST FEEDING**

- Present in milk in low concentration, but appropriate to use.
Infection

ANTIBACTERIALS

• MEDICINAL FORMS
  - With intramuscular use or intravenous use, single doses over 750 mg should be administered by the intravenous route only.
  - With intravenous use, displacement value may be significant when reconstituting injection, consult local guidelines. For intermittent intravenous infusion, dilute reconstituted solution further in glucose 5% or sodium chloride 0.9%; give over 30 minutes.

• PRESCRIBING AND DISPENSING INFORMATION
  - With oral use, see Lyme disease p. 374 for information on treatment.

• MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, infusion.

Tablet

CAUTIONARY AND ADVISORY LABELS
  - 9, 21, 25
  - Cefuroxime (as Cefuroxime axetil) 250 mg: Cefuroxime 250 mg tablets | 14 tablet (PMD) £17.27 DT = £17.72
  - Zinnat (GlaxoSmithKline UK Ltd) Cefuroxime (as Cefuroxime axetil) 125 mg: Zinnat 125 mg tablets | 14 tablet (PMD) £4.56 DT = £4.56
  - Cefuroxime (as Cefuroxime axetil) 250 mg: Zinnat 250 mg tablets | 14 tablet (PMD) £9.11 DT = £9.72

Powder for injection

ELECTROLYTES: May contain Sodium
  - Cefuroxime (as Cefuroxime sodium) 250 mg: Cefuroxime 250 mg powder for injection vials | 10 vial (PMD) £3.25 (Hospital only)
  - Cefuroxime (as Cefuroxime sodium) 750 mg: Cefuroxime 750 mg powder for injection vials | 1 vial (PMD) £2.52 | 10 vial (PMD) £25.20 | 100 vial (PMD) £249.40 (Hospital only)
  - Cefuroxime (as Cefuroxime sodium) 1.5 g: Cefuroxime 1.5 g powder for injection vials | 1 vial (PMD) £5.05 | 10 vial (PMD) £50.50 (Hospital only)
  - Zinacef (GlaxoSmithKline UK Ltd) Cefuroxime (as Cefuroxime sodium) 250 mg: Zinacef 250 mg powder for injection vials | 5 vial (PMD) £4.70
  - Cefuroxime (as Cefuroxime sodium) 750 mg: Zinacef 750 mg powder for injection vials | 5 vial (PMD) £11.72 (Hospital only)
  - Cefuroxime (as Cefuroxime sodium) 1.5 g: Zinacef 1.5 g powder for injection vials | 1 vial (PMD) £4.70

Oral suspension

CAUTIONARY AND ADVISORY LABELS
  - 9, 21
EXCipients: May contain Aspartame, sucrose
  - Zinacef (GlaxoSmithKline UK Ltd) Cefuroxime (as Cefuroxime axetil) 25 mg per 1 ml: Zinacef 125 mg/ml oral suspension | 70 ml (PMD) £5.20 DT = £5.20

ANTIBACTERIALS

Cefixime

• INDICATIONS AND DOSE
  - Acute infections due to sensitive Gram-positive and Gram-negative bacteria
    - By mouth
      - Child 6–11 months: 75 mg daily
      - Child 1–4 years: 100 mg daily
      - Child 5–9 years: 200 mg daily
      - Child 10–17 years: 200–400 mg daily, alternatively 100–200 mg twice daily
  - Uncomplicated gonorrhoea
    - By mouth
      - Child 12–17 years: 400 mg for 1 dose

• UNLICENSED USE
  - Use of cefixime for uncomplicated gonorrhoea is an unlicensed indication.

• INTERACTIONS
  - Appendix 1: cephalosporins

• SIDE-EFFECTS
  - Acute kidney injury, arthralgia, drug fever, dyspepsia, dyspnœa, face oedema, flatulence, genital pruritus, hypeerosinophilia, jaundice, serum sickness-like reaction, thrombocytosis

• PREGNANCY
  - Not known to be harmful.

• BREAST FEEDING
  - Manufacturer advises avoid unless essential — no information available.

• RENAL IMPAIRMENT
  - Dose adjustments: Reduce dose if estimated glomerular filtration rate less than 20 ml/minute/1.73 m².

• MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS
  - 9, 21, 25
  - Suprax (Sanofi) Cefixime 200 mg: Suprax 200 mg tablets | 7 tablet (PMD) £13.23 DT = £13.23

Cefotaxime

• INDICATIONS AND DOSE
  - Uncomplicated gonorrhoea
    - By intramuscular injection
      - Child 12–17 years: 500 mg for 1 dose

  - Severe exacerbations of Haemophilus influenzae infection in cystic fibrosis
    - By intravenous injection, or by intravenous infusion
      - Child: 50 mg/kg every 6–8 hours; maximum 12 g per day

  - Congenital gonococcal conjunctivitis
    - By intramuscular injection
      - Neonate: 100 mg/kg (max. per dose 1 g) for 1 dose.

Infections due to sensitive Gram-positive and Gram-negative bacteria: Surgical prophylaxis | Haemophilus epiglottitis
  - By intramuscular injection, or by intravenous infusion, or by intravenous infusion
  - Neonate up to 7 days: 25 mg/kg every 12 hours.

  - Neonate 7 days to 20 days: 25 mg/kg every 8 hours.

  - Neonate 21 days to 28 days: 25 mg/kg every 6–8 hours.

  - Child: 50 mg/kg every 8–12 hours

Severe susceptible infections due to sensitive Gram-positive and Gram-negative bacteria | Meningitis
  - By intramuscular injection, or by intravenous infusion, or by intravenous infusion
  - Neonate up to 7 days: 50 mg/kg every 12 hours.

  - Neonate 7 days to 20 days: 50 mg/kg every 8 hours.

  - Neonate 21 days to 28 days: 50 mg/kg every 6–8 hours.

  - Child: 50 mg/kg every 6 hours; maximum 12 g per day

Emergency treatment of suspected bacterial meningitis or meningococcal disease, before urgent transfer to hospital, in patients who cannot be given benzylpenicillin (e.g. because of an allergy)
  - By intravenous injection, or by intramuscular injection
  - Child 1 month–11 years: 50 mg/kg for 1 dose
  - Child 12–17 years: 1 g for 1 dose

• INTERACTIONS
  - Appendix 1: cephalosporins

• SIDE-EFFECTS
  - Uncommon: Drug fever, Jarisch-Hersheimer reaction, renal impairment, seizure
**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**

- **Cefotaxime (Non-proprietary)**
  - Ceftazidime (as Ceftazidime pentahydrate) 500 mg: Ceftazidime 500 mg powder for solution for injection vials | 10 vial (PO) £30.00 |
  - Ceftazidime (as Ceftazidime pentahydrate) 1 gram: Ceftazidime 1 g powder for solution for injection vials | 10 vial (PO) £35.00 | 10 vial (PO) £42.00 (Hospital only)
  - Ceftazidime (as Ceftazidime pentahydrate) 2 gram: Ceftazidime 2 g powder for solution for injection vials | 10 vial (PO) £37.50

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### Ceftazidime

**INDICATIONS AND DOSE**

**Pseudomonal lung infection in cystic fibrosis**

- **BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION, OR BY DEEP INTRAMUSCULAR INJECTION**
  - Child: 50 mg/kg every 8 hours; maximum 9 g per day

**Febrile neutropenia**

- **BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
  - Child: 50 mg/kg every 8 hours; maximum 6 g per day

**Meningitis**

- **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Neonate up to 7 days: 50 mg/kg every 24 hours.

- Neonate 7 days to 20 days: 50 mg/kg every 12 hours.

- Neonate 21 days to 28 days: 50 mg/kg every 8 hours.

- Child: 50 mg/kg every 8 hours; maximum 6 g per day

**Susceptible infections due to sensitive Gram-positive and Gram-negative bacteria**

- **BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
  - Neonate up to 7 days: 25 mg/kg every 24 hours.

- Neonate 7 days to 20 days: 25 mg/kg every 12 hours.

- Neonate 21 days to 28 days: 25 mg/kg every 8 hours.

- Child: 25 mg/kg every 8 hours; maximum 6 g per day

**Severe susceptible infections due to sensitive Gram-positive and Gram-negative bacteria**

- **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Neonate up to 7 days: 50 mg/kg every 24 hours.

- Neonate 7 days to 20 days: 50 mg/kg every 12 hours.

- Neonate 21 days to 28 days: 50 mg/kg every 8 hours.

- Child: 50 mg/kg every 8 hours; maximum 6 g per day

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### Chronic Burkholderia cepacia infection in cystic fibrosis

- **BY INHALATION OF NEBULISED SOLUTION**
  - Child: 1 g twice daily

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**INTERACTIONS**

- **Appendix 1: cephalosporins**

**SIDE-EFFECTS**

- **Common or very common**
  - Thrombocytosis - thrombophlebitis

- **Rare or very rare**
  - Acute kidney injury

**FREQUENCY not known**

- **Coma, eunephropathy, jaundice, lymphocytosis, myoclonus, neurological effects, paraesthesia, seizure, taste altered, tremor**

**PREGNANCY**

- Not known to be harmful.

**BREAST FEEDING**

- Present in milk in low concentration, but appropriate to use.

**HEPATIC IMPAIRMENT**

- Manufacturer advises close monitoring in severe impairment—no information available.

**RENAL IMPAIRMENT**

- Dose adjustments
  - Manufacturer advises reduce dose if creatinine clearance 50 mL/minute or less—consult product literature.

**DIRECTIONS FOR ADMINISTRATION**

- Intramuscular

- For nebulisation, dissolve dose in water and administer over 30 minutes.

**ELECTROLYTES**

- May contain Sodium

**Powder for solution for injection**

- **Ceftazidime (Non-proprietary)**
  - Ceftazidime (as Ceftazidime pentahydrate) 500 mg: Ceftazidime 500 mg powder for solution for injection vials | 1 vial (PO) £4.26–£4.68 (Hospital only)
  - Ceftazidime (as Ceftazidime pentahydrate) 1 gram: Ceftazidime 1 g powder for solution for injection vials | 1 vial (PO) £13.90–£17.00 | 10 vial (PO) £78.10 (Hospital only)
  - Ceftazidime (as Ceftazidime pentahydrate) 2 gram: Ceftazidime 2 g powder for solution for injection vials | 1 vial (PO) £19.09 (Hospital only) | 5 vial (PO) £79.15 (Hospital only) | 10 vial (PO) £27.79–£176.00
  - Ceftazidime (as Ceftazidime pentahydrate) 3 gram: Ceftazidime 3 g powder for solution for injection vials | 10 vial (PO) £257.60 (Hospital only)
  - **Fortum** (GlaxoSmithKline UK Ltd)
    - Ceftazidime (as Ceftazidime pentahydrate) 500 mg: Fortum 500 mg powder for solution for injection vials | 1 vial (PO) £4.40 (Hospital only)
    - Ceftazidime (as Ceftazidime pentahydrate) 1 gram: Fortum 1 g powder for solution for injection vials | 1 vial (PO) £8.79 (Hospital only)
    - Ceftazidime (as Ceftazidime pentahydrate) 2 gram: Fortum 2 g powder for solution for injection vials | 1 vial (PO) £17.59 (Hospital only)
    - Ceftazidime (as Ceftazidime pentahydrate) 3 gram: Fortum 3 g powder for solution for injection vials | 1 vial (PO) £25.76 (Hospital only)
### Ceftriaxone

#### INDICATIONS AND DOSE

<table>
<thead>
<tr>
<th>Community-acquired pneumonia</th>
<th>Hospital-acquired pneumonia</th>
<th>Intra-abdominal infections</th>
<th>Complicated urinary-tract infections</th>
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</thead>
<tbody>
<tr>
<td><strong>BY INTRAVENOUS INJECTION</strong></td>
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<td>Neonate 15 days to 28 days: 50–100 mg/kg once daily, doses at the higher end of the recommended range used in severe cases.</td>
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<td>Child 1 month–11 years (body-weight up to 50 kg): 50–80 mg/kg once daily, doses at the higher end of the recommended range used in severe cases; maximum 4 g per day</td>
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<td><strong>Suspected bacterial infection in neutropenic patients</strong></td>
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<tr>
<td><strong>BY INTRAVENOUS INJECTION</strong></td>
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<td>**Complicated skin and soft tissue infections</td>
<td>Infections of bones and joints**</td>
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<td>**Bacterial meningitis</td>
<td>Bacterial endocarditis**</td>
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<td>Neonate up to 15 days: 50 mg/kg once daily.</td>
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<tr>
<td>Neonate up to 15 days: 100 mg/kg once daily dose should be used for bacterial endocarditis.</td>
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</table>
Surgical prophylaxis

- BY INTRAVENOUS INFUSION
- Neonate up to 15 days: 20–50 mg/kg for 1 dose, to be administered 30–90 minutes before procedure.
- Neonate 15 days to 28 days: 50–80 mg/kg for 1 dose, dose to be administered 30–90 minutes before procedure.
- Child 1 month–11 years (body-weight up to 50 kg): 50–80 mg/kg (max. per dose 2 g) for 1 dose, dose to be administered 30–90 minutes before procedure.
- Child 9–11 years (body-weight 50 kg and above): 2 g for 1 dose, dose to be administered 30–90 minutes before procedure.
- Child 12–17 years: 2 g for 1 dose, dose to be administered 30–90 minutes before procedure.
- BY INTRAVENOUS INJECTION
- Child 9–11 years (body-weight 50 kg and above): 2 g for 1 dose, dose to be administered 30–90 minutes before procedure.
- Child 12–17 years: 2 g for 1 dose, dose to be administered 30–90 minutes before procedure.
- Uncomplicated gonorrhoea | Pelvic inflammatory disease
  - BY DEEP INTRAMUSCULAR INJECTION
  - Child 1 month–11 years (body-weight up to 45 kg): 125 mg for 1 dose.
  - Child 9–11 years (body-weight 45 kg and above): 250 mg for 1 dose.
  - Child 12–17 years: 500 mg for 1 dose.
- Syphilis
  - BY INTRAVENOUS INFUSION
  - Neonate up to 15 days: 50 mg/kg once daily for 10–14 days.
  - Neonate 15 days to 28 days: 75–100 mg/kg once daily for 10–14 days.
  - Child 1 month–11 years (body-weight up to 50 kg): 75–100 mg/kg once daily for 10–14 days; maximum 4 g per day.
  - Child 9–11 years (body-weight 50 kg and above): 0.5–1 g once daily for 10–14 days; dose increased to 2 g once daily for neurosyphilis.
  - Child 12–17 years: 0.5–1 g once daily for 10–14 days; dose increased to 2 g once daily for neurosyphilis.
  - BY INTRAVENOUS INJECTION
  - Child 9–11 years (body-weight 50 kg and above): 0.5–1 g once daily for 10–14 days; dose increased to 2 g once daily for neurosyphilis.
  - Child 12–17 years: 0.5–1 g once daily for 10–14 days; dose increased to 2 g once daily for neurosyphilis.
  - BY DEEP INTRAMUSCULAR INJECTION
  - Child 1 month–11 years (body-weight up to 50 kg): 75–100 mg/kg daily for 10–14 days; maximum 4 g per day.
  - Child 9–11 years (body-weight 50 kg and above): 0.5–1 g once daily for 10–14 days; dose increased to 2 g once daily for neurosyphilis.
  - Child 12–17 years: 0.5–1 g once daily for 10–14 days; dose increased to 2 g once daily for neurosyphilis.

Disseminated Lyme borreliosis (early [Stage II] and late [Stage III]) (administered on expert advice)
  - BY INTRAVENOUS INFUSION
  - Neonate up to 15 days: 50–80 mg/kg once daily for 14–21 days, the recommended treatment durations vary and national or local guidelines should be taken into consideration.

Lyme disease [affecting central nervous system]
  - BY INTRAVENOUS INFUSION
  - Child 1 month–11 years (administered on expert advice) (body-weight up to 50 kg): 80 mg/kg once daily (max. per dose 4 g) for 21 days.
  - Child 1 month–11 years (administered on expert advice) (body-weight 50 kg and above): 2 g twice daily for 21 days, alternatively 4 g once daily for 21 days.
  - Child 12–17 years (administered on expert advice): 2 g twice daily for 21 days, alternatively 4 g once daily for 21 days.
  - BY INTRAVENOUS INJECTION
  - Child 1 month–11 years (administered on expert advice) (body-weight 50 kg and above): 2 g twice daily for 21 days.
  - Child 12–17 years (administered on expert advice): 2 g twice daily for 21 days, alternatively 4 g once daily for 21 days.

Lyme arthritis | Acrodermatitis chronica atrophicans
  - BY INTRAVENOUS INFUSION
  - Child 1 month–11 years (administered on expert advice) (body-weight up to 50 kg): 80 mg/kg once daily (max. per dose 2 g) for 28 days.
  - BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION
  - Child 1 month–11 years (administered on expert advice) (body-weight 50 kg and above): 2 g once daily for 28 days.
  - Child 12–17 years (administered on expert advice): 2 g once daily for 28 days.

Lyme carditis
  - BY INTRAVENOUS INFUSION
  - Child 1 month–11 years (administered on expert advice) (body-weight up to 50 kg): 80 mg/kg once daily (max. per dose 2 g) for 21 days.
  - BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION
  - Child 1 month–11 years (administered on expert advice) (body-weight 50 kg and above): 2 g once daily for 21 days.
  - Child 12–17 years (administered on expert advice): 2 g once daily for 21 days.

Congenital gonococcal conjunctivitis
  - BY DEEP INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INFUSION
  - Neonate: 25–50 mg/kg (max. per dose 125 mg) for 1 dose, intravenous infusion to be administered over 60 minutes.

Prevention of secondary case of meningococcal meningitis
  - BY INTRAMUSCULAR INJECTION
  - Child 1 month–11 years: 125 mg for 1 dose.
  - Child 12–17 years: 250 mg for 1 dose.

Prevention of secondary case of Haemophilus influenzae type b disease
  - BY INTRAVENOUS INFUSION
  - Child 1 month–11 years: 50 mg/kg daily (max. per dose 1 g) for 2 days.
  - BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
  - Child 12–17 years: 1 g daily for 2 days.

Acute otitis media
  - BY DEEP INTRAMUSCULAR INJECTION
  - Child 1 month–11 years (body-weight up to 50 kg): 50 mg/kg (max. per dose 2 g) for 1 dose, dose can be given for 3 days if severely ill or previous therapy failed.

continued →
Bacterial infection

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- Child 9–11 years (body-weight 50 kg and above): 1–2 g for 1 dose, dose can be given for 3 days if severely ill or previous therapy failed.
- Child 12–17 years: 1–2 g for 1 dose, dose can be given for 3 days if severely ill or previous therapy failed.

- **UNLICENSED USE** Not licensed for prophylaxis of Haemophilus influenzae type b disease. Not licensed for prophylaxis of meningococcal meningitis.
- **SIDE-EFFECTS**
  - **Uncommon** Anaemia, coagulation disorder
  - **Rare or very rare** Bronchospasm, glycosuria, haematuria, oedema
  - **Frequency not known** Cholelithiasis, hypersensitivity, kernicterus (in neonates), nephrolithiasis, oral disorders, pancreatitis, seizure, vertigo

- **PRESCRIBING AND DISPENSING INFORMATION** Precipitates of calcium ceftriaxone can occur in the gall bladder and urine (particularly in very young, dehydrated or those who are immobilised)—consider discontinuation if symptomatic.
- **PREGNANCY** Manufacturer advises use only if benefit outweighs risk—limited data available but not known to be harmful in animal studies. Specialist sources indicate suitable for use in pregnancy.
- **BREAST FEEDING** Specialist sources advise ceftriaxone is compatible with breastfeeding—present in milk in low concentration but limited effects to breast-fed infant.
- **RENAL IMPAIRMENT** Dose adjustments Manufacturer advises reduce dose and monitor efficacy in patients with severe renal impairment in combination with hepatic impairment—no information available. Manufacturer advises reduce dose if estimated glomerular filtration rate less than 10 mL/minute/1.73 m² max. 50 mg/kg daily or max. 2 g daily.
- **MONITORING REQUIREMENTS** Manufacturer advises to monitor full blood count regularly during prolonged treatment.

- **DIRECTIONS FOR ADMINISTRATION**
  - With intramuscular use or intravenous use Twice daily dosing may be considered for doses greater than 2 g daily.
  - With intravenous use For intravenous infusion (preferred route), dilute reconstituted solution with Glucose 5% (or 10% in neonates) or Sodium Chloride 0.9%; give over at least 30 minutes (60 minutes in neonates)—may displace bilirubin from serum albumin. Not to be given simultaneously with parenteral nutrition or infusion fluids containing calcium, even by different infusion lines; in children, may be infused sequentially with infusion fluids containing calcium if infusion lines at different sites are used, or if the infusion lines are replaced or thoroughly flushed between infusions with Sodium Chloride 0.9% to avoid precipitation—consult product literature.

- **INTERACTIONS** Concomitant treatment with intravenous calcium (including total parenteral nutrition containing calcium) in premature and full-term neonates—risk of precipitation in urine and lungs (fatal reactions) of full-term neonates with jaundice, hypoalbuminaemia, acidosis, unconjugated hyperbilirubinaemia, or impaired bilirubin binding—risk of developing bilirubin encephalopathy—premature neonates less than 41 weeks corrected gestational age.

- **SIDE-EFFECTS, FURTHER INFORMATION** Precipitates of calcium ceftriaxone can occur in the gall bladder and urine (particularly in very young, dehydrated or those who are immobilised)—consider discontinuation if symptomatic.

- **CONTRA-INDICATIONS** Concomitant treatment with intravenous calcium (including total parenteral nutrition containing calcium) in premature and full-term neonates—risk of precipitation in urine and lungs (fatal reactions) of full-term neonates with jaundice, hypoalbuminaemia, acidosis, unconjugated hyperbilirubinaemia, or impaired bilirubin binding—risk of developing bilirubin encephalopathy—premature neonates less than 41 weeks corrected gestational age.

- **CAUTIONS** History of hypercalciuria, history of kidney stones, use with caution in neonates.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion

  - **Powder for solution for injection ELECTROLYTES** May contain Sodium

    - Ceftriaxone (Non-proprietary)
      - Ceftriaxone (as Ceftriaxone sodium) 250 mg Ceftriaxone 250mg powder for solution for injection vials | 1 vial (£8.50) | £2.30 DT = £2.40 (Hospital only)
      - Ceftriaxone (as Ceftriaxone sodium) 1 gram Ceftriaxone 1g powder for solution for injection vials | 1 vial (£28.50) | £9.50 DT = £9.58 | 10 vial (£28.50) | £9.50 DT = £9.58 (Hospital only)
      - Ceftriaxone (as Ceftriaxone sodium) 2 gram Ceftriaxone 2g powder for solution for injection vials | 1 vial (£47.20) | £18.30 DT = £18.18 | 10 vial (£47.20) | £18.30 DT = £18.18 (Hospital only)
      - Ceftriaxone 2g powder for solution for infusion vials | 1 vial (£58.00) | £19.18 DT = £19.18 | 10 vial (£58.00) | £19.18 DT = £19.18 (Hospital only)
      - Rocephin (Roche Products Ltd)
        - Ceftriaxone (as Ceftriaxone sodium) 250 mg Rocephin 250mg powder for solution for injection vials | 1 vial (£4.00) | £2.40 DT = £2.40
        - Ceftriaxone (as Ceftriaxone sodium) 1 gram Rocephin 1g powder for solution for injection vials | 1 vial (£18.00) | £6.98 DT = £6.98 (Hospital only)
        - Ceftriaxone (as Ceftriaxone sodium) 2 gram Rocephin 2g powder for solution for injection vials | 1 vial (£36.00) | £13.98 DT = £13.98 (Hospital only)

  - **GLYCOPEPTIDE**

    - **Teicoplanin** 27-Nov-2017

      - **DRUG ACTION** The glycopeptide antibiotic teicoplanin has bactericidal activity against aerobic and anaerobic Gram-positive bacteria including multi-resistant staphylococci. However, there are reports of Staphylococcus aureus with reduced susceptibility to glycopeptides and increasing reports of glycopeptide-resistant enterococci. Teicoplanin is similar to vancomycin, but has a significantly longer duration of action, allowing once daily administration after the loading dose.

      - **INDICATIONS AND DOSE** Clostridium difficile infection
        - **BY MOUTH** Child 12–17 years: 100–200 mg twice daily for 7–14 days
Serious infections caused by Gram-positive bacteria (e.g., complicated skin and soft-tissue infections, pneumonia, complicated urinary tract infections)
- By intravenous injection, or by intramuscular injection
  - Child 12-17 years: Initially 6 mg/kg every 12 hours for 3 doses, then 6 mg/kg once daily

Streptococcal or enterococcal endocarditis (in combination with another antibacterial) | Bone and joint infections
- Initially by intravenous injection, or by intravenous infusion
  - Child 12-17 years: 12 mg/kg every 12 hours for 3–5 doses, then (by intravenous injection or by intravenous infusion or by intramuscular injection) 12 mg/kg once daily

Surgical prophylaxis
- By intravenous injection
- Child: (consult local protocol)

Serious infections caused by Gram-positive bacteria (including endocarditis, complicated skin and soft-tissue infections, pneumonia, complicated urinary tract infections, bone and joint infections)
- By intravenous injection, or by intravenous infusion

Neonate: Initially 16 mg/kg for 1 dose, followed by 8 mg/kg once daily, subsequent dose to be administered 24 hours after initial dose, doses to be given by intravenous infusion.
- Child 1-month: Initially 16 mg/kg for 1 dose, followed by 8 mg/kg once daily, subsequent dose to be administered 24 hours after initial dose, doses to be given by intravenous infusion.
- Child 2 months–11 years: Initially 10 mg/kg every 12 hours for 3 doses, then 6–10 mg/kg once daily

Peritonitis associated with peritoneal dialysis (added to dialysis fluid)
- By intraperitoneal infusion
- Child 12-17 years: (consult local protocol)

PHARMACOKINETICS
- Teicoplanin should not be given by mouth for systemic infections because it is not absorbed significantly.

- UNLICENSED USE Not licensed for surgical prophylaxis.
- INTERACTIONS → Appendix 1: teicoplanin
- SIDE-EFFECTS
  - Common or very common: Fever, pain, skin reactions
  - Uncommon: Bronchospasm, diarrhoea, dizziness, eosinophilia, headache, hearing impairment, hypersensitivity, leucopenia, nausea, otorrhea, thrombocytopenia, vomiting
  - Rare or very rare: Abcess, red man syndrome
  - Frequency not known: Agranulocytosis, angioedema, chills, neutropenia, overgrowth of nonsusceptible organisms, renal impairment, seizure, severe cutaneous adverse reactions (SCARs) - thrombophlebitis

SIDE-EFFECTS, FURTHER INFORMATION: Teicoplanin is associated with a lower incidence of nephrotoxicity than vancomycin.

- ALLERGY AND CROSS-SENSITIVITY: Caution if history of vancomycin sensitivity.
- PREGNANCY: Manufacturer advises use only if potential benefit outweighs risk.
- BREAST FEEDING: No information available.
- RENAL IMPAIRMENT
  - Dose adjustments: Use normal dose regimen on days 1–4, then use normal maintenance dose every 48 hours if estimated glomerular filtration rate 30–80 mL/minute/1.73 m² and use normal maintenance dose every 72 hours if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².
  - Monitoring: Monitor renal and auditory function during prolonged treatment in renal impairment.

- MONITORING REQUIREMENTS
  - With intramuscular use or intravenous use: Manufacturer advises monitor serum-teicoplanin trough concentration at steady state after completion of loading dose and during maintenance treatment—consult product literature.
  - Blood counts and liver and kidney function tests required.
  - Manufacturer advises monitoring for adverse reactions when doses of 12 mg/kg twice daily are administered.

- DIRECTIONS FOR ADMINISTRATION
  - With intravenous use: For intermittent intravenous infusion, dilute reconstituted solution further in sodium chloride 0.9% or glucose 5%; give over 30 minutes.
  - With oral use: Injection can be used to prepare solution for oral administration.

- MEDICINAL FORMS: There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

Powder and solvent for solution for injection
ELECTROLYTES: May contain Sodium
  - Teicoplanin (non-proprietary) ▼
    - Teicoplanin 200 mg Teicoplanin 200 mg powder and solvent for solution for injection vials | 1 vial £0.80 DT = £3.93
    - Teicoplanin 400 mg Teicoplanin 400 mg powder and solvent for solution for injection vials | 1 vial £1.17 DT = £7.32
  - Targocid (Sanofi) ▼
    - Teicoplanin 200 mg Targocid 200 mg powder and solvent for solution for injection vials | 1 vial £0.93 DT = £3.93
    - Teicoplanin 400 mg Targocid 400 mg powder and solvent for solution for injection vials | 1 vial £1.32 DT = £7.32

Vancomycin

- DRUG ACTION: The glycopeptide antibiotic vancomycin has bactericidal activity against aerobic and anaerobic Gram-positive bacteria including multi-resistant staphylococci. However, there are reports of Staphylococcus aureus with reduced susceptibility to glycopeptides. There are increasing reports of glycopeptide-resistant enterococci. Penetration into cerebrospinal fluid is poor.

- INDICATIONS AND DOSE
  - Clostridium difficile infection
    - By mouth
      - Neonate: 10 mg/kg every 6 hours for 10 days, treatment duration may need to be tailored to the clinical course of individual patients.
      - Child 1 month–11 years: 10 mg/kg every 6 hours for 10 days, treatment duration may need to be tailored to the clinical course of individual patients; maximum 2 g per day.
      - Clostridium difficile infection [first episode]
        - By mouth
          - Child 12–17 years: 125 mg every 6 hours for 10 days; increased if necessary to 500 mg every 6 hours for 10 days, increased dose if severe or complicated infection
      - Clostridium difficile infection [multiple recurrences]
        - By mouth
          - Child 12–17 years: 125 mg every 6 hours for 10 days, followed by, either tapering the dose (gradually reducing until 125 mg daily) or a pulse regimen (125–500 mg every 2–3 days for at least 3 weeks)

continued ▶
Complicated skin and soft tissue infections | Bone infections | Joint infections | Community-acquired pneumonia | Hospital-acquired pneumonia | Including ventilator-associated pneumonia | Infective endocarditis | Acute bacterial meningitis | Bacteraemia [occuring in association with or suspected to be associated with the licensed indications]

- By Intravenous Infusion
  - Neonate up to 29 weeks corrected gestational age (administered on expert advice): 15 mg/kg every 24 hours adjusted according to plasma-concentration monitoring, duration should be tailored to type and severity of infection and the individual clinical response—consult product literature for further information.

- Neonate 29 weeks to 35 weeks corrected gestational age (administered on expert advice): 15 mg/kg every 12 hours adjusted according to plasma-concentration monitoring, duration should be tailored to type and severity of infection and the individual clinical response—consult product literature for further information.

- Neonate 35 weeks corrected gestational age and above (administered on expert advice): 15 mg/kg every 8 hours adjusted according to plasma-concentration monitoring, duration should be tailored to type and severity of infection and the individual clinical response—consult product literature for further information.

- Child 1 month–11 years: 10–15 mg/kg every 6 hours adjusted according to plasma-concentration monitoring, duration should be tailored to type and severity of infection and the individual clinical response—consult product literature for further information, doses higher than 60 mg/kg/day cannot be generally recommended as the safety of increased dosing has not been fully assessed

- Child 12–17 years: 15–20 mg/kg every 8–12 hours (max. per dose 2 g) adjusted according to plasma-concentration monitoring, duration should be tailored to type and severity of infection and the individual clinical response—consult product literature for further information, in seriously ill patients, a loading dose of 25–30 mg/kg (usual max. 2 g) can be used to facilitate rapid attainment of the target trough serum-vancomycin concentration

Perioperative prophylaxis of bacterial endocarditis [in patients at high risk of developing bacterial endocarditis when undergoing major surgical procedures]

- By Intravenous Infusion
  - Neonate: 15 mg/kg, to be given prior to induction of anaesthesia, a second dose may be required depending on duration of surgery.

- Child: 15 mg/kg, to be given prior to induction of anaesthesia, a second dose may be required depending on duration of surgery

Surgical prophylaxis (when high risk of MRSA)

- By Intravenous Infusion
  - Child: (consult local protocol)

CNS infection e.g. ventriculitis (administered on expert advice)

- By Intraventricular Administration

- Neonate: 10 mg every 24 hours.

- Child: 10 mg every 24 hours, for all children reduce to 5 mg daily if ventricular size reduced or increase to 15–20 mg once daily if ventricular size increased, adjust dose according to CSF concentration after 3–4 days; aim for pre-dose (‘trough’) concentration less than 10 mg/litre. If CSF not draining free reduce dose frequency to once every 2–3 days

Peritonitis associated with peritoneal dialysis

- By intraperitoneal administration

- Child: Add to each bag of dialysis fluid to achieve a concentration of 20–25 mg/litre

Eradication of meticillin-resistant Staphylococcus aureus from the respiratory tract in cystic fibrosis

- By inhalation of nebulised solution

- Child: 4 mg/kg twice daily (max. per dose 250 mg) for 5 days, alternatively 4 mg/kg 4 times a day (max. per dose 250 mg) for 5 days

Pharmacokinetics

- Vancomycin should not be given by mouth for systemic infections because it is not absorbed significantly.

- Unlicensed Use Vancomycin doses in BNF publications may differ from those in product literature. Use of vancomycin (added to dialysis fluid) for the treatment of peritonitis associated with peritoneal dialysis is an unlicensed route. Not licensed for intravenous use or inhalation. Not licensed for use by the intrathecal route for the treatment of meningitis.

Important safety information

Safe practice

For intraventricular administration, seek specialist advice.

Contra-indications

- With intravenous use Previous hearing loss

Caution

- With intravenous use premature neonates (monitor serum-concentration carefully) · young infants (monitor serum-concentration carefully)

- With oral use systemic absorption may be enhanced in patients with inflammatory disorders of the intestinal mucosa or with Clostridium difficile-induced pseudomembranous colitis (increased risk of adverse reactions)

Interactions → Appendix 1: vancomycin

Side-effects

General side-effects
Agranulocytosis · dizziness · drug fever · eosinophilia · hypersensitivity · nausea · nephritis tubulointerstitial · neutropenia (more common after 1 week or cumulative dose of 25 g) · renal failure · severe cutaneous adverse reactions (SCARs) · skin reactions · thrombocytopenia · tinnitus (discontinue) · vasculitis · vertigo

Specific side-effects

- With intravenous use Back pain · bradycardia · cardiac arrest (on rapid intravenous injection) · cardiogenic shock (on rapid intravenous injection) · chest pain · dyspnoea · hearing loss · hypotension · muscle complaints · pseudomembranous enterocolitis · red man syndrome · wheezing

Side-effects, further information
Vancomycin is associated with a higher incidence of nephrotoxicity than teicoplanin.

Allergy and cross-sensitivity
Caution if teicoplanin sensitivity.

Pregnancy
Manufacturer advises use only if potential benefit outweighs risk

Monitoring Plasma-vancomycin concentration monitoring essential to reduce risk of fetal toxicity.

Breast feeding
Present in milk—significant absorption following oral administration unlikely.
**Renal impairment** Manufacturer advises serial monitoring of renal function.

- With intravenous use Manufacturer advises use with caution — increased risk of toxic effects with prolonged high blood concentration.

**Dose adjustments** With oral use Manufacturer advises dose adjustment is unlikely to be required unless substantial oral absorption occurs in inflammatory disorders of the intestinal mucosa or with *Clostridium difficile*-induced pseudomembranous colitis, see Monitoring.

- With intravenous use Manufacturer advises initial dose must not be reduced — consult product literature.

**Monitoring requirements**

- With intravenous use Manufacturer advises initial doses should be based on body-weight; subsequent dose adjustments should be based on serum-vancomycin concentrations to achieve targeted therapeutic concentrations. All patients require serum-vancomycin measurement (on the second day of treatment, immediately before the next dose if renal function normal, earlier if renal impairment — consult product literature).

Frequency of monitoring depends on the clinical situation and response to treatment; regular monitoring indicated in high-dose therapy and longer-term use, particularly in patients with impaired renal function, impaired hearing, or concurrent use of nephrotoxic or ototoxic drugs.

Manufacturer advises pre-dose (‘trough’) concentration should normally be 10–20 mg/litre depending on the site of infection and the susceptibility of the pathogen; trough concentration of 15–20 mg/litre is usually recommended to cover susceptible pathogens with MIC greater than or equal to 1 mg/litre — consult product literature.

Manufacturer advises periodic testing of auditory function. Manufacturer advises monitor blood counts, urinalysis, hepatic and renal function periodically in all patients; monitor leucocyte count regularly in patients receiving long-term vancomycin or if given concurrently with other drugs that may cause neutropenia or agranulocytosis.

- With oral use Manufacturer advises monitoring serum-vancomycin concentration in inflammatory intestinal disorders.

Manufacturer advises serial tests of auditory function may be helpful to minimise the risk of ototoxicity in patients with an underlying hearing loss, or who are receiving concomitant therapy with other ototoxic drugs.

- With intravenous use Aim for pre-dose (‘trough’) concentration less than 10 mg/litre.

- When used by inhalation Measure lung function before and after initial dose of vancomycin and monitor for bronchospasm.

**Directions for administration**

- With intravenous use Avoid rapid infusion (risk of anaphylactoid reactions) and rotate infusion sites. Displacement value may be significant, consult product literature and local guidelines. For intermittent intravenous infusion, the reconstituted preparation should be further diluted in sodium chloride 0.9% or glucose 5% to a concentration of up to 5 mg/mL; give over at least 60 minutes (rate not to exceed 10 mg/minute for doses over 500 mg); use continuous infusion only if intermittent not available (limited evidence); 10 mg/mL can be used if infused via a central venous line over at least 1 hour.

- With oral use Injection can be used to prepare solution for oral administration — consult product literature.

- When used by inhalation For nebulisation administer required dose in 4 mL of sodium chloride 0.9% (or water for injections). Administer inhaled bronchodilator before vancomycin.

**Antibacterials > Lincosamides**

**Clindamycin**

- **Drug action** Clindamycin is active against Gram-positive cocci, including streptococci and penicillin-resistant staphylococci, and also against many anaerobes, especially *Bacteroides fragilis*. It is well concentrated in bone and excreted in bile and urine.

- **indications and dose** Staphylococcal bone and joint infections such as osteomyelitis | Peritonitis | Intra-abdominal sepsis | Metcillin-resistant *Staphylococcus aureus* (MRSA) in bronchiectasis, bone and joint infections, and skin and soft-tissue infections | Erysipelas or cellulitis in penicillin-allergic patients (alternative to macrolides)

  - **By mouth**

  - Neonate up to 14 days: 3–6 mg/kg 3 times a day.

  - Neonate 14 days to 28 days: 3–6 mg/kg 4 times a day.

    - Child: 3–6 mg/kg 4 times a day (max. per dose 450 mg)

    - By deep intramuscular injection, or by intravenous infusion

    - Child: 3.75–6.25 mg/kg 4 times a day; increased if necessary up to 10 mg/kg 4 times a day (max. per dose 1.2 g), increased dose used for severe infections, total daily dose may alternatively be given in 3 divided doses, single doses above 600 mg to be administered by intravenous infusion only, single doses by intravenous infusion not to exceed 1.2 g

  - Staphylococcal lung infection in cystic fibrosis

    - **By mouth**

    - Child: 5–7 mg/kg 4 times a day (max. per dose 600 mg)
Clindamycin has been associated with antibiotic-associated colitis, which may be fatal. Although antibiotic-associated colitis can occur with most antibacterials, it occurs more frequently with clindamycin. If *Clostridium difficile* infection is suspected or confirmed, discontinue the antibiotic if appropriate. Seek specialist advice if the antibiotic cannot be stopped and the diarrhoea is severe.

**Pregnancy** Manufacturer advises not known to be harmful in the second and third trimesters; use with caution in the first trimester—limited data.

**Breastfeeding** Specialist sources indicate use with caution—present in milk. Monitor infant for effects on the gastrointestinal flora such as diarrhoea, candidiasis, or rarely, blood in the stool indicating possible antibiotic-associated colitis.

**Monitoring Requirements** Monitor liver and renal function if treatment exceeds 10 days. Monitor liver and renal function in neonates and infants.

**Directions for Administration**
- With intravenous use: Avoid rapid intravenous administration. For intravenous infusion, dilute to a concentration of not more than 18 mg/ml with glucose 5% or Sodium Chloride 0.9%; give over 10–60 minutes at a max. rate of 20 mg/kg/hour.
- With oral use: Capsules should be swallowed with a glass of water.

**Profession Specific Information**
- Dental practitioners’ formulary
  - With oral use: Clindamycin capsules may be prescribed.

**Antibacterials > Macrolides**

### Overview
The macrolides have an antibacterial spectrum that is similar but not identical to that of penicillin; they are thus an alternative in penicillin-allergic patients. They are active against many—penicillin-resistant staphylococci, but some are now also resistant to the macrolides.

Indications for the macrolides include campylobacter enteritis, respiratory infections (including pneumonia, whooping cough, Legionella, chlamydia, and mycoplasma infection), and skin infections. Erythromycin p. 341 is also used in the treatment of early syphilis, uncomplicated genital chlamydial infection, and non-gonococcal urethritis. Erythromycin has poor activity against *Haemophilus influenzae*. Erythromycin causes nausea, vomiting, and diarrhoea in some patients; in mild to moderate infections this can be avoided by giving a lower dose or the total dose in 4 divided doses, but if a more serious infection, such as Legionella pneumonia, is suspected higher doses are needed.

Azithromycin p. 339 is a macrolide with slightly less activity than erythromycin against Gram-positive bacteria, but enhanced activity against some Gram-negative organisms including *H. influenzae*. Plasma concentrations are very low, but tissue concentrations are much higher. It has a long tissue half-life and once daily dosage is recommended. Azithromycin is also used in the treatment of uncomplicated genital chlamydial infection, non-gonococcal urethritis, typhoid [unlicensed indication], trachoma [unlicensed indication], and Lyme disease [unlicensed indication].

Clarithromycin p. 340 is an erythromycin derivative with slightly greater activity than the parent compound. Tissue concentrations are higher than with erythromycin. Clarithromycin is also used in regimens for *Helicobacter pylori* eradication.
Spiramycin is also a macrolide which is used for the treatment of toxoplasmosis.

**Macrolides**

**CAUTIONS**
- With intravenous use or oral use electrolyte disturbances (predisposition to QT interval prolongation) may aggravate myasthenia gravis; predisposition to QT interval prolongation
- Common or very common Appetite decreased; diarrhoea; dizziness; gastrointestinal discomfort; gastrointestinal disorders; headache; hearing impairment; insomnia; nausea; pancreatitis; paraesthesia; skin reactions; taste altered; vasodilation; vision disorders; vomiting
- Uncommon Angioedema; anxiety; arrhythmias; candida infection; chest pain; constipation; drowsiness; eosinophilia; hepatic disorders; leucopenia; neutropenia; palpatitions; QT interval prolongation; severe cutaneous adverse reactions (SCARs); tinnitus; vertigo
- Rare or very rare Antibiotic associated colitis; myasthenia gravis; nephritis tubulointerstitial
- Frequency not known Hallucination; hypotension; seizure; smell altered; thrombocytopenia; tongue discolouration

**Azithromycin**

11-Jul-2018

**INDICATIONS AND DOSE**

Prevention of secondary case of invasive group A streptococcal infection in patients who are allergic to penicillin
- **BY MOUTH**
  - Child 6-months-11 years: 12 mg/kg once daily (max. per dose 500 mg) for 5 days
  - Child 12-17 years: 500 mg once daily for 5 days

Respiratory-tract infections, otitis media, skin and soft-tissue infections
- **BY MOUTH**
  - Child 6 months-17 years: 10 mg/kg once daily (max. per dose 500 mg) for 3 days
  - Child 6 months-17 years (body-weight 15-25 kg): 200 mg once daily for 3 days
  - Child 6 months-17 years (body-weight 26-35 kg): 300 mg once daily for 3 days
  - Child 6 months-17 years (body-weight 36-45 kg): 400 mg once daily for 3 days
  - Child 6 months-17 years (body-weight 46 kg and above): 500 mg once daily for 3 days

Infection in cystic fibrosis
- **BY MOUTH**
  - Child 6 months-17 years: 10 mg/kg once daily (max. per dose 500 mg) for 3 days, repeated after 1 week to complete course, treatment may be repeated as necessary

Chronic *Pseudomonas aeruginosa* infection in cystic fibrosis
- **BY MOUTH**
  - Child 6-17 years (body-weight 25-40 kg): 250 mg 3 times a week
  - Child 6-17 years (body-weight 41 kg and above): 500 mg 3 times a week

Uncomplicated genital chlamydial infections; Non-gonococcal urethritis
- **BY MOUTH**
  - Child 12-17 years: 1 g for 1 dose

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**Lyme disease [erythema migrans and/or non-focal symptoms]**
- **BY MOUTH**
  - Child 1 month-11 years (administered on expert advice) (body-weight up to 51 kg): 10 mg/kg daily for 17 days
  - Child 1 month-11 years (administered on expert advice) (body-weight 51 kg and above): 500 mg daily for 17 days
  - Child 12-17 years (administered on expert advice): 500 mg daily for 17 days

Mild to moderate typhoid due to multiple-antibacterial resistant organisms
- **BY MOUTH**
  - Child 6 months-17 years: 10 mg/kg once daily (max. per dose 500 mg) for 7 days

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**SIDE-EFFECTS**
- **Common or very common** Angioedema; anxiety; arrhythmias; candida infection; chest pain; constipation; drowsiness; eosinophilia; hepatic disorders; leucopenia; neutropenia; palpatitions; QT interval prolongation; severe cutaneous adverse reactions (SCARs); tinnitus; vertigo
- **Uncommon** Angioedema; anxiety; arrhythmias; candida infection; chest pain; constipation; drowsiness; eosinophilia; hepatic disorders; leucopenia; neutropenia; palpatitions; QT interval prolongation; severe cutaneous adverse reactions (SCARs); tinnitus; vertigo
- **Rare or very rare** Antibiotic associated colitis; myasthenia gravis; nephritis tubulointerstitial
- **Frequency not known** Hallucination; hypotension; seizure; smell altered; thrombocytopenia; tongue discolouration

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**UNLICENSED USE** Azithromycin may be used as detailed below, although these situations are considered outside the scope of its licence:
- Prevention of group A streptococcal infection;
- chronic *Pseudomonas aeruginosa* infection in cystic fibrosis:
  - **BY MOUTH** Lyme disease [erythema migrans and/or non-focal symptoms];
  - mild to moderate typhoid due to multiple-antibacterial resistant organisms.

**INTERACTIONS** ➔ Appendix 1: macrolides

**PRESCRIBING AND DISPENSING INFORMATION** See Lyme disease p. 374 for place in therapy and further information on treatment. Flavours of oral liquid formulations may include cherry or banana.

**PATIENT AND CARER ADVICE** Medicines for Children leaflet: Azithromycin for bacterial infections www.medicinesforchildren.org.uk/azithromycin-bacterial-infections-0

**PROFESSION SPECIFIC INFORMATION**

Dental practitioners’ formulary
Azithromycin Capsules may be prescribed. Azithromycin Tablets may be prescribed. Azithromycin Oral Suspension 200 mg/5 mL may be prescribed.

**EXCEPTIONS TO LEGAL CATEGORY** Azithromycin tablets can be sold to the public for the treatment of confirmed, asymptomatic *Chlamydia trachomatis* genital infection in those over 16 years of age, and for the epidemiological treatment of their sexual partners, subject to maximum single dose of 1 g, maximum daily dose 1 g, and a pack size of 1 g.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 5, 9

**Azithromycin (Non-proprietary)**

Azithromycin 250 mg Azithromycin 250mg tablets | 4 tablet [PO2] £10.11 DT = £11.24 | 6 tablet [PO2] £2.01-E14.46
Azithromycin 500 mg Azithromycin 500mg tablets | 3 tablet [PO2] £9.80 DT = £11.09
Oral suspension
CAUTIONARY AND ADVISORY LABELS 5, 9
- Azithromycin (Non-proprietary)
  Azithromycin 40 mg per 1 ml Azithromycin 200mg/5ml oral suspension | 15 ml (P65) £6.16 DT = £6.06 | 30 ml (P65) £11.04 DT = £11.04
- Zithromax (Pfizer Ltd)
  Azithromycin 40 mg per 1 ml Zithromax 200mg/5ml oral suspension | 15 ml (P65) £4.06 DT = £4.06 | 22.5 ml (P65) £6.10 DT = £6.10 | 30 ml (P65) £11.04 DT = £11.04

Capsule
CAUTIONARY AND ADVISORY LABELS 5, 9, 23
- Azithromycin (as Azithromycin dihydrate) 250 mg Azithromycin (Non-proprietary)
  Capsule 250mg capsules | 4 capsule (P85) £2.44–10.10 | 6 capsule (P85) £15.15 DT = £15.02
- Zithromax (Pfizer Ltd)
  Azithromycin (as Azithromycin dihydrate) 250 mg Zithromax 250mg capsules | 4 capsule (P82) £1.16 | 6 capsule (P82) £10.74 DT = £10.74

Clarithromycin

**INDICATIONS AND DOSE**
Respiratory-tract infections | Mild to moderate skin and soft-tissue infections

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Neonate: 7.5 mg/kg twice daily.
  - Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily
  - Child 1 month–11 years (body-weight 8–11 kg): 62.5 mg twice daily
  - Child 1 month–11 years (body-weight 12–19 kg): 125 mg twice daily
  - Child 1 month–11 years (body-weight 20–29 kg): 187.5 mg twice daily
  - Child 1 month–11 years (body-weight 30–40 kg): 250 mg twice daily
  - Child 12–17 years: 250–500 mg twice daily for 5 days

*Acute otitis media*

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Neonate: 7.5 mg/kg twice daily.
  - Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily for 5–7 days
  - Child 1 month–11 years (body-weight 8–11 kg): 62.5 mg twice daily for 5–7 days
  - Child 1 month–11 years (body-weight 12–19 kg): 125 mg twice daily for 5–7 days
  - Child 1 month–11 years (body-weight 20–29 kg): 187.5 mg twice daily for 5–7 days
  - Child 12–17 years: 250–500 mg twice daily for 5–7 days

*Helicobacter pylori eradication in combination with omeprazole, and amoxicillin or metronidazole*

**BY MOUTH**
- Child 1–5 years: 7.5 mg/kg twice daily (max. per dose 500 mg)
- Child 6–11 years: 7.5 mg/kg twice daily (max. per dose 500 mg)
- Child 12–17 years: 500 mg twice daily

*Acute sinusitis*

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily for 5 days
- Child 1 month–11 years (body-weight 8–11 kg): 62.5 mg twice daily for 5 days
- Child 1 month–11 years (body-weight 12–19 kg): 125 mg twice daily for 5 days
- Child 1 month–11 years (body-weight 20–29 kg): 187.5 mg twice daily for 5 days
- Child 1 month–11 years (body-weight 30–40 kg): 250 mg twice daily for 5 days
- Child 12–17 years: 250 mg twice daily for 5 days

**Prevention of pertussis**

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Neonate: 7.5 mg/kg twice daily for 7 days.
  - Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily for 7 days
  - Child 1 month–11 years (body-weight 8–11 kg): 62.5 mg twice daily for 7 days
  - Child 1 month–11 years (body-weight 12–19 kg): 125 mg twice daily for 7 days
  - Child 1 month–11 years (body-weight 20–29 kg): 187.5 mg twice daily for 7 days
  - Child 12–17 years: 500 mg twice daily for 7 days

**Acute exacerbation of bronchiectasis**

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily for 7–14 days
- Child 1 month–11 years (body-weight 8–11 kg): 62.5 mg twice daily for 7–14 days
- Child 1 month–11 years (body-weight 12–19 kg): 125 mg twice daily for 7–14 days
- Child 1 month–11 years (body-weight 20–29 kg): 187.5 mg twice daily for 7–14 days
- Child 1 month–11 years (body-weight 30–40 kg): 250 mg twice daily for 7–14 days
- Child 12–17 years: 250–500 mg twice daily for 7–14 days

**Acute cough**

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily for 5 days

**Acute sinusitis**

**BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 1 month–11 years (body-weight up to 8 kg): 7.5 mg/kg twice daily for 5 days
- Child 1 month–11 years (body-weight 8–11 kg): 62.5 mg twice daily for 5 days
- Child 1 month–11 years (body-weight 12–19 kg): 125 mg twice daily for 5 days
- Child 1 month–11 years (body-weight 20–29 kg): 187.5 mg twice daily for 5 days
- Child 1 month–11 years (body-weight 30–40 kg): 250 mg twice daily for 5 days
- Child 12–17 years: 250 mg twice daily for 5 days, alternatively 500 mg twice daily for 5 days

**UNLICENSED USE** Duration of treatment for acute sinusitis differs from product literature and adheres to
**Erythromycin**

**INDICATIONS AND DOSE**

Sustainable infections in patients with penicillin hypersensitivity (e.g. respiratory-tract infections (including Legionella infection), skin and oral infections, and campylobacter enteritis)

- **By Mouth**
  - Neonate: 12.5 mg/kg every 6 hours.
    - Child 1-2 months: 125 mg 4 times a day, total daily dose may alternatively be given in two divided doses, increased to 250 mg 4 times a day, dose increase may be used in severe infections
    - Child 2-7 years: 250 mg 4 times a day, total daily dose may alternatively be given in two divided doses, increased to 500 mg 4 times a day, dose increase may be used in severe infections
    - Child 8-17 years: 250–500 mg 4 times a day, total daily dose may alternatively be given in two divided doses, increased to 500–1000 mg 4 times a day, dose increase may be used in severe infections

- **By Intravenous Infusion**
  - Neonate: 10–12.5 mg/kg every 6 hours.
    - Child: 12.5 mg/kg every 6 hours (max. per dose 1 g)

**Acute cough [if systemically very unwell or at higher risk of complications]**

- **By Mouth**
  - Child 1-2 months: 125 mg 4 times a day for 5 days, alternatively 250 mg twice daily for 5 days
  - Child 2-7 years: 250 mg 4 times a day for 5 days, alternatively 500 mg twice daily for 5 days
  - Child 8-17 years: 250–500 mg 4 times a day for 5 days, alternatively 500–1000 mg twice daily for 5 days

**Granules**

**CAUTIONARY AND ADVISORY LABELS** 9, 13

- **Klaricid (Mylan)**
  - Clarithromycin 250 mg Claritoxid Adult 250 mg granules sachets 14 sachets [PBM] £11.68

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 9

- **Clarithromycin (Non-proprietary)**
  - Clarithromycin 250 mg Clarithromycin 250mg tablets 14 tablet [PBM] £10.50 DT = £1.29
  - Clarithromycin 500 mg Clarithromycin 500mg tablets 14 tablet [PBM] £21.50 DT = £2.10

**Oral suspension**

**CAUTIONARY AND ADVISORY LABELS** 9

- **Clarithromycin (Non-proprietary)**
  - Clarithromycin 25 mg per 1 ml Clarithromycin 125mg/5ml oral suspension 70 ml [PBM] £3.75 DT = £3.36
  - Clarithromycin 50 mg per 1 ml Clarithromycin 250mg/5ml oral suspension 70 ml [PBM] £5.25 DT = £4.46

- **Klaricid (Mylan)**
  - Clarithromycin 25 mg per 1 ml Klaricid Paediatric 125mg/5ml oral suspension 70 ml [PBM] £3.26 DT = £3.16 | 100 ml [PBM] £9.04
  - Clarithromycin 50 mg per 1 ml Klaricid Paediatric 250mg/5ml oral suspension 70 ml [PBM] £10.51 DT = £4.46

**Powder for solution for infusion**

**ELECTROLYTES** May contain Sodium

- **Clarithromycin (Non-proprietary)**
  - Clarithromycin 500 mg Clarithromycin 500mg powder for solution for infusion vials 1 vial [PBM] £11.25 DT = £9.45 (Hospital only)
  - Clarithromycin 500mg powder for concentrate for solution for infusion vials 1 vial [PBM] £11.15 DT = £9.45 | 10 vial [PBM] £111.50

- **Klaricid (Mylan)**
  - Clarithromycin 500 mg Klaricid IV 500mg powder for solution for infusion vials 1 vial [PBM] £9.45 DT = £9.45

**National guidelines. See Sinusitis (acute) p. 721 for further information.**

- With oral use Duration of treatment for acute otitis media differs from product literature and adheres to national guidelines. See Ear infections, antibacterial therapy p. 315 for further information. Tablets not licensed for use in children under 12 years; oral suspension not licensed for use in infants under 6 months.

- With intravenous use Intravenous infusion not licensed for use in children under 12 years.

**INTERACTIONS** Appendix 1: macrodides

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **Uncommon** Burping - dry mouth - muscle complaints - oral disorders - thrombocytopenia - tremor

- **Frequency not known** Abnormal dreams - agranulocytosis - depersonalisation - depression - mania - myopathy - psychotic disorder - renal failure - tooth discoloration - urine discolouration

**SPECIFIC SIDE-EFFECTS**

- **Uncommon**
  - With oral use Epistaxis
  - With parenteral use Cardiac arrest - dyskinesia - haemorrhage - loss of consciousness - pulmonary embolism

- **PREGNANCY** Manufacturer advises avoid, particularly in the first trimester, unless potential benefit outweighs risk.

- **BREAST FEEDING** Manufacturer advises avoid unless potential benefit outweighs risk—present in milk.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in mild-to-moderate impairment; avoid in severe failure if renal impairment also present.

- **RENAI IMPAIRMENT** Avoid if severe hepatic impairment also present.

- With oral use Avoid Klaricid XL® or clarithromycin m/r preparations if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

Dose adjustments Use half normal dose if estimated glomerular filtration rate less than 30 mL/minute/1.73 m², max. duration 14 days.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use For intermittent intravenous infusion dilute reconstituted solution further in Glucose 5% or Sodium chloride 0.9% to a concentration of 2 mg/mL; give into large proximal vein over 60 minutes.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Clarithromycin for bacterial infections www.medicinesforchildren.org.uk/clarithromycin-bacterial-infections

**PROFESSION SPECIFIC INFORMATION**

Dental practitioners’ formulary Clarithromycin Tablets may be prescribed.

Clarithromycin Oral Suspension may be prescribed.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion

**Modified-release tablet**

CAUTIONARY AND ADVISORY LABELS 9, 21, 25

- **Clarie XL (Teva UK Ltd)**
  - Clarithromycin 500 mg Clarie XL 500mg tablets 7 tablet [PBM] £6.72 DT = £6.72 | 14 tablet [PBM] £13.23

- **Klaricid XL (Mylan)**
  - Clarithromycin 500 mg Klaricid XL 500mg tablets 7 tablet [PBM] £6.72 DT = £6.72 | 14 tablet [PBM] £13.23

- **Xetinin XL (Morningside Healthcare Ltd)**
  - Clarithromycin 500 mg Xetinin XL 500mg tablets 7 tablet [PBM] £6.72 DT = £6.72 | 14 tablet [PBM] £13.23
Bacterial infection

**Acute otitis media**
- **BY MOUTH**
  - Child 1–23 months: 125 mg 4 times a day for 5–7 days, alternatively 250 mg twice daily for 5–7 days
  - Child 2–7 years: 250 mg 4 times a day for 5–7 days, alternatively 500 mg twice daily for 5–7 days
  - Child 8–17 years: 250–500 mg 4 times a day for 5–7 days, alternatively 500–1000 mg twice daily for 5–7 days

**Chlamydial ophthalmia**
- **BY MOUTH**
  - Neonate: 12.5 mg/kg every 6 hours.

**Early syphilis**
- **BY MOUTH**
  - Child 12–17 years: 500 mg 4 times a day for 14 days

**Uncomplicated genital chlamydia / Non-gonococcal urethritis**
- **BY MOUTH**
  - Child 1–23 months: 12.5 mg/kg 4 times a day for 14 days
  - Child 2–11 years: 250 mg twice daily for 14 days
  - Child 12–17 years: 500 mg twice daily for 14 days

**Pelvic inflammatory disease**
- **BY MOUTH**
  - Child 1–23 months: 12.5 mg/kg 4 times a day for 14 days
  - Child 2–11 years: 250 mg twice daily for 14 days
  - Child 12–17 years: 500 mg twice daily for 14 days

**Prevention and treatment of pertussis**
- **BY MOUTH**
  - Neonate: 12.5 mg/kg every 6 hours.

**Prevention of secondary case of diphtheria in non-immune patient**
- **BY MOUTH**
  - Child 1–23 months: 125 mg every 6 hours for 7 days, treat for further 10 days if nasopharyngeal swabs positive after first 7 days’ treatment

**Prevention of secondary case of invasive group A streptococcal infection in penicillin allergic patients**
- **BY MOUTH**
  - Child 1–23 months: 125 mg every 6 hours for 10 days
  - Child 2–7 years: 250 mg every 6 hours for 10 days
  - Child 8–17 years: 250–500 mg every 6 hours for 10 days

**Prevention of pneumococcal infection in asplenia or in patients with sickle-cell disease (if penicillin-allergic)**
- **BY MOUTH**
  - Child 1–23 months: 125 mg twice daily, antibiotic prophylaxis is not fully reliable
  - Child 2–7 years: 250 mg twice daily, antibiotic prophylaxis is not fully reliable. It may be discontinued in those over 5 years of age with sickle-cell disease who have received pneumococcal immunisation and who do not have a history of severe pneumococcal infection
  - Child 8–17 years: 500 mg twice daily, antibiotic prophylaxis is not fully reliable. It may be discontinued in those with sickle-cell disease who have received pneumococcal immunisation and who do not have a history of severe pneumococcal infection

**Prevention of recurrence of rheumatic fever**
- **BY MOUTH**
  - Child 1–23 months: 125 mg twice daily
  - Child 2–17 years: 250 mg twice daily

**Acne**
- **BY MOUTH**
  - Child 1–23 months: 250 mg once daily, alternatively 125 mg twice daily
  - Child 12–17 years: 500 mg twice daily

**Gastro-intestinal stasis**
- **BY MOUTH**
  - Neonate: 3 mg/kg 4 times a day.
  - Child: 3 mg/kg 4 times a day.
  - **BY INTRAVENOUS INFUSION**

  - Neonate: 3 mg/kg 4 times a day.
  - Child: 1–11 months: 3 mg/kg 4 times a day

**UNLICENSED USE** Duration of treatment for acute otitis media differs from product literature and adheres to national guidelines. See Ear infections, antibacterial therapy p. 315 for further information.

**CAUTIONS**
- Avoid in Acute porphyrias p. 624 - neonate under 2 weeks (risk of hypertrophic pyloric stenosis)
- **INTERACTIONS** → Appendix 1: macrolides
- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Rare or very rare Hearing loss (can occur after large doses)
  - **SPECIFIC SIDE-EFFECTS**
    - With oral use Cerebral impairment
    - With parenteral use Atrioventricular block
  - **PREGNANCY** Not known to be harmful.
  - **BREAST FEEDING** Only small amounts in milk—not known to be harmful.
  - **HEPATIC IMPAIRMENT** May cause idiosyncratic hepatotoxicity
  - **RENAl IMPAIRMENT** Dose adjustments Reduce dose in severe renal impairment (ototoxicity)
Bacterial infection 343

Antibacterials > monobactams

Aztreonam

**Drug Action** Aztreonam is a monocyclic beta-lactam (‘monobactam’) antibiotic with an antibacterial spectrum limited to Gram-negative aerobic bacteria including *Pseudomonas aeruginosa*, *Neisseria meningitidis*, and *Haemophilus influenzae*; it should not be used alone for ‘blind’ treatment since it is not active against Gram-positive organisms. Aztreonam is also effective against *Neisseria gonorrhoeae* (but not against concurrent chlamydial infection).

**Indications and Use**

- **Gram-negative infections including *Pseudomonas aeruginosa*, *Haemophilus influenzae*, and *Neisseria meningitidis***
  - By intravenous injection, or by intravenous infusion
  - Neonate up to 7 days: 30 mg/kg every 12 hours.
  - Neonate 7 days to 28 days: 30 mg/kg every 6–8 hours.

- **Severe gram-negative infections including *Pseudomonas aeruginosa*, *Haemophilus influenzae*, *Neisseria meningitidis*, and lung infections in cystic fibrosis***
  - By intravenous infusion, or by intravenous injection
  - Child 2–11 years: 50 mg/kg every 6–8 hours (max. per dose 2 g 4 times a day)
  - Child 12–17 years: 2 g every 6–8 hours

**Chronic pulmonary *Pseudomonas aeruginosa* infection in patients with cystic fibrosis**

- By inhalation of nebulised solution
  - Child 6–17 years: 75 mg 3 times a day for 28 days, doses to be administered at least 4 hours apart, subsequent courses repeated after 28-day interval without aztreonam nebuliser solution

**Unlicensed Use**

- With systemic use Injection not licensed for use in children under 7 days.

**Caution**

- When used by inhalation Haemoptysis—risk of further haemorrhage

**Side-effects**

**General side-effects**

- Common or very common Dyspnoea · respiratory disorders

**Specific side-effects**

- Common or very common
  - When used by inhalation Cough · haemoptysis · joint disorders · laryngeal pain · nasal complaints · rash
  - Rare or very rare
    - With parental use Anaemia · asthenia · breast tenderness · chest pain · confusion · diplopia · dizziness · eosinophilia · haemorrhage · headache · hepatic disorders · hypotension · insomnia · leucocytosis · myalgia · nasal congestion · neutropenia · oral disorders · pancyclopenia · paraesthesia · pseudemembranous enterocolitis · seizure · thromboctopenia · thromboctyosis · tinnitus · vertigo · vulvovaginal candidiasis

Powder for solution for infusion

- **Erythromycin (Non-proprietary)**
  - Erythromycin (as Erythromycin lactobionate)
    - 1 gram Erythromycin 1g powder for solution for infusion vials
      - 1 vial [POT] £18.45–£22.92

**Patient and Carer Advice**


**Prescribing and dispensing information**

- Flavours of oral liquid formulations may include banana.
Bacterial infection

- Frequency not known
- With parenteral use: Abdominal pain, angioedema, diarrhea, nausea, skin reactions, taste altered, toxic epidermal necrolysis, vomiting.
- **ALLERGY AND CROSS-SENSITIVITY**: Contra-indicated in aztreonam hypersensitivity. Use with caution in patients with hypersensitivity to other beta-lactam antibiotics (although aztreonam may be less likely than other beta-lactams to cause hypersensitivity in penicillin-sensitive patients).
- **PREGNANCY**
  - With systemic use: No information available; manufacturer of injection advises avoid.
  - When used by inhalation: No information available; manufacturer of powder for nebuliser solution advises avoid unless essential.
- **BREAST FEEDING**: Amount in milk probably too small to be harmful.
- **HEPATIC IMPAIRMENT**
  - With systemic use: Manufacturer advises caution in chronic impairment with cirrhosis, especially in alcoholic cirrhosis and concomitant renal impairment.
- **RENAL IMPAIRMENT**
  - Dose adjustments: With systemic use: Manufacturer advises dose reduction of 20–25% for long-term treatment of patients with chronic impairment with cirrhosis, especially in alcoholic cirrhosis and concomitant renal impairment.
- **MONITORING REQUIREMENTS**
  - When used by inhalation: Measure lung function before and after initial dose of aztreonam and monitor for bronchospasm.
- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use: For intravenous injection, give over 3–5 minutes. Displacement value of injection may be significant, consult local guidelines. For intermittent intravenous infusion, dilute reconstituted solution further in Glucose 5% or Sodium chloride 0.9% to a concentration of less than 20 mg/mL to be given over 20–60 minutes.
  - When used by inhalation: Other inhaled drugs should be administered before aztreonam; a bronchodilator should be administered before each dose.
- **NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**

SMC No. 753/12
The Scottish Medicines Consortium has advised (January 2015) that aztreonam powder for nebuliser solution (Cayston®) is accepted for restricted use within NHS Scotland when inhaled colistimethate sodium and inhaled tobramycin are not tolerated or are not providing satisfactory therapeutic benefit (measured as ≥2% decline in forced expiratory volume in 1 second). This advice is contingent upon the continuing availability of the Patient Access Scheme in NHS Scotland or a list price that is equivalent or lower.

**MEDICINAL FORMS**

- **Powder and solvent for nebuliser solution**
  - **Aztreonam (as Aztreonam lysine) 75 mg**: Cayston 75 mg powder and solvent for nebuliser solution vials with Altera Nebuliser Handset – 84 vial (£218.53 DT = £218.53)
  - **Powder for solution for injection**
    - **Azactam (Bristol-Myers Squibb Pharmaceuticals Ltd)**
      - **Aztreonam 1 gram**: Azactam 1g powder for solution for injection vials – 1 vial (£30.40 (Hospital only))

**ANTIBACTERIALS > NITROIMIDAZOLE DERIVATIVES**

**Metronidazole**

- **DRUG ACTION**: Metronidazole is an antimicrobial drug with high activity against anaerobic bacteria and protozoa.

**INDICATIONS AND DOSE**

**Anaerobic infections**

- **BY MOUTH**
  - Child 1 month: 7.5 mg/kg every 12 hours usually treated for 7 days (for 10–14 days in *Clostridium difficile* infection)
  - Child 2 months–1 year: 7.5 mg/kg every 8 hours (max. per dose 400 mg) usually treated for 7 days (for 10–14 days in *Clostridium difficile* infection)
  - Child 12–17 years: 400 mg every 8 hours usually treated for 7 days (for 10–14 days in *Clostridium difficile* infection)
  - **BY RECTUM**
    - Child 1–11 months: 125 mg 3 times a day for 3 days, then 125 mg twice daily, for usual total treatment duration of 7 days
    - Child 1–4 years: 250 mg 3 times a day for 3 days, then 250 mg twice daily, for usual total treatment duration of 7 days
    - Child 5–9 years: 500 mg 3 times a day for 3 days, then 500 mg twice daily, for usual total treatment duration of 7 days
    - Child 10–17 years: 1 g 3 times a day for 3 days, then 1 g twice daily, for usual total treatment duration of 7 days
  - **BY INTRAVENOUS INFUSION**
    - Neonate up to 26 weeks corrected gestational age: Loading dose 15 mg/kg, followed by 7.5 mg/kg after 24 hours, then 7.5 mg/kg daily usually treated for a total duration of 7 days (for 10–14 days in *Clostridium difficile* infection)
    - Neonate 26 weeks to 34 weeks corrected gestational age: Loading dose 15 mg/kg, followed by 7.5 mg/kg after 12 hours, then 7.5 mg/kg every 12 hours usually treated for a total duration of 7 days (for 10–14 days in *Clostridium difficile* infection)
    - Neonate 34 weeks corrected gestational age and above: Loading dose 15 mg/kg, followed by 7.5 mg/kg after 8 hours, then 7.5 mg/kg every 8 hours usually treated for a total duration of 7 days (for 10–14 days in *Clostridium difficile* infection)
- **Helicobacter pylori eradication; in combination with clarithromycin and omeprazole**
  - **BY MOUTH**
    - Child 1–5 years: 100 mg twice daily
    - Child 6–11 years: 200 mg twice daily
    - Child 12–17 years: 400 mg twice daily

**Helicobacter pylori eradication; in combination with amoxicillin and omeprazole**

- **BY MOUTH**
  - Child 1–5 years: 100 mg 3 times a day
  - Child 6–11 years: 200 mg 3 times a day

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**Aztreonam 2 gram**: Azactam 2g powder for solution for injection vials – 1 vial (£30.40 (Hospital only))
Bacterial prophylaxis

- Child 12-17 years: 400 mg 3 times a day
- Fistulating Crohn’s disease
  - BY MOUTH
  - Child: 7.5 mg/kg 3 times a day usually given for 1 month but should not be used for longer than 3 months because of concerns about peripheral neuropathy

Bacterial vaginosis
- BY VAGINA USING VAGINAL GEL
- Child: 1 applicatorful daily for 5 days, dose to be administered at night

Pelvic inflammatory disease
- BY MOUTH
- Child 12-17 years: 400 mg twice daily for 14 days

Acute ulcerative gingivitis
- BY MOUTH
- Child 1-2 years: 50 mg every 8 hours for 3–7 days
- Child 3–6 years: 100 mg every 12 hours for 3–7 days
- Child 7–9 years: 100 mg every 8 hours for 3–7 days
- Child 10-17 years: 200–250 mg every 8 hours for 3–7 days

Acute oral infections
- BY MOUTH
- Child 1-2 years: 50 mg every 8 hours for 3–7 days
- Child 3–6 years: 100 mg every 12 hours for 3–7 days
- Child 7–9 years: 100 mg every 8 hours for 3–7 days
- Child 10-17 years: 200–250 mg every 8 hours for 3–7 days

Surgical prophylaxis
- BY MOUTH
- Child 1 month–11 years: 30 mg/kg (max. per dose 500 mg), to be administered 2 hours before surgery
- Child 12-17 years: 400–500 mg, to be administered 2 hours before surgery, then 400–500 mg every 8 hours if required for up to 3 doses (in high-risk procedures)
- BY RECTUM
- Child 5–9 years: 500 mg, to be administered 2 hours before surgery, then 500 mg every 8 hours if required for up to 3 doses (in high-risk procedures)
- Child 10-17 years: 1 g, to be administered 2 hours before surgery, then 1 g every 8 hours if required for up to 3 doses (in high-risk procedures)
- BY INTRAVENOUS INFUSION
- Neonate up to 40 weeks corrected gestational age: 10 mg/kg, to be administered up to 30 minutes before the procedure.
- Neonate 40 weeks corrected gestational age and above: 20–30 mg/kg, to be administered up to 30 minutes before the procedure.

Invasive intestinal amoebiasis/Extra-intestinal amoebiasis (including liver abscess)
- BY MOUTH
- Child 1-2 years: 200 mg 3 times a day for 5 days in intestinal infection (for 5–10 days in extra-intestinal infection)
- Child 3–6 years: 200 mg 4 times a day for 5 days in intestinal infection (for 5–10 days in extra-intestinal infection)
- Child 7–9 years: 400 mg 3 times a day for 5 days in intestinal infection (for 5–10 days in extra-intestinal infection)
- Child 10–17 years: 800 mg 3 times a day for 5 days in intestinal infection (for 5–10 days in extra-intestinal infection)

Urogenital trichomoniasis
- BY MOUTH
- Child 1-2 years: 50 mg 3 times a day for 7 days
- Child 3–6 years: 100 mg twice daily for 7 days
- Child 7–9 years: 100 mg 3 times a day for 7 days
- Child 10–17 years: 200 mg 3 times a day for 7 days, alternatively 400–500 mg twice daily for 5–7 days, alternatively 2 g for 1 dose

Giardiasis
- BY MOUTH
- Child 1-2 years: 500 mg once daily for 3 days
- Child 3–6 years: 600–800 mg once daily for 3 days
- Child 7–9 years: 1 g once daily for 3 days
- Child 10–17 years: 2 g once daily for 3 days, alternatively 400 mg 3 times a day for 5 days, alternatively 500 mg twice daily for 7–10 days

Established case of tetanus
- BY INTRAVENOUS INFUSION
- Child: consult product literature

- UNLICENSED USE
  - With vaginal use Metronidazole vaginal gel not licensed for use in children under 18 years.

- CAUTIONS
  - With vaginal use avoid intravaginal preparations (particularly those that require the use of an applicator) in young girls who are not sexually active, unless there is no alternative - not recommended during menstruation - some systemic absorption may occur with vaginal gel

- INTERACTIONS
  - Appendix 1: metronidazole

- SIDE-EFFECTS
  - Common or very common
    - With systemic use Dry mouth - myalgia - nausea - oral disorders - taste altered - vomiting
    - With vaginal use Pelvic discomfort - vulvovaginal candidiasis - vulvovaginal disorders
  - Uncommon
    - With systemic use Asthenia - headache - leucopenia (with long term or intensive therapy)
    - With vaginal use Menstrual cycle irregularities - vaginal haemorrhage
  - Rare or very rare
    - With systemic use Agranulocytosis - angioedema - appetite decreased - ataxia - cerebellar syndrome - confusion - diarrhoea - dizziness - drowsiness - encephalopathy - epigastric pain - epileptiform seizure (with long term or intensive therapy) - flushing - hallucination - hepatic disorders - meningitis aseptic - mucositis - nerve disorders - neutropenia - pancreatitis - pancytopenia - peripheral neuropathy (with long term or intensive therapy) - psychiatric disorder - seizure - severe cutaneous adverse reactions (SCARs) - skin reactions - thrombocytopenia - urine dark - vision disorders
  - Frequency not known
    - With systemic use Depressed mood - gastrointestinal disorder - hearing impairment

- PREGNANCY
  - With systemic use Manufacturer advises avoidance of high-dose regimens; use only if potential benefit outweighs risk.

- BREAST FEEDING
  - With systemic use Significant amount in milk; manufacturer advises avoid large single doses though otherwise compatible; may give milk a bitter taste.

- HEPATIC IMPAIRMENT
  - With systemic use Use with caution in hepatic encephalopathy.

Dose adjustments
- With systemic use In severe liver disease reduce total daily dose to one-third, and give once daily.
**MONITORING REQUIREMENTS**

- With systemic use: Clinical and laboratory monitoring advised if treatment exceeds 10 days.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use: For intravenous infusion, give over 20–30 minutes.

**PRESCRIBING AND DISPENSING INFORMATION**

- With systemic use: Metronidazole is well absorbed orally and the intravenous route is normally reserved for severe infections. Metronidazole by the rectal route is an effective alternative to the intravenous route when oral administration is not possible.

**PATIENT AND CARER ADVISE**

Medicines for Children leaflet: Metronidazole for bacterial infections: www.medicinesforchildren.org.uk/metronidazole

**PROFESSION SPECIFIC INFORMATION**

- Dental practitioners’ formulary:
  - With oral use: Metronidazole Tablets may be prescribed. Metronidazole Oral Suspension may be prescribed.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, suppository.

**Tablet**

- Metronidazole (Non-proprietary)
  - Metronidazole 200 mg: Metronidazole 200mg tablets | 21 tablet (P) £4.99 DT = £1.83
  - Metronidazole 400 mg: Metronidazole 400mg tablets | 21 tablet (P) £13.03 DT = £5.47
  - Metronidazole 500 mg: Metronidazole 500mg tablets | 21 tablet (P) £39.27 DT = £19.27
  - Flagyl (Sanofi
  - Metronidazole 200 mg: Flagyl 200mg tablets | 21 tablet (P) £4.49 DT = £1.83
  - Metronidazole 400 mg: Flagyl 400mg tablets | 14 tablet (P) £6.34

- Suppository

- Metronidazole (Non-proprietary)
  - Metronidazole 500 mg: Flagyl 500mg suppositories | 10 suppository (P) £16.18 DT = £15.18
  - Metronidazole 1 gram: Flagyl 1g suppositories | 10 suppository (P) £23.06

**Oral suspension**

- Metronidazole (Non-proprietary)
  - Metronidazole (as Metronidazole benzoate) 40 mg per 1 ml: Metronidazole 200mg/5ml oral suspension | 100 ml (P) £37.50 DT = £35.22

**Vaginal gel**

- Excipients: May contain Disodium edetate, hydroxybenzoates (parabens), propylene glycol
  - Zidovudine (Sanofi
  - Metronidazole 25 mg per 1 gram: Zidovudine 0.75% vaginal gel | 40 gram (P) £4.31 DT = £4.31

**Infusion**

- Electrolytes: May contain Sodium
  - Metronidazole (Non-proprietary)
  - Metronidazole 5 per 1 ml: Metronidazole 500mg/100ml infusion 100ml bags | 20 bag (P) £63.86 DT = £63.86

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**Tinidazole**

- **Drug Action**: Tinidazole is an antimicrobial drug with high activity against anaerobic bacteria and protozoa; it has a longer duration of action than metronidazole.

- **Indications and Dose**
  - **Intestinal amoebiasis**
    - **By mouth**
      - Child 1 month–11 years: 50–60 mg/kg once daily (max. per dose 2 g) for 3 days
      - Child 12–17 years: 2 g once daily for 2–3 days
  - **Amoebic involvement of liver**
    - **By mouth**
      - Child 1 month–11 years: 50–60 mg/kg once daily (max. per dose 2 g) for 5 days
      - Child 12–17 years: 1.5–2 g once daily for 3–6 days
  - **Urogenital trichomoniasis / Giardiasis**
    - **By mouth**
      - Child 1 month–11 years: 50–75 mg/kg (max. per dose 2 g) for 1 single dose, dose may be repeated once if necessary
      - Child 12–17 years: 2 g for 1 single dose, dose may be repeated once if necessary

**Interactions**

- Appendices: tinidazole

**Side-effects**

- **Common or very common**: Abdominal pain · appetite decreased · diarrhoea · headache · nausea · skin reactions · vertigo · vomiting

- **Frequency not known**:
  - Angioedema · ataxia · dizziness · fatigue · flushing · leucopenia · oral disorders · peripheral neuropathy · seizure · sensation abnormal · taste altered · tongue discolouration · urine discolouration

**Pregnancy**

- Manufacturer advises avoid in first trimester.

**Breast feeding**

- Present in milk—manufacturer advises avoid breast-feeding during and for 3 days after stopping treatment.

**Monitoring requirements**

- Clinical and laboratory monitoring advised if treatment exceeds 10 days.

**Medicinal forms**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, suppository.

**Tablet**

- Metronidazole (Non-proprietary)
  - Metronidazole 500 mg: Metronidazole 500mg tablets | 174 tablet (P) £11.04 DT = £11.04
  - Metronidazole 300 mg: Metronidazole 300mg tablets | 174 tablet (P) £11.04 DT = £11.04
  - Metronidazole 200 mg: Metronidazole 200mg tablets | 174 tablet (P) £11.04 DT = £11.04

**Antibacterials**

**Penicillins**

**Benzylpenicillin and phenoxymethylpenicillin**

- Benzylpenicillin sodium p. 349 (Penicillin G) remains an important and useful antibiotic but is inactivated by bacterial beta-lactamas. It is effective for many streptococcal (including pneumococcal), gonococcal, and meningococcal infections and also for anthrax, diphtheria, gas, gangrene, and leptospirosis. It is also used in combination with gentamicin p. 322 for the empirical treatment of sepsis in neonates less than 48 hours old. Pneumococci, meningococci, and gonococci which have decreased sensitivity to penicillin have been isolated; benzylpenicillin sodium is no longer the drug of first choice for pneumococcal meningitis. Although benzylpenicillin sodium is effective in the treatment of tetanus, metronidazole p. 344 is preferred. Benzylpenicillin sodium is inactivated by gastric acid and absorption from the gastro-intestinal tract is low; therefore it must be given by injection.
Benzathine benzylpenicillin or procaine benzylpenicillin are used in the treatment of syphilis. Phenoxymethylpenicillin p. 350 (Penicillin V) has a similar antibacterial spectrum to benzylpenicillin sodium, but is less active. It is gastric acid-stable, so is suitable for oral administration. It should not be used for serious infections because absorption can be unpredictable and plasma concentrations variable. It is indicated principally for respiratory-tract infections in children, for streptococcal tonsillitis, and for continuing treatment after one or more injections of benzylpenicillin sodium when clinical response has begun. It should not be used for meningococcal or gonococcal infections. Phenoxymethylpenicillin is used for prophylaxis against streptococcal infections following rheumatic fever and against pneumococcal infections following splenectomy or in sickle cell disease.

Penicillinase-resistant penicillins
Most staphylococci are now resistant to benzylpenicillin because they produce penicillinases. Flucloxacillin p. 357, however, is not inactivated by these enzymes and is thus effective in infections caused by penicillin-resistant staphylococci, which is the main indication for its use. Flucloxacillin is acid-stable and can, therefore, be given by mouth as well as by injection. Flucloxacillin is well absorbed from the gut.

Broad-spectrum penicillins
Ampicillin p. 353 is active against certain Gram-positive and Gram-negative organisms but is inactivated by penicillinases including those produced by Staphylococcus aureus and by common Gram-negative bacilli such as Escherichia coli. Ampicillin is also active against Listeria spp. and enterococci. Almost all staphylococci, approx. 60% of E. coli strains and approx. 20% of Haemophilus influenzae strains are now resistant. The likelihood of resistance should therefore be considered before using ampicillin for the ‘blind’ treatment of infections; in particular, it should not be used for hospital patients without checking sensitivity.

Ampicillin can be given by mouth, but less than half the dose is absorbed and absorption is further decreased by the presence of food in the gut. Ampicillin is well excreted in the bile and urine.

Amoxicillin p. 351 is a derivative of ampicillin and has a similar antibacterial spectrum. It is better absorbed than ampicillin when given by mouth, producing higher plasma and tissue concentrations; unlike ampicillin, absorption is not affected by the presence of food in the stomach.

Amoxicillin or ampicillin are principally indicated for the treatment of community-acquired pneumonia and middle ear infections, both of which may be due to Streptococcus pneumoniae and H. influenzae, and for urinary-tract infections. They are also used in the treatment of endocarditis and lobar meningitis. Amoxicillin is also used for the treatment of Lyme disease.

Maculopapular rashes occur commonly with ampicillin (and amoxicillin) but are not usually related to true penicillin allergy. They often occur in children with glandular fever; broad-spectrum penicillins should not therefore be used for ‘blind’ treatment of a sore throat. The risk of rash is also increased in children with acute or chronic lymphoid leukemia or in cytomegalovirus infection.

Co-amoxiclav p. 354 consists of amoxicillin with the beta-lactamase inhibitor clavulanic acid. Clavulanic acid itself has no significant antibacterial activity but, by inactivating beta-lactamases, it makes the combination active against beta-lactamase-producing bacteria that are resistant to amoxicillin. These include resistant strains of Staph. aureus, E. coli, and H. influenzae, as well as many Bacteroides and Klebsiella spp. Co-amoxiclav should be reserved for infections likely, or known, to be caused by amoxicillin-resistant beta-lactamase-producing strains.

A combination of ampicillin with flucloxacillin (as co-flumacillin p. 354) is available to treat infections involving either streptococci or staphylococci (e.g. cellulitis).

Antipseudomonal penicillins
Piperacillin, a ureidopenicillin, is only available in combination with the beta-lactamase inhibitor tazobactam. Ticarcillin, a carboxypenicillin, is only available in combination with the beta-lactamase inhibitor clavulanic acid. Both preparations have a broad spectrum of activity against a range of Gram-positive and Gram-negative bacteria, and anaerobes. Piperacillin with tazobactam p. 348 has activity against a wider range of Gram-negative organisms than ticarcillin with clavulanic acid p. 348 and it is more active against Pseudomonas aeruginosa. These antibacterials are not active against MRSA. They are used in the treatment of septicaemia, hospital-acquired pneumonia, and complicated infections involving the urinary-tract, skin and soft tissue, or intra-abdomen. They may be used for the empirical treatment of septicaemia in immunocompromised children but otherwise should generally be reserved for serious infections resistant to other antibacterials. For severe pseudomonas infections these antipseudomonal penicillins can be given with an aminoglycoside (e.g. gentamicin) since they have a synergistic effect.

Piperacillin with tazobactam is used in cystic fibrosis for the treatment of Ps. aeruginosa colonisation when ciprofloxacin p. 361 and nebulised colistimethate sodium p. 358 have been ineffective; it can also be used in infective exacerbations, when it is combined with an aminoglycoside.

Mecillinams
Pivmecillinam hydrochloride p. 356 has significant activity against many Gram-negative bacteria including Escherichia coli, klebsiella, enterobacter, and salmonellae. It is not active against Pseudomonas aeruginosa or enterococci.

Pivmecillinam hydrochloride is hydrolysed to mecillinam, which is the active drug.

**Penicillins**

- **Drug Action** The penicillins are bactericidal and act by interfering with bacterial cell wall synthesis. They diffuse well into body tissues and fluids, but penetration into the cerebrospinal fluid is poor except when the meninges are inflamed. They are excreted in the urine in therapeutic concentrations.

- **Caution** History of allergy

- **Side-effects**
  - Common or very common Diarrhoea · hypersensitivity · nausea · skin reactions · thrombocytopenia · vomiting
  - Uncommon Antibiotic associated colitis · leucopenia
  - Rare or very rare Agranulocytosis · angioedema · haemolytic anaemia · hepatic disorders · nephritis · tubulointerstitial · neutropenia · seizure · severe cutaneous adverse reactions (SCARs)

**Side-effects, further information** Diarrhoea frequently occurs during oral penicillin therapy. It is most common with broad-spectrum penicillins, which can cause antibiotic-associated colitis.

- **Allergy and Cross-Sensitivity** The most important side-effect of the penicillins is hypersensitivity which causes rashes and anaphylaxis and can be fatal. Allergic reactions to penicillins occur in 1–10% of exposed individuals; anaphylactic reactions occur in fewer than 0.05% of treated patients. Patients with a history of atopic allergy (e.g. asthma, eczema, hay fever) are at a higher risk of anaphylactic reactions to penicillins. Individuals with a history of anaphylaxis, urticaria, or rash immediately after penicillin administration are at risk of immediate hypersensitivity to a penicillin; these individuals should
not receive a penicillin. Individuals with a history of a minor rash (i.e. non-confluent, non-pruritic rash restricted to a small area of the body) or a rash that occurs more than 72 hours after penicillin administration are probably not allergic to penicillin and in these individuals a penicillin should not be withheld unnecessarily for serious infections; the possibility of an allergic reaction should, however, be borne in mind. Other beta-lactam antibiotics (including cephalosporins) can be used in these patients. Patients who are allergic to one penicillin will be allergic to all because the hypersensitivity is related to the basic penicillin structure. Patients with a history of immediate hypersensitivity to penicillins may also react to the cephalosporins and other beta-lactam antibiotics, they should not receive these antibiotics. If a penicillin (or another beta-lactam antibiotic) is essential in an individual with immediate hypersensitivity to penicillin then specialist advice should be sought on hypersensitivity testing or using a beta-lactam antibiotic with a different structure to the penicillin that caused the hypersensitivity.

**ANTIBACTERIALS > PENICILLINS, ANTIPSEUDOMONAL WITH BETA-LACTAMASE INHIBITOR**

**Piperacillin with tazobactam**

**INDICATIONS AND DOSE**

- **Hospital-acquired pneumonia | Septicaemia | Complicated infections involving the urinary-tract | Complicated infections involving the skin | Complicated infections involving the soft-tissues**
  - **By intravenous infusion**
  - **Neonate:** 90 mg/kg every 8 hours.
  - **Child 1 month-11 years:** 90 mg/kg every 6–8 hours (max. per dose 4.5 g every 6 hours)
  - **Child 12-17 years:** 4.5 g every 8 hours; increased if necessary to 4.5 g every 6 hours, increased frequency may be used for severe infections

- **Complicated intra-abdominal infections**
  - **By intravenous infusion**
  - **Child 2-11 years:** 112.5 mg/kg every 8 hours (max. per dose 4.5 g)
  - **Child 12-17 years:** 4.5 g every 8 hours; increased if necessary to 4.5 g every 6 hours, increased frequency may be used for severe infections

- **Acute exacerbation of bronchiectasis**
  - **By intravenous infusion**
  - **Child 1 month-11 years:** 90 mg/kg every 6–8 hours (max. per dose 4.5 g every 6 hours)
  - **Child 12-17 years:** 4.5 g every 8 hours; increased if necessary to 4.5 g every 6 hours, increased frequency may be used for severe infections

- **Infections in neutropenic patients**
  - **By intravenous infusion**
  - **Child:** 90 mg/kg every 6 hours (max. per dose 4.5 g)

**UNLICENSED USE** Not licensed for use in children under 12 years (except for children 2–12 years with neutropenia and complicated intra-abdominal infections). Piperacillin with tazobactam is used for the treatment of acute exacerbation of bronchiectasis, but is not licensed for this indication. See Respiratory system infections, antibacterial therapy p. 318 for further information.

**CAUTIONS** High doses may lead to hypernatraemia (owing to sodium content of preparations).

**INTERACTIONS** → Appendix 1: penicillins

**SIDE-EFFECTS**
- **Common or very common** Anaemia | candida infection | constipation | gastrointestinal discomfort | headache | insomnia
- **Uncommon** Arthralgia | flushing | hypokalaemia | hypotension | myalgia | thrombophlebitis
- **Rare or very rare** Epistaxis | stomatitis
- **Frequency not known** Eosinophilia | pancytopenia | pneumonia eosinophilic | renal failure | thrombocytosis

**PREGNANCY** Manufacturers advise use only if potential benefit outweighs risk.

**BREAST FEEDING** Trace amount in milk, but appropriate to use.

**RENAL IMPAIRMENT**

- **Dose adjustments**
  - **Child under 12 years:** 78.75 mg/kg (max. 4.5 g) every 8 hours if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².
  - **Child 12–18 years:** max. 4.5 g every 8 hours if estimated glomerular filtration rate 20–40 mL/minute/1.73 m²; max. 4.5 g every 12 hours if estimated glomerular filtration rate less than 20 mL/minute/1.73 m².

- **Effect on laboratory tests** False-positive urinary glucose (if tested for reducing substances).

- **Directions for administration** Displacement value may be significant when reconstituting injection, consult local guidelines. For intravenous infusion, dilute reconstituted solution to a concentration of 15–90 mg/mL with Glucose 5% or Sodium Chloride 0.9%; give over 30 minutes.

- **Prescribing and dispensing information** Dose expressed as a combination of piperacillin and tazobactam (both as sodium salts) in a ratio of 8:1.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion

**Powder for solution for infusion**

**ELECTROLYTES:** May contain Sodium

- **Piperacillin with tazobactam (Non-proprietary)**
  - **Tazobactam (as Tazobactam sodium) 500 mg, Piperacillin (as Piperacillin sodium) 4 gram** Piperacillin 4 g / Tazobactam 500mg powder for solution for infusion vials | 1 vial (£3.75–£3.97) (Hospital only) | 1 vial (Pfizer) £12.90 | 10 vial (Pfizer) £48.00–£53.00 | 10 vial (Pfizer) £163.30 (Hospital only)

- **Tazocin (Pfizer Ltd)**
  - **Tazobactam (as Tazobactam sodium) 500 mg, Piperacillin (as Piperacillin sodium) 4 gram** Tazocin 4g/0.5g powder for solution for infusion vials | 1 vial (£3.75–£4.17) (Hospital only)

**Powder for solution for injection**

**ELECTROLYTES:** May contain Sodium

- **Piperacillin with tazobactam (Non-proprietary)**
  - **Tazobactam (as Tazobactam sodium) 250 mg, Piperacillin (as Piperacillin sodium) 2 gram** Piperacillin 2g / Tazobactam 250mg powder for solution for infusion vials | 1 vial (£3.95 DT + £7.65) (Hospital only) | 10 vial (£3.95 DT + £48.20) (Hospital only)

- **Tazocin (Pfizer Ltd)**
  - **Tazobactam (as Tazobactam sodium) 250 mg, Piperacillin (as Piperacillin sodium) 2 gram** Tazocin 2g/0.25g powder for solution for infusion vials | 1 vial (£7.65 DT + £7.65)

**Ticarcillin with clavulanic acid**

**INDICATIONS AND DOSE**

- **Infections due to Pseudomonas and Proteus spp.**
  - **By intravenous infusion**
  - **Preterm neonate (body-weight up to 2 kg):** 80 mg/kg every 12 hours.
  - **Preterm neonate (body-weight 2 kg and above):** 80 mg/kg every 8 hours; increased if necessary to 80 mg/kg every 6 hours, increased frequency used for more severe
**BENZYL Penicillin sodium**

**Indications and dose**

*Mild to moderate susceptible infections*  
*Throat infections*  
*Otitis media*  
*Cellulitis*  
*Pneumonia*

- **By intramuscular injection, or by slow intravenous injection, or by intravenous infusion**
- **Neonate up to 7 days:** 25 mg/kg every 12 hours; increased if necessary to 25 mg/kg every 8 hours, intravenous route recommended in neonates.
- **Neonate up to 7 days:** 50 mg/kg every 8 hours; increased if necessary to 50 mg/kg every 8 hours in severe infection, intravenous route recommended in neonates.
- **Child:** 25 mg/kg every 6 hours; increased if necessary to 50 mg/kg every 4–6 hours (max. per dose 2.4 g every 4 hours) in severe infection, intravenous route recommended in infants.

**Endocarditis (in combination with other antibacterial if necessary)**

- **By slow intravenous injection, or by intravenous infusion**
- **Child:** 25 mg/kg every 4 hours; increased if necessary to 50 mg/kg every 4 hours (max. per dose 2.4 g every 4 hours).

**Meningitis/Meningococcal disease**

- **By intravenous infusion**
- **Neonate up to 7 days:** 50 mg/kg every 12 hours.

**Neonate 7 days to 28 days:** 50 mg/kg every 8 hours.

- **Child:** 50 mg/kg every 4–6 hours (max. per dose 2.4 g every 4 hours)

**Suspected meningococcal disease (meningitis with non-blanching rash or meningococcal septicaemia) prior to urgent transfer to hospital**

- **By intravenous injection, or by intramuscular injection**
- **Child 1–11 months:** 300 mg, administer as single dose prior to urgent transfer to hospital so long as does not delay transfer.
- **Child 1–9 years:** 600 mg, administer as single dose prior to urgent transfer to hospital so long as does not delay transfer.
- **Child 10–17 years:** 1.2 g, administer as single dose prior to urgent transfer to hospital so long as does not delay transfer.

**Suspected bacterial meningitis without non-blanching rash where patient cannot be transferred to hospital urgently**

- **By intravenous injection, or by intramuscular injection**
- **Child 1–11 months:** 300 mg, administer as single dose prior to transfer to hospital.
- **Child 1–9 years:** 600 mg, administer as single dose prior to transfer to hospital.
- **Child 10–17 years:** 1.2 g, administer as single dose prior to transfer to hospital.
**Phenoxymethylpenicillin**  
(Penicillin V)

### Indications and Dose

**Oral infections** | **Tonsillitis** | **Otitis media** | **Erysipelas** | **Cellulitis**
---|---|---|---|---
**By Mouth**
- Child 1-11 months: 62.5 mg 4 times a day; increased if necessary up to 12.5 mg/kg 4 times a day
- Child 1-5 years: 125 mg 4 times a day; increased if necessary up to 25 mg/kg 4 times a day
- Child 6-11 years: 250 mg 4 times a day; increased if necessary up to 25 mg/kg 4 times a day
- Child 12-17 years: 500 mg 4 times a day; increased if necessary up to 1 g 4 times a day

### Prevention of recurrence of rheumatic fever
- **By Mouth**
- Child 1 month to 5 years: 125 mg twice daily
- Child 6-17 years: 250 mg twice daily

### Prevention of secondary case of invasive group A streptococcal infection
- **By Mouth**
- Neonate: 12.5 mg/kg every 6 hours (max. per dose 62.5 mg) for 10 days.

### Prevention of pneumococcal infection in asplenia or in patients with sickle-cell disease
- **By Mouth**
- Child 1-11 months: 62.5 mg every 6 hours for 10 days
- Child 1-5 years: 125 mg every 6 hours for 10 days
- Child 6-11 years: 250 mg every 6 hours for 10 days
- Child 12-17 years: 500–500 mg every 6 hours for 10 days

### Acute sinusitis
- **By Mouth**
- Child 1-11 months: 62.5 mg 4 times a day for 5 days
- Child 1-5 years: 125 mg 4 times a day for 5 days
- Child 6-11 years: 250 mg 4 times a day for 5 days
- Child 12-17 years: 500 mg 4 times a day for 5 days

### Important Safety Information

- **Intrathecal Injection** of phenoxymethylpenicillin is **not** recommended.

### Cautions

- Accumulation of sodium from injection can occur with high doses.
- **Interactions** | Appendix 1: penicillins
- **Side-effects**
  - Common or very common | Fever, Jarisch-Herxheimer reaction
  - Rare or very rare | Neurotoxicity
  - Frequency not known | Coma
- **Pregnancy** | Not known to be harmful.
- **Breast Feeding** | Trace amounts in milk, but appropriate to use.

### Renal Impairment

- Accumulation of sodium from injection can occur in renal failure. High doses may cause neurotoxicity, including cerebral irritation, convulsions, or coma.

### Dose Adjustments

<table>
<thead>
<tr>
<th>Age</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonate up to 7 days</td>
<td>25 mg/kg every 12 hours; increased if necessary up to 25 mg/kg every 8 hours in severe infection, intravenous route recommended in neonates.</td>
</tr>
<tr>
<td>Neonate 7 days to 28 days</td>
<td>25 mg/kg every 8 hours; increased if necessary to 50 mg/kg every 8 hours in severe infection, intravenous route recommended in neonates.</td>
</tr>
<tr>
<td>Child 1 month to 5 years</td>
<td>125 mg every 6 hours for 10 days</td>
</tr>
<tr>
<td>Child 6-17 years</td>
<td>250 mg twice daily</td>
</tr>
</tbody>
</table>

### Effect on Laboratory Tests

- False-positive urinary glucose (if tested for reducing substances).

### Directions for Administration

- With intravenous use | Intravenous route recommended in neonates and infants. For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%; give over 15–30 minutes. Longer administration time is particularly important when using doses of 50 mg/kg (or greater) to avoid CNS toxicity.

### Medicinal Forms

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion
  - Phenoxymethylpenicillin sodium (Non-proprietary) | Benzylpenicillin sodium 600 mg | Benzylpenicillin 600mg powder for solution for injection vials | 2 vial (£1.62–£1.68 DT + £1.08) | 25 vial (£75.12–£76.00)
  - Benzylpenicillin sodium 1.2 gram | Benzylpenicillin 1.2g powder for solution for injection vials | 25 vial (£109.49–£113.92 DT + £113.92)

### Unlicensed Use

- Duration of treatment for acute sinusitis adheres to national guidelines. | See Sinusitis (acute) p. 721 for further information.

- **Interactions** | Appendix 1: penicillins
- **Side-effects**
  - Arthralgia
  - Respiratory infection
  - Skin rash
  - Increased risk of infection, neurotoxicity, oral disorders, paraesthesia
- **Pregnancy** | Not known to be harmful.
- **Breast Feeding** | Trace amounts in milk, but appropriate to use.

- **Effect on Laboratory Tests** | False-positive urinary glucose (if tested for reducing substances).

### Patient and Carer Advice

- **Medicines for Children leaflet: Penicillin V for bacterial infections**
- **Penicillin V for prevention of pneumococcal infection**
- **Penicillin V-prevention-pneumococcal-infection**

### Profession Specific Information

- Dental practitioners’ formulation
  - Phenoxympenilicillin Tablets may be prescribed.
  - Phenoxympenilicillin Oral Solution may be prescribed.

### Medicinal Forms

- There can be variation in the licensing of different medicines containing the same drug.

### Oral Solution

- **Cautionary and Advisory Labels** 9, 23
  - Phenoxympenilicillin (Non-proprietary): Phenoxympenilicillin (as Phenoxympenilicillin potassium) | 25 mg per 1 ml | Phenoxympenilicillin 125mg/5ml oral solution | 100 ml (£34.00 DT + £14.29)
  - Phenoxympenilicillin 125mg/5ml oral solution sugar free | 100 ml (£25.00 DT + £7.10)
BROAD-SPECTRUM ANTIBACTERIALS

Amoxicillin
(Amoxycillin)

**INDICATIONS AND DOSE**

Susceptible infections (including urinary-tract infections, sinusitis, uncomplicated community acquired pneumonia, salmonellosis, oral infections)

- **BY MOUTH**
  - Neonate 7 days to 28 days: 30 mg/kg 3 times a day (max. per dose 125 mg).
  - Child 1-11 months: 125 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day
  - Child 1-4 years: 250 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day
  - Child 5-11 years: 500 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day (max. per dose 1 g)
  - Child 12-17 years: 500 mg 3 times a day; increased if necessary up to 1 g 3 times a day, use increased dose in severe infections

- **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Neonate up to 7 days: 30 mg/kg every 12 hours, increased if necessary to 60 mg/kg every 12 hours, increased dose used in severe infection
  - Neonate 7 days to 28 days: 30 mg/kg every 8 hours, increased if necessary to 60 mg/kg every 8 hours, increased dose used in severe infection
  - Child: 20–30 mg/kg every 8 hours (max. per dose 500 mg), increased if necessary to 40–60 mg/kg every 8 hours (max. per dose 1 g every 8 hours), increased dose used in severe infection

**Acute exacerbation of bronchiectasis**

- **BY MOUTH**
  - Child 1-11 months: 125 mg 3 times a day for 7–14 days
  - Child 1-4 years: 250 mg 3 times a day for 7–14 days
  - Child 5-7 years: 500 mg 3 times a day for 7–14 days

**Acute cough [if systemically very unwell or at higher risk of complications]**

- **BY MOUTH**
  - Child 1-11 months: 125 mg 3 times a day for 5 days
  - Child 1-4 years: 250 mg 3 times a day for 5 days
  - Child 5-7 years: 500 mg 3 times a day for 5 days

**Acute otitis media**

- **BY MOUTH**
  - Child 1-11 months: 125 mg 3 times a day for 5–7 days
  - Child 1-4 years: 250 mg 3 times a day for 5–7 days
  - Child 5-7 years: 500 mg 3 times a day for 5–7 days

**Neonate up to 7 days:** BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION

- Neonate 7 days to 28 days: 30 mg/kg 3 times a day (max. per dose 125 mg).

**Child 1-11 months:**

- 125 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day

**Child 1-4 years:**

- 250 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day

**Child 5-11 years:**

- 500 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day (max. per dose 1 g)

**Child 12-17 years:**

- 500 mg 3 times a day; increased if necessary up to 1 g 3 times a day, use increased dose in severe infections

**Lyme disease (under expert supervision)**

- **BY MOUTH**
  - Neonate 7 days to 28 days: 30 mg/kg every 12 hours, increased if necessary to 60 mg/kg every 12 hours, increased dose used in severe infection

**Lyme disease [erythema migrans and/or non-focal symptoms] [Lyme disease [affecting cranial nerves or peripheral nervous system]]**

- **BY MOUTH**
  - Child 1 month-11 years (administered on expert advice) (body-weight up to 34 kg): 30 mg/kg 3 times a day for 21 days
  - Child 1 month-11 years (administered on expert advice) (body-weight 34 kg and above): 1 g 3 times a day for 21 days
  - Child 12-17 years (administered on expert advice): 1 g 3 times a day for 21 days

**Lyme arthritis / Acrodermatitis chronica atrophicans**

- **BY MOUTH**
  - Child 1 month-11 years (administered on expert advice) (body-weight up to 34 kg): 30 mg/kg 3 times a day for 28 days
  - Child 1 month-11 years (administered on expert advice) (body-weight 34 kg and above): 1 g 3 times a day for 28 days
  - Child 12-17 years (administered on expert advice): 1 g 3 times a day for 28 days

**Anthrax (treatment and post-exposure prophylaxis)**

- **BY MOUTH**
  - Child (body-weight up to 20 kg): 80 mg/kg daily in 3 divided doses
  - Child (body-weight 20 kg and above): 500 mg 3 times a day

**Cystic fibrosis (treatment of asymptomatic Haemophilus influenzae carriage or mild exacerbation)**

- **BY MOUTH**
  - Neonate 7 days to 28 days: 30 mg/kg 3 times a day (max. per dose 125 mg).

  - Child 1-11 months: 125 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day

  - Child 1-4 years: 250 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day

  - Child 5-11 years: 500 mg 3 times a day; increased if necessary up to 30 mg/kg 3 times a day (max. per dose 1 g)

  - Child 12-17 years: 500 mg 3 times a day; increased if necessary up to 1 g 3 times a day, use increased dose in severe infections

  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Neonate 7 days to 28 days: 30 mg/kg every 12 hours, increased if necessary to 60 mg/kg every 12 hours, increased dose used in severe infection.
**Lisztial meningitis (in combination with another antibiotic)**

- **BY INTRAVENOUS INFUSION**
  - Neonate up to 7 days: 50–100 mg/kg every 12 hours.
  - Neonate 7 days to 28 days: 50–100 mg/kg every 8 hours.
  - Child: 50 mg/kg every 4–6 hours (max. per dose 2 g every 4 hours)

**Group B streptococcal infection | Enterococcal endocarditis (in combination with another antibiotic)**

- **BY INTRAVENOUS INFUSION**
  - Neonate up to 7 days: 50 mg/kg every 12 hours.
  - Neonate 7 days to 28 days: 50 mg/kg every 8 hours.
  - Child: 50 mg/kg every 4–6 hours (max. per dose 2 g every 4 hours)

**UNLICENSED USE**

- Amoxicillin doses in BNF Publications may differ from those in product literature. [Read more](#).
- Duration of treatment for acute otitis media differs from product literature and adheres to national guidelines. [Read more](#).
- Amoxicillin is used for the treatment of acute exacerbation of bronchiectasis, but is not licensed for this indication. See Respiratory system infections, antibacterial therapy p. 318 for further information.

**CAUTIONS**

- **GENERAL CAUTIONS**
  - Acute lymphocytic leukaemia (increased risk of erythematous rashes) – chronic lymphocytic leukaemia (increased risk of erythematous rashes) – cytomegalovirus infection (increased risk of erythematous rashes) – glandular fever (erythematous rashes common) – maintain adequate hydration with high doses (particularly during parenteral therapy)

**SPECIFIC CAUTIONS**

- With intravenous use accumulation of sodium can occur with high parenteral doses
- [INTERACTIONS](#) 

**SIDE-EFFECTS**

- **GENERAL SIDE-EFFECTS**
  - Rare or very rare Colitis haemorrhagic, crystalluria, dizziness, hypokinesia, hypersensitivity vasculitis, mucocutaneous candidiasis

- **Frequency not known** Jarisch–Herxheimer reaction

- **Rare or very rare**
  - With oral use Black hairy tongue

**PREGNANCY**

- Not known to be harmful.

**PRESCRIBING AND DISPENSING INFORMATION**

- See Lyme disease p. 374 for place in therapy and further information on treatment.

**PATIENT AND CARER ADVICE**

- Patient counselling is advised for Amoxicillin (Amoxil®) paediatric suspension (use of pipette).

**PROFESSION SPECIFIC INFORMATION**

- Dental practitioners’ formulary
- Amoxicillin capsules may be prescribed.
- Amoxicillin sachets may be prescribed as Amoxicillin Oral Powder.
- Amoxicillin Oral Suspension may be prescribed.

**MUSCULAR FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**

- **ELECTROLYTES:** May contain Sodium
  - Amoxicillin (Non-proprietary) Amoxicillin (as Amoxicillin sodium) 250 mg Amoxicillin 250 mg powder for solution for injection vials | 10 vial (P) £4.80 | 10 vial (P) £4.50 (Hospital only)
  - Amoxicillin (as Amoxicillin sodium) 500 mg Amoxicillin 500 mg powder for solution for injection vials | 10 vial (P) £9.60 DT + £5.48 | 10 vial (P) £12.00 DT + £5.48 (Hospital only)
  - Amoxicillin (as Amoxicillin sodium) 1 gram Amoxicillin 1g powder for solution for injection vials | 1 vial (P) £1.82 | 10 vial (P) £16.50 DT + £10.96 (Hospital only)
  - Amoxicillin (GlaxoSmithKline UK Ltd) Amoxicillin (as Amoxicillin sodium) 500 mg Amoxicillin 500 mg powder for solution for injection vials | 10 vial (P) £5.48 DT + £5.48
  - Amoxicillin (as Amoxicillin sodium) 1 gram Amoxicillin 1g powder for solution for injection vials | 10 vial (P) £10.96 DT + £10.96

**Oral suspension**

- **CAUTIONARY AND ADVISORY LABELS**
  - 9
  - Exipients: May contain Sucrose
  - Amoxicillin (Non-proprietary)
    - Amoxicillin (as Amoxicillin trihydrate) 25 mg per 1 ml Amoxicillin 125mg/5ml oral suspension sugar free sugar-free | 100 ml (P) £25.00 DT + £11.13
    - Amoxicillin 125mg/5ml oral suspension | 100 ml (P) £25.00 DT + £11.40
    - Amoxicillin (as Amoxicillin trihydrate) 50 mg per 1 ml Amoxicillin 250mg/5ml oral suspension sugar free sugar-free | 100 ml (P) £35.00 DT + £11.26
    - Amoxicillin 250mg/5ml oral suspension | 100 ml (P) £35.00 DT + £11.59
  - Amoxicillin (GlaxoSmithKline UK Ltd) Amoxicillin (as Amoxicillin trihydrate) 100 mg per 1 ml Amoxicillin 125mg/1.25ml paediatric oral suspension | 20 ml (P) £3.18 DT + £1.18
Bacterial infection 353

Ampicillin

- INDICATIONS AND DOSE

Susceptible infections (including bronchitis, urinary-tract infections, otitis media, sinusitis, uncomplicated community-acquired pneumonia, salmonellosis)

- BY MOUTH

  - Neonate 7 days to 20 days: 30 mg/kg 3 times a day (max. per dose 125 mg).

  - Neonate 21 days to 28 days: 30 mg/kg 4 times a day (max. per dose 125 mg).

  - Child 1-11 months: 125 mg 4 times a day; increased if necessary up to 30 mg/kg 4 times a day

  - Child 1-4 years: 250 mg 4 times a day; increased if necessary up to 30 mg/kg 4 times a day

  - Child 5-11 years: 500 mg 4 times a day; increased if necessary up to 30 mg/kg 4 times a day (max. per dose 1 g)

  - Child 12-17 years: 500 mg 4 times a day; increased if necessary to 1 g 4 times a day, use increased dose in severe infection

- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION

  - Neonate up to 7 days: 30 mg/kg every 12 hours, increased if necessary to 60 mg/kg every 12 hours, increased dose used in severe infection, community-acquired pneumonia or salmonellosis

  - Neonate 7 days to 20 days: 30 mg/kg every 8 hours, increased if necessary to 60 mg/kg every 8 hours, increased dose used in severe infection, community-acquired pneumonia or salmonellosis

  - Neonate 21 days to 28 days: 30 mg/kg every 6 hours, increased if necessary to 60 mg/kg every 6 hours, increased dose used in severe infection, community-acquired pneumonia or salmonellosis

  - Child: 25 mg/kg every 6 hours (max. per dose 500 mg every 6 hours), increased if necessary to 50 mg/kg every 6 hours (max. per dose 1 g every 6 hours), increased dose used in severe infection

- Group B streptococcal infection / Enterococcal endocarditis (in combination with another antibacterial)

  - BY INTRAVENOUS INFUSION

  - Neonate up to 7 days: 50 mg/kg every 12 hours.

  - Neonate 7 days to 20 days: 50 mg/kg every 8 hours.

  - Neonate 21 days to 28 days: 50 mg/kg every 6 hours.

  - Child: 50 mg/kg every 4–6 hours (max. per dose 2 g every 4 hours)

Listerial meningitis

- BY INTRAVENOUS INFUSION

  - Neonate up to 7 days: 100 mg/kg every 12 hours.

  - Neonate 7 days to 20 days: 100 mg/kg every 8 hours.

  - Neonate 21 days to 28 days: 100 mg/kg every 6 hours.

  - Child: 50 mg/kg every 4–6 hours (max. per dose 2 g every 4 hours)

- CAUTIONS

  - GENERAL CAUTIONS Acute lymphocytic leukaemia (increased risk of erythematous rashes) - chronic lymphocytic leukaemia (increased risk of erythematous rashes) - cytomegalovirus infection (increased risk of erythematous rashes) - glandular fever (erythematous rashes common)

  - SPECIFIC CAUTIONS With intravenous use accumulation of electrolytes contained in parenteral preparations can occur with high doses

- INTERACTIONS

  -Appendix 1: penicillins

- SIDE-EFFECTS

  - Colitis haemorrhagic

- PREGNANCY

  - Not known to be harmful.

- BREAST FEEDING

  - Trace amounts in milk, but appropriate to use.

- RENAL IMPAIRMENT

  - With intravenous use Accumulation of electrolytes contained in parenteral preparations can occur in patients with renal failure.

  -Dose adjustments If estimated glomerular filtration rate less than 10 mL/minute/1.73 m² reduce dose or frequency; rashes more common.

- DIRECTIONS FOR ADMINISTRATION

  - With oral use Administer at least 30 minutes before food.

  - With intravenous use Displacement value may be significant when reconstituting injection, consult local guidelines. Dilute intravenous injection to a concentration of 50–100 mg/mL. May be further diluted with glucose 5% or 10% or sodium chloride 0.9% or 0.45% for infusion. Give over 30 minutes when using doses of greater than 50 mg/kg to avoid CNS toxicity including convulsions.

- PATIENT AND CARER ADVICE

  - Medicines for Children leaflet: Ampicillin for bacterial infection

  -www.medicinesforchildren.org.uk/ampicillin-bacterial-infection

- MEDICINAL FORMS

  -There can be variation in the licensing of different medicines containing the same drug.

- Oral suspension

  - CAUTIONARY AND ADVISORY LABELS 9, 23

  - Ampicillin (Non-proprietary)

    - Ampicillin 25 mg per 1 ml Ampicillin 125mg/5ml oral suspension

    - 100 ml (POM) £23.86 DT = £23.86

    - Ampicillin 50 mg per 1 ml Ampicillin 250mg/5ml oral suspension

    - 100 ml (POM) £38.86 DT = £38.86

- Capsule

  - CAUTIONARY AND ADVISORY LABELS 9, 23

  - Ampicillin (Non-proprietary)

    - Ampicillin 250 mg Ampicillin 250mg capsules | 28 capsule (POM) £20.50 DT = £20.50

    - Ampicillin 500 mg Ampicillin 500mg capsules | 28 capsule (POM) £40.30 DT = £40.30

- Powder for solution for injection

  - Ampicillin (Non-proprietary)

    - Ampicillin (as Ampicillin sodium) 500 mg Ampicillin 500mg powder for solution for injection vials | 10 vial (POM) £78.30 DT = £78.30
Co-fluampicil

**INDICATIONS AND DOSE**

Mixed infections involving beta-lactamase-producing staphylococci

- **BY MOUTH**
  - Child 1 month–9 years: 125/250 mg every 6 hours
  - Child 10–17 years: 250/500 mg every 6 hours
- **BY INTRAMUSCULAR INJECTION, OR BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Child 1 month–1 year: 62.5/125 mg every 6 hours
  - Child 2–9 years: 125/250 mg every 6 hours
  - Child 10–17 years: 250/500 mg every 6 hours

Severe mixed infections involving beta-lactamase-producing staphylococci

- **BY MOUTH**
  - Child 1 month–9 years: 250/500 mg every 6 hours
  - Child 10–17 years: 500/1000 mg every 6 hours
- **BY INTRAMUSCULAR INJECTION, OR BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Child 1 month–1 year: 125/250 mg every 6 hours
  - Child 2–9 years: 250/500 mg every 6 hours
  - Child 10–17 years: 500/1000 mg every 6 hours

**SIDE-EFFECTS**

- Jarisch-Herxheimer reaction
- Dyspnoea
- Arthralgia
- Acute lymphocytic leukaemia
- Glomerular nephritis
- Chronic electrolyte imbalance
- Bronchospasm
- Electrolyte imbalance
- Coma
- Hallucination
- Fever
- Seizure
- Hypersensitivity reactions

**INTERACTIONS**

- **Rhabdomyolysis**
- **Hepatic failure**
- **Renal failure**
- **Hypersensitivity**

**EFFECT ON LABORATORY TESTS**

- False-positive urinary glucose (if tested for reducing substances).

**PRESCRIBING AND DISPENSING INFORMATION**

- Co-fluampicil is expressed as a combination of equal parts by mass of flucloxacillin and ampicillin.

- Medicinal forms: There can be variation in the licensing of different medicines containing the same drug.

**Oral suspension**

- **CAUTIONARY AND ADVISORY LABELS:** 9, 22
- Co-fluampicil (Non-proprietary)
  - Ampicillin (as Ampicillin trihydrate) 25 mg per 1 ml, Flucloxacillin (as Flucloxacillin magnesium) 25 mg per 1 ml
  - Co-fluampicil 250mg/250mg powder for solution for injection vials 10 ml (POM) £23.93 DT + £23.93

**Capsule**

- **CAUTIONARY AND ADVISORY LABELS:** 9, 22
- Co-fluampicil (Non-proprietary)
  - Ampicillin (as Ampicillin magnesium) 250 mg, Flucloxacillin (as Flucloxacillin sodium) 250 mg
  - Co-fluampicil 250mg/250mg capsules 28 capsule (POM) £13.33

**Antibacterials > Penicillins, broad-spectrum with beta-lactamase inhibitor**

Co-amoxiclav

**INDICATIONS AND DOSE**

Infections due to beta-lactamase-producing strains (where amoxicillin alone not appropriate), including respiratory tract infections, bone and joint infections, genito-urinary and abdominal infections, cellulitis and animal bites

- **BY MOUTH USING TABLETS**
  - Child 12–17 years: 250/125 mg every 8 hours; increased to 500/125 mg every 8 hours, increased dose used for severe infection
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
  - Neonate: 30 mg/kg every 12 hours, intravenous infusion recommended in children less than 3 months.

- Child 1–2 months: 30 mg/kg every 12 hours, intravenous infusion recommended in children less than 3 months
- Child 3 months–17 years: 30 mg/kg every 8 hours (max. per dose 1.2 g every 8 hours)

Infections due to beta-lactamase-producing strains (where amoxicillin alone not appropriate) including respiratory-tract infections, bone and joint infections, genito-urinary and abdominal infections, cellulitis, animal bites (doses for 125/31 suspension)

- **BY MOUTH USING ORAL SUSPENSION**
  - Neonate: 0.25 mL/kilogram 3 times a day.
  - Child 1–11 months: 0.25 mL/kilogram 3 times a day, dose doubled in severe infection
  - Child 1–5 years: 0.25 mL/kilogram 3 times a day, alternatively 5 mL 3 times a day, dose doubled in severe infection

**IMPORTANT SAFETY INFORMATION**

**HEPATIC DISORDERS**

Cholestatic jaundice and hepatitis may occur very rarely, up to two months after treatment with flucloxacillin has been stopped. Administration for more than two weeks and increasing age are risk factors. Healthcare professionals are reminded that:

- Flucloxacillin should not be used in patients with a history of hepatic dysfunction associated with flucloxacillin.
- Flucloxacillin should be used with caution in patients with hepatic impairment.
- Careful enquiry should be made about hypersensitivity reactions to beta-lactam antibacterials.

**CAUTIONS**

**GENERAL CAUTIONS**

- Acute lymphocytic leukaemia
- Increased risk of erthythematous rashes
- Chronic lymphocytic leukaemia
- Increased risk of erthythematous rashes
- Cyto-megalovirus infection
- Increased risk of erthythematous rashes
- Glandular fever (erythematous rashes common)

**SPECIFIC CAUTIONS**

- With intravenous use: accumulation of electrolytes contained in parenteral preparations can occur with high doses.

**INTERACTIONS**

- **Appendix 1: penicillins**

**SIDE-EFFECTS**

- Arthralgia
- Bronchospasm
- Coma
- Dyspnoea
- Electrolyte imbalance
- Eosinophilia
- Erythema nodosum
- Gastrointestinal disorder
- Hallucination
- Jarisch-Herxheimer reaction
- Myalgia
- Purpura
- Non-thrombocytopenic vasculitis

**PREGNANCY**

- Not known to be harmful.

**BREAST FEEDING**

- Trace amount in milk, but appropriate to use.

**HEPATIC IMPAIRMENT**

- Manufacturer advises use with caution in hepatic dysfunction.

**RENAL IMPAIRMENT**

- With intravenous use: accumulation of electrolytes contained in parenteral preparations can occur in patients with renal failure.

- **Dose adjustments**
  - Reduce dose or frequency if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; rashes more common.
Infections due to beta-lactamase-producing strains (where amoxicillin alone not appropriate) including respiratory-tract infections, bone and joint infections, genito-urinary and abdominal infections, cellulitis, animal bites (doses for 250/62 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 6-11 years: 0.15 mL/kilogram 3 times a day, alternatively 5 mL 3 times a day, dose doubled in severe infection

Infections due to beta-lactamase-producing strains (where amoxicillin alone not appropriate) including respiratory-tract infections, bone and joint infections, genito-urinary and abdominal infections, cellulitis, animal bites (doses for 400/57 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 2-23 months: 0.15 mL/kilogram twice daily, doubled in severe infection
- Child 2-6 years (body-weight 13-21 kg): 2.5 mL twice daily, doubled in severe infection
- Child 7-12 years (body-weight 22-40 kg): 5 mL twice daily, doubled in severe infection
- Child 12 years (body-weight 41 kg and above): 10 mL twice daily; increased if necessary to 10 mL 3 times a day, increased frequency to be used in severe infection

Severe dental infection with spreading cellulitis: Dental infection not responding to first-line antibacterial
- BY MOUTH USING TABLETS
- Child 12-17 years: 250/125 mg every 8 hours for 5 days

Acute exacerbation of bronchiectasis (doses for 125/31 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 1-11 months: 0.25 mL/kilogram 3 times a day for 7–14 days
- Child 1-5 years: 5 mL 3 times a day for 7–14 days, alternatively 0.25 mL/kilogram 3 times a day for 7–14 days

Acute exacerbation of bronchiectasis (doses for 250/62 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 6-11 years: 5 mL 3 times a day for 7–14 days, alternatively 0.15 mL/kilogram 3 times a day for 7–14 days

Acute exacerbation of bronchiectasis
- BY MOUTH USING TABLETS
- Child 12-17 years: 250/125 mg 3 times a day for 7–14 days, alternatively 500/125 mg 3 times a day for 7–14 days
- BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION
- Child 1-2 months: 30 mg/kg every 12 hours, intravenous infusion is recommended in children less than 3 months
- Child 3 months-17 years: 30 mg/kg every 12 hours, intravenous infusion is recommended in children less than 3 months

Acute sinusitis (doses for 125/31 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 1-11 months: 0.25 mL/kilogram 3 times a day for 5 days
- Child 1-5 years: 5 mL 3 times a day for 5 days, alternatively 0.25 mL/kilogram 3 times a day for 5 days

Acute sinusitis (doses for 250/62 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 6-11 years: 5 mL 3 times a day for 5 days, alternatively 0.15 mL/kilogram 3 times a day for 5 days

Acute sinusitis
- BY MOUTH USING TABLETS
- Child 12-17 years: 250/125 mg 3 times a day for 5 days, alternatively 500/125 mg 3 times a day for 5 days

Acute otitis media (doses for 125/31 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 1-11 months: 0.25 mL/kilogram 3 times a day for 5–7 days
- Child 1-5 years: 5 mL 3 times a day for 5–7 days, alternatively 0.25 mL/kilogram 3 times a day for 5–7 days

Acute otitis media (doses for 250/62 suspension)
- BY MOUTH USING ORAL SUSPENSION
- Child 6-11 years: 5 mL 3 times a day for 5–7 days, alternatively 0.15 mL/kilogram 3 times a day for 5–7 days

Dose equivalence and conversion
- Doses are expressed as co-amoxiclav.
- A mixture of amoxicillin (as the trihydrate or as the sodium salt) and clavulanic acid (as potassium clavulanate); the proportions are expressed in the form x/y where x and y are the strengths in milligrams of amoxicillin and clavulanic acid respectively.

UNLICENSED USE (see product literature and adhere to national guidelines)
- See Sinusitis (acute) p. 721 for further information.
- Duration of treatment for acute otitis media differs from product literature and adheres to national guidelines. See Ear infections, antibacterial therapy p. 315 for further information.
- Co-amoxiclav is used for the treatment of acute exacerbation of bronchiectasis, but is not licensed for this indication. See Respiratory system infections, antibacterial therapy p. 318 for further information.

CONTRA-INDICATIONS
- History of co-amoxiclav-associated jaundice or hepatic dysfunction - history of penicillin-associated jaundice or hepatic dysfunction

CAUTIONS
- Acute lymphocytic leukaemia (increased risk of erythematous rashes) - chronic lymphocytic leukaemia (increased risk of erythematous rashes) - cytomegalovirus infection (increased risk of erythematous rashes) - glandular fever (erythematous rashes common) - maintain adequate hydration with high doses (particularly during parental therapy)

SPECIFIC CAUTIONS
- With intravenous use accumulation of electrolytes contained in parenteral preparations can occur with high doses

CAUTIONS, FURTHER INFORMATION
- Cholestatic jaundice: Cholestatic jaundice can occur either during or shortly after the use of co-amoxiclav. An epidemiological study has shown that the risk of acute liver toxicity was about 6 times greater with co-amoxiclav than with amoxicillin. Cholestatic jaundice is more common in patients above the age of 65 years and in men; these reactions have only rarely been reported in children. Jaundice is usually self-limiting and very rarely fatal. The duration of treatment should be appropriate to the indication and should not usually exceed 14 days.

INTERACTIONS
- Appendix 1: clavulanic acid - penicillins

SIDE-EFFECTS
- GENERAL SIDE-EFFECTS
- Common or very common: Increased risk of infection
- Uncommon: Dizziness - dyspepsia - headache
- Frequency not known: Colitis haemorrhagic - crystalluria - hypersensitivity vasculitis - meningitis aseptic
SPECIFIC SIDE-EFFECTS

- With oral use: Akathisia • black hairy tongue
- PREGNANCY: Not known to be harmful.
- BREAST FEEDING: Trace amount in milk, but appropriate to use.
- HEPATIC IMPAIRMENT: Manufacturer advises caution.
- MONITORING: Monitor liver function in liver disease.
- RENAL IMPAIRMENT: Risk of crystalluria with high doses (particularly during parenteral therapy).
- With intravenous use: Accumulation of electrolytes contained in parenteral preparations can occur in patients with renal failure.

Dose adjustments

- With oral use: Co-amoxiclav 125/31 suspension, 250/62 suspension, 250/125 tablets, or 500/125 tablets: use normal dose every 12 hours if estimated glomerular filtration rate 10–30 mL/minute/1.73 m². Use the normal dose recommended for mild or moderate infections every 12 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

- With oral use: Co-amoxiclav 400/57 suspension: avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- With intravenous use: Co-amoxiclav injection: use normal initial dose and then use half normal dose every 12 hours if estimated glomerular filtration rate 10–30 mL/minute/1.73 m²; use normal initial dose and then use half normal dose every 24 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

DIRECTIONS FOR ADMINISTRATION

- With intravenous use: For intravenous infusion, dilute reconstituted solution to a concentration of 10 mg/mL with Sodium Chloride 0.9%; give intermittently over 30–40 minutes. For intravenous injection, administer over 3–4 minutes.

PRESCRIBING AND DISPENSING INFORMATION

Doses are expressed as co-amoxiclav: a mixture of amoxicillin (as the trihydrate or as the sodium salt) and clavulanic acid (as potassium clavulanate); the proportions are expressed in the form x/y where x and y are the strengths in milligrams of amoxicillin and clavulanic acid respectively.

- With oral use: Flavours of oral liquid formulations may include raspberry and orange.

PATIENT AND CARER ADVICE

Medicines for Children leaflet: Co-amoxiclav for bacterial infections www.medicinesforchildren.org.uk/co-amoxiclav-bacterial-infections-0

PROFESSION SPECIFIC INFORMATION

Dental practitioners’ formulary
Co-amoxiclav 250/125 Tablets may be prescribed.
Co-amoxiclav 125/31 Suspension may be prescribed.
Co-amoxiclav 250/62 Suspension may be prescribed.

MEDIcINAL FORMs

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion

Oral suspension

CAUTIONARY AND ADVISORY LABELS 9
EXCIPiENTS: May contain Aspartame

Clavulanic acid (as Potassium clavulanate) 6.25 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 25 mg per 1 mL Co-amoxiclav 125mg/31mg/5ml oral suspension | 100 mL (PON) £1.65 DT + £1.65

Clavulanic acid (as Potassium clavulanate) 12.5 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 50 mg per 1 mL Co-amoxiclav 250mg/62mg/5ml oral suspension | 100 mL (PON) £5.00 DT + £5.00

Clavulanic acid (as Potassium clavulanate) 25 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 100 mg per 1 mL Co-amoxiclav 500mg/125mg/5ml oral suspension | 100 mL (PON) £8.50 DT + £8.50

Clavulanic acid (as Potassium clavulanate) 37.5 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 250 mg per 1 mL Co-amoxiclav 750mg/250mg/5ml oral suspension | 100 mL (PON) £10.00 DT + £10.00

Clavulanic acid (as Potassium clavulanate) 100 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 500 mg per 1 mL Co-amoxiclav 1250mg/250mg/5ml oral suspension | 100 mL (PON) £16.50 DT + £16.50

Clavulanic acid (as Potassium clavulanate) 200 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 1000 mg per 1 mL Co-amoxiclav 2500mg/500mg/5ml oral suspension | 100 mL (PON) £29.00 DT + £29.00

Augmentin (GlaxoSmithKline UK Ltd)
Clavulanic acid (as Potassium clavulanate) 6.25 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 25 mg per 1 mL Augmentin 125/25 5F oral suspension sugar-free | 35 mL (PON) £4.13 DT + £4.13 sugar-free | 70 mL (PON) £6.97 DT + £5.79

Augmentin 250/50 5F oral suspension sugar-free | 100 mL (PON) £3.60 DT + £1.67

Augmentin-Duo (GSK UK Ltd)
Clavulanic acid (as Potassium clavulanate) 11.4 mg per 1 mL, Amoxicillin (as Amoxicillin trihydrate) 50 mg per 1 mL Augmentin-Duo 250/50 5F oral suspension sugar-free | 35 mL (PON) £4.13 DT + £4.13 sugar-free | 70 mL (PON) £5.79 DT + £5.79

Tablet

CAUTIONARY AND ADVISORY LABELS 9

Co-amoxiclav (Non-proprietary)
Clavulanic acid (as Potassium clavulanate) 125 mg, Amoxicillin (as Amoxicillin trihydrate) 250 mg Co-amoxiclav 2500mg/125mg tablets | 21 tablet (PON) £6.00 DT + £1.79

Clavulanic acid (as Potassium clavulanate) 125 mg, Amoxicillin (as Amoxicillin trihydrate) 500 mg Co-amoxiclav 500mg/125mg tablets | 21 tablet (PON) £15.00 DT + £1.79

Clavulanic acid (as Potassium clavulanate) 125 mg, Amoxicillin (as Amoxicillin trihydrate) 875 mg Co-amoxiclav 875mg/125mg tablets | 14 tablet (PON) £18.00 DT + £18.00

Augmentin (GlaxoSmithKline UK Ltd)
Clavulanic acid (as Potassium clavulanate) 125 mg, Amoxicillin (as Amoxicillin trihydrate) 250 mg Augmentin 375mg tablets | 21 tablet (PON) £5.03 DT + £1.79

Clavulanic acid (as Potassium clavulanate) 125 mg, Amoxicillin (as Amoxicillin trihydrate) 500 mg Augmentin 625mg tablets | 21 tablet (PON) £9.60 DT + £2.31

Powder for solution for injection

ELECTROLYTES: May contain Potassium, sodium

Co-amoxiclav (Non-proprietary)
Clavulanic acid (as Potassium clavulanate) 100 mg, Amoxicillin (as Amoxicillin sodium) 500 mg Co-amoxiclav 500mg/100mg powder for solution for injection vials | 10 vial (PON) £10.60–£14.90 | 10 vial (PON) £13.50 (Hospital only)

Clavulanic acid (as Potassium clavulanate) 200 mg, Amoxicillin (as Amoxicillin sodium) 1000 mg Co-amoxiclav 1000mg/200mg powder for solution for injection vials | 10 vial (PON) £16.00–£29.70 | 10 vial (PON) £27.50 (Hospital only)

Augmentin IntraVenous (GlaxoSmithKline UK Ltd)
Clavulanic acid (as Potassium clavulanate) 100 mg, Amoxicillin (as Amoxicillin sodium) 500 mg Augmentin IntraVenous 600mg powder for solution for injection vials | 10 vial (PON) £10.60

Clavulanic acid (as Potassium clavulanate) 200 mg, Amoxicillin (as Amoxicillin sodium) 1000 mg Augmentin IntraVenous 1.2g powder for solution for injection vials | 10 vial (PON) £10.60

ANTIBACTERIALS > PEniCILLINS, MECiLLiNAM-TYPE

Pivmecillinam hydrochloride

18-Sep-2018

INDICATIONS AND DOSE

Acute uncomplicated cystitis

- BY MOUTH

Child (body-weight 40 kg and above): Initially 400 mg for 1 dose, then 200 mg every 8 hours to a total of 10 tablets

Chronic or recurrent bacteriuria

- BY MOUTH

Child (body-weight 40 kg and above): 400 mg every 6–8 hours

Urinary-tract infections

- BY MOUTH

Child (body-weight up to 40 kg): 5–10 mg/kg every 6 hours, alternatively 20–40 mg/kg daily in 3 divided doses
UNLICENSED USE Not licensed for use in children under 3 months.

CONTRA-INDICATIONS Carnitine deficiency • gastrointestinal obstruction • infants under 3 months • oesophageal strictures

CAUTIONS Avoid in Acute porphyrias p. 624

INTERACTIONS • penicillins

SIDE-EFFECTS
• Common or very common Vulvovaginal fungal infection
• Uncommon Dizziness • fatigue • gastrointestinal discomfort • gastrointestinal disorders • headache • oral ulceration • vertigo

PREGNANCY Not known to be harmful, but manufacturer advises avoid.

BREAST FEEDING Trace amount in milk, but appropriate to use.

MONITORING REQUIREMENTS Liver and renal function tests required in long-term use.

EFFECT ON LABORATORY TESTS False positive urinary glucose (if tested for reducing substances). False positive newborn screening results for isovaleric acidemia may occur in neonates born to mothers receiving pivmecillinam during late pregnancy.

DIRECTIONS FOR ADMINISTRATION Tablets should be swallowed whole with plenty of fluid during meals while sitting or standing.

PATIENT AND CARER ADVICE Patient counselling is advised on administration of pivmecillinam hydrochloride tablets (posture).

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Tablet

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS</th>
<th>9, 21, 27</th>
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</thead>
<tbody>
<tr>
<td>Pivmecillinam hydrochloride (Non-proprietary)</td>
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<tr>
<td>Pivmecillinam hydrochloride 200 mg</td>
<td>Pivmecillinam 200mg tablets</td>
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<tr>
<td>10 tablet (PO) £5.40 DT = £5.40</td>
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<td>Selexid (LEO Pharma)</td>
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<tr>
<td>Pivmecillinam hydrochloride 200 mg</td>
<td>Selexid 200mg tablets</td>
</tr>
<tr>
<td>10 tablet (PO) £5.40 DT = £5.40</td>
<td>18 tablet (PO) £9.72</td>
</tr>
</tbody>
</table>

ANTIBACTERIALS > PENICILLINS, PENICILLINASE-RESISTANT

Flucloxacillin

INDICATIONS AND DOSE

Infections due to beta-lactamase-producing staphylococci including otitis externa • Adjunct in pneumonia • Adjunct in impetigo • Adjunct in cellulitis

BY MOUTH

• Neonate up to 7 days: 25 mg/kg twice daily.
• Neonate 7 days to 20 days: 25 mg/kg 3 times a day.
• Neonate 21 days to 28 days: 25 mg/kg 4 times a day.
• Child: 2.5–25 mg/kg every 6 hours (max. per dose 1 g every 6 hours)

Severe infections due to beta-lactamase-producing staphylococci including otitis externa • Adjunct in pneumonia (severe infection) • Adjunct in impetigo (severe infection) • Adjunct in cellulitis (severe infection)

• BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION

• Neonate up to 7 days: 50 mg/kg every 12 hours.
• Neonate 7 days to 20 days: 50 mg/kg every 8 hours.
• Neonate 21 days to 28 days: 50 mg/kg every 6 hours.
• Child: 25–50 mg/kg every 6 hours (max. per dose 2 g every 6 hours)

Endocarditis (in combination with other antibacterial if necessary)

• BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
• Child: 50 mg/kg every 6 hours (max. per dose 2 g every 6 hours)

Osteomyelitis

• BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION

• Neonate up to 7 days: 50–100 mg/kg every 12 hours.
• Neonate 7 days to 20 days: 50–100 mg/kg every 8 hours.
• Neonate 21 days to 28 days: 50–100 mg/kg every 6 hours.
• Child: 50 mg/kg every 6 hours (max. per dose 2 g every 6 hours)

CHILDRAEBALABSCES • STAPHYLOCOCCAL MENSINGITIS

• BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION

• Neonate up to 7 days: 50–100 mg/kg every 12 hours.
• Neonate 7 days to 20 days: 50–100 mg/kg every 8 hours.
• Neonate 21 days to 28 days: 50–100 mg/kg every 6 hours.
• Child: 50 mg/kg every 6 hours (max. per dose 2 g every 6 hours)

STAPHYLOCOCCAL LUNG INFECTION IN CYSTIC FIBROSIS

• BY MOUTH
• Child: 25 mg/kg 4 times a day (max. per dose 1 g), alternatively 100 mg/kg daily in 3 divided doses; maximum 4 g per day
• BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
• Child: 50 mg/kg every 6 hours (max. per dose 2 g every 6 hours)

Prevention of Staphylococcus aureus lung infection in cystic fibrosis—primary prevention

• BY MOUTH
• Neonate: 125 mg twice daily.
• Child 1 month–3 years: 125 mg twice daily

Prevention of Staphylococcus aureus lung infection in cystic fibrosis—secondary prevention

• BY MOUTH
• Child: 50 mg/kg twice daily (max. per dose 1 g twice daily)

IMPORTANT SAFETY INFORMATION

HEPATIC DISORDERS

Cholestatic jaundice and hepatitis may occur very rarely, up to two months after treatment with flucloxacillin has
been stopped. Administration for more than 2 weeks and increasing age are risk factors. Healthcare professionals are reminded that:

- Fluocoxacin should not be used in patients with a history of hepatic dysfunction associated with fluocoxacin.
- Fluocoxacin should be used with caution in patients with hepatic impairment.
- Careful enquiry should be made about hypersensitivity reactions to beta-lactam antibacterials.

### CAUTIONS
- With intravenous use, accumulation of electrolytes can occur with high doses - risk of kernicterus in jaundiced neonates when high doses given parenterally.
- **INTERACTIONS** → Appendix 1: penicillins.

### SIDE-EFFECTS

#### GENERAL SIDE-EFFECTS
- Rare or very rare: Arthralgia - fever

#### SPECIFIC SIDE-EFFECTS
- Common or very common:
  - With oral use: Gastrointestinal disorder
  - Rare or very rare:
    - With oral use: Eosinophilia - myalgia
- Frequency not known:
- **PREGNANCY** Not known to be harmful.
- **BREAST FEEDING** Trace amounts in milk, but appropriate to use.

#### HEPATIC IMPAIRMENT
Manufacturer advises caution; including in those with risk factors for hepatic reactions.

#### RENAL IMPAIRMENT
With intravenous use, accumulation of electrolytes can occur in patients with renal failure.
- **Dose adjustments** Use normal dose every 8 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

#### EFFECT ON LABORATORY TESTS
False-positive urinary glucose (if tested for reducing substances).

### DIRECTIONS FOR ADMINISTRATION
With intravenous use:
- For intravenous infusion, dilute reconstituted solution in Glucose 5% or Sodium Chloride 0.9% and give intermittently over 30–60 minutes.

### PATIENT AND CARER ADVICE

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion

#### Oral solution

- **Fluocoxacin (Non-proprietary)**
  - Fluocoxacin (as Fluocoxacin sodium) 25 mg per 1 ml Fluocoxacin 125mg/5ml oral solution | 100 ml (PFS) £20.39 DT + £5.37
  - Fluocoxacin 125mg/5ml oral solution sugar free sugar-free | 100 ml (PFS) £26.70 DT + £21.05
  - Fluocoxacin (as Fluocoxacin sodium) 50 mg per 1 ml Fluocoxacin 250mg/5ml oral solution sugar free sugar-free | 100 ml (PFS) £32.19 DT + £25.47
  - Fluocoxacin 250mg/5ml oral solution | 100 ml (PFS) £35.09 DT + £31.71

### Capsule

#### CAUTIONARY AND ADVISORY LABELS 9, 23
- **Fluocoxacin (Non-proprietary)**
  - Fluocoxacin (as Fluocoxacin sodium) 250 mg Fluocoxacin 250mg capsules | 28 capsule (PFS) £1.42 DT + £1.42
  - Fluocoxacin (as Fluocoxacin sodium) 500 mg Fluocoxacin 500mg capsules | 28 capsule (PFS) £10.50 DT + £2.34

### Powder for solution for injection

- **Fluocoxacin (Non-proprietary)**
  - Fluocoxacin (as Fluocoxacin sodium) 250 mg Fluocoxacin 250 mg powder for solution for injection vials | 10 vial (PFS) £8.60 DT + £8.60
  - Fluocoxacin (as Fluocoxacin sodium) 500 mg Fluocoxacin 500 mg powder for solution for injection vials | 10 vial (PFS) £24.30–£35.00 DT + £11.20
  - Fluocoxacin (as Fluocoxacin sodium) 1 gram Fluocoxacin 1g powder for solution for injection vials | 10 vial (PFS) £34.50 DT + £34.50

**Combinations available:** Co-fluampicil, p. 354

### ANTIBACTERIALS > POLYMXYINS

#### Colistimethate sodium

- **(Colistin sulphomethate sodium)**

#### DRUG ACTION
The polymyxin antibiotic, colistimethate sodium, is active against Gram-negative organisms including *Pseudomonas aeruginosa*, *Acinetobacter baumanii*, and *Klebsiella pneumoniae*. It is not absorbed by mouth and thus needs to be given by injection for a systemic effect.

#### INDICATIONS AND DOSE

**Serious infections due to selected aerobic Gram-negative bacteria in patients with limited treatment options**
- Child (body-weight up to 41 kg): 75 000–150 000 units/kg daily in 3 divided doses, the data supporting the dose regimen are very limited—consult product literature for available information, including recommendation to use lean body-weight for dosing.
- Child (body-weight 41 kg and above): 9 million units daily in 2–3 divided doses, the data supporting the dose regimen are very limited—consult product literature for available information, including recommendation to use lean body-weight for dosing.

**Management of chronic pulmonary infections due to Pseudomonas aeruginosa in patients with cystic fibrosis**
- **BY INHALATION OF NEBULISED SOLUTION**
  - Child 1–2 years: 0.5–1 million units twice daily, for specific advice on administration using nebulisers—consult product literature; maximum 2 million units per day
  - Child 2–7 years: 1–2 million units 2–3 times a day, for specific advice on administration using nebulisers—consult product literature; maximum 6 million units per day
- **BY INHALATION OF POWDER**
  - Child 6–17 years: 1.66 million units twice daily

#### CONTRA-INDICATIONS
Myasthenia gravis

#### CAUTIONS

- **General Caution** Children under 1 year of age (effects of immature renal and metabolic function on conversion to active colistin not known)

#### SPECIFIC CAUTIONS
- When used by inhalation: Severe haemoptysis—risk of further haemorrhage
● INTERACTIONS ➔ Appendix 1: colistimethate

● SIDE-EFFECTS
  ➔ Common or very common
  ➔ When used by inhalation Arthralgia · asthenia · asthma · balance impaired · chest discomfort · cough · dysphonia · dyspnoea · fever · haemorrhage · headache · lower respiratory tract infection · nausea · respiratory disorders · taste altered · throat complaints · tinnitus · vomiting
  ➔ Uncommon
  ➔ When used by inhalation Anxiety · appetite decreased · diarrhoea · drowsiness · ear congestion · flatulence · oral disorders · proteinuria · seizure · sputum purulent · thirst · weight change
  ➔ Rare or very rare
  ➔ With parenteral use Confusion · nephrotoxicity · presyncope · psychosis · speech slurred · visual impairment
  ➔ Frequency not known
  ➔ With parenteral use Apnoea · neurological effects · neurotoxicity · renal disorder · sensory disorder
  ➔ SIDE-EFFECTS, FURTHER INFORMATION Neurotoxicity and nephrotoxicity are dose-related.

● PREGNANCY
  ➔ When used by inhalation Clinical use suggests probably safe.
  ➔ With intravenous use Manufacturer advises use only if potential benefit outweighs risk.

● BREAST FEEDING
  ➔ Present in milk but poorly absorbed from gut; manufacturers advise avoid (or use only if potential benefit outweighs risk).

● HEPATIC IMPAIRMENT
  ➔ With intravenous use Manufacturer advises caution (no information available).

● RENAL IMPAIRMENT
  ➔ When used by inhalation Manufacturer advises caution.
  ➔ With intravenous use Consult product literature.
  ➔ Monitoring ➔ With intravenous use In renal impairment, monitor plasma colistimethate sodium concentration during parenteral treatment—consult product literature. Recommended ‘peak’ plasma colistimethate sodium concentration (approx. 1 hour after intravenous injection or infusion) 5–15 mg/litre; pre-dose (‘trough’) concentration 2–6 mg/litre.

● MONITORING REQUIREMENTS
  ➔ With intravenous use Monitor renal function.
  ➔ When used by inhalation Measure lung function before and after initial dose of colistimethate sodium and monitor for bronchospasm; if bronchospasm occurs in a patient not using a bronchodilator, repeat test using a bronchodilator before the dose of colistimethate sodium.

● DIRECTIONS FOR ADMINISTRATION
  ➔ When used by inhalation Manufacturer advises if other treatments are being administered, they should be taken in the order recommended by the physician. For nebulisation, consult product literature for information on reconstitution and dilution.
  ➔ With intravenous use For intravenous infusion, dilute to a concentration of 40,000 units/mL with Sodium Chloride 0.9%; give over 30–60 minutes. Patients fitted with a totally implantable venous access device may tolerate an injection. For slow intravenous injection into a totally implantable venous access device, dilute to a concentration of 90,000 units/mL with Sodium Chloride 0.9% for child under 12 years (200,000 units/mL for child over 12 years); give over at least 5 minutes.

● PRESCRIBING AND DISPENCING INFORMATION
  ➔ Colistimethate sodium is included in some preparations for topical application.

● PATIENT AND CARER ADVICE
  ➔ When used by inhalation Patient should be advised to rinse mouth with water after each dose of dry powder inhalation. Patients or carers should be given advice on how to administer colistimethate sodium; first dose should be given under medical supervision.

Driving and skilled tasks ➔ Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness, confusion and visual disturbances.

● NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions
  ➔ Colistimethate sodium and tobramycin dry powders for inhalation for treating Pseudomonas lung infection in cystic fibrosis (March 2013) NICE TA276
  ➔ Colistimethate sodium dry powder for inhalation is recommended for chronic pulmonary infection caused by Pseudomonas aeruginosa in patients with cystic fibrosis who would benefit from continued treatment, but do not tolerate the drug in its nebulised form. The manufacturer must provide colistimethate sodium dry powder for inhalation at the discount agreed as part of the patient access scheme to primary, secondary and tertiary care in the NHS. Patients currently receiving colistimethate sodium dry powder for inhalation can continue treatment until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/ta276

● MEDICINAL FORMS
  ➔ There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for injection

| ELECTROLYTES: May contain Sodium | Colistimethate sodium (Non-proprietary) |
| Colistimethate sodium 1000000 unit | Colistimethate 1 million unit powder for solution for injection vials | 10 vial | £18.00 DT + £30.00 (hospital only) |
| Colistimethate sodium 2000000 unit | Colistin 2 million unit powder for solution for injection vials | 10 vial | £32.40 DT + £32.40 |

Promixin (Profile Pharma Ltd)

| Colistimethate sodium 1000000 unit | Promixin 1 million unit powder for solution for injection vials | 10 vial | £37.50 DT + £18.00 (hospital only) |

Inhalation powder

| Colobreathe (Teva UK Ltd) |
| Colistimethate sodium 1662500 unit | Colobreathe 1,662,500 unit inhalation powder capsules | 56 capsule | £968.80 DT + £968.80 |

| Promixin (Profile Pharma Ltd) |
| Colistimethate sodium 1000000 unit | Promixin 1 million unit powder for nebuliser solution unit dose vials | 30 unit dose | £204.00 DT + £204.00 |

ANTIBACTERIALS ➔ QUINOLONES

Quinolones

MHRA/CHM advice: Systemic and inhaled fluoroquinolones (November 2018, and March 2019)

The MHRA and CHM have released important safety information regarding the use of systemic and inhaled fluoroquinolones. For restrictions and precautions, see Important safety information for all quinolones (ciprofloxacin p. 361).

Overview

In the UK, only fluoroquinolones are available; the recommendations below therefore refer to the use of fluoroquinolones.

Ciprofloxacin is active against both Gram-positive and Gram-negative bacteria. It is particularly active against Gram-negative bacteria, including Salmonella, Shigella,
**Quinolones**

**IMPORTANT SAFETY INFORMATION**

- With intravenous use or oral use or when used by inhalation

  The CSM has warned that quinolones may induce convulsions in patients with or without a history of convulsions; taking NSAIDs at the same time may also induce them.

**TENDON DAMAGE**

- With intravenous use or oral use

  Tendon damage (including rupture) has been reported very rarely with fluoroquinolone. The MHRA advises that benefit-risk should be assessed and other therapeutic options considered before using fluoroquinolones in patients at risk of aortic aneurysm and dissection. Patients (particularly those at risk) and their carers should be informed about rare events of aortic aneurysm and dissection, and advised to seek immediate medical attention if sudden-onset severe abdominal, chest, or back pain develops.

**MHRA/CHM ADVICE: SYSTEMIC AND INHALED FLUOROQUINOLONES: SMALL INCREASED RISK OF AORTIC ANEURYSM AND DISSECTION; ADVICE FOR PRESCRIBING IN HIGH-RISK PATIENTS (NOVEMBER 2018)**

- With intravenous use or oral use

  The MHRA advises that benefit-risk should be assessed and other therapeutic options considered before using fluoroquinolones in patients at risk of aortic aneurysm and dissection. Patients (particularly those at risk) and their carers should be informed about rare events of aortic aneurysm and dissection, and advised to seek immediate medical attention if sudden-onset severe abdominal, chest, or back pain develops.

**MHRA/CHM ADVICE: FLUOROQUINOLONE ANTIBIOTICS: NEW RESTRICTIONS AND PRECAUTIONS FOR USE DUE TO VERY RARE REPORTS OF DISABLING AND POTENTIALLY LONG-LASTING OR IRREVERSIBLE SIDE EFFECTS (MARCH 2019)**

- With intravenous use or oral use

  Disabling, long-lasting or potentially irreversible adverse reactions affecting musculoskeletal and nervous systems have been reported very rarely with fluoroquinolone antibiotics. Healthcare professionals are advised to inform patients to stop treatment at the first signs of a serious adverse reaction, such as tendonitis or tendon rupture, muscle pain, muscle weakness, joint pain, joint swelling, peripheral neuropathy, and CNS effects, and to contact their doctor immediately. Fluoroquinolones should not be prescribed for non-severe or self-limiting infections, or non-bacterial conditions. Unless other commonly recommended antibiotics are inappropriate, fluoroquinolones should not be prescribed for mild to moderate infections. Fluoroquinolones should be avoided in patients who have previously had serious adverse reactions. Use of fluoroquinolones with corticosteroids should also be avoided as it may exacerbate fluoroquinolone-induced tendonitis and tendon rupture. Fluoroquinolones should be prescribed with caution in patients with renal impairment or solid-organ transplants as they are at a higher risk of tendon injury.

- **CONTRA-INDICATIONS**
  - With intravenous use or oral use or when used by inhalation
  - History of tendon disorders related to quinolone use

- **CAUTIONS**
  - With intravenous use or oral use or when used by inhalation
  - Can prolong the QT interval · conditions that predispose to seizures · diabetes (may affect blood glucose) · exposure to excessive sunlight should be avoided (discontinue if photosensitization occurs) · G6PD deficiency · history of epilepsy · myasthenia gravis (risk of exacerbation)
  - With intravenous use or oral use
  - Children or adolescents (arthropathy has developed in weight-bearing joints in young animals)

**SIDE-EFFECTS**

- **Common or very common** Diarrhoea · eye discomfort · eye disorders · nausea · skin reactions · taste altered · vision disorders · vomiting

- **Uncommon** Anxiety · appetite decreased · arrhythmias · arthralgia · asthenia · chest pain · confusion · dizziness · dry eye · eosinophilia · eye inflammation · fever · flattulence · gastrointestinal discomfort · hallucination · headache · hearing impairment · hepatic disorders · hypotension · movement disorders · oedema · pain · renal impairment · rhinitis · seizure · sensation abnormal · sleep disorders · thrombocytopenia · thrombocytosis · tinnitus · vasodilatation · vertigo

- **Rare or very rare** Agranulocytosis · anaemia · angioedema · antibiotic associated colitis · arthritis · asthma · depression · dyspnoea · gait abnormal · haemolytic anaemia · hyperglycaemia · hyperhidrosis · hypersensitivity · hypoglycaemia · idiopathic intracranial hypertension · laryngeal oedema · leucopenia · muscle complaints · muscle weakness · myasthenia gravis aggravated · nephritis · tubulointerstitial · neutropenia · pancreatitis · pancytopenia · photosensitization reaction · psychotic disorder · severe cutaneous adverse reactions (SCARs) · suicidal tendencies · syncope · tendon disorders · tremor · vasculitis

- **Frequency not known** Cornal deposits (reversible after completion of treatment) · increased risk of aortic aneurysm · increased risk of aortic dissection · palpitations · peripheral neuropathy (sometimes irreversible) · polynuropathy · QT interval prolongation

**SIDE-EFFECTS, FURTHER INFORMATION**

The drug should be discontinued if neurological, psychiatric, tendon disorders or hypersensitivity reactions (including severe rash) occur. For more information regarding the safety of fluoroquinolones, please see Important Safety Information.

- **ALLERGY AND CROSS-SENSITIVITY** Use of quinolones contra-indicated in quinolone hypersensitivity.

- **PREGNANCY**
  - With intravenous use or oral use or when used by inhalation
  - Avoid in pregnancy—shown to cause arthropathy in animal studies; safer alternatives are available.
PATIENT AND CARER ADVICE
With intravenous use or oral use The MHRA has produced an advice sheet on serious adverse reactions affecting musculoskeletal and nervous systems associated with fluoroquinolone use, which should be provided to patients and their carers.

Ciprofloxacin

INDICATIONS AND DOSE

Fistulating Crohn’s disease
BY MOUTH
Child: 5 mg/kg twice daily

Severe respiratory-tract infections, gastro-intestinal infection
BY MOUTH
Neonate: 15 mg/kg twice daily.
Child: 20 mg/kg twice daily (max. per dose 750 mg)
BY INTRAVENOUS INFUSION
Neonate: 10 mg/kg every 12 hours, to be given over 60 minutes.
Child: 10 mg/kg every 8 hours (max. per dose 400 mg), to be given over 60 minutes

Acute exacerbation of bronchiectasis (administered on expert advice)
BY MOUTH
Child 1-17 years: 20 mg/kg twice daily (max. per dose 750 mg) for 7-14 days
BY INTRAVENOUS INFUSION
Child 1-17 years: 10 mg/kg every 8 hours (max. per dose 400 mg), to be given over 60 minutes

Pseudomonal lower respiratory-tract infection in cystic fibrosis
BY MOUTH
Child: 20 mg/kg twice daily (max. per dose 750 mg)
BY INTRAVENOUS INFUSION
Child: 10 mg/kg every 8 hours (max. per dose 400 mg), to be given over 60 minutes

Complicated urinary-tract infections
BY MOUTH
Neonate: 10 mg/kg twice daily.
Child: 10 mg/kg twice daily, dose to be doubled in severe infection (max. 750 mg twice daily)
BY INTRAVENOUS INFUSION
Neonate: 6 mg/kg every 12 hours, to be given over 60 minutes.
Child: 6 mg/kg every 8 hours; increased to 10 mg/kg every 8 hours (max. per dose 400 mg), in severe infection

Gonorrhoea
BY MOUTH
Child 12-17 years: 500 mg for 1 dose

Anthrax (treatment and post-exposure prophylaxis)
BY MOUTH
Child: 15 mg/kg twice daily (max. per dose 500 mg)
BY INTRAVENOUS INFUSION
Child: 10 mg/kg every 12 hours (max. per dose 400 mg)

Prevention of secondary case of meningococcal meningitis
BY MOUTH
Neonate: 30 mg/kg (max. per dose 125 mg) for 1 dose.
Child 1 month-4 years: 30 mg/kg (max. per dose 125 mg) for 1 dose
Child 5-11 years: 250 mg for 1 dose
Child 12-17 years: 500 mg for 1 dose

UNLICENSED USE

CAUTIONS
Acute myocardial infarction (risk factor for QT interval prolongation) - avoid excessive alkalinity of urine (risk of crystalluria) - bradycardia (risk factor for QT interval prolongation) - congenital long QT syndrome (risk factor for QT interval prolongation) - electrolyte disturbances (risk factor for QT interval prolongation) - ensure adequate fluid intake (risk of crystalluria) - heart failure with reduced left ventricular ejection fraction (risk factor for QT interval prolongation) - history of symptomatic arrhythmias (risk factor for QT interval prolongation)

INTERACTIONS
Appendix 1: quinolones

SIDE-EFFECTS
Common or very common Arthropy
Uncommon Fungal superinfection
Rare or very rare Bone marrow depression - crystalluria - erythema nodosum - haematuria - intracranial pressure increased - leucocytosis - migraine - muscle tone increased - olfactory nerve disorder - status epilepticus
Frequency not known Mood altered
PREGNANCY
A single dose of ciprofloxacin may be used for the prevention of a secondary case of meningococcal meningitis.

BREAST FEEDING
Amount too small to be harmful but manufacturer advises avoid.

RENAL IMPAIRMENT
Dose adjustments Reduce dose if estimated glomerular filtration rate less than 30 mL/minute/1.73 m² - consult product literature.

PRESCRIBING AND DISPENSING INFORMATION
With oral use Flavours of oral liquid formulations may include strawberry.

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Ciprofloxacin for bacterial infections www.medicinesforchildren.org.uk/ciprofloxacin-bacterial-infection
Driving and skilled tasks May impair performance of skilled tasks (e.g. driving); effects enhanced by alcohol.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension Tablet

CAUTIONARY AND ADVISORY LABELS
7, 9, 25
Ciprofloxacin (Non-proprietary)
Ciprofloxacin (as Ciprofloxacin hydrochloride)
100 mg Ciprofloxacin 100mg tablets | 6 tablet £2.11 DT = £2.11
Ciprofloxacin (as Ciprofloxacin hydrochloride)
250 mg Ciprofloxacin 250mg tablets | 10 tablet £5.60 DT = £0.74 | 20 tablet £1.18-£1.20 | 100 tablet £3.90-£7.90
Ciprofloxacin (as Ciprofloxacin hydrochloride)
500 mg Ciprofloxacin 500mg tablets | 10 tablet £10.62 DT = £0.91 | 20 tablet £1.64-£21.23 | 100 tablet £8.20-£9.10
Ciprofloxacin (as Ciprofloxacin hydrochloride)
750 mg Ciprofloxacin 750mg tablets | 10 tablet £15.11 DT = £8.00 | 20 tablet £11.99
Ciprox (Bayer Plc)
Ciprofloxacin (as Ciprofloxacin hydrochloride) 500 mg Ciprox 500mg tablets | 10 tablet £12.49 DT = £0.91
362 Bacterial infection

Infection

DRUG ACTION

ANTIBACTERIALS

Sulfamethoxazole and trimethoprim are used in combination (as co-trimoxazole) because of their synergistic activity (the importance of the sulfonamides has decreased as a result of increasing bacterial resistance and their replacement by antibacterials which are generally more active and less toxic).

INDICATIONS AND DOSE

TREATMENT OF SUSCEPTIBLE INFECTIONS

BY MOUTH

Child 6 weeks–5 months: 120 mg twice daily, alternatively 24 mg/kg twice daily
Child 6 months–5 years: 240 mg twice daily, alternatively 24 mg/kg twice daily
Child 6–11 years: 480 mg twice daily, alternatively 24 mg/kg twice daily
Child 12–17 years: 960 mg twice daily

BY INTRavenous INFUSION

Child 6–17 years: 18 mg/kg every 12 hours; increased to 27 mg/kg every 12 hours (max. per dose 1.44 g), increased dose used in severe infection.

TREATment of Pneumocystis jirovecii (Pneumocystis carinii) infections (undertaken where facilities for appropriate monitoring available—consult microbiologist and product literature)

BY MOUTH, OR BY INTRavenous INFUSION

Child: 120 mg/kg daily in 2–4 divided doses for 14–21 days, oral route preferred for children

Prophylaxis of Pneumocystis jirovecii (Pneumocystis carinii) infections

BY MOUTH

Child: 450 mg/m² twice daily (max. per dose 960 mg twice daily) for 3 days of the week (either consecutively or on alternate days), dose regimens may vary, consult local guidelines

DOSE EQUIVALENCE AND CONVERSION

480 mg of co-trimoxazole consists of sulfamethoxazole 400 mg and trimethoprim 80 mg.

UNLICENSED USE

Not licensed for Burkholderia cepacia infections in cystic fibrosis. Not licensed for Stenotrophomonas maltophilia infections.

Not licensed for use in children under 6 weeks.

IMPORTANT SAFETY INFORMATION

RESTRICTIONS ON THE USE OF CO-TRIMOXAZOLE

Co-trimoxazole is the drug of choice in the prophylaxis and treatment of Pneumocystis jirovecii (Pneumocystis carinii) pneumonia; it is also indicated for nocardiosis, Stenotrophomonas maltophilia infection [unlicensed indication], and toxoplasmosis. It should only be considered for use in acute exacerbations of chronic bronchitis and infections of the urinary tract when there is bacteriological evidence of sensitivity to co-trimoxazole and good reason to prefer this combination to a single antibacterial; similarly it should only be used in acute otitis media in children when there is good reason to prefer it. Co-trimoxazole is also used for the treatment of infections caused by Burkholderia cepacia in cystic fibrosis [unlicensed indication].

CONTRA-INDICATIONS

Acute porphyrias p. 624

CAUTIONS

Asthma - avoid in blood disorders (unless under specialist supervision) - avoid in infants under 6 weeks (except for treatment or prophylaxis of pneumocystis pneumonia) because of the risk of kernicterus - G6PD deficiency (risk of haemolytic anaemia) - maintain adequate fluid intake - predisposition to folate deficiency

INTERACTIONS

Appendix 1: sulfonamides - trimethoprim

SIDE-EFFECTS

Common or very common

Diarrhoea - electrolyte imbalance - fungal overgrowth - headache - nausea - skin reactions

Uncommon

Vomiting

Rare or very rare


SIDE-EFFECTS, FURTHER INFORMATION

Co-trimoxazole is associated with rare but serious side effects. Discontinue immediately if blood disorders (including leucopenia, thrombocytopenia, megaloblastic anaemia, eosinophilia) or rash (including Stevens-Johnson syndrome or toxic epidermal necrolysis) develop.

PREGNANCY

Teratogenic risk in first trimester (trimethoprim a folate antagonist). Neonatal haemolysis and methaemoglobinaemia in third trimester; fear of increased risk of kernicterus in neonates appears to be unfounded.

BREAST FEEDING

Small risk of kernicterus in jaundiced infants and of haemolysis in G6PD-deficient infants (due to sulfamethoxazole).

HEPATIC IMPAIRMENT

Manufacturer advises avoid in severe liver disease.

RENAL IMPAIRMENT

Avoid if estimated glomerular filtration rate less than 15 mL/minute/1.73 m² and if
**Sulfadiazine**

**Drug Action** Sulfadiazine is a short-acting sulphonamide with bacteriostatic activity against a broad spectrum of organisms. The importance of the sulfonamides has decreased as a result of increasing bacterial resistance and their replacement by antibacterials which are generally more active and less toxic.

**Indications and Dose**

- **Toxoplasmosis in pregnancy (in combination with pyrimethamine and folinic acid)**
  - By mouth
  - Child 12–17 years: 1 g 3 times a day until delivery
  - Congenital toxoplasmosis (in combination with pyrimethamine and folinic acid)
    - By mouth
    - Neonate: 50 mg/kg twice daily for 12 months.

**Unlicensed Use** Not licensed for use in toxoplasmosis.

**Important Safety Information**

**Safe Practice**

Sulfadiazine has been confused with sulfasalazine; care must be taken to ensure the correct drug is prescribed and dispensed.

**Contra-Indications**

- Acute porphyrias p. 624

**Caution**

- Asthma - avoid in blood disorders (unless under specialist supervision) - avoid in infants under 6 weeks (except for treatment or prophylaxis of pneumocystis pneumonia) because of the risk of kernicterus - G6PD deficiency (risk of haemolytic anaemia) - maintain adequate fluid intake - predisposition to folate deficiency

**Interactions**

- → Appendix 1: Sulphonamides

**Side-Effects**

- Rare or very rare
  - Haemolytic anaemia
  - Frequency not known

**Side-effects, Further Information**

Discontinue immediately if blood disorders (including leucopenia, thrombocytopenia, megaloblastic anaemia, eosinophilia) or rash (including Stevens-Johnson syndrome, toxic epidermal necrolysis) develop.

**Pregnancy**

Risk of neonatal haemolysis and methaemoglobinaemia in third trimester; fear of increased risk of kernicterus in neonates appears to be unfounded.

**Breast Feeding**

Small risk of kernicterus in jaundiced infants and of haemolysis in G6PD-deficient infants.

**Hepatic Impairment**

Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment or jaundice.
Tetracyclines

Overview
The tetracyclines are broad-spectrum antibiotics whose value has decreased owing to increasing bacterial resistance. In children over 12 years of age they are useful for infections caused by chlamydia (trachoma, psitacosis, salpingitis), urethritis, and lymphogranuloma venereum, rickettsia (including Q-fever), brucella (doxycycline below with either streptomycin p. 323 or rifampicin p. 379), and the spirochaete, Borrelia burgdorferi (See Lyme disease). They are also used in respiratory and genital mycoplasma infections, in acne, in destructive (refractory) periodontal disease, in exacerbations of chronic respiratory diseases (because of their activity against Haemophilus influenzae), and for leptospirosis in penicillin hypersensitivity (as an alternative to erythromycin p. 341).

Microbiologically, there is little to choose between the various tetracyclines, the only exception being minocycline p. 366 which has a broader spectrum; it is active against Neisseria meningitidis and has been used for meningococcal prophylaxis but is no longer recommended because of side-effects including dizziness and vertigo. Compared to other tetracyclines, minocycline is associated with a greater risk of lupus-erythematosus-like syndrome. Minocycline sometimes causes irreversible pigmentation.

Tetracyclines have a role in the management of meticillin-resistant Staphylococcus aureus (MRSA) infections.

Demeclocycline hydrochloride

INDICATIONS AND DOSE
Susceptible infections (e.g. chlamydia, rickettsia and mycoplasma)
» BY MOUTH
- Child 12-17 years: 150 mg 4 times a day, alternatively 300 mg twice daily

CONTRA-INDICATIONS
Children under 12 years (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia)

CAUTIONS
Photosensitivity more common than with other tetracyclines
INTERACTIONS → Appendix 1: tetracyclines

SIDE-EFFECTS
» Rare or very rare
  - Agranulocytosis - aplastic anaemia - hearing impairment - nephritis - severe cutaneous adverse reactions (SCARs)
  - Frequency not known
    - Intracranial pressure increased
    - Muscle weakness - nephrogenic diabetes insipidus - vision disorders

HEPATIC IMPAIRMENT
Dose adjustments Max. 1 g daily in divided doses.

RENAL IMPAIRMENT
May exacerbate renal failure and should not be given to patients with renal impairment.

PATIENT AND CARER ADVICE
Patients should be advised to avoid exposure to sunlight or sun lamps.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral suspension, oral solution
Tablet
- Demeclocycline hydrochloride (Non-proprietary)
  - Demeclocycline hydrochloride 150 mg Demeclocycline 150mg tablets | 100 tablet (POH)
- Capsule
  - Demeclocycline hydrochloride (Non-proprietary)
    - Demeclocycline hydrochloride 150 mg Demeclocycline 150mg capsules | 28 capsule (POH) £200.66 DT £200.66

Doxycycline

INDICATIONS AND DOSE
Susceptible infections (e.g. chlamydia, rickettsia and mycoplasma)
» BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
- Child 8-11 years (administered on expert advice) (body-weight up to 45 kg): Initially 4.4 mg/kg daily in 1–2 divided doses for 1 day, then maintenance 2.2 mg/kg daily in 1–2 divided doses
- Child 8-11 years (administered on expert advice) (body-weight 45 kg and above): Initially 200 mg daily in
1–2 divided doses for 1 day, then maintenance 100 mg daily

- Child 12-17 years: Initially 200 mg daily in 1–2 divided doses for 1 day, then maintenance 100 mg daily

**Acute sinusitis** / **Acute cough** [if systemically very unwell or at higher risk of complications]
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: Initially 200 mg daily for 1 dose, then maintenance 100 mg once daily for 5 days in total

**Acute exacerbation of bronchiectasis**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: Initially 200 mg daily for 1 dose, then maintenance 100 mg once daily for 7–14 days in total

**Severe infections** (including refractory urinary-tract infections)
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 8-11 years (administered on expert advice) (body-weight up to 45 kg): Initially 4.4 mg/kg daily in 1–2 divided doses for 1 day, then maintenance 2.2–4.4 mg/kg daily in 1–2 divided doses
- Child 8-11 years (administered on expert advice) (body-weight 45 kg and above): 200 mg daily
- Child 12-17 years: 200 mg daily

**Acne**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 100 mg once daily

**Early syphilis**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 100 mg twice daily for 14 days

**Late latent syphilis**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 100 mg twice daily for 28 days

**Uncomplicated genital chlamydia** / **Non-gonococcal urethritis**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 100 mg twice daily for 7 days

**Pelvic inflammatory disease**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 100 mg twice daily for 14 days

**Lyme disease** [erythema migrans and/or non-focal symptoms] / **Lyme carditis**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 9-11 years (administered on expert advice) (body-weight up to 45 kg): Initially 5 mg/kg in 2 divided doses on day 1, then 2.5 mg/kg daily in 1–2 divided doses for a total of 21 days, increased if necessary up to 5 mg/kg daily for 21 days, increased dose used in severe infections; maximum 200 mg per day
- Child 9-11 years (administered on expert advice) (body-weight 45 kg and above): 200 mg daily in 1–2 divided doses for 21 days
- Child 12-17 years (administered on expert advice): 200 mg daily in 1–2 divided doses for 21 days

**Lyme disease** [affecting central nervous system]
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 9-11 years (administered on expert advice) (body-weight up to 45 kg): Initially 5 mg/kg in 2 divided doses on day 1, then 2.5 mg/kg daily in 1–2 divided doses for a total of 21 days, increased if necessary up to 5 mg/kg daily, increased dose used in severe infections
- Child 9-11 years (administered on expert advice) (body-weight 45 kg and above): 400 mg daily in 1–2 divided doses for 21 days
- Child 12-17 years (administered on expert advice): 400 mg daily in 1–2 divided doses for 21 days

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**Lyme arthritis** / **Acrodermatitis chronica atrophicans**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 9-11 years (administered on expert advice) (body-weight up to 45 kg): Initially 5 mg/kg in 2 divided doses on day 1, then 2.5 mg/kg daily in 1–2 divided doses for a total of 28 days, increased if necessary up to 5 mg/kg daily for 28 days, increased dose used in severe infections; maximum 200 mg per day
- Child 9-11 years (administered on expert advice) (body-weight 45 kg and above): 200 mg daily in 1–2 divided doses for 28 days
- Child 12-17 years (administered on expert advice): 200 mg daily in 1–2 divided doses for 28 days

**Anthrax** (treatment or post-exposure prophylaxis)
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 9-11 years: 2.5 mg/kg twice daily (max. per dose 100 mg twice daily), only to be used in children under 12 years if alternative antibacterial cannot be given
- Child 12-17 years: 100 mg twice daily

**Prophylaxis of malaria**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 100 mg once daily, to be started 1–2 days before entering endemic area and continued for 4 weeks after leaving, can be used for up to 2 years

**Adjunct to quinine in treatment of Plasmodium falciparum malaria**
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 200 mg daily for 7 days

**Periodontitis** (as an adjunct to gingival scaling and root planing)
- **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
- Child 12-17 years: 20 mg twice daily for 3 months

**Rocky Mountain spotted fever**
- **BY MOUTH USING DISPERSIBLE TABLETS**
- Child (administered on expert advice) (body-weight up to 45 kg): 2.2 mg/kg twice daily, continue treatment for at least 3 days after fever subsides, minimum treatment duration is 5–7 days
- Child (administered on expert advice) (body-weight 45 kg and above): 100 mg twice daily, continue treatment for at least 3 days after fever subsides, minimum treatment duration is 5–7 days

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**UNLICENSED USE** Doxycycline may be used as detailed below, although these situations are considered outside the scope of its licence:

- **DOS** Duration of treatment for acute sinusitis, see Sinusitis (acute) p. 721 for further information;
- Lyme disease
- treatment or post-exposure prophylaxis of anthrax;
- malaria prophylaxis during pregnancy;
- recurrent aphthous ulceration.

**CAUTIONS** Alcohol dependence - children 8–11 years—use only in acute or severe infections when there are no adequate alternatives (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia) - children under 8 years—use only in severe or life-threatening conditions (e.g. Rocky Mountain spotted fever) when there are no adequate alternatives (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia)

**INTERACTIONS**

- Appendix 1: tetracyclines

**SIDE-EFFECTS**

- Common or very common Dyspnoea - hypotension - peripheral oedema - tachycardia
- Uncommon Gastrointestinal discomfort
- Rare or very rare Antibiotic associated colitis - anxiety - arthralgia - flushing - intracranial pressure increased with papilloedema - Jarisch-Herxheimer reaction - myalgia -
photoonycholysis • severe cutaneous adverse reactions (SCARs) • skin hyperpigmentation (long term use) • tinnitus • vision disorders

- PREGNANCY When travel to malarious areas is unavoidable during pregnancy, doxycycline can be used for malaria prophylaxis if other regimens are unsuitable, and if the entire course of doxycycline can be completed before 12 weeks’ gestation.
- RENAL IMPAIRMENT Use with caution (avoid excessive doses).
- MONITORING REQUIREMENTS When used for periodontitis, monitor for superficial fungal infection, particularly if predisposition to oral candidiasis.
- DIRECTIONS FOR ADMINISTRATION Capsules and Tablets should be swallowed whole with plenty of fluid, while sitting or standing. Capsules should be taken during meals.
- PRESCRIBING AND DISPENSING INFORMATION See Lyme disease p. 374 for place in therapy and further information on treatment.
- PATIENT AND CARER ADVICE Counselling on administration advised. Photosensitivity Patients should be advised to avoid exposure to sunlight or sun lamps.
- PROFESSIONAL SPECIFIC INFORMATION
  - Dental practitioners’ formulary
  - Doxycycline Capsules 100 mg may be prescribed. Dispersible tablets may be prescribed as Dispersible Doxycycline Tablets.
  - Tablets may be prescribed as Doxycycline Tablets 20 mg.

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution
  - Capsule
    - CAUTIONARY AND ADVISORY LABELS 6, 9
    - Doxycycline (as Doxycycline hyclate) 100 mg
      - Periostat
      - Vibramycin-D
      - Lymecycline
      - Minocycline (Non-proprietary)
      - Doxycycline (as Doxycycline hyclate) 50 mg
        - Lymecycline
        - Vibramycin-D
        - Lymecycline
        - Minocycline (Non-proprietary)
      - Doxycycline (as Doxycycline hyclate) 20 mg
        - Vibramycin-D
        - Lymecycline
        - Minocycline (Non-proprietary)
      - Doxycycline hyclate 100 mg
        - Vibramycin-D
        - Lymecycline
        - Periostat
        - Minocycline (Non-proprietary)
      - Doxycycline hyclate 50 mg
        - Vibramycin-D
        - Lymecycline
        - Minocycline (Non-proprietary)
      - Doxycycline hyclate 20 mg
        - Vibramycin-D
        - Lymecycline
        - Minocycline (Non-proprietary)

Minocycline

- INDICATIONS AND DOSE
  - Susceptible infections (e.g. chlamydia, rickettsia and mycoplasma)
    - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 12-17 years: 100 mg twice daily
    - Acne
      - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 12-17 years: 100 mg once daily, alternatively 50 mg twice daily
      - BY MOUTH USING MODIFIED-RELEASE MEDICINES
      - Child 12-17 years: 100 mg daily

- CONTRA-INDICATIONS
  - Children under 12 years (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia)
- CAUTIONS
  - Systemic lupus erythematosus
- INTERACTIONS
  - Appendix 1: tetracyclines
- SIDE-EFFECTS
  - Rare or very rare
    - Acute kidney injury • hearing impairment • respiratory disorders • tinnitus
  - Frequency not known
    - Alopecia • antibiotic associated colitis • arthralgia • ataxia • breast secretion • conjunctival discoloration • drug reaction with eosinophilia and systemic symptoms (DRESS) • dyspepsia • hyperbilirubinaemia • hyperhidrosis • polyarteritis nodosa • sensation abnormal • tear discoloration • tongue discoloration • vertigo
- RENAL IMPAIRMENT
  - Use with caution (avoid excessive doses).
- MONITORING REQUIREMENTS
  - If treatment continued for longer than 6 months, monitor every 3 months for hepatotoxicity, pigmentation and for systemic lupus erythematosus—discontinue if these develop or if pre-existing systemic lupus erythematosus worsens.
- DIRECTIONS FOR ADMINISTRATION
  - Tablets or capsules should be swallowed whole with plenty of fluid while sitting or standing.
- PATIENT AND CARER ADVICE
  - Counselling on administration advised (posture).
- LESS SUITABLE FOR PRESCRIBING
  - Less suitable for prescribing compared with other tetracyclines, minocycline is associated with a greater risk of lupus-erythematosus-like syndrome; it sometimes causes irreversible pigmentation.

Lymecycline

- INDICATIONS AND DOSE
  - Susceptible infections (e.g. chlamydia, rickettsia and mycoplasma)
    - BY MOUTH
      - Child 12-17 years: 408 mg twice daily, increased to 1.224–1.632 g daily, (in severe infection)
    - Acne
      - BY MOUTH
      - Child 12-17 years: 408 mg daily for at least 8 weeks
- CONTRA-INDICATIONS
  - Children under 8 years (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia)
- INTERACTIONS
  - Appendix 1: tetracyclines
- SIDE-EFFECTS
  - Common or very common
    - Gastrointestinal discomfort
  - Frequency not known
    - Visual impairment
  - RENAL IMPAIRMENT
    - May exacerbate renal failure and should not be given to patients with renal impairment.

MINOCYCLINE

- INDICATIONS AND DOSE
  - Susceptible infections (e.g. chlamydia, rickettsia and mycoplasma)
    - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 12-17 years: 100 mg twice daily
    - Acne
      - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 12-17 years: 100 mg once daily, alternatively 50 mg twice daily
      - BY MOUTH USING MODIFIED-RELEASE MEDICINES
      - Child 12-17 years: 100 mg daily
- CONTRA-INDICATIONS
  - Children under 12 years (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia)
- CAUTIONS
  - Systemic lupus erythematosus
- INTERACTIONS
  - Appendix 1: tetracyclines
- SIDE-EFFECTS
  - Rare or very rare
    - Acute kidney injury • hearing impairment • respiratory disorders • tinnitus
  - Frequency not known
    - Alopecia • antibiotic associated colitis • arthralgia • ataxia • breast secretion • conjunctival discoloration • drug reaction with eosinophilia and systemic symptoms (DRESS) • dyspepsia • hyperbilirubinaemia • hyperhidrosis • polyarteritis nodosa • sensation abnormal • tear discoloration • tongue discoloration • vertigo
  - RENAL IMPAIRMENT
    - Use with caution (avoid excessive doses).
- MONITORING REQUIREMENTS
  - If treatment continued for longer than 6 months, monitor every 3 months for hepatotoxicity, pigmentation and for systemic lupus erythematosus—discontinue if these develop or if pre-existing systemic lupus erythematosus worsens.
- DIRECTIONS FOR ADMINISTRATION
  - Tablets or capsules should be swallowed whole with plenty of fluid while sitting or standing.
- PATIENT AND CARER ADVICE
  - Counselling on administration advised (posture).
- LESS SUITABLE FOR PRESCRIBING
  - Less suitable for prescribing compared with other tetracyclines, minocycline is associated with a greater risk of lupus-erythematosus-like syndrome; it sometimes causes irreversible pigmentation.

MINOCYCLINE
Tigecycline

**DRUG ACTION** Tigecycline is a glycyclcline antibacterial structurally related to the tetracyclines. Tigecycline is active against Gram-positive and Gram-negative bacteria, including tetracycline-resistant organisms, and some anaerobes. It is also active against meticillin-resistant *Staphylococcus aureus* and vancomycin-resistant enterococci, but *Pseudomonas aeruginosa* and many strains of *Proteus* spp are resistant to tigecycline.

**INDICATIONS AND DOSE**

Complicated skin and soft tissue infections (when other antibiotics are not suitable) | Complicated intra-abdominal infections (when other antibiotics are not suitable)
---|---
**BY INTRAVENOUS INFUSION**
* Child 8–11 years (under expert supervision): 1.2 mg/kg every 12 hours (max. per dose 50 mg) for 5–14 days
* Child 12–17 years (under expert supervision): 50 mg every 12 hours for 5–14 days

**CONTRA-INDICATIONS** Children under 8 years (deposition in growing bone and teeth, by binding to calcium, causes staining and occasionally dental hypoplasia) - Diabetic foot infections
Infection

Drugs Action

Antibacterials

Directions for Administration

Monitoring Requirements

Hepatic Impairment

Breast Feeding

Pregnancy

Side-effects

Side-effects, Further Information

Allergy and Cross-sensitivity

Contra-indications

Caution

Contra-indications

Contraindicated

Antibacterials

Chloramphenicol

Drug Action

Chloramphenicol is a potent broad-spectrum antibiotic.

Indications and Dose

Life-threatening infections particularly those caused by Haemophilus influenzae
  
  ➢ By mouth, or by intravenous injection, or by intravenous infusion
  
  Child: 12.5 mg/kg every 6 hours, dose may be doubled in severe infections such as septicemia, meningitis and epiglottitis providing plasma-chloramphenicol concentrations are measured and high doses reduced as soon as indicated

  ➢ By intravenous injection
  
  • Neonate up to 14 days: 12.5 mg/kg twice daily, doses should be checked carefully as overdosage can be fatal.

  • Neonate 14 days to 28 days: 12.5 mg/kg 2–4 times a day, doses should be checked carefully as overdosage can be fatal.

Cystic fibrosis for the treatment of respiratory Burkholderia cepacia infection resistant to other antibacterials

• By mouth, or by intravenous infusion, or by intravenous injection
  
  Child: (consult product literature)

Contra-indications

Acute porphyrias p. 624

Caution

Avoid repeated courses and prolonged treatment

Interactions

➢ Appendix 1: chloramphenicol

Side-effects

➢ Rare or very rare

With parenteral use
  
  • Agranulocytosis
  
  • Aplastic anaemia (reversible or irreversible, with reports of resulting leukaemia)

• Frequency not known

• With oral use
  
  • Bone marrow disorders – circulatory collapse - diarrhea - enterocolitis - nausea - optic neuritis - oral disorders - ototoxicity - vomiting

• With parenteral use
  
  • Agranulocytosis - bone marrow disorders - depression - diarrhea - dry mouth - fungal superinfection - headache - nausea - nerve disorders - thrombocytopenic purpura - urticaria - vision disorders - vomiting

Side-effects, further information

Associated with serious haematological side-effects when given systemically and should therefore be reserved for the treatment of life-threatening infections.

Grey Syndrome

Grey baby syndrome (abdominal distension, pallid cyanosis, circulatory collapse) may follow excessive doses in neonates with immature hepatic metabolism.

Pregnancy

Manufacturer advises avoid; neonatal ‘grey-baby syndrome’ if used in third trimester.

Breast Feeding

Manufacturer advises avoid; use another antibiotic; may cause bone-marrow toxicity in infant; concentration in milk usually insufficient to cause ‘grey syndrome’.

Hepatic Impairment

Avoid if possible—increased risk of bone-marrow depression.

Dose adjustments

Reduce dose.

Monitoring

Monitor plasma-chloramphenicol concentration in hepatic impairment.

Renal Impairment

Avoid in severe renal impairment unless no alternative; dose-related depression of haematopoesis.

Monitoring Requirements

• Plasma concentration monitoring preferred in those under 4 years of age.

• Recommended peak plasma concentration (approx. 2 hours after administration by mouth, intravenous injection or infusion) 10–25 mg/litre; pre-dose (‘trough’) concentration should not exceed 15 mg/litre. Blood counts required before and periodically during treatment.

• In neonates Plasma concentration monitoring required in neonates. Grey baby syndrome may follow excessive doses in neonates with immature hepatic metabolism.
**DIRECTIONS FOR ADMINISTRATION**
- With intravenous use: Displacement value may be significant for injection, consult local guidelines. For intermittent intravenous infusion, dilute reconstituted solution further in glucose 5% or sodium chloride 0.9%.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**

**Chloramphenicol (Non-proprietary)**
- Chloramphenicol (as Chloramphenicol sodium succinate) 1 gram
- Chloramphenicol 1g powder for solution for injection vials | 1 vial £3.00

**Capsule**
- Chloramphenicol (Non-proprietary)
- Chloramphenicol 250 mg
- Chloramphenicol 250mg capsules | 60 capsule £3.77

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**Daptomycin**

21-Feb-2019

**DRUG ACTION**
Daptomycin is a lipopeptide antibacterial with a spectrum of activity similar to vancomycin but its efficacy against enterococci has not been established. It needs to be given with other antibacterials for mixed infections involving Gram-negative bacteria and some anaerobes.

**INDICATIONS AND DOSE**
Complicated skin and soft-tissue infections caused by Gram-positive bacteria

- **BY INTRAVENOUS INFUSION**
  - Child 12-25 months: 10 mg/kg once daily for up to 14 days, alternatively 12 mg/kg once daily, higher dose only if associated with Staphylococcus aureus bacteraemia—duration of treatment in accordance with risk of complications in individual patients
  - Child 2-6 years: 9 mg/kg once daily for up to 14 days, alternatively 12 mg/kg once daily, higher dose only if associated with Staphylococcus aureus bacteraemia—duration of treatment in accordance with risk of complications in individual patients
  - Child 7-11 years: 7 mg/kg once daily for up to 14 days, alternatively 9 mg/kg once daily, higher dose only if associated with Staphylococcus aureus bacteraemia—duration of treatment in accordance with risk of complications in individual patients
  - Child 12-17 years: 5 mg/kg once daily for up to 14 days, alternatively 7 mg/kg once daily, higher dose only if associated with Staphylococcus aureus bacteraemia—duration of treatment in accordance with risk of complications in individual patients

**SIDE-EFFECTS**
- **FURTHER INFORMATION**
  If unexplained muscle pain, tenderness, weakness, or cramps develop during treatment, measure creatine kinase every 2 days; discontinue if unexplained muscular symptoms and creatine elevated markedly.

**PREGNANCY**
Manufacturer advises use only if potential benefit outweighs risk—no information available.

**BREAST FEEDING**
Present in milk in small amounts, but absorption from gastrointestinal tract negligible.

**HEPATIC IMPAIRMENT**
Manufacturer advises caution in severe impairment—no information available.

**RENAL IMPAIRMENT**
Manufacturer advises the dosage regimen has not been established—use with caution and monitor renal function regularly.

**MONITORING REQUIREMENTS**
- Manufacturer advises monitor plasma creatine kinase (CPK) before treatment and then at least weekly during treatment; monitor CPK more frequently in patients at higher risk of developing myopathy, including those with renal impairment, taking other drugs associated with myopathy, or if CPK elevated more than 5 times upper limit of normal before treatment.
- Manufacturer advises monitor renal function regularly during concomitant administration of potentially nephrotoxic drugs.

**EFFECT ON LABORATORY TESTS**
Interference with assay for prothrombin time and INR—take blood sample immediately before daptomycin dose.

**DIRECTIONS FOR ADMINISTRATION**
For intravenous infusion, manufacturer advises give intermittently in Sodium Chloride 0.9%; reconstitute with Sodium Chloride 0.9% (350 mg in 7 mL, 500 mg in 10 mL); gently rotate vial without shaking; allow to stand for at least 10 minutes then rotate gently to dissolve; dilute requisite dose in 50 mL infusion fluid and give over 60 minutes for children aged 1–6 years and over 30 minutes for children aged 7–17 years.

**HANDLING AND STORAGE**
Manufacturer advises store in a refrigerator (2–8 °C)—consult product literature for further information regarding storage after reconstitution and dilution.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for infusion**
- **Daptomycin (Non-proprietary)**
  - Daptomycin 350 mg: Daptomycin 350mg powder for solution for infusion vials | 1 vial £6.00
  - Daptomycin 500 mg: Daptomycin 500mg powder for solution for infusion vials | 1 vial £8.88
- **Cubicin (Merck Sharp & Dohme Ltd)**
  - Daptomycin 350 mg Cubicin 350mg powder for concentrate for solution for infusion vials | 1 vial £62.00
  - Daptomycin 500 mg Cubicin 500mg powder for concentrate for solution for infusion vials | 1 vial £88.57

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**Fosfomycin**

25-Apr-2019

**DRUG ACTION**
Fosfomycin, a phosphonic acid antibacterial, is active against a range of Gram-positive and Gram-negative bacteria including Staphylococcus aureus and Enterobacteriaceae.

**INDICATIONS AND DOSE**
Acute uncomplicated lower urinary-tract infections (in females)
- **BY MOUTH USING GRANULES**
  - Child 12-17 years (female): 3 g for 1 dose.
Osteomyelitis when first-line treatments are inappropriate or ineffective | Hospital-acquired lower respiratory-tract infections when first-line treatments are inappropriate or ineffective

- **BY INTRAVENOUS INFUSION**
- Neonate up to 40 weeks corrected gestational age: 100 mg/kg daily in 2 divided doses.
- Neonate 40 weeks to 44 weeks corrected gestational age:
  - Child 1-11 months (body-weight up to 10 kg): 200–300 mg/kg daily in 3 divided doses.
  - Child 1-11 years (body-weight 10–39 kg): 200–400 mg/kg daily in 3–4 divided doses, consider using the high-dose regimen in severe infection, particularly when suspected or known to be caused by less sensitive organisms.
  - Child 12-17 years (body-weight 40 kg and above): 12–24 g daily in 2–3 divided doses (max. per dose 8 g), use the high-dose regimen in severe infection, particularly when suspected or known to be caused by less sensitive organisms.

Complicated urinary-tract infections when first-line treatment ineffective or inappropriate

- **BY INTRAVENOUS INFUSION**
- Neonate up to 40 weeks corrected gestational age: 100 mg/kg daily in 2 divided doses.
- Neonate 40 weeks to 44 weeks corrected gestational age:
  - Child 1-11 months (body-weight up to 10 kg): 200–300 mg/kg daily in 3 divided doses.
  - Child 1-11 years (body-weight 10–39 kg): 200–400 mg/kg daily in 3–4 divided doses, consider using the high-dose regimen in severe infection, particularly when suspected or known to be caused by less sensitive organisms.
  - Child 12-17 years (body-weight 40 kg and above): 12–16 g daily in 2–3 divided doses (max. per dose 8 g), use the high-dose regimen in severe infection, particularly when suspected or known to be caused by less sensitive organisms.

Bacterial meningitis when first-line treatment ineffective or inappropriate

- **BY INTRAVENOUS INFUSION**
- Neonate up to 40 weeks corrected gestational age: 100 mg/kg daily in 2 divided doses.
- Neonate 40 weeks to 44 weeks corrected gestational age:
  - Child 1-11 months (body-weight up to 10 kg): 200–300 mg/kg daily in 3 divided doses.
  - Child 1-11 years (body-weight 10–39 kg): 200–400 mg/kg daily in 3–4 divided doses, consider using the high-dose regimen in severe infection, particularly when suspected or known to be caused by less sensitive organisms.
  - Child 12-17 years (body-weight 40 kg and above): 16–24 g daily in 3–4 divided doses (max. per dose 8 g), use the high-dose regimen in severe infection suspected or known to be caused by less sensitive organisms.

**High-dose regimen in severe infection suspected or known to be caused by less sensitive organisms**

- **CAUTIONS**
  - With intravenous use Cardiac insufficiency, hyperaldosteronism, hypernatremia, hypertension, pulmonary oedema
- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Common or very common Abdominal pain, diarrhoea, headache, nausea, vomiting
    - Uncommon Skin reactions
  - **Frequency not known** Antibiotic-associated colitis
- **SPECIFIC SIDE-EFFECTS**
  - Common or very common
    - With oral use Dizziness, vulvovaginal infection
  - Uncommon
    - With parenteral use Bone marrow disorders, eosinophilia, hepatic disorders, visual impairment
  - **Frequency not known**
    - With parenteral use Agranulocytosis, asthmatic attack, confusion, leucopenia, neutropenia, tachycardia, thrombocytopenia
- **PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.
- **BREAST FEEDING** Manufacturer advises use only if potential benefit outweighs risk—present in milk.
- **RENAI IMPAIRMENT**
  - With oral use Avoid oral treatment if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².
  - With intravenous use Age under 12 years (body-weight under 40 kg)—no information available. Age 12–18 years (body-weight over 40 kg)—use with caution if estimated glomerular filtration rate 40–80 mL/minute/1.73 m², and consult product literature for dose if estimated glomerular filtration rate less than 40 mL/minute/1.73 m².
- **MONITORING REQUIREMENTS**
  - With intravenous use Monitor electrolytes and fluid balance.
- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use Displacement value may be significant when reconstituting injection, consult local guidelines. Reconstitute each 2-g vial with 50 mL Glucose 5% or Glucose 10% or Water for Injections; do not exceed infusion rate of 133 mg/minute.
  - With oral use Manufacturer advises granules should be taken on an empty stomach (about 2–3 hours before or after a meal), preferably before bedtime and after emptying the bladder. The granules should be dissolved into a glass of water and taken immediately.
- **PRESCRIBING AND DISPENSING INFORMATION** Doses expressed as fosfomycin base.
- **NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

SMC No. 1033/15

The Scottish Medicines Consortium has advised (March 2015) that fosfomycin (Fomicyt®) is accepted for restricted use within NHS Scotland; initiation should be restricted to microbiologists or infectious disease specialists.

SMC No. 1163/16

The Scottish Medicines Consortium has advised (September 2016) that fosfomycin trometamol (Monuril®) is accepted for use within NHS Scotland for the treatment of acute lower uncomplicated urinary tract infections, caused by pathogens sensitive to fosfomycin in adult and adolescent females and for prophylaxis in diagnostic and surgical transurethral procedures.
**Fusidic acid**

**DRUG ACTION**  Fusidic acid and its salts are narrow-spectrum antibiotics used for staphylococcal infections.

**INDICATIONS AND DOSE**

**Staphylococcal skin infection**
- **BY MOUTH USING TABLETS**
  - Child: 250 mg every 12 hours for 5–10 days, dose expressed as sodium fusidate.
  - Child: Apply 3–4 times a day usually for 7 days.

**Penicillin-resistant staphylococcal infection including osteomyelitis; Staphylococcal endocarditis in combination with other antibacterials**
- **BY MOUTH USING ORAL SUSPENSION**
  - Neonate: 15 mg/kg 3 times a day.
  - Child 1–11 months: 15 mg/kg 3 times a day.
  - Child 1–4 years: 250 mg 3 times a day.
  - Child 5–11 years: 500 mg 3 times a day.
  - Child 12–17 years: 750 mg 3 times a day.

**Staphylococcal infections due to susceptible organisms**
- **BY INTRAVENOUS INFUSION**
  - Child (body-weight up to 50 kg): 6–7 mg/kg 3 times a day, dose expressed as sodium fusidate.
  - Child (body-weight 50 kg and above): 500 mg 3 times a day, dose expressed as sodium fusidate.

**DOSE EQUIVALENCE AND CONVERSION**
- Fusidic acid is incompletely absorbed and doses recommended for suspension are proportionately higher than those for sodium fusidate tablets.

**CAUTIONS**
- With systemic use: Impaired transport and metabolism of bilirubin.
- With topical use: Avoid contact of cream or ointment with eyes.

**CAUTIONS, FURTHER INFORMATION**
- Avoiding resistance: To avoid the development of resistance, fusidic acid should not be used for longer than 10 days and local microbiology advice should be sought before using it in hospital.

**INTERACTIONS**  Appendix 1: fusidic acid

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**
- Uncommon  Skin reactions.

**SPECIFIC SIDE-EFFECTS**
- Common or very common
  - With intravenous use: Dizziness, drowsiness, hepatic disorders, hyperbilirubinaemia, thrombophlebitis, vascular pain (reduced if given via central vein).
  - With oral use: Diarrhoea, dizziness, drowsiness, gastrointestinal discomfort, nausea, vomiting.

- Uncommon
  - With intravenous use: Appetite decreased, asthenia, headache, malaise.
  - With oral use: Appetite decreased, asthenia, headache, malaise, rash, purpur.

- Rare or very rare
  - With topical use: Angioedema, conjunctivitis.

- Frequency not known
  - With intravenous use: Agranulocytosis, anaemia, leucopenia, neutropenia, pancytopenia, renal failure, rhabdomyolysis, thrombocytopenia.

  - With oral use: Agranulocytosis, anaemia, hepatic disorders, hyperbilirubinaemia, leucopenia, neutropenia, pancytopenia, renal failure, rhabdomyolysis, thrombocytopenia.

**SIDE-EFFECTS, FURTHER INFORMATION**
- Elevated liver enzymes, hyperbilirubinaemia and jaundice can occur with systemic use—these effects are usually reversible following withdrawal of therapy.

**PREGNANCY**
- With systemic use: Not known to be harmful; manufacturer advises use only if potential benefit outweighs risk.

**BREAST FEEDING**
- With systemic use: Present in milk—manufacturer advises caution.

**HEPATIC IMPAIRMENT**
- With systemic use: Manufacturer advises caution.

**MONITORING REQUIREMENTS**
- With systemic use: Manufacturer advises monitor liver function with high doses or on prolonged therapy; monitoring also advised for patients with biliary tract obstruction, those taking potentially hepatotoxic medication, or those taking concurrent medication with a similar excretion pathway.

**DIRECTIONS FOR ADMINISTRATION**
- With intravenous use: Manufacturer advises for intravenous infusion, give intermittently in Sodium chloride 0.9% or Glucose 5%; reconstitute each vial with 10 mL buffer solution, then add contents of vial to 500 mL infusion fluid to give a solution containing approximately 1 mg/mL. Give requisite dose via a central line over 2 hours (give over at least 6 hours if administered via a large peripheral vein).

**PRESCRIBING AND DISPENSING INFORMATION**
- With oral use: Flavours of oral liquid formulations may include banana and orange.

**PROFESSION SPECIFIC INFORMATION**
- Dental practitioners’ formulary: May be prescribed as Sodium Fusidate ointment.

**MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for infusion**
- **Expiry**

  - **Sodium fusidate**
    - 250 mg 5 sachets
    - 250 mg 10 sachets
  - **Fosfomycin trometamol** 3 g 10 sachets
  - **Fosfomycin sodium** 5 g 10 sachets

**Granules**
- **Expiry**
  - **Fosfomycin trometamol** 3 g 10 sachets
  - **Fosfomycin sodium** 5 g 10 sachets

**Infectofos**
- **Expiry**
  - **Fosfomycin trometamol** 3 g 10 sachets
  - **Fosfomycin sodium** 5 g 10 sachets

**BNFC 2019–2020**
**Linezolid**

**DRUG ACTION** Linezolid, an oxazolidinone antibacterial, is active against Gram-positive bacteria including meticillin-resistant *Staphylococcus aureus* (MRSA), and glycopeptide-resistant enterococci. Resistance to linezolid can develop with prolonged treatment or if the dose is less than that recommended. Linezolid is not active against common Gram-negative organisms; it must be given in combination with other antibacterials for mixed infections that also involve Gram-negative organisms.

**INDICATIONS AND DOSE**

- **Pneumonia (when other antibacterials e.g. a glycopeptide, such as vancomycin, cannot be used) (initiated under specialist supervision)** Complicated skin and soft-tissue infections caused by Gram-positive bacteria, when other antibacterials cannot be used (initiated under specialist supervision)
  - **BY MOUTH, OR BY INTRAVENOUS INFUSION**
    - Neonate up to 7 days: 10 mg/kg every 12 hours, increased if necessary to 10 mg/kg every 8 hours, increased dose can be used if poor response.
    - Neonate 7 days to 28 days: 10 mg/kg every 8 hours.
    - Child 1 month–11 years: 10 mg/kg every 8 hours (max. per dose 600 mg)
    - Child 12–17 years: 600 mg every 12 hours

**UNLICENSED USE** Not licensed for use in children.

**IMPORTANT SAFETY INFORMATION**

**CHM ADVISE (OPTIC NEUROPATHY)** Severe optic neuropathy may occur rarely, particularly if linezolid is used for longer than 28 days. The CHM recommends that:
- patients should be warned to report symptoms of visual impairment (including blurred vision, visual field defect, changes in visual acuity and colour vision) immediately;
- patients experiencing new visual symptoms (regardless of treatment duration) should be evaluated promptly, and referred to an ophthalmologist if necessary;
- visual function should be monitored regularly if treatment is required for longer than 28 days.

**BLOOD DISORDERS** Haematopoietic disorders (including thrombocytopenia, anaemia, leucopenia, and pancytopenia) have been reported in patients receiving linezolid. It is recommended that full blood counts are monitored weekly. Close monitoring is recommended in patients who:
- receive treatment for more than 10–14 days;
- have pre-existing myelosuppression;
- are receiving drugs that may have adverse effects on haemoglobin, blood counts, or platelet function;
- have severe renal impairment.

If significant myelosuppression occurs, treatment should be stopped unless it is considered essential, in which case intensive monitoring of blood counts and appropriate management should be implemented.

**CAUTIOUS** Acute confusional states · bipolar depression · carcinoid tumour · phaeochromocytoma · schizophrenia · thyrotoxicosis · uncontrolled hypertension

**CAUTIONS, FURTHER INFORMATION**

- Close observation. Unless close observation and blood pressure monitoring possible, linezolid should be avoided in uncontrolled hypertension, phaeochromocytoma, carcinoid tumour, thyrotoxicosis, bipolar depression, schizophrenia, or acute confusional states.

**INTERACTIONS** 

**SIDE-EFFECTS**

- Common or very common
  - Anaemia · constipation · diarrhoea · dizziness · gastrointestinal discomfort · headache · hypertension · increased risk of infection · insomnia · localised pain · nausea · skin reactions · taste altered · vomiting
- Uncommon
  - Arrhythmia · chills · dry mouth · eosinophilia · fatigue · gastritis · hyperhidrosis · hyponatraemia · leucopenia · neutropenia · oral disorders · pancreatitis · polyaenia · renal failure · seizure · sensation abnormal · thirst · thrombocytopenia · thrombophlebitis · tinnitus · tongue discolouration · transient ischaemic attack · vision disorders · vulvovaginal disorder
- Rare or very rare
  - Antibiotic associated colitis · bone marrow disorders · tooth discolouration
- Frequency not known
  - Alopecia · angioedema · lactic acidosis · nerve disorders · serotonin syndrome · severe cutaneous adverse reactions (SCARs)

**PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk — no information available.

**BREAST FEEDING** Manufacturer advises avoid — present in milk in animal studies.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in severe impairment (no information available).

**RENAL IMPAIRMENT** No dose adjustment necessary but metabolites may accumulate if estimated glomerular filtration rate less than 30 ml/minute/1.73 m².

**MONITORING REQUIREMENTS** Monitor full blood count (including platelet count) weekly.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use: Infusion to be administered over 30–120 minutes.

**PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral liquid formulations may include orange. There is limited information on use in children and expert advice should be sought.

**PATIENT AND CARER ADVICE** Patients should be advised to read the patient information leaflet given with linezolid.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
**INDICATIONS AND DOSE**

**Urinary-tract infections | Respiratory-tract infections**

- **BY MOUTH**
  - Child: 4–5 weeks: 4 mg/kg twice daily (max. per dose 200 mg)  
  - Child 6 weeks–5 months: 4 mg/kg twice daily (max. per dose 200 mg), alternatively 25 mg twice daily  
  - Child 6 months–5 years: 4 mg/kg twice daily (max. per dose 200 mg), alternatively 50 mg twice daily  
  - Child 6–11 years: 4 mg/kg twice daily (max. per dose 200 mg), alternatively 100 mg twice daily  
  - Child 12–17 years: 200 mg twice daily

**Prophylaxis of urinary-tract infection (considered for recurrent infection, significant urinary-tract anomalies, or significant kidney damage)**

- **BY MOUTH**
  - Neonate: 2 mg/kg once daily, dose to be taken at night.

**Respiratory-tract infections**

- **BY MOUTH**
  - Child: 5 mg/kg every 6–8 hours

**Shigellosis | Invasive salmonella infection**

- **BY MOUTH**
  - Child: (consult product literature)

**UNLICENSED USE**


**CONTRA-INDICATIONS**

- Blood dyscrasias

**CAUTIONS**

- Acute porphyrias p. 624 | neonates (specialist supervision required) | predisposition to folate deficiency

**INTERACTIONS**

- Appendix 1: trimethoprim

**SIDE-EFFECTS**

- **Common or very common** Diarrhoea | electrolyte imbalance | fungal overgrowth | headache | nausea | skin reactions | vomiting

- **Rare or very rare** Agranulocytosis | angioedema | anxiety | appetite decreased | arthralgia | behaviour abnormal | bone marrow disorders | confusion | constipation | cough | depression | dizziness | dysphoria | eosinophilia | erythema nodosum | fever | haemolysis | haemolytic anaemia | haemorrhage | hallucination | hepatic disorders | hypoglycaemia | lethargy | leukopenia | meningitis aseptic | movement disorders | myalgia | neutropenia | oral disorders | pancreatitis | paraesthesia | peripheral neuritis | photosensitivity reaction | pseudomembranous enterocolitis | renal impairment | seizure | severe cutaneous adverse reactions (SCARs) | sleep disorders | syncpe | systemic lupus erythematosus (SLE) | thrombocytopenia | tinnitus | tremor | uveitis | vasculitis | vertigo | wheezing

- **Frequency not known** Gastrointestinal disorder | megaloblastic anaemia | methaemoglobinemia

**PREGNANCY**

Teratogenic risk in first trimester (folic acid antagonist). Manufacturers advise avoid during pregnancy.

**BREAST FEEDING**

Present in milk—short-term use not known to be harmful.

**RENAL IMPAIRMENT**

- **Dose adjustments** Use half normal dose after 3 days if estimated glomerular filtration rate 15–30 mL/minute/1.73 m².
  - Use half normal dose if estimated glomerular filtration rate less than 15 mL/minute/1.73 m².

**MONITORING REQUIREMENTS**

Manufacturer recommends blood counts on long-term therapy (but evidence of practical value unsatisfactory).

**PATIENT AND CARER ADVICE**

Blood disorders (On long-term treatment, patients and their carers should be told how to recognise signs of blood disorders and advised to seek immediate medical attention if symptoms such as fever, sore throat, rash, mouth ulcers, purpura, bruising or bleeding develop.)

Medicines for Children leaflet: Trimethoprim for bacterial infections www.medicinesforchildren.org.uk/trimethoprim-bacterial-infections

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Oral suspension**

- **CAUTIONARY AND ADVISORY LABELS 9**
  - **Trimethoprim (Non-proprietary)**
    - Trimethoprim 10 mg per 1 ml
      - Trimethoprim 50 mg/5 ml oral suspension sugar-free $3.60
      - Trimethoprim 50 mg/5 ml oral suspension $3.60
    - **Monotrime** (Chemixde Pharma Ltd)
      - Trimethoprim 10 mg per 1 ml
        - Monotrime 50 mg/5 ml oral suspension sugar-free $3.60
        - Monotrime 50 mg/5 ml oral suspension $3.60

**Tablet**

- **CAUTIONARY AND ADVISORY LABELS 9**
  - **Trimethoprim (Non-proprietary)**
    - Trimethoprim 100 mg
      - Trimethoprim 100 mg tablets $9.99
    - Trimethoprim 200 mg
      - Trimethoprim 200 mg tablets $9.99

**Combinations available:**

- Co-trimoxazole, p. 362
1.1 Anthrax

**Anthrax**

**Treatment and post-exposure prophylaxis**

_Inhalation or gastro-intestinal anthrax_ should be treated initially with either ciprofloxacin p. 361 or, in patients over 12 years, doxycycline p. 364 [unlicensed indication] combined with one or two other antibacterials (such as amoxicillin p. 351, benzylpenicillin sodium p. 349, chloramphenicol p. 368, clarithromycin p. 340, clindamycin p. 337, imipenem with cilastatin p. 325, rifampicin p. 379 [unlicensed indication], and vancomycin p. 335). When the condition improves and the sensitivity of the _Bacillus anthracis_ strain is known, treatment may be switched to a single antibacterial. Treatment should continue for 60 days because germination may be delayed.

_Cutaneous anthrax_ should be treated with either ciprofloxacin [unlicensed indication] or doxycycline [unlicensed indication] for 7 days. Treatment may be switched to amoxicillin if the infecting strain is susceptible. Treatment may need to be extended to 60 days if exposure is due to aerosol. A combination of antibacterials for 14 days is recommended for cutaneous anthrax with systemic features, extensive oedema, or lesions of the head or neck.

_Ciprofloxacin_ or _doxycycline_ may be given for _post-exposure prophylaxis_. If exposure is confirmed, antibacterial prophylaxis should continue for 60 days. Antimicrobial prophylaxis may be switched to amoxicillin after 10–14 days if the strain of _B. anthracis_ is susceptible. Vaccination against anthrax may allow the duration of antimicrobial prophylaxis to be shortened.

1.2 Lyme disease

**Lyme disease**

_Description of condition_:

Lyme disease, also known as Lyme borreliosis, is an infection caused by bacteria called _Borrelia burgdorferi_. It is transmitted to humans by the bite of an infected tick. Ticks are mainly found in grassy and wooded areas including urban gardens and parks. Most tick bites do not cause Lyme disease, and the prompt and correct removal of the tick reduces the risk of infection.

Lyme disease usually presents with a characteristic erythema migrans rash. This usually becomes visible 1–4 weeks after a tick bite, but can appear from 3 days to 3 months, and last for several weeks. It may be accompanied by non-focal (non-organ related) symptoms, such as fever, swollen glands, malaise, fatigue, neck pain or stiffness, joint or muscle pain, headache, cognitive impairment, or paraesthesia.

Other signs and symptoms of Lyme disease may also appear months or years after the initial infection and are typically characterised by focal symptoms (relating to at least 1 organ system). These include neurological (affecting cranial nerves, peripheral and central nervous systems), joint (Lyme arthritis), cardiac (Lyme carditis), or skin (acrodematitis chronica atrophicans) manifestations.

**Drug treatment**

*If symptoms continue to persist or worsen after antibiotic treatment, patients should be assessed for possible alternative causes, re-infection with Lyme disease, treatment failure or non-adherence to previous antibiotic treatment, or progression to organ damage caused by Lyme disease (such as nerve palsy).*

In children presenting with _erythema migrans rash with or without non-focal symptoms_ oral doxycycline p. 364 [unlicensed] is recommended as first-line treatment. If doxycycline p. 364 cannot be given, oral amoxicillin p. 351 should be used as an alternative. Oral azithromycin p. 339 [unlicensed] should be given if both doxycycline p. 364 and amoxicillin p. 351 are unsuitable.

In children presenting with focal symptoms of _cranial nerve or peripheral nervous system_ involvement, oral doxycycline p. 364 [unlicensed] is recommended as first-line treatment. If doxycycline p. 364 cannot be given, oral amoxicillin p. 351 should be used as an alternative.

In children presenting with _symptoms of central nervous system_ involvement, intravenous ceftriaxone p. 332 is recommended as first-line treatment. Oral doxycycline p. 364 [unlicensed] should be used as an alternative if ceftriaxone p. 332 cannot be given, or when switching to oral antibacterial treatment.

In children with symptoms of _Lyme arthritis or acrodematitis chronica atrophicans_, oral doxycycline p. 364 [unlicensed] is recommended as first-line treatment. If doxycycline p. 364 cannot be given, oral amoxicillin p. 351 should be used as an alternative. Intravenous ceftriaxone p. 332 should be used if both doxycycline p. 364 and amoxicillin p. 351 are unsuitable.

In children with symptoms of _Lyme carditis who are haemodynamically stable_, oral doxycycline p. 364 [unlicensed] is recommended as first-line treatment. If doxycycline p. 364 cannot be given, intravenous ceftriaxone p. 332 should be used as an alternative.

In children with symptoms of _Lyme carditis who are haemodynamically unstable_, intravenous ceftriaxone p. 332 is recommended. If ceftriaxone p. 332 cannot be given, oral doxycycline p. 364 [unlicensed] should be used as an alternative.

**Ongoing symptom management**

*If symptoms continue to persist or worsen after antibiotic treatment, patients should be assessed for possible alternative causes, re-infection with Lyme disease, treatment failure or non-adherence to previous antibiotic treatment, or progression to organ damage caused by Lyme disease (such as nerve palsy).*

A second course of antibiotic treatment should be given to patients presenting with signs and symptoms of re-infection. In patients presenting with ongoing symptoms due to possible treatment failure, treatment with an alternative antibacterial drug should be considered. A third course of antibacterial treatment is not recommended, and
further management should be discussed with a national reference laboratory or suitable specialist depending on symptoms (for example, a rheumatologist or neurologist).

Useful Resources

1.3 Methicillin-resistant staphylococcus aureus

MRSA

Management
Infection from Staphylococcus aureus strains resistant to methicillin [now discontinued] (methicillin-resistant Staph. aureus, MRSA) and to flucloxacillin p. 357 can be difficult to manage. Treatment is guided by the sensitivity of the infected strain.

Rifampicin p. 379 or fusidic acid p. 371 should not be used alone because resistance may develop rapidly. Clindamycin p. 337 alone or a combination of rifampicin and fusidic acid can be used for skin and soft-tissue infections caused by MRSA; a tetracycline is an alternative in children over 12 years of age. A glycopeptide (e.g. vancomycin p. 335) can be used for severe skin and soft-tissue infections associated with MRSA. A combination of a glycopeptide and fusidic acid or a glycopeptide and rifampicin can be considered for skin and soft-tissue infections that have failed to respond to a single antibacterial. Linezolid p. 372 should be reserved for skin and soft-tissue infections that have not responded to other antibiotics or for children who cannot tolerate other antibiotics.

A glycopeptide can be used for pneumonia associated with MRSA. Linezolid should be reserved for hospital-acquired pneumonia that has not responded to other antibiotics or for children who cannot tolerate other antibiotics.

Trimethoprim p. 373 or nitrofurantoin p. 384 can be used for urinary-tract infections caused by MRSA; a tetracycline is an alternative in children over 12 years of age. A glycopeptide can be used for urinary-tract infections that are severe or resistant to other antibiotics.

A glycopeptide can be used for septicaemia associated with MRSA.

See the management of endocarditis, osteomyelitis, or septic arthritis associated with MRSA.

Prophylaxis with vancomycin or teicoplanin p. 334 (alone or in combination with another antibacterial active against other pathogens) is appropriate for patients undergoing surgery if:

- there is a history of MRSA colonisation or infection without documented eradication;
- there is a risk that the patient’s MRSA carriage has recurred;
- the patient comes from an area with a high prevalence of MRSA.

It is important that hospitals have infection control guidelines to minimise MRSA transmission, including policies on isolation and treatment of MRSA carriers and on hand hygiene. See eradication of nasal carriage of MRSA in Nose p. 748.

1.4 Tuberculosis

Tuberculosis

Treatment phases, overview
Active tuberculosis is treated in two phases—an initial phase using four drugs and a continuation phase using two drugs in fully sensitive cases. Treatment requires specialised knowledge and supervision, particularly where the disease involves resistant organisms or non-respiratory organs.

There are two regimens recommended for the treatment of tuberculosis in the UK; variations occur in other countries. Either the unsupervised regimen or the supervised regimen should be used; the two regimens should not be used concurrently. Compliance with therapy is a major determinant of its success. Treatment needs to be carefully monitored in families in whom concordance may be problematic.

Initial phase
The concurrent use of four drugs during the initial phase is designed to reduce the bacterial population as rapidly as possible and to prevent the emergence of drug-resistant bacteria. The drugs are best given as fixed dose combination preparations unless the child is unable to swallow the tablets or one of the components cannot be given because of resistance, intolerance or an inappropriate dose combination. The treatment of choice for the initial phase is the daily use of rifampicin p. 379, ethambutol hydrochloride p. 381, pyrazinamide p. 383 and isoniazid p. 382 (with pyridoxine hydrochloride p. 650 for prophylaxis of isoniazid-induced neuropathy); modified according to drug susceptibility testing. Treatment should be started without waiting for culture results if clinical features or histology results are consistent with tuberculosis; treatment should be continued even if initial culture results are negative. The initial phase drugs should be continued for two months. Where a positive culture for M. tuberculosis has been obtained, but susceptibility results are not available after two months, treatment with rifampicin, ethambutol hydrochloride, pyrazinamide and isoniazid (with pyridoxine hydrochloride) should be continued until full susceptibility is confirmed, even if this is for longer than two months. Streptomycin p. 323 is rarely used in the UK although it may be used in the initial phase of treatment if resistance to isoniazid has been established before therapy is commenced and ethambutol hydrochloride is contra-indicated, or when patients cannot tolerate standard treatment.

Continuation phase
After the initial phase, daily treatment is continued for a further 4 months with rifampicin and isoniazid (preferably given as a combination preparation) with pyridoxine hydrochloride. Longer treatment is necessary for meningitis, direct spinal cord involvement, and for resistant organisms which may also require modification of the regimen.

Unsupervised treatment
The unsupervised treatment regimen should be used for children who are likely to take antituberculosis drugs reliably without supervision by a healthcare worker. Children and families who are unable or unlikely to comply with daily administration of therapy should be treated with the regimen described under Supervised Treatment.

Pregnancy and breast-feeding
The standard unsupervised 6-month treatment regimen may be used during pregnancy. Streptomycin should not be given in pregnancy.
### Recommended dosage for standard unsupervised 6-month treatment

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
<td>10 mg/kg once daily (max. per dose 300 mg) for 6 months (initial and continuation phases)</td>
</tr>
<tr>
<td>Rifampicin</td>
<td></td>
</tr>
<tr>
<td>50 kg and above 15 mg/kg once daily for 6 months (initial and continuation phases); maximum 450 mg per day; 15 mg/kg once daily for 6 months (initial and continuation phases); maximum 600 mg per day</td>
<td></td>
</tr>
<tr>
<td>Pyrazinamide</td>
<td></td>
</tr>
<tr>
<td>50 kg and above 15 mg/kg once daily for 6 months (initial phase); maximum 1.5 g per day; 15 mg/kg once daily for 6 months (initial phase); maximum 2 g per day</td>
<td></td>
</tr>
<tr>
<td>Ethambutol hydrochloride</td>
<td>20 mg/kg once daily for 2 months (initial phase)</td>
</tr>
</tbody>
</table>

In general, doses should be rounded up to facilitate administration of suitable volumes of liquid or an appropriate strength of tablet. The exception is ethambutol hydrochloride due to the risk of toxicity. Doses may also need to be recalculated to allow for weight gain in younger children. The fixed-dose combination preparations (Rifater®, Rifinah®) are unlicensed for use in children. Consideration may be given to use of these preparations in older children, provided the respective dose of each drug is appropriate for the weight of the child.

### Recommended dosage for intermittent supervised 6-month treatment

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
<td>15 mg/kg 3 times a week (max. per dose 900 mg) for 6 months (initial and continuation phases)</td>
</tr>
<tr>
<td>Rifampicin</td>
<td>15 mg/kg 3 times a week (max. per dose 900 mg) for 6 months (initial and continuation phases)</td>
</tr>
<tr>
<td>Pyrazinamide</td>
<td></td>
</tr>
<tr>
<td>50 kg and above 15 mg/kg once daily for 6 months (initial phase); maximum 1.5 g per day; 15 mg/kg once daily for 6 months (initial phase); maximum 2 g per day</td>
<td></td>
</tr>
<tr>
<td>Ethambutol hydrochloride</td>
<td>30 mg/kg 3 times a week for 2 months (initial phase)</td>
</tr>
</tbody>
</table>

In general, doses should be rounded up to facilitate administration of suitable volumes of liquid or an appropriate strength of tablet. The exception is ethambutol hydrochloride due to the risk of toxicity. Doses may also need to be recalculated to allow for weight gain in younger children. The fixed-dose combination preparations (Rifater®, Rifinah®) are unlicensed for use in children. Consideration may be given to use of these preparations in older children, provided the respective dose of each drug is appropriate for the weight of the child.

The standard unsupervised 6-month treatment regimen may be used during breast-feeding.

**Neonates**

Congenital tuberculosis is acquired from maternal extrapulmonary sites at birth, particularly the genital tract; if infection is suspected, the baby will require treatment with rifampicin, ethambutol hydrochloride, pyrazinamide and isoniazid (with pyridoxine hydrochloride). This regimen is used for 2 months during the initial phase of treatment. After the initial phase, rifampicin and isoniazid with pyridoxine hydrochloride is continued for a further 4 months.

**Supervised treatment**

Drug administration should be fully supervised by a healthcare worker (directly observed therapy, DOT) in children or families who cannot comply reliably with the treatment regimen. If daily directly observed therapy is not possible, a supervised dosing schedule of three times a week should be considered. Regimens with a dosing schedule of fewer than three times a week should not be used.

Directly observed therapy should be offered to children or to children whose carers:
- have a history of non-adherence;
- have previously been treated for tuberculosis;
- are in denial of the tuberculosis diagnosis;
- have multidrug-resistant tuberculosis;
- have a major psychiatric or cognitive disorder;
- have a history of homelessness, drug or alcohol misuse;
- are in prison, or have been in the past 5 years;
- are too ill to self-administer treatment;
- request directly observed therapy.

Advice and support should be offered to these children and their carers to assist with treatment completion.

**Immunocompromised patients**

Multi-resistant Mycobacterium tuberculosis may be present in immunocompromised children. The organism should always be cultured to confirm its type and drug sensitivity. Confirmed M. tuberculosis infection sensitive to first-line drugs should be treated with a standard six-month regimen; after completing treatment, children should be closely monitored. The regimen may need to be modified if infection is caused by resistant organisms, and specialist advice is needed.

Specialist advice should be sought about tuberculosis treatment or chemoprophylaxis in a child who is HIV-positive (see also Latent tuberculosis below); care is required in choosing the regimen and in avoiding potentially serious interactions. Starting antiretroviral treatment in the first two months of antituberculosis treatment increases the risk of immune reconstitution syndrome. Treatment for tuberculosis should not routinely extend beyond 12 months. Infection may also be caused by other mycobacteria e.g. M. avium complex, in which case specialist advice on management is needed.

**Extrapulmonary tuberculosis**

**Central nervous system tuberculosis**

Children with central nervous system tuberculosis should be offered rifampicin, ethambutol hydrochloride, pyrazinamide and isoniazid (with pyridoxine hydrochloride) for two months. After completion of the initial treatment phase, rifampicin and isoniazid (with pyridoxine hydrochloride) should be continued for a further 10 months. Treatment for tuberculosis meningitis should be offered if clinical signs and laboratory findings are consistent with the diagnosis, even if a rapid diagnostic test is negative.
An initial high dose dexamethasone p. 455 or prednisolone p. 458 should be started at the same time as antituberculosis therapy and then slowly withdrawn over 4–8 weeks.

Referral for surgery should be considered only in children who have raised intracranial pressure.

**Pericardial tuberculosis**
An initial high dose of oral prednisolone should be offered to children with active pericardial tuberculosis at the same time as initiation of antituberculosis therapy; it should then be slowly withdrawn over 2–3 weeks.

**Latent tuberculosis**
Clinicians should be aware that some groups of children with latent tuberculosis are at increased risk of developing active tuberculosis (such as children who are HIV-positive, diabetic or receiving treatment with a tumour necrosis factor alpha inhibitor). These children and their carers should be advised of the risks and symptoms of active tuberculosis.

**Close contacts**
All children who are a close contact (prolonged, frequent or intense contact, e.g. household contacts or relations) of a person with confirmed pulmonary or laryngeal tuberculosis should be tested for latent tuberculosis. Children under 2 years should be assessed by a specialist.

**Immunocompromised**
Children in whom latent tuberculosis is suspected and who are anticipated to be, or who are currently immunocompromised (for example, if they are from a high incidence country or have been in close contact with people with suspected infectious or confirmed pulmonary or laryngeal tuberculosis), should be referred to a tuberculosis specialist.

**Chemoprophylaxis for latent tuberculosis**
Neonates who have been in close contact with a person with tuberculosis which has not yet been treated for at least two weeks, should be treated with isoniazid p. 382 (with pyridoxine hydrochloride p. 650) followed by a Mantoux test after six weeks of treatment. If the test is positive (and active tuberculosis is not present) treatment should be continued for six months; if negative (and confirmed by a negative interferon-gamma release assay), the treatment should be stopped and a BCG vaccination given.

Children aged 4 weeks to 2 years who have been in close contact with a person with tuberculosis which has not been treated for at least two weeks, should be treated with either isoniazid (with pyridoxine hydrochloride) alone for six months (preferred regimen if interactions with rifamycins are a concern) or rifampicin p. 379 and isoniazid (with pyridoxine hydrochloride) for three months (recommended when hepatotoxicity is a concern); and then have a Mantoux test. If the test is positive (and active tuberculosis is not present), the treatment course should be completed. If the test is negative, treatment should be continued and reassessed after 6 weeks. If the results are then negative (and confirmed by a negative interferon-gamma release assay), the treatment should be stopped and a BCG vaccination given (if the child has not already had one). If the result is positive (and active tuberculosis is not present), the course of treatment should be continued.

Children aged over 2 years should be offered a Mantoux test, and if positive (active tuberculosis is not present), then treated as above for children aged 4 weeks to 2 years. If the test is negative, reassess after 6 weeks.

Testing for hepatitis B and hepatitis C should be considered before starting treatment for tuberculosis as this may affect the choice of therapy. Children with severe liver disease should be treated under the care of a specialist team; careful monitoring of liver function is necessary in children with non-severe liver disease, abnormal liver function, or who misuse alcohol or drugs.

See advice on immunisation against tuberculosis and tuberculin testing in BCG vaccine p. 802.

**Treatment failure**
Major causes of treatment failure are incorrect prescribing by the physician and inadequate compliance by the child or their carer. Monthly tablet counts and urine examination (rifampicin imparts an orange-red coloration) may be useful indicators of compliance with treatment. Avoid both excessive and inadequate dosage. Treatment should be specialised by a specialist paediatrician.

**Treatment interruptions**
A break in antituberculosis treatment of at least two weeks (during the initial phase), or missing more than 20% of prescribed doses is classified as treatment interruption. Re-establishing treatment appropriately following interruptions is key to ensuring treatment success without relapse, drug resistance or further adverse events. If an adverse reaction recurs upon re-introducing a particular drug, do not give that drug in future regimens and consider extending the total regimen accordingly.

**Treatment interruptions due to drug-induced hepatotoxicity**
Following treatment interruption due to drug-induced hepatotoxicity, all potential causes of hepatotoxicity should be investigated. Once hepatic function has recovered, antituberculosis therapy should be sequentially reintroduced at previous full doses over a period of no more than ten days, initially with ethambutol hydrochloride p. 381 and either isoniazid (with pyridoxine hydrochloride) or rifampicin.

In children with severe or highly infectious tuberculosis who need to interrupt the standard regimen, consider continuing treatment with at least two drugs with low risk of hepatotoxicity, such as ethambutol hydrochloride and streptomycin p. 323 (with or without a quinolone, such as levofloxacin p. 700 or moxifloxacin p. 700), and with ongoing monitoring by a liver specialist.

**Treatment interruptions due to cutaneous reactions**
If a child with severe or highly infectious tuberculosis has a cutaneous reaction, consider continuing treatment with a combination of at least two drugs with a low risk of causing cutaneous reactions, such as ethambutol hydrochloride and streptomycin with monitoring by a dermatologist.

**Antituberculosis drugs**
Isoniazid is cheap and highly effective. Like rifampicin it should always be included in any antituberculosis regimen unless there is a specific contra-indication.

Rifampicin, a rifamycin, is a key component of any antituberculosis regimen. Like isoniazid it should always be included unless there is a specific contra-indication.

During the first two months (“initial phase”) of rifampicin administration transient disturbance of liver function with elevated serum transaminases is common but generally does not require interruption of treatment. Occasionally more serious liver toxicity requires a change of treatment particularly in those with pre-existing liver disease.

On intermittent treatment six toxicity syndromes have been recognised—influenza-like, abdominal, and respiratory symptoms, shock, renal failure, and thrombocytopenic purpura—and can occur in 20–30% of patients.

Rifabutin p. 378 is licensed in adults for the treatment of non-tuberculous mycobacterial disease and pulmonary tuberculosis. There is limited experience in children.

Pyrazinamide p. 383 is a bactericidal drug only active against intracellular dividing forms of *Mycobacterium tuberculosis*; it exerts its main effect only in the first two or three months. It is particularly useful in tuberculous meningitis because of good meningeal penetration. It is not active against *M. bovis*. 

See advice on immunisation against tuberculosis and tuberculin testing in BCG vaccine p. 802.
Ethambutol hydrochloride is included in a treatment regimen if isoniazid resistance is suspected; it can be omitted if the risk of resistance is low.

Streptomycin [unlicensed] is now rarely used in the UK except for resistant organisms.

Drug-resistant tuberculosis

Drug-resistant tuberculosis should be treated by a specialist paediatrician with experience in such cases, and where appropriate facilities for infection-control exist. Multidrug-resistant tuberculosis (resistance to isoniazid and rifampicin, with or without any other resistance) requires treatment with at least six antituberculosis drugs to which the mycobacterium is likely to be sensitive. Testing for resistance to second-line drugs is recommended and treatment should be modified according to susceptibility. The risk of resistance is minimised by ensuring therapy is administered in the correct dose and combination for the prescribed duration.

Second-line drugs available for infections caused by resistant organisms, or when first-line drugs cause unacceptable side-effects, include amikacin and streptomycin, capreomycin, cycloserine (marketed in the UK as Pyrophos), ethionamide (marketed in the UK as Mycomycin), ethambutol (marketed in the UK as Mycobutin), ofloxacin (marketed in the UK as Oxilat, and in the USA as CuragraT), and moxifloxacin (marketed in the USA as vibramycin), etc. Availability of suitable formulations may limit choice in children.

Single drug-resistant tuberculosis

For single drug-resistance the following treatment regimen is recommended:

**Resistance to isoniazid p. 382:**
- First two months (initial phase): rifampicin p. 379, pyrazinamide p. 383 and ethambutol hydrochloride p. 381
- Continue with (continuation phase): rifampicin and ethambutol hydrochloride for seven months (up to ten months for extensive disease)

**Resistance to pyrazinamide:**
- First two months (initial phase): rifampicin, ethambutol hydrochloride and isoniazid (with pyridoxine hydrochloride p. 650)
- Continue with (continuation phase): rifampicin and isoniazid (with pyridoxine hydrochloride) for seven months

**Resistance to ethambutol hydrochloride:**
- First two months (initial phase): rifampicin, pyrazinamide and isoniazid (with pyridoxine hydrochloride)
- Continue with (continuation phase): rifampicin and isoniazid (with pyridoxine hydrochloride) for four months

**Resistance to rifampicin:**
- Offer treatment with at least six antituberculosis drugs to which the mycobacterium is likely to be sensitive.

**ANTIMYCOBACTERIALS > RIFAMYCINS**

**Rifabutin**

- **INDICATIONS AND DOSE**
  
  Prophylaxis of Mycobacterium avium complex infections in immunosuppressed patients with low CD4 count
  - BY MOUTH
    - Child 1 month–11 years: 5 mg/kg once daily (max. per dose 300 mg), also consult product literature
    - Child 12–17 years: 300 mg once daily, also consult product literature

  Treatment of non-tuberculous mycobacterial disease, in combination with other drugs
  - BY MOUTH
    - Child 1 month–11 years: 5 mg/kg once daily for up to 6 months after cultures negative

- **Treatment of pulmonary tuberculosis, in combination with other drugs**
  - BY MOUTH
  - Child 12–17 years: 150–450 mg once daily for at least 6 months

- **UNLICENSED USE** Not licensed for use in children.
- **CAUTIONS** Acute porphyrias p. 624 - discosolurs soft contact lenses
- **INTERACTIONS** > Appendix 1: rifabutin
- **SIDE-EFFECTS** Agranulocytosis - anaemia - arthralgia - bronchospasm - chest pain - corneal deposits - decreased leucocytes - dyspnoea - eosinophilia - fever - haemolysis - hepatic disorders - influenza like illness - myalgia - nausea - neutropenia - pancytopenia - skin reactions - thrombocytopenia - urine discoloration - uveitis (more common following high doses or concomitant use with drugs that increase plasma concentration) - vomiting
- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with rifampycin hypersensitivity.
- **CONCEPTION AND CONTRACEPTION** Important Rifabutin induces hepatic enzymes and the effectiveness of hormonal contraceptives is reduced; alternative family planning advice should be offered.
- **PREGNANCY** Manufacturer advises avoid - no information available.
- **BREAST FEEDING** Manufacturer advises avoid - no information available.
- **HEPATIC IMPAIRMENT**
  
  Dose adjustments Reduce dose in severe impairment.
  Monitoring In patients with pre-existing liver disease or hepatic impairment monitor liver function regularly and particularly frequently in the first 2 months; blood counts should also be monitored in these patients.

- **RENAL IMPAIRMENT**
  
  Dose adjustments Use half normal dose if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- **MONITORING REQUIREMENTS**
  
  Renal function should be checked before treatment.
  Hepatic function should be checked before treatment. If there is no evidence of liver disease (and pre-treatment liver function is normal), further checks are only necessary if the patient develops fever, malaise, vomiting, jaundice or unexplained deterioration during treatment. However, hepatic function should be monitored on prolonged therapy.

- **BLOOD COUNTS**
  
  Blood counts should be monitored on prolonged therapy.

- **PRESCRIBING AND DISPENSING INFORMATION** If treatment interruption occurs, re-introduce with low dosage and increase gradually.

- **PATIENT AND CARER ADVICE**
  
  Soft contact lenses Patients or their carers should be advised that rifabutin discolours soft contact lenses.
  Hepatic disorders Patients or their carers should be told how to recognise signs of liver disorder, and advised to discontinue treatment and seek immediate medical attention if symptoms such as persistent nausea, vomiting, malaise or jaundice develop.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution
  
  **Capsule**

  CAUTIONARY AND ADVISORY LABELS B, 14
  - **Mycobutin** (Pfizer Ltd)
  - **Rifabutin** 150 mg Mycobutin 150mg capsules | 30 capsule £90.38
Tuberculosis 379

Rifampicin

**INDICATIONS AND DOSE**

- Brucellosis in combination with other antibiotics
- Legionnaires disease in combination with other antibiotics
- Serious staphylococcal infections in combination with other antibiotics
  - BY MOUTH, OR BY INTRAVENOUS INFUSION

  - Neonate: 5–10 mg/kg twice daily.
  - Child 1-11 months: 5–10 mg/kg twice daily
  - Child 1-17 years: 10 mg/kg twice daily (max. per dose 600 mg)

**Tuberculosis, in combination with other drugs (intermittent supervised 6-month treatment) (under expert supervision)**

  - BY MOUTH
  - Child: 15 mg/kg 3 times a week (max. per dose 900 mg) for 6 months (initial and continuation phases).

**Tuberculosis, in combination with other drugs (standard unsupervised 6-month treatment)**

  - BY MOUTH
  - Child (body-weight up to 50 kg): 15 mg/kg once daily for 6 months (initial and continuation phases); maximum 450 mg per day
  - Child (body-weight 50 kg and above): 15 mg/kg once daily for 6 months (initial and continuation phases); maximum 600 mg per day

**Congenital tuberculosis**

  - BY MOUTH

  - Neonate: 15 mg/kg once daily for 6 months (initial and continuation phases).

**Prevention of tuberculosis in susceptible close contacts or those who have become tuberculin positive, in combination with isoniazid**

  - BY MOUTH
  - Child 1 month-11 years (body-weight up to 50 kg): 15 mg/kg daily for 3 months; maximum 450 mg per day
  - Child 1 month-11 years (body-weight 50 kg and above): 15 mg/kg daily for 3 months; maximum 600 mg per day
  - Child 12-17 years (body-weight up to 50 kg): 450 mg daily for 3 months
  - Child 12-17 years (body-weight 50 kg and above): 600 mg daily for 3 months

**Prevention of tuberculosis in susceptible close contacts or those who have become tuberculin positive, who are isoniazid-resistant**

  - BY MOUTH
  - Child 1 month-11 years (body-weight up to 50 kg): 15 mg/kg daily for 6 months; maximum 450 mg per day
  - Child 1 month-11 years (body-weight 50 kg and above): 15 mg/kg daily for 6 months; maximum 600 mg per day
  - Child 12-17 years (body-weight up to 50 kg): 450 mg daily for 6 months
  - Child 12-17 years (body-weight 50 kg and above): 600 mg daily for 6 months

**Prevention of secondary case of Haemophilus influenzae type b disease**

  - BY MOUTH
  - Neonate: 5 mg/kg every 12 hours for 2 days.
  - Child 1-11 months: 5 mg/kg every 12 hours for 2 days

**Prevention of secondary case of meningococcal meningitis**

  - BY MOUTH

  - Neonate: 5 mg/kg every 12 hours for 2 days.
  - Child 1-11 months: 10 mg/kg every 12 hours (max. per dose 600 mg), for 2 days
  - Child 12-17 years: 600 mg every 12 hours for 2 days

**Pruritus due to cholestasis**

  - BY MOUTH

  - Child: 5–10 mg/kg once daily (max. per dose 600 mg)

**UNLICENSED USE**

- Not licensed for use in children for pruritus due to cholestasis.

**CONTRA-INDICATIONS**

- Acute porphyria p. 624. jaundice
- **CAUTIONS**
  - Discolours soft contact lenses

**INTERACTIONS**

- Appendix 1: rifampicin

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **With intravenous use** Bone pain - gastrointestinal disorder - hyperbilirubinaemia - psychotic disorder
- **With oral use** Psychosis

**SIDE-EFFECTS, FURTHER INFORMATION**

- Side-effects that mainly occur with intermittent therapy include influenza-like symptoms (with chills, fever, dizziness, bone pain), respiratory symptoms (including shortness of breath), collapse and shock, haemolytic anaemia, thrombocytopenia purpura, and acute renal failure.
  - Discontinue if serious side-effects develop.

**ALLERGY AND CROSS-SENSITIVITY**

- Contra-indicated in patients with rifampicin hypersensitivity.

**CONCEPTION AND CONTRACEPTION**

- Important Effectiveness of hormonal contraceptives is reduced and alternative family planning advice should be offered.

**PREGNANCY**

- Manufacturers advise very high doses teratogenic in animal studies in first trimester; risk of neonatal bleeding may be increased in third trimester.

**BREAST FEEDING**

- Amount too small to be harmful.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution—monitor liver function weekly for two weeks, then every two weeks for the next six weeks.

**Dose adjustments**

- Manufacturer advises maximum 8 mg/kg per day.

**RENAL IMPAIRMENT**

- Use with caution if doses above 10 mg/kg daily.

**MONITORING REQUIREMENTS**

- Renal function should be checked before treatment.
- Hepatic function should be checked before treatment. If there is no evidence of liver disease (and pre-treatment liver function is normal), further checks are only necessary if the patient develops fever, malaise, vomiting, jaundice or unexplained deterioration during treatment. However, liver function should be monitored on prolonged therapy.
- Blood counts should be monitored in patients on prolonged therapy.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use Displacement value may be significant, consult local reconstitution guidelines; reconstitute with
Infection

please consider, rifampicin p.

The properties listed below are those particular to the

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Patient and carer advice

soft contact lenses patients or their carers should be advised

Hepatic disorders Patients or their carers should be told how
to recognise signs of liver disorder, and advised to
discontinue treatment and seek immediate medical
attention if symptoms such as persistent nausea,
vomiting, malaise or jaundice develop.

Medicines for Children leaflet: Rifampicin for meningococcal
prophylaxis www.medicinesforchildren.org.uk/rifampicin-
meningococcal-prophylaxis

Medicines for Children leaflet: Rifampicin for meningococcal
prophylaxis www.medicinesforchildren.org.uk/rifampicin-
tenogenic-
prophylaxis

Each

DOSE EQUIVALENCE AND CONVERSION

Rifinah ® Tablets contain rifampicin and isoniazid; the
proportions are expressed in the form x/y where x and y
are the strengths in milligrams of rifampicin and
isoniazid respectively.

Each Rifinah ® 150/100 Tablet contains rifampicin
150 mg and isoniazid 100 mg.

Each Rifinah ® 300/150 Tablet contains rifampicin
300 mg and isoniazid 150 mg.

Rifampicin with isoniazid and
pyrazinamide

The properties listed below are those particular to the
combination only. For the properties of the components
please consider, rifampicin p. 379, isoniazid p. 382,
pyrazinamide p. 383.

Rifampicin with isoniazid

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**Antimycobacterials** > Other

### Cycloserine

**Indications and Dose**

- **Tuberculosis resistant to first-line drugs, in combination with other drugs**
  - **By mouth**
    - Child 2-11 years: Initially 5 mg/kg twice daily (max. per dose 250 mg), then increased if necessary up to 10 mg/kg twice daily (max. per dose 500 mg), dose to be increased according to blood concentration and response.
    - Child 12-17 years: Initially 250 mg every 12 hours for 2 weeks, then increased if necessary up to 500 mg every 12 hours, dose to be increased according to blood concentration and response.

**Pharmacokinetics**

- Cycloserine penetrates the CNS.
- **Unlicensed use** Licensed for use in children (age range not specified by manufacturer).
- **Contra-Indications** Alcohol dependence • depression • epilepsy • psychotic states • severe anxiety
- **Interactions** Appendix 1: cycloserine
- **Side-Effects** Behaviour abnormal • coma • confusion • congestive heart failure • drowsiness • dysarthria • headache • hyperirritability • megaloblastic anaemia • memory loss • neurological effects • paraesthesia • paresis • psychosis • rash • reflexes increased • seizures • suicidal ideation • tremor • vertigo

**Side-Effects, Further Information**

- CNS toxicity
  - Discontinue or reduce dose if symptoms of CNS toxicity occur.
- Rashes or allergic dermatitis
  - Discontinue or reduce dose if rashes or allergic dermatitis develop.
- **Pregnancy** Manufacturer advises use only if potential benefit outweighs risk—crosses the placenta.
- **Breast Feeding** Present in milk—amount too small to be harmful.
- **Renal Impairment**
  - Dose adjustments Increase interval between doses if creatinine clearance less than 50 mL/minute/1.73 m².
  - Monitoring Monitor blood-cycloserine concentration if creatinine clearance less than 50 mL/minute/1.73 m².
- **Monitoring Requirements**
  - Blood concentration should not exceed a peak concentration of 30 mg/litre (measured 3–4 hours after the dose).
  - Monitor haematological, renal, and hepatic function.
- **Medicinal Forms** There can be variation in the licensing of different medicines containing the same drug.

**Capsule**

- **Cautionary and Advisory Labels** 2, 8
- Cycloserine (Non-proprietary)
- Cycloserine 250 mg
- 100 capsule pod £442.89 DT = £442.89

### Ethambutol hydrochloride

**Indications and Dose**

- **Tuberculosis, in combination with other drugs (standard unsupervised 6-month treatment)**
  - **By mouth**
  - Child: 30 mg/kg 3 times a week for 2 months (initial phase)

**Prescribing and Dispensing Information**

- The RCPCH and NPPG recommend that, when a liquid special of ethambutol is required, the following strength is used: 400 mg/5 mL.

**Patient and Carer Advice**

- Ocular toxicity: The earliest features of ocular toxicity are subjective and patients should be advised to discontinue therapy immediately if they develop deterioration in vision and promptly seek further advice.
Isoniazid

INDICATIONS AND DOSE
Tuberculosis, in combination with other drugs (standard unsupervised 6-month treatment)
- By mouth, or by intramuscular injection, or by intravenous injection

Tuberculosis, in combination with other drugs (intermittent supervised 6-month treatment) (under expert supervision)
- By mouth, or by intramuscular injection, or by intravenous injection

Congenital tuberculosis, in combination with other drugs
- By mouth, or by intramuscular injection, or by intravenous injection

Prevention of tuberculosis in susceptible close contacts or those who have become tuberculin positive
- Initially by mouth, or by intramuscular injection, or by intravenous injection

Neonate: 10 mg/kg daily for 6 months (initial and continuation phases).

Child 1 month–11 years: 10 mg/kg daily (max. per dose 300 mg) for 6 months (initial and continuation phases) to be taken in combination with rifampicin.

Child 12–17 years: 300 mg daily for 6 months, alternatively (by mouth) 300 mg daily for 3 months, to be taken in combination with rifampicin.

CONTRA-INDICATIONS
- Drug-induced liver disease
- Caution: Acute porphyrias p. 624; alcohol dependence; diabetes mellitus; epilepsy; history of psychosis; HIV infection; malnutrition; slow acetylator status (increased risk of side-effects)

CAUTIONS, FURTHER INFORMATION
- Neuralgia Peripheral neuropathy is more likely to occur where there are pre-existing risk factors such as diabetes, alcohol dependence, chronic renal failure, pregnancy, malnutrition and HIV infection. In patients at increased risk of peripheral neuropathy, pyridoxine hydrochloride p. 650 should be given prophylactically from the start of treatment.

INTERACTIONS
- Appendix 1: isoniazid

SIDE-EFFECTS
- Uncommon Hepatic disorders
- Rare or very rare Severe cutaneous adverse reactions (SCARs)

MEDICINAL FORMS

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

Tablet

CAUTIONARY AND ADVISORY LABELS
- Ethambutol hydrochloride (Non-proprietary)
  - Ethambutol hydrochloride 100 mg Ethambutol 100mg tablets
  - 56 tablet £17.00 ST £11.51
  - Ethambutol hydrochloride 400 mg Ethambutol 400mg tablets
  - 56 tablet £42.74 ST £42.74

- Ethambutol 10 mg/kg daily (max. per dose 300 mg) for 6 months (initial and continuation phases)

- Ethambutol 10 mg/kg once daily (max. per dose 300 mg) for 6 months (initial and continuation phases)

- Ethambutol 15 mg/kg 3 times a week (max. per dose 900 mg) for 6 months (initial and continuation phases)

- Ethambutol 30 mg/kg daily for 6 months, alternatively (by mouth) 30 mg/kg daily for 3 months, to be taken in combination with rifampicin

- Ethambutol 361 mg for 6 months.

- Ethambutol 50 mg/ampoule

PRESCRIBING AND DISPENSING INFORMATION
- With oral use in general, doses should be rounded up to facilitate administration of suitable volumes of liquid or an appropriate strength of tablet. The RCPCH and NHG recommend that, when a liquid special of isoniazid is required, the following strength is used: 50 mg/mL.

- Doses may need to be recalculated to allow for weight gain in younger children.

PATIENT AND CARER ADVICE
- Hepatic disorders
- Patients or their carers should be told how to recognise signs of liver disorder, and advised to discontinue treatment and seek immediate medical attention if symptoms such as persistent nausea, vomiting, malaise or jaundice develop.

- Medicines for Children leaflet: Isoniazid for latent tuberculosis

- www.medicinesforchildren.org.uk/isoniazid-latent-tuberculosis

- Medicines for Children leaflet: Isoniazid for the treatment of tuberculosis

- www.medicinesforchildren.org.uk/isoniazid-treatment-tuberculosis

MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

SOLUTION FOR INJECTION
- Isoniazid (Non-proprietary)
  - Isoniazid 25 mg per 1 ml Isoniazid 50mg/2ml solution for injection ampoules
  - 10 ampoule £36.19

Tablet

CAUTIONARY AND ADVISORY LABELS
- Isoniazid 50 mg Isoniazid 50mg tablets
  - 56 tablet £19.25
  - 28 tablet £19.24

- Isoniazid 100 mg Isoniazid 100mg tablets
  - 28 tablet £19.24

- Isoniazid 300 mg Isoniazid 300mg tablets
  - 30 tablet £54.99

COMBINATIONS AVAILABLE
- Rifampicin with isoniazid, p. 380
  - Rifampicin with isoniazid and pyrazinamide, p. 380
Pyrazinamide

**INDICATIONS AND DOSE**

Tuberculosis, in combination with other drugs (standard unsupervised 6-month treatment)

- **BY MOUTH**
  - Child (body-weight up to 50 kg): 35 mg/kg once daily for 2 months (initial phase); maximum 1.5 g per day
  - Child (body-weight 50 kg and above): 35 mg/kg once daily for 2 months (initial phase); maximum 2 g per day

Tuberculosis, in combination with other drugs (intermittent supervised 6-month treatment) (under expert supervision)

- **BY MOUTH**
  - Child (body-weight up to 50 kg): 50 mg/kg 3 times a week (max. per dose 2 g 3 times a week) for 2 months (initial phase)
  - Child (body-weight 50 kg and above): 50 mg/kg 3 times a week (max. per dose 2.5 g 3 times a week) for 2 months (initial phase)

Congenital tuberculosis, in combination with other drugs

- **BY MOUTH**
  - Neonate: 35 mg/kg once daily for 2 months (initial phase).

**CAUTIONS**

- Diabetes

**INTERACTIONS**

- Appendix 1: pyrazinamide

**SIDE-EFFECTS**

- Appetite decreased, arthralgia, dysuria, flushing, gout aggravated, hepatic disorders, malaise, nausea, peptic ulcer aggravated, photosensitivity reaction, sideroblastic anaemia, skin reactions, splenomegaly, vomiting

**PREGNANCY**

Manufacturer advises use only if potential benefit outweighs risk.

**BREAST-FEEDING**

Amount too small to be harmful.

**HEPATIC IMPAIRMENT**

Manufacturer advises avoid in severe impairment, acute hepatic disease and for up to 6 months after occurrence of hepatitis (risk of increased exposure).

**REnal IMPAIRMENT**

Dose adjustments

If estimated glomerular filtration rate less than 30 ml/min/1.73 m², use 25–30 mg/kg 3 times a week.

**MONITORING REQUIREMENTS**

- Renal function should be checked before treatment.
- Hepatic function should be checked before treatment. If there is no evidence of liver disease (and pre-treatment liver function is normal), further checks are only necessary if the patient develops fever, malaise, vomiting, jaundice or unexplained deterioration during treatment.

**PREScribing AND DISPensing INFORMATION**

In general, doses should be rounded up to facilitate administration of suitable volumes of liquid or an appropriate strength of tablet. Doses may also need to be recalculated to allow for weight gain in younger children.

The RCPCH and NPG recommend that, when a liquid special of pyrazinamide is required, the following strength is used: 500 mg/5 ml.

**PATIENT AND CARER ADVICE**

Hepatic disorders

Patients or their carers should be told how to recognise signs of liver disorder, and advised to continue treatment and seek immediate medical attention if symptoms such as persistent nausea, vomiting, malaise or jaundice develop.


**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

<table>
<thead>
<tr>
<th>Strength</th>
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<th>Price</th>
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<tbody>
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<td>Pyrazinamide 500 mg</td>
<td>Pyrazinamide 500mg tablets</td>
<td>£36.12 DT £36.12</td>
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<tr>
<td>Pyrazinamide 500 mg</td>
<td>Zinamide 500mg tablets</td>
<td>£31.35 DT £36.12</td>
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</table>

Combinations available: Rifampicin with isoniazid and pyrazinamide, p. 380

### 1.5 Urinary tract infections

**Urinary-tract infections**

**Description of condition**

Urinary-tract infections are common bacterial infections usually caused by *Escherichia coli*, *Proteus mirabilis*, or *Staphylococcus saprophyticus*. Occasionally, urinary-tract infections can also be caused by *Citrobacter species*, *Serratia marcescens*, *Pseudomonas species*, *Klebsiella aerogenes*, or *Staphylococcus epidermidis*.

The most common urinary-tract infection symptoms in children younger than 3 months are fever, vomiting, lethargy, and irritability. Children older than 3 months usually present with fever with urinary frequency or dysuria.

Lower urinary-tract infections are associated with inflammation of the bladder (cystitis) and urethra (urethritis), whereas upper urinary-tract infections are associated with inflammation of the renal pelvis and the kidneys (pyelonephritis). Urinary-tract infections are considered recurrent after at least two episodes of acute pyelonephritis, three episodes of cystitis or one episode of acute pyelonephritis plus one or more episodes of cystitis.

Urinary-tract infections are more common in girls than boys. The risk of contracting a urinary-tract infection is greater in children with functional and structural abnormalities that may cause urinary retention (e.g. vesicoureteric reflux, genital malformation, dysfunctional elimination syndrome, or constipation). Acute pyelonephritis, especially in children with vesicoureteric reflux, may lead to renal scarring and hypertension.

**Aims of treatment**

The aim of treatment is to relieve symptoms, prevent systemic infection, and to reduce the risk of complications.

**Treatment**

Urinary-tract infections require prompt antibacterial treatment to minimise the risk of complications including renal scarring, hypertension and renal failure.

**Initial treatment for symptomatic bacteriuria should not be delayed while waiting for urine culture results and the antibacterial used should reflect local bacterial sensitivity.**

Urine culture results will determine the subsequent choice of antibacterial therapy.

Children under 3 months of age with a suspected urinary-tract infection and all children with a high risk of serious illness should be referred urgently to paediatric specialist care.

Parenteral antibacterials should be used to treat urinary-tract infections in children under 1 month old who present with a fever or, children 1–3 months old who appear unwell or present with abnormal white blood cell counts. A third-generation cephalosporin (such as cefotaxime p. 330 or ceftriaxone p. 332) should be given in combination with an
antibacterial active against listeria (such as ampicillin p. 353 or amoxicillin p. 351).

Children over 3 months of age with cystitis should receive a 3-day course of oral antibacterial in line with the local formulary which may include trimethoprim p. 373, nitrofurantoin below, a cephalosporin or amoxicillin as options. Children should be reassessed if they are still feeling unwell 24–48 hours after starting treatment.

Children over 3 months of age with acute pyelonephritis should be treated with an oral antibacterial with low resistance patterns such as a cephalosporin or co-amoxiclav p. 354 for 7–10 days and referral to a paediatric specialist should be considered. Alternatively, a broad-spectrum antibacterial such as cefotaxime or ceftriaxone can be administered intravenously for the first 2–4 days followed by an oral antibacterial for a total duration of 10 days. Once-daily dosing is recommended when intravenous aminoglycosides (e.g. gentamicin p. 322, amikacin p. 321) are used in children with urinary-tract infections. If intravenous treatment is indicated but not possible, intramuscular treatment should be considered.

Prevention of recurrence

Children who have had a urinary-tract infection should be encouraged to drink plenty of fluids. Dysfunctional elimination syndromes and constipation should also be addressed. Antibacterial prophylaxis may be considered in children with recurrent symptomatic urinary-tract infections (see Prevention of urinary-tract infection in Antibacterials, use for prophylaxis p. 311). When children develop a urinary-tract infection whilst taking antibacterial prophylaxis, a different antibacterial should be chosen to treat the infection rather than increasing the dose of the antibacterial used for prophylaxis.

ANTIBACTERIALS > OTHER

Nitrofurantoin

- INDICATIONS AND DOSE
  - Acute uncomplicated urinary-tract infections
    - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 3 months–11 years: 750 micrograms/kg 4 times a day for 3–7 days
      - Child 12–17 years: 50 mg 4 times a day for 3–7 days
    - BY MOUTH USING MODIFIED-RELEASE MEDICINES
      - Child 12–17 years: 100 mg twice daily, dose to be taken with food
  - Severe chronic recurrent urinary-tract infections
    - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
      - Child 12–17 years: 100 mg 4 times a day for 3–7 days
    - Propphylaxis of urinary-tract infection (considered for recurrent infection, significant urinary-tract anomalies, or significant kidney damage)
      - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
        - Child 3 months–11 years: 1 mg/kg once daily, dose to be taken at night
        - Child 12–17 years: 50–100 mg once daily, dose to be taken at night
    - Genito-urinary surgical prophylaxis
      - BY MOUTH USING MODIFIED-RELEASE MEDICINES
        - Child 12–17 years: 100 mg twice daily on day of procedure and for 3 days after surgery.

- CONTRA-INDICATIONS
  - Acute porphyrias p. 624 - G6PD deficiency
  - Infants less than 3 months old

- CAUTIONS
  - Anemia - diabetes mellitus - electrolyte imbalance - folate deficiency - pulmonary disease - susceptibility to peripheral neuropathy - urine may be coloured yellow or brown - vitamin B deficiency

- INTERACTIONS
  - Appendix 1: nitrofurantoin

- SIDE-EFFECTS

- PREGNANCY
  - Avoid at term — may produce neonatal haemolysis.

- BREAST FEEDING
  - Avoid; only small amounts in milk but enough to produce haemolysis in G6PD-deficient infants.

- HEPATIC IMPAIRMENT
  - Manufacturer advises caution.

- RENAL IMPAIRMENT
  - Risk of peripheral neuropathy; antibacterial efficacy depends on renal secretion of the drug into urinary tract. Avoid if estimated glomerular filtration rate less than 45 mL/minute/1.73 m²; may be used with caution if estimated glomerular filtration rate 30–44 mL/minute/1.73 m² as a short-course only (3 to 7 days), to treat uncomplicated lower urinary-tract infection caused by suspected or proven multidrug resistant bacteria and only if potential benefit outweighs risk.

- MONITORING REQUIREMENTS
  - On long-term therapy, monitor liver function and monitor for pulmonary symptoms (discontinue if deterioration in lung function).

- EFFECT ON LABORATORY TESTS
  - False positive urinary glucose (if tested for reducing substances).

- PATIENT AND CARER ADVICE

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

<table>
<thead>
<tr>
<th>Tablet</th>
<th>CAUTIONARY AND ADVISORY LABELS 9, 14, 21</th>
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<tr>
<td>Nitrofurantoin 50 mg</td>
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<td>Nitrofurantoin 100 mg</td>
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<tr>
<td>Genfura (Genesis Pharmaceuticals Ltd)</td>
<td>Genfura 50 mg Genfura 50 mg tablets</td>
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<tr>
<td>Nitrofurantoin 100 mg</td>
<td>Genfura 100 mg tablets</td>
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</tbody>
</table>

- Oral suspension
  - CAUTIONARY AND ADVISORY LABELS 9, 14, 21
  - Nitrofurantoin (Non-proprietary)
  - Nitrofurantoin 5 mg per 1 ml Nitrofurantoin 25mg/5ml oral suspension sugar free sugar-free | 300 ml (£4.95) | 646.95 DT = £446.95 |

- Modified-release capsule
  - CAUTIONARY AND ADVISORY LABELS 9, 14, 21, 25
  - Macrosid (Advanz Pharma)
  - Nitrofurantoin 100 mg Macrosid 100mg modified-release capsules | 14 capsule (£9.50) | 15.42 DT = £10.42 |

- Capsule
  - CAUTIONARY AND ADVISORY LABELS 9, 14, 21
  - Nitrofurantoin (Non-proprietary)
  - Nitrofurantoin 50 mg Nitrofurantoin 50mg capsules | 30 capsule (£15.42) | 45.42 DT = £15.42 |
  - Nitrofurantoin 100 mg Nitrofurantoin 100mg capsules | 30 capsule (£10.42) | 40.42 DT = £10.42 |
Fungal infection

Antifungals, systemic use

Fungal infections

The systemic treatment of common fungal infections is outlined below; specialist treatment is required in most forms of systemic or disseminated fungal infections. Local treatment is suitable for a number of fungal infections (genital, bladder, eye, ear, oropharynx, and skin).

Aspergillosis

Aspergillosis most commonly affects the respiratory tract but in severely immunocompromised patients, invasive forms can affect the heart, brain, and skin. Voriconazole p. 392 is the treatment of choice for aspergillosis; liposomal amphotericin p. 387 is an alternative first-line treatment when voriconazole cannot be used. Caspofungin p. 386 or itraconazole p. 390 can be used in patients who are refractory to, or intolerant of voriconazole and liposomal amphotericin. Itraconazole is also used for the treatment of chronic pulmonary aspergillosis or as an adjunct in the treatment of allergic bronchopulmonary aspergillosis [unlicensed indication].

Candidiasis

Many superficial candidal infections, including infections of the skin, are treated locally. Systemic antifungal treatment is required in widespread or intractable infection. Vaginal candidiasis can be treated with locally acting antifungals; alternatively, fluconazole p. 389 can be given by mouth. Oropharyngeal candidiasis generally responds to topical therapy. Fluconazole is given by mouth for unresponsive infections; it is reliably absorbed and is effective. Itraconazole may be used for infections that do not respond to fluconazole. Topical therapy may not be adequate in immunocompromised children and an oral triazole antifungal is preferred.

For invasive or disseminated candidiasis, either amphotericin by intravenous infusion or an echinocandin can be used. Fluconazole is an alternative for Candida albicans infection in clinically stable children who have not received an azole antifungal recently. Amphotericin should be considered for the initial treatment of CNS candidiasis.

Voriconazole can be used for infections caused by fluconazole-resistant Candida spp. when oral therapy is required, or in children intolerant of amphotericin or an echinocandin. In refractory cases, flucytosine p. 393 can be used with intravenous amphotericin.

Cryptococcosis

Cryptococcosis is uncommon but infection in the immunocompromised, especially in HIV-positive patients, can be life-threatening; cryptococcal meningitis is the most common form of fungal meningitis. The treatment of choice in cryptococcal meningitis is amphotericin by intravenous infusion and flucytosine by intravenous infusion for 2 weeks, followed by fluconazole by mouth for 8 weeks or until cultures are negative. In cryptococcosis, fluconazole is sometimes given alone as an alternative in HIV-positive patients with mild, localised infections or in those who cannot tolerate amphotericin. Following successful treatment, fluconazole can be used for prophylaxis against relapse until immunity recovers.

Histoplasmosis

Histoplasmosis is rare in temperate climates; it can be life-threatening, particularly in HIV-infected persons. Itraconazole can be used for the treatment of immunocompetent patients with indolent non-meningeal infection, including chronic pulmonary histoplasmosis. Amphotericin by intravenous infusion is used for the initial treatment of fulminant or severe infections, followed by a course of itraconazole by mouth. Following successful treatment, itraconazole can be used for prophylaxis against relapse until immunity recovers.

Skin and nail infections

Mild localised fungal infections of the skin (including tinea corporis, tinea cruris, and tinea pedis) respond to topical therapy. Systemic therapy is appropriate if topical therapy fails, if many areas are affected, or if the site of infection is difficult to treat such as in infections of the nails (onychomycosis) and of the scalp (tinea capitis). Oral imidazole or triazole antifungals (particularly itraconazole) and terbinafine p. 750 are used more frequently than griseofulvin p. 394 because they have a broader spectrum of activity and require a shorter duration of treatment.

Tinea capitis is treated systemically; additional topical application of an antifungal may reduce transmission. Griseofulvin is used for tinea capitis in adults and children; it is effective against infections caused by Trichophyton tonsurans and Microsporum spp. Terbinafine is used for tinea capitis caused by T. tonsurans [unlicensed indication]. The role of terbinafine in the management of Microsporum infections is uncertain. Fluconazole or itraconazole are alternatives in the treatment of tinea capitis caused by T. tonsurans or Microsporum spp. [both unlicensed indications].

Pityriasis versicolor may be treated with itraconazole by mouth if topical therapy is ineffective; fluconazole by mouth is an alternative. Oral terbinafine is not effective for pityriasis versicolor.

Antifungal treatment may not be necessary in asymptomatic patients with tinea infection of the nails. If treatment is necessary, a systemic antifungal is more effective than topical therapy. Terbinafine and itraconazole have largely replaced griseofulvin for the systemic treatment of onychomycosis, particularly of the toenail; they should be used under specialist advice in children. Although terbinafine is not licensed for use in children, it is considered to be the drug of choice for onychomycosis. Itraconazole can be administered as intermittent ‘pulse’ therapy. Topical antifungals also have a role in the treatment of onychomycosis.

Immunocompromised children

Immunocompromised children are at particular risk of fungal infections and may receive antifungal drugs prophylactically; oral triazole antifungals are the drugs of choice for prophylaxis. Fluconazole is more reliably absorbed than itraconazole, but fluconazole is not effective against Aspergillus spp. Itraconazole is preferred in patients at risk of invasive aspergillosis. Micafungin p. 387 can be used for prophylaxis of candidiasis in patients undergoing haematopoietic stem cell transplantation when fluconazole or itraconazole cannot be used.

Amphotericin by intravenous infusion or caspofungin is used for the empirical treatment of serious fungal infections in immunocompromised children; caspofungin is not effective against fungal infections of the CNS.

Triazole antifungals

Triazole antifungal drugs have a role in the prevention and systemic treatment of fungal infections.

Fluconazole is very well absorbed after oral administration. It also achieves good penetration into the cerebrospinal fluid to treat fungal meningitis. Fluconazole is excreted largely unchanged in the urine and can be used to treat candiduria.

Itraconazole is active against a wide range of dermatophytes. There is limited information available on use in children. Itraconazole capsules require an acid environment in the stomach for optimal absorption. Itraconazole has been associated with liver damage and should be avoided or used with caution in patients with liver
Infection

amphotericin is inadequate; lipid formulations are more recommended when the conventional formulation of 
Flucytosine p.

Other antifungals

The polyene antifungals include amphotericin and nystatin. They are used for the local treatment of vaginal candidiasis and for dermatophyte infections. Miconazole p. 734 can be used locally for oral infections; it is also effective in intestinal infections. Systemic absorption may follow use of miconazole oral gel and may result in significant drug interactions.

Polyene antifungals

The polyene antifungals include amphotericin and nystatin. It is highly protein bound and penetrates poorly into body fluids and tissues. When given parenterally amphotericin is toxic and side-effects are common. Lipid formulations of amphotericin (Abelcet® and AmBisome®) are significantly less toxic and are recommended when the conventional formulation of amphotericin is contra-indicated because of toxicity, especially nephrotoxicity or when response to conventional amphotericin is inadequate; lipid formulations are more expensive.

Echinocandin antifungals

The echinocandin antifungals include caspofungin below Echinocandin antifungals p. 734. Neither drug is absorbed when given by mouth. Nystatin p. 734 is used for oral, opharyngitis, and perioral infections by local application in the mouth. Nystatin is also used for Candida albicans infection of the skin.

Amphotericin p. 387 by intravenous infusion is used for the treatment of systemic fungal infections and is active against most fungi and yeasts. It is a highly protein bound and penetrates poorly into body fluids and tissues. When given parenterally amphotericin is toxic and side-effects are common. Lipid formulations of amphotericin (Abelcet® and AmBisome®) are significantly less toxic and are recommended when the conventional formulation of amphotericin is contra-indicated because of toxicity, especially nephrotoxicity or when response to conventional amphotericin is inadequate; lipid formulations are more expensive.

Echinocandin antifungals

The echinocandin antifungals include caspofungin below and micafungin p. 387. They are only active against Aspergillus spp. and Candida spp.; however, micafungin is not used for the treatment of aspergillosis. Echinocandins are not effective against fungal infections of the CNS. Echinocandin antifungals have a role in the prevention and systemic treatment of fungal infections.

Other antifungals

Flucytosine p. 393 is used with amphotericin in a synergistic combination. Bone marrow depression can occur which limits its use, particularly in HIV-positive patients; weekly blood counts are necessary during prolonged therapy. Resistance to flucytosine can develop during therapy and sensitivity testing is essential before and during treatment. Flucytosine has a role in the treatment of systemic candidiasis and cryptococcal menigitis.

Griseofulvin p. 394 is effective for widespread or intractable dermatophyte infections but has been superseded by newer antifungals, particularly for nail infections. Griseofulvin is used in the treatment of tinea capitis. It is the drug of choice for trichophytin infections in children. Duration of therapy is dependent on the site of the infection and may extend to a number of months.

Terbinafine p. 750 is the drug of choice for fungal nail infections and is also used for ringworm infections where oral treatment is considered appropriate.

386 Fungal infection

ANTIFUNGALS > ECHINOCANDIN ANTIFUNGALS

Caspofungin

- INDICATIONS AND DOSE

Invasive aspergillosis | Invasive candidiasis | Empirical treatment of systemic fungal infections in patients with neutropenia

- BY INTRAVENOUS INFUSION

- Neonate: 25 mg/m² once daily.
- Child 1-2 months: 25 mg/m² once daily
- Child 3-11 months: 50 mg/m² once daily
- Child 1-17 years: 70 mg/m² once daily (max. per dose 70 mg) for 1 day, then 50 mg/m² once daily (max. per dose 70 mg); increased to 70 mg/m² once daily (max. per dose 70 mg), dose may be increased if lower dose tolerated but inadequate response

DOSE ADJUSTMENTS DUE TO INTERACTIONS

- Manufacturer advises increase dose to 70 mg/m² daily (max. 70 mg daily) with concurrent use of some enzyme inducers (such as carbamazepine, dexamethasone, phenytoin, and rifampicin).

- INTERACTIONS → Appendix 1: caspofungin

- SIDE-EFFECTS

- Common or very common Arthralgia · arthralgia · diarrhea · dyspnoea · electrolyte imbalance · fever · flushing · headache · hyperhidrosis · hypotension · nausea · skin reactions · vomiting
- Uncommon Anaemia · anxiety · appetite decreased · ascites · chest discomfort · coagulation disorder · congestive heart failure · constipation · cough · disorientation · dizziness · drowsiness · dry mouth · dysphagia · excessive tearing · eyelid oedema · fatigue · flatulence · fluid overload · gastrointestinal discomfort · haematuria · hepatic disorders · hyperbilirubinemia · hyperglycaemia · hypertension · hypoxia · induration · insomnia · laryngeal pain · leucopenia · malaise · metabolic acidosis · muscle weakness · myalgia · nasal congestion · oedema · pain · palpitations · renal impairment · respiratory disorders · sensation abnormal · taste altered · thrombocytopenia · thrombophlebitis · tremor · vision blurred
- Frequency not known Severe cutaneous adverse reactions (SCARs)

- PREGNANCY Manufacturer advises avoid unless essential—toxicity in animal studies.

- BREAST FEEDING Present in milk in animal studies—manufacturer advises avoid.

- HEPATIC IMPAIRMENT No information available for severe impairment.

Dose adjustments Usual initial dose, then use 70% of normal maintenance dose in moderate impairment.

- DIRECTIONS FOR ADMINISTRATION For intravenous infusion (Cancidas®), allow vial to reach room temperature; initially reconstitute 50 mg with 10.5 mL Water for Injections to produce a 5.2 mg/mL solution, or reconstitute 70 mg with 10.5 mL Water for Injections to produce a 7.2 mg/mL solution; mix gently to dissolve; dilute requisite dose to a final concentration not exceeding 500 micrograms/mL; store at room temperature; discard if solution is not clear or becomes cloudy.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for infusion

- Caspofungin (Non-proprietary) Caspofungin (as Caspofungin acetate) 50 mg Caspofungin 50mg powder for concentrate for solution for infusion vials | 1 vial £69.77–£327.67
Micafungin

**INDICATIONS AND DOSE**

**Invasive candidiasis**
- BY INTRAVENOUS INFUSION
  - Neonate (administered on expert advice): 2 mg/kg once daily for at least 14 days; increased if necessary to 4 mg/kg once daily, increase dose if response inadequate.

- Child (body-weight up to 40 kg): 2 mg/kg once daily for at least 14 days; increased if necessary to 4 mg/kg once daily, increase dose if response inadequate

- Child (body-weight 40 kg and above): 100 mg once daily for at least 14 days; increased if necessary to 200 mg once daily, increase dose if response inadequate

**Oesophageal candidiasis**
- BY INTRAVENOUS INFUSION
  - Child 16-17 years (body-weight up to 40 kg): 3 mg/kg once daily
  - Child 16-17 years (body-weight 40 kg and above): 150 mg once daily

**Prophylaxis of candidiasis in patients undergoing bone-marrow transplantation or who are expected to become neutropenic for over 10 days**
- BY INTRAVENOUS INFUSION
  - Neonate: 1 mg/kg once daily continue for at least 7 days after neutrophil count is in desirable range.

- Child (body-weight up to 40 kg): 1 mg/kg once daily continue for at least 7 days after neutrophil count is in desirable range

- Child (body-weight 40 kg and above): 50 mg once daily continue for at least 7 days after neutrophil count is in desirable range

**INTERACTIONS** → Appendix 1: micafungin

**SIDE-EFFECTS**
- Anaemia, anxiety, appetite decreased, arrhythmias, confusion, constipation, diarrhoea, disseminated intravascular coagulation, dizziness, drowsiness, dyspnoea, electrolyte imbalance, eosinophilia, flushing, gastrointestinal discomfort, haemolysis, haemolytic anaemia, headache, hepatic disorders, hepatic failure (potentially life-threatening), hyperbilirubinaemia, hyperhidrosis, hypersensitivity, hypertension, hypalbuminaemia, hypotension, insomnia, leucopenia, nausea, neutropenia, palpitations, pancytopenia, peripheral oedema, renal impairment, severe cutaneous adverse reactions (SCARs), shock, skin reactions, taste altered, thrombocytopenia, tremor, vomiting

**PREGNANCY**

**BREAST FEEDING**

**HEPATIC IMPAIRMENT**

**RENAI IMPAIRMENT**

Use with caution; renal function may deteriorate.

**MONITORING REQUIREMENTS**
- Monitor renal function.
- Monitor liver function—discontinue if significant and persistent abnormalities in liver function tests develop.

**DIRECTIONS FOR ADMINISTRATION**

For intravenous infusion reconstitute each vial with 5 mL Glucose 5% or Sodium Chloride 0.9%; gently rotate vial, without shaking, to dissolve; dilute requisite dose to a concentration of 0.5–2 mg/mL with Glucose 5% or Sodium Chloride 0.9%; protect infusion from light; give over 60 minutes.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

- **Powder for solution for infusion**
  - **Mycamine (Astellas Pharma Ltd)**
    - Micafungin (as Micafungin sodium) 100 mg Mycamine 100mg powder for solution for infusion vials | 1 vial | £341.00
  - Micafungin (as Micafungin sodium) 50 mg Mycamine 50mg powder for solution for infusion vials | 1 vial | £196.08

**ANTIFUNGALS**

**Amphotericin**

(Amphotericin B)

**INDICATIONS AND DOSE**

**ABELCET ®**

- **Severe invasive candidiasis**: Severe systemic fungal infections in patients not responding to conventional amphotericin or to other antifungal drugs or where toxicity or renal impairment precludes conventional amphotericin, including invasive aspergillosis, cryptococcal meningitis and disseminated cryptoccosis in HIV patients
  - BY INTRAVENOUS INFUSION
    - **Child**: Test dose 100 micrograms/kg (max. per dose 1 mg), then 5 mg/kg once daily

  **AMBISOME ®**

- **Severe systemic or deep mycoses where toxicity (particularly nephrotoxicity) precludes use of conventional amphotericin**: Suspected or proven infection in febrile neutropenic patients unresponsive to broad-spectrum antibacterials
  - BY INTRAVENOUS INFUSION
    - **Child**: Test dose 100 micrograms/kg (max. per dose 1 mg), to be given over 10 minutes, then 3 mg/kg once daily; maximum 5 mg/kg per day.

- **Visceral leishmaniasis (unresponsive to the antimonial alone)**
  - BY INTRAVENOUS INFUSION
    - **Child**: 1–3 mg/kg daily for 10–21 days to a cumulative dose of 21–30 mg/kg, alternatively 3 mg/kg for 5 consecutive days, followed by 3 mg/kg after 6 days for 1 dose

**FUNIGZONE ®**

**Systemic fungal infections**
- BY INTRAVENOUS INFUSION
  - **Neonate**: 1 mg/kg once daily, increased if necessary to 3 mg/kg once daily; maximum 5 mg/kg per day.

  **Child**: Test dose 100 micrograms/kg (max. per dose 1 mg), to be given over 10 minutes, then 3 mg/kg once daily; maximum 5 mg/kg per day.

**FUNIGZONE ®**

**Systemic fungal infections**
- BY INTRAVENOUS INFUSION
  - **Neonate**: 1 mg/kg once daily, increased if necessary to 1.5 mg/kg daily for 7 days, then reduced to 1–1.5 mg/kg once daily on alternate days if required.

  **Child**: Test dose 100 micrograms/kg (max. per dose 1 mg), included as part of first dose of 250 micrograms/kg daily, then increased if tolerated to 1 mg/kg daily, dose is gradually increased over 2–4 days; in severe infection max. 1.5 mg/kg daily or on alternate days. Prolonged treatment usually continued →
necessary; if interrupted for longer than 7 days recommence at 250 micrograms/kg daily and increase gradually

- **UNLICENSED USE**
  - **AMBISOME**® Ambrisome® not licensed for use in children under 1 month.
  - **FUNGIZONE**® Intravenous conventional formulation amphotericin (Fungizone®) is licensed for use in children (age range not specified by manufacturer).

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: PARENTERAL AMPHOTERICIN B: REMINDER OF RISK OF POTENTIALLY FATAL ADVERSE REACTION IF FORMULATIONS CONFUSED (JULY 2018)**

The MHRA is aware of three fatal overdoses which were caused by medication error in which Fungizone® was administered (a non-lipid-based formulation of amphotericin B) instead of a lipid-based formulation. Healthcare professionals are advised:
- when prescribing and dispensing amphotericin products, both the complete generic name and the proprietary name should be used;
- the product name and dose should be verified before administration, especially if the dose prescribed exceeds the maximum recommended dose for Fungizone®.

- **Cautions** Avoid rapid infusion (risk of arrhythmias) - when given parenterally, toxicity common (close supervision necessary and close observation required for at least 30 minutes after test dose)

- **Cautions, further information**
  - Anaphylaxis Anaphylaxis can occur with any intravenous amphotericin product and a test dose is advisable before the first infusion in children over 1 month of age; the patient should be carefully observed for at least 30 minutes after the test dose. Prophylactic antipyretics or hydrocortisone should only be used in patients who have previously experienced acute adverse reactions (in whom continued treatment with amphotericin is essential).

- **Interactions** → Appendix 1: amphotericin

- **Side-effects**
  - Common or very common Anaemia - appetite decreased - azotaemia - chillis - diarrhoea - dyspepsia - electrolyte imbalance - fever - headache - hepatitis should be considered.
  - Uncommon Anaglycosuria - arthralgia - flushing - gastrointestinal discomfort - hepatic disorders - leucopenia - myalgia - peripheral neuropathy - respiratory disorders - thrombocytopenia
  - Rare or very rare Arthralgia - cardiac arrest - coagulation disorder - deafness - encephalopathy - eosinophilia - haemorrhage - heart failure - hypersensitivity - hypertension - malaise - nephrogenic diabetes insipidus - pain - pulmonary oedema non-cardiogenic - seizure - severe cutaneous adverse reactions (SCARs) - shock - tinnitus - vertigo - vision disorders - weight decreased

- **Pregnancy** Not known to be harmful but manufacturers advise avoid unless potential benefit outweighs risk.

- **Breast Feeding** No information available.

- **Renal Impairment** Use only if no alternative; nephrotoxicity may be reduced with use of lipid formulation.

- **Monitoring Requirements** Hepatic and renal function tests, blood counts, and plasma electrolyte (including plasma-potassium and magnesium concentration) monitoring required.

- **Directions for Administration**
  - **Abelcet**® Amphotericin (lipid complex)
    - For intravenous infusion, allow suspension to reach room temperature, shake gently to ensure no yellow settlement, withdraw requisite dose (using 17–19 gauge needle) into one or more 20-ml syringes; replace needle on syringe with a 5-micron filter needle provided (fresh needle for each syringe) and dilute in Glucose 5% to a concentration of 2 mg/mL; preferably give via an infusion pump at a rate of 2.5 mg/kg/hour (initial test dose given over 15 minutes); an in-line filter (pore size no less than 15 micron) may be used; do not use sodium chloride or other electrolyte solutions—flush existing intravenous line with Glucose 5% or use separate line.
  - **Ambisome**® Amphotericin (liposomal)
    - For intravenous infusion, reconstitute each vial with 12 ml. Water for Injections and shake vigorously to produce a preparation containing 4 mg/mL; withdraw requisite dose from vial and introduce into Glucose 5% or 10% through the 5-micron filter provided, to produce a final concentration of 0.2–2 mg/mL; infuse over 30–60 minutes, or if non-anaphylactic infusion-related reactions occur infuse over 2 hours (initial test dose given over 10 minutes); an in-line filter (pore size no less than 1 micron) may be used; incompatible with sodium chloride solutions—flush existing intravenous line with Glucose 5% or 10%, or use separate line.
  - **Fungizone**® Amphotericin (as sodium deoxycylcholate complex)
    - For intravenous infusion, reconstitute each vial with 10 ml. Water for Injections and shake immediately to produce a 5 mg/mL colloidal solution; dilute further in Glucose 5% to a concentration of 100 micrograms/mL (in fluid-restricted children, up to 400 micrograms/mL, given via a central line); pH of glucose solution must not be below 4.2 (check each container—consult product literature for details of buffer); infuse over 4–6 hours, or if tolerated over a minimum of 2 hours (initial test dose given over 20–30 minutes); begin infusion immediately after dilution and protect from light; incompatible with Sodium Chloride solutions—flush existing intravenous line with Glucose 5% or use separate line; an in-line filter (pore size no less than 1 micron) may be used.

- **Prescribing and dispensing information** Different preparations of intravenous amphotericin vary in their pharmacodynamics, pharmacokinetics, dosage, and administration; these preparations should not be considered interchangeable. To avoid confusion, prescribers should specify the brand to be dispensed.

- **Medicinal forms** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for infusion**

**Electrolytes**: May contain Sodium

- **Abelcet** (Tevis UK Ltd)
  - Amphotericin B (as Amphotericin B phospholipid complex) 5 mg per 1 ml
  - Abelcet 100mg/20ml concentrate for suspension for infusion vials | 10 vial | £77.50 (Hospital only)

**Powder for solution for infusion**

**Excipients**: May contain Sucrose

- **Electrolytes**: May contain Sodium

- **Ambisome** (Gilead Sciences International Ltd)
  - Amphotericin B liposomal 50 mg
  - Ambisome 50mg powder for solution for infusion vials | 10 vial | £82.87

- **Fungizone** (Bristol-Myers Squibb Pharmaceuticals Ltd)
  - Amphotericin B 50 mg
  - Fungizone Intravenous 50mg powder for solution for infusion vials | 1 vial | £3.88
# Fluconazole

### INDICATIONS AND DOSE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidal balanitis</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Vaginal candidiasis</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Vulvovaginal candidiasis (recurrent)</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Mucosal candidiasis (except genital)</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Neonate up to 14 days</td>
<td>3–6 mg/kg, dose to be given on first day, then 3 mg/kg every 48 hours</td>
</tr>
<tr>
<td>Neonate 14 days to 28 days</td>
<td>3–6 mg/kg, dose to be given on first day, then 3 mg/kg every 48 hours</td>
</tr>
<tr>
<td>Child 1 month-11 years</td>
<td>3–6 mg/kg, dose to be given on first day, then 3 mg/kg daily (max. per dose 100 mg) for 7–14 days in oropharyngeal candidiasis (max. 14 days except in severely immunocompromised patients); for 14–30 days in other mucosal infections (e.g. oesophagitis, candiduria, non-invasive bronchopulmonary infections)</td>
</tr>
<tr>
<td>Child 12-17 years</td>
<td>50 mg daily for 7–14 days in oropharyngeal candidiasis (max. 14 days except in severely immunocompromised patients); for 14–30 days in other mucosal infections (e.g. oesophagitis, candiduria, non-invasive bronchopulmonary infections); increased to 100 mg daily, increased dose only for unusually difficult infections</td>
</tr>
<tr>
<td>Tinea capitis</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Child 1-7 years</td>
<td>6 mg/kg daily (max. per dose 300 mg) for 2–4 weeks</td>
</tr>
<tr>
<td>Tinea pedis, corporis, cruris, pityriasis versicolor</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Dermal candidiasis</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Invasive candidal infections (including candidaemia and disseminated candidiasis) and cryptococcal infections (including meningitis)</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Neonate up to 14 days</td>
<td>6–12 mg/kg every 72 hours, treatment continued according to response (at least 8 weeks for cryptococcal meningitis)</td>
</tr>
<tr>
<td>Neonate 14 days to 28 days</td>
<td>6–12 mg/kg every 48 hours, treatment continued according to response (at least 8 weeks for cryptococcal meningitis)</td>
</tr>
<tr>
<td>Child 16–17 years</td>
<td>150 mg for 1 dose, for use in patients who are post-puberty</td>
</tr>
<tr>
<td>Child:</td>
<td></td>
</tr>
<tr>
<td>Initially</td>
<td></td>
</tr>
<tr>
<td>Duration of treatment</td>
<td>8 weeks for cryptococcal meningitis</td>
</tr>
<tr>
<td>Prevention of fungal infections in immunocompromised patients</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Neonate up to 14 days</td>
<td>3–12 mg/kg every 72 hours, dose given according to extent and duration of neutropenia</td>
</tr>
<tr>
<td>Neonate 14 days to 28 days</td>
<td>3–12 mg/kg every 48 hours, dose given according to extent and duration of neutropenia</td>
</tr>
<tr>
<td>Child:</td>
<td></td>
</tr>
<tr>
<td>Prevention of fungal infections in immunocompromised patients (for patients with high risk of systemic infections e.g. following bone-marrow transplantation)</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
<tr>
<td>Prevention of relapse of cryptococcal meningitis in HIV-infected patients after completion of primary therapy</td>
<td>BY MOUTH, OR BY INTRAVENOUS INFUSION</td>
</tr>
</tbody>
</table>

### CONTRA-INDICATIONS
- Acute porphyrias p. 624

### CAUTIONS
- Susceptibility to QT interval prolongation

### INTERACTIONS
- Appendix 1: antifungals, azoles

### SIDE-EFFECTS

#### GENERAL SIDE-EFFECTS
- Common or very common
- Diarrhoea, gastrointestinal discomfort, headache, nausea, skin reactions, vomiting
- Uncommon
- Dizziness, flattulence, hepatic disorders, seizure, taste altered
- Rare or very rare
- Agranulocytosis, alopecia, dyslipidaemia, hypokalaemia, leucopenia, neutropenia, QT interval prolongation, severe cutaneous adverse reactions (SCARs), thrombocytopenia, torsade de pointes

#### SPECIFIC SIDE-EFFECTS
- Uncommon
- With parental use
- Angioedema, face oedema, tremor
- Frequency not known
- With oral use
- Cardio-respiratory distress, oedema

#### SIDE-EFFECTS, FURTHER INFORMATION
- If rash occurs, discontinue treatment (or monitor closely if infection invasive or systemic); severe cutaneous reactions are more likely in patients with AIDS.
- Manufacturer advises avoid—multiple congenital abnormalities reported with long-term high doses.
- Manufacturer advises caution—limited information available.
- Dose adjustments
- Usual initial dose then halve subsequent doses if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².
Itraconazole

**INDICATIONS AND DOSE**

**Oropharyngeal candidiasis**
- **BY MOUTH**
  - Child 1 month-11 years: 3–5 mg/kg once daily for 15 days; maximum 100 mg per day
  - Child 12-17 years: 100 mg once daily for 15 days

**Oropharyngeal candidiasis in patients with AIDS or neutropenia**
- **BY MOUTH**
  - Child 1 month-11 years: 3–5 mg/kg once daily for 15 days; maximum 200 mg per day
  - Child 12-17 years: 200 mg once daily for 15 days

**Systemic candidiasis where other antifungal drugs inappropriate or ineffective**
- **BY MOUTH**
  - Child: 5 mg/kg once daily (max. per dose 200 mg), dose increased in invasive or disseminated disease and in cryptococcal meningitis, increased to 5 mg/kg twice daily (max. per dose 200 mg)
- **BY INTRAVENOUS INJECTION**
  - Child: 2.5 mg/kg every 12 hours (max. per dose 200 mg) for 2 days, then 2.5 mg/kg once daily (max. per dose 200 mg) for max. 12 days

**Pityriasis versicolor**
- **BY MOUTH**
  - Child 1 month-11 years: 3–5 mg/kg once daily (max. per dose 200 mg) for 7 days
  - Child 12-17 years: 200 mg once daily for 7 days

**Tinea pedis / Tinea manuum**
- **BY MOUTH**
  - Child 1 month-11 years: 3–5 mg/kg once daily (max. per dose 100 mg) for 30 days
  - Child 12-17 years: 100 mg once daily for 30 days, alternatively 200 mg twice daily for 7 days

**Tinea corporis / Tinea cruris**
- **BY MOUTH**
  - Child 1 month-11 years: 3–5 mg/kg once daily (max. per dose 100 mg) for 15 days
  - Child 12-17 years: 100 mg once daily for 15 days, alternatively 200 mg once daily for 7 days

**Tinea capitis**
- **BY MOUTH**
  - Child 1-7 years: 3–5 mg/kg once daily (max. per dose 200 mg) for 2–6 weeks

**Onychomycosis**
- **BY MOUTH**
  - Child 1-11 years: 5 mg/kg daily (max. per dose 200 mg) for 7 days, subsequent courses repeated after 21-day intervals; fingernails 2 courses, toenails 3 courses
  - Child 12-17 years: 200 mg once daily for 3 months, alternatively 200 mg twice daily for 7 days, subsequent courses repeated after 21-day intervals; fingernails 2 courses, toenails 3 courses

**Systemic aspergillosis where other antifungal drugs inappropriate or ineffective**
- **BY INTRAVENOUS INJECTION**
  - Child: 2.5 mg/kg every 12 hours (max. per dose 200 mg) for 2 days, then 2.5 mg/kg once daily (max. per dose 200 mg) for max. 12 days
  - **BY MOUTH**
    - Child: 5 mg/kg once daily (max. per dose 200 mg), increased to 5 mg/kg twice daily (max. per dose 200 mg), dose increased in invasive or disseminated disease and in cryptococcal meningitis

**Histoplasmosis**
- **BY MOUTH**
  - Child: 5 mg/kg 1–2 times a day (max. per dose 200 mg)
**Fungal infection 391**

**Systemic cryptococcosis including cryptococcal meningitis where other antifungal drugs inappropriate or ineffective**

- **BY MOUTH**
  - **Child:** 5 mg/kg once daily (max. per dose 200 mg), dose increased in invasive or disseminated disease and in cryptococcal meningitis, increased to 5 mg/kg twice daily (max. per dose 200 mg)
  - **BY INTRAVENOUS INFUSION**
  - **Child:** 2.5 mg/kg every 12 hours (max. per dose 200 mg) for 2 days, then 2.5 mg/kg once daily (max. per dose 200 mg) for max. 12 days

**Maintenance in HIV-infected patients to prevent relapse of underlying fungal infection and prophylaxis in neutropenia when standard therapy inappropriate**

- **BY MOUTH**
  - **Child:** 5 mg/kg once daily (max. per dose 200 mg), then increased to 5 mg/kg twice daily (max. per dose 200 mg), dose increased only if low plasma-itraconazole concentration

**Prophylaxis of deep fungal infections (when standard therapy inappropriate) in patients with haematological malignancy or undergoing bone-marrow transplantation who are expected to become neutropenic**

- **BY MOUTH USING ORAL SOLUTION**
  - **Child:** 2.5 mg/kg twice daily, to be started before transplantation or before chemotherapy (taking care to avoid interaction with cytotoxic drugs) and continued until neutrophil count recovers, safety and efficacy not established

**SPECIFIC SIDE-EFFECTS**

- Common or very common
  - **With intravenous use** Chest pain, confusion, cough, dizziness, drowsiness, electrolyte imbalance, fatigue, gastrointestinal disorder, granulocytopenia, hyperglycaemia, hyperhidrosis, hypersensitivity, hypertension, myalgia, pain, renal impairment, tachycardia, tremor, urinary incontinence
  - **Uncommon**
    - With intravenous use Dysphonia, numbness, thrombocytopenia
    - With oral use Flatulence, increased risk of infection, menstrual disorder
  - **Rare or very rare**
    - **With oral use** Erectile dysfunction, leucopenia, neuralgia, peripheral oedema, taste altered, unusual taste

**SIDE-EFFECTS, FURTHER INFORMATION**

- Potentially life-threatening hepatotoxicity reportedly very rarely — discontinue if signs of hepatitis develop.

**CONCEPTION AND CONTRACEPTION**

- Ensure effective contraception during treatment and until the next menstrual period following end of treatment.

**PREGNANCY**

- Manufacturer advises use only in life-threatening situations (toxicity at high doses in animal studies).

**BREAST FEEDING**

- Small amounts present in milk — may accumulate; manufacturer advises avoid.

**HEPATIC IMPAIRMENT**

- Use only if potential benefit outweighs risk of hepatotoxicity.

**Dose adjustments**

- Dose reduction may be necessary.

**RENAL IMPAIRMENT**

- Risk of congestive heart failure.

- **With oral use** Bioavailability of oral formulations possibly reduced.

- **With intravenous use** Use intravenous infusion with caution if estimated glomerular filtration rate less than 30 mL/minute/1.73 m² (monitor renal function); avoid intravenous infusion if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

**MONITORING REQUIREMENTS**

- Absorption reduced in AIDS and neutropenia (monitor plasma-itraconazole concentration and increase dose if necessary).

- **Monitor liver function if treatment continues for longer than one month, if receiving other hepatotoxic drugs, if history of hepatotoxicity with other drugs, or in hepatic impairment.**

**DIRECTIONS FOR ADMINISTRATION**

- **With intravenous use** For intravenous infusion, dilute 250 mg with 50 mL Sodium Chloride 0.9% and give requisite dose through an in-line filter (0.2 micron) over 60 minutes.

- **With oral use** For oral liquid, do not take with food; swish around mouth and swallow, do not rinse afterwards.

**PRESCRIBING AND DISPENSING INFORMATION**

- Flavours of oral liquid formulations may include cherry.

**PATIENT AND CARER ADVICE**

- Patients should be told how to recognise signs of liver disorder and advised to seek prompt medical attention if symptoms such as anorexia, nausea, vomiting, fatigue, abdominal pain or dark urine develop.

- With oral use Patients or carers should be given advice on how to administer itraconazole oral liquid.

**IMPORTANT SAFETY INFORMATION**

**HEART FAILURE**

- Following reports of heart failure, caution is advised when prescribing itraconazole to patients at high risk of heart failure. Those at risk include:
  - patients receiving high doses and longer treatment courses;
  - older adults and those with cardiac disease;
  - patients with chronic lung disease (including chronic obstructive pulmonary disease) associated with pulmonary hypertension;
  - patients receiving treatment with negative inotropic drugs, e.g. calcium channel blockers. Itraconazole should be avoided in patients with ventricular dysfunction or a history of heart failure unless the infection is serious.

**CONTRA-INDICATIONS**

- Acute porphyrias p. 624

**CAUTIONS**

- Active liver disease, history of hepatotoxicity with other drugs, susceptibility to congestive heart failure

**INTERACTIONS**

- Appendix 1: antifungals, azoles

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **Common or very common** Alopecia, constipation, diarrhoea, dysphonia, gastrointestinal discomfort, headache, heart failure, hepatic disorders, hyperbilirubinaemia, hypotension, nausea, oedema, pulmonary oedema, skin reactions, vision disorders, vomiting

- **Uncommon** Hearing loss, taste altered

- **Rare or very rare** Angioedema, hypersensitivity vasculitis, hypertrichy, uraemia, pancreatitis, photosensitivity reaction, severe cutaneous adverse reactions (SCARs)

- **Frequency not known** Peripheral neuropathy (discontinue)

**UNLICENSED USE**

- Not licensed for use in children (age range not specified by manufacturer).
Infection solution from special-order manufacturers include: oral suspension, oral solution

Solution for infusion
EXCIPIENTS: May contain Propylene glycol
- **Sporanox** (Janssen-Cilag Ltd)
  - Itraconazole 10 mg per 1 ml Itraconazole 50mg/5ml oral solution sugar-free sugar-free | 150 ml $58.34-$59.25 DT = $59.25
  - Sporanox (Janssen-Cilag Ltd)
  - Itraconazole 10 mg per 1 ml Itraconazole 50mg/5ml oral solution sugar-free | 150 ml $58.34 DT = $59.25

**Oral solution**
CAUTIONARY AND ADVISORY LABELS 9, 23
- **Itraconazole** (Non-proprietary)
  - Itraconazole 10 mg per 1 ml Itraconazole 50mg/5ml oral solution sugar-free sugar-free | 150 ml $58.34-$59.25 DT = $59.25
  - Sporanox (Janssen-Cilag Ltd)
  - Itraconazole 10 mg per 1 ml Itraconazole 50mg/5ml oral solution sugar-free | 150 ml $58.34 DT = $59.25

**Capsule**
CAUTIONARY AND ADVISORY LABELS 5, 9, 21, 25
- **Itraconazole** (Non-proprietary)
  - Itraconazole 100 mg Itraconazole 100mg capsules | 15 capsule $13.77 DT = $13.74 | 60 capsule $12.96-$15.10
  - Sporanox (Janssen-Cilag Ltd)
  - Itraconazole 100 mg Sporanox-Pulse 100mg capsules | 28 capsule $25.72
  - Sporanox 100mg capsules | 4 capsule $3.67 | 15 capsule $13.77 DT = $13.24 | 60 capsule $15.10

**Voriconazole**

**INDICATIONS AND DOSE**
**Invasive aspergillosis** | Serious infections caused by *Scedosporium spp., Fusarium spp.,* or invasive fluconazole-resistant *Candida spp.* (including *C. krusei*)

- **By mouth**
  - Child 2-11 years: Treatment should be initiated with intravenous regimen, and oral regimen should be considered only after there is a significant clinical improvement; maintenance 9 mg/kg every 12 hours, adjusted in steps of 1 mg/kg and increased if necessary up to 350 mg every 12 hours, then adjusted in steps of 50 mg as required
  - Child 12-14 years (body-weight up to 50 kg): Treatment should be initiated with intravenous regimen, and oral regimen should be considered only after there is a significant clinical improvement; maintenance 9 mg/kg every 12 hours, adjusted in steps of 1 mg/kg and increased if necessary up to 350 mg every 12 hours, then adjusted in steps of 50 mg as required
  - Child 12-14 years (body-weight 50 kg and above): Initially 400 mg every 12 hours for 2 doses, then 200 mg every 12 hours, increased if necessary to 300 mg every 12 hours
  - Child 15-17 years (body-weight up to 40 kg): Initially 200 mg every 12 hours for 2 doses, then 100 mg every 12 hours, increased if necessary to 150 mg every 12 hours
  - Child 15-17 years (body-weight 40 kg and above): Initially 400 mg every 12 hours for 2 doses, then 200 mg every 12 hours, increased if necessary to 300 mg every 12 hours

- **By intravenous infusion**
  - Child 2-11 years: Initially 9 mg/kg every 12 hours for 2 doses, then 8 mg/kg every 12 hours; adjusted in steps of 1 mg/kg as required; for max. 6 months
  - Child 12-14 years (body-weight up to 50 kg): Initially 9 mg/kg every 12 hours for 2 doses, then 8 mg/kg every 12 hours; adjusted in steps of 1 mg/kg as required; for max. 6 months
  - Child 12-14 years (body-weight 50 kg and above): Initially 6 mg/kg every 12 hours for 2 doses, then 4 mg/kg every 12 hours; reduced if not tolerated to 3 mg/kg every 12 hours; for max. 6 months

- **DOSE ADJUSTMENTS DUE TO INTERACTIONS**
  - Manufacturer advises increasing the maintenance dose with concurrent use of fosphenytoin, phenytoin, or rifabutin—no specific recommendations made for children.

- **CONTRA-INDICATIONS**
  - Acidic porphyrias p. 624

- **CAUTIONS**
  - Avoid exposure to sunlight, bradycardia, cardiomyopathy, electrolyte disturbances, history of QT interval prolongation, patients at risk of pancreatitis, symptomatic arrhythmias

- **INTERACTIONS** → Appendix 1: antifungals, azoles

- **SIDE-EFFECTS**

  - **GENERAL SIDE-EFFECTS**
    - Common or very common  
      - Acute kidney injury
      - agranulocytosis, alopecia, anaemia, anxiety, arrhythmias
      - asthenia, bone marrow disorders, chest pain, chills
      - confusion, constipation, depression, diarrhea, dizziness, drowsiness, dyspnoea, electrolyte imbalance, eye disorders, eye inflammation, fever, gastrointestinal discomfort, haemorrhage, hallucination, headache, hepatic disorders, hypoglycaemia, hypotension
      - increased risk of infection, insomnia, leucopenia, muscle tone increased, nausea, neutropenia, oedema, oral disorders, pain, pulmonary oedema, respiratory disorders, seizure, sensation abnormal, skin reactions, syncope, tetany, thrombocytopenia, tremor, vision disorders, vomiting
    - Uncommon  
      - Adrenal insufficiency, arthritis, brain oedema, duodenitis, encephalopathy, eosinophilia, gallbladder disorders, hearing impairment, hypothyroidism, influenza like illness, lymphadenopathy, lymphangitis, movement disorders, nephritis, nerve disorders, pancreatitis, parkinsonism, photoxicity, proteinuria, pseudomembranous enterocolitis, QT interval prolongation, renal tubular necrosis, severe cutaneous adverse reactions (SCARs), taste altered, thrombophlebitis, tinnitus, vertigo
    - Rare or very rare  
      - Angioedema, cardiac conduction disorders, disseminated intravascular coagulation, hyperthyroidism
    - Frequency not known  
      - Cutaneous lupus erythematosus, peristitis (more common in transplant patients), squamous cell carcinoma (more common in presence of phototoxicity)

  - **SPECIFIC SIDE-EFFECTS**
    - With intravenous use  
      - Infusion related reaction

- **SIDE-EFFECTS, FURTHER INFORMATION**

  - **Hepatotoxicity**
    - Hepatitis, cholestasis, and acute hepatic failure have been reported; risk of hepatotoxicity increased in patients with haematological malignancy. Consider treatment discontinuation if severe abnormalities in liver function tests.

  - **Phototoxicity** Phototoxicity occurs uncommonly. If phototoxicity occurs, consider treatment discontinuation; if treatment is continued, monitor for pre-malignant skin lesions and squamous cell carcinoma, and discontinue treatment if they occur.

- **CONCEPTION AND CONTRACEPTION** Effective contraception required during treatment.

- **PREGNANCY** Toxicity in animal studies—manufacturer advises avoid unless potential benefit outweighs risk.

- **BREAST FEEDING** Manufacturer advises avoid—no information available.
Fungal infection 393

ANTIFUNGALS  OTHER

Flucytosine

INDICATIONS AND DOSE
Systemic fungal infections | Adjunct to amphotericin B in severe systemic candidiasis and in other severe or long-standing infections

By intravenous infusion, or by mouth

Neonate: 50 mg/kg every 12 hours.

Child: Usual dose 50 mg/kg every 6 hours usually for not more than 7 days, alternatively 25–37.5 mg/kg every 6 hours usually for not more than 7 days, lower dose may be sufficient for sensitive organisms

Cryptococcal meningitis (adjunct to amphotericin B)

By intravenous infusion, or by mouth

Neonate: 50 mg/kg every 12 hours.

Child: 25 mg/kg every 6 hours for 2 weeks

UNLICENSED USE

With oral use Tablets not licensed.

CAUTIONS
Blood disorders

INTERACTIONS

Appendix 1: flucytosine

SIDE EFFECTS
Agranulocytosis • aplastic anaemia • blood disorder • cardiotoxicity • confusion • diarrhoea • hallucination • headache • hepatic disorders • leucopenia • nausea • rash • sedation • seizure • thrombocytopenia • toxic epidermal necrolysis • ventricular dysfunction • vertigo • vomiting

PREGNANCY
Teratogenic in animal studies; manufacturer advises use only if potential benefit outweighs risk.

BREAST FEEDING
Manufacturer advises avoid.

RENAL IMPAIRMENT
Dose adjustments Use normal dose every 12 hours if creatinine clearance 20–40 mL/minute; use normal dose every 24 hours if creatinine clearance 10–20 mL/minute; use initial normal dose if creatinine clearance less than 10 mL/minute and then adjust dose according to plasma-flucytosine concentration. Monitoring In renal impairment liver- and kidney-function tests and blood counts required weekly.

MONITORING REQUIREMENTS
For plasma concentration monitoring, blood should be taken shortly before starting the next infusion; plasma concentration for optimum response 25–50 mg/litre (200–400 micromol/litre)—should not be allowed to exceed 80 mg/litre (620 micromol/litre).

Liver and kidney function tests and blood counts required (weekly in blood disorders).

DIRECTIONS FOR ADMINISTRATION For intravenous infusion, give over 20–40 minutes.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for injection

Voriconazole (Non-proprietary)

Voriconazole 200 mg Voriconazole 200 mg powder for solution for infusion via | 1 vial | £51.43–£77.14 (Hospital only)

VFEND (Pfizer Ltd)

Voriconazole 200 mg VFEND 200 mg powder for solution for infusion via | 1 vial | £77.14 (Hospital only)

Oral suspension

CAUTIONARY AND ADVISORY LABELS
9, 11, 23

VFEND (Pfizer Ltd)

Voriconazole 40 mg per 1 ml VFEND 40mg/ml oral suspension | 75 ml | £55.17

Tablet

CAUTIONARY AND ADVISORY LABELS
9, 11, 23

VFEND (Pfizer Ltd)

Voriconazole 50 mg Voriconazole 50mg tablets | 28 tablet | £275.68 DT = £194.79

Voriconazole 100 mg Voriconazole 100mg tablets | 28 tablet | £275.68

Voriconazole 200 mg Voriconazole 200mg tablets | 28 tablet | £1,102.74 DT = £680.92

VFEND (Pfizer Ltd)

Voriconazole 50 mg VFEND 50mg tablets | 28 tablet | £275.68 DT = £194.79

Voriconazole 200 mg VFEND 200mg tablets | 28 tablet | £1,102.74 DT = £680.92

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

Solution for infusion

ELECTROLYTES: May contain Sodium

Ancotil (Meda Pharmaceuticals Ltd)

Flucytosine 10 mg per 1 ml Ancotil 2.5g/250ml solution for infusion bottles | 5 bottle | £151.67 (Hospital only)

Tablet

Ancotil (ICI Pharmaceuticals France S.A.)

Flucytosine 500 mg Ancotil 500mg tablets | 100 tablet | £6.95

BNFC 2019–2020 INFECTION

Hepatic impairment

Manufacturer advises caution, particularly in severe impairment (no information available).

Dose adjustments

Child 12–17 years Manufacturer advises use usual initial loading dose then halve maintenance doses in mild to moderate cirrhosis.

Renal impairment

Child 2–12 years No information available.

Child 12–17 years Intravenous vehicle may accumulate if estimated glomerular filtration rate less than 50 mL/minute/1.73 m²—use intravenous infusion only if potential benefit outweighs risk, and monitor renal function; alternatively, use tablets or oral suspension (no dose adjustment required).

Monitoring requirements

Monitor renal function.

Monitor liver function before starting treatment, then at least weekly for 1 month, and then monthly during treatment.

DIRECTIONS FOR ADMINISTRATION

With intravenous use For intravenous infusion, reconstitute each 200 mg with 19 mL Water for Injections or Sodium Chloride 0.9% to produce a 10 mg/mL solution; dilute dose to concentration of 0.5–5 mg/mL with Glucose 5% or Sodium Chloride 0.9% and give intermittently at a rate not exceeding 3 mg/kg/hour.

Monitoring

In renal impairment liver- and kidney-function tests and blood counts required weekly.

Caution

Children and neonates should be told how to recognise symptoms of liver disorder, and advised to seek immediate medical attention if symptoms such as persistent nausea, vomiting, malaise or jaundice develop.

Patients and their carers should be advised that patients should avoid intense or prolonged exposure to direct sunlight, and to avoid the use of sunbeds. In sunlight, patients should cover sun-exposed areas of skin and use a sunblock with high sun protection factor. Patients should seek medical attention if they experience sunburn or a severe skin reaction following exposure to light or sun.

Patients and their carers should be advised to keep the alert card with them at all times.

Excipients: May contain Sulfobutylether beta cyclodextrin sodium

Flavours of oral liquid formulations may include orange.

Patient and carer advice

Patients and their carers should be told how to recognise symptoms of liver disorder, and advised to seek immediate medical attention if symptoms such as persistent nausea, vomiting, malaise or jaundice develop.

Patients and their carers should be advised that patients should avoid intense or prolonged exposure to direct sunlight, and to avoid the use of sunbeds. In sunlight, patients should cover sun-exposed areas of skin and use a sunblock with high sun protection factor. Patients should seek medical attention if they experience sunburn or a severe skin reaction following exposure to light or sun.

Patients and their carers should be advised to keep the alert card with them at all times.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for infusion

Voriconazole (Non-proprietary)

Voriconazole 200 mg Voriconazole 200mg powder for solution for infusion via | 1 vial | £51.43–£77.14 (Hospital only)

VFEND (Pfizer Ltd)

Voriconazole 200 mg VFEND 200mg powder for solution for infusion via | 1 vial | £77.14 (Hospital only)

Oral suspension

CAUTIONARY AND ADVISORY LABELS
9, 11, 23

VFEND (Pfizer Ltd)

Voriconazole 40 mg per 1 ml VFEND 40mg/ml oral suspension | 75 ml | £55.17

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9, 11, 23

VFEND (Pfizer Ltd)

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VFEND (Pfizer Ltd)

Voriconazole 50 mg VFEND 50mg tablets | 28 tablet | £275.68 DT = £194.79

Voriconazole 200 mg VFEND 200mg tablets | 28 tablet | £1,102.74 DT = £680.92
Griseofulvin

**INDICATIONS AND DOSE**

Dermatophyte infections of the skin, scalp, hair and nails where topical therapy has failed or is inappropriate

- **BY MOUTH**
  - Child 1 month–11 years: Usual dose 10 mg/kg daily (max. per dose 500 mg), increased if necessary to 20 mg/kg daily (max. per dose 1 g), for severe infections; reduce dose when response occurs, daily dose may be taken once daily or in divided doses
  - Child 12–17 years: 500 mg daily, increased if necessary to 1 g daily, for severe infections; reduce dose when response occurs, daily dose may be taken once daily or in divided doses

**SIDE-EFFECTS**

- Common or very common: Appetite decreased, dizziness, drowsiness, incoordination, irritable, peripheral neuropathy, photosensitivity reaction, skin reactions, taste alteration, toxic epidermal necrolysis

- Rare or very rare: Anaemia, hepatic disorders, leucopenia, neutropenia, systemic lupus erythematosus (SLE)

**CONCEPTION AND CONTRACEPTION**

Effective contraception required during and for at least 6 months after administration to women (important: effectiveness of oral contraceptives may be reduced, additional contraceptive precautions e.g. barrier method, required). Men should avoid fathering a child while taking the drug and for at least 6 months after administration.

**PREGNANCY**

Avoid (fetotoxicity and teratogenicity in animals).

**BREAST FEEDING**

Avoid—no information available.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in mild to moderate impairment (risk of deterioration); avoid in severe impairment.

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Griseofulvin for fungal infections
- www.medicinesforchildren.org.uk/griseofulvin-fungal-infections

Driving and skilled tasks: May impair performance of skilled tasks (e.g. driving); effects of alcohol enhanced.

**UNLICENSED USE**

Licensed for use in children (age range not specified by manufacturer).

**CONTRA-INDICATIONS**

Acute porphyrias p. 624 - systemic lupus erythematosus (risk of exacerbation)

**INTERACTIONS**

- Appendix 1: griseofulvin

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

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### 2.1 Pneumocystis pneumonia

**Pneumocystis pneumonia**

**Overview**

Pneumonia caused by *Pneumocystis jirovecii* (*Pneumocystis carinii*) occurs in immunosuppressed patients; it is a common cause of pneumonia in AIDS. Pneumocystis pneumonia should generally be treated by those experienced in its management. Blood gas measurement is used to assess disease severity.

**Treatment**

The recommended duration of treatment is generally 14–21 days.

**Mild to moderate disease**

Co-trimoxazole p. 362 in high dosage is the drug of choice for the treatment of mild to moderate pneumocystis pneumonia.

Atovaquone p. 395 or a combination of dapsone p. 395 with trimethoprim p. 373 is given by mouth for the treatment of mild to moderate disease [unlicensed indication] in children who cannot tolerate co-trimoxazole.

A combination of clindamycin p. 337 and primaquine p. 412 may be used in the treatment of mild to moderate disease [unlicensed indication]; this combination is associated with considerable toxicity.

**Severe disease**

Co-trimoxazole in high dosage, given by mouth or by intravenous infusion, is the drug of choice for the treatment of severe pneumocystis pneumonia. Pentamidine isetionate p. 395 given by intravenous infusion is an alternative for children who cannot tolerate co-trimoxazole, or who have not responded to it. Pentamidine isetionate is a potentially toxic drug that can cause severe hypotension during or immediately after infusion. If there is clinical improvement after 7–10 days of intravenous therapy with pentamidine isetionate, patients can be switched to oral treatment (e.g. atovaquone) to complete 21 days treatment.

Corticosteroid treatment can be lifesaving in those with severe pneumocystis pneumonia.

**Adjunctive therapy**

In moderate to severe pneumocystis infections associated with HIV infection, prednisolone p. 458 is given by mouth for 5 days (alternatively, hydrocortisone p. 456 may be given parenterally); the dose is then reduced over the next 16 days and then stopped. Corticosteroid treatment should ideally be started at the same time as the anti-pneumocystis therapy and certainly no later than 24–72 hours afterwards. The corticosteroid should be withdrawn before anti-pneumocystis treatment is complete.

**Prophylaxis**

Prophylaxis against pneumocystis pneumonia should be given to all children with a history of this infection, and to all HIV-infected infants aged 1 month–1 year. Prophylaxis against pneumocystis pneumonia should also be considered for severely immunocompromised children. Prophylaxis should continue until immunity recovers sufficiently. It should not be discontinued if the child has oral candidiasis, continues to lose weight, or is receiving cytotoxic therapy or long-term immunosuppressant therapy.

Prophylaxis should also be given to infants aged 1 month–1 year who are suspected to be HIV-positive, or whose mothers had a viral load greater than 1000 HIV RNA copies/mL between 36 weeks’ gestation and delivery; prophylaxis should be continued until HIV infection is excluded or until immunity recovers.
Co-trimoxazole by mouth is the drug of choice for prophylaxis against pneumocystis pneumonia. Co-trimoxazole may be used in infants born to mothers with a high risk of transmission of infection.

Inhaled pentamidine isetionate is better tolerated than parenteral pentamidine isetionate. Intermittent inhalation of pentamidine isetionate is used for prophylaxis against pneumocystis pneumonia in children unable to tolerate co-trimoxazole. It is effective but children may be prone to extrapulmonary infection. Alternatively, dapsone can be used.

**ANTIPROTOZOALS**

### Atovaquone

**INDICATIONS AND DOSE**

**Treatment of mild to moderate Pneumocystis jirovecii (Pneumocystis carinii) pneumonia in patients intolerant of co-trimoxazole**

- **BY MOUTH**
  - Child 1-2 months: 15–20 mg/kg twice daily for 14–21 days, dose to be taken with food, particularly high fat food
  - Child 3 months-1 year: 22.5 mg/kg twice daily for 14–21 days, dose to be taken with food, particularly high fat food
  - Child 2-17 years: 15–20 mg/kg twice daily (max. per dose 750 mg) for 14–21 days, dose to be taken with food, particularly high fat food

- **UNLICENSED USE** Not licensed for use in children.
- **CAUTIONS** Other causes of pulmonary disease should be sought and treated - initial diarrhoea and difficulty in taking food may reduce absorption (and require alternative therapy)
- **INTERACTIONS** → Appendix 1: antimalarials
- **SIDE-EFFECTS**
  - *Common or very common* Anaemia - angioedema - bronchospasm - diarrhoea - headache - hypersensitivity - hyponatraemia - insomnia - nausea - neutropenia - skin reactions - throat tightness - vomiting
  - *Frequency not known* Stevens-Johnson syndrome
- **PREGNANCY** Manufacturer advises avoid unless potential benefit outweighs risk
- **BREAST FEEDING** Manufacturer advises avoid.
- **HEPATIC IMPAIRMENT** Manufacturer advises use with caution in significant impairment and monitor closely — no information available.
- **RENAL IMPAIRMENT** Manufacturer advises caution.
- **PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral liquid formulations may include tutti-frutti.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Oral suspension**
    - **CAUTIONARY AND ADVISORY LABELS** 21
    - **Wellvone** (GlaxoSmithKline UK Ltd)
      - Atovaquone 150 mg per 1 ml Wellvone 750mg/5ml oral suspension sugar-free | 226 ml [POD] £486.37 DT = £486.37

### Dapsone

**INDICATIONS AND DOSE**

**Treatment of mild to moderate Pneumocystis jirovecii (Pneumocystis carinii) pneumonia (in combination with trimethoprim)**

- **BY MOUTH**
  - Child 1 month-11 years: 2 mg/kg once daily (max. per dose 100 mg)
  - Child 12-17 years: 100 mg once daily

**Prophylaxis of Pneumocystis jirovecii (Pneumocystis carinii) pneumonia**

- **BY MOUTH**
  - Child: 2 mg/kg once daily (max. per dose 100 mg)

- **UNLICENSED USE** Not licensed for treatment of pneumocystis (P. jirovecii) pneumonia. Monotherapy not licensed for children for prophylaxis of P. jirovecii pneumonia.
- **CAUTIONS** Anaemia (treat severe anaemia before starting)
- **INTERACTIONS** → Appendix 1: dapsone
- **SIDE-EFFECTS** Agranulocytosis - appetite decreased - haemolysis - haemolytic anaemia - headache - hepatic disorders - hypoalbuminaemia - insomnia - lepra reaction - methaemoglobinemia - motor loss - nausea - peripheral neuropathy - photosensitivity reaction - psychosis - severe cutaneous adverse reactions (SCARs) - skin reactions - tachycardia - vomiting
- **SIDE-EFFECTS, FURTHER INFORMATION** Side-effects are dose-related. If dapsone syndrome occurs ( rash with fever and eosinophilia )—discontinue immediately ( may progress to exfoliative dermatitis, hepatitis, hypoalbuminaemia, psychosis and death).
- **PREGNANCY** Folic acid p. 594 ( higher dose ) should be given to mother throughout pregnancy; neonatal haemolysis and methaemoglobinemia reported in third trimester.
- **BREAST FEEDING** Haemolytic anaemia; although significant amount in milk, risk to infant very small unless infant is G6PD deficient.
- **PATIENT AND CARER ADVICE**
  - Blood disorders On long-term treatment, patients and their carers should be told how to recognise signs of blood disorders and advised to seek immediate medical attention if symptoms such as fever, sore throat, rash, mouth ulcers, purpura, bruising or bleeding develop.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 8

- **Dapsone (Non-proprietary)**
  - **Dapsone 50 mg** Dapsone 50mg tablets | 28 tablet [POD] £36.22 DT = £18.62
  - **Dapsone 100 mg** Dapsone 100mg tablets | 28 tablet [POD] £97.39 DT = £89.29

### Pentamidine isetionate

**INDICATIONS AND DOSE**

**Treatment of Pneumocystis jirovecii (Pneumocystis carinii) pneumonia (specialist use only)**

- **BY INTRAVENOUS INFUSION**
  - Child: 4 mg/kg once daily for at least 7–10 days

continued →
**396 Helminth infection**

**Helminth infections**

Advice on prophylaxis and treatment of helminth infections is available from the following specialist centres:

- **Birmingham** (0121) 424 0357
- **Scotland** Contact local Infectious Diseases Unit
- **Liverpool** (0151) 705 3100
- **London** 0845 155 5000 (treatment)

**Threadworms**

Anthelmintics are effective in threadworm (pinworms, *Enterobius vermicularis*) infections, but their use needs to be combined with hygienic measures to break the cycle of auto-infection. All members of the family require treatment. Adult threadworms do not live for longer than 6 weeks and for development of fresh worms, ova must be swallowed and exposed to the action of digestive juices in the upper intestinal tract. Direct multiplication of worms does not take place in the large bowel. Adult female worms lay ova on the perianal skin which causes pruritus; scratching the area then leads to ova being transmitted on fingers to the mouth, often via food eaten with unwashed hands. Washing hands and scrubbing nails before each meal and after each visit to the toilet is essential. A bath taken immediately after rising will remove ova laid during the night.

Mebendazole p. 398 is the drug of choice for treating threadworm infection in patients of all ages over 6 months. It is given as a single dose; as reinfection is very common, a second dose may be given after 2 weeks.

**Ascaricides (common roundworm infections)**

Mebendazole is effective against *Ascaris lumbricoides* and is generally considered to be the drug of choice.

Levamisole p. 398 [unlicensed] (available from ‘special-order’ manufacturers or special importer companies) is

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**Prophylaxis of Pneumocystis jirovecii (Pneumocystis carinii) pneumonia (specialist use only)**

- **By inhalation of nebulised solution**
  - Child 5–17 years: 300 mg every 4 weeks, alternatively 150 mg every 2 weeks, using suitable equipment—consult product literature

**Visceral leishmaniasis (specialist use only)**

- **By deep intramuscular injection**
  - Child 1–7 years: 3–4 mg/kg once daily on alternate days, maximum total of 10 injections, course may be repeated if necessary

**Cutaneous leishmaniasis (specialist use only)**

- **By deep intramuscular injection**
  - Child 1–7 years: 3–4 mg/kg 1–2 times a week until condition resolves

**Trypanosomiasis (specialist use only)**

- **By deep intramuscular injection, or by intravenous infusion**
  - Child 1–7 years: 4 mg/kg once daily or on alternate days for a total of 7–10 injections

**SIDE-EFFECTS**

- **GENERAL SIDE-EFFECTS**
  - Common or very common Dizziness, hypoglycaemia
  - Rare or very rare QT interval prolongation

**SPECIFIC SIDE-EFFECTS**

- Common or very common
  - When used by inhalation: Cough, dyspnoea, respiratory disorders
  - With parenteral use: Acute kidney injury, anaemia, azotaemia, electrolyte imbalance, flushing, haematuria, hyperglycaemia, induration, leucopenia, local pain, myopathy, syncope, thrombocytopenia, vomiting
  - Rare or very rare
    - With parenteral use: Arrhythmia (can be severe and sometimes fatal), pancreatitis (can be severe and sometimes fatal)
  - Frequency not known
    - When used by inhalation: Angioedema, appetite decreased, bradycardia, fatigue, renal failure
    - With parenteral use: Arrhythmias, perioral hypoaesthesia, sensation abnormal—Stevens-Johnson syndrome

**PREGNANCY**

Manufacturer advises avoid unless essential.

**BREAST FEEDING**

Manufacturer advises avoid unless essential—no information available.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution.

**RENAL IMPAIRMENT**

Dose adjustments Reduce intravenous dose for pneumocystis pneumonia if creatinine clearance less than 10 mL/minute: in *life-threatening infection*, use 4 mg/kg once daily for 7–10 days, then 4 mg/kg on alternate days to complete course of at least 14 doses; in less severe infection, use 4 mg/kg on alternate days for at least 14 doses.

**MONITORING REQUIREMENTS**

- Monitor blood pressure before starting treatment, during administration, and at regular intervals, until treatment concluded.
- Carry out laboratory monitoring according to product literature.

**DIRECTIONS FOR ADMINISTRATION**

Patient should be lying down when receiving drug parenterally. Direct intravenous injection should be avoided whenever possible and never given rapidly; intramuscular injections should be deep and preferably given into the buttock. For *intravenous infusion*, reconstitute 300 mg with 3–5 mL. Water for Injections (displacement value may be significant), then dilute required dose with 50–250 mL. Glucose 5% or Sodium Chloride 0.9%; give over at least 60 minutes.

Powder for injection (dissolved in water for injection) may be used for nebulisation.

**HANDLING AND STORAGE**

Pentamidine isetionate is toxic and personnel should be adequately protected during handling and administration—consult product literature.

**UNLICENSED USE**

Not licensed for prevention of pneumocystis pneumonia in children.

**CAUTIONS**

Anaemia, bradycardia, coronary heart disease, history of ventricular arrhythmias, hyperglycaemia, hypotension, hypoglycaemia, hypokalaemia, hypomagnesaemia, hypotension, leucopenia, risk of severe hypotension following administration, thrombocytopenia

**INTERACTIONS**

Appendix 1: pentamidine

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**

- Pentacarinat (Sanofi) Pentamidine isetionate 300 mg Pentacarinat 300 mg powder for solution for injection vials | 5 vial (pack) £158.86
an alternative when mebendazole cannot be used. It is very well tolerated.

**Tapeworm infections**

**Taenicides**

**Niclosamide** [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is the most widely used drug for tapeworm infections and side-effects are limited to occasional gastro-intestinal upset, lightheadedness, and pruritus; it is not effective against larval worms. Fears of developing cystercerosis in *Taenia solium* infections have proved unfounded. All the same, an antiemetic can be given before treatment and a laxative can be given 2 hours after niclosamide.

Praziquantel p. 399 [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is as effective as niclosamide.

**Hydatid disease**

Cysts caused by *Echinococcus granulosus* grow slowly and asymptomatic patients do not always require treatment. Surgical treatment remains the method of choice in many situations. Albendazole below [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is used in conjunction with surgery to reduce the risk of recurrence or as primary treatment in inoperable cases. Alveolar echinococcosis due to *E. multilocularis* is usually fatal if untreated. Surgical removal with albendazole cover is the treatment of choice, but where effective surgery is impossible, repeated cycles of albendazole (for a year or more) may help. Careful monitoring of liver function is particularly important during drug treatment.

**Hookworms**

Hookworms (ancylostomiasis, necatoriasis) live in the upper small intestine and draw blood from the point of their attachment to their host. An iron-deficiency anaemia may occur and, if present, effective treatment of the infection requires not only expulsion of the worms but treatment of the anaemia.

Mebendazole has a useful broad-spectrum activity, and is effective against hookworms. Albendazole [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is an alternative. Levamisole is also is also effective in children.

**Schistosomicides (bilharziasis)**

Adult *Schistosoma haematobium* worms live in the genito-urinary veins and adult *S. mansoni* in those of the colon and mesentery. *S. japonicum* is more widely distributed in veins of the alimentary tract and portal system.

Praziquantel [unlicensed] is available from Merck Serono (Cysticide *) and is effective against all human schistosomes. No serious adverse effects have been reported. Of all the available schistosomicides, it has the most attractive combination of effectiveness, broad-spectrum activity, and low toxicity.

**Filaricides**

*Diethylcarbamazine* [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is effective against microfilariae and adults of *Loa loa*, *Wuchereria bancrofti*, and *Brugia malayi*. To minimise reactions, treatment in adults and children over 1 month, is commenced with a dose of diethylcarbamazine citrate on the first day and increased gradually over 3 days. Length of treatment varies according to infection type, and usually gives a radical cure for these infections. Close medical supervision is necessary particularly in the early phase of treatment.

In heavy infections there may be a febrile reaction, and in heavy *Loa loa* infection there is a small risk of encephalopathy. In such cases specialist advice should be sought, and treatment must be given under careful in-patient supervision and stopped at the first sign of cerebral involvement.

Ivermectin p. 398 [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is very effective in onchocerciasis and it is now the drug of choice; reactions are usually slight. Diethylcarbamazine or suramin should no longer be used for *onchocerciasis* because of their toxicity.

**Cutaneous larva migrans (creeping eruption)**

Dog and cat hookworm larvae may enter human skin where they produce slowly extending itching tracks usually on the foot. Single tracks can be treated with topical thiabendazole (no commercial preparation available). Multiple infections respond to ivermectin, albendazole or thiabendazole (thiabendazole) by mouth [all unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies).

**Strongyloidiasis**

Adult *Strongyloides stercoralis* live in the gut and produce larvae which penetrate the gut wall and invade the tissues, setting up a cycle of auto-infection. Ivermectin [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) is the treatment of choice for chronic *Strongyloides* infection in adults and children over 5 years. Albendazole [unlicensed] (available from ‘special order’ manufacturers or specialist importing companies) is an alternative given to adults and children over 2 years.

### ANTHELMINTICS

#### Albendazole

- **INDICATIONS AND DOSE**
  - **Chronic Strongyloides infection**
    - **BY MOUTH**
      - Child 2-17 years: 400 mg twice daily for 3 days, dose may be repeated after 3 weeks if necessary
  - **Hydatid disease, in conjunction with surgery to reduce the risk of recurrence or as primary treatment in inoperable cases**
    - **BY MOUTH**
      - Child 2-17 years: 7.5 mg/kg twice daily (max. per dose 400 mg twice daily) for 28 days followed by 14-day break, repeated for up to 2–3 cycles
  - **Hookworm infections**
    - **BY MOUTH**
      - Child 2-17 years: 400 mg for 1 dose

- **UNLICENSED USE** Albendazole is an unlicensed drug.

- **INTERACTIONS** → Appendix 1: albendazole

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, chewable tablet, oral suspension

**Tablet**

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<tbody>
<tr>
<td>Eskazole (Imported (Franco))</td>
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| Albendazole 400 mg Eskazole 400mg tablets | 60 tablet |

**Chewable tablet**

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<tr>
<th>Albendazole 400 mg Zentel 400mg chewable tablets</th>
<th>1 tablet</th>
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Medicines for Children leaflet: Levamisole for nephrotic syndrome
www.medicinesforchildren.org.uk/levamisole-nephrotic-syndrome

**Nephrotic syndrome (initiated under specialist supervision)**
- **BY MOUTH**
  - Child: 2.5 mg/kg once daily on alternate days (max. per dose 150 mg)

**UNLICENSED USE** Not licensed.
**CONTRA-INDICATIONS** Blood disorders
**CAUTIONS** Epilepsy - juvenile idiopathic arthritis - Sjögren’s syndrome
**INTERACTIONS** → Appendix 1: levamisole
**SIDE-EFFECTS** Arthralgia (long term use) - blood disorder (long term use) - diarrhoea - dizziness - headache - influenza like illness (long term use) - insomnia (long term use) - myalgia (long term use) - nausea - rash (long term use) - seizure (long term use) - taste altered (long term use) - vasculitis (long term use) - vomiting
**PREGNANCY** Embryotoxic in animal studies, avoid if possible.
**BREAST FEEDING** No information available.
**HEPATIC IMPAIRMENT** Dose adjustments Use with caution—dose adjustment may be necessary.

**DIETARY ADVICE**
- Use with caution
- Dose adjustments
- Use with caution—dose adjustment may be necessary.

**INTERACTIONS** → Appendix 1: mebendazole

**SIDE-EFFECTS**
- Common or very common Gastrointestinal discomfort
- Uncommon Diarrhoea - flatulence
- Rare or very rare Alopecia - atulence - dizziness - hepatitis - neutropenia - seizure - severe cutaneous adverse reactions (SCARs) - skin reactions
- **PREGNANCY** Manufacturer advises avoid—toxicity in animal studies.
- **BREAST FEEDING** Amount present in milk too small to be harmful but manufacturer advises avoid.
4 Protozoal infection

Antiprotozoal drugs

Amoebicides

Metronidazole p. 344 is the drug of choice for acute invasive amoebic dysentery since it is very effective against vegetative forms of Entamoeba histolytica in ulcers. Tinidazole p. 346 is also effective. Metronidazole and tinidazole are also active against amoebae which may have migrated to the liver.

Treatment with metronidazole (or tinidazole) is followed by a 10-day course of diloxanide furoate.

Diloxanide furoate is the drug of choice for asymptomatic patients with E. histolytica cysts in the faeces; metronidazole and tinidazole are relatively ineffective. Diloxanide furoate is relatively free from toxic effects and the usual course is of 10 days, given alone for chronic infections or following metronidazole or tinidazole treatment. For amoebic abscesses of the liver metronidazole is effective; tinidazole is an alternative. Aspiration of the abscess is indicated where it is suspected that it may rupture or where there is no improvement after 72 hours of metronidazole; the aspiration may need to be repeated.

Aspiration aids penetration of metronidazole and, for abscesses with large volumes of pus, if carried out in conjunction with drug therapy, may reduce the period of disability.

Diloxanide furoate is not effective against hepatic amoebiasis, but a 10-day course should be given at the completion of metronidazole or tinidazole treatment to destroy any amoebae in the gut.

Triclofenamides

Metronidazole is the treatment of choice for Trichomonas vaginalis infection. Contact tracing is recommended and sexual contacts should be treated simultaneously. If metronidazole is ineffective, tinidazole may be tried.

Antigiardial drugs

Metronidazole is the treatment of choice for Giardia lamblia infections. Tinidazole may be used as an alternative to metronidazole.

Leishmaniadies

Cutaneous leishmaniasis frequently heals spontaneously but if skin lesions are extensive or unsightly, treatment is indicated, as it is in visceral leishmaniasis (kala-azar). Leishmaniasis should be treated under specialist supervision.

Sodium stibogluconate p. 400, an organic pentavalent antimony compound, is used for visceral leishmaniasis. The dosage varies with different geographical regions and expert advice should be obtained. Skin lesions can also be treated with sodium stibogluconate.

Amphotericin p. 387 is used with or after an antimony compound for visceral leishmaniasis unresponsive to the antimonial alone; side-effects may be reduced by using liposomal amphotericin (AmBisome®). Abelcet® is a lipid formulation of amphotericin, is also likely to be effective but less information is available.

Pentamidine isethionate p. 395 (pentamidine isethionate) has been used in antimony-resistant visceral leishmaniasis, but although the initial response is often good, the relapse rate is high; it is associated with serious side-effects. Other treatments include paromomycin [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies).
Trypanocides
The prophylaxis and treatment of trypanosomiasis is difficult and differs according to the strain of organism. Expert advice should therefore be obtained.

Toxoplasmosis
Most infections caused by Toxoplasma gondii are self-limiting, and treatment is not necessary. Exceptions are patients with eye involvement (toxoplasma chorioretinitis), and those who are immunosuppressed. Toxoplasmic encephalitis is a common complication of AIDS. The treatment of choice is a combination of pyrimethamine p. 412 and sulfadiazine p. 363, given for several weeks (expert advice essential). Pyrimethamine is a folate antagonist, and adverse reactions to this combination are relatively common (folinic acid supplements and weekly blood counts needed). Alternative regimens use combinations of pyrimethamine with clindamycin p. 337 or clarithromycin p. 340 or azithromycin p. 339. Long-term secondary prophylaxis is required after treatment of toxoplasmosis in immunocompromised patients; prophylaxis should continue until immunity recovers.

If toxoplasmosis is acquired in pregnancy, transplacental infection may lead to severe disease in the fetus; specialist advice should be sought on management. Spiramycin [unlicensed] (available from ‘special-order’ manufacturers or specialist importing companies) may reduce the risk of infection if pharyngeal or tracheal involvement (may be life-threatening inflammation around the lesions (may be life-threatening pneumonia)).

Other neonates without signs of toxoplasmosis, but born to mothers known to have become infected, spiramycin is given while awaiting laboratory results. If toxoplasmosis is confirmed in the infant, pyrimethamine and sulfadiazine are given for 12 months, together with folinic acid.

4.1 Leishmaniasis

Other drugs used for Leishmaniasis Amphotericin, p. 387 • Pentamidine isetionate, p. 395

ANTIPROTOZOALS
Sodium stibogluconate

- INDICATIONS AND DOSE
  Visceral leishmaniasis (specialist use only)
  - BY INTRAVENOUS INJECTION, OR BY INTRAMUSCULAR INJECTION
    - Child: 20 mg/kg daily for at least 20 days

- UNLICENSED USE
  - With intravenous use Licensed for use in children (age range not specified by manufacturer).

- CAUTIONS
  Heart disease (withdraw if conduction disturbances occur) • mucocutaneous disease • predisposition to QT interval prolongation • treat intercurrent infection (e.g. pneumonia)

- CAUTIONS, FURTHER INFORMATION
  Mucocutaneous disease Successful treatment of mucocutaneous leishmaniasis may induce severe inflammation around the lesions (may be life-threatening if pharyngeal or tracheal involvement)—may require corticosteroid.

- INTERACTIONS • Appendix 1: sodium stibogluconate

- SIDE-EFFECTS
  - Common or very common Abdominal pain • appetite decreased • arthralgia • diarrhoea • headache • lethargy • malaise • myalgia • nausea • vomiting
  - Rare or very rare Chest pain • chills • fever • flushing • haemorrhage • hyperhidrosis • jaundice • skin reactions • vertigo

- Frequency not known Arrhythmias • cough • pain • pancreatitis • pneumonia • QT interval prolongation • thrombosis

- PREGNANCY
  - Manufacturer advises use only if potential benefit outweighs risk.

- BREAST FEEDING
  - Amount probably too small to be harmful.

- HEPATIC IMPAIRMENT
  - Manufacturer advises caution (limited information available; abnormalities in hepatic function may be expected in visceral leishmaniasis).

- RENAL IMPAIRMENT
  - Avoid in significant impairment.

- MONITORING REQUIREMENTS
  - Monitor ECG before and during treatment.

- DIRECTIONS FOR ADMINISTRATION
  - Intravenous injections must be given slowly over 5 minutes (to reduce risk of local thrombosis) and stopped if coughing or substernal pain occurs. Injection should be filtered immediately before administration using a filter of 5 microns or less.

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.

Solution for injection
- Pentostam (GlaxoSmithKline UK Ltd) Antimony pentavalent (as Sodium stibogluconate) 100 mg per 1 ml Pentostam 10g/100ml solution for injection vials | 1 vial (Price £66.43)

4.2 Malaria

Antimalarials

Artemether with lumefantrine
Artemether with lumefantrine p. 408 is licensed for the treatment of acute uncomplicated falciparum malaria.

Arteminol with piperaquine
Arteminol with piperaquine phosphate p. 408 is not recommended for the first-line treatment of acute uncomplicated falciparum malaria because there is limited experience of its use in travellers who usually reside in areas where malaria is not endemic. Piperaquine has a long half-life.

Atovaquone with proguanil
Atovaquone with proguanil hydrochloride p. 409 is licensed for the prophylaxis of falciparum malaria (for details, see Recommended regimens for prophylaxis against malaria p. 402) and for the treatment of acute, uncomplicated falciparum malaria.

Chloroquine
Chloroquine p. 410 is usually used with proguanil hydrochloride p. 412 for the prophylaxis of malaria in areas of the world where there is little chloroquine resistance, but this regimen may not give optimal protection (for details, see Recommended regimens for prophylaxis against malaria P. 402).

Guidelines for malaria prevention in travellers from the United Kingdom (2018) published by Public Health England state that patients already taking hydroxychloroquine sulfate p. 662 for another indication, and for whom
chloroquine would be an appropriate antimalarial, can remain on hydroxychloroquine sulfate.

Chloroquine is no longer recommended for the treatment of falciparum malaria owing to widespread resistance, nor is it recommended if the infective species is not known or if the infection is mixed; in these cases treatment should be with quinine p. 413, atovaquone with proguanil hydrochloride p. 409, or arteether with lumefantrine. It is still recommended for the treatment of non-falciparum malaria.

**Doxycycline**

Doxycycline p. 364 is used in adults and children over 12 years for the prophylaxis of malaria in areas of widespread mefloquine or chloroquine resistance. Doxycycline is also used as an alternative to mefloquine p. 411 or atovaquone with proguanil hydrochloride p. 409 (for details, see Recommended regimens for prophylaxis against malaria p. 402).

**Mefloquine**

Mefloquine is used for the prophylaxis of malaria in areas of the world where there is a high risk of chloroquine resistant falciparum malaria (for details, see Recommended regimens for prophylaxis against malaria p. 402). Mefloquine is now rarely used for the treatment of falciparum malaria because of increased resistance. It is rarely used for the treatment of non-falciparum malaria because better tolerated alternatives are available. Mefloquine should not be used for treatment if it has been used for prophylaxis.

**Primaquine**

Primaquine p. 412 is used to eliminate the liver stages of *P. vivax* or *P. ovale* following chloroquine treatment.

**Proguanil**

Proguanil hydrochloride is usually used in combination with chloroquine or atovaquone for the prophylaxis of malaria, (for details, see Recommended regimens for prophylaxis against malaria p. 402).

Proguanil hydrochloride used alone is not suitable for the treatment of malaria; however atovaquone with proguanil hydrochloride p. 409 is licensed for the treatment of acute uncomplicated falciparum malaria. Atovaquone with proguanil hydrochloride is also used for the prophylaxis of falciparum malaria in areas of widespread mefloquine or chloroquine resistance. Atovaquone with proguanil hydrochloride is also used as an alternative to mefloquine or doxycycline. Atovaquone with proguanil hydrochloride is particularly suitable for short trips to highly chloroquine-resistant areas because it needs to be taken only for 7 days after leaving an endemic area.

**Pyrimethamine**

Pyrimethamine p. 412 should not be used alone, but is used with sulfadoxine.

Pyrimethamine with sulfadoxine is not recommended for the prophylaxis of malaria, but can be used in the treatment of falciparum malaria with (or following) quinine.

**Quinine**

Quinine is not suitable for the prophylaxis of malaria. Quinine is used for the treatment of falciparum malaria, if the infective species is not known, or if the infection is mixed (for details see Malaria, treatment p. 407).

**Useful resources**

All recommendations on prophylaxis against malaria reflect guidelines agreed by UK malaria specialists, published in the Public Health England Guidelines for malaria prevention in travellers from the United Kingdom, 2018. The advice is aimed at residents of the UK who travel to endemic areas.
### Key to recommended regimens for prophylaxis against malaria

<table>
<thead>
<tr>
<th>Codes for regimens</th>
<th>Details of regimens for prophylaxis against malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>No risk</td>
</tr>
<tr>
<td>1</td>
<td>Chemoprophylaxis not recommended, but avoid mosquito bites and consider malaria if fever presents</td>
</tr>
<tr>
<td>2</td>
<td>Chloroquine only</td>
</tr>
<tr>
<td>3</td>
<td>Chloroquine with proguanil</td>
</tr>
<tr>
<td>4</td>
<td>Atovaquone with proguanil hydrochloride or doxycycline or mefloquine</td>
</tr>
</tbody>
</table>

### Specific recommendations

<table>
<thead>
<tr>
<th>Country</th>
<th>Comments on risk of malaria and regional or seasonal variation</th>
<th>Codes for regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Afghanistan</strong></td>
<td>Low risk below 2000 m from May–November</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk below 2000 m from December–April</td>
<td>1</td>
</tr>
<tr>
<td><strong>Algeria</strong></td>
<td>Very low risk in remote focus in Illizi department only</td>
<td>1</td>
</tr>
<tr>
<td><strong>Andaman and Nicobar Islands (India)</strong></td>
<td>Low risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Angola</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Argentina</strong></td>
<td>Very low risk in low altitude areas of Salta provinces bordering Bolivia and in Chaco, Corrientes, and Misiones provinces close to border with Paraguay and Brazil</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Iguacu Falls and areas other than those above</td>
<td>-</td>
</tr>
<tr>
<td><strong>Armenia</strong></td>
<td>No risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Azerbaijan</strong></td>
<td>Very low risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Bangladesh</strong></td>
<td>High risk in Chittagong Hill Tract districts (but not Chittagong city)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Very low risk in Chittagong city and other areas, except Chittagong Hill Tract districts</td>
<td>1</td>
</tr>
<tr>
<td><strong>Belize</strong></td>
<td>Low risk in rural areas</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Belize district (including Belize city and islands)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Benin</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Bhutan</strong></td>
<td>Low risk in southern belt districts, along border with India: Chukha, Geyleg-phug, Samchi, Samdrup Jonkhar, and Shemgang</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in areas other than those above</td>
<td>-</td>
</tr>
<tr>
<td><strong>Bolivia</strong></td>
<td>Low risk in Amazon basin</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Low risk in rural areas below 2500 m (other than above)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk above 2500 m</td>
<td>-</td>
</tr>
<tr>
<td><strong>Botswana</strong></td>
<td>High risk from November–June in northern half, including Okavango Delta area</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Low risk from July–October in northern half</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in southern half</td>
<td>1</td>
</tr>
<tr>
<td><strong>Brazil</strong></td>
<td>Low risk in Amazon basin, including city of Manaus</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in areas other than those above</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Iguacu Falls</td>
<td>-</td>
</tr>
<tr>
<td><strong>Brunei Darussalam</strong></td>
<td>Very low risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Burkina Faso</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Burundi</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Cambodia</strong></td>
<td>Low risk. Mefloquine resistance widespread in western provinces bordering Thailand</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in Angkor Wat and Lake Tonle Sap, including Siem Reap</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Phnom Penh</td>
<td>-</td>
</tr>
<tr>
<td><strong>Cameroon</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Cape Verde</strong></td>
<td>Individuals travelling to Praia who are at increased risk of malaria (such as long-term travellers and those at risk of severe complications from malaria including pregnant women, infants and young children, the elderly, and asplenic individuals) should consider taking antimalarials, seek advice from a travel health advisor. Very low risk on island of Santiago (Sao Tiago) and Boa Vista</td>
<td>1</td>
</tr>
<tr>
<td><strong>Central African Republic</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Chad</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Country</td>
<td>Comments on risk of malaria and regional or seasonal variation</td>
<td>Codes for regimens</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>China</td>
<td>Low risk in Yunnan and Hainan provinces</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in southern and some central provinces, including Anhui, Ghuizhou, Henan, Hubei, and Jiangsu below 1500 m</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in areas other than those above and below</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Hong Kong</td>
<td>-</td>
</tr>
<tr>
<td>Colombia</td>
<td>Low risk in rural areas below 1600 m</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk above 1600 m and in Cartagena</td>
<td>1</td>
</tr>
<tr>
<td>Comoros</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Congo</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>Low risk in Limon province, but not city of Limon (Puerto Limon)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in areas other than those above</td>
<td>1</td>
</tr>
<tr>
<td>Cote d’Ivoire (Ivory Coast)</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Djibouti</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>Low risk</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in cities of Santiago and Santo Domingo</td>
<td>-</td>
</tr>
<tr>
<td>East Timor (Timor-Leste)</td>
<td>Risk present</td>
<td>4</td>
</tr>
<tr>
<td>Ecuador</td>
<td>Low risk in areas below 1500 m including coastal provinces and Amazon basin</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Galapagos islands or city of Guayaquil</td>
<td>-</td>
</tr>
<tr>
<td>Egypt</td>
<td>No risk</td>
<td>1</td>
</tr>
<tr>
<td>El Salvador</td>
<td>Low risk in rural areas of Santa Ana, Ahauchapán, and La Unión provinces in western part of country; very low risk in other areas</td>
<td>1</td>
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<tr>
<td>Equatorial Guinea</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Eritrea</td>
<td>High risk below 2200 m</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>No risk in Asmara or in areas above 2200 m</td>
<td>-</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>High risk below 2000 m</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>No risk in Addis Ababa or in areas above 2000 m</td>
<td>-</td>
</tr>
<tr>
<td>French Guiana</td>
<td>Risk present (particularly in border areas) except city of Cayenne or Devil’s Island (Ile du Diable)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Low risk in city of Cayenne or Devil’s Island (Ile du Diable)</td>
<td>1</td>
</tr>
<tr>
<td>Gabon</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Gambia</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Georgia</td>
<td>Very low risk in rural south east from June-October</td>
<td>1</td>
</tr>
<tr>
<td>Ghana</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Guatemala</td>
<td>Low risk below 1500 m</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Guatemala City, Antigua, or Lake Atitlan and above 1500 m</td>
<td>-</td>
</tr>
<tr>
<td>Guinea</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Guyana</td>
<td>Risk present in all interior regions</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Very low risk in Georgetown and coastal region</td>
<td>1</td>
</tr>
<tr>
<td>Haiti</td>
<td>Risk present</td>
<td>3</td>
</tr>
<tr>
<td>Honduras</td>
<td>Low risk below 1000 m and in Roatán and other Bay Islands</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in San Pedro Sula or Tegucigalpa and areas above 1000 m</td>
<td>-</td>
</tr>
<tr>
<td>India</td>
<td>Risk present in states of Assam and Orissa, districts of East Godavari, Srikakulam, Vishakhapatnam, and Vizianagaram in the state of Andhra Pradesh, and districts of Balaghat, Dindori, Mandla, and Seoni in the state of Madhya Pradesh</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Low risk in areas other than those above or below (including Goa, Andaman and Nicobar islands)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Exceptional circumstances in low risk areas (dependent on individual risk assessment)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>No risk in Lakshadweep islands</td>
<td>-</td>
</tr>
<tr>
<td>Indonesia</td>
<td>High risk in Irian Jaya (Papua)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Low risk in Bali, Lombok and islands of Java and Sumatra</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in city of Jakarta</td>
<td>-</td>
</tr>
<tr>
<td>Indonesia (Borneo)</td>
<td>Low risk</td>
<td>1</td>
</tr>
</tbody>
</table>
### Key to recommended regimens for prophylaxis against malaria

<table>
<thead>
<tr>
<th>Codes for regimens</th>
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<tbody>
<tr>
<td>-</td>
<td>No risk</td>
</tr>
<tr>
<td>1</td>
<td>Chemoprophylaxis not recommended, but avoid mosquito bites and consider malaria if fever presents</td>
</tr>
<tr>
<td>2</td>
<td>Chloroquine only</td>
</tr>
<tr>
<td>3</td>
<td>Chloroquine with proguanil</td>
</tr>
<tr>
<td>4</td>
<td>Atovaquone with proguanil hydrochloride or doxycycline or mefloquine</td>
</tr>
</tbody>
</table>

### Specific recommendations

<table>
<thead>
<tr>
<th>Country</th>
<th>Comments on risk of malaria and regional or seasonal variation</th>
<th>Codes for regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Iran</strong></td>
<td>Low risk from March–November in rural south eastern provinces and in north, along Azerbaijan border in Ardabil, and near Turkmenistan border in North Khorasan</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in areas other than those above</td>
<td>1</td>
</tr>
<tr>
<td><strong>Iraq</strong></td>
<td>Very low risk from May–November in rural northern area below 1500 m</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in areas other than those above</td>
<td>-</td>
</tr>
<tr>
<td><strong>Kenya</strong></td>
<td>High risk (except city of Nairobi)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Very low risk in the highlands above 2500 m and in city of Nairobi</td>
<td>1</td>
</tr>
<tr>
<td><strong>Lao People’s Democratic Republic (Laos)</strong></td>
<td>Low risk</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in city of Vientiane</td>
<td>1</td>
</tr>
<tr>
<td><strong>Liberia</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Libya</strong></td>
<td>No risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Madagascar</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Malawi</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Malaysia</strong></td>
<td>Low risk in mainland Malaysia</td>
<td>1</td>
</tr>
<tr>
<td><strong>Malaysia (Borneo)</strong></td>
<td>Low risk in inland areas of Sabah and in inland, forested areas of Sarawak</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in areas other than those above, including coastal areas of Sabah and Sarawak</td>
<td>1</td>
</tr>
<tr>
<td><strong>Mali</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Mauritania</strong></td>
<td>High risk all year in southern provinces, and from July–October in the northern provinces</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Low risk from November–June in the northern provinces</td>
<td>1</td>
</tr>
<tr>
<td><strong>Mauritius</strong></td>
<td>No risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Mayotte</strong></td>
<td>Risk present</td>
<td>4</td>
</tr>
<tr>
<td><strong>Mexico</strong></td>
<td>Very low risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Mozambique</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Myanmar</strong></td>
<td>Low risk</td>
<td>1</td>
</tr>
<tr>
<td><strong>Namibia</strong></td>
<td>High risk all year in regions of Caprivi Strip, Kavango, and Kunene river, and from November–June in northern third of country</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Very low risk in areas other than those above; low risk from July–October in northern third of country</td>
<td>1</td>
</tr>
<tr>
<td><strong>Nepal</strong></td>
<td>Low risk below 1500 m, including the Terai district</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in city of Kathmandu and on typical Himalayan treks</td>
<td>-</td>
</tr>
<tr>
<td><strong>Nicaragua</strong></td>
<td>Low risk (except Managua)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk in Managua</td>
<td>1</td>
</tr>
<tr>
<td><strong>Niger</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>Nigeria</strong></td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td><strong>North Korea</strong></td>
<td>Very low risk in some southern areas</td>
<td>1</td>
</tr>
<tr>
<td><strong>Pakistan</strong></td>
<td>Low risk below 2000 m</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk above 2000 m</td>
<td>1</td>
</tr>
<tr>
<td><strong>Panama</strong></td>
<td>Low risk east of Canal Zone</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very low risk west of Canal Zone</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in Panama City or Canal Zone itself</td>
<td>-</td>
</tr>
<tr>
<td><strong>Papua New Guinea</strong></td>
<td>High risk below 1800 m</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Very low risk above 1800 m</td>
<td>1</td>
</tr>
<tr>
<td><strong>Paraguay</strong></td>
<td>No risk</td>
<td>1</td>
</tr>
<tr>
<td>Country</td>
<td>Comments on risk of malaria and regional or seasonal variation</td>
<td>Codes for regimens</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Peru</td>
<td>Low risk in Amazon basin along border with Brazil, particularly in Loreto province and in rural areas below 2000 m including the Amazon basin bordering Bolivia. No risk in city of Lima and coastal region south of Chiclayo.</td>
<td>1</td>
</tr>
<tr>
<td>Philippines</td>
<td>Low risk in rural areas below 600 m and on islands of Luzon, Mindanao, Mindoro, and Palawan. No risk in cities or on islands of Boracay, Bohol, Catanduanes, Cebu, or Leyte.</td>
<td>1</td>
</tr>
<tr>
<td>Rwanda</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>São Tomé and Príncipe</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>Low risk in south-western provinces along border with Yemen, including below 2000 m in Asir province. No risk in cities of Jeddah, Makkah (Mecca), Medina, Riyadh, or Ta’if, or above 2000 m in Asir province.</td>
<td>1</td>
</tr>
<tr>
<td>Senegal</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Somalia</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>South Africa</td>
<td>Risk from September–May in low altitude areas of Mpumalanga and Limpopo, particularly those bordering Mozambique, Swaziland (Estwatini), and Zimbabwe (including Kruger National Park). Low risk in north-east KwaZulu-Natal and in designated areas of Mpumalanga and Limpopo. Very low risk in North West Province (adjacent to Molopo river) and Northern Cape Province (adjacent to Orange river).</td>
<td>4</td>
</tr>
<tr>
<td>South Korea</td>
<td>Very low risk in northern areas, in Gangwon-do and Gyeonggi-do provinces, and Incheon city (towards Demilitarized Zone).</td>
<td>1</td>
</tr>
<tr>
<td>South Sudan</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Low risk north of Vavuniya. Very low risk in areas other than those above and below. No risk in Colombo or Kandy.</td>
<td>1</td>
</tr>
<tr>
<td>Sudan</td>
<td>High risk in central and southern areas; risk also present in rest of country (except Khartoum). Very low risk in Khartoum.</td>
<td>4</td>
</tr>
<tr>
<td>Suriname</td>
<td>Risk present on the French Guiana border. Low risk in areas other than above and below. No risk in city of Paramaribo.</td>
<td>4</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Risk in northern and eastern regions bordering Mozambique and South Africa, including all of Lubombo district and Big Bend, Mhlume, Simunye, and Tshaneni regions. Very low risk in the areas other than those above.</td>
<td>4</td>
</tr>
<tr>
<td>Syria</td>
<td>Very low risk in small, remote foci of El Hasakah.</td>
<td>1</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>Very low risk. No risk above 2000 m.</td>
<td>1</td>
</tr>
<tr>
<td>Tanzania</td>
<td>High risk below 1800 m; risk also in Zanzibar. No risk above 1800 m.</td>
<td>4</td>
</tr>
<tr>
<td>Thailand</td>
<td>Mefloquine resistance present. Low risk in rural forested borders with Cambodia, Laos, and Myanmar. Low risk in areas other than those above, including Kanchanaburi (Kwai Bridge). No risk in cities of Bangkok, Chiang Mai, Chiang Rai, Koh Phangan, Koh Samui, and Pattaya.</td>
<td>1</td>
</tr>
<tr>
<td>Togo</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Turkey</td>
<td>Very low risk.</td>
<td>1</td>
</tr>
<tr>
<td>Uganda</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>Very low risk in extreme south-east.</td>
<td>1</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Risk present</td>
<td>4</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Risk in all areas south of, and including, the Orinoco river and Angel Falls, rural areas of Apure, Monagas, Sucre, and Zulia states. No risk in city of Caracas or on Margarita Island.</td>
<td>1</td>
</tr>
</tbody>
</table>
Key to recommended regimens for prophylaxis against malaria

<table>
<thead>
<tr>
<th>Codes for regimens</th>
<th>Details of regimens for prophylaxis against malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>No risk</td>
</tr>
<tr>
<td>1</td>
<td>Chemoprophylaxis not recommended, but avoid mosquito bites and consider malaria if fever presents</td>
</tr>
<tr>
<td>2</td>
<td>Chloroquine only</td>
</tr>
<tr>
<td>3</td>
<td>Chloroquine with proguanil</td>
</tr>
<tr>
<td>4</td>
<td>Atovaquone with proguanil hydrochloride or doxycycline or mefloquine</td>
</tr>
</tbody>
</table>

Specific recommendations

<table>
<thead>
<tr>
<th>Country</th>
<th>Comments on risk of malaria and regional or seasonal variation</th>
<th>Codes for regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam</td>
<td>Low risk in rural areas, and in southern provinces of Tay Ninh, Lam Dong, Dac Lac, Gia Lai, and Kon Tum</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No risk in large cities (including Ho Chi Minh City (Saigon) and Hanoi), the Red River delta, coastal areas north of Nha Trang and Phu Quoc island</td>
<td>1</td>
</tr>
<tr>
<td>Western Sahara</td>
<td>No risk</td>
<td>1</td>
</tr>
<tr>
<td>Yemen</td>
<td>Risk below 2000 m</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Very low risk on Socrota Island; no risk above 2000 m, including Sana’a city</td>
<td>1</td>
</tr>
<tr>
<td>Zambia</td>
<td>High risk</td>
<td>4</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>High risk all year in Zambezi valley, and from November–June in areas below 1200 m</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Low risk from July–October in areas below 1200 m; very low risk all year in Harare and Bulawayo</td>
<td>1</td>
</tr>
</tbody>
</table>

up to 3 years). Doxycycline can be used for up to 2 years, and atovaquone with proguanil hydrochloride for up to 1 year. Prophylaxis with mefloquine, doxycycline, or Malarone™ may be considered for longer durations if it is justified by the risk of exposure to malaria. Specialist advice should be sought for long-term prophylaxis.

Return from malarial region

It is important to consider that any illness that occurs within 1 year and especially within 3 months of return might be malaria even if all recommended precautions against malaria were taken. Travellers should be warned of this and told that if they develop any illness particularly within 3 months of their return they should see a doctor immediately and specifically mention their exposure to malaria.

Epilepsy

Both chloroquine and mefloquine are unsuitable for malaria prophylaxis in individuals with a history of epilepsy. In these patients, doxycycline (children aged 12 years and over) or atovaquone with proguanil hydrochloride may be used. However doxycycline may interact with some antiepileptics and its dose may need to be adjusted, see interactions information for doxycycline.

Asplenia

Asplenic individuals (or those with severe splenic dysfunction) are at particular risk of severe malaria. If travel to malarious areas is unavoidable, rigorous precautions are required against contracting the disease.

Pregnancy

Travel to malarious areas should be avoided during pregnancy; if travel is unavoidable, effective prophylaxis must be used. Chloroquine and proguanil hydrochloride can be given in the usual doses during pregnancy, but these drugs are not appropriate for most areas because their effectiveness has declined; in the case of proguanil hydrochloride, folic acid p. 594 (dosed as a pregnancy at ‘high-risk’ of neural tube defects) should be given for at least the first trimester. If travelling to high risk areas or there is resistance to other drugs, mefloquine may be considered during the second or third trimester of pregnancy.

Mefloquine can be used in the first trimester with caution if the benefits outweigh the risks. Doxycycline is contra-indicated during pregnancy; however, it can be used for malaria prophylaxis if other regimens are unsuitable, and if the entire course of doxycycline can be completed before 15 weeks’ gestation [unlicensed]. Atovaquone with proguanil hydrochloride should be avoided during pregnancy, however, it can be considered during the second and third trimesters if there is no suitable alternative. Folic acid (dosed as a pregnancy at ‘high-risk’ of neural tube defects) should be given if atovaquone with proguanil hydrochloride is used during pregnancy.

Breast-feeding

Some antimalarials should be avoided when breast feeding, see individual drugs for details.

Prophylaxis is required in breast-fed infants; although antimalarials are present in milk, the amounts are too variable to give reliable protection.

Anticoagulants

Travellers taking warfarin sodium p. 99 should begin chemoprophylaxis 2–3 weeks before departure and the INR should be stable before departure. It should be measured before starting chemoprophylaxis, 7 days after starting, and after completing the course. For prolonged stays, the INR should be checked at regular intervals.

Other medical conditions

For additional information on malaria prophylaxis in patients with other medical conditions, see Public Health England Guidelines for malaria prevention in travellers from the UK.

Standby treatment

Children and their parents or carers visiting remote, malarious areas for prolonged periods should carry standby treatment if they are likely to be more than 24 hours away from medical care. Self-medication should be avoided if medical help is accessible.

In order to avoid excessive self-medication, the traveller should be provided with written instructions that urgent medical attention should be sought if fever (38°C or more) develops 7 days (or more) after arriving in a malarious area.
and that self-treatment is indicated if medical help is not available within 24 hours of fever onset.

In view of the continuing emergence of resistant strains and of the different regimens required for different areas, expert advice should be sought on the best treatment course for an individual traveller. A drug used for chemoprophylaxis should not be considered for standby treatment for the same traveller.

**Malaria prophylaxis, specific recommendations**

Travellers planning journeys across continents can travel into areas that have different malaria prophylaxis recommendations. The choice of prophylaxis medication must reflect overall risk to ensure protection in all areas; it may be possible to change from one regimen to another. Those travelling to remote or little-visited areas may require expert advice. For further information see Recommended regimens for prophylaxis against malaria, and Public Health England Guidelines for malaria prevention in travellers from the United Kingdom.

**Important**

Settled immigrants (or long-term visitors) to the UK may be unaware that any immunity they may have acquired while living in malarious areas is lost rapidly after migration to the UK, or that any non-malarious areas where they lived previously may now be malarious.

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**Malaria, treatment**

**Advice for healthcare professionals**

A number of specialist centres are able to provide advice on specific problems.

- PHE (Public Health England) Malaria Reference Laboratory (020) 7637 0248 (fax) (prophylaxis only) www.malaria-reference.co.uk
- National Travel Health Network and Centre 0845 602 6712 Monday and Friday: 9–11 a.m. and 1–2 p.m., Tuesday to Thursday: 9–11 a.m. and 1–3:30 p.m. travelhealthpro.org.uk/
- Travel Medicine Team, Health Protection Scotland (registered users of Travax only) www.travax.nhs.uk (for registered users of the NHS Travax website only) (0141) 300 1100 (weekdays 2–4 p.m. only)
- Birmingham (0121) 424 2358
- Liverpool (0151) 705 3100
- London 0845 155 5000 (treatment) Oxford (01865) 225 430

**Advice for travellers**

- Hospital for Tropical Diseases Travel Healthline (020) 7950 7799 www.fitfortravel.nhs.uk
- WHO advice on international travel and health www.who.int/ith
- National Travel Health Network and Centre (NaTHNaC) www.travelhealthpro.org.uk/

**Treatment**

Recommends on the prophylaxis and treatment of malaria reflect guidelines agreed by UK malaria specialists. Choice will depend on the age of the child. If the infective species is not known, or if the infection is mixed, initial treatment should be as for *falciparum malaria* with quinine p. 413, *Malarone*® (atovaquone with proguanil hydrochloride p. 409), or *Riamet*® (artemether with lumefantrine) can be given by mouth if the child can swallow and retain tablets and there are no serious manifestations (e.g. impaired consciousness); quinine should be given by intravenous infusion if the child is seriously ill or unable to take tablets. Mefloquine p. 411 is now rarely used for treatment because of concerns about resistance.

Oral quinine is well tolerated by children although the salts are bitter. Quinine is given by mouth together with or followed by clindamycin p. 337 [unlicensed indication] or, in children over 12 doxycycline p. 364.

If the parasite is likely to be sensitive, pyrimethamine with sulfadoxine as a single dose [unlicensed] may be given (instead of either clindamycin or doxycycline) together with, or after, a course of quinine.

Alternatively, *Malarone*® or *Riamet*® may be given instead of quinine. It is not necessary to give clindamycin, doxycycline, or pyrimethamine with sulfadoxine after *Malarone*® or *Riamet*® treatment.

If the child is seriously ill or unable to swallow tablets, or if more than 2% of red blood cell are parasitized, quinine should be given by intravenous infusion [unlicensed] (until patient can swallow tablets to complete the 7-day course together with or followed by either doxycycline in children over 12 years, or clindamycin).

Specialist advice should be sought in difficult cases (e.g. very high parasite count, deterioration on optimal doses of quinine, infection acquired in quinine-resistant areas of south east Asia) because intravenous artesunate may be available for ‘named-patient’ use.

**Pregnancy**

Falciparum malaria is particularly dangerous in pregnancy, especially in the last trimester. The treatment doses of oral and intravenous quinine (including the loading dose) can safely be given in pregnancy. Clindamycin [unlicensed indication] should be given for 7 days with or after quinine. Doxycycline should be avoided in pregnancy (affects teeth and skeletal development in fetus); pyrimethamine with sulfadoxine, *Malarone*®, and *Riamet*® are also best avoided until more information is available. Specialist advice should be sought in difficult cases (e.g. very high parasite count, deterioration on optimal doses of quinine, infection acquired in quinine-resistant areas of south east Asia) because intravenous artesunate may be available for ‘named patient’ use.

**Non-falciparum malaria (treatment)**

Non-falciparum malaria is usually caused by *Plasmodium vivax* and less commonly by *P. ovale* and *P. malariae*. *P. knowlesi* is also present in the Asia-Pacific region.

Chloroquine is the drug of choice for the treatment of non-falciparum malaria (but chloroquine-resistant *P. vivax* has been reported in the Indonesian archipelago, the Malay Peninsula, including Myanmar, and eastward to Southern Vietnam).

For the treatment of chloroquine-resistant non-falciparum malaria, *Malarone*® [unlicensed indication], quinine, or *Riamet*® [unlicensed indication] can be used; as with chloroquine, primaquine p. 412 should be given for radical cure.

Chloroquine alone is adequate for *P. malariae* and *P. knowlesi* infections but in the case of *P. vivax* and *P. ovale*, a radical cure (to destroy parasites in the liver and thus prevent relapses) is required. This is achieved with primaquine [unlicensed] given after chloroquine.
For a radical cure, primaquine [unlicensed] is then given to children over 6 months of age; specialist advice should be sought for children under 6 months of age.

**Parenteral**
If the child is unable to take oral therapy, quinine can be given by intravenous infusion, changed to oral chloroquine as soon as the patient’s condition permits.

**Pregnancy**
Treatment doses of chloroquine can be given for non-falciparum malaria. In the case of P. vivax or P. ovale, however, the radical cure with primaquine should be postponed until the pregnancy is over; instead chloroquine should be continued, given weekly, during the pregnancy.

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**ANTIPROTOZOALS ▶ ANTIMALARIALS**

**Artemether with lumefantrine**

Treatment of acute uncomplicated falciparum malaria | Treatment of chloroquine-resistant non-falciparum malaria

- **BY MOUTH**
  - Child (body-weight 5-14 kg): Initially 1 tablet, followed by 1 tablet for 5 doses each given at 8, 24, 36, 48, and 60 hours (total 6 tablets over 60 hours)
  - Child (body-weight 15-24 kg): Initially 2 tablets, followed by 2 tablets for 5 doses each given at 8, 24, 36, 48, and 60 hours (total 12 tablets over 60 hours)
  - Child (body-weight 25-34 kg): Initially 3 tablets, followed by 3 tablets for 5 doses each given at 8, 24, 36, 48, and 60 hours (total 18 tablets over 60 hours)
  - Child 12-17 years (body-weight 35 kg and above): Initially 4 tablets, followed by 4 tablets for 5 doses each given at 8, 24, 36, 48, and 60 hours (total 24 tablets over 60 hours)

- **UNLICENSED USE** Use in treatment of non-falciparum malaria is an unlicensed indication.

- **CONTRA-INDICATIONS** Family history of congenital QT interval prolongation - family history of sudden death - history of arrhythmias - history of clinically relevant bradycardia - history of congestive heart failure accompanied by reduced left ventricular ejection fraction

- **CAUTIONS** Avoid in Acute porphyrias p. 624 - electrolyte disturbances

- **INTERACTIONS** ▶ Appendix 1: antimalarials

- **SIDE-EFFECTS** ▶ Common or very common Abdominal pain - appetite decreased - arthralgia - asthma - cough - diarrhoea - dizziness - headache - myalgia - nausea - palpitations - QT interval prolongation - skin reactions - sleep disorders - vomiting
  - Uncommon Clonus - drowsiness
  - Frequency not known Angioedema

- **PREGNANCY** Toxicity in animal studies with artemether. Manufacturer advises use only if potential benefit outweighs risk.

- **BREAST FEEDING** Manufacturer advises avoid breastfeeding for at least 1 week after last dose. Present in milk in animal studies.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in severe impairment (no information available)—monitor ECG and plasma potassium concentration.

- **RENAL IMPAIRMENT** Manufacturer advises caution in severe impairment.
  - Monitoring In severe renal impairment monitor ECG and plasma potassium concentration.
  - MONITORING REQUIREMENTS Monitor patients unable to take food (greater risk of recrudescence).

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**Artrenimol with piperaquine phosphate**

(Piperaquine tetraphosphate with dihydroartemisinin)

**INDICATIONS AND DOSE**
Treatment of uncomplicated falciparum malaria

- **BY MOUTH**
  - Child 6-17 years (body-weight 7-12 kg): 0.5 tablet once daily for 3 days, max. 2 courses in 12 months; second course given at least 2 months after first course
  - Child 6-17 years (body-weight 13-23 kg): 1 tablet once daily for 3 days, max. 2 courses in 12 months; second course given at least 2 months after first course
  - Child 6-17 years (body-weight 24-35 kg): 2 tablets once daily for 3 days, max. 2 courses in 12 months; second course given at least 2 months after first course
  - Child 6-17 years (body-weight 36-74 kg): 3 tablets once daily for 3 days, max. 2 courses in 12 months; second course given at least 2 months after first course
  - Child 6-17 years (body-weight 75-99 kg): 4 tablets once daily for 3 days, max. 2 courses in 12 months; second course given at least 2 months after first course

- **CONTRA-INDICATIONS** Acute myocardial infarction - bradycardia - congenital long QT syndrome - electrolyte disturbances - family history of sudden death - heart failure with reduced left ventricular ejection fraction - history of symptomatic arrhythmias - left ventricular hypertrophy - risk factors for QT interval prolongation - severe hypertension

- **INTERACTIONS** ▶ Appendix 1: antimalarials

- **SIDE-EFFECTS** ▶ Common or very common Abdominal pain - anaemia - appetite decreased - asthenia - conjunctivitis - cough - diarrhoea - eosinophilia - fever - increased risk of infection - leucocytosis - leucopenia - increased risk of infection - QT interval prolongation - skin reactions - thrombocytopenia - vomiting
  - Uncommon Arthralgia - cardiac conduction disorder - epistaxis - headache - hepatic disorders - hypochromia - lymphadenopathy - nausea - rhinorrhoea - seizure - splenomegaly - stomatitis - thrombocytosis

- **PREGNANCY** Teratogenic in animal studies—manufacturer advises use only if other antimalarials cannot be used.

- **BREAST FEEDING** Manufacturer advises avoid—present in milk in animal studies.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in jaundice or in moderate to severe failure (no information available)—monitor ECG and plasma potassium concentration.
  - Monitoring Manufacturer advises monitor ECG and plasma-potassium concentration in moderate to severe hepatic impairment.
Atovaquone with proguanil hydrochloride

**INDICATIONS AND DOSE**

**MALARONE® 250MG/100MG**

Prophylaxis of falciparum malaria, particularly where resistance to other antimalarial drugs suspected

- **BY MOUTH**
  - Child (body-weight 40 kg and above): 1 tablet once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving
  - Child (body-weight 5–11 kg): 0.5 tablet once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving

Treatment of acute uncomplicated falciparum malaria

- **BY MOUTH**
  - Child (body-weight 20–29 kg): 2 tablets once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving
  - Child (body-weight 30–39 kg): 3 tablets once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving
  - Child (body-weight 40 kg and above): Use Malarone® (standard) tablets.

**DOSE EQUIVALENCE AND CONVERSION**

- Each tablet of Malarone® contains 250 mg of atovaquone and 100 mg of proguanil hydrochloride.

**MALARONE® PEDIATRIC**

Prophylaxis of falciparum malaria, particularly where resistance to other antimalarial drugs suspected

- **BY MOUTH**
  - Child (body-weight 5–7 kg): 0.5 tablet once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving
  - Child (body-weight 8–9 kg): 0.75 tablet once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving
  - Child (body-weight 10–19 kg): 1 tablet once daily, to be started 1–2 days before entering endemic area and continued for 1 week after leaving

**UNLICENSED USE**


**CAUTIONS**

Diarrhoea or vomiting (reduced absorption of atovaquone), efficacy not evaluated in cerebral or complicated malaria (including hyperparasitaemia, pulmonary oedema or renal failure)

**INTERACTIONS**

- See also Pregnancy in Malaria, prophylaxis p. 401.

- Breastfeeding
  - Use only if no suitable alternative available.

**RENAL IMPAIRMENT**

Avoid for malaria prophylaxis and, if possible, for treatment if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

**DIRECTIONS FOR ADMINISTRATION**

- Tablets may be crushed and mixed with food or milky drink just before administration.

**PATIENT AND CARER ADVICE**

- Warn travellers about importance of avoiding mosquito bites, importance of taking prophylaxis regularly, and importance of immediate visit to doctor if ill within 1 year and especially within 3 months of return.

- Medicines for Children leaflet: Malarone for prevention of malaria www.medicinesforchildren.org.uk/malarone-prevention-malaria

**NATIONAL FUNDING/ACCESS DECISIONS**

NHS restrictions Drugs for malaria prophylaxis are not prescribable in NHS primary care; health authorities may investigate circumstances under which antimalarials are prescribed.
410 Protozoal infection

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 21

- **Malanore** (GlaxoSmithKline UK Ltd)
- **Proguanil hydrochloride** 25 mg, Atovaquone 62.5 mg Malanore Paediatric 62.5mg/25mg tablets | 12 tablet (PO) £6.26 DT + £6.26
- **Proguanil hydrochloride 100 mg, Atovaquone 250 mg** Malanore 250mg/100mg tablets | 12 tablet (PO) £25.21 DT + £25.21

**Chloroquine**

**INDICATIONS AND DOSE**

**Prophylaxis of malaria**

- **INITIALLY BY MOUTH USING SYRUP**
  - Child: 4-5 weeks (body-weight up to 4.5 kg): 25 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 6 weeks–5 months (body-weight 4.5-7 kg): 50 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 6-11 months (body-weight 8-10 kg): 75 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 1-2 years (body-weight 11-14 kg): 100 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 3-4 years (body-weight 15-16.4 kg): 125 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 5-7 years (body-weight 16.5-24 kg): 150 mg once weekly, alternatively (by mouth using tablets) 155 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 8-13 years (body-weight 25-44 kg): 225 mg once weekly, alternatively (by mouth using tablets) 232.5 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving
  - Child: 14-17 years (body-weight 45 kg and above): 310 mg once weekly, alternatively (by mouth using syrup) 300 mg once weekly, started 1 week before entering endemic area and continued for 4 weeks after leaving

- **BY MOUTH**
  - Child: 10 mg/kg (max. per dose 620 mg), then 5 mg/kg after 6–8 hours (max. per dose 310 mg), then 5 mg/kg daily (max. per dose 310 mg) for 2 days

- **P. vivax or P. ovale infection during pregnancy while radical cure is postponed**
  - **BY MOUTH**
  - Child: 10 mg/kg once weekly (max. per dose 310 mg)

**DOSE EQUIVALENCE AND CONVERSION**

- **Doses expressed as chloroquine base**.
  - Each tablet contains 155 mg of chloroquine base (equivalent to 250 mg of chloroquine phosphate).
  - Syrup contains 50 mg/5 mL of chloroquine base (equivalent to 80 mg/5 mL of chloroquine phosphate).

**SIDE-EFFECTS**

- **Rare or very rare** Cardiomyopathy • hallucination • hepatitis
- **Frequency not known** Abdominal pain • agranulocytosis • alopecia • anxiety • atrioventricular block • bone marrow disorders • confusion • corneal deposits • depression • diarrhoea • eye disorders • gastrointestinal disorder • headache • hearing impairment • hypoglycaemia • hypotension • insomnia • interstitial lung disease • movement disorders • myopathy • nausea • neuromyopathy • neutropenia • personality change • photosensitivity reaction • psychotic disorder • QT interval prolongation • seizure • severe cutaneous adverse reactions (SCARs) • skin reactions • thrombocytopenia • tinnitus • tongue protrusion • vision disorders • vomiting

**SIDE-EFFECTS, FURTHER INFORMATION** Side-effects which occur at doses used in the prophylaxis or treatment of malaria are generally not serious.

- **Overdose** Chloroquine is very toxic in overdosage; overdosage is extremely hazardous and difficult to treat. Urgent advice from the National Poisons Information Service is essential. Life-threatening features include arrhythmias (which can have a very rapid onset) and convulsions (which can be intractable).

- **PREGNANCY** Benefit of use in prophylaxis and treatment in malaria outweighs risk. For rheumatoid disease, it is not necessary to withdraw an antimalarial drug during pregnancy if the disease is well controlled.

- **BREASTFEEDING** Present in breast milk and breastfeeding should be avoided when used to treat rheumatic disease. Amount in milk probably too small to be harmful when used for malaria.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution, particularly in cirrhosis.

- **RENAI IMPAIRMENT** Manufacturers advise caution.

- **Dose adjustments** Only partially excreted by the kidneys particularly in cirrhosis.

- **INTERACTIONS**

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

**Oral solution**

**CAUTIONARY AND ADVISORY LABELS** 5

- **Malarivon** (Wallace Manufacturing Chemists Ltd) Chloroquine phosphate 16 mg per 1 ml Malarivon 80mg/5ml syrup | 75 ml (PO) £30.00 DT + £30.00

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 5

- **Avloclor** (Alliance Pharmaceuticals Ltd) Chloroquine phosphate 250 mg Avloclor 250mg tablets | 20 tablet (PO) £8.59 DT + £8.59
Malaria 411

Chloroquine with proguanil

The properties listed below are those particular to the combination only. For the properties of the components please consider, chloroquine p. 410, proguanil hydrochloride p. 412.

● INDICATIONS AND DOSE
Prophylaxis of malaria
▶ BY MOUTH
▶ Child: (consult product literature)

● INTERACTIONS → Appendix 1: antimalarials
● EXCEPTIONS TO LEGAL CATEGORY Can be sold to the public provided it is licensed and labelled for the prophylaxis of malaria.

● MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.
Tablet
▶ Paludrine/Avloclor (Alliance Pharmaceuticals Ltd)
Paludrine/Avloclor tablets anti-malarial travel pack | 112 tablet £13.50

Mefloquine

● INDICATIONS AND DOSE
Treatment of malaria
▶ BY MOUTH
▶ Child: (consult product literature)
Prophylaxis of malaria
▶ BY MOUTH
▶ Child (body-weight 5–15 kg): 62.5 mg once weekly, dose to be started 2–3 weeks before entering endemic area and continued for 4 weeks after leaving
▶ Child (body-weight 16–24 kg): 125 mg once weekly, dose to be started 2–3 weeks before entering endemic area and continued for 4 weeks after leaving
▶ Child (body-weight 25–44 kg): 187.5 mg once weekly, dose to be started 2–3 weeks before entering endemic area and continued for 4 weeks after leaving
▶ Child (body-weight 45 kg and above): 250 mg once weekly, dose to be started 2–3 weeks before entering endemic area and continued for 4 weeks after leaving

● UNLICENSED USE Mefloquine doses in BNF Publications may differ from those in product literature.
Not licensed for use in children under 5 kg body-weight and under 3 months.
● CONTRA-INDICATIONS Avoid for prophylaxis if history of psychiatric disorders (including depression) or convulsions - avoid for standby treatment if history of convulsions - history of blackwater fever
● CAUTIONS Cardiac conduction disorders - epilepsy (avoid for prophylaxis) - not recommended in infants under 5 months (5 kg) - traumatic brain injury

CAUTIONS, FURTHER INFORMATION
Neuropsychiatric reactions. Mefloquine is associated with potentially serious neuropsychiatric reactions. Abnormal dreams, insomnia, anxiety, and depression occur commonly. Psychosis, suicidal ideation, and suicide have also been reported. Neuropsychiatric symptoms such as insomnia, nightmares, acute anxiety, depression, restlessness, or confusion should be regarded as potentially prodromal for a more serious event. Adverse reactions may occur and persist up to several months after discontinuation because mefloquine has a long half-life. For a prescribing checklist, and further information on side-effects, particularly neuropsychiatric side-effects, which may be associated with the use of mefloquine for malaria prophylaxis, see the Guide for Healthcare Professionals provided by the manufacturer.

● INTERACTIONS → Appendix 1: antimalarials
● SIDE-EFFECTS
▶ Common or very common Anxiety · depression · diarrhoea · dizziness · gastrointestinal discomfort · headache · nausea · skin reactions · sleep disorders · vision disorders · vomiting
▶ Frequency not known Acute kidney injury · agranulocytosis · alopecia · aplastic anaemia · appetite decreased · arrhythmias · arthralgia · asthenia · behaviour abnormal · cardiac conduction disorders · cataract · chest pain · chills · concentration impaired · confusion · cranial nerve paralysis · delusional disorder · depersonalisation · drowsiness · dyspnoea · encephalopathy · eye disorder · fever · flushing · gait abnormal · hallucination · hearing impairment · hepatic disorders · hyperacausis · hyperhidrosis · hypertension · hypotension · leucocytosis · leucopenia · malaise · memory loss · mood altered · movement disorders · muscle complaints · muscle weakness · nephritis · nerve disorders · oedema · palpatitations · pancreatitis · paranaesthesia · pneumonia · pneumonitis · psychosis · seizure · self-endangering behaviour · speech disorder · Stevens-Johnson syndrome · suicidal tendencies · syncope · thrombocytopenia · tinnitus · tremor · vertigo

● ALLERGY AND CROSS-SENSITIVITY Contra-indicated in patients with hypersensitivity to quinine.

● CONCEPTION AND CONTRACEPTION Manufacturer advises adequate contraception during prophylaxis and for 3 months after stopping (teratogenicity in animal studies).
● PREGNANCY Manufacturer advises avoid (particularly in the first trimester) unless the potential benefit outweighs the risk; however, studies of mefloquine in pregnancy (including use in the first trimester) indicate that it can be considered for travel to chloroquine-resistant areas.

● BREAST FEEDING Present in milk but risk to infant minimal.
● HEPATIC IMPAIRMENT Manufacturer advises avoid in severe impairment—elimination may be prolonged.

● RENAL IMPAIRMENT Manufacturer advises caution.
● DIRECTIONS FOR ADMINISTRATION Tablet may be crushed and mixed with food such as jam or honey just before administration.

● PATIENT AND CARER ADVICE Manufacturer advises that patients receiving mefloquine for malaria prophylaxis should be informed to discontinue its use if neuropsychiatric symptoms occur and seek immediate medical advice so that mefloquine can be replaced with an alternative antimalarial. Travellers should also be warned about importance of avoiding mosquito bites, importance of taking prophylaxis regularly, and importance of immediate visit to doctor if ill within 1 year and especially within 3 months of return.

A patient alert card should be provided.
Driving and skilled tasks Dizziness or a disturbed sense of balance may affect performance of skilled tasks (e.g. driving); effects may occur and persist up to several months after stopping mefloquine.

● NATIONAL FUNDING/ACCESS DECISIONS
NHS restrictions Drugs for malaria prophylaxis are not prescribable in NHS primary care; health authorities may investigate circumstances under which antimalarials are prescribed.

● MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.
Tablet
CAUTIONARY AND ADVISORY LABELS 10, 21, 27
▶ Lariam (Cheplapharm Arzneimittel GmbH)
Mefloquine (as Mefloquine hydrochloride) 250 mg Lariam 250mg tablets | 8 tablet (PO) £14.53 DT + £14.53
Primaquine

**INDICATIONS AND DOSE**

Adjunct in the treatment of non-falciparum malaria caused by *P. vivax* infection
- **BY MOUTH**
  - Child: 750 micrograms/kg once weekly for 8 weeks; maximum 45 mg per week

Adjunct in the treatment of non-falciparum malaria caused by *P. ovale* infection
- **BY MOUTH**
  - Child: 250 micrograms/kg daily (max. per dose 30 mg) for 14 days

Adjunct in the treatment of non-falciparum malaria caused by *P. falciparum* infection
- **BY MOUTH**
  - Child: This combination is associated with considerable toxicity (consult product literature)

**SIDE-EFFECTS**

- Alopecia
- Abdominal pain
- Nausea
- Vomiting
- Diarrhoea
- Gastric disorder
- Skin reactions
- Gastric haemorrhage
- Urticaria
- Megaloblastic anaemia
- Leucopenia
- Megaloblastic anaemia
- Methaemoglobinaemia

**INTERACTIONS** → Appendix 1: antimalarials

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Proguanil doses in BNF Publications may differ from those in product literature.

**INDICATIONS AND DOSE**

Proguanil hydrochloride

**INDICATIONS AND DOSE**

Prophylaxis of malaria
- **BY MOUTH**
  - Child 4-11 years (body-weight up to 6 kg): 25 mg once daily
  - Child 3-6 months (body-weight 6-9 kg): 50 mg once daily

Pregnancy
- Benefit of prophylaxis in malaria outweighs risk. Adequate folate supplements should be given to mother.

Breast feeding
- Amount in milk probably too small to be harmful when used for malaria prophylaxis.

**SIDE-EFFECTS**

- Bowel disorders
- Gastric disorder
- Abdominal pain
- Nausea
- Vomiting
- Diarrhoea
- Skin reactions
- Megaloblastic anaemia
- Leucopenia

**INTERACTIONS** → Appendix 1: antimalarials

**CAUTIONARY AND ADVISORY LABELS**

- Drugs for malaria prophylaxis are not prescribable in NHS primary care; health authorities may investigate circumstances under which antimalarials are used.

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.

**UNLICENSED USE** Not licensed.

**CAUTIONS**

- G6PD deficiency - systemic diseases associated with granulocytopenia (e.g. juvenile idiopathic arthritis, rheumatoid arthritis, lupus erythematosus)

**RENAI IMPAIRMENT**

- Glomerular filtration rate less than 20 mL/minute/1.73 m²:
  - Use one-quarter normal dose on alternate days if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²; increased risk of haematological toxicity in severe impairment.
**Quinine**

**INDICATIONS AND DOSE**

Non-falciparum malaria

- Child: 10 mg/kg every 8 hours (max. per dose 700 mg), infused over 4 hours, given if patient is unable to take oral therapy. Change to oral chloroquine as soon as the patient’s condition permits, reduce dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.

Falciparum malaria

- Child: Loading dose 20 mg/kg, infused over 4 hours, the loading dose of 20 mg/kg should not be used if the patient has received quinine or mefloquine during the previous 12 hours, then maintenance 10 mg/kg every 8 hours until patient can swallow oral medication to complete the 7-day course, maintenance dose to be given 8 hours after the start of the loading dose and infused over 4 hours, to be given together with or followed by doxycycline (in children over 12 years), or clindamycin, reduce maintenance dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.

- Neonate: Loading dose 7 mg/kg, infused over 30 minutes, followed immediately by 10 mg/kg, infused over 4 hours, then maintenance 10 mg/kg every 8 hours until patient can swallow oral medication to complete the 7-day course, maintenance dose to be given 8 hours after the start of the loading dose and infused over 4 hours, to be given together with or followed by clindamycin, reduce maintenance dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.

Falciparum malaria (in intensive care unit)

- Child: Loading dose 7 mg/kg, infused over 30 minutes, followed immediately by 10 mg/kg, infused over 4 hours, then maintenance 10 mg/kg every 8 hours until patient can swallow oral medication to complete the 7-day course, maintenance dose to be given 8 hours after the start of the loading dose and infused over 4 hours, to be given together with or followed by clindamycin, reduce maintenance dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.

**DOSE EQUIVALENCE AND CONVERSION**

- When using quinine for malaria, doses are valid for quinine hydrochloride, dihydrochloride, and sulfate; they are not valid for quinine bisulfate which contains a correspondingly smaller amount of quinine.

- Quinine (anhydrous base) 100 mg = quinine bisulfate 169 mg; quinine dihydrochloride 122 mg; quinine hydrochloride 122 mg; and quinine sulfate 121 mg.

Quinine bisulfate 300 mg tablets are available but provide less quinine than 300 mg of the dihydrochloride, hydrochloride, or sulfate.

**UNLICENSED USE**

Injection not licensed.

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: REMINDER OF DOSE-DEPENDENT QT-PROLONGING EFFECTS (NOVEMBER 2017)

Quinine has been associated with dose-dependent QT-interval-prolonging effects and should be used with caution in patients with risk factors for QT prolongation or in those with ativoventricular block—see Cautions for further information.

**CONTRA-INDICATIONS**

- Haemoglobinuria
- Myasthenia gravis
- Optic neuritis
- Tinnitus

**CAUTIONS**

- Atrial fibrillation (monitor ECG during parenteral treatment)
- Cardiac disease (monitor ECG during parenteral treatment)
- Conduction defects (monitor ECG during parenteral treatment)
- Electrolyte disturbance
- G6PD deficiency
- Heart block (monitor ECG during parenteral treatment)

**INTERACTIONS**

- Appendix 1: antimalarials

**SIDE-EFFECTS**

- Abdominal pain
- Agitation
- Agranulocytosis
- Angioedema
- Asthma
- Ativoventricular conduction changes
- Bronchospasm
- Cardiotoxicity
- Cerebral impairment
- Coagulation disorders
- Coma
- Confusion

**DOSE**

- **BY MOUTH**
  - Child: 10 mg/kg every 8 hours (max. per dose 700 mg), infused over 4 hours, given if patient is unable to take oral therapy. Change to oral chloroquine as soon as the patient’s condition permits, reduce dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.
  - Neonate: Loading dose 20 mg/kg, infused over 4 hours, the loading dose of 20 mg/kg should not be used if the patient has received quinine or mefloquine during the previous 12 hours, then maintenance 10 mg/kg every 8 hours until patient can swallow oral medication to complete the 7-day course, maintenance dose to be given 8 hours after the start of the loading dose and infused over 4 hours, to be given together with or followed by clindamycin, reduce maintenance dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.

**CONTRA-INDICATIONS**

- Haemoglobinuria
- Myasthenia gravis
- Optic neuritis
- Tinnitus

**CAUTIONS**

- Atrial fibrillation (monitor ECG during parenteral treatment)
- Cardiac disease (monitor ECG during parenteral treatment)
- Conduction defects (monitor ECG during parenteral treatment)
- Electrolyte disturbance
- G6PD deficiency
- Heart block (monitor ECG during parenteral treatment)

**INTERACTIONS**

- Appendix 1: antimalarials

**SIDE-EFFECTS**

- Abdominal pain
- Agitation
- Agranulocytosis
- Angioedema
- Asthma
- Ativoventricular conduction changes
- Bronchospasm
- Cardiotoxicity
- Cerebral impairment
- Coagulation disorders
- Coma
- Confusion

**DOSE**

- **BY MOUTH**
  - Child: 10 mg/kg every 8 hours (max. per dose 700 mg), infused over 4 hours, given if patient is unable to take oral therapy. Change to oral chloroquine as soon as the patient’s condition permits, reduce dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.
  - Neonate: Loading dose 20 mg/kg, infused over 4 hours, the loading dose of 20 mg/kg should not be used if the patient has received quinine or mefloquine during the previous 12 hours, then maintenance 10 mg/kg every 8 hours until patient can swallow oral medication to complete the 7-day course, maintenance dose to be given 8 hours after the start of the loading dose and infused over 4 hours, to be given together with or followed by clindamycin, reduce maintenance dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.

**CONTRA-INDICATIONS**

- Haemoglobinuria
- Myasthenia gravis
- Optic neuritis
- Tinnitus

**CAUTIONS**

- Atrial fibrillation (monitor ECG during parenteral treatment)
- Cardiac disease (monitor ECG during parenteral treatment)
- Conduction defects (monitor ECG during parenteral treatment)
- Electrolyte disturbance
- G6PD deficiency
- Heart block (monitor ECG during parenteral treatment)

**INTERACTIONS**

- Appendix 1: antimalarials

**SIDE-EFFECTS**

- Abdominal pain
- Agitation
- Agranulocytosis
- Angioedema
- Asthma
- Ativoventricular conduction changes
- Bronchospasm
- Cardiotoxicity
- Cerebral impairment
- Coagulation disorders
- Coma
- Confusion

**DOSE**

- **BY MOUTH**
  - Child: 10 mg/kg every 8 hours (max. per dose 700 mg), infused over 4 hours, given if patient is unable to take oral therapy. Change to oral chloroquine as soon as the patient’s condition permits, reduce dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.
  - Neonate: Loading dose 20 mg/kg, infused over 4 hours, the loading dose of 20 mg/kg should not be used if the patient has received quinine or mefloquine during the previous 12 hours, then maintenance 10 mg/kg every 8 hours until patient can swallow oral medication to complete the 7-day course, maintenance dose to be given 8 hours after the start of the loading dose and infused over 4 hours, to be given together with or followed by clindamycin, reduce maintenance dose to 5–7 mg/kg if parenteral treatment is required for more than 48 hours.
4.3 Toxoplasmosis

Other drugs used for Toxoplasmosis Pyrimethamine, p. 412

4.3.1 Antimicrobials - Macrolides

**Spiramycin**

- **INDICATIONS AND DOSE**
  - **Toxoplasmosis in pregnancy**
    - Child 12–17 years: 1.5 g twice daily until delivery
  - **Chemoprophylaxis of congenital toxoplasmosis**
    - *By mouth*
  - Neonate: 50 mg/kg twice daily.

- **DOSE EQUIVALENCE AND CONVERSION**
  - 3000 units ≡ 1 mg spiramycin.

4.3.2 Other antimicrobials

- **ANTIBACTERIALS**
  - **MACROLIDES**
    - **Spiramycin**
      - **INDICATIONS AND DOSE**
        - **Toxoplasmosis in pregnancy**
          - Child 12–17 years: 1.5 g twice daily until delivery
        - **Chemoprophylaxis of congenital toxoplasmosis**
          - *By mouth*
        - Neonate: 50 mg/kg twice daily.

- **DOSE EQUIVALENCE AND CONVERSION**
  - 3000 units ≡ 1 mg spiramycin.
5.2 Hepatitis infections

5.2a Chronic hepatitis B

Other drugs used for Chronic hepatitis B Interferon alfa, p. 577 • Lamivudine, p. 436 • Tenoforv disoproxil, p. 437

**ANTIVIRALS > NUUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS**

<table>
<thead>
<tr>
<th>Tenofovir alafenamide</th>
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- **INDICATIONS AND DOSE**
  - Chronic hepatitis B (initiated by a specialist)
    - **BY MOUTH**
      - Child 12-17 years (body-weight 35 kg and above): 25 mg once daily (for duration of treatment consult product literature)

- **CAUTIONS**
  - Decompensated liver disease • HIV co-infection

- **INTERACTIONS**
  - Appendix 1: tenofovir alafenamide

- **SIDE-EFFECTS**
  - Common or very common: Abdominal distension
  - Frequency not known: Hepatitis aggravated (during or following treatment)

- **BREAST FEEDING**
  - Manufacturer advises avoid—present in milk in animal studies.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution in decompensated hepatic disease (no information available).

- **PRE-TREATMENT SCREENING**
  - Manufacturer advises HIV antibody testing should be offered to those with unknown HIV-1 status before initiation of treatment.

- **MONITORING REQUIREMENTS**
  - Manufacturer advises monitor liver function tests at repeated intervals during treatment and for at least 6 months after last dose—recurrent hepatitis may occur on discontinuation.

- **PATIENT AND CARER ADVICE**
  - Missed doses
    - Manufacturer advises if a dose is more than 18 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

<table>
<thead>
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<tr>
<td>CAUTIONARY AND ADVISORY LABELS 21</td>
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</table>

  - Vemlidy (Gilead Sciences International Ltd)

  - Tenofovir alafenamide (as Tenofovir alafenamide fumarate)
    - 25 mg Vemlidy 25 mg tablets | 30 tablet pack | £325.73

5.2b Chronic hepatitis C

Other drugs used for Chronic hepatitis C Interferon alfa, p. 577 • Peginterferon alfa, p. 419

**ANTIVIRALS > NUUCLEOSIDE ANALOGUES**

<table>
<thead>
<tr>
<th>Ribavirin</th>
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<td>(Tribavirin)</td>
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</table>

- **INDICATIONS AND DOSE**
  - Bronchiolitis
    - **BY INHALATION OF AEROSOL, OR BY INHALATION OF NEBULISED SOLUTION**
      - Child 1-23 months: Inhale a solution containing 20 mg/mL for 12–18 hours for at least 3 days, maximum of 7 days, to be administered via small particle aerosol generator

  - Life-threatening RSV, parainfluenza virus, and adenovirus infection in immunocompromised children

    - **BY INTRAVENOUS INFUSION**
      - Child: 33 mg/kg for 1 dose, to be administered over 15 minutes, then 16 mg/kg every 6 hours for 4 days, then 8 mg/kg every 8 hours for 3 days

  - **REBETOL ® CAPSULES**
    - Chronic hepatitis C (in combination with interferon alfa or peginterferon alfa) in previously untreated children without liver decompensation
      - **BY MOUTH**
        - Child 3-17 years (body-weight up to 47 kg): 15 mg/kg daily in 2 divided doses
        - Child 3-17 years (body-weight 47-49 kg): 200 mg, dose to be given in the morning and 400 mg, dose to be given in the evening
        - Child 3-17 years (body-weight 50-64 kg): 400 mg twice daily
        - Child 3-17 years (body-weight 65-80 kg): 600 mg, dose to be given in the morning and 600 mg, dose to be given in the evening
        - Child 3-17 years (body-weight 81-104 kg): 600 mg twice daily
        - Child 3-17 years (body-weight 105 kg and above): 600 mg, dose to be given in the morning and 800 mg, dose to be given in the evening

  - **REBETOL ® ORAL SOLUTION**
    - Chronic hepatitis C (in combination with interferon alfa or peginterferon alfa) in previously untreated children without liver decompensation
      - **BY MOUTH**
        - Child 3-17 years (body-weight up to 47 kg): 15 mg/kg daily in 2 divided doses
        - Child 3-17 years (body-weight 47-49 kg): 200 mg, dose to be given in the morning and 400 mg, dose to be given in the evening
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        - Child 3-17 years (body-weight 65-80 kg): 600 mg, dose to be given in the morning and 600 mg, dose to be given in the evening
        - Child 3-17 years (body-weight 81-104 kg): 600 mg twice daily
        - Child 3-17 years (body-weight 105 kg and above): 600 mg, dose to be given in the morning and 800 mg, dose to be given in the evening

- **UNLICENSED USE**
  - When used by inhalation
    - Inhalation licensed for use in children (age range not specified by manufacturer).
  - With intravenous use
    - Intravenous preparation not licensed.

- **CONTRA-INDICATIONS**
  - With systemic use
    - Active severe psychiatric condition • autoimmune disease • autoimmune hepatitis • haemoglobinopathies • history of severe psychiatric condition • severe debilitating medical conditions • severe, uncontrolled cardiac disease in children with chronic hepatitis C

- **CAUTIONS**
  - When used by inhalation
    - Maintain standard supportive respiratory and fluid management therapy
  - With systemic use
    - Cardiac disease (assessment including ECG recommended before and during treatment—discontinue if deterioration)

  - Consult product literature for specific precautions when ribavirin used in combination with other medicinal products—patients with a
transplant—risk of rejection - risk of growth retardation in children, the reversibility of which is uncertain—if possible, consider starting treatment after pubertal growth spurt

- **INTERACTIONS** ➔ Appendix 1: ribavirin
- **SIDE-EFFECTS**
  - Uncommon Dehydration - diabetes mellitus - hallucination - hearing loss - hepatic disorders - hypertension - nerve disorders - sarcoidosis - suicidal tendencies - thyroiditis
  - Rare or very rare Angina pectoris - angiodema - bone marrow disorders - cardiac inflammation - cerebral ischaemia - cholangitis - coma - congestive heart failure - facial paralysis - hepatic failure (discontinue) - hypersensitivity - intracranial haemorrhage - myocardial infarction - myopathy - pancreatitis - psychotic disorder - pulmonary embolism - retinopathy - seizure - severe cutaneous adverse reactions (SCARs) - systemic lupus erythematosus (SLE) - vasculitis
  - Frequency not known Haemolytic anaemia - homicidal ideation - nephrotic syndrome - pure red cell aplasia - renal failure - solid organ transplant rejection - tongue discolouration - ulcerative colitis

**SIDE-EFFECTS, FURTHER INFORMATION** Side effects listed are reported when oral ribavirin is used in combination with peginterferon alfa or interferon alfa, consult product literature for details.

- **CONCEPTION AND CONTRACEPTION**
  - With systemic use Exclude pregnancy before treatment in females of childbearing age. Effective contraception essential during treatment and for 4 months after treatment in females and for 7 months after treatment in males of childbearing age. Routine monthly pregnancy tests recommended. Condoms must be used if partner of male patient is pregnant (ribavirin excreted in semen).
  - When used by inhalation Women planning pregnancy should avoid exposure to aerosol.

- **PREGNANCY** Avoid; teratogenicity in animal studies.
  - When used by inhalation Pregnant women should avoid exposure to aerosol.

- **BREAST FEEDING** Avoid—no information available.

- **HEPATIC IMPAIRMENT** Avoid oral ribavirin in severe hepatic dysfunction or decompensated cirrhosis.

- **RENAL IMPAIRMENT** Plasma-ribavirin concentration increased. Manufacturer advises avoid oral ribavirin if estimated glomerular filtration rate less than 50 mL/minute/1.73 m²—monitor haemoglobin concentration closely.
  - Manufacturer advises use intravenous preparation with caution if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- **MONITORING REQUIREMENTS**
  - When used by inhalation Monitor electrolytes closely. Monitor equipment for precipitation.
  - With systemic use Determine full blood count, platelets, electrolytes, serum creatinine, liver function tests and uric acid before starting treatment and then on weeks 2 and 4 of treatment, then as indicated clinically—adjust dose if adverse reactions or laboratory abnormalities develop (consult product literature). Test thyroid function before treatment and then every 3 months.
  - With oral use Eye examination recommended before treatment. Eye examination also recommended during treatment if pre-existing ophthalmological disorder or if decrease in vision reported—discontinue treatment if ophthalmological disorder deteriorates or if new ophthalmological disorder develops.

- **PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral liquid formulations may include bubble-gum.

- **NATIONAL FUNDING/ACCESS DECISIONS**

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- Peginterferon alfa and ribavirin for chronic hepatitis C (November 2013) NICE TA300
  - Peginterferon alfa in combination with ribavirin is recommended (within the marketing authorisation) as an option for treating chronic hepatitis C in children. www.nice.org.uk/TA300

- **LESS SUITABLE FOR PRESCRIBING** Ribavirin inhalation is less suitable for prescribing.

- **ANTIVIRALS** ➔ NUCLEOTIDE ANALOGUES

**Ledipasvir with sofosbuvir**

The properties listed below are those particular to the combination only. For the properties of the components please consider, sofosbuvir p. 417.

- **DRUG ACTION** Sofosbuvir is a nucleotide analogue inhibitor and ledipasvir is an HCV inhibitor; they reduce viral load by inhibiting hepatitis C virus RNA replication.

**INDICATIONS AND DOSE** Chronic hepatitis C infection (initiated by a specialist)
- **BY MOUTH**
  - Child 12-17 years: 90/400 mg once daily, for duration of treatment consult product literature

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**
- Manufacturer advises reduce dose of concurrent H₂-receptor antagonist if above a dose comparable to famotidine 40 mg twice daily.
- Manufacturer advises reduce dose of concurrent proton pump inhibitor if above a dose comparable to
**SOFOSVURIR**

26-Mar-2019

**INDICATIONS AND DOSE**

**Chronic hepatitis C infection**

- By mouth
- Child 12-17 years: 400 mg once daily, for duration of treatment consult product literature

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRALS TO TREAT CHRONIC HEPATITIS C: RISK OF INTERACTION WITH VITAMIN K ANTAGONISTS AND CHANGES IN INR (JANUARY 2017)

An EU-wide review has identified that changes in liver function, secondary to hepatitis C treatment with direct-acting antivirals, may affect the efficacy of vitamin K antagonists; the MHRA has advised that INR should be monitored closely in patients receiving concomitant treatment.

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRAL INTERFERON-FREE REGIMENS TO TREAT CHRONIC HEPATITIS C: RISK OF HEPATITIS B REACTIVATION (JANUARY 2017)

An EU-wide review has concluded that direct-acting antiviral interferon-free regimens for chronic hepatitis C can cause hepatitis B reactivation in patients co-infected with hepatitis B and C viruses; the MHRA recommends to screen patients for hepatitis B before starting treatment—patients infected with both hepatitis B and C viruses must be monitored and managed according to current clinical guidelines.

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRALS FOR CHRONIC HEPATITIS C: RISK OF HYPOGLYCAEMIA IN PATIENTS WITH DIABETES (DECEMBER 2018)

Rapid reduction in hepatitis C viral load during direct-acting antiviral therapy for hepatitis C may improve glucose metabolism in patients with diabetes and result in symptomatic hypoglycaemia if diabetic treatment is continued at the same dose.

The MHRA advises healthcare professionals:
- to monitor glucose levels closely in patients with diabetes during direct-acting antiviral therapy for hepatitis C, especially within the first 3 months of treatment and modify diabetic medication or doses when necessary;
- to be vigilant for changes in glucose tolerance and advise patients of the risk of hypoglycaemia;
- to inform the healthcare professional in charge of the diabetic care of the patient when direct-acting antiviral therapy is initiated.

**CAUTIONS**

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

SMC No. 1343/18

The Scottish Medicines Consortium has advised (June 2018) that ledipasvir with sofosbuvir (Harvoni®) is accepted for restricted use within NHS Scotland for the treatment of chronic hepatitis C infection of genotypes 1 and 4 only in patients aged 12 years up to 18 years.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

CAUTIONARY AND ADVISORY LABELS

- Harvoni (Gilead Sciences International Ltd)

Ledipasvir 90 mg, Sofosbuvir 400 mg | Harvoni 90mg/400mg tablets | 28 tablet blister | £12,993.33

**PRESCRIBING AND DISPENSING INFORMATION**

Dispense in original container (contains desiccant).

**PATIENT AND CARER ADVICE**

Vomiting. If vomiting occurs within 5 hours of administration, an additional dose should be taken.

Missed doses. If a dose is more than 18 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

**SIDE-EFFECTS**

- Common or very common: Fatigue, headache, rash
- Frequency not known: Angioedema, arrhythmia

**INTERACTIONS**

- Appendix 1: ledipasvir, sofosbuvir

**CAUTIONS**

**FURTHER INFORMATION**

Manufacturer advises—in limited information available.

**PREGNANCY**

Manufacturer advises avoid.

**RENAI IMPAIRMENT**

Safety and efficacy not established if eGFR less than 30 mL/minute/1.73 m²—accumulation may occur.

**BREAST FEEDING**

Manufacturer advises avoid.

**NICE decisions**

- Sofosbuvir for treating chronic hepatitis C (February 2015)

NICE TA320

Sofosbuvir (Sovaldi®) in combination with peginterferon alfa and ribavirin is an option for treating adults with chronic hepatitis C infection:

- of genotype 1
- of genotype 3 with cirrhosis (treatment naïve patients)
- of genotype 3 that has not adequately responded to interferon–based treatment
- of genotype 4, 5, or 6 with cirrhosis.

Sofosbuvir (Sovaldi®) in combination with ribavirin is an option for treating adults with chronic hepatitis C infection:

- of genotype 2 who are intolerant to or ineligible for interferon (treatment naïve patients)
- of genotype 2 that has not adequately responded to interferon–based treatment
- of genotype 3 with cirrhosis who are intolerant to or ineligible for interferon (treatment naïve patients)
Infection

ANTIVIRALS

▶ different medicines containing the same drug.

Dose expressed as x/y mg glecaprevir/pibrentasvir.

DOSE EQUIVALENCE AND CONVERSION

Chronic hepatitis C (specialist use only)

INDICATIONS AND DOSE

25-Oct-2017

Sovaldi

21, 25

CAUTIONARY AND ADVISORY LABELS

Tablet

CAUTIONARY AND ADVISORY LABELS 21, 25

Sovaldi (Gilead Sciences International Ltd) ▼

Sofosbuvir 400 mg Sovaldi 400mg tablets | 28 tablet £11,660.98

Scottish Medicines Consortium (SMC) decisions

SMC No. 964/14

The Scottish Medicines Consortium has advised (June 2014) that sofosbuvir (Sovaldi®) is accepted for restricted use within NHS Scotland for the treatment of chronic hepatitis C infection of genotypes 1, 4, 5, or 6.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/ta330

Sofosbuvir for treating chronic hepatitis C (February 2015)

NICE TA330

Sofosbuvir (Sovaldi®) in combination with ribavirin is not recommended for the treatment of adults with chronic hepatitis C infection of genotypes 1, 4, 5, or 6.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/ta330

Scottish Medicines Consortium (SMC) decisions

NATIONAL FUNDING/ACCESS DECISIONS

PATIENT AND CARER ADVICE

Missed doses Manufacturer advises if a dose is more than 18 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions

Glecaprevir-pibrentasvir for treating chronic hepatitis C (January 2018) NICE TA499

Glecaprevir with pibrentasvir is recommended, within its marketing authorisation, as an option for treating chronic hepatitis C in adults, only if the manufacturer provides the drug at the same price or lower than that agreed with the Commercial Medicines Unit.

www.nice.org.uk/guidance/ta499

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (November 2017) that glecaprevir with pibrentasvir (Maviret®) is accepted for use within NHS Scotland for the treatment of chronic hepatitis C virus (HCV) infection in adults. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

MEDIcular SAFETY INFORMATION

Hepatitis B infection

Cases of hepatitis B reactivation, sometimes fatal, have been reported in patients co-infected with hepatitis B and C viruses; manufacturer advises to assess patients for hepatitis B prior to initiation of therapy and manage according to current clinical guidelines.

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRALS TO TREAT CHRONIC HEPATITIS C: RISK OF INTERACTION WITH VITAMIN K ANTAGONISTS AND CHANGES IN INR (JANUARY 2017)

An EU-wide review has identified that changes in liver function, secondary to hepatitis C treatment with direct-acting antivirals, may affect the efficacy of vitamin K antagonists; the MHRA has advised that INR should be monitored closely in patients receiving concomitant treatment.

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRALS FOR CHRONIC HEPATITIS C: RISK OF HYPOGLYCAEMIA IN PATIENTS WITH DIABETES (DECEMBER 2018)

Rapid reduction in hepatitis C viral load during direct-acting antiviral therapy for hepatitis C may improve glucose metabolism in patients with diabetes and result in symptomatic hypoglycaemia if diabetic treatment is continued at the same dose.

The MHRA advises healthcare professionals:

▶ to monitor glucose levels closely in patients with diabetes during direct-acting antiviral therapy for hepatitis C, especially within the first 3 months of treatment and modify diabetic medication or doses when necessary;

▶ to be vigilant for changes in glucose tolerance and advise patients of the risk of hypoglycaemia;

▶ to inform the healthcare professional in charge of the diabetic care of the patient when direct-acting antiviral therapy is initiated.

renal SAFETY INFORMATION

Hepatitis B infection

Hepatitis C infection of genotypes 2, or 3, is restricted to those who cannot use peginterferon alfa because of intolerance or contra-indications.

MEDIcular SAFETY INFORMATION

Hepatitis B infection

Hepatitis C infection of genotypes 1, 4, 5, or 6.

MEDIcular SAFETY INFORMATION

Diabetes

An EU-wide review has identified that changes in liver function, secondary to hepatitis C treatment with direct-acting antivirals, may affect the efficacy of vitamin K antagonists; the MHRA has advised that INR should be monitored closely in patients receiving concomitant treatment.

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▶ to be vigilant for changes in glucose tolerance and advise patients of the risk of hypoglycaemia;

▶ to inform the healthcare professional in charge of the diabetic care of the patient when direct-acting antiviral therapy is initiated.

renal SAFETY INFORMATION

Hepatitis B infection

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MEDIcular SAFETY INFORMATION

Hepatitis B infection

Hepatitis C infection of genotypes 1, 4, 5, or 6.

MEDIcular SAFETY INFORMATION

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▶ to monitor glucose levels closely in patients with diabetes during direct-acting antiviral therapy for hepatitis C, especially within the first 3 months of treatment and modify diabetic medication or doses when necessary;

▶ to be vigilant for changes in glucose tolerance and advise patients of the risk of hypoglycaemia;

▶ to inform the healthcare professional in charge of the diabetic care of the patient when direct-acting antiviral therapy is initiated.

renal SAFETY INFORMATION

Hepatitis B infection

Hepatitis C infection of genotypes 2, or 3, is restricted to those who cannot use peginterferon alfa because of intolerance or contra-indications.

MEDIcular SAFETY INFORMATION

Hepatitis B infection

Hepatitis C infection of genotypes 1, 4, 5, or 6.

MEDIcular SAFETY INFORMATION

Diabetes

An EU-wide review has identified that changes in liver function, secondary to hepatitis C treatment with direct-acting antivirals, may affect the efficacy of vitamin K antagonists; the MHRA has advised that INR should be monitored closely in patients receiving concomitant treatment.

MHRA/CHM ADVICE: DIRECT-ACTING ANTIVIRALS TO TREAT CHRONIC HEPATITIS C: RISK OF HYPOGLYCAEMIA IN PATIENTS WITH DIABETES (DECEMBER 2018)

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The MHRA advises healthcare professionals:

▶ to monitor glucose levels closely in patients with diabetes during direct-acting antiviral therapy for hepatitis C, especially within the first 3 months of treatment and modify diabetic medication or doses when necessary;

▶ to be vigilant for changes in glucose tolerance and advise patients of the risk of hypoglycaemia;

▶ to inform the healthcare professional in charge of the diabetic care of the patient when direct-acting antiviral therapy is initiated.
Monitoring of hepatic function is recommended. Monitoring of lipid concentration is recommended.

**MONITORING REQUIREMENTS**

- **RENAL IMPAIRMENT**
- **HEPATIC IMPAIRMENT**

**SIDE-EFFECTS**

- **Common or very common**
  - Alopecia
  - Anaemia
  - Anxiety
  - Appetite decreased
  - Arthralgia
  - Asthenia
  - Behaviour abnormal
  - Chills
  - Concentration impaired
  - Cough
  - Depression
  - Diabetes mellitus
  - Diarrhoea
  - Dizziness
  - Drowsiness
  - Dyspnoea
  - Ear pain
  - Eye discomfort
  - Face oedema
  - Feeling cold
  - Fever
  - Flushing
  - Gastrointestinal discomfort
  - Growth retardation
  - Haemorrhage
  - Headaches
  - Hypotension
  - Hypothyroidism
  - Increased risk of infection
  - Influenza like illness
  - Laryngeal pain
  - Leucopenia
  - Lymphadenopathy
  - Malaise
  - Mood altered
  - Muscle complaints
  - Nausea
  - Neutropenia
  - Oral disorders
  - Pain
  - Palpitations
  - Skin reactions
  - Sleep disorders
  - Syncope
  - Tachycardia
  - Taste altered
  - Thrombocytopenia
  - Urinary disorders
  - Urinary tract disorder
  - Vertigo
  - Vision disorders
  - Vomiting

- **Uncommon**
  - Akathisia
  - Chest discomfort
  - Dysmenorrhoea
  - Hallucination
  - Hypersensitivity
  - Keratitis
  - Muscle contractions involuntary
  - Nasal complaints
  - Paller
  - Photosensitivity reaction
  - Proteinuria
  - Retinal exudate
  - Sensation abnormal
  - Tension
  - Vaginal discharge

**MEDICATION FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **EXCIPIENTS**: May contain Benyl alcohol
- **Pegasys (Roche Products Ltd)**
  - Peginterferon alfa-2a 180 microgram per 1 ml
    - Pegasys
    - 90micrograms/0.5ml solution for injection pre-filled syringes | 1 pre-filled disposable injection (Peg) £76.51
  - Peginterferon alfa-2a 270 microgram per 1 ml
    - Pegasys
    - 135micrograms/0.5ml solution for injection pre-filled syringes | 1 pre-filled disposable injection (Peg) €107.76 DT + €107.76
  - Peginterferon alfa-2a 360 microgram per 1 ml
    - Pegasys
    - 180micrograms/0.5ml solution for injection pre-filled syringes | 4 pre-filled disposable injection (Peg) £497.60

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### Herpesvirus infections

#### 5.3 Herpesvirus infections

**Herpes simplex infections**

The two most important herpesvirus pathogens are herpes simplex virus (herpesvirus hominis) and varicella–zoster virus.

**Herpes simplex infections**

Infection of the mouth and lips and in the eye is generally associated with herpes simplex virus serotype 1 (HSV-1); other areas of the skin may also be infected, especially in immunodeficiency. Genital infection is most often associated with HSV-2 and also HSV-1. Treatment of herpes simplex infection should start as early as possible and usually within 5 days of the appearance of the infection.

In individuals with good immune function, mild infection of the eye (ocular herpes) and of the lips (herpes labialis or cold sores) is treated with a topical antiviral drug. Primary herpetic gingivostomatitis is managed by changes to diet and with analgesics. Severe infection, neonatal herpes infection or infection in immunocompromised individuals requires treatment with a systemic antiviral drug. After completing parental treatment of neonatal herpes simplex encephalitis, oral suppression therapy with aciclovir p. 420 for 6 months can be considered on specialist advice. Primary or recurrent genital herpes simplex infection is treated with an antiviral drug given by mouth. Persistence of a lesion or recurrence in an immunocompromised patient may signal the development of resistance.

Specialist advice should be sought for systemic treatment of herpes simplex infection in pregnancy.

**Varicella–zoster infections**

Regardless of immune function and the use of any immunoglobulins, neonates with chickenpox should be treated with a parenteral antiviral to reduce the risk of severe disease. Oral therapy in children is not recommended as absorption is variable. Chickenpox in otherwise healthy children between 1 month and 12 years is usually mild and antiviral treatment is not usually required.

Chickenpox is more severe in adolescents than in children; antiviral treatment started within 24 hours of the onset of rash may reduce the duration and severity of symptoms in otherwise healthy adolescents. Antiviral treatment is generally recommended in immunocompromised patients and those at special risk (e.g. because of severe
Infection supervision.

Cytomegalovirus infection

Aciclovir is active against herpesviruses but does not eradicate them. Uses of aciclovir include systemic treatment of varicella–zoster and the systemic and topical treatment of herpes simplex infections of the skin and mucous membranes. It is used by mouth for severe herpetic stomatitis. Aciclovir eye ointment is used for herpes simplex infections of the eye; it is combined with systemic treatment for ophthalmic zoster.

Famciclovir, a prodrug of penciclovir, is similar to aciclovir and is licensed in adults for use in herpes zoster and genital herpes; there is limited information available on use in children.

Valaciclovir is an ester of aciclovir, licensed in adults for herpes zoster and herpes simplex infections of the skin and mucous membranes (including genital herpes); it is also licensed in children over 12 years for preventing cytomegalovirus disease following solid organ transplantation. Valaciclovir may be used for the treatment of mild herpes zoster in immunocompromised children over 12 years; treatment should be initiated under specialist supervision.

Cytomegalovirus infection

Ganciclovir p. 423 is related to aciclovir but it is more active against cytomegalovirus (CMV); it is also much more toxic than aciclovir and should therefore be prescribed under specialist supervision and only when the potential benefit outweighs the risks. Ganciclovir is administered by intravenous infusion for the initial treatment of CMV infection. The use of ganciclovir may also be considered for symptomatic congenital CMV infection. Ganciclovir causes profound myelosuppression when given with zidovudine p. 438; the two should not normally be given together particularly during initial ganciclovir therapy. The likelihood of ganciclovir resistance increases in patients with a high viral load or in those who receive the drug over a long duration.

Valaciclovir is licensed for use in children over 12 years for prevention of cytomegalovirus disease following renal transplantation.

Foscarnet sodium p. 424 is also active against cytomegalovirus; it is toxic and can cause renal impairment. It is deposited in teeth, bone and cartilage, and animal studies have shown that deposition is greater in young animals. Its effect on skeletal development in children is not known. Foscarnet sodium should be prescribed under specialist supervision.

Aciclovir (Aciclovir)

- **INDICATIONS AND DOSE**
  - **Herpes simplex, suppression**
    - **BY MOUTH**
      - Child 12-17 years: 400 mg twice daily, alternatively 200 mg 4 times a day; increased to 400 mg 3 times a day, dose may be increased if recurrences occur on standard suppressive therapy or for suppression of genital herpes during late pregnancy (from 36 weeks gestation), therapy interrupted every 6–12 months to reassess recurrence frequency—consider restarting after two or more recurrences
  - **Herpes simplex, prophylaxis in the immunocompromised**
    - **BY MOUTH**
      - Child 1-23 months: 100–200 mg 4 times a day
      - Child 2-17 years: 200–400 mg 4 times a day
  - **Herpes simplex, treatment**
    - **BY MOUTH**
      - Child 1-23 months: 100 mg 5 times a day usually for 5 days (longer if new lesions appear during treatment or if healing incomplete)
      - Child 2-17 years: 200 mg 5 times a day usually for 5 days (longer if new lesions appear during treatment or if healing incomplete)
    - **BY INTRAVENOUS INFUSION**
      - Neonate: 20 mg/kg every 8 hours for 14 days (for at least 21 days if CNS involvement—confirm cerebrospinal fluid negative for herpes simplex virus before stopping treatment).

  - **Herpes simplex, treatment, in immunocompromised or if absorption impaired**
    - **BY MOUTH**
      - Child 1-23 months: 200 mg 5 times a day usually for 5 days (longer if new lesions appear during treatment or if healing incomplete)
    - **BY INTRAVENOUS INFUSION**
      - Child 3 months-11 years: 250 mg/m² every 8 hours usually for 5 days
      - Child 12-17 years: 5 mg/kg every 8 hours usually for 5 days
  - **Herpes simplex, treatment, in immunocompromised or in simplex encephalitis**
    - **BY INTRAVENOUS INFUSION**
      - Child 3 months-11 years: 500 mg/m² every 8 hours usually for 5 days (given for at least 21 days in encephalitis—confirm cerebrospinal fluid negative for herpes simplex virus before stopping treatment)

  - **Varicella zoster (chickenpox), treatment**
    - **BY MOUTH**
      - Child 1-23 months: 200 mg 4 times a day for 5 days
      - Child 2-5 years: 400 mg 4 times a day for 5 days
      - Child 6-11 years: 800 mg 4 times a day for 5 days
      - Child 12-17 years: 800 mg 5 times a day for 7 days
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- **INTERACTIONS** ➔ Appendix 1: aciclovir
- **SIDE-EFFECTS**
  - Common or very common
    - With intravenous use Nausea, photosensitivity reaction, skin reactions, vomiting
    - With oral use Abdominal pain, diarrhoea, dizziness, fatigue, fever, headache, nausea, photosensitivity reaction, skin reactions, vomiting
  - Uncommon
    - With intravenous use Anaemia, leucopenia, thrombocytopenia
  - Rare or very rare
    - With intravenous use Abdominal pain, agitation, angioedema, ataxia, coma, confusion, diarrhoea, dizziness, drowsiness, dysarthria, dysphonia, encephalopathy, fatigue, fever, hallucination, headache, hepatic disorders, inflammation, localised, psychosis, renal impairment, renal pain, seizure, tremor
    - With oral use Agitation, anaemia, angioedema, ataxia, coma, confusion, drowsiness, dysarthria, dysphonia, encephalopathy, hallucination, hepatic disorders, leucopenia, psychosis, renal impairment, renal pain, seizure, thrombocytopenia, tremor
  - Frequency not known
    - With intravenous use Crystalluria
    - With oral use Alopecia, crystalluria
  - **PREGNANCY** Not known to be harmful—manufacturers advise use only when potential benefit outweighs risk.
  - **BREAST FEEDING** Significant amount in milk after systemic administration—not known to be harmful but manufacturer advises caution.
  - **RENAL IMPAIRMENT** Risk of neurological reactions increased. Maintain adequate hydration (especially during renal impairment).
  - **Dose adjustments**
    - With intravenous use Use normal intravenous dose every 12 hours if estimated glomerular filtration rate 25–50 mL/minute/1.73 m² (every 24 hours if estimated glomerular filtration rate 10–25 mL/minute/1.73 m². Consult product literature for intravenous dose if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².
    - With oral use For herpes zoster, use normal oral dose every 8 hours if estimated glomerular filtration rate 10–25 mL/minute/1.73 m² (every 12 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m². For herpes simplex, use normal dose every 12 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².
  - **DIRECTIONS FOR ADMINISTRATION**
    - With intravenous use For intravenous infusion, reconstitute to 25 mg/mL with Water for Injections or Sodium Chloride 0.9% then dilute to concentration of 5 mg/mL with Sodium Chloride 0.9% or Sodium Chloride and Glucose and give over 1 hour; alternatively, may be administered in a concentration of 25 mg/mL using a suitable infusion pump and central venous access and given over 1 hour.
  - **PRESCRIBING AND DISPENSING INFORMATION**
    - With oral use Flavours of oral liquid preparations may include banana, or orange.
  - **PATIENT AND CARER ADVICE**
    - Medicines for Children leaflet: Aciclovir (oral) for viral infections
    - With oral use www.medicinesforchildren.org.uk/aciclovir-oral-viral-infections-0
  - **PROFESSION SPECIFIC INFORMATION**
    - Dental practitioners’ formulary
      - With oral use Aciclovir Tablets 200 mg or 800 mg may be prescribed. Aciclovir Oral Suspension 200 mg/5mL may be prescribed.

**VARICELLA ZOSTER (CHICKENPOX), TREATMENT IN IMMUNOCOMPROMISED | HERPES ZOSTER (SHINGLES), TREATMENT IN IMMUNOCOMPROMISED**

- **BY INTRAVENOUS INFUSION**
  - Neonate: 10–20 mg/kg every 8 hours for at least 7 days.
  - Child 1–2 months: 10–20 mg/kg every 8 hours for at least 7 days.
  - Child 3 months–11 years: 250 mg/m² every 8 hours usually for 5 days.
  - Child 12–17 years: 5 mg/kg every 8 hours usually for 5 days.
  - **Varicella zoster (chickenpox), treatment in immunocompromised | Herpes zoster (shingles), treatment in immunocompromised**
    - **BY INTRAVENOUS INFUSION**
      - Child 1–2 months: 200 mg 4 times a day continued for 2 days after crusting of lesions.
      - Child 2–5 years: 400 mg 4 times a day continued for 2 days after crusting of lesions.
      - Child 6–11 years: 800 mg 4 times a day continued for 2 days after crusting of lesions.
      - Child 12–17 years: 800 mg 5 times a day continued for 2 days after crusting of lesions.
  - **Herpes zoster, treatment in encephalitis | Varicella zoster, treatment in encephalitis**
    - **BY INTRAVENOUS INFUSION**
      - Neonate: 10–20 mg/kg every 8 hours given for 10–14 days in encephalitis, possibly longer if also immunocompromised.
      - Child 1–2 months: 10–20 mg/kg every 8 hours given for 10–14 days in encephalitis, possibly longer if also immunocompromised.
      - Child 3 months–11 years: 500 mg/m² every 8 hours given for 10–14 days in encephalitis, possibly longer if also immunocompromised.
      - Child 12–17 years: 10 mg/kg every 8 hours given for 10–14 days in encephalitis, possibly longer if also immunocompromised.
  - **Varicella zoster (chickenpox), attenuation of infection if varicella-zoster immunoglobulin not indicated**
    - **BY MOUTH**
      - Child: 10 mg/kg 4 times a day for 7 days, to be started 1 week after exposure.
  - **Varicella zoster (chickenpox), prophylaxis after delivery**
    - **BY INTRAVENOUS INFUSION**
      - Neonate: 10 mg/kg every 8 hours continued until serological tests confirm absence of virus.

**DOSES AT EXTREMES OF BODY-WEIGHT**

- With intravenous use To avoid excessive dosage in obese patients parenteral dose should be calculated on the basis of ideal weight for height.
- **UNLICENSED USE**
  - With intravenous use Intravenous infusion not licensed for herpes zoster in children under 18 years.
  - With oral use Tablets and suspension not licensed for suppression of herpes simplex or for treatment of herpes zoster in children (age range not specified by manufacturer).
  - Aciclovir doses in BNF may differ from those in product literature. Attenuation of chickenpox is an unlicensed indication.
- **CAUTIONS** Maintain adequate hydration (especially with infusion or high doses).
Infection

Infection

l MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS

l Aciclovir (Non-proprietary)

Aciclovir 200 mg Aciclovir 200mg tablets | 25 tablet (PO) £1.25 DT = £1.03
Aciclovir 400 mg Aciclovir 400mg tablets | 56 tablet (PO) £3.30 DT = £2.42
Aciclovir 800 mg Aciclovir 800mg tablets | 35 tablet (PO) £4.35 DT = £3.25

Dispersible tablet

CAUTIONARY AND ADVISORY LABELS

l Aciclovir (Non-proprietary)

Aciclovir 200 mg Aciclovir 200mg dispersible tablets | 25 tablet (PO) £1.05 DT = £1.01
Aciclovir 400 mg Aciclovir 400mg dispersible tablets | 56 tablet (PO) £1.98 DT = £1.96
Aciclovir 800 mg Aciclovir 800mg dispersible tablets | 35 tablet (PO) £1.90 DT = £1.98

v Zovirax (GlaxoSmithKline UK Ltd)

Aciclovir 200 mg Zovirax 200mg dispersible tablets | 25 tablet (PO) £2.85 DT = £1.01
Aciclovir 800 mg Zovirax 800mg dispersible tablets | 35 tablet (PO) £1.50 DT = £1.08

Oral suspension

CAUTIONARY AND ADVISORY LABELS

l Aciclovir (Non-proprietary)

Aciclovir 40 mg per 1 ml Aciclovir 200mg/5ml oral suspension sugar free sugar-free | 125 ml (PO) £35.76 DT = £35.76
Aciclovir 80 mg per 1 ml Aciclovir 400mg/5ml oral suspension sugar free sugar-free | 100 ml (PO) £39.47 DT = £39.47

v Zovirax (GlaxoSmithKline UK Ltd)

Aciclovir 40 mg per 1 ml Zovirax 200mg/5ml oral suspension sugar-free | 125 ml (PO) £29.56 DT = £29.56
Aciclovir 80 mg per 1 ml Zovirax Double Strength 400mg/5ml oral suspension sugar-free | 100 ml (PO) £33.02 DT = £33.02

Solution for infusion

ELECTROLYTES: May contain Sodium

l Aciclovir (Non-proprietary)

Aciclovir (as Aciclovir sodium) 25 mg per 1 ml Aciclovir 1g/40ml solution for infusion vials | 1 vial (PO) £40.00 (Hospital only)
Aciclovir 250mg/10ml concentrate for solution for infusion vials | 5 vial (PO) £50.00 (Hospital only) | 5 vial (PO) £30.00–£40.00
Aciclovir 500mg/20ml solution for infusion vials | 5 vial (PO) £100.00 (Hospital only) | 5 vial (PO) £50.00
Aciclovir 500mg/20ml concentrate for solution for infusion vials | 5 vial (PO) £40.00 (Hospital only)

Powder for solution for infusion

ELECTROLYTES: May contain Sodium

l Aciclovir (Non-proprietary)

Aciclovir (as Aciclovir sodium) 250 mg Aciclovir 250mg powder for solution for infusion vials | 5 vial (PO) £116.50 (Hospital only)
Aciclovir 250mg powder for solution for infusion vials | 5 vial (PO) £49.30 | 10 vial (PO) £91.30 (Hospital only)
Aciclovir (as Aciclovir sodium) 500 mg Aciclovir 500mg powder for solution for infusion vials | 5 vial (PO) £182.00 (Hospital only)

v Zovirax IV. (GlaxoSmithKline UK Ltd)

Aciclovir (as Aciclovir sodium) 250 mg Zovirax IV. 250mg powder for solution for infusion vials | 5 vial (PO) £116.70
Aciclovir (as Aciclovir sodium) 500 mg Zovirax IV. 500mg powder for solution for infusion vials | 5 vial (PO) £170.00

l UNLICENSED USE Not licensed for treatment of herpes zoster in children. Not licensed for treatment or suppression of herpes simplex infection in immunocompromised or HIV-positive children.

l CAUTIONS Maintain adequate hydration (especially with high doses).

l INTERACTIONS → Appendix 1: valaciclovir

l SIDE-EFFECTS

Common or very common Diarrhoea, dizziness, headache, nausea, photosensitivity reaction, skin reactions, vomiting

Uncommon Abdominal discomfort, agitation, confusion, dysphoria, hallucination, leucopenia, level of consciousness decreased, renal pain, thrombocytopenia, tremor

Rare or very rare Angioedema, ataxia, coma, delirium, dysarthria, encephalopathy, neuphotaxis, psychosis, renal impairment, seizure

Frequency not known Microangiopathic haemolytic anaemia

SIDE-EFFECTS, FURTHER INFORMATION Neurological reactions more frequent with higher doses.

l PREGNANCY Not known to be harmful—manufacturers advise use only when potential benefit outweighs risk.

l BREAST FEEDING Significant amount in milk after systemic administration—not known to be harmful but manufacturer advises caution.

l HEPATIC IMPAIRMENT Manufacturer advises caution with doses of 4 g or more per day (no information available).

l RENAL IMPAIRMENT Maintain adequate hydration.

## Valaciclovir

l INDICATIONS AND DOSE

Herpes zoster infection, treatment in immunocompromised patients

BY MOUTH

Child 12–17 years: 1 g 3 times a day for at least 7 days and continued for 2 days after crusting of lesions

Herspes simplex, treatment of first infective episode

BY MOUTH

Child 12–17 years: 500 mg twice daily for 5 days (longer if new lesions appear during treatment or healing is incomplete)

Herspes simplex infections treatment of first episode in immunocompromised or HIV-positive patients

BY MOUTH

Child 12–17 years: 1 g twice daily for 10 days

Herspes simplex, treatment of recurrent infections

BY MOUTH

Child 12–17 years: 1 g twice daily for 3–5 days

Treatment of recurrent herpes simplex infections in immunocompromised or HIV-positive patients

BY MOUTH

Child 12–17 years: 1 g twice daily for 5–10 days

Herspes labialis treatment

BY MOUTH

Child 12–17 years: Initially 2 g, then 2 g after 12 hours

Herspes simplex, suppression of infections

BY MOUTH

Child 12–17 years: 500 mg daily in 1–2 divided doses, therapy to be interrupted every 6–12 months to reassess recurrence frequency—consider restarting after two or more recurrences

Herspes simplex, suppression of infections in immunocompromised or HIV-positive patients

BY MOUTH

Child 12–17 years: 500 mg twice daily, therapy to be interrupted every 6–12 months to reassess recurrence frequency—consider restarting after two or more recurrences

Prevention of cytomegalovirus disease following solid organ transplantation when valganciclovir or ganciclovir cannot be used

BY MOUTH

Child 12–17 years: 2 g 4 times a day usually for 90 days, preferably starting within 72 hours of transplantation

Herspes labialis treatment

BY MOUTH

Child 12–17 years: Initially 2 g, then 2 g after 12 hours

Herspes simplex, suppression of infections

BY MOUTH

Child 12–17 years: 500 mg daily in 1–2 divided doses, therapy to be interrupted every 6–12 months to reassess recurrence frequency—consider restarting after two or more recurrences

Prevention of cytomegalovirus disease following solid organ transplantation when valganciclovir or ganciclovir cannot be used

BY MOUTH

Child 12–17 years: 2 g 4 times a day usually for 90 days, preferably starting within 72 hours of transplantation

**HERPES SIMPLEX, TREATMENT OF FIRST INFECTIVE EPISODE**

- **BY MOUTH**
  - Child 12–17 years: 500 mg twice daily for 5 days (longer if new lesions appear during treatment or healing is incomplete)

**HERPES SIMPLEX INFECTIONS TREATMENT OF FIRST EPISODE IN IMMUNOCOMPROMISED OR HIV-POSITIVE PATIENTS**

- **BY MOUTH**
  - Child 12–17 years: 1 g twice daily for 10 days

**HERPES SIMPLEX TREATMENT OF RECURRENT INFECTIONS**

- **BY MOUTH**
  - Child 12–17 years: 1 g twice daily for 3–5 days

**TREATMENT OF RECURRENT HERPES SIMPLEX INFECTIONS IN IMMUNOCOMPROMISED OR HIV-POSITIVE PATIENTS**

- **BY MOUTH**
  - Child 12–17 years: 1 g twice daily for 5–10 days

**HERPES LABIALS TREATMENT**

- **BY MOUTH**
  - Child 12–17 years: Initially 2 g, then 2 g after 12 hours

**HERPES SIMPLEX, SUPPRESSION OF INFECTIONS**

- **BY MOUTH**
  - Child 12–17 years: 500 mg daily in 1–2 divided doses, therapy to be interrupted every 6–12 months to reassess recurrence frequency—consider restarting after two or more recurrences

**PREVENTION OF CYTOMEGALOVIRUS DISEASE FOLLOWING SOLID ORGAN TRANSPLANTATION WHEN VALGANCICLOVIR OR GANCICLOVIR CANNOT BE USED**

- **BY MOUTH**
  - Child 12–17 years: 2 g 4 times a day usually for 90 days, preferably starting within 72 hours of transplantation
Dose adjustments For herpes zoster, 1 g every 12 hours if estimated glomerular filtration rate 30–50 mL/minute/1.73 m² (1 g every 24 hours if estimated glomerular filtration rate 10–30 mL/minute/1.73 m²; 500 mg every 24 hours if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²).

For treatment of herpes simplex, 500 mg (1 g in immunocompromised or HIV-positive children) every 24 hours if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

For treatment of herpes labialis, if estimated glomerular filtration rate 30–50 mL/minute/1.73 m², initially 1 g, then 1 g 12 hours after initial dose (if estimated glomerular filtration rate 10–30 mL/minute/1.73 m², initially 500 mg, then 500 mg 12 hours after initial dose; if estimated glomerular filtration rate less than 10 mL/minute/1.73 m², 500 mg as a single dose).

For suppression of herpes simplex, 250 mg (500 mg in immunocompromised or HIV-positive children) every 24 hours if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

Reduce dose according to estimated glomerular filtration rate for cytomegalovirus prophylaxis following solid organ transplantation (consult product literature).

Prescribing and dispensing information Valaciclovir is a pro-drug of aciclovir.

Medicinal forms There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

Tablet

Cautions and Advisory Labels 9

Valaciclovir (Non-proprietary)

Valaciclovir (as Valaciclovir hydrochloride) 500 mg Valaciclovir

500 mg tablets | 10 tablet | £20.59 OT = £2.47 | 42 tablet | £8.99-£8.30

Valtrex (GlaxoSmithKline UK Ltd)

Valaciclovir (as Valaciclovir hydrochloride) 250 mg Valtrex 250 mg tablets | 60 tablet | £123.28 OT = £212.28

Valaciclovir (as Valaciclovir hydrochloride) 500 mg Valtrex

500 mg tablets | 10 tablet | £20.59 OT = £2.47 | 42 tablet | £8.30

5.3a Cytomegalovirus infections

Antivirals Nucleoside Analogues

Ganciclovir

Indications and dose Prevention of cytomegalovirus disease [pre-emptive therapy in patients with drug-induced immunosuppression]

By intravenous infusion

Child 12-17 years: Initially 5 mg/kg every 12 hours for 7–14 days, then maintenance 6 mg/kg once daily, on 5 days of the week, alternatively maintenance 5 mg/kg once daily

Prevention of cytomegalovirus disease [universal prophylaxis in patients with drug-induced immunosuppression]

By intravenous infusion

Neonate: (consult product literature).

Child 1 month-16 years: (consult product literature)

Child 17 years: 6 mg/kg once daily, on 5 days of the week, alternatively 5 mg/kg once daily

Treatment of cytomegalovirus disease [in immunocompromised patients]

By intravenous infusion

Child: Initially 5 mg/kg every 12 hours for 14–21 days, then maintenance 6 mg/kg once daily, on 5 days of the week, alternatively maintenance 5 mg/kg once daily, maintenance only for patients at risk of relapse; if disease progresses initial induction treatment may be repeated

Congenital cytomegalovirus infection of the CNS

By intravenous infusion

Neonate: 6 mg/kg every 12 hours for 6 weeks.

Unlicensed use Not licensed for use in children under 12 years for the treatment of cytomegalovirus disease in immunocompromised patients.

In neonates Not licensed for congenital cytomegalovirus infection of the CNS.

Contra-indications Abnormally low haemoglobin count (consult product literature) - abnormally low neutrophil count (consult product literature) - abnormally low platelet count (consult product literature)

Caution History of cytopenia - potential carcinogen (including long-term carcinogenicity) - potential teratogen (including long-term teratogenicity) - radiotherapy

Interactions Appendix 1: Ganciclovir

Side-effects


Uncommon Alopecia - arthralgia - deafness - haematuria - hypotension - infertility male - oral ulceration - pancreatitis - psychotic disorder - tremor - visual impairment

Rare or very rare Agranulocytosis - hallucination

Allergy and cross-sensitivity Contra-indicated in patients hypersensitive to valganciclovir, aciclovir, or valaciclovir.

Conception and contraception Manufacturer advises women of childbearing potential should use effective contraception during and for at least 30 days after treatment; men with partners of childbearing potential should be advised to use barrier contraception during and for at least 90 days after treatment. Ganciclovir may cause temporary or permanent inhibition of spermatogenesis — impaired fertility observed in animal studies.

Pregnancy Manufacturer advises avoid unless potential benefit outweighs risk — teratogenicity in animal studies.

Breast feeding Manufacturer advises avoid — present in milk in animal studies.

Renal impairment Dose adjustments Manufacturer advises reduce dose for patients receiving mg/kg dosing if creatinine clearance less than 70 mL/minute — consult product literature.

Monitoring requirements Monitor full blood count closely (severe deterioration may require correction and possibly treatment interruption).

Directions for administration Manufacturer advises, for intravenous infusion, give intermittently in Glucose 5% or Sodium Chloride 0.9%. Reconstitute with Water for

Cytomegalovirus infections 423

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Infections (500 mg/10 mL) then dilute requisite dose to a concentration of not more than 10 mg/mL with infusion fluid; give over 1 hour into a vein with adequate flow, preferably using a plastic cannula.

**CONTRA-INDICATIONS** Abnormally low haemoglobin count (consult product literature) - abnormally low neutrophil count (consult product literature) - abnormally low platelet count (consult product literature)

**CAUTIONS** History of cytopenia - potential carcinogen (including long-term carcinogenicity) - potential teratogen (including long-term teratogenicity) - radiotherapy

**INTERACTIONS** → Appendix 1: valganciclovir

**SIDE-EFFECTS**
- **Common or very common** Anaemia - anxiety - appetite decreased - arthralgia - asthenia - bone marrow disorders - chest pain - confusion - constipation - cough - depression - diarrhoea - dizziness - dysphagia - dyspnoea - ear pain - eye disorders - eye inflammation - eye pain - flatulence - gastrointestinal discomfort - headache - hepatic function abnormal - increased risk of infection - insomnia - leucopenia - malaise - muscle complaints - nausea - neutropenia - night sweats - pain - peripheral neuropathy - renal impairment - seizure - sensation abnormal - sepsis - skin reactions - taste altered - thinking abnormal - thrombocytopenia - vomiting - weight decreased
- **Uncommon** Alopecia - arrhythmia - deafness - haematuria - hallucination - hypotension - infertility male - oral ulceration - pancreatitis - psychotic disorder - tremor - visual impairment

**ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients hypersensitive to ganciclovir, aciclovir, or valaciclovir.

**CONCEPTION AND CONTRACEPTION** Manufacturer advises women of childbearing potential should use effective contraception during and for at least 90 days after treatment. Ganciclovir may cause temporary or permanent inhibition of spermatogenesis—impaired fertility observed in animal studies.

**PREGNANCY** Manufacturer advises avoid unless potential benefit outweighs risk—teratogenicity observed with ganciclovir in animal studies.

**BREAST FEEDING** Manufacturer advises avoid—ganciclovir present in milk in animal studies.

**MONITORING REQUIREMENTS** Monitor full blood count closely (severe deterioration may require correction and possibly treatment interruption).

**PRESCRIBING AND DISPENSING INFORMATION**
Valganciclovir is a pro-drug of ganciclovir. Flavours of oral liquid formulations may include tutti-frutti.

**HANDLING AND STORAGE** Manufacturer advises reconstituted powder for oral solution should be stored in a refrigerator (2–8°C) for up to 49 days. Caution in handling Valganciclovir is a potential teratogen and carcinogen. Manufacturer advises caution when handling the powder, reconstituted solution, or broken tablets and avoid inhalation of powder; if contact with skin or mucous membranes occurs, wash thoroughly with soap and water; rinse eyes thoroughly with plain water.

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**Valganciclovir**

**INDICATIONS AND DOSE**
Prevention of cytomegalovirus disease (following solid organ transplantation from a cytomegalovirus positive donor)

**BY MOUTH**
- Neonate: (consult product literature).
- Child: (consult product literature)

**DOSE EQUIVALENCE AND CONVERSION**
- Oral valganciclovir 900 mg twice daily is equivalent to intravenous ganciclovir 5 mg/kg twice daily.

**CONTRA-INDICATIONS** Abnormally low haemoglobin count (consult product literature) - abnormally low neutrophil count (consult product literature) - abnormally low platelet count (consult product literature)

**CAUTIONS** History of cytopenia - potential carcinogen (including long-term carcinogenicity) - potential teratogen (including long-term teratogenicity) - radiotherapy

**INTERACTIONS** → Appendix 1: valganciclovir

**SIDE-EFFECTS**
- **Common or very common** Anaemia - anxiety - appetite decreased - arthralgia - asthenia - bone marrow disorders - chest pain - confusion - constipation - cough - depression - diarrhoea - dizziness - dysphagia - dyspnoea - ear pain - eye disorders - eye inflammation - eye pain - flatulence - gastrointestinal discomfort - headache - hepatic function abnormal - increased risk of infection - insomnia - leucopenia - malaise - muscle complaints - nausea - neutropenia - night sweats - pain - peripheral neuropathy - renal impairment - seizure - sensation abnormal - sepsis - skin reactions - taste altered - thinking abnormal - thrombocytopenia - vomiting - weight decreased
- **Uncommon** Alopecia - arrhythmia - deafness - haematuria - hallucination - hypotension - infertility male - oral ulceration - pancreatitis - psychotic disorder - tremor - visual impairment

**ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients hypersensitive to ganciclovir, aciclovir, or valaciclovir.

**CONCEPTION AND CONTRACEPTION** Manufacturer advises women of childbearing potential should use effective contraception during and for at least 90 days after treatment; men with partners of childbearing potential should be advised to use barrier contraception during and for at least 90 days after treatment.

**PREGNANCY** Manufacturer advises avoid unless potential benefit outweighs risk—teratogenicity observed with ganciclovir in animal studies.

**BREAST FEEDING** Manufacturer advises avoid—ganciclovir present in milk in animal studies.

**MONITORING REQUIREMENTS** Monitor full blood count closely (severe deterioration may require correction and possibly treatment interruption).

**PRESCRIBING AND DISPENSING INFORMATION**
Valganciclovir is a pro-drug of ganciclovir. Flavours of oral liquid formulations may include tutti-frutti.

**HANDLING AND STORAGE** Manufacturer advises reconstituted powder for oral solution should be stored in a refrigerator (2–8°C) for up to 49 days. Caution in handling Valganciclovir is a potential teratogen and carcinogen. Manufacturer advises caution when handling the powder, reconstituted solution, or broken tablets and avoid inhalation of powder; if contact with skin or mucous membranes occurs, wash thoroughly with soap and water; rinse eyes thoroughly with plain water.

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**Foscarnet sodium**

**INDICATIONS AND DOSE**
Cytomegalovirus disease

**BY INTRAVENOUS INFUSION**
- Child (under expert supervision): Initially 60 mg/kg every 8 hours 2–3 weeks, then maintenance 60 mg/kg daily, increased if tolerated to 90–120 mg/kg daily, if disease progresses on maintenance dose, repeat induction regimen

**Mucocutaneous herpes simplex virus infections unresponsive to aciclovir in immunocompromised patients**

**BY INTRAVENOUS INFUSION**
- Child (under expert supervision): 40 mg/kg every 8 hours for 2–3 weeks or until lesions heal

**UNLICENSED USE** Not licensed for use in children.

**CAUTIONS** Ensure adequate hydration

**INTERACTIONS** → Appendix 1: foscarnet

**SIDE-EFFECTS**
- **Common or very common** Aggression - anaemia - anxiety - appetite decreased - arthralgia - asthenia - chest pain - chills - confusion - constipation - coordination abnormal - dehydration - depression - diarrhoea - dizziness - electrolyte imbalance - fever - gastrointestinal discomfort - genital
discomfort (due to high concentrations excreted in urine), genital ulceration (due to high concentrations excreted in urine), haemorrhage, headache, hepatic function abnormal, hypertension, hypotension, leucopenia, malaise, muscle contractions involuntary, myalgia, nausea, reduced infusion rate, neutropenia, numbness, oedema, palpatations, pancreatitis, paraesthesia (reduced infusion rate), peripheral neuropathy, proteinuria, renal impairment, seizure, sepsis, skin reactions, thrombocytopenia, thrombophlebitis, tremor, urinary disorders, vomiting.

- **Uncommon** Acidosis, angioedema, glomerulonephritis, nephropathy, pancytopenia
- **Frequency not known** Anaphylactoid reaction, diabetes insipidus, muscle weakness, myopathy, oesophageal ulcer, QT interval prolongation, renal pain, renal tubular acidosis, severe cutaneous adverse reactions (SCARs)

**CONCEPTION AND CONTRACEPTION** Men should avoid fathering a child during and for 6 months after treatment.

**PREGNANCY** Manufacturer advises avoid.

**BREAST FEEDING** Avoid—present in milk in animal studies.

**RENAL IMPAIRMENT** Dose adjustments: Reduce dose; consult product literature.

**MONITORING REQUIREMENTS**
- Monitor electrolytes, particularly calcium and magnesium.
- Monitor serum creatinine every second day during induction and every week during maintenance.

**DIRECTIONS FOR ADMINISTRATION** Avoid rapid infusion. For *intravenous infusion*, give undiluted solution via a central venous catheter; alternatively dilute to a concentration of 12 mg/ml with glucose 5% or Sodium Chloride 0.9% for administration via a peripheral vein; give over at least 1 hour (give doses greater than 60 mg/kg over 2 hours).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for infusion**

**ELECTROLYTES:** May contain Sodium
- Foscavir (Clinigen Healthcare Ltd)
- Foscarnet sodium 24 mg per 1 ml Foscavir 6g/250ml solution for infusion bottles 1 bottle £119.85 (Hospital only)

### 5.4 HIV infection

**HIV infection**

**Overview**

There is no cure for infection caused by the human immunodeficiency virus (HIV) but a number of drugs slow or halt disease progression. Drugs for HIV infection (antiretrovirals) may be associated with serious side-effects. Although antiretrovirals increase life expectancy considerably and decrease the risk of complications associated with premature ageing, mortality and morbidity remain slightly higher than in uninfected individuals.

The natural progression of HIV disease is different in children compared to adults; drug treatment should only be undertaken by specialists within a formal paediatric HIV clinical network. Guidelines and dose regimens are under constant review and for this reason some dose recommendations have not been included in BNF for Children.

Further information on the management of children with HIV can be obtained from the Children’s HIV Association (CHIVA) www.chiva.org.uk; and further information on antiretroviral use and toxicity can be obtained from the Paediatric European Network for Treatment of AIDS (PENTA) website penta-id.org/.

**Aims of treatment**

Treatment is aimed at suppressing viral replication for as long as possible; it should be started before the immune system is irreversibly damaged. The need for early drug treatment should, however, be balanced against the risk of toxicity. Commitment to treatment and strict adherence over many years are required; the regimen chosen should take into account convenience and the child’s tolerance of treatment. The development of drug resistance is reduced by using a combination of drugs; such combinations should have synergistic or additive activity while ensuring that their toxicity is not additive. It is recommended that viral sensitivity to antiretroviral drugs is established before starting treatment or before switching drugs if the infection is not responding.

**Initiation of treatment**

Treatment is started in all HIV infected children under 1 year of age regardless of clinical and immunological parameters. In children over 1 year of age, treatment is based on the child’s age, CD4 cell count, viral load, and symptoms. The choice of antiviral treatment for children should take into account the method and frequency of administration, risk of side-effects, compatibility of drugs with food, palatability, and the appropriateness of the formulation. Initiating treatment with a combination of drugs (‘highly active antiretroviral therapy’ which includes 2 nucleoside reverse transcriptase inhibitors with *either* a non-nucleoside reverse transcriptase inhibitor or a boosted protease inhibitor) is recommended. Abacavir p. 431 and lamivudine p. 436 are the nucleoside reverse transcriptase inhibitors of choice for initial therapy; however, zidovudine p. 438 and lamivudine are used in children who are positive for the HLA-B*5701 allele. Nevirapine p. 430 is the preferred non-nucleoside reverse transcriptase inhibitor in children under 3 years of age, but efavirenz p. 429 is preferred in older children. Lopinavir with ritonavir p. 441 is the preferred boosted protease inhibitor for initial therapy. The metabolism of many antiretrovirals varies in young children; it may therefore be necessary to adjust the dose according to the plasma-drug concentration. Children who require treatment for both HIV and chronic hepatitis B should receive antivirals that are active against both diseases.

**HIV infection, switching therapy**

Deterioration of the condition (including clinical, virological changes, and CD4 cell changes) may require a complete change of therapy. The choice of an alternative regimen depends on factors such as the response to previous treatment, tolerance, and the possibility of cross-resistance.

**HIV infection and pregnancy**

Treatment of HIV infection in pregnancy aims to reduce the risk of toxicity to the fetus (although information on the teratogenic potential of most antiretroviral drugs is limited), to minimise the viral load and disease progression in the mother, and to prevent transmission of infection to the neonate. *All treatment options require careful assessment by a specialist.* Combination antiretroviral therapy maximises the chance of preventing transmission and represents optimal therapy for the mother. However, it may be associated with a greater risk of preterm delivery. Local protocols and national guidelines (www.bhiva.org) should be consulted for recommendations on treatment during pregnancy and the perinatal period. Pregnancies in HIV-positive women and babies born to them should be reported prospectively to the National Study of HIV in Pregnancy and Childbirth at www.ucl.ac.uk/nshpc/ and to the Antiretroviral Pregnancy Registry at www.apregistry.com.
**HIV infection and breast-feeding**

Breast-feeding by HIV-positive mothers may cause HIV infection in the infant and should be avoided.

**HIV infection, post-exposure prophylaxis**

Children exposed to HIV infection through needlestick injury or by another route should be taken immediately to an accident and emergency department for post-exposure prophylaxis [unlicensed indication]. Antiretrovirals for prophylaxis are chosen on the basis of efficacy and potential for toxicity. Recommendations have been developed by the Children’s HIV Association, www.chiva.org.uk.

**Drug treatment**

Zidovudine, a nucleoside reverse transcriptase inhibitor (or 'nucleoside analogue'), was the first anti-HIV drug to be introduced. Other nucleoside reverse transcriptase inhibitors include abacavir, didanosine p. 433, emtricitabine p. 434, lamivudine, stavudine p. 437, and tenofovir disoproxil p. 437. There are concerns about renal toxicity and effects on bone mineralisation when tenofovir disoproxil is used in prepubertal children.

The protease inhibitors include atazanavir p. 439, darunavir p. 439, fosamprenavir p. 441 (a pro-drug of amprenavir), lopinavir (available as lopinavir with ritonavir), ritonavir p. 442, and tipranavir p. 442. Ritonavir in low doses boosts the activity of atazanavir, darunavir, fosamprenavir, lopinavir (available as lopinavir with ritonavir), and tipranavir increasing the persistence of plasma concentrations of these drugs; at such a low dose, ritonavir has no intrinsic antiviral activity. The protease inhibitors are metabolised by cytochrome P450 enzyme systems and therefore have a significant potential for drug interactions. Protease inhibitors are associated with lipodystrophy and metabolic effects.

The non-nucleoside reverse transcriptase inhibitors efavirenz, etravirine p. 429, nevirapine and rilpivirine p. 431 are active against the subtype HIV-1 but not HIV-2, a subtype that is rare in the UK. These drugs may interact with a number of drugs metabolised in the liver. Nevirapine is associated with a high incidence of rash (including Stevens-Johnson syndrome) and rarely fatal hepatitis. Rash is also associated with efavirenz and etravirine but it is usually milder. Psychiatric or CNS disturbances are common with efavirenz. CNS disturbances are often self-limiting and can be reduced by taking the dose at bedtime (especially in the first 2–4 weeks of treatment). Efavirenz has also been associated with an increased plasma cholesterol concentration. Etravirine is used in regimens containing a boosted protease inhibitor for HIV infection resistant to other non-nucleoside reverse transcriptase inhibitors and protease inhibitors.

Enfuvirtide below, which inhibits the fusion of HIV to the host cell, is licensed for managing infection that has failed to respond to a regimen of other antiretroviral drugs.

Enfuvirtide below should be combined with other potentially active antiretroviral drugs; it is given by subcutaneous injection.

Maraviroc p. 443 is an antagonist of the CCR5 chemokine receptor. It is used in patients exclusively infected with CCR5–tropic HIV.

Dolutegravir p. 427 and raltegravir p. 427 are inhibitors of HIV integrase. They are used for the treatment of HIV infection when non-nucleoside reverse transcriptase inhibitors or protease inhibitors cannot be used because of intolerance, drug interactions, or resistance.

**Immune reconstitution syndrome**

Improvement in immune function as a result of antiretroviral treatment may provoke a marked inflammatory reaction against residual opportunistic organisms; these reactions may occur within the first few weeks or months of initiating treatment. Autoimmune disorders (such as Graves’ disease) have also been reported many months after initiation of treatment.

**Osteonecrosis**

Osteonecrosis has been reported in children with advanced HIV disease or following long-term exposure to combination antiretroviral therapy.

**HIV infection in neonates**

In order to prevent transmission of infection, neonates born to HIV-positive mothers should be given post-exposure prophylaxis as soon as possible after birth, but starting no later than 72 hours after birth. Zidovudine p. 438 alone should be given to neonates whose mothers had a viral load less than 50 HIV RNA copies/mL between 36 weeks’ gestation and delivery, or whose mothers underwent caesarean section while taking zidovudine monotherapy. Combination antiretroviral therapy should be given to neonates whose mothers had a viral load over 50 HIV RNA copies/mL at delivery or whose mothers are found to be HIV positive after delivery. Prophylaxis is continued for 4 weeks.

**ANTIVIRALS)**

**HIV-FUSION INHIBITORS**

**Enfuvirtide**

- **DRUG ACTION** Enfuvirtide inhibits the fusion of HIV to the host cell.

- **INDICATIONS AND DOSE**

  HIV infection in combination with other antiretroviral drugs for resistant infection or for patients intolerant to other antiretroviral regimens

  - **BY SUBCUTANEOUS INJECTION**
    - Child 6–15 years: 2 mg/kg twice daily (max. per dose 90 mg)
    - Child 16–17 years: 90 mg twice daily

- **SIDE-EFFECTS**

  - Common or very common Anxiety - appetite decreased - asthenia - concentration impaired - conjunctivitis - diabetes mellitus - gastrooesophageal reflux disease - haematuria - hyperglycaemia - increased risk of infection - influenza like illness - iritability - lymphadenopathy - myalgia - nasal congestion - nephrolithiasis - night mare - numbness - pancreatitis - peripheral neuropathy - skin papilloma - skin reactions - tremor - vertigo - weight decreased

  - Frequency not known Diarrhoea - hypersensitivity - immune reconstitution inflammatory syndrome - nausea - osteonecrosis

- **SIDE-EFFECTS, FURTHER INFORMATION**

  - Hypersensitivity

    Hypersensitivity reactions including rash, fever, nausea, vomiting, chills, rigors, low blood pressure, respiratory distress, glomerulonephritis, and raised liver enzymes reported; discontinue immediately if any signs or symptoms of systemic hypersensitivity develop and do not rechallenge.

**Osteonecrosis** Osteonecrosis has been reported in patients with advanced HIV disease or following long-term exposure to combination antiretroviral therapy.

- **PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution—no information available; chronic hepatitis B or C (possibly greater risk of hepatic side-effects).

- **DIRECTIONS FOR ADMINISTRATION** For subcutaneous injection, reconstitute with 1.1 mL Water for Injections and allow to stand (for up to 45 minutes) to dissolve; do not shake or invert vial.
HIV infection 427

**PATIENT AND CARER ADVICE**

Hypersensitivity reactions. Patients or carers should be told how to recognise signs of hypersensitivity, and advised to discontinue treatment and seek immediate medical attention if symptoms develop.

**MEDICINAL FORMS**

There can be a variation in the licensing of different medicines containing the same drug.

**SIDE-EFFECTS**

**Common or very common** Depression, diarrhoea, dizziness, fatigue, flatsulence, gastrointestinal discomfort, headache, nausea, skin reactions, sleep disorders, vomiting

**Uncommon** Arthralgia, hepatitis, hypersensitivity, immune reconstitution inflammatory syndrome, myalgia, suicidal tendencies

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**COMMON DRUGS**

**Dolutegravir**

**INDICATIONS AND DOSE**

**HIV infection without resistance to other inhibitors of HIV integrase, in combination with other antiretroviral drugs**

- By mouth
  - Child 12-17 years (body-weight 40 kg and above): 50 mg once daily

**HIV infection in combination with other antiretroviral drugs**

- With concomitant carboamazepine, efavirenz, etravirine (without boosted protease inhibitors, but see also interactions), fosphenytoin, phenobarbital, phenytoin, primidone, nevirapine, oxcarbazepine, St John’s wort, rifampicin, or tipranavir
  - By mouth
    - Child 12-17 years (body-weight 40 kg and above): 50 mg twice daily, avoid concomitant use with these drugs if resistance to other inhibitors of HIV integrase suspected

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**COMMUNICATION WITH PATIENTS**

**PREGNANCY**

Manufacturer advises avoid, see **Important Safety Information**.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in severe impairment.

**NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**

The **Scottish Medicines Consortium (SMC)** has advised (October 2017) that dolutegravir (Tivicay®) is recommended as an option for use within NHS Scotland when used in combination with other anti-retroviral medicinal products for the treatment of HIV infected children aged 6 to 12 years of age. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland when used in combination with other anti-retroviral medicines for the treatment of HIV infected children aged 6 to 12 years of age. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

The **Scottish Medicines Consortium (SMC)** has advised (July 2017) that dolutegravir (Tivicay®) is recommended for use within NHS Scotland when used in combination with other anti-retroviral medicines for the treatment of HIV infected children aged 6 to 12 years of age. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

**All Wales Medicines Strategy Group (AWMSG) decisions**

The **All Wales Medicines Strategy Group (AWMSG)** has advised (October 2017) that dolutegravir (Tivicay®) is recommended as an option for use within NHS Wales in combination with other anti-retroviral medicinal products for the treatment of HIV infected patients above 6 years of age. This recommendation applies only in circumstances where the approved Wales Patient Access Scheme (WPAS) is utilised or where the list/contract price is equivalent or lower than the WPAS price.

**MEDICINAL FORMS**

There can be a variation in the licensing of different medicines containing the same drug.

**SIDE-EFFECTS, FURTHER INFORMATION**

**Hypersensitivity**

Hypersensitivity reactions (including severe rash, or rash accompanied by fever, malaise, arthralgia, myalgia, blistering, oral lesions, conjunctivitis, angioedema, eosinophilia, or raised liver enzymes) reported uncommonly. Discontinue immediately if any sign or symptoms of hypersensitivity reactions develop.

**Osteonecrosis**

Osteonecrosis has been reported in patients with advanced HIV disease or following long-term exposure to combination antiretroviral therapy.

**PREGNANCY**

Manufacturer advises avoid, see **Important Safety Information**.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in severe impairment—no information available.

**PATIENT AND CARER ADVICE**

Patients or carers should be given advice on how to administer dolutegravir tablets.

**Missed doses**

If a dose is more than 20 hours late on the once daily regimen (or more than 8 hours late on the twice daily regimen), the missed dose should not be taken and the next dose should be taken at the normal time.

**INTERACTIONS**

Appendix 1: dolutegravir

**Important Safety Information**

**MHRA/CHM ADVICE: Dolutegravir (Tivicay®, Triumeq®, Juluca®): Signal of Increased Risk of Neural Tube Defects; Do Not Prescribe to Women Seeking to Become Pregnant; Exclude Pregnancy Before Initiation and Advise Use of Effective Contraception (June 2018)**

New safety recommendations have been issued whilst an EU review evaluates cases of neural tube defects in babies born to mothers who became pregnant while taking dolutegravir. The MHRA advises:

- Dolutegravir should not be prescribed to women who are trying to become pregnant.
- Pregnancy should be excluded in women of childbearing potential with pregnancy testing before starting dolutegravir.
- Women of childbearing potential should be advised to use effective contraception throughout treatment with dolutegravir.
- If pregnancy is confirmed in the first trimester while a woman is taking dolutegravir, switch to an alternative treatment unless there is no suitable alternative.
- Women taking dolutegravir for HIV should be advised not to stop taking their medicine without first consulting their doctor.

**Interactions**

Appendix 1: dolutegravir

**SIDE-EFFECTS**

**Common or very common** Depression, diarrhoea, dizziness, fatigue, flatsulence, gastrointestinal discomfort, headache, nausea, skin reactions, sleep disorders, vomiting

**Uncommon** Arthralgia, hepatitis, hypersensitivity, immune reconstitution inflammatory syndrome, myalgia, suicidal tendencies

**INDICATIONS AND DOSE**

**HIV infection (initiated by a specialist)**

- By mouth using tablets
  - Child (body-weight 25 kg and above): 400 mg twice daily
  - Child (body-weight 40 kg and above): 1200 mg once daily, once daily dosing for use in patients who are not started on a twice daily regimen

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**Raltegravir**

**DRUG ACTION**

Raltegravir is an inhibitor of HIV integrase.

**INDICATIONS AND DOSE**

**HIV-1 infection (initiated by a specialist)**

- By mouth using tablets
  - Child (body-weight 25 kg and above): 10 mg twice daily
  - Child (body-weight 40 kg and above): 20 mg twice daily

**SIDE-EFFECTS**

**Common or very common** Depression, diarrhoea, dizziness, fatigue, flatsulence, gastrointestinal discomfort, headache, nausea, skin reactions, sleep disorders, vomiting

**Uncommon** Arthralgia, hepatitis, hypersensitivity, immune reconstitution inflammatory syndrome, myalgia, suicidal tendencies
treatment naïve or virologically suppressed on an initial regimen of 400 mg twice daily—use 600 mg tablets only

- **BY MOUTH USING CHEWABLE TABLETS**
  - Child (body-weight 11-13 kg): 75 mg twice daily
  - Child (body-weight 14-19 kg): 100 mg twice daily
  - Child (body-weight 20-27 kg): 150 mg twice daily
  - Child (body-weight 28-39 kg): 200 mg twice daily
  - Child (body-weight 40 kg and above): 300 mg twice daily
- **BY MOUTH USING ORAL SUSPENSION**
  - Neonate up to 7 days (body-weight 2-2.5 kg): 4 mg once daily.
  - Neonate up to 7 days (body-weight 3-3.5 kg): 5 mg once daily.
  - Neonate 7 days to 28 days (body-weight 2.5-4 kg): 7 mg once daily.
  - Neonate 7 days to 28 days (body-weight 4-4.5 kg): 8 mg twice daily.
  - Neonate 7 days to 28 days (body-weight 4-4.5 kg): 10 mg twice daily.
  - Child (body-weight 3-3.5 kg): 25 mg twice daily
  - Child (body-weight 4-5 kg): 30 mg twice daily
  - Child (body-weight 6-7.5 kg): 40 mg twice daily
  - Child (body-weight 8-10 kg): 60 mg twice daily
  - Child (body-weight 11-13 kg): 80 mg twice daily
  - Child (body-weight 14-19 kg): 100 mg twice daily

- **DOSE EQUIVALENCE AND CONVERSION**
  - Raltegravir granules for oral suspension and chewable tablets are not bioequivalent or interchangeable with the 400 mg and 600 mg standard tablets.

- **CONTRA-INDICATIONS**
  - Pre-term neonates—no information available

- **CAUTIONS**
  - Psychiatric illness (may exacerbate underlying illness including depression) - risk factors for myopathy - risk factors for rhabdomyolysis

- **INTERACTIONS**

- **SIDE-EFFECTS**
  - **Common or very common**
    - Akathisia
    - Appetite abnormal
    - Asthenia
    - Behaviour abnormal
    - Depression
    - Diarrhoea
    - Dizziness
    - Fever
    - Gastrointestinal discomfort
    - Gastrointestinal disorders
    - Headaches
    - Nausea
    - Skin reactions
    - Sleep disorders
    - Vertigo
    - Vomiting
  - **Uncommon**
    - Alopecia
    - Anaemia
    - Anxiety
    - Arrhythmias
    - Arthralgia
    - Arthritis
    - Body fat disorder
    - Burping
    - Cachexia
    - Chest discomfort
    - Chills
    - Cognitive disorder
    - Concentration impaired
    - Confusion
    - Constipation
    - Diabetes mellitus
    - Drowsiness
    - Dry mouth
    - Dyslipidaemia
    - Dysphonia
    - Erectile dysfunction
    - Feeling jittery
    - Glossitis
    - Gynaecomastia
    - Haemorrhage
    - Hepatic disorders
    - Hot flush
    - Hyperglycaemia
    - Hypersensitivity
    - Hypertension
    - Immune reconstitution inflammatory syndrome
    - Increased risk of infection
    - Lipodystrophy
    - Lymph node abscess
    - Lymphatic abnormalities
    - Malaise
    - Memory loss
    - Menopausal symptoms
    - Mood altered
    - Myalgia
    - Myopathy
    - Nasal congestion
    - Nephritis
    - Nephrolithiasis
    - Nerve disorders
    - Neutropenia
    - Nocturia
    - Odynophagia
    - Oedema
    - Osteopenia
    - Pain
    - Palpitations
    - Pancreatitis acute
    - Polydipsia
    - Psychiatric disorder
    - Renal cyst
    - Renal impairment
    - Sensation abnormal
    - Severe cutaneous adverse reactions (SCARs)
    - Skin papilloma
    - Submandibular mass
    - Suicidal tendencies
    - Sweat changes
    - Taste altered
    - Tendinitis
    - Thrombocytopenia
    - Timidity
    - Tremor
    - Visual impairment
    - Weight increased
  - **Frequency not known**
    - Osteonecrosis

- **SIDE-EFFECTS, FURTHER INFORMATION**
  - Rash occurs commonly. Discontinue if severe rash or rash accompanied by fever, malaise, arthralgia, myalgia, blistering, mouth ulceration, conjunctivitis, angioedema, hepatitis, or eosinophilia.

  - For further information regarding lipodystrophy and osteonecrosis see HIV infection p. 425

- **PREGNANCY**
  - Manufacturer advises avoid—toxicity in animal studies.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution in severe impairment—no information available. Use with caution in patients with chronic hepatitis B or C (at greater risk of hepatic side-effects).

- **DIRECTIONS FOR ADMINISTRATION**
  - Manufacturer advises for chewable tablets, the 100 mg strength can be divided into equal 50 mg doses.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Dispense raltegravir chewable tablets in original container (contains desiccant).

- **NATIONAL FUNDING/ACCESS DECISIONS**

  **Scottish Medicines Consortium (SMC) decisions**

  SMC No. 902/13
  - The Scottish Medicines Consortium has advised (September 2013) that raltegravir (Isentress®) is accepted for restricted use within NHS Scotland for the treatment of HIV-1 infection in adolescents and children aged 2 to 17 years when non-nucleoside reverse transcriptase inhibitors or protease inhibitors cannot be used because of intolerance, drug interactions, or resistance; raltegravir should be prescribed under the supervision of specialists in paediatric HIV.

  SMC No. 1102/15
  - The Scottish Medicines Consortium has advised (November 2015) that raltegravir granules for oral suspension (Isentress®) are accepted for restricted use within NHS Scotland for the treatment of HIV-1 infection in adults, adolescents, children, toddlers and infants from the age of 4 weeks when non-nucleoside reverse transcriptase inhibitors or protease inhibitors cannot be used because of intolerance, drug interactions, or resistance; raltegravir granules should be prescribed under the supervision of specialists in paediatric HIV.

  SMC No. 3113/17
  - The Scottish Medicines Consortium has advised (November 2015) that raltegravir chewable tablets (Isentress®) are accepted for restricted use within NHS Scotland for the treatment of HIV-1 infection in children from the age of 4 weeks to <2 years when non-nucleoside reverse transcriptase inhibitors or protease inhibitors cannot be used because of intolerance, drug interactions, or resistance; raltegravir chewable tablets should be prescribed under the supervision of specialists in paediatric HIV.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

- **Granules**
  - **EXCIPIENTS:** May contain Sorbitol
  - Isentress (Merck Sharp & Dohme Ltd)
  - Raltegravir 100 mg (Isentress 100mg granules sachets)
  - 60 sachet pack £213.02 DT = £213.02
TRANSCRIPTASE INHIBITORS

Uncommon

▶ SIDE-EFFECTS INTERACTIONS

ANTIVIRALS > NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

Efavirenz

● INDICATIONS AND DOSE
HIV infection in combination with other antiretroviral drugs

▶ BY MOUTH USING CAPSULES
Child 3 months-17 years (body-weight 3.5-4 kg): 100 mg once daily
Child 3 months-17 years (body-weight 5-7.4 kg): 150 mg once daily
Child 3 months-17 years (body-weight 7.5-14 kg): 200 mg once daily
Child 3 months-17 years (body-weight 15-19 kg): 250 mg once daily
Child 3 months-17 years (body-weight 20-24 kg): 300 mg once daily
Child 3 months-17 years (body-weight 25-32.4 kg): 350 mg once daily
Child 3 months-17 years (body-weight 32.5-39 kg): 400 mg once daily
Child 3 months-17 years (body-weight 40 kg and above): 600 mg once daily
▶ BY MOUTH USING TABLETS
Child (body-weight 40 kg and above): 600 mg once daily

● CAUTIONS
Acute porphyrinas p. 624 · history of psychiatric disorders · history of seizures

● INTERACTIONS ▶ Appendix 1: efavirenz

● SIDE-EFFECTS
Common or very common Abdominal pain · anxiety · concentration impaired · depression · diarrhoea · dizziness · drowsiness · dyslipidaemia · fatigue · headache · movement disorders · nausea · skin reactions · sleep disorders · vomiting

Uncommon Behaviour abnormal · confusion · flushing · gynaecomastia · hallucination · hepatic disorders · memory loss · mood altered · pancreatitis · psychosis · seizure · Stevens-Johnson syndrome · suicidal tendencies · thinking abnormal · tinnitus · tremor · vertigo · vision blurred

Rare or very rare Delusions · photosensitivity reaction

Frequency not known Immune reconstitution inflammatory syndrome · osteonecrosis

SIDE-EFFECTS, FURTHER INFORMATION For further information regarding osteonecrosis, immune reconstitution syndrome and lipodystrophy, see HIV infection p. 425

Rash Rash, usually in the first 2 weeks, is the most common side-effect; discontinue if severe rash with blistering, desquamation, mucosal involvement or fever; if rash mild or moderate, may continue without interruption—usually resolves within 1 month.

CNS effects Administration at bedtime especially in first 2–4 weeks reduces CNS effects.

● PREGNANCY
Reports of neural tube defects when used in first trimester.

● HEPATIC IMPAIRMENT
Greater risk of hepatic side-effects in chronic hepatitis B or C. Avoid in severe impairment.

Monitoring In mild to moderate liver disease, monitor for dose-related side-effects (e.g. CNS effects) and liver function.

● RENAL IMPAIRMENT
Manufacturer advises caution in severe renal failure—no information available.

● MONITORING REQUIREMENTS
Monitor liver function if receiving other hepatotoxic drugs.

● DIRECTIONS FOR ADMINISTRATION
For patients who cannot swallow capsules, the capsule may be opened and contents added to a small amount of food—consult product literature. No additional food should be consumed for up to 2 hours after administration of efavirenz.

● PATIENT AND CARER ADVICE
Psychiatric disorders. Patients or their carers should be advised to seek immediate medical attention if symptoms such as severe depression, psychosis or suicidal ideation occur.

● MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Tablette

Tablet
CAUTIONARY AND ADVISORY LABELS 25
▶ Isentress (Merck Sharp & Dohme Ltd)
Raltegravir 400 mg Isentress 400mg tablets | 60 tablet £471.41
Raltegravir 600 mg Isentress 600mg tablets | 60 tablet £471.41

Chewable tablet
CAUTIONARY AND ADVISORY LABELS 24
EXCIPIENTS: May contain Aspartame
▶ Isentress (Merck Sharp & Dohme Ltd)
Raltegravir 25 mg Isentress 25mg chewable tablets | 60 tablet £28.46 DT = £29.46
Raltegravir 100 mg Isentress 100mg chewable tablets | 60 tablet £117.85 DT = £117.85

● CONTRA-INDICATIONS
Acute porphyrinas p. 624

● INTERACTIONS ▶ Appendix 1: etravirine

● SIDE-EFFECTS
Common or very common Diabetes mellitus · diarrhoea · headache · hyperglycaemia · myocardial infarction · nausea · skin reactions · vomiting

Uncommon Angioedema · bronchospasm · dry mouth · dyslipidaemia · gynaecomastia · haematemesis · hepatic disorders · hyperhidrosis · hypersensitivity · hypersomnia · numbness · pancreatitis · sluggishness · vision blurred

Rare or very rare Severe cutaneous adverse reactions (SCARs)

Etravirine

12-Jul-2018

● INDICATIONS AND DOSE
HIV infection resistant to other non-nucleoside reverse transcriptase inhibitor and protease inhibitors in combination with other antiretroviral drugs (including a boosted protease inhibitor)

▶ BY MOUTH
Child 6-17 years (body-weight 16-19 kg): 100 mg twice daily
Child 6-17 years (body-weight 20-24 kg): 125 mg twice daily
Child 6-17 years (body-weight 25-29 kg): 150 mg twice daily
Child 6-17 years (body-weight 30 kg and above): 200 mg twice daily

● CONTRA-INDICATIONS
Acute porphyrinas p. 624

● INTERACTIONS ▶ Appendix 1: etravirine

● SIDE-EFFECTS
Common or very common Headache · insomnia · muscle aches · myalgia · neck pain · numbness · peripheral oedema · photophobia · sensory peripheral neuropathy · swelling of the feet · vertigo · weight gain · weight loss

Uncommon Abdominal pain · anxiety · depression · diarrhoea · dizziness · drowsiness · dyspepsia · dysphagia · dysphonia · electric shock sensation · emesis · fever · flushing · hair loss · hallucinations · heartburn · increased appetite · increased creatine phosphokinase · increased liver function tests · increased salivation · nausea · neuralgia · nocturnal enuresis · paresthesia · pruritus · rhinitis · somnolence · tinnitus · urticaria · vaginal pruritus · vomiting · vomiting blood

Rare or very rare Reactions at gastrointestinal level are not uncommon

Malignant lymphoma

Liver failure

Hypersensitivity

Hypersensitivity skin reactions

Physiologic symptoms and signs of severe cutaneous reactions

Psychiatric symptoms and signs

Seizures

SUDDEN DEATH

SENSE OR PERCEPTION CHANGES

APPLICATIONS OR CUT ANGIOEDEMA

THROMBOCYTOPENIA
Infection

MEDICINAL FORMS

PRESCRIBING AND DISPENSING INFORMATION

DIRECTIONS FOR ADMINISTRATION

HEPATIC IMPAIRMENT

Frequency not known

Haemorrhagic stroke - osteonecrosis - weight increased

SIDE-EFFECTS, FURTHER INFORMATION

For further information regarding osteonecrosis, immune reconstitution syndrome and lipodystrophy, see HIV infection p. 425

Hypersensitivity reactions

Rash, usually in the second week, is the most common side-effect and appears more frequently in females. Life-threatening hypersensitivity reactions reported usually during week 3–6 of treatment and characterised by rash, eosinophilia, and systemic symptoms (including fever, general malaise, myalgia, arthralgia, blistering, oral lesions, conjunctivitis, and hepatitis). Discontinue permanently if hypersensitivity reaction or severe rash develop. If rash mild or moderate (without signs of hypersensitivity reaction), may continue without interruption—usually resolves within 2 weeks.

Hepatic impairment

Manufacturer advises caution in moderate impairment and in patients with hepatitis B or C (increased risk of hepatic side effects); avoid in severe impairment (no information available).

DIRECTIONS FOR ADMINISTRATION

Patients with swallowing difficulties may disperse tablets in a glass of water just before administration.

PRESCRIBING AND DISPENSING INFORMATION

Dispense in original container (contains desiccant).

PATIENT AND CARER ADVICE

Hypersensitivity reactions

Patients or carers should be told how to recognise hypersensitivity reactions and advised to seek immediate medical attention if hypersensitivity reaction or severe rash develop.

Missed doses

If a dose is more than 6 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS 21

Intelege (Janssen-Cilag Ltd)

Etravirine 25 mg Intelege 25mg tablets | 120 tablet £75.32

Etravirine 100 mg Intelege 100mg tablets | 120 tablet £90.27

Etravirine 200 mg Intelege 200mg tablets | 60 tablet £130.27

Nevirapine

INDICATIONS AND DOSE

HIV infection in combination with other antiretroviral drugs (initial dose)

BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child: Initially 150–200 mg/m² once daily (max. per dose 200 mg) for first 14 days, initial dose titration using ‘immediate-release’ preparation should not exceed 28 days; if rash occurs and is not resolved within 28 days, alternative treatment should be sought. If treatment interrupted for more than 7 days, restart using the lower dose of the ‘immediate-release’ preparation for the first 14 days as for new treatment

HIV infection in combination with other antiretroviral drugs (maintenance dose following initial dose titration if no rash present)

BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child 1-month-2 years: 150–200 mg/m² twice daily (max. per dose 200 mg), alternatively 300–400 mg/m² once daily (max. per dose 400 mg)

Child 3-17 years: 150–200 mg/m² twice daily (max. per dose 200 mg)

HIV infection in combination with other antiretroviral drugs (maintenance dose following initial dose titration if no rash present)

BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child 3-17 years (body surface area 0.58–0.83 m²): 200 mg once daily

Child 3-17 years (body surface area 0.84–1.17 m²): 300 mg once daily

Child 3-17 years (body surface area 1.18 m² and above): 400 mg once daily

BY MOUTH USING MODIFIED-RELEASE MEDICINES

Child 3-17 years (body surface area 0.58–0.83 m²): 200 mg once daily

Child 3-17 years (body surface area 0.84–1.17 m²): 300 mg once daily

Child 3-17 years (body surface area 1.18 m² and above): 400 mg once daily

UNLICENSED USE

‘Immediate-release’ tablets not licensed for use in children weighing less than 50 kg or with body surface area less than 1.25 m²; ‘immediate-release’ tablets and suspension not licensed for once daily dose after the initial dose titration.

CONTRA-INDICATIONS

Acute porphyrias p. 624. - post-exposure prophylaxis

CAUTIONS

Females (at greater risk of hepatic side effects) - high CD4 cell count (at greater risk of hepatic side effects)

INTERACTIONS

Appendix 1: nevirapine

SIDE-EFFECTS, FURTHER INFORMATION

Hepatic effects

Potentially life-threatening hepatotoxicity including fatal fulminant hepatitis reported usually in first 6 weeks; discontinue permanently if abnormalities in liver function tests accompanied by hypersensitivity reaction (rash, fever, arthralgia, myalgia, lymphadenopathy, hepatitis, renal impairment, eosinophilia, granulocytopenia); suspend if severe abnormalities in liver function tests but no hypersensitivity reaction—discontinue permanently if significant liver function abnormalities recur; monitor patient closely if mild to moderate abnormalities in liver function tests with no hypersensitivity reaction.

Rash

Usually in first 6 weeks, is most common side-effect; incidence reduced if introduced at low dose and dose increased gradually (after 14 days); Discontinue permanently if severe rash or if rash accompanied by blistering, oral lesions, conjunctivitis, facial oedema, general malaise or hypersensitivity reactions; if rash mild or moderate may continue without interruption but dose should not be increased until rash resolves.

Osteonecrosis

Osteonecrosis has been reported in patients with advanced HIV disease or following long-term exposure to combination antiretroviral therapy.

Hepatic impairment

Manufacturer advises caution in moderate impairment and in patients with hepatitis B or C (increased risk of hepatic side effects); avoid in severe impairment (no information available).

RENAL IMPAIRMENT

Manufacturer advises caution in moderate impairment and in patients with hepatitis B or C (increased risk of hepatic side effects); avoid in severe impairment (no information available).
**Rilpivirine**

**INDICATIONS AND DOSE**

HIV infection in combination with other antiretroviral drugs in patients not previously treated with antiretroviral therapy and if plasma HIV-1 RNA concentration less than or equal to 100,000 copies/mL

- **BY MOUTH**
  - Child 12-17 years: 25 mg once daily

- **CAUTIONS**
  - Acute porphyrias p. 264

- **INTERACTIONS** → Appendix 1: rilpivirine

- **SIDE-EFFECTS**
  - Common or very common
    - Appetite decreased
    - Depression
    - Dizziness
    - Drowsiness
    - Dry mouth
    - Fatigue
    - Gastrointestinal discomfort
    - Headache
    - Myalgia
    - Nausea
    - Rash
    - Sleep disorders
    - Vomiting
  - Uncommon
    - Immune reconstitution inflammatory syndrome

- **SIDE-EFFECTS, FURTHER INFORMATION**
  - For further information regarding lipodystrophy, see HIV infection p. 265

**PRENANCY**

Monitoring Mitochondrial dysfunction has been reported in infants exposed to nucleoside reverse transcriptase inhibitors in utero; the main effects include haematological, metabolic, and neurological disorders; all infants whose mothers received nucleoside reverse transcriptase inhibitors during pregnancy should be monitored for relevant signs or symptoms.

**HEPATIC IMPAIRMENT**

In general, manufacturers advise caution in patients with chronic hepatitis B or C (increased risk of hepatic side-effects).

**Abacavir**

**INDICATIONS AND DOSE**

HIV infection in combination with other antiretroviral drugs

- **BY MOUTH**
  - Child 3 months-11 years: 8 mg/kg twice daily (max. per dose 300 mg), alternatively 16 mg/kg once daily (max. per dose 600 mg)
  - Child 3 months-11 years (body-weight 14-20 kg): 150 mg twice daily, alternatively 300 mg once daily
  - Child 3 months-11 years (body-weight 21-29 kg): 150 mg, taken in the morning and 300 mg, taken in the evening, alternatively 450 mg once daily
  - Child 3 months-11 years (body-weight 30 kg and above): 300 mg twice daily, alternatively 600 mg once daily
  - Child 12-17 years: 300 mg twice daily, alternatively 600 mg once daily

- **INTERACTIONS** → Appendix 1: abacavir
Abacavir with dolutegravir and lamivudine

The properties listed below are those particular to the combination only. For the properties of the components please consider, abacavir p. 431, lamivudine p. 436, dolutegravir p. 427.

**INDICATIONS AND DOSE**

**HIV infection**

- Child 12–17 years (body-weight 40 kg and above): 1 tablet once daily

**INTERACTIONS** → Appendix 1: abacavir - dolutegravir - lamivudine

**RENAL IMPAIRMENT** Avoid Triumeq® if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².

**PATIENT AND CARER ADVICE**

Missed doses If a dose is more than 20 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- Triumeq (ViiV Healthcare UK Ltd) ▼
  - Dolutegravir (as Dolutegravir sodium) 50 mg, Lamivudine 300 mg, Abacavir (as Abacavir sulfate) 600 mg Triumeq® 50mg/600mg/300mg tablets | 30 tablet [PBP] £71.18

Abacavir with lamivudine

The properties listed below are those particular to the combination only. For the properties of the components please consider, abacavir p. 431, lamivudine p. 436.

**INDICATIONS AND DOSE**

**HIV infection in combination with other antiretrovirals**

- Child 12-17 years (body-weight 40 kg and above): 1 tablet once daily

**INTERACTIONS** → Appendix 1: abacavir - lamivudine

**RENAL IMPAIRMENT** Avoid Kivexa® if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- Abacavir with lamivudine (Non-proprietary)
  - Lamivudine 300 mg, Abacavir 600 mg Abacavir 600mg | Lamivudine 300mg tablets | 30 tablet [PBP] £190.00–£229.41 | 30 tablet [PBP] £224.56 (Hospital only)
- Kivexa® (ViiV Healthcare UK Ltd) Lamivudine 300 mg, Abacavir 600 mg Kivexa® 300mg tablets | 30 tablet [PBP] £152.25

Abacavir with lamivudine and zidovudine

The properties listed below are those particular to the combination only. For the properties of the components please consider, abacavir p. 431, lamivudine p. 436, zidovudine p. 438.

**INDICATIONS AND DOSE**

**HIV infection (use only if patient is stabilised for 6–8 weeks on the individual components in the same proportions)**

- Child (body-weight 30 kg and above): 1 tablet twice daily
Didanosine (ddI; DDI)

**INDICATIONS AND DOSE**

**HIV infection in combination with other antiretroviral drugs**
- **BY MOUTH**
  - Child 1-7 months: 50–100 mg/m² twice daily
  - Child 8 months-17 years: 180–240 mg/m² once daily; usual dose 200 mg/m² once daily; maximum 400 mg per day

**SIDE-EFFECTS**
- **Common or very common** Arthralgia • chills • dry mouth • fever • flatulence • gynaecomastia • hepatic disorders • pain • peripheral neuropathy
- **Uncommon** Acute kidney injury • alopecia • diabetes mellitus • dry eye • haemodialysis • hyperglycaemia • hypoglycaemia • leucopenia • myopathy • optic neuritis • retinal discolouration • sialadenitis
- **Rare or very rare** Parotid gland enlargement
- **Frequency not known** Lipoatrophy

**SIDE-EFFECTS, FURTHER INFORMATION**
- **Pancreatitis** Suspend treatment if serum lipase raised or if symptoms of pancreatitis develop; discontinue if pancreatitis confirmed. Whenever possible avoid concomitant treatment with other drugs known to cause pancreatitis toxicity; monitor closely if concomitant therapy unavoidable. Since significant elevations of triglycerides cause pancreatitis monitor closely if elevated.

**Lipoatrophy syndrome** Metabolic effects may occur with didanosine: these include fat redistribution, insulin resistance, and dyslipidaemia—collectively termed lipoatrophy syndrome. Manufacturer advises monitoring of plasma lipids and blood-glucose.

**PREGNANCY** Manufacturer advises use only if potential benefit outweighs risks.

**UNLICENSED USE** Tablets not licensed for use in children under 3 months. EC capsules not licensed for use in children under 6 years.

**CAUTIONS** History of pancreatitis (preferably avoid, otherwise extreme caution) • hyperuricaemia • lactic acidosis • peripheral neuropathy

**CAUTIONS, FURTHER INFORMATION**
- **Lactic acidosis** Lactic acidosis associated with hepatomegaly and hepatic steatosis has been reported with didanosine. Use with caution in patients with hepatomegaly, hepatitis, or other risk factors for liver disease and hepatic steatosis (including obesity and alcohol abuse). Discontinue treatment if symptoms of hyperlactataemia, lactic acidosis, progressive hepatomegaly or rapid deterioration of liver function become apparent.

**INTERACTIONS**
- **Appendix 1: didanosine**
- **By MOUTH**
  - Avoid Trizivir if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².
  - There can be variation in the licensing of different medicines containing the same drug.

**MEDICINAL FORMS**
- Trizivir (ViiV Healthcare UK Ltd)
  - Lamivudine 150 mg, Abacavir (as Abacavir sulfate) 300 mg, Zidovudine 300 mg

**INTERACTIONS**
- **Appendix 1: abacavir • lamivudine • zidovudine**
- **RENAL IMPAIRMENT** Avoid Trizivir if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².

**MONITORING REQUIREMENTS**
- **Ophthalmological examination** (including visual acuity, colour vision, and dilated fundus examination) recommended annually or if visual changes occur.

**DIRECTIONS FOR ADMINISTRATION**
- Capsules should be swallowed whole and taken at least 2 hours before or 2 hours after food.

**PATIENT AND CARER ADVICE**
- Patients or carers should be given advice on how to administer didanosine capsules.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Gastro-resistant capsule**
- **CAUTIONARY AND ADVISORY LABELS 25**
  - **Videx EC** (Bristol-Myers Squibb Pharmaceuticals Ltd)
    - Didanosine 125 mg Capsule VIDEX 125 mg 30 capsule
      - £48.18 (Hospital only)
    - Didanosine 250 mg Capsule VIDEX 250 mg 30 capsule
      - £96.37 (Hospital only)
    - Didanosine 400 mg Capsule VIDEX 400 mg 30 capsule
      - £154.19 (Hospital only)

**Elvitegravir with cobicistat, emtricitabine and tenofovir alafenamide**

The properties listed below are those particular to the combination only. For the properties of the components please consider, emtricitabine p. 434, elvitegravir, cobicistat, tenofovir alafenamide p. 415.

**INDICATIONS AND DOSE**
- **HIV-1 infection (specialist use only)**
  - **BY MOUTH**
    - Child 6–11 years (body-weight 25 kg and above): 1 tablet once daily
    - Child 12–17 years (body-weight 35 kg and above): 1 tablet once daily

**IMPORTANT SAFETY INFORMATION**
- **MHRA/CHM ADVICE: ELVITEGRAVIR BOOSTED WITH COBICISTAT: AVOID USE IN PREGNANCY DUE TO RISK OF TREATMENT FAILURE AND MATERNAL-TO-CHILD TRANSMISSION OF HIV-1 (APRIL 2019)**
- Pharmacokinetic data show mean exposure of elvitegravir boosted with cobicistat (available in combination in Genvoya® and Stribild®) to be lower during the second and third trimesters of pregnancy than postpartum. Low elvitegravir exposure may be associated with an increased risk of treatment failure and an increased risk of HIV-1 transmission to the unborn child. For further information, see Pregnancy.

**INTERACTIONS**
- **Appendix 1: cobicistat • elvitegravir • tenofovir alafenamide**
- **SIDE-EFFECTS**
  - **Common or very common** Abnormal dreams • diarrhoea • dizziness • fatigue • flatulence • gastrointestinal discomfort • headache • nausea • skin reactions • vomiting
  - **Uncommon** Anaemia • angioedema • depression
  - **Frequency not known** Nephrotoxicity • osteonecrosis • weight increased

**CONCEPTION AND CONTRACEPTION**
- Manufacturer advises effective contraception in women of childbearing potential; if using a hormonal contraceptive, it must...
Emtricitabine

**Viral infection**

**Emtricitabine**

- **INDICATIONS AND DOSE**
  - HIV infection in combination with other antiretroviral drugs
  - By mouth using capsules
  - Child (body-weight 33 kg and above): 200 mg once daily

**Emtricitabine with rilpivirine and tenofovir alafenamide**

- **INDICATIONS AND DOSE**
  - HIV infection in patients with plasma HIV-1 RNA concentration of 100 000 copies/mL or less (specialist use only)
    - By mouth
    - Child 12-17 years (body-weight 35 kg and above): 1 tablet once daily

- **SIDE-EFFECTS**
  - Common or very common
    - Appetite decreased, depression, diarrhoea, dizziness, drowsiness, dry mouth, fatigue, flatulence, gastrointestinal discomfort, headache, nausea, skin reactions, sleep disorders, vomiting
  - Uncommon
    - Anaemia, angioedema, arthralgia, immune reconstitution inflammatory syndrome
  - Frequency not known
    - Conjunctivitis, drug reaction with eosinophilia and systemic symptoms (DRESS)
eosinophilia - fever - osteonecrosis - QT interval prolongation - weight increased

**SIDE-EFFECTS, FURTHER INFORMATION** Systemic symptoms reported with severe skin reactions include fever, blisters, conjunctivitis, angioedema, elevated liver function tests, and eosinophilia.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in moderate impairment (increased risk of hepatic side-effects); avoid in severe impairment (no information available).
- **RENAL IMPAIRMENT** Manufacturer advises avoid if creatinine clearance less than 30 mL/minute—no information available.
- **PATIENT AND CARER ADVICE**
  - Vomiting: Manufacturer advises if vomiting occurs within 4 hours of taking a dose, a replacement dose should be taken.
  - Driving and skilled tasks: Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness.

**NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**
The Scottish Medicines Consortium has advised (October 2016) that emtricitabine with tenofovir alafenamide (Odefsey®) is accepted for use within NHS Scotland for the treatment of human immunodeficiency virus type 1 (HIV-1), without known mutations associated with resistance to the non-nucleoside reverse transcriptase inhibitor (NNRTI) class, tenofovir or emtricitabine, and with viral load HIV-1 RNA of 100 000 copies/mL or less.

**All Wales Medicines Strategy Group (AWMSG) decisions**
The All Wales Medicines Strategy Group has advised (November 2016) that emtricitabine with rilpivirine and tenofovir alafenamide (Odefsey®) is recommended as an option for use within NHS Wales for the treatment of human immunodeficiency virus type 1, without known mutations associated with resistance to the non-nucleoside reverse transcriptase inhibitor (NNRTI) class, tenofovir or emtricitabine, and with viral load HIV-1 RNA of 100 000 copies/mL or less.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

CAUTIONARY AND ADVISORY LABELS 3, 21

- Odefsey (Gilead Sciences International Ltd) ▼
- Rilpivirine (as Rilpivirine hydrochloride) 25 mg, Tenofovir alafenamide (as Tenofovir alafenamide fumarate) 25 mg, Emtricitabine 200 mg Odefsey 200mg/25mg/25mg tablets 30 tablet £525.95

Emtricitabine with tenofovir alafenamide 05-Jun-2017

The properties listed below are those particular to the combination only. For the properties of the components please consider, emtricitabine p. 415, tenofovir alafenamide p. 415.

**INDICATIONS AND DOSE**

**HIV infection in combination with other antiretroviral drugs (specialist use only)**

- **BY MOUTH**
  - Child 12–17 years (body-weight 35 kg and above): 200/10–200/25 mg once daily, dose is dependent on drug regimen—consult product literature

**DOSE EQUIVALENCE AND CONVERSION**

- Dose expressed as x/y mg emtricitabine/tenofovir alafenamide.

**INTERACTIONS** → Appendix 1: tenofovir alafenamide

**SIDE-EFFECTS**

- Common or very common Abnormal dreams - diarrhoea - dizziness - fatigue - flatulence - gastrointestinal discomfort - headache - nausea - skin reactions - vomiting
- Uncommon Anaemia - arthralgia
- Frequency not known Angioedema - osteonecrosis

**HEPATIC IMPAIRMENT** Manufacturer advises use with caution (greater risk of hepatic side-effects).

**RENAL IMPAIRMENT** Manufacturer advises avoid if creatinine clearance less than 30 mL/minute—limited information available.

**PATIENT AND CARER ADVICE**

- Driving and skilled tasks: Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness.

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions
The Scottish Medicines Consortium has advised (August 2016) that emtricitabine with tenofovir alafenamide (Descovy®) is accepted for use within NHS Scotland for the treatment of human immunodeficiency virus type 1 in combination with other antiretroviral agents.

All Wales Medicines Strategy Group (AWMSG) decisions
The All Wales Medicines Strategy Group has advised (September 2016) that emtricitabine with tenofovir alafenamide (Descovy®) is recommended as an option for use within NHS Wales for the treatment of human immunodeficiency virus type 1 in combination with other antiretroviral agents.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- Descovy (Gilead Sciences International Ltd) ▼
  - Tenofovir alafenamide (as Tenofovir alafenamide fumarate) 25 mg, Emtricitabine 200 mg Descovy 200mg/25mg tablets
  - 30 tablet £355.73
- Tenofovir alafenamide (as Tenofovir alafenamide fumarate) 10 mg, Emtricitabine 200 mg Descovy 200mg/10mg tablets
  - 30 tablet £355.73

Emtricitabine with tenofovir disoproxil 15-Nov-2018

The properties listed below are those particular to the combination only. For the properties of the components please consider, tenofovir disoproxil p. 437, emtricitabine p. 434.

**INDICATIONS AND DOSE**

**HIV-1 infection (initiated by a specialist)**

- **BY MOUTH**
  - Child 12–17 years (body-weight 35 kg and above): 200/245 mg once daily

**Pre-exposure prophylaxis of HIV-1 infection (initiated by a specialist)**

- **BY MOUTH**
  - Child 12–17 years (body-weight 35 kg and above): 200/245 mg once daily

**DOSE EQUIVALENCE AND CONVERSION**

- Dose expressed as x/y mg emtricitabine/tenofovir disoproxil.

**INTERACTIONS** → Appendix 1: tenofovir disoproxil

**RENA lMPAIRMENT**

Manufacturer advises avoid.

**DIRECTIONS FOR ADMINISTRATION**

Patients with swallowing difficulties may disperse tablet in half a glass of water, orange juice, or grape juice (but bitter taste).
PATIENT AND CARER ADVICE  Patients or carers should be given advice on how to administer emtricitabine with tenofovir tablets.

Missed doses  If a dose is more than 12 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS  21

Emtricitabine with tenofovir disoproxil (Non-proprietary)

Emtricitabine 200 mg, Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 245 mg  Emtricitabine 200mg / Tenofovir 245mg tablets  30 tablet (P) £106.72–£355.73 (Hospital only)  3 tablet (P) £355.73 DT + £355.73

Ictastan (Actavis UK Ltd)

Emtricitabine 200 mg, Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 245 mg  Ictastan 200mg/245mg tablets  30 tablet (P) £355.73 DT + £355.73 (Hospital only)

Truvada (Gilead Sciences International Ltd)

Emtricitabine 200 mg, Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 245 mg  Truvada 200mg/245mg tablets  30 tablet (P) £355.73 DT + £355.73

Lamivudine (3TC)

INDICATIONS AND DOSE  EPIVIR ® ORAL SOLUTION

HIV infection in combination with other antiretroviral drugs  

> BY MOUTH
  - Child 1-2 months: 4 mg/kg twice daily
  - Child 3 months–11 years (body-weight up to 14 kg): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg)
  - Child 3 months–11 years (body-weight 14-20 kg): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg), alternatively 75 mg twice daily, alternatively 150 mg once daily
  - Child 3 months–11 years (body-weight 21-29 kg): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg), alternatively 75 mg daily, dose to be taken in the morning and 150 mg daily, dose to be taken in the evening, alternatively 225 mg once daily
  - Child 3 months–11 years (body-weight 30 kg and above): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg), alternatively 150 mg twice daily, alternatively 300 mg once daily
  - Child 12-17 years: 150 mg twice daily, alternatively 300 mg once daily

EPIVIR ® TABLETS

HIV infection in combination with other antiretroviral drugs  

> BY MOUTH
  - Child 1-2 months: 4 mg/kg twice daily
  - Child 3 months–11 years (body-weight up to 14 kg): 4 mg/kg twice daily, alternatively 8 mg/kg once daily
  - Child 3 months–11 years (body-weight 14-20 kg): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg), alternatively 75 mg twice daily, alternatively 150 mg once daily
  - Child 3 months–11 years (body-weight 21-29 kg): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg), alternatively 75 mg daily, dose to be taken in the morning and 150 mg daily, dose to be taken in the evening, alternatively 225 mg once daily
  - Child 3 months–11 years (body-weight 30 kg and above): 4 mg/kg twice daily (max. per dose 150 mg), alternatively 8 mg/kg once daily (max. per dose 300 mg), alternatively 150 mg twice daily, alternatively 300 mg once daily

ZEFFIX ®

Chronic hepatitis B infection either with compensated liver disease (with evidence of viral replication and histology of active liver inflammation or fibrosis) when first-line treatments cannot be used, or (in combination with another antiviral drug without cross-resistance to lamivudine) with decompensated liver disease  

> BY MOUTH
  - Child 2-11 years: 3 mg/kg once daily (max. per dose 100 mg), children receiving lamivudine for concomitant HIV infection should continue to receive lamivudine in a dose appropriate for HIV infection
  - Child 12-17 years: 100 mg once daily, patients receiving lamivudine for concomitant HIV infection should continue to receive lamivudine in a dose appropriate for HIV infection

UNLICENSED USE

EPIVIR ® ORAL SOLUTION  Not licensed for use in children under 3 months.

EPIVIR ® TABLETS  Not licensed for use in children under 3 months.

ZEFFIX ®  Not licensed for use in children.

CAUTIONS  Recurrent hepatitis in patients with chronic hepatitis B may occur on discontinuation of lamivudine.

INTERACTIONS  → Appendix 1: lamivudine

SIDE-EFFECTS

> Common or very common  Hepatitis aggravated - muscle cramps - myopathy
> Rare or very rare  Angioedema
> Frequency not known  Abdominal discomfort - malaise - respiratory tract infection - throat complaints

BREAST FEEDING

Can be used with caution in women infected with chronic hepatitis B alone, providing that adequate measures are taken to prevent hepatitis B infection in infants.

RENAI IMPAIRMENT

Dose adjustments  Reduce dose if estimated glomerular filtration rate less than 50 mL/minute/1.73 m²; consult product literature.

MONITORING REQUIREMENTS  When treating chronic hepatitis B with lamivudine, monitor liver function tests every 3 months, and viral markers of hepatitis B every 3–6 months, more frequently in patients with advanced liver disease or following transplantation (monitoring to continue for at least 1 year after discontinuation—recurrent hepatitis may occur on discontinuation).

PRESCRIBING AND DISPENSING INFORMATION

Flavours of oral liquid formulations may include banana and strawberry.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Oral solution

EXCipients:  May contain Sucrose

Epigiv (VIIV Healthcare UK Ltd)

Lamivudine 10 mg per 1 ml  Epigiv 50mg/5ml oral solution  240 ml (P) £39.01

Tablet

Epigiv (VIIV Healthcare UK Ltd)

Lamivudine 150 mg  Epigiv 150mg tablets  60 tablet (P) £143.32 DT + £143.32
Stavudine (d4T)

**INDICATIONS AND DOSE**

**HIV infection in combination with other antiretroviral drugs when no suitable alternative available and when prescribed for shortest period possible**

- **BY MOUTH**
  - Child (body-weight up to 30 kg): 1 mg/kg twice daily, to be taken preferably at least 1 hour before food
  - Child (body-weight 30-59 kg): 30 mg twice daily, to be taken preferably at least 1 hour before food
  - Child (body-weight 60 kg and above): 40 mg twice daily, to be taken preferably at least 1 hour before food

**SIDE-EFFECTS**

- **Common or very common** Depression - drowsiness - dyspepsia - hyperlactacidaemia - lipoatrophy - nerve disorders - paraesthesia - peripheral neuropathy (switch to another antiretroviral if peripheral neuropathy develops) - sleep disorders - thinking abnormal
- **Uncommon** Anxiety - arthralgia - emotional lability - gynaecomastia - hepatic disorders
- **Rare or very rare** Diabetes mellitus - hyperglycaemia - muscle weakness - neutropenia

**SIDE-EFFECTS, FURTHER INFORMATION** Metabolic effects may occur with stavudine; plasma lipids and blood glucose concentrations should be measured routinely.

**PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.

**RENAAL IMPAIRMENT** Risk of peripheral neuropathy.

- **Dose adjustments** Reduce dose to 50% if estimated glomerular filtration rate 25–50 mL/minute/1.73 m²; reduce dose to 25% if estimated glomerular filtration rate less than 25 mL/minute/1.73 m².

**PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral liquid formulations may include cherry.

**LESS SUITABLE FOR PRESCRIBING** Stavudine (especially in combination with didanosine) is associated with a higher risk of lipoatrophy and should be used only if alternative regimens are not suitable; it is considered to be less suitable for prescribing.

**INTERACTIONS** → Appendix 1: stavudine

**INTERACTIONS** → Appendix 1: tenofovir disoproxil

**SIDE-EFFECTS**

- **Common or very common** Abdominal distension - flatulence
- **Uncommon** Proximal renal tubulopathy
- **Rare or very rare** Acute tubular necrosis - angioedema - hepatitis - nephritis - nephrogenic diabetes insipidus - renal impairment

**HEPATIC IMPAIRMENT** Manufacturer advises caution in decompensated hepatic disease (limited information available).

**RENAAL IMPAIRMENT** Manufacturer advises avoid—no information available.

**MONITORING REQUIREMENTS**

- Test renal function and serum phosphate before treatment, then every 4 weeks (more frequently if at increased risk of renal impairment) for 1 year and then every 3 months, interrupt treatment if renal function deteriorates or serum phosphate decreases.
- When treating chronic hepatitis B with tenofovir, monitor liver function tests every 3 months and viral markers for hepatitis B every 3–6 months during treatment (continue monitoring for at least 1 year after discontinuation—recurrent hepatitis may occur on discontinuation).

**DIRECTIONS FOR ADMINISTRATION** Granules: mix 1 scoop of granules with 1 tablespoon of soft food (e.g. yoghurt, apple sauce) and take immediately without chewing. Do not mix granules with liquids.

**PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer tenofovir granules.

**Missed doses** If a dose is more than 12 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.
Infection

Lactic acidosis

CAUTIONS

CONTRA-INDICATIONS

Lactic acidosis associated with hepatomegaly and hepatic steatosis has been reported with zidovudine.

INTERACTIONS → Appendix 1: zidovudine

SIDE-EFFECTS

Common or very common Leucopenia, malaise, neutropenia

Uncommon Bone marrow disorders, dyspnoea, fever, flatulence, generalised pain, myopathy

Rare or very rare Alertness decreased, anxiety, cardiomyopathy, chest pain, chills, cough, depression, drowsiness, dyspepsia, gynaecomastia, hepatic disorders, hyperhidrosis, influenza-like illness, insomnia, nail discoulouration, oral discolouration, paraesthesia, pure red cell aplasia, seizure, taste altered, urinary frequency increased

Frequency not known Lipoatrophy

SIDE-EFFECTS, FURTHER INFORMATION Anaemia and myelosuppression If anaemia or myelosuppression occur, reduce dose or interrupt treatment according to product literature, or consider other treatment.

Lipodystrophy syndrome Metabolic effects may occur with zidovudine; plasma lipids and blood glucose concentrations should be measured routinely.

HEPATIC IMPAIRMENT Manufacturer advises caution in moderate to severe impairment (increased risk of accumulation).

Dose adjustments Manufacturer advises consider dose reduction in moderate to severe impairment—consult product literature.

RENAL IMPAIRMENT

Dose adjustments Reduce dose if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²—consult product literature.

MONITORING REQUIREMENTS Monitor full blood count after 4 weeks of treatment, then every 3 months.

DIRECTIONS FOR ADMINISTRATION

With intravenous use For intermittent intravenous infusion, dilute to a concentration of 2 mg/mL or 4 mg/mL with Glucose 5% and give 1 hour.

PRESCRIBING AND DISPENSING INFORMATION The abbreviation AZT which is sometimes used for zidovudine has also been used for another drug.

PATIENT AND CARER ADVICE


MEDITINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Granules

CAUTIONARY AND ADVISORY LABELS 21

Viread (GlaxoSmithKline International Ltd)

Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 33 mg per 1 gram Viread 33mg/6 granules | 60 gram (P) £54.50

Tablet

CAUTIONARY AND ADVISORY LABELS 21

Tenofovir disoproxil (Non-proprietary) 245 mg Tenofovir 245mg tablets | 30 tablet (P) £16.84 | 240.39 DT = £30.25 | 168 tablet (P) £15.48

Viread (GlaxoSmithKline International Ltd)

Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 123 mg Viread 123mg tablets | 30 tablet (P) £102.60 DT = £102.60

Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 163 mg Viread 163mg tablets | 30 tablet (P) £135.98 DT = £135.98

Tenofovir disoproxil (as Tenofovir disoproxil fumarate) 204 mg Viread 204mg tablets | 30 tablet (P) £170.19 DT = £170.19

Tenofovir disoproxil 245 mg Viread 245mg tablets | 30 tablet (P) £204.39 DT = £30.25

Zidovudine

(Azidothymidine; AZT)

INDICATIONS AND DOSE

HIV infection in combination with other antiretroviral drugs

BY MOUTH

Child: 180 mg/m² twice daily (max. per dose 300 mg)

Child (body-weight 8–13 kg): 100 mg twice daily

Child (body-weight 14–20 kg): 100 mg, to be taken in the morning and 200 mg, to be taken in the evening

Child (body-weight 21–27 kg): 200 mg twice daily

Child (body-weight 28–29 kg): 200–250 mg twice daily

Child (body-weight 30 kg and above): 250–300 mg twice daily

HIV infection in combination with other antiretroviral drugs (dose expressed in mg/kg)

BY MOUTH

Child (body-weight 4–8 kg): 12 mg/kg twice daily

Child (body-weight 9–29 kg): 9 mg/kg twice daily

Prevention of maternal-fetal HIV transmission

BY MOUTH, OR BY INTRAVENOUS INFUSION

Child: Seek specialist advice (combination therapy preferred) (consult local protocol)

HIV infection in combination with other antiretroviral drugs in patients temporarily unable to take zidovudine by mouth

BY INTRAVENOUS INFUSION

Child 3 months–11 years: 60–80 mg/m² every 6 hours usually for not more than 2 weeks, dose approximating to 9–12 mg/kg twice daily by mouth

Child 12–17 years: 0.8–1 mg/kg every 4 hours usually for not more than 2 weeks, dose approximating to 1.2–1.5 mg/kg every 4 hours by mouth

CONTRA-INDICATIONS

Abnormally low haemoglobin concentration (consult product literature) - abnormally low neutrophil counts (consult product literature) - neonates with hyperbilirubinaemia requiring treatment other than phototherapy, or with raised transaminase (consult product literature)

CAUTIONS

Lactic acidosis - risk of haematological toxicity particularly with high dose and advanced disease - vitamin B₁₂ deficiency (increased risk of neutropenia)

CAUTIONS, FURTHER INFORMATION

Lactic acidosis Lactic acidosis associated with hepatomegaly and hepatic steatosis has been reported with zidovudine.

Use with caution in patients with hepatomegaly, hepatitis, or other risk factors for liver disease and hepatic steatosis (including obesity and alcohol abuse). Discontinue treatment if symptoms of hyperlactataemia, lactic acidosis, progressive hepatomegaly or rapid deterioration of liver function become apparent.

INTERACTIONS → Appendix 1: zidovudine

SIDE-EFFECTS

Common or very common Leucopenia, malaise, neutropenia

Uncommon Bone marrow disorders, dyspnoea, fever, flatulence, generalised pain, myopathy

Rare or very rare Alertness decreased, anxiety, cardiomyopathy, chest pain, chills, cough, depression, drowsiness, dyspepsia, gynaecomastia, hepatic disorders, hyperhidrosis, influenza-like illness, insomnia, nail discoulouration, oral discolouration, paraesthesia, pure red cell aplasia, seizure, taste altered, urinary frequency increased

Frequency not known Lipoatrophy

SIDE-EFFECTS, FURTHER INFORMATION Anaemia and myelosuppression If anaemia or myelosuppression occur, reduce dose or interrupt treatment according to product literature, or consider other treatment.

Lipodystrophy syndrome Metabolic effects may occur with zidovudine; plasma lipids and blood glucose concentrations should be measured routinely.

HEPATIC IMPAIRMENT Manufacturer advises caution in moderate to severe impairment (increased risk of accumulation).

Dose adjustments Manufacturer advises consider dose reduction in moderate to severe impairment—consult product literature.

RENAL IMPAIRMENT

Dose adjustments Reduce dose if estimated glomerular filtration rate less than 10 mL/minute/1.73 m²—consult product literature.

MONITORING REQUIREMENTS Monitor full blood count after 4 weeks of treatment, then every 3 months.

DIRECTIONS FOR ADMINISTRATION

With intravenous use For intermittent intravenous infusion, dilute to a concentration of 2 mg/mL or 4 mg/mL with Glucose 5% and give 1 hour.

PRESCRIBING AND DISPENSING INFORMATION The abbreviation AZT which is sometimes used for zidovudine has also been used for another drug.

PATIENT AND CARER ADVICE


MEDITINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Solution for infusion

Retrovir (ViiV Healthcare UK Ltd)

Zidovudine 10 mg per 1 ml Retrovir IV 200mg/20ml concentrate for solution for infusion vials | 5 vial (P) £52.48

Oral solution

Retrovir (ViiV Healthcare UK Ltd)

Zidovudine 10 mg per 1 ml Retrovir 50mg/5ml oral solution sugar-free | 200 ml (P) £20.91

Capsule

Zidovudine (Non-proprietary)

Zidovudine 100 mg Zidovudine 100mg capsules | 60 capsule (P) £53.31

Zidovudine 250 mg Zidovudine 250mg capsules | 60 capsule (P) £13.32

Retrovir (ViiV Healthcare UK Ltd)

Zidovudine 100 mg Retrovir 100mg capsules | 100 capsule (P) £104.54

Zidovudine 250 mg Retrovir 250mg capsules | 40 capsule (P) £104.54

01-Sep-2016
Zidovudine with lamivudine

The properties listed below are those particular to the combination only. For the properties of the components please consider, zidovudine p. 438, lamivudine p. 436.

† INDICATIONS AND DOSE
HIV infection in combination with other antiretroviral drugs

▶ BY MOUTH
- Child (body-weight 14–20 kg): 0.5 tablet twice daily
- Child (body-weight 21–29 kg): 0.5 tablet, to be given in the morning and 1 tablet, to be given in the evening
- Child (body-weight 30 kg and above): 1 tablet twice daily

† INTERACTIONS ➔ Appendix 1: lamivudine - zidovudine
† RENAL IMPAIRMENT Avoid if estimated glomerular filtration rate less than 50 mL/minute/1.73 m².
† DIRECTIONS FOR ADMINISTRATION
COMBIVIR™ TABLETS Tablets may be crushed and mixed with semi-solid food or liquid just before administration.

† MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.
Tablet
- Zidovudine with lamivudine (Non-proprietary)
  Lamivudine 150 mg, Zidovudine 300 mg
- Lamivudine 150 mg tablets | 60 tablet PDTD £24.01–£255.10
- Combivir (ViiV Healthcare UK Ltd)
  Lamivudine 150 mg, Zidovudine 300 mg
  Combivir 150mg/300mg tablets | 60 tablet PDTD £30.11

ANTIVIRALS ➔ PROTEASE INHIBITORS, HIV

Protease inhibitors

† CONTRA-INDICATIONS Acute porphyrias p. 624
† CAUTIONS Haemophilia (increased risk of bleeding)
† SIDE-EFFECTS Common or very common Alopopenia - anaemia - angioedema - anxiety - appetite abnormal - arthralgia - asthma - diabetes mellitus - diarrhoea - dizziness - dry mouth - dyslipidaemia - dyspepsia - fever - gastrointestinal discomfort - gastrointestinal disorders - headache - hepatic disorders - hypersensitivity - hypertension - malaise - muscle complaints - nausea - neutropenia - oral ulceration - pancreatitis - peripheral neuropathy - seizure - skin reactions - sleep disorders - taste altered - vomiting
† Uncommon Drowsiness - immune reconstitution inflammatory syndrome - osteonecrosis - Stevens-Johnson syndrome - weight increased
† HEPATIC IMPAIRMENT In general, manufacturers advise use with caution in patients with chronic hepatitis B or C (increased risk of hepatic side-effects).

Atazanavir

† INDICATIONS AND DOSE
HIV infection in combination with other antiretroviral drugs— with low-dose ritonavir

▶ BY MOUTH
- Child 6–17 years (body-weight 15–29 kg): 150 mg once daily
- Child 6–17 years (body-weight 20–39 kg): 200 mg once daily
- Child 6–17 years (body-weight 40 kg and above): 300 mg once daily

† CAUTIONS Cardiac conduction disorders - electrolyte disturbances - predisposition to QT interval prolongation

† INTERACTIONS ➔ Appendix 1: HIV–protease inhibitors
† SIDE-EFFECTS
thoracic: · thrombocytopenia · urinary disorders · urinary abnormalities · vertigo

- Rare or very rare: Arthritis, chills, feeling abnormal, joint stiffness, musculoskeletal stiffness, palpitations, rhinorrhoea, severe cutaneous adverse reactions (SCARs), syncope, visual impairment

**SIDE-EFFECTS, FURTHER INFORMATION.** Mild to moderate rash occurs commonly, usually within the first 4 weeks of therapy and resolves without stopping treatment. Severe skin rash (including Stevens-Johnson syndrome and toxic epidermal necrolysis) occurs less frequently and may be accompanied by fever, malaise, arthralgia, myalgia, oral lesions, conjunctivitis, hepatitis, or eosinophilia; treatment should be stopped if this develops.

- **ALLERGY AND CROSS-SENSITIVITY.** Use with caution in patients with sulfonamide sensitivity.

- **PREGNANCY.** Manufacturer advises use only if potential benefit outweighs risk; if required, use the twice daily dose regimen.

- **HEPATIC IMPAIRMENT.** Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment (no information available).

- **MONITORING REQUIREMENTS.** Monitor liver function before and during treatment.

- **PRESCRIBING AND DISPENSING INFORMATION.** Flavours of oral liquid formulations may include strawberry.

- **PATIENT AND CARER ADVICE.**
  - Missed doses: If a dose is more than 6 hours late on the twice daily regimen (or more than 12 hours late on the once daily regimen), the missed dose should not be taken and the next dose should be taken at the normal time.

- **MEDICINAL FORMS.** There can be variation in the licensing of different medicines containing the same drug.

### Oral suspension

<table>
<thead>
<tr>
<th>Product</th>
<th>Strength</th>
<th>Dose</th>
<th>Pack Size</th>
<th>Price</th>
<th>VAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darunavir (as Darunavir ethanolate) 100 mg per 1 ml</td>
<td>Prezista 100mg/ml oral suspension sugar-free</td>
<td>200 ml</td>
<td>£248.17</td>
<td></td>
<td></td>
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**Tablet**

<table>
<thead>
<tr>
<th>Product</th>
<th>Strength</th>
<th>Dose</th>
<th>Pack Size</th>
<th>Price</th>
<th>VAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darunavir (as Darunavir ethanolate) 400 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>60 tablet</td>
<td>£446.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darunavir (as Darunavir ethanolate) 600 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>60 tablet</td>
<td>£373.67</td>
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<td></td>
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<tr>
<td>Darunavir (as Darunavir ethanolate) 800 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>30 tablet</td>
<td>£253.13/£297.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darunavir (as Darunavir ethanolate) 75 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>480 tablet</td>
<td>£446.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darunavir (as Darunavir ethanolate) 150 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>240 tablet</td>
<td>£446.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darunavir (as Darunavir ethanolate) 400 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>60 tablet</td>
<td>£297.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darunavir (as Darunavir ethanolate) 600 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>60 tablet</td>
<td>£297.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darunavir (as Darunavir ethanolate) 800 mg</td>
<td>Prezista (Janssen-Cilag Ltd)</td>
<td>30 tablet</td>
<td>£297.80</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Darunavir with cobicistat, emtricitabine and tenofovir alafenamide**

**25-Jul-2018**

The properties listed below are those particular to the combination only. For the properties of the components please consider, darunavir p. 439, cobicistat, emtricitabine p. 434, tenofovir alafenamide p. 415.

- **INDICATIONS AND DOSE.**
  - **HIV infection (initiated by a specialist).**
    - **BY MOUTH.**
      - Child 12-17 years (body-weight 40 kg and above): 1 tablet once daily

**IMPORTANT SAFETY INFORMATION.**

**MHRA/CHM ADVICE: DARUNAVIR BOOSTED WITH COBICISTAT: AVOID USE IN PREGNANCY DUE TO RISK OF TREATMENT FAILURE AND MATERNAL-TO-CHILD TRANSMISSION OF HIV-1 (JULY 2018)**

Pharmacokinetic data show mean exposure of darunavir boosted with cobicistat (available in combination in Rezolsta® and Symtuza®) to be lower during the second and third trimesters of pregnancy than during 6–12 weeks postpartum. Low darunavir exposure may be associated with an increased risk of treatment failure and an increased risk of HIV-1 transmission to the unborn child. For further information, see Pregnancy.

- **INTERACTIONS.**
  - Appendix 1: cobicistat - HIV-protease inhibitors - tenofovir alafenamide

- **PREGNANCY.** Manufacturer advises not to be initiated during pregnancy due to low darunavir exposure; women who become pregnant during therapy should be switched to an alternative regimen.

- **RENAL IMPAIRMENT.** Manufacturer advises avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m²—no information available.

- **PATIENT AND CARER ADVICE.**
  - Driving and skilled tasks: Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness.

- **NATIONAL FUNDING/ACCESS DECISIONS.**

  **Scottish Medicines Consortium (SMC) decisions**

  SMC No. 1290/18

  The Scottish Medicines Consortium has advised (January 2018) that darunavir with cobicistat, emtricitabine and tenofovir alafenamide (Symtuza®) is accepted for use within NHS Scotland for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in adults and adolescents (aged 12 years and older with body weight at least 40 kg).

  **All Wales Medicines Strategy Group (AWMSG) decisions**

  AWMSG No. 2418

  The All Wales Medicines Strategy Group has advised (March 2018) that darunavir with cobicistat, emtricitabine and tenofovir alafenamide (Symtuza®) is recommended as an option for use within NHS Wales for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in adults and adolescents (aged 12 years and older with body weight at least 40 kg).

- **MEDICINAL FORMS.** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

<table>
<thead>
<tr>
<th>Product</th>
<th>Strength</th>
<th>Dose</th>
<th>Pack Size</th>
<th>Price</th>
<th>VAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenofovir alafenamide (as Tenofovir alafenamide fumarate) 10 mg, Cobicistat 150 mg, Emtricitabine 200 mg, Darunavir (as Darunavir ethanolate) 800 mg</td>
<td>Symtuza (Janssen-Cilag Ltd)</td>
<td>30 tablet</td>
<td>£672.97</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Fosamprenavir

**DRUG ACTION** Fosamprenavir is a pro-drug of amprenavir.

**INDICATIONS AND DOSE**

**HIV infection in combination with other antiretroviral drugs—with low-dose ritonavir**

- **BY MOUTH**
  - Child 14 days (body-weight 5–14 kg): 25 mg/kg twice daily.
  - Child 2–17 years (body-weight up to 40 kg and above): 200 mg twice daily.
  - Child 2–17 years (body-weight 40 kg and above): 300 mg twice daily.

**DOSE EQUIVALENCE AND CONVERSION**

- 700 mg of fosamprenavir is equivalent to 500 mg amprenavir.

**SIDE-EFFECTS**

- Rash may occur, usually the second week of therapy; may continue without interruption—usually resolves and may respond to antihistamines.

**PRESCRIBING AND DISPENSING INFORMATION**

- Flavours of oral liquid formulations may include grape, bubblegum, or peppermint.

**PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer fosamprenavir oral suspension.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Oral suspension**
  - EXCIPIENTS: May contain Propylene glycol, peppermint.
  - Telzir (ViiV Healthcare UK Ltd)
    - Fosamprenavir (as Fosamprenavir calcium) 50 mg per 1 mL Telzir 50 mg/ml oral suspension
    - 225 mL (PO) £69.06
  - Tablet
    - Telzir (ViiV Healthcare UK Ltd)
      - Fosamprenavir (as Fosamprenavir calcium) 700 mg Telzir 700 mg tablets
      - 60 tablet (PO) £258.97

Lopinavir with ritonavir

**INDICATIONS AND DOSE**

**HIV infection in combination with other antiretroviral drugs**

- **BY MOUTH USING TABLETS**
  - Child 2–17 years (body-weight up to 40 kg and body surface area 0.5–0.7 m²): 200/50 mg twice daily.
  - Child 2–17 years (body-weight up to 40 kg and body surface area 0.8–1.1 m²): 300/75 mg twice daily.
  - Child 2–17 years (body-weight 40 kg and above and body surface area 1.2 m² and above): 400/100 mg twice daily.

- **BY MOUTH USING ORAL SOLUTION**
  - Child 14 days–5 months: 3.75 mL/m² twice daily.
  - Child 6 months–17 years: 2.9 mL/m² twice daily (max. per dose 5 mL).

**DOSE EQUIVALENCE AND CONVERSION**

- Oral solution contains 400 mg lopinavir, 100 mg ritonavir/5 mL (or 80 mg lopinavir, 20 mg ritonavir/mL).

**SIDE-EFFECTS**

- Rash may occur, usually in the second week of therapy; may continue without interruption—usually resolves and may respond to antihistamines.

**SIDE-EFFECTS, FURTHER INFORMATION**

- Signs and symptoms suggestive of pancreatitis (including raised serum lipase) should be evaluated—discontinue if pancreatitis diagnosed.

**PREGNANCY** Avoid oral solution due to high alcohol and propylene glycol content; use tablets only if potential benefit outweighs risk (toxicity in animal studies).

**HEPATIC IMPAIRMENT** For oral solution, manufacturer advises avoid due to propylene glycol content (risk of toxicity). For tablets, manufacturer advises avoid in severe impairment (no information available).

**RENAL IMPAIRMENT** Avoid oral solution due to high propylene glycol content.

**MONITORING REQUIREMENTS**

- Monitor liver function before and during treatment.

- With oral solution, monitor for signs of alcohol and propylene glycol toxicity (particularly in infants).

**PRESCRIBING AND DISPENSING INFORMATION**

- With oral solution, manufacturer advises high alcohol (42 % v/v) and propylene glycol content—consider total amounts from all medicines that are to be given to infants in order to avoid toxicity; caution in patients for which consumption may be harmful.

**PATIENT AND CARER ADVICE** Oral solution tastes bitter.

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

SMC No. 1302/18
The Scottish Medicines Consortium has advised (February 2018) that lopinavir with ritonavir oral solution (Kaletra®) is accepted for use within NHS Scotland in combination with other antiretrovirals for the treatment of HIV–1 infected children aged from 14 days to less than 2 years.

SMC No. 326/06
The Scottish Medicines Consortium has advised (November 2006) that lopinavir with ritonavir tablet (Kaletra®) is accepted for use within NHS Scotland in combination with other antiretrovirals for the treatment of HIV–1 infected adults and children above the age of 2 years.

All Wales Medicines Strategy Group (AWMSG) decisions

AWMSG No. 3557
The All Wales Medicines Strategy Group has advised (March 2018) that lopinavir with ritonavir oral solution (Kaletra®) is recommended as an option for use within NHS Wales in combination with other antiretroviral medicinal products for the treatment of human immunodeficiency virus (HIV–1) infected children aged from 14 days to less than 2 years old.
Viral infection

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral solution**

**CAUTIONARY AND ADVISORY LABELS 21**

**EXCIPIENTS:** May contain Alcohol, propylene glycol

- Kaletra (AbbVie Ltd)

Ritonavir 20 mg per 1 mL, Lopinavir 80 mg per 1 mL

Kaletra 80 mg/20 mg/1 mL oral solution | 120 mL (PO) £122.96

300 mL (PO) £307.39

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 25**

- Kaletra (AbbVie Ltd)

Ritonavir 25 mg, Lopinavir 100 mg | 60 tablet (PO) £76.85

Ritonavir 50 mg, Lopinavir 200 mg | 120 tablet (PO) £285.41

**Ritonavir**

18-Apr-2019

**INDICATIONS AND DOSE**

HIV infection in combination with other antiretroviral drugs (high-dose ritonavir)

- **BY MOUTH**
  - Child 2-17 years: Initially 250 mg/m² twice daily, increased in steps of 50 mg/m² every 2-3 days; increased to 350 mg/m² twice daily (max. per dose 600 mg twice daily), tolerability of this regimen is poor

**Low-dose ritonavir to increase the effect of atazanavir**

- **BY MOUTH**
  - Child 6-17 years (body-weight 15-19 kg): 80–100 mg once daily
  - Child 6-17 years (body-weight 20 kg and above): 100 mg once daily

**Low-dose ritonavir to increase the effect of darunavir**

- **BY MOUTH**
  - Child 3-17 years (body-weight 15-29 kg): 50 mg twice daily
  - Child 3-17 years (body-weight 30-39 kg): 60 mg twice daily
  - Child 3-17 years (body-weight 40 kg and above): 100 mg twice daily
  - Child 12-17 years (body-weight 40 kg and above): 100 mg once daily for use in patients taking darunavir once daily

**Low-dose ritonavir to increase the effect of fosamprenavir**

- **BY MOUTH**
  - Child 6-17 years (body-weight 25-32 kg): 3 mg/kg twice daily
  - Child 6-17 years (body-weight 33 kg and above): 100 mg twice daily

**Low-dose ritonavir to increase the effect of tipranavir**

- **BY MOUTH**
  - Child 2-11 years: 150 mg/m² twice daily (max. per dose 200 mg)
  - Child 12-17 years: 200 mg twice daily

**SIDE-EFFECTS, FURTHER INFORMATION**

**SIGNS AND SYMPTOMS** Signs and symptoms suggestive of pancreatitis (including raised serum lipase) should be evaluated — discontinue if pancreatitis diagnosed.

**PREGNANCY**

Dose adjustments

- Only use low-dose booster to increase the effect of other protease inhibitors.

**HEPATIC IMPAIRMENT**

When used as a low-dose booster, manufacturer advises caution in severe impairment; avoid in decompensated liver disease. When used in high-doses, manufacturer advises avoid in severe impairment.

Dose adjustments

Manufacturer advises consult product literature of co-administered protease inhibitor.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

**CAUTIONARY AND ADVISORY LABELS 21, 25**

- Ritonavir (Non-proprietary)
  - Ritonavir 100 mg Ritonavir 100 mg tablets | 30 tablet (PO) £16.52-£19.40
  - Norvir (AbbVie Ltd)
  - Ritonavir 100 mg Norvir 100 mg tablets | 30 tablet (PO) £19.44

**Tipranavir**

**INDICATIONS AND DOSE**

HIV infection resistant to other protease inhibitors, in combination with other antiretroviral drugs in patients previously treated with antiretrovirals—with low-dose ritonavir

- **BY MOUTH USING CAPSULES**
  - Child 12-17 years: 500 mg twice daily

- **BY MOUTH USING ORAL SOLUTION**
  - Child 2-11 years: 375 mg/m² twice daily (max. per dose 500 mg)

**DOSE EQUIVALENCE AND CONVERSION**

The bioavailability of tipranavir oral solution is higher than that of the capsules; the oral solution is not interchangeable with the capsules on a milligram-for-milligram basis.

**CAUTIONS**

Abnormal liver function tests and/or signs of symptoms of liver injury (consider delaying treatment if serum transaminases are greater than 5 times the upper limit of normal—consult product literature) — patients at risk of increased bleeding from trauma, surgery or other pathological conditions

**INTERACTIONS**

- Appendix 1: HIV-protease inhibitors

**SIDE-EFFECTS**

- Uncommon Hyperamylasaemia · hyperglycaemia · influenza like illness · renal failure · thrombocytopenia

- Rare or very rare Dehydration · hyperbilirubinaemia · intracranial haemorrhage

- Frequency not known Bleeding tendency

**SIDE-EFFECTS, FURTHER INFORMATION**

Potentially life-threatening hepatotoxicity reported. Discontinue if signs or symptoms of hepatitis develop or if liver-function abnormality develops (consult product literature).

**PREGNANCY**

Manufacturer advises use only if potential benefit outweighs risk—toxicity in animal studies.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution in mild impairment (risk of increased exposure)—monitor liver function before treatment, then every two weeks for 3 months, then monthly until 48 weeks, then every 8 to 12 weeks thereafter, and discontinue if liver function worsens; avoid in moderate to severe impairment.

**MONITORING REQUIREMENTS**

Monitor liver function before treatment, then every 2 weeks for 1 month, then...
Influenza

5.5 Influenza

Management

Oseltamivir p. 444 and zanamivir p. 445 are most effective for the treatment of influenza if started within a few hours of the onset of symptoms; oseltamivir is licensed for use within 48 hours of the first symptoms while zanamivir is licensed for use within 36 hours of the first symptoms. In otherwise healthy individuals they reduce the duration of symptoms by about 1–1.5 days.

Oseltamivir and zanamivir are licensed for post-exposure prophylaxis of influenza when influenza is circulating in the community. Oseltamivir should be given within 48 hours of exposure to influenza while zanamivir should be given within 36 hours of exposure to influenza. However, in children with severe influenza or in those who are immuno compromised, antivirals may still be effective after this time if viral shedding continues [unlicensed use]. Oseltamivir and zanamivir are also licensed for use in exceptional circumstances (e.g. when vaccination does not cover the infecting strain) to prevent influenza in an epidemic.

There is evidence that some strains of influenza A virus have reduced susceptibility to oseltamivir, but may retain susceptibility to zanamivir. Resistance to oseltamivir may be greater in severely immunocompromised children.

Zanamivir should be reserved for patients who are severely immunocompromised, or when oseltamivir cannot be used, or when resistance to oseltamivir is suspected. For those unable to use the dry powder for inhalation, zanamivir is available as a solution that can be administered by nebuliser or intravenously [unlicensed use].

Information on pandemic influenza, avian influenza, and swine influenza may be found at www.gov.uk/phe.

Immunisation against influenza is recommended for persons at high risk, and to reduce transmission of infection.

Oseltamivir in children under 1 year of age

Data on the use of oseltamivir in children under 1 year of age is limited. Furthermore, oseltamivir may be ineffective in neonates because they may not be able to metabolise oseltamivir to its active form. However, oseltamivir can be used (under specialist supervision) for the treatment or post-exposure prophylaxis of influenza in children under 1 year of age. The Department of Health has advised (May 2009) that during a pandemic, treatment with oseltamivir can be overseen by healthcare professionals experienced in assessing children.

Amantadine hydrochloride is licensed for prophylaxis and treatment of influenza A in children over 10 years of age, but it is no longer recommended.
Oseltamivir

**DRUG ACTION**
Reduces replication of influenza A and B viruses by inhibiting viral neuraminidase.

**INDICATIONS AND DOSE**

**Prevention of influenza**
- **BY MOUTH**
  - Neonate: 3 mg/kg once daily for 10 days for post-exposure prophylaxis.
  - Child 1-11 months: 3 mg/kg once daily for 10 days for post-exposure prophylaxis.
  - Child 1-12 years (body-weight 10-15 kg): 30 mg once daily for 10 days for post-exposure prophylaxis; for up to 6 weeks during an epidemic.
  - Child 1-12 years (body-weight 15-23 kg): 45 mg once daily for 10 days for post-exposure prophylaxis; for up to 6 weeks during an epidemic.
  - Child 1-12 years (body-weight 23-40 kg): 60 mg once daily for 10 days for post-exposure prophylaxis; for up to 6 weeks during an epidemic.
  - Child 1-12 years (body-weight 40 kg and above): 75 mg once daily for 10 days for post-exposure prophylaxis; for up to 6 weeks during an epidemic.
  - Child 13-17 years: 75 mg once daily for 10 days for post-exposure prophylaxis; for up to 6 weeks during an epidemic.

**Treatment of influenza**
- **BY MOUTH**
  - Neonate: 3 mg/kg twice daily for 5 days.
  - Child 1-11 months: 3 mg/kg twice daily for 5 days.
  - Child 1-12 years (body-weight 10-15 kg): 30 mg twice daily for 5 days.
  - Child 1-12 years (body-weight 15-23 kg): 45 mg twice daily for 5 days.
  - Child 1-12 years (body-weight 23-40 kg): 60 mg twice daily for 5 days.
  - Child 1-12 years (body-weight 40 kg and above): 75 mg twice daily for 5 days.
  - Child 13-17 years: 75 mg twice daily for 5 days.

**UNLICENSED USE**
Not licensed for use in premature infants.

**INTERACTIONS**
Appendix 1: oseltamivir

**SIDE-EFFECTS**
- **Common or very common**
  - Dizziness.
  - Gastrointestinal discomfort.
  - Herpes simplex.
  - Nausea.
  - Sleep disorders.
  - Vertigo.
  - Vomiting.

- **Uncommon**
  - Arrhythmia.
  - Seizure.
  - Skin reactions.

- **Rare or very rare**
  - Angioedema.
  - Anxiety.
  - Behaviour abnormal.
  - Confusion.
  - Delirium.
  - Delusions.
  - Gastrointestinal haemorrhage.
  - Hallucination.
  - Hepatic disorders.
  - Self-injurious behaviour.
  - Severe cutaneous adverse reactions (SCARs).
  - Thrombocytopenia.
  - Visual impairment.

**PREGNANCY**
Although safety data are limited, oseltamivir can be used in women who are pregnant when the potential benefit outweighs the risk (e.g. during a pandemic).

**BREAST FEEDING**
Although safety data are limited, oseltamivir can be used in women who are breast-feeding when the potential benefit outweighs the risk (e.g. during a pandemic). Oseltamivir is the preferred drug in women who are breast-feeding.

**RENAL IMPAIRMENT**
Avoid for treatment and prevention if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².

**Dose adjustments**
For treatment, use 40% of normal dose twice daily if estimated glomerular filtration rate 30–60 mL/minute/1.73 m² (40% of normal dose once daily if estimated glomerular filtration rate 10–30 mL/minute/1.73 m²).

For prevention, use 40% of normal dose once daily if estimated glomerular filtration rate 30–60 mL/minute/1.73 m² (40% of normal dose every 48 hours if estimated glomerular filtration rate 10–30 mL/minute/1.73 m²).

**DIRECTIONS FOR ADMINISTRATION**
If suspension not available, capsules can be opened and the contents mixed with a small amount of sweetened food, such as sugar water or chocolate syrup, just before administration.

**PRESCRIBING AND DISPENSING INFORMATION**
Flavours of oral liquid formulations may include tutti-frutti.

**PATIENT AND CARER ADVICE**
Medicines for Children leaflet: Oseltamivir for influenza (flu)
www.medicinesforchildren.org.uk/oseltamivir-influenza-flu

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**
- Oseltamivir, zanamivir, and amantadine for prophylaxis of influenza (September 2008) NICE TA158
  - Oseltamivir is not a substitute for vaccination, which remains the most effective way of preventing illness from influenza.
- Oseltamivir is not recommended for seasonal prophylaxis against influenza.
- When influenza is circulating in the community, oseltamivir is an option recommended (in accordance with UK licensing) for post-exposure prophylaxis in at-risk patients who are not effectively protected by influenza vaccine, and who have been in close contact with someone suffering from influenza-like illness in the same household or residential setting. Oseltamivir should be given within 48 hours of exposure to influenza. (National surveillance schemes, including those run by Public Health England, should be used to indicate when influenza is circulating in the community.)
- During local outbreaks of influenza-like illness, when there is a high level of certainty that influenza is present, oseltamivir may be used for post-exposure prophylaxis in at-risk patients (regardless of influenza vaccination) living in long-term residential or nursing homes.
- At risk patients include those aged 65 years or older or those who have one or more of the following conditions:
  - Chronic respiratory disease (including asthma and chronic obstructive pulmonary disease);
  - Chronic heart disease;
  - Chronic renal disease;
  - Chronic liver disease;
  - Chronic neurological disease;
  - Immunosuppression;
  - Diabetes mellitus.

The Department of Health in England has advised (November 2010 and April 2011) that ‘at risk patients’ also includes patients under 65 years of age who are at risk of developing medical complications from influenza (treatment only) or who are pregnant.

This guidance does not cover the circumstances of a pandemic, an impending pandemic, or a widespread epidemic of a new strain of influenza to which there is little or no immunity in the community.

www.nice.org.uk/guidance/ta158

Oseltamivir, zanamivir, and amantadine for treatment of influenza (February 2009) NICE TA168
  - Oseltamivir is not a substitute for vaccination, which remains the most effective way of preventing illness from influenza.
When influenza is circulating in the community, oseltamivir is an option recommended (in accordance with UK licensing) for the treatment of influenza in at-risk patients who can start treatment within 48 hours of the onset of symptoms. (National surveillance schemes, including those run by Public Health England, should be used to indicate when influenza is circulating in the community.)

During local outbreaks of influenza-like illness, when there is a high level of certainty that influenza is present, oseltamivir may be used for treatment in at-risk patients living in long-term residential or nursing homes. At risk patients include those aged over 65 years or those who have one or more of the following conditions:
- chronic respiratory disease (including asthma and chronic obstructive pulmonary disease);
- chronic heart disease;
- chronic renal disease;
- chronic liver disease;
- chronic neurological disease;
- immunosuppression;
- diabetes mellitus.

The Department of Health in England has advised (November 2010 and April 2011) that ‘at risk patients’ also includes patients under 65 years of age who are at risk of developing medical complications from influenza (treatment only) or women who are pregnant.

This guidance does not cover the circumstances of a pandemic, an impending pandemic, or a widespread epidemic of a new strain of influenza (treatment only) or women who are pregnant.

When in the community.

Zanamivir

- **DRUG ACTION** Reduces replication of influenza A and B viruses by inhibiting viral neuraminidase.

- **INDICATIONS AND DOSE**

  - **Post-exposure prophylaxis of influenza**
    - **BY INHALATION OF POWDER**
    - Child 5-17 years: 10 mg once daily for 10 days
  
  - **Prevention of influenza during an epidemic**
    - **BY INHALATION OF POWDER**
    - Child 5-17 years: 10 mg once daily for up to 28 days

- **TREATMENT OF INFLUENZA**
  - **BY INHALATION OF POWDER**
  - Child 5-17 years: 10 mg twice daily for 5 days (for up to 10 days if resistance to oseltamivir suspected)

- **UNLICENSED USE** Use of zanamivir for up to 10 days if resistance to oseltamivir suspected is an unlicensed duration.

- **CAUTIONS** Asthma, chronic pulmonary disease, uncontrolled chronic illness

  - **CAUTIONS, FURTHER INFORMATION**
    - Asthma and chronic pulmonary disease Risk of bronchospasm—short-acting bronchodilator should be available. Avoid in severe asthma unless close monitoring possible and appropriate facilities available to treat bronchospasm.

- **SIDE-EFFECTS**

  - **Common or very common** Skin reactions
  
  - **Uncommon** Bronchospasm, dehydration, dyspnoea, oropharyngeal oedema, presyncope, severe cutaneous adverse reactions (SCARs), throat tightness

  - **Rare or very rare** Face oedema

  - **Frequency not known** Behaviour abnormal, delirium, hallucination, level of consciousness decreased, psychiatric disorder, seizure

- **SIDE-EFFECTS, FURTHER INFORMATION** Neurological and psychiatric disorders occur more commonly in children and adolescents.

- **PREGNANCY** Although safety data are limited, zanamivir can be used in women who are pregnant when the potential benefit outweighs the risk (e.g. during a pandemic). Use only if potential benefit outweighs risk (e.g. during a pandemic).

- **BREAST FEEDING** Although safety data are limited, zanamivir can be used in women who are breast-feeding when the potential benefit outweighs the risk (e.g. during a pandemic). Amount probably too small to be harmful; use only if potential benefit outweighs risk (e.g. during a pandemic).

- **DIRECTIONS FOR ADMINISTRATION** Other inhaled drugs should be administered before zanamivir.

- **PRESCRIBING AND DISPENSING INFORMATION** Except for the treatment and prophylaxis of influenza as indicated in the NICE guidance; endorse prescription ‘SLS’.

- **NATIONAL FUNDING/ACCESS DECISIONS**

  - **NICE decisions**
    - Oseltamivir, zanamivir, and amantadine for prophylaxis of influenza (September 2008) NICE TA158

  - **Zanamivir** is not a substitute for vaccination, which remains the most effective way of preventing illness from influenza.

  - **Zanamivir** is not recommended for seasonal prophylaxis against influenza.

  - When influenza is circulating in the community, zanamivir is an option recommended (in accordance with UK licensing) for post-exposure prophylaxis in at-risk patients who are not effectively protected by influenza vaccine, and who have been in close contact with someone suffering from influenza-like illness in the same household or residential setting. Zanamivir should be given within 36 hours of exposure to influenza.

  - When influenza is circulating in the community, zanamivir is an option recommended (in accordance with UK licensing) for post-exposure prophylaxis in at-risk patients who are not effectively protected by influenza vaccine, and who have been in close contact with someone suffering from influenza-like illness in the same household or residential setting. Zanamivir should be given within 36 hours of exposure to influenza.

  - During local outbreaks of influenza-like illness, when there is a high level of certainty that influenza is present, zanamivir may be used for post-exposure prophylaxis in at-risk patients (regardless of influenza vaccination) living in long-term residential or nursing homes.
At risk patients include those aged over 65 years or those who have one or more of the following conditions:
- chronic respiratory disease (including asthma and chronic obstructive pulmonary disease);
- chronic heart disease;
- chronic renal disease;
- chronic liver disease;
- chronic neurological disease;
- immunosuppression;
- diabetes mellitus.

The Department of Health in England has advised (November 2010 and April 2011) that ‘at risk patients’ also includes patients under 65 years of age who are at risk of developing medical complications from influenza (treatment only) or women who are pregnant.

This guidance does not cover the circumstances of a pandemic, an impending pandemic, or a widespread epidemic of a new strain of influenza to which there is little or no immunity in the community.

www.nice.org.uk/guidance/TA158

Oseltamivir, zanamivir, and amantadine for treatment of influenza (February 2009) NICE TA168

Zanamivir is not a substitute for vaccination, which remains the most effective way of preventing illness from influenza.

When influenza is circulating in the community, zanamivir is an option recommended (in accordance with UK licensing) for the treatment of influenza in at-risk patients who can start treatment within 48 hours (within 36 hours for zanamivir in children) of the onset of symptoms. (National surveillance schemes, including those run by Public Health England, should be used to indicate when influenza is circulating in the community.)

During local outbreaks of influenza-like illness, when there is a high level of certainty that influenza is present, zanamivir may be used for treatment in at-risk patients living in long-term residential or nursing homes.

At risk patients include those aged over 65 years or those who have one or more of the following conditions:
- chronic respiratory disease (including asthma and chronic obstructive pulmonary disease);
- chronic heart disease;
- chronic renal disease;
- chronic liver disease;
- chronic neurological disease;
- immunosuppression;
- diabetes mellitus.

The Department of Health in England has advised (November 2010 and April 2011) that ‘at risk patients’ also includes patients under 65 years of age who are at risk of developing medical complications from influenza (treatment only) or who are pregnant.

This guidance does not cover the circumstances of a pandemic, an impending pandemic, or a widespread epidemic of a new strain of influenza to which there is little or no immunity in the community.

www.nice.org.uk/guidance/TA168

5.6 Respiratory syncytial virus

Respiratory syncytial virus

Management
Ribavirin p. 415 inhibits a wide range of DNA and RNA viruses. It is licensed for administration by inhalation for the treatment of severe bronchiolitis caused by the respiratory syncytial virus (RSV) in infants, especially when they have other serious diseases. However, there is no evidence that ribavirin produces clinically relevant benefit in RSV bronchiolitis. Ribavirin is effective in Lassa fever and has also been used parenterally in the treatment of life-threatening RSV, para-influenza virus, and adenovirus infections in immunocompromised children [unlicensed indications].

Palivizumab below is a monoclonal antibody licensed for preventing serious lower respiratory-tract disease caused by respiratory syncytial virus in children at high risk of the disease; it should be prescribed under specialist supervision and on the basis of the likelihood of hospitalisation.

Palivizumab is recommended for:
- children under 9 months of age with chronic lung disease (defined as requiring oxygen for at least 28 days from birth) and who were born preterm;
- children under 6 months of age with haemodynamically significant, acyanotic congenital heart disease who were born preterm.

Palivizumab should be considered for:
- children under 2 years of age with severe combined immunodeficiency syndrome;
- children under 1 year of age who require long-term ventilation;
- children 1–2 years of age who require long-term ventilation and have an additional co-morbidity (including cardiac disease or pulmonary hypertension).

For details of the preterm age groups included in the recommendations, see Immunisation against Infectious Disease (2006), available at www.gov.uk/dh.

DRUGS FOR RESPIRATORY DISEASES

MONOCLONAL ANTIBODIES

Palivizumab

- INDICATIONS AND DOSE
  Prevention of serious lower respiratory-tract disease caused by respiratory syncytial virus in children at high risk of the disease (under expert supervision)
    - BY INTRAMUSCULAR INJECTION
      - Neonate: 15 mg/kg once a month, preferably injected in the anterolateral thigh, to be administered during season of RSV risk.
      - Child 1–23 months: 15 mg/kg once a month, preferably injected in the anterolateral thigh, to be administered during season of RSV risk.
    - BY INTRAMUSCULAR INJECTION
      - Child 1–23 months: Initially 15 mg/kg, to be administered as soon as stable after surgery, preferably in the anterolateral thigh, then 15 mg/kg once a month, preferably injected in the anterolateral thigh.

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

Inhalation powder
- Relenza (GlaxoSmithKline UK Ltd)
  Zanamivir 5 mg Relenza 5mg inhalation powder blisters with Diskhaler 20 blister £16.36
to be administered during season of RSV risk, injection volume over 1 mL should be divided between 2 or more sites

- **UNLICENSED USE** Licensed for the prevention of serious lower respiratory-tract disease caused by respiratory syncytial virus (RSV) in children under 6 months of age (at the start of the RSV season) and born at less than 35 weeks corrected gestational age, or in children under 2 years of age who have received treatment for bronchopulmonary dysplasia in the last 6 months, or in children under 2 years of age with haemodynamically significant congenital heart disease.

- **CAUTIONS** Moderate to severe acute infection • moderate to severe febrile illness • serum-palivizumab concentration may be reduced after cardiac surgery • thrombocytopenia

- **SIDE-EFFECTS**
  - **Common or very common** Apnoea
  - **Uncommon** Seizure • thrombocytopenia • urticaria
  - **Frequency not known** Hypersensitivity

- **ALLERGY AND CROSS-SENSITIVITY** Hypersensitivity to humanised monoclonal antibodies.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Synagis** (AbbVie Ltd)
  - Palivizumab 100 mg per 1 mL Synagis 100mg/1ml solution for injection vials | 1 vial £563.64
  - Synagis 50mg/0.5ml solution for injection vials | 1 vial £306.34
**Chapter 6**

**Endocrine system**

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**1 Antidiuretic hormone disorders**

**Posterior pituitary hormones and antagonists**

**Posterior pituitary hormones**

**Diabetes insipidus**

Diabetes insipidus is caused by either a deficiency of antidiuretic hormone (ADH, vasopressin p. 69) secretion (cranial, neurogenic, or pituitary diabetes insipidus) or by failure of the renal tubules to react to secreted antidiuretic hormone (nephrogenic diabetes insipidus).

Vasopressin (antidiuretic hormone, ADH) is used in the treatment of *pituitary diabetes insipidus* as is its analogue desmopressin below. Dosage is tailored to produce a regular diuresis every 24 hours to avoid water intoxication.

Treatment may be required permanently or for a limited period only in diabetes insipidus following trauma or pituitary surgery.

Desmopressin is more potent and has a longer duration of action than vasopressin; unlike vasopressin it has no vasoconstrictor effect. It is given by mouth or intranasally for maintenance therapy, and by injection in the postoperative period or in unconscious patients.

Desmopressin is also used in the differential diagnosis of diabetes insipidus; following an intramuscular or intranasal dose, restoration of the ability to concentrate urine after water deprivation confirms a diagnosis of pituitary diabetes insipidus. Failure to respond suggests nephrogenic diabetes insipidus. Fluid input must be managed carefully to avoid hyponatraemia; this test is not usually recommended in young children.

In nephrogenic and partial pituitary diabetes insipidus benefit may be gained from the paradoxical antidiuretic effect of thiazides.

**Other uses**

Desmopressin is also used to boost factor VIII concentration in mild to moderate haemophilia and in von Willebrand’s disease; it is also used to test fibrinolytic response. Desmopressin also has a role in nocturnal enuresis.

Vasopressin infusion is used to control variceal bleeding in portal hypertension, before introducing more definitive treatment. Terlipressin acetate, a derivative of vasopressin with reportedly less pressor and antidiuretic activity, and octreotide are used similarly but experience in children is limited.

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**1.1 Diabetes insipidus**

**Other drugs used for Diabetes insipidus** Chlorothiazide, p. 113 · Chlortalidone, p. 144

**PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES › VASOPRESSIN AND ANALOGUES**

**Desmopressin**

**Drug action**

Desmopressin is an analogue of vasopressin.

**Indications and dose**

**Diabetes insipidus, treatment**

**By mouth**

- Neonate: Initially 1–4 micrograms 2–3 times a day, adjusted according to response.
- Child 1–2 years: Initially 5 micrograms 2–3 times a day, adjusted according to response; usual dose 60–180 micrograms daily
- Child 2–4 years: Initially 20 micrograms 2–3 times a day, adjusted according to response; usual dose 100–300 micrograms daily
- Child 12–17 years: Initially 100 micrograms 2–3 times a day, adjusted according to response; usual dose 0.2–1.2 mg daily
Child 15–17 years: 40 micrograms, empty bladder at time of administration and limit fluid intake to 500 mL from 1 hour before until 8 hours after administration to avoid fluid overload

- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Child 1-11 months: 400 nanograms, empty bladder at time of administration and restrict fluid intake to 50% at next 2 days to avoid fluid overload
  - Child 1-17 years: 2 micrograms, empty bladder at time of administration and restrict fluid intake to 500 mL from 1 hour before until 8 hours after administration to avoid fluid overload

**Mild to moderate haemophilia and von Willebrand’s disease**

- **BY INTRANASAL ADMINISTRATION**
  - Child 1-17 years: 4 micrograms/kg for 1 dose, for pre-operative use give 2 hours before procedure
  - **BY INTRAVENOUS INFUSION, OR BY SUBCUTANEOUS INJECTION**
  - Child: 300 nanograms/kg for 1 dose, to be administered immediately before surgery or after trauma; may be repeated at intervals of 12 hours if no tachycardia

**Fibrinolytic response testing**

- **BY SUBCUTANEOUS INJECTION, OR BY INTRAVENOUS INJECTION**
  - Child 2-17 years: 300 nanograms/kg for 1 dose to be sampled after 20 minutes for fibrinolytic activity

**Assessment of antidiuretic hormone secretion (congenital deficiency suspected) (specialist use only)**

- **BY INTRANASAL ADMINISTRATION**
  - Child 1-23 months: Initially 100–500 nanograms for 1 dose

**Assessment of antidiuretic hormone secretion (congenital deficiency not suspected) (specialist use only)**

- **BY INTRANASAL ADMINISTRATION**
  - Child 1-23 months: 1–5 micrograms for 1 dose

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**Diabetes insipidus, diagnosis (water deprivation test)**

- **BY INTRANASAL ADMINISTRATION**
  - Child 1-23 months: 5–10 micrograms for 1 dose, manage fluid input carefully to avoid hyponatraemia, not usually recommended
  - Child 2-11 years: 10–20 micrograms for 1 dose, manage fluid input carefully to avoid hyponatraemia
  - Child 12-17 years: 20 micrograms for 1 dose, manage fluid input carefully to avoid hyponatraemia

- **BY SUBLINGUAL ADMINISTRATION**
  - Child 5-7 years: 200 micrograms once daily, only increased to 400 micrograms if lower dose not effective; withdraw for at least 1 week for reassessment after 3 months, dose to be taken at bedtime, limit fluid intake from 1 hour before to 8 hours after administration

- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Child 1-23 months: 5–10 micrograms for 1 dose, manage fluid input carefully to avoid hyponatraemia, not usually recommended

- **BY INTRAMUSCULAR INJECTION, OR BY SUBCUTANEOUS INJECTION**
  - Child 2-11 years: 0.5–1 microgram for 1 dose, manage fluid input carefully to avoid hyponatraemia
  - Child 12-17 years: 1–2 micrograms for 1 dose, manage fluid input carefully to avoid hyponatraemia

**Renal function testing**

- **BY INTRANASAL ADMINISTRATION**
  - Child 1-11 months: 10 micrograms, empty bladder at time of administration and restrict fluid intake to 50% at next 2 feeds to avoid fluid overload
  - Child 1-14 years: 20 micrograms, empty bladder at time of administration and restrict fluid intake to 500 mL from 1 hour before until 8 hours after administration to avoid fluid overload

**Frequency not known**

- Child 1-11 months: 400 nanograms, empty bladder at time of administration and restrict fluid intake to 50% at next 2 feeds to avoid fluid overload
  - Child 1-17 years: 2 micrograms, empty bladder at time of administration and restrict fluid intake to 500 mL from 1 hour before until 8 hours after administration to avoid fluid overload

**INTERACTIONS**

- Appendix 1: desmopressin

**SIDE-EFFECTS**

- **Common or very common** Hyponatraemia (on administration without restricting fluid intake) - nausea
  - **Frequency not known** Abdominal pain - aggression - allergic dermatitis - emotional disorder - fluid retention - headache - hyponatraemic seizure - vomiting - weight increased

**SPECIFIC SIDE-EFFECTS**

- With intranasal use Epistaxis - nasal congestion - rhinitis
  - With intravenous use Vasodilation

**SIDE-EFFECTS, FURTHER INFORMATION**

Manufacturer advises avoiding concomitant use of drugs which increase
secretion of vasopressin (e.g. tricyclic antidepressants)—increases risk of hyponatraemia.
- **PREGNANCY** Small oxytocic effect in third trimester; increased risk of pre-eclampsia.
- **BREAST Feeding** Amount too small to be harmful.
- **RENAL IMPAIRMENT** Use with caution; antidiuretic effect may be reduced.
- **MONITORING REQUIREMENTS** In nocturia, periodic blood pressure and weight checks are needed to monitor for fluid overload.
- **DIRECTIONS FOR ADMINISTRATION** DDAVP® and Desmotsabs® tablets may be crushed. DDAVP® intranasal solution may be diluted with Sodium Chloride 0.9% to a concentration of 10 micrograms/mL. DDAVP® injection may be administered orally. Desmopressin oral hyaluronicates are for sublingual administration.
- **With intravenous use** Higher doses of DDAVP® by intravenous infusion, used in mild to moderate haemophilia and von Willebrand’s disease, may be diluted with 30–50 mL Sodium Chloride 0.9% intravenous infusion. For intravenous infusion (Octim®), dilute with 50 mL of Sodium Chloride 0.9% and give over 20 minutes.
- **PRESCRIBING AND DISPENSING INFORMATION** Oral, intranasal, intravenous, subcutaneous and intramuscular doses are expressed as desmopressin acetate; sublingual doses are expressed as desmopressin base.
- **Children** requiring an intranasal dose of less than 10 micrograms should be given DDAVP® intranasal solution.
- **PATIENT AND CARER ADVICE** Hyponatraemic convulsions. Patients being treated for primary nocturnal enuresis should be warned to avoid fluid overload (including during swimming) and to stop taking desmopressin during an episode of vomiting or diarrhoea (until fluid balance normal).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution, spray, nasal drops.

**Tablet**
- Desmopressin (Non-proprietary)
  - Desmopressin acetate 100 microgram Desmopressin 100microgram tablets | 90 tablet [P] £76.62 DT + £63.08
- DDAVP (Ferring Pharmaceuticals Ltd)
  - Desmopressin acetate 100 microgram DDAVP 0.1mg tablets | 90 tablet [P] £88.23
  - Desmopressin acetate 200 microgram DDAVP 0.2mg tablets | 30 tablet [P] £90.12 DT + £63.08
- Desmotsabs (Ferring Pharmaceuticals Ltd)
  - Desmotsabs (Desmopressin acetate) 200 microgram Desmotsabs 200microgram tablets | 30 tablet [P] £11.47

**Solution for injection**
- DDAVP (Ferring Pharmaceuticals Ltd)
  - Desmopressin acetate 4 microgram per 1 ml DDAVP 4micrograms/1ml solution for injection ampoules | 10 ampoule [P] £13.16
- Octim (Ferring Pharmaceuticals Ltd)
  - Desmopressin acetate 15 microgram per 1 ml Octim 15micrograms/1ml solution for injection ampoules | 10 ampoule [P] £35.37

**Spray**
- Desmopressin (Non-proprietary)
  - Desmopressin acetate 10 microgram per 1 dose Desmopressin 10micrograms/dose nasal spray | 60 dose [P] £25.02 DT + £23.35
  - Desmopressin acetate 2.5 microgram per 1 dose Desmopressin 2.5micrograms/dose nasal spray | 50 dose [P]

**Desmopressin acetate 10 microgram per 1 dose** Desmospray 10micrograms/dose nasal spray | 60 dose [P] £25.02 DT + £23.35

- **Octim** (Ferring Pharmaceuticals Ltd)
  - Desmopressin acetate 150 microgram per 1 dose Octim 150micrograms/dose nasal spray | 25 dose [P] £576.60 DT + £576.60

**Oral hyaluronicates**

**DDAVP Melt** (Ferring Pharmaceuticals Ltd)
- Desmopressin (as Desmopressin acetate) 60 microgram DDAVP Melt 60microgram oral hyaluronicates sugar-free | 100 tablet [P] £50.53 DT + £50.53
- Desmopressin (as Desmopressin acetate) 120 microgram DDAVP Melt 120microgram oral hyaluronicates sugar-free | 100 tablet [P] £101.07 DT + £101.07
- Desmopressin (as Desmopressin acetate) 240 microgram DDAVP Melt 240microgram oral hyaluronicates sugar-free | 100 tablet [P] £202.14

- **DesmoMelt** (Ferring Pharmaceuticals Ltd)
  - Desmopressin (as Desmopressin acetate) 120 microgram DesmoMelt 120microgram oral hyaluronicates sugar-free | 30 tablet [P] £30.34 DT + £30.34
  - Desmopressin (as Desmopressin acetate) 240 microgram DesmoMelt 240microgram oral hyaluronicates sugar-free | 30 tablet [P] £60.68 DT + £60.68
- **Noqdírina** (Ferring Pharmaceuticals Ltd)
  - Desmopressin (as Desmopressin acetate) 25 microgram Noqdírina 25microgram oral hyaluronicates sugar-free | 30 tablet [P] £15.16 DT + £15.16
- Desmopressin (as Desmopressin acetate) 50 microgram Noqdírina 50microgram oral hyaluronicates sugar-free | 30 tablet [P] £15.16 DT + £15.16

**Nasal drops**
- DDAVP (Ferring Pharmaceuticals Ltd)
  - Desmopressin acetate 100 microgram per 1 ml DDAVP 100micrograms/ml intranasal solution | 2.5 ml [P] £3.72 DT + £3.72

**2 Corticosteroid responsive conditions**

**CORTICOSTEROIDS**

**Overview**
Dosages of corticosteroids vary widely in different diseases and in different patients. If the use of a corticosteroid can save or prolong life, as in exfoliative dermatitis, pemphigus, acute leukaemia or acute transplant rejection, high doses may need to be given, because the complications of therapy are likely to be less serious than the effects of the disease itself.

When long-term corticosteroid therapy is used in some chronic diseases, the adverse effects of treatment may become greater than the disabilities caused by the disease. To minimise side-effects the maintenance dose should be kept as low as possible.

When potentially less harmful measures are ineffective corticosteroids are used topically for the treatment of inflammatory conditions of the skin. Corticosteroids should be avoided or used only under specialist supervision in psoriasis.

Corticosteroids are used both topically (by rectum) and systemically (by mouth or intravenously) in the management of ulcerative colitis and Crohn’s disease.

Use can be made of the mineralocorticoid activity of fludrocortisone acetate p. 456 to treat postural hypotension in autonomic neuropathy.

High-dose corticosteroids should be avoided for the management of septic shock. However, low-dose hydrocortisone p. 456 can be used in septic shock that is
resistant to volume expansion and catecholamines, and is accompanied by suspected or proven adrenal insufficiency. The suppressive action of glucocorticoids on the hypothalamic-pituitary-adrenal axis is greatest and most prolonged when they are given at night. In most adults a single dose of dexamethasone p. 455 at night is sufficient to inhibit cortisol secretion for 24 hours. This is the basis of the ‘overnight dexamethasone suppression test’ for diagnosing Cushing’s syndrome.

Betamethasone p. 454 and dexamethasone are also appropriate for conditions where water retention would be a disadvantage.

A corticosteroid may be used in the management of raised intracranial pressure or cerebral oedema that occurs as a result of malignancy (see Prescribing in palliative care p. 22); high doses of betamethasone or dexamethasone are generally used. However, a corticosteroid should not be used for the management of head injury or stroke because it is unlikely to be of benefit and may even be harmful.

In acute hypersensitivity reactions, such as angioedema of the upper respiratory tract and anaphylaxis, corticosteroids are indicated as an adjunct to emergency treatment with adrenaline/epinephrine p. 138. In such cases hydrocortisone (as sodium succinate) by intravenous injection may be required.

In the management of asthma, corticosteroids are preferably used by inhalation but systemic therapy along with bronchodilators is required for the emergency treatment of severe acute asthma.

Betamethasone is used in women at risk of preterm delivery to reduce the incidence of neonatal respiratory distress syndrome [unlicensed use].

Dexamethasone should not be used routinely for the prophylaxis and treatment of chronic lung disease in neonates because of an association with adverse neurological effects.

Corticosteroids may be useful in conditions such as autoimmune hepatitis, rheumatoid arthritis, and sarcoidosis; they may also lead to remissions of acquired haemolytic anaemia and thrombocytopenic purpura.

High doses of a corticosteroid (usually prednisolone p. 455) are used in the treatment of glomerular kidney disease, including nephrotic syndrome. The condition frequently recurs; a corticosteroid given in high doses and for prolonged periods may delay relapse but the higher incidence of adverse effects limits the overall benefit. Those who suffer frequent relapses may be treated with prednisolone given in a low dose (daily or on alternate days) for 3–6 months; the dose should be adjusted to minimise effects on growth and development. Other drugs used in the treatment of glomerular kidney disease include levamisole p. 398, cyclophosphamide p. 555, chlorambucil p. 554, and ciclosporin p. 537. Congenital nephrotic syndrome may be resistant to corticosteroids and immunosuppressants; indomethacin p. 581 and an ACE inhibitor such as captopril p. 114 have been used.

Corticosteroids can improve the prognosis of serious conditions such as systemic lupus erythematosus and polymyalitis nodosa; the effects of the disease process may be suppressed and symptoms relieved, but the underlying condition is not cured, although it may ultimately remit. It is usual to begin therapy in these conditions at fairly high dose and then to reduce the dose to the lowest commensurate with disease control.

For other references to the use of corticosteroids see: Prescribing in Palliative Care, immunosuppression, rheumatic diseases, eye, otitis externa, allergic rhinitis, and aphthous ulcers.

Side-effects
MHRA/CHM advice: Corticosteroids: rare risk of central serous chorioretinopathy with local as well as systemic administration (August 2017)

Central serous chorioretinopathy is a retinal disorder that has been linked to the systemic use of corticosteroids. Recently, it has also been reported after local administration of corticosteroids via inhaled and intranasal, epidural, intrarticularal, topical dermal, and periorcular routes. The MHRA recommends that patients should be advised to report any blurred vision or other visual disturbances with corticosteroid treatment given by any route; consider referral to an ophthalmologist for evaluation of possible causes if a patient presents with vision problems.

Overdosage or prolonged use can exaggerate some of the normal physiological actions of corticosteroids leading to mineralocorticoid and glucocorticoid side-effects.

Mineralocorticoid side effects
- hypertension
- sodium retention
- water retention
- potassium loss
- calcium loss

Mineralocorticoid side effects are most marked with fludrocortisone acetate, but are significant with hydrocortisone, corticotropin, and tetracosactide p. 491. Mineralocorticoid actions are negligible with the high potency glucocorticoids, betamethasone and dexamethasone, and occur only slightly with methylprednisolone p. 458, prednisolone, and triamcinolone.

Glucocorticoid side effects
- diabetes
- osteoporosis
- in addition high doses are associated with avascular necrosis of the femoral head.
- Muscle wasting (proximal myopathy) can also occur.
- Corticosteroid therapy is also weakly linked with peptic ulceration and perforation.
- Psychiatric reactions may also occur.

Managing side-effects
Side-effects can be minimised by using lowest effective dose for minimum period possible. The suppressive action of a corticosteroid on cortisol secretion is least when it is given as a single dose in the morning. In an attempt to reduce pituitary-adrenal suppression further, the total dose for two days can sometimes be taken as a single dose on alternate days; alternate-day administration has not been very successful in the management of asthma. Pituitary-adrenal suppression can also be reduced by means of intermittent therapy with short courses. In some conditions it may be possible to reduce the dose of corticosteroid by adding a small dose of an immunosuppressive drug.

Whenever possible local treatment with creams, intra-articular injections, inhalations, eye-drops, or enemas should be used in preference to systemic treatment.

Inhaled corticosteroids have considerably fewer systemic effects than oral corticosteroids, but adverse effects including adrenal suppression have been reported. Use of other corticosteroid therapy (including topical) or concurrent use of drugs which inhibit corticosteroid metabolism should be taken into account when assessing systemic risk. In children, growth restriction associated with systemic corticosteroid therapy does not seem to occur with recommended doses of inhaled therapy; although initial growth velocity may be reduced, there appears to be no effect on achieving normal adult height. Large-volume spacer devices should be used for administering inhaled corticosteroids in children under 15 years; they are also useful in older children and adults, particularly if high doses
are required. Spacer devices increase airway deposition and reduce oropharyngeal deposition.

**Corticosteroids, replacement therapy**

**Overview**
The adrenal cortex normally secretes hydrocortisone p. 456 (cortisol) which has glucocorticoid activity and weak mineralocorticoid activity. It also secretes the mineralocorticoid aldosterone.

In deficiency states, physiological replacement is best achieved with a combination of hydrocortisone and the mineralocorticoid fludrocortisone acetate p. 456; hydrocortisone alone does not usually provide sufficient mineralocorticoid activity for complete replacement.

In Addison’s disease or following adrenalectomy, hydrocortisone by mouth is usually required. This is given in 2-3 divided doses, the larger in the morning and the smaller in the evening, mimicking the normal diurnal rhythm of cortisol secretion. The optimum daily dose is determined on the basis of clinical response. Glucocorticoid therapy is supplemented by fludrocortisone acetate.

In acute adrenocortical insufficiency, hydrocortisone is given intravenously (preferably as sodium succinate) every 6 to 8 hours in sodium chloride intravenous infusion 0.9% p. 610.

In hypopituitarism, glucocorticoids should be given as in adrenocortical insufficiency, but since production of aldosterone is also regulated by the renin-angiotensin system a mineralocorticoid is not usually required. Additional replacement therapy with levothyroxine sodium p. 503 and sex hormones should be given as indicated by the pattern of hormone deficiency.

In congenital adrenal hyperplasia, the pituitary gland increases production of corticotropin to compensate for reduced formation of cortisol; this results in excessive adrenal androgen production. Treatment is aimed at suppressing corticotropin using hydrocortisone. Careful and continual dose titration is required to avoid growth retardation and toxicity; for this reason potent, synthetic glucocorticoids such as dexamethasone are usually reserved for use in adolescents. The dose is adjusted according to clinical response and measurement of adrenal androgens and 17-hydroxyprogesterone. Salt-losing forms of congenital adrenal hyperplasia (where there is a lack of aldosterone production) also require mineralocorticoid replacement and salt supplementation (particularly in early life). The dose of mineralocorticoid is adjusted according to electrolyte concentration and plasma-renin activity.

**Glucocorticoid therapy**

**Glucocorticoid and mineralocorticoid activity**

In comparing the relative potencies of corticosteroids in terms of their anti-inflammatory (glucocorticoid) effects it should be borne in mind that high glucocorticoid activity in itself is of no advantage unless it is accompanied by relatively low mineralocorticoid activity (see Disadvantages of Corticosteroids). The mineralocorticoid activity of fludrocortisone acetate p. 456 is so high that its anti-inflammatory activity is of no clinical relevance.

<table>
<thead>
<tr>
<th>Equivalent anti-inflammatory doses of corticosteroids</th>
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<tbody>
<tr>
<td>This table takes no account of mineralocorticoid effects, nor does it take account of variations in duration of action</td>
</tr>
<tr>
<td>Prednisolone 1 mg = Betamethasone 150 micrograms</td>
</tr>
<tr>
<td>= Deflazacort 1.2 mg</td>
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<tr>
<td>= Dexamethasone 150 micrograms</td>
</tr>
<tr>
<td>= Hydrocortisone 4 mg</td>
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<tr>
<td>= Methylprednisolone 800 micrograms</td>
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<tr>
<td>= Triamcinolone 800 micrograms</td>
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</table>

The relatively high mineralocorticoid activity of hydrocortisone p. 456, and the resulting fluid retention, makes it unsuitable for disease suppression on a long-term basis. However, hydrocortisone can be used for adrenal replacement therapy. Hydrocortisone is used on a short-term basis by intravenous injection for the emergency management of some conditions. The relatively moderate anti-inflammatory potency of hydrocortisone also makes it a useful topical corticosteroid for the management of inflammatory skin conditions because side-effects (both topical and systemic) are less marked.

Prednisolone p. 458 has predominantly glucocorticoid activity and is the corticosteroid most commonly used by mouth for long-term disease suppression.

Betamethasone p. 454 and dexamethasone p. 455 have very high glucocorticoid activity in conjunction with insignificant mineralocorticoid activity. This makes them particularly suitable for high-dose therapy in conditions where fluid retention would be a disadvantage.

Betamethasone and dexamethasone also have a long duration of action and this, coupled with their lack of mineralocorticoid action makes them particularly suitable for conditions which require suppression of corticotropin (corticotrophin) secretion.

Some esters of betamethasone and of beclometasone dipropionate p. 162 (beclometasone) exert a considerably more marked topical effect (e.g. on the skin or the lungs) than when given by mouth; use is made of this to obtain topical effects whilst minimising systemic side-effects (e.g. for skin applications and asthma inhalations).

Deflazacort p. 454 has a high glucocorticoid activity; it is derived from prednisolone.

**Corticosteroids (systemic)**

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHIORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

Central serous chorioretinopathy is a retinal disorder that has been linked to the systemic use of corticosteroids. Recently, it has also been reported after local administration of corticosteroids via inhaled and intranasal, epidural, intra-articular, topical dermal, and periorcular routes. The MHRA recommends that patients should be advised to report any blurred vision or other visual disturbances with corticosteroid treatment given by any route; consider referral to an ophthalmologist for evaluation of possible causes if a patient presents with vision problems.

**CONTRA-INDICATIONS**

Avoid injections containing benzyl alcohol in neonates (in neonates): - avoid live virus vaccines in those receiving immunosuppressive doses (serum antibody response diminished) - systemic infection (unless specific therapy given)
CONTRA-INDICATIONS, FURTHER INFORMATION

- With intra-articular use or intradermal use or intralional use For further information on contra-indications associated with intra-articular, intradermal and intralional preparations, consult product literature.

- CAUTIONS Congestive heart failure - diabetes mellitus (including a family history of) - diverticulitis - epilepsy - glaucoma (including a family history of or susceptibility to) - history of steroid myopathy - history of tuberculosis or X-ray changes (frequent monitoring required) - hypertension - hypothyroidism - infection (particularly untreated) - myasthenia gravis - oculer herpes simplex (risk of corneal perforation) - osteoporosis - peptic ulcer - psychiatric reactions - recent intestinal anastomoses - recent myocardial infarction (rupture reported) - severe affective disorders (particularly if history of steroid-induced psychosis) - should not be used long-term - thromboembolic disorders - ulcerative colitis

CAUTIONS, FURTHER INFORMATION

- With intra-articular use or intradermal use or intralional use For further information on cautions associated with intra-articular, intradermal and intralional preparations, consult product literature.

SIDE-EFFECTS

- Common or very common Anxiety - behaviour abnormal - cataract subcapsular - cognitive impairment - Cushing's syndrome - electrolyte imbalance - fluid retention - gastrointestinal discomfort - growth retardation - headache - healing impaired - hirsutism - hypotension - increased risk of infection - menstrual cycle irregularities - mood altered - nausea - osteoporosis - peptic ulcer - psychotic disorder - skin reactions - sleep disorders - weight increased


- Rare or very rare Malaise - tendon rupture

- Frequency not known Chorioretinopathy - intracranial pressure increased with papilloedema (usually after withdrawal) - telangiectasia

SIDE-EFFECTS, FURTHER INFORMATION Adrenal suppression During prolonged therapy with corticosteroids, particularly with systemic use, adrenal atrophy develops and can persist for years after stopping. Abrupt withdrawal after a prolonged period can lead to acute adrenal insufficiency, hypotension, or death. To compensate for a diminished adrenocortical response caused by prolonged corticosteroid treatment, any significant intercurrent illness, trauma, or surgical procedure requires a temporary increase in corticosteroid dose, or if already stopped, a temporary reintroduction of corticosteroid treatment. Patients on long-term corticosteroid treatment should carry a steroid treatment card which gives guidance on minimising risk and provides details of prescriber, drug, dosage and duration of treatment.

- Infections Prolonged courses of corticosteroids increase susceptibility to infections and severity of infections; clinical presentation of infections may also be atypical. Serious infections e.g. septicaemia and tuberculous may reach an advanced stage before being recognised, and amebiasis or strongyloidiasis may be activated or exacerbated (exclude before initiating a corticosteroid in those at risk or with suggestive symptoms). Fungal or viral ocular infections may also be exacerbated.

- Chickenpox Unless they have had chickenpox, patients receiving oral or parenteral corticosteroids for purposes other than replacement should be regarded as being at risk of severe chickenpox. Manifestations of fulminant illness include pneumonia, hepatitis and disseminated intravascular coagulation; rash is not necessarily a prominent feature. Passive immunisation with varicella-zoster immunoglobulin is needed for exposed non-immune patients receiving systemic corticosteroids or for those who have used them within the previous 2 months. Confirmed chickenpox warrants specialist care and urgent treatment. Corticosteroids should not be stopped and dosage may need to be increased.

- Measles Patients taking corticosteroids should be advised to take particular care to avoid exposure to measles and to seek immediate medical advice if exposure occurs. Prophylaxis with intramuscular normal immunoglobulin may be needed.

- Psychiatric reactions Systemic corticosteroids, particularly in high doses, are linked to psychiatric reactions including euphoria, insomnia, irritability, mood lability, suicidal thoughts, psychotic reactions, and behavioural disturbances. These reactions frequently subside on reducing the dose or discontinuing the corticosteroid but they may also require specific management. Patients should be advised to seek medical advice if psychiatric symptoms (especially depression and suicidal thoughts) occur and they should also be alert to the rare possibility of such reactions during withdrawal of corticosteroid treatment. Systemic corticosteroids should be prescribed with care in those predisposed to psychiatric reactions, including those who have previously suffered corticosteroid-induced psychosis, or who have a personal or family history of psychiatric disorders.

PREGNANCY The benefit of treatment with corticosteroids during pregnancy outweighs the risk. Corticosteroid cover is required during labour. Following a review of the data on the safety of systemic corticosteroids used in pregnancy and breast-feeding the CSM (May 1998) concluded that corticosteroids vary in their ability to cross the placenta but there is no convincing evidence that systemic corticosteroids increase the incidence of congenital abnormalities such as cleft palate or lip. When administration is prolonged or repeated during pregnancy, systemic corticosteroids increase the risk of intra-uterine growth restriction; there is no evidence of intra-uterine growth restriction following short-term treatment (e.g. prophylactic treatment for neonatal respiratory distress syndrome). Any adrenal suppression in the neonate following prenatal exposure usually resolves spontaneously after birth and is rarely clinically important.

- Monitoring Pregnancy women with fluid retention should be monitored closely when given systemic corticosteroids.

- Breast feeding The benefit of treatment with corticosteroids during breast-feeding outweighs the risk.

- Hepatic impairment In general, manufacturers advise caution (risk of increased exposure).

- Renal impairment Use by oral and injectable routes should be undertaken with caution.

- Monitoring requirements The height and weight of children receiving prolonged treatment with corticosteroids should be monitored annually; if growth is slowed, referral to a paediatrician should be considered.

- Effect on laboratory tests May suppress skin test reactions.

- Treatment cessation The magnitude and speed of dose reduction in corticosteroid withdrawal should be determined on a case-by-case basis, taking into consideration the underlying condition that is being treated, and individual patient factors such as the likelihood of relapse and the duration of corticosteroid treatment. Gradual withdrawal of systemic corticosteroids should be considered in those whose disease is unlikely to relapse and have:
Corticosteroid responsive conditions

- received more than 40 mg prednisolone (or equivalent) daily for more than 1 week or 2 mg/kg daily for 1 week or 1 mg/kg daily for 1 month;
- been given repeat doses in the evening;
- received more than 3 weeks’ treatment;
- recently received repeated courses (particularly if taken for longer than 3 weeks);
- taken a short course within 1 year of stopping long-term therapy;
- other possible causes of adrenal suppression.

Systemic corticosteroids may be stopped abruptly in those whose disease is unlikely to relapse and who have received treatment for 3 weeks or less and who are not included in the patient groups described above. During corticosteroid withdrawal the dose may be reduced rapidly down to physiological doses (equivalent to prednisolone 2–2.5 mg/m² daily) and then reduced more slowly. Assessment of the disease may be needed during withdrawal to ensure that relapse does not occur.

**PATIENT AND CARER ADVICE**

Advice for patients

Patients on long-term corticosteroid treatment should carry a Steroid Treatment Card which gives guidance on minimising risk and provides details of prescriber, drug, dosage and duration of treatment. A patient information leaflet should be supplied to every patient when a systemic corticosteroid is prescribed. Patients should especially be advised of the following:

- **Immunosuppression** Prolonged courses of corticosteroids can increase susceptibility to infection and serious infections can go unrecognised. Unless already immune, patients are at risk of severe chickenpox and should avoid close contact with people who have chickenpox or shingles. Similarly, precautions should also be taken against contracting measles;
- **Adrenal suppression** If the corticosteroid is given for longer than 3 weeks, treatment must not be stopped abruptly. Adrenal suppression can last for a year or more after stopping treatment and the patient must mention the course of corticosteroid when receiving treatment for any illness or injury;
- **Mood and behaviour changes** Corticosteroid treatment, especially with high doses, can alter mood and behaviour early in treatment—the patient can become confused, irritable and suffer from delusion and suicidal thoughts. These effects can also occur when corticosteroid treatment is being withdrawn. Medical advice should be sought if worrying psychological changes occur;
- **Other serious effects** Serious gastro-intestinal, musculoskeletal, and ophthalmic effects which require medical help can also occur.

Steroid treatment cards

Steroid treatment cards should be issued where appropriate. Consider giving a ‘steroid card’ to support communication of the risks associated with treatment, and specific written advice to consider corticosteroid replacement during an episode of stress, such as severe intercurrent illness or an operation, to patients using greater than maximum licensed doses of inhaled corticosteroids. Steroid treatment cards are available for purchase from the NHS Print online ordering portal www.nhsforms.co.uk.

GP practices can obtain supplies through Primary Care Support England. NHS Trusts can order supplies via the online ordering portal.

In Scotland, steroid treatment cards can be obtained from APS Group Scotland by emailing stockorders.dpPas@apsgroup.co.uk or by fax on 0131 629 9967.

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**Betamethasone**

- **DRUG ACTION** Betamethasone has very high glucocorticoid activity and insignificant mineralocorticoid activity.

- **INDICATIONS AND DOSE**

  **Suppression of inflammatory and allergic disorders**

  - **Congenital adrenal hyperplasia**
    - BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
    - Child 1–11 months: Initially 1 mg, repeated up to 4 times in 24 hours according to response
    - Child 1–5 years: Initially 2 mg, repeated up to 4 times in 24 hours according to response
    - Child 6–11 years: Initially 4 mg, repeated up to 4 times in 24 hours according to response
    - Child 12–17 years: 4–20 mg, repeated up to 4 times in 24 hours according to response

- **INTERACTIONS** → Appendix 1: corticosteroids

- **SIDE-EFFECTS** Hiccups, mycotic infarction (following recent myocardial infarction) - oedema - Stevens-Johnson syndrome

- **PREGNANCY** Readily crosses the placenta. Transient effect on fetal movements and heart rate.

- **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion, dilute with Glucose 5% or Sodium Chloride 0.9%.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS 10</th>
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<tr>
<td>&gt; Betamethasone (Non-proprietary)</td>
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</table>

- **Betamethasone (as Betamethasone sodium phosphate) 4 mg per 1 ml**
  - Betamethasone 4mg/1ml solution for injection ampoules
  - 5 ampoule pack £23.93 DT = £23.61

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**Deflazacort**

- **DRUG ACTION** Deflazacort is derived from prednisolone; it has predominantly glucocorticoid activity.

- **INDICATIONS AND DOSE**

  **Inflammatory and allergic disorders**

  - **BY MOUTH**
    - Child 1 month–11 years: 0.25–1.5 mg/kg once daily or on alternate days; increased if necessary up to 2.4 mg/kg daily (max. per dose 120 mg), in emergency situations
    - Child 12–17 years: 3–18 mg once daily or on alternate days; increased if necessary up to 2.4 mg/kg daily (max. per dose 120 mg), in emergency situations

  **Nephrotic syndrome**

  - **BY MOUTH**
    - Child: Initially 1.5 mg/kg once daily (max. per dose 120 mg), reduced to the lowest effective dose for maintenance

- **INTERACTIONS** → Appendix 1: corticosteroids

- **SIDE-EFFECTS**

  - Uncommon Oedema

- **HEPATIC IMPAIRMENT**

  **Dose adjustments** Manufacturer advises adjust to the minimum effective dose.

- **PATIENT AND CARER ADVICE** Patient counselling is advised for deflazacort tablets (steroid card).
**Corticosteroid responsive conditions**

With oral use
For administration by mouth tablets may be dispersed in water or injection solution given by mouth.

With intravenous use
For intravenous infusion dilute with Glucose 5% or Sodium Chloride 0.9%; give over 15–20 minutes.

**PRESCRIBING AND DISPENSING INFORMATION**
Dexamethasone 3.8 mg/mL Injection has replaced dexamethasone 4 mg/mL Injection. All dosage recommendations for intravenous, intramuscular, intrarticular use or local infiltration; are given in units of dexamethasone base.

**PREGNANCY**
Dexamethasone readily crosses the placenta.

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**DIRECTIONS FOR ADMINISTRATION**

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 5, 10

- Calcort (Sanofi)
- Deflazacort 6 mg Calcort 6mg tablets | 60 tablet (POM) £15.82 DT = £15.82

**Dexamethasone**

**DRUG ACTION**
Dexamethasone has very high glucocorticoid activity and insignificant mineralocorticoid activity.

**INDICATIONS AND DOSE**

- **Physiological replacement**
  - By mouth, or by slow intravenous injection
  - Child: 250–500 micrograms/m² every 12 hours, adjusted according to response

- **Suppression of inflammatory and allergic disorders**
  - By mouth
  - Child: 10–100 micrograms/kg daily in 1–2 divided doses, adjusted according to response; up to 300 micrograms/kg daily may be required in emergency situations
  - By intramuscular injection, or by slow intravenous injection, or by intravenous infusion
  - Child 1 month–11 years: 83–333 micrograms/kg daily in 1–2 divided doses; maximum 20 mg per day
  - Child 12–17 years: Initially 0.4–20 mg daily

- **Mild croup**
  - By mouth
  - Child: 150 micrograms/kg for 1 dose

- **Severe croup (or mild croup that might cause complications)**
  - Initially by mouth
  - Child: Initially 150 micrograms/kg for 1 dose, to be given before transfer to hospital, then (by mouth or by intravenous injection) 150 micrograms/kg, then (by mouth or by intravenous injection) 150 micrograms/kg after 12 hours if required

- **Adjunctive treatment of bacterial meningitis (starting before or with first dose of antibacterial)**
  - By slow intravenous injection
  - Child 3 months–17 years: 150 micrograms/kg every 6 hours (max per dose 10 mg) for 4 days

- **Life-threatening cerebral oedema**
  - By intravenous injection
  - Child (body weight up to 35 kg): Initially 16.7 mg, then 3.3 mg every 3 hours for 3 days, then 3.3 mg every 6 hours for 1 day, then 1.7 mg every 6 hours for 4 days, then reduced in steps of 0.8 mg daily
  - Child (body weight 35 kg and above): Initially 20.8 mg, then 3.3 mg every 2 hours for 3 days, then 3.3 mg every 4 hours for 1 day, then 3.3 mg every 6 hours for 4 days, then reduced in steps of 1.7 mg daily

**UNLICENSED USE**
- With intravenous use: Consult product literature; not licensed for use in bacterial meningitis.

**INTERACTIONS** Appendix 1: corticosteroids

**SIDE-EFFECTS**
- With oral use
  - Hiccups - hyperglycaemia - myocardial rupture (following recent myocardial infarction) - protein catabolism
- With parenteral use
  - Perineal irritation (may occur following the intravenous injection of large doses of the phosphate ester)

**Bronchodilator**
Dexamethasone readily crosses the placenta.

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**PRESCRIBING AND DISPENSING INFORMATION**
Dexamethasone 3.8 mg/mL Injection has replaced dexamethasone 4 mg/mL Injection. All dosage recommendations for intravenous, intramuscular, intrarticular use or local infiltration; are given in units of dexamethasone base.

**Patiend and carer advice**
Medicines for Children leaflet: Dexamethasone for croup

www.medicinesforchildren.org.uk/dexamethasone-croup-0

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

**Soluble tablet**

- **Dexamethasone (Non-proprietary)**
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 2 mg Dexamethasone 2mg soluble tablets sugar-free sugar-free | 50 tablet (POM) £30.00–£30.01 DT = £30.01
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 4 mg Dexamethasone 4mg soluble tablets sugar-free sugar-free | 50 tablet (POM) £60.00–£60.01 DT = £60.01
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 8 mg Dexamethasone 8mg soluble tablets sugar-free sugar-free | 50 tablet (POM) £120.00–£120.01 DT = £120.01.

- **Glenisolude (Glenmark Pharmaceuticals Europe Ltd)**
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 2 mg Glenisolude 2mg soluble tablets sugar-free | 50 tablet (POM) £10.00 DT = £10.01
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 4 mg Glenisolude 4mg soluble tablets sugar-free | 50 tablet (POM) £20.00 DT = £60.01
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 8 mg Glenisolude 8mg soluble tablets sugar-free | 50 tablet (POM) £40.00 DT = £120.01

**Tablet**

**CAUTIONARY AND ADVISORY LABELS** 10, 21

- **Dexamethasone 500 microgram**
  - Dexamethasone 500 microgram tablets | 28 tablet (POM) £19.51–£54.24 DT = £10.27 | 30 tablet (POM) £11.00–£64.82

- **Dexamethasone 2 mg**
  - Dexamethasone 2mg tablets | 50 tablet (POM) £49.00 DT = £9.79 | 100 tablet (POM) £17.32–£98.00

- **Dexamethasone 4 mg**
  - Dexamethasone 4mg tablets | 30 tablet (POM) £48.00–£51.00 | 50 tablet (POM) £84.64–£96.00 DT = £84.64 | 100 tablet (POM) £160.00–£170.00

- **Dexamethasone 8 mg**
  - Dexamethasone 8mg tablets | 30 tablet (POM) £65.00–£72.00 DT = £72.00 | 50 tablet (POM) £115.00–£120.00 | 100 tablet (POM) £230.00–£240.00

- **Neofordex (Aspire Pharma Ltd)**
  - Dexamethasone 40 mg Neofordex 40mg tablets | 10 tablet (POM) £200.00 DT = £200.00

Solution for injection

**CAUTIONARY AND ADVISORY LABELS** 10

- **Dexamethasone (Non-proprietary)**
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 3.3 mg per 1 ml Dexamethasone (base) 6.6mg/2ml solution for injection ampoules | 10 ampoule (POM) £22.00 DT = £22.00
  - Dexamethasone (base) 6.6mg/2ml solution for injection vials | 5 vial (POM) £24.00 DT = £24.00
  - Dexamethasone (base) 3.3mg/1ml solution for injection ampoules | 5 ampoule (POM) £12.00 | 10 ampoule (POM) £15.00–£22.78 DT = £22.78
  - Dexamethasone (as Dexamethasone sodium phosphate)
    - 3.8 mg per 1 ml Dexamethasone (base) 3.8mg/1ml solution for injection vials | 10 vial (POM) £19.99–£20.00
Corticosteroid responsive conditions

Oral solution

**CAUTIONARY AND ADVISORY LABELS** 10, 21

- **Dexamethasone (Non-proprietary)**
  - Dexamethasone (as Dexamethasone sodium phosphate) 400 microgram per 1 ml Dexamethasone 2mg/5ml oral solution sugar free sugar-free | 150 ml [POT] £42.30 DT = £42.30
  - Dexamethasone (as Dexamethasone sodium phosphate) 2 mg per 1 ml Dexamethasone 10mg/5ml oral solution sugar free sugar-free | 50 ml [POT] £24.50–£24.95 sugar-free | 150 ml [POT] £101.40 DT = £94.44
  - Dexamethasone (as Dexamethasone sodium phosphate) 4 mg per 1 ml Dexamethasone 20mg/5ml oral solution sugar free sugar-free | 75 ml [POT] £21.15 sugar-free | 150 ml [POT] £42.30 DT = £42.30
  - Dexsol (Rosemont Pharmaceuticals Ltd)
  - Dexamethasone (as Dexamethasone sodium phosphate) 400 microgram per 1 ml Dexsol 2mg/5ml oral solution sugar-free | 456 ml oral solution sugar-free | 90 ml [POT] £44.4
  - Martapan (Martindale Pharmaceuticals Ltd)
  - Dexamethasone (as Dexamethasone sodium phosphate) 400 microgram per 1 ml Martapan 2mg/5ml oral solution sugar-free | 150 ml [POT] £35.96 DT = £42.30

Fludrocortisone acetate

**DRUG ACTION** Fludrocortisone has very high mineralocorticoid activity and insignificant glucocorticoid activity.

- **INDICATIONS AND DOSE**
  - Mineralocorticoid replacement in adrenocortical insufficiency
    - **BY MOUTH**
      - Neonate: Initially 50 micrograms once daily, adjusted according to response; usual dose 50–200 micrograms once daily, higher doses may be required, dose adjustment may be required if salt supplements are administered.
    - Child: Initially 50–100 micrograms once daily; maintenance 50–300 micrograms once daily, adjusted according to response, dose adjustment may be required if salt supplements are administered.

- **INTERACTIONS** → Appendix 1: corticosteroids
- **SIDE-EFFECTS** Conjunctivitis; idiopathic intracranial hypertension; muscle weakness; thrombophlebitis
- **HEPATIC IMPAIRMENT**
- **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: Fludrocortisone for hormone replacement [www.medicinesforchildren.org.uk/fludrocortisone-hormone-replacement]

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension

**Tablet**

- **CAUTIONARY AND ADVISORY LABELS** 10
  - Fludrocortisone acetate (Non-proprietary)
    - Fludrocortisone acetate 100 microgram Fludrocortisone 100microgram tablets | 30 tablet [POT] £13.60 DT = £13.60

Hydrocortisone

**DRUG ACTION** Hydrocortisone has equal glucocorticoid and mineralocorticoid activity.

- **INDICATIONS AND DOSE**
  - Acute adrenocortical insufficiency (Addisonian crisis)
    - **INITIALLY BY SLOW INTRAVENOUS INJECTION**
    - Neonate: Initially 10 mg, then (by continuous intravenous infusion) 100 mg/m² daily, alternatively (by intravenous infusion) 100 mg/m² daily in divided doses, to be given every 6–8 hours; adjusted according to response, when stable reduce over 4–5 days to oral maintenance dose.

  - **BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child 1 month–11 years: Initially 2–4 mg/kg, then 2–4 mg/kg every 6 hours, adjusted according to response, when stable reduce over 4–5 days to oral maintenance dose.
    - Child 12–17 years: 100 mg every 6–8 hours

  - **CONGENITAL ADRENAL HYPERPLASIA**
    - **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
      - Neonate: 9–15 mg/m² in 3 divided doses, adjusted according to response.
      - Child: 9–15 mg/m² in 3 divided doses, adjusted according to response.

  - **ADRENAL HYPOPLASIA** (Addison’s disease, chronic maintenance or replacement therapy)
    - **BY MOUTH USING IMMEDIATE-RELEASE MEDICINES**
      - Neonate: 8–10 mg/m² daily in 3 divided doses, the larger dose to be given in the morning and the smaller in the evening, higher doses may be needed.
      - Child: 8–10 mg/m² daily in 3 divided doses, the larger dose to be given in the morning and the smaller in the evening, higher doses may be needed.

  - **INFLAmMATory BOWEL DISEASE—INDUCTION OF REMISSION**
    - **BY INTRAVENOUS INJECTION**
      - Child 2–17 years: 2.5 mg/kg every 6 hours (max. per dose 100 mg)
      - **BY CONTINUOUS INTRAVENOUS INFUSION**
        - Child 2–17 years: 10 mg/kg daily; maximum 400 mg per day

  - **ULCERATIVE COLITIS** | Proctitis | Proctosigmoiditis
    - **BY INTRAVENOUS INJECTION**
      - Child 2–17 years: Initially 1 metered application 1–2 times a day for 2–3 weeks, then reduced to 1 metered application once daily on alternate days, to be inserted into the rectum

  - **ACUTE HYPERSENSITIVITY REACTIONS** | Angioedema
    - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INJECTION**
      - Child 1–5 months: Initially 25 mg 3 times a day, adjusted according to response.
      - Child 6 months–5 years: Initially 50 mg 3 times a day, adjusted according to response.
      - Child 6–11 years: Initially 100 mg 3 times a day, adjusted according to response.
      - Child 12–17 years: Initially 200 mg 3 times a day, adjusted according to response.

  - **Hypotension resistant to inotropic treatment and volume replacement (limited evidence)**
    - **BY INTRAVENOUS INJECTION**
      - Neonate: Initially 2.5 mg/kg, then 2.5 mg/kg after 4 hours if required, followed by 2.5 mg/kg every 6 hours for 48 hours or until blood pressure recovers, dose to then be reduced gradually over at least 48 hours.

      - Child: 1 mg/kg every 6 hours (max. per dose 100 mg)

  - **Severe acute asthma** | Life-threatening acute asthma
    - **BY INTRAVENOUS INJECTION**
      - Child 1 month–1 year: 4 mg/kg every 6 hours (max. per dose 100 mg), alternatively 25 mg every 6 hours until conversion to oral prednisolone is possible, dose given, preferably, as sodium succinate.
      - Child 2–4 years: 4 mg/kg every 6 hours (max. per dose 100 mg), alternatively 50 mg every 6 hours until
conversion to oral prednisolone is possible, dose given, preferably, as sodium succinate

- Child 5-11 years: 4 mg/kg every 6 hours (max. per dose 100 mg), alternatively 100 mg every 6 hours until conversion to oral prednisolone is possible, dose given, preferably, as sodium succinate
- Child 12-17 years: 4 mg/kg every 6 hours (max. per dose 100 mg), alternatively 100 mg every 6 hours until conversion to oral prednisolone is possible, dose given, preferably, as sodium succinate

### CONTRA-INDICATIONS
- With rectal use Bowel perforation - extensive fistulas - intestinal obstruction - recent intestinal anastomoses
- With oral use Use of injection by mouth is unlicensed.

### IMPORTANT SAFETY INFORMATION

**MHRA/CHM ADVICE: HYDROCORTISONE MUCO-ADHESIVE BUCAL TABLETS - SHOULDN'T BE USED OFF-LABEL FOR ADRENAL INSUFFICIENCY IN CHILDREN DUE TO SERIOUS RISKS (DECEMBER 2018)**

The MHRA has received reports of off-label use of hydrocortisone muco-adhesive buccal tablets for adrenal insufficiency in children.

Healthcare professionals are advised that:
- hydrocortisone muco-adhesive buccal tablets are indicated only for local use in the mouth for aphthous ulceration and should not be used to treat adrenal insufficiency;
- substitution of licensed oral hydrocortisone formulations with muco-adhesive buccal tablets can result in insufficient cortisol absorption and, in stress situations, life-threatening adrenal crisis;
- only hydrocortisone products licensed for adrenal replacement therapy should be used.

### CAUTIONS
- With rectal use Systemic absorption may occur

### INTERACTIONS
- Appendix 1: corticosteroids

### SIDE-EFFECTS
- With oral use Dyslipidaemia - myocardial rupture (following recent myocardial infarction) - oedema
- With parenteral use Hiccups - Kaposi's sarcoma - lipomatosis - myocardial rupture (following recent myocardial infarction)

### DIRECTIONS FOR ADMINISTRATION
- With intravenous use For intravenous administration, dilute with Glucose 5% or Sodium Chloride 0.9%. For intermittent infusion give over 20–30 minutes.
- With oral use For administration by mouth, injection solution may be swallowed [unlicensed use] but consider phosphate content. For Alkindi®, manufacturer advises capsule should be opened and granules either administered directly into the mouth and then followed immediately with a drink, or sprinkled onto a spoonful of soft food (such as yoghurt) and given immediately. Granules should not be chewed or added to liquid before administration due to the bitter taste, and they should not be given via a nasogastric tube.

### PRESCRIBING AND DISPENSING INFORMATION

The RCPCH and NPPG recommend that, when a liquid special of hydrocortisone is required, the following strength is used: 5 mg/5 mL.

### PATIENT AND CARER ADVICE
- With systemic use Patient counselling is advised for hydrocortisone tablets and injections (steroid card).

### NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

SMC No. SMC2088

- With oral use The Scottish Medicines Consortium (October 2018) has advised that hydrocortisone (Alkindi®) is accepted for restricted use within NHS Scotland for the first-line treatment of patients with adrenal insufficiency aged from birth to less than six years of age for whom hydrocortisone must otherwise be individually prepared by manipulation such as by compounding (or crushing) or by production of special solutions in order to produce age-appropriate doses, or hydrocortisone given as off-label buccal tablets. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

- With intravenous use Hydrocortisone as the sodium phosphate is less suitable for prescribing as paraesthesia and pain (particularly in the perineal region) may follow intravenous injection.

### EXCEPTIONS TO LEGAL CATEGORY
- With intramuscular use or intravenous use Prescription only medicine restriction does not apply where administration is for saving life in emergency.

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

#### Granules

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Dose/Strength</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alkindi (Diurnal Ltd)</td>
<td>Hydrocortisone 500 microgram</td>
<td>£33.75</td>
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<tr>
<td>Hydrocortisone 1mg</td>
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<tr>
<td>Hydrocortisone 5mg</td>
<td>£337.50</td>
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</tbody>
</table>

#### Soluble tablet

- Hydrocortisone (Non-proprietary)
  - Hydrocortisone (as Hydrocortisone sodium phosphate) 10 mg Hydrocortison 10mg soluble tablets sugar free sugar-free | 30 tablet | £37.50 |

#### Tablet

- Hydrocortisone (Non-proprietary) 10 mg
  - Hydrocortison 10mg tablets | 30 tablet | £68.18 DT = £20.75 |

#### Powder for solution for injection

- Solu-Cortef (Pfizer Ltd)
  - Hydrocortisone (as Hydrocortisone sodium succinate) 100 mg | 10 vial | £3.17 |

#### Suspension for injection

- Hydrocortistab (Advanz Pharma)
  - Hydrocortisone acetate 25 mg per 1 ml | 1 vial | £1.16 DT = £1.16 |

#### Powder and solvent for solution for injection

- Solu-Cortef (Pfizer Ltd)
  - Hydrocortisone (as Hydrocortisone sodium succinate) 100 mg | 5 ampoule | £10.60 DT = £10.60 |
Methylprednisolone

**DRUG ACTION** Methylprednisolone exerts predominantly glucocorticoid effects with minimal mineralocorticoid effects.

**INDICATIONS AND DOSE**

**Inflammatory and allergic disorders**
- **By mouth, or by slow intravenous injection, or by intravenous infusion**
  - Child: 0.5–1.7 mg/kg daily in 2–4 divided doses, divide doses depending on condition and response

**Treatment of graft rejection reactions**
- **By intravenous injection**
  - Child: 10–20 mg/kg once daily for 3 days, alternatively 400–600 mg/m² once daily (max. per dose 1 g) for 3 days

**Severe erythema multiforme / Lupus nephritis / Systemic onset juvenile idiopathic arthritis**
- **By intravenous injection**
  - Child: 10–30 mg/kg once daily or on alternate days (max. per dose 1 g) for up to 3 doses

**DEPO-MEDRONE**

**Suppression of inflammatory and allergic disorders**
- **By deep intramuscular injection**
  - Child: Seek specialist advice, to be injected into the gluteal muscle

**INDICATIONS**

**Common or very common**
- Diarrhoea
- Severe erythema multiforme
- Lipomatosis

**Rare**
- Myocardial infarction
- Severe erythema multiforme
- Abrupt withdrawal syndrome
- Depression
- Delusions
- Suicidal thoughts

**MEDICATION FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, tablet, injection vials.

**SIDE-EFFECTS**
- Common: glucocorticoid effects with minimal mineralocorticoid effects
- Rare: mild croup, mild withdrawal syndrome, emotional lability

**INTERACTIONS**

**Important Safety Information**

**BNFC 2019–2020**
Autoimmune inflammatory disorders (including juvenile idiopathic arthritis, connective tissue disorders and systemic lupus erythematosus)

- **BY MOUTH**
  - Child: Initially 1–2 mg/kg once daily, to be reduced after a few days if appropriate; maximum 60 mg per day

Autoimmune hepatitis

- **BY MOUTH**
  - Child: Initially 2 mg/kg once daily, to then be reduced to minimum effective dose; maximum 40 mg per day

Corticosteroid replacement therapy

- **BY MOUTH**
  - Child 12–17 years: 2–2.5 mg/m<sup>2</sup> daily in 1–2 divided doses, adjusted according to response

Infantile spasms

- **BY MOUTH**
  - Child 1 month–1 year: Initially 10 mg 4 times a day for 14 days; increased to 20 mg 3 times a day for 7 days if seizures not controlled after initial 7 days, reduce dose gradually over 15 days until stopped

Infantile spasms (dose reduction in patient taking 40 mg daily)

- **BY MOUTH**
  - Child 1 month–1 year: Reduced in steps of 10 mg every 5 days, then stop

Infantile spasms (dose reduction in patient taking 60 mg daily)

- **BY MOUTH**
  - Child 1 month–1 year: Reduced to 40 mg daily for 5 days, then reduced to 20 mg daily for 5 days, then reduced to 10 mg daily for 5 days and then stop

Idiopathic thrombocytopenic purpura

- **BY MOUTH**
  - Child 1–9 years: 1–2 mg/kg daily for maximum of 14 days, alternatively 4 mg/kg daily for a maximum of 4 days

Nephrotic syndrome

- **BY MOUTH**
  - Child: Initially 60 mg/m<sup>2</sup> once daily for 4–6 weeks until proteinuria ceases, then reduced to 40 mg/m<sup>2</sup> once daily on alternate days for 4–6 weeks, then withdraw by reducing dose gradually; maximum 80 mg per day

Nephrotic syndrome (prevention of relapse)

- **BY MOUTH**
  - Child: 0.5–1 mg/kg once daily or on alternate days for 3–6 months

Ulcerative colitis | Crohn’s disease

- **BY MOUTH**
  - Child 2–17 years: 2 mg/kg once daily (max. per dose 60 mg) until remission occurs, followed by reducing doses

Pneumocystis pneumonia in moderate to severe infections associated with HIV infection

- **BY MOUTH**
  - Child: 2 mg/kg daily for 5 days, the dose is then reduced over the next 16 days and then stopped, corticosteroid treatment should ideally be started at the same time as the anti-pneumocystis therapy and certainly no later than 24–72 hours afterwards, the corticosteroid should be withdrawn before anti-pneumocystis treatment is complete; maximum 80 mg per day

Proctitis

- **BY RECTUM USING RECTAL FOAM**
  - Child 12–17 years: 1 metered application 1–2 times a day for 2 weeks, continued for further 2 weeks if good response, to be inserted into the rectum, 1 metered application contains 20 mg prednisolone

- **BY RECTUM USING SUPPOSITORIES**
  - Child 2–17 years: 5 mg twice daily, to be inserted in to the rectum morning and night, after a bowel movement

Distal ulcerative colitis

- **BY RECTUM USING SUPPOSITORIES**
  - Child 12–17 years: 1 metered application 1–2 times a day for 2 weeks, continued for further 2 weeks if good response, to be inserted into the rectum, 1 metered application contains 20 mg prednisolone

Rectal complications of Crohn’s disease

- **BY RECTUM USING SUPPOSITORIES**
  - Child 2–17 years: 5 mg twice daily, to be inserted in to the rectum morning and night, after a bowel movement

**UNLICENSED USE**

- With rectal use Prednisolone rectal foam not licensed for use in children (age range not specified by manufacturer).

**IMPORTANT SAFETY INFORMATION**

**SAFE PRACTICE**

Prednisolone has been confused with propranolol; care must be taken to ensure the correct drug is prescribed and dispensed.

**CONTRA-INDICATIONS**

- With rectal use Bowel perforation· extensive fistulas· intestinal obstruction· recent intestinal anastomoses

**CAUTIONS**

- With rectal use systemic absorption may occur with rectal preparations
- With systemic use Duchenne’s muscular dystrophy (possible transient rhabdomyolysis and myoglobinuria following strenuous physical activity)· systemic sclerosis (increased incidence of scleroderma renal crisis with a daily dose of 15 mg or more)

**INTERACTIONS** → Appendix 1: corticosteroids

**SIDE-EFFECTS**

- With oral use Diarrhoea· dizziness· dyslipidaemia· lipomatosis· protein catabolism· scleroderma renal crisis

**PREGNANCY**

- As it crosses the placenta 88% of prednisolone is inactivated.
  - Monitoring: With systemic use Pregnant women with fluid retention should be monitored closely.

**BREAST FEEDING**

- Prednisolone appears in small amounts in breast milk but maternal doses of up to 40 mg daily are unlikely to cause systemic effects in the infant.
  - Monitoring: With systemic use Infant should be monitored for adrenal suppression if mother is taking a dose higher than 40 mg.

**MONITORING REQUIREMENTS**

- With systemic use Manufacturer advises monitor blood pressure and renal function (s-creatinine) routinely in patients with systemic sclerosis—increased incidence of scleroderma renal crisis.

**PATIENT AND CARER ADVICE**

- Prednisolone (oral) for nephrotic syndrome
  - www.medicinesforchildren.org.uk/prednisolone-oral-nephrotic-syndrome
- Medicines for Children leaflet: Prednisolone for asthma
  - www.medicinesforchildren.org.uk/prednisolone-asthma

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution

**Foam**

- Prednisolone (Non-proprietary)
  - Prednisolone (as Prednisolone sodium metasulphobenzoate) 20 mg per 1 application Prednisolone 20mg/application foam enema | 14 dose (FOAM) £187.00 (47) £187.00
Gastro-resistant tablet

**CAUTIONARY AND ADVISORY LABELS 5, 10, 25**

- Prednisolone (Non-proprietary)
  - Prednisolone 1 mg Prednisolone 1mg gastro-resistant tablets | 30 tablet [POD] £1.60–£1.92 DT = £1.92
  - Prednisolone 2.5 mg Prednisolone 2.5mg gastro-resistant tablets | 28 tablet [POD] £0.93 DT = £0.93 | 30 tablet [POD] £0.98–£6.15
  - Prednisolone 5 mg Prednisolone 5mg gastro-resistant tablets | 28 tablet [POD] £2.34 DT = £0.94 | 30 tablet [POD] £0.96–£6.29

- Deltacortril Enteric (Alliance Pharmaceuticals Ltd)
  - Prednisolone 2.5 mg Deltacortril 2.5mg gastro-resistant tablets | 30 tablet [POD] £1.16
  - Prednisolone 5 mg Deltacortril 5mg gastro-resistant tablets | 30 tablet [POD] £1.19

- Dilacort (Crescent Pharma Ltd, Teva UK Ltd)
  - Prednisolone 2.5 mg Dilacort 2.5mg gastro-resistant tablets | 28 tablet [POD] £1.14–£1.85 DT = £0.93
  - Prednisolone 5 mg Dilacort 5mg gastro-resistant tablets | 28 tablet [POD] £1.45–£1.85 DT = £0.94

Soluble tablet

**CAUTIONARY AND ADVISORY LABELS 10, 13, 21**

- Prednisolone (Non-proprietary)
  - Prednisolone (as Prednisolone sodium phosphate) 5 mg Prednisolone 5mg soluble tablets | 30 tablet [POD] £53.48 DT = £17.27

- Soluble tablet

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<tr>
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| Suppository
  - Prednisolone (Non-proprietary)
    - Prednisolone (as Prednisolone sodium phosphate) 5 mg Prednisolone sodium phosphate 5mg suppositories | 10 suppository [POD] £70.73 DT = £69.79 |

Oral solution

**CAUTIONARY AND ADVISORY LABELS 10**

- Prednisolone (Non-proprietary)
  - Prednisolone 1 mg per 1 ml Prednisolone 5mg/5ml oral solution unit dose | 10 unit dose [POD] £11.41 DT = £11.41
  - Prednisolone 1 mg per 1 ml Prednisolone 10mg/1ml oral solution sugar free sugar-free | 30 ml [POD] £55.50 DT = £55.50

2.1 Cushing’s syndrome and disease

**Cushing’s Syndrome**

**Management**

Most types of Cushing’s syndrome are treated surgically. Metyrapone p. 461 may be useful to control the symptoms of the disease or to prepare the child for surgery. The dosages of metyrapone used are either low, and tailored to cortisol production, or high, in which case corticosteroid replacement therapy is also needed.

Ketoconazole below may have a direct effect on corticotropic tumour cells in patients with Cushing’s disease. It is used under specialist supervision in children over 12 years for treatment of endogenous Cushing’s syndrome.

**ENZYME INHIBITORS**

**Ketoconazole**

- **DRUG ACTION** An imidazole derivative which acts as a potent inhibitor of cortisol and aldosterone synthesis by inhibiting the activity of 17α-hydroxylase, 11-hydroxylation steps and at higher doses the cholesterol side-chain cleavage enzyme. It also inhibits the activity of adrenal C17-20 lyase enzymes resulting in androgen synthesis inhibition, and may have a direct effect on corticotrophic tumour cells in patients with Cushing’s disease.

- **INDICATIONS AND DOSE**
  - **Endogenous Cushing’s syndrome (specialist use only)**
    - **BY MOUTH**
      - Child 12-17 years: Initially 400–600 mg daily in 2–3 divided doses, increased to 800–1200 mg daily; maintenance 400–800 mg daily in 2–3 divided doses, for dose titrations in patients with established dose, adjustments in adrenal insufficiency, or concomitant corticosteroid replacement therapy, consult product literature; maximum 1200 mg per day

- **CONTRA-INDICATIONS** Acquired QTc prolongation. Acute porphyrias p. 624 – avoid concomitant use of hepatotoxic drugs – congenital QTc prolongation

- **CAUTIONS** Pre-treatment liver enzymes should not exceed 2 times the normal upper limit - risk of adrenal insufficiency

- **INTERACTIONS** → Appendix 1: antifungals, azoles

- **SIDE-EFFECTS**
  - **Common or very common** Adrenal insufficiency - diarrhoea - gastrointestinal discomfort - nausea - skin reactions - vomiting
  - **Uncommon** Allergic conditions - alopecia - angioedema - asthenia - dizziness - drowsiness - headache - thrombocytopenia
  - **Rare or very rare** Fever - hepatic disorders - taste altered
  - **Frequency not known** Alcohol intolerance - appetite abnormal - arthralgia - azoospermia - dry mouth - epistaxis - flatulence -fontanelle bulging - glycaemostasis - hot flush - insomnia - intracranial pressure increased - malaise - menstrual disorder - myalgia - nervousness - papilloedema - paraesthesia - peripheral oedema - photosensitivity reaction - tongue discolouration

**SIDE-EFFECTS, FURTHER INFORMATION** Potentially life-threatening hepatotoxicity reported rarely with oral use.

- **CONCEPTION AND CONTRACEPTION** Effective contraception must be used in women of child-bearing potential.

- **PREGNANCY** Manufacturer advises avoid—teratogenic in animal studies.

- **BREAST FEEDING** Manufacturer advises avoid—present in breast milk.

- **HEPATIC IMPAIRMENT** Manufacturer advises avoid.

- **MONITORING REQUIREMENTS**
  - Monitor ECG before and one week after initiation, and then as clinically indicated thereafter.
  - Adrenal insufficiency Monitor adrenal function within one week of initiation, then regularly thereafter. When cortisol levels are normalised or close to target and effective dose
established, monitor every 3–6 months as there is a risk of autoimmune disease development or exacerbation after normalisation of cortisol levels. If symptoms suggestive of adrenal insufficiency such as fatigue, anorexia, nausea, vomiting, hypotension, hypoponatremia, hyperkalaemia, and/or hypoglycaemia occur, measure cortisol levels and discontinue treatment temporarily (can be resumed thereafter at lower dose) or reduce dose and if necessary, initiate corticosteroid substitution.

- Hepatotoxicity Monitor liver function before initiation of treatment, then weekly for 1 month after initiation, then monthly for 6 months—more frequently if dose adjusted or abnormal liver function detected. Reduce dose if liver enzymes increase less than 3 times the normal upper limit—consult product literature; if liver enzymes are raised to 3 times or greater the normal upper limit, discontinue treatment permanently.

- PATIENT AND CARER ADVICE Patients or their carers should be told how to recognise signs of liver disorder, and advised to discontinue treatment and seek prompt medical attention if symptoms such as anorexia, nausea, vomiting, fatigue, jaundice, abdominal pain, or dark urine develop. Patients or their carers should also be told how to recognise signs of adrenal insufficiency.

- Driving and skilled tasks Dizziness and somnolence may affect the performance of skilled tasks (e.g. driving).

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

- Tablet
  - CAUTIONARY AND ADVISORY LABELS 2, 5, 21
  - Ketoconazole (non-proprietary)
  - Ketoconazole 200 mg
  - 60 tablet | £480.00 DT + £480.00

Metyrapone

- DRUG ACTION Metyrapone is a competitive inhibitor of 11β-hydroxylation in the adrenal cortex; the resulting inhibition of cortisol (and to a lesser extent aldosterone) production leads to an increase in ACTH production which, in turn, leads to increased synthesis and release of cortisol precursors. Metyrapone may be used as a test of adrenal function.

- INDICATIONS AND DOSE
  - Differential diagnosis of ACTH-dependent Cushings syndrome (specialist supervision in hospital)
    - BY MOUTH
    - Child: 15 mg/kg every 4 hours for 6 doses, alternatively 300 mg/m² every 4 hours for 6 doses; usual dose 250–750 mg every 4 hours
  - Management of Cushings syndrome (specialist supervision in hospital)
    - BY MOUTH
    - Child: Usual dose 0.25–6 g daily, dose to be tailored to cortisol production, dose is either low, and tailored to cortisol production, or high, in which case corticosteroid replacement therapy is also needed

- CONTRA-INDICATIONS Adrenocortical insufficiency

- CAUTIONS Avoid in Acute porphyria p. 624 - gross hypopituitarism (risk of precipitating acute adrenal failure) - hypotension on long-term administration - hypothryoidism (delayed response)

- INTERACTIONS → Appendix 1: metyrapone

- SIDE-EFFECTS
  - Common or very common Dizziness - headache - hypotension - nausea - sedation - vomiting
  - Rare or very rare Abdominal pain - adrenal insufficiency - allergic dermatitis - hirsutism

- FREQUENCY NOT KNOWN Alopeia - bone marrow failure - hypertension

- PREGNANCY Avoid (may impair biosynthesis of fetal-placental steroids).

- BREAST FEEDING Avoid—no information available.

- HEPATIC IMPAIRMENT Manufacturer advises caution (risk of delayed response).

- PATIENT AND CARER ADVICE Driving and skilled tasks Drowsiness may affect the performance of skilled tasks (e.g. driving).

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

- Capsule
  - CAUTIONARY AND ADVISORY LABELS 21
  - Metyrapone (HRA Pharma UK Ltd)
  - Metyrapone 250 mg Metopirone 250mg capsules | 100 capsule [POD] £363.66 DT + £363.66

3 Diabetes mellitus and hypoglycaemia

3.1 Diabetes mellitus

Diabetes

Description of condition

Diabetes mellitus is a group of metabolic disorders in which persistent hyperglycaemia is caused by deficient insulin secretion or by resistance to the action of insulin. This leads to the abnormalities of carbohydrate, fat, and protein metabolism that are characteristic of diabetes mellitus.

Type 1 diabetes p. 462 mellitus and Type 2 diabetes p. 465 mellitus are the two most common classifications of diabetes. Other common types of diabetes are gestational diabetes (develops during pregnancy and resolves after delivery) and secondary diabetes (may be caused by pancreatic damage, hepatic cirrhosis, or endocrine disease). Treatment with endocrine, antiviral or antipsychotic drugs may also cause secondary diabetes. In children, conditions such as cystic fibrosis can lead to diabetes; monogenic diabetes (previously known as maturity onset diabetes in the young) can also occur due to a single gene defect.

Driving

Information on the requirements for driving vehicles by young people receiving treatment for diabetes is available in the BNF or from the DVLA at www.gov.uk/guidance/diabetes-mellitus-assessing-fitness-to-drive.

Alcohol

Adolescents and their carers should be made aware that alcohol can make the signs of hypoglycaemia less clear, and can cause delayed hypoglycaemia; (note: specialist sources recommend that adult patients with diabetes should drink alcohol only in moderation, and when accompanied by food).

Oral glucose tolerance tests

The oral glucose tolerance test is used mainly for diagnosis of impaired glucose tolerance; it is not recommended or necessary for routine diagnostic use of diabetes when severe symptoms of hyperglycaemia are present. In children who have less severe symptoms and blood-glucose levels that do not establish or exclude diabetes (e.g. impaired fasting glycaemia), an oral glucose tolerance test may be required. It may be useful for diagnosis of monogenic diabetes or cystic fibrosis related diabetes, and is used to establish the presence of gestational diabetes.
**Type 1 diabetes**

**Description of condition**

Type 1 diabetes describes an absolute insulin deficiency in which there is little or no endogenous insulin secretory capacity due to destruction of insulin-producing beta-cells in the pancreatic islets of Langerhans. This form of the disease has an auto-immune basis in most cases, and it can occur at any age, but most commonly before adulthood. Loss of insulin secretion results in hyperglycaemia and other metabolic abnormalities. If poorly managed, the resulting tissue damage has both short-term and long-term adverse effects on health; this can result in retinopathy, nephropathy, premature cardiovascular disease, and peripheral artery disease.

Typical features in children presenting with type 1 diabetes are hyperglycaemia, polyuria, polydipsia, weight loss, and excessive tiredness.

**Aims of treatment**

Treatment is aimed at using insulin regimens to achieve as optimal a level of blood-glucose control as is feasible, while avoiding or reducing the frequency of hypoglycaemic episodes, in order to minimise the risk of long-term microvascular and macrovascular complications. Disability from complications can often be prevented by early detection and active management of the disease (Diabetic complications p. 466).

The target for glycaemic control should be individualised for each child, considering factors such as daily activities, aspirations, likelihood of complications, adherence to treatment, comorbidities, and history of hypoglycaemia. Tighter control of blood-glucose is now recommended for children with type 1 diabetes and treatment should attempt to reach near normal HbA1c and blood-glucose concentration. A target HbA1c concentration of 48 mmol/mol (6.5%) or lower is recommended in children to minimise the risk of long-term complications. The optimal plasma glucose targets for children are:

- fasting blood-glucose concentration of 4–7 mmol/litre on waking;
- a blood-glucose concentration of 4–7 mmol/litre before meals at other times of the day;
- a blood-glucose concentration of 5–9 mmol/litre after meals;
- a blood-glucose concentration of at least 5 mmol/litre in young people when driving.

**Overview**

Type 1 diabetes requires insulin replacement, supported when necessary by active management of other associated cardiovascular risk factors such as hypertension. Tight glycaemic control may be achieved by intensive insulin management (multiple daily injections or insulin pump therapy) from diagnosis, accompanied by carbohydrate counting.

The effectiveness of metformin in combination with insulin is not yet known in children, and so should not be used; other oral antidiabetic drugs should not be used in combination with insulin as their use may increase the risk of hypoglycaemia.

Dietary control is important in both type 1 and type 2 diabetes and children (with their families) should be encouraged to develop good knowledge of nutrition and how it affects their diabetes and insulin requirements. Healthy eating, regular exercise, and control of body-weight can reduce cardiovascular risk and help improve glycaemic control.

Children with type 1 diabetes over the age of 6 months should receive immunisation against influenza and pneumococcal infection (in children treated with...
antidiabetic drugs)—see Influenza vaccine p. 806 and Pneumococcal vaccine p. 809.  

Insulin therapy in type 1 diabetes

All children with type 1 diabetes require insulin therapy (see also Insulin p. 464). Treatment should be initiated and managed by clinicians with relevant expertise; there are three basic types of insulin regimen, although each regimen should be individualised.

Children should also be offered carbohydrate-counting training as part of a structured education programme.  

Multiple daily injection basal-bolus insulin regimens

One or more separate daily injections of intermediate-acting insulin or long-acting insulin analogue as the basal insulin; alongside multiple bolus injections of short-acting insulin before meals. This regimen offers flexibility to tailor insulin therapy with the carbohydrate load of each meal.

Mixed (biphasic) regimen

One, two, or three insulin injections per day of short-acting insulin mixed with intermediate-acting insulin. The insulin preparations may be mixed by the patient at the time of injection, or a premixed product can be used.

Continuous subcutaneous insulin infusion (insulin pump)

A regular or continuous amount of insulin (usually in the form of a rapid-acting insulin analogue or soluble insulin), delivered by a programmable pump and insulin storage reservoir via a subcutaneous needle or cannula.

Recommended insulin regimens

Children should be offered multiple daily injection basal-bolus regimens initiated at diagnosis, considering personal and family circumstances, and personal preferences. Children and their carers should be encouraged to adjust the insulin dose as appropriate after each blood-glucose measurement, and to inject rapid-acting insulin analogues before eating (rather than after eating); this reduces blood-glucose concentrations after meals and helps to optimise blood-glucose control.

If a multiple daily injection basal-bolus insulin regimen is unsuitable, or the child does not have optimal blood-glucose control, it may be necessary to offer an alternative insulin regimen (either continuous subcutaneous insulin infusion or once-, twice- or three-times daily mixed injections) as well as additional support (such as increased contact with their specialist diabetes team).

Continuous subcutaneous insulin infusion (or insulin pump) therapy may be considered under the care of a specialist team. It should only be offered to children over 12 years who suffer disabling hypoglycaemia, or, who have high HbA1c concentrations (69 mmol/mol [8.5%] or above) with multiple daily injection therapy (including, if appropriate, the use of long-acting insulin analogues) despite a high level of care. Children under 12 years may be offered insulin pump therapy if a multiple daily injection regimen is impractical or inappropriate, but they should undergo a trial of a multiple dose injection regimen between the ages of 12 and 18 years.

If the chosen regimen is a twice daily injection regimen, the insulin dose should be adjusted according to the general trend in pre-meal, bedtime and occasional night-time blood-glucose concentration.  

Insulin requirements

The dosage of insulin must be determined individually for each child and should be adjusted as necessary according to the results of regular monitoring of blood-glucose concentrations.

Prescribers and patients should be aware that initiation of insulin may be followed by a temporary partial remission phase or ‘honeymoon period’ when lower doses of insulin are required than are subsequently necessary to maintain glycaemic control with an HbA1c concentration of less than 48 mmol/mol (6.5%).  

Insulin doses should be reviewed after puberty (around 1 year after menarche or after the growth spurt in boys) as insulin resistance falls after puberty, and maintenance of pubertal doses may increase the risk for excessive weight gain.  

Persistent poor glucose control, leading to erratic insulin requirements or episodes of hypoglycaemia, may be due to many factors, including adherence, injection technique, injection site problems, blood-glucose monitoring skills, lifestyle issues (including diet and exercise), psychological issues, and organic causes such as renal disease, thyroid disorders, coeliac disease, Addison’s disease or gastroparesis.  

A review of the child’s injection sites should be offered at each clinic visit.  

Infection, stress, accidental or surgical trauma, and puberty may all increase the required insulin dose. Insulin requirements may be decreased (and therefore susceptibility to hypoglycaemia increased) by physical activity, intercurrent illness, reduced food intake, and in certain endocrine disorders, such as anterior pituitary or adrenocortical insufficiency and hypothyroidism.

Rapid-acting insulin analogues should be supplied for use during intercurrent illness and episodes of hypoglycaemia.  

Risks of hypoglycaemia with insulin

Hypoglycaemia is an inevitable adverse effect of insulin treatment, and children and their carers should be advised of the warning signs and actions to take (for guidance on management, see Hypoglycaemia p. 482).  

Impaired awareness of hypoglycaemia can occur, when the ability to recognise usual symptoms is lost, or when the symptoms are blunted or no longer present.  

AWARENESS of hypoglycaemia should be discussed and assessed with the child and their carer approximately every 3 months.  

An increase in the frequency of hypoglycaemic episodes may reduce the warning symptoms experienced by the child. Impaired awareness of symptoms below 3 mmol/litre is associated with a significantly increased risk of severe hypoglycaemia. Beta-blockers can also blunt hypoglycaemic awareness, by reducing warning signs such as tremor.

Loss of warning of hypoglycaemia among insulin-treated children can be a serious hazard, especially for adolescents who are drivers, cyclists, or in dangerous occupations.

Advice should be given in line with the Driver and Vehicle Licensing Agency (DVLA) guidance (see Driving, under Diabetes p. 461).  

To restore the warning signs, episodes of hypoglycaemia must be minimised. Insulin regimens, doses and blood-glucose targets should be reviewed and continuous subcutaneous insulin infusion therapy and real-time continuous glucose monitoring should be considered.

Children and their carers should receive structured education to ensure they are following the principles of a flexible insulin regimen correctly, with additional education regarding avoiding and treating hypoglycaemia for those who continue to have impaired awareness. If recurrent severe episodes of hypoglycaemia continue despite appropriate interventions, the child should be referred to a specialist centre.  

Manufacturers advise any switch between brands or formulation of insulin (including switching from animal to human insulin) should be done under strict supervision; a change in dose may be required.

Hyodermic equipment

Children and their carers should be advised on the safe disposal of lancets, single-use syringes, and needles, and should be provided with suitable disposal containers.
Arrangements should be made for the suitable disposal of these containers.

Lancets, needles, syringes, and accessories are listed under Hypodermic Equipment in Part IXA of the Drug Tariff (Part III of the Northern Ireland Drug Tariff, Part 3 of the Scottish Drug Tariff). The drug Tariffs can be accessed online at:

- Health and Personal Social Services for Northern Ireland Drug Tariff: www.hscbusiness.hscni.net/services/2034.htm
- Scottish Drug Tariff: www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff

Advanced Pharmacy Services

Patients with type 1 diabetes may be eligible for the Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

Useful Resources


Insulin

Overview

For recommended insulin regimens see Type 1 diabetes p. 462 and Type 2 diabetes p. 465.

Insulin is a polypeptide hormone secreted by pancreatic beta-cells. Insulin increases glucose uptake by adipose tissue and muscles, and suppresses hepatic glucose release. The role of insulin is to lower blood-glucose concentrations in order to prevent hyperglycaemia and its associated microvascular, macrovascular and metabolic complications.

The natural profile of insulin secretion in the body consists of basal insulin (a low and steady secretion of background insulin that controls the glucose continuously released from the liver) and meal-time bolus insulin (secreted in response to glucose absorbed from food and drink).

Sources of insulin

Three types of insulin are available in the UK: human insulin, human insulin analogues, and animal insulin. Animal insulins are extracted and purified from animal sources (bovine or porcine insulin). Although widely used in the past, animal insulins are no longer initiated in people with diabetes but may still be used by some adult patients who cannot, or do not wish to, change to human insulins.

Human insulins are produced by recombinant DNA technology and have the same amino acid sequence as endogenous human insulin. Human insulin analogues are produced in the same way as human insulins, but the insulin is modified to produce a desired kinetic characteristic, such as an extended duration of action or faster absorption and onset of action.

Immunological resistance to insulin is uncommon and true insulin allergy is rare. Human insulin and insulin analogues are less immunogenic than animal insulins.

Administration of insulin

Insulin is inactivated by gastro-intestinal enzymes and must therefore be given by injection; the subcutaneous route is ideal in most circumstances. Insulin should be injected into a body area with plenty of subcutaneous fat—usually the abdomen (fastest absorption rate) or outer thighs/buttocks (slower absorption compared with the abdomen or inner thighs).

Absorption from a limb site can vary considerably (by as much as 20–40%) day-to-day, particularly in children. Local tissue reactions, changes in insulin sensitivity, injection site, blood flow, depth of injection, and the amount of insulin injected can all affect the rate of absorption. Increased blood flow around the injection site due to exercise can also increase insulin absorption.

Lipohypertrophy can occur due to repeatedly injecting into the same small area, and can cause erratic absorption of insulin, and contribute to poor glycaemic control. Patients should be advised not to use affected areas for further injection until the skin has recovered.

Lipohypertrophy can be minimised by using different injection sites in rotation. Injection sites should be checked for signs of infection, swelling, bruising, and lipohypertrophy before administration.

Insulin preparations

Insulin preparations can be broadly categorised into three groups based on their time-action profiles: short-acting insulins (including soluble insulin and rapid-acting insulins), intermediate-acting insulins and long-acting insulins. The duration of action of each particular type of insulin varies considerably from one patient to another, and needs to be assessed individually.

Short-acting insulins

Short-acting insulins have a short duration and a relatively rapid onset of action, to replicate the insulin normally produced by the body in response to glucose absorbed from a meal. These are available as soluble insulin (human and, bovine or porcine—both rarely used), and the rapid-acting insulin analogues (insulin aspart p. 472, insulin glulisine p. 473 and insulin lispro p. 473).

Soluble insulin

Soluble insulin is usually given subcutaneously but some preparations can be given intravenously and intramuscularly. For maintenance regimens, it is usual to inject the insulin 15 to 30 minutes before meals, depending on the insulin preparation used.

When injected subcutaneously, soluble insulin has a rapid onset of action (30 to 60 minutes), a peak action between 1 and 4 hours, and a duration of action of up to 9 hours.

When injected intravenously, soluble insulin has a short half-life of only a few minutes and its onset of action is instantaneous.

Soluble insulin administered intravenously is the most appropriate form of insulin for use in diabetic emergencies e.g. Diabetic ketoacidosis p. 466 and peri-operatively.

Rapid-acting insulin

Insulin aspart, insulin glulisine, and insulin lispro have a faster onset of action (within 15 minutes) and shorter duration of action (approximately 2–5 hours) than soluble insulin, and are usually given by subcutaneous injection.

For maintenance regimens, these insulins should ideally be injected immediately before meals. Rapid-acting insulin, administered before meals, has an advantage over short-acting soluble insulin in terms of improved glucose control, reduction of HbA1c, and reduction in the incidence of severe hypoglycaemia, including nocturnal hypoglycaemia.

The routine use of post-meal injections of rapid-acting insulin should be avoided—when given during or after meals, they are associated with poorer glucose control, an increased risk of high postprandial-glucose concentration, and subsequent hypoglycaemia.

Intermediate-acting insulin

Intermediate-acting insulins (isophane insulin p. 474) have an intermediate duration of action, designed to mimic the effect of endogenous basal insulin. When given by subcutaneous injection, they have an onset of action of
Lifestyle interventions such as diet and exercise, from the achieving glycaemic control in children, therefore resulting in hyperglycaemia. Insulin production also occurs progressively over time, characterised by insulin resistance. Insufficient pancreatic insulin can be supplied (biphasic isophane insulin p. 474, biphasic insulin aspart p. 475 and biphasic insulin lispro p. 475).

Biphasic insulins (biphasic isophane insulin, biphasic insulin aspart, biphasic insulin lispro) are pre-mixed insulin preparations containing various combinations of short-acting insulin (soluble insulin or rapid-acting analogue insulin) and an intermediate-acting insulin.

The percentage of short-acting insulin varies from 15% to 50%. These preparations should be administered by subcutaneous injection immediately before a meal.

**Long-acting insulin**

Like intermediate-acting insulins, the long-acting insulins (protamine zinc insulin p. 477, insulin zinc suspension p. 476, insulin detemir p. 476, insulin glargine p. 476, insulin degludec p. 475) mimic endogenous basal insulin secretion, but their duration of action may last up to 36 hours. They achieve a steady-state level after 2–4 days to produce a constant level of insulin.

Insulin glargine and insulin degludec are given once daily and insulin detemir is given once or twice daily according to individual requirements. The older long-acting insulins, (insulin zinc suspension and protamine zinc insulin) are now rarely prescribed.

### Type 2 diabetes

**Description of condition**

Type 2 diabetes is a chronic metabolic condition characterised by insulin resistance. Insufficient pancreatic insulin production also occurs progressively over time, resulting in hyperglycaemia. Type 2 diabetes in children is associated with increased body-weight, increased risk of renal complications, hypertension, and dyslipidaemia; therefore it increases cardiovascular risk. It is associated with long-term microvascular and macrovascular complications, together with reduced quality of life and life expectancy.

Type 2 diabetes typically develops later in life but is increasingly diagnosed in children, despite previously being considered a disease of adulthood.

**Aims of treatment**

Treatment is aimed at minimising the risk of long-term microvascular and macrovascular complications by effective blood-glucose control and maintenance of HbA1c at or below the target value set for each individual child.

**Overview**

Lifestyle modifications (including weight loss, smoking cessation and regular exercise) can help to reduce both hyperglycaemia and cardiovascular risk and should be encouraged where appropriate. Children and their carers should also receive advice from a paediatric dietitian to help optimise body-weight and blood-glucose control.

Lifestyle modifications alone are often unsuccessful at achieving glycaemic control in children, therefore antidiabetic drugs should be offered and initiated alongside lifestyle interventions such as diet and exercise, from the time of diagnosis.

Children with type 2 diabetes should receive immunisation against influenza (over the age of 6 months) and pneumococcal infection—see Influenza vaccine p. 806 and Pneumococcal vaccine p. 809.

### Antidiabetic drugs

In children, type 2 diabetes does not usually occur until adolescence and information on the use of oral antidiabetic drugs in children is limited. For recommended treatment regimens and the place in therapy of each drug, see *Treatment of type 2 diabetes*.

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**Treatment with antidiabetic drugs should be initiated under specialist supervision only.**

Metformin hydrochloride p. 468 is the only oral antidiabetic drug licensed for use in children. It has an anti-hyperglycaemic effect, lowering both basal and postprandial blood-glucose concentrations. Metformin hydrochloride does not stimulate insulin secretion and therefore, when given alone, does not cause hypoglycaemia.

**The dose of standard-release metformin hydrochloride should be increased gradually to minimise the risk of gastro-intestinal side-effects.**

There is little experience of the use of other non-insulin antidiabetic drugs in children, with most evidence extrapolated from adult studies.

Several sulfonylureas (such as gliclazide p. 470, glibenclamide p. 469 and tolbutamide p. 470) are available but experience in children is limited; they are not the recommended choice of treatment in children; therefore treatment should be initiated by a specialist. The sulfonylureas may cause hypoglycaemia which may be more common in children than in adults. Hypoglycaemia is more likely with long-acting sulfonylureas such as glibenclamide, which has been associated with severe, prolonged and sometimes fatal cases—for this reason sulfonylureas are usually avoided in children.

**Treatment of type 2 diabetes**

A target HbA1c concentration of 48 mmol/mol (6.5%) or lower is ideal to minimise the risk of long-term complications, however an individualised lowest achievable target should be agreed with each child and their carers taking into account factors such as daily activities, individual life goals, complications, and comorbidities. HbA1c concentrations should be monitored every 3 months.

**Note:** Consider relaxing the target HbA1c level on a case-by-case basis, with particular consideration for children where tight blood-glucose control is not appropriate or poses a high risk of the consequences of hypoglycaemia.

Standard-release metformin hydrochloride is the first-line choice for initial treatment in children and should be offered from diagnosis, alongside nutrition and lifestyle advice.

If the combination of lifestyle changes and metformin hydrochloride fails to reduce HbA1c to the agreed target within 3 to 4 months of therapy, addition of a long-acting insulin or once-daily human isophane insulin p. 474 should be considered (see also, Insulin p. 464).

**Initiation of insulin should be under specialist care.**

**Metformin hydrochloride should be continued alongside insulin, to improve insulin sensitivity.**

The combination of metformin hydrochloride and once-daily insulin is usually an effective treatment for maintaining glycaemic control in the majority of children for extended periods of time.

If the combination of basal insulin and metformin does not achieve the HbA1c target (and postprandial hyperglycaemia persists) addition of prandial rapid- or short-acting insulin should be initiated and titrated until the target HbA1c is met.

**Weight gain may occur and can be particularly problematic in children with type 2 diabetes when insulin therapy is initiated, unless there is careful attention and...**
adherence to dietary measures. The importance of diet and exercise should be emphasised.

**Advanced Pharmacy Services**

Children with type 2 diabetes may be eligible for the New Medicines Service / Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

**Useful Resources**


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**Diabetic complications**

See also

Diabetes p. 461
  - Type 1 diabetes p. 462
  - Type 2 diabetes p. 465

**Diabetes and cardiovascular disease**

Diabetes is a strong risk factor for cardiovascular disease later in life. Other risk factors for cardiovascular disease that should also be addressed are: smoking, hypertension, obesity and dyslipidaemia. The use of an ACE inhibitor (or an angiotensin-II receptor antagonist) and lipid-regulating drugs can be beneficial in children with diabetes and a high cardiovascular disease risk. ACE inhibitors and angiotensin-II receptor antagonists may also have a role in the management of diabetic nephropathy. For guidance on stopping smoking, see Smoking cessation p. 304.

**Diabetic nephropathy**

In diabetic children with nephropathy, blood pressure should be reduced to the lowest achievable level to slow the rate of decline of glomerular filtration rate and reduce proteinuria. Microalbuminuria can occur transiently during puberty. Provided there are no contra-indications, all diabetic children with nephropathy causing proteinuria or with established microalbuminuria should be treated with an ACE inhibitor or an angiotensin-II receptor antagonist, even if the blood pressure is normal. ACE inhibitors or angiotensin-II receptor antagonists should also be given as monotherapy, or combined therapy, in children with chronic kidney disease and proteinuria, to reduce the rate of progression of chronic kidney disease.

ACE inhibitors can potentiate the hypoglycaemic effect of insulin and oral antidiabetic drugs; this effect is more likely during the first weeks of combined treatment and in children with renal impairment. See also treatment of hypertension in diabetes in Hypertension p. 100.

**Diabetic neuropathy**

Clinical neuropathy is rare in children whose diabetes is well controlled.

**Visual impairment**

Optimal diabetic control (HbA1c ideally around 7% or 53 mmol/mol) and blood pressure control (<130/80 mmHg) should be maintained to prevent onset and progression of diabetic eye disease.

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**Diabetic ketoacidosis**

**Management**

The management of diabetic ketoacidosis involves the replacement of fluid and electrolytes and the administration of insulin. Guidelines for the Management of Diabetic Ketoacidosis, published by the British Society of Paediatric Endocrinology and Diabetes, (available at www.bsped.org.uk) should be followed. Clinically well children with mild ketoacidosis who are dehydrated up to 5% usually respond to oral rehydration and subcutaneous insulin. For those who do not respond, or are clinically unwell, or are dehydrated by more than 5%, insulin and replacement fluids are best given by intravenous infusion.

- To restore circulating volume for children in shock, give 10 mL/kg sodium chloride 0.9% as a rapid infusion, repeat as necessary up to a maximum of 30 mL/kg.
- Further fluid should be given by intravenous infusion at a rate that replaces deficit and provides maintenance over 48 hours; initially use sodium chloride 0.9%, changing to sodium chloride 0.45% and glucose 5% after 12 hours if response is adequate and plasma-sodium concentration is stable.
- Include potassium chloride in the fluids unless anuria is suspected, adjust according to plasma-potassium concentration.
- Insulin infusion is necessary to switch off ketogenesis and reverse acidosis; it should not be started until at least 1 hour after the start of intravenous rehydration fluids.
- **Soluble insulin should be diluted (and mixed thoroughly) with sodium chloride 0.9% intravenous infusion to a concentration of 1 unit/mL and infused at a rate of 0.1 units/kg/hour.**
- **Sodium bicarbonate** infusion (1.26% or 2.74%) is rarely necessary and is used only in cases of extreme acidosis (blood pH less than 6.9) and shock, since the acid-base disturbance is normally corrected by treatment with insulin.
- Once blood glucose falls to 14 mmol/litre, **glucose intravenous infusion 5% or 10% should be added to the fluids.**
- The insulin infusion rate can be reduced to no less than 0.05 units/kg/hour when blood-glucose concentration has fallen to 14 mmol/litre and blood pH is greater than 7.3 and a glucose infusion has been started; it is continued until the child is ready to take food by mouth. Subcutaneous insulin can then be started.
- The insulin infusion should not be stopped until 1 hour after starting subcutaneous soluble or long acting insulin, or 10 minutes after starting subcutaneous insulin aspart p. 472, or insulin glulisine p. 473, or insulin lispro p. 473.
- Hyperosmolar hyperglycaemic state or hyperosmolar hyperglycaemic nonketotic coma occurs rarely in children. Treatment is similar to that of diabetic ketoacidosis, although lower rates of insulin infusion and slower rehydration may be required.

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**Diabetes, surgery and medical illness**

**Management of diabetes during surgery**

Children with diabetes should undergo surgery in centres with facilities and expertise for the care of children with diabetes. Detailed local protocols should be available to all healthcare professionals involved in the treatment of these children. All surgery requiring general anaesthesia in children with type 1 and type 2 diabetes requires hospital admission.
Note: The following recommendations provide general guidance for the management of diabetes during surgery. Local protocols and guidelines should be referred to where they exist.

Use of insulin during surgery

**Elective surgery—minor procedures**

Minor procedures (procedures of less than 2 hours requiring either general anaesthesia or heavy sedation) in children who have type 1 or type 2 diabetes should ideally be performed when diabetes is under optimal control. If glycaemic control is poor, the procedure should be delayed if possible; otherwise it is advisable to admit the child well in advance of surgery for stabilisation of glycaemic control. Blood-glucose concentration should be maintained within the usual target range of 5–10 mmol/litre throughout the peri-operative period for all surgical procedures.

Children usually prescribed insulin for type 1 or type 2 diabetes require an intravenous insulin infusion p. 471 during surgery (even if fasting) to avoid ketoacidosis. Detailed local protocols should be consulted. In general, the following steps should be followed:

- on the **evening before surgery**, the usual insulin regimen should be given as usual; the usual bedtime snack should be given and hourly capillary blood-glucose monitoring should be initiated to detect hypoglycaemia or hyperglycaemia before the procedure. Ketones should also be checked if blood-glucose is above 14 mmol/litre, and an appropriate dose of short-acting insulin should be administered to restore blood-glucose to the target range;
- on the **morning of surgery** the usual insulin dose should be omitted;
- at least **2 hours before the procedure**, a maintenance fluid infusion of sodium chloride 0.45% and glucose 5% (sodium chloride with glucose) intravenous infusion should be started. A switch to sodium chloride 0.9% infusion p. 610 may be required if sodium concentration falls and there is risk of hypotension. After surgery, potassium chloride p. 623 should be added to the intravenous fluid, according to the child’s body weight and fluid requirements. Electrolytes must be measured frequently throughout, and adjustments to the infusion made as necessary;
- soluble human insulin 1 unit/mL in sodium chloride 0.9% intravenous infusion should be started with the maintenance fluids at an infusion rate appropriate to the blood-glucose concentration, to maintain a concentration between 5 and 10 mmol/litre, adjusted according to hourly blood-glucose monitoring;
- if the blood-glucose concentration falls below 6 mmol/litre the insulin infusion should not be stopped as this will cause rebound hyperglycaemia; instead the rate should be reduced; however, if blood-glucose concentration drops below 4 mmol/litre the insulin infusion can be stopped temporarily for 10–15 minutes.

After surgery, continue the glucose infusion, and the intravenous insulin infusion or additional short-acting insulin as necessary, until the child can eat and drink normally and their usual treatment regimen can resume. A short-acting insulin can also be given if required to reduce hyperglycaemia.

**Emergency surgery**

Children with diabetes (type 1 and 2) requiring emergency surgery, should always have their blood-glucose, blood or urinary ketone concentration, and serum electrolytes checked before surgery. If ketones are high, blood gases should also be checked. If ketoacidosis is present, recommendations for Diabetic ketoacidosis p. 466 should be followed immediately, and surgery delayed if possible. If there is no acidosis, intravenous fluids and an insulin infusion should be started and managed as for major elective surgery (above).

**Use of antidiabetic drugs during surgery**

If elective minor surgical procedures only require a short-fasting period (just one missed meal), it may be possible to adjust antidiabetic drugs to avoid a switch to a variable rate intravenous insulin infusion; normal drug treatment can continue.

Children who usually take sulfonylureas should have their medication stopped on the day of surgery.

Sulfonylureas are associated with hypoglycaemia in the fasted state and therefore should not be recommenced until the child is eating and drinking normally.

Children undergoing minor procedures require hourly blood-glucose monitoring and, if blood-glucose concentration rises above 10 mmol/litre, should be treated with subcutaneous rapid-acting insulin no more frequently than every 3 hours.

Children undergoing a major surgical procedure expected to last at least 2 hours should be managed on an intravenous insulin infusion following the recommendations for Elective surgery (above).

Insulin is almost always required in medical and surgical emergencies.

Metformin hydrochloride p. 468 is renally excreted; renal impairment may lead to accumulation and lactic acidosis during surgery. In children undergoing major surgery lasting more than 2 hours, metformin hydrochloride should be discontinued 24 hours before the procedure. Children having minor surgery lasting less than 2 hours may stop their metformin on the day of surgery. Metformin hydrochloride should not be restarted until at least 48 hours after surgery or after the child is eating again, and only once normal renal function has been established.

The manufacturer advises that metformin should also be omitted if contrast medium is administered during surgery to reduce the risk of contrast-induced nephropathy. It should be stopped prior to, or at the time of the test, and not to be restarted until 48 hours afterwards, and only once normal renal function has been established.

**Use of antidiabetic drugs during medical illness**

Manufacturers of some antidiabetic drugs recommend that they may need to be replaced temporarily with insulin during intercurrent illness when the drug is unlikely to control hyperglycaemia (such as coma, severe infection, trauma and other medical emergencies). Consult individual product literature.

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**Diabetes, pregnancy and breast-feeding**

**Description of condition**

Diabetes in pregnancy is associated with increased risks to the young woman (such as pre-eclampsia and rapidly worsening retinopathy), and to the developing fetus, compared with pregnancy in non-diabetic young women. Effective blood-glucose control before conception and throughout pregnancy reduces (but does not eliminate) the...
risk of adverse outcomes such as miscarriage, congenital malformation, stillbirth, and neonatal death.

**Management of pre-existing diabetes**

**CGG** Young women with pre-existing diabetes who are planning on becoming pregnant should aim to keep their HbA1c concentration below 48 mmol/mol (6.5%) if possible without causing problematic hyperglycaemia. Any reduction towards this target is likely to reduce the risk of congenital malformations in the newborn.

Young women with pre-existing diabetes who are planning to become pregnant should be advised to take folic acid at the dose for young women who are at high-risk of conceiving a child with a neural tube defect, see folic acid p. 594.

**Overview**

**Oral antidiabetic drugs**

**CGG** All oral antidiabetic drugs, except metformin hydrochloride below, should be discontinued before pregnancy (or as soon as an unplanned pregnancy is identified) and substituted with insulin therapy. Young women with diabetes may be treated with metformin hydrochloride below [unlicensed in pregnancy] as an adjunct or alternative to insulin in the preconception period and during pregnancy, when the likely benefits from improved blood-glucose control outweigh the potential for harm. Metformin hydrochloride below can be continued immediately after birth and during breast-feeding for those with pre-existing Type 2 diabetes p. 465. All other antidiabetic drugs should be avoided while breast-feeding.

**Insulin**

Limited evidence suggests that the rapid-acting insulin analogues (insulin aspart p. 472 and insulin lispro p. 473) can be associated with fewer episodes of hyperglycaemia, a reduction in postprandial glucose excursions, and an improvement in overall glycaemic control compared with regular human insulin.

**Isophane insulin** p. 474 is the first-choice for long-acting insulin during pregnancy, however in young women who have good blood-glucose control before pregnancy with the long-acting insulin analogues (insulin detemir p. 476 or insulin glargine p. 476), it may be appropriate to continue their use throughout pregnancy.

Continuous subcutaneous insulin infusion p. 471 (insulin pump therapy) may be appropriate for young women who have difficulty achieving glycaemic control with multiple daily injections of insulin p. 471 without significant disabling hypoglycaemia.

All young women treated with insulin p. 471 during pregnancy should be aware of the risks of hypoglycaemia, particularly in the first trimester, and should be advised to always carry a fast-acting form of glucose, such as dextrose tablets or a glucose-containing drink. Pregnant young women with Type 1 diabetes p. 462 should also be prescribed glucagon p. 482 for use if needed.

Young women with pre-existing diabetes treated with insulin p. 471 during pregnancy are at increased risk of hypoglycaemia in the postnatal period and should reduce their insulin immediately after birth. Blood-glucose levels should be monitored carefully to establish the appropriate dose.

**Medication for diabetic complications**

**CGG** Angiotensin-converting enzyme inhibitors and angiotensin-II receptor antagonists should be discontinued and replaced with an alternative antihypertensive suitable for use in pregnancy before conception or as soon as pregnancy is confirmed. Statins should not be prescribed during pregnancy and should be discontinued before a planned pregnancy.

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**Gestational diabetes**

**CGG** Young women with gestational diabetes who have a fasting plasma glucose below 7 mmol/litre at diagnosis, should first attempt a change in diet and exercise alone in order to reduce blood-glucose. If blood-glucose targets are not met within 1 to 2 weeks, metformin hydrochloride below may be prescribed [unlicensed use]. Insulin p. 471 may be prescribed if metformin is contra-indicated or not acceptable, and may also be added to treatment if metformin is not effective alone.

Young women who have a fasting plasma glucose above 7 mmol/litre at diagnosis should be treated with insulin p. 471 immediately with or without metformin hydrochloride below, in addition to a change in diet and exercise.

Young women who have a fasting plasma glucose between 6 and 6.9 mmol/litre alongside complications, such as macrosomia or hydramnios, should be considered for immediate insulin p. 471 treatment, with or without metformin hydrochloride below.

Young women with gestational diabetes should discontinue hypoglycaemic treatment immediately after giving birth.

**Useful Resources**


www.sign.ac.uk/assets/sign116.pdf


www.nice.org.uk/guidance/ng3

**BLOOD GLUCOSE LOWERING DRUGS**

**Biguanides**

**Metformin hydrochloride**

- **Drug Action** Metformin exerts its effect mainly by decreasing gluconeogenesis and by increasing peripheral utilisation of glucose; since it acts only in the presence of endogenous insulin it is effective only if there are some residual functioning pancreatic islet cells.

- **Indications and Dose**
  - **Type 2 diabetes mellitus [monotherapy or in combination with other antidiabetic drugs (including insulin)]**
    - By mouth using immediate-release medicines
    - Child 6–9 years (specialist use only): Initially 200 mg once daily, dose to be adjusted according to response at intervals of at least 1 week, maximum daily dose to be given in 2–3 divided doses; maximum 2 g per day
    - Child 10–17 years (specialist use only): Initially 500 mg once daily, dose to be adjusted according to response at intervals of at least 1 week, maximum daily dose to be given in 2–3 divided doses; maximum 2 g per day

- **Unlicensed Use** Not licensed for use in children under 10 years.

- **Contra-Indications** Acute metabolic acidosis (including lactic acidosis and diabetic ketoacidosis)

- **Caution** Risk factors for lactic acidosis

- **Caution, Further Information** Risk factors for lactic acidosis Manufacturer advises caution in chronic stable heart failure (monitor cardiac function), and concomitant use of drugs that can acutely impair renal function; interrupt treatment if dehydration occurs, and avoid in conditions that can acutely worsen renal function, or cause tissue hypoxia.

- **Interactions** → Appendix 1: metformin
Diabetes mellitus 469

Glibenclamide

- INDICATIONS AND DOSE
  - Type 2 diabetes mellitus
  - By mouth
  - Child 12–17 years: Initially 2.5 mg daily, adjusted according to response, dose to be taken with or immediately after breakfast; maximum 15 mg per day

Maturity-onset diabetes of the young (specialist use only)

- By mouth
  - Child 12–17 years: Initially 2.5 mg daily, adjusted according to response, dose to be taken with or immediately after breakfast; maximum 15 mg per day

- UNLICENSED USE
  - Not licensed for use in children.

- CONTRA-INDICATIONS
  - Avoid where possible in Acute porphyrias p. 624

- INTERACTIONS
  - Appendix 1: sulfonylureas

- SIDE-EFFECTS
  - Appetite decreased - gastrointestinal discomfort - SIADH - taste metallic

- PREGNANCY
  - The use of sulfonylureas in pregnancy should generally be avoided because of the risk of neonatal hypoglycaemia; however, glibenclamide can be used during the second and third trimesters of pregnancy in women with gestational diabetes.

- BREAST FEEDING
  - Glibenclamide can be used during breast-feeding in women with pre-existing diabetes.

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

Glibenclamide (Non-proprietary)

- Glipizide 2.5 mg
- Glibenclamide 5 mg

- MEASUREMENTS
  - 500 mg Metformin hydrochloride 500 mg per 1 ml
  - 1000 mg Metformin hydrochloride 1000 mg per 1 ml

- INDICATIONS
  - Type 2 diabetes mellitus
  - Maturity-onset diabetes of the young

- CONTRA-INDICATIONS
  - Presence of ketoacidosis

- CAUTIONS
  - Can encourage weight gain (should be prescribed only if poor control and symptoms persist despite adequate attempts at dieting) - G6PD deficiency

- SIDE-EFFECTS
  - Common or very common
  - Abdominal pain - diarrhea - hypoglycaemia - nausea
  - Uncommon
  - Hepatic disorders - vomiting
  - Rare or very rare
  - Agranulocytosis - erythromenia - granulocytopenia - haemolytic anaemia - leucopenia - pancytopenia - thrombocytopenia

- FREQUENCY
  - Not known

- MEDICATIONS
  - Glucophage (Merck Serono Ltd)

- PATIENT AND CARER ADVICE
  - Driving and skilled tasks
  - Drivers need to be particularly careful to avoid hypoglycaemia and should be warned of the problems.

BLOOD GLUCOSE LOWERING DRUGS 》 SULfonylureAS

Sulfonylureas

- DRUG ACTION
  - The sulfonylureas act mainly by augmenting insulin secretion and consequently are effective only when some residual pancreatic beta-cell activity is present; during long-term administration they also have an extrapancreatic action.

- CONTRA-INDICATIONS
  - Presence of ketoacidosis

- CAUTIONS
  - Can encourage weight gain (should be prescribed only if poor control and symptoms persist despite adequate attempts at dieting) - G6PD deficiency

- SIDE-EFFECTS
  - Common or very common
  - Abdominal pain - diarrhea - hypoglycaemia - nausea
  - Uncommon
  - Hepatic disorders - vomiting
  - Rare or very rare
  - Agranulocytosis - erythromenia - granulocytopenia - haemolytic anaemia - leucopenia - pancytopenia - thrombocytopenia

- FREQUENCY
  - Not known

- MEDICATIONS
  - Glucophage (Merck Serono Ltd)

- PATIENT AND CARER ADVICE
  - Driving and skilled tasks
  - Drivers need to be particularly careful to avoid hypoglycaemia and should be warned of the problems.
Gliclazide

**INDICATIONS AND DOSE**

**Type 2 diabetes mellitus**
- By mouth using immediate-release medicines
- Child 12-17 years: Initially 20 mg once daily, adjusted according to response, increased if necessary up to 160 mg once daily (max. per dose 160 mg twice daily), dose to be taken with breakfast

**Maturity-onset diabetes of the young (specialist use only)**
- By mouth using immediate-release medicines
- Child 12-17 years: Initially 20 mg once daily, adjusted according to response, increased if necessary up to 160 mg once daily (max. per dose 160 mg twice daily), dose to be taken with breakfast

**UNLICENSED USE** Not licensed for use in children.

**CONTRA-INDICATIONS** Avoid where possible in Acute porphyrias p. 624

**INTERACTIONS** → Appendix 1: sulfonylureas

**SIDE-EFFECTS**
- Rare or very rare Aplastic anaemia - blood disorder
- Frequency not known Alcohol intolerance - appetite abnormal - erythema multiforme (usually in the first 6-8 weeks of therapy) - exfoliative dermatitis (usually in the first 6-8 weeks of therapy) - fever (usually in the first 6-8 weeks of therapy) - headache - hypersensitivity (usually in the first 6-8 weeks of therapy) - paraesthesia - photosensitivity reaction - tinnitus - weight increased

**PREGNANCY**
- The use of sulfonylureas in pregnancy should generally be avoided because of the risk of neonatal hypoglycaemia.

**BREAST FEEDING**
- The use of sulfonylureas in breast-feeding should be avoided because there is a theoretical possibility of hypoglycaemia in the infant.

**RENAL IMPAIRMENT**
- If necessary, gliclazide which is principally metabolised in the liver, can be used in renal impairment but careful monitoring of blood-glucose concentration is essential.

**PATIENT AND CARER ADVICE**
- Medicines for Children leaflet: Gliclazide for type 2 diabetes mellitus and maturity-onset diabetes of the young

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

**Tablet**
- Gliclazide 40 mg, 80 mg, 160 mg
- Tolbutamide 500 mg

**INSULINS**

**Insulins**

**IMPORTANT SAFETY INFORMATION**

**NHS IMPROVEMENT PATIENT SAFETY ALERT: RISK OF SEVERE HARM AND DEATH DUE TO WITHDRAWING INSULIN FROM PEN DEVICES (NOVEMBER 2016)**

Insulin should not be extracted from insulin pen devices.

The strength of insulin in pen devices can vary by multiples of 100 units/mL. Insulin syringes have graduations only suitable for calculating doses of standard 100 units/mL. If insulin extracted from a pen or cartridge is of a higher strength, and that is not considered in determining the volume required, it can lead to a significant and potentially fatal overdose.

**SIDE-EFFECTS**
- Common or very common Oedema
- Uncommon Lipodystrophy

**SIDE-EFFECTS, FURTHER INFORMATION**

**Overdose**
- Overdose causes hypoglycaemia.

**PREGNANCY**
- Dose adjustments During pregnancy, insulin requirements may alter and doses should be assessed frequently by an experienced diabetes physician.
- The dose of insulin generally needs to be increased in the second and third trimesters of pregnancy.

**BREAST FEEDING**
- Dose adjustments During breast-feeding, insulin requirements may alter and doses should be assessed frequently by an experienced diabetes physician.

**HEPATIC IMPAIRMENT**
- Dose adjustments Insulin requirements may be decreased in patients with hepatic impairment.

**RENAL IMPAIRMENT**
- The compensatory response to hypoglycaemia is impaired in renal impairment.
- Dose adjustments Insulin requirements may decrease in patients with renal impairment and therefore dose reduction may be necessary.
MONITORING REQUIREMENTS

- Many patients now monitor their own blood-glucose concentrations; all carers and children need to be trained to do this.
- Since blood-glucose concentration varies substantially throughout the day, ‘normoglycaemia’ cannot always be achieved throughout a 24-hour period without causing damaging hypoglycaemia.
- It is therefore best to recommend that children should maintain a blood-glucose concentration of between 4 and 10 mmol/litre for most of the time (4–8 mmol/litre before meals and less than 10 mmol/litre after meals).
- While accepting that on occasions, for brief periods, the blood-glucose concentration will be above these values; strenuous efforts should be made to prevent it from falling below 4 mmol/litre. Patients using multiple injection regimens should understand how to adjust their insulin dose according to their carbohydrate intake. With fixed-dose insulin regimens, the carbohydrate intake needs to be regulated, and should be distributed throughout the day to match the insulin regimen. The intake of energy and of simple and complex carbohydrates should be adequate to allow normal growth and development but obesity must be avoided.

DIRECTIONS FOR ADMINISTRATION

Insulin is generally given by subcutaneous injection; the injection site should be rotated to prevent lipodystrophy. Injection devices (‘pens’), which hold the insulin in a cartridge and meter the required dose, are convenient to use. Insulin syringes (for use with needles) are required for insulin not available in cartridge form, but are less popular with children and carers. For intensive insulin regimens multiple subcutaneous injections (3 or more times daily) are usually recommended.

PRESCRIBING AND DISPENSING INFORMATION

Show container to patient or carer and confirm the expected version is dispensed.

Units

The word ‘unit’ should not be abbreviated.

PATIENT AND CARER ADVICE

Hypoglycaemia

Hypoglycaemia is a potential problem with insulin therapy. All patients must be carefully instructed on how to avoid it; this involves appropriate adjustment of insulin type, dose and frequency together with suitable timing and quantity of meals and snacks.

Insulin Passport

Insulin Passports and patient information booklets should be offered to patients receiving insulin. The Insulin Passport provides a record of the patient’s current insulin preparations and contains a section for emergency information. The patient information booklet provides advice on the safe use of insulin. They are available for purchase from:

3M Security Print and Systems Limited
Gorse Street, Chadderton
Oldham
OL9 9QH
Tel: 0845 610 1112
GP practices can obtain supplies through their Local Area Team stores.

NHS Trusts can order supplies from www.nhsforms.co.uk/ or by emailing nhsforms@mmm.com. Further information is available at www.npsa.nhs.uk.

Driving and skilled tasks

Drivers need to be particularly careful to avoid hypoglycaemia and should be warned of the problems.

INSULINS > INSULINS, RAPID-ACTING

Insulin

(Inulin Injection; Neutral Insulin; Soluble Insulin—short acting)

INDICATIONS AND DOSE

Diabetes mellitus

- By subcutaneous injection
- Child: According to requirements

Hyperglycaemia during illness

- By intravenous infusion
- Neonate: 0.02–0.125 unit/kg/hour, dose to be adjusted according to blood-glucose concentration.
- Child: 0.025–0.1 unit/kg/hour, dose to be adjusted according to blood-glucose concentration

Neonatal hyperglycaemia | Neonatal diabetes

- By intravenous infusion
- Neonate: 0.02–0.125 unit/kg/hour, dose to be adjusted according to blood-glucose concentration.

Diabetic ketoacidosis | Diabetes during surgery

- By intravenous infusion
- Child: (consult local protocol)

SIDE-EFFECTS

- Uncommon Skin reactions

RARE OR VERY RARE

- Refraction disorder

DIRECTIONS FOR ADMINISTRATION

Short-acting injectable insulins can be given by continuous subcutaneous infusion using a portable infusion pump. This device delivers a continuous basal insulin infusion and patient-activated bolus doses at meal times. This technique can be useful for patients who suffer recurrent hypoglycaemia or marked morning rise in blood-glucose concentration despite optimised multiple-injection regimens. Patients on subcutaneous insulin infusion must be highly motivated, able to monitor their blood-glucose concentration, and have expert training, advice and supervision from an experienced healthcare team. Some insulin preparations are not recommended for use in subcutaneous insulin infusion pumps—may precipitate in catheter or needle—consult product literature.

- With intravenous use For intravenous infusion, dilute to a concentration of 1 unit/mL with Sodium Chloride 0.9% and mix thoroughly; insulin may be adsorbed by plastics, flush giving set with 5 mL of infusion fluid containing insulin. For intravenous infusion in neonatal intensive care, dilute 5 units to a final volume of 50 mL with Sodium Chloride 0.9% and mix thoroughly; an intravenous infusion rate of 0.1 mL/kg/hour provides a dose of 0.01 units/kg/hour.

PRESCRIBING AND DISPENSING INFORMATION

A sterile solution of insulin (i.e. bovine or porcine) or of human insulin; pH 6.6–8.0.

NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions

- Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (type 1) (July 2008) NICE TA151

Continuous subcutaneous insulin infusion is recommended as an option in adults and children over 12 years with type 1 diabetes:

- who suffer repeated or unpredictable hypoglycaemia, whilst attempting to achieve optimal glycaemic control with multiple-injection regimens, or
- whose glycaemic control remains inadequate (HbA1c over 8.5% [69 mmol/mol]) despite optimised multiple-injection regimens (including the use of long-acting insulin analogues where appropriate).
Continuous subcutaneous insulin infusion is also recommended as an option for children under 12 years with type 1 diabetes for whom multiple-injection regimens are considered impractical or inappropriate. Children on insulin pumps should undergo a trial of multiple-injection therapy between the ages of 12 and 18 years.

www.nice.org.uk/TA151

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, solution for infusion

**Solution for injection**
- **Humulin R (Imported (United States))**
  - Insulin human 500 unit per 1 ml Humulin R 500units/ml solution for injection 20ml vials | 1 vial (PO) £15.68
  - Humulin R KnipPen 500units/ml solution for injection 3ml pre-filled pen | 2 pre-filled disposable injection (PO) £12.18
- **Actrapid (Novo Nordisk Ltd)**
  - Insulin human (as Insulin soluble human) 100 unit per
    - 1 ml Actrapid 100units/ml solution for injection 10ml vials | 1 vial (PO) £7.48 DT = £15.68
  - Humulin S (Eli Lilly and Company Ltd)
    - Insulin human (as Insulin soluble human) 100 unit per
      - 1 ml Humulin S 100units/ml solution for injection 10ml vials | 1 vial (PO) £15.68 DT = £31.30
    - Humulin S 100units/ml solution for injection 3ml cartridges | 5 cartridge (PO) £15.68 DT = £78.40
- **Hypurin Bovine Neutral (Wockhardt UK Ltd)**
  - Insulin bovine (as Insulin soluble bovine) 100 unit per
    - 1 ml Hypurin Bovine Neutral 100units/ml solution for injection 10ml vials | 1 vial (PO) £27.72 DT = £55.44
  - Hypurin Bovine Neutral 100units/ml solution for injection 3ml cartridges | 5 cartridge (PO) £41.58 DT = £207.90
- **Hypurin Porcine Neutral (Wockhardt UK Ltd)**
  - Insulin porcine (as Insulin soluble porcine) 100 unit per
    - 1 ml Hypurin Porcine Neutral 100units/ml solution for injection 10ml vials | 1 vial (PO) £33.80 DT = £67.60
  - Hypurin Porcine Neutral 100units/ml solution for injection 3ml cartridges | 5 cartridge (PO) £50.71 DT = £253.55
- **Insulan Infusat (Sanofi)**
  - Insulin human 100 unit per 1 ml Insulan Infusat 100units/ml solution for injection 3.15ml cartridges | 5 cartridge (PO) £250.00
  - Insulan Infusat 100units/ml solution for injection 10ml vials | 3 vial (PO) £250.00
- **Insuman Rapid (Sanofi)**
  - Insulin human (as Insulin soluble human) 100 unit per
    - 1 ml Insuman Rapid 100units/ml solution for injection 3ml cartridges | 5 cartridge (PO) £17.50 DT = £87.50

**Diabetes mellitus**
- **BY SUBCUTANEOUS INJECTION**
  - Child 1 month–1 year: Administer immediately before meals or when necessary shortly after meals, according to requirements
  - Child 2–17 years: Administer immediately before meals or when necessary shortly after meals, according to requirements
- **BY SUBCUTANEOUS INFUSION, OR BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
  - Child 1 month–1 year: According to requirements
  - Child 2–17 years: According to requirements

**PREGNANCY** Not known to be harmful—may be used during pregnancy.

**BREAST FEEDING** Not known to be harmful—may be used during lactation.

**DIRECTIONS FOR ADMINISTRATION** Short-acting injectable insulins can be given by continuous subcutaneous infusion using a portable infusion pump. This device delivers a continuous basal insulin infusion and patient-activated bolus doses at meal times. This technique can be useful for patients who suffer recurrent hypoglycaemia or marked morning rise in blood-glucose concentration despite optimised multiple-injection regimens. Patients on subcutaneous insulin infusion must be highly motivated, able to monitor their blood-glucose concentration, and have expert training, advice and supervision from an experienced healthcare team.

**With intravenous use** For *intravenous infusion*, dilute to a concentration of 0.05–1 unit/ml, with Glucose 5% or Sodium Chloride 0.9% and mix thoroughly; insulin may be adsorbed by plastics, flush giving set with 5 mL of infusion fluid containing insulin.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**
- Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (type 1) (July 2008) NICE TA151
  - Continuous subcutaneous insulin infusion is recommended as an option in adults and children over 12 years with type 1 diabetes:
    - who suffer repeated or unpredictable hypoglycaemia, while attempting to achieve optimal glycaemic control with multiple-injection regimens, or
    - whose glycaemic control remains inadequate (HbA1c over 8.5% [69 mmol/mol]) despite optimised multiple-injection regimens (including the use of long-acting insulin analogues where appropriate).
  - Continuous subcutaneous insulin infusion is also recommended as an option for children under 12 years with type 1 diabetes for whom multiple-injection regimens are considered impractical or inappropriate. Children on insulin pumps should undergo a trial of multiple-injection therapy between the ages of 12 and 18 years.

www.nice.org.uk/TA151

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **NovoRapid (Novo Nordisk Ltd)**
  - Insulin aspart 100 unit per 1 ml NovoRapid 100units/ml solution for injection 10ml vials | 1 vial (PO) £14.08 DT = £28.16
- **NovoRapid FlexPen (Novo Nordisk Ltd)**
  - Insulin aspart 100 unit per 1 ml NovoRapid FlexPen 100units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (PO) £30.60 DT = £61.20
- **NovoRapid FlexTouch (Novo Nordisk Ltd)**
  - Insulin aspart 100 unit per 1 ml NovoRapid FlexTouch 100units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (PO) £32.13 DT = £64.26
- **NovoRapid Penfill (Novo Nordisk Ltd)**
  - Insulin aspart 100 unit per 1 ml NovoRapid Penfill 100units/ml solution for injection 3ml cartridges | 5 cartridge (PO) £28.31 DT = £56.62
- **NovoRapid PumpCart (Novo Nordisk Ltd)**
  - Insulin aspart 100 unit per 1 ml NovoRapid PumpCart 100units/ml solution for injection 1.6ml cartridges | 5 cartridge (PO) £15.10 DT = £30.20

**Diabetes mellitus**
- **BY SUBCUTANEOUS INJECTION**
  - Child 1 month–1 year: Administer immediately before meals or when necessary shortly after meals, according to requirements
  - Child 2–17 years: Administer immediately before meals or when necessary shortly after meals, according to requirements

**INTERACTIONS**
- Appendix 1: insulins

**SIDE-EFFECTS**
- Uncommon: Refraction disorder - skin reactions
**Insulin glulisine**
(Recombinant human insulin analogue—short acting)

- **INDICATIONS AND DOSE**
  - **Diabetes mellitus**
    - **BY SUBCUTANEOUS INJECTION**
      - Child: Administer immediately before meals or when necessary shortly after meals, according to requirements
    - **SUBCUTANEOUS INFUSION, OR BY INTRAVENOUS INFUSION**
      - Child: According to requirements

- **UNLICENSED USE**
  - Not licensed for use in children under 6 years.

- **INTERACTIONS**
  - Appendix 1: insulins

- **DIRECTIONS FOR ADMINISTRATION**
  - Short-acting injectable insulins can be given by continuous subcutaneous infusion using a portable infusion pump. This device delivers a continuous basal insulin infusion and patient-activated bolus doses at meal times. This technique can be useful for patients who suffer recurrent hypoglycaemia or marked morning rise in blood-glucose concentration despite optimised multiple-injection regimens. Patients on subcutaneous insulin infusion must be highly motivated, able to monitor their blood-glucose concentration, and have expert training, advice and supervision from an experienced healthcare team.

- **NATIONAL FUNDING/ACCESS DECISIONS**
  - **NICE decisions**
    - Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (type 1) (July 2008) NICE TA151
    - Continuous subcutaneous insulin infusion is recommended as an option in adults and children over 12 years with type 1 diabetes:
      - who suffer repeated or unpredictable hypoglycaemia, whilst attempting to achieve optimal glycaemic control with multiple-injection regimens, or
      - whose glycaemic control remains inadequate (HbA1c over 8.5% [69 mmol/mol]) despite optimised multiple-injection regimens (including the use of long-acting insulin analogues where appropriate).
    - Continuous subcutaneous insulin infusion is also recommended as an option for children under 12 years with type 1 diabetes for whom multiple-injection regimens are considered impractical or inappropriate. Children on insulin pumps should undergo a trial of multiple-injection therapy between the ages of 12 and 18 years.

  - **Scottish Medicines Consortium (SMC) decisions**
    - The Scottish Medicines Consortium has advised (October 2008) that Apidra® is accepted for restricted use within NHS Scotland for the treatment of adults and children over 6 years with diabetes mellitus in whom the use of a short-acting insulin analogue is appropriate.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

- **Solution for injection**
  - **Apidra** (Sanofi)
    - **Insulin glulisine 100 unit per 1 ml**
      - Apidra 100 units/ml solution for injection 3ml cartridges | 5 cartridge (PST) £28.30 DT + £28.30
      - Apidra 100 units/ml solution for injection 10ml vials | 1 vial (PST) £16.00 DT + £16.00
  - **Apidra SoloStar** (Sanofi)
    - **Insulin glulisine 100 unit per 1 ml**
      - Apidra 100 units/ml solution for injection 3ml pre-filled SoloStar pen | 5 pre-filled disposable injection (PST) £28.30 DT + £28.30

**Insulin lispro**
(Recombinant human insulin analogue—short acting)

- **INDICATIONS AND DOSE**
  - **Diabetes mellitus**
    - **BY SUBCUTANEOUS INJECTION**
      - Child 1 month-1 year: Administer shortly before meals or when necessary shortly after meals, according to requirements
      - Child 2-17 years: Administer shortly before meals or when necessary shortly after meals, according to requirements
    - **SUBCUTANEOUS INFUSION, OR BY INTRAVENOUS INFUSION, OR BY INTRAVENOUS INJECTION**
      - Child 1 month-1 year: According to requirements
      - Child 2-17 years: According to requirements

- **UNLICENSED USE**
  - Not licensed for use in children under 2 years.

- **CAUTIONS**
  - **Children under 12 years (use only if benefit likely compared to soluble insulin)**

- **INTERACTIONS**
  - **Appendix 1: insulins**

- **PREGNANCY**
  - Not known to be harmful—may be used during pregnancy.

- **BREAST FEEDING**
  - Not known to be harmful—may be used during lactation.

- **DIRECTIONS FOR ADMINISTRATION**
  - Short-acting injectable insulins can be given by continuous subcutaneous infusion using a portable infusion pump. This device delivers a continuous basal insulin infusion and patient-activated bolus doses at meal times. This technique can be useful for patients who suffer recurrent hypoglycaemia or marked morning rise in blood-glucose concentration despite optimised multiple-injection regimens (see also NICE guidance, below). Patients on subcutaneous insulin infusion must be highly motivated, able to monitor their blood-glucose concentration, and have expert training, advice and supervision from an experienced healthcare team.

  - **With intravenous use**
    - For intravenous infusion, dilute to a concentration of 0.1–1 unit/ml with Glucose 5% or Sodium Chloride 0.9% and mix thoroughly; insulin may be adsorbed by plastics, flush giving set with 5 ml of infusion fluid containing insulin.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Insulin lispro is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1.

- **NATIONAL FUNDING/ACCESS DECISIONS**
  - **NICE decisions**
    - Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (type 1) (July 2008) NICE TA151
    - Continuous subcutaneous insulin infusion is recommended as an option in adults and children over 12 years with type 1 diabetes:
      - who suffer repeated or unpredictable hypoglycaemia, whilst attempting to achieve optimal glycaemic control with multiple-injection regimens, or
      - whose glycaemic control remains inadequate (HbA1c over 8.5% [69 mmol/mol]) despite optimised multiple-injection regimens (including the use of long-acting insulin analogues where appropriate).
    - Continuous subcutaneous insulin infusion is also recommended as an option for children under 12 years with type 1 diabetes for whom multiple-injection regimens are considered impractical or inappropriate. Children on
insulin pumps should undergo a trial of multiple-injection therapy between the ages of 12 and 18 years.

www.nice.org.uk/TA151

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Insulin lispro (non-proprietary)**

  Insulin lispro Sanofi 100units/ml solution for injection 3ml cartridges | 5 cartridge (£90) | £24.96 DT = £2.38

  Insulin lispro Sanofi 100units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£50) | £25.04 DT = £2.50

  Insulin lispro Sanofi 100units/ml solution for injection 10ml vials | 5 vial (£60) | £11.42 DT = £1.61

- **Humalog** (Eli Lilly and Company Ltd)

  Insulin lispro 100 unit per 1 ml Humalog 100units/ml solution for injection 10ml vials | 1 vial (£50) | £16.61 DT = £1.61

  Humalog 100units/ml solution for injection 3ml cartridges | 5 cartridge (£70) | £28.31 DT = £2.83

  Humalog Junior KwikPen (Eli Lilly and Company Ltd)

  Insulin lispro 100 unit per 1 ml Humalog Junior KwikPen 100units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£70) | £29.46 DT = £2.95

  Humalog KwikPen (Eli Lilly and Company Ltd)

  Insulin lispro 100 unit per 1 ml Humalog KwikPen 100units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£70) | £29.46 DT = £2.95

  Insulin lispro 200 unit per 1 ml Humalog KwikPen 200units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£70) | £58.92 DT = £5.89

**INSULINS** > INTERMEDIATE-ACTING

**Biphasic isophane insulin**

(Biphasic Isophane Insulin Injection—intermediate acting)

**INDICATIONS AND DOSE**

*Diabetes mellitus*

- **BY SUBCUTANEOUS INJECTION**

- Child: According to requirements

**INTERACTIONS** → Appendix 1: Insulins

**SIDE-EFFECTS**

- Rare or very rare Angioedema

- Frequency not known Hypokalaemia - weight increased

**PRESCRIBING AND DISPENSING INFORMATION** A sterile buffered suspension of either porcine or human insulin complexed with protamine sulfate (or another suitable protamine) in a solution of insulin of the same species.

Check product container—the proportions of the two components should be checked carefully (the order in which the proportions are stated may not be the same in other countries).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for injection**

- **Humulin M3** (Eli Lilly and Company Ltd)

  Insulin human (as Insulin soluble human) 30 unit per 1 ml, Insulin human (as Insulin isophane human) 70 unit per 1 ml Humulin M3 100units/ml suspension for injection 3ml cartridges | 5 cartridge (£90) | £19.08 DT = £1.91

  Humulin M3 100units/ml suspension for injection 10ml vials | 1 vial (£50) | £15.68 DT = £1.57

- **Humulin M3 KwikPen** (Eli Lilly and Company Ltd)

  Insulin human (as Insulin soluble human) 30 unit per 1 ml, Insulin human (as Insulin isophane human) 70 unit per 1 ml Humulin M3 KwikPen 100units/ml suspension for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£90) | £21.70 DT = £2.17

- **Hypurin Porcine 30/70 Mix** (Wockhardt UK Ltd)

  Insulin porcine (as Insulin soluble porcine) 30 unit per 1 ml, Insulin porcine (as Insulin isophane porcine) 70 unit per 1 ml Hypurin Porcine 30/70 Mix 100units/ml suspension for injection 3ml cartridges | 5 cartridge (£90) | £50.71 DT = £5.07

  Hypurin Porcine 30/70 Mix 100units/ml suspension for injection 10ml vials | 1 vial (£30) | £33.80 DT = £3.38

- **Insuman Comb 15** (Sanofi)

  Insulin human (as Insulin soluble human) 15 unit per 1 ml, Insulin human (as Insulin isophane human) 85 unit per 1 ml Insuman Comb 15 100units/ml suspension for injection 3ml cartridges | 5 cartridge (£90) | £17.50 DT = £1.75

- **Insuman Comb 25** (Sanofi)

  Insulin human (as Insulin soluble human) 25 unit per 1 ml, Insulin human (as Insulin isophane human) 75 unit per 1 ml Insuman Comb 25 100units/ml suspension for injection 3ml vials | 1 vial (£50) | £5.61

  Insuman Comb 25 100units/ml suspension for injection 3ml pre-filled SoloStar pen | 5 pre-filled disposable injection (£50) | £19.80 DT = £1.98

  Insuman Comb 25 100units/ml suspension for injection 3ml cartridges | 5 cartridge (£90) | £17.50 DT = £1.75

- **Insuman Comb 50** (Sanofi)

  Insulin human (as Insulin soluble human) 50 unit per 1 ml, Insulin human (as Insulin soluble human) 50 unit per 1 ml Insuman Comb 50 100units/ml suspension for injection 3ml vials | 5 cartridge (£90) | £17.50 DT = £1.75

**Isophane insulin**

(Isophane Insulin Injection; Isophane Protamine Insulin Injection; Isophane Insulin (NPH)—intermediate acting)

**INDICATIONS AND DOSE**

*Diabetes mellitus*

- **BY SUBCUTANEOUS INJECTION**

- Child: According to requirements

**INTERACTIONS** → Appendix 1: Insulins

**PREGNANCY** Recommended where longer-acting insulins are needed.

**PRESCRIBING AND DISPENSING INFORMATION** A sterile suspension of bovine or porcine insulin or of human insulin in the form of a complex obtained by the addition of protamine sulfate or another suitable protamine.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for injection**

- **Humulin I** (Eli Lilly and Company Ltd)

  Insulin human (as Insulin isophane human) 100 unit per 1 ml Humulin I 100units/ml suspension for injection 10ml vials | 1 vial (£50) | £15.68 DT = £1.57

  Humulin I 100units/ml suspension for injection 3ml cartridges | 5 cartridge (£90) | £19.08 DT = £1.91

- **Humulin I KwikPen** (Eli Lilly and Company Ltd)

  Insulin human (as Insulin isophane human) 100 unit per 1 ml Humulin I KwikPen 100units/ml suspension for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£90) | £21.70 DT = £2.17

- **Hypurin Porcine Isophane** (Wockhardt UK Ltd)

  Insulin porcine (as Insulin isophane porcine) 100 unit per 1 ml Hypurin Porcine Isophane 100units/ml suspension for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£90) | £21.70 DT = £2.17

- **Insulatard** (Novo Nordisk Ltd)

  Insulin human (as Insulin isophane human) 100 unit per 1 ml Insulatard 100units/ml suspension for injection 10ml vials | 1 vial (£30) | £7.48 DT = £0.75

- **Insulatard InnoLet** (Novo Nordisk Ltd)

  Insulin human (as Insulin isophane human) 100 unit per 1 ml Insulatard InnoLet 100units/ml suspension for injection 3ml pre-filled pen | 5 pre-filled disposable injection (£90) | £20.40 DT = £2.04

- **Insulatard Penfill** (Novo Nordisk Ltd)

  Insulin human (as Insulin isophane human) 100 unit per 1 ml Insulatard Penfill 100units/ml suspension for injection 3ml cartridges | 5 cartridge (£90) | £22.90 DT = £2.29
DIABETES MELLITUS

INSULINS > INTERMEDIATE-ACTING COMBINED WITH RAPID-ACTING

Biphasic insulin aspart
(Intermediate-acting insulin)

INDICATIONS AND DOSE
Diabetes mellitus
- By subcutaneous injection
- Child: Administer up to 10 minutes before or soon after a meal, according to requirements

INTERACTIONS
- Appendix 1: insulins

SIDE-EFFECTS
- Uncommon: Skin reactions

PRESCRIBING AND DISPENSING INFORMATION
Check product container—the proportions of the two components should be checked carefully (the order in which the proportions are stated may not be the same in other countries).

MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug.

Suspension for injection
- NovoMix 30 FlexPen (Novo Nordisk Ltd)
- Insulin aspart 30 unit per 1 ml, insulin aspart (as insulin aspart protamine) 70 unit per 1 ml NovoMix 30 FlexPen 100 units/ml suspension for injection 3 ml pre-filled pen | 5 pre-filled disposable injection pens £13.90 DT = £21.70

Biphasic insulin lispro
(Intermediate-acting insulin)

INDICATIONS AND DOSE
Diabetes mellitus
- By subcutaneous injection
- Child: Administer up to 15 minutes before or soon after a meal, according to requirements

CAUTIONS
- Children under 12 years (use only if benefit likely compared to soluble insulin)

INTERACTIONS
- Appendix 1: insulins

PRESCRIBING AND DISPENSING INFORMATION
- Check product container—the proportions of the two components should be checked carefully (the order in which the proportions are stated may not be the same in other countries).

MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug.

Suspension for injection
- Humalog Mix25 (Eli Lilly and Company Ltd)
- Insulin lispro 25 unit per 1 ml, insulin lispro (as insulin lispro protamine) 75 unit per 1 ml Humalog Mix25 100 units/ml suspension for injection 3 ml pre-filled pen | 5 pre-filled disposable injection pens £30.98 DT = £50.98

INSULINS > LONG-ACTING

Insulin degludec
(Recombinant human insulin analogue—long acting)

INDICATIONS AND DOSE
Diabetes mellitus
- By subcutaneous injection
- Child 1-17 years: Dose to be given according to requirements

INTERACTIONS
- Appendix 1: insulins

SIDE-EFFECTS
- Rare or very rare: Urticaria

PREGNANCY
- Evidence of the safety of long-acting insulin analogues in pregnancy is limited, therefore isophane insulin is recommended where longer-acting insulins are needed; insulin detemir may also be considered.

PRESCRIBING AND DISPENSING INFORMATION
- Insulin degludec (Tresiba®) is available in strengths of 100 units/ml (allows 1-unit dose adjustment) and 200 units/ml (allows 2-unit dose adjustment)—ensure correct strength prescribed.

NATIONAL FUNDING/ACCESS DECISIONS
- All Wales Medicines Strategy Group (AWMSG) decisions
- AWMSG No. 3158
- The All Wales Medicines Strategy Group has advised (October 2016) that insulin degludec (Tresiba®) is not recommended for use within NHS Wales for the treatment of diabetes mellitus in adolescents and children from the age of 1 year.

MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug.

Solution for injection
- Tresiba FlexTouch (Novo Nordisk Ltd)
- Insulin human (as insulin degludec) 100 unit per 1 ml Tresiba FlexTouch 100 units/ml solution for injection 3 ml pre-filled pen | 5 pre-filled disposable injection pens £46.00 DT = £46.60
- Insulin human (as insulin degludec) 200 unit per 1 ml Tresiba FlexTouch 200 units/ml solution for injection 3 ml pre-filled pen | 3 pre-filled disposable injection pens £55.92 DT = £55.92
- Tresiba Penfill (Novo Nordisk Ltd)
- Insulin human (as insulin degludec) 100 unit per 1 ml Tresiba Penfill 100 units/ml solution for injection 3 ml cartridges | 5 cartridges £46.00 DT = £46.60
Insulin detemir  
(Recombinant human insulin analogue—long acting)

- **INDICATIONS AND DOSE**
  - Diabetes mellitus
    - By subcutaneous injection
      - Child 2-17 years: According to requirements
  - Interactions → Appendix 1: insulins
  - Side-effects
    - Rare or very rare
      - Myalgia - sodium retention - taste altered
  - Pregnancy
    - Evidence of the safety of long-acting insulin analogues in pregnancy is limited, therefore isophane insulin p. 474 is recommended where longer-acting insulins are needed; insulin detemir may also be considered where longer-acting insulins are needed.
- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
- **Solution for injection**
  - Levemir FlexPen (Novo Nordisk Ltd)
    - Insulin human (as Insulin detemir) 100 unit per 1 ml
      - Levemir FlexPen 100 units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (POM) £42.00 DT = £42.00
    - Levemir InnoLet (Novo Nordisk Ltd)
      - Insulin human (as Insulin detemir) 100 unit per 1 ml
        - Levemir InnoLet 100 units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (POM) £44.85 DT = £42.00
    - Levemir Penfill (Novo Nordisk Ltd)
      - Insulin human (as Insulin detemir) 100 unit per 1 ml
        - Levemir Penfill 100 units/ml solution for injection 3ml cartridges | 5 cartridge (POM) £42.00 DT = £42.00

Insulin glargine  
(Recombinant human insulin analogue—long acting)

- **INDICATIONS AND DOSE**
  - Diabetes mellitus
    - By subcutaneous injection
      - Child 2-17 years: According to requirements
  - Interactions → Appendix 1: insulins
  - Side-effects
    - Rare or very rare
      - Myalgia - sodium retention - taste altered
  - Pregnancy
    - Evidence of the safety of long-acting insulin analogues in pregnancy is limited, therefore isophane insulin p. 474 is recommended where longer-acting insulins are needed; insulin detemir may also be considered where longer-acting insulins are needed.
  - Prescribing and dispensing information
    - Insulin glargine is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1. Dose adjustments and close metabolic monitoring is recommended if switching between insulin glargine preparations.
  - National funding/access decisions
    - Scottish Medicines Consortium (SMC) decisions
      - The Scottish Medicines Consortium has advised that Lantus® preparations (April 2013) and Toujeo® (August 2015) are accepted for restricted use within NHS Scotland for the treatment of type 1 diabetes:
        - In those who are at risk of or experience unacceptable frequency or severity of nocturnal hypoglycaemia on attempting to achieve better hypoglycaemic control during treatment with other insulins
        - As a once daily insulin therapy for patients who require a carer to administer their insulin

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**Insulin zinc suspension**  
(Insulin zinc suspension (mixed)—long acting)

- **INDICATIONS AND DOSE**
  - Diabetes mellitus
    - By subcutaneous injection
      - Child: According to requirements
  - Interactions → Appendix 1: insulins
  - Side-effects
    - Hypokalaemia - weight increased
  - Pregnancy
    - Evidence of the safety of long-acting insulin analogues in pregnancy is limited, therefore isophane insulin p. 474 is recommended where longer-acting insulins are needed; insulin detemir above may also be considered.
  - Prescribing and dispensing information
    - A sterile neutral suspension of bovine and/or porcine insulin or of human insulin in the form of a complex obtained by the addition of a suitable zinc salt; consists of rhombohedral crystals (10–40 microns) and of particles of no uniform shape (not exceeding 2 microns).
  - Medicinal forms
    - There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- Hypurin Bovine Lente (Wockhardt UK Ltd)
  - Insulin bovine (as Insulin zinc suspension mixed bovine) 100 unit per 1 ml
  - Hypurin Bovine Lente 100 units/ml solution for injection 10ml vials | 1 vial (POM) £27.72
- Abasaglar (Eli Lilly and Company Ltd)
  - Insulin human (as Insulin glargine) 100 unit per 1 ml
  - Abasaglar 100 units/ml solution for injection 3ml cartridges | 5 cartridge (POM) £35.28 DT = £37.77
  - Abasaglar KwikPen (Eli Lilly and Company Ltd)
  - Insulin human (as Insulin glargine) 100 unit per 1 ml
  - Abasaglar KwikPen 100 units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (POM) £35.28 DT = £37.77
  - Lantus (Sanofi)
  - Insulin human (as Insulin glargine) 100 unit per 1 ml
  - Lantus 100 units/ml solution for injection 3ml cartridges | 5 cartridge (POM) £37.77 DT = £37.77
  - Lantus 100 units/ml solution for injection 3ml pre-filled SoloStar pen | 5 pre-filled disposable injection (POM) £37.77 DT = £37.77
  - Lantus 100 units/ml solution for injection 10ml vials | 1 vial (POM) £27.92 DT = £27.92
  - Semglee (Mylan)
  - Insulin human (as Insulin glargine) 100 unit per 1 ml
  - Semglee 100 units/ml solution for injection 3ml pre-filled pen | 5 pre-filled disposable injection (POM) £29.99 DT = £37.77
  - Toujeo (Sanofi)
  - Insulin human (as Insulin glargine) 300 unit per 1 ml
  - Toujeo 300 units/ml solution for injection 1.5ml pre-filled SoloStar pen | 3 pre-filled disposable injection (POM) £33.13 DT = £33.13
  - Toujeo DoubleStar (Sanofi)
  - Insulin human (as Insulin glargine) 300 unit per 1 ml
  - Toujeo 300 units/ml solution for injection 3ml pre-filled DoubleStar pen | 3 pre-filled disposable injection (POM) £66.26

It is not recommended for routine use in patients with type 2 diabetes unless they suffer from recurrent episodes of hypoglycaemia or require assistance with their insulin injections.
understanding of the normal blood glucose monitoring systems and the appropriate actions to take on the results obtained, including when to seek medical attention.

Other drugs used for Diabetes, diagnosis and monitoring
Glucose, p. 611

Blood glucose testing strips

4SURE testing strips (Nipro Diagnostics (UK) Ltd)
50 strip - NHS indicative price = £3.95 - Drug Tariff (Part IX)

Accu-Chek Inform II testing strips (Roche Diagnostics Ltd)
50 strip - No NHS indicative price available - Drug Tariff (Part IX)

Active testing strips (Roche Diabetes Care Ltd)
50 strip - NHS indicative price = £10.03 - Drug Tariff (Part IX)

Advocate Redi-Code testing strips (Diabetes Care Technology Ltd)
50 strip - NHS indicative price = £3.95 - Drug Tariff (Part IX)

AutoSense testing strips (Advance Diagnostic Products (NL) Ltd)
25 strip - NHS indicative price = £4.50 - Drug Tariff (Part IX)

Aviva testing strips (Roche Diabetes Care Ltd)
50 strip - NHS indicative price = £16.21 - Drug Tariff (Part IX)

BGStar testing strips (Sanofi)
50 strip - NHS indicative price = £14.73 - Drug Tariff (Part IX)

Betachek C50 cassette (National Diagnostic Products)
100 device - NHS indicative price = £29.98 - Drug Tariff (Part IX)

Betachek G5 testing strips (National Diagnostic Products)
50 strip - NHS indicative price = £14.19 - Drug Tariff (Part IX)

Betachek Visual testing strips (National Diagnostic Products)
50 strip - NHS indicative price = £6.80 - Drug Tariff (Part IX)

Breeze 2 testing discs (Bayer Plc)
50 strip - NHS indicative price = £15.00 - Drug Tariff (Part IX)

CareSens N testing strips (Spirit Healthcare Ltd)
50 strip - NHS indicative price = £11.75 - Drug Tariff (Part IX)

CareSens PRO testing strips (Spirit Healthcare Ltd)
50 strip - NHS indicative price = £19.95 - Drug Tariff (Part IX)

Compact testing strips (Roche Diabetes Care Ltd)
51 strip - NHS indicative price = £16.65 - Drug Tariff (Part IX)

Contour Next testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £15.16 - Drug Tariff (Part IX)

Contour Plus testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £18.50 - Drug Tariff (Part IX)

Contour TS testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £19.50 - Drug Tariff (Part IX)

Dario Lite testing strips (LabStyle Innovations Ltd)
50 strip - NHS indicative price = £9.35 - Drug Tariff (Part IX)

Dario testing strips (LabStyle Innovations Ltd)
50 strip - NHS indicative price = £14.95 - Drug Tariff (Part IX)

Diastix testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £2.89 - Drug Tariff (Part IX)

Element testing strips (Neon Diagnostics Ltd)
50 strip - NHS indicative price = £19.89 - Drug Tariff (Part IX)

Finetest Lite testing strips (Neon Diagnostics Ltd)
50 strip - NHS indicative price = £5.95 - Drug Tariff (Part IX)

Fora Advanced pro GD40 testing strips (B.Braun Medical Ltd)
50 strip - NHS indicative price = £9.25 - Drug Tariff (Part IX)

FreeStyle Lite testing strips (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £16.23 - Drug Tariff (Part IX)

FreeStyle Optimum H testing strips (Abbott Laboratories Ltd)
100 strip - No NHS indicative price available - Drug Tariff (Part IX)

FreeStyle Optimum testing strips (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £16.12 - Drug Tariff (Part IX)

FreeStyle Precision Pro testing strips (Abbott Laboratories Ltd)
100 strip - No NHS indicative price available - Drug Tariff (Part IX)

FreeStyle testing strips (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £16.23 - Drug Tariff (Part IX)

3.1a Diabetes, diagnosis and monitoring

Diabetes mellitus, diagnostic and monitoring devices

Urinalysis: urinary glucose
Reagent strips are available for measuring for glucose in the urine. Tests for ketones by patients are rarely required unless they become unwell—see Blood Monitoring. Microalbuminuria can be detected with Microl-Test H® but this should be followed by confirmation in the laboratory, since false positive results are common.

Blood glucose monitoring
Blood glucose monitoring using a meter gives a direct measure of the glucose concentration at the time of the test and can detect hyperglycaemia as well as hypoglycaemia. Carers and children should be properly trained in the use of blood glucose monitoring systems and the appropriate action to take on the results obtained. Inadequate understanding of the normal fluctuations in blood glucose can lead to confusion and inappropriate action.

Children using multiple injection regimens should understand how to adjust their insulin dose according to their carbohydrate intake. With fixed-dose insulin regimens, the carbohydrate intake needs to be regulated, and should be distributed throughout the day to match the insulin regimen. In the UK blood-glucose concentration is expressed in mmol/litre and Diabetes UK advises that these units should be used for self-monitoring of blood glucose. In other European countries units of mg/100 mL (or mg/dL) are commonly used.

It is advisable to check that the meter is pre-set in the correct units.

If the blood glucose level is high or if the child is unwell, blood ketones should be measured according to local guidelines in order to detect diabetic ketoacidosis. Children and their carers should be trained in the use of blood ketone monitoring systems and to take appropriate action on the results obtained, including when to seek medical attention.

Medicinal forms
There can be variation in the licensing of different medicines containing the same drug.

Suspension for injection

- Hypurin Bovine Protamine Zinc (Wockhardt UK Ltd)
- Insulin bovine (as Insulin protamine zinc bovine) 100 unit per 1 mL
- Hypurin Bovine Protamine Zinc 100 units/mL suspension for injection 10mL vials | 1 vial (55g) £27.72

Blood glucose testing strips

4SURE testing strips (Nipro Diagnostics (UK) Ltd)
50 strip - NHS indicative price = £3.95 - Drug Tariff (Part IX)

Accu-Chek Inform II testing strips (Roche Diagnostics Ltd)
50 strip - No NHS indicative price available - Drug Tariff (Part IX)

Active testing strips (Roche Diabetes Care Ltd)
50 strip - NHS indicative price = £10.03 - Drug Tariff (Part IX)

Advocate Redi-Code testing strips (Diabetes Care Technology Ltd)
50 strip - NHS indicative price = £3.95 - Drug Tariff (Part IX)

AutoSense testing strips (Advance Diagnostic Products (NL) Ltd)
25 strip - NHS indicative price = £4.50 - Drug Tariff (Part IX)

Aviva testing strips (Roche Diabetes Care Ltd)
50 strip - NHS indicative price = £16.21 - Drug Tariff (Part IX)

BGStar testing strips (Sanofi)
50 strip - NHS indicative price = £14.73 - Drug Tariff (Part IX)

Betachek C50 cassette (National Diagnostic Products)
100 device - NHS indicative price = £29.98 - Drug Tariff (Part IX)

Betachek G5 testing strips (National Diagnostic Products)
50 strip - NHS indicative price = £14.19 - Drug Tariff (Part IX)

Betachek Visual testing strips (National Diagnostic Products)
50 strip - NHS indicative price = £6.80 - Drug Tariff (Part IX)

Breeze 2 testing discs (Bayer Plc)
50 strip - NHS indicative price = £15.00 - Drug Tariff (Part IX)

CareSens N testing strips (Spirit Healthcare Ltd)
50 strip - NHS indicative price = £11.75 - Drug Tariff (Part IX)

CareSens PRO testing strips (Spirit Healthcare Ltd)
50 strip - NHS indicative price = £19.95 - Drug Tariff (Part IX)

Compact testing strips (Roche Diabetes Care Ltd)
51 strip - NHS indicative price = £16.65 - Drug Tariff (Part IX)

Contour Next testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £15.16 - Drug Tariff (Part IX)

Contour Plus testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £18.50 - Drug Tariff (Part IX)

Contour TS testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £19.50 - Drug Tariff (Part IX)

Dario Lite testing strips (LabStyle Innovations Ltd)
50 strip - NHS indicative price = £9.35 - Drug Tariff (Part IX)

Dario testing strips (LabStyle Innovations Ltd)
50 strip - NHS indicative price = £14.95 - Drug Tariff (Part IX)

Diastix testing strips (Ascensia Diabetes Care UK Ltd)
50 strip - NHS indicative price = £2.89 - Drug Tariff (Part IX)

Element testing strips (Neon Diagnostics Ltd)
50 strip - NHS indicative price = £19.89 - Drug Tariff (Part IX)

Finetest Lite testing strips (Neon Diagnostics Ltd)
50 strip - NHS indicative price = £5.95 - Drug Tariff (Part IX)

Fora Advanced pro GD40 testing strips (B.Braun Medical Ltd)
50 strip - NHS indicative price = £9.25 - Drug Tariff (Part IX)

FreeStyle Lite testing strips (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £16.23 - Drug Tariff (Part IX)

FreeStyle Optimum H testing strips (Abbott Laboratories Ltd)
100 strip - No NHS indicative price available - Drug Tariff (Part IX)

FreeStyle Optimum testing strips (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £16.12 - Drug Tariff (Part IX)

FreeStyle Precision Pro testing strips (Abbott Laboratories Ltd)
100 strip - No NHS indicative price available - Drug Tariff (Part IX)

FreeStyle testing strips (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £16.23 - Drug Tariff (Part IX)
### Meters and test strips

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<td>Blood glucose</td>
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<td>Blood glucose</td>
<td>Aviva®</td>
<td>50 strip= £16.21</td>
<td>0.6–33.3 mmol/litre</td>
<td>Roche Diabetes Care Ltd</td>
</tr>
<tr>
<td>Accu-Chek® Aviva Expert</td>
<td>Blood glucose</td>
<td>Aviva®</td>
<td>50 strip= £16.21</td>
<td>0.6–33.3 mmol/litre</td>
<td>Roche Diabetes Care Ltd</td>
</tr>
<tr>
<td>Accu-Chek® Compact Plus</td>
<td>Blood glucose</td>
<td>Compact®</td>
<td>3 x 17 strips= £16.65</td>
<td>0.6–33.3 mmol/litre</td>
<td>Roche Diabetes Care Ltd</td>
</tr>
<tr>
<td>Accu-Chek® Mobile</td>
<td>Blood glucose</td>
<td>Mobile®</td>
<td>100 device= £0.00</td>
<td>0.3–33.3 mmol/litre</td>
<td>Roche Diabetes Care Ltd</td>
</tr>
<tr>
<td>Accu-Chek® Aviva Nano</td>
<td>Blood glucose</td>
<td>Aviva®</td>
<td>50 strip= £16.21</td>
<td>0.6–33.3 mmol/litre</td>
<td>Roche Diabetes Care Ltd</td>
</tr>
<tr>
<td>BGStar® Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>BGStar®</td>
<td>50 strip= £14.73</td>
<td>1.1–33.3 mmol/litre</td>
<td>Sanofi</td>
</tr>
<tr>
<td>Breeze 2®</td>
<td>Blood glucose</td>
<td>Breeze 2®</td>
<td>50 strip= £15.00</td>
<td>0.6–33.3 mmol/litre</td>
<td>Bayer Plc</td>
</tr>
<tr>
<td>CareSens N® Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>CareSens N®</td>
<td>50 strip= £12.75</td>
<td>1.1–33.3 mmol/litre</td>
<td>Spirit Healthcare Ltd</td>
</tr>
<tr>
<td>Contour®</td>
<td>Blood glucose</td>
<td>Contour®</td>
<td>50 strip= £9.95</td>
<td>0.6–33.3 mmol/litre</td>
<td>Ascensia Diabetes Care UK Ltd</td>
</tr>
<tr>
<td>Contour® XT</td>
<td>Blood glucose</td>
<td>Contour® Next</td>
<td>50 strip= £15.16</td>
<td>0.6–33.3 mmol/litre</td>
<td>Ascensia Diabetes Care UK Ltd</td>
</tr>
<tr>
<td>Element®</td>
<td>Blood glucose</td>
<td>Element®</td>
<td>50 strip= £9.89</td>
<td>0.55–33.3 mmol/litre</td>
<td>Neon Diagnostics Ltd</td>
</tr>
<tr>
<td>FreeStyle® Meter no longer available</td>
<td>Blood glucose</td>
<td>FreeStyle®</td>
<td>50 strip= £16.23</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Freedom® Meter no longer available</td>
<td>Blood glucose</td>
<td>FreeStyle®</td>
<td>50 strip= £16.23</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Freedom Lite®</td>
<td>Blood glucose</td>
<td>FreeStyle Lite®</td>
<td>50 strip= £16.23</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Insulinx®</td>
<td>Blood glucose</td>
<td>FreeStyle Insulinx®</td>
<td>50 strip= £16.23</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Lite®</td>
<td>Blood glucose</td>
<td>FreeStyle Lite®</td>
<td>50 strip= £16.23</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Mini® Meter no longer available</td>
<td>Blood glucose</td>
<td>FreeStyle®</td>
<td>50 strip= £16.23</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Optium®</td>
<td>Blood glucose</td>
<td>FreeStyle Optium®</td>
<td>50 strip= £16.12</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Optium®</td>
<td>Blood ketones</td>
<td>FreeStyle Optium® β-ketone</td>
<td>10 strip= £21.71</td>
<td>0–8.0 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Optium Neo®</td>
<td>Blood glucose</td>
<td>FreeStyle Optium®</td>
<td>50 strip= £16.12</td>
<td>1.1–27.8 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>FreeStyle Optium Neo®</td>
<td>Blood ketones</td>
<td>FreeStyle Optium® β-ketone</td>
<td>10 strip= £21.71</td>
<td>0–8.0 mmol/litre</td>
<td>Abbott Laboratories Ltd</td>
</tr>
<tr>
<td>GlucoDock® module</td>
<td>Blood glucose</td>
<td>GlucoDock®</td>
<td>50 strip= £14.90</td>
<td>1.1–33.3 mmol/litre</td>
<td>Medisana Healthcare (UK) Ltd</td>
</tr>
<tr>
<td>Meter (all</td>
<td>Type of monitoring</td>
<td>Compatible test strips</td>
<td>Test strip net price</td>
<td>Sensitivity range (mmol/litre)</td>
<td>Manufacturer</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
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</tr>
<tr>
<td>GlucoLab®</td>
<td>Blood glucose</td>
<td>GlucoLab®</td>
<td>50 strip= £9.89</td>
<td>0.55- 33.3 mmol/litre</td>
<td>Neon Diagnostics Ltd</td>
</tr>
<tr>
<td>GlucoMen® GM</td>
<td>Blood glucose</td>
<td>GlucoMen® GM</td>
<td>50 strip= £9.95</td>
<td>0.6- 33.3 mmol/litre</td>
<td>A. Menarini Diagnostics Ltd</td>
</tr>
<tr>
<td>GlucoMen® LX</td>
<td>Blood glucose</td>
<td>GlucoMen® LX Sensor</td>
<td>50 strip= £15.76</td>
<td>1.1- 33.3 mmol/litre</td>
<td>A. Menarini Diagnostics Ltd</td>
</tr>
<tr>
<td>GlucoMen® LX Plus</td>
<td>Blood glucose</td>
<td>GlucoMen® LX Sensor</td>
<td>50 strip= £15.76</td>
<td>1.1- 33.3 mmol/litre</td>
<td>A. Menarini Diagnostics Ltd</td>
</tr>
<tr>
<td>GlucoMen® LX Plus</td>
<td>Blood ketones</td>
<td>GlucoMen® LX Ketone</td>
<td>10 strip= £21.06</td>
<td>0- 0.8 mmol/litre</td>
<td>A. Menarini Diagnostics Ltd</td>
</tr>
<tr>
<td>GlucoMen® Visio</td>
<td>Blood glucose</td>
<td>GlucoMen® Visio Sensor</td>
<td>50 strip= £0.00</td>
<td>1.1- 33.3 mmol/litre</td>
<td>A. Menarini Diagnostics Ltd</td>
</tr>
<tr>
<td>GlucoRx® Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>GlucoRx®</td>
<td>50 strip= £5.45</td>
<td>1.1- 33.3 mmol/litre</td>
<td>GlucoRx Ltd</td>
</tr>
<tr>
<td>GlucoRx Nexus® Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>GlucoRx Nexus®</td>
<td>50 strip= £9.95</td>
<td>1.1- 33.3 mmol/litre</td>
<td>GlucoRx Ltd</td>
</tr>
<tr>
<td>Glucotrend® Meter no longer available</td>
<td>Blood glucose</td>
<td>Active®</td>
<td>50 strip= £10.03</td>
<td>0.6- 33.3 mmol/litre</td>
<td>Roche Diabetes Care Ltd</td>
</tr>
<tr>
<td>iBGStar®</td>
<td>Blood glucose</td>
<td>BGStar®</td>
<td>50 strip= £14.73</td>
<td>1.1- 33.3 mmol/litre</td>
<td>Sanofi</td>
</tr>
<tr>
<td>IME-DC®</td>
<td>Blood glucose</td>
<td>IME-DC®</td>
<td>50 strip= £14.10</td>
<td>1.1- 33.3 mmol/litre</td>
<td>Arctic Medical Ltd</td>
</tr>
<tr>
<td>Mendor Discreet®</td>
<td>Blood glucose</td>
<td>Mendor Discreet®</td>
<td>50 strip= £14.75</td>
<td>1.1- 33.3 mmol/litre</td>
<td>SpringMed Solutions Ltd</td>
</tr>
<tr>
<td>Microdot®*</td>
<td>Blood glucose</td>
<td>Microdot®*</td>
<td>50 strip= £9.49</td>
<td>1.1- 29.2 mmol/litre</td>
<td>Cambridge Sensors Ltd</td>
</tr>
<tr>
<td>MyGlucoHealth®</td>
<td>Blood glucose</td>
<td>MyGlucoHealth®</td>
<td>50 strip= £15.50</td>
<td>0.6- 33.3 mmol/litre</td>
<td>Entra Health Systems Ltd</td>
</tr>
<tr>
<td>Omnitest® 3</td>
<td>Blood glucose</td>
<td>Omnitest® 3</td>
<td>50 strip= £9.89</td>
<td>0.6- 33.3 mmol/litre</td>
<td>B.Braun Medical Ltd</td>
</tr>
<tr>
<td>One Touch Ultra® Meter no longer available</td>
<td>Blood glucose</td>
<td>One Touch Ultra®</td>
<td>50 strip= £9.99</td>
<td>1.1- 33.3 mmol/litre</td>
<td>LifeScan</td>
</tr>
<tr>
<td>One Touch Ultra 2® Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>One Touch Ultra®</td>
<td>50 strip= £9.99</td>
<td>1.1- 33.3 mmol/litre</td>
<td>LifeScan</td>
</tr>
<tr>
<td>One Touch UltraEasy®</td>
<td>Blood glucose</td>
<td>One Touch Ultra®</td>
<td>50 strip= £9.99</td>
<td>1.1- 33.3 mmol/litre</td>
<td>LifeScan</td>
</tr>
<tr>
<td>One Touch UltraSmart® Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>One Touch Ultra®</td>
<td>50 strip= £9.99</td>
<td>1.1- 33.3 mmol/litre</td>
<td>LifeScan</td>
</tr>
<tr>
<td>One Touch® VerioPro Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>One Touch® Verio</td>
<td>50 strip= £15.12</td>
<td>1.1- 33.3 mmol/litre</td>
<td>LifeScan</td>
</tr>
<tr>
<td>One Touch® Vita Free of charge from diabetes healthcare professionals</td>
<td>Blood glucose</td>
<td>One Touch® Vita</td>
<td>50 strip= £15.07</td>
<td>1.1- 33.3 mmol/litre</td>
<td>LifeScan</td>
</tr>
<tr>
<td>SD CodeFree®</td>
<td>Blood glucose</td>
<td>SD CodeFree®</td>
<td>50 strip= £6.99</td>
<td>0.6- 33.3 mmol/litre</td>
<td>SD Biosensor Inc</td>
</tr>
<tr>
<td>Sensocard Plus®</td>
<td>Blood glucose</td>
<td>Sensocard®</td>
<td>50 strip= £16.30</td>
<td>1.1- 33.3 mmol/litre</td>
<td>BBI Healthcare Ltd</td>
</tr>
<tr>
<td>Meter (all part)</td>
<td>Type of monitoring</td>
<td>Compatible test strips</td>
<td>Test strip net price</td>
<td>Sensitivity range (mmol/litre)</td>
<td>Manufacturer</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------</td>
<td>------------------------</td>
<td>---------------------</td>
<td>-----------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>SuperCheck®</strong></td>
<td>Blood glucose</td>
<td>SuperCheck®</td>
<td>£0.00</td>
<td>1.1-33.3 mmol/litre</td>
<td>Apollo Medical Technologies Ltd</td>
</tr>
<tr>
<td><strong>Mendor Discreet testing strips</strong></td>
<td>Blood glucose</td>
<td>TRUEone® All-in-one test strips and meter</td>
<td>£0.00</td>
<td>1.1-33.3 mmol/litre</td>
<td>Nipro Diagnostics (UK) Ltd</td>
</tr>
<tr>
<td><strong>MediTouch testing strips</strong></td>
<td>Blood glucose</td>
<td>TRUEresult® Free of charge from diabetes healthcare professionals</td>
<td>£14.99</td>
<td>1.1-33.3 mmol/litre</td>
<td>Nipro Diagnostics (UK) Ltd</td>
</tr>
<tr>
<td><strong>MediSense SoftSense testing strips</strong></td>
<td>Blood glucose</td>
<td>TRUEresult twist® Free of charge from diabetes healthcare professionals</td>
<td>£14.99</td>
<td>1.1-33.3 mmol/litre</td>
<td>Nipro Diagnostics (UK) Ltd</td>
</tr>
<tr>
<td><strong>MODZ testing strips</strong></td>
<td>Blood glucose</td>
<td>TRUEtrack® Free of charge from diabetes healthcare professionals</td>
<td>£14.99</td>
<td>1.1-33.3 mmol/litre</td>
<td>Nipro Diagnostics (UK) Ltd</td>
</tr>
<tr>
<td><strong>GlucoRx Q testing strips</strong></td>
<td>Blood glucose</td>
<td>TRUEyou® Mini® Free of charge from diabetes healthcare professionals</td>
<td>£9.92</td>
<td>1.1-33.3 mmol/litre</td>
<td>Nipro Diagnostics (UK) Ltd</td>
</tr>
<tr>
<td><strong>GlucoMen areo Sensor testing strips</strong></td>
<td>Blood glucose</td>
<td>WaveSense JAZZ® Free of charge from diabetes healthcare professionals</td>
<td>£8.74</td>
<td>1.1-33.3 mmol/litre</td>
<td>AgaMatrix Europe Ltd</td>
</tr>
</tbody>
</table>

**GluNEO testing strips** (Neon Diagnostics Ltd)
50 strip - NHS indicative price = £9.49 - Drug Tariff (Part IXr)

**GlucoDock testing strips** (Medisana Healthcare (UK) Ltd)
50 strip - NHS indicative price = £19.00 - Drug Tariff (Part IXr)

**GlucoLab testing strips** (Neon Diagnostics Ltd)
50 strip - NHS indicative price = £9.99 - Drug Tariff (Part IXr)

**GlucoMen LX Sensor testing strips** (A. Menarini Diagnostics Ltd)
50 strip - NHS indicative price = £15.76 - Drug Tariff (Part IXr)

**GlucoMen areo Sensor testing strips** (A. Menarini Diagnostics Ltd)
50 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)

**GlucoRx GO Professional testing strips** (GlucoRx Ltd)
50 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)

**GlucoRx HCT Glucose testing strips** (GlucoRx Ltd)
50 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)

**GlucoRx Nexus testing strips** (GlucoRx Ltd)
50 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)

**GlucoRx Q testing strips** (GlucoRx Ltd)
50 strip - NHS indicative price = £9.45 - Drug Tariff (Part IXr)

**GlucoZen auto testing strips** (GlucoZen Ltd)
50 strip - NHS indicative price = £7.64 - Drug Tariff (Part IXr)100 strip - NHS indicative price = £10.85 - Drug Tariff (Part IXr)

**Glucoflex-R testing strips** (Bio-Diagnostics Ltd)
50 strip - NHS indicative price = £6.75 - Drug Tariff (Part IXr)

**IME-DC testing strips** (Arctic Medical Ltd)
50 strip - NHS indicative price = £14.10 - Drug Tariff (Part IXr)

**MODZ testing strips** (Medyz Oy)
50 strip - NHS indicative price = £14.00 - Drug Tariff (Part IXr)

**Medi-Test Glucose testing strips** (BH Pharmaaceuticals Ltd)
50 strip - NHS indicative price = £2.33 - Drug Tariff (Part IXr)

**MediSense SoftSense testing strips** (Abbott Laboratories Ltd)
50 strip - NHS indicative price = £15.05 - Drug Tariff (Part IXr)

**MediTouch 2 testing strips** (Medisana Healthcare (UK) Ltd)
50 strip - NHS indicative price = £12.49 - Drug Tariff (Part IXr)

**MediTouch testing strips** (Medisana Healthcare (UK) Ltd)
50 strip - NHS indicative price = £14.90 - Drug Tariff (Part IXr)

**Mendor Discreet testing strips** (SpringMed Solutions Ltd)
50 strip - NHS indicative price = £14.75 - Drug Tariff (Part IXr)

**Microdot® testing strips** (Cambridge Sensors Ltd)
50 strip - NHS indicative price = £9.49 - Drug Tariff (Part IXr)

**Mobile cassette** (Roche Diabetes Care Ltd)
50 device - NHS indicative price = £9.99 - Drug Tariff (Part IXr)

**Myglucosehealth testing strips** (Entra Health Systems Ltd)
50 strip - NHS indicative price = £15.50 - Drug Tariff (Part IXr)

**Mylife Pura testing strips** (Ypomed Ltd)
50 strip - NHS indicative price = £9.50 - Drug Tariff (Part IXr)

**Mylife Unio testing strips** (Ypomed Ltd)
50 strip - NHS indicative price = £9.50 - Drug Tariff (Part IXr)

**OKmeter Core testing strips** (Syringa UK Ltd)
50 strip - NHS indicative price = £9.90 - Drug Tariff (Part IXr)

**Omnitest 3 testing strips** (B.Braun Medical Ltd)
50 strip - NHS indicative price = £9.89 - Drug Tariff (Part IXr)

**Omnitest 5 testing strips** (B.Braun Medical Ltd)
50 strip - NHS indicative price = £9.89 - Drug Tariff (Part IXr)

**On-Call Advanced testing strips** (Point Of Care Testing Ltd)
50 strip - NHS indicative price = £13.65 - Drug Tariff (Part IXr)

**OneTouch Select Plus testing strips** (LifeScan)
50 strip - NHS indicative price = £9.39 - Drug Tariff (Part IXr)

**OneTouch Verio testing strips** (LifeScan)
50 strip - NHS indicative price = £15.12 - Drug Tariff (Part IXr)

**Performa testing strips** (Roche Diabetes Care Ltd)
50 strip - NHS indicative price = £7.50 - Drug Tariff (Part IXr)

**SD CodeFree testing strips** (SD Biosensor Inc)
50 strip - NHS indicative price = £6.99 - Drug Tariff (Part IXr)

**SURESEND Resure testing strips** (Ciga Healthcare Ltd)
50 strip - NHS indicative price = £8.49 - Drug Tariff (Part IXr)

**Sensocard testing strips** (BBI Healthcare Ltd)
50 strip - NHS indicative price = £16.30 - Drug Tariff (Part IXr)

**StatStrip testing strips** (Nova Biomedical)
50 strip - No NHS indicative price available - Drug Tariff (Part IXr)

**TEEK testing strips** (Spirit Healthcare Ltd)
50 strip - NHS indicative price = £7.75 - Drug Tariff (Part IXr)

**TRUEresult testing strips** (Nipro Diagnostics (UK) Ltd)
50 strip - NHS indicative price = £14.99 - Drug Tariff (Part IXr)

**TRUEyou testing strips** (Nipro Diagnostics (UK) Ltd)
50 strip - NHS indicative price = £9.92 - Drug Tariff (Part IXr)

**True Metrix testing strips** (Trividia Health UK Ltd)
50 strip - NHS indicative price = £6.95 - Drug Tariff (Part IXr)
TrueTrack System testing strips (Nipro Diagnostics (UK) Ltd) 50 strip - NHS indicative price = £14.99 - Drug Tariff (Part IXr)
VivaChek One testing strips (IR Biomedical Ltd) 50 strip - NHS indicative price = £8.99 - Drug Tariff (Part IXr)
WaveSense JAZZ Duo testing strips (AgaMatrix Europe Ltd) 50 strip - NHS indicative price = £8.74 - Drug Tariff (Part IXr)
WaveSense JAZZ testing strips (AgaMatrix Europe Ltd) 50 strip - NHS indicative price = £8.74 - Drug Tariff (Part IXr)
Xceed Precision Pro testing strips (Abbott Laboratories Ltd) 10 strip - No NHS indicative price available 50 strip - No NHS indicative price available - Drug Tariff (Part IXr) 100 strip - No NHS indicative price available - Drug Tariff (Part IXr)
eBcheck testing strips (IRASCO Ltd) 50 strip - NHS indicative price = £15.89 - Drug Tariff (Part IXr)
iHealth testing strips (Technomed Ltd) 50 strip - NHS indicative price = £49.9 - Drug Tariff (Part IXr)
palmodc iCare Advanced Solo testing strips (Palmodc Ltd) 50 strip - NHS indicative price = £13.50 - Drug Tariff (Part IXr)
palmodc iCare Advanced testing strips (Palmodc Ltd) 50 strip - NHS indicative price = £9.70 - Drug Tariff (Part IXr)
palmodc testing strips (Palmodc Ltd) 50 strip - NHS indicative price = £9.40 - Drug Tariff (Part IXr)

Blood ketones testing strips

Blood ketones testing strips

4SURE beta-ketone testing strips (Nipro Diagnostics (UK) Ltd) 10 strip - NHS indicative price = £9.92 - Drug Tariff (Part IXr)
Fora Advanced pro GD40 Ketone testing strips (B.Braun Medical Ltd) 10 strip - NHS indicative price = £9.25 - Drug Tariff (Part IXr)
FreeStyle Optium H beta-ketone testing strips (Abbott Laboratories Ltd) 10 strip - No NHS indicative price available - Drug Tariff (Part IXr)
FreeStyle Optium beta-ketone testing strips (Abbott Laboratories Ltd) 10 strip - No NHS indicative price available - Drug Tariff (Part IXr)
FreeStyle Precision Pro beta-ketone testing strips (Abbott Laboratories Ltd) 50 strip - No NHS indicative price available
GlucOmen LX beta-ketone testing strips (A. Menarini Diagnostics Ltd) 10 strip - NHS indicative price = £21.06 - Drug Tariff (Part IXr)
GlucOmen areo Ketone Sensor testing strips (A. Menarini Diagnostics Ltd) 10 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)
GlucoRx HCT Ketone testing strips (GlucoRx Ltd) 10 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)
KetoSens testing strips (Spirit Healthcare Ltd) 10 strip - NHS indicative price = £9.95 - Drug Tariff (Part IXr)
StatStrip beta-ketone testing strips (Nova Biomedical) 50 strip - No NHS indicative price available
Xceed Precision Pro beta-ketone testing strips (Abbott Laboratories Ltd) 10 strip - No NHS indicative price available - Drug Tariff (Part IXr) 50 strip - No NHS indicative price available 100 strip - No NHS indicative price available

Hypodermic insulin injection pens

Hypodermic insulin injection pens

AUTOPEN® 24

Autopen® 24 (for use with Sanofi® - Aventis 3-mL insulin cartridges), allowing 1-unit dosage adjustment, max. 21 units (single-unit version) or 2-unit dosage adjustment, max. 42 units (2-unit version).

Autopen 24 hypodermic insulin pen reusable for 3 ml cartridge 1 unit dial up / range 1-21 units (Owen Mumford Ltd) 1 device - NHS indicative price = £16.71 - Drug Tariff (Part IXa)

Autopen 24 hypodermic insulin pen reusable for 3 ml cartridge 2 unit dial up / range 2-42 units (Owen Mumford Ltd) 1 device - NHS indicative price = £16.71 - Drug Tariff (Part IXa)

AUTOPEN® CLASSIC

Autopen® Classic (for use with Lilly and Woolhard 3-mL insulin cartridges), allowing 1-unit dosage adjustment,
3.2 Hypoglycaemia

Hypoglycaemia

Treatment of hypoglycaemia

Prompt treatment of hypoglycaemia in children from any cause is essential as severe hypoglycaemia may cause subsequent neurological damage. Hyperinsulinism, fatty acid oxidation disorders and glycogen storage disease are less common causes of acute hypoglycaemia in children. Initially glucose 10–20 g p. 611 is given by mouth either in liquid form or as granulated sugar or sugar lumps. If necessary this may be repeated after 10–15 minutes. After initial treatment, a snack providing sustained availability of carbohydrate (e.g. a sandwich, fruit, milk, or biscuits) or the next meal (if it is due) can prevent blood-glucose concentration from falling again.

Proprietary products of quick-acting carbohydrate (e.g. GlucoGel®, Dextrogel®, GSF-Syrup®, Rapilose® gel) are available on prescription for patients to keep on hand in case of hypoglycaemia. Alternatively, approximately 10 g of glucose is available from 2 teaspoons of sugar, or from 3 sugar lumps, and also from non-diet versions of the following soft drinks: 110 mL of Lucozade® Energy Original (also, see note below), 100 mL of Coca-Cola®, 19 mL of Ribena® Blackcurrant (to be diluted).

Note: the carbohydrate content of commercially available glucose-containing drinks is currently subject to change — individual product labels should be checked.

Patients should be aware that for a time, both old and new bottles and cans may be available — individual product labels should be checked.

Hypoglycaemia which causes unconsciousness or seizures is an emergency. Glucagon below, a polypeptide hormone produced by the alpha cells of the islets of Langerhans, increases blood-glucose concentration by mobilising glycogen stored in the liver. In hypoglycaemia, if sugar cannot be given by mouth, glucagon can be given by injection. Carbohydrates should be given as soon as possible to restore liver glycogen; glucagon is not appropriate for chronic hypoglycaemia. Glucagon can be issued to parents or carers of insulin-treated children for emergency use in hypoglycaemic attacks. It is often advisable to prescribe it on an ‘if necessary’ basis for hospitalised insulin-treated children, so that it can be given rapidly by the nurses during a hypoglycaemic emergency. If not effective in 10 minutes intravenous glucose should be given.

Alternatively, glucose intravenous infusion 10% can be given intravenously into a large vein through a large-gauge needle; care is required since this concentration is irritant especially if extravasation occurs. Glucose intravenous infusion 50% is not recommended, as it is very viscous and hypertonic. Close monitoring is necessary, particularly in the case of an overdose with a long-acting insulin because further administration of glucose may be required. Children whose hypoglycaemia is caused by an oral antidiabetic drug should be transferred to hospital because the hypoglycaemic effects of these drugs can persist for many hours.

Glucagon is not effective in the treatment of hypoglycaemia due to fatty acid oxidation or glycogen storage disorders.

Chronic hypoglycaemia

Diazoxide p. 483 is useful in the management of chronic hypoglycaemia due to excessive insulin secretion, either from a tumour involving the islets of Langerhans or from persisting hyperinsulinaemic hypoglycaemia of infancy (nesidioblastosis). Diazoxide has no place in the management of acute hypoglycaemia. Chlorothiazide p. 113 reduces diazoxide-induced sodium and water retention and has the added benefit of potentiating the glycaemic effect of diazoxide.

If diazoxide and chlorothiazide fail to suppress excessive glucose requirements in chronic hypoglycaemia then octreotide p. 483 or nifedipine p. 111 can be added. Octreotide suppresses secretion of growth hormone, but growth is unlikely to be affected in the long term.

Neonatal hypoglycaemia

Neonatal hypoglycaemia at birth is treated with glucose intravenous infusion 10%. Mild asymptomatic persistent hypoglycaemia may respond to a single dose of glucagon. Glucagon has also been used in the short-term management of endogenous hyperinsulinism.

GLYCOGENOLYTIC HORMONES

Glucagon

- **INDICATIONS AND DOSE**
  - **Insulin-induced hypoglycaemia**
    - By subcutaneous injection, or by intramuscular injection
    - Neonate: 20 micrograms/kg.
    - Child 1 month–1 year: 500 micrograms
    - Child 2–7 years (body-weight up to 25 kg): 500 micrograms, if no response within 10 minutes intravenous glucose must be given
    - Child 2–7 years (body-weight 25 kg and above): 1 mg, if no response within 10 minutes intravenous glucose must be given
  - **Endogenous hyperinsulinism**
    - By intramuscular injection, or by intravenous injection
    - Neonate: 200 micrograms/kg (max. per dose 1 mg) for 1 dose.
    - Child 1 month–1 year: 1 mg for 1 dose
    - By continuous intravenous infusion
    - Neonate: 1–18 micrograms/kg/hour (max. per dose 50 micrograms/kg/hour), adjusted according to response.
    - Child 1 month–1 year: 1–10 micrograms/kg/hour, dose to be adjusted as necessary
  - **Diagnosis of growth hormone secretion (specialist use only)**
    - By intramuscular injection
    - Child: 100 micrograms/kg (max. per dose 1 mg) for 1 dose, dose may vary, consult local guidelines
  - **Beta-blocker poisoning (cardiogenic shock unresponsive to atropine)**
    - Initially by intravenous injection
    - Child: 50–150 micrograms/kg (max. per dose 10 mg), to be administered in glucose 5% (with precautions to protect the airway in case of vomiting), followed by (by intravenous infusion) 50 micrograms/kg/hour

- **DOSE EQUIVALENCE AND CONVERSION**
  - 1 unit of glucagon = 1 mg of glucagon.

- **UNLICENSED USE** Dose and indication for cardiogenic shock unresponsive to atropine in beta-blocker overdose not licensed.

Unlicensed for growth hormone test and hyperinsulinism.

- **CONTRA-INDICATIONS** Phaeochromocytoma
- **CAUTIONS** Glucagonoma - ineffective in chronic hypoglycaemia, starvation, and adrenal insufficiency - insulinoma - when used in the diagnosis of growth
3.2a Chronic hypoglycaemia

Other drugs used for Chronic hypoglycaemia
Chlorothiazide, p. 113

GLYCOGENOLYTIC HORMONES

Diazoxide

- **INDICATIONS AND DOSE**
  - **Resistant hypertension**
    - **BY MOUTH**
      - Neonate: Initially 1.7 mg/kg 3 times a day, adjusted according to response; maximum 15 mg/kg per day.
      - Child: Initially 1.7 mg/kg 3 times a day, adjusted according to response; maximum 15 mg/kg per day.
  - **Chronic intractable hypoglycaemia**
    - **BY MOUTH**
      - Neonate: Initially 5 mg/kg twice daily, adjusted according to response, initial dose used to establish response; maintenance 1.5–3 mg/kg 2–3 times a day; increased if necessary up to 7 mg/kg 3 times a day, higher doses are unlikely to be beneficial, but may be required in some cases.
      - Child: Initially 1.7 mg/kg 3 times a day, adjusted according to response; maintenance 1.5–3 mg/kg 2–3 times a day, increased if necessary up to 5 mg/kg 3 times a day, doses up to 5 mg/kg may be required in some cases, but higher doses are unlikely to be beneficial.

- **UNLICENSED USE**
  Not licensed for resistant hypertension.

- **CAUTIONS**
  - Aortic coarctation • aortic stenosis • arteriovenous shunt • heart failure • hyperuricaemia • impaired cardiac circulation • impaired cerebral circulation

- **INTERACTIONS**
  
  - **SIDE-EFFECTS**
    - Abdominal pain • albuminuria • appetite decreased (long term use) • arrhythmia • azotemia • cardiomegaly • cataract • constipation • diabetic hyperosmolar coma • diarrhoea • dizziness • dyspnoea • eosinophilia • extrapyramidal symptoms • face abnormal • fever • fluid retention • galactorrhoea • haemorrhage • headache • heart failure • hirsutism • hyperglycaemia • hyperuricaemia (long term use) • hypogammaglobulinaemia • hypotension • ileus • ketoacidosis • leucopenia • libido decreased • muscular skeletal pain • nausea • nephritic syndrome • oculogyric crisis • pancreatitis • parkinsonism • pulmonary hypertension • skin reactions • sodium retention • taste altered • thrombocytopenia • tinnitus • vision disorders • voice alteration (long term use) • vomiting

- **PREGNANCY**
  - Use only if essential; alopecia and hypertrichosis reported in neonates with prolonged use; may inhibit uterine activity during labour.

- **BREAST FEEDING**
  - Manufacturer advises avoid—no information available.

- **RENAL IMPAIRMENT**
  - Dose adjustments: Dose reduction may be required.

- **MONITORING REQUIREMENTS**
  - Monitor blood pressure.
  - Monitor white cell and platelet count during prolonged use.
  - Regularly assess growth, bone, and psychological development during prolonged use.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Powder and Solvent for solution for injection
    - GlucaGen Hypokit (Novo Nordisk Ltd)

  Glucagon hydrochloride 1 mg
  Glucagon powder for injection 1 vial £11.52 DT = £11.52

Chronic hypoglycaemia 483

Diazoxide 50 mg
(RPH Pharmaceuticals AB)
Diazoxide 25 mg
(RPH Pharmaceuticals AB)

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

Somatostatin analogues

**CAUTIONS**
- Diabetes mellitus (antidiabetic requirements may be reduced) • insulinoma (increased depth and duration of hypoglycaemia may occur—observe patients and monitor blood glucose levels when initiating treatment and changing doses)

**SIDE-EFFECTS**
- Common or very common • Alopecia • appetite decreased • asthenia • cholecystitis • cholelithiasis (following long term use) • cholesterol • constipation • diabetes mellitus • diarrhoea • dizziness • gastrointestinal discomfort • gastrointestinal disorders • glucose tolerance impaired (following long term use) • headache • hyperglycaemia (long term use) • hypoglycaemia • myalgia • nausea • pruritus • sinus bradycardia • vomiting

**DIRECTIONS FOR ADMINISTRATION**
- Injection sites should be rotated.

Octreotide

**INDICATIONS AND DOSE**

- **Persistent hyperinsulinaemic hypoglycaemia unresponsive to diazoxide and glucose**

  - **BY SUBCUTANEOUS INJECTION**

  - Neonate: Initially 2–5 micrograms/kg every 6–8 hours, adjusted according to response; increased if necessary up to 7 micrograms/kg every 4 hours, dosing up to 7 micrograms/kg may rarely be required.
Disorders of bone metabolism

Bone metabolism

Disorders of bone metabolism

The two main disorders of bone metabolism that occur in children are rickets and osteoporosis. The two most common forms of rickets are Vitamin D deficiency rickets and hypophosphataemic rickets. See also calcium.

Osteoporosis

Osteoporosis in children may be primary (e.g. osteogenesis imperfecta and idiopathic juvenile osteoporosis), or secondary (e.g. due to inflammatory disorders, immobilisation, or corticosteroids); specialist management is required.

Corticosteroid-induced osteoporosis

To reduce the risk of osteoporosis doses of oral corticosteroids should be as low as possible and courses of treatment as short as possible.

Calcitonin

Calcitonin is involved with parathyroid hormone in the regulation of bone turnover and hence in the maintenance of calcium balance and homeostasis. Calcitonin (salmon) is used by specialists to lower the plasma-calcium concentration in children with hypercalcaemia associated with malignancy.

Bisphosphonates

A bisphosphonate such as pamidronate disodium p. 486 is used in the management of severe forms of osteogenesis imperfecta and other causes of osteoporosis in children to reduce the number of fractures; the long-term effects of bisphosphonates in children has not been established. Single doses of bisphosphonates are also used to manage hypercalcaemia. Treatment should be initiated under specialist advice only.

Other drugs used for Disorders of bone metabolism

Calcitriol, p. 653
Bisphosphonates

Bisphosphonates are adsorbed onto hydroxyapatite crystals in bone, slowing both their rate of growth and dissolution, and therefore reducing the rate of bone turnover.

Important Safety Information

**Mhra/Cmh Advice: Bisphosphonates: Atypical Femoral Fractures (June 2013)**

Atypical femoral fractures have been reported rarely with bisphosphonate treatment, mainly in patients receiving long-term treatment for osteoporosis.

The need to continue bisphosphonate treatment for osteoporosis should be re-evaluated periodically based on an assessment of the benefits and risks of treatment for individual patients, particularly after 5 or more years of use.

Patients should be advised to report any thigh, hip, or groin pain during treatment with a bisphosphonate.

Discontinuation of bisphosphonate treatment in patients suspected to have an atypical femoral fracture should be considered after an assessment of the benefits and risks of continued treatment.

**Mhra/Cmh Advice: Bisphosphonates: Osteonecrosis of the Jaw (November 2009) and Intravenous Bisphosphonates: Osteonecrosis of the Jaw—Further Measures to Minimise Risk (July 2015)**

The risk of osteonecrosis of the jaw is substantially greater for patients receiving intravenous bisphosphonates in the treatment of cancer than for patients receiving oral bisphosphonates for osteoporosis or Paget’s disease.

Risk factors for developing osteonecrosis of the jaw that should be considered are: potency of bisphosphonate (highest for zoledronic), route of administration, cumulative dose, duration and type of malignant disease, concomitant treatment, smoking, comorbid conditions, and history of dental disease.

All patients should have a dental check-up (and any necessary remedial work should be performed) before bisphosphonate treatment, or as soon as possible after starting treatment. Patients should also maintain good oral hygiene, receive routine dental check-ups, and report any oral symptoms such as dental mobility, pain, or swelling.

Before prescribing an intravenous bisphosphonate, patients should be given a patient reminder card and informed of the risk of osteonecrosis of the jaw. Advise patients to tell their doctor if they have any problems with their mouth or teeth before starting treatment, and if the patient wears dentures, they should make sure their dentures fit properly. Patients should tell their doctor and dentist that they are receiving an intravenous bisphosphonate if they need dental treatment or dental surgery.


**Mhra/Cmh Advice: Bisphosphonates: Osteonecrosis of the External Auditory Canal (December 2015)**

Benign idiopathic osteonecrosis of the external auditory canal has been reported very rarely with bisphosphonate treatment, mainly in patients receiving long-term therapy (2 years or longer).

The possibility of osteonecrosis of the external auditory canal should be considered in patients receiving bisphosphonates who present with ear symptoms, including chronic ear infections, or suspected cholesteatoma.

Risk factors for developing osteonecrosis of the external auditory canal include: steroid use, chemotherapy, infection, an ear operation, or cotton bud use.

Patients should be advised to report any ear pain, discharge from the ear, or an ear infection during treatment with a bisphosphonate.

**Side-effects**

- Common or very common Alopoeia - anaemia - arthralgia - asthenia - constipation - diarrhoea - dizziness - dysphagia - electrolyte imbalance - eye inflammation - fever - gastritis - gastrointestinal discomfort - headache - influenza like illness - malaise - myalgia - nausea - oesophageal ulcer (discontinue) - oesophagitis (discontinue) - pain - peripheral oedema - renal impairment - skin reactions - taste altered - vomiting

- uncommon Anaphylactic reaction - angioedema - bronchospasm - oesophageal stenosis (discontinue) - osteonecrosis

- Rare or very rare Atypical femur fracture - Stevens-Johnson syndrome

**Patient and Carer Advice**

Atypical femoral fractures: Patients should be advised to report any thigh, hip, or groin pain during treatment with a bisphosphonate.

Osteonecrosis of the jaw: During bisphosphonate treatment patients should maintain good oral hygiene, receive routine dental check-ups, and report any oral symptoms.

Osteonecrosis of the external auditory canal: Patients should be advised to report any ear pain, discharge from ear or an ear infection during treatment with a bisphosphonate.

Alendronic Acid

(Alendronate)

**Indications and Dose**

Osteoporosis (due to osteogenesis imperfecta and other causes) (initiated under specialist supervision)
- By mouth
- Child: (consult local protocol)

**Unlicensed Use**

Not licensed for use in children.

**Contra-Indications**

Abnormalities of oesophagus · hypocalcaemia · other factors which delay emptying (e.g. stricture or achalasia)

**Caution**

Active gastro-intestinal bleeding · atypical femoral fractures · duodenitis · dysphagia · exclude other causes of osteoporosis · gastritis · history (within 1 year) of ulcers · surgery of the upper gastro-intestinal tract · symptomatic oesophageal disease · ulcers · upper gastro-intestinal disorders

**Interactions**

- Appendix 1: bisphosphonates

**Side-effects**

- Common or very common Gastrointestinal disorders · joint swelling · vertigo
- Uncommon Haemorrhage
- Rare or very rare Femoral stress fracture · oropharyngeal ulceration · photosensitivity reaction · severe cutaneous adverse reactions (SCARs)

**Side-effects, Further Information**

Severe oesophageal reactions (oesophagitis, oesophageal ulcers, oesophageal stricture and oesophageal erosions) have been reported; patients should be advised to stop taking the tablets and to seek medical attention if they develop symptoms of oesophageal irritation such as dysphagia, new or
worsening heartburn, pain on swallowing or retrosternal pain.

- **PREGNANCY** Avoid.
- **BREAST FEEDING** Manufacturer advises avoidance—no information available.
- **RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate is less than 35 mL/minute/1.73 m².
- **MONITORING REQUIREMENTS** Correct disturbances of calcium and mineral metabolism (e.g. vitamin-D deficiency, hypocalcaemia) before starting treatment. Monitor serum-calcium concentration during treatment.
- **DIRECTIONS FOR ADMINISTRATION** Tablets should be swallowed whole and oral solution should be swallowed as a single 100 mL dose. Doses should be taken with plenty of water while sitting or standing, on an empty stomach at least 30 minutes before breakfast (or another oral medicine); patient should stand or sit upright for at least 30 minutes after administration.

- **PATIENT AND CARER ADVICE** Patients or their carers should be given advice on how to administer alendronic acid tablets and oral solution. Oesophageal reactions Patients (or their carers) should be advised to stop taking alendronic acid and to seek medical attention if they develop symptoms of oesophageal irritation such as dysphagia, new or worsening heartburn, pain on swallowing or retrosternal pain.

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

- **Alendronic acid (Non-proprietary)**
  - Alendronic acid 700 microgram per 1 mL Alendronic acid 700mg/100ml oral solution unit dose sugar-free (specialist use only) | 4 unit dose (P) £28.56 DT + £28.56

- **Effervescent tablet**
  - **Binosto (Interis Pharmaceuticals Ltd)**
    - Alendronic acid (as Alendronate sodium) 70 mg Binosto 70mg effervescent tablets sugar-free | 4 tablet (P) £22.80 DT + £22.80

- **Tablet**
  - **Alendronic acid (Non-proprietary)**
    - Alendronic acid (as Alendronate sodium) 10 mg Alendronic acid 10mg tablets | 28 tablet (P) £3.25 DT + £1.46
    - Alendronic acid (as Alendronate sodium) 70 mg Alendronic acid 70mg tablets | 4 tablet (P) £22.80 DT + £0.86

- **Fosamax Once Weekly (Merck Sharp & Dohme Ltd)**
  - Alendronic acid (as Alendronate sodium) 70 mg Fosamax Once Weekly 70mg tablets | 4 tablet (P) £22.80 DT + £0.86

### Pamidronate disodium

(Formerly called aminohydroxypropyldenediphosphonate disodium (APD))

- **INDICATIONS AND DOSE**
  - **Osteoporosis (due to osteogenesis imperfecta and other causes) (specialist use only)** Hypercalcaemia (specialist use only)
    - **BY INTRAVENOUS INFUSION**
      - Child: (consult product literature)
  - **UNLICENSED USE** Not licensed for use in children.
  - **CAUTIONS** Atypical femoral fractures - cardiac disease - ensure adequate hydration - previous thyroid surgery (risk of hypocalcaemia)
  - **INTERACTIONS** → Appendix 1: bisphosphonates
  - **SIDE-EFFECTS**
    - Common or very common Appetite decreased - chills - decreased leucocytes - drowsiness - flushing - hypertension - insomnia - paraesthesia - tetany - thrombocytopenia
    - Uncommon Agitation - dyspnoea - hypotension - muscle cramps - seizure
    - Rare or very rare Confusion - glomerulonephritis - haematuria - heart failure - nephritis tubulointerstitial - nephrotic syndrome - oedema - pulmonary oedema - reactivation of infections - renal disorder exacerbated - renal tubular disorder - respiratory disorders - visual hallucinations - xanthopsia
    - Frequency not known Atrial fibrillation
  - **PREGNANCY** Avoid—toxicity in animal studies.
  - **BREAST FEEDING** Avoid.
  - **HEPATIC IMPAIRMENT** Manufacturer advises caution in severe hepatic impairment (no information available).
  - **RENAL IMPAIRMENT** Monitoring Monitor renal function in renal disease or predisposition to renal impairment (e.g. in tumour-induced hypercalcaemia).
  - **DIRECTIONS FOR ADMINISTRATION** For slow intravenous infusion (Pamidronate disodium, Hospira, Medac, Wockhardt), give intermittently in glucose 5% or sodium chloride 0.9%; give at a rate not exceeding 1 mg/minute; not to be given with infusion fluids containing calcium. For Pamidronate disodium (Medac, Hospira, Wockhardt) dilute with infusion fluid to a concentration of not more than 90 mg in 250 mL.
  - **PATIENT AND CARER ADVICE** A patient reminder card should be provided (risk of osteonecrosis of the jaw).
  - **Driving and skilled tasks** Patients should be warned against performing skilled tasks (e.g. cycling, driving or operating machinery) immediately after treatment (somnolence or dizziness can occur).

### Risedronate sodium

- **INDICATIONS AND DOSE**
  - **Osteoporosis (due to osteogenesis imperfecta and other causes) (specialist use only)** Hypercalcaemia (specialist use only)
    - **BY MOUTH**
      - Child: (consult local protocol)
  - **UNLICENSED USE** Not licensed for use in children.
  - **CONTRA-INDICATIONS** Hypocalcaemia
  - **CAUTIONS** Atypical femoral fractures - oesophageal abnormalities - other factors which delay transit or emptying (e.g. stricture or achalasia)
  - **INTERACTIONS** → Appendix 1: bisphosphonates
Disorders of bone metabolism

Risedronate sodium 35 mg Tablet

> **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

**Tablet**

> **Risedronate sodium (Non-proprietary)**
> Risedronate sodium 5 mg Risedronate sodium 5mg tablets | 28 tablet (Pos) £24.78 DT = £11.85
> Risedronate sodium 30 mg Risedronate sodium 30mg tablets | 28 tablet (Pos) £155.26 DT = £55.25
> Risedronate sodium 35 mg Risedronate sodium 35mg tablets | 4 tablet (Pos) £135.12 DT = £0.77
> Actonel (Warner Chilcott UK Ltd, Teva UK Ltd)
> Risedronate sodium 5 mg Actonel 5mg tablets | 28 tablet (Pos) £17.99 DT = £11.85
> Risedronate sodium 30 mg Actonel 30mg tablets | 28 tablet (Pos) £143.95 DT = £55.25
> Risedronate sodium 35 mg Actonel Once a Week 35mg tablets | 4 tablet (Pos) £135.12 DT = £0.77
> Actonel 35mg tablets | 4 tablet (Pos) DT = £0.77

Sodium clodronate

> **INDICATIONS AND DOSE**

Osteoporosis (due to osteogenesis imperfecta or other causes) (specialist use only) | Hypercalcaemia (specialist use only)

> **BY MOUTH**
> 1. **Child:** (consult local protocol)

> **UNLICENSED USE** Not licensed for use in children.
> 1. **CONTRA-INDICATIONS**
> 1. Acute gastro-intestinal inflammatory conditions
> 1. **CAUTIONS**
> 1. Atypical femoral fractures - maintain adequate fluid intake during treatment

> **INTERACTIONS** → Appendix 1: bisphosphonates
> 1. **SIDE-EFFECTS**
> 1. Proteinuria • respiratory disorder
> 1. **PREGNANCY** Avoid.
> 1. **BREAST FEEDING** Manufacturer advises avoid—no information available.
> 1. **RENAI IMPAIRMENT** Avoid if estimated glomerular filtration rate less than 10 mL/minute/1.73 m².
> 1. **Dose adjustments** Reduce dose if estimated glomerular filtration rate 30—50 mL/minute/1.73m².
> 1. Use half normal dose if estimated glomerular filtration rate 10—30 mL/minute/1.73 m².
> 1. **MONITORING REQUIREMENTS** Monitor renal function, serum calcium and serum phosphate before and during treatment.

> **DIRECTIONS FOR ADMINISTRATION** Avoid food for 2 hours before and 1 hour after treatment, particularly calcium-containing products e.g. milk; also avoid iron and mineral supplements and antacids; maintain adequate fluid intake.

> **PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer sodium clodronate capsules and tablets.

> **MEDICAL adverses** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

> **Bonefos (Bayer Plc)**
> Sodium clodronate 800 mg Bonefos 800mg tablets | 60 tablet (Pos) £114.43 DT = £14.63
> **Loron (Intrapharm Laboratories Ltd)**
> Sodium clodronate 520 mg Loron 520mg tablets | 60 tablet (Pos) £114.44 DT = £11.44

**Capsule**

> **Sodium clodronate (Non-proprietary)**
> Sodium clodronate 400 mg Sodium clodronate 400mg capsules | 30 capsule (Pos) £34.96 | 120 capsule (Pos) £119.83 DT = £139.83
> **Bonefos (Bayer Plc)**
> Sodium clodronate 400 mg Bonefos 400mg capsules | 120 capsule (Pos) £139.83 DT = £139.83
> **Clasteon (Kent Pharmaceuticals Ltd)**
> Sodium clodronate 400 mg Clasteon 400mg capsules | 30 capsule (Pos) £34.96 | 120 capsule (Pos) £119.83 DT = £139.83
Endocrine system

DRUGS AFFECTING BONE STRUCTURE AND MINERALISATION

MONOClonal antibodies

Denosumab

26-Sep-2018

Drug action

Denosumab is a human monoclonal antibody that inhibits osteoclast formation, function, and survival, thereby decreasing bone resorption.

Indications and dose

XGEVA

Giant cell tumour of bone that is unresectable or where surgical resection is likely to result in severe morbidity in skeletally mature adolescents

By subcutaneous injection

Child: 120 mg every 4 weeks, give additional dose on days 8 and 15 of the first month of treatment only, supplementation of at least calcium 500 mg and Vitamin D 400 units daily should also be taken unless hypercalcaemia is present, to be administered into the thigh, abdomen or upper arm

Important safety information

MHRA/CHM advice: denosumab: minimising the risk of osteonecrosis of the jaw; monitoring for hypercalcaemia—updated recommendations (September 2014) and denosumab: osteonecrosis of the jaw—further measures to minimise risk (July 2015)

Denosumab is associated with a risk of osteonecrosis of the jaw (ONJ) and with a risk of hypercalcaemia.

Osteonecrosis of the jaw

Osteonecrosis of the jaw is a well-known and common side-effect in patients receiving denosumab 120 mg for cancer. Risk factors include smoking, poor oral hygiene, invasive dental procedures (including tooth extractions, dental implants, oral surgery), comorbidity (including dental disease, anaemia, coagulopathy, infection), advanced cancer, previous treatment with bisphosphonates, and concomitant treatments (including chemotherapy, anti-angiogenic biologics, corticosteroids, and radiotherapy to head and neck). The following precautions are now recommended to reduce the risk of ONJ:

Denosumab 120 mg (cancer indication)

A dental examination and appropriate preventative dentistry before starting treatment are now recommended for all patients

Do not start denosumab in patients with a dental or jaw condition requiring surgery, or in patients who have unhealed lesions from dental or oral surgery

All patients should be given a patient reminder card and informed of the risk of ONJ. Advise patients to tell their doctor if they have any problems with their mouth or teeth before starting treatment, if they wear dentures they should make sure their dentures fit properly before starting treatment, to maintain good oral hygiene, receive routine dental check-ups during treatment, and immediately report any oral symptoms such as dental mobility, pain, swelling, non-healing sores or discharge to a doctor and dentist. Patients should tell their doctor and dentist that they are receiving denosumab if they need dental treatment or dental surgery.

Hypercalcaemia

Denosumab is associated with a risk of hypercalcaemia. This risk increases with the degree of renal impairment. Hypercalcaemia usually occurs in the first weeks of denosumab treatment, but it can also occur later in treatment.

Plasma-calcium concentration monitoring is recommended for denosumab 120 mg (cancer indication):

before the first dose

within two weeks after the initial dose

if suspected symptoms of hypercalcaemia occur

consider monitoring more frequently in patients with risk factors for hypercalcaemia (e.g. severe renal impairment, creatinine clearance less than 30 mL/minute)

All patients should be advised to report symptoms of hypercalcaemia to their doctor (e.g. muscle spasms, twitches, cramps, numbness or tingling in the fingers, toes, or around the mouth).

MHRA/CHM advice: denosumab: reports of osteonecrosis of the external auditory canal (June 2017)

Osteonecrosis of the external auditory canal has been reported with denosumab and this should be considered in patients who present with ear symptoms including chronic ear infections or in those with suspected cholesteatoma. Possible risk factors include steroid use and chemotherapy, with or without local risk factors such as infection or trauma. The MHRA recommends advising patients to report any ear pain, discharge from the ear, or an ear infection during denosumab treatment.

MHRA/CHM advice: denosumab (XGEVA) for giant cell tumour of bone: risk of clinically significant hypercalcaemia following discontinuation (June 2018)

Cases of clinically significant hypercalcaemia (rebound hypercalcaemia) have been reported up to 5 months after discontinuation of denosumab treatment for giant cell tumour of bone. The MHRA recommends that prescribers should monitor patients for signs and symptoms of hypercalcaemia after discontinuation, consider periodic assessment of serum calcium, re-evaluate the patient’s calcium and vitamin D

RH

London

Page 488

Disorders of bone metabolism

BNFC 2019–2020
supplementation requirements, and advise patients to report symptoms of hypercalcaemia. Denosumab is not recommended in patients with growing skeletons.

- **CONTRA-INDICATIONS** Hypocalcaemia
  - Xgeva®: Unhealed lesions from dental or oral surgery

- **CAUTIONS** Atypical femoral fractures - hypocalcaemia - osteonecrosis of the jaw—consider temporary interruption of treatment if occurs

- **SIDE-EFFECTS**
  - **Common or very common** Abdominal discomfort - cataract - constipation - hypocalcaemia (including fatal cases) - increased risk of infection - pain - sciatica - secondary primary malignancy - skin reactions
  - **Uncommon** Cellulitis (seek prompt medical attention) - hypercalcaemia (on discontinuation)
  - **Rare or very rare** Atypical femur fracture - osteonecrosis

- **CONCEPTION AND CONTRACEPTION** Ensure effective contraception in women of child-bearing potential, during treatment and for at least 5 months after stopping treatment.

- **PREGNANCY** Manufacturer advises avoid—toxicity in animal studies; risk of toxicities increases with each trimester.

- **BREAST FEEDING** Manufacturer advises avoid.

- **RENAL IMPAIRMENT** Increased risk of hypocalcaemia if creatinine clearance less than 30 mL/minute.

- **MONITORING REQUIREMENTS** Correct hypocalcaemia and vitamin D deficiency before starting. Monitor plasma-calcium concentration during therapy.

- **PATIENT AND CARER ADVICE**
  - Atypical femoral fractures: Patients should be advised to report any new or unusual thigh, hip, or groin pain during treatment with denosumab.
  - Osteonecrosis of the jaw: All patients should be informed to maintain good oral hygiene, receive routine dental check-ups, and immediately report any oral symptoms such as dental mobility, pain, or swelling to a doctor and dentist. Hypocalcaemia: All patients should be advised to report symptoms of hypocalcaemia to their doctor (e.g. muscle spasms, twitches, cramps, numbness or tingling in the fingers, toes, or around the mouth).

- **PATIENT REMINDER CARD** A patient reminder card should be provided (risk of osteonecrosis of the jaw).

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  - **Solution for injection**
    - Xgeva (Amgen Ltd)
      - Denosumab 70 mg per 1 ml Xgeva 120mg/1.7ml solution for injection vials | 1 vial £309.86 DT = £309.86

- **INDICATIONS AND DOSE**
  - **ZOLADEX LA®**
    - Gonadotrophin-dependent precocious puberty
      - **BY SUBCUTANEOUS INJECTION**
        - Child: 10.8 mg every 12 weeks, to be administered into the anterior abdominal wall, injections may be required more frequently in some cases
        - **ZOLADEX®**
          - Gonadotrophin-dependent precocious puberty
            - **BY SUBCUTANEOUS INJECTION**
              - Child: 3.6 mg every 28 days, to be administered into the anterior abdominal wall, injections may be required more frequently in some cases

- **UNLICENSED USE** Not licensed for use in children.

- **CONTRA-INDICATIONS** Undiagnosed vaginal bleeding

- **CAUTIONS** Depression - patients with metabolic bone disease (decrease in bone mineral density can occur)

- **SIDE-EFFECTS** Asthma - body hair change - breast abnormalities - depression - headache - hypersensitivity - mood altered - ovarian cyst - paraesthesia - skin reactions - vaginal haemorrhage - visual impairment - weight change - withdrawal bleed

- **CONCEPTION AND CONTRACEPTION** Non-hormonal, barrier methods of contraception should be used during entire treatment period. Pregnancy should be excluded before treatment, the first injection should be given during menstruation or shortly afterwards or use barrier contraception for 1 month beforehand.

- **PREGNANCY** Avoid.

- **BREAST FEEDING** Avoid.

- **MONITORING REQUIREMENTS** Monitor bone mineral density.

- **DIRECTIONS FOR ADMINISTRATION** Rotate injection site to prevent atrophy and nodule formation.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  - **Implant**
    - Zoladex (AstraZeneca UK Ltd)
      - Goserelin (as Goserelin acetate) 3.6 mg: Zoladex 3.6mg implant SafeSystem pre-filled syringes | 1 pre-filled disposable injection £70.00 DT = £70.00
      - Zoladex LA (AstraZeneca UK Ltd)
        - Goserelin (as Goserelin acetate) 10.8 mg: Zoladex LA 10.8mg implant SafeSystem pre-filled syringes | 1 pre-filled disposable injection £235.00 DT = £235.00
**Leuprolrelin acetate**

- **DRUG ACTION** Administration of gonadorelin analogues produces an initial phase of stimulation; continued administration is followed by down-regulation of gonadotrophin-releasing hormone receptors, thereby reducing the release of gonadotrophins (follicle stimulating hormone and luteinising hormone) which in turn leads to inhibition of androgen and oestrogen production.

- **INDICATIONS AND DOSE**
  - **PROSTAP 3 DCS**
    - **Gonadotrophin-dependent precocious puberty**
      - By subcutaneous injection, or by intramuscular injection.
      - Child: 11.25 mg every 12 weeks, injections may be required more frequently in some cases.
  - **PROSTAP SR DCS**
    - **Gonadotrophin-dependent precocious puberty**
      - By subcutaneous injection, or by intramuscular injection.
      - Child: 3.75 mg every 4 weeks, half this dose is sometimes used in children with body-weight under 20 kg, injections may be required more frequently in some cases.

- **SIDE-EFFECTS**
  - Common or very common: Acne, emotional lability, gastrointestinal discomfort, haemorrhage, headache, metrorrhagia, nausea, vaginal discharge, vomiting.
  - Frequency not known: Seizure.
  - PREGNANCY: Avoid—teratogenic in animal studies.
  - BREAST FEEDING: Avoid.
  - MONITORING REQUIREMENTS: Monitor bone mineral density.
  - DIRECTIONS FOR ADMINISTRATION: Rotate injection site to prevent atrophy and nodule formation.

- **MEDICINAL FORMS**
  - Powder and solvent for suspension for injection:
    - **Prostap 3 DCS** (Takeda UK Ltd)
      - Leuprolrelin acetate 11.25 mg: Prostap 3 DCS 11.25 mg powder and solvent for suspension for injection pre-filled syringes | 1 pre-filled disposable injection | £225.72 DT = £225.72.
    - **Prostap SR DCS** (Takeda UK Ltd)
      - Leuprolrelin acetate 3.75 mg: Prostap SR DCS 3.75 mg powder and solvent for suspension for injection pre-filled syringes | 1 pre-filled disposable injection | £75.24 DT = £75.24.

- **UNLICENSED USE**: Not licensed for use in children.
- **CONTRA-INDICATIONS**: Undiagnosed vaginal bleeding.
- **CAUTIONS**: Patients with metabolic bone disease (decrease in bone mineral density can occur).

**Triptorelin**

- **DRUG ACTION** Administration of gonadorelin analogues produces an initial phase of stimulation; continued administration is followed by down-regulation of gonadotrophin-releasing hormone receptors, thereby reducing the release of gonadotrophins (follicle stimulating hormone and luteinising hormone) which in turn leads to inhibition of androgen and oestrogen production.

- **INDICATIONS AND DOSE**
  - **DecaPeptyl® SR 11.25MG**
    - **Gonadotrophin-dependent precocious puberty**
      - By intramuscular injection.
      - Child: 11.25 mg every 3 months, discontinue when bone maturation consistent with age of 12 years in girls or 13–14 years in boys.
  - **GonaPeptyl Depot®**
    - **Gonadotrophin-dependent precocious puberty**
      - By subcutaneous injection, or by deep intramuscular injection.
      - Child (body-weight up to 20 kg): Initially 1.875 mg every 2 weeks for 3 doses, to be administered on days 0, 14, and 28 of treatment, then 1.875 mg every 3–4 weeks, discontinue when bone maturation consistent with age over 12 years in girls and over 13 years in boys.
      - Child (body-weight 20–30 kg): Initially 2.5 mg every 2 weeks for 3 doses, to be administered on days 0, 14, and 28 of treatment, then 2.5 mg every 3–4 weeks, discontinue when bone maturation consistent with age over 12 years in girls and over 13 years in boys.
      - Child (body-weight 31 kg and above): Initially 3.75 mg every 2 weeks for 3 doses, to be administered on days 0, 14, and 28 of treatment, then 3.75 mg every 3–4 weeks, discontinue when bone maturation consistent with age over 12 years in girls and over 13 years in boys.

- **SIDE-EFFECTS**
  - Common or very common: Depression, mood altered.
  - Uncommon: Anaphylactic reaction, haemorrhage, nausea, vaginal discharge, vomiting.
  - Frequency not known: Alopecia, angioedema, epiphysiolysis, gastrointestinal discomfort, headache, hot flush, malaise, myalgia, nervousness, pain, skin reactions, vision disorders, weight increased.

- **CONCEPTION AND CONTRACEPTION**: Non-hormonal, barrier methods of contraception should be used during entire treatment period. Pregnancy should be excluded before treatment, the first injection should be given during menstruation or shortly afterwards or use barrier contraception for 1 month beforehand.

- **PREGNANCY**: Avoid.
- **BREAST FEEDING**: Avoid.
- **MONITORING REQUIREMENTS**: Monitor bone mineral density.
- **DIRECTIONS FOR ADMINISTRATION**: Rotate injection site to prevent atrophy and nodule formation.
- **PRESCRIBING AND DISPENSING INFORMATION**
  - **DecaPeptyl® SR 11.25MG**: Each vial includes an overage to allow accurate administration of an 11.25 mg dose.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  - Powder and solvent for suspension for injection:
    - **Decapeptyl SR** (Ipsen Ltd)
      - Triptorelin 11.25 mg: Decapeptyl SR 11.25 mg powder and solvent for suspension for injection vials | 1 vial | £207.00 DT = £207.00.
6 Hypothalamic and anterior pituitary hormone related disorders

Hypothalamic and anterior pituitary hormones

Anterior pituitary hormones

Corticotrophins

Tetracosactide below (tetracosactrin), an analogue of corticotropin (adrenocorticotropic hormone, ACTH), is used to test adrenocortical function; failure of plasma-cortisol concentration to rise after administration of tetracosactide indicates adrenocortical insufficiency. A low-dose test is considered by some clinicians to be more sensitive when used to confirm established, partial adrenal suppression.

Tetracosactide should be given only if no other ACTH preparations have been given previously. Tetracosactide depot injection (Synacthen Depot®) is also used in the treatment of infantile spasms but it is contra-indicated in neonates because of the presence of benzyl alcohol in the injection. Corticotropin-releasing factor, corticolin p. 492, (also known as corticotropin-releasing hormone, CRH) is used to test anterior pituitary function and secretion of corticotropin.

Gonadotrophins

Gonadotrophins are occasionally used in the treatment of hypogonadotrophic hypogonadism and associated oligospermia. There is no justification for their use in primary gonadal failure.

Growth hormone

Growth hormone is used to treat proven deficiency of the hormone, Prader-Willi syndrome, Turner’s syndrome, growth disturbance in children born small for gestational age, chronic renal insufficiency, and short stature homeobox-containing gene (SHOX) deficiency. Growth hormone is also used in Noonan syndrome and idiopathic short stature [unlicensed indications] under specialist management. Treatment should be initiated and monitored by a paediatrician with expertise in managing growth-hormone disorders; treatment can be continued under a shared-care protocol by a general practitioner.

Growth hormone of human origin (HGH; somatotrophin) has been replaced by a growth hormone of human sequence, somatropin p. 492, produced using recombinant DNA technology.

Mecasermin p. 494, a human insulin-like growth factor-I (rhIGF-I), is licensed to treat growth failure in children with severe primary insulin-like growth factor-I deficiency.

Hypothalamic hormones

Gonadorelin p. 492 when injected intravenously in post-pubertal girls leads to a rapid rise in plasma concentrations of both luteinising hormone (LH) and follicle-stimulating hormone (FSH). It has not proved to be very helpful, however, in distinguishing hypothalamic from pituitary lesions. It is used in the assessment of delayed or precocious puberty.

Other growth hormone stimulation tests involve the use of insulin, glucagon p. 482, arginine p. 635, and clonidine hydrochloride p. 103 [all unlicensed uses]. The tests should be carried out in specialist centres.

6.1 Adrenocortical function testing

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES > CORTICOTROPHINS

Tetracosactide

(Tetracosactrin)

- **INDICATIONS AND DOSE**
  - Diagnosis of adrenocortical insufficiency (diagnostic 30-minute test), standard-dose test
    - **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
    - Child: 145 micrograms/m² (max. per dose 250 micrograms) for 1 dose
  - Diagnosis of adrenocortical insufficiency (diagnostic 30-minute test), low-dose test
    - **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
    - Child: 0.3 microgram/m² for 1 dose
  - Infantile spasm
    - **BY INTRAMUSCULAR INJECTION USING DEPOT INJECTION**
    - Child 1-23 months: Initially 500 micrograms once daily on alternate days, adjusted according to response


- **CONTRA-INDICATIONS** Acute psychosis - adrenogenital syndrome - allergic disorders - asthma - avoid injections containing benzyl alcohol in neonates - Cushing’s syndrome - infectious diseases - peptic ulcer - primary adrenocortical insufficiency - refractory heart failure

- **CAUTIONS** Active infectious diseases (should not be used unless adequate disease-specific therapy is being given) - active systemic diseases (should not be used unless adequate disease-specific therapy is being given) - diabetes mellitus - diverticulitis - history of asthma - history of atopic allergy - history of eczema - history of hayfever - history of hypersensitivity - hypertension - latent amoebiasis (may become activated) - latent tuberculosis (may become activated) - myasthenia gravis - ocular herpes simplex - osteoporosis - predisposition to thromboembolic - psychological disturbances may be triggered - recent intestinal anastomosis - reduced immune response (should not be used unless adequate disease-specific therapy is being given) - ulcerative colitis

- **CAUTIONS, FURTHER INFORMATION**
  - Risk of anaphylaxis. Should only be administered under medical supervision. Consult product literature.
  - Hypertension. Patients already receiving medication for moderate to severe hypertension must have their dosage adjusted if treatment started.
  - Diabetes mellitus. Patients already receiving medication for diabetes mellitus must have their dosage adjusted if treatment started.

- **SIDE-EFFECTS** Abdominal distension - abcess - adrenocortical unresponsiveness - angioedema - appetite increased - bone fractures - congestive heart failure - Cushing’s syndrome - diabetes mellitus exacerbated - dizziness - dysphoea - electrolyte imbalance - exophthalmos - fluid retention - flushing - gastrointestinal disorders - glaucoma - growth retardation - haemorrhage - headache - healing impaired - hirsutism - hyperglycaemia -
hyperhidrosis • hypersensitivity (may be more severe in patients susceptible to allergies, especially asthma) • hypertension • idiopathic intracranial hypertension exacerbated • increased risk of infection • leucocytosis • malaise • menstruation irregular • muscle weakness • myopathy • nausea • osteonecrosis • osteoporosis • pancreatitis • papilloedema • pituitary unresponsiveness • posterior subcapsular cataract • protein catabolism • psychiatric disorder • seizure • skin reactions • tendinopathy • thromboembolism • vasculitis necrotising • ventricular hypertrophy • vertigo • vomiting • weight increased

- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with history of hypersensitivity to tetracosactide/corticotrophins or excipients.
- **PREGNANCY** Avoid (but may be used diagnostically if essential).
- **BREAST FEEDING** Avoid (but may be used diagnostically if essential).
- **HEPATIC IMPAIRMENT** For depot injection, manufacturer advises caution in cirrhosis (may enhance effect of tetracosactide therapy).
- **RENAL IMPAIRMENT** Use with caution in patients with renal impairment.
- **EFFECT ON LABORATORY TESTS** May suppress skin test reactions.
  
  Post administration total plasma cortisol levels during 30-minute test for diagnosis of adrenocortical insufficiency might be misleading due to altered cortisol binding globulin levels in some special clinical situations including, patients on oral contraceptives, post-operative patients, critical illness, severe liver disease and nephrotic syndrome.
- **DIRECTIONS FOR ADMINISTRATION** For intramuscular or intravenous injection, may be diluted in sodium chloride 0.9% to 250 nanograms/mL.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  
  **Solution for injection**
  
  Synacthen (Mallinckrodt Specialty Pharmaceuticals Ireland Ltd)
  Tetracosactide acetate 250 microgram per 1 ml Synacthen 250 micrograms/1ml solution for injection ampoules ▶ 1 ampoule £38.00 DT + £38.00
  
  **Suspension for injection**
  
  EXCIPIENTS: May contain Benzyl alcohol ▶ Synacthen Depot (Mallinckrodt Specialty Pharmaceuticals Ireland Ltd)
  Tetracosactide acetate 1 mg per 1 ml Synacthen Depot 1mg/1ml suspension for injection ampoules ▶ 1 ampoule £346.28 DT + £346.28

### 6.2 Assessment of pituitary function

#### DIAGNOSTIC AGENTS

- **Corticotelin**
  
  (Corticotrophin-releasing hormone; CRH)

- **INDICATIONS AND DOSE**
  
  Test of anterior pituitary function ▶ BY INTRAVENOUS INJECTION
  
  Child: 1 microgram/kg (max. per dose 100 micrograms) for 1 dose, to be administered over 30 seconds

- **UNLICENSED USE** Not licensed.
- **SIDE-EFFECTS** Altered smell sensation • flushing • hypotension • taste altered

- **PREGNANCY** Avoid.
- **BREAST FEEDING** Avoid.
- **MEDICINAL FORMS** No licensed medicines listed.

### 6.3 Growth hormone disorders

#### PITUITY AND HYPOTHALAMIC HORMONES AND ANALOGUES

- **GONADOTROPIN-RELEASING HORMONES**
  
  **Gonadorelin**
  
  (Gonadotrophin-releasing hormone; GnRH; LH-RH)

- **INDICATIONS AND DOSE**
  
  Assessment of anterior pituitary function | Assessment of delayed puberty
  
  ▶ BY INTRAVENOUS INJECTION, OR BY SUBCUTANEOUS INJECTION
  
  Child 1-17 years: 2.5 micrograms/kg (max. per dose 100 micrograms) for 1 dose

- **UNLICENSED USE** Not licensed for use in children under 1 year.
- **CAUTIONS** Pituitary adenoma
- **SIDE-EFFECTS**
  
  ▶ Uncommon
  
  Pain • skin reactions • swelling
  
  ▶ Rare or very rare
  
  Abdominal discomfort • bronchospasm • dizziness • eye erythema • flushing • headache • nausea • tachycardia
  
  ▶ Frequency not known
  
  Menorrhagia • sepsis • thrombophebitis
  
  **PREGNANCY** Avoid.
  
  **BREAST FEEDING** Avoid.

- **MEDICINAL FORMS** No licensed medicines listed.
Chronic renal insufficiency (renal function decreased to less than 50%) ▶ By Subcutaneous Injection ▶ Child: 45–50 micrograms/kg daily, alternatively 1.4 mg/m² daily, higher doses may be needed, adjust if necessary after 6 months

SHOX deficiency ▶ By Subcutaneous Injection ▶ Child: 45–50 micrograms/kg daily

Dose equivalence and conversion ▶ Dose formerly expressed in units; somatropin 1 mg = 3 units.

● Unlicensed use Not licensed for use in Noonan syndrome.

● Contra-indications Avoid injections containing benzyl alcohol in neonates • evidence of tumour activity (complete antitumour therapy and ensure intracranial lesions inactive before starting) • not to be used after renal transplantation • not to be used for growth promotion in children with closed epiphyses (or near closure in Prader-Willi syndrome) • severe obesity in Prader-Willi syndrome • severe respiratory impairment in Prader-Willi syndrome

● Cautions Diabetes mellitus (adjustment of antidiabetic therapy may be necessary) • disorders of the epiphysis of the hip (monitor for limping) • history of malignant disease • hypoadrenalism (initiation or adjustment of glucocorticoid replacement therapy may be necessary) • hypothyroidism • manufacturers recommend periodic thyroid function tests but limited evidence of clinical value • initiation of treatment close to puberty not recommended in child born small for corrected gestational age • papilloedema • relative deficiencies of other pituitary hormones • resolved intracranial hypertension (monitor closely) • Silver-Russell syndrome

● Interactions ▶ Appendix 1: somatropin

● Side-effects ▶ Common or very common Headache • lipodystrophy

Uncommon Arthralgia • carpal tunnel syndrome • fluid retention • gynaecomastia • idiopathic intracranial hypertension • musculoskeletal stiffness • myalgia • oedema • paraesthesia

Rare or very rare Hyperglycaemia • hyperinsulinism • hypothyroidism • osteonecrosis of femur • pancreatitis • slipped capital femoral epiphysis

Frequency not known Leukaemia

Side-effects, further information Fundoscopy for papilloedema recommended if severe or recurrent headache, visual problems, nasea and vomiting occur—if papilloedema confirmed consider benign intracranial hypertension (rare cases reported).

● Pregnancy Discontinue if pregnancy occurs—no information available.

● Breast feeding No information available. Absorption from milk unlikely.

● Directions for administration Rotate subcutaneous injection sites to prevent lipodystrophy.

Genotropin®, Norditropin®, Nutropin® A®, Omnitrope®, Saizen®, Zomacton® For use by subcutaneous injection.

Humatrope® Cartridges for use by subcutaneous injection. Powder for reconstitution for use by subcutaneous or intramuscular injection.

● Prescribing and dispensing information Somatropin is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1.

Saizen® Solution for injection For use with cool.click® needle-free autoinjector device or easypod® autoinjector device (non-NHS but available free of charge from clinics).

Norditropin® Preparations Cartridges are for use with appropriate NordiPen® device (non-NHS but available free of charge from clinics).

Multidose disposable prefilled pens for use with NovoFine® or NovoTwist® needles.

Omnitrope® For use with Omnitrope Pen 5® and Omnitrope Pen 10® devices (non-NHS but available free of charge from clinics).

Nutropin® A For use with Nutropina® A Pen device (non-NHS but available free of charge from clinics).

Zomacton® 4 mg vial for use with ZomaJet 2® Vision needle-free device (non-NHS but available free of charge from clinics) or with needles and syringes.

10 mg vial for use with ZomaJet Vision X® needle-free device (non-NHS but available free of charge from clinics) or with needles and syringes.

Saizen® Powder and solvent for solution for injection For use with one. click® autoinjector device or cool.click® needle-free autoinjector device or easypod® autoinjector device (non-NHS but available free of charge from clinics).

Genotropin® Preparations Cartridges are for use with Genotropin® Pen device (non-NHS but available free of charge from clinics).

● National funding/access decisions

NICE decisions ▶ Somatropin for the treatment of growth failure in children (May 2010) NICE TA188

Somatropin is recommended for children with growth failure who:

• have growth-hormone deficiency

• have Turner syndrome

• have Prader-Willi syndrome

• have chronic renal insufficiency

• are born small for gestational age with subsequent growth failure at 4 years of age or later

• have short stature homeobox-containing gene (SHOX) deficiency.

Treatment should be discontinued if growth velocity increases by less than 50% from baseline in the first year of treatment.

www.nice.org.uk/TA188

● Medicinal forms There can be variation in the licensing of different medicines containing the same drug.

Solution for injection Excipients: May contain Benzyl alcohol

Norditropin NordiFlex (Novo Nordisk Ltd)

Somatropin (ep) 3.3 mg per 1 ml Norditropin NordiFlex 5mg/1.5ml solution for injection pre-filled pen | 1 pre-filled disposable injection £115.90 DT + £115.90 (C04-2)

Somatropin (ep) 6.7 mg per 1 ml Norditropin NordiFlex 10mg/1.5ml solution for injection pre-filled pen | 1 pre-filled disposable injection £231.80 DT + £231.80 (C04-2)

Somatropin (ep) 10 mg per 1 ml Norditropin NordiFlex 15mg/1.5ml solution for injection pre-filled pen | 1 pre-filled disposable injection £347.70 DT + £347.70 (C04-2)

Norditropin Simplex (Novo Nordisk Ltd)

Somatropin (ep) 3.3 mg per 1 ml Norditropin SimplexX 5mg/1.5ml solution for injection cartridges | 1 cartridge £106.35 DT + £106.35 (C04-2)

Somatropin (ep) 6.7 mg per 1 ml Norditropin SimplexX 10mg/1.5ml solution for injection cartridges | 1 cartridge £212.70 DT + £212.70 (C04-2)

Somatropin (ep) 10 mg per 1 ml Norditropin SimplexX 15mg/1.5ml solution for injection cartridges | 1 cartridge £319.05 DT + £319.05 (C04-2)
6.3a Insulin-like growth factor-i deficiency

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES > SOMATOMEDINS

Mecasermin
(Recombinant human insulin-like growth factor-i, rhIGF-I)

- **DRUG ACTION** Somatomedins are a group of polypeptide hormones structurally related to insulin and commonly known as insulin-like growth factors (IGFs). Mecasermin, a human insulin-like growth factor-i (rhIGF-I), is the principal mediator of the somatotropic effects of human growth hormone.

- **INDICATIONS AND DOSE** Treatment of growth failure in children with severe primary insulin-like growth factor-i deficiency
  - **BY SUBCUTANEOUS INJECTION**
    - Child 2-7 years: Initially 40 micrograms/kg twice daily for 1 week, increased, if tolerated, in steps of 40 micrograms/kg (max. per dose 120 micrograms/kg twice daily), discontinue if no response within 1 year, reduce dose if hypoglycaemia occurs despite adequate food intake; withhold injection if patient unable to eat

- **CONTRA-INDICATIONS** Evidence of tumour activity (discontinue treatment)

- **CAUTIONS** Correct hypothyroidism before initiating treatment - diabetes mellitus (adjustment of antidiabetic therapy may be necessary) - papillodema

- **SIDE-EFFECTS**
  - Common or very common Adenoidal hypertrophy - arthralgia - dizziness - ear discomfort - gastrointestinal discomfort - gynaecomastia - hair texture abnormal - headache - hearing impairment - hyperglycaemia - hypoglycaemia - melanocytic naevus - myalgia - otitis media - pain in extremity - papillodema - scoliosis - seizures - skin hypertrophy - sleep apnoea - snoring - tachycardia - thymus enlargement - tonsillar hypertrophy - tremor - vomiting
  - Uncommon Cardiac hypertrophy - cardiac valve disorders - depression - idiopathic intracranial hypertension - lipohypertrophy - nervousness - weight increased
  - Frequency not known Alopecia

SIDE-EFFECTS, FURTHER INFORMATION Funduscropy for papillodema recommended regularly during treatment and if severe or recurrent headache, visual problems, nausea and vomiting occur—if papillodema confirmed consider benign intracranial hypertension.

CONCEPTION AND CONTRACEPTION Contraception advised in women of child-bearing potential.

PREGNANCY Avoid unless essential.

BREAST FEEDING Avoid.
Sex hormone responsive conditions

Sex hormones

Hormone replacement therapy

Sex hormone replacement therapy is indicated in children for the treatment of gonadotrophin deficiency, gonadal disorders, or delayed puberty that interferes with quality of life. Indications include constitutional delay in puberty, congenital or acquired hypogonadotrophic hypogonadism, hypergonadotrophic hypogonadism (Turner’s syndrome, Klinefelter’s syndrome), endocrine disorders (Cushing’s syndrome or hyperprolactinaemia), and chronic illnesses, such as cystic fibrosis or sickle-cell disease, that may affect the onset of puberty.

Replacement therapy is generally started at the appropriate age for the development of puberty and should be managed by a paediatric endocrinologist. Patients with constitutional delay, chronic illness, or eating disorders may need only small doses of hormone supplements for 4 to 6 months to induce puberty and endogenous sex hormone production, which is then sustained. Patients with organic causes of hormone deficiency will require life-long replacement, adjusted to allow normal development. Inadequate treatment may lead to poor bone mineralisation, resulting in fractures and osteoporosis.

Female sex hormones

Oestrogens

Oestrogens are necessary for the development of female secondary sexual characteristics. If onset of puberty is delayed because of organic pathology, puberty can be induced with ethinylestradiol p. 496 in increasing doses, guided by breast staging and uterine scans. Cyclical progestogen replacement is added after 12–18 months of oestrogen treatment. Once the adult dosage of oestrogen has been reached, it may be more convenient to provide replacement either as a low-dose oestrogen containing oral contraceptive formulation [unlicensed indication] or as a combined oestrogen and progestogen hormone replacement therapy preparation [unlicensed indication]. There is limited experience in the use of transdermal patches or gels in children; compliance and skin irritation are sometimes a problem.

Ethinylestradiol is occasionally used, under specialist supervision, for the management of hereditary haemorrhagic telangiectasia (but evidence of benefit is limited), for the prevention of tall stature, and in tests of growth hormone secretion. Topical oestrogen creams are used in the treatment of labial adhesions.

Progestogens

There are two main groups of progestogen, progesterone and its analogues (dydrogesterone and medroxypregesterone acetate p. 531) and testosterone analogues (norethisterone p. 497 and norgestrel). The newer progestogens (desogestrel p. 526, norgestimate, and gestodene) are all derivatives of norgestrel; levonorgestrel p. 527 is the active isomer of norgestrel and has twice its potency. Progesterone and its analogues are less androgenic than the testosterone derivatives and neither progesterone nor dydrogesterone causes virilisation.

In delayed puberty cyclical progestogen is added after 12–18 months of oestrogen therapy to establish a menstrual cycle. Norethisterone is also used to postpone menstruation during a cycle; treatment is started 3 days before the expected onset of menstruation.

Heavy menstrual bleeding

Description of condition

Heavy menstrual bleeding, also known as menorrhagia, is excessive menstrual blood loss of 80 mL or more, or for a duration of more than 7 days, which results in the need to change menstrual products every 1–2 hours. Heavy menstrual bleeding occurs regularly, every 24–35 days.

Drug treatment

The choice of treatment should be guided by the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms (such as pressure or pain), co-morbidities, and patient preference.

In females with heavy menstrual bleeding and unidentified pathology, fibroids less than 3 cm in diameter causing no distortion of the uterine cavity, or suspected or diagnosed adenomyosis, a levonorgestrel p. 527-releasing intra-uterine system is the first-line treatment option. Patients should be advised that irregular menstrual bleeding can occur particularly during the first months of use and that the full benefit of treatment may take at least 6 months.

If a levonorgestrel p. 527-releasing intra-uterine system is unsuitable, either tranexamic acid p. 83, an NSAID, a combined hormonal contraceptive, or a cyclical oral progestogen should be considered. Progestogen-only contraceptives may suppress menstruation and be beneficial to females with heavy menstrual bleeding. A non-hormonal treatment is recommended in patients actively trying to conceive.

If drug treatment is unsuccessful or declined by the patient, or if symptoms are severe, referral to a specialist for alternative drug treatment or surgery should be considered.

In females with fibroids of 3 cm or more in diameter, referral to a specialist should be considered. Treatment options include tranexamic acid, an NSAID, a levonorgestrel p. 527-releasing intra-uterine system, a combined hormonal contraceptive, a cyclical oral progestogen, uterine artery embolisation, or surgery. Treatment choice depends on the size, number and location of the fibroids, and severity of symptoms. If drug treatment is required while investigations and definitive treatment is being organised, either tranexamic acid, or an NSAID, or both, can be given.

The effectiveness of drug treatment for heavy menstrual bleeding may be limited in females with fibroids that are substantially greater than 3 cm in diameter. [Evi ]

Treatment
OESTROGENS

Ethinylestradiol (Ethinylestradiol)

- **INDICATIONS AND DOSE**
  - **Induction of sexual maturation in girls**
    - **BY MOUTH**
      - Child (female): Initially 2 micrograms daily for 6 months, then increased to 5 micrograms daily for 6 months, then increased to 10 micrograms daily for 6 months, then increased to 20 micrograms daily, after 12–18 months of treatment give progesterogen for 7 days of each 28-day cycle.
  - **Maintenance of sexual maturation in girls**
    - **BY MOUTH**
      - Child (female): 20 micrograms daily, to be given with cyclical progesterogen for 7 days of each 28-day cycle.
  - **Prevention of tall stature in girls**
    - **BY MOUTH**
      - Child 2–11 years (female): 20–50 micrograms daily.
  - **Pituitary priming before growth hormone secretion test in girls with bone age over 10 years**
    - **BY MOUTH**
      - Child (female): 100 micrograms daily for 3 days before test.

- **UNLICENSED USE**
  - Unlicensed for use in children.
- **CONTRA-INDICATIONS**
  - Acute porphyrias p. 624.
  - Cardiovascular disease (sodium retention with oedema).
  - Family history of thromboembolism.
  - Gallstones.
  - Heart disease associated with pulmonary hypertension.
  - Heart disease associated with risk of embolus.
  - History during pregnancy of cholestatic jaundice.
  - Hypothyroidism.
  - History during pregnancy of pemphigoid gestationis.
  - History during pregnancy of pruritus.
  - History of breast cancer.
  - History of haemolytic uraemic syndrome.
  - Malignancy.
  - Migraine with aura.
  - Migraine with aura (focal symptoms).
  - Severe migraine frequently lasting over 72 hours despite treatment.
  - Migraine treated with ergot derivatives.
  - Pregnancy.
  - Severe or multiple risk factors for arterial disease.
  - Severe or multiple risk factors for venous thromboembolism.
  - Systemic lupus erythematosus.
  - Transient cerebral ischaemic attacks without headaches.
  - Undiagnosed vaginal bleeding.
  - Venous thromboembolism.
  - History of recurrent venous thromboembolism (unless already on anticoagulant treatment).

- **CAUTIONS**
  - Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration)—seek specialist advice.
  - Crohn’s disease.
  - Gene mutations associated with breast cancer (e.g. BRCA 1).
  - History of severe depression (especially if induced by hormonal contraceptive).
  - Hyperprolactinaemia (seek specialist advice).
  - Inflammatory bowel disease.
  - Migraine (migraine-like headaches).
  - Personal or family history of hypertriglyceridaemia.
  - Increased risk of pancreatitis.
  - Risk factors for arterial disease.
  - Risk factors for migraine.
  - Risk factors for venous thromboembolism.
  - Sickle-cell disease.
  - Undiagnosed breast mass.

- **USEFUL RESOURCES**
  - www.nice.org.uk/guidance/ng88

Other drugs used for Female sex hormone responsive conditions

- Clonidine hydrochloride, p. 103.
- Medroxyprogesterone acetate, p. 531.
- Ulipristal acetate, p. 525.

Risk of venous thromboembolism

- Use with caution if any of following factors present but avoid if two or more factors present:
  - Family history of venous thromboembolism: in first-degree relative aged under 45 years (avoid if known prothrombotic coagulation abnormality e.g. factor V Leiden or antiphospholipid antibodies (including lupus anticoagulant));
  - Obesity—body mass index ≥30 kg/m² (avoid if body mass index ≥35 kg/m² unless no suitable alternative); (In adolescents, caution if obese according to BMI (adjusted for age and gender); in those who are markedly obese, avoid unless no suitable alternative);
  - Long-term immobilisation e.g. in wheelchair (avoid if confined to bed or leg in plaster cast);
  - History of superficial thrombophlebitis;
  - Age over 35 years (avoid if over 50 years);
  - Smoking.

- Risk factors for arterial disease
  - Use with caution if any one of following factors present but avoid if two or more factors present:
    - Family history of arterial disease: in first degree relative aged under 45 years (avoid if atherogenic lipid profile);
    - Diabetes mellitus (avoid if diabetes complications present);
    - Hypertension—blood pressure above systolic 140 mmHg or diastolic 90 mmHg (avoid if blood pressure above systolic 160 mmHg or diastolic 95 mmHg); (In adolescents, avoid if blood pressure very high);
    - Smoking (avoid if smoking 40 or more cigarettes daily);
    - Age over 35 years (avoid if over 50 years);
    - Obesity (avoid if body mass index ≥35 kg/m² unless no suitable alternative); (In adolescents, caution if obese according to BMI (adjusted for age and gender); in those who are markedly obese, avoid unless no suitable alternative);
    - Migraine without aura (avoid if migraine with aura (focal symptoms), or severe migraine frequently lasting over 72 hours despite treatment, or migraine treated with ergot derivatives).

- Migraine
  - Women should report any increase in headache frequency or onset of focal symptoms (discontinue immediately and refer urgently to neurology expert if focal neurological symptoms not typical of aura persist for more than 1 hour).

- INTERACTIONS
  - Appendix 1: hormone replacement therapy.

- SIDE-EFFECTS
  - Breast abnormalities.
  - Cervical mucus increased.
  - Cholelithiasis.
  - Contact lens intolerance.
  - Depression.
  - Electrolyte imbalance.
  - Embolism and thrombosis.
  - Erthema nodosum.
  - Femur fracture.
  - Fluid retention.
  - Headache.
  - Hypertension.
  - Jaundice.
  - Metrorrhagia.
  - Mood altered.
  - Myocardial infarction.

- CAUTIONS
  - Use with caution if any of following factors present but avoid if two or more factors present:
    - Pregnancy.
    - Severe or multiple risk factors for arterial disease.
    - Severe or multiple risk factors for venous thromboembolism.
    - Sickle-cell disease.
    - Undiagnosed breast mass.

- FURTHER INFORMATION
  - Other conditions
    - The product literature advises caution in other conditions including hypertension, renal disease, asthma, epilepsy, sickle-cell disease, melanoma, osteosclerosis, multiple sclerosis, and systemic lupus erythematosus (but care required if antiphospholipid antibodies present, see above). Evidence for caution in these conditions is unsatisfactory and many women with these conditions may stand to benefit from treatment.

- Risk of venous thromboembolism:
  - Use with caution if any of the following factors present but avoid if two or more factors present:
    - Family history of venous thromboembolism: in first-degree relative aged under 45 years (avoid if known prothrombotic coagulation abnormality e.g. factor V Leiden or antiphospholipid antibodies (including lupus anticoagulant));
    - Obesity—body mass index ≥30 kg/m² (avoid if body mass index ≥35 kg/m² unless no suitable alternative); (In adolescents, caution if obese according to BMI (adjusted for age and gender); in those who are markedly obese, avoid unless no suitable alternative);
    - Long-term immobilisation e.g. in wheelchair (avoid if confined to bed or leg in plaster cast);
    - History of superficial thrombophlebitis;
    - Age over 35 years (avoid if over 50 years);
    - Smoking.

- Risk factors for arterial disease
  - Use with caution if any one of the following factors present but avoid if two or more factors present:
    - Family history of arterial disease: in first degree relative aged under 45 years (avoid if atherogenic lipid profile);
    - Diabetes mellitus (avoid if diabetes complications present);
    - Hypertension—blood pressure above systolic 140 mmHg or diastolic 90 mmHg (avoid if blood pressure above systolic 160 mmHg or diastolic 95 mmHg); (In adolescents, avoid if blood pressure very high);
    - Smoking (avoid if smoking 40 or more cigarettes daily);
    - Age over 35 years (avoid if over 50 years);
    - Obesity (avoid if body mass index ≥35 kg/m² unless no suitable alternative); (In adolescents, caution if obese according to BMI (adjusted for age and gender); in those who are markedly obese, avoid unless no suitable alternative);
    - Migraine without aura (avoid if migraine with aura (focal symptoms), or severe migraine frequently lasting over 72 hours despite treatment, or migraine treated with ergot derivatives).

- Migraine
  - Women should report any increase in headache frequency or onset of focal symptoms (discontinue immediately and refer urgently to neurology expert if focal neurological symptoms not typical of aura persist for more than 1 hour).

- INTERACTIONS
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- SIDE-EFFECTS
  - Breast abnormalities.
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  - Erthema nodosum.
  - Femur fracture.
  - Fluid retention.
  - Headache.
  - Hypertension.
  - Jaundice.
  - Metrorrhagia.
  - Mood altered.
  - Myocardial infarction.
nausea · neoplasms · skin reactions · stroke · uterine disorders · vomiting · weight change

**PREGNANCY** Avoid.

**BREAST FEEDING** Avoid until weaning or for 6 months after birth (adverse effects on lactation).

**HEPATIC IMPAIRMENT** Avoid in liver disease including disorders of hepatic excretion (e.g. Dubin-Johnson orRotor syndromes), infective hepatitis (until liver function returns to normal), and jaundice.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension

Tablet
- Ethinylestradiol (Non-proprietary) Ethinylestradiol 2 microgram tablets | 100 tablet (PSt) £200.00
- Ethinylestradiol 10 microgram tablets | 21 tablet (PSt) £200.00 DT + £200.00
- Ethinylestradiol 50 microgram tablets | 21 tablet (PSt) £200.00 DT + £200.00
- Ethinylestradiol 1 mg Ethinylestradiol 1mg tablets | 28 tablet (PSt) £200.00 DT + £200.00

**PROGESTOGENS**

**Norethisterone**

- **INDICATIONS AND DOSE**
  - **Postponement of menstruation**
    - **BY MOUTH**
      - Females of childbearing potential: 5 mg 3 times a day, to be started 3 days before expected onset (menstruation occurs 2–3 days after stopping)
  - **Induction and maintenance of sexual maturation in females**
    - **(combined with an oestrogen after 12–18 months oestrogen therapy)**
      - **BY MOUTH**
        - Child: 5 mg once daily for the last 7 days of 28-day cycle
      - **Short-term contraception**
        - **BY DEEP INTRAMUSCULAR INJECTION**
          - Females of childbearing potential: 200 mg, to be administered within first 5 days of cycle or immediately after parturition (duration 8 weeks). To be injected into the gluteal muscle, then 200 mg after 8 weeks if required
  - **Contraception**
    - **BY MOUTH**
      - Females of childbearing potential: 350 micrograms daily, dose to be taken at same time each day, starting on day 1 of cycle then continuously, if administration delayed for 3 hours or more it should be regarded as a ‘missed pill’

- **UNLICENSED USE**
  - When used for Induction and maintenance of sexual maturation in females or Postponement of menstruation Not licensed for use in children
  - When used for Contraception Consult product literature for the licensing status of individual preparations.

- **CONTRA-INDICATIONS**
  - **GENERAL CONTRA-INDICATIONS**
    - Avoid in patients with a history of liver tumours · breast cancer (unless progestogens are being used in the management of this condition) · genital cancer (unless progestogens are being used in the management of this condition) · history during pregnancy of idiopathic jaundice · history during pregnancy of pempigoid gestationis (non-contraceptive indications) · history during pregnancy of severe pruritus (non-contraceptive indications) · when used as a contraceptive, history of breast cancer (can be used after 5 years if no evidence of disease and non-hormonal contraceptive methods unacceptable)
    - **SPECIFIC CONTRA-INDICATIONS**
      - With oral use Acute porphyrias p. 624 · severe arterial disease · undiagnosed vaginal bleeding
  - **CAUTIONS**
    - **GENERAL CAUTIONS** Asthma · cardiac dysfunction · conditions that may worsen with fluid retention · diabetes (progestogens can decrease glucose tolerance—monitor patient closely) · epilepsy · history of depression · hypertension · migraine · susceptibility to thromboembolism (particular caution with high dose)
    - **SPECIFIC CAUTIONS**
      - When used for contraception active trophoblastic disease (until return to normal of urine- and plasma-hCG concentration) · seek specialist advice · arterial disease · functional ovarian cysts · history of jaundice in pregnancy · malabsorption syndromes · past ectopic pregnancy · sex-steroid dependent cancer · systemic lupus erythematosus with positive (or unknown) anti-phospholipid antibodies
      - With intramuscular use for contraception disturbances of lipid metabolism · history during pregnancy of deterioration of otosclerosis · history during pregnancy of pruritus · possible risk of breast cancer
    - **CAUTIONS, FURTHER INFORMATION**
      - Use as a contraceptive in co-morbidities The product literature advises caution in patients with history of thromboembolism, hypertension, diabetes mellitus and migraine; evidence for caution in these conditions is unsatisfactory.
      - Breast cancer risk with contraceptive use There is a small increase in the risk of having breast cancer diagnosed in women using, or who have recently used, a progestogen-only contraceptive pill; this relative risk may be due to an earlier diagnosis. The most important risk factor appears to be the age at which the contraceptive is stopped rather than the duration of use; the risk disappears gradually during the 10 years after stopping and there is no excess risk by 10 years. A possible small increase in the risk of breast cancer should be weighed against the benefits.
      - **INTERACTIONS** Appendix 1: norethisterone

- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Common or very common Menstrual cycle irregularities
    - Uncommon Breast tenderness
    - Frequency not known Hepatic cancer · thromboembolism
  - **SPECIFIC SIDE-EFFECTS**
    - Common or very common
      - With intramuscular use Dizziness · haemorrhage · headache · hypersensitivity · nausea · skin reactions · weight increased
    - Uncommon
      - With intramuscular use Abdominal distension · depressed mood
      - Frequency not known
        - With oral use Appetite change · depression · fatigue · gastrointestinal disorder · headaches · hypertension · libido disorder · nervousness · rash · weight change
  - **PREGNANCY** Not known to be harmful in contraceptive doses. Avoid in other indications.
  - **BREAST FEEDING** Progestogen-only contraceptives do not affect lactation.
    - With intramuscular use Withhold breast-feeding for neonates with severe or persistent jaundice requiring medical treatment.
  - **HEPATIC IMPAIRMENT** When used as a contraceptive; caution in severe liver disease and recurrent cholestatic jaundice, avoid in liver tumour. Caution when used for
sexual maturation and to postpone menstruation; avoid if severe.

- **RENAL IMPAIRMENT** Use with caution in non-contraceptive indications.

- **PATIENT AND CARER ADVICE**
  
  Diarrhoea and vomiting with oral contraceptives. Vomiting and persistent, severe diarrhoea can interfere with the absorption of oral progestogen-only contraceptives. If vomiting occurs within 2 hours of taking an oral progestogen-only contraceptive, another pill should be taken as soon as possible. If a replacement pill is not taken within 3 hours of the normal time for taking the progestogen-only pill, or in cases of persistent vomiting or very severe diarrhoea, additional precautions should be used during illness and for 2 days after recovery.

  Starting routine for oral contraceptives: One tablet daily, on a continuous basis, starting on day 1 of cycle and taken at the same time each day (if delayed by longer than 3 hours contraceptive protection may be lost). Additional contraceptive precautions are not required if norethisterone is started up to and including day 5 of the menstrual cycle; if started after this time, additional contraceptive precautions are required for 2 days.

  Changing from a combined oral contraceptive: Start on the day following completion of the combined oral contraceptive course without a break (or in the case of ED tablets omitting the inactive ones).

  After childbirth: Oral progestogen-only contraceptives can be started up to and including day 21 postpartum without the need for additional contraceptive precautions. If started more than 21 days postpartum, additional contraceptive precautions are required for 2 days.

  Contraceptives by injection: Full counselling backed by patient information leaflet required before administration—likelihood of menstrual disturbance and the potential for a delay in return to full fertility. Delayed return of fertility and irregular cycles may occur after discontinuation of treatment but there is no evidence of permanent infertility.

- **Missed oral contraceptive pill** The following advice is recommended: ‘If you forget a pill, take it as soon as you remember and carry on with the next pill at the right time. If the pill was more than 3 hours overdue you are not protected. Continue normal pill-taking but you must also use another method, such as the condom, for the next 2 days.’

  The Faculty of Sexual and Reproductive Healthcare recommends emergency contraception if one or more progestogen-only contraceptive tablets are missed or taken more than 3 hours late and unprotected intercourse has occurred before 2 further tablets have been correctly taken.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

  **Solution for injection**

  - **Noristerat** (Bayer Plc)
    - Norethisterone enantate 200 mg per 1 ml
    - Noristerat 200mg/1ml solution for injection ampoules | 1 ampoule (POM) £9.05

  **Tablet**

  - Norethisterone (Non-proprietary)
    - Norethisterone 5 mg: Norethisterone 5mg tablets | 30 tablet (POM) £2.40 DT + £2.35
    - Noriday (Pfizer Ltd)
    - Norethisterone 350 microgram: Norethisterone 350mcg tablets | 84 tablet (POM) £2.10 DT + £2.10
    - Prinolut N (Bayer Plc)
    - Norethisterone 5 mg: Prinolut N 5mg tablets | 30 tablet (POM) £2.26 DT + £2.35
    - Utovlan (Pfizer Ltd)
    - Norethisterone 5 mg: Utovlan 5mg tablets | 30 tablet (POM) £1.40 DT + £2.35 | 90 tablet (POM) £4.21

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### 7.2 Male sex hormone responsive conditions

#### Androgens, anti-androgens and anabolic steroids

**Androgens**

Androgens cause masculinisation; they are used as replacement therapy in androgen deficiency, in delayed puberty, and in those who are hypogonadal due to either pituitary or testicular disease.

When given to patients with hypopituitarism androgens can lead to normal sexual development and potency but not to fertility. If fertility is desired, the usual treatment is with gonadotrophins or pulsatile gonadotrophin-releasing hormone which stimulates spermatogenesis as well as androgen production.

Intramuscular depot preparations of **testosterone esters** are preferred for replacement therapy. Testosterone enantate or propionate or alternatively Sustanon®, which consists of a mixture of testosterone esters and has a longer duration of action, can be used. For induction of puberty, depot testosterone injections are given monthly and the doses increased every 6 to 12 months according to response. Single ester testosterone injections may need to be given more frequently.

**Oral testosterone undecanoate** is used for induction of puberty. An alternative approach that promotes growth rather than sexual maturation uses oral oxandrolone p. 499.

Testosterone topical gel is also available but experience of use in children under 15 years is limited. Topical testosterone is applied to the penis in the treatment of microphallus; an extemporaneously prepared cream should be used because the alcohol in proprietary gel formulations causes irritation.

**Anti-androgens and precocious puberty**

The gonadorelin stimulation test is used to distinguish between gonadotrophin-independent (central) precocious puberty and gonadotrophin-dependent precocious puberty. Treatment requires specialist management.

Gonadorelin analogues, used in the management of gonadotrophin-dependent precocious puberty, delay development of secondary sexual characteristics and growth velocity.

Testolactone p. 500 and cyproterone acetate p. 500 are used in the management of gonadotrophin-independent precocious puberty, resulting from McCune-Albright syndrome, familial male precocious puberty (testotoxiosis), hormone-secreting tumours, and ovarian and testicular disorders. Testolactone inhibits the aromatisation of testosterone, the rate-limiting step in oestrogen synthesis. Cyproterone acetate is a progestogen with anti-androgen properties.

Spironolactone p. 128 is sometimes used in combination with testolactone because it has some androgen receptor blocking properties.

High blood concentration of sex hormones may activate release of gonadotrophin releasing hormone, leading to development of secondary, central gonadotrophin-dependent precocious puberty. This may require the addition of gonadorelin analogues to prevent progression of pubertal development and skeletal maturation.

Anabolic steroids have some androgenic activity but they cause less virilisation than androgens in girls. They are used in the treatment of some aplastic anaemias.

Oxandrolone is used to stimulate late pre-pubertal growth prior to induction of sexual maturation in boys with short
stature and in girls with Turner’s syndrome; specialist management is required.

**ANABOLIC STEROIDS** > ANDROSTAN DERIVATIVES

**Oxandrolone**

- **INDICATIONS AND DOSE**
  
  **Stimulation of late pre-pubertal growth in boys (of appropriate age) with short stature**
  
  - **BY MOUTH**
  - Child 10–17 years (male): 1.25–2.5 mg daily for 3–6 months.
  
  **Stimulation of late pre-pubertal growth in girls with Turner’s syndrome**
  
  - **BY MOUTH**
  - Child (female): 0.625–2.5 mg daily, to be taken in combination with growth hormone.

- **CONTRA-INDICATIONS**
  
  - History of primary liver tumours - hypercalcaemia - nephrosis
  
  - **CAUTIONS**
  
  - Cardiac impairment - diabetes mellitus - epilepsy - hypertension - migraine - skeletal metastases (risk of hypercalcaemia)
  
  - **SIDE-EFFECTS**
  
  - Common or very common Anorexia - alopecia - anorexia - anxiety - asthenia - bone formation increased - depression - electrolyte imbalance - epiphyses premature fusion (in pre-pubertal males) - gastrointestinal haemorrhage - gynaecomastia - headache - hirsutism - hypertension - jaundice - cholestatic - nausea - oedema - paraesthesia - polycythaemia - precocious puberty (in pre-pubertal males) - seborrhoea - sexual dysfunction - skin reactions - spermatogenesis reduced - virilism - weight increased
  
  - Rare or very rare Hepatic neoplasm
  
  - **PREGNANCY**
  
  - Avoid — causes masculinisation of female fetus.
  
  - **BREAST FEEDING**
  
  - Avoid; may cause masculinisation in the female infant or precocious development in the male infant. High doses suppress lactation.
  
  - **HEPATIC IMPAIRMENT**
  
  - Avoid if possible — fluid retention and dose-related toxicity.
  
  - **RENAL IMPAIRMENT**
  
  - Use with caution — potential for fluid retention.

- **MEDICINAL FORMS**
  
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet
  
  - **Tablet**
  
  - Oxandrolone (Imported (Australia))
  
  - Oxandrolone 2.5 mg
  
  - Oxandrin 2.5mg tablets | 100 tablet (£39.10) (£44.24)

**ANDROGENS**

**Androgens**

- **CONTRA-INDICATIONS**
  
  - Breast cancer in males - history of liver tumours - hypercalcaemia - prostate cancer
  
  - **CAUTIONS**
  
  - Cardiac impairment - diabetes mellitus - epilepsy - hypertension - migraine - pre-pubertal boys (fusion of epiphyses is hastened and may result in short stature) — statural growth and sexual development should be monitored - skeletal metastases — risk of hypercalcaemia or hypercalciuria (if this occurs, treat appropriately and restart treatment once normal serum calcium concentration restored) - sleep apnoea - stop treatment or reduce dose if severe polycythaemia occurs - tumours — risk of hypercalcaemia or hypercalciuria (if this occurs, treat appropriately and restart treatment once normal serum calcium concentration restored)

  - **SIDE-EFFECTS**
  
  - Common or very common Headache - hot flush - hypertension - polycythaemia - prostate abnormalities - skin reactions - weight increased
  
  - Uncommon Alopecia - asthenia - behaviour abnormal - depression - dizziness - dysphoria - dysuria - gynaecomastia - hyperhidrosis - insomnia - nausea - sexual dysfunction
  
  - Rare or very rare Pulmonary oil microembolism - sperm abnormalities
  
  - Frequency not known Anxiety - epiphyses premature fusion - fluid retention - jaundice - oedema - paraesthesia - precocious puberty - prostate cancer - seborrhoea - sleep apnoea - urinary tract obstruction
  
  - **SIDE-EFFECTS, FURTHER INFORMATION**
  
  - Stop treatment or reduce dose if severe polycythaemia occurs.
  
  - **PREGNANCY**
  
  - Avoid — causes masculinisation of female fetus.
  
  - **BREAST FEEDING**
  
  - Avoid.
  
  - **HEPATIC IMPAIRMENT**
  
  - Avoid if possible — fluid retention and dose-related toxicity.
  
  - **RENAL IMPAIRMENT**
  
  - Caution — potential for fluid retention.
  
  - **MONITORING REQUIREMENTS**
  
  - Monitor haematocrit and calcium concentration restored.

- **MEDICINAL FORMS**
  
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, cream

- **Testosterone enantate**
  
  - **INDICATIONS AND DOSE**
  
  - Induction and maintenance of sexual maturation in males (specialist use only)
  
  - **BY DEEP INTRAMUSCULAR INJECTION**
  
  - Child 12–17 years: 25–50 mg/m² every month, increase dose every 6–12 months according to response

  - **UNLICENSED USE**
  
  - Not licensed for use in children.

  - **CAUTIONS**
  
  - Thrombophilia — increased risk of thrombosis

  - **SIDE-EFFECTS**
  
  - Bone formation increased - circulatory system disorder - gastrointestinal disorder - gastrointestinal haemorrhage - hepatomegaly - hypercalcaemia - neoplasms

- **MEDICINAL FORMS**
  
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, cream

- **Testosterone propionate**
  
  - **INDICATIONS AND DOSE**
  
  - Delayed puberty in males
  
  - **BY INTRAMUSCULAR INJECTION**
  
  - Child: 50 mg once weekly

  - **TREATMENT OF MICROPHALLUS (SPECIALIST USE ONLY)**
  
  - **TO THE SKIN USING CREAM**
  
  - Child: Apply 3 times a day for 3 weeks

  - **CAUTIONS**
  
  - Thrombophilia — increased risk of thrombosis

  - **MEDICINAL FORMS**
  
  - Forms available from special-order manufacturers include: solution for injection, cream
7.2a Male sex hormone antagonism

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<th>ANTI-ANDROGENS</th>
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**Cyproterone acetate**

- **INDICATIONS AND DOSE**
  - Gonadotrophin-independent precocious puberty (specialist use only)
  - **BY MOUTH**
  - Child: Initially 25 mg twice daily, adjusted according to response

- **Cautions**
  - Diabetes mellitus - in prostate cancer, severe depression - in prostate cancer, sickle-cell anaemia - ineffective for male hypersexuality in chronic alopecia
  - **Side-effects**
    - Common or very common: Depressed mood, dyspnoea, fatigue, gynaecomastia, hepatic disorders, hot flush, hyperhidrosis, nipple pain, restlessness, weight change
    - Uncommon: Skin reactions
    - Rare or very rare: Galactorrhoea, neoplasms
    - Frequency not known: Adrenocortical suppression, anaemia, azoospermia, hair changes, hypotrichosis, osteoporosis, sebaceous gland underactivity (may clear acne), thromboembolism

- **Medicinal forms**
  - Tablet (specialist use only)

- **Patient and carer advice**
  - Driving and skilled tasks: Fatigue and lassitude may impair performance of skilled tasks (e.g. driving).

- **Side-effects, further information**
  - Direct hepatic toxicity including jaundice, hepatisis and hepatic failure have been reported (fatalities reported, usually after several months, at dosages of 100 mg and above). If hepatotoxicity is confirmed, cyproterone should normally be withdrawn unless the hepatotoxicity can be explained by another cause such as metastatic disease (in which case cyproterone should be continued only if the perceived benefit exceeds the risk).
  - **Hepatic impairment**: Avoid.
  - **Pregnancy**: Avoid.
  - **Breast feeding**: No information available.

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<th>HORMONE ANTAGONISTS AND RELATED AGENTS</th>
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**Testolactone**

- **INDICATIONS AND DOSE**
  - Gonadotrophin-independent precocious puberty (specialist use only)
  - **BY MOUTH**
  - Child: 5 mg/kg 3–4 times a day; increased if necessary up to 10 mg/kg 4 times a day

- **Side-effects**
  - Common or very common: Appetite decreased, diarrhoea, hair growth abnormal, hypertension, nausea, peripheral neuropathy, vomiting, weight change
  - Rare or very rare: Hypersensitivity, rash

- **Medicinal forms**
  - Table (imported (United States))

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<tr>
<td>Teslac</td>
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<td>100 tablet</td>
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- **Patient and carer advice**
  - Unlicensed for use in children.
  - **Contra-indications**
    - Dubin–Johnson syndrome - history of thrombomembolic disorders - liver disorders - malignant diseases - meningoia or history of meningioma - previous or existing liver tumours - Rotor syndrome - severe depression - severe diabetes (with vascular changes) - sickle-cell anaemia - wasting diseases - youths under 18 years (may arrest bone maturation and testicular development)

- **Cautions**
  - Thrombophilia - increased risk of thrombosis
8 Thyroid disorders

8.1 Hyperthyroidism

Antithyroid drugs

Overview
Antithyroid drugs are used for hyperthyroidism either to prepare children for thyroidectomy or for long-term management. In the UK carbimazole below is the most commonly used drug. Propylthiouracil p. 502 should be reserved for children who are intolerant of, or for those who experience sensitivity reactions to carbimazole (sensitivity is not necessarily displayed to both drugs), and for whom other treatments are inappropriate. Both drugs act primarily by interfering with the synthesis of thyroid hormones. Treatment in children should be undertaken by a specialist.

Carbimazole or propylthiouracil are initially given in large doses to block thyroid function. This dose is continued until the child becomes euthyroid, usually after 4 to 8 weeks, and is then gradually reduced to a maintenance dose of 30–60% of the initial dose. Alternatively high-dose treatment is continued in combination with levothyroxine sodium p. 503 replacement (blocking–replacement regimen); this is particularly useful when dose adjustment proves difficult. Treatment is usually continued for 12 to 24 months. The blocking–replacement regimen is not suitable during pregnancy. Hypothyroidism should be avoided particularly during pregnancy as it can cause fetal goitre.

Iodine has been used as an adjunct to antithyroid drugs for 10 to 14 days before partial thyroidectomy; however, there is little evidence of a beneficial effect. Iodine should not be used for long-term treatment because its antithyroid action tends to diminish.

Radioactive sodium iodide (¹³¹I) solution is used increasingly for the treatment of thyrotoxicosis at all ages, particularly where medical therapy or compliance is a problem, in patients with cardiac disease, and in patients who relapse after thyroideocytomectomy.

Propranolol hydrochloride p. 106 is useful for rapid relief of thyrotoxic symptoms and can be used in conjunction with antithyroid drugs or as an adjunct to radioactive iodine. Beta-blockers are also useful in neonatal thyrotoxicosis and in supraventricular arrhythmias due to hyperthyroidism. Propranolol hydrochloride has been used in conjunction with iodine to prepare mildly thyrotoxic patients for surgery but it is preferable to make the patient euthyroid with carbimazole. Laboratory tests of thyroid function are not altered by beta-blockers. Most experience in treating thyrotoxicosis has been gained with propranolol but atenolol p. 108 is also used.

Thyrotoxic crisis ('thyroid storm') requires emergency treatment with intravenous administration of fluids, propranolol hydrochloride and hydrocortisone p. 456 as sodium succinate, as well as oral iodine solution and carbimazole or propylthiouracil which may need to be administered by nasogastric tube.

Antithyroid drugs in pregnancy
Radioactive iodine therapy is contra-indicated during pregnancy. Propylthiouracil and carbimazole can be given but the blocking–replacement regimen is not suitable. Carbimazole is associated with congenital defects, including aplasia cutis of the neonate, therefore propylthiouracil remains the drug of choice during the first trimester of pregnancy. In the second trimester, consider switching to carbimazole because of the potential risk of hepatotoxicity with propylthiouracil. Both propylthiouracil and carbimazole cross the placenta and in high doses may cause fetal goitre and hypothyroidism—the lowest dose that will control the hyperthyroid state should be used (requirements in Graves’ disease tend to fall during pregnancy). See also Important safety information in the carbimazole below drug monograph.

Advanced Pharmacy Services
Children with thyroid disorders may be eligible for the Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

Antithyroid drugs in neonates
Neonatal hyperthyroidism is treated with carbimazole or propylthiouracil, usually for 8 to 12 weeks. In severe symptomatic disease iodine may be needed to block the thyroid and propranolol required to treat peripheral symptoms.

Other drugs used for Hyperthyroidism Metoprolol tartrate, p. 109

ANTITHYROID DRUGS > SULFUR-CONTAINING IMIDAZOLES

Carbimazole

- INDICATIONS AND DOSE
Hyperthyroidism (blocking–replacement regimen) in combination with levothyroxine
  - BY MOUTH
  - Child: Therapy usually given for 12 to 24 months (consult product literature or local protocols)

Hyperthyroidism (including Graves’ disease)
  - BY MOUTH
  - Neonate: Initially 750 micrograms/kg daily until patient is euthyroid, usually after 8 to 12 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses (up to 1 mg/kg daily) are occasionally required, particularly in thyrotoxic crisis, dose may be given in single or divided doses.
  - Child 1 month–11 years: Initially 750 micrograms/kg daily until patient is euthyroid, usually after 4–8 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses are occasionally required, particularly in thyrotoxic crisis, dose may be given in single or divided doses; maximum 30 mg per day
  - Child 12–17 years: Initially 30 mg daily until euthyroid, usually after 4–8 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses are occasionally required, particularly in thyrotoxic crisis, dose may be given in single or divided doses

DOSE EQUIVALENT AND CONVERSION
  - When substituting, carbimazole 1 mg is considered equivalent to propylthiouracil 10 mg but the dose may need adjusting according to response.

IMPORTANT SAFETY INFORMATION
NEUTROPENIA AND AGRANULOCYTOSIS
Doctors are reminded of the importance of recognising bone marrow suppression induced by carbimazole and the need to stop treatment promptly.
  - Patient should be asked to report symptoms and signs suggestive of infection, especially sore throat.
  - A white blood cell count should be performed if there is any clinical evidence of infection.
  - Carbimazole should be stopped promptly if there is clinical or laboratory evidence of neutropenia.
BREAST FEEDING

Women of childbearing potential should use effective contraception during treatment with carbimazole. It should only be considered in pregnancy after a thorough benefit-risk assessment, and at the lowest effective dose without additional administration of thyroid hormones—close maternal, fetal, and neonatal monitoring is recommended.

MHRA/CHM ADVICE: CARBIMAZOLE: RISK OF ACUTE PANCREATITIS (FEBRUARY 2019)

Cases of acute pancreatitis have been reported during treatment with carbimazole. It should be stopped immediately and permanently if acute pancreatitis occurs.

Carbimazole should not be used in patients with a history of acute pancreatitis associated with previous treatment—re-exposure may result in life-threatening acute pancreatitis with a decreased time to onset.

INTERACTIONS

→ Appendix 1: carbimazole

SIDE-EFFECTS

▶ Rare or very rare Bone marrow disorders - haemolytic anaemia - severe cutaneous adverse reactions (SCARs) - thrombocytopenia


CONCEPTION AND CONCEPTION

The MHRA advises that females of childbearing potential should use effective contraception during treatment.

PREGNANCY

The MHRA advises consider use only after a thorough benefit-risk assessment. See Important Safety Information and Antithyroid drugs p. 501 for further information.

BREAST FEEDING

Present in breast milk but this does not preclude breast-feeding as long as neonatal development is closely monitored and the lowest effective dose is used. Amount in milk may be sufficient to affect neonatal thyroid function therefore lowest effective dose should be used.

HEPATIC IMPAIRMENT

Manufacturer advises use with caution in mild to moderate insufficiency—half-life may be prolonged; avoid in severe insufficiency.

PATIENT AND CARER ADVICE

Warn patient or carers to tell doctor immediately if sore throat, mouth ulcers, bruising, fever, malaise, or non-specific illness develops.

Medicines for Children leaflet: Carbimazole for hyperthyroidism

www.medicinesforchildren.org.uk/carbimazole-hyperthyroidism

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

Tablet

Carbimazole (Non-proprietary)

Carbimazole 5 mg Carbimazole 5mg tablets | 100 tablet £84.80 DT = £21.36
Carbimazole 10 mg Carbimazole 10mg tablets | 100 tablet £81.32 DT = £21.32
Carbimazole 15 mg Carbimazole 15mg tablets | 100 tablet £115.98-£127.50 DT = £32.75

ANTITHYROID DRUGS > THIOURACILS

Propylthiouracil

INDICATIONS AND DOSE

Hyperthyroidism (including Graves' disease)

▶ BY MOUTH

Neonate: Initially 2.5–5 mg/kg twice daily until euthyroid, usually after 8 to 12 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses are occasionally required, particularly in thyrotoxic crisis.

Child 1-11 months: Initially 2.5 mg/kg 3 times a day until euthyroid, usually after 4 to 8 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses are occasionally required, particularly in thyrotoxic crisis

Child 1-4 years: Initially 25 mg 3 times a day until euthyroid, usually after 4 to 8 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses are occasionally required, particularly in thyrotoxic crisis

Child 5-11 years: Initially 50 mg 3 times a day until euthyroid, usually after 4 to 8 weeks, then gradually reduce to a maintenance dose of 30–60% of the initial dose; higher initial doses are occasionally required, particularly in thyrotoxic crisis

DOSE EQUIVALENCE AND CONVERSION

▶ When substituting, carbimazole 1 mg is considered equivalent to propylthiouracil 10 mg but the dose may need adjusting according to response.

UNLICENSED USE

Not licensed for use in children under 6 years of age.

INTERACTIONS

→ Appendix 1: propylthiouracil

SIDE-EFFECTS

▶ Rare or very rare Agranulocytosis - bone marrow disorders - glomerulonephritis acute - hearing impairment - leucopenia - thrombocytopenia - vomiting


SIDE-EFFECTS, FURTHER INFORMATION

Severe hepatic reactions have been reported, including fatal cases and cases requiring liver transplant—discontinue if significant liver-enzyme abnormalities develop.

PREGNANCY

Propylthiouracil can be given but the blocking-replacement regimen is not suitable. Propylthiouracil crosses the placenta and in high doses may cause fetal goitre and hypothyroidism—the lowest dose that will control the hyperthyroid state should be used (requirements in Graves’ disease tend to fall during pregnancy).

BREAST FEEDING

Present in breast milk but this does not preclude breast-feeding as long as neonatal development is closely monitored and the lowest effective dose is used. Amount in milk probably too small to affect infant; high doses may affect neonatal thyroid function.
8.2 Hypothyroidism

Thyroid hormones

Overview
Thyroid hormones are used in hypothyroidism (juvenile myxoedema), and also in diffuse non-toxic goitre, congenital or neonatal hypothyroidism, and Hashimoto’s thyroiditis (lymphadenoid goitre). Neonatal hypothyroidism requires prompt treatment to facilitate normal development.

Levothyroxine sodium below (thyroxine sodium) is the treatment of choice for maintenance therapy.

Doses for congenital hypothyroidism and juvenile myxoedema should be titrated according to clinical response, growth assessment, and measurement of plasma thyroxine and thyroid-stimulating hormone concentrations. In congenital hypothyroidism higher initial doses may normalise metabolism more quickly, with associated beneficial effects on mental development.

Liothryronine sodium p. 504 has a similar action to levothyroxine sodium but is more rapidly metabolised and has a more rapid effect. Its effects develop after a few hours and disappear within 24 to 48 hours of discontinuing treatment. It may be used in severe hypothyroid states when a rapid response is desired.

Liothyrionate sodium by intravenous injection is the treatment of choice in hypothyroid coma. Adjunctive therapy includes intravenous fluids, hydrocortisone p. 456, and treatment of infection; assisted ventilation is often required.

Advanced Pharmacy Services
Children with thyroid disorders may be eligible for the Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

THYROID HORMONES

Levothyroxine sodium
(Thyroxine sodium)

INDICATIONS AND DOSE
Hypothyroidism
> BY MOUTH

- Neonate: Initially 10–15 micrograms/kg once daily (max. per dose 50 micrograms); adjusted in steps of 5 micrograms/kg every 2 weeks, alternatively adjusted in steps of 5 micrograms/kg as required; maintenance 20–50 micrograms daily, levothyroxine should be taken at the same time each day, preferably 30 minutes before meals, caffeine-containing drinks, or other medicines; this could be before breakfast or another more convenient time.

- Child 1 month–1 year: Initially 5 micrograms/kg once daily (max. per dose 50 micrograms); adjusted in steps of 10–25 micrograms every 2–4 weeks until metabolism normalised; maintenance 25–75 micrograms daily, levothyroxine should be taken at the same time each day, preferably 30 minutes before meals, caffeine-containing drinks, or other medicines; this could be before breakfast or another more convenient time.

- Child 2–11 years: Initially 50 micrograms once daily; adjusted in steps of 25 micrograms every 2–4 weeks until metabolism normalised; maintenance 75–100 micrograms daily, levothyroxine should be taken at the same time each day, preferably...
30 minutes before meals, caffeine-containing drinks, or other medicines; this could be before breakfast or another more convenient time

- Child 12-17 years: Initially 50 micrograms once daily; adjusted in steps of 25–50 micrograms every 3–4 weeks until metabolism normalised; maintenance 100–200 micrograms daily, levothyroxine should be taken at the same time each day, preferably 30 minutes before meals, caffeine-containing drinks, or other medicines; this could be before breakfast or another more convenient time

**Hyperthyroidism (blocking-replacement regimen) in combination with carbimazole**

- BY MOUTH
  - Child: Therapy usually given for 12 to 24 months (consult product literature or local protocols)

**CAUTIONS** Cardiac disorders (monitor ECG; start at low dose and carefully titrate) - diabetes insipidus - diabetes mellitus (dose of antidiabetic drugs including insulin may need to be increased) - long-standing hypothyroidism - panhypopituitarism (initiate corticosteroid therapy before starting levothyroxine) - predisposition to adrenal insufficiency (initiate corticosteroid therapy before starting levothyroxine)

**INTERACTIONS** → Appendix 1: thyroid hormones


**PREGNANCY** Levothyroxine may cross the placenta. Excessive or insufficient maternal thyroid hormones can be detrimental to fetus.

**Dose adjustments** Levothyroxine requirement may increase during pregnancy.

**Monitoring** Assess maternal thyroid function before conception (if possible), at diagnosis of pregnancy, at antenatal booking, during both the second and third trimesters, and after delivery (more frequent monitoring required on initiation or adjustment of levothyroxine).

**BREAST FEEDING** Amount too small to affect tests for neonatal hypothyroidism.

**PRESCRIBING AND DISPENSING INFORMATION** Levothyroxine equivalent to 100 micrograms/m²/day can be used as a guide to the requirements in children.

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Levothyroxine for hypothyroidism
- www.medicinesforchildren.org.uk/levothyroxine-hypothyroidism

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

- **Tablet**
  - Levothyroxine sodium (Non-proprietary)
    - Levothyroxine sodium anhydrous 12.5 microgram | 28 tablet | £2.09
    - Levothyroxine sodium anhydrous 25 microgram | 28 tablet | £3.05
    - Levothyroxine sodium anhydrous 50 microgram | 100 tablet | £6.79

- **Injectable**
  - Levothyroxine sodium anhydrous 75 microgram
  - Levothyroxine sodium anhydrous 100 microgram
  - Levothyroxine sodium anhydrous 150 microgram
  - Levothyroxine sodium anhydrous 200 microgram

**SIDE-EFFECTS**

- Rare or very rare: Decreased appetite - angina pectoris - diabetes insipidus - diabetes mellitus (dose of antidiabetic drugs including insulin may need to be increased) - prolonged hypothyroidism (initiate corticosteroid therapy in adrenal insufficiency) - severe hypothyroidism (initiate corticosteroid therapy in adrenal insufficiency)

**INTERACTIONS** → Appendix 1: thyroid hormones

**INDICATIONS AND DOSE**

- **Hypothyroidism**
  - **BY MOUTH**
  - Child 12-17 years: Initially 10–20 micrograms daily; increased to 60 micrograms daily in 2–3 divided doses

- **Hypothyroid coma**
  - **BY SLOW INTRAVENOUS INJECTION**
  - Child 12-17 years: 5–20 micrograms every 12 hours, increased to 5–20 micrograms every 4 hours if required, alternatively initially 50 micrograms for 1 dose, then 25 micrograms every 8 hours, reduced to 25 micrograms twice daily

- **Hypothyroidism (replacement for oral levothyroxine)**
  - **BY SLOW INTRAVENOUS INJECTION**
  - Child: Convert daily levothyroxine dose to liothyronine and give in 2–3 divided doses, adjusted according to response

- **DOSE EQUIVALENCE AND CONVERSION**
  - 20–25 micrograms of liothyronine sodium is equivalent to approximately 100 micrograms of levothyroxine sodium.
  - Brands without a UK licence may not be bioequivalent and dose adjustment may be necessary.

**CAUTIONS** Cardiac disorders (monitor ECG; start at low dose and carefully titrate) - diabetes insipidus - diabetes mellitus (dose of antidiabetic drugs including insulin may need to be increased) - prolonged hypothyroidism (initiate corticosteroid therapy in adrenal insufficiency) - severe hypothyroidism (initiate corticosteroid therapy in adrenal insufficiency)

**GENERAL SIDE-EFFECTS**
Frequency not known  Agitation · fever · flushing · headache 
· hyperhidrosis · insomnia (more common at excessive dosage) · oedema · restlessness (more common at excessive dosage) · skin reactions · tremor (more common at excessive dosage) · weight decreased

SPECIFIC SIDE-EFFECTS

Rare or very rare

With intravenous use  Epiphyses premature fusion · idiopathic intracranial hypertension · menstruation irregular

PREGNANCY  Does not cross the placenta in significant amounts. Excessive or insufficient maternal thyroid hormones can be detrimental to fetus.

Dose adjustments  Liothyronine requirement may increase during pregnancy.

Monitoring  Assess maternal thyroid function before conception (if possible), at diagnosis of pregnancy, at antenatal booking, during both the second and third trimesters, and after delivery (more frequent monitoring required on initiation or adjustment of liothyronine).

BREAST FEEDING  Amount too small to affect tests for neonatal hypothyroidism.

PRESCRIBING AND DISPENSING INFORMATION

Switching to a different brand  Patients switched to a different brand should be monitored (particularly if pregnant or if heart disease present) as brands without a UK licence may not be bioequivalent. Pregnant women or those with heart disease should undergo an early review of thyroid status, and other patients should have thyroid function assessed if experiencing a significant change in symptoms. If liothyronine is continued long-term, thyroid function tests should be repeated 1–2 months after any change in brand.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution, solution for injection

Tablet

Liothyronine sodium (Non-proprietary)
Liothyronine sodium 20 microgram  Liothyronine 20 microgram tablets |  28 tablet [PPh] £245.29 DT + £206.71

Cytomel (Imported (United States))
Liothyronine sodium 5 microgram  Cytomel 5 microgram tablets |  100 tablet [PPh] £
Liothyronine sodium 25 microgram  Cytomel 25 microgram tablets |  100 tablet [PPh]

Powder for solution for injection

Liothyronine sodium (Non-proprietary)
Liothyronine sodium 20 microgram  Liothyronine 20 microgram powder for solution for injection vials |  5 vial [PPh] £1,567.50
Chapter 7
Genito-urinary system

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1 Bladder and urinary disorders

1.1 Urinary frequency, enuresis, and incontinence

Urinary frequency, enuresis and incontinence

Urinary incontinence
Antimuscarinic drugs reduce symptoms of urgency and urge incontinence and increase bladder capacity; oxybutynin hydrochloride p. 507 also has a direct relaxant effect on urinary smooth muscle. Oxybutynin hydrochloride can be considered first for children under 12 years. Side-effects limit the use of oxybutynin hydrochloride, but they may be reduced by starting at a lower dose and then slowly titrating upwards; alternatively oxybutynin hydrochloride can be given by intravesical instillation. Tolterodine tartrate p. 508 is also effective for urinary incontinence; it can be considered for children over 12 years, or for younger children who have failed to respond to oxybutynin hydrochloride. Modified-release preparations of oxybutynin hydrochloride and tolterodine tartrate are available; they may have fewer side-effects. Antimuscarinic treatment should be reviewed soon after it is commenced, and then at regular intervals; a response generally occurs within 6 months but occasionally may take longer. Children with nocturnal enuresis may require specific additional measures if night-time symptoms also need to be controlled.

See also Nocturnal enuresis in children below.

Nocturnal enuresis in children

23-May-2017

Description of condition
Nocturnal enuresis is the involuntary discharge of urine during sleep, which is common in young children. Children are generally expected to be dry by a developmental age of 5 years, and historically it has been common practice to consider children for treatment only when they reach 7 years; however, symptoms may still persist in a small proportion by the age of 10 years.

Treatment
Children under 5 years
For children under 5 years, treatment is usually unnecessary as the condition is likely to resolve spontaneously. Reassurance and advice can be useful for some families.

Non Drug Treatment
Initially, advice should be given on fluid intake, diet, toileting behaviour, and use of reward systems. For children who do not respond to this advice (more than 1–2 wet beds per week), an enuresis alarm should be the recommended treatment for motivated, well-supported children. Alarms in children under 7 years should be considered depending on the child’s maturity, motivation and understanding of the alarm. Alarms have a lower relapse rate than drug treatment when discontinued.

Treatment using an alarm should be reviewed after 4 weeks and continued until a minimum of 2 weeks’ uninterrupted dry nights have been achieved. If complete dryness is not achieved after 3 months but the condition is still improving and the child remains motivated to use the alarm, it is recommended to continue the treatment. Combined treatment with desmopressin p. 448, or the use of desmopressin alone, is recommended if the initial alarm treatment is unsuccessful or it is no longer appropriate or desirable.

Drug Treatment
Treatment with oral or sublingual desmopressin is recommended for children over 5 years of age when alarm use is inappropriate or undesirable, or when rapid or short-term results are the priority (for example, to cover periods away from home). Desmopressin alone can also be used if there has been a partial response to a combination of desmopressin and an alarm following initial treatment with an alarm alone. Treatment should be assessed after 4 weeks and continued for 3 months if there are signs of response. Repeated courses of desmopressin can be used in responsive children who experience repeated recurrences of bedwetting, but should be withdrawn gradually at regular intervals (for 1 week every 3 months) for full reassessment.

Under specialist supervision, nocturnal enuresis associated with daytime symptoms (overactive bladder) can be managed with desmopressin alone or in combination with an antimuscarinic drug (such as oxybutynin hydrochloride p. 507 or tolterodine tartrate p. 508 [unlicensed indication]).
Treatment should be continued for 3 months; the course can be repeated if necessary.

The tricyclic antidepresant imipramine hydrochloride p. 246 can be considered for children who have not responded to all other treatments and have undergone specialist assessment, however relapse is common after withdrawal and children and their carers should be aware of the dangers of overdose. Initial treatment should continue for 3 months; further courses can be considered following a medical review every 3 months. Tricyclic antidepressants should be withdrawn gradually.

Useful Resources

ANTIMUSCARINICS

Antimuscarinics (systemic)

- CONTRA-INDICATIONS Gastro-intestinal obstruction - intestinal atony - myasthenia gravis (but some antimuscarinics may be used to decrease muscarinic side-effects of anticholinesterases) - paralytic ileus - pyloric stenosis - severe ulcerative colitis - significant bladder outflow obstruction - toxic megacolon - urinary retention

- CAUTIONS Arrhythmias (may be worsened) - autonomic neuropathy - cardiac insufficiency (due to association with tachycardia) - cardiac surgery (due to association with tachycardia) - children (increased risk of side-effects) - conditions characterised by tachycardia - congestive heart failure (may be worsened) - coronary artery disease (may be worsened) - diarrhoea - gastro-oesophageal reflux disease - hiatus hernia with reflux oesophagitis - hypertension - hyperthyroidism (due to association with tachycardia) - individuals susceptible to angle-closure glaucoma - pyrexia - ulcerative colitis

- SIDE-EFFECTS Common or very common - Confusion - constipation - dizziness - drowsiness - dry mouth - dyspepsia - flushing - headache - nausea - palpitations - skin reactions - tachycardia - urinary disorders - vision disorders - vomiting

- Rare or very rare - Angioedema

- PATIENT AND CARER ADVICE Driving and skilled tasks - Antimuscarinics can affect the performance of skilled tasks (e.g. driving).

ANTIMUSCARINICS > URINARY

Oxybutynin hydrochloride

- INDICATIONS AND DOSE Urinary frequency / Urinary urgency / Urinary incontinence | Neurogenic bladder instability

  - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
    - Child 2-4 years: 1.25–2.5 mg 2–3 times a day
    - Child 5-11 years: Initially 2.5–3 mg twice daily, increased to 5 mg 2–3 times a day
    - Child 12-17 years: Initially 5 mg 2–3 times a day, increased if necessary up to 10 mg 4 times a day

  - BY INTRAVESICAL INSTILLATION
    - Child 2–7 years: 5 mg 2–3 times a day
    - BY MOUTH USING MODIFIED-RELEASE TABLETS
    - Child 5-11 years: Initially 5 mg once daily, adjusted in steps of 5 mg every week, adjusted according to response; maximum 15 mg per day

  - BY MOUTH USING MODIFIED-RELEASE TABLETS

- CONTRA-INDICATIONS Gastro-intestinal obstruction - intestinal atony - myasthenia gravis (but some antimuscarinics may be used to decrease muscarinic side-effects of anticholinesterases) - paralytic ileus - pyloric stenosis - severe ulcerative colitis - significant bladder outflow obstruction - toxic megacolon - urinary retention

- CAUTIONS Arrhythmias (may be worsened) - autonomic neuropathy - cardiac insufficiency (due to association with tachycardia) - cardiac surgery (due to association with tachycardia) - children (increased risk of side-effects) - conditions characterised by tachycardia - congestive heart failure (may be worsened) - coronary artery disease (may be worsened) - diarrhoea - gastro-oesophageal reflux disease - hiatus hernia with reflux oesophagitis - hypertension - hyperthyroidism (due to association with tachycardia) - individuals susceptible to angle-closure glaucoma - pyrexia - ulcerative colitis

- SIDE-EFFECTS Common or very common - Confusion - constipation - dizziness - drowsiness - dry mouth - dyspepsia - flushing - headache - nausea - palpitations - skin reactions - tachycardia - urinary disorders - vision disorders - vomiting

- Rare or very rare - Angioedema

- PATIENT AND CARER ADVICE Driving and skilled tasks - Antimuscarinics can affect the performance of skilled tasks (e.g. driving).

ANTIMUSCARINICS > URINARY

Oxybutynin hydrochloride

- INDICATIONS AND DOSE Urinary frequency / Urinary urgency / Urinary incontinence | Neurogenic bladder instability

  - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
    - Child 2-4 years: 1.25–2.5 mg 2–3 times a day
    - Child 5-11 years: Initially 2.5–3 mg twice daily, increased to 5 mg 2–3 times a day
    - Child 12-17 years: Initially 5 mg 2–3 times a day, increased if necessary up to 5 mg 4 times a day

- BY INTRAVESICAL INSTILLATION
    - Child 2–7 years: 5 mg 2–3 times a day

- BY MOUTH USING MODIFIED-RELEASE TABLETS

  - Child 5-11 years: Initially 5 mg once daily, adjusted in steps of 5 mg every week, adjusted according to response; maximum 15 mg per day

- DOSE EQUIVALENCE AND CONVERSION

  - Patients taking immediate-release oxybutynin may be transferred to the nearest equivalent daily dose of Lyrinel® XL


  - CAUTIONS Acute porphyrias p. 624

  - INTERACTIONS - Appendix 1: oxybutynin

  - SIDE-EFFECTS

    - Common or very common - Diarrhoea - dry eye

    - Uncommon - Abdominal discomfort - appetite decreased - dysphagia

    - Frequency not known - Anxiety - arrhythmia - cognitive disorder - depressive symptom - drug dependence - gastrointestinal disorders - glaucoma - hallucination - heat stroke - hypohidrosis - mydriasis - nightmare - paraesthesia - photosensitivity reaction - seizure - urinary tract infection

    - PREGNANCY - Manufacturers advise avoid unless essential—toxicity in animal studies.

    - BREAST FEEDING - Manufacturers advise avoid—present in milk in animal studies.

    - HEPATIC IMPAIRMENT - Manufacturer advises caution.

    - RENAL IMPAIRMENT - Manufacturer advises caution.

    - PRESCRIBING AND DISPENSING INFORMATION The need for therapy for urinary indications should be reviewed soon after it has been commenced and then at regular intervals; a response usually occurs within 6 months but may take longer. Intravesical instillation may be available from ‘special-order’ manufacturers or specialist importing companies.

    - PATIENT AND CARER ADVICE


- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, bladder irrigation.

- Modified-release tablet

  - CAUTIONARY AND ADVISORY LABELS 3, 25

    - Lyrinel XL (Janssen-Cilag Ltd)
      - Oxybutynin hydrochloride 5 mg Lyrinel XL 5mg tablets | 30 tablet (P) £11.77 DT + £11.77
      - Oxybutynin hydrochloride 10 mg Lyrinel XL 10mg tablets | 30 tablet (P) £27.54 DT + £27.54

  - Tablet

    - CAUTIONARY AND ADVISORY LABELS 3

      - Oxybutynin hydrochloride (Non-proprietary)
        - Oxybutynin hydrochloride 2.5 mg Oxybutynin 2.5mg tablets | 56 tablet (P) £6.58 DT + £2.17 | 84 tablet (P) £3.26–£7.71
        - Oxybutynin hydrochloride 3 mg Oxybutynin 3mg tablets | 56 tablet (P) £11.23 DT + £11.44
        - Oxybutynin hydrochloride 5 mg Oxybutynin 5mg tablets | 56 tablet (P) £13.85 DT + £3.09 | 84 tablet (P) £4.64–£20.77
        - Cystrin (Sanofi)
          - Oxybutynin hydrochloride 5 mg Cystrin 5mg tablets | 84 tablet (P) £21.99
        - Ditropan (Sanofi)
          - Oxybutynin hydrochloride 2.5 mg Ditropan 2.5mg tablets | 84 tablet (P) £11.00

- Nocturnal enuresis associated with overactive bladder

  - BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

    - Child 5-17 years: 2.5–3 mg twice daily, increased to 5 mg 2–3 times a day, last dose to be taken before bedtime

  - BY MOUTH USING MODIFIED-RELEASE TABLETS

    - Child 5-17 years: Initially 5 mg once daily, adjusted in steps of 5 mg every week, adjusted according to response; maximum 15 mg per day

- DOSE EQUIVALENCE AND CONVERSION

  - Patients taking immediate-release oxybutynin may be transferred to the nearest equivalent daily dose of Lyrinel® XL
Oxybutynin hydrochloride 5 mg Diltozan 5mg tablets | 84 tablet £2.90

**Oral solution**

**MEDICINAL FORMS**

- **TABLET**
- **Solution**
- **Powder**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, powder.

**BREAST FEEDING**

- Common or very common
- Uncommon
- Rare or very rare
- Frequency not known

**PREGNANCY**

- Manufacturer advises avoid
- Manufacturer advises caution
- Not licensed for use in children.

**INTERACTIONS**

- By mouth using immediate-release medicines
- By mouth using modified-release capsules
- Child 2-17 years: dose to be taken at bedtime, then increased if necessary up to 2 mg twice daily, adjusted according to response

**SIDE-EFFECTS**

- Abdominal pain
- Bronchitis
- Chest pain
- Diarrhoea
- Fatigue
- Headache
- Hypertension
- Gastrointestinal disorder
- Nervousness
- Urinary frequency
- Urinary incontinence

**DOSE EQUIVALENCE AND CONVERSION**

- Children stabilised on immediate-release tolterodine tartrate 2 mg twice daily may be transferred to modified-release tolterodine tartrate 4 mg once daily.

**SIDE-EFFECTS**

- Abdominal pain
- Bronchitis
- Chest pain
- Diarrhoea
- Dry eye
- Fatigue
- Gastrointestinal disorder
- Nervousness
- Urinary frequency
- Urinary incontinence

**DOSE EQUIVALENCE AND CONVERSION**

- Children stabilised on immediate-release tolterodine tartrate 2 mg twice daily may be transferred to modified-release tolterodine tartrate 4 mg once daily.

**INTERACTIONS**

- By mouth using immediate-release medicines
- Child 5-17 years: dose to be taken at bedtime, then increased if necessary up to 2 mg twice daily, adjusted according to response

**SIDE-EFFECTS**

- Abdominal pain
- Bronchitis
- Chest pain
- Diarrhoea
- Fatigue
- Headache
- Hypertension
- Gastrointestinal disorder
- Nervousness
- Urinary frequency
- Urinary incontinence

**DOSE EQUIVALENCE AND CONVERSION**

- Children stabilised on immediate-release tolterodine tartrate 2 mg twice daily may be transferred to modified-release tolterodine tartrate 4 mg once daily.

**INTERACTIONS**

- By mouth using immediate-release medicines
- Child 2-17 years: 1 mg once daily, then increased if necessary up to 2 mg twice daily, adjusted according to response

**SIDE-EFFECTS**

- Abdominal pain
- Bronchitis
- Chest pain
- Diarrhoea
- Fatigue
- Headache
- Hypertension
- Gastrointestinal disorder
- Nervousness
- Urinary frequency
- Urinary incontinence

**DOSE EQUIVALENCE AND CONVERSION**

- Children stabilised on immediate-release tolterodine tartrate 2 mg twice daily may be transferred to modified-release tolterodine tartrate 4 mg once daily.

**INDICATIONS AND DOSE**

- Urinary frequency
- Urinary urgency
- Urinary incontinence

- Frequency not known

**PREGNANCY**

- Manufacturer advises avoid—toxicity in animal studies.

**BREAST FEEDING**

- Manufacturer advises avoid—no information available.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution (risk of increased exposure).

**Dose adjustments**

- In adults, manufacturers advise dose reduction—consult product literature.

**RENAI IMPAIRMENT**

- Avoid modified-release preparations if estimated glomerular filtration rate less than 30 mL/minute/1.73m².

**Dose adjustments**

- Reduce dose if estimated glomerular filtration rate less than 30 mL/minute/1.73m².

**PRESCRIBING AND DISPENSING INFORMATION**

- The need for therapy for urinary indications should be reviewed soon after it has been commenced and then at regular intervals; a response usually occurs within 6 months but may take longer.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, powder.

**Tolterodine tartrate**

- **INDICATIONS AND DOSE**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**

**Tropism chloride**

- **INDICATIONS AND DOSE**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **DOSE EQUIVALENCE AND CONVERSION**
- **INTERACTIONS**
1.2 Urinary retention

Urinary retention

Description of condition

Urinary retention is the inability to voluntarily urinate. Causes in children can include severe voiding dysfunction, urethral blockage, drug treatment (such as opioids and antimuscarinic drugs), conditions that reduce detrusor contractions or interfere with relaxation of the urethra, and neurogenic causes. Acute urinary retention is a medical emergency characterised by the abrupt (over a period of hours) development of the inability to pass urine, associated with increasing pain and the presence of a distended bladder, which can be palpated on examination. Chronic urinary retention is the gradual (over months or years) development of the inability to empty the bladder completely, characterised by difficulties with initiating and maintaining urinary stream, urinary overflow, no sensation for needing to void and a post-void residual.

Treatment

Treatment of urinary retention depends on the underlying condition. Catheterisation is used as an effective initial management strategy, which should be followed by diagnostic evaluation and appropriate treatment of the underlying cause. Clean intermittent catheterisation on a long-term basis is effective for children with idiopathic or neurogenic bladder dysfunction.

The selective alpha-adrenoceptor blockers, doxazosin below and tamsulosin hydrochloride p. 510, have been shown to be of use in primary bladder neck dysfunction and dysfunctional voiding; they reduce urethral sphincteric pressure, thereby improving bladder emptying in children. Treatment should be under specialist advice only.

ALPHA-ADRENOCEPTOR BLOCKERS

Doxazosin

<table>
<thead>
<tr>
<th>INDICATIONS AND DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypertension</strong></td>
</tr>
<tr>
<td>▶ By mouth using immediate-release medicines</td>
</tr>
<tr>
<td>Child 6–11 years: Initially 500 micrograms once daily, then increased to 2–4 mg once daily, dose should be increased at intervals of 1 week.</td>
</tr>
<tr>
<td>Child 12–17 years: Initially 1 mg once daily for 1–2 weeks, then increased to 2 mg once daily, then increased if necessary to 4 mg once daily, rarely doses of up to 16 mg daily may be required</td>
</tr>
<tr>
<td><strong>Dysfunctional voiding (initiated under specialist supervision)</strong></td>
</tr>
<tr>
<td>▶ By mouth using immediate-release medicines</td>
</tr>
<tr>
<td>Child 4–11 years: Initially 0.5 mg daily, adjusted according to response, dose should be increased at monthly intervals; maximum 2 mg per day</td>
</tr>
<tr>
<td>Child 12–17 years: Initially 1 mg daily, adjusted according to response, dose may be doubled at intervals of 1 month; usual maintenance 2–4 mg daily; maximum 8 mg per day</td>
</tr>
</tbody>
</table>

DOSAGE EQUIVALENT AND CONVERSION

- Patients stabilised on immediate-release doxazosin can be transferred to the equivalent dose of modified-release doxazosin.

- **UNLICENSED USE** Not licensed for use in children.

- **CONTRA-INDICATIONS** History of postural hypotension

- **CAUTIONS** Care with initial dose (postural hypotension) - cataract surgery (risk of intra-operative floppy iris syndrome) - heart failure - pulmonary oedema due to aortic or mitral stenosis

- **INTERACTIONS** ▶ Appendix 1: alpha blockers

- **SIDE-EFFECTS**
  - Common or very common Arrhythmias - asthenia - chest pain - cough - cystitis - dizziness - drowsiness - dry mouth - dyspnœa - gastrointestinal discomfort - headache - hypotension - increased risk of infection - influenza like illness - muscle complaints - nausea - oedema - pain - palpitations - skin reactions - urinary disorders - vertigo
  - Uncommon Angina pectoris - anxiety - appetite abnormal - arthralgia - constipation - depression - diarrhoea - gastrointestinal disorders - gout - haemorrhage - insomnia - myocardial infarction - sensation abnormal - sexual dysfunction - stroke - syncope - tinnitus - tremor - vomiting - weight increased
  - Rare or very rare Alopecia - bronchospasm - flushing - gynaecomastia - hepatic disorders - leucopenia - malaise - muscle weakness - thrombocytopenia - vision blurred
  - Frequency not known Floppy iris syndrome

- **PREGNANCY** No evidence of teratogenicity; manufacturers advise use only when potential benefit outweighs risk.

- **BREAST FEEDING** Accumulates in milk in animal studies - manufacturer advises avoid.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in mild to moderate impairment (limited information available); avoid in severe impairment (no information available).

- **PATIENT AND CARER ADVICE** Patient counselling is advised for doxazosin tablets (initial dose).

- Driving and skilled tasks May affect performance of skilled tasks e.g. driving.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

- **Modified-release tablet**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Cardura XL (Pfizer Ltd)</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 4 mg</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 8 mg</td>
</tr>
<tr>
<td>▶ Doxodura XL (Discovery Pharmaceuticals)</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 4 mg</td>
</tr>
<tr>
<td>▶ Larbex XL (Teva UK Ltd)</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 4 mg</td>
</tr>
<tr>
<td>▶ Rapsorin XL (Actavis UK Ltd)</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 4 mg</td>
</tr>
<tr>
<td>▶ Slocinx XL (Zeneca)</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 4 mg</td>
</tr>
</tbody>
</table>

- **Tablet**

<table>
<thead>
<tr>
<th>Doxazosin (Non-proprietary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 1 mg</td>
</tr>
<tr>
<td>Doxazosin (as Doxazosin mesilate) 2 mg</td>
</tr>
</tbody>
</table>
Tamsulosin hydrochloride

**INDICATIONS AND DOSE**
Dysfunctional voiding (administered on expert advice)

**SIDE-EFFECTS**

**CAUTIONARY AND ADVISORY LABELS**

**13 Urolithiasis**

Renal and ureteric stones

**Description of condition**
Renal and ureteric stones are crystalline calculi that may form anywhere in the upper urinary tract. They are often asymptomatic but may cause pain when they move or obstruct the flow of urine. Most stones are composed of calcium salts (calcium oxalate, calcium phosphate or both). The rest are composed of struvite, uric acid, cystine and other substances. Patients are susceptible to stone formation when there is a decrease in urine volume and/or an excess of other substances. Patients are susceptible to stone formation when there is a decrease in urine volume and/or an excess of other substances.

The following are risk factors that have been associated with stone formation: dehydration, change in urine pH, positive family history, obesity, urinary anatomical abnormalities, and excessive dietary intake of oxalate, urate, sodium, and animal protein. Certain diseases which alter urinary volume, pH, and concentrations of certain ions (such as calcium, phosphate, oxalate, sodium, and uric acid) may also increase the risk of stone formation. Certain drugs such as calcium or vitamin D supplements, protease inhibitors, or diuretics may also increase the risk of stone formation.

Symptoms of acute renal or ureteric stones can include an abrupt onset of severe unilateral abdominal pain radiating to the groin (known as renal colic) that may be accompanied with nausea, vomiting, haematuria, increased urinary frequency, dysuria and fever (if concomitant urinary infection is present).

Stones can pass spontaneously and will depend on a number of factors, including the size of the stone (stones greater than 6 mm have a very low chance of spontaneous passage), the location (distal ureteral stones are more likely to pass than proximal ureteral stones), and the degree of obstruction.
Aims of treatment

The aim of treatment is to improve the detection, clearance and prevention of renal and ureteric stones thereby reducing pain and improving quality of life. 

Non-drug treatment

Consider watchful waiting for asymptomatic renal stones if they are less than 5 mm in diameter. If they are larger than this then the specialist will discuss the risk and benefit of this option with the patient or parents.

Options for surgical stone removal should be discussed by the specialist team in hospital depending on severity of obstruction, patient factors, size and site of stone. Options include shockwave lithotripsy, percutaneous nephrolithotomy and ureteroscopy.

For patients with recurrent calcium stones avoid excessive dietary intake of oxalate-rich products, such as rhubarb, spinach, cocoa, tea, nuts, soy products, strawberries, and wheat bran. For patients with recurrent uric acid stones, avoid excessive intake of urate rich products, such as liver, kidney, call thymus, poultry skin, and certain fish (herring with skin, sardines and anchovies).

Child aged under 16 years

Consider referring children and young patients with renal or ureteric stones to a paediatric nephrologist or urologist with expertise in this area for assessment and metabolic investigations.

Advise children to drink or carers to give their children 2.5–3 litres of water a day (depending on age) with the addition of fresh lemon juice and to avoid carbonated drinks. Advise children or carers to maintain a normal daily calcium intake of 350–1000 mg and daily salt intake of 2–6 g (depending on age).

Child aged 16 years and over

Consider stone analysis and measure serum calcium for children with recurring renal or ureteric stones.

Along with maintaining a healthy lifestyle, advise children to drink 2.5–3 litres of water a day with the addition of fresh lemon juice and to avoid carbonated drinks. Maintain a normal daily calcium intake of 700–1,200 mg and salt intake of no more than 6 g a day.

Pain Management

Offer NSAIDs as first line treatment for the management of pain associated with suspected renal colic or renal and ureteric stones. If NSAIDs are contra-indicated or not sufficiently controlling the pain, consider intravenous paracetamol. Subsequently, opioids can be used if both paracetamol and NSAIDs are contra-indicated or not sufficiently controlling the pain. Do not offer antispasmodics to patients with suspected renal colic.

Medical Expulsive Therapy

Consider alpha-adrenoceptor blockers for children with distal ureteric stones less than 10 mm in diameter.

Child aged 16 years and over

Alpha-adrenoceptor blockers may also be considered as adjunctive therapy for children having shockwave lithotripsy for ureteric stones less than 10 mm.

Prevention of recurrence of stones

Child aged under 16 years

Alongside lifestyle advice, consider potassium citrate [unlicensed] in children with recurrent stones composed of at least 50% calcium oxalate, and those with hypercalciuria and hypocitraturia.

Child aged 16 years and over

Alongside lifestyle advice, consider potassium citrate [unlicensed] in children with recurrent stones composed of at least 50% calcium oxalate. Thiazides [unlicensed] may be given if children also have hypercalciuria after restricting their sodium intake to no more than 6 g a day.

1.4 Urological pain

Urological pain

Treatment

Lidocaine hydrochloride gel is a useful topical application in urethral pain or to relieve the discomfort of catheterisation.

For information on the management of pain in renal and ureteric stones, see Renal and ureteric stones p. 510.

Alkalisation of urine

Alkalisation of urine can be undertaken with potassium citrate. The alkalinising action may relieve the discomfort of cystitis caused by lower urinary tract infections.

ALKALISING DRUGS

Citric acid with potassium citrate

INDICATIONS AND DOSE

Relief of discomfort in mild urinary-tract infections

Alkalisation of urine

BY MOUTH USING ORAL SOLUTION

Child 1-5 years: 5 mL 3 times a day, diluted well with water

Child 6-17 years: 10 mL 3 times a day, diluted well with water

CAUTIONS

Cardiac disease

INTERACTIONS

Appendix 1: potassium citrate

SIDE-EFFECTS

Hyperkalaemia, nausea, vomiting

RENAL IMPAIRMENT

Avoid in severe impairment.

Monitoring

Close monitoring required in renal impairment—high risk of hyperkalaemia.

PRESCRIBING AND DISPENSING INFORMATION

When prepared extemporaneously, the BP states Potassium Citrate Mixture BP consists of potassium citrate 30%, citric acid monohydrate 5% in a suitable vehicle with a lemon flavour. Extemporaneous preparations should be recently prepared according to the following formula: potassium citrate 3 g, citric acid monohydrate 500 mg, syrup 2.5 mL, quillaja tincture 0.1 mL, lemon spirit 0.05 mL, double-strength chloroform water 3 mL, water to 10 mL. Contains about 28 mmol K+/10 mL.

EXCEPTIONS TO LEGAL CATEGORY

Proprietary brands of potassium citrate are on sale to the public for the relief of discomfort in mild urinary-tract infections.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Oral solution

CAUTIONARY AND ADVISORY LABELS

Citric acid with potassium citrate (Non-proprietary)

Potassium citrate mixture

Potassium citrate mixture 300 mg per 1 ml Potassium citrate mixture

200 mL £1.38 DT + £1.38

200 mL £1.38 DT
2 Bladder instillations and urological surgery

Bladder instillations and urological surgery

Bladder infection
Various solutions are available as irrigations or washouts.
Aqueous chlorhexidine p. 727 can be used in the management of common infections of the bladder but it is ineffective against most Pseudomonas spp. Solutions containing chlorhexidine 1 in 5000 (0.02%) are used but they may irritate the mucosa and cause burning and haematuria (in which case they should be discontinued); sterile sodium chloride solution 0.9% p. 610 (physiological saline) is usually adequate and is preferred as a mechanical irrigant.

Dissolution of blood clots
Clot retention is usually treated by irrigation with sterile sodium chloride solution 0.9% but sterile sodium citrate solution for bladder irrigation 3% may also be helpful.

Maintenance of indwelling urinary catheters
The deposition which occurs in catheterised patients is usually chiefly composed of phosphate and to minimise this the catheter (if latex) should be changed at least as often as every 6 weeks. If the catheter is to be left for longer periods a silicone catheter should be used together with the appropriate use of catheter maintenance solutions. Repeated blockage usually indicates that the catheter needs to be changed.

Catheter maintenance solutions

<table>
<thead>
<tr>
<th>CATHETER MAINTENANCE SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OptiFlo G citric acid</strong> 3.23% catheter maintenance solution (Bard Ltd)</td>
</tr>
<tr>
<td>50 ml – NHS indicative price = £16.66 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td>100 ml – NHS indicative price = £33.32 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td><strong>OptiFlo R citric acid 6% catheter maintenance solution</strong> (Bard Ltd)</td>
</tr>
<tr>
<td>50 ml – NHS indicative price = £16.66 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td>100 ml – NHS indicative price = £33.32 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td><strong>Uro-Tainer PHMB polihexanide 0.02% catheter maintenance solution</strong> (B.Braun Medical Ltd)</td>
</tr>
<tr>
<td>100 ml – NHS indicative price = £4.46 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td><strong>Uro-Tainer Twin Soluto R citric acid 6% catheter maintenance solution</strong> (B.Braun Medical Ltd)</td>
</tr>
<tr>
<td>60 ml – NHS indicative price = £4.89 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td><strong>Uro-Tainer Twin Suby G citric acid 3.23% catheter maintenance solution</strong> (B.Braun Medical Ltd)</td>
</tr>
<tr>
<td>60 ml – NHS indicative price = £5.87 • Drug Tariff (Part IXa)</td>
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<tr>
<td><strong>OptiFlo S saline 0.9% catheter maintenance solution</strong> (Bard Ltd)</td>
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<tr>
<td>50 ml – NHS indicative price = £3.45 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td>100 ml – NHS indicative price = £6.90 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td><strong>Uro-Tainer M sodium chloride 0.9% catheter maintenance solution</strong> (B.Braun Medical Ltd)</td>
</tr>
<tr>
<td>Sodium chloride 9 mg per 1 ml 50 ml – NHS indicative price available • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td>100 ml – No NHS indicative price available • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td><strong>Uro-Tainer sodium chloride 0.9% catheter maintenance solution</strong> (B.Braun Medical Ltd)</td>
</tr>
<tr>
<td>Sodium chloride 9 mg per 1 ml 50 ml – NHS indicative price = £3.57 • Drug Tariff (Part IXa)</td>
</tr>
<tr>
<td>100 ml – NHS indicative price = £3.57 • Drug Tariff (Part IXa)</td>
</tr>
</tbody>
</table>

3 Contraception

Contraceptives, hormonal

Overview
The Fraser Guidelines (Department of Health Guidance (July 2004): Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health, available at www.tinyurl.com/bpg16) should be followed when prescribing contraception for women under 16 years. The UK Medical Eligibility Criteria for Contraceptive Use (available at www.fsrh.org) is published by the Faculty of Sexual and Reproductive Healthcare; it categorises the risks of using contraceptive methods with pre-existing medical conditions.

Hormonal contraception is the most effective method of fertility control, but can have major and minor side-effects, especially for certain groups of women. Hormonal contraception should only be used by adolescents after menarche.

Intra-uterine devices are a highly effective method of contraception but may produce undesirable local side-effects. They may be used in women of all ages irrespective of parity, but are less appropriate for those with an increased risk of pelvic inflammatory disease.

Barrier methods alone (condoms, diaphragms, and caps) are less effective but can be reliable for well-motivated couples if used in conjunction with a spermicide. Occasionally sensitivity reactions occur. A female condom (Femidom®) is also available; it is pre-lubricated but does not contain a spermicide.

Combined hormonal contraceptives
Oral contraceptives containing an oestrogen and a progestogen (‘combined oral contraceptives’) are effective preparations for general use. Advantages of combined oral contraceptives include:

- reliable and reversible;
- reduced dysmenorrhoea and menorrhagia;
- reduced incidence of premenstrual tension;
- less symptomatic fibroids and functional ovarian cysts;
- less benign breast disease;
- reduced risk of ovarian and endometrial cancer;
- reduced risk of pelvic inflammatory disease.

Combined oral contraceptives containing a fixed amount of an oestrogen and a progestogen in each active tablet are termed ‘monophasic’; those with varying amounts of the two hormones are termed ‘phasic’. A transdermal patch and a vaginal ring, both containing an oestrogen with a progestogen, are also available.
## Combined Oral Contraceptives Monophasic 21-day preparations

<table>
<thead>
<tr>
<th>Oestrogen content</th>
<th>Progestogen content</th>
<th>Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethinylestradiol</td>
<td>Desogestrel 150 micrograms</td>
<td>Gedarel® 20/150</td>
</tr>
<tr>
<td>20 micrograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Desogestrel 150 micrograms</td>
<td>Mercilon®</td>
</tr>
<tr>
<td>20 micrograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Gestodene 75 micrograms</td>
<td>Femodette®</td>
</tr>
<tr>
<td>20 micrograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Gestodene 75 micrograms</td>
<td>Millinette® 20/75</td>
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<tr>
<td>20 micrograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Gestodene 75 micrograms</td>
<td>Sunya® 20/75</td>
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<tr>
<td>20 micrograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Norethisterone acetate 1 mg</td>
<td>Loestrin® 20</td>
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<tr>
<td>20 micrograms</td>
<td></td>
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</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Desogestrel 150 micrograms</td>
<td>Gedarel® 30/150</td>
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<tr>
<td>30 micrograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Desogestrel 150 micrograms</td>
<td>Marvelon®</td>
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<tr>
<td>30 micrograms</td>
<td></td>
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<td>Drospirenone 3 mg</td>
<td>Yasmin®</td>
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<td></td>
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<tr>
<td>Ethinylestradiol</td>
<td>Gestodene 75 micrograms</td>
<td>Femodene®</td>
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<tr>
<td>30 micrograms</td>
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<tr>
<td>Ethinylestradiol</td>
<td>Gestodene 75 micrograms</td>
<td>Katya® 30/75</td>
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<tr>
<td>30 micrograms</td>
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<td>Gestodene 75 micrograms</td>
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<td>Ethinylestradiol</td>
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<td>Ovranette®</td>
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<td>Ethinylestradiol</td>
<td>Norethisterone 500 micrograms</td>
<td>Brevinor®</td>
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<tr>
<td>35 micrograms</td>
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<td>Ethinylestradiol</td>
<td>Norethisterone 1 mg</td>
<td>Norimin®</td>
</tr>
<tr>
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</tr>
<tr>
<td>Mestranol 40 micrograms</td>
<td>Norethisterone 1 mg</td>
<td>Norinyl-1®</td>
</tr>
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## Combined Oral Contraceptives Phasic 21-day preparations

<table>
<thead>
<tr>
<th>Oestrogen content</th>
<th>Progestogen content</th>
<th>Brand</th>
</tr>
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<tbody>
<tr>
<td>Ethinylestradiol</td>
<td>Levonorgestrel 50 micrograms</td>
<td>Logynon®</td>
</tr>
<tr>
<td>30 micrograms</td>
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</tr>
<tr>
<td>Ethinylestradiol</td>
<td>Levonorgestrel 75 micrograms</td>
<td>Logynon®</td>
</tr>
<tr>
<td>40 micrograms</td>
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<td></td>
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<tr>
<td>Ethinylestradiol</td>
<td>Levonorgestrel 125 micrograms</td>
<td>Logynon®</td>
</tr>
<tr>
<td>30 micrograms</td>
<td></td>
<td></td>
</tr>
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<td>Ethinylestradiol</td>
<td>Levonorgestrel 75 micrograms</td>
<td>TriRegol®</td>
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<td></td>
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<tr>
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<td>Norethisterone 500 micrograms</td>
<td>Synphase®</td>
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<tr>
<td>Ethinylestradiol</td>
<td>Norethisterone 1 mg</td>
<td>Synphase®</td>
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## Combined Oral Contraceptives Phasic 28-day preparations

<table>
<thead>
<tr>
<th>Oestrogen content</th>
<th>Progestogen content</th>
<th>Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethinylestradiol</td>
<td>Levonorgestrel 50 micrograms</td>
<td>Logynon® ED</td>
</tr>
<tr>
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<td>Ethinylestradiol</td>
<td>Levonorgestrel 75 micrograms</td>
<td>Logynon® ED</td>
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<td>40 micrograms</td>
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<tr>
<td>Ethinylestradiol</td>
<td>Levonorgestrel 125 micrograms</td>
<td>Logynon® ED</td>
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<td>30 micrograms</td>
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<td>Estradiol valerate</td>
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<td>Qlaira®</td>
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<tr>
<td>Estradiol valerate</td>
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<td>Qlaira®</td>
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<td>Estradiol valerate</td>
<td>2 mg</td>
<td>Qlaira®</td>
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<tr>
<td>50 micrograms</td>
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<td></td>
</tr>
</tbody>
</table>

## Choice

The majority of combined oral contraceptives contain ethinylestradiol p. 496 as the oestrogen component; mestranol and estradiol are also used. The ethinylestradiol content of combined oral contraceptives ranges from 20 to 40 micrograms. Generally a preparation with the lowest oestrogen and progestogen content which gives good cycle control and minimal side-effects in the individual woman is chosen. It is recommended that combined hormonal contraceptives are not continued beyond 50 years of age since more suitable alternatives exist.

- **Low strength preparations** (containing ethinylestradiol 20 micrograms) are particularly appropriate for women with risk factors for circulatory disease, provided a combined oral contraceptive is otherwise suitable.
- **Standard strength preparations** (containing ethinylestradiol 30 or 35 micrograms or in 30–40 microgram phased preparations) are appropriate for standard use. Phased preparations are generally reserved for women who either do not have withdrawal bleeding or who have breakthrough bleeding with monophasic products.

The progestogens ethinylestradiol with desogestrel p. 519, ethinylestradiol with drospirenone p. 520, and ethinylestradiol with gestodene p. 521 may be considered for...
women who have side-effects (such as acne, headache, depression, breast symptoms, and breakthrough bleeding) with other progestogens. Drosiprene, a derivative of spironolactone, has anti-androgenic and anti-mineralocorticoid activity; it should be used with care if an increased plasma-potassium concentration might be hazardous.

Dienogest with estradiol valerate p. 519 is in the combined oral contraceptive Qlaira®. Nomegestrol is the progestogen contained in the combined oral contraceptive Zoely®, in combination with estradiol.

The progestogen norelgestromin is combined with ethinylestradiol in a transdermal patch (Evra®). The vaginal contraceptive ring contains the progestogen etonogestrel combined with ethinylestradiol (NuvaRing®).

**Surgery**

Oestrogen-containing contraceptives should preferably be discontinued (and adequate alternative contraceptive arrangements made) 4 weeks before major elective surgery and all surgery to the legs or surgery which involves prolonged immobilisation of a lower limb; they should normally be recommenced at the first menses occurring at least 2 weeks after full mobilisation. A progestogen-only contraceptive may be offered as an alternative and the oestrogen-containing contraceptive restarted after mobilisation. When discontinuation of an oestrogen-containing contraceptive is not possible, e.g. after trauma or if a patient admitted for an elective procedure is still on an oestrogen-containing contraceptive, thromboprophylaxis (with unfractionated or low molecular weight heparin and graduated compression hosiery) is advised. These recommendations do not apply to minor surgery with short duration of anaesthesia, e.g. laparoscopic sterilisation or tooth extraction, or to women using oestrogen-free hormonal contraceptives.

**Reason to stop immediately**

Combined hormonal contraceptives or hormone replacement therapy (HRT) should be stopped (pending investigation and treatment), if any of the following occur:

- sudden severe chest pain (even if not radiating to left arm);
- sudden breathlessness (or cough with blood-stained sputum);
- unexplained swelling or severe pain in calf of one leg;
- severe stomach pain;
- serious neurological effects including unusual severe, prolonged headache especially if getting progressively worse or sudden partial or complete loss of vision or sudden disturbance of hearing or other perceptual disorders or dysphasia or bad fainting attack or collapse or first unexplained epileptic seizure or weakness, motor disturbances, very marked numbness suddenly affecting one side or one part of body;
- hepatic, jaundice, liver enlargement;
- blood pressure above systolic 160 mmHg or diastolic 95 mmHg; (in adolescents stop if blood pressure very high);
- prolonged immobility after surgery or leg injury;
- detection of a risk factor which contra-indicates treatment.

**Progestogen-only contraceptives**

**Oral progestogen-only contraceptives**

Oral progestogen-only preparations alter cervical mucus to prevent sperm penetration and may inhibit ovulation in some women; oral desogestrel-only preparations consistently inhibit ovulation and this is their primary mechanism of action. There is insufficient clinical trial evidence to compare the efficacy of oral progestogen-only contraceptives with each other or with combined hormonal contraceptives. Progestogen-only contraceptives offer a suitable alternative to combined hormonal contraceptives when oestrogens are contra-indicated (including those with venous thrombosis or a past history or predisposition to venous thrombosis, heavy smokers, those with hypertension above systolic 160 mmHg or diastolic 95 mmHg, valvular heart disease, diabetes mellitus with complications, and migraine with aura).

**Parenteral progestogen-only contraceptives**

Medroxyprogesterone acetate p. 531 (Depo-Provera®, SAYANA PRESS®) is a long-acting progestogen given by injection; it is at least as effective as the combined oral preparations but because of its prolonged action it should never be given without full counselling backed by the patient information leaflet. It may be used as a short-term or long-term contraceptive for women who have been counselled about the likelihood of menstrual disturbance and the potential for a delay in return to full fertility. Delayed return of fertility and irregular cycles may occur after discontinuation of treatment but there is no evidence of permanent infertility. Troublesome bleeding has been reported in patients given medroxyprogesterone acetate in the immediate puerperium; delaying the first injection until 6 weeks after birth may minimise bleeding problems. If the woman is not breast-feeding, the first injection may be given within 5 days postpartum (she should be warned that the risk of troublesome bleeding may be increased):

- in adolescents, medroxyprogesterone acetate (Depo-Provera®, SAYANA PRESS®) should be used only when other methods of contraception are inappropriate;
- in all women, the benefits of using medroxyprogesterone acetate beyond 2 years should be evaluated against the risks;
- in women with risk factors for osteoporosis, a method of contraception other than medroxyprogesterone acetate should be considered.

**Norethisterone enantate** (Noristerat®) is a long-acting progestogen given as an oily injection which provides contraception for 8 weeks; it is used as short-term interim contraception e.g. before vasectomy becomes effective.

**An etonogestrel-releasing implant** (Nexplanon®) is also available. It is a highly effective long-acting contraceptive, consisting of a single flexible rod that is inserted subdermally into the lower surface of the upper arm and provides contraception for up to 3 years. The manufacturer advises that in heavier women, blood-etongestrel concentrations are lower and therefore the implant may not provide effective contraception during the third year; they advise that earlier replacement may be considered in such patients—however, evidence to support this recommendation is lacking. Local reactions such as bruising and itching can occur at the insertion site. The contraceptive effect of etonogestrel is rapidly reversed on removal of the implant.

**Intra-uterine progestogen-only device**

The progestogen-only intra-uterine systems Mirena®, Jaydess® and Levovist® release levonorgestrel p. 527 directly into the uterine cavity. Mirena® is licensed for use as a contraceptive, for the treatment of primary menorrhagia and for the prevention of endometrial hyperplasia during oestrogen replacement therapy. Jaydess® and Levovist® are licensed for contraception, and Levovist® is additionally licensed for the treatment of menorrhagia. These may therefore be a contraceptive method of choice for women who have excessively heavy menses.

The effects of the progestogen-only intra-uterine system are mainly local and hormonal including prevention of endometrial proliferation, thickening of cervical mucus, and suppression of ovulation in some women (in some cycles). In addition to the progestogenic activity, the intra-uterine system itself may contribute slightly to the contraceptive
effect. Return of fertility after removal is rapid and appears to be complete.

Advantages of the progestogen-only intra-uterine system over copper intra-uterine devices are that there may be an improvement in any dysmenorrhoea and a reduction in blood loss; there is also evidence that the frequency of pelvic inflammatory disease may be reduced (particularly in the youngest age groups who are most at risk).

In primary menorrhagia, menstrual bleeding is reduced significantly within 3–6 months of inserting the progestogen-only intra-uterine system, probably because it prevents endometrial proliferation. Another treatment should be considered if menorrhagia does not improve within this time.

Surgery
All progestogen-only contraceptives (including those given by injection) are suitable for use as an alternative to combined hormonal contraceptives before major elective surgery, before all surgery to the legs, or before surgery which involves prolonged immobilisation of a lower limb.

### Contraceptives, non-hormonal

#### Spermicidal contraceptives

Spermicidal contraceptives are useful additional safeguards but do not give adequate protection if used alone unless fertility is already significantly diminished. They have two components: a spermicide and a vehicle which itself may have some inhibiting effect on sperm activity. They are suitable for use with barrier methods, such as diaphragms or caps; however, spermicidal contraceptives are not generally recommended for use with condoms, as there is no evidence of any additional protection compared with non-spermicidal lubricants.

Spermicidal contraceptives are not suitable for use in those with or at high risk of sexually transmitted infections (including HIV); high frequency use of the spermicide nonoxinol p. 532 9° has been associated with genital lesions, which may increase the risk of acquiring these infections.

#### Contraceptive devices

##### Intra-uterine devices

The intra-uterine device (IUD) is a suitable contraceptive for young women irrespective of parity; however, it is less appropriate for those with an increased risk of pelvic inflammatory disease e.g. women under 25 years.

The most effective intra-uterine devices have at least 380 mm² of copper and have banded copper on the arms. Smaller devices have been introduced to minimise side-effects; these consist of a plastic carrier wound with copper wire or fitted with copper bands; some also have a central core of silver to prevent fragmentation of the copper.

A frameless, copper-bearing intra-uterine device (Cyne Fix®) is also available. It consists of a knotted, polypropylene thread with 6 copper sleeves; the device is anchored in the uterus by inserting the knot into the uterine fundus.

##### Caution with oil-based lubricants

Products such as petroleum jelly (Vaseline®), baby oil and oil-based vaginal and rectal preparations are likely to damage condoms and contraceptive diaphragms made from latex rubber, and may render them less effective as a barrier method of contraception and as a protection from sexually transmitted infections (including HIV).

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### Emergency contraception

#### Overview

Emergency contraception is intended for occasional use, to reduce the risk of pregnancy after unprotected sexual intercourse. It does not replace effective regular contraception.

Women who do not wish to conceive should be offered emergency contraception after unprotected sexual intercourse that has taken place on any day of a natural menstrual cycle. Emergency contraception should also be offered after unprotected intercourse from day 21 after childbirth (unless the criteria for lactational amenorrhoea are met), and from day 5 after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.

Emergency contraception should also be offered to women if their regular contraception has been compromised or has been used incorrectly.

### Emergency contraceptive methods

#### Copper intra-uterine devices

Insertion of a copper intra-uterine device (see intra-uterine contraceptive devices (copper) p. 524) is the most effective form of emergency contraception and should be offered (if appropriate) to all women who have had unprotected sexual intercourse and do not want to conceive. A copper intra-uterine contraceptive device can be inserted up to 120 hours (5 days) after unprotected intercourse or up to 5 days after the earliest likely calculated ovulation (i.e. within the minimum period before implantation), regardless of the number of episodes of unprotected intercourse earlier in the cycle. Antibacterial cover should be considered for copper intra-uterine contraceptive device insertion if there is a significant risk of sexually transmitted infection that could be associated with ascending pelvic infection.

A copper intra-uterine device is not known to be affected by body mass index (BMI) or body-weight or by other drugs.

#### Hormonal methods

Hormonal emergency contraceptives (includes levonorgestrel p. 527 and ulipristal acetate p. 525) should be offered as soon as possible after unprotected intercourse if a copper intra-uterine device is not appropriate or is not acceptable to the patient; either drug should be taken as soon as possible after unprotected intercourse to increase efficacy. Hormonal emergency contraception administered after ovulation is ineffective.

Levonorgestrel is effective if taken within 72 hours (3 days) of unprotected intercourse and may also be used between 72 and 96 hours after unprotected intercourse [unlicensed use], but efficacy decreases with time. Ulipristal acetate is effective if taken within 120 hours (5 days) of unprotected intercourse. Ulipristal acetate has been demonstrated to be more effective than levonorgestrel for emergency contraception.

It is possible that a higher body-weight or BMI could reduce the effectiveness of oral emergency contraception, particularly levonorgestrel, if BMI is greater than 25 kg/m² or body-weight is greater than 70 kg. It is recommended that either ulipristal acetate or a double dose of levonorgestrel [unlicensed indication] (see Emergency contraception under levonorgestrel) is given. It is unknown which is more effective.

Ulipristal acetate should be considered as the first-line hormonal emergency contraceptive for a woman who has had unprotected intercourse 96–120 hours ago (even if she has also had unprotected intercourse within the last 96 hours). It should also be considered first line for a woman who has had unprotected sexual intercourse within the last
5 days if it is likely to have taken place during the 5 days before the estimated day of ovulation. ❧

**Hormonal emergency contraception interactions**
See Contraceptives, interactions below.

**Starting hormonal contraception after emergency hormonal contraception**
Emergency hormonal contraception methods do not provide ongoing contraception. ❧ After taking levonorgestrel, women should start suitable hormonal contraception immediately. They must use condoms reliably or abstain from intercourse until contraception becomes effective.

Women should wait 5 days after taking ulipristal acetate before starting suitable hormonal contraception. Women must use condoms reliably or abstain from intercourse during the 5 day waiting period and also until their contraceptive method is effective.

The copper intra-uterine device immediately provides effective ongoing contraception.

**Useful Resources**

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### Contraceptives, interactions

#### Overview
The effectiveness of combined oral contraceptives, progestogen-only oral contraceptives, contraceptive patches, vaginal rings, and emergency hormonal contraception can be considerably reduced by interaction with drugs that induce hepatic enzyme activity (e.g. carbamazepine p. 200, esicarbazine acetate, nevirapine p. 430, oxcarbazepine p. 209, phenoxytoin p. 211, phenobarbital p. 223, primidone p. 224, ritonavir p. 442, St John’s Wort, topiramate p. 218 and, above all, rifabutin p. 378 and rifampicin p. 379), and possibly also griseofulvin p. 394. A condom together with a long-acting method (such as an injectable contraceptive) may be more suitable for patients with HIV infection or at risk of HIV infection; advice on the possibility of interaction with antiretroviral drugs should be sought from HIV specialists.

**Combined hormonal contraceptives interactions**
Women using combined hormonal contraceptive patches, vaginal rings or oral tablets who require enzyme-inducing drugs or griseofulvin should be advised to change to a reliable contraceptive method that is unaffected by enzyme-inducers, such as some parenteral progestogen-only contraceptives (medroxyprogesterone acetate p. 531 and norethisterone p. 497) or intra-uterine devices (levonorgestrel p. 527; see also Contraceptives, non-hormonal p. 515). This should be continued for the duration of treatment and for four weeks after stopping. If a change in contraceptive method is undesirable or inappropriate, changes should be discussed:

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**Short course (2 months or less) of an enzyme-inducing drug**
Continuing the combined hormonal contraceptive method may be appropriate if used in combination with consistent and careful use of condoms for the duration of treatment and for four weeks after stopping the enzyme-inducing drug.

**Long-term course (over 2 months) of an enzyme-inducing drug**
Exiting the combined hormonal contraceptive method may be appropriate if used in combination with consistent and careful use of condoms for the duration of treatment and for four weeks after stopping.

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### Hormonal emergency contraception interactions
The effectiveness of levonorgestrel and ulipristal acetate p. 525 is reduced in women taking enzyme-inducing drugs or griseofulvin and an alternative contraceptive method, unaffected by the interacting drug, is recommended during treatment with the interacting drug and for at least 4 weeks afterwards.

For a short course of an enzyme-inducing drug (less than two months), continuing the progestogen-only oral method may be appropriate if used in combination with consistent and careful use of condoms for the duration of treatment and for four weeks after stopping the enzyme-inducing drug.

**Antibacterials that do not induce liver enzymes**
It is recommended that no additional contraceptive precautions are required when combined oral contraceptives, contraceptive patches or vaginal rings are used with antibacterials that do not induce liver enzymes, unless diarrhoea or vomiting occur. These recommendations should be discussed with the woman.

There had been concerns that some antibacterials that do not induce liver enzymes (e.g. ampicillin p. 353, doxycycline p. 364) reduce the efficacy of combined oral contraceptives by impairing the bacterial flora responsible for recycling ethinylestradiol from the large bowel. However, there is a lack of evidence to support this interaction.

**Oral progestogen-only contraceptives interactions**
Effectiveness of oral progestogen-only preparations is not affected by antibacterials that do not induce liver enzymes. The efficacy of oral progestogen-only preparations is, however, reduced by enzyme-inducing drugs or griseofulvin and an alternative contraceptive method, unaffected by the interacting drug, is recommended during treatment with an interacting drug and for at least 4 weeks afterwards.

For a short course of an enzyme-inducing drug (less than two months), continuing the progestogen-only oral method may be appropriate if used in combination with consistent and careful use of condoms for the duration of treatment and for four weeks after stopping the enzyme-inducing drug.

**Parenteral progestogen-only contraceptives interactions**
Effectiveness of parenteral progestogen-only contraceptives is not affected by antibacterials that do not induce liver enzymes. The effectiveness of intramuscular norethisterone injection and intramuscular and subcutaneous medroxyprogesterone acetate injections is not affected by enzyme-inducing drugs and they may be continued as normal during courses of these drugs.

Effectiveness of the etonogestrel-releasing implant p. 530 may be reduced by enzyme-inducing drugs or griseofulvin and an alternative contraceptive method, unaffected by the interacting drug, is recommended during treatment with the interacting drug and for at least 4 weeks after stopping.

For a short course of an enzyme-inducing drug, if a change in contraceptive method is undesirable or inappropriate, continued contraception with the implant may be appropriate if used in combination with consistent and careful use of condoms for the duration of treatment and for four weeks after stopping the enzyme-inducing drug.

**Hormonal emergency contraception interactions**
The effectiveness of levonorgestrel and ulipristal acetate p. 525 is reduced in women taking enzyme-inducing drugs or griseofulvin (and for at least 4 weeks after stopping). ❧ A copper intra-uterine device can be offered instead. If the copper intra-uterine device is declined or unsuitable, the dose of levonorgestrel should be increased (See Dose adjustments due to interactions under levonorgestrel). There
is no need to increase the dose for emergency contraception if the patient is taking antibiotics that are not enzyme inducers. ❍

The effectiveness of ulipristal acetate for emergency contraception in women using drugs that increase gastric pH has not been studied. Levonorgestrel or a copper intra-uterine device should be considered as alternatives.

Hormonal contraception should not be newly initiated in a patient until five days after administration of ulipristal acetate as emergency hormonal contraception—the contraceptive effect of ulipristal acetate will be reduced. Consistent and careful use of condoms is recommended.

Ulipristal acetate can be used as emergency hormonal contraception more than once in the same cycle. ❍ Conversely, manufacturer advises that use of levonorgestrel as emergency contraception more than once in the same cycle is not advisable due to increased risk of side-effects (such as menstrual irregularities).

Levonorgestrel should not be used (as emergency hormonal contraception) within 5 days of administration of ulipristal acetate (as emergency hormonal contraception), as the contraceptive effect of ulipristal acetate may be reduced by progestogens.

Ulipristal acetate is not recommended for use in women who have severe asthma treated by oral corticosteroids, due to the antilucogocorticoid effect of ulipristal acetate. ❍

### Useful Resources


### 3.1 Contraception, combined

**OESTROGENS COMBINED WITH PROGESTOGENS**

**Combined hormonal contraceptives**

- **CONTRA-INDICATIONS** Acute porphyrias p. 624 · gallstones · heart disease associated with pulmonary hypertension or risk of embolus · history during pregnancy of cholestatic jaundice · history during pregnancy of phegmoid gestations · history during pregnancy of pruritus · history of breast cancer (but can be used after 5 years if no evidence of disease and non-hormonal methods unacceptable) · history of haemolytic uraemic syndrome · migraine with aura · personal history of venous or arterial thrombosis · sclerosing treatment for varicose veins · severe or multiple risk factors for arterial disease · severe or multiple risk factors for venous thromboembolism · systemic lupus erythematosus · transient cerebral ischaemic attacks without headaches · undiagnosed vaginal bleeding.

- **CAUTIONS** Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration)—seek specialist advice · Crohn’s disease · gene mutations associated with breast cancer (e.g. BRCA 1) · history of severe depression especially if induced by hormonal contraceptive · hyperprolactinemia (seek specialist advice) · inflammatory bowel disease · migraine · personal or family history of hypertriglyceridaemia (increased risk of pancreatitis) · risk factors for arterial disease · risk factors for venous thromboembolism · sickle-cell disease · undiagnosed breast mass

### Combined Hormonal Contraception and Risk of Venous Thromboembolism

<table>
<thead>
<tr>
<th>Progestogen in Combined Hormonal Contraceptive</th>
<th>Estimated incidence per 10 000 women per year of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pregnant, not using combined hormonal contraception</td>
<td>2</td>
</tr>
<tr>
<td>Levonorgestrol</td>
<td>5–7</td>
</tr>
<tr>
<td>Norgestimate</td>
<td>5–7</td>
</tr>
<tr>
<td>Norethisterone</td>
<td>5–7</td>
</tr>
<tr>
<td>Etonogestrel</td>
<td>6–12</td>
</tr>
<tr>
<td>Norelgestromin</td>
<td>6–12</td>
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<tr>
<td>Gestodene</td>
<td>9–12</td>
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<tr>
<td>Desogestrel</td>
<td>9–12</td>
</tr>
<tr>
<td>Drospirenone</td>
<td>9–12</td>
</tr>
<tr>
<td>Dienogest</td>
<td>Not known—insufficient data</td>
</tr>
<tr>
<td>Nomegestrol</td>
<td>Not known—insufficient data</td>
</tr>
<tr>
<td><em>Combined with ethinylestradiol</em></td>
<td>Combined with estradiol</td>
</tr>
</tbody>
</table>

- Risk factors for arterial disease. Use with caution if any one of following factors present but avoid if two or more factors present:
  - **family history of arterial disease** in first degree relative aged under 45 years (avoid if atherogenic lipid profile);
Genito-urinary system

DIRECTIONS FOR ADMINISTRATION

HEPATIC IMPAIRMENT

BREAST FEEDING

SIDE-EFFECTS

Migraine

Women should report any increase in headache frequency or onset of focal symptoms (discontinue immediately and refer urgently to neurology expert if focal neurological symptoms not typical of aura persist for more than 1 hour).

Combined hormonal contraceptives should be stopped (pending investigation and treatment), if serious neurological effects occur, including unusual severe, prolonged headache especially if first time or getting progressively worse or sudden partial or complete loss of vision or sudden disturbance of hearing or other perceptual disorders or dysphasia or bad fainting attack or collapse or first unexplained epileptic seizure or weakness, motor disturbances, very marked numbness suddenly affecting one side or one part of body.

SIDE-EFFECTS, FURTHER INFORMATION

Breast cancer

There is a small increase in the risk of having breast cancer diagnosed in women taking the combined oral contraceptive pill; this relative risk may be due to an earlier diagnosis. In users of combined oral contraceptive pills the cancers are more likely to be localised to the breast. The most important factor for diagnosing breast cancer appears to be the age at which the contraceptive is stopped rather than the duration of use; any increase in the rate of diagnosis diminishes gradually during the 10 years after stopping and disappears by 10 years.

Cervical cancer

Use of combined oral contraceptives for 5 years or longer is associated with a small increased risk of cervical cancer; the risk diminishes after stopping and disappears by about 10 years. The possible small increase in the risk of breast cancer and cervical cancer should be weighed against the protective effect against cancers of the ovary and endometrium.

Pregnancy

Not known to be harmful.

Breast feeding

Avoid until weaning or for 6 months after birth (adverse effects on lactation).

Hepatic impairment

Avoid in active liver disease including disorders of hepatic excretion (e.g. Dubin-Johnson or Rotor syndromes), Infective hepatitis (until liver function returns to normal), liver tumours.

Directions for administration

With oral use Each tablet should be taken at approximately same time each day; if delayed, contraceptive protection may be lost. 21-day combined preparations, 1 tablet daily for 21 days; subsequent courses repeated after a 7-day interval (during which withdrawal bleeding occurs); if reasonably certain woman is not pregnant, first course can be started on any day of cycle— if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days.

Every day (ED) combined preparations, 1 active tablet daily for 21 days, followed by 1 inactive tablet daily for 7 days; subsequent courses repeated without interval (withdrawal bleeding occurs when inactive tablets being taken); if reasonably certain woman is not pregnant, first course can be started on any day of cycle—if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days. Changing to combined preparation containing different progestogen If previous contraceptive used correctly, or pregnancy can reasonably be excluded, start the first active tablet of new brand immediately. See individual monographs for requirements of specific preparations. Changing from progestogen-only tablet If previous contraceptive used correctly, or pregnancy can reasonably be excluded, start new brand immediately, additional precautions (barrier methods) necessary for first 7 days. Secondary amenorrhoea (exclude pregnancy) Start any day, additional precautions (barrier methods) necessary during first 7 days (9 days for Qlaira®).

After childbirth (not breast-feeding) Start 3 weeks after birth (increased risk of thrombosis if started earlier); later than 3 weeks postpartum additional precautions (barrier methods) necessary for first 7 days (9 days for Qlaira®). After abortion or miscarriage Start same day.

Patient and carer advice

Travel

Women taking oral contraceptives or using the patch or vaginal ring are at an increased risk of deep vein thrombosis during travel involving long periods of immobility (over 3 hours). The risk may be reduced by appropriate exercise during the journey and possibly by wearing graduated compression hosiery. Diarrhoea and vomiting Vomiting and severe diarrhoea can interfere with the absorption of combined oral contraceptives. The FSRH advises following the instructions for missed pills if vomiting occurs within 3 hours of taking a combined oral contraceptive or severe diarrhoea occurs for more than 24 hours. Use of non-oral contraception should be considered if diarrhoea or vomiting persist.

Missed doses

The critical time for loss of contraceptive protection is when a pill is omitted at the beginning or end of a cycle (which lengthens the pill-free interval). If a woman forgets to take a pill, it should be taken as soon as she remembers, and the next one taken at the normal time (even if this means taking 2 pills together). A missed pill is one that is 24 or more hours late. If a woman misses only one pill, she should take an active pill as soon as she remembers and then resume normal pill-taking. No additional precautions are necessary. If a woman misses 2 or more pills (especially from the first 7 in a packet), she may not be protected. She should take an active pill as soon as she remembers and then resume normal pill-taking. In addition, she must either abstain from sex or use an additional method of contraception such as a condom for the next 7 days. If these 7 days run beyond the end of the packet, the next packet should be started at once, omitting the pill-free interval (or, in the case of everyday (ED) pills, omitting the 7 inactive tablets). Emergency contraception is recommended if 2 or more combined oral contraceptive tablets are missed from the first 7 tablets in a packet and unprotected intercourse has occurred since finishing the last packet.
**Dienogest with estradiol valerate**

**INDICATIONS AND DOSE**

**Contraception with 28-day combined preparations**

**Menstrual symptoms with 28-day combined preparations**

- **BY MOUTH**
  - Females of childbearing potential: 1 active tablet daily for 26 days, followed by 1 inactive tablet daily for 2 days, to be started on day 1 of cycle with first active tablet (withdrawal bleeding may occur during the 2-day interval of inactive tablets); subsequent courses repeated without interval

**DIRECTIONS FOR ADMINISTRATION**

Changing to Zoely® Start the first active Zoely® tablet on the day after taking the last active tablet of the previous brand or, at the latest, the day after the tablet-free or inactive tablet interval of the previous brand.

**SIDE-EFFECTS**

- **Common or very common** Breast abnormalities - depression - menstrual cycle irregularities - mood altered - pelvic pain - sexual dysfunction
- **Uncommon** Abdominal distension - appetite abnormal - galactorrhoea - hot flush - hyperhidrosis - oedema - painful sexual intercourse - seborrhoea - sensation of pressure - skin reactions - uterine cramps - vulvovaginal disorders
- **Rare or very rare** Cerebrovascular insufficiency - concentration impaired - contact lens intolerance - dry eye - dry mouth - gallbladder disorders - hypertrichosis

**PREGNANCY**

Toxicity in animal studies.

**DIRECTIONS FOR ADMINISTRATION**

Zoely® (every day (ED) combined (monophasic) preparation), 1 active tablet daily for 24 days, followed by 1 inactive tablet daily for 4 days, starting on day 1 of cycle with first active tablet; subsequent courses repeated without interval (withdrawal bleeding occurs when inactive tablets are taken). Changing to Zoely® Start the first active Zoely® tablet on the day after taking the last active tablet of the previous brand.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- **Zoely** (Merck Sharp & Dohme Ltd)
  - Estradiol (as Estradiol hemihydrate) 1.5 mg, Nomegestrol acetate 2.5 mg, Zoely 2.5mg/1.5mg tablets | 84 tablet £19.80 DT = £19.80

**Ethinylestradiol with desogestrel**

**INDICATIONS AND DOSE**

**Contraception with 21-day combined preparations**

**Menstrual symptoms with 21-day combined preparations**

- **BY MOUTH**
  - Females of childbearing potential: 1 tablet once daily for 21 days; subsequent courses repeated after 7-day interval, withdrawal bleeding occurs during the 7-day interval, if reasonably certain woman is not pregnant, first course can be started on any day of cycle— if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days, tablets should be taken at approximately the same time each day

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- **Alenvona** (Teva UK Ltd)
  - Ethinylestradiol 30 microgram, Desogestrel 150 microgram, Alenvona 150microgram/30microgram tablets | 63 tablet £6.13 DT = £4.19
**520 Contraception**

- **Bimizza** (Morningside Healthcare Ltd)
  Ethinylestradiol 20 microgram, Desogestrel
  150 microgram Bimizza 150microgram/20microgram tablets | 63 tablet (PO) £5.04 DT + £5.08
- **Cimizt** (Morningside Healthcare Ltd)
  Ethinylestradiol 30 microgram, Desogestrel
  150 microgram Cimizt 30microgram/150microgram tablets | 63 tablet (PO) £3.80 DT + £4.19
- **Gedarel** (Consilent Health Ltd)
  Ethinylestradiol 20 microgram, Desogestrel
  150 microgram Gedarel 20microgram/150microgram tablets | 63 tablet (PO) £5.08 DT + £5.08
- **Marvelon** (Merk Sharp & Dohme Ltd)
  Ethinylestradiol 30 microgram, Desogestrel
  150 microgram Marvelon tablets | 63 tablet (PO) £7.10 DT + £4.19
- **Mercilon** (Merk Sharp & Dohme Ltd)
  Ethinylestradiol 20 microgram, Desogestrel
  150 microgram Mercilon 150microgram/20microgram tablets | 63 tablet (PO) £8.44 DT + £5.08
- **Munalea** (Lupin Healthcare (UK) Ltd)
  Ethinylestradiol 20 microgram, Desogestrel
  150 microgram Munalea 150microgram/20microgram tablets | 63 tablet (PO) £5.07 DT + £5.08
- **Yasmin** (Bayer Plc)
  Ethinylestradiol 30 microgram, Drospirenone 3 mg
  7 Yasmin tablets | 63 tablet (PO) £14.70 DT = £14.70
- **Yznell** (Lupin Healthcare (UK) Ltd)
  Ethinylestradiol 30 microgram, Drospirenone 3 mg
  0.03mg/3mg tablets | 63 tablet (PO) £8.30 DT = £14.70

**Ethinylestradiol with etonogestrel**

- **INDICATIONS AND DOSE**
  Contraception: Menstrual symptoms
  - By Vagina
  - Females of childbearing potential: 1 unit, insert the ring into the vagina on day 1 of cycle and leave in for 3 weeks; remove ring on day 22; subsequent courses repeated after 7-day ring free interval (during which withdrawal bleeding occurs)

- **INTERACTIONS** → Appendix 1: combined hormonal contraceptives

- **DIRECTIONS FOR ADMINISTRATION**
  Changing method of contraception to vaginal ring
  Changing from combined hormonal contraception Insert ring at the latest on the day after the usual tablet-free, patch-free, or inactive-tablet interval. If previous contraceptive used correctly, or pregnancy can reasonably be excluded, can switch to ring on any day of cycle.
  Changing from progestogen-only method From an implant or intra-uterine progestogen–only device, insert ring on the day implant or intra-uterine progestogen–only device removed; from an injection, insert ring when next injection due; from oral preparation, first ring may be inserted on any day after stopping pill. For all methods additional precautions (barrier methods) should be used concurrently for first 7 days.
  - **PATIENT AND CARER ADVICE**
    Patients or carers should be given advice on how to administer vaginal ring.
    Counselling The presence of the ring should be checked regularly.

- **Missed doses**
  Expulsion, delayed insertion or removal, or broken vaginal ring If the vaginal ring is expelled for less than 3 hours, rinse the ring with cool water and reinsert immediately; no additional contraception is needed.
  If the ring remains outside the vagina for more than 3 hours or if the user does not know when the ring was expelled, contraceptive protection may be reduced:
  - If ring expelled during week 1 or 2 of cycle, rinse ring with cool water and reinsert; use additional precautions (barrier methods) for next 7 days;
  - If ring expelled during week 3 of cycle, either insert a new ring to start a new cycle or allow a withdrawal bleed and insert a new ring no later than 7 days after ring was expelled; latter option only available if ring was used continuously for at least 7 days before expulsion.
  If insertion of a new ring at the start of a new cycle is delayed, contraceptive protection is lost. A new ring should be inserted as soon as possible; additional precautions (barrier methods) should be used for the first 7 days of the new cycle. If intercourse occurred during the extended ring-free interval, pregnancy should be considered.

- **UNLICENSED USE**
  Consult product literature for the licensing status.

- **INTERACTIONS** → Appendix 1: combined hormonal contraceptives

- **SIDE-EFFECTS**
  - Common or very common Breast abnormalities - depressed mood - increased risk of infection - menstrual disorder - vaginal discharge
  - Uncommon Diarrhoea - hypotension - sexual dysfunction - skin reactions - vomiting - weight decreased
  - Rare or very rare Arterial thromboembolism - asthma - erythema nodosum - hearing impairment

- **PATIENT AND CARER ADVICE**
  Pill-free interval Withdrawal bleeding can occur during the 7-day tablet-free interval.

- **MEDICINAL FORMS**
  - Ethinylestradiol 30 microgram, Drospirenone 3 mg
    - Dretine (Theramex HQ UK Ltd)
      0.03mg/3mg tablets | 63 tablet (PO) £8.34 DT = £14.70
    - ELOINE (Bayer Plc)
      0.02mg/3mg tablets | 84 tablet (PO) £14.70 DT = £14.70
    - Lucette (Consilent Health Ltd)
      0.03mg/3mg tablets | 63 tablet (PO) £9.35 DT + £14.70
    - Yacella (Morningside Healthcare Ltd)
      0.03mg/3mg tablets | 63 tablet (PO) £8.30 DT = £14.70

- **Ethinylestradiol with drospirenone**

  - **INDICATIONS AND DOSE**
    Contraception with 21-day combined preparations
    Menstrual symptoms with 21-day combined preparations
    - By Mouth
    - Females of childbearing potential: 1 tablet once daily for 21 days; subsequent courses repeated after 7-day interval, withdrawal bleeding occurs during the 7-day interval

  - **UNLICENSED USE**
    Consult product literature for the licensing status.

  - **INTERACTIONS** → Appendix 1: combined hormonal contraceptives

  - **SIDE-EFFECTS**
    - Common or very common Breast abnormalities - depressed mood - increased risk of infection - menstrual disorder - vaginal discharge
    - Uncommon Diarrhoea - hypotension - sexual dysfunction - skin reactions - vomiting - weight decreased
    - Rare or very rare Arterial thromboembolism - asthma - erythema nodosum - hearing impairment

  - **MEDICINAL FORMS**
    There can be variation in the licensing of different medicines containing the same drug.

    **Tablet**
    - Dretine (Theramex HQ UK Ltd)
      Ethinylestradiol 30 microgram, Drospirenone 3 mg
      0.03mg/3mg tablets | 63 tablet (PO) £8.34 DT = £14.70
    - ELOINE (Bayer Plc)
      Ethinylestradiol 20 microgram, Drospirenone 3 mg
      0.02mg/3mg tablets | 84 tablet (PO) £14.70 DT = £14.70
    - Lucette (Consilent Health Ltd)
      Ethinylestradiol 30 microgram, Drospirenone 3 mg
      0.03mg/3mg tablets | 63 tablet (PO) £9.35 DT + £14.70
    - Yacella (Morningside Healthcare Ltd)
      Ethinylestradiol 30 microgram, Drospirenone 3 mg
      0.03mg/3mg tablets | 63 tablet (PO) £8.30 DT = £14.70
**Ethinyelstradiol with gestodene**

### INDICATIONS AND DOSE

**Contraception with 21-day combined preparations**

**Menstrual symptoms with 21-day combined preparations**

**BY MOUTH**

- Females of childbearing potential: 1 tablet once daily for 21 days; subsequent courses repeated after 7-day interval, withdrawal bleeding occurs during the 7-day interval, if reasonably certain woman is not pregnant, first course can be started on any day of cycle—if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days, tablets should be taken at approximately the same time each day.

**Contraception with 28-day combined preparations**

**Menstrual symptoms with 28-day combined preparations**

**BY MOUTH**

- Females of childbearing potential: 1 active tablet once daily for 21 days, followed by 1 inactive tablet daily for 7 days; subsequent courses repeated without interval, withdrawal bleeding occurs during the 7-day interval of inactive tablets being taken, if reasonably certain woman is not pregnant, first course can be started on any day of cycle—if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days, tablets should be taken at approximately the same time each day.

### UNLICENSED USE

Consult product literature for the licensing status.

### INTERACTIONS

Appendix 1: combined hormonal contraceptives

### SIDE-EFFECTS

- **Common or very common** Abdominal pain · breast abnormalities · depression · dizziness · increased risk of infection · menstrual cycle irregularities · mood swings · nervousness · vaginal discharge

- **Uncommon** Appetite abnormal · diarrhoea · hirsutism · hypertriglyceridaemia · sexual dysfunction · skin reactions · vomiting

- **Rare or very rare** Angioedema · chorea exacerbated · ear disorders · embolism and thrombosis · erythema nodosum · eye irritation · gallbladder disorders · gastrointestinal disorders · haemolytic uraemic syndrome · hepatic disorders · hypersensitivity · inflammatory bowel disease · neoplasms · optic neuritis · pancreatitis · systemic lupus erythematosus exacerbated · varicose veins exacerbated · weight decreased

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- **Ethinyelstradiol with gestodene (Non-proprietary)**
- **Ethinyelstradiol 30 microgram, Gestodene 50 microgram**

### Ethinyelstradiol with levonorgestrel

### INDICATIONS AND DOSE

**Contraception with 21-day combined preparations**

**Menstrual symptoms with 21-day combined preparations**

**BY MOUTH**

- Females of childbearing potential: 1 tablet once daily for 21 days; subsequent courses repeated after 7-day interval, withdrawal bleeding occurs during the 7-day interval, if reasonably certain woman is not pregnant, first course can be started on any day of cycle—if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days, tablets should be taken at approximately the same time each day.

### UNLICENSED USE

Consult product literature for the licensing status of individual preparations.

### INTERACTIONS

Appendix 1: combined hormonal contraceptives
Ethinylestradiol with norelgestromin

08-Feb-2019

**INDICATIONS AND DOSE**

**Contraception | Menstrual symptoms**

▷ **BY TRANSDERMAL APPLICATION**

- Females of childbearing potential: Apply 1 patch once weekly for 3 weeks, apply first patch on day 1 of cycle, change patch on days 8 and 15; remove third patch on day 22 and apply new patch after 7-day patch-free interval to start subsequent contraceptive cycle, subsequent courses repeated after a 7-day patch free interval (during which withdrawal bleeding occurs)

**UNLICENSED USE** Consult product literature for the licensing status of individual preparations.

**INTERACTIONS** → Appendix 1: combined hormonal contraceptives

**SIDE-EFFECTS**

- **Common or very common** Anxiety, breast abnormalities, diarrhea, dizziness, fatigue, gastrointestinal discomfort, increased risk of infection, malaise, menstrual cycle irregularities, mood altered, muscle spasms, skin reactions, uterine cramps, vaginal haemorrhage, vomiting, vulvovaginal disorders

- **Uncommon** Appetite increased, dyslipidaemia, insomnia, lactation disorders, oedema, photosensitivity reaction, sexual dysfunction

- **Rare or very rare** Embolism and thrombosis, gallbladder disorders, genital discharge, neoplasms, stroke, swelling

- **Frequency not known** Anger, angioedema, cervical dysplasia, colitis, contact lens intolerance, erythema nodosum, hepatic disorders, hyperglycaemia, intracranial haemorrhage, myocardial infarction, pulmonary artery thrombosis, taste altered

**DIRECTIONS FOR ADMINISTRATION** Adhesives or bandages should not be used to hold patch in place. If no longer sticky do not reapply but use a new patch.

Changing to a transdermal combined hormonal contraceptive

**Changing from combined oral contraception** Apply patch on the first day of withdrawal bleeding; if no withdrawal bleeding within 5 days of taking last active tablet, rule out pregnancy before applying first patch. Unless patch is applied on first day of withdrawal bleeding, additional precautions (barrier methods) should be used concurrently for 7 days.

**Changing from progestogen-only method**

- from an implant, apply first patch on the day implant removed
- from an injection, apply first patch when next injection due
- from a oral progestogen, first patch may be applied on any day after stopping pill

For all methods additional precautions (barrier methods) should be used concurrently for first 7 days.

**After childbirth (not breast-feeding)** Start 4 weeks after birth; if started later than 4 weeks after birth additional precautions (barrier methods) should be used for first 7 days.

**After abortion or miscarriage** Before 20 weeks’ gestation start immediately; no additional contraception required if started immediately. After 20 weeks’ gestation start on day 21 after abortion or on the first day of first spontaneous menstruation; additional precautions (barrier methods) should be used for first 7 days after applying the patch.

**PATIENT AND CARER ADVICE** Patients and carers should be given advice on how to administer patches.

Travel Women using patches are at an increased risk of deep vein thrombosis during travel involving long periods of immobility (over 3 hours). The risk may be reduced by appropriate exercise during the journey and possibly by wearing graduated compression hosiery.

**Missed doses** Delayed application or detached patch If a patch is partly detached for less than 24 hours, reapply to the same site or replace with a new patch immediately; no additional contraception is needed and the next patch should be applied on the usual ‘change day’. If a patch remains detached for more than 24 hours or if the user is not aware when the patch became detached, then stop the current contraceptive cycle and start a new cycle by applying a new patch, giving a new ‘Day 1’; an additional non-hormonal contraceptive must be used concurrently for the first 7 days of the new cycle.

If application of a new patch at the start of a new cycle is delayed, contraceptive protection is lost. A new patch should be applied as soon as remembered giving a new ‘Day 1’; additional non-hormonal methods of contraception should be used for the first 7 days of the new cycle.

If application of a patch in the middle of the cycle is delayed (i.e. the patch is not changed on day 8 or day 15):

- for up to 48 hours, apply a new patch immediately; next patch ‘change day’ remains the same and no additional contraception is required;
- for more than 48 hours, contraceptive protection may have been lost. Stop the current cycle and start a new 4-week cycle immediately by applying a new patch giving a new ‘Day 1’; additional non-hormonal contraception should be used for the first 7 days of the new cycle.

If the patch is not removed at the end of the cycle (day 22), remove it as soon as possible and start the next cycle on the usual ‘change day’, the day after day 28; no additional contraception is required.
Ethinylestradiol with norgestimate

**INDICATIONS AND DOSE**
Contraception with 21-day combined preparations
Menstrual symptoms with 21-day combined preparations

**BY MOUTH**
- Females of childbearing potential: 1 tablet once daily for 21 days; subsequent courses repeated after 7-day interval, withdrawal bleeding occurs during the 7-day interval, if reasonably certain woman is not pregnant, first course can be started on any day of cycle— if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days, tablets should be taken at approximately the same time each day

**SIDE-EFFECTS**
- Common or very common: Anxiety; asthenic conditions; breast abnormalities; chest pain; constipation; depression; diarrhea; dizziness; gastrointestinal discomfort; gastrointestinal disorders; genitourinary disorders; genital discharge; hypersensitivity; increased risk of infection; insomnia; menstrual cycle irregularities; mood altered; muscle complaints; oedema; pain; skin reactions; vomiting
- Uncommon: Appetite abnormal; cervical dysplasia; dry eye; dyspnoea; embolism and thrombosis; hirsutism; hot flush; libido disorder; ovarian cyst; palpitations; paraesthesia; syncope; visual impairment; vulvovaginal disorders; weight changes
- Rare or very rare: Hepatic disorders; pancreatitis; photosensitivity reaction; sweat changes; tachycardia; vertigo
- Frequency not known: Angioedema; contact lens intolerance; dyslipidaemia; erythema nodosum; neoplasms; seizure; suppressed lactation

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Tablet**
- Ethinylestradiol with norgestimate (Non-proprietary)
  - Ethinylestradiol 35 microgram, Norgestimate
    - 500 microgram Ethinylestradiol 35 microgram / Norgestimate 500 microgram tablets | 5 tablet 
  - Ethinylestradiol 35 microgram, Norgestimate
    - 750 microgram Ethinylestradiol 35 microgram / Norgestimate 750 microgram tablets | 21 tablet 
  - Ethinylestradiol 35 microgram, Norgestimate
    - 1 mg Ethinylestradiol 35 microgram / Norgestimate 1 mg tablets | 9 tablet 
  - Brevirin (Pfizer Ltd)
  - Ethinylestradiol 35 microgram, Norgestimate
    - 500 microgram Brevinor 500 microgram/35 microgram tablets | 63 tablet 
  - Loestrin 20 (Galen Ltd)
  - Ethinylestradiol 20 microgram, Norgestimate acetate
    - 1 mg Loestrin 20 tablets | 63 tablet 
  - Loestrin 30 (Galen Ltd)
  - Ethinylestradiol 30 microgram, Norgestimate acetate
    - 1.5 mg Loestrin 30 tablets | 63 tablet 
  - Norimin (Pfizer Ltd)
  - Ethinylestradiol 35 microgram, Norgestimate 1 mg Norimin 1mg/35 microgram tablets | 63 tablet

**Norethisterone with mestranol**

**INDICATIONS AND DOSE**
Contraception | Menstrual symptoms

**BY MOUTH**
- Females of childbearing potential: 1 tablet once daily for 21 days; subsequent courses repeated after 7-day interval, withdrawal bleeding can occur during the 7-day interval, if reasonably certain woman is not pregnant, first course can be started on any day of cycle— if starting on day 6 of cycle or later, additional precautions (barrier methods) necessary during first 7 days, tablets should be taken at the same time each day
CONTRACEPTIVE DEVICES

3.2 Contraception, devices

Other drugs used for Contraception, devices
Levonorgestrel, p. 527

CONTRACEPTIVE DEVICES

Intra-uterine contraceptive devices (copper)

INDICATIONS AND DOSE

Contraception
- BY INTRA-UTERINE ADMINISTRATION
- Females of childbearing potential: (consult product literature)

IMPORTANT SAFETY INFORMATION

MHRA/CHM ADVICE (JUNE 2015) INTRA-UTERINE CONTRACEPTION: UTERINE PERFORATION—UPDATED INFORMATION ON RISK FACTORS

Uterine perforation most often occurs during insertion, but might not be detected until sometime later. The risk of uterine perforation is increased when the device is inserted up to 36 weeks postpartum or in patients who are breastfeeding. Before inserting an intra-uterine contraceptive device, inform patients that perforation occurs in approximately 1 in every 1000 insertions and signs and symptoms include:
- severe pelvic pain after insertion (worse than period cramps);
- pain or increased bleeding after insertion which continues for more than a few weeks;
- sudden changes in periods;
- pain during intercourse;
- unable to feel the threads.

Patients should be informed on how to check their threads and to arrange a check-up if threads cannot be felt, especially if they also have significant pain. Partial perforation may occur even if the threads can be seen; consider this if there is severe pain following insertion and perform an ultrasound.

CONTRA-INDICATIONS

Active trophoblastic disease (until return to normal of urine and plasma-gonadotrophin concentration) · distorted uterine cavity · established or marked immunosuppression · genital malignancy · medical diabetes · pelvic inflammatory disease · recent sexually transmitted infection (if not fully investigated and treated) · severe anaemia · small uterine cavity · unexplained uterine bleeding · Wilson’s disease

CAUTIONS

Anemia · anticoagulant therapy (avoid if possible) · diabetes · disease-induced immunosuppression (risk of infection—avoid if marked immunosuppression) · drug-induced immunosuppression (risk of infection—avoid if marked immunosuppression) · endometriosis · epilepsy (risk of seizure at time of insertion) · fertility problems · history of pelvic inflammatory disease · increased risk of expulsion if inserted before uterine involution · menorrhagia (progestogen intra-uterine system might be preferable) · nulliparity · severe cervical stenosis · severe primary dysmenorrhoea · severely scarred uterus (including after endometrial resection) · young age

CAUTIONS, FURTHER INFORMATION

The Faculty of Sexual and Reproductive Healthcare advises if removal is after day 3 of the menstrual cycle, intercourse should be avoided or another method of contraception used for at least 7 days before removal of device—emergency contraception may need to be considered if recent intercourse has occurred and the intra-uterine device is removed after day 3 of the menstrual cycle.

Risk of infection

The main excess risk of infection occurs in the first 20 days after insertion and is believed to be related to existing carriage of a sexually transmitted infection. Women are considered to be at a higher risk of sexually transmitted infections if:
- they are under 25 years old or
- they are over 25 years old and
  - have a new partner or
  - have had more than one partner in the past year or
  - their regular partner has other partners.

In these women, pre-insertion screening (for chlamydia and, depending on sexual history and local prevalence of disease, Neisseria gonorrhoeae) should be performed. If results are unavailable at the time of fitting an intra-uterine device for emergency contraception, appropriate prophylactic antibacterial cover should be given. The woman should be advised to attend as an emergency if she experiences sustained pain during the next 20 days.

SIDE-EFFECTS

Device complications · epilepsy (on insertion) · haemorrhage (on insertion) · hypersensitivity · menstrual cycle irregularities · pain (on insertion—alleviated by NSAID such as ibuprofen 30 minutes before insertion) · pelvic infection exacerbated · premenstrual (on insertion) · uterine injuries

SIDE-EFFECTS, FURTHER INFORMATION

Advise the patient to seek medical attention promptly in case of significant symptoms—very small risk of uterine perforation, ectopic pregnancy and pelvic inflammatory disease.

ALLERGY AND CROSS-SENSITIVITY

Contra-indicated if patient has a copper allergy.

PREGNANCY

If an intra-uterine device fails and the woman wishes to continue to full-term the device should be removed in the first trimester if possible. Remove device; if pregnancy occurs, increased likelihood that it may be ectopic.

BRACE FEEDING

Not known to be harmful.

MONITORING REQUIREMENTS

Gynaecological examination before insertion, 6–8 weeks after insertion, then annually.

DIRECTIONS FOR ADMINISTRATION

The timing and technique of fitting an intra-uterine device are critical for its subsequent performance. The healthcare professional inserting (or removing) the device should be fully trained in the technique and should provide full counselling backed, where available, by the patient information leaflet. Devices should not be fitted during the heavy days of the period; they are best fitted after the end of menstruation and before the calculated time of implantation.

PRESCRIBING AND DISPENSING INFORMATION

TT380 ® SLIMLINE For uterine length 6.5–9 cm; replacement every 10 years.

LOAD ® 375 For uterine length over 7 cm; replacement every 5 years.
NOVAPLUS T 380 ® Ag · ‘Mini’ size for minimum uterine length 5 cm; ‘Normal’ size for uterine length 6.5–9 cm; replacement every 5 years.

MULTILOAD ® CU375 For uterine length 6–9 cm; replacement every 5 years.

GYNEFIX ® Suitable for all uterine sizes; replacement every 5 years.

UT380 STANDARD ® For uterine length 6.5–9 cm; replacement every 5 years.

UT380 SHORT® For uterine length 5–7 cm; replacement every 5 years.

MULTI-SAFE ® 375 For uterine length 6–9 cm; replacement every 5 years.

ANCORA ® 375 CU For uterine length over 6.5 cm; replacement every 5 years.

T-SAFE ® 380A QL For uterine length 6.5–9 cm; replacement every 10 years.

NEO-SAFE ® T 380 For uterine length 6.5–9 cm; replacement every 5 years.

MINI TT380 ® SLIMLINE For minimum uterine length 5 cm; replacement every 5 years.

COOPER T380 ® A For uterine length 6.5–9 cm; replacement every 10 years.

NOVAPLUS T 380 ® cu · ‘Mini’ size for minimum uterine length 5 cm; ‘Normal’ size for uterine length 6.5–9 cm; replacement every 5 years.

NOVA-T ® 380 For uterine length 6.5–9 cm; replacement every 5 years.

FLEXI-T ® 300 For uterine length over 6 cm; replacement every 5 years.

Silicone contraceptive pessaries

- **SILICONE CONTRACEPTIVE PESSARIES**
  - FemCap 22mm (Durbin Plc) | 1 device · NHS indicative price = £15.29 · Drug Tariff (Part Ixa)
  - FemCap 26mm (Durbin Plc) | 1 device · NHS indicative price = £15.29 · Drug Tariff (Part Ixa)

### 3.3 Contraception, emergency

#### Ulipristal acetate

**Drug action** Ulipristal acetate is a progestosterone receptor modulator with a partial progestosterone antagonist effect.

- **Indications and dose**
  - Emergency contraception
    - **By mouth**
      - Females of childbearing potential: 30 mg for 1 dose, to be taken as soon as possible after coitus, but no later than after 120 hours
    - **Common or very common** Back pain · breast tenderness · dizziness · fatigue · gastrointestinal discomfort · headaches · menstrual cycle irregularities · mood altered · myalgia · nausea · pelvic pain · vomiting
    - **Uncommon** Anxiety · appetite disorder · chills · concentration impaired · diarrhea · drowsiness · dry mouth · fever · flatulence · hot flush · increased risk of infection · insomnia · libido disorder · malaise · skin reactions · vision disorders · vulvovaginal disorders
    - **Rare or very rare** Abnormal sensation in eye · disorientation · dry throat · eye erythema · genital pruritus · ovarian cyst ruptured · painful sexual intercourse · syncope · taste altered · thirst · tremor · vertigo

- **Pregnancy**
  - When used for emergency contraception Limited information available—if pregnancy occurs, manufacturer advises report to the ellaOne® pregnancy registry.

- **Breast feeding**
  - When used for emergency contraception Manufacturer advises avoid for 1 week after administration—present in milk.

- **Hepatic impairment**
  - When used for emergency contraception Manufacturer advises avoid in severe impairment (no information available).

- **Prescribing and dispensing information** The manufacturer of Esmya® has provided a Physician’s Guide to Prescribing Esmya®.

- **Patient and carer advice**
  - When used for emergency contraception When prescribing or supplying hormonal emergency contraception, manufacturer advises women should be told:
    - If vomiting occurs within 3 hours of taking a dose, a replacement dose should be taken;
    - That their next period may be early or late;
    - To seek medical attention promptly if any lower abdominal pain occurs because this could signify an ectopic pregnancy.

The Faculty of Sexual and Reproductive Healthcare also advises women should be told:

- That a barrier method of contraception needs to be used—see Emergency contraception p. 515 for further information;
- That a pregnancy test should be performed if the next menstrual period is delayed by more than 7 days, is
lighter than usual, or is associated with abdominal pain that is not typical of the woman’s usual dysmenorrhoea; • that a pregnancy test should be performed if hormonal contraception is started soon after use of emergency contraception even if they have bleeding; bleeding associated with the contraceptive method may not represent menstruation.

● MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Tablet
• Ellione (HRA Pharma UK Ltd)
  Ulipristal acetate 30 mg Ellione 30mg tablets 1 tablet £14.05 DT = £14.05
• Esmya (Gedeon Richter (UK) Ltd)
  Ulipristal acetate 5 mg Esmya 5mg tablets 28 tablet £114.13 DT = £114.13

3.4 Contraception, oral progestogen-only

Desogestrel

Other drugs used for Contraception, oral progestogen-only Norethisterone, p. 497

PROGESTOGENS

Desogestrel

19-Jul-2018

● INDICATIONS AND DOSE
Contraception

• BY MOUTH
  • Females of childbearing potential: 75 micrograms daily, dose to be taken at same time each day, starting on day 1 of cycle then continuously, if administration delayed for 12 hours or more it should be regarded as a ‘missed pill’.

● LICENSED USE Consult product literature for the licensing status of individual preparations.

● CONTRA-INDICATIONS Acute porphyrias p. 624 - history of breast cancer but can be used after 5 years if no evidence of disease and non-hormonal contraceptive methods unacceptable - severe arterial disease - undiagnosed vaginal bleeding

● CAUTIONS Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration)—seek specialist advice - arterial disease - functional ovarian cysts - history of jaundice in pregnancy - malabsorption syndromes - past ectopic pregnancy - sex-steroid dependent cancer - systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies

CAUTIONS, FURTHER INFORMATION

Other conditions The product literature advises caution in patients with history of thromboembolism, hypertension, diabetes mellitus and migraine; evidence for caution in these conditions is unsatisfactory.

● INTERACTIONS • Appendix 1: desogestrel

● SIDE-EFFECTS
  • Common or very common Breast abnormalities - depressed mood - headache - libido decreased - menstrual cycle irregularities - mood altered - nausea - skin reactions - weight increased
  • Uncommon Alopecia - contact lens intolerance - fatigue - ovarian cyst - vomiting - vulvovaginal infection
  • Rare or very rare Erythema nodosum
  • Frequency not known Angioedema - embolism and thrombosis - neoplasms

SIDE-EFFECTS, FURTHER INFORMATION The benefits of using progestogen-only contraceptives (POCs), such as desogestrel, should be weighed against the possible risks for each individual woman.

There is a small increase in the risk of having breast cancer diagnosed in women using a combined oral contraceptive pill (COC); this relative risk may be due to an earlier diagnosis, biological effects of the pill or a combination of both. This increased risk is related to the age of the woman using the COC rather than the duration of use and disappears gradually within 10 years after discontinuation.

The risk of breast cancer in users of POCs is possibly of similar magnitude as that associated with COCs, however the evidence is less conclusive.

Available evidence does not support an association between the use of a progestogen-only contraceptive pill and breast cancer. Any increased risk is likely to be small and reduces gradually during the 10 years after stopping; there is no excess risk 10 years after stopping. The older age at which the contraceptive is stopped appears to have a greater influence on increased risk rather than the duration of use.

● PREGNANCY Not known to be harmful.

● BREAST FEEDING Progestogen-only contraceptives do not affect lactation.

● HEPATIC IMPAIRMENT Caution in severe liver disease and recurrent cholestatic jaundice. Avoid in liver tumour.

● PATIENT AND CARER ADVICE
  Surgery All progestogen-only contraceptives are suitable for use as an alternative to combined hormonal contraceptives before major elective surgery, before all surgery to the legs, or before surgery which involves prolonged immobilisation of a lower limb.

Starting routine One tablet daily, on a continuous basis, starting on day 1 of cycle and taken at the same time each day (if delayed by longer than 12 hours contraceptive protection may be lost). Additional contraceptive precautions are not required if desogestrel is started up to and including day 5 of the menstrual cycle; if started after this time, additional contraceptive precautions are required for 2 days.

Changing from a combined oral contraceptive Start on the day following completion of the combined oral contraceptive course without a break (or in the case of ED tablets omitting the inactive ones).

After childbirth Oral progestogen-only contraceptives can be started up to and including day 21 postpartum without the need for additional contraceptive precautions. If started more than 21 days postpartum, additional contraceptive precautions are required for 2 days.

Diarrhoea and vomiting Vomiting and persistent, severe diarrhoea can interfere with the absorption of oral progestogen-only contraceptives. If vomiting occurs within 2 hours of taking desogestrel, another pill should be taken as soon as possible. If a replacement pill is not taken within 12 hours of the normal time for taking desogestrel, or in cases of persistent vomiting or very severe diarrhoea, additional precautions should be used during illness and for 2 days after recovery.

Missed doses The following advice is recommended: ‘If you forget a pill, take it as soon as you remember and carry on with the next pill at the right time. If the pill was more than 12 hours overdue you are not protected. Continue normal pill-taking but you must also use another method, such as the condom, for the next 2 days’.

The Faculty of Sexual and Reproductive Healthcare recommends emergency contraception if one or more tablets are missed or taken more than 12 hours late and unprotected intercourse has occurred before 2 further tablets have been correctly taken.
Levonorgestrel

**INDICATIONS AND DOSE**

**Emergency contraception**

- **BY MOUTH**
  - Females of childbearing potential: 1.5 mg for 1 dose, taken as soon as possible after coitus, preferably within 12 hours and no later than after 72 hours (may also be used between 72–96 hours after coitus but efficacy decreases with time), alternatively 3 mg for 1 dose, taken as soon as possible after coitus, preferably within 12 hours and no later than after 72 hours (may also be used between 72–96 hours after coitus but efficacy decreases with time). Higher dose should be considered for patients with body-weight over 70 kg or BMI over 26 kg/m²

**Contraception**

- **BY MOUTH**
  - Females of childbearing potential: 30 micrograms daily starting on day 1 of the cycle then continuously, dose is to be taken at the same time each day, if administration delayed for 3 hours or more it should be regarded as a “missed pill”

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- When used orally as an emergency contraceptive, the effectiveness of levonorgestrel is reduced in women taking enzyme-inducing drugs (and for up to 4 weeks after stopping); a copper intra-uterine device should preferably be used instead. If the copper intra-uterine device is undesirable or inappropriate, the dose of levonorgestrel should be increased to a total of 3 mg taken as a single dose; pregnancy should be excluded following use, and medical advice sought if pregnancy occurs.
  - There is no need to increase the dose for emergency contraception if the patient is taking antibacterials that are not enzyme inducers.
  - With the progestogen-only intra-uterine device, levonorgestrel is released close to the site of the main contraceptive action (on cervical mucus and endometrium) and therefore progestogenic side-effects and interactions are less likely; in particular, enzyme-inducing drugs are unlikely to significantly reduce the contraceptive effect of the progestogen-only intra-uterine system and additional contraceptive precautions are not required.

**JAYDESS® 13.5MG INTRA-UTERINE DEVICE**

**Contraception**

- **BY INTRA-UTERINE ADMINISTRATION**
  - Females of childbearing potential: Insert into uterine cavity within 7 days of onset of menstruation, or any time if replacement (additional precautions (e.g. barrier methods) advised for at least 7 days before), or any time if reasonably certain woman is not pregnant and there is no risk of conception (additional precautions (e.g. barrier methods) necessary for next 7 days), or immediately following termination of pregnancy below 24 weeks’ gestation; postpartum insertions should be delayed until at least 4 weeks after delivery; effective for 3 years

**KYLEENA® 19.5MG INTRA-UTERINE DEVICE**

**Contraception**

- **BY INTRA-UTERINE ADMINISTRATION**
  - Females of childbearing potential: Insert into uterine cavity within 7 days of onset of menstruation, or any time if replacement (additional precautions (e.g. barrier methods) advised for at least 7 days before), or any time if reasonably certain woman is not pregnant and there is no risk of conception (additional precautions (e.g. barrier methods) necessary for next 7 days), or immediately following termination of pregnancy below 24 weeks’ gestation; postpartum insertions should be delayed until at least 4 weeks after delivery; effective for 5 years

**LEVOSERT® 20MICROGRAMS/24HOURS INTRA-UTERINE DEVICE**

**Contraception | Menorrhagia**

- **BY INTRA-UTERINE ADMINISTRATION**
  - Females of childbearing potential: Insert into uterine cavity within 7 days of onset of menstruation, or any time if replacement (additional precautions (e.g. barrier methods) advised for at least 7 days before), or any time if reasonably certain woman is not pregnant and there is no risk of conception (additional precautions (e.g. barrier methods) necessary for next 7 days), or immediately following termination of pregnancy below 24 weeks’ gestation; postpartum insertions should be delayed until at least 4 weeks after delivery; effective for 4 years

**MIRENA® 20MICROGRAMS/24HOURS INTRA-UTERINE DEVICE**

**Contraception | Menorrhagia**

- **BY INTRA-UTERINE ADMINISTRATION**
  - Females of childbearing potential: Insert into uterine cavity within 7 days of onset of menstruation, or any time if replacement (additional precautions (e.g. barrier methods) advised for at least 7 days before), or any time if reasonably certain woman is not pregnant and there is no risk of conception (additional precautions (e.g. barrier methods) necessary for next 7 days), or immediately following termination of pregnancy below 24 weeks’ gestation; continued →
postpartum insertions should be delayed until at least 4 weeks after delivery; effective for 5 years

Prevention of endometrial hyperplasia during oestrogen replacement therapy
- By intra-uterine administration
  - Females of childbearing potential: Insert during last days of menstruation or withdrawal bleeding or at any time if amenorrhoeic; effective for 4 years

Contraception

- With intra-uterine use
  - The Faculty of Sexual and Reproductive Healthcare (FSRH) advises levonorgestrel is used as detailed below, although these situations are considered unlicensed:
    - Insertion at any time if reasonably certain the woman is not pregnant or at risk of pregnancy;
    - Additional precautions (e.g. barrier methods) for at least 7 days before replacement even if immediate replacement is intended;
    - Insertion immediately following termination of pregnancy below 24 weeks' gestation;
    - Postpartum insertions 4 weeks after delivery.
- With oral use
  - The FSRH advises levonorgestrel is used as detailed below, although these situations are considered unlicensed:
    - Higher dose option for emergency contraception in patients with body-weight over 70 kg or BMI over 26 kg/m²;
    - Use for emergency contraception between 72–96 hours after coitus.
- With intra-uterine use or oral use
  - Consult product literature for licensing status of individual preparations.

- With oral use
  - Acute porphyrias p. 624
  - History of breast cancer but can be used after 5 years if no evidence of disease and non-hormonal contraceptive methods unacceptable - severe arterial disease - undiagnosed vaginal bleeding

Caution

General cautions
- Risk factors for ectopic pregnancy (including previous ectopic pregnancy, tubal surgery or pelvic infection)

Specific cautions
- Disease-induced immunosuppression (risk of infection—avoid if marked immunosuppression).
- Acute venous thromboembolism (consider removal).
- Anaemia - anticoagulant therapy (avoid if possible).
- Diabetes - drug-induced immunosuppression (risk of infection—avoid if marked immunosuppression).
- Endometriosis - epilepsy (risk of seizure at time of insertion).
- Fertility problems.
- History of pelvic inflammatory disease.
- Increased risk of expulsion if inserted before uterine involution - jaundice (consider removal).
- Marked increase of blood pressure (consider removal).
- Migraine (consider removal).
- Undiagnosed vaginal bleeding.
- Undiagnosed cervical intraepithelial neoplasia.
- Uterine or cervical malignancy.

Unlicensed use
- With intra-uterine use
  - The Faculty of Sexual and Reproductive Healthcare advises levonorgestrel is used as detailed below, although these situations are considered unlicensed:
    - Acute porphyrias p. 624
- With oral use
  - History of breast cancer but can be used after 5 years if no evidence of disease and non-hormonal contraceptive methods unacceptable - severe arterial disease - undiagnosed vaginal bleeding

Caution

General cautions
- Risk factors for ectopic pregnancy (including previous ectopic pregnancy, tubal surgery or pelvic infection)

Specific cautions
- Disease-induced immunosuppression (risk of infection—avoid if marked immunosuppression).
- Acute venous thromboembolism (consider removal).
- Anaemia - anticoagulant therapy (avoid if possible).
- Diabetes - drug-induced immunosuppression (risk of infection—avoid if marked immunosuppression).
- Endometriosis - epilepsy (risk of seizure at time of insertion).
- Fertility problems.
- History of pelvic inflammatory disease.
- Increased risk of expulsion if inserted before uterine involution - jaundice (consider removal).
- Marked increase of blood pressure (consider removal).
- Migraine (consider removal).
- Undiagnosed vaginal bleeding.
- Undiagnosed cervical intraepithelial neoplasia.
- Uterine or cervical malignancy.

Intra-uterine contraception
- Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration) — seek specialist advice.
- Arterial disease.
- Functional ovarian cysts.
- History of jaundice in pregnancy.
- Malabsorption syndromes.
- Past ectopic pregnancy.
- Sex-steroid dependent cancer.
- Systemic lupus erythematosus.
- Antiphospholipid antibodies.

Use as a contraceptive
- Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration) — seek specialist advice.
- Postpartum insertions should be delayed until at least 6 weeks after delivery.
- Postpartum insertions should be delayed until at least 5 weeks postpartum in patients who are breastfeeding.
- Insertion immediately following termination of pregnancy below 24 weeks' gestation.
- Postpartum insertions 4 weeks after delivery.
- With intra-uterine use
  - Insert during last days postpartum or in patients who experiences sustained pain during the next 20 days.
  - Use as a contraceptive in co-morbidities.
  - With oral use
    - The product literature advises caution in patients with history of thromboembolism, hypertension, diabetes mellitus and migraine; evidence for caution in these conditions is unsatisfactory.

Important safety information
MHRA/CHM Advice (June 2015) Intra-uterine contraception

Uterine perforation most often occurs during insertion, but might not be detected until sometime later. The risk of uterine perforation is increased when the device is inserted up to 36 weeks postpartum or in patients who are breastfeeding. Before inserting an intra-uterine contraceptive device, inform patients that perforation occurs in approximately 1 in every 1000 insertions and signs and symptoms include:
- Severe pelvic pain after insertion (worse than period cramps);
- Pain or increased bleeding after insertion which continues for more than a few weeks;
- Sudden changes in periods;
- Pain during intercourse;
- Unable to feel the threads.

Patients should be informed on how to check their threads and to arrange a check-up if threads cannot be felt, especially if they also have significant pain. Partial perforation may occur even if the threads can be seen; consider this if there is severe pain following insertion and perform an ultrasound.

Contra-indications
- With intra-uterine use
  - Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration).
- Acute cervicitis.
- Distorted uterine cavity.
- History of breast cancer but can be considered for a woman in long-term remission who has menorrhagia and requires effective contraception.
- Increased risk factors for pelvic infections.
- Infected abortion during the previous three months.
- Not suitable for emergency contraception.
- Pelvic inflammatory disease.
- Postpartum endometritis.
- Unexplained uterine bleeding.
- Unresolved cervical intraepithelial neoplasia.
- Uterine or cervical malignancy.
Contraception, oral progestogen-only

MIRENA® 20MICROGRAMS/24HOURS INTRA-UTERINE DEVICE

Advanced uterine atrophy

INTERACTIONS

Appendix 1: levonorgestrel

SIDE-EFFECTS

GENERAL SIDE-EFFECTS

Common or very common

Gastrointestinal discomfort - headaches - menstrual cycle irregularities - nausea - skin reactions

SPECIFIC SIDE-EFFECTS

Common or very common

With intra-uterine use: Back pain - breast abnormalities - depression - device expulsion - hirsutism - increased risk of infection - libido decreased - nervousness - ovarian cyst - pelvic disorders - uterine haemorrhage (on insertion) - vaginal haemorrhage (on insertion) - vulvovaginal disorders - weight increased

With oral use: Breast tenderness - diarrhoea - dizziness - fatigue - haemorrhage - vomiting

Uncommon

With intra-uterine use: Alopecia - endometritis - oedema - uterine rupture

Rare or very rare

With oral use: Face oedema - pelvic pain

Frequency not known

With oral use: Cerebrovascular insufficiency - depressed mood - diabetes mellitus - embolism and thrombosis - neoplasms - sexual dysfunction - weight changes

SIDE-EFFECTS, FURTHER INFORMATION

Breast cancer

There is a small increase in the risk of having breast cancer diagnosed in women using, or who have recently used, a progestogen-only contraceptive pill; this relative risk may be due to an earlier diagnosis. The most important risk factor appears to be the age at which the contraceptive is stopped rather than the duration of use; the risk disappears gradually during the 10 years after stopping and there is no excess risk by 10 years. A possible small increase in the risk of breast cancer should be weighed against the benefits.

With intra-uterine use

There is no evidence of an association between the levonorgestrel intra-uterine system and breast cancer. The levonorgestrel intra-uterine system should be avoided in patients with a history of breast cancer; any consideration of it’s use should be by a specialist in contraception and in consultation with the patients cancer specialist.

Patients should be informed about the device that has been inserted and when it should be removed or replaced (including referring them to a patient information leaflet and other sources of information).

Patients may experience irregular, prolonged or infrequent menstrual bleeding in the 3–6 months following insertion; bleeding pattern improves with time but persists in some patients.

Progestogenic side-effects resolve with time (after the first few months).

PREGNANCY

With oral use: Not known to be harmful.

With intra-uterine use: If an intra-uterine device fails and the woman wishes to continue to full-term the device should be removed in the first trimester if possible. Avoid; if pregnancy occurs remove intra-uterine system.

BREAST FEEDING

Progestogen-only contraceptives do not affect lactation.

HEPATIC IMPAIRMENT

With oral use: For Contraception or Emergency contraception. Manufacturer advises avoid in severe impairment.

With intra-uterine use: Manufacturer advises avoid in severe impairment—no information available; avoid in acute hepatic disease.

MONITORING REQUIREMENTS

With intra-uterine use: Gynaecological examination before insertion, 4–6 weeks after insertion, then annually.

DIRECTIONS FOR ADMINISTRATION

With intra-uterine use: The doctor or nurse administering (or removing) the system should be fully trained in the technique and should provide full counselling reinforced by the patient information leaflet.

PRESCRIBING AND DISPENSING INFORMATION

With intra-uterine use: Levonorgestrel-releasing intra-uterine devices vary in licensed indication, duration of use and insertion technique—the MHRA recommends to prescribe and dispense by brand name to avoid inadvertent switching.

PATIENT AND CARER ADVICE

Diarrhoea and vomiting with use as an oral contraceptive. Vomiting and persistent, severe diarrhoea can interfere with the absorption of oral progestogen-only contraceptives. If vomiting occurs within 2 hours of taking an oral progestogen-only contraceptive, another pill should be taken as soon as possible. If a replacement pill is not taken within 3 hours of the normal time for taking the progestogen-only pill, or in cases of persistent vomiting or very severe diarrhoea, additional precautions should be used during illness and for 2 days after recovery.

Starting routine

With oral use for Contraception: One tablet daily, on a continuous basis, starting on day 1 of cycle and taken at the same time each day (if delayed by longer than 3 hours contraceptive protection may be lost). Additional contraceptive precautions are not required if levonorgestrel is started up to and including day 5 of the menstrual cycle; if started after this time, additional contraceptive precautions are required for 2 days. Changing from a combined oral contraceptive. Start on the day following completion of the combined oral contraceptive course without a break (or in the case of ED tablets omitting the inactive ones).

After childbirth: Oral progestogen-only contraceptives can be started up to and including day 21 postpartum without the need for additional contraceptive precautions. If started more than 21 days postpartum, additional contraceptive precautions are required for 2 days.

With oral use for Emergency contraception: When prescribing or supplying hormonal emergency contraception, manufacturer advises women should be told:

• that a pregnancy test should be performed if the next menstrual period is delayed by more than 7 days, is lighter than usual, or is associated with abdominal pain that is not typical of the woman’s usual dysmenorrhoea;

• that a pregnancy test should be performed if hormonal contraception is started soon after use of emergency contraception even if they have bleeding; bleeding associated with the contraceptive method may not represent menstruation.

Missed doses: When used as an oral contraceptive, the following advice is recommended. If you forget a pill, take it as soon as you remember and carry on with the next pill at the right time. If the pill was more than 3 hours overdue...
you are not protected. Continue normal pill-taking but you must also use another method, such as the condom, for the next 2 days.\textsuperscript{1}

The Faculty of Sexual and Reproductive Healthcare recommends emergency contraception if one or more progestogen-only contraceptive tablets are missed or taken more than 3 hours late and unprotected intercourse has occurred before 2 further tablets have been correctly taken.

\textbf{NATIONAL FUNDING/ACCESS DECISIONS}

\textbf{Scottish Medicines Consortium (SMC) decisions}

SMC No. 1299/18

The Scottish Medicines Consortium has advised (February 2018) that levonorgestrel (Kyleena\textsuperscript{®}) is accepted for use within NHS Scotland as a contraceptive device for up to 5 years.

\textbf{All Wales Medicines Strategy Group (AWMSG) decisions}

AWMSG No. 3582

The All Wales Medicines Strategy Group has advised (September 2018) that levonorgestrel (Kyleena\textsuperscript{®}) is recommended as an option for use within NHS Wales for contraception for up to five years.

\textbf{EXCEPTIONS TO LEGAL CATEGORY}

Levonelle\textsuperscript{®} One Step can be sold to women over 16 years; when supplying emergency contraception to the public, pharmacists should refer to guidance issued by the Royal Pharmaceutical Society.

\textbf{MEDICINAL FORMS}

There can be variation in the licensing of different medicines containing the same drug.

\textbf{Intra-uterine device}

\begin{itemize}
  \item Jaydess (Bayer Plc)\textsuperscript{↓}
    \begin{itemize}
      \item Jaydess 13.5 mg Jaydess 13.5 mg intra-uterine device 1 device \textsuperscript{POM} £69.22 DT = £69.22
    \end{itemize}
  \item Kyleena (Bayer Plc)
    \begin{itemize}
      \item Kyleena 19.5 mg Kyleena 19.5 mg intra-uterine device 1 device \textsuperscript{POM} £76.00 DT = £76.00
    \end{itemize}
  \item Levosert (Gedeon Richter (UK) Ltd)
    \begin{itemize}
      \item Levosert 20 microgram per 24 hour Levosert 20 micrograms/24 hours intra-uterine device 1 device \textsuperscript{POM} £66.00 DT = £88.00
    \end{itemize}
  \item Mirena (Bayer Plc)
    \begin{itemize}
      \item Mirena 20 micrograms/24 hours Mirena 20 micrograms/24 hours intra-uterine device 1 device \textsuperscript{POM} £88.00 DT = £88.00
    \end{itemize}
\end{itemize}

\textbf{Tablet}

\begin{itemize}
  \item Levonorgestrel (Non-proprietary)
    \begin{itemize}
      \item Levonorgestrel 1.5 mg Levonorgestrel 1.5 mg tablets 1 tablet \textsuperscript{POM} £3.74–£5.20 DT = £5.20
      \item Emeres (Morningside Healthcare Ltd)
        \begin{itemize}
          \item Emeres 1.5 mg tablets 1 tablet \textsuperscript{POM} £3.65 DT = £5.20
        \end{itemize}
      \item Ezinelle (Mylan)
        \begin{itemize}
          \item Ezinelle 1.5 mg tablets 1 tablet \textsuperscript{POM} £9.64 DT = £5.20
        \end{itemize}
      \item Levonelle (Bayer Plc)
        \begin{itemize}
          \item Levonelle 1.5 mg Levonelle 1500 microgram tablets 1 tablet \textsuperscript{POM} £3.20 DT = £3.20
          \item Levonelle One Step (Bayer Plc)
            \begin{itemize}
              \item Levonelle One Step 1.5 mg tablets 1 tablet \textsuperscript{POM} £13.83 DT = £5.20
            \end{itemize}
          \item Melkine (Crescent Pharma Ltd)
            \begin{itemize}
              \item Melkine 1.5 mg tablets 1 tablet \textsuperscript{POM} £4.16 DT = £5.20
            \end{itemize}
          \item Norgeston (Bayer Plc)
            \begin{itemize}
              \item Norgeston 30 microgram Norgeston 30 microgram tablets 35 tablet \textsuperscript{POM} £0.92 DT = £0.92
              \item Upostelle (Counsyl Health Ltd)
                \begin{itemize}
                  \item Upostelle 1.5 mg Upostelle 1500 microgram tablets 1 tablet \textsuperscript{POM} £3.75 DT = £5.20
                \end{itemize}
            \end{itemize}
        \end{itemize}
    \end{itemize}
\end{itemize}

\textbf{INDICATIONS AND DOSE}

\textbf{Contraception (no hormonal contraceptive use in previous month)}

\begin{itemize}
  \item BY SUBDERMAL IMPLANTATION
    \begin{itemize}
      \item Females of childbearing potential: 1 implant inserted during first 5 days of cycle, implant should be removed within 3 years of insertion
    \end{itemize}
  \item Contraception (postpartum)
    \begin{itemize}
      \item Females of childbearing potential: 1 implant to be inserted 21–28 days after delivery (delay until 28 days postpartum if breast-feeding), implant should be removed within 3 years of insertion
    \end{itemize}
  \item Contraception following abortion or miscarriage in the second trimester
    \begin{itemize}
      \item BY SUBDERMAL IMPLANTATION
        \begin{itemize}
          \item Females of childbearing potential: 1 implant to be inserted 21–28 days after abortion or miscarriage, implant should be removed within 3 years of insertion
        \end{itemize}
    \end{itemize}
  \item Contraception following abortion or miscarriage in the first trimester
    \begin{itemize}
      \item BY SUBDERMAL IMPLANTATION
        \begin{itemize}
          \item Females of childbearing potential: 1 implant to be inserted within 5 days after abortion or miscarriage, implant should be removed within 3 years of insertion
        \end{itemize}
    \end{itemize}
  \item Contraception (changing from other hormonal contraceptive)
    \begin{itemize}
      \item BY SUBDERMAL IMPLANTATION
        \begin{itemize}
          \item Females of childbearing potential: Implant should be removed within 3 years of insertion (consult product literature)
        \end{itemize}
    \end{itemize}
\end{itemize}

\textbf{UNLICENCED USE}

Nexplanon\textsuperscript{®} not licensed for use in females outside of the age range 18–40 years.

\section*{IMPORTANT SAFETY INFORMATION}

\textbf{MRHA/CHM ADVICE (JUNE 2016): NEXPLANON\textsuperscript{®} (ETONOGESTREL) CONTRACEPTIVE IMPLANTS: REPORTS OF DEVICE IN VASCULARITY AND LUNG}

There have been rare reports of Nexplanon\textsuperscript{®} implants reaching the lung via the pulmonary artery. An implant that cannot be palpated at its insertion site should be located and removed as soon as possible; if unable to locate implant within the arm, the MHRA recommends using chest imaging. Correct subdermal insertion reduces the risk of these events.

\textbf{CONTRA-INDICATIONS}

Acute porphyrrias p. 624 – history of breast cancer but can be used after 5 years if no evidence of disease and non-hormonal contraceptive methods unacceptable – severe arterial disease – undiagnosed vaginal bleeding

\textbf{CAUTIONS}

malabsorption syndromes • possible risk of breast cancer • sex-steroid dependent cancer • systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies

- INTERACTIONS  ➔ Appendix 1: etonogestrel
- SIDE-EFFECTS
  - Common or very common Abdominal pain • alopecia • anxiety • appetite increased • breast abnormalities • depressed mood • dizziness • emotional lability • fatigue • flatulence • headaches • hot flush • increased risk of infection • influenza like illness • libido decreased • menstrual cycle irregularities • nausea • ovarian cyst • pain • skin reactions • weight changes
  - Uncommon Arthralgia • constipation • diarrhoea • drowsiness • dysuria • fever • galactorrhoea • genital abnormalities • hypertrichosis • insomnia • myalgia • oedema • vomiting • vulvovaginal discomfort
  - Frequency not known Abscess • angioedema • embolism and thrombosis • haemorrhage • insulin resistance • neoplasms • paraesthesia • seborrhoea

SIDE-EFFECTS, FURTHER INFORMATION The benefits of using progesterone-only contraceptives (POCs), such as etonogestrel, should be weighed against the possible risks for each individual woman.

There is a small increase in the risk of having breast cancer diagnosed in women using a combined oral contraceptive pill (COC); this relative risk may be due to an earlier diagnosis, biological effects of the pill or a combination of both. This increased risk is related to the age of the woman using the COC rather than the duration of use and disappears gradually within 10 years after discontinuation.

The risk of breast cancer in users of POCs is possibly of similar magnitude as that associated with COCs, however the evidence is less conclusive.

- PREGNANCY Not known to be harmful, remove implant if pregnancy occurs.
- BREAST FEEDING Progestogen-only contraceptives do not affect lactation.
- DIRECTIONS FOR ADMINISTRATION The doctor or nurse administering (or removing) the system should be fully trained in the technique and should provide full counselling reinforced by the patient information leaflet.
- PATIENT AND CARER ADVICE Full counselling backed by patient information leaflet required before administration.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Implant
  - Nexplanon (Merck Sharp & Dohme Ltd)
  - Etonogestrel 68 mg  Nexplanon 68mg implant  | 1 device £83.43 £83.43

**Medroxyprogesterone acetate**

- INDICATIONS AND DOSE
  - Contraception
    - BY DEEP INTRAMUSCULAR INJECTION
      - Females of childbearing potential: 150 mg, to be administered within the first 5 days of cycle or within first 5 days after parturition (delay until 6 weeks after parturition if breast-feeding)
    - BY SUBCUTANEOUS INJECTION
      - Females of childbearing potential: 104 mg, to be administered within first 5 days of cycle or within 5 days postpartum (delay until 6 weeks postpartum if breast-feeding), injected into anterior thigh or abdomen, dose only suitable if no hormonal contraceptive use in previous month

**Long-term contraception**

- BY DEEP INTRAMUSCULAR INJECTION
  - Females of childbearing potential: 150 mg every 12 weeks, first dose to be administered within the first 5 days of cycle or within first 5 days after parturition (delay until 6 weeks after parturition if breast-feeding)
- BY SUBCUTANEOUS INJECTION
  - Females of childbearing potential: 104 mg every 13 weeks, first dose to be administered within first 5 days of cycle or within 5 days postpartum (delay until 6 weeks postpartum if breast-feeding), injected into anterior thigh or abdomen, dose only suitable if no hormonal contraceptive use in previous month

**Contraception (when patient changing from other hormonal contraceptive)**

- BY SUBCUTANEOUS INJECTION
  - Females of childbearing potential: (consult product literature)

**SIDE-EFFECTS**

- Common or very common Abdominal pain • alopecia • anxiety • appetite increased • breast abnormalities • depressed mood • dizziness • emotional lability • fatigue • flatulence • headaches • hot flush • increased risk of infection • influenza like illness • libido decreased • menstrual cycle irregularities • nausea • ovarian cyst • pain • skin reactions • weight changes
- Uncommon Arthralgia • constipation • diarrhoea • drowsiness • dysuria • fever • galactorrhoea • genital abnormalities • hypertrichosis • insomnia • myalgia • oedema • vomiting • vulvovaginal discomfort
- Frequency not known Abscess • angioedema • embolism and thrombosis • haemorrhage • insulin resistance • neoplasms • paraesthesia • seborrhoea

**SIDE-EFFECTS, FURTHER INFORMATION** The benefits of using progestogen-only contraceptives (POCs), such as etonogestrel, should be weighed against the possible risks for each individual woman.

There is a small increase in the risk of having breast cancer diagnosed in women using a combined oral contraceptive pill (COC); this relative risk may be due to an earlier diagnosis, biological effects of the pill or a combination of both. This increased risk is related to the age of the woman using the COC rather than the duration of use and disappears gradually within 10 years after discontinuation.

The risk of breast cancer in users of POCs is possibly of similar magnitude as that associated with COCs, however the evidence is less conclusive.

- PREGNANCY Not known to be harmful, remove implant if pregnancy occurs.
- BREAST FEEDING Progestogen-only contraceptives do not affect lactation.
- DIRECTIONS FOR ADMINISTRATION The doctor or nurse administering (or removing) the system should be fully trained in the technique and should provide full counselling reinforced by the patient information leaflet.
- PATIENT AND CARER ADVICE Full counselling backed by patient information leaflet required before administration.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

Implant
  - Nexplanon (Merck Sharp & Dohme Ltd)
  - Etonogestrel 68 mg  Nexplanon 68mg implant  | 1 device £83.43 £83.43

MEDROXYPROGESTERONE ACETATE 24-May-2017

**Long-term contraception**

- BY DEEP INTRAMUSCULAR INJECTION
  - Females of childbearing potential: 150 mg every 12 weeks, first dose to be administered within the first 5 days of cycle or within first 5 days after parturition (delay until 6 weeks after parturition if breast-feeding)
- BY SUBCUTANEOUS INJECTION
  - Females of childbearing potential: 104 mg every 13 weeks, first dose to be administered within first 5 days of cycle or within 5 days postpartum (delay until 6 weeks postpartum if breast-feeding), injected into anterior thigh or abdomen, dose only suitable if no hormonal contraceptive use in previous month

**Contraception (when patient changing from other hormonal contraceptive)**

- BY SUBCUTANEOUS INJECTION
  - Females of childbearing potential: (consult product literature)

**SIDE-EFFECTS**

- Common or very common Abdominal pain • alopecia • anxiety • appetite increased • breast abnormalities • depressed mood • dizziness • emotional lability • fatigue • flatulence • headaches • hot flush • increased risk of infection • influenza like illness • libido decreased • menstrual cycle irregularities • mood altered • nausea • pain • sexual dysfunction • skin reactions • vulvovaginal infection • weight changes
- Uncommon Arthralgia • constipation • diarrhoea • drowsiness • fever • fluid retention • galactorrhoea • hirsutism • hot flush • hypertension • muscle spasms • ovarian cyst • painful sexual intercourse • tachycardia • under eye haemorrhage • varicose veins • vertigo • vulvovaginal disorders
- Rare or very rare Breast cancer • lipodystrophy
  - Frequency not known Embolism and thrombosis • hepatic disorders • osteoporosis • osteoporotic fractures • seizure

**SIDE-EFFECTS, FURTHER INFORMATION** Reduction in bone mineral density is greater with increasing duration of use. The loss is mostly recovered on discontinuation.

**CONCEPTION AND CONTRACEPTION**

- With intramuscular use If interval between dose is greater than 12 weeks and 5 days (in long-term contraception), rule out pregnancy before next injection and advise patient to use additional contraceptive measures (e.g. barrier) for 14 days after the injection.
- With subcutaneous use If interval between dose is greater than 13 weeks and 7 days (in long-term contraception), rule out pregnancy before next injection.
- PREGNANCY Not known to be harmful.
- BREAST FEEDING Present in milk—no adverse effects reported. Progestogen-only contraceptives do not affect lactation. The manufacturers advise that in women who are breast-feeding, the first dose should be delayed until 6 weeks after birth; however, evidence suggests no
Genito-urinary system can be useful when the symptoms are due to non-specific irritation, but systemic drugs are required in the treatment of bacterial infection or threadworm infestation. Intravaginal preparations, particularly those that require the use of an applicator, are not generally suitable for young girls; topical preparations may be useful in some adolescent girls.

In older girls symptoms are often restricted to the vulva, but infections almost invariably involve the vagina, which should also be treated; treatment should be as for adults.

Vaginal and vulval changes
Topical oestrogen creams containing estriol 0.01% (Gynest®) are used in the treatment of labial adhesions; treatment is usually restricted to symptomatic cases. Estriol cream should be applied to the adhesions once or twice daily for 2–6 weeks; adhesions may recur following treatment.

Vaginal and vulval infections
Effective specific treatments are available for the common vaginal infections.

Fungal infections
Vaginal fungal infections are not normally a problem in younger girls but can occur in adolescents. Candidal vulvitis can be treated locally with cream, but is almost invariably associated with vaginal infection which should also be treated. Vaginal candidiasis, rare in girls before puberty, can be treated with antifungal pessaries or cream inserted high into the vagina (including during menstruation), however, these are not recommended for pre-pubertal girls and treatment with an external cream may be more appropriate. Single-dose intravaginal preparations offer an advantage when compliance is a problem. Local irritation can occur on application of vaginal antifungal products.

Imidazole drugs ( clotrimazole p. 533, econazole nitrate p. 534, fenticonazole nitrate p. 534, and miconazole) are effective against candida in short courses of 1 to 3 days according to the preparation used; treatment can be repeated if initial course fails to control symptoms or if symptoms recur. Vaginal applications may be supplemented with antifungal cream for vulvitis and to treat other superficial sites of infection.

Oral treatment of vaginal infection with fluconazole p. 389 may be considered for girls post-puberty.

Vulvovaginal candidiasis in pregnancy
Vulvovaginal candidiasis is common during pregnancy and can be treated with vaginal application of an imidazole (such as clotrimazole), and a topical imidazole cream for vulvitis. Pregnant women need a longer duration of treatment, usually about 7 days, to clear the infection. There is limited absorption of imidazoles from the skin and vagina. Oral antifungal treatment should be avoided during pregnancy.

Recurrent vulvovaginal candidiasis
Recurrent vulvovaginal candidiasis is very rare in children, but can occur if there are predisposing factors such as antibacterial therapy, pregnancy, diabetes mellitus, or possibly oral contraceptive use. Reservoirs of infection can also lead to recontamination and should be treated; these include other skin sites such as the digits, nail beds, and umbilicus, as well as the gastro-intestinal tract and the bladder. The sexual partner may also be the source of re-infection and, if symptomatic, should be treated with a topical imidazole cream at the same time.

Treatment against candida may need to be extended for 6 months in recurrent vulvovaginal candidiasis.

Other infections
Trichomonal infections commonly involve the lower urinary tract as well as the genital system and need systemic treatment with metronidazole p. 344 or tinidazole p. 346. Bacterial infections with Gram-negative organisms are particularly common in association with gynaecological operations and trauma. Metronidazole is effective against

3.6 Contraception, spermicidal

Spermidicals

Nonoxinol

- INDICATIONS AND DOSE
  Spermicidal contraceptive in conjunction with barrier methods of contraception such as diaphragms or caps
  • BY VAGINA
  • Females of childbearing potential: consult product literature

- SIDE-EFFECTS
  Genital erosion - increased risk of HIV infection - pain - paraesthesia - skin reactions - vaginal redness

SIDE-EFFECTS, FURTHER INFORMATION
High frequency use of the spermicide nonoxinol-9 has been associated with genital lesions, which may increase the risk of acquiring sexually transmitted infections.

- CONCEPTION AND CONTRACEPTION
  No evidence of harm to latex condoms and diaphragms.

- PREGNANCY
  Toxicity in animal studies.

- BREAST FEEDING
  Present in milk in animal studies.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Suspension for injection
- Depo-Provera (Pfizer Ltd)
- Medroxyprogesterone acetate 150 mg per 1 ml Depo-Provera 150mg/ml suspension for injection pre-filled syringes
- 1 pre-filled disposable injection (PSt) £6.01 DT = £6.01
- Sayana Press (Pfizer Ltd)
- Medroxyprogesterone acetate 160 mg per 1 ml Sayana Press 104mg/0.65 ml suspension for injection pre-filled disposable devices
- 1 pre-filled disposable injection (PSt) £6.90 DT = £6.90

4 Vaginal and vulval conditions

Vaginal and vulval conditions

Management
Pre-pubertal girls may be particularly susceptible to vulvovaginitis. Barrier preparations applied after cleansing can be useful when the symptoms are due to non-specific...
certain Gram-negative organisms, especially Bacteroides spp. and can be used prophylactically in gynaecological surgery. Clindamycin cream below and metronidazole gel are indicated for bacterial vaginosis.

The antiviral drugs aciclovir p. 420 and valaciclovir p. 422 can be used in the treatment of genital infection due to herpes simplex virus, the HSV type 2 being a major cause of genital ulceration. They have a beneficial effect on virus shedding and healing, generally giving relief from pain and other symptoms.

4.1 Vaginal and Vulval infections

4.1a Vaginal and Vulval Bacterial Infections

**Antibacterials > Lincosamides**

**Clindamycin**

- **Indications and Dose**
  - **Dalacin® 2% Cream**
  - **Bacterial vaginosis**
    - Child: 1 applicatorful daily for 3–7 nights, dose to be administered at night
    - **Dose equivalence and conversion**
      - 1 applicatorful delivers a 5 g dose of clindamycin 2%.  

- **Unlicensed Use** Not licensed for use in children.
- **Caution** Avoid intravaginal preparations (particularly those that require the use of an applicator) in young girls who are not sexually active, unless there is no alternative
- **Interactions** → Appendix 1: clindamycin
- **Side-effects**
  - **Common or very common** Skin reactions
  - **Frequency not known** Constipation, diarrhoea (discontinue), dizziness, gastrointestinal discomfort, headache, increased risk of infection, nausea, vertigo, vomiting, vulvovaginal irritation
- **Side-effects, further information** Clindamycin 2% cream is poorly absorbed into the blood—low risk of systemic effects.
- **Conception and contraception** Damages latex condoms and diaphragms.
- **Patient and carer advice** Patients and their carers should be advised to discontinue and contact a doctor immediately if severe, prolonged or bloody diarrhoea develops.
- **Medicinal forms** There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**
    - EXCipients: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates, propylene glycol
    - Dalacin (Pfizer Ltd)
    - Clindamycin (as Clindamycin phosphate) 20 mg per 1 gram Dalacin 2% cream | 40 gram | £6.86 DT | £10.86

4.1b Vaginal and Vulval Fungal Infections

**Antifungals > Imidazole**

**Clotrimazole**

- **Indications and Dose**
  - **Superficial sites of infection in vaginal and vulval candidiasis (dose for 1% or 2% cream)**
    - Child: Apply 2–3 times a day, to be applied to anogenital area
  - **Vaginal candidiasis (dose for 10% intravaginal cream)**
    - Child: 5 g for 1 dose, one applicatorful to be inserted into the vagina at night, dose can be repeated once if necessary
  - **Vaginal candidiasis**
    - Child: 200 mg for 3 nights, course can be repeated once if necessary, alternatively 500 mg for 1 night, dose can be repeated once if necessary
  - **Recurrent vulvovaginal candidiasis**
    - Child: 500 mg every week for 6 months, dose to be administered following topical imidazole for 10–14 days

- **Unlicensed use** Consult product literature for individual preparations.
- **Caution** Avoid intravaginal preparations (particularly those that require use of an applicator) in young girls who are not sexually active, unless there is no alternative
- **Interactions** → Appendix 1: antifungals, azoles
- **Side-effects** Abdominal pain, discomfort, genital peeling, oedema, paraesthesia, pelvic pain, skin reactions, syncope, vaginal haemorrhage
- **Conception and Contraception** Cream and pessaries may damage latex condoms and diaphragms.
- **Pregnancy**
  - **Dose adjustments** Pregnant women need a longer duration of treatment, usually about 7 days, to clear the infection.
Econazole nitrate

- **INDICATIONS AND DOSE**
  
  **GYNO-PEVARYL® ONCE**
  
  **Vaginal and vulval candidiasis**
  
  ▶️ BY VAGINA
  
  - Child: 1 pessary for 1 dose, pessary to be inserted at night, dose to be repeated once if necessary

  **GYNO-PEVARYL® PESSARY**
  
  **Vaginal and vulval candidiasis**
  
  ▶️ BY VAGINA
  
  - Child: 1 pessary daily for 3 days, pessary to be inserted at night, course can be repeated once if necessary

- **CAUTIONS**
  
  Avoid intravaginal preparations (particularly those that require use of an applicator) in young girls who are not sexually active, unless there is no alternative

- **SIDE-EFFECTS**
  
  ▶️ Common or very common Skin reactions
  
  ▶️ Uncommon Vaginal burning
  
  ▶️ Frequency not known Angioedema

- **CONCEPTION AND CONTRACEPTION**
  
  Cream and pessaries damage latex condoms and diaphragms.

- **PREGNANCY**
  
  Pregnant women need a longer duration of treatment, usually about 7 days, to clear the infection.

- **MEDICINAL FORMS**
  
  There can be variation in the licensing of different medicines containing the same drug.

  **Pessary**
  
  ▶️ Gyno-Pevaryl (Janssen-Cilag Ltd)

  Econazole nitrate 150 mg Gyno-Pevaryl Once 150mg vaginal pessary | 1 pessary £3.69
  
  Gyno-Pevaryl 150mg vaginal pessaries | 3 pessary £4.17

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Fenticonazole nitrate

- **INDICATIONS AND DOSE**
  
  **Vaginal and vulva candidiasis**
  
  ▶️ BY VAGINA USING CAPSULES
  
  - Child: 200 mg daily for 3 days, alternatively 600 mg daily for 1 dose, to be inserted at night

  ▶️ BY VAGINA USING CREAM
  
  - Child: 1 applicatorful twice daily for 3 days

  **DOSE EQUIVALENCE AND CONVERSION**
  
  ▶️ 1 applicatorful delivers a 5 g dose of fenticonazole 2%.

- **CAUTIONS**
  
  Avoid intravaginal preparations (particularly those that require use of an applicator) in young girls who are not sexually active, unless there is no alternative

- **SIDE-EFFECTS**
  
  Paraesthesia

- **CONCEPTION AND CONTRACEPTION**
  
  Intravaginal cream and vaginal capsules damage latex condoms and diaphragms.

- **MEDICINAL FORMS**
  
  There can be variation in the licensing of different medicines containing the same drug.

  **Cream**
  
  EXCIPIENTS: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), propylene glycol, woolfat and related substances (including lanolin).

  ▶️ Gynoxin (Recordati Pharmaceuticals Ltd)
  
  Fenticonazole nitrate 20 mg per 1 gram Gynoxin 2% vaginal cream | 30 gram £3.74

  **Capsule**
  
  EXCIPIENTS: May contain Hydroxybenzoates (parabens)

  ▶️ Gynoxin (Recordati Pharmaceuticals Ltd)
  
  Fenticonazole nitrate 200 mg Gynoxin 200mg vaginal capsules | 3 capsule £2.42
  
  Fenticonazole nitrate 600 mg Gynoxin 600mg vaginal capsules | 1 capsule £2.62

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Oral antifungal treatment should be avoided during pregnancy.

- **PATIENT AND CARER ADVICE**
  
  Medicines for Children leaflet: Clotrimazole for fungal infections
  
  www.medicinesforchildren.org.uk/clotrimazole-fungal-infections

- **EXCEPTIONS TO LEGAL CATEGORY**
  
  Brands for sale to the public include Canesten® Internal Cream.

**DOSE EQUIVALENCE AND CONVERSION**

- Child: 1 applicatorful twice daily for 3 days

- 1 applicatorful delivers a 5 g dose of fenticonazole 2%.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Cream**

EXCIPIENTS: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates

- Clotrimazole (Non-proprietary)
  
  Clotrimazole 10 mg per 1 gram Canesten 100mg pessaries | 6 pessary £3.85 DT = £3.85
  
  Clotrimazole 20 mg per 1 gram Canesten 200mg pessaries | 3 pessary £3.41 DT = £3.41
  
  Clotrimazole 50 mg Canesten Vaginal 500mg pessaries | 1 pessary £2.00 DT = £4.71

**Cream**

EXCIPIENTS: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates

- Clotrimazole (Non-proprietary)
  
  Clotrimazole 10 mg per 1 gram Canesten 1% cream | 20 gram £1.80 DT = £0.95
  
  Clotrimazole 20 mg per 1 gram Canesten 2% cream | 20 gram £2.26 DT = £0.95

- Canesten (clotrimazole) (Bayer Plc)
  
  Canesten Antifungal cream | 30 gram £2.85 DT = £2.31

**Pessary**

EXCIPIENTS: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates

- Canesten (clotrimazole) (Bayer Plc)
  
  Canesten 1% cream | 20 gram £1.80 DT = £0.95
  
  Canesten 2% cream | 20 gram £2.26 DT = £0.95
  
  Canesten Antifungal 1% cream | 20 gram £1.85 DT = £0.95

**Capsule**

EXCIPIENTS: May contain Hydroxybenzoates (parabens)

- Canesten (clotrimazole) (Bayer Plc)
  
  Canesten Capsules 500 mg | 10 capsule £8.50 DT = £4.75

**Capsule**

EXCIPIENTS: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates

- Canesten (clotrimazole) (Bayer Plc)
  
  Canesten Antifungal capsules 150 mg | 15 capsule £8.50 DT = £4.75
Immune system disorders and transplantation

Chapter 8
Immune system and malignant disease

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Immune system

1 Immune system disorders and transplantation

Immune response

Inflammatory bowel disease
Azathioprine p. 536, mercaptopurine p. 562, or once weekly methotrexate p. 563 are used to induce remission in unresponsive or chronically active Crohn’s disease. Azathioprine or mercaptopurine may also be helpful for retaining remission in frequently relapsing inflammatory bowel disease; once weekly methotrexate is used in Crohn’s disease when azathioprine or mercaptopurine are ineffective or not tolerated. Response to azathioprine or mercaptopurine may not become apparent for several months. Folic acid p. 594 should be given to reduce the possibility of methotrexate toxicity. Folic acid is usually given weekly on a different day to the methotrexate; alternative regimens may be used in some settings.

Ciclosporin p. 537 (cyclosporin) is a potent immunosuppressant and is markedly nephrotoxic. In children with severe ulcerative colitis unresponsive to other treatment, ciclosporin may reduce the need for urgent colorectal surgery.

Immunosuppressant therapy
Immunosuppressants are used to suppress rejection in organ transplant recipients and to treat a variety of chronic inflammatory and autoimmune diseases. Solid organ transplant patients are maintained on drug regimens, which may include antiproliferative drugs (azathioprine or mercaptopurine), calcineurin inhibitors (ciclosporin or tacrolimus p. 540), corticosteroids, or sirolimus p. 539. Choice is dependent on the type of organ, time after transplant, and clinical condition of the patient. Specialist management is required and other immunomodulators may be used to initiate treatment or to treat rejection.

Impaired immune responsiveness
Infections in the immunocompromised child can be severe and show atypical features. Specific local protocols should be followed for the management of infection. Corticosteroids may suppress clinical signs of infection and allow diseases such as sepsicaemia or tuberculosis to reach an advanced stage before being recognised. Children should be up-to-date with their childhood vaccinations before initiation of immunosuppressant therapy (e.g. before transplantation); vaccination with varicella-zoster vaccine is also necessary during this period—important: normal immunoglobulin administration should be considered as soon as possible after measles exposure, and varicella-zoster immunoglobulin (VZIG) is recommended for individuals who have significant chickenpox (varicella) exposure. Specialist advice should be sought on the use of live vaccines for those being treated with immunosuppressive drugs.

Antiproliferative immunosuppressants
Azathioprine is widely used for transplant recipients and it is also used to treat a number of auto-immune conditions, usually when corticosteroid therapy alone provides inadequate control. It is metabolised to mercaptopurine, and doses should be reduced (to one quarter of the original dose in children) when allopurinol p. 576 is given concurrently.

Mycophenolate mofetil is metabolised to mycophenolic acid which has a more selective mode of action than azathioprine.

There is evidence that compared with similar regimens incorporating azathioprine, mycophenolate mofetil may reduce the risk of acute rejection episodes; the risk of opportunistic infections (particularly due to tissue-invading cytomegalovirus) and the occurrence of blood disorders such as leucopenia may be higher. Children may suffer a high incidence of side-effects, particularly gastrointestinal effects, calling for temporary reduction in dose or interruption of treatment.

Cyclophosphamide p. 555 is less commonly prescribed as an immunosuppressant.

Corticosteroids and other immunosuppressants
The corticosteroids prednisolone p. 458 and dexamethasone p. 455 are widely used in paediatric oncology; they have a marked antitumour effect. Dexamethasone is preferred for acute lymphoblastic leukaemia whilst prednisolone may be used for Hodgkin’s disease, non-Hodgkin’s lymphoma, and B-cell lymphoma and leukaemia.

Dexamethasone is the corticosteroid of choice in paediatric supportive and palliative care. For children who are not receiving a corticosteroid as a component of their chemotherapy, dexamethasone may be used to reduce raised intracranial pressure, or to help control emesis when combined with an appropriate anti-emetic.

The corticosteroids are also powerful immunosuppressants. They are used to prevent organ transplant rejection, and in high dose to treat rejection episodes.

Ciclosporin (cyclosporin), a calcineurin inhibitor, is a potent immunosuppressant which is virtually non-
myelotoxic but markedly nephrotoxic. It may be used in organ and tissue transplantation, for prevention of graft rejection following bone marrow, kidney, liver, pancreas, heart, lung, and heart-lung transplantation, and for prophylaxis and treatment of graft-versus-host disease. Ciclosporin also has a role in steroid-sensitive and steroid-resistant nephrotic syndrome; in corticosteroid-sensitive nephrotic syndrome it may be given with prednisolone. Tacrolimus is also a calcineurin inhibitor. Although not chemically related to ciclosporin it has a similar mode of action and side-effects.

Other drugs used for Immune system disorders and transplantation
Anakinra, p. 662 • Chloroquine, p. 410 • Everolimus, p. 580 • Hydroxychloroquine sulfate, p. 662 • Rituximab, p. 550


IMMUNE SERA AND IMMUNOGLOBULINS

Antithymocyte immunoglobulin (rabbit)

28-Nov-2017

**INDICATIONS AND DOSE**

- **Prophylaxis of organ rejection in heart allograft recipients**
  - **By intravenous infusion**
    - Child: 1–2.5 mg/kg daily for 3–5 days, start treatment on day of transplantation, to be given over at least 6 hours
  - **Prophylaxis of organ rejection in renal allograft recipients**
    - **By intravenous infusion**
      - Child 1–7 years: 1–1.5 mg/kg daily for 3–9 days, start treatment on day of transplantation, to be given over at least 6 hours
  - **Treatment of corticosteroid-resistant allograft rejection in renal transplantation**
    - **By intravenous infusion**
      - Child 1–7 years: 1.5 mg/kg daily for 7–14 days, to be given over at least 6 hours

**DOSES AT EXTREMES OF BODY-WEIGHT**

- To avoid excessive dosage in obese patients, calculate dose on the basis of ideal body weight.

**CONTRA-INDICATIONS**

- Infection

**INTERACTIONS**

- **Common or very common**
  - Chills • diarrhoea • dysphagia • dyspnoea • fever • hypotension • infection • lymphopenia • myalgia • nausea • leukopenia malignant • neutropenia • reactivation of infection • secondary malignancy • sepsis • skin reactions • thrombocytopenia • vomiting
- **Uncommon**
  - Cytokine release syndrome • hepatic disorders • hypersensitivity • infusion related reaction

**SIDE-EFFECTS, FURTHER INFORMATION**

- Tolerability is increased by pretreatment with an intravenous corticosteroid and antihistamine; an antipyretic drug such as paracetamol may also be beneficial.

**PREGNANCY**

- Manufacturer advises use only if potential benefit outweighs risk—no information available.

**BREAST FEEDING**

- Manufacturer advises avoid—no information available.

**MONITORING REQUIREMENTS**

- Monitor blood count.

**DIRECTIONS FOR ADMINISTRATION**

- For continuous intravenous infusion reconstitute each vial with 5 mL water for injections to produce a solution of 5 mg/mL; gently rotate to dissolve. Dilute requisite dose with Glucose 5% or Sodium Chloride 0.9% to an approx. concentration of 0.5 mg/mL; begin infusion immediately after dilution; give through an in-line filter (pore size 0.22 micron); incompatible with unfractionated heparin and hydrocortisone in glucose infusion—precipitation reported.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

- Immunosuppressive therapy for kidney transplant in children and young people (October 2017) NICE TA482

- Antithymocyte immunoglobulin (rabbit) is not recommended as an initial treatment to prevent organ rejection in patients having a kidney transplant. Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/TA482

**MEDITATIONAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

- Powder and solvent for solution for infusion
  - Thymoglobulin (Sanofi)
  - Antithymocyte immunoglobulin (rabbit) 25 mg Thymoglobulin 25mg powder and solvent for solution for infusion vials | 1 vial £158.77 (Hospital only)

**IMMUNOSUPPRESSANTS**

Azathioprine

13-Jun-2018

**INDICATIONS AND DOSE**

- Severe ulcerative colitis • Severe Crohn’s disease
  - **By mouth**
    - Child 2–7 years: Initially 2 mg/kg once daily, then increased if necessary up to 2.5 mg/kg once daily
  - Systemic lupus erythematosus • Vasculitis • Autoimmune conditions usually when corticosteroid therapy alone has proved inadequate
  - **By mouth**
    - Child: Initially 1 mg/kg daily, then adjusted according to response to 3 mg/kg daily, consider withdrawal if no improvement within 3 months; maximum 3 mg/kg per day

- Suppression of transplant rejection
  - **By mouth, or by intravenous infusion**
    - Child: Maintenance 1–3 mg/kg daily, adjusted according to response, consult local treatment protocol for details, oral route preferred, but if oral route is not possible then can be given by intravenous infusion, the total daily dose may alternatively be given in 2 divided doses

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- Manufacturer advises reduce dose to one-quarter of the usual dose with concurrent use of allopurinol.

**CAUTIONS**

- Reduced thiopurine methyltransferase activity

**INTERACTIONS**

- **Appendix 1: azathioprine**

**SIDE-EFFECTS**

- **GENERAL SIDE-EFFECTS**
  - **Common or very common**
    - Bone marrow depression (dose-related) • increased risk of infection • leucopenia • thrombocytopenia
  - **Uncommon**
    - Anaemia • hepatic disorders • hypersensitivity • pancreatitis
  - Rare or very rare
    - Agranulocytosis • alopecia • bone marrow disorders • diarrhoea • gastrointestinal disorders • neoplasms • photosensitivity reaction • pneumonitis • severe cutaneous adverse reactions (SCARS)
Frequency not known Nodular regenerative hyperplasia - sinusoidal obstruction syndrome

SPECIFIC SIDE-EFFECTS
With oral use Nausea

SIDE-EFFECTS, FURTHER INFORMATION Side-effects may require drug withdrawal.

Hypersensitivity reactions Hypersensitivity reactions (including malaise, dizziness, vomiting, diarrhoea, fever, rigors, myalgia, arthralgia, rash, hypotension and renal dysfunction) call for immediate withdrawal.

Neutropenia and thrombocytopenia Neutropenia is dose-dependent. Management of neutropenia and thrombocytopenia requires careful monitoring and dose adjustment.

ALLERGY AND CROSS-SENSITIVITY Contra-indicated in hypersensitivity to mercaptopurine.

PREGNANCY Transplant patients immunosuppressed with azathioprine should not discontinue it on becoming pregnant. However, there have been reports of premature birth and low birth-weight following exposure to azathioprine, particularly in combination with corticosteroids. Spontaneous abortion has been reported following maternal or paternal exposure. Azathioprine is teratogenic in animal studies. The use of azathioprine during pregnancy needs to be supervised in specialist units. Treatment should not generally be initiated during pregnancy.

BREAST FEEDING Present in milk in low concentration. No evidence of harm in small studies—use if potential benefit outweighs risk.

HEPATIC IMPAIRMENT Manufacturer advises caution (impaired metabolism)—monitor liver function and complete blood count more frequently in those with severe impairment.

Dose adjustments Manufacturer advises use doses at lower end of the dose range in hepatic failure; reduce dose if hepatic or haematological toxicity occur.

RENAI IMPAIRMENT Dose adjustments Reduce dose.

PRE-TREATMENT SCREENING Thiopurine methyltransferase The enzyme thiopurine methyltransferase (TPMT) metabolises thiopurine drugs (azathioprine, mercaptopurine, thioguanine); the risk of myelosuppression is increased in patients with reduced activity of the enzyme, particularly for the few individuals in whom TPMT activity is undetectable. Consider measuring TPMT activity before starting azathioprine, mercaptopurine, or thioguanine therapy. Patients with absent TPMT activity should not receive thiopurine drugs; those with reduced TPMT activity may be treated under specialist supervision.

MONITORING REQUIREMENTS
Monitor for toxicity throughout treatment.
Monitor full blood count weekly (more frequently with higher doses or if severe renal impairment) for first 4 weeks (manufacturer advises weekly monitoring for 8 weeks but evidence of practical value unsatisfactory), thereafter reduce frequency of monitoring to at least every 3 months.
Blood tests and monitoring for signs of myelosuppression are essential in long-term treatment.

DIRECTIONS FOR ADMINISTRATION
With intravenous use Consult local treatment protocol for details. For intravenous injection, reconstitute 50 mg with 5–15 mL Water for Injections; give over at least 1 minute. For intravenous infusion, reconstitute 50 mg with 5–15 mL Water for Injections; dilute requisite dose to a concentration of 0.25–2.5 mg/mL in Glucose 5% or Sodium Chloride 0.9%. Intravenous injection is alkaline and very irritating. Intravenous route should therefore be used only if oral route not feasible and discontinued as soon as oral route can be tolerated. To reduce irritation flush line with infusion fluid.

PRESCRIBING AND DISPENSING INFORMATION The RCPCH and NPPG recommend that, when a liquid special of azathioprine is required, the following strength is used: 50 mg/5 mL.

PATIENT AND CARER ADVICE Bone marrow suppression Patients and their carers should be warned to report immediately any signs or symptoms of bone marrow suppression e.g. inexplicable bruising or bleeding, infection.


Medicines for Children leaflet: Azathioprine for severe atopic eczema www.medicinesforchildren.org.uk/azathioprine-severe-atopic-eczema-0

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

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IMMUNOSUPPRESSANTS > CALCINEURIN INHIBITORS AND RELATED DRUGS

Ciclosporin
(Cyclosporin)

DRUG ACTION Ciclosporin inhibits production and release of lymphokines, thereby suppressing cell-mediated immune response.

INDICATIONS AND DOSE
Refractory ulcerative colitis
| BY MOUTH |
| Child 2-17 years: Initially 2 mg/kg twice daily (max. per dose 5 mg/kg twice daily), dose adjusted according to blood-ciclosporin concentration and response |
| BY INTRAVENOUS INFUSION |
| Child 3-17 years: Initially 0.5–1 mg/kg twice daily, dose adjusted according to blood-ciclosporin concentration and response |

Short-term treatment of severe atopic dermatitis where conventional therapy ineffective or inappropriate (administered on expert advice)
| BY MOUTH |
| Child: Initially 1.25 mg/kg twice daily (max. per dose 2.5 mg/kg twice daily) usual maximum duration of 8 weeks but may be used for longer under specialist supervision, if good initial response not continued |

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| BY MOUTH |
| Child: Initially 1.25 mg/kg twice daily (max. per dose 2.5 mg/kg twice daily) usual maximum duration of 8 weeks but may be used for longer under specialist supervision, if good initial response not continued |
Immune system disorders and transplantation

achieved within 2 weeks, increase dose rapidly up to maximum

Short-term treatment of very severe atopic dermatitis where conventional therapy ineffective or inappropriate (administered on expert advice)

- **BY MOUTH**
  - Child: 2.5 mg/kg twice daily usual maximum duration of 8 weeks but may be used for longer under specialist supervision

Severe psoriasis where conventional therapy ineffective or inappropriate (administered on expert advice)

- **BY MOUTH**
  - Child: Initially 1.25 mg/kg twice daily (max. per dose 2.5 mg/kg twice daily), increased gradually to maximum if no improvement within 1 month, initial dose of 2.5 mg/kg twice daily justified if condition requires rapid improvement; discontinue if inadequate response after 3 months at the optimum dose; max. duration of treatment usually 1 year unless other treatments cannot be used

Prevention of graft rejection following bone-marrow, kidney, liver, pancreas, heart, lung, and heart-lung transplantation Prevention and treatment of graft-versus-host disease

- **BY MOUTH**
  - Child: 3 mg/kg twice daily, dose can be increased if necessary in corticosteroid-resistant disease; for maintenance reduce to lowest effective dose according to whole blood-ciclosporin concentrations, proteinuria, and renal function

**DOSE ADJUSTMENTS DUE TO INTERACTIONS**

- With oral use Manufacturer advises increase dose by 50% or switch to intravenous administration with concurrent use of octreotide

**SIDE-EFFECTS**

- **GENERAL SIDE-EFFECTS**
  - Common or very common
    - Headache
    - Nausea
    - Vomiting
    - Seizure
    - Tremor
    - Fatigue
    - Appetite decreased
    - Haemolytic anaemia
    - Muscle weakness
    - Gastrointestinal discomfort
    - Electrolyte imbalance
    - Renal impairment (renal structural changes — proteinuria, and renal function

- **SPECIFIC SIDE-EFFECTS**
  - Rare or very rare
    - Gynaecomastia
    - Anaphylactic shock
    - Idiopathic intracranial hypertension
    - Multifocal motor neuropathy
    - Muscle weakness
    - Pancreatitis
    - Gingival hyperplasia
    - Seizure
    - Tremor
    - Vomiting

- **CONTRA-INDICATIONS**
  - Abnormal baseline renal function (in non-transplant indications) - malignancy (in non-transplant indications) - uncontrolled hypertension (in non-transplant indications) - uncontrolled infections (in non-transplant indications)

- **CAUTIONS**
  - Hyperuricaemia - in atopic dermatitis, active herpes simplex infections — allow injection to clear before starting (if they occur during treatment withdraw if severe)
  - In atopic dermatitis, Staphylococcus aureus skin infections — not absolute contra-indication providing controlled (but avoid erythromycin unless no other alternative) - in psoriasis; patients with malignant or pre-malignant conditions of skin only after appropriate treatment (and if no other option) - in uveitis, Behcet’s syndrome (monitor neurological status) - lymphoproliferative disorders (discontinue treatment) - malignancy

**MONITORING REQUIREMENTS**

- Monitor whole blood ciclosporin concentration (tough level dependent on indication — consult local treatment protocol for details)
- In long-term management of nephrotic syndrome, perform renal biopsies every 1–2 years

**DIRECTIONS FOR ADMINISTRATION**

- With oral use Mix solution with orange or apple juice, or other soft drink (to improve taste) immediately before taking (and rinse with more to ensure total dose). Do not mix with grapefruit juice. Total daily dose should be taken in 2 divided doses.
With intravenous use For intermittent intravenous infusion, dilute to a concentration of 0.5–2.5 mg/ml with Glucose 5% or Sodium Chloride 0.9%; give over 2–6 hours; not to be used with PVC equipment. Observe patient for signs of anaphylaxis for at least 30 minutes after starting infusion and at frequent intervals thereafter.

PRESCRIBING AND DISPENSING INFORMATION
Brand name prescribing. Prescribing and dispensing of ciclosporin should be by brand name to avoid inadvertent switching. If it is necessary to switch a patient to a different brand of ciclosporin, the patient should be monitored closely for changes in blood-ciclosporin concentration, serum creatinine, blood pressure, and transplant function (for transplant indications). Sandimmun® capsules and oral solution are available direct from Novartis for patients who cannot be transferred to a different oral preparation.

PATIENT AND CARER ADVICE
Patients and carers should be counselled on the administration of different formulations of ciclosporin. Manufacturer advises avoid excessive exposure to UV light, including sunlight. In psoriasis and atopic dermatitis, avoid use of UVB or PUVA.

Medicines for Children leaflet: Ciclosporin for nephrotic syndrome
With systemic use www.medicinesforchildren.org.uk/ciclosporin-nephrotic-syndrome-0

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Solution for infusion
CAUTIONARY AND ADVISORY LABELS
EXCIPIENTS: May contain Alcohol, polyoxy castor oils

- Deximune (Dexcel-Pharma Ltd)
  - Ciclosporin 50 mg | 30 capsule (POM) £25.60 DT = £35.97
  - Ciclosporin 100 mg | 30 capsule (POM) £48.90 DT = £68.28
- Neoral (Novartis Pharmaceuticals UK Ltd)
  - Ciclosporin 10 mg | 60 capsule (POM) £18.25 DT = £18.25
  - Ciclosporin 25 mg | 30 capsule (POM) £18.37 DT = £18.37
  - Ciclosporin 50 mg | 30 capsule (POM) £35.97 DT = £35.97
- Ciclosporin 100 mg | 30 capsule (POM)
  - Neoral 100 mg capsules | 30 capsule (POM)

- Sandimmun (Novartis Pharmaceuticals UK Ltd)
  - Ciclosporin 25 mg | 30 capsule (POM) £29.58 DT = £18.37
  - Ciclosporin 50 mg | 30 capsule (POM) £57.92 DT = £35.97
- Capsorin (Morningside Healthcare Ltd)
  - Ciclosporin 100 mg capsule | 10 capsule (POM) £109.93 DT = £68.28
  - Capimune (Morningside Healthcare Ltd)

Capsule
CAUTIONARY AND ADVISORY LABELS
EXCIPIENTS: May contain Ethanol, ethyl lactate, propylene glycol

- Capimune (Morningside Healthcare Ltd)
  - Ciclosporin 25 mg | 30 capsule (POM) £11.14 DT = £18.37
  - Ciclosporin 50 mg | 30 capsule (POM) £21.80 DT = £35.97
  - Ciclosporin 100 mg | 30 capsule (POM) £41.59 DT = £68.28
- Deximune (Dexcel-Pharma Ltd)
  - Ciclosporin 25 mg | 30 capsule (POM) £11.05 DT = £18.37

Sirolimus
16-Nov-2017

DRUG ACTION
Sirolimus is a non-calcineurin inhibiting immunosuppressant.

INDICATIONS AND DOSE
As a component of immunosuppressive therapy for renal transplantation in children and adolescents only if intolerance necessitates the withdrawal of a calcineurin inhibitor.

BY MOUTH
Child: (consult local protocol)

DOSE EQUIVALENCE AND CONVERSION
The 500 microgram tablet is not bioequivalent to the 1 mg and 2 mg tablets. Multiples of 500 microgram tablets should not be used as a substitute for other tablet strengths.

UNLICENSED USE
Not licensed for use in children.

CAUTIONS
Hyperlipidaemia · increased susceptibility to infection (especially urinary-tract infection) · increased susceptibility to lymphoma and other malignancies, particularly of the skin (limit exposure to UV light)

INTERACTIONS
Appendix 1: sirolimus

SIDE-EFFECTS
- Common or very common Abdominal pain · anaemia · arthralgia · ascites · constipation · diabetes mellitus · diarrhoea · dyslipidaemia · electrolyte imbalance · embolism and thrombosis · fever · haemolytic uraemic syndrome · haemorrhage · headache · healing impaired · hyperglycaemia · hypertension · increased risk of infection · leucopenia · lymphatic vessel disorders · menstrual cycle irregularities · nausea · neoplasms · neutropenia · oedema · osteonecrosis · ovarian cyst · pain · pancreatitis · pericardial effusion · proteinuria · respiratory disorders · sepsis · skin reactions · stomatitis · tachycardia · thrombocytopenia
- Uncommon Antibiotic associated colitis · focal segmental glomerulosclerosis · hepatic failure · nephrotic syndrome · pancytopenia · post transplant lymphoproliferative disorder
- Frequency not known Posterior reversible encephalopathy syndrome (PRES)
CONCEPTION AND CONTRACEPTION  Effective contraception must be used during treatment and for 12 weeks after stopping.

PREGNANCY  Avoid unless essential—toxicity in animal studies.

BREAST FEEDING  Discontinue breast-feeding.

HEPATIC IMPAIRMENT  Manufacturer advises caution (risk of increased exposure). Dose adjustments  In adults, manufacturer advises maintenance dose reduction in severe impairment—consult product literature.

MONITORING REQUIREMENTS  Monitor whole blood-sirolimus trough concentration.

PATIENT AND CARER ADVICE  Patient or carers should be advised on how to administer sirolimus. Patients should be advised to avoid excessive exposure to UV light.

NATIONAL FUNDING/ACCESS DECISIONS  NICE decisions

Immunosuppressive therapy for kidney transplant in children and young people (October 2017) NICE TA482

Sirolimus is not recommended as an initial treatment to prevent organ rejection in patients having a kidney transplant. Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop. www.nice.org.uk/guidance/TA482

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Oral solution EXCIPIENTS: May contain Ethanol

Rapamune (Pfizer Ltd)

Sirolimus 1 mg per 1 ml Rapamune 1mg/ml oral solution sugar-free 60 ml £162.41 DT = £162.41

Tablet

Rapamune (Pfizer Ltd)

Sirolimus 500 microgram Rapamune 0.5mg tablets 30 tablet £69.00 DT = £69.00

Sirolimus 1 mg Rapamune 1mg tablets 30 tablet £86.49 DT = £86.49

Sirolimus 2 mg Rapamune 2mg tablets 30 tablet £172.98 DT = £172.98

Tacrolimus 19-Mar-2018

DRUG ACTION  Tacrolimus is a calcineurin inhibitor.

INDICATIONS AND DOSE

ADOPORT

Prophylaxis of graft rejection following liver transplantation, starting 12 hours after transplantation

BY MOUTH

Neonate: Initially 150 micrograms/kg twice daily.

Child: Initially 150 micrograms/kg twice daily

Prophylaxis of graft rejection following kidney transplantation, starting within 24 hours of transplantation

BY MOUTH

Neonate: Initially 150 micrograms/kg twice daily.

Child: Initially 150 micrograms/kg twice daily, a lower initial dose of 100 micrograms/kg twice daily has been used in adolescents to prevent very high ‘tough’ concentrations

Prophylaxis of graft rejection following heart transplantation following antibody induction, starting within 5 days of transplantation

BY MOUTH

Neonate: Initially 50–150 micrograms/kg twice daily.

Child: Initially 50–150 micrograms/kg twice daily

Prophylaxis of graft rejection following heart transplantation without antibody induction, starting within 12 hours of transplantation

BY MOUTH

Neonate: Initially 150 micrograms/kg twice daily, dose to be given as soon as clinically possible (8–12 hours after discontinuation of intravenous infusion).

Child: Initially 150 micrograms/kg twice daily, dose to be given as soon as clinically possible (8–12 hours after discontinuation of intravenous infusion)

Allograft rejection resistant to conventional immunosuppressive therapy

BY MOUTH

Child: Seek specialist advice

MODIGRAF

Prophylaxis of graft rejection following liver transplantation, starting 12 hours after transplantation

BY MOUTH

Neonate: Initially 150 micrograms/kg twice daily.

Child: Initially 150 micrograms/kg twice daily

Prophylaxis of graft rejection following kidney transplantation, starting within 24 hours of transplantation

BY MOUTH

Neonate: Initially 150 micrograms/kg twice daily.

Child: Initially 150 micrograms/kg twice daily

Prophylaxis of graft rejection following heart transplantation following antibody induction, starting within 5 days of transplantation

BY MOUTH

Neonate: Initially 50–150 micrograms/kg twice daily.

Child: Initially 50–150 micrograms/kg twice daily

Prophylaxis of graft rejection following heart transplantation without antibody induction, starting within 12 hours of transplantation

BY MOUTH

Neonate: Initially 150 micrograms/kg twice daily, dose to be given as soon as clinically possible (8–12 hours after discontinuation of intravenous infusion).

Child: Initially 150 micrograms/kg twice daily, dose to be given as soon as clinically possible (8–12 hours after discontinuation of intravenous infusion)
Prophylaxis of graft rejection following heart transplantation without antibody induction, starting within 12 hours of transplantation
- BY CONTINUOUS INTRAVENOUS INFUSION
- Neonate: Initially 30–50 micrograms/kg daily for up to 7 days (then transfer to oral therapy), dose to be administered over 24 hours.
- Child: Initially 30–50 micrograms/kg daily for up to 7 days (then transfer to oral therapy), dose to be administered over 24 hours.

Allograft rejection resistant to conventional immunosuppressive therapy
- BY CONTINUOUS INTRAVENOUS INFUSION
- Child: Seek specialist advice (consult local protocol) **TACNI®**

Prophylaxis of graft rejection following liver transplantation, starting within 12 hours of transplantation
- BY MOUTH
- Neonate: Initially 150 micrograms/kg twice daily.
- Child: Initially 50–150 micrograms/kg twice daily.

Prophylaxis of graft rejection following kidney transplantation without antibody induction, starting within 5 days of transplantation
- BY MOUTH
- Neonate: Initially 50–150 micrograms/kg twice daily.
- Child: Initially 50–150 micrograms/kg twice daily.

Allograft rejection resistant to conventional immunosuppressive therapy
- BY MOUTH
- Child: Seek specialist advice **PROGRAF® CAPSULES**

Prophylaxis of graft rejection following liver transplantation, starting within 5 days of transplantation when oral route not appropriate
- BY CONTINUOUS INTRAVENOUS INFUSION
- Neonate: Initially 50 micrograms/kg daily for up to 7 days (then transfer to oral therapy), dose to be administered over 24 hours.
- Child: Initially 50–150 micrograms/kg daily for up to 7 days (then transfer to oral therapy), dose to be administered over 24 hours.

Prophylaxis of graft rejection following kidney transplantation, starting within 24 hours of transplantation when oral route not appropriate
- BY CONTINUOUS INTRAVENOUS INFUSION
- Neonate: Initially 75–100 micrograms/kg daily for up to 7 days (then transfer to oral therapy), dose to be administered over 24 hours.
- Child: Initially 75–100 micrograms/kg daily for up to 7 days (then transfer to oral therapy), dose to be administered over 24 hours.
Immune system disorders and transplantation

- **Adaprot®**, **Prograf®**, **Capzixon®** and **Tacni®** are immediate-release capsules that are taken twice daily, once in the morning and once in the evening;
- **Modigraf®** granules are used to prepare an immediate-release oral suspension which is taken twice daily, once in the morning and once in the evening;
- **Advagraf®** is a prolonged-release capsule that is taken once daily in the morning.

Switching between tacrolimus brands requires careful supervision and therapeutic monitoring by an appropriate specialist.

Important: **Envarsus®** is not interchangeable with other oral tacrolimus containing products; the MHRA has advised (June 2012) that oral tacrolimus products should be prescribed and dispensed by brand only.

- **CAUTIONS** Increased risk of infections • lymphoproliferative disorders • malignancies • neurotoxicity • QT-interval prolongation • UV light (avoid excessive exposure to sunlight and sunlamps)
- **INTERACTIONS** → Appendix 1: tacrolimus
- **SIDE-EFFECTS**
  - **GENERAL SIDE-EFFECTS**
    - Common or very common Alopecia • anaemia • anxiety • appetite decreased • arthralgias • ascites • asthenic conditions • bile duct disorders • confusion • consciousness impaired • constipation • coronary artery disease • cough • depression • diabetes mellitus • diarrhoea • dizziness • dysgraphia • dyslipidaemia • dyspnoea • electrolyte imbalance • embolism and thrombosis • eye disorder • febrile disorders • fluid imbalance • gastrointestinal discomfort • gastrointestinal disorders • gastrointestinal inflammatory disorders • haemorrhage • hallucination • headache • hepatic disorders • hyperglycaemia • hyperhidrosis • hypertension • hyperuricaemia • hypotension • increased risk of infection • ischaemia • joint disorders • leucocytosis • leucopenia • metabolic acidosis • mood altered • muscle spasms • nasal complaints • nausea • nephropathy • nervous system disorder • oedema • oral disorders • pain • peripheral neuropathy • peripheral vascular disease • primary transplant dysfunction • psychiatric disorder • renal impairment • renal tubular necrosis • respiratory disorders • seizure • sensation abnormal • skin reactions • sleep disorders • temperature alteration • thrombocytopenia • tinnitus • tremor • urinary tract disorder • urine abnormal • visual disorders • vomiting • weight changes
  - Uncommon Asthma • cardiac arrest • cardiomyopathy • cataract • central nervous system haemorrhage • chest discomfort • coagulation disorders • coma • dysmenorrhoea • encephalopathy • feeling abnormal • haemolytic anaemia • hearing impairment • heart failure • hypoglycaemia • hypoproteinaemia • influenza like illness • memory loss • multi organ failure • neutropenia • palpitations • pancreatitis • pancytopenia • paralysis • paresis • photosensitivity reaction • psychotic disorder • shock • speech disorder • stroke • ventricular hypertrophy
  - Rare or very rare Fall • hirsutism • mobility decreased • muscle tone increased • muscle weakness • pancreatic pseudocyst • pericardial effusion • QT interval prolongation • severe cutaneous adverse reactions (SCARs) • sinusoidal obstruction syndrome • thirst • ulcer
  - Frequency not known Agranulocytosis • neoplasms malignancy • neoplasms • polyomavirus-associated nephropathy • progressive multifocal leukoencephalopathy (PML) • pure red cell aplasia

**SPECIFIC SIDE-EFFECTS**

- With intravenous use Anaphylactoid reaction (due to excipient) • hypersensitivity

**SIDE-EFFECTS, FURTHER INFORMATION** Cardiomyopathy has been reported to occur primarily in children with tacrolimus blood trough concentrations much higher than the recommended maximum levels. Patients should be monitored by echocardiography for hypertrophic changes—consider dose reduction or discontinuation if these occur.

- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated if history of hypersensitivity to macrolides.
- **CONCEPTION AND CONCEPTION** Exclude pregnancy before treatment.
- **PREGNANCY** Avoid unless potential benefit outweighs risk—crosses the placenta and risk of premature delivery, intra-uterine growth restriction, and hyperkalaemia.
- **BREAST FEEDING** Avoid—present in breast milk (following systemic administration).
- **HEPATIC IMPAIRMENT** Manufacturer advises caution in severe impairment.
- **Dose adjustments** Manufacturer advises consider dose reduction in severe impairment.
- **MONITORING REQUIREMENTS**
  - After initial dosing, and for maintenance treatment, tacrolimus doses should be adjusted according to whole-blood concentration. Monitor whole blood-tacrolimus trough concentration (especially during episodes of diarrhoea)—consult local treatment protocol for details.
  - Monitor blood pressure, ECG (for hypertrophic changes—risk of cardiomyopathy), fasting blood-glucose concentration, haematological and neurological (including visual) and coagulation parameters, electrolytes, hepatic and renal function.
- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use For continuous intravenous infusion over 24 hours, dilute to a concentration of 4–100 micrograms/mL with Glucose 5% or Sodium Chloride 0.9%, to a total volume between 20–500mL. Tacrolimus is incompatible with PVC.
- **PRESCRIBING AND DISPENSING INFORMATION** The RCPCH and NPPG recommend that, when a liquid special of tacrolimus is required, the following strength is used: 5 mg/5 mL.
- **PROGRAF® INFUSION** Intravenous route should only be used if oral route is inappropriate.
- **PATIENT AND CARER ADVICE** Avoid excessive exposure to UV light including sunlight. Medicines for Children leaflet: Tacrolimus for prevention of transplant rejection www.medicinesforchildren.org.uk/tacrolimus-prevention-transplant-rejection
- **Driving and skilled tasks** With systemic use May affect performance of skilled tasks (e.g. driving).
- **NATIONAL FUNDING/ACCESS DECISIONS**
  - **NICE decisions**
    - Immunosuppressive therapy for kidney transplant in children and young people (October 2017) NICE TA482
      Immediate-release tacrolimus, when used as part of an immunosuppressive regimen, is recommended as an initial option to prevent organ rejection in patients having a kidney transplant. Treatment should be started with the least expensive product, but if this is not suitable, an alternative dosage form may be given. Tacrolimus granules for oral suspension (Modigraf®) should be used only if the manufacturer provides it at the same price or lower than that agreed with the Commercial Medicines Unit. Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop. www.nice.org.uk/guidance/TA482
  - Immunosuppressive therapy for kidney transplant in children and young people (October 2017) NICE TA482
Prolonged-release tacrolimus is not recommended as an initial treatment to prevent organ rejection in patients having a kidney transplant. Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/TA482

Scottish Medicines Consortium (SMC) decisions
The Scottish Medicines Consortium has advised (December 2010) that tacrolimus granules for suspension (Modigraf®) are accepted for restricted use within NHS Scotland in patients for whom tacrolimus is an appropriate choice of immunosuppressive therapy and where small changes (less than 500 micrograms) in dosing increments are required (such as, in paediatric patients) or in seriously ill patients who are unable to swallow tacrolimus capsules.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Granules

CAUTIONARY AND ADVISORY LABELS 13, 23
- **Modigraf (Astellas Pharma Ltd)**
  - Tacrolimus (as Tacrolimus monohydrate) 200 microgram Modigraf 0.2mg granules sachets sugar-free | 50 sachet [PDR] £71.30 DT + £71.30
  - Tacrolimus (as Tacrolimus monohydrate) 1 mg Modigraf 1mg granules sachets sugar-free | 50 sachet [PDR] £356.65 DT + £356.65

**Solution for infusion**
EXCIPIENTS: May contain Polyoxyl castor oils
- **Prograf (Astellas Pharma Ltd)**
  - Tacrolimus 5 mg per 1 ml Prograf 5mg/1ml solution for infusion ampoules | 10 ampoule [PDR] £584.51

**Capsule**
CAUTIONARY AND ADVISORY LABELS 23
- **Adoport (Sandz Ltd)**
  - Tacrolimus 500 microgram Adoport 0.5mg capsules | 50 capsule [PDR] £42.92 DT + £61.88
  - Tacrolimus 1 mg Adoport 1mg capsules | 50 capsule [PDR] £55.69 DT + £80.28 | 100 capsule [PDR] £111.36
  - Tacrolimus 5 mg Adoport 5mg capsules | 50 capsule [PDR] £205.74 DT + £296.58
- **Prograf (Astellas Pharma Ltd)**
  - Tacrolimus 500 microgram Prograf 500microgram capsules | 50 capsule [PDR] £61.88 DT + £61.88
  - Tacrolimus 1 mg Prograf 1mg capsules | 50 capsule [PDR] £80.28 DT + £80.28 | 100 capsule [PDR] £160.54
  - Tacrolimus 5 mg Prograf 5mg capsules | 50 capsule [PDR] £296.58 DT + £296.58

#### IMMUNOSUPPRESSANTS > MONOClonal ANTIBODIES

### Canakinumab

26-Jun-2018

**DRUG ACTION** Canakinumab is a recombinant human monoclonal antibody that selectively inhibits interleukin-1 beta receptor binding.

**INDICATIONS AND DOSE**

**Cryopyrin-associated periodic syndromes (specialist use only)**

- **BY SUBCUTANEOUS INJECTION**
  - Child 2-3 years (body-weight 7.5-14 kg): 4 mg/kg every 8 weeks, to be administered to the upper thigh, abdomen, upper arm or buttocks, additional doses may be considered if clinical response not achieved within 7 days—consult product literature
  - Child 4-17 years (body-weight 7.5-14 kg): 4 mg/kg every 8 weeks, to be administered to the upper thigh, abdomen, upper arm or buttocks, additional doses may be considered if clinical response not achieved within 7 days—consult product literature
● **PATIENT AND CARER ADVICE**  Manufacturer advises patients and carers should be instructed to seek medical advice if signs or symptoms suggestive of tuberculosis (including persistent cough, weight loss and subfebrile temperature) occur.

**Driving and skilled tasks**  Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness and drowsiness.

● **MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- Ilaris (Novartis Pharmaceuticals UK Ltd)
  Canakinumab 150 mg per 1 ml Ilaris 150mg/1ml solution for injection vials | 1 vial (£39,927.80)

**IMMUNOSUPPRESSANTS**  > **MONOCLONAL ANTIBODIES**  > **ANTI-LYMPHOCYTE**

| Basiliximab |
| 16-Nov-2017 |

● **DRUG ACTION**  Basiliximab is a monoclonal antibody that acts as an interleukin-2 receptor antagonist and prevents T-lymphocyte proliferation.

● **INDICATIONS AND DOSE**  Prophylaxis of acute rejection in allogeneic renal transplantation used in combination with ciclosporin and corticosteroid-containing immunosuppression regimens (specialist use only)

  → BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
  - Child: 1-17 years (body-weight up to 35 kg): Initially 10 mg, dose to be administered within 2 hours before transplant surgery, followed by 10 mg after 4 days, dose administered after transplant surgery, withheld second dose if severe hypersensitivity or graft loss occurs
  - Child: 1-17 years (body-weight: 35 kg and above): Initially 20 mg administered within 2 hours before transplant surgery, followed by 20 mg after 4 days, dose to be administered after surgery, withheld second dose if severe hypersensitivity or graft loss occurs

● **CAUTIONS**  Off-label use in cardiac transplantation—increased risk of serious cardiac side-effects

● **INTERACTIONS**  → Appendix 1: monoclonal antibodies

● **SIDE-EFFECTS**  Capillary leak syndrome · constipation · cytokine release syndrome · dyspnoea · fever · heart failure · hypersensitivity · hypertension · hypotrichosis · hypotension · increased risk of infection · myocardial infarction · pulmonary oedema · respiratory disorders · sepsis · skin reactions · sneezing · tachycardia

● **CONCESSION AND CONTRACEPTION**  Adequate contraception must be used during treatment and for 16 weeks after last dose.

● **PREGNANCY**  Manufacturer advises avoid—no information available.

● **BREAST FEEDING**  Manufacturer advises avoid—no information available.

● **DIRECTIONS FOR ADMINISTRATION**  For intravenous infusion, dilute reconstituted solution to a concentration not exceeding 400 micrograms/mL, with Glucose 5% or Sodium Chloride 0.9%; give over 20–30 minutes.

● **NATIONAL FUNDING/ACCESS DECISIONS**  

**NICE decisions**
- Immunosuppressive therapy for kidney transplant in children and young people (October 2017) NICE TA482
  Basiliximab, when used as part of an immunosuppressive regimen that includes a calcineurin inhibitor, is recomended as an initial option to prevent organ rejection in patients having a kidney transplant. The use of basiliximab with tacrolimus is outside the terms of the marketing authorisation. If this combination is prescribed, the prescriber should follow relevant professional guidance, taking full responsibility for the decision.

Informed consent should be obtained and documented.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/TA482

● **MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for solution for injection**
- Simulect (Novartis Pharmaceuticals UK Ltd)
  Basiliximab 10 mg Simulect 10mg powder and solvent for solution for injection vials | 1 vial (£104.28 Hospital only)

**IMMUNOSUPPRESSANTS**  > **PURINE SYNTHESIS INHIBITORS**

| Mycophenolate mofetil |
| 09-Mar-2018 |

● **INDICATIONS AND DOSE**  Prophylaxis of acute rejection in renal transplantation (in combination with a corticosteroid and ciclosporin) (under expert supervision)

  → BY MOUTH
  - Child: 600 mg/m² twice daily, consult local protocol for details; maximum 2 g per day

**Prophylaxis of acute rejection in renal transplantation (in combination with a corticosteroid and tacrolimus) (under expert supervision)**

  → BY MOUTH
  - Child: 300 mg/m² twice daily, consult local protocol for details; maximum 2 g per day

**Prophylaxis of acute rejection in hepatic transplantation (in combination with a corticosteroid and ciclosporin or tacrolimus) (under expert supervision)**

  → BY MOUTH
  - Child: 10 mg/kg twice daily, increased to 20 mg/kg twice daily, consult local protocol for details; maximum 2 g per day


**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID: UPDATED CONTRACEPTION ADVICE FOR MALE PATIENTS**

(FEBRUARY 2018)

Available clinical evidence does not indicate an increased risk of malformations or miscarriage in pregnancies where the father was taking mycophenolate medicines, however mycophenolate mofetil and mycophenolic acid are genotoxic and a risk cannot be fully excluded; for further information, see Conception and contraception and Patient and carer advice.

● **CAUTIONS**  Active serious gastro-intestinal disease (risk of haemorrhage, ulceration and perforation) · children (higher incidence of side-effects may call for temporary reduction of dose or interruption) · delayed graft function · increased susceptibility to skin cancer (avoid exposure to strong sunlight) · risk of hypogammaglobulinaemia or bronchiectasis when used in combination with other immunosuppressants
PATIENT AND CARER ADVICE

**PRESCRIBING AND DISPENSING INFORMATION**

**MONITORING REQUIREMENTS**

- Renal impairment: Monitor full blood count every week for 4 weeks then twice a month for 2 months then every month in the first year (consider interrupting treatment if neutropenia develops).

**PREScribing AND Dispensing INFORMATION**

- Tablets and capsules not appropriate for dose titration in children with body surface area less than 1.25 m².

**PATIENT AND CARER ADVICE**

Pregnancy prevention advice: The MHRA advises that prescribers should ensure that female patients understand the need to comply with the pregnancy prevention advice, and they should be informed to seek immediate medical attention if there is a possibility of pregnancy; male patients planning to conceive children should be informed of the implications of both immunosuppression and the effect of the prescribed medications on the pregnancy.

Bone marrow suppression: Patients should be warned to report immediately any signs or symptoms of bone marrow suppression e.g. infection or inescapable bruising or bleeding.


**NATIONAL FUNDING/ACCESS DECISIONS**

NICE decisions

- Immunosuppressive therapy for kidney transplant in children and young people (October 2017) NICE TA482

Mycophenolate mofetil, when used as part of an immunosuppressive regimen, is recommended as an initial option to prevent organ rejection in patients having a kidney transplant. Treatment should be started with the least expensive product, but if this is not suitable, an alternative dosage form may be given. The use of mycophenolate mofetil with tacrolimus is outside the terms of the marketing authorisation. If this combination is prescribed, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

[www.nice.org.uk/guidance/TA482](http://www.nice.org.uk/guidance/TA482)

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

  **Tablet**

  - Mycophenolate mofetil (Non-proprietary)
    - Mycophenolate mofetil 500 mg: Mycophenolate mofetil 500mg tablets | 50 tablet | £42.50 DT = £5.83
    - CellCept (Roche Products Ltd)
      - Mycophenolate mofetil 500 mg: CellCept 500mg tablets | 50 tablet | £82.26 DT = £5.83
      - Myfenax (Teva UK Ltd)
        - Mycophenolate mofetil 500 mg: Myfenax 500mg tablets | 50 tablet | £78.15 DT = £5.83
  
  **Oral suspension**

  - EXCIPIENTS: May contain Aspartame
    - CellCept (Roche Products Ltd)
      - Mycophenolate mofetil 200 mg per 1 ml: CellCept 1g/5ml oral suspension sugar-free | 175 ml | £115.16 DT = £115.16
      - Myfenax (Teva UK Ltd)
        - Mycophenolate mofetil 250 mg: Myfenax 250mg capsules | 100 capsule | £82.26 DT = £82.26
        - Myfenax (Teva UK Ltd)
          - Mycophenolate mofetil 250 mg: Myfenax 250mg capsules | 100 capsule | £78.15 DT = £82.26

- | DT = |
Malignant disease

1 Antibody responsive malignancy

ANTINEOPLASTIC DRUGS > MONOCLONAL ANTIBODIES

Blinatumomab

DRUG ACTION The anti-lymphocyte monoclonal antibodies cause lysis of B lymphocytes.

INDICATIONS AND DOSE
Relapsed or refractory Philadelphia chromosome-negative acute lymphoblastic leukaemia (initiated by a specialist)
- BY CONTINUOUS INTRAVENOUS INFUSION
- Child 1-17 years: (consult product literature)

CAUTIONS Aphasias, brain injuries (severe), cerebellar disease, dementia, elderly—limited information available
- epilepsy, paraparesis, Parkinson’s disease—patients may need pre-medication to minimise adverse reactions
- psychosis, seizure, severe hepatic impairment, severe renal impairment—stroke

CAUTIONS, FURTHER INFORMATION
- Pre-medication Manufacturer advises pre-medication with a corticosteroid and an anti-pyretic—consult product literature.
- Neurological events There is potentially a higher risk of neurological events in patients with clinically relevant CNS pathology—manufacturer advises caution.

INTERACTIONS ➔ Appendix 1: monoclonal antibodies

SIDE-EFFECTS
- Common or very common Abdominal pain, anaemia, aphasia, appetite decreased, arthralgia, chest pain, chills, cognitive disorder, confusion, constipation, cough, decreased leucocytes, diarrhoea, dizziness, dysphonia, electrolyte imbalance, encephalopathy, facial swelling, fatigue, fever, flushing, headache, hyperglycaemia, hypersensitivity, hypotension, hypertension, hypoalbuminaemia, hypotension—immune disorder—increased risk of infection—infusion related reaction, insomnia, leucocytosis, memory loss, nausea, neutropenia, oedema, pain, paraesthesia, rash, respiratory disorders, seizure, sepsis, tachycardia, thrombocytopenia, tremor—tumour lysis syndrome—vomiting—weight increased
- Uncommon Capillary leak syndrome, cranial nerve disorder, pancreatitis
- Frequency not known Device related infection, hypoxia, multi organ failure

SIDE-EFFECTS, FURTHER INFORMATION Pancreatitis Life-threatening or fatal cases of pancreatitis have been reported; manufacturer advises monitor for signs and symptoms of pancreatitis during treatment—temporary interruption or discontinuation may be required (consult product literature).

Cytokine release syndrome, infusion reactions and tumour lysis syndrome Life-threatening (including fatal) cases of cytokine release syndrome and tumour lysis syndrome have been reported in patients taking blinatumomab. Manufacturer advises monitor signs and symptoms of cytokine release syndrome and infusion reactions during treatment; temporary interruption or discontinuation may be required—consult product literature.

CONCEPTION AND CONTRACEPTION Manufacturer advises effective contraception during treatment and for at least 48 hours after treatment in women of child-bearing potential. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY Manufacturer advises avoid unless potential benefit outweighs risk—no information available; if exposed during pregnancy, monitor infant for B-cell depletion. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BRONCHOLOGY Manufacturer advises avoid during and for at least 48 hours after treatment—no information available.

HEPATIC IMPAIRMENT Manufacturer advises caution in severe impairment (no information available).

RENAL IMPAIRMENT Manufacturer advises caution in severe impairment—no information available.

MONITORING REQUIREMENTS Manufacturer advises neurological examination prior to the initiation of treatment and continued monitoring during treatment—consult product literature.

HANDLING AND STORAGE Manufacturer advises store in a refrigerator (2–8°C); consult product literature for storage conditions after reconstitution and dilution.

PATIENT AND CARER ADVICE A patient alert card should be provided. Educational materials should be provided to patients, carers and healthcare professionals to ensure blinatumomab is used in a safe and effective way, and to prevent the risk of medication errors and neurological events—consult product information.

Driving and skilled tasks Manufacturer advises patients and carers should be counselled about the effects on driving and performance of skilled tasks—increased risk of confusion, disorientation, co-ordination and balance disorders, seizures and disturbances in consciousness.

NATIONAL FUNDING/ACCESS DECISIONS
Scottish Medicines Consortium (SMC) decisions
SMC No. SMC2148

The Scottish Medicines Consortium has advised (April 2019) that blinatumomab (Blincyto®) is accepted for use within NHS Scotland as monotherapy for the treatment of paediatric patients aged 1 year or older with Philadelphia chromosome-negative CD19 positive B-cell precursor acute lymphoblastic leukaemia which is refractory or in relapse after receiving at least two prior therapies or in relapse after receiving prior allogeneic hematopoietic stem cell transplantation. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

All Wales Medicines Strategy Group (AWMSG) decisions
AWMSG No. 3169

The All Wales Medicines Strategy Group has advised (April 2019) that blinatumomab (Blincyto®) is recommended as an option for use within NHS Wales as monotherapy for the treatment of paediatric patients aged 1 year or older with Philadelphia chromosome-negative CD19 positive B-cell precursor acute lymphoblastic leukaemia which is refractory or in relapse after receiving at least two prior therapies or in relapse after receiving prior allogeneic haematopoietic stem cell transplantation. This recommendation applies only in circumstances where the approved Patient Access Scheme (PAS) is utilised or where the list/contract price is equivalent or lower than the PAS price.
Dinutuximab beta

**DRUG ACTION** Dinutuximab beta is a chimeric monoclonal antibody; it specifically targets the carbohydrate moiety of disialoganglioside 2, which is overexpressed on neuroblastoma cells.

**INDICATIONS AND DOSE**
- **High-risk neuroblastoma (specialist use only)**
  - By intravenous infusion
  - Child 1–17 years: consult product literature

**CONTRA-INDICATIONS** Acute grade 3 or 4, or severe chronic graft-versus-host disease

**CAUTIONS** Avoid vaccinations during and for at least 3 months after treatment and for 6 months after the last dose—no information available.

**INTERACTIONS** Appendix 1: monoclonal antibodies

**SIDE-EFFECTS**
- Common or very common: Abdominal distension, anaemia, anxiety, appetite decreased, ascites, capillary leak syndrome, chills, cough, cytokine release syndrome, decreased leucocytes, device related infection, dizziness, dyspnoea, electrolyte imbalance, eye disorders, eye inflammation, fever, fluid imbalance, gastrointestinal disorders, haematuria, headache, heart failure, hyperhidrosis, hypersensitivity, hypertension, hypertiglycaemia, hypoalbuminaemia, hypotension, hypoxia, increased risk of infection, left ventricular dysfunction, muscle spasms, nausea, neutropenia, oedema, oral disorders, pain, paraesthesia, pericardial effusion, peripheral neuropathy, photosensitization reaction, pulmonary oedema, renal impairment, respiratory disorders, seizure, sepsis, skin reactions, tachycardia, thrombocytopenia, tremor, urinary retention, urine abnormalities, vision disorders, vomiting, weight changes
- Uncommon: Disseminated intravascular coagulation, eosinophilia, hepatocellular injury, hypovolaemic shock, intracranial pressure increased, peripheral vascular disease, posterior reversible encephalopathy syndrome (PRES)

**CONCEPTION AND CONTRACEPTION**
- Manufactuer advises women of childbearing potential should use contraception during and for 6 months after stopping treatment. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**PREGNANCY**
- Manufactuer advises avoid—no information available. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**BREAST FEEDING**
- Manufacturer advises avoid during treatment and for 6 months after the last dose—no information available.

**MONITORING REQUIREMENTS**
- Manufacturer advises pre-treatment evaluation of pulse oximetry, bone marrow function, liver function and renal function—consult product literature for values required for treatment initiation.
- Manufacturer advises monitor circulatory and respiratory function—risk of capillary leak syndrome.
- Manufactuer advises monitor liver function and electrolytes regularly.

**HANDLING AND STORAGE** Manufacturer advises store in a refrigerator (2–8°C)—consult product literature for further information regarding storage conditions outside refrigerator and after preparation of the infusion.

**PATIENT AND CARER ADVICE**
- Driving and skilled tasks: Manufacturer advises patients should not use or drive machines during treatment.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**
- Dinutuximab beta for treating neuroblastoma (August 2018)

**Scottish Medicines Consortium (SMC) decisions**
- SMC No. SMC2105

The Scottish Medicines Consortium has advised (November 2018) that dinutuximab beta (Qarziba®) is recommended as an option for treating high-risk neuroblastoma in people aged 12 months and over whose disease has at least partially responded to induction chemotherapy, followed by myeloablative therapy and stem cell transplant, only if:
- they have not already had anti-GD2 immunotherapy, and
- the manufacturer provides dinutuximab beta according to the commercial arrangement.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/ta538

Scottish Medicines Consortium (SMC) decisions

**SMC No. SMC2105**

The Scottish Medicines Consortium has advised (November 2018) that dinutuximab beta (Qarziba®) is accepted for use within NHS Scotland for the treatment of high-risk neuroblastoma in patients aged 12 months and over whose disease has at least partially responded to induction chemotherapy, followed by myeloablative therapy and stem cell transplant, as well as patients with a history of relapsed or refractory neuroblastoma, with or without residual disease.

In patients with a history of relapsed or refractory disease and in patients who have not achieved a complete response after first line therapy, dinutuximab beta should be combined with interleukin-2.

This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for infusion**
- Excipients: May contain Polysorbates
  - Blinatumomab 38.5 microgram
  - Blinatumomab 38.5 microgram powder for concentrate and solution for infusion vials | 1 vial [Post] £2,017.00

**Antibody responsive malignancy**

547
Gemtuzumab ozogamicin

**Drug Action** Gemtuzumab ozogamicin is a monoclonal antibody that binds to CD33-expressing tumour cells to induce cell cycle arrest and apoptotic cell death.

**Indications and Dose**

- **CD33-positive acute myeloid leukaemia (specialist use only)**
  - **By Intravenous Infusion**
  - Child 15–17 years: (consult product literature)

**Caution** Adverse-risk cytogenetics (consider benefits and risks of treatment, consult product literature) - haematopoietic stem cell transplantation (increased risk of hepatotoxicity) - pre-medication recommended to minimise adverse reactions

**Side-effects**

- Common or very common: Anaemia - appetite decreased - ascites - chills - constipation - decreased leucocytes - diarrhoea - dyspnoea - fatigue - fever - gastrointestinal discomfort - gastrointestinal disorders - haemorrhage - headache - hepatic disorders - hyperbilirubinaemia - hyperglycaemia - hypertension - hypotension - infection - infusion related reaction (including fatal cases) - multi organ failure - nausea - neutropenia - oedema - pancytopenia - sinusoidal obstruction syndrome - skin reactions - stomatitis - tachycardia - thrombocytopenia - tumour lysis syndrome (including fatal cases) - vomiting

- Frequency not known: Interstitial pneumonia

**Prescribing and Dispensing Information**

- **Gemtuzumab ozogamicin for untreated acute myeloid leukaemia (November 2018) NICE TAs545**
- Gemtuzumab ozogamicin (Mylotarg®) with daunorubicin and cytarabine, is recommended as an option for untreated de novo CD33-positive acute myeloid leukaemia (AML), except acute promyelocytic leukaemia, in people 15 years and over, only if:
  - they start induction therapy when either the cytogenetic test confirms that the disease has favourable, intermediate or unknown cytogenetics (that is, because the test was unsuccessful) or when their cytogenetic test results are not yet available, and
  - they start consolidation therapy when their cytogenetic test confirms that the disease has favourable, intermediate or unknown cytogenetics (because the test was unsuccessful), and
  - the manufacturer provides gemtuzumab ozogamicin according to the commercial arrangement.

**National Funding/Access Decisions**

**NICE decisions**

- **Gemtuzumab ozogamicin for untreated acute myeloid leukaemia (November 2018) NICE TAs545**

**Scottish Medicines Consortium (SMC) decisions**

- **SMC No. SMC2089**

  The Scottish Medicines Consortium has advised (October 2018) that gemtuzumab ozogamicin (Mylotarg®) is accepted for restricted use within NHS Scotland as combination therapy with daunorubicin and cytarabine for the treatment of previously untreated, de novo CD33-positive acute myeloid leukaemia in patients aged 15 years and above with a favourable, intermediate or unknown cytogenetic profile.

**Medicinal Forms** There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for infusion**

- **Mylotarg (Pfizer Ltd)**
- Gemtuzumab ozogamicin 5 mg Mylotarg 5mg powder for concentrate for solution for infusion vials | 1 vial [500] £6,300.00 (Hospital only)
**Ipilimumab**

**Drug Action** Ipilimumab is a monoclonal antibody which causes T-cell activation resulting in tumour cell death.

**Indications and Dosage**

- **Melanoma (as monotherapy) (specialist use only)**
- **By Intravenous Infusion**
  - Child 12-17 years: 3 mg/kg every 3 weeks for 4 doses, for dose interruption or discontinuation of treatment due to immune-related side-effects—consult product literature

**Cautions, Further Information**

- **Cautions, Further Information** For full details consult product literature.

- **Interactions** → Appendix 1: monoclonal antibodies

- **Side-Effects**
  - **Rare or very rare** Myasthenia gravis - proteinuria - thyroiditis
  - **Frequency not known** Cytomegalovirus infection reactivation

**Important Safety Information**

MHRA/CHM Advice: Ipilimumab (Yervoy®): Reports of Cytomegalovirus (CMV) Gastrointestinal Infection or Reactivation (January 2019)

There have been post-marketing cases of gastrointestinal CMV infection or reactivation in ipilimumab-treated patients reported to have corticosteroid-refractory immune-related colitis, including fatal cases.

Patients should be advised to contact their healthcare professional immediately at the onset of symptoms of colitis. Possible causes, including infections, should be investigated; a stool infection work-up should be performed and patients screened for CMV. For patients with corticosteroid-refractory immune-related colitis, use of an additional immunosuppressive agent should only be considered if other causes are excluded using viral PCR on biopsy, and eliminating other viral, bacterial, and parasitic causes.

**Side-Effects, Further Information** A corticosteroid can be used after starting ipilimumab, to treat immune-related reactions.

- **Conception and Contraception** Use effective contraception.

- **Pregnancy** Manufacturer advises avoid unless potential benefit outweighs risk—toxicity in animal studies.

- **Breast Feeding** Manufacturer advises avoid—present in milk in animal studies.

- **Hepatic Impairment** Manufacturer advises caution if bilirubin greater than 3 times upper limit of normal range or if transaminases equal to or greater than 5 times upper limit of normal range (limited information available).

- **Monitoring Requirements**
  - Manufacturer advises monitor liver function tests and thyroid function prior to initiation of treatment and before each dose.
  - Manufacturer advises monitor for signs or symptoms of immune-related side-effects and gastrointestinal perforation—consult product literature.

- **Directions for Administration** Manufacturer advises for intravenous infusion, give undiluted or dilute to a concentration of 1–4 mg/mL with Glucose 5% or Sodium Chloride 0.9%; give over 90 minutes.

- **Prescribing and Dispensing Information** Infusion-related side-effects have been reported; premedication with paracetamol and an antihistamine is recommended.

- **Handling and Storage** Manufacturer advises store in a refrigerator (2–8 °C) and protect from light—consult product literature for further information regarding storage conditions outside refrigerator and after preparation of the infusion.

**National Funding/Access Decisions**

Scottish Medicines Consortium (SMC) decisions

SMC No. SMC2094

The Scottish Medicines Consortium has advised (October 2018) that ipilimumab (Yervoy®) is accepted for use within NHS Scotland as monotherapy for the treatment of advanced (unresectable or metastatic) melanoma in adolescents 12 years of age and older. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

All Wales Medicines Strategy Group (AWMSG) decisions

AWMSG No. 3604

The All Wales Medicines Strategy Group has advised (November 2018) that ipilimumab (Yervoy®) is recommended as an option for use within NHS Wales as monotherapy for the treatment of advanced (unresectable or metastatic) melanoma in adolescents 12 to 17 years of age. This recommendation applies only in circumstances where the approved Wales Patient Access Scheme (WPAS) is utilised or where the list/contract price is equivalent or lower than the WPAS price.

**Medicinal Forms** There can be variation in the licensing of different medicines containing the same drug.

**Solution for Infusion**

Electrolytes: May contain Sodium

- **Yervoy** (Bristol-Myers Squibb Pharmaceuticals Ltd)

Ipilimumab 5 mg per 1 ml

Yervoy 50mg/10ml concentrate for solution for infusion vials | 1 vial £3,750.00 (Hospital only)

Yervoy 200mg/40ml concentrate for solution for infusion vials | 1 vial £15,000.00 (Hospital only)
Anti-lymphocyte monoclonal antibodies

**DRUG ACTION** The anti-lymphocyte monoclonal antibodies cause lysis of B lymphocytes.

**IMPORTANT SAFETY INFORMATION**
All anti-lymphocyte monoclonal antibodies should be given under the supervision of an experienced specialist, in an environment where full resuscitation facilities are immediately available.

**SIDE-EFFECTS**
- **Common or very common** Alopecia, anaemia, arthralgia, asthenia, back pain, constipation, depression, diarrhoea, fever, headache, hypersensitivity (discontinue permanently), hypertension, increased risk of infection, infusion related reaction, leukopenia, myocardial infarction, neutropenia, night sweats, thrombocytopenia, vomiting.
- **Uncommon** Progressive multifocal leukoencephalopathy (PML).
- **Frequency not known** Anaphylactic reaction.

**INFUSION-RELATED SIDE-EFFECTS** In rare cases infusion reactions may be fatal. Infusion-related side-effects occur predominantly during the first infusion. Patients should receive premedication before administration of anti-lymphocyte monoclonal antibodies to reduce these effects—consult product literature for details of individual regimens. The infusion may have to be stopped temporarily and the infusion-related effects treated—consult product literature for appropriate management.

**Cytokine release syndrome** Fatalities following severe cytokine release syndrome (characterised by severe dyspnoea) and associated with features of tumour lysis syndrome have occurred after infusions of anti-lymphocyte monoclonal antibodies. Patients with a high tumour burden as well as those with pulmonary insufficiency or infiltration are at increased risk and should be monitored very closely (and a slower rate of infusion considered).

**PRE-TREATMENT SCREENING** All patients should be screened for hepatitis B before treatment.

**CAUTIONS, FURTHER INFORMATION** For full details on cautions, consult product literature or local treatment protocol.

- Hepatitis B infection and reactivation. Hepatitis B infection and reactivation (including fatal cases) have been reported in patients taking rituximab. Patients with positive hepatitis B serology should be referred to a liver specialist for monitoring and initiation of antiviral therapy before treatment initiation; treatment should not be initiated in patients with evidence of current hepatitis B infection until the infection has been adequately treated. Patients should be closely monitored for clinical and laboratory signs of active hepatitis B infection during treatment and for up to a year following the last infusion (consult product literature).
- **INTERACTIONS** → Appendix 1: monoclonal antibodies
- **SIDE-EFFECTS**
  - **Common or very common** Angioedema, anxiety, appetite decreased, arthralgia, bone marrow disorders, bursitis, cancer pain, cardiac disorder, chest pain, chills, conjunctivitis, cough aggravated, dizziness, dysphagia, dyspnoea, ear pain, gastrointestinal discomfort, gastrintestinal disorders, hepatitis B, hypercholesterolaemia, hyperglycaemia, hyperhidrosis, hypocalcaemia, hypotension, insomnia, lamination disorder, malaise, migraine, multi organ failure, muscle tone increased, myalgia, nausea, nerve disorders, oedema, oral disorders, oropharyngeal pain, osteoarthritis, pain, respiratory disorders, sensation abnormal, sepsis, skin reactions, throat irritation, tinnitus, vasodilatation, weight decreased.
  - **Uncommon** Asthma, coagulation disorder, haemolytic anaemia, heart failure, hypoxia, ischaemic heart disease, lymphadenopathy, taste altered.
  - **Rare or very rare** Cytokine release syndrome, facial paralysis, hepatitis B reactivation, renal failure, Stevens-Johnson syndrome (discontinue), toxic epidermal necrolysis (discontinue), tumour lysis syndrome, vasculitis, vision disorders.
  - **Frequency not known** Hearing loss, hypogammaglobulinaemia, infective thrombosis, irritability, posterior reversible encephalopathy syndrome (PRES), psychiatric disorder, seizure, skin papilloma.

**INDICATIONS AND DOSE**
- Post-transplantation lymphoproliferative disease (under expert supervision).
- Non-Hodgkin’s lymphoma (under expert supervision).

**BY INTRAVENOUS INFUSION**
- Child: Patients should receive premedication before each dose (consult product literature for details) (consult local protocol).

**UNLICENSED USE** Not licensed for use in children.

**CAUTIONS** History of cardiovascular disease; in adults exacerbation of angina, arthralgia, and heart failure have been reported; transient hypotension occurs frequently during infusion (anti-hypertensives may need to be withheld for 12 hours before infusion).
Cytotoxic responsive malignancy

Cytotoxic drugs

Overview

The management of childhood cancer is complex and is generally confined to specialist regional centres and some associated shared-care units.

Cytotoxic drugs have both anti-cancer activity and the potential for damage to normal tissue. In children, chemotherapy is almost always started with curative intent, but may be continued as palliation if the disease is refractory.

Chemotherapy with a combination of two or more cytotoxic drugs aims to reduce the development of resistance and to improve cytotoxic effect. Treatment protocols generally incorporate a series of treatment courses at defined intervals with clear criteria for starting each course, such as adequate bone-marrow recovery and renal or cardiac function. The principal component of treatment for leukaemias in children is cytotoxic therapy, whereas solid tumours may be managed with surgery or radiotherapy in addition to chemotherapy.

Only medical or nursing staff who have received appropriate training should administer parenteral cytotoxics. In most instances central venous access will be required for the intravenous administration of cytotoxics to children; care is required to avoid the risk of extravasation (see Side-effects of Cytotoxic Drugs and their Management).

Cytotoxic drug handling guidelines

- Trained personnel should reconstitute cytotoxics
- Reconstitution should be carried out in designated pharmacy areas
- Protective clothing (including gloves, gowns, and masks) should be worn
- The eyes should be protected and means of first aid should be specified
- Pregnant staff should avoid exposure to cytotoxic drugs (all females of child-bearing age should be informed of the reproductive hazard)
- Use local procedures for dealing with spillages and safe disposal of waste material, including syringes, containers, and absorbent material
- Staff exposure to cytotoxic drugs should be monitored

Solution for infusion

EXCIPIENTS: May contain Polysorbates

MabThera (Roche Products Ltd)

Rituximab 10 mg per 1 ml MabThera 100mg/10ml concentrate for solution for infusion vials | 2 vial \( \text{POD} \) £346.25

MabThera 500mg/50ml concentrate for solution for infusion 1 vial \( \text{POD} \) £873.15

Rixathon (Sandoz Ltd)

Rituximab 10 mg per 1 ml Rixathon 100mg/10ml concentrate for solution for infusion vials | 2 vial \( \text{POD} \) £314.33 (Hospital only)

Rixathon 500mg/50ml concentrate for solution for infusion vials | 1 vial \( \text{POD} \) £785.84 (Hospital only) | 2 vial \( \text{POD} \) £1.571.67 (Hospital only)

Truxima (Napp Pharmaceuticals Ltd)

Rituximab 10 mg per 1 ml Truxima 100mg/10ml concentrate for solution for infusion vials | 2 vial \( \text{POD} \) £314.33

Truxima 500mg/50ml concentrate for solution for infusion vials | 1 vial \( \text{POD} \) £785.84

Intrathecal chemotherapy

A Health Service Circular (HSC 2008/001) provides guidance on the introduction of safe practice in NHS Trusts where intrathecal chemotherapy is administered; written local guidance covering all aspects of national guidance should be available. Support for training programmes is also available. Copies, and further information may be obtained from: Department of Health PO Box 777 London SE1 6XH Fax: 01623 724524 It is also available from the Department of Health website (www.dh.gov.uk).

Safe systems for cytotoxic medicines

Safe system requirements for cytotoxic medicines:

- Cytotoxic drugs for the treatment of cancer should be given as part of a wider pathway of care that is co-ordinated by a multi-disciplinary team
- Cytotoxic drugs should be prescribed, dispensed and administered only in the context of a written protocol or treatment plan
- Injectable cytotoxic drugs should only be dispensed if they are prepared for administration
- Oral cytotoxic medicines should be dispensed with clear directions for use

Cytotoxic drugs: important safety information

Risks of incorrect dosing of oral anti-cancer medicines

The National Patient Safety Agency has advised (January 2008) that the prescribing and use of oral cytotoxic medicines should be carried out to the same standard as parenteral cytotoxic therapy. Standards to be followed to achieve this include:

- non-specialists who prescribe or administer on-going oral cytotoxic medication should have access to written protocols and treatment plans, including guidance on the monitoring and treatment of toxicity;
- staff dispensing oral cytotoxic medicines should confirm that the prescribed dose is appropriate for the patient. Patients should have written information that includes details of the intended oral anti-cancer regimen, the treatment plan, and arrangements for monitoring, taken from the original protocol from the initiating hospital. Staff dispensing oral cytotoxic medicines should also have access to this information, and to advice from an experienced cancer pharmacist in the initiating hospital.

Cytotoxic drug doses

Doses of cytotoxic drugs are determined using a variety of different methods including age, body-surface area, or body-weight. Alternatively, doses may be fixed. Doses may be further adjusted following consideration of a patient’s neutrophil count, renal and hepatic function, and history of previous adverse effects to the cytotoxic drug. Doses may also differ depending on whether a drug is used alone or in combination.

Because of the complexity of dosage regimens in the treatment of malignant disease, dose statements have been omitted from many of the drug entries in this chapter.

Cytotoxic drugs: effect on pregnancy and reproductive function

Most cytotoxic drugs are teratogenic and should not be administered during pregnancy, especially during the first trimester. Exclude pregnancy before treatment with cytotoxic drugs. Considerable caution is necessary if a pregnant woman presents with cancer requiring chemotherapy, and specialist advice should always be sought.
Contraceptive advice should be given to men and women before cytotoxic therapy begins (and should cover the duration of contraception required after therapy has ended). Alkylating drugs can have an adverse effect on gametogenesis, which may be reversible particularly in females. Regimens that do not contain an alkylating drug or procarbazine may have less effect on fertility, but those with an alkylating drug or procarbazine carry the risk of causing permanent male sterility (there is no effect on potency). Pretreatment counselling and consideration of sperm storage may be appropriate. Women are less severely affected, though the span of reproductive life may be shortened by the onset of a premature menopause. No increase in fetal abnormalities or abortion rate has been recorded in patients who remain fertile after cytotoxic chemotherapy. Amenorrhoea may occur, which also may be reversible.

**Management of cytotoxic drug side-effects**

**Gastro-intestinal effects**
Management of gastrointestinal effects of cytotoxic drugs includes the use of antacids, H₂-receptor antagonists, and proton pump inhibitors to protect the gastric mucosa, laxatives to treat constipation, and enteral and parenteral nutritional support.

**Oral mucositis**
Good oral hygiene keeps the mouth clean and moist and helps to prevent mucositis; prevention is more effective than treatment of the complication. Good oral hygiene measures for children over 6 months include brushing teeth with a soft small brush with fluoride toothpaste 2–3 times daily, and rinsing the mouth frequently. Daily fluoride supplements can be used on the advice of the child’s dental team. For children under 6 months or when it is not possible to brush teeth, carers should be instructed how to clean the mouth using an oral sponge moistened with water or with an antimicrobial solution such as diluted chlorhexidine. Mucositis related to chemotherapy can be extremely painful and may, in some circumstances, require opioid analgesia. Secondary infection with candida is frequent; treatment with a systemically absorbed antifungal, such as fluconazole p. 389, is effective.

**Nausea and vomiting**
Nausea and vomiting cause considerable distress to many children who receive chemotherapy, and to a lesser extent abdominal radiotherapy, and may lead to refusal of further treatment; prophylaxis of nausea and vomiting is therefore extremely important. Symptoms may be acute (occurring within 24 hours of treatment), delayed (first occurring more than 24 hours after treatment), or anticipatory (occurring prior to subsequent doses). Delayed and anticipatory symptoms are more difficult to control than acute symptoms and require different management. Susceptibility to nausea and vomiting may increase with repeated exposure to the cytotoxic drug.

Drugs may be divided according to their emetogenic potential and some examples are given below, but the symptoms vary according to the dose, to other drugs administered, and to the individual’s susceptibility to emetogenic stimuli.

**Mildly emetogenic treatment**— fluorouracil, etoposide p. 569, low doses of methotrexate p. 563, the vinca alkaloids, and abdominal radiotherapy.

**Moderately emetogenic treatment**— carboplatin p. 567, doxorubicin hydrochloride p. 559, intermediate and low doses of cyclophosphamide p. 555, mitoxantrone p. 560, and high doses of methotrexate.

**Highly emetogenic treatment**— cisplatin p. 568, dacarbazine p. 556, and high doses of alkylating drugs.

Anti-emetic drugs, when given regularly, help prevent or ameliorate emesis associated with chemotherapy in children.

**Prevention of acute symptoms**: For patients at low risk of emesis, pretreatment with a 5HT₁-receptor antagonist may be of benefit. For patients at high risk of emesis or when other treatment is inadequate, a 5HT₁-receptor antagonist is often highly effective. The addition of dexamethasone p. 455 and other anti-emetics may also be required.

**Prevention of delayed symptoms**: Dexamethasone, given by mouth, is the drug of choice for preventing delayed symptoms; it is used alone or with metoclopramide hydrochloride p. 269. Due to the risks of neurological side-effects, metoclopramide hydrochloride should only be used in children as a second-line option. The 5HT₁-receptor antagonists may have a role in preventing uncontrolled symptoms. Aprepitant p. 269 given in combination with a 5HT₁-receptor antagonist (with or without dexamethasone) is licensed for prevention of nausea and vomiting associated with highly and moderately emetogenic cancer chemotherapy.

**Prevention of anticipatory symptoms**: Good symptom control is the best way to prevent anticipatory symptoms. Lorazepam p. 228 can be helpful for its amnesiac, sedative, and anxiolytic effects.

**Bone-marrow suppression**
All cytotoxic drugs except vincristine sulfate p. 570 and bleomycin p. 566 cause bone-marrow suppression. This commonly occurs 7 to 10 days after administration, but is delayed for certain drugs, such as melphalan p. 557. Peripher al blood counts must be checked before each treatment. The duration and severity of neutropenia can be reduced by the use of granulocyte-colony stimulating factors; their use should be reserved for children who have previously experienced severe neutropenia.

Cytotoxic drugs may be contra-indicated in children with acute infection; any infection should be treated before, or when starting, cytotoxic drugs. Infection in a child with neutropenia requires immediate broad-spectrum antibacterial treatment that covers all likely pathogens. Appropriate bacteriological investigations should be conducted as soon as possible. Children taking cytotoxic drugs who have signs or symptoms of infection (or their carers) should be advised to seek prompt medical attention. All children should be investigated and treated under the supervision of an appropriate oncology or haematology specialist. Antifungal treatment may be required in a child with prolonged neutropenia or fever lasting longer than 4–5 days. Chickenpox and measles can be particularly hazardous in immunocompromised children. Varicella-zoster immunoglobulin p. 796 is indicated if the child does not have immunity against varicella and has had close contact with infectious chickenpox or herpes zoster. Antiviral prophylaxis can be considered in addition to varicella-zoster immunoglobulin or as an alternative if varicella–zoster immunoglobulin is inappropriate. If an immunocompromised child has come into close contact with an infectious individual with measles, normal immunoglobulin p. 796 should be given.

**Alopecia**
Reversible hair loss is a common complication, although it varies in degree between drugs and individual patients.

**Long-term and delayed toxicity**
Cytotoxic drugs may produce specific organ-related toxicity in children (e.g. cardiotoxicity with doxorubicin hydrochloride or nephrotoxicity with cisplatin and ifosfamide p. 556). Manifestations of such toxicity may not appear for several months or even years after cancer treatment. Careful follow-up of survivors of childhood cancer is therefore vital; national and local guidelines have been developed to facilitate this.
Thromboembolism
Venous thromboembolism can be a complication of cancer itself, but chemotherapy increases the risk.

Tumour lysis syndrome
Tumour lysis syndrome occurs secondary to spontaneous or treatment related rapid destruction of malignant cells. Patients at risk of tumour lysis syndrome include those with non- Hodgkin’s lymphoma (especially if high grade and bulky disease), Burkitt’s lymphoma, acute lymphoblastic leukaemia and acute myeloid leukaemia (particularly if high white blood cell counts or bulky disease), and occasionally those with solid tumours. Pre-existing hyperuricaemia, dehydration and renal impairment are also predisposing factors. Features, include hyperkalaemia, hyperuricaemia, and hyperphosphataemia with hypocalcaemia; renal damage and arrhythmias can follow. Early recognition of patients at risk, and initiation of prophylaxis or therapy for tumour lysis syndrome, is essential.

Treatment of cytotoxic drug side-effects
Hyperuricaemia
Hyperuricaemia, which may be present in high-grade lymphoma and leukaemia, can be markedly worsened by chemotherapy and is associated with acute renal failure.

Allopurinol p. 576 is used routinely in children at low to moderate risk of hyperuricaemia. It should be started 24 hours before treatment; patients should be adequately hydrated (consideration should be given to omitting phosphate and potassium from hydration fluids). The dose of mercaptopurine p. 562 or azathioprine p. 536 should be reduced if allopurinol is given concomitantly.

Rasburicase p. 576 is a recombinant urate oxidase used in children who are at high-risk of developing hyperuricaemia. It rapidly reduces plasma uric acid concentration and may be of particular value in preventing complications following treatment of leukaemias or bulky lymphomas.

Methotrexate-induced mucositis and myelosuppression
Folinic acid p. 575 (given as calcium folinate) is used to counteract the folate-antagonist action of methotrexate and thus speed recovery from methotrexate-induced mucositis or myelosuppression (‘folinic acid rescue’).

The calcium salt of levofoinic acid p. 575, a single isomer of folinic acid, is also used following methotrexate administration. The dose of calcium levofolinate is generally half that of calcium folinate.

The disodium salts of folinic acid and levofolinic acid are also used for rescue therapy following methotrexate administration.

The efficacy of high dose methotrexate is enhanced by delaying initiation of folinic acid for at least 24 hours, local protocols define the correct time. Folinic acid is normally continued until the plasma-methotrexate concentration falls to 45–90 nanogrammes/mL (100–200 nanomol/litre).

In the treatment of methotrexate p. 562 overdose, folinate should be administered immediately; other measures to enhance the elimination of methotrexate are also necessary.

Urothelial toxicity
Haemorrhagic cystitis is a common manifestation of urothelial toxicity which occurs with the oxazaphosphorines, cyclophosphamide p. 555 and ifosfamide p. 556; it is caused by the metabolite acrolein. Adequate hydration is essential to reduce the risk of urothelial toxicity. Mesna p. 574 reacts specifically with acrolein in the urinary tract, preventing toxicity. Mesna is given for the same duration as cyclophosphamide or ifosfamide. It is generally given intravenously; the dose of mesna is equal to or greater than that of the oxazaphosphorine.

Cytotoxic antibiotics
Cytotoxic antibiotics are widely used. Many act as radiomimetics and simultaneous use of radiotherapy should be avoided because it may markedly increase toxicity.

Daunorubicin p. 558, doxorubicin hydrochloride p. 559, and epirubicin hydrochloride p. 560 are anthracycline antibiotics. Mitoxantrone p. 560 (mitozantrone) is an anthracycline derivative.

Epirubicin hydrochloride and mitoxantrone are considered less toxic than the other anthracycline antibiotics, and may be suitable for children who have received high cumulative doses of other anthracyclines.

Vincadalkoids
The vincadalkoids, vindristine sulfate p. 569 and vincristine sulfate p. 570 are used to treat a variety of cancers including leukaemias, lymphomas, and some solid tumours.

Antimetabolites
Antimetabolites are incorporated into new nuclear material or they combine irreversibly with cellular enzymes and prevent normal cellular division. Cytarabine p. 561, fludarabine phosphate p. 562, mercaptopurine p. 562, methotrexate, and tioguanine p. 566 are commonly used in paediatric chemotherapy.

Other antineoplastic drugs
Asparaginase
Asparaginase is used almost exclusively in the treatment of acute lymphoblastic leukaemia. Hypersensitivity reactions may occur and facilities for the management of anaphylaxis should be available. A number of different preparations of asparaginase exist and only the product specified in the treatment protocol should be used.

ANTINEOPLASTIC DRUGS > ALKYLATING AGENTS

### Busulfan

(Busulphan)

- **INDICATIONS AND DOSE**
  - Conditioning treatment before haematopoietic progenitor cell transplantation
    - By mouth, or by intravenous infusion
    - Child: (consult local protocol)
  - **DOSES AT EXTREMES OF BODY-WEIGHT**
    - Dose may need to be calculated based on body surface area or adjusted ideal body weight in obese patients—consult product literature.

### IMPORTANT SAFETY INFORMATION

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

- **CAUTIONS**
  - Avoid in Acute porphyrias p. 624: high dose (antiepileptic prophylaxis required) - history of seizures (antiepileptic prophylaxis required) - ineffective once in blast crisis phase - previous progenitor cell transplant (increased risk of hepatic veno-occlusive disease) - previous radiation therapy (increased risk of hepatic veno-occlusive disease) - risk of second malignancy - three or more cycles of chemotherapy (increased risk of hepatic veno-occlusive disease)

- **INTERACTIONS**
  - Appendix 1: alkylating agents

- **SIDE-EFFECTS**

  **GENERAL SIDE-EFFECTS**

  > Common or very common
    - Alopecia - diarrhoea - hepatic disorders - nausea - respiratory disorders - sinusoidal obstruction syndrome - skin reactions - thrombocytopenia - vomiting
Monitor full blood count regularly throughout treatment.

**MEDICINAL FORMS**

- **Busulfan (Non-proprietary)**
  - Busulfan 2 mg | 25 tablet [PO] £69.02 DT + £69.02

**HEPATIC IMPAIRMENT**

- With intravenous use Anaemia • appetite decreased • arrhythmias • ascites • jaundice • cardiomegaly • chest pain • confusion • constipation • cough • depression • diziness • dyspnoea • dysuria • electrolyte imbalance • embolism and thrombosis • fever • gastrointestinal discomfort • haemorrhage • headache • hiccups • hyperglycaemia • hypokalaemia • hypertension • hypoalbuminaemia • hypotension • increased risk of infection • insomnia • mucositis • myalgia • nervous system disorder • neutropenia • oedema • pain • pancytopenia • pericardial effusion • pericarditis • reactivation of infections • renal disorder • renal impairment • stomatitis • vasodilatation • weight increased
- uncommon
- with oral use Amnorrhea (may be reversible) • bone marrow disorders • cardiovascular disorder • delayed puberty • hyperbilirubinaemia • infertility male • leucopenia • leukaemia • menopausal disorders • oral disorders • ovarian and fallopian tube disorders • testicular atrophy
- uncommon
- with intravenous use Capillary leak syndrome • delirium • encephalopathy • hallucination • hypoxia • intracranial haemorrhage
- rare or very rare
- with oral use Dry mouth • erythema nodosum • gynaecomastia • myasthenia gravis • radiation injury • Sjögren’s syndrome
- frequency not known
- with intravenous use Hypogonadism • ovarian failure • premature menopause • sepsis

**SIDE-EFFECTS, FURTHER INFORMATION**

- Lung toxicity
  - Discontinue if lung toxicity develops.
- Secondary malignancy
  - Use of busulfan is associated with an increased incidence of secondary malignancy.
- Fluid retention
  - Alkylating drugs can cause fluid retention with oedema and dilutional hyponatraemia in younger children; the risk of this complication is higher in the first 2 days and also when given with concomitant vinca alkaloids.

**CONCEPTION AND CONTRACEPTION**

- Manufacturers advise effective contraception during and for 6 months after treatment in men or women. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.
- PREGNANCY
  - Avoid (teratogenic in animals). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.
- Lactation
  - Discontinue breast-feeding.
- Hepatic Impairment
  - Manufacturer advises caution.

**MEDITICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

**Tablet**

- **Busulfan**
  - Busulfan 2 mg | 25 tablet [PO] £69.02 DT + £69.02

**Solution for infusion**

- **Busulfan (Non-proprietary)**
  - Busulfan 6 mg per 1 ml Busulfan 60mg/10ml concentrate for solution for infusion vials | 8 vial [PHS] £1.529.50–£2.054.80 (Hospital only)
  - Busilvex (Pierre Fabre Ltd)
  - Busulfan 6 mg per 1 ml Busulfan 60mg/10ml concentrate for solution for infusion ampoules | 8 ampoule [PHS] £1.610.00 (Hospital only)

**Chlorambucil**

- **INDICATIONS AND DOSE**
  - Hodgkin’s disease | Non-Hodgkin’s lymphoma
  - BY MOUTH
  - Child: (consult local protocol)

- **SIDE-EFFECTS**
  - Common or very common Anaemia • bone marrow disorders • diarrhoea • gastrointestinal disorder • leucopenia • neoplasms • neutropenia • oral ulceration • seizures • thrombocytopenia • vomiting
  - uncommon
  - rare or very rare Cystitis • fever • hepatic disorders • movement disorders • muscle twitching • peripheral neuropathy • respiratory disorders • severe cutaneous adverse reactions (SCARs) • tremor
  - frequency not known
  - SIDE-EFFECTS, FURTHER INFORMATION
    - Secondary malignancy
      - Use of chlorambucil is associated with an increased incidence of acute leukaemia, particularly with prolonged use.
    - Skin reactions
      - Manufacturer advises assessing continued use if rash occurs—has been reported to progress to Stevens-Johnson syndrome and toxic epidermal necrolysis.
    - Fluid retention
      - Alkylating drugs can cause fluid retention with oedema and dilutional hyponatraemia in younger children; the risk of this complication is higher in the first 2 days and also when given with concomitant vinca alkaloids.
  - CONCEPTION AND CONTRACEPTION
  - Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.
  - PREGNANCY
    - Avoid. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.
  - Lactation
    - Discontinue breast-feeding.
  - Hepatic Impairment
    - Manufacturer advises caution—monitor for signs and symptoms of toxicity.
  - Dose adjustments
    - Manufacturer advises consider dose reduction in severe impairment—limited information available.
  - MONITORING REQUIREMENTS
    - Monitor full blood count regularly throughout treatment.
Cytotoxic responsive malignancy 555

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Chlorambucil for nephrotic syndrome www.medicinesforchildren.org.uk/chlorambucil-nephrotic-syndrome-0

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Tablet
- Chlorambucil (Non-proprietary)
  Chlorambucil 2 mg Chlorambucil 2mg tablets | 25 tablet PSt £42.87 DT = £42.87

INDICATIONS AND DOSE
Acute lymphoblastic leukaemia, non-Hodgkin’s lymphoma, retinoblastoma, neuroblastoma, rhabdomyosarcoma, soft-tissue sarcomas, Ewing tumour, neuroectodermal tumours (including medulloblastoma), infant brain tumours, ependymoma, high-dose conditioning for bone marrow transplantation, lupus nephritis
- BY MOUTH, OR BY INTRAVENOUS INFUSION
- Child: (consult local protocol)

Stomatose-sensitive nephrotic syndrome
- BY MOUTH
- Child 3 months-17 years: 2–3 mg/kg daily for 8 weeks
- BY INTRAVENOUS INFUSION
- Child 3 months-17 years: 500 mg/m² once a month for 6 months

UNLICENSED USE
Not licensed for use in children.

IMPORTANT SAFETY INFORMATION
RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES
See Cytotoxic drugs p. 551.

CONTRA-INDICATIONS
Haemorrhagic cystitis

CAUTIONS
Avoid in Acute porphyrias p. 624, diabetes mellitus - previous or concurrent medistinal irradiation — risk of cardiotoxicity

INTERACTIONS
- Appendix 1: alkylating agents

SIDE-EFFECTS
GENERAL SIDE-EFFECTS
Common or very common
- Agranulocytosis - alopecia - anaemia - asthenia - bone marrow disorders - cystitis - decreased leucocytes - fever - haemolytic uraemic syndrome - haemorrhage - hepatic disorders - immunosuppression - increased risk of infection - mucosal abnormalities - neutropenia - progressive multifocal leukoencephalopathy (PML) - reactivation of infections - sperm abnormalities - thrombocytopenia

Uncommon
- Appetite decreased - embolism and thrombosis - flushing - hypersensitivity - ovarian and fallopian tube disorders - sepsis

RARE or very rare

Frequency not known

SPECIFIC SIDE-EFFECTS
- With intravenous use: Infusion site necrosis - injection site necrosis

SIDE-EFFECTS, FURTHER INFORMATION
Haemorrhagic cystitis
- A urinary metabolite of cyclophosphamide, acrolein, can cause haemorrhagic cystitis; this is a rare but serious complication that may be prevented by increasing fluid intake for 24–48 hours after intravenous injection. Mesna can also help prevent cystitis.

Secondary malignancy
- As with all cytotoxic therapy, treatment with cyclophosphamide is associated with an increased incidence of secondary malignancies.

Fluid retention
- Alkylating drugs can cause fluid retention with oedema and dilutional hyponaetraemia in younger children; the risk of this complication is higher in the first 2 days and also with concomitant vinca alkaloids.

CONCEPTION AND CONTRACEPTION
Manufacturer advises effective contraception during and for at least 3 months after treatment in men or women. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY
Avoid. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING
Discontinue breast-feeding during and for 36 hours after stopping treatment.

HEPATIC IMPAIRMENT
Manufacturer advises caution (risk of decreased cyclophosphamide activation and increased risk of veno-occlusive liver disease).

Dose adjustments
Manufacturer advises consider dose adjustment in severe impairment—consult product literature.

RENAL IMPAIRMENT
Dose adjustments
Reduce dose—consult local treatment protocol for details.

DIRECTIONS FOR ADMINISTRATION
Consult local treatment protocol for details.

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Cyclophosphamide for nephrotic syndrome www.medicinesforchildren.org.uk/cyclophosphamide-nephrotic-syndrome-0

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral suspension, oral solution, solution for injection, solution for infusion

Tablet
CAUTIONARY AND ADVISORY LABELS 25, 27
- Cyclophosphamide (Non-proprietary)
  Cyclophosphamide (as Cyclophosphamide monohydrate)
  50 mg Cyclophosphamide 50mg tablets | 100 tablet PSt £139.00 DT = £139.00
- Cytoxan (Imported (United States))
  Cyclophosphamide 25 mg Cytoxan 25mg tablets | 100 tablet PSt £

Powder for solution for injection
- Cyclophosphamide (Non-proprietary)
  Cyclophosphamide (as Cyclophosphamide monohydrate)
  500 mg Cyclophosphamide 500mg powder for solution for injection vials | 1 vial PSt £9.66 (Hospital only) | 1 vial PSt £9.66
  1 gram Cyclophosphamide 1g powder for solution for injection vials | 1 vial PSt £17.06 (Hospital only) | 1 vial PSt £17.06

Cytoxan (as Cyclophosphamide monohydrate)
  1 gram Cyclophosphamide 1g powder for solution for injection vials | 1 vial PSt £34.12 (Hospital only)
Dacarbazine

- **INDICATIONS AND DOSE**
  - Hodgkin's disease | Paediatric solid tumours
  - By intravenous injection, or by intravenous infusion
  - Child: consult local protocol

- **CAUTIONS**
  - Caution in handling—irritant to tissues

- **INTERACTIONS**
  - Appendix 1: alkylating agents

- **SIDE-EFFECTS**
  - Common or very common
    - Anaemia
    - Appetite decreased
    - Leucopenia
    - Nausea
    - Photosensitivity reaction
  - Rare or very rare
    - Agranulocytosis
    - Confusion
    - Diarrhoea
    - Photosensitivity reaction
    - Seizure
    - Visual impairment

- **CONCEPTION AND CONTRAINDICATIONS**
  - Ensure effective contraception during and for at least 6 months after treatment in men or women. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **PREGNANCY**
  - Avoid (carcinogenic and teratogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**
  - Discontinue breast-feeding.

- **HEPATIC IMPAIRMENT**
  - Avoid in severe impairment.
  - Dose reduction may be required in combined renal and hepatic impairment.

- **RENAL IMPAIRMENT**
  - Avoid in severe impairment.
  - Dose reduction may be required in combined renal and hepatic impairment.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Dacarbazine is a component of a commonly used combination for Hodgkin’s disease (ABVD—doxorubicin [previously Adriamycin®], bleomycin, vinblastine, and dacarbazine).

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  **Powder for solution for infusion**
  - Dacarbazine (Non-proprietary)
    - Dacarbazine (as Dacarbazine citrate) 500 mg Dacarbazine 500mg powder for solution for infusion vials | 1 vial (POD) £37.50
    - Dacarbazine (as Dacarbazine citrate) 1 gram Dacarbazine 1g powder for solution for infusion vials | 1 vial (POD) £70.00
  - **Powder for solution for injection**
    - Dacarbazine (Non-proprietary)
      - Dacarbazine (as Dacarbazine citrate) 100 mg Dacarbazine 100mg powder for solution for injection vials | 10 vial (POD) £90.00
      - Dacarbazine (as Dacarbazine citrate) 200 mg Dacarbazine 200mg powder for solution for injection vials | 10 vial (POD) £160.00

Ifosfamide

- **INDICATIONS AND DOSE**
  - Rhabdomyosarcoma | Soft-tissue sarcomas | Ewing tumour | Germ cell tumour | Osteogenic sarcoma
  - By intravenous infusion
  - Child: consult local protocol

- **CONTRA-INDICATIONS**
  - Acute infection · urinary-tract infection · urinary-tract obstruction · urothelial damage

- **CAUTIONS**
  - Avoid in acute porphyrias p. 624

- **INTERACTIONS**
  - Appendix 1: alkylating agents

- **SIDE-EFFECTS**
  - Common or very common
    - Alopecia
    - Appetite decreased
    - Bone marrow disorders
    - Haemorrhage
    - Hepatic disorders
    - Infection
    - Leucopenia
    - Nausea
    - Reactivation of infection
    - Renal impairment
    - Thrombocytopenia
    - Vomiting
  - Uncommon
    - Cardiotoxicity
    - Diarrhoea
    - Hypotension
    - Oral disorders
  - Rare or very rare
    - Skin reactions

- **FREQUENCY NOT KNOWN**
  - Abdominal pain
  - Agranulocytosis
  - Amenorrhoea
  - Anaemia
  - Angina pectoris
  - Anorexia
  - Arrhythmias
  - Arthralgia
  - Asterixis
  - Behavioural abnormal
  - Blood disorders
  - Bone disorders
  - Cancer progression
capillary leak syndrome
  - Cardiac arrest
  - Cardiomyopathy
  - Chills
  - Conjunctivitis
  - Constipation
  - Cough
  - Deafness
  - Delirium
  - Delusions
  - Disseminated intravascular coagulation
  - Dysaesthesia
  - Dyspnoea
  - Electrolyte imbalance
  - Embolism
  - Encephalopathy
  - Eye irritation
  - Fatigue
  - Fever
  - Flushing
  - Gastritis
  - Gastrointestinal disorders
  - Growth retardation
  - Haemolytic anaemia
  - Heart failure
  - Hyperglycaemia
  - Hyperhidrosis
  - Hyperphosphaturia
  - Hypertension
  - Hypoxia
  - Immunosuppression
  - Infertility
  - Malaise
  - Mania
  - Memory loss
  - Metabolic acidosis
  - Movement disorders
  - Mucosal ulceration
  - Multi organ failure
  - Muscle complaints
  - Myocardial infarction
  - Nail disorder
  - Neurotoxicity
  - Nephritis
  - Neurotoxicity
  - Night sweats
  - Nystagmus
  - Oedema
  - Olfactory loss
  - Opioid withdrawal
  - Osteonecrosis
  - Ovarian failure
  - Pain
  - Pancreatitis
  - Panic attack
  - Peripheral neuropathy
  - Polydipsia
  - Premature menopause
  - Psychiatric disorders
  - Pulmonary hypertension
  - Pulmonary oedema
  - Radiation recall reaction
  - Respiratory disorders
  - Rhematoid arthritis
  - Secondary malignancy
  - Sensation abnormal
  - Sepsis
  - Severe cutaneous adverse reactions (SCARs)
  - SIADH
  - Sinusoidal obstruction syndrome
  - Sperm abnormalities
  - Stomatitis
  - Tumour lysis syndrome
  - Urinary disorders
  - Vascularitis
  - Vertigo
  - Visual impairment

- **SIDE-EFFECTS, FURTHER INFORMATION**
  - Urothelial toxicity
  - Mesna is routinely given with ifosfamide to reduce urothelial toxicity.

  **Secondary malignancy**
  - Use of ifosfamide is associated with an increased incidence of acute leukaemia.

  **Fluid retention**
  - Alkylation drugs can cause fluid retention with oedema and dilutional hyponatraemia in younger children; the risk of this complication is higher in the first 2 days and also when given with concomitant vinca alkaloids.

- **CONCEPTION AND CONTRAINDICATIONS**
  - Manufacturer advises avoid adequate contraception during and for at least 6 months after treatment in men or women. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **PREGNANCY**
  - Avoid (teratogenic and carcinogenic in animals). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**
  - Discontinue breast-feeding.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises avoid.

- **RENAL IMPAIRMENT**
  - Avoid.

- **MONITORING REQUIREMENTS**
  - Ensure satisfactory electrolyte balance and renal function before each course (risk of tubular dysfunction, Fanconi’s syndrome or diabetes insipidus if renal toxicity not treated promptly).

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  **Powder for solution for injection**
  - Ifosfamide (Non-proprietary)
    - Ifosfamide 1 gram Ifosfamide 1g powder for concentrate for solution for injection vials | 1 vial (POD) £115.79–£119.27
    - Ifosfamide 2 gram Ifosfamide 2g powder for concentrate for solution for injection vials | 1 vial (POD) £228.09–£234.94
Melphalan

- **INDICATIONS AND DOSE**
  
  High intravenous dose with haematopoietic stem cell transplantation in the treatment of childhood neuroblastoma and some other advanced embryonal tumours
  
  - BY INTRAVENOUS INFUSION
  - Child: (consult local protocol)

- **UNLICENSED USE**
  
  Not licensed for use in embryonal tumours.

**IMPORTANT SAFETY INFORMATION**

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

- **CAUTIONS**
  
  Consider use of prophylactic anti-infective agents - for high-dose intravenous administration establish adequate hydration - haematopoietic stem cell transplantation essential for high dose treatment (consult local treatment protocol for details)

- **INTERACTIONS**
  
  → Appendix 1: alkylating agents

- **SIDE-EFFECTS**

  - Common or very common
    

  - Rare or very rare
    
    Haemolytic anaemia - hepatic disorders - peripheral vascular disease - respiratory disorders - skin reactions

  **SIDE-EFFECTS, FURTHER INFORMATION**

  **Secondary malignancy** Use of melphalan is associated with an increased incidence of acute leukaemias.

  **Fluid retention** Alkylating drugs can cause fluid retention with oedema and dilutional hypovolaemia in younger children; the risk of this complication is higher in the first 2 days and also when given with concomitant vinca alkaloids.

  **CONCEPTION AND CONTRACEPTION**

  Manufacturer advises adequate contraception during treatment in men or women. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

  **PREGNANCY**

  Avoid. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

  **BREAST FEEDING**

  Discontinue breast-feeding.

  **RENAL IMPAIRMENT**

  Dose adjustments Reduce dose initially (consult product literature).

  **MONITORING REQUIREMENTS**

  Monitor full blood count before and throughout treatment.

- **MEDICINAL FORMS**

  There can be variation in the licensing of different medicines containing the same drug.

  **Powder and solvent for solution for injection**

  - Melphalan (Non-proprietary)
    
    Melphalan (as Melphalan hydrochloride) 50 mg Melphalan 50mg powder and solvent for solution for injection vials | 1 vial £137.37

---

Temozolomide

- **DRUG ACTION**

  Temozolomide is structurally related to dacarbazine.

- **INDICATIONS AND DOSE**

  Treatment of recurrent or progressive malignant glioma

  - BY MOUTH
    
    Child 3-17 years: (consult local protocol)

**IMPORTANT SAFETY INFORMATION**

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

- **CAUTIONS**

  Pneumocystis jirovecii pneumonia—consult product literature for monitoring and prophylaxis requirements

- **INTERACTIONS**

  → Appendix 1: alkylating agents

- **SIDE-EFFECTS**

  - Common or very common
    

  - Rare or very rare
    
    Neoplasms - respiratory disorders - secondary malignancy - severe cutaneous adverse reactions (SCARs), including Steven-Johnson syndrome and toxic epidermal necrolysis

  **CONCEPTION AND CONTRACEPTION**

  Manufacturer advises adequate contraception during treatment. Men should avoid fathering a child during and for at least 6 months after treatment. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

  **PREGNANCY**

  Avoid (teratogenic and embryotoxic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

  **BREAST FEEDING**

  Discontinue breast-feeding.

  **HEPATIC IMPAIRMENT**

  Manufacturer advises caution in severe impairment (no information available).

  **RENAL IMPAIRMENT**

  Manufacturer advises caution — no information available.

- **MONITORING REQUIREMENTS**

  → Monitor liver function before treatment initiation, after each treatment cycle and midway through 42-day treatment cycles — consider the balance of benefits and risks of treatment if results are abnormal at any point (fetal liver injury reported).

  → Monitor for myelodysplastic syndrome.

  → Monitor for secondary malignancies.
## Cytotoxic responsive malignancy

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

<table>
<thead>
<tr>
<th>Capsule</th>
<th>CAUTIONARY AND ADVISORY LABELS 23, 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temozolomide 5 mg</td>
<td>Temozolomide 5 mg capsules</td>
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<tr>
<td>£10.06–£16.00</td>
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<td>Temozolomide 20 mg</td>
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<td>Temozolomide 180 mg</td>
<td>Temozolomide 180 mg capsules</td>
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<tr>
<td>£381.18–£586.00</td>
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<tr>
<td>Temozolomide 250 mg</td>
<td>Temozolomide 250 mg capsules</td>
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<td>Temodal (Merck Sharp &amp; Dohme Ltd)</td>
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<td>Temodal 5 mg capsules</td>
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<td>Temodal 20 mg capsules</td>
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<td>Temodal 100 mg capsules</td>
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<td>Temodal 250 mg capsules</td>
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</table>

### CAUTIONS
Avoid in Acute porphyrías p. 624

### INTERACTIONS
→ Appendix 1: alkylating agents

### SIDE-EFFECTS
<table>
<thead>
<tr>
<th>Common or very common</th>
</tr>
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<tbody>
<tr>
<td>Abdominal pain</td>
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<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Appetite decreased</td>
</tr>
<tr>
<td>Ataxia</td>
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<tr>
<td>Bladder disorder</td>
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<tr>
<td>Cardiac arrhythmia</td>
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<tr>
<td>Cardiotoxicity</td>
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<tr>
<td>Cardiovascular insufficiency</td>
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<tr>
<td>Diarrhoea</td>
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<tr>
<td>Encephalopathy</td>
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<tr>
<td>Fever</td>
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<tr>
<td>Gastrointestinal disorders</td>
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<tr>
<td>Graft versus host disease</td>
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<tr>
<td>Growth retardation</td>
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<tr>
<td>Haemorrhage</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Hearing impairment</td>
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<tr>
<td>Heart failure</td>
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<tr>
<td>Hepatic failure</td>
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<tr>
<td>Hyperglycaemia</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Hypogonadism</td>
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<tr>
<td>Hypopituitarism</td>
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<tr>
<td>Hypothyroidism</td>
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<tr>
<td>Hypoxia</td>
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<tr>
<td>Increased risk of infection</td>
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<tr>
<td>Intracranial haemorrhage</td>
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<tr>
<td>Memory loss</td>
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<tr>
<td>Mucositis</td>
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<tr>
<td>Multi organ failure</td>
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<td>Nausea</td>
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<td>Neutrophilia</td>
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<td>Pain</td>
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<td>Renal failure</td>
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<td>Secondary malignancy</td>
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</tr>
<tr>
<td>Skin reactions</td>
</tr>
<tr>
<td>Stomatitis</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
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<tr>
<td>Vomiting</td>
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</table>

<table>
<thead>
<tr>
<th>Frequency not known</th>
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<tbody>
<tr>
<td>Pulmonary arterial hypertension</td>
</tr>
<tr>
<td>Severe cutaneous adverse reactions (SCARs)</td>
</tr>
</tbody>
</table>

### SIDE-EFFECTS, FURTHER INFORMATION
Alkylating drugs can cause fluid retention with oedema and dilutional hyponatraemia in younger children; the risk of this complication is higher in the first 2 days and also when given with concomitant vinca alkaloids.

### CONCEPTION AND CONCEPTION
Contraceptive advice required; see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

### PREGNANCY
Avoid (teratogenic and embryotoxic in animals). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

### ANTINEOPLASTIC DRUGS > ANTHRACYCLINES AND RELATED DRUGS

#### Daunorubicin

**31-Jul-2018**

### INDICATIONS AND DOSE
- Acute myelogenous leukaemia
- Acute lymphocytic leukaemia

### BY INTRAVENOUS INFUSION
- Child: (consult local protocol)

### CONTRA-INDICATIONS
- Cardiotoxicity is potentially severe. Avoid in children.

### CAUTIONS
- Avoid in children.
- Avoid in severe heart failure.
- Avoid in severe arrhythmia.

### INTERACTIONS
- Appendix 1: anthracyclines
- Appendix 1: anthracyclines

### SIDE-EFFECTS
- Abdominal pain
- Alopecia
- Amnionrrhoea
- Anemia
- Arrhythmias
- Ascites
- Atroventricular block
- Azoospermia
- Bone marrow disorders
- Cardiac inflammation
- Cardiomyopathy
- Chills
- Congestive heart failure
- Cytosis
- Death
- Dehydration
- Diarrhoea
- Dysphoria
- Extravasation necrosis
- Fever
- Flushing
- Gastrointestinal disorders
- Haemorrhage
- Hepatomegaly
- Hyperpyrexia
- Hyperuricaemia
- Hypoxia
- Infection
- Ischaemic heart disease
- Leucopenia
- Mucositis
- Myocardial infarction
- Nail discoloration
- Nausea
- Nephropathy
- Neutropenia
- Oedema
- Pain
- Paraesthesia
- Pleural effusion
- Radiation injuries
- Shock
- Skin reactions
- Stomatitis
- Thrombocytopenia
- Thrombophlebitis
- Urine red
- Venous sclerosis
- Vomiting

### SIDE-EFFECTS, FURTHER INFORMATION
Cardiotoxicity is cumulative and may be irreversible, however responds to treatment if detected early.

### CONCEPTION AND CONCEPTION
Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

### PREGNANCY
Avoid (teratogenic and carcinogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

### BREAST FEEDING
Discontinue breast-feeding.

### HEPATIC IMPAIRMENT
For solution for infusion manufacturer advises caution. For powder for solution for infusion manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.
Dose adjustments  Manufacturer advises dose reduction according to serum bilirubin concentration—consult product literature.

**RENAL IMPAIRMENT**  Avoid in severe impairment.

Dose adjustments  Reduce dose—consult local treatment protocol for details.

**MONITORING REQUIREMENTS**
- Cardiac monitoring essential.
- Cardiac function should be monitored before and at regular intervals throughout treatment and afterwards.

**MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug.

### Solution for infusion

- **Daunoxome** (Galen Ltd)
  Daunorubicin (as Daunorubicin hydrochloride citrate liposomal pegylated) 2 mg per 1 ml Daunoxome 50mg/25ml concentrate for solution for infusion vials  |  1 vial  | £20.00

- **Powder for solution for infusion**
  Daunorubicin (Non-proprietary)
  Daunorubicin (as Daunorubicin hydrochloride) 20 mg Daunorubicin 20mg powder for solution for infusion vials  |  10 vial  | £17.50  (Hospital only)

### Doxorubicin hydrochloride

**INDICATIONS AND DOSE**
- Some paediatric malignancies  Ewing’s sarcoma  Osteogenic sarcoma  Wilm’s tumour  Neuroblastoma  Retinoblastoma  Some liver tumours  Acute lymphoblastic leukaemia  Hodgkin’s lymphoma  Non-Hodgkin’s lymphoma

**CONTRA-INDICATIONS**
- Acute inflammatory heart disease
- Consult product literature
- Increased haemorrhagic tendency
- Marked persisting myelosuppression induced by previous treatment
- Marked persisting stomatitis induced by previous treatment
- Previous myocardial infarction
- Previous treatment with maximum cumulative doses of doxorubicin
- Previous treatment with maximum cumulative doses of other anthracycline
- Severe arrhythmia
- Severe myocardial insufficiency

**CONTRA-INDICATIONS, FURTHER INFORMATION**
- Anthracycline antibiotics should not normally be used in children with left ventricular dysfunction.

**CAUTIONS**
- Caution in handling—irritant to tissues—consult product literature

**INTERACTIONS**
- Appendix 1: anthracyclines

**SIDE-EFFECTS**
- **Common or very common**
  - Alopecia
  - Anaemia
  - Anxiety
  - Appetite decreased
  - Arthralgia
  - Asthenia
  - Bone marrow depression
  - Breast pain
  - Cachexia
  - Cardiovascular disorder
  - Chest discomfort
  - Chills
  - Constipation
  - Cough
  - Decreased leucocytes
  - Dehydration
  - Depression
  - Diarrhoea
  - Dizziness
  - Dry mouth
  - Dysphagia
  - Dyspnoea
  - Dysuria
  - Electrolyte imbalance
  - Epistaxis
  - Eye inflammation
  - Fever
  - Gastrointestinal discomfort
  - Gastrointestinal disorders
  - Headache
  - Hyperhidrosis
  - Hypersensitivity
  - Hypertension
  - Hyperthermia
  - Hypotension
  - Increased risk of infection
  - Influenza like illness
  - Infusion related reaction
  - Insomnia
  - Malaise
  - Mucosal abnormalities
  - Muscle complaints
  - Muscle tone increased
  - Muscle weakness
  - Nail disorder
  - Nausea
  - Nerve disorders
  - Neutropenia
  - Oedema
  - Oral disorders
  - Pain
  - Pruritus
  - Rashes
  - Recurrent infections
  - Renal failure
  - Reversal of radiation
  - Secondary malignancy
  - Sepsis
  - Skin complaints
  - Skin ulcer
  - Syncope
  - Taste altered
  - Thrombocytopenia
  - Vasodilation
  - Vision blurred
  - Vomiting
  - Weight decreased

- **Uncommon**
  - Confusion
  - Embolism
  - Thrombosis

- **Rare or very rare**
  - Secondary oral neoplasms
  - Secondary cutaneous adverse reactions (SCARs)

- **Frequency not known**
  - Asthma
  - Congestive heart failure
  - Secondary malignancy
  - Throat tightness

**SIDE-EFFECTS, FURTHER INFORMATION**
- Extravasation can cause tissue necrosis.

**Cardiotoxicity**
- All anthracycline antibiotics have been associated with varying degrees of cardiac toxicity—this may be idiosyncratic and reversible, but is commonly related to total cumulative dose and is irreversible.

**CONCEPTION AND CONTRACEPTION**
- Manufacturer advises effective contraception during and for at least 6 months after treatment in men or women.

**PREGNANCY**
- Avoid (teratogenic and toxic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551

**BREAST FEEDING**
- Discontinue breast-feeding.

**HEPATIC IMPAIRMENT**
- For solution for injection or infusion, manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

**Dose adjustments**
- Manufacturer advises dose reduction according to bilirubin concentration.

**RENAL IMPAIRMENT**
- Consult product literature in severe impairment.

**MONITORING REQUIREMENTS**
- Cardiac function should be monitored before and at regular intervals throughout treatment and afterwards.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Doxorubicin hydrochloride (Non-proprietary)**
  Doxorubicin hydrochloride 2 mg per 1 ml Doxorubicin 10mg/5ml solution for injection vials  |  1 vial  | £18.54  (Hospital only)
  Doxorubicin 50mg/25ml solution for injection Cytosafe vials  |  1 vial  | £103.00  (Hospital only)
  Doxorubicin 50mg/25ml solution for infusion vials  |  1 vial  | £103.00  (Hospital only)
  Doxorubicin 10mg/5ml solution for injection Cytosafe vials  |  1 vial  | £20.60  (Hospital only)
  Doxorubicin 10mg/5ml concentrate for solution for infusion vials  |  1 vial  | £113.12  (Hospital only)  |  1 vial  | £113.57
  Doxorubicin 10mg/5ml concentrate for solution for infusion vials  |  1 vial  | £20.60  (Hospital only)  |  1 vial  | £20.60  (Hospital only)
  Doxorubicin 50mg/25ml solution for injection vials  |  1 vial  | £92.70  (Hospital only)
  Doxorubicin 50mg/25ml concentrate for solution for infusion vials  |  1 vial  | £61.41  (Hospital only)  |  1 vial  | £97.85

**Solution for infusion**

- **Doxorubicin hydrochloride (Non-proprietary)**
  Doxorubicin hydrochloride 2 mg per 1 ml Doxorubicin 200mg/100ml solution for infusion vials  |  1 vial  | £412.00  (Hospital only)
  Doxorubicin 20mg/10ml concentrate for solution for infusion vials  |  1 vial  | £412.00  (Hospital only)
  Doxorubicin 100mg/50ml concentrate for solution for infusion vials  |  1 vial  | £412.00  (Hospital only)
  Doxorubicin 200mg/100ml solution for injection Cytosafe vials  |  1 vial  | £412.00  (Hospital only)
  Doxorubicin 200mg/100ml concentrate for solution for infusion vials  |  1 vial  | £360.23

**Powder and solvent for suspension for infusion**
- Electrolytes: May contain Sodium
- **Myocet** (Teva UK Ltd)
  Doxorubicin hydrochloride liposomal pegylated 50 mg Myocet 50mg powder and solvent for suspension for infusion vials  |  2 vial  | £912.26  (Hospital only)
Epirubicin hydrochloride

- **INDICATIONS AND DOSE**
  - Recurrent acute lymphoblastic leukaemia | Rhabdomyosarcoma | Other soft-tissue tumours of childhood
  - **BY INTRAVENOUS INFUSION**
    - Child: (consult local protocol)

- **UNLICENSED USE** Not licensed for use in children.
- **CONTRA-INDICATIONS**
  - Bladder infection or contraction (when used as a bladder instillation), catheterisation difficulties (when used as a bladder instillation), haematuria (when used as a bladder instillation), invasive tumours penetrating the bladder (when used as a bladder instillation), myocardopathy, previous treatment with maximum cumulative doses of epirubicin or other anthracycline, recent myocardial infarction, severe arrhythmia, severe myocardial insufficiency, unstable angina, urinary tract infections (when used as a bladder instillation).
- **CONTRA-INDICATIONS, FURTHER INFORMATION**
  - Anthracycline antibiotics should not normally be used in children with left ventricular dysfunction.
- **CAUTIONS**
  - Caution in handling—irritant to tissues
- **INTERACTIONS** → Appendix 1: anthracyclines
- **SIDE-EFFECTS**
  - Common or very common
    - Alopecia, anaemia, appetite decreased, bone marrow depression, dehydration, diarrhoea, increased risk of infection, leucopenia, mucositis, nausea, neutropenia, oesophagitis, stomatitis, urea red, vasodilation, vomiting.
  - Uncommon
    - Embolism and thrombosis, thrombocytopenia.
  - Rare or very rare
    - Anaemia, arthralgias, ascites, anemia, azoospermia, cardiac conduction disorders, cardiomypathy, cardiotoxicity, chills, congestive heart failure, dizziness, dyspnoea, fever, hepatitis, hyperuricaemia, malaise, neuropsychia, oedema, pleural effusion, pulmonary oedema, skin reactions.
  - Frequency not known
    - Eye inflammation, haemorrhage, hypoxia, nail discoulouration, paraphysaemia, photosensitivity reaction, radiation injuries, shock, urinary frequency increased.
- **SIDE-EFFECTS, FURTHER INFORMATION**
  - Cardiotoxicity: All anthracycline antibiotics have been associated with varying degrees of cardiac toxicity—this may be idiosyncratic and reversible, but is commonly related to total cumulative dose and is irreversible.
  - Cumulative doses of other anthracyline: Epirubicin is considered less toxic than other anthracyline antibiotics, and may be suitable for children who have received high cumulative doses of other anthracyclines.
- **CONCEPTION AND CONTRACEPTION**
  - Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.
- **PREGNANCY**
  - Avoid (carcinogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.
- **BREAST FEEDING**
  - Discontinue breast-feeding.
- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.
  - Dose adjustments
    - In adults, manufacturer advises dose reduction according to bilirubin level.
- **RENAL IMPAIRMENT**
  - Dose adjustments
    - Dose reduction may be necessary in severe impairment.
- **MONITORING REQUIREMENTS**
  - Cardiac toxicity: Cardiac function should be monitored before and at regular intervals throughout treatment and afterwards.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, solution for infusion
- **Solution for injection**
  - Epirubicin hydrochloride (Non-proprietary)
    - Pharmorubicin (Pfizer Ltd)
      - Epirubicin hydrochloride 2 mg per 1 ml
        - Solution for injection vials | 1 vial £106.19 (Hospital only)
        - Pharmorubicin 10mg/5ml solution for injection Cytosafe vials | 1 vial £21.24 (Hospital only)
  - Epirubicin hydrochloride 2 mg per 1 ml
    - Pharmorubicin 200mg/100ml solution for infusion vials | 1 vial £366.85
    - Pharmorubicin 100mg/50ml solution for infusion vials | 1 vial £201.76
    - Pharmorubicin (Pfizer Ltd)
      - Epirubicin hydrochloride 2 mg per 1 ml
        - Pharmorubicin 200mg/100ml solution for infusion Cytosafe vials | 1 vial £386.16 (Hospital only)

Mitoxantrone

- **INDICATIONS AND DOSE**
  - Acute myeloid leukaemia | Recurrent acute lymphoblastic leukaemia
  - **BY INTRAVENOUS INFUSION**
    - Child: (consult local protocol)

- **UNLICENSED USE** Not licensed for use in children.
- **CONTRA-INDICATIONS**
- **CONTRA-INDICATIONS, FURTHER INFORMATION**
  - Anthracycline antibiotics should not normally be used in children with left ventricular dysfunction.
- **INTERACTIONS** → Appendix 1: anthracyclines
- **SIDE-EFFECTS**
  - Abdominal pain, acute leukaemia, alopecia, amenorrhoea, anxiety, appetite decreased, arthralgia, ascites, anemia, azoospermia, bone marrow depression, cancer, confusion, constipation, cough, dizziness, dyspnoea, fever, gastrointestinal haemorrhage, heart attack, mucositis, nail discoulouration, nail dystrophy, nausea, neurological effects, paraesthesia, scleral discoulouration, skin discoulouration, stomatitis, thrombocytopenia, uric acid, vomiting.
- **SIDE-EFFECTS, FURTHER INFORMATION**
  - All anthracycline antibiotics have been associated with varying degrees of cardiac toxicity—this may be idiosyncratic and reversible, but is commonly related to total cumulative dose and is irreversible.

- **CONCEPTION AND CONTRACEPTION**
  - Manufacturer advises effective contraception during and for at least 6 months after treatment in men or women.
- **PREGNANCY**
  - Avoid. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.
- **BREAST FEEDING**
  - Discontinue breast-feeding.
- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution (limited information available).
  - Dose adjustments
    - Manufacturer advises consider dose reduction.
- **MONITORING REQUIREMENTS**
  - Cardiac toxicity: Cardiac function should be monitored before and at regular intervals throughout treatment and afterwards.
Cytotoxic responsive malignancy  561

Cytarabine

• **DRUG ACTION**  Cytarabine acts by interfering with pyrimidine synthesis.

• **INDICATIONS AND DOSE**  
  - Acute lymphoblastic leukaemia  
  - Acute myeloid leukaemia  
  - Non-Hodgkin’s lymphoma
  - **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION, OR BY SUBCUTANEOUS INJECTION**
  - Child: (consult local protocol)

• **UNLICENSED USE**  DepoCyt® intrathecal injection not licensed for use in children.

— **IMPORTANT SAFETY INFORMATION**  Not all cytarabine preparations can be given by intrathecal injection—consult product literature.

• **INTERACTIONS**  → Appendix 1: cytarabine

• **SIDE-EFFECTS**
  - **Common or very common**  Alopecia - anaemia - appetite decreased - consciousness impaired - diarrhoea - dysphagia - eye disorders - eye inflammation - eye stinging - fever - gastrointestinal discomfort - gastrointestinal disorders - haemorrhagic conjunctivitis (consider prophylactic corticosteroid eye drops) - hyperuricaemia - leucopenia - nausea - oral disorders - renal impairment - skin reactions - thrombocytopenia - urinary retention - vasculitis - vision disorders - vomiting
  - **Uncommon**  Arthralgia - dyspnoea - headache - increased risk of infection - myalgia - nerve disorders - pain - paranoid disorders - periarteritis nodosa - peripheral neuropathy - psychiatric disorder - renal impairment - respiratory disorders - sepsis - sinusoidal obstruction syndrome - skin reactions - systemic inflammatory response syndrome - tachycardia - tremor - tumour lysis syndrome - vomiting - weight decreased
  - **Frequency not known**  Antibiotic associated colitis - gastrointestinal disorders - hypomagnesaemia - pancreatitis - severe cutaneous adverse reactions (SCARs)

• **CONCEPTION AND CONTRACEPTION**  Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

• **PREGNANCY**  Avoid (teratogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

• **BREAST FEEDING**  Discontinue breast-feeding.

• **HEPATIC IMPAIRMENT**  Dose adjustments  Reduce dose—consult product literature.

• **RENAL IMPAIRMENT**  Consult local treatment protocols.

• **MONITORING REQUIREMENTS**  Haematological monitoring  Cytarabine is a potent myelosuppressant and requires careful haematological monitoring.

• **PRESCRIBING AND DISPENSING INFORMATION**  Dose is based on weight or body-surface area, children may tolerate higher doses of cytarabine than adults.

• **NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (July 2007) that liposomal cytarabine suspension (DepoCyte®) is not recommended for use within NHS Scotland for the intrathecal treatment of lymphomatous meningitis.
Fludarabine phosphate

**INDICATIONS AND DOSE**

- Poor prognosis or relapsed acute myeloid leukaemia
- Relapsed acute lymphoblastic leukaemia | Conditioning before bone marrow transplantation
  - By mouth, or by intravenous injection, or by intravenous infusion
  - Child: (consult local protocol)

**UNLICENSED USE** Not licensed for use in children.

**IMPORTANT SAFETY INFORMATION**

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

**CONTRA-INDICATIONS** Haemolytic anaemia

**CAUTIONS** Increased susceptibility to skin cancer - worsening of existing skin cancer

**CAUTIONS, FURTHER INFORMATION**

- Immunosuppression: Fludarabine has a potent and prolonged immunosuppressive effect. Patients treated with fludarabine are more prone to serious bacterial, opportunistic fungal, and viral infections, and prophylactic therapy is recommended in those at risk. To prevent potentially fatal transfusion-related graft-versus-host reaction, only irradiated blood products should be administered. Prescribers should consult specialist literature when using highly immunosuppressive drugs.

**INTERACTIONS** Appendix 1: fludarabine

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- Common or very common: Anaemia - appetite decreased - asthenia - bone marrow depression (may be cumulative) - chills - cough - diarrhoea - fever - increased risk of infection - malaise - mucositis - nausea - neutropenia - oedema - stomatitis - thrombocytopenia - vision disorders - vomiting

- Uncommon: Autoimmune disorder - confusion - haemorrhage - tumour lysis syndrome

**SPECIAL SIDE-EFFECTS**

- Rare or very rare: Agitation - arrhythmia - coma - heart failure - seizure - severe cutaneous adverse reactions (SCARs)

**CONCESSION AND CONTRAINDICATION** Manufacturer advises effective contraception during and for at least 6 months after treatment in men or women.

**PREGNANCY** Avoid (embryotoxic and teratogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**BREAST FEEDING** Discontinue breast-feeding.

**RENAL IMPAIRMENT** Avoid if creatinine clearance less than 30 mL/minute/1.73 m².

**Dose adjustments** Reduce dose by up to 50% if creatinine clearance 30–70 mL/minute/1.73 m².

**MONITORING REQUIREMENTS**

- Monitor for signs of haemolysis.
- Monitor for neurological toxicity.

**DIRECTIONS FOR ADMINISTRATION** Concentrate for intravenous injection or infusion must be diluted before administration (consult product literature).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

**SOLUTION FOR INJECTION**

- Cytarabine (Non-proprietary)
  - Fludarabine phosphate 20 mg per 1 ml: Cytarabine 100mg/5ml solution for injection Cytosafe vials | 5 vial (POD) £20.48 (Hospital only)
  - Cytarabine 500mg/25ml solution for injection vials | 1 vial (POD) £13.50
  - Cytarabine 100mg/5ml solution for injection vials | 5 vial (POD) £30.00 (Hospital only) | 5 vial (POD) £20.98
  - Cytarabine 500mg/25ml solution for injection Cytosafe vials | 1 vial (POD) £19.50 (Hospital only)

- Cytarabine 100 mg per 1 ml: Cytarabine 1g/10ml solution for injection Cytosafe vials | 1 vial (POD) £30.00 (Hospital only) | 1 vial (POD) £40.00–£49.78 (Hospital only) | 1 vial (POD) £37.05–£39.00
  - Cytarabine 1g/10ml solution for injection vials | 1 vial (POD) £40.00–£49.78 (Hospital only) | 1 vial (POD) £37.05–£39.00
  - Cytarabine 500mg/5ml solution for injection vials | 5 vial (POD) £100.00 (Hospital only) | 5 vial (POD) £83.78
  - Cytarabine 100mg/1ml solution for injection vials | 5 vial (POD) £26.93

- Cytarabine liposomal pegylated 10 mg per 1 ml: DepoCyte
  - 50mg/5ml suspension for injection vials | 1 vial (POD) £1,223.75 (Hospital only)

**MERCATORPURINE**

**INDICATIONS AND DOSE**

- Severe ulcerative colitis | Severe Crohn’s disease
  - By mouth
  - Child 2-17 years: Initially 1–1.5 mg/kg once daily (max. per dose 50 mg), then increased if necessary up to 75 mg once daily

**ACUTE LYMPHOBlastic LEUKAEMIA | LYMPHOMAS**

- By mouth
  - Child: (consult local protocol)
DOSE ADJUSTMENTS DUE TO INTERACTIONS
- Manufacturer advises reduce dose to one-quarter of the usual dose with concurrent use of allopurinol.

DOSE EQUIVALENCE AND CONVERSION
- Mercaptopurine tablets and Xaluprine® oral suspension are not bioequivalent, haematological monitoring is advised when switching formulations.

UNLICENSED USE
- Not licensed for use in severe ulcerative colitis and Crohn’s disease.
- Not licensed for use in children for acute lymphoblastic lymphoma or T-cell non-Hodgkins lymphoma.

IMPORTANT SAFETY INFORMATION
SAFE PRACTICE
Mercaptopurine has been confused with mercaptamide; care must be taken to ensure the correct drug is prescribed and dispensed.

RISKS OF INCORRECT DOING OF ORAL ANTI-CANCER MEDICINES
See Cytotoxic drugs p. 551.

CONTRA-INDICATIONS
- Absent thiopurine methyltransferase activity

CAUTIONS
- Reduced thiopurine methyltransferase activity

CAUTIONS, FURTHER INFORMATION
- Thiopurine methyltransferase. The enzyme thiopurine methyltransferase (TPMT) metabolises thiopurine drugs (azathioprine, mercaptopurine, tioguanine); the risk of myelosuppression is increased in patients with reduced activity of the enzyme, particularly for the few individuals in whom TPMT activity is undetectable. Patients with absent TPMT activity should not receive thiopurine drugs; those with reduced TPMT activity may be treated under specialist supervision.

INTERACTIONS
- Appendix 1: mercaptopurine

SIDE-EFFECTS
- Common or very common: Anaemia; appetite decreased; bone marrow depression; diarrhoea; hepatic disorders; hepatotoxicity (more common at high doses); leucopenia; nausea; oral disorders; thrombocytopenia; vomiting
- Uncommon: Arthralgia; fever; increased risk of infection; neutropenia; pancreatitis; rash
- Rare or very rare: Alopecia - face oedema; intestinal ulcer; neoplasms; oligozoospermia
- Frequency not known: Hypoglycaemia; photosensitivity reaction

CONCEPTION AND CONTRACEPTION
- Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY
- Avoid (teratogenic). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING
- Discontinue breast-feeding

HEPATIC IMPAIRMENT
- Dose adjustments: May need dose reduction.

RENAL IMPAIRMENT
- Dose adjustments: Manufacturer advises consider reducing dose.

PRE-TREATMENT SCREENING
- Consider measuring thiopurine methyltransferase (TPMT) activity before starting mercaptopurine therapy.

MONITORING REQUIREMENTS
- Monitor liver function—discontinue if jaundice develops.
- When used for severe ulcerative colitis or severe Crohn’s disease: Monitor for toxicity throughout treatment. Monitor full blood count weekly (more frequently with higher doses or if severe hepatic or renal impairment) for first 4 weeks (manufacturer advises weekly monitoring for 8 weeks but evidence of practical value unsatisfactory), thereafter reduce frequency of monitoring to at least every 3 months.

METHOTREXATE

01-Feb-2019

Drug Action
- Methotrexate inhibits the enzyme dihydrofolate reductase, essential for the synthesis of purines and pyrimidines.

INDICATIONS AND DOSE
Severe Crohn’s disease
- By subcutaneous injection, or by intramuscular injection
- Child 7-17 years: 15 mg/m² once weekly (max. per dose 25 mg)

Maintenance of remission of severe Crohn’s disease
- By mouth, or by subcutaneous injection, or by intramuscular injection
- Child 7-17 years: 15 mg/m² once weekly (max. per dose 25 mg), dose reduced according to response to lowest effective dose

Juvenile idiopathic arthritis | Juvenile dermatomyositis | Vasculitis | Uveitis | Systemic lupus erythematosus | Localised scleroderma | Sarcoidosis
- By mouth, or by subcutaneous injection, or by intramuscular injection
- Child: Initially 10–15 mg/m² once weekly, then increased if necessary up to 25 mg/m² once weekly

Maintenance and remission of acute lymphoblastic leukaemia, lymphoblastic lymphoma
- By mouth
- Child: (consult local protocol)

Treatment of early stage Burkitt’s lymphoma, non-Hodgkin’s lymphoma, osteosarcoma, some CNS tumours including infant brain tumours, acute lymphoblastic leukaemia
- By intravenous injection, or by intravenous infusion
- Child: (consult local protocol)

Meningeal leukaemia, treatment and prevention of CNS involvement of leukaemia
- By intrathecal injection
- Child: (consult local protocol)

Severe psoriasis unresponsive to conventional therapy (specialist use only)
- By mouth
- Child 2-17 years: Initially 200 micrograms/kg once weekly (max. per dose 10 mg), then increased if necessary to 400 micrograms/kg once weekly (max. per dose 25 mg), adjusted according to response, stop treatment if inadequate response after 3 months at the optimum dose

UNLICENSED USE
- Methotrexate is licensed for use in children over 3 years for polyarticular forms of juvenile idiopathic
arthritis; other preparations not licensed for use in children for non-malignant conditions.

**IMPORTANT SAFETY INFORMATION**

Note that the dose is a **weekly** dose. To avoid error with low-dose methotrexate, it is recommended that:
- the child or their carer is carefully advised of the **dose** and frequency and the reason for taking methotrexate and any other prescribed medication (e.g. folic acid);
- only one strength of methotrexate tablet (usually 2.5 mg) is prescribed and dispensed;
- the prescription and the dispensing label clearly show the dose and frequency of methotrexate administration;
- the child or their carer is warned to report immediately the onset of any feature of blood disorders (e.g. sore throat, bruising, and mouth ulcers), liver toxicity (e.g. nausea, vomiting, abdominal discomfort, and dark urine), and respiratory effects (e.g. shortness of breath).

**CONTRA-INDICATIONS** Active infection (in non-malignant conditions), ascites, immunodeficiency syndromes (in non-malignant conditions), significant pleural effusion.

**CAUTIONS** Photosensitivity—porokeratosis lesions aggravated by UV radiation (skin ulcers). extreme caution in blood disorders (avoid if severe), peptic ulceration, risk of accumulation in pleural effusion or ascites—drain before treatment. ulcerative colitis.

**SIDE-EFFECTS** Pulmonary toxicity. Acute pulmonary toxicity is rare in children treated for juvenile idiopathic arthritis, but children and carers should seek medical attention if dyspnoea, cough, or fever develops; discontinue if pneumonia is suspected.

**INTERACTIONS** → Appendix 1: methotrexate

**SIDE-EFFECTS**
- Common or very common
  - With intrathecal use. Necrotising demyelinating leukoencephalopathy.
  - With oral use. Anaemia, appetite decreased, diarrhoea, drowsiness, fatigue, gastrointestinal discomfort, headache, increased risk of infection, leucopenia, nausea, oral disorders, respiratory disorders, skin reactions, throat ulcer, thrombocytopenia, vomiting.
  - With parental use. Anaemia, appetite decreased, chest pain, cough, diarrhoea, drowsiness, dysphagia, fatigue, fever, gastrointestinal discomfort, headache, leucopenia, malaise, nausea, oral disorders, respiratory disorders, skin reactions, throat complaints, thrombocytopenia, vomiting.
- Uncommon
  - With oral use. Agranulocytosis, alopecia, arthralgia, bone marrow disorders, chill, confusion, cystitis, depression, diabetes mellitus, dysuria, fever, gastrointestinal disorders, haemorrhage, healing impaired, hepatic disorders, myalgia, neutropenia, nephropathy, osteoporosis, photosensitivity reaction, rheumatoid arthritis aggravated, seizure, severe cutaneous adverse reactions (SCARs), vasculitis, vertigo, vulvovaginal disorders.
  - With parenteral use. Agranulocytosis, alopecia, arthralgia, bone marrow disorders, confusion, cystitis, depression, diabetes mellitus, drug toxicity, dysuria, gastrointestinal disorders, haemorrhage, healing impaired, hepatic disorders, increased risk of infection, lipotrophy, local reaction, myalgia, neutropenia, osteoporosis, pain, paraesthesia, photosensitivity reaction, rheumatoid arthritis aggravated, seizure, severe cutaneous adverse reactions (SCARs), sterile abscess, vasculitis, vertigo, vulvovaginal disorders.
  - Rare or very rare
  - With oral use. Azotaemia, brain oedema, cognitive impairment, conjunctivitis, cough, dyspnoea, eosinophilia, gynaecomastia, hypotension, immune deficiency, infertility, insomnia, lymphadenopathy, meningitis, musculoskeletal disorder, mood altered, muscle weakness, nail discoloration, neutropenia, oligozoospermia, pain, pancreatitis, paresis, pericardial disorders, pericarditis, proteinuria, psychosis, radiation injuries, renal impairment, retinopathy, sensation abnormal, sepis, sexual dysfunction, speech impairment, stress fracture, taste metallic, telangiectasia, tinnitus, visual impairment.
  - With parenteral use. Aponoea, asthma-like conditions, azotaemia, conjunctivitis, embolism and thrombosis, eosinophilia, gynaecomastia, hypotension, immune deficiency, infertility, influenza like illness, insomnia, lymphadenopathy, meningitis, musculoskeletal disorder, mood altered, muscle weakness, nail discoloration, necrosis, neutropenia, paralysis, pericardial disorders, pericarditis, proteinuria, reactivation of infection, renal impairment, retinopathy, sepis, sexual dysfunction, sperm abnormalities, stress fracture, taste altered, telangiectasia, vision disorders.
  - Frequency not known
  - With oral use. Encephalopathy.
  - With parenteral use. Aphasia, chill, cognitive disorder, defective oogenesis, dizziness, hemiparesis, leukoencephalopathy, metabolic change, mucusitis, nephropathy, pancreatitis, pulmonary oedema, skin ulcer, sudden death, tinnitus.

**SIDE-EFFECTS, FURTHER INFORMATION**

Give folic acid to reduce side-effects. Folic acid decreases mucosal and gastrointestinal side-effects of methotrexate and may prevent hepatotoxicity; there is no evidence of a reduction in haematological side-effects.

Withdraw treatment if ulcerative stomatitis develops—may be first sign of gastro-intestinal toxicity.

**TREATMENT**

Treatment with folinic acid (as calcium folinate) may be required in acute toxicity.

**CONCEPTION AND CONTRACEPTION**

Manufacturer advises effective contraception during and for at least 6 months after treatment in men and women.

**PREGNANCY** Avoid (teratogenic; fertility may be reduced during therapy but this may be reversible).

**BREAST FEEDING** Discontinue breast-feeding—present in milk.

**HEPATIC IMPAIRMENT** When used for malignancy, avoid in severe hepatic impairment—consult local treatment protocol for details. Avoid with hepatic impairment in non-malignant conditions—dose-related toxicity.

**RENAL IMPAIRMENT** Risk of nephrotoxicity at high doses. Avoid in severe impairment.

**DOSE ADJUSTMENTS** Reduce dose.

**PRE-TREATMENT SCREENING** Exclude pregnancy before treatment.

Patients should have full blood count and renal and liver function tests before starting treatment.
Check immunity to varicella-zoster and consider vaccination before initiating therapy.

- **Monitoring requirements** Full blood count and liver function tests repeated fortnightly for at least the first 4 weeks of treatment and at this frequency after any change in dose until therapy stabilised, thereafter monthly; renal function tests should be performed regularly during treatment.

- **Prescribing and dispensing information** Folinic acid following methotrexate administration helps to prevent methotrexate-induced mucositis and myelosuppression.

The licensed routes of administration for parenteral preparations vary—further information can be found in the product literature for the individual preparations.

- **Patient and carer advice** Patients and their carers should be warned to report immediately the onset of any feature of blood disorders (e.g. sore throat, bruising, and mouth ulcers), liver toxicity (e.g. nausea, vomiting, abdominal discomfort and dark urine), and respiratory effects (e.g. shortness of breath).

Children and carers should be advised to avoid self-medication with over-the-counter ibuprofen.

Children and their carers should be counselled on the dose and use of NSAIAs.

Medicines for Children leaflet: Methotrexate for skin conditions www.medicinesforchildren.org.uk/methotrexate-skin-conditions

- **Medicinal forms** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution for injection

**Tablet**

- Methotrexate (Non-proprietary) Methotrexate 2.5 mg | 24 tablet | £1.52–£1.75 | 28 tablet | £3.82 DT + £1.77 | 100 tablet | £5.75–£14.10
- Methotrexate 10 mg | 100 tablet | £55.74 DT + £46.66
- Maxtrex (Pfizer Ltd) Methotrexate 2.5 mg | 24 tablet | £2.39
- Methotrexate 10 mg | 100 tablet | £9.96

**Solution for injection**

- Methotrexate (Non-proprietary) Methotrexate (as Methotrexate sodium) 2.5 mg per 1 ml Methotrexate 5mg/2ml solution for injection vials | 5 vial | £36.00 (Hospital only)
- Methotrexate (as Methotrexate sodium) 25 mg per 1 ml Methotrexate 1g/40ml solution for injection vials | 1 vial | £1.452.55 (Hospital only) | 1 vial | £44.57
- Methotrexate 500mg/20ml solution for injection vials | 1 vial | £48.00–£72.62 (Hospital only) | 1 vial | £25.07
- Methotrexate 50mg/2ml solution for injection vials | 1 vial | £2.62–£72.63 | 5 vial | £35.00 (Hospital only)
- Methotrexate 200mg/8ml solution for injection vials | 1 vial | £10.02
- Methotrexate (as Methotrexate sodium) 100 mg per 1 ml Methotrexate 1g/10ml solution for injection vials | 1 vial | £85.00 (Hospital only)
- Methofill (Accord Healthcare Ltd) Methotrexate 50 mg per 1 ml Methofill 12.5mg/0.25ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £14.34 DT + £14.35
- Methofill 22.5mg/0.45ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £16.10 DT + £16.11
- Methofill 30mg/0.6ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £16.55 DT + £16.56
- Methofill 27.5mg/0.55ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £16.49 DT + £16.50
- Methofill 7.5mg/0.15ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £12.86 DT + £12.87
- Methofill 20mg/0.4ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £16.85 DT + £16.86
- Methofill 10mg/0.2ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £13.25 DT + £13.26

Methofill 15mg/0.3ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £14.40 DT + £14.41
- Methofill 17.5mg/0.35ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £15.24 DT + £15.25
- Methofill 25mg/0.5ml solution for injection pre-filled injector | 1 pre-filled disposable injection | £16.12 DT + £16.13
- Methotrexate (as Methotrexate sodium) 2 mg per 1 ml Methotrexate 2mg/mL oral solution for suspension-sugar-free-sugar-free-solution | 35 ml | £35.00 | 65 ml | £65.00
- Methotrexate (as Methotrexate sodium) 2 mg per 1 ml Methotrexate 2mg/mL oral solution for suspension-sugar-free-sugar-free-solution | 35 ml | £35.00 | 65 ml | £65.00
- Jylano (Intrapharm Laboratories Ltd) Methotrexate (as Methotrexate sodium) 2 mg per 1 ml Jylano 2mg/mL oral solution sugar-free | 60 ml | £12.50

**Solution for infusion**

- Methotrexate (Non-proprietary) Methotrexate (as Methotrexate sodium) 25 mg per 1 ml Methotrexate 5g/200ml solution for infusion vials | 1 vial | £200.57
- Methotrexate (as Methotrexate sodium) 100 mg per 1 ml Methotrexate 5g/50ml solution for infusion vials | 1 vial | £400.00 (Hospital only)

**Oral solution**

- Methotrexate (Non-proprietary) Methotrexate (as Methotrexate sodium) 2 mg per 1 ml Methotrexate 2mg/mL oral solution for suspension-sugar-free-sugar-free-solution | 35 ml | £35.00 | 65 ml | £65.00
- Jylano (Intrapharm Laboratories Ltd) Methotrexate (as Methotrexate sodium) 2 mg per 1 ml Jylano 2mg/mL oral solution sugar-free | 60 ml | £12.50
**Nelarabine**

- **INDICATIONS AND DOSE**
  T-cell acute lymphoblastic leukaemia and T-cell lymphoblastic lymphoma in children who have relapsed or who are refractory after receiving at least two previous regimens
  - BY INTRAVENOUS INFUSION
  - Child: (consult local protocol)

- **CAUTIONS**
  - Previous or concurrent craniospinal irradiation (increased risk of neurotoxicity)
  - Previous or concurrent intrathecal chemotherapy (increased risk of neurotoxicity)

- **INTERACTIONS** → Appendix 1: nelarabine

- **SIDE-EFFECTS**
  - Common or very common
    - Anaemia
    - Arthralgia
    - Asthenia
    - Ataxia
    - Confusion
    - Constipation
    - Diarrhoea
    - Drowsiness
    - Electrolyte imbalance
    - Fever
    - Headache
    - Hyperbilirubinaemia
    - Hypoglycaemia
    - Increased risk of infection
    - Leucopenia
    - Nausea
    - Neutropenia
    - Pain in extremity
    - Peripheral neuropathy
    - Seizures
    - Sensation abnormal
    - Stomatitis
    - Thrombocytopenia
    - Tremor
    - Vomiting

- **SIDE-EFFECTS, FURTHER INFORMATION**
  - If neurotoxicity occurs, treatment should be discontinued.

- **CONCEPTION AND CONTRACEPTION**
  - Manufacturer advises effective contraception during for at least 3 months after treatment in men and women.

- **PREGNANCY**
  - Avoid (toxicity in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**
  - Discontinue breast-feeding.

- **MONITORING REQUIREMENTS**
  - Neurotoxicity
    - Close monitoring for neurological events is strongly recommended—discontinue if neurotoxicity occurs.

- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks
    - Drowsiness may affect performance of skilled tasks (e.g. cycling or driving).

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Solution for infusion
    - ELECTROLYTES: may contain Sodium
      - Atriance (Novartis Pharmaceuticals UK Ltd) ▼
    - Nelarabine 5 mg per 1 ml Atriance 250mg/50ml solution for infusion vials 6 vial £1.332.00

- **ANTINEOPLASTIC DRUGS** → CYTOTOXIC

**Tioguanine**

*(Thioguanine)*

- **INDICATIONS AND DOSE**
  - Infant acute lymphoblastic leukaemia
    - **BY MOUTH**
    - Child: Can be given at various stages of treatment in short-term cycles (consult local protocol)

- **CONTRA-INDICATIONS**
  - Absent thiopurine methyltransferase activity

- **CAUTIONS**
  - Thiopurine methyltransferase status

- **CAUTIONS, FURTHER INFORMATION**
  - Thiopurine methyltransferase: The enzyme thiopurine methyltransferase (TPMT) metabolises thiopurine drugs (azathioprine, mercaptopurine, tioguanine); the risk of myelosuppression is increased in patients with reduced activity of the enzyme, particularly for the few individuals in whom TPMT activity is undetectable. Patients with absent TPMT activity should not receive thiopurine drugs; those with reduced TPMT activity may be treated under specialist supervision.
  - Long-term therapy
    - Long-term therapy is no longer recommended because of the high risk of liver toxicity.

- **INTERACTIONS** → Appendix 1: tioguanine

- **SIDE-EFFECTS**
  - Common or very common
    - Bone marrow failure
    - Gastrointestinal disorders
    - Hepatic disorders
    - Hyperbilirubinaemia
    - Hyperuricaemia
    - Nodular regenerative hyperplasia
    - Oesophageal varices
    - Sinusoidal obstruction syndrome
    - Splenomegaly
    - Stomatitis
    - Thrombocytopenia
    - Uric acid nephropathy
    - Weight increased
  - Frequency not known
    - Photosensitivity reaction

- **CONCEPTION AND CONTRACEPTION**
  - Ensure effective contraception during treatment in men or women.

- **PREGNANCY**
  - Avoid (teratogenicity reported when men receiving tioguanine have fathered children). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**
  - Discontinue breast-feeding.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution.

- **Dose adjustments**
  - Manufacturer advises consider dose reduction.

- **RENAI IMPAIRMENT**
  - Dose adjustments
    - Reduce dose.

- **PRE-TREATMENT SCREENING**
  - Consider measuring thiopurine methyltransferase (TPMT) activity before starting tioguanine therapy.

- **MONITORING REQUIREMENTS**
  - Monitor liver function weekly—discontinue if liver toxicity develops.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule

  - **Tablet**
    - Tioguanine (Non-proprietary)
      - Tioguanine 40 mg Tioguanine 40mg tablets 25 tablet £0.97

**Bleomycin**

- **INDICATIONS AND DOSE**
  - Some germ cell tumours: Hodgkin’s lymphoma
    - **BY INTRAVENOUS INFUSION**
    - Child: (consult local protocol)

- **UNLICENSED USE**
  - Not licensed for use in children.

- **CONTRA-INDICATIONS**
  - Acute pulmonary infection

- **CAUTIONS**
  - Caution in handling—irritant to tissues

- **INTERACTIONS** → Appendix 1: bleomycin

- **SIDE-EFFECTS**
  - Common or very common
    - Alopecia
    - Angular stomatitis
    - Appetite decreased
    - Chills
    - Fever (after administration)
    - Haemorrhage
    - Headache
    - Interstitial pneumonia
    - Leucopenia
    - Malaise
    - Nail discolouration
    - Nail disorder
    - Nausea
    - Pain
    - Pulmonary fibrosis (dose-related)
    - Scleroderma
    - Skin reactions
    - Stomatitis
    - Vomiting
    - Weight decreased

- **Uncommon**
  - Diarrhoea
  - Dizziness
  - Hepatocellular injury
  - Oliguria
  - Shock
  - Urinary disorders
  - Vein wall hypertrophy
  - Venous stenosis

**Important Safety Information**

**Risks of incorrect dosing of oral anti-cancer medicines**

See Cytotoxic drugs p. 551.
CONCEPTION AND CONTRACEPTION

Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY

Avoid (teratogenic and carcinogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING

Discontinue breast feeding.

RENAL IMPAIRMENT

Dose adjustments Reduce dose—consult local treatment protocol for details.

MONITORING REQUIREMENTS

Ensure monitoring of pulmonary function—investigate any shortness of breath before initiation.

PRESCRIBING AND DISPENSING INFORMATION

To conform to the European Pharmacopoeia vials previously labelled as containing 15 units of bleomycin are now labelled as containing 15 000 units. The amount of bleomycin in the vial has not changed.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for injection

- Bleomycin (Non-proprietary)
  - Bleomycin (as Bleomycin sulfate) 5000 unit
  - Bleo-Kyowa
  - 15 000 unit powder for solution for injection vials | 10 vial
  - £170.00
  - £100.60

- Bleomycin (as Bleomycin sulfate) 5000 unit
  - Bleo-Kyowa (Kyowa Kirin Ltd)
  - 15 000 unit powder for solution for injection vials | 10 vial
  - £190

ANTINEOPLASTIC DRUGS > PLATINUM COMPOUNDS

Carboplatin

10-Jun-2016

- INDICATIONS AND DOSE
  - Stage 4 neuroblastoma | Germ cell tumours | Low-grade gliomas (including astrocytomas) | Neuroectodermal tumours (including medulloblastoma) | Rhabdomyosarcoma (metastatic and non-metastatic disease) | Soft-tissue sarcomas | Retinoblastoma | High risk Wilms’ tumour: Some liver tumours
  - By INTRAVENOUS INFUSION
  - Child: (consult local protocol)

- UNLICENSED USE
  - Not licensed for use in children.

- INTERACTIONS
  - Appendix 1: platinum compounds

- SIDE-EFFECTS
  - Common or very common Alopeia · anaemia · asthenia · cardiovascular disorder · constipation · diarrhoea · gastrointestinal discomfort · haemorrhage · hypersensitivity · increased risk of infection · leucopenia · mucosal abnormalities · musculoskeletal disorder · nausea · neutropenia · ototoxicity · peripheral neuropathy · reflexes decreased · respiratory disorders · sensation abnormal · skin reactions · taste altered · thrombocytopenia · urogenital disorder · vision disorders · vomiting
  - Rare or very rare Cardiac discomfort · dyspnoea
  - Frequency not known Appetite decreased · bone marrow failure · chills · dehydration · embolism · encephalopathy · extravasation necrosis · fever · haemolytic uraemic syndrome · heart failure · hypertension · hypotension · injection site necrosis · malaise · pancreatitis · stomatitis · stroke · treatment related secondary malignancy

- CONCEPTION AND CONTRACEPTION

Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY

Avoid (teratogenic and embryotoxic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING

Discontinue breast-feeding.

RENAL IMPAIRMENT

Avoid if creatinine clearance less than 20 mL/minute/1.73 m².

Dose adjustments Reduce dose.

Monitoring Monitor haematological parameters in renal impairment.

Monitor renal function in renal impairment.

Dactinomycin

(Actinomycin D)

- INDICATIONS AND DOSE
  - Wilms’ tumour | Childhood rhabdomyosarcoma and other soft-tissue sarcomas | Ewing’s sarcoma
  - By INTRAVENOUS INJECTION
  - Child: (consult local protocol)

- UNLICENSED USE
  - Not licensed for use in children under 12 years.

- CAUTIONS
  - Caution in handling—irritant to tissues

- INTERACTIONS
  - Appendix 1: dactinomycin

- SIDE-EFFECTS
  - Agranulocytosis · alopecia · anaemia · appetite decreased · ascites · bone marrow disorders · diarrhoea · dysphagia · fatigue · fever · gastrointestinal discomfort · gastrointestinal disorders · growth retardation · healing impaired · hepatic disorders · hypocalcaemia · increased risk of infection · lethargy · leucopenia · leukaemia secondary · malaise · myalgia · nausea · neutropenia · oedema · oral disorders · pneumonitis · renal impairment · reticulocytopenia · secondary neoplasia · sepsis · severe cutaneous adverse reactions (SCARs) · sinusoidal obstruction syndrome · skin reactions · soft tissue damage · thrombocytopenia · tumour lysis syndrome · venous thrombosis · vomiting

- CONCEPTION AND CONTRACEPTION

Exclude pregnancy before treatment with cytotoxic drugs. Contraceptive advice should be given to men and women before cytotoxic therapy begins (and should cover the duration of contraception required after therapy has ended). Regimens that do not contain an alkylating drug or procarbazine may have less effect on fertility, but those with an alkylating drug or procarbazine carry the risk of causing permanent male sterility (there is no effect on potency). Pretreatment counselling and consideration of sperm storage may be appropriate. Women are less severely affected, though the span of reproductive life may be shortened by the onset of a premature menopause. No increase in fetal abnormalities or abortion rate has been recorded in patients who remain fertile after cytotoxic chemotherapy.

- PREGNANCY

Avoid (teratogenic in animal studies). Most cytotoxic drugs are teratogenic and should not be administered during pregnancy, especially during the first trimester. Considerable caution is necessary if a pregnant woman presents with cancer requiring chemotherapy, and specialist advice should always be sought

- BREAST FEEDING

Discontinue breast-feeding.

- HEPATIC IMPAIRMENT

Dose adjustments Consider dose reduction if raised serum bilirubin or biliary obstruction; consult local treatment protocols.

- MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for injection

- Cosmegen (Recordati Rare Diseases UK Ltd)
  - Dactinomycin 500 microgram
  - Cosmegen Lyovac 500microgram powder for solution for injection vials | 1 vial
  - £52.58

ANTINEOPLASTIC DRUGS > PLATINUM COMPOUNDS
Bevacizumab in combination with paclitaxel and carboplatin for the first-line treatment of advanced ovarian cancer (May 2013) NICE TA284
Bevacizumab in combination with paclitaxel and carboplatin is not recommended for the first-line treatment of advanced ovarian cancer (including fallopian tube and primary peritoneal cancer).
www.nice.org.uk/TA284

Bevacizumab in combination with gemcitabine and carboplatin for the treatment of the first recurrence of platinum-sensitive advanced ovarian cancer (May 2013) NICE TA285
Bevacizumab in combination with gemcitabine and carboplatin is not recommended within its marketing authorisation, that is, for the treatment of the first recurrence of platinum-sensitive advanced ovarian cancer (including fallopian tube and primary peritoneal cancer) that has not been previously treated with bevacizumab or other vascular endothelial growth factor (VEGF) inhibitors or VEGF receptor-targeted agents.
www.nice.org.uk/TA285

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Solution for infusion
- Carboplatin (Non-proprietary)
  Carboplatin 10 mg per 1 ml Carboplatin 50mg/5ml concentrate for solution for infusion vials | 1 vial (POM) £20.67–£22.04 (Hospital only) | 1 vial (POM) £20.20
  Carboplatin 15mg/15ml concentrate for solution for infusion vials | 1 vial (POM) £53.39–£56.92 (Hospital only) | 1 vial (POM) £60.59
  Carboplatin 600mg/60ml concentrate for solution for infusion vials | 1 vial (POM) £243.89–£264.53 (Hospital only) | 1 vial (POM) £232.64
  Carboplatin 600mg/60ml solution for infusion vials | 1 vial (POM) £260.00 (Hospital only) | 1 vial (POM) £260.00
  Carboplatin 450mg/45ml concentrate for solution for infusion vials | 1 vial (POM) £138.40–£168.85 (Hospital only) | 1 vial (POM) £131.77
  Carboplatin 450mg/45ml solution for infusion vials | 1 vial (POM) £197.48 (Hospital only) | 1 vial (POM) £197.48
  Carboplatin 150mg/15ml solution for infusion vials | 1 vial (POM) £65.83 (Hospital only) | 1 vial (POM) £65.83
  Carboplatin 50mg/5ml solution for infusion vials | 1 vial (POM) £22.86 (Hospital only) | 1 vial (POM) £22.86

Cisplatin

INDICATIONS AND DOSE
Osteogenic sarcoma | Stage 4 neuroblastoma | Some liver tumours | Brain tumours | Intra-cranial germ-cell tumours
- By intravenous infusion
- Child: (consult local protocol)

UNLICENSED USE
Not licensed for use in children.

CAUTIONS
CAUTIONS, FURTHER INFORMATION
Hydration: Cisplatin requires intensive intravenous hydration; routine use of intravenous fluids containing potassium or magnesium may also be required to help control hypokalaemia and hypomagnesaemia. Treatment may be complicated by severe nausea and vomiting; delayed vomiting may occur and is difficult to control.

INTERACTIONS
- Appendix 1: platinum compounds

SIDE-EFFECTS
- Common or very common Anaemia | arrhythmias | bone marrow failure | electrolyte imbalance | extravasation | necrosis | fever | leucopenia | nephrotoxicity (dose-related and potentially cumulative) | sepsis | thrombocytopenia
- Uncommon Anaphylactoid reaction | ototoxicity (dose-related and potentially cumulative) | spermatogenesis abnormal
- Rare or very rare Acute leukaemia | cardiac arrest | encephalopathy | myocardial infarction | nerve disorders | seizure | stomatitis
- Frequency not known Alopecia | appetite decreased | asthenia | autonomic dysfunction | cardiac disorder | cerebrovascular insufficiency | deafness | dehydration | diarrhoea | haemolytic anaemia | hiccups | hyperuricaemia | infection | Lhermitte’s sign | malaise | muscle spasms | myelopathy | nausea | papilloedema | pulmonary embolism | rash | Raynaud’s phenomenon | renal impairment | renal tubular disorder | retinal discolouration | SIADH | taste loss | tetany | thrombotic microangiopathy | tininitus | vision disorders | vomiting

CONCEPTION AND CONTRACEPTION
Manufacturer advises effective contraception during and for at least 6 months after treatment in men or women.

PREGNANCY
Avoid (teratogenic and toxic in animal studies. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING
Discontinue breast-feeding.

RENAL IMPAIRMENT
Avoid if possible—nephrotoxic.

Monitoring
Baseline testing of renal function is required; for children with pre-existing renal impairment, consideration should be given to withholding treatment or using another drug.

MONITORING REQUIREMENTS
- Monitor full blood count.
- Monitor audiology.
- Monitor plasma electrolytes.
- Baseline testing of hearing is required; for children with pre-existing hearing impairment, consideration should be given to withholding treatment or using another drug.
- For children with pre-existing marked bone-marrow suppression, consideration should be given to withholding treatment or using another drug.
- Monitor renal function.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Solution for infusion
- Cisplatin (Non-proprietary)
  Cisplatin 1 mg per 1 ml Cisplatin 50mg/5ml concentrate for solution for infusion vials | 1 vial (POM) £25.11–£28.11 DT = £26.51 (Hospital only)
  Cisplatin 100mg/100ml solution for infusion vials | 1 vial (POM) £50.22 DT = £50.88 | 1 vial (POM) £50.22 DT = £50.88 (Hospital only)
  Cisplatin 10mg/10ml solution for infusion vials | 1 vial (POM) £5.90
  Cisplatin 50mg/50ml solution for infusion vials | 1 vial (POM) £25.37–£28.11 DT = £26.51 | 1 vial (POM) £25.37 DT = £26.51 (Hospital only)
  Cisplatin 10mg/10ml concentrate for solution for infusion vials | 1 vial (POM) £5.36 (Hospital only)
  Cisplatin 100mg/100ml concentrate for solution for infusion vials | 1 vial (POM) £50.22–£55.64 DT = £50.88 (Hospital only)
**ANTINEOPLASTIC DRUGS > PODOPHYLLOTOXIN DERIVATIVES**

**Etoposide**  
12-Jul-2018

- **INDICATIONS AND DOSE**
  - Stage 4 neuroblastoma | Germ-cell tumours | Intracranial germ-cell tumours | Rhabdomyosarcoma | Soft-tissue sarcomas | Neuroectodermal tumours (including medulloblastoma) | Relapsed Hodgkin's disease | Non-Hodgkin's lymphoma | Ewing tumour | Acute lymphoblastic leukaemia | Acute myeloid leukaemia
  - By mouth, or by intravenous infusion
  - Child: (consult local protocol)

- **SIDE-EFFECTS**
  - Common or very common: Abdominal pain · acute leukaemia · alopecia · anaemia · appetite decreased · arrhythmia · asthenia · bone marrow depression · constipation · diarrhoea · dizziness · hepatotoxicity · hypertension · leucopenia · malaise · mucositis · myocardial infarction · nausea · neutropenia · skin reactions · thrombocytopenia · vomiting
  - Uncommon: Nerve disorders
  - Rare or very rare: Dysphagia · neurotoxicity · radiation recall reaction · respiratory disorders · seizure · severe cutaneous adverse reactions (SCARs) · taste altered · vision loss

- **SPECIFIC SIDE-EFFECTS**
  - Common or very common: With intravenous use · Anaphylactic reaction · hypotension · infection
  - With oral use: Oesophagitis · stomatitis · transient systolic hypotension
  - Uncommon: With intravenous use · Haemorrhage
  - Rare or very rare: With intravenous use · Fever
  - With oral use: Drowsiness
  - Frequency not known: With intravenous use · Angioedema · extravasation necrosis · infertility · tumour lysis syndrome

- **CONCEPTION AND CONTRACEPTION**
  - Contraceptive advice: required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **PREGNANCY**
  - Avoid (teratogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**
  - Discontinue breast-feeding.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution (increased risk of accumulation).

- **RENAL IMPAIRMENT**
  - Dose adjustments: Consider dose reduction—consult local treatment protocol for details.

- **DIRECTIONS FOR ADMINISTRATION**
  - Etoposide is usually given by slow intravenous infusion. It may also be given by mouth, but it is unpredictably absorbed.

- **UNLICENSED USE**
  - Not licensed for use in children.

- **IMPORTANT SAFETY INFORMATION**

- **INTERACTIONS**
  - Appendix 1: etoposide

- **SIDE-EFFECTS**
  - General side-effects:
    - Common or very common: Abdominal pain · acute leukaemia · alopecia · anaemia · appetite decreased · arrhythmia · asthenia · bone marrow depression · constipation · diarrhoea · dizziness · hepatotoxicity · hypertension · leucopenia · malaise · mucositis · myocardial infarction · nausea · neutropenia · skin reactions · thrombocytopenia · vomiting
    - Uncommon: Nerve disorders
    - Rare or very rare: Dysphagia · neurotoxicity · radiation recall reaction · respiratory disorders · seizure · severe cutaneous adverse reactions (SCARs) · taste altered · vision loss

- **SPECIFIC SIDE-EFFECTS**
  - Common or very common: With intravenous use · Anaphylactic reaction · hypotension · infection
  - With oral use: Oesophagitis · stomatitis · transient systolic hypotension
  - Uncommon: With intravenous use · Haemorrhage
  - Rare or very rare: With intravenous use · Fever
  - With oral use: Drowsiness
  - Frequency not known: With intravenous use · Angioedema · extravasation necrosis · infertility · tumour lysis syndrome

- **CONCEPTION AND CONTRACEPTION**
  - Contraceptive advice: required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

- **Solution for infusion**
  - Etoposide (Non-proprietary)
    - Etoposide 20 mg per 1 ml (etoposide 100mg/5ml concentrate for solution for infusion vials) 1 vial (£11.50–13.51) (Hospital only)
    - Etoposide 200 mg/10ml concentrate for solution for infusion vials 1 vial (£10.70–11.75) (Hospital only)
    - Etoposide 500 mg/25ml concentrate for solution for infusion vials 1 vial (£12.00–17.75) (Hospital only)

- **Capsule**
  - CAUTIONARY AND ADVISORY LABELS
    - Vepesid (Bristol-Myers Squibb Pharmaceuticals Ltd)
      - Etoposide 50 mg Vepesid 50mg capsules 20 capsule (£99.82) (Hospital only)
      - Etoposide 100 mg Vepesid 100mg capsules 10 capsule (£115.00–119.88) (Hospital only)

- **Powder for solution for injection**
  - Etophos (Bristol-Myers Squibb Pharmaceuticals Ltd)
    - Etoposide (as Etoposide phosphate) 100 mg Etophos 100mg powder for solution for injection vials 10 vial (£261.68) (Hospital only)

**ANTINEOPLASTIC DRUGS > VINCA ALKALOIDS**

**Vinblastine sulfate**

- **INDICATIONS AND DOSE**
  - Hodgkin’s disease and other lymphomas
  - By intravenous injection
    - Child: (consult local protocol)

- **UNLICENSED USE**
  - Licensed for use in children (age range not specified by manufacturer).

- **IMPORTANT SAFETY INFORMATION**
  - Vinblastine is for intravenous administration only. Inadvertent intrathecal administration can cause severe neurotoxicity, which is usually fatal.
  - The National Patient Safety Agency has advised (August 2008) that adult and teenage patients treated in an adult or adolescent unit should receive their vinca alkaloid dose in a 50 mL minibag. Teenagers and children treated in a child unit may receive their vinca alkaloid dose in a syringe.

- **CONTRA-INDICATIONS**
  - Contra-indications, further information: Intrathecal injection contra-indicated.

- **CAUTIONS**
  - Caution in handling—irritant to tissues

- **INTERACTIONS**
  - Appendix 1: vinca alkaloids

- **SIDE-EFFECTS**
  - Rare or very rare: Hearing impairment · nerve disorders · vestibular damage
  - Frequency not known: Abdominal pain · acute respiratory distress syndrome (ARDS) · alopecia (reversible) · anaemia · appetite decreased · asthenia · balance impaired · cancer pain · constipation · depression · diarrhoea · dizziness · dyspnoea · haemorrhage · headache · hypertension · ileus · increased risk of infection · leucopenia (dose-limiting) · malaise · mediastinal disorder · myalgia · myocardial infarction · nausea · nyctagmus · oral blistering · pain · Raynaud’s phenomenon · refexes absent · seizure · sensation abnormal · SIADH · skin reactions · stroke · thrombocytopenia · vertigo · vomiting

- **SIDE-EFFECTS, FURTHER INFORMATION**
  - Constipation
  - Prophylactic use of laxatives may be considered.

- **CONCEPTION AND CONTRACEPTION**
  - Contraceptive advice: required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.
**PREGNANCY** Avoid (limited experience suggests fetal harm; teratogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**BREAST FEEDING** Discontinue breast-feeding.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in significantly impaired hepatic or biliary function.

**Dose adjustments** Manufacturer advises consider initial dose reduction in significantly impaired hepatic or biliary function.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**SOLUTION FOR INJECTION**
- **Vincristine sulfate (Non-proprietary)**
  - Vincristine sulfate 1 mg per 1 ml: Vinblastine 10mg/10ml solution for injection vials | 5 vial (Hospital only)

**VINCRISTINE SULFATE**

| **INDICATIONS AND DOSE** | **Acute leukaemias | Lymphomas | Paediatric solid tumours** |
|--------------------------|-------------------|
| **Child:** (consult local protocol) |

**UNLICENSED USE** Licensed for use in children (age range not specified by manufacturer).

**IMPORTANT SAFETY INFORMATION**

Vincristine injections are for intravenous administration only. Inadvertent intrathecal administration can cause severe neurotoxicity, which is usually fatal.

The National Patient Safety Agency has advised (August 2008) that adult and teenage patients treated in an adult or adolescent unit should receive their vinca alkaloid dose in a 50 ml minibag. Teenagers and children treated in a child unit may receive their vinca alkaloid dose in a syringe.

**CONTRA-INDICATIONS**

CONTRA-INDICATIONS, FURTHER INFORMATION

Intrathecal injection contra-indicated.

**CAUTIONS** Caution in handling—irritant to tissues • ileus • neuromuscular disease

**INTERACTIONS** Appendix 1: vinca alkaloids

**SIDE-EFFECTS**

- Rare or very rare
  - Hypersensitivity • rash • SIAHD
- **Frequency not known**
  - Abdominal cramps • adrenal disorder • alopecia • anaemia • appetite decreased • azotemia • bladder atony • bronchospasm • connective tissue disorders • constipation • coronary artery disease • dehydration • diarrhoea • dizziness • dyspnoea • eighth cranial nerve damage • eye disorders • fever • gait abnormalities • gastrointestinal disorders • haemolytic anaemia • headache • hearing impairment • hypertension • hyponatraemia • hypotension • infection • leucopenia • movement disorders • muscle atrophy • myalgia • myocardial infarction • nausea • neuromuscular effects (dose-limiting) • neutropenia • oedema • oral disorders • pain • paralysis • paresis • reflexes absent • renal disorder • secondary malignancy • seizure • sensation abnormal • sepsis • throat pain • thrombocytopenia • urinary disorders • vertigo • vestibular damage • vision loss • vomiting • weight decreased

SIDE-EFFECTS, FURTHER INFORMATION

**Bromochaspm**

Severe bronchospasm following administration is more common when used in combination with mitomycin-C.

**Neurotoxicity** Sensory and motor neuropathies are common and are cumulative. Manufacturer advises monitoring patients for symptoms of neuropathy, such as hypoesthesia, hyperesthesia, paresthesia, hyperreflexia, areflexia, neuralgia, jaw pain, decreased vibratory sense, cranial neuropathy, ileus, burning sensation, arthralgia, myalgia, muscle spasm, or weakness, both before and during treatment—requires dose reduction, treatment interruption or treatment discontinuation, depending on severity.

Motor weakness can also occur and dose reduction or discontinuation of therapy may be appropriate if motor weakness increases. Recovery from neurotoxic effects is usually slow but complete.

**Constipation** Prophylactic use of laxatives may be considered.

**CONCEPTION AND CONTRACEPTION** Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**PREGNANCY** Avoid (teratogenicity and fetal loss in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**BREAST FEEDING** Discontinue breast-feeding.

**HEPATIC IMPAIRMENT** Manufacturer advises consider dose reduction.

**Dose adjustments** Manufacturer advises dose reduction.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**SOLUTION FOR INJECTION**

- **Vincristine sulfate (Non-proprietary)**
  - Vinblastine sulfate 1 mg per 1 ml: Vinblastine 10mg/10ml solution for injection vials | 5 vial (Hospital only)

**ANTINEOPLASTIC DRUGS** OTHER

**Asparaginase**

**DRUG ACTION** Asparaginase is an enzyme which acts by breaking down L-asparagine to aspartic acid and ammonia, this disrupts protein synthesis of tumour cells.

**INDICATIONS AND DOSE**

Acute lymphoblastic leukaemia (in combination with other antineoplastic drugs) (specialist use only)

- **BY INTRAVENOUS INJECTION**
  - Neonate: (consult product literature or local protocols).
  - Child 1-11 months: (consult product literature or local protocols)
  - Child 1-17 years: 5000 units/m² every 3 days

**CONTRA-INDICATIONS** History of pancreatitis related to asparaginase therapy • history of serious haemorrhage related to asparaginase therapy • history of serious thrombosis related to asparaginase therapy • pancreatitis • pre-existing known coagulopathy

**CAUTIONS** Diabetes (may raise blood glucose) • hypersensitivity reactions • hypertriglyceridaemia (severe)—increased risk of acute pancreatitis

**CONTRA-INDICATIONS, FURTHER INFORMATION**

History of pancreatitis related to asparaginase therapy • history of serious haemorrhage related to asparaginase therapy • history of serious thrombosis related to asparaginase therapy • pancreatitis • pre-existing known coagulopathy.

**CAUTIONS** Diabetes (may raise blood glucose) • hypersensitivity reactions • hypertriglyceridaemia (severe)—increased risk of acute pancreatitis

**INTERACTIONS** Appendix 1: asparaginase
Cytotoxic responsive malignancy

SIDE-EFFECTS
- Common or very common: Abdominal pain, agitation, anaemia, angioedema, appetite decreased, arthralgia, back pain, bronchospasm, confusion, depression, diarrhoea, disseminated intravascular coagulation, dizziness, drowsiness, dyspnoea, embolism and thrombosis, fatigue, flushing, haemorrhage, hallucination, hyperglycaemia, hypersensitivity, hypoaalbuminaemia, hypoglycaemia, hypotension, increased risk of infection, leucopenia, nausea, neurological effects, oedema, pancreatitis, skin reactions, thrombocytopenia, vomiting, weight decreased
- Uncommon: Headache, hyperammonaemia, hyperuricaemia
- Rare or very rare: Coma, consciousness impaired, diabetic ketoacidosis, hepatic disorders, hyperparathyroidism, hypoparathyroidism, ischaemic stroke, necrotising pancreatitis, pancreatic pseudocyst, posterior reversible encephalopathy syndrome (PRES), seizure, tremor

SIDE-EFFECTS, FURTHER INFORMATION
There have been rare reports of cholesterol, icterus, hepatic cell necrosis and hepatic failure with fatal outcome; manufacturer advises interrupt treatment if these symptoms develop.

CONCEPTION AND CONTRACEPTION
Manufacturer advises effective contraception in men and women of child-bearing potential during treatment and for at least 3 months after last dose; asparaginase may reduce effectiveness of oral contraceptives—additional precautions (e.g. barrier method) are required, see also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY
Manufacturer advises avoid unless essential—toxicity in animal studies. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING
Manufacturer advises avoid—no information available.

HEPATIC IMPAIRMENT
Manufacturer advises avoid in severe impairment—no information available.

MONITORING REQUIREMENTS
- Manufacturer advises monitor trough serum asparaginase levels 3 days after administration; consider switching to a different asparaginase preparation if target levels not reached—seek expert advice.
- Manufacturer advises monitor bilirubin, hepatic transaminases, and coagulation parameters before and during treatment; in addition, monitor plasma and urinary glucose, amylase, lipase, triglycerides, cholesterol and serum protein levels during treatment.

HANDLING AND STORAGE
Manufacturer advises store in a refrigerator (2–8°C)—consult product literature for storage conditions after reconstitution and dilution.

PATIENT AND CARER ADVICE
- Driving and skilled tasks: Manufacturer advises asparaginase has moderate influence on driving and performance of skilled tasks—increased risk of dizziness and somnolence.

NATIONAL FUNDING/ACCESS DECISIONS
Scottish Medicines Consortium (SMC) decisions
SMC No. 1319/18
The Scottish Medicines Consortium has advised (April 2018) that asparaginase (Spectrila®) is accepted for use within NHS Scotland when used as a component of antineoplastic combination therapy for the treatment of acute lymphoblastic leukaemia in paediatric patients from birth to 18 years and adults.

DRUG ACTION
Crisantaspase is the enzyme asparaginase produced by Erwinia chrysanthemi.

INDICATIONS AND DOSE
- Acute lymphoblastic leukaemia
- Acute myeloid leukaemia
- Non-Hodgkin’s lymphoma

DIRECTIONS FOR ADMINISTRATION
BY INTRAVENOUS INJECTION, OR BY INTRAMUSCULAR INJECTION, OR BY SUBCUTANEOUS INJECTION
Child: (consult local protocol)

UNLICENSED USE
Preparations of asparaginase derived from Escherichia coli are available but they are not licensed, they include: Medac® asparaginase and Elspar® asparaginase.

CONTRA-INDICATIONS
History of pancreatitis related to asparaginase therapy

CAUTIONS
Diabetes (may raise blood glucose)

INTERACTIONS
- Appendix 1: crisantaspase

SIDE-EFFECTS
- Common or very common: Chills, coagulation disorders, confusion, diarrhoea, dizziness, drowsiness, dyspnoea, face oedema, fever, headache, hepatic disorders, hypersensitivity, limb swelling, lip swelling, neurotoxicity, pain, pallor, pancreatitis, seizures, skin reactions, thrombosis
- Uncommon: Hyperglycaemia, hyperlipidaemia, hypoxia, increased risk of infection, respiratory disorders
- Rare or very rare: Arthritis reactive, coma, diabetic ketoacidosis, dysphagia, dysphasia, encephalopathy, haemorrhage, level of consciousness decreased, myalgia, myocardial infarction, necrotising pancreatitis, neuropenia, paresis, sepsis, thrombocytopenia
- Frequency not known: Abdominal pain, flushing, hyperammonaemia, hypertension, hypotension, nausea, pseudocyst, vomiting

ALLERGY AND CROSS-SENSITIVITY
Children who are hypersensitive to asparaginase derived from one organism but cross-sensitivity occurs in about 20–30% of individuals.

CONCEPTION AND CONTRACEPTION
Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

PREGNANCY
Avoid. See also, Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING
Discontinue breast-feeding.

DIRECTIONS FOR ADMINISTRATION
Facilities for the management of anaphylaxis should be available.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for infusion
- Spectrila (medac UK) ▼
  Asparaginase 10000 unit Spectrila, 10,000 unit powder for concentrate for solution for infusion vials | 1 vial (p) £450.00 (Hospital only)

CRISANTASPASE

Drug Action
Crisantaspase is the enzyme asparaginase produced by Erwinia chrysanthemi.

Indications and Dose
- Acute lymphoblastic leukaemia | Acute myeloid leukaemia
- Non-Hodgkin’s lymphoma

DIRECTIONS FOR ADMINISTRATION
BY INTRAVENOUS INJECTION, OR BY INTRAMUSCULAR INJECTION, OR BY SUBCUTANEOUS INJECTION
Child: (consult local protocol)

Unlicensed Use
Preparations of asparaginase derived from Escherichia coli are available but they are not licensed, they include: Medac® asparaginase and Elspar® asparaginase.

Contra-indications
History of pancreatitis related to asparaginase therapy

Cautions
Diabetes (may raise blood glucose)

Interactions
- Appendix 1: crisantaspase

Side-effects
- Common or very common: Chills, coagulation disorders, confusion, diarrhoea, dizziness, drowsiness, dyspnoea, face oedema, fever, headache, hepatic disorders, hypersensitivity, limb swelling, lip swelling, neurotoxicity, pain, pallor, pancreatitis, seizures, skin reactions, thrombosis
- Uncommon: Hyperglycaemia, hyperlipidaemia, hypoxia, increased risk of infection, respiratory disorders
- Rare or very rare: Arthritis reactive, coma, diabetic ketoacidosis, dysphagia, dysphasia, encephalopathy, haemorrhage, level of consciousness decreased, myalgia, myocardial infarction, necrotising pancreatitis, neuropenia, paresis, sepsis, thrombocytopenia
- Frequency not known: Abdominal pain, flushing, hyperammonaemia, hypertension, hypotension, nausea, pseudocyst, vomiting

Allergy and Cross-sensitivity
Children who are hypersensitive to asparaginase derived from one organism but cross-sensitivity occurs in about 20–30% of individuals.

Conception and Contraception
Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

Pregnancy
Avoid. See also, Pregnancy and reproductive function in Cytotoxic drugs p. 551.

Breast Feeding
Discontinue breast-feeding.

Directions for Administration
Facilities for the management of anaphylaxis should be available.

Medicinal Forms
There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for injection
- Erwinase (Jazz Pharmaceuticals UK)
  Crisantaspase 10000 unit Erwinase, 10,000 unit powder for solution for injection vials | 1 vial (p) £13,065.00
Hydroxycarbamide
(Hydroxyurea)

22-Mar-2018

- **INDICATIONS AND DOSE**

  **SIKLOS®**
  Sickle-cell disease [prevention of recurrent vaso-occlusive crises] (initiated by a specialist)
  
  ▶ **BY MOUTH**
  
  - Child 2-17 years: Initially 10–15 mg/kg once daily, increased in steps of 2.5–5 mg/kg daily, dose to be increased every 12 weeks according to response; usual dose 15–30 mg/kg daily; maximum 35 mg/kg per day

- **SIDE-EFFECTS**

  
  ▶ **Rare or very rare** Gangrene

- **CONCEPTION AND CONTRACEPTION**

  Manufacturer advises caution in mild to moderate impairment. Avoid in severe impairment.

- **PREGNANCY**

  Avoid (teratogenic in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**

  Discontinue breast-feeding.

- **HEPATIC IMPAIRMENT**

  Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment (unless used for malignant conditions).

- **RENAL IMPAIRMENT**

  In sickle-cell disease, avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m². 
  
  **Dose adjustments**
  
  In sickle-cell disease, reduce initial dose by 50% if estimated glomerular filtration rate less than 60 mL/minute/1.73 m².

- **MONITORING REQUIREMENTS**

  ▶ **Monitor renal and hepatic function before and during treatment.**
  
  ▶ **Monitor full blood count before treatment, and repeatedly throughout use; in sickle-cell disease monitor every 2 weeks for the first 2 months and then every 2 months thereafter (or every 2 weeks if on maximum dose).**
  
  ▶ **Patients receiving long-term therapy for malignant disease should be monitored for secondary malignancies.**

- **PATIENT AND CARER ADVICE**

  Patients receiving long-term therapy with hydroxycarbamide should be advised to protect skin from sun exposure.

  Medicines for Children leaflet: Hydroxycarbamide for sickle cell disease www.medicinesforchildren.org.uk/hydroxycarbamide-sickle-cell-disease

- **MEDICINAL FORMS**

  There can be variation in the licensing of different medicines containing the same drug.

  **Tablet**

  ▶ **SIKLOS (Nordic Pharma Ltd)**
  
  Hydroxycarbamide 100 mg SIKLOS 100mg tablets | 60 tablet POM £100.00 DT + £300.00
  
  Hydroxycarbamide 1 gram SIKLOS 1000mg tablets | 30 tablet POM £500.00 DT + £500.00

**Mitotane**

- **DRUG ACTION**

  Mitotane selectively inhibits the activity of the adrenal cortex, necessitating corticosteroid replacement therapy.

- **INDICATIONS AND DOSE**

  Symptomatic treatment of advanced or inoperable adrenocortical carcinoma

  – **BY MOUTH**
  
  – Child: (consult local protocol)

- **UNLICENSED USE**

  Not licensed for use in children.

**IMPORTANT SAFETY INFORMATION**

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

- **CAUTIONS**

  Avoid in Acute porphyrias p. 524. risk of accumulation in overweight patients.

- **INTERACTIONS**

  **Appendix 1: mitotane**

- **SIDE-EFFECTS**

  ▶ **Common or very common** Adrenal insufficiency - anaemia - appetite decreased - asthenia - cognitive impairment - confusion - diarrhoea - dizziness - drowsiness - dyslipidaemia - gastrointestinal discomfort - gynaecomastia - headache - hepatic disorders - leucopenia - movement disorders - mucositis - muscle weakness - nausea - paraesthesia - polynuropathy - rash - thrombocytopenia - vertigo - vomiting
  
  ▶ **Rare or very rare** Encephalopathy - eye disorders - flushing - fungal infection - generalised pain - growth retardation - haemorrhage - hyperpyrexia - hypersalivation - hypertension - hypothyroidism - hypouricaemia - lens opacity - neuro-psychological retardation - ovarian cyst - postural hypotension - proteinuria - taste altered - thyroid disorder - vision disorders

- **CONCEPTION AND CONTRACEPTION**

  Contraceptive advice required, see Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **PREGNANCY**

  Manufacturer advises avoid. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING**

  Discontinue breast-feeding.

- **HEPATIC IMPAIRMENT**

  Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment (limited information available).

  Monitoring In mild to moderate hepatic impairment, monitoring of plasma-mitotane concentration is recommended.

- **RENAL IMPAIRMENT**

  Manufacturer advises caution in mild to moderate impairment. Avoid in severe impairment.

  Monitoring In mild to moderate renal impairment, monitoring of plasma-mitotane concentration is recommended.

**MONITORING REQUIREMENTS**

- **Monitor plasma-mitotane concentration—consult product literature.**

**PRESCRIBING AND DISPENSING INFORMATION**

Corticosteroid replacement therapy
Corticosteroid replacement therapy is necessary with treatment with
mito.

- **PATIENT AND CARER ADVICE** Patients should be warned to contact doctor immediately if injury, infection, or illness occurs (because of risk of acute adrenal insufficiency). Driving and skilled tasks Central nervous system toxicity may affect performance of skilled tasks (e.g. driving).

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  **Tablet**
  - CAUTIONARY AND ADVISORY LABELS 2, 10, 21
  - Lysodren (HRA Pharma UK Ltd)
  - Mitotane 500 mg Lysodren 500mg tablets | 100 tablet (PO)
  - £550.97

### Pegasparase

- **DRUG ACTION** Pegasparase breaks down the amino acid L-asparagine, thereby interfering with the growth of malignant cells, which are unable to synthesise L-asparagine.

- **INDICATIONS AND DOSE** Acute lymphoblastic leukaemia (in combination with other antineoplastic drugs) (specialist use only)
  - BY INTRAMUSCULAR INJECTION, OR BY INTRA VENOUS INFUSION
  - Neonate: 82.5 units/kg every 14 days.
  - Child (body surface area up to 0.6 m²): 82.5 units/kg every 14 days.
  - Child (body surface area 0.6 m² and above): 2500 units/m² every 14 days.

- **IMPORTANT SAFETY INFORMATION** Be aware that doses are calculated either using units/kg or units/m², depending on the size of the child.

- **CONTRA-INDICATIONS** History of pancreatitis - history of serious haemorrhagic event with previous L-asparaginase therapy - history of serious thrombosis with previous L-asparaginase therapy

- **CAUTIONS** Concomitant use of other hepatotoxic drugs (particularly in pre-existing hepatic impairment)—monitor hepatic function - diabetes (may raise blood glucose). Hypersensitivity reactions - marked decrease of leucocyte count at start of treatment is possible—may be associated with significant rise in serum uric acid and development of uric acid nephropathy

- **CAUTIONS, FURTHER INFORMATION**
  - Hyposensitivity reactions Serious hypersensitivity reactions, including life-threatening anaphylaxis, can occur—pegasparagse should only be administered when appropriately trained staff and resuscitation facilities are immediately available; manufacturer advises patients should be closely monitored for signs of hypersensitivity during treatment and for an hour after administration. In the event of a hypersensitivity reaction, treatment should be stopped immediately and appropriate management initiated.

- **INTERACTIONS** → Appendix 1: pegasparase

- **SIDE-EFFECTS**
  - Common or very common Abdominal pain - bone marrow depression - diarrhea - hyperglycaemia - hyponatraemia - hypoxia - pain in extremity - pancreatitis (discontinue if suspected and do not restart if confirmed) - peripheral neuropathy - rash - sepsis - stomatitis - syncope - thrombosis (discontinue) - vomiting
  - Rare or very rare Acute kidney injury - posterior reversible encephalopathy syndrome (PRES) - tremor

- **Frequency not known** Confusion - diabetic ketoadiposis - drowsiness - hepatobiliary disorder - hyperammonaemia (monitor if symptoms present) - toxic epidermal necrolysis

- **SIDE-EFFECTS, FURTHER INFORMATION** There have been rare reports of cholestasis, icterus, hepatic cell necrosis and hepatic failure with fatal outcome in patients receiving pegasparagse.

- **CONCEPTION AND CONTRACEPTION** Manufacturer advises effective contraception in men and women of child-bearing potential during treatment and for at least 6 months after discontinuing treatment; pegasparagse may reduce effectiveness of oral contraceptives—additional precautions (e.g. barrier method) are required, see also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **PREGNANCY** Manufacturer advises avoid unless essential. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- **BREAST FEEDING** Manufacturer advises avoid—no information available.

- **HEPATIC IMPAIRMENT** Manufacturer advises avoid in severe impairment.

- **MONITORING REQUIREMENTS**
  - Manufacturer advises trough serum asparaginase activity levels may be measured before the next administration of pegasparagse; consider switching to a different asparaginase preparation if target levels not reached—seek expert advice.
  - Manufacturer advises monitor plasma and urine glucose levels during treatment; monitor coagulation profile at baseline and periodically during and after treatment (particularly with concomitant use of other drugs that inhibit coagulation); monitor serum amylase.

- **DIRECTIONS FOR ADMINISTRATION** Manufacturer advises for intramuscular injection, volumes over 2 mL must be divided between more than one site.

- **HANDLING AND STORAGE** Manufacturer advises store in a refrigerator between 2–8°C.

- **PATIENT AND CARER ADVICE** Pancreatitis Manufacturer advises patients and carers should be told how to recognise signs and symptoms of pancreatitis and advised to seek medical attention if symptoms such as persistent, severe abdominal pain develop.

  Driving and skilled tasks Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of confusion and somnolence.

- **NATIONAL FUNDING/ACCESS DECISIONS**

  **NICE decisions**
  - Pegasparagse for treating acute lymphoblastic leukaemia (September 2016) NICE TA408
  - Pegasparagse, as part of antineoplastic combination therapy, is recommended as an option for treating acute lymphoblastic leukaemia only in patients with untreated newly diagnosed disease.
  - Patients whose treatment was started within the NHS before this guidance was published may continue treatment until they and their clinician consider it appropriate to stop.
  - www.nice.org.uk/guidance/ta408

  **Scottish Medicines Consortium (SMC) decisions**
  - The Scottish Medicines Consortium has advised (October 2016) that pegasparagse (Onaspar) is accepted for use within NHS Scotland as a component of antineoplastic combination therapy in acute lymphoblastic leukaemia.
574 Cytotoxic response to malignant disease

MEDICINAL FORMS There can be variation in the labeling of different medicines containing the same drug.

Solution for injection
- Oncaspar (Servier Laboratories Ltd)
- Pegaspargase 750 unit per ml (Servier Laboratories Ltd)

For injection vials | 1 vial | £1,296.19

Procarbazine

DRUG ACTION Procarbazine is a mild monoamine-oxidase inhibitor.

INDICATIONS AND DOSE Hodgkin’s lymphoma
- BY MOUTH
- Child: (consult local protocol)

SIDE-EFFECTS
- Common or very common Abdominal pain, alopecia, anxiety, appetite decreased, arthralgia, asthenia, bone pain, chills, chest pain, confusion, constipation, depression, diarrhea, dizziness, dry mouth, flushing, headache, hearing impairment, hyperhidrosis, idiopathic intracranial hypertension (children particularly susceptible - consider dose reduction if intractable headache in children), insomnia, intracranial pressure increased, malaise, nasal dryness, nausea, pancreatitis, paraesthesia, respiratory disorders, skin reactions, visual impairment, vomiting
- Frequency not known Embolism and thrombosis, erythema nodosum, genital ulceration, hepatotoxicity, hypercalcemia, increased leucocytes, myocardial infarction, myositis, necrotising fasciitis, QT interval prolongation, stroke, thrombocytopenia, vasculitis

SIDE-EFFECTS, FURTHER INFORMATION Children are particularly susceptible to nervous system effects.

RETINOIC ACID SYNDROME Fever, dyspnoea, acute respiratory distress, pulmonary infiltrates, pleural effusion, hyperleucocytosis, hypotension, oedema, weight gain, hepatic, renal and multi-organ failure requires immediate treatment — consult product literature.

CONCEPTION AND CONTRACEPTION Effective contraception must be used for at least 1 month before oral treatment, during treatment and for at least 1 month after stopping (oral progesterone-only contraceptives not considered effective).

PREGNANCY Teratogenic. See Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING Avoid (discontinue breast-feeding).

HEPATIC IMPAIRMENT Manufacturer advises caution.
Dose adjustments Manufacturer advises dose reduction.

RENAL IMPAIRMENT
Dose adjustments Reduce dose — consult local treatment protocol for details.

MONITORING REQUIREMENTS Monitor haematological and coagulation profile, liver function, serum calcium and plasma lipids before and during treatment.

PRESCRIBING AND DISPENSING INFORMATION Tretinoin is the acid form of vitamin A.

MEDICINAL FORMS There can be variation in the labeling of different medicines containing the same drug.

Capsule

CAUTIONARY AND ADVISORY LABELS
- 21, 25
- Tretinoin (Non-proprietary)
- Tretinoin 10 mg Tretinoin 10mg capsules | 100 capsule | £300.00–£315.00 DT = £300.00

2.1 Cytotoxic drug-induced side effects

DETOXIFYING DRUGS > UROPROTECTIVE DRUGS

Mesna

INDICATIONS AND DOSE
- Urothelial toxicity following oxazaphosphorine therapy
  - BY INTRAVENOUS INJECTION, OR BY CONTINUOUS INTRAVENOUS INFUSION
  - Child: (consult local protocol)

Mucolytic in cystic fibrosis
- BY INHALATION OF NEBULISED SOLUTION
  - Child: 3–6 ml twice daily, use a 20% solution

UNLICENSED USE Not licensed for use in children.
VITAMINS AND TRACE ELEMENTS

Folinic acid

**INDICATIONS AND DOSE**

Reduction of methotrexate-induced toxicity

- By mouth, or by intravenous infusion, or by intravenous injection
- Child: (consult local protocol)

Methotrexate overdose

- By intravenous infusion, or by intravenous injection
- Child: (consult local protocol)

Megaloblastic anaemia due to folate deficiency

- By mouth
- Child 1 month-11 years: 250 micrograms/kg once daily
- Child 12-17 years: 15 mg once daily

Metabolic disorders leading to folate deficiency

- By mouth, or by intravenous infusion
- Child: 15 mg once daily, larger doses may be required in older children

Prevention of megaloblastic anaemia associated with pyrimethamine and sulfadiazine treatment of congenital toxoplasmosis

- By mouth

- Neonate: 5 mg 3 times a week; increased if necessary up to 20 mg 3 times a week, if the patient is neutropenic.

- Child 1-11 months: 10 mg 3 times a week

**SODIOFOLIN**

As an antidote to methotrexate

- By intravenous infusion, or by intravenous injection
- Child: (consult product literature)

**UNLICENSED USE** Consult product literature for licensing status of individual preparations.

**CONTRA-INDICATIONS** Intrathecal injection

**CAUTIONS** Avoid simultaneous administration of methotrexate • not indicated for pernicious anaemia or other megaloblastic anaemias caused by vitamin B12 deficiency

**INTERACTIONS** → Appendix 1: folates

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **Uncommon** Fever
- **Rare or very rare** Agitation (with high doses) • depression (with high doses) • epilepsy exacerbated • gastrointestinal disorder (with high doses) • insomnia (with high doses) • urticaria

**SPECIFIC SIDE-EFFECTS**

- **Common or very common**
- With intravenous use • Bone marrow failure • dehydration • diarrhoea (with high doses) • mucositis • nausea • oral disorders • skin reactions • vomiting
- **Rare or very rare**
- With intravenous use • Sensitisation
- **Fever not known**
- With intravenous use • Hyperammonaemia
- **PREGNANCY** Not known to be harmful; benefit outweighs risk.
- **BREAST FEEDING** Presence in milk unknown but benefit outweighs risk.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Mesna (Non-proprietary)**
  - Mesna 100 mg per ml Mesna 1g/10ml solution for injection ampoules | 1 ampoule (£39.40) Mesna 400mg/4ml solution for injection ampoules | 5 ampoule (£308)
  - £7.00 | 15 ampoule (£39.40) £201.15

**Megaloblastic anaemia due to folate deficiency**

- By mouth
- Child 1 month-11 years: 250 micrograms/kg once daily
- Child 12-17 years: 15 mg once daily

**Metabolic disorders leading to folate deficiency**

- By mouth, or by intravenous infusion
- Child: 15 mg once daily, larger doses may be required in older children

**Prevention of megaloblastic anaemia associated with pyrimethamine and sulfadiazine treatment of congenital toxoplasmosis**

- By mouth

- Neonate: 5 mg 3 times a week; increased if necessary up to 20 mg 3 times a week, if the patient is neutropenic.

- Child 1-11 months: 10 mg 3 times a week

**SODIOFOLIN**

As an antidote to methotrexate

- By intravenous infusion, or by intravenous injection
- Child: (consult product literature)

**UNLICENSED USE** Consult product literature for licensing status of individual preparations.

**CONTRA-INDICATIONS** Intrathecal injection

**CAUTIONS** Avoid simultaneous administration of methotrexate • not indicated for pernicious anaemia or other megaloblastic anaemias caused by vitamin B12 deficiency

**INTERACTIONS** → Appendix 1: folates

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- **Uncommon** Fever
- **Rare or very rare** Agitation (with high doses) • depression (with high doses) • epilepsy exacerbated • gastrointestinal disorder (with high doses) • insomnia (with high doses) • urticaria

**SPECIFIC SIDE-EFFECTS**

- **Common or very common**
- With intravenous use • Bone marrow failure • dehydration • diarrhoea (with high doses) • mucositis • nausea • oral disorders • skin reactions • vomiting
- **Rare or very rare**
- With intravenous use • Sensitisation
- **Fever not known**
- With intravenous use • Hyperammonaemia
- **PREGNANCY** Not known to be harmful; benefit outweighs risk.
- **BREAST FEEDING** Presence in milk unknown but benefit outweighs risk.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, tablet.

**Tablet**

- Folinic acid (Non-proprietary)
- Folinic acid (as Calcium folinate) 15 mg Calcium folinate 15mg tablets | 10 tablet (£49.00 DT + £43.55)
- Refolinon (Pfizer Ltd) Folinic acid (as Calcium folinate) 15 mg Refolinon 15mg tablets | 30 tablet (£50) £85.74

**Solution for injection**

- Folinic acid (Non-proprietary)
- Folinic acid (as Calcium folinate) 7.5 mg per 1 ml Calcium folinate 15mg/2ml solution for injection ampoules | 5 ampoule (£39.00 DT + £39.00 (Hospital only))
- Folinic acid (as Calcium folinate) 10 mg per 1 ml Calcium folinate 350mg/35ml solution for injection vials | 1 vial (£120.00 | 10 vial (£1,216.80 Hospital only)) Calcium folinate 50mg/5ml solution for injection vials | 1 vial (£20.00 (Hospital only)) Calcium folinate 300mg/30ml solution for injection vials | 1 vial (£100.00 (Hospital only)) Calcium folinate 100mg/10ml solution for injection vials | 1 vial (£37.50 (Hospital only)) | 1 vial (£37.50 | 10 vial (£385.20 (Hospital only))
- Refolinon (Pfizer Ltd) Folinic acid (as Calcium folinate) 3 mg per 1 ml Refolinon 30mg/10ml solution for injection ampoules | 5 ampoule (£23.12 (Hospital only))
- Sodiofolin (medac UK) Folinic acid (as Disodium folinate) 50 mg per 1 ml Sodiofolin 400mg/8ml solution for injection vials | 1 vial (£126.25 (Hospital only)) Sodiofolin 100mg/2ml solution for injection vials | 1 vial (£35.09 (Hospital only))

**Levofolinic acid**

**DRUG ACTION** Levofolinic acid is an isomer of folic acid.

**INDICATIONS AND DOSE**

Reduction of methotrexate-induced toxicity

- By intramuscular injection, or by intravenous injection, or by intravenous infusion
- Child: (consult local protocol)

**SODIOFOLIN**

As an antidote to methotrexate

- By intravenous infusion, or by intravenous injection
- Child: (consult product literature)
2.1a Hyperuricaemia associated with cytotoxic drugs

Other drugs used for Hyperuricaemia associated with cytotoxic drugs Allopurinol, below

DETOXIFYING DRUGS > URATE OXIDASES

Rasburicase

- INDICATIONS AND DOSE
  Prophylaxis and treatment of acute hyperuricaemia with initial chemotherapy for haematological malignancy
    > BY INTRAVENOUS INFUSION
    > Child: (consult local protocol)

- UNLICENSED USE
  Not licensed for use in children.

- CONTRA-INDICATIONS
  G6PD deficiency

- CAUTIONS
  Atopic allergies

- SIDE-EFFECTS
  > Common or very common
    Diarrhoea • fever • headache • nausea • skin reactions • vomiting
  > Uncommon
    Bronchospasm • haemolysis • haemolytic anaemia • hypersensitivity • hypotension • methaemoglobinemia • seizure
  > Rare or very rare
    Rhinitis
  > Frequency not known
    Muscle contractions involuntary

- PREGNANCY
  Manufacturer advises avoid—no information available.

- MONITORING REQUIREMENTS
  Monitor closely for hypersensitivity.

- EFFECT ON LABORATORY TESTS
  May interfere with test for uric acid—consult product literature.

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

Powder and solvent for solution for infusion
  > Fasturtec (Sanofi)
    Rasburicase 1.5 mg. Fasturtec 1.5mg powder and solvent for solution for infusion vials | 3 vial £208.89 (Hospital only)
    Rasburicase 7.5 mg. Fasturtec 7.5mg powder and solvent for solution for infusion vials | 1 vial £347.32 (Hospital only)

XANTHINE OXIDASE INHIBITORS

Allopurinol

- INDICATIONS AND DOSE
  Prophylaxis of hyperuricaemia associated with cancer chemotherapy / Prophylaxis of hyperuricaemic nephropathy, enzyme disorders causing increased serum urate e.g. Lesch-Nyhan syndrome
    > BY MOUTH
  > Child 1 month-14 years: 10–20 mg/kg daily, dose to be taken preferably after food; maximum 400 mg per day
  > Child 15-17 years: Initially 100 mg daily, taken preferably after food; dose to be increased according to response, up to 900 mg daily in divided doses (max. per dose 300 mg)

- CAUTIONS
  Ensure adequate fluid intake • for hyperuricaemia associated with cancer therapy, allopurinol treatment should be started before cancer therapy

- INTERACTIONS
  > Common or very common
    Rash (discontinue therapy; if rash mild re-introduce cautiously but discontinue immediately if recurrence)
  > Uncommon
    Hypersensitivity • nausea • vomiting
  > Rare or very rare
    Agranulocytosis • alopecia • angina pectoris • angioedema • angioimmunoblastic T-cell lymphoma • aplastic anaemia • asthma • ataxia • boil • bradycardia • cataract • coma • depression • diabetes mellitus • drowsiness • erectile dysfunction • fever • gastrointestinal disorders • gynaecomastia • haemorrhage • hair colour changes • headache • hepatic disorders • hyperlipidaemia • hypertension • infertility male • maculopathy • malaise • oedema • paraesthesia • paralysis • peripheral neuropathy • severe cutaneous adverse reactions (SCARs) • skin reactions • stomatitis • taste altered • thrombocytopenia • vertigo • visual impairment

- PREGNANCY
  Toxicity not reported. Manufacturer advises use only if no safer alternative and disease carries risk for mother or child.

- BREAST FEEDING
  Present in milk—not known to be harmful.

- HEPATIC IMPAIRMENT
  Manufacturer advises monitor liver function periodically during early stages of therapy.

- Dose adjustments
  Manufacturer advises reduce dose.

- RENAL IMPAIRMENT
  Dose adjustments
  Manufacturer advises reduce dose or increase dose interval in severe impairment; adjust dose to maintain plasma-oxipurinol concentration below 100 micromol/litre.

- PATIENT AND CARER ADVICE
  Medicines for Children leaflet: Allopurinol for hyperuricaemia
  www.medicinesforchildren.org.uk/allopurinol-hyperuricaemia
### Immunotherapy responsive malignancy

#### IMMUNOSTIMULANTS

**Interferon alfa**

**Drug Action**

Interferon alfa has shown some antitumour effect in certain lymphomas and solid tumours.

- **Indications and Dose**

  - **Induction of early regression of life-threatening corticosteroid resistant haemangiomata of infancy**
    - By subcutaneous injection
    - Child: (consult local protocol)

  - **IntronA® Pen**
    - Chronic active hepatitis B
      - By subcutaneous injection
      - Child 2-17 years: 5 000 000–10 000 000 units/m² 3 times a week
    - Chronic active hepatitis C (in combination with oral ribavirin)
      - By subcutaneous injection
      - Child 3-17 years: 3 000 000 units/m² 3 times a week

  - **IntronA® IVials**
    - Chronic active hepatitis B
      - By subcutaneous injection
      - Child 2-17 years: 5 000 000–10 000 000 units/m² 3 times a week
    - Chronic active hepatitis C (in combination with ribavirin)
      - By subcutaneous injection
      - Child 3-17 years: 3 000 000 units/m² 3 times a week

  - **Roferon-A®**
    - Chronic active hepatitis B
      - By subcutaneous injection
      - Child 2-17 years: 2 500 000–5 000 000 units/m² 3 times a week, up to 10 000 000 units/m² has been used 3 times a week

- **Unlicensed Use**

  Not licensed for use in children for chronic active hepatitis B.

- **Contraindications**

  Avoid injections containing benzyl alcohol in neonates - history of severe psychiatric illness

  For contra-indications consult product literature and local treatment protocol.

- **Medicinal Forms**

  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, mouthwash

- **Tablet**

  **CAUTIONARY AND ADVISORY LABELS**

  - Alloquin (Non-proprietary)
    - Alloquin 100 mg Alloquin 100mg tablets | 28 tablet
      - Price £8.15 DT £1.72
    - Alloquin 300 mg Alloquin 300mg tablets | 28 tablet
      - Price £8.53 DT £6.35
  - Zyloric (Ennogen Pharma Ltd)
    - Zyloric 100 mg Zyloric 100mg tablets | 100 tablet
      - Price £30.19
    - Zyloric 300 mg Zyloric 300mg tablets | 28 tablet
      - Price £7.31

- **Medicines and pregnancy**

  Avoid injections containing benzyl alcohol in neonates

- **Medicines and breastfeeding**

  Unlikely to be harmful.

- **Hepatic impairment**

  Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

- **Monitoring**

  Close monitoring required in mild to moderate hepatic impairment.

- **Renal impairment**

  Avoid in severe renal impairment.

- **Monitoring Requirements**

  Monitoring of lipid concentration is recommended.

- **Monitoring of hepatic function is recommended.**

- **Directions for Administration**

  **IntronA® IVials**

  Introna® injection vials for subcutaneous injection or intravenous infusion.

  **Roferon-A®**

  Roferon-A® injection for subcutaneous injection.

- **Medicinal Forms**

  There can be variation in the licensing of different medicines containing the same drug.

  **Solution for injection**

  - **Excipients**
    - May contain Benzyl alcohol
      - IntronaA (Merck Sharp & Dohme Ltd)
    - **IntronA alfa 2b 10 mega u per 1 ml Introna 10ml units/1ml solution for injection vials | 1 vial**
      - Introna 25ml units/2.5ml solution for injection multidose vials | 1 vial
        - Price £103.94
    - **IntronA alfa 2b 15 mega u per 1 ml Introna 18ml units/1.2ml solution for injection multidose pens | 1 pre-filled disposable injection**
      - Price £74.83

- **Caution**

  **Cautionary, Further Information**

  For cautions consult product literature and local treatment protocol.

  Interferon alfa should always be used under the close supervision of a specialist; the decision to treat should be made only after careful assessment of the expected benefits versus the potential risks, in particular the risk of growth inhibition caused by combination therapy.

  **Interactions**

  Appendix 1: interferons

  **Side-Effects**

  - Common or very common

  **Side-Effects, Further Information**

  Respiratory symptoms should be investigated and if pulmonary infiltrates are suspected or lung function is impaired the discontinuation of interferon alfa should be considered.

  **Conception and contraception**

  Effective contraception required during treatment—consult product literature.

  **Pregnancy**

  Avoid unless potential benefit outweighs risk (toxicity in animal studies).

  **Breastfeeding**

  Unlikely to be harmful.

  **Hepatic Impairment**

  Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

  **Monitoring**

  Close monitoring required in mild to moderate hepatic impairment.

  **Renal Impairment**

  Avoid in severe renal impairment.

  **Monitoring**

  Close monitoring required in mild to moderate renal impairment.

  **Monitoring Requirements**

  Monitoring of lipid concentration is recommended.

  **Monitoring of hepatic function is recommended.**

  **Directions for Administration**

  **IntronA® IVials**

  Introna® injection vials for subcutaneous injection or intravenous infusion.

  **Roferon-A®**

  Roferon-A® injection for subcutaneous injection.

  **Medicinal Forms**

  There can be variation in the licensing of different medicines containing the same drug.

  **Solution for injection**

  **Excipients**

  - May contain Benzyl alcohol
    - **IntronA (Merck Sharp & Dohme Ltd)**
      - **IntronA alfa 2b 10 mega u per 1 ml Introna 10ml units/1ml solution for injection vials | 1 vial**
        - Introna 25ml units/2.5ml solution for injection multidose vials | 1 vial
          - Price £103.94
      - **IntronA alfa 2b 15 mega u per 1 ml Introna 18ml units/1.2ml solution for injection multidose pens | 1 pre-filled disposable injection**
        - Price £74.83

  **Caution**

  **Cautionary, Further Information**

  For cautions consult product literature and local treatment protocol.

  Interferon alfa should always be used under the close supervision of a specialist; the decision to treat should be made only after careful assessment of the expected benefits versus the potential risks, in particular the risk of growth inhibition caused by combination therapy.

  **Interactions**

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  **Side-Effects, Further Information**

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  Avoid unless potential benefit outweighs risk (toxicity in animal studies).

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  Unlikely to be harmful.

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  Monitoring of lipid concentration is recommended.

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  There can be variation in the licensing of different medicines containing the same drug.

  **Solution for injection**

  **Excipients**

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      - **IntronA alfa 2b 15 mega u per 1 ml Introna 18ml units/1.2ml solution for injection multidose pens | 1 pre-filled disposable injection**
        - Price £74.83
Interferon gamma-1b
(Immune interferon)

**INDICATIONS AND DOSE**
To reduce the frequency of serious infection in chronic granulomatous disease
- **BY SUBCUTANEOUS INJECTION**
  - Child 6 months-17 years (body surface area up to 0.6 m²): 1.5 micrograms/kg 3 times a week
  - Child 6 months-17 years (body surface area 0.6 m² and above): 50 micrograms/m² 3 times a week
To reduce the frequency of serious infection in severe malignant osteosarcoma
- **BY SUBCUTANEOUS INJECTION**
  - Child (body surface area up to 0.6 m²): 1.5 micrograms/kg 3 times a week
  - Child (body surface area 0.6 m² and above): 50 micrograms/m² 3 times a week

**CONTRA-INDICATIONS**
Simultaneous administration of foreign proteins including immunological products (such as vaccines)—risk of exaggerated immune response

**CAUTIONS**
Arrhythmias—cardiac disease; congestive heart failure—ischæmia; seizure disorders (including seizures associated with fever)

**SIDE-EFFECTS**
- Common or very common Abdominal pain—arthralgia—back pain—chills—depression—diarrhoea—fatigue—fever—headache—nausea—rash—vomiting

**CONCEPTION AND CONTRACEPTION**
Effective contraception required during treatment—consult product literature.

**PREGNANCY**
Manufacturers recommend avoid unless potential benefit outweighs risk (toxicity in animal studies).

**BREAST FEEDING**
Manufacturers advise avoid—no information available.

**HEPATIC IMPAIRMENT**
Manufacturer advises caution in severe impairment (increased risk of accumulation).

**RENAL IMPAIRMENT**
Manufacturer advises caution in severe impairment—risk of accumulation.

**MONITORING REQUIREMENTS**
Monitor before and during treatment: haematological tests (including full blood count, differential white cell count, and platelet count), blood chemistry tests (including renal and liver function tests) and urinalysis.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Immukin** (Roche Products Ltd)
  - Interferon alfa-2b 50 mega u per 1 ml
  - Interferon alfa-2b 50 million units per 1 ml

**IMMUNOSTIMULANTS**

**Mifamurtide**

**INDICATIONS AND DOSE**
Treatment of high-grade, resectable, non-metastatic osteosarcoma after complete surgical resection (in combination with chemotherapy)
- **BY INTRAVENOUS INFUSION**
- Child 2-17 years: Infusion to be given over 1 hour (consult product literature or local protocols)

**UNLICENSED USE**
Not licensed for use in patients under 2 years of age at initial diagnosis.

**CAUTIONS**
- Asthma—consider prophylactic bronchodilator therapy—chronic obstructive pulmonary disease—consider prophylactic bronchodilator therapy—history of autoimmune disease—history of collagen disease—history of inflammatory disease

**INTERACTIONS**
Appendix 1: mifamurtide

**SIDE-EFFECTS**

**CONCEPTION AND CONTRACEPTION**
Effective contraception required.

**PREGNANCY**
Avoid.

**BREAST FEEDING**
Avoid—no information available.

**HEPATIC IMPAIRMENT**
Manufacturer advises caution in moderate impairment (risk of increased half-life and exposure); avoid in severe impairment (no information available).

**RENAL IMPAIRMENT**
Use with caution—no information available.

**MONITORING REQUIREMENTS**
Monitor renal function, hepatic function and clotting parameters.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**
Mifamurtide for the treatment of osteosarcoma (October 2011) NICE TA235
Mifamurtide in combination with postoperative multi-agent chemotherapy is recommended (within its licensed
4 Targeted therapy responsive malignancy

ANTINEOPLASTIC DRUGS > PROTEIN KINASE INHIBITORS

Dasatinib

30-Apr-2019

- DRUG ACTION Dasatinib is a tyrosine kinase inhibitor.

- INDICATIONS AND DOSE
  Chronic phase chronic myeloid leukaemia (initiated by a specialist) / Acute lymphoblastic leukaemia (in combination with chemotherapy) (initiated by a specialist)

  - BY MOUTH USING TABLETS
    Child 1-17 years (body-weight 10-19 kg): 40 mg once daily, adjust dose based on changes in body-weight every 3 months or more often if necessary; for dose escalation, or dose adjustment due to side-effects—consult product literature
    Child 1-17 years (body-weight 20-29 kg): 60 mg once daily, adjust dose based on changes in body-weight every 3 months or more often if necessary; for dose escalation, or dose adjustment due to side-effects—consult product literature
    Child 1-17 years (body-weight 30-44 kg): 70 mg once daily, adjust dose based on changes in body-weight every 3 months or more often if necessary; for dose escalation, or dose adjustment due to side-effects—consult product literature
    Child 1-17 years (body-weight 45 kg and above): 100 mg once daily, adjust dose based on changes in body-weight every 3 months or more often if necessary; for dose escalation, or dose adjustment due to side-effects—consult product literature

- IMPORTANT SAFETY INFORMATION
  RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES
  See Cytotoxic drugs p. 551.

  MHRA/CHM ADVICE (MAY 2016): RISK OF HEPATITIS B VIRUS REACTIVATION WITH BCR-ABL TYROSINE KINASE INHIBITORS
  An EU wide review has concluded that dasatinib can cause hepatitis B reactivation; the MHRA recommends establishing hepatitis B virus status in all patients before initiation of treatment.

- CAUTIONS Hepatitis B infection - risk of cardiac dysfunction (monitor closely) - susceptibility to QT-interval prolongation (correct hypokalaemia or hypomagnesaemia before starting treatment)

- CAUTIONS, FURTHER INFORMATION
  Hepatitis B infection The MHRA advises that patients who are carriers of hepatitis B virus should be closely monitored for signs and symptoms of active infection throughout treatment and for several months after stopping treatment; expert advice should be sought for patients who test positive for hepatitis B virus and in those with active infection.

- INTERACTIONS > Appendix 1: dasatinib

- SIDE-EFFECTS


  - Rare or very rare Cardiac arrest - dementia - diabetes mellitus - facial paralysis - gait abnormal - hypersensitivity vasculitis - hyperthyroidism - pure red cell aplasia - seizure - thyroiditis

  - Frequency not known Hepatitis B reactivation - nephrotic syndrome - Stevens-Johnson syndrome

- CONCEPTION AND CONTRACEPTION Effective contraception required during treatment.

- PREGNANCY Manufacturer advises avoid unless potential benefit outweighs risk—toxicity in animal studies. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

- BREAST FEEDING Discontinue breast-feeding.

- HEPATIC IMPAIRMENT Manufacturer advises caution.

- MONITORING REQUIREMENTS
  Manufacturer advises evaluate for signs and symptoms of underlying cardiopulmonary disease before initiation of therapy—echocardiography should be performed at treatment initiation in patients with symptoms of cardiac disease and considered for patients with risk factors for cardiac or pulmonary disease.

  Manufacturer advises monitor patients with risk factors or a history of cardiac disease for signs or symptoms of cardiac dysfunction during treatment.

  When used for Chronic phase chronic myeloid leukaemia Manufacturer advises monitor full blood count every 2 weeks for 3 months, then every 3 months or as clinically indicated thereafter.
Immune system and malignant disease

When used for Acute lymphoblastic leukaemia Manufacturer advises monitor full blood count prior to each treatment cycle and as clinically indicated thereafter. During consolidation treatment, manufacturer advises monitor full blood count every 2 days until recovery.

NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium (SMC) has advised (April 2019) that dasatinib (Sprycel<sup>®</sup>) is accepted for use within NHS Scotland for the treatment of paediatric patients weighing 10 kg and above with newly diagnosed chronic phase Philadelphia chromosome-positive chronic myeloid leukaemia (Ph<sup>+</sup> CML-CP) or Ph<sup>+</sup> CML-CP resistant or intolerant to prior therapy including imatinib. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

All Wales Medicines Strategy Group (AWMSG) decisions

All Wales Medicines Strategy Group (AWMSG) No. 1514

The All Wales Medicines Strategy Group has advised (April 2019) that dasatinib (Sprycel<sup>®</sup>) is recommended as an option for use within NHS Wales for the treatment of paediatric patients weighing 10 kg and above with newly diagnosed chronic phase Philadelphia chromosome-positive chronic myeloid leukaemia (Ph<sup>+</sup> CML-CP) or Ph<sup>+</sup> CML-CP resistant or intolerant to prior therapy including imatinib. This recommendation applies only in circumstances where the approved Patient Access Scheme (PAS) is utilised or where the list/contract price is equivalent or lower than the PAS price.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS 25

- Sprycel (Bristol-Myers Squibb Pharmaceuticals Ltd)
- Dasatinib 20 mg Sprycel<sup>®</sup> 20mg tablets | 60 tablet POM £1,252.48 DT = £1,252.48 (Hospital only)
- Dasatinib 50 mg Sprycel<sup>®</sup> 50mg tablets | 60 tablet POM £2,504.96 DT = £2,504.96 (Hospital only)
- Dasatinib 80 mg Sprycel<sup>®</sup> 80mg tablets | 30 tablet POM £2,504.96 DT = £2,504.96 (Hospital only)
- Dasatinib 100 mg Sprycel<sup>®</sup> 100mg tablets | 30 tablet POM £2,504.96 DT = £2,504.96 (Hospital only)
- Dasatinib 140 mg Sprycel<sup>®</sup> 140mg tablets | 30 tablet POM £2,504.96 DT = £2,504.96 (Hospital only)

Sprycel<sup>®</sup>

BY MOUTH USING TABLETS

Subependymal giant cell astrocytoma associated with tuberous sclerosis complex

- Child 1-17 years: (consult product literature)

Adjunctive treatment of refractory partial-onset seizures, with or without secondary generalisation, associated with tuberous sclerosis complex

- BY MOUTH USING DISPERSIBLE TABLETS
- Child 2-17 years: (consult product literature)

Everolimus

INDICATIONS ACTION

Everolimus is a protein kinase inhibitor.

INDICATIONS AND DOSE

VOTUBIA<sup>®</sup> DISPERSIBLE TABLETS

Subependymal giant cell astrocytoma associated with tuberous sclerosis complex

- BY MOUTH USING DISPERSIBLE TABLETS
- Child 1-17 years: (consult product literature)

Adjunctive treatment of refractory partial-onset seizures, with or without secondary generalisation, associated with tuberous sclerosis complex

- BY MOUTH USING DISPERSIBLE TABLETS
- Child 2-17 years: (consult product literature)

VOTUBIA<sup>®</sup> TABLETS

Subependymal giant cell astrocytoma associated with tuberous sclerosis complex

- BY MOUTH USING TABLETS
- Child 1-17 years: (consult product literature)

CAUTIONS

History of bleeding disorders - peri-surgical period (impaired wound healing)

INTERACTIONS

Appendix 1: everolimus

SIDE-EFFECTS

Common or very common


Rare or very rare

- Congestive heart failure - embolism and thrombosis - flushing - healing impaired - hepatitis B - musculoskeletal chest pain - pancytopenia - sepsis - urinary frequency increased

SIDE-EFFECTS, FURTHER INFORMATION

Reduce dose or discontinue if severe side-effects occur—consult product literature.

CONCEPTION AND CONTRCEPTION

Effective contraception must be used during and for up to 8 weeks after treatment.

PREGNANCY

Manufacturer advises avoid (toxicity in animal studies). See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

BREAST FEEDING

Manufacturer advises avoid.

HEPATIC IMPAIRMENT

Consult product literature.

MONITORING REQUIREMENTS

- For Votubia<sup>®</sup> preparations: manufacturer advises everolimus blood concentration monitoring is required—consult product literature.

- Manufacturer advises monitor blood glucose concentration, complete blood count, serum-triglycerides and serum-cholesterol before treatment and periodically thereafter.

- Manufacturer advises monitor renal function before treatment and periodically thereafter.

- Manufacturer advises monitor for signs and symptoms of infection before and during treatment.

DIRECTIONS FOR ADMINISTRATION

VOTUBIA<sup>®</sup> DISPERSIBLE TABLETS

Manufacturer advises tablets must be dispersed in water before administration—consult product literature for details.

VOTUBIA<sup>®</sup> TABLETS

Tablets may be dispersed in approximately 30 mL of water by gently stirring, immediately before drinking. After solution has been swallowed, any residue must be re-dispersed in the same volume of water and swallowed.

PRESCRIBING AND DISPENSING INFORMATION

Votubia<sup>®</sup> is available as both tablets and dispersible tablets. These formulations vary in their licensed indications and are not interchangeable—consult product literature for information on switching between formulations.

IMPORTANT SAFETY INFORMATION

Risks of incorrect dosing of oral anti-cancer medicines

See Cytotoxic drugs p. 551.

580 Targeted therapy responsive malignancy

BNFC 2019-2020

8
Targeted therapy responsive malignancy 581

**PATIENT AND CARER ADVICE**

*Pneumonitis* Non-infectious pneumonitis reported. Manufacturer advises patients and their carers should be informed to seek urgent medical advice if new or worsening respiratory symptoms occur.

*Infections* Manufacturer advises patients and their carers should be informed of the risk of infection.

**NATIONAL FUNDING/ACCESS DECISIONS**

**VOTUBIA® DISPERSIBLE TABLETS**

**Scottish Medicines Consortium (SMC) decisions**

SMC No. 331/18

The Scottish Medicines Consortium has advised (June 2018) that everolimus (Votubia®) dispersible tablets are accepted for use within NHS Scotland for the adjunctional treatment of patients aged two years and older whose refractory partial-onset seizures, with or without secondary generalisation, are associated with tuberous sclerosis complex. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

**IMPORTANT SAFETY INFORMATION**

**SIDE EFFECTS**

- **Common or very common** Alopecia - anaemia - appetite abnormal - asthenia - bone marrow disorders - chills - constipation - cough - diarrhoea - diziness - dry eye - dry mouth - dyspnoea - excessive tearing - eye inflammation - fever - fluid imbalance - flushing - gastrointestinal discomfort - gastrointestinal disorders - haemorrhage - headaches - insomnia - joint disorders - muscle complaints - nausea - neutropenia - oedema - pain - photosensitivity reaction - sensation abnormal - skin reactions - sweat changes - taste altered - thrombocytopenia - vision blurred - vomiting - weight changes


- **Rare or very rare** Angina pectoris - angioedema - arthritis - cardiac arrest - cataplexy - confusion - glaucoma - haemolytic anaemia - haemorrhagic ovarian cyst - hepatic failure (including fatal cases) - hypersensitivity vasculitis - inflammatory bowel disease - intracranial pressure increased - muscle weakness - myocardial infarction - myopathy - nail discoloration - pericardial disorders - pulmonary hypertension - seizure - severe cutaneous adverse reactions (SCARs) - tumour lysis syndrome

- **Frequency not known** Embolism and thrombosis - growth retardation - hepatitis B reactivation - pejoeplasm complications - osteonecrosis - pericarditis

**CONCEPTION AND CONTRACEPTION**

Effective contraception required during treatment.

**PREGNANCY**

Manufacturer advises avoid unless potential benefit outweighs risk. See also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**BREAST FEEDING**

Discontinue breast-feeding.

**HEPATIC IMPAIRMENT**

**Dose adjustments** Start with minimum recommended dose; reduce dose further if not tolerated; consult local treatment protocol.

**RENAL IMPAIRMENT**

**Dose adjustments** Start with minimum recommended dose; reduce dose further if not tolerated; consult local treatment protocol.

**MONITORING REQUIREMENTS**

- Monitor for gastrointestinal haemorrhage.
- Monitor complete blood counts regularly.
- Monitor for fluid retention.
- Monitor liver function.
- Monitor growth in children (may cause growth retardation).

**DIRECTIONS FOR ADMINISTRATION**

Tablets may be dispersed in water or apple juice.

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**Imatinib**

**DRUG ACTION**

Imatinib is a tyrosine kinase inhibitor.

**INDICATIONS AND DOSE**

Treatment of newly diagnosed Philadelphia-chromosome-positive chronic myeloid leukaemia when bone marrow transplantation is not considered first line treatment.

Treatment of Philadelphia-chromosome-positive chronic myeloid leukaemia in chronic phase after failure of interferon alfa, or in accelerated phase, or in blast crisis in combination with chemotherapy.

- **BY MOUTH**
- Child: (consult local protocol)

**IMPORTANT SAFETY INFORMATION**

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

**MHRA/CHM ADVICE (MAY 2016): RISK OF HEPATITIS B VIRUS REACTIVATION WITH BCR-ABL TYROSINE KINASE INHIBITORS**

An EU wide review has concluded that imatinib can cause hepatitis B reactivation; the MHRA recommends establishing hepatitis B virus status in all patients before initiation of treatment.

**CAUTIONS**

Cardiac disease - hepatitis B infection - history of renal failure - risk factors for heart failure

**CAUTIONS, FURTHER INFORMATION**

- Hepatitis B infection The MHRA advises that patients who are carriers of hepatitis B virus should be closely monitored for signs and symptoms of active infection throughout treatment and for several months after stopping treatment; expert advice should be sought for patients who test positive for hepatitis B virus and in those with active infection.

**INTERACTIONS**

Appendix 1: imatinib
Targeted therapy responsive malignancy

**PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer imatinib tablets.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Tablet

**CAUTIONARY AND ADVISORY LABELS** 21, 27

- **Imatinib (Non-proprietary)**
  - Imatinib (as imatinib mesilate) 100 mg: Imatinib 100mg tablets | 30 tablet (PZN) £486.66 | 60 tablet (PZN) £973.32 DT = £603.10
  - Imatinib (as imatinib mesilate) 400 mg: Imatinib 400mg tablets | 30 tablet (PZN) £1,946.67 DT = £1,157.46 | 60 tablet (PZN) £3,893.34
- **Glivec (Novartis Pharmaceuticals UK Ltd)**
  - Imatinib (as imatinib mesilate) 100 mg: Glivec 100mg tablets | 60 tablet (PZN) £1,946.67 DT = £1,157.46
  - Imatinib (as imatinib mesilate) 400 mg: Glivec 400mg tablets | 30 tablet (PZN) £1,946.67 DT = £1,157.46

**IMPORTANT SAFETY INFORMATION**

**RISKS OF INCORRECT DOSING OF ORAL ANTI-CANCER MEDICINES**

See Cytotoxic drugs p. 551.

**MHRA/CHM ADVICE (MAY 2016): RISK OF HEPATITIS B VIRUS REACTIVATION WITH TYROSINE KINASE INHIBITORS**

An EU wide review has concluded that nilotinib can cause hepatitis B virus reactivation; the MHRA recommends establishing hepatitis B virus status in all patients before initiation of treatment.

**CAUTIONS**

- **Clinically significant bradycardia**
- **Congestive heart failure**
- **Hepatitis B infection**
- **History of pancreatitis**
- **Recent myocardial infarction**
- **Susceptibility to QT-interval prolongation (including electrolyte disturbances)**
- **Unstable angina**

**CAUTIONS, FURTHER INFORMATION**

- **Hepatitis B infection** The MHRA advises that patients who are carriers of hepatitis B virus should be closely monitored for signs and symptoms of active infection throughout treatment and for several months after stopping treatment; expert advice should be sought for patients who test positive for hepatitis B virus and in those with active infection.

**INTERACTIONS** → Appendix 1: nilotinib

**SIDE-EFFECTS**

- **Common or very common** Alopecia, anaemia, angina, pectoris, anxiety, appetite abnormal, arthralgia, asthenia, bone marrow disorders, cardiac conduction disorders, chest discomfort, constipation, cough, decreased leucocytes, depression, diabetes mellitus, diarrhoea, dizziness, dry eye, dyslipidaemia, dyspnoea, electrolyte imbalance, eosinophilia, eye discomfort, eye disorders, eye inflammation, fever, flushing, gastrointestinal discomfort, gastrointestinal disorders, headaches, hepatic disorders, hyperbilirubinaemia, hyperglycaemia, hypertension, increased risk of infection, insomnia, muscle complaints, muscle weakness, myocardial infarction, nausea, neoplasms, neutropenia, oedema, pain, palpitations, peripheral neuropathy, QT interval prolongation, respiratory disorders, sensation abnormal, skin reactions, sweat changes, taste altered, thrombocytopenia, vertigo, vomiting, weight changes
- **Uncommon** Atherosclerosis, cerebrovascular insufficiency, chills, cyanosis, erectile dysfunction, gout, haemorrhage, heart failure, hyperaemia, malaise, oral disorders, pancreatitis, peripheral vascular disease, temperature sensation altered, vision disorders
- **Frequency not known** Breast abnormalities, chorioretinopathy, diastolic dysfunction, dry mouth, facial swelling, gynaecomastia, hepatitis B reactivation, hyperparathyroidism, hyperuricaemia, hypoglycaemia, lethargy, memory loss, menorrhagia, oesophageal pain, oropharyngeal pain, pericardial effusion, pericarditis, restless legs, sebaceous hyperplasia, syncope, tremor, urinary disorders, urine discoloration

**CONCEPTION AND CONTRACEPTION** Manufacturer advises highly effective contraception in women of childbearing potential during treatment and for up to two weeks after stopping treatment.

**PREGNANCY**

Manufacturer advises avoid unless potential benefit outweighs risk—tocolytics in animal studies; see also Pregnancy and reproductive function in Cytotoxic drugs p. 551.

**BREAST FEEDING**

Manufacturer advises avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT**

Manufacturer advises caution (risk of increased exposure).

**MONITORING REQUIREMENTS**

- Manufacturer advises monitor lipids before initiating treatment, at 3 and 6 months, and then yearly thereafter; monitor blood glucose before initiating treatment and then periodically during treatment, as clinically indicated.
- Manufacturer advises monitor full blood count every 2 weeks for the first 2 months of treatment, then monthly thereafter, or as clinically indicated.
- Manufacturer advises perform baseline ECG before treatment and as clinically indicated thereafter; correct any electrolyte disturbances before treatment and monitor periodically during treatment.
- Manufacturer advises monitor and actively manage cardiovascular risk factors during treatment.
- Manufacturer advises monitor liver function (including bilirubin and hepatic transaminases) monthly or as clinically indicated.

**DIRECTIONS FOR ADMINISTRATION**

Manufacturer advises capsules should either be swallowed whole or the contents of each capsule may be dispersed in one teaspoon of apple sauce and taken immediately.

**PRESCRIBING AND DISPENSING INFORMATION**

All prescribers should be familiar with the Summary of Key Safety Recommendations for Tasigna ® (nilotinib) provided by the manufacturer.

**PATIENT AND CARER ADVICE**

Manufacturer advises patients and carers should seek immediate medical attention if signs or symptoms of cardiovascular events occur.

All patients should be provided with the Important Information About How to Take Your Medication leaflet provided by the manufacturer.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Capsule

**CAUTIONARY AND ADVISORY LABELS** 23, 25, 27

- **Tasigna (Novartis Pharmaceuticals UK Ltd)**
  - Nilotinib (as Nilotinib hydrochloride monohydrate) 150 mg: Tasigna 150mg capsules | 112 capsule (PZN) £2,432.85
  - Nilotinib (as Nilotinib hydrochloride monohydrate) 200 mg: Tasigna 200mg capsules | 112 capsule (PZN) £2,432.85
Chapter 9

Blood and nutrition

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Blood and blood-forming organs

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Blood and blood-forming organs

1 Anaemias

Anaemia treatment considerations

Before initiating treatment for anaemia it is essential to determine which type is present. Iron salts may be harmful and result in iron overload if given alone to patients with anaemias other than those due to iron deficiency.

Sickle-cell anaemia

Sickle-cell disease is caused by a structural abnormality of haemoglobin resulting in deformed, less flexible red blood cells. Acute complications in the more severe forms include sickle-cell crisis, where infarction of the microvasculature and blood supply to organs results in severe pain. Sickle-cell crisis requires hospitalisation, intravenous fluids, analgesia and treatment of any concurrent infection. Chronic complications include skin ulceration, renal failure, and increased susceptibility to infection. Pneumococcal vaccine, haemophilus influenzae type b vaccine, an annual influenza vaccine and prophylactic penicillin reduce the risk of infection. Hepatitis B vaccine should be considered if the patient is not immune.

In most forms of sickle-cell disease, varying degrees of haemolytic anaemia are present accompanied by increased erythropoiesis; this may increase folate requirements and folate supplementation may be necessary.

Hydroxycarbamide p. 572 can reduce the frequency of crises and the need for blood transfusions in sickle-cell disease. The beneficial effects of hydroxycarbamide may not become evident for several months.

G6PD deficiency

Glucose 6-phosphate dehydrogenase (G6PD) deficiency is highly prevalent in individuals originating from most parts of Africa, from most parts of Asia, from Oceania, and from Southern Europe; it can also occur, rarely, in any other individuals. G6PD deficiency is more common in males than it is in females.

Individuals with G6PD deficiency are susceptible to developing acute haemolytic anaemia when they eat fava beans (broad beans, Vicia faba); this is termed favism and can be more severe in children or when the fresh fava beans are eaten raw.

When prescribing drugs for patients with G6PD deficiency, the following three points should be kept in mind:
Blood and nutrition

Ideally, information about G6PD deficiency is genetically heterogeneous; susceptibility to the haemolytic risk from drugs varies; thus, a drug found to be safe in some G6PD-deficient individuals may not be equally safe in others; manufacturers do not routinely test drugs for their effects in G6PD-deficient individuals; the risk and severity of haemolysis is almost always dose-related.

The lists below should be read with these points in mind. Ideally, information about G6PD deficiency should be available before prescribing a drug listed below. However, in the absence of this information, the possibility of haemolysis should be considered, especially if the patient belongs to a group in which G6PD deficiency is common. A very few G6PD-deficient individuals with chronic non-spherocytic haemolytic anaemia have haemolysis even in the absence of an exogenous trigger. These patients must be regarded as being at high risk of severe exacerbation of haemolysis following administration of any of the drugs listed below.

**Drugs with definite risk of haemolysis in most G6PD-deficient individuals**
- Dapsone and other sulfones (higher doses for dermatitis herpetiformis more likely to cause problems)
- Fluoroquinolones (including ciprofloxacin, moxifloxacin, norfloxacin, and ofloxacin)
- Methylthioninium chloride
- Nitrazole [not on UK market]
- Nitrofurantoin
- Pamaquin [not on UK market]
- Primamquil (30 mg weekly for 8 weeks has been found to be without undue harmful effects in African and Asian people)
- Quinolones (such as nalidixic acid [not on UK market])
- Rasburicase
- Sulfonamides (including co-trimoxazole; some sulfonamides, e.g. sulfadiazine, have been tested and found not to be haemolytic in many G6PD-deficient individuals)

**Drugs with possible risk of haemolysis in some G6PD-deficient individuals**
- Aspirin (acceptable up to a dose of at least 1 g daily in most G6PD-deficient individuals)
- Chloroquine (acceptable in acute malaria and malaria chemoprophylaxis)
- Menadione, water-soluble derivatives (e.g. menadiol sodium phosphate)
- Quinidine (acceptable in acute malaria) [not on UK market]
- Quinine (acceptable in acute malaria)
- Sulfomethoxazole

Naphthalene in mothballs also causes haemolysis in G6PD-deficient individuals with chronic non-spherocytic haemolytic anaemia and may cause severe reactions in patients with haemolytic anaemia in the absence of an exogenous trigger. These patients must be regarded as being at high risk of severe exacerbation of haemolysis following administration of any of these drugs.

It is unlikely that dietary deprivation of pyridoxine hydrochloride produces clinically relevant haematological effects. However, certain forms of sideroblastic anaemia respond to pharmacological doses, possibly reflecting its role as a co-enzyme during haemoglobin synthesis. Pyridoxine hydrochloride is indicated in both idiopathic acquired and hereditary sideroblastic anaemias. Although complete cures have not been reported, some increase in haemoglobin can occur with high doses. Reversible sideroblastic anaemias respond to treatment of the underlying cause but pyridoxine hydrochloride is indicated in pregnancy, haemolytic anaemias, or during isoniazid p. 382 treatment.

Corticosteroids have an important place in the management of haematological disorders including autoimmune haemolytic anaemia, idiopathic thrombocytopenias and neutropenias, and major transfusion reactions. They are also used in chemotherapy schedules for many types of lymphomas, lymphoid leukemias, and paraproteinaemias, including multiple myeloma.

**Erythropoietins**

Epoetins (recombinant human erythropoietins) are used to treat the anaemia associated with erythropoietin deficiency in chronic renal failure.

Epoetin beta p. 587 is also used for the prevention of anaemia in preterm neonates of low birth-weight; a therapeutic response may take several weeks.

There is insufficient information to support the use of erythropoietins in children with leukaemia or in those receiving cancer chemotherapy. Darbepoetin is a glycosylated derivative of epoetin; it persists longer in the body and can be administered less frequently than epoetin.

### 1.1 Hypoplastic, haemolytic, and renal anaemias

**Other drugs used for Hypoplastic, haemolytic, and renal anaemias**
- Epoetins

### Oxymetholone

**INDICATIONS AND DOSE**
- **Aplastic anaemia**
  - **BY MOUTH**
    - Child: 1–5 mg/kg daily for 3 to 6 months

**INTERACTIONS**
- Appendix 1: oxymetholone

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension
- **Capsule**
  - Oxymetholone (Non-proprietary)
  - Oxymetholone 50 mg: Oxymetholone 50mg capsules | 50 capsule (PMS) £17.00 (@60)

### EPOETINS

**Epoetins**

**IMPORTANT SAFETY INFORMATION**
- **MHRA/CHM ADVICE: RECOMBINANT HUMAN ERYTHROPOEITINS: VERY RARE RISK OF SEVERE CUTANEOUS ADVERSE REACTIONS**

The MHRA is aware of very rare cases of severe cutaneous adverse reactions, including Stevens-Johnson...
syndrome and toxic epidermal necrolysis, in patients treated with erythropoietins; some cases were fatal. More severe cases were recorded with long-acting agents (darbepoetin alfa and methoxy polyethylene glycol-epoetin beta).

Patients and their carers should be advised of the signs and symptoms of severe skin reactions when starting treatment and instructed to stop treatment and seek immediate medical attention if they develop widespread rash and blistering; these rashes often follow fever or flu-like symptoms—discontinue treatment permanently if such reactions occur.

**ERYTHROPOIETINS—HAEMOGLOBIN CONCENTRATION**
In chronic kidney disease, the use of erythropoietins can be considered in a child with anaemia. The aim of treatment is to relieve symptoms of anaemia and to avoid the need for blood transfusion. The optimum haemoglobin concentration is dependent on the child’s age and factors such as symptoms, comorbidities, and patient preferences. The haemoglobin concentration should not be increased beyond that which provides adequate control of symptoms of anaemia. In adults, overcorrection of haemoglobin concentration with erythropoietins in those with chronic kidney disease may increase the risk of serious cardiovascular events and death; haemoglobin concentrations higher than 12 g/100 mL should be avoided in children.

**CONTRA-INDICATIONS** Avoid injections containing benzyl alcohol in neonates - pure red cell aplasia following erythropoietin therapy - uncontrolled hypertension

**CAUTIONS** Aluminium toxicity (can impair the response to erythropoietin) - concurrent infection (can impair the response to erythropoietin) - correct factors that contribute to the anaemia of chronic renal failure, such as iron or folate deficiency, before treatment - during dialysis (increase in unfraccionated or low molecular weight heparin dose may be needed) - epilepsy - inadequately treated or poorly controlled blood pressure—interrupt treatment if blood pressure uncontrolled - ischaemic vascular disease - malignant disease - other inflammatory disease (can impair the response to erythropoietin) - sickle-cell disease (lower target haemoglobin concentration may be appropriate) - sudden stabbing migraine-like pain (warning of a hypertensive crisis) - thrombocytosis (monitor platelet count for first 8 weeks)

**SIDE-EFFECTS**
- Common or very common Arthralgia - embolism and thrombosis - headache - hypertension (dose-dependent) - influenza like illness - skin reactions - stroke
- Uncommon Hypertensive crisis (in isolated patients with normal or low blood pressure) - respiratory tract congestion - seizure
- Rare or very rare Thrombocytosis
- Frequency not known Pure red cell aplasia (more common following subcutaneous administration in patients with chronic renal failure)

**SIDE-EFFECTS, FURTHER INFORMATION**

**Hypertensive crisis** In isolated patients with normal or low blood pressure, hypertensive crisis with encephalopathy-like symptoms and generalised tonic-clonic seizures requiring immediate medical attention has occurred with epoetin.

**Pure red cell aplasia** There have been very rare reports of pure red cell aplasia in patients treated with erythropoietins. In patients who develop a lack of efficacy with erythropoietin therapy and with a diagnosis of pure red cell aplasia, treatment with erythropoietins must be discontinued and testing for erythropoietin antibodies considered. Patients who develop pure red cell aplasia should not be switched to another form of erythropoietin.

**MONITORING REQUIREMENTS**
- Monitor closely blood pressure, reticulocyte counts, haemoglobin, and electrolytes—interrupt treatment if blood pressure uncontrolled.
- Other factors, such as iron or folate deficiency, that contribute to the anaemia of chronic renal failure should be corrected before treatment and monitored during therapy. Supplemental iron may improve the response in resistant patients and in preterm neonates.

**Darbepoetin alfa**

**INDICATIONS AND DOSE**

Symptomatic anaemia associated with chronic renal failure in patients on dialysis
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAVENOUS INJECTION**
  - Child 11–17 years: Initially 450 nanograms/kg once weekly, dose to be adjusted according to response by approximately 25% at intervals of at least 4 weeks, maintenance dose to be given once weekly or once every 2 weeks, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose, when changing route give same dose then adjust according to weekly or fortnightly haemoglobin measurements, adjust doses not more frequently than every 2 weeks during maintenance treatment

Symptomatic anaemia associated with chronic renal failure in patients not on dialysis
- **BY SUBCUTANEOUS INJECTION**
  - Child 11–17 years: Initially 450 nanograms/kg once weekly, alternatively initially 750 nanograms/kg every 2 weeks, dose to be adjusted according to response by approximately 25% at intervals of at least 4 weeks, maintenance dose can be given once weekly, every 2 weeks, or once a month, subcutaneous route preferred in patients not on haemodialysis, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose, when changing route give same dose then adjust according to weekly or fortnightly haemoglobin measurements, adjust doses not more frequently than every 2 weeks during maintenance treatment

Symptomatic anaemia associated with chronic renal failure in infants not on dialysis
- **BY INTRAVENOUS INJECTION**
  - Child 11–17 years: Initially 450 nanograms/kg once weekly, dose to be adjusted according to response by approximately 25% at intervals of at least 4 weeks, maintenance dose given once weekly, subcutaneous route preferred in patients not on haemodialysis, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose, when changing route give same dose then adjust according to weekly or fortnightly haemoglobin measurements, adjust doses not more frequently than every 2 weeks during maintenance treatment

**Blood and nutrition**
Blood and nutrition

INTERACTIONS ➔ Appendix 1: darbepoetin alfa

SIDE-EFFECTS ➔ Common or very common: Hypersensitivity - oedema

PREGNANCY: No evidence of harm in animal studies—manufacturer advises caution.

HEPATIC IMPAIRMENT: Manufacturer advises caution (no information available).

HEPATIC IMPAIRMENT: Manufacturer advises caution.

INDICATIONS AND DOSE

Epoetin alfa

EPRELX® Pre-filled syringes

Symptomatic anaemia associated with chronic renal failure in patients on haemodialysis

BY INTRAVENOUS INJECTION

Child (body-weight up to 10 kg): Initially 50 units/kg 3 times a week, dose adjusted according to response at intervals of at least 4 weeks; maintenance 75–100 units/kg 3 times a week, intravenous injection to be given over 1–5 minutes, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose

Child (body-weight 10–30 kg): Initially 50 units/kg 3 times a week, adjusted in steps of 25 units/kg 3 times a week, dose adjusted according to response at intervals of at least 4 weeks; maintenance 60–100 units/kg 3 times a week, intravenous injection to be given over 1–5 minutes, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose

Child (body-weight 31–60 kg): Initially 50 units/kg 3 times a week, adjusted in steps of 25 units/kg 3 times a week, dose adjusted according to response at intervals of at least 4 weeks; maintenance 30–100 units/kg 3 times a week, intravenous injection to be given over 1–5 minutes, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose

Child (body-weight 61 kg and above): Initially 50 units/kg 3 times a week, adjusted in steps of 25 units/kg 3 times a week, dose adjusted according to response at intervals of at least 4 weeks; maintenance 75–300 units/kg once weekly, maintenance dose can be given as a single dose or in divided doses, intravenous injection to be given over 1–5 minutes, reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose

INTERACTIONS ➔ Appendix 1: epoetin alfa

SIDE-EFFECTS ➔ Common or very common: Chills • cough • diarrhoea • fever • myalgia • nausæa • pain • peripheral oedema • vomiting

Uncommon: Hyperkalaemia

• **BREAST FEEDING**  Unlikely to be present in milk. Minimal effect on infant.

• **HEPATIC IMPAIRMENT**  Manufacturer advises caution in chronic hepatic failure.

• **PRESCRIBING AND DISPENSING INFORMATION**  Epoetin alfa is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1.

• **MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **Eprex** (Janssen-Cilag Ltd)
  - Epoetin alfa 2000 unit per 1 ml | Eprex 1,000 units/0.5ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £33.18 DT + £33.18
  - Epoetin alfa 4000 unit per 1 ml | Eprex 2,000 units/0.5ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £66.37 DT + £66.37

- **Eprex** (10000 unit per 1 ml | Eprex 6,000 units/0.6ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £199.11 DT + £199.11
  - Eprex 4,000 units/0.4ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £132.74 DT + £132.74
  - Eprex 5,000 units/0.5ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £165.92 DT + £165.92
  - Eprex 3,000 units/0.3ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £99.55 DT + £99.55
  - Eprex 10,000 units/1ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £331.85 DT + £331.85
  - Eprex 6,000 units/0.6ml solution for injection pre-filled syringes | 6 pre-filled disposable injection | £265.48 DT + £265.48

- **Epoetin alfa 40000 unit per 1 ml | Eprex 20,000 units/0.6ml solution for injection pre-filled syringes | 1 pre-filled disposable injection | £199.11 DT + £199.11
  - Eprex 40,000 units/1ml solution for injection pre-filled syringes | 1 pre-filled disposable injection | £265.48 DT + £265.48

**Epoetin beta**

30-Apr-2019

**INDICATIONS AND DOSE**

Symptomatic anaemia associated with chronic renal failure

- **BY SUBCUTANEOUS INJECTION**
  
  - Neonate: Initially 20 units/kg 3 times a week for 4 weeks, increased in steps of 20 units/kg 3 times a week, according to response at intervals of 4 weeks, total weekly dose may be divided into daily doses; maintenance dose, initially reduce dose by half then adjust according to response at intervals of 1–2 weeks, total weekly maintenance dose may be given as a single dose or in 3 or 7 divided doses. Subcutaneous route preferred in patients not on haemodialysis. Reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration approaches or exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose; maximum 720 units/kg per week.

- Child: Initially 20 units/kg 3 times a week for 4 weeks, increased in steps of 20 units/kg 3 times a week, according to response at intervals of 4 weeks, total weekly dose may be divided into daily doses; maintenance dose, initially reduce dose by half then adjust according to response at intervals of 1–2 weeks, total weekly maintenance dose may be given as a single dose or in 3 or 7 divided doses. Subcutaneous route preferred in patients not on haemodialysis. Reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration approaches or exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose; maximum 720 units/kg per week.

- **BY INTRAVENOUS INJECTION**
  
  - Neonate: Initially 40 units/kg 3 times a week for 4 weeks, then increased to 80 units/kg 3 times a week, then increased in steps of 20 units/kg 3 times a week if required, at intervals of 4 weeks; maintenance dose, initially reduce dose by half then adjust according to response at intervals of 1–2 weeks. Intravenous injection to be administered over 2 minutes. Subcutaneous route preferred in patients not on haemodialysis. Reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration approaches or exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose; maximum 720 units/kg per week.

- Child: Initially 40 units/kg 3 times a week for 4 weeks, then increased to 80 units/kg 3 times a week, then increased in steps of 20 units/kg 3 times a week if required, at intervals of 4 weeks; maintenance dose, initially reduce dose by half then adjust according to response at intervals of 1–2 weeks. Intravenous injection to be administered over 2 minutes. Subcutaneous route preferred in patients not on haemodialysis. Reduce dose by approximately 25% if rise in haemoglobin concentration exceeds 2 g/100 mL over 4 weeks or if haemoglobin concentration approaches or exceeds 12 g/100 mL; if haemoglobin concentration continues to rise, despite dose reduction, suspend treatment until haemoglobin concentration decreases and then restart at a dose approximately 25% lower than the previous dose; maximum 720 units/kg per week.

**Prevention of anaemias of prematurity in neonates**

- **BY SUBCUTANEOUS INJECTION**
  
  - Neonate up to 33 weeks corrected gestational age (body-weight 0.75–1.5 kg): 250 units/kg 3 times a week preferably started within 3 days of birth and continued for 6 weeks, using single-dose unsupervised injection.

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE (MAY 2015) EPOETIN BETA (NEORECORMON): INCREASED RISK OF RETINOPATHY IN PRETERM INFANTS CANNOT BE EXCLUDED

There is a possible increased risk of retinopathy in preterm infants, when epoetin beta is used for preventing anaemia of prematurity. When using epoetin beta in preterm infants:

- consider the benefits and risks of treatment, including the possible risk of retinopathy,
- monitor the infant for features of retinopathy, and
- advise parents or carers that their baby’s eyes will be carefully monitored for any ill effects.

**INTERACTIONS**  ➔ Appendix 1: epoetin beta

**SIDE-EFFECTS**  Severe cutaneous adverse reactions (SCARS)
PREGNANCY  No evidence of harm. Benefits probably outweigh risk of anaemia and of blood transfusion in pregnancy.

BREAST FEEDING  Unlikely to be present in milk. Minimal effect on infant.

HEPATIC IMPAIRMENT  Manufacturer advises caution in chronic hepatic failure.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Solution for injection
EXCIPIENTS: May contain Phenylalanine  
- NeoRecormon  (Roche Products Ltd)  
  Epoetin beta 1667 unit per 1 ml NeoRecormon 500 units/0.3 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £21.05 DT  =  £21.25  
  Epoetin beta 6667 unit per 1 ml NeoRecormon 2,000 units/0.3 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £84.17 DT  =  £84.17  
  Epoetin beta 10000 unit per 1 ml NeoRecormon 3,000 units/0.3 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £116.34 DT  =  £116.34  
  Epoetin beta 16667 unit per 1 ml NeoRecormon 10,000 units/0.6 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £420.85 DT  =  £420.85  
  NeoRecormon 5,000 units/0.3 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £210.42 DT  =  £210.42  
  Epoetin beta 20000 unit per 1 ml NeoRecormon 6,000 units/0.3 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £252.50 DT  =  £252.50  
  Epoetin beta 33333 unit per 1 ml NeoRecormon 20,000 units/0.6 ml solution for injection pre-filled syringes  |  6 pre-filled disposable injection (PSI)  £841.71 DT  =  £841.71  
  Epoetin beta 50000 unit per 1 ml NeoRecormon 30,000units/0.6 ml solution for injection pre-filled syringes  |  4 pre-filled disposable injection (PSI)  £841.71 DT  =  £841.71

Epoetin zeta  
30-Apr-2019  

INDICATIONS AND DOSE  
Symptomatic anaemia associated with chronic renal failure in patients on haemodialysis
- By intravenous injection  
  Child (body-weight up to 10 kg): Initially 50 units/kg 3 times a week, adjusted according to response, to be administered at intervals of at least 4 weeks; maintenance 75–150 units/kg 3 times a week, to be administered over 1–5 minutes, avoid increasing haemoglobin concentration at a rate exceeding 2 g/100 ml over 4 weeks  
  Child (body-weight 10–30 kg): Initially 50 units/kg 3 times a week, adjusted according to response, to be administered at intervals of at least 4 weeks; maintenance 60–150 units/kg 3 times a week, to be administered over 1–5 minutes, avoid increasing haemoglobin concentration at a rate exceeding 2 g/100 ml over 4 weeks  
  Child (body-weight >30 kg): Initially 50 units/kg 3 times a week, adjusted according to response, to be administered at intervals of at least 4 weeks; maintenance 60–150 units/kg 3 times a week, to be administered over 1–5 minutes, avoid increasing haemoglobin concentration at a rate exceeding 2 g/100 ml over 4 weeks

INTERACTIONS  
- Appendix 1: epoetin zeta

SIDE-EFFECTS  
- Common or very common  Asthenia • dizziness

1.1a Atypical haemolytic uraemic syndrome and paroxysmal nocturnal haemoglobinuria

IMMUNOSUPPRESSANTS  
MONOCLONAL ANTIBODIES

Eculizumab  
04-Dec-2017

DRUG ACTION  Eculizumab, a recombinant monoclonal antibody, inhibits terminal complement activation at the C5 protein and thereby reduces haemolysis and thrombotic microangiopathy.

INDICATIONS AND DOSE  
Reduce haemolysis in paroxysmal nocturnal haemoglobinuria (PNH), in those with a history of blood transfusions (under expert supervision)
- By intravenous infusion
- Child: Refer for specialist advice, experience very limited
Iron deficiency anaemia

Anaemia, iron deficiency

Iron deficiency, treatment and prophylaxis

Treatment with an iron preparation is justified only in the presence of a demonstrable iron-deficiency state. Before starting treatment, it is important to exclude any serious underlying cause of the anaemia (e.g. gastrointestinal bleeding). The possibility of thalassaemia should be

**1.2 Iron deficiency anaemia**
Blood and nutrition supplementation is started babies of low birth-weight who are solely breast-fed; some oral preparations contain ascorbic acid p. Compound preparations unless dietary intake is adequate. All babies require an iron substantial iron stores but these stores can become depleted does not respond to iron therapy. Similarly, change rapidly. These changes are not due to iron deficiency anaemia. The oral dose of elemental iron to treat deficiency is 3–6 mg/kg (max. 200 mg) daily given in 2–3 divided doses. Iron supplementation may also be required to produce an optimum response to erythropoietins in iron-deficient children with chronic renal failure or in preterm neonates. When prescribing, express the dose in terms of elemental iron and iron salt and select the most appropriate preparation; specify both the iron salt and formulation on the prescription. The iron content of artificial formula feeds should also be considered.

### Iron content of different iron salts

<table>
<thead>
<tr>
<th>Iron salt/amount</th>
<th>Content of ferrous iron</th>
</tr>
</thead>
<tbody>
<tr>
<td>ferrous fumarate 200 mg</td>
<td>65 mg</td>
</tr>
<tr>
<td>ferrous gluconate 300 mg</td>
<td>35 mg</td>
</tr>
<tr>
<td>ferrous sulfate 300 mg</td>
<td>60 mg</td>
</tr>
<tr>
<td>ferrous sulfate, dried 200 mg</td>
<td>65 mg</td>
</tr>
<tr>
<td>sodium feredate 190 mg</td>
<td>27.5 mg</td>
</tr>
</tbody>
</table>

### Prophylaxis of iron deficiency

In neonates, haemoglobin and haematocrit concentrations change rapidly. These changes are not due to iron deficiency and cannot be corrected by iron supplementation. Similarly, neonatal anaemia resulting from repeated blood sampling does not respond to iron therapy.

All babies, including preterm neonates, are born with substantial iron stores but these stores can become depleted unless dietary intake is adequate. All babies require an iron intake of 400–700 nanograms daily to maintain body stores. Iron in breast milk is well absorbed but that in artificial feeds or in cow’s milk is less so. Most artificial formula feeds are sufficiently fortified with iron to prevent deficiency and their iron content should be taken into account when considering further iron supplementation.

Prophylactic iron supplementation may be required in babies of low birth-weight who are solely breast-fed; supplementation is started 4–6 weeks after birth and continued until mixed feeding is established.

Infants with a poor diet may become anaemic in the second year of life, particularly if cow’s milk, rather than fortified formula feed, is a major part of the diet.

**Compound preparations**

Some oral preparations contain ascorbic acid p. 652 to aid absorption of the iron, but the therapeutic advantage of such preparations is minimal and cost may be increased.

There is no justification for the inclusion of other ingredients, such as the B group of vitamins, except folic acid p. 594 for pregnant women.

### Parenteral iron

Iron can be administered parenterally as iron dextran p. 591, iron sucrose p. 591 or ferric carboxymaltose p. 591. Parenteral iron is generally reserved for use when oral therapy is unsuccessful because the baby cannot tolerate oral iron, or does not take it reliably, or if there is continuing bleeding loss, or in malabsorption. Many children with chronic renal failure who are receiving haemodialysis (and some who are receiving peritoneal dialysis) also require iron by the intravenous route on a regular basis. With the exception of children with severe renal failure receiving haemodialysis, parenteral iron does not produce a faster haemoglobin response than oral iron provided that the oral iron preparation is taken reliably and is absorbed adequately. If parenteral iron is necessary, the dose should be calculated according to the child’s body-weight and total iron deficit. Depending on the preparation used, parenteral iron is given as a total dose or in divided doses. Further treatment should be guided by monitoring haemoglobin and serum iron concentrations.

### MINERALS AND TRACE ELEMENTS > IRON, INJECTABLE

**Iron (injectable)**

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: SERIOUS HYPERSENSITIVITY REACTIONS WITH INTRAVENOUS IRON (AUGUST 2013)**

Serious hypersensitivity reactions, including lifethreatening and fatal anaphylactic reactions, have been reported in patients receiving intravenous iron. These reactions can occur even when a previous administration has been tolerated (including a negative test dose). Test doses are no longer recommended and caution is needed with every dose of intravenous iron.

Intravenous iron products should only be administered when appropriately trained staff and resuscitation facilities are immediately available; patients should be closely monitored for signs of hypersensitivity during and for at least 30 minutes after every administration. In the event of a hypersensitivity reaction, treatment should be stopped immediately and appropriate management initiated.

The risk of hypersensitivity is increased in patients with known allergies, immune or inflammatory conditions, or those with a history of severe asthma, eczema, or other atopic allergy; in these patients, intravenous iron should only be used if the benefits outweigh the risks.

Intravenous iron should be avoided in the first trimester of pregnancy and used in the second or third trimesters only if the benefit outweighs the potential risks for both mother and fetus.

**CONTRA-INDICATIONS** Disturbances in utilisation of iron - iron overload

**CAUTIONS** Allergic disorders - eczema - hepatic dysfunction - immune conditions - infection (discontinue if ongoing bacteraemia) - inflammatory conditions - oral iron should not be given until 5 days after the last injection - severe asthma

**SIDE-EFFECTS**

- **Common or very common** Dizziness - flushing - headache - hypertension - hypophosphataemia - hypotension - nausea - taste altered
- **Uncommon** Arthralgia - bronchospasm - chest pain - chills - constipation - diarrhoea - dyspnoea - fatigue - fever - gastrointestinal discomfort - hyperhidrosis - hypersensitivity - loss of consciousness - muscle
complaints - pain - peripheral oedema - sensation abnormal - skin reactions - vision blurred - vomiting

- Rare or very rare Angioedema, anxiety, circulatory collapse - influenza like illness - malaise - paller - palpitations - psychiatric disorder - seizure - syncope - tremor

SIDE-EFFECTS, FURTHER INFORMATION Anaphylactic reactions can occur with parenteral administration of iron complexes and facilities for cardiopulmonary resuscitation must be available. If children complain of acute symptoms particularly nausea, back pain, breathlessness, or develop hypotension, the infusion should be stopped.

Overdose For details on the management of poisoning, see Iron salts, under Emergency treatment of poisoning p. 695.

Ferric carboxymaltose

- INDICATIONS AND DOSE
  Iron-deficiency anaemia
  BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
  Child: Dose calculated according to body-weight and iron deficit (consult product literature)

- UNLICENSED USE
  Not licensed for use in children under 14 years.

- INTERACTIONS
  Appendix 1: iron (injectable)

- SIDE-EFFECTS
  Rare or very rare Face oedema - flatulence

- PREGNANCY
  Avoid in first trimester; crosses the placenta in animal studies. May influence skeletal development.

- HEPATIC IMPAIRMENT
  Manufacturer advises caution—monitor iron status to avoid iron overload; avoid where iron overload increases risk of impairment (particularly porphyria cutanea tarda).

- PRESCRIBING AND DISPENSING INFORMATION
  A ferric carboxymaltose complex containing 5% (50 mg/mL) of iron.

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.
  Solution for injection
  ELECTROLYTES: May contain Sodium
  - Ferinject (Vifor Pharma UK Ltd)
    Iron (as Ferric carboxymaltose) 50 mg per 1 ml
    Ferinject 1000mg/20ml solution for injection vials | 1 vial | £154.23
    Ferinject 100mg/2ml solution for injection vials | 5 vial | £81.18
    Ferinject 500mg/10ml solution for injection vials | 5 vial | £405.88

Iron dextran

- INDICATIONS AND DOSE
  Iron-deficiency anaemia
  BY DEEP INTRAMUSCULAR INJECTION
  Child 14–17 years: Intramuscular injection to be administered into the gluteal muscle, doses calculated according to body-weight and iron deficit (consult product literature)
  BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
  Child: Doses calculated according to body-weight and iron deficit (consult product literature)

- UNLICENSED USE
  Not licensed for use in children under 14 years.

- INTERACTIONS
  Appendix 1: iron (injectable)

- SIDE-EFFECTS
  Uncommon Feeling hot
  Rare or very rare Deafness (transient) - haemolysis

  Frequency not known Injection site necrosis - rheumatoid arthritis aggravated

- PREGNANCY
  Avoid in first trimester.

- HEPATIC IMPAIRMENT
  Avoid in severe impairment.

- RENAL IMPAIRMENT
  Avoid in acute renal failure.

- PRESCRIBING AND DISPENSING INFORMATION
  A complex of ferric hydroxide with dextran containing 5% (50 mg/mL) of iron.

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

  Solution for injection
  - Venofer (Vifor Pharma UK Ltd)
    Iron (as Iron dextran) 50 mg per 1 ml
    Venofer 50mg/0.5ml solution for injection vials | 5 vial | £43.52
    Venofer 50mg/2.5ml solution for injection vials | 5 vial | £90.88

Iron sucrose

- INDICATIONS AND DOSE
  Iron-deficiency anaemia
  BY SLOW INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
  Child (body-weight up to 67 kg): Dose calculated according to body-weight and iron deficit, each divided dose should not exceed 3 mg/kg/dose (consult product literature)
  Child (body-weight 67 kg and above): Dose calculated according to body-weight and iron deficit, each divided dose should not exceed max. 200 mg/dose (consult product literature)

- UNLICENSED USE
  Not licensed for use in children.

- INTERACTIONS
  Appendix 1: iron (injectable)

- SIDE-EFFECTS
  Uncommon Asthenia
  Rare or very rare Drowsiness - urine discoloration
  Frequency not known Cold sweat - confusion - level of consciousness decreased - thrombophlebitis

- PREGNANCY
  Avoid in first trimester.

- HEPATIC IMPAIRMENT
  Manufacturer advises caution—monitor iron status to avoid iron overload; avoid where iron overload is a precipitating factor (particularly porphyria cutanea tarda).

- PRESCRIBING AND DISPENSING INFORMATION
  A complex of ferric hydroxide with sucrose containing 2% (20 mg/mL) of iron.

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

  Solution for injection
  - Venofer (Vifor Pharma UK Ltd, Imported (United States))
    Iron (as Iron sucrose) 20 mg per 1 ml
    Venofer 20mg/1ml solution for injection vials | 5 vial | £45.57

MINERALS AND TRACE ELEMENTS > IRON, ORAL

Iron (oral)

- SIDE-EFFECTS
  Common or very common Constipation - diarrhoea - gastrointestinal discomfort - nausea
  Uncommon Vomiting
  Frequency not known Appetite decreased - faeces discoloured

SIDE-EFFECTS, FURTHER INFORMATION
Iron can be constipating and occasionally lead to faecal impaction. Oral iron, particularly modified-release preparations, can exacerbate diarrhoea in patients with inflammatory bowel
592 Anaemias

Ferrous fumarate

**INDICATIONS AND DOSE**

**Iron-deficiency anaemia (prophylactic)**  
- **BY MOUTH USING TABLETS**  
  - Child 12-17 years: 210 mg 1–2 times a day  
  - Child 12-17 years: 140 mg twice daily

**Iron-deficiency anaemia (therapeutic)**  
- **BY MOUTH USING TABLETS**  
  - Child 12-17 years: 210 mg 2–3 times a day  
  - Child 12-17 years: 280 mg twice daily

**GALFER® CAPSULES**

**Iron-deficiency anaemia (prophylactic)**  
- **BY MOUTH**  
  - Child 12-17 years: 305 mg daily

**By mouth**

- Neonate up to 36 weeks corrected gestational age (body-weight up to 3 kg): 0.5 mL daily, prophylactic iron supplementation may be required in babies of low birth-weight who are solely breast-fed; supplementation is started 4–6 weeks after birth and continued until mixed feeding is established.
- Neonate: 0.25 mL/kilogram twice daily, the total daily dose may alternatively be given in 3 divided doses, prophylactic iron supplementation may be required in babies of low birth-weight who are solely breast-fed; supplementation is started 4–6 weeks after birth and continued until mixed feeding is established.
- Child 1 month–11 years: 0.25 mL/kilogram twice daily, the total daily dose may alternatively be given in 3 divided doses, prophylactic iron supplementation may be required in babies of low birth-weight who are solely breast-fed; supplementation is started 4–6 weeks after birth and continued until mixed feeding is established.  
- Child 12-17 years: 10 mL once daily

**Iron-deficiency anaemia (therapeutic)**  
- **BY MOUTH**  
  - Neonate: 0.25 mL/kilogram twice daily, the total daily dose may alternatively be given in 3 divided doses.

**Ferrous gluconate**

**INDICATIONS AND DOSE**

**Prophylaxis of iron-deficiency anaemia**  
- **BY MOUTH USING TABLETS**  
  - Child 6–11 years: 300–900 mg daily  
  - Child 12-17 years: 600 mg daily

**Treatment of iron-deficiency anaemia**  
- **BY MOUTH USING TABLETS**  
  - Child 6–11 years: 300–900 mg daily  
  - Child 12-17 years: 1.2–1.8 g daily in divided doses

**INTERACTIONS**  
- Appendix 1: iron (oral)

**SIDE-EFFECTS**  
- Gastrointestinal disorders

**PRESCRIBING AND DISPENSING INFORMATION**  
- Ferrous gluconate 300 mg contains 35 mg iron.
PATIENT AND CARER ADVICE
Medicines for Children leaflet: Ferrous gluconate for iron-deficiency anaemia www.medicinesforchildren.org.uk/ferrous-gluconate-iron-deficiency-anaemia

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Tablet
- Ferrous gluconate (Non-proprietary)
- Ferrous gluconate 300 mg
  - 28 tablet (£3.35 DT = £0.84)
  - 100 tablet (£2.75–£11.64)

Ferrous sulfate

INDICATIONS AND DOSE
Iron-deficiency anaemia (prophylactic)
- BY MOUTH
  - Child 6–17 years: 200 mg daily
  - Iron-deficiency anaemia (therapeutic)
  - BY MOUTH
  - Child 6–17 years: 200 mg 2–3 times a day

FEOSPAN
Iron-deficiency anaemia
- BY MOUTH
  - Child 1–17 years: 1 capsule daily, capsule can be opened and sprinkled on food

FERROGRAD
Iron-deficiency anaemia (prophylactic and therapeutic)
- BY MOUTH
  - Child 1–17 years: 1 tablet daily

IRONORM
Iron-deficiency anaemia (prophylactic)
- BY MOUTH
  - Child 1 month–5 years: 0.2 mL daily until mixed feeding established, higher doses up to max. 0.08 mL/kg daily may be needed, then 0.5–1.2 mL daily
  - Child 6–11 years: 2.4 mL daily
  - Child 12–17 years: 2.4–4.8 mL daily

Iron-deficiency anaemia (therapeutic)
- BY MOUTH
  - Child 1 month–5 years: 0.12–0.24 mL/kg/kilogram daily in 2–3 divided doses; maximum 8 mL per day
  - Child 6–11 years: 0.12–0.24 mL/kg/kilogram daily in 2–3 divided doses; maximum 8 mL per day
  - Child 12–17 years: 4 mL 1–2 times a day

INTERACTIONS
- Appendix 1: folates - iron (oral)

SIDE-EFFECTS
Tooth discoloration

PRESCRIBING AND DISPENSING INFORMATION
Iron content
Ferrous sulfate 200 mg is equivalent to 65 mg iron; Ironorm® drops contain ferrous sulfate 125 mg (equivalent to 25 mg iron)/mL; Feospan® spansules contains ferrous sulfate 150 mg (47 mg iron) (spansule (= capsules m/v)); Ferrograd® tablets contain ferrous sulfate 325 mg (105 mg iron).

PATIENT AND CARER ADVICE
Medicines for Children leaflet: Ferrous sulfate for iron-deficiency anaemia www.medicinesforchildren.org.uk/ferrous-sulfate-iron-deficiency-anaemia

NATIONAL FUNDING/ACCESS DECISIONS
NHS restrictions Feospan® is not prescribable in NHS primary care.

LESS SUITABLE FOR PRESCRIBING
Feospan® is less suitable for prescribing. Ferrograd® is less suitable for prescribing.

Ferrous sulfate with folic acid
22-Mar-2019

The properties listed below are those particular to the combination only. For the properties of the components please consider, ferrous sulfate above, folic acid p. 594.

INDICATIONS AND DOSE
Iron-deficiency anaemia
- BY MOUTH USING MODIFIED-RELEASE TABLETS
  - Child 12–17 years: 1 tablet daily, to be taken before food

INTERACTIONS
- Appendix 1: folates - iron (oral)

LESS SUITABLE FOR PRESCRIBING
Ferrograd Folic® is less suitable for prescribing.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Modified-release tablet
CAUTIONARY AND ADVISORY LABELS 25

- Ferrograd (Teofarma)
  - Ferrous sulfate dried 325 mg
    - Ferrograd 325mg modified-release tablets | 30 tablet (£2.58 DT = £2.58

Tablet
- Ferrous sulfate (Non-proprietary)
  - Ferrous sulfate dried 200 mg
    - Ferrous sulfate 200mg tablets | 28 tablet (£8.15 DT = £1.06)
    - 60 tablet (£3.78–£3.05)
    - 100 tablet (£3.68–£10.80)
    - 1000 tablet (£37.86–£108.00

Modified-release capsule
CAUTIONARY AND ADVISORY LABELS 25

- Feospan Spansules (intrapharm Laboratories Ltd)
  - Ferrous sulfate dried 150 mg
    - Feospans 150mg Capsules | 30 capsule (£3.95

Oral drops
- Ironorm (Wallace Manufacturing Chemists Ltd)
  - Ferrous sulfate 125 mg per 1 mL
    - Ironorm 125mg/ml oral drops sugar-free
      - 15 mL (£30.00 DT = £30.00

Sodium feredate
(Sodium ironedetate)

INDICATIONS AND DOSE
Iron-deficiency anaemia (therapeutic)
- BY MOUTH USING ORAL SOLUTION
  - Neonate: Up to 2.5 mL twice daily, smaller doses to be used initially.

- Child 1–11 months: Up to 2.5 mL twice daily, smaller doses to be used initially
  - Child 1–4 years: 2.5 mL 3 times a day
  - Child 5–11 years: 5 mL 3 times a day
  - Child 12–17 years: 5 mL 3 times a day, increased to 10 mL 3 times a day, dose to be increased gradually

Iron-deficiency anaemia (prophylactic)
- BY MOUTH USING ORAL SOLUTION

- Neonate: 1 mL daily, prophylactic iron supplementation may be required in babies of low birth-weight who are solely breast-fed; supplementation is started 4–6 weeks after birth and continued until mixed feeding is established.

- Child 1–11 months: 1 mL daily, prophylactic iron supplementation may be required in babies continued →
of low birth-weight who are solely breast-fed; supplementation is started 4–6 weeks after birth and continued until mixed feeding is established

- **UNLICENSED USE** Not licensed for prophylaxis of iron deficiency.
- **INTERACTIONS** → Appendix 1: iron (oral)
- **PRESCRIBING AND DISPENSING INFORMATION** Sytron® contains 207.5 mg sodium feredetate trihydrate, which is equivalent to 27.5 mg of iron/5 mL.
- **PATIENT AND CARER ADVICE**

### Medicinal forms
There can be variation in the licensing of different medicines containing the same drug.

- **Oral solution**
  - Sodium feredetate (Non-proprietary)
    - Iron (as Sodium feredetate) 5.5 mg per 1 ml
    - Sodium feredetate (iron 22.5 mg/5 ml) oral solution sugar free sugar-free 500 ml (95) £14.95 DT £14.95
  - **Sytron** (Forum Health Products Ltd)
    - Iron (as Sodium feredetate) 5.5 mg per 1 ml
    - Sytron oral solution sugar-free 500 ml (95) £14.95 DT £14.95

## 1.3 Megaloblastic anaemia

### Anaemia, megaloblastic

#### Overview
Megaloblastic anaemias are rare in children; they may result from a lack of either vitamin B₁₂ or folate and it is essential to establish in every case whether deficiency is present and the underlying cause. In emergencies, when delay might be dangerous, it is sometimes necessary to administer both substances after the bone marrow test while plasma assay results are awaited. Normally, however, appropriate treatment should not be instituted until the results of tests are available.

Vitamin B₁₂ is used in the treatment of megaloblastosis caused by prolonged nitrous oxide anaesthesia, which inactivates the vitamin, and in the rare disorders of congenital transcobalamin II deficiency and homocystinuria. Vitamin B₁₂ should be given prophylactically after total ileal resection.

Apart from dietary deficiency, all other causes of vitamin B₁₂ deficiency are attributable to malabsorption. There is little place for the use of low-dose vitamin B₁₂ orally and none for vitamin B₁₂ intrinsic factor complexes given by mouth. Vitamin B₁₂ in large oral doses [unlicensed] may be effective.

Hydroxocobalamin p. 595 has completely replaced cyanocobalamin p. 595 as the form of vitamin B₁₂ of choice for therapy; it is retained in the body longer than cyanocobalamin and thus for maintenance therapy can be given at intervals of up to 3 months. Treatment is generally initiated with frequent administration of intramuscular injections to replenish the depleted body stores. Thereafter, maintenance treatment, which is usually for life, can be instituted. There is no evidence that doses larger than those recommended provide any additional benefit in vitamin B₁₂ neuropathy.

Folic acid below has few indications for long-term therapy since most causes of folate deficiency are self-limiting or will yield to a short course of treatment. It should not be used in undiagnosed megaloblastic anaemia unless vitamin B₁₂ is administered concurrently otherwise neuropathy may be precipitated.

In folate-deficient megaloblastic anaemia (e.g. because of poor nutrition, pregnancy, or antiepileptic drugs), daily folic acid supplementation for 4 months brings about haematological remission and replenishes body stores; higher doses may be necessary in malabsorption states. In pregnancy, folic acid daily is continued to term.

For prophylaxis in chronic haemolytic states, malabsorption, or in renal dialysis, folic acid is given daily or sometimes weekly, depending on the diet and the rate of haemolysis.

Folic acid is also used for the prevention of methotrexate-induced side-effects in juvenile idiopathic arthritis, severe Crohn’s disease and severe psoriasis.

Folic acid is actively excreted in breast milk and is well absorbed by the infant. It is also present in cow’s milk and artificial formula feeds but is heat labile. Serum and red cell folate concentrations fall after delivery and urinary losses are high, particularly in low birth-weight neonates. Although symptomatic deficiency is rare in the absence of malabsorption or prolonged diarrhoea, it is common for neonatal units to give supplements of folic acid to all preterm neonates from 2 weeks of age until full-term corrected age is reached, particularly if heated breast milk is used without an artificial formula fortifier.

Folinic acid p. 575 is also effective in the treatment of folate deficient megaloblastic anaemia but it is normally only used in association with cytotoxic drugs; it is given as calcium folinate.

There is no justification for prescribing multiple ingredient vitamin preparations containing vitamin B₁₂ or folic acid.

For the use of folic acid before and during pregnancy, see Neural tube defects (prevention in pregnancy) p. 660.

### Vitamins and trace elements > FOLATES

#### Folic acid

- **INDICATIONS AND DOSE**
  - **Folate-deficient megaloblastic anaemia**
    - **BY MOUTH**
      - Neonate: Initially 500 micrograms/kg once daily for up to 4 months.
      - Child 1-11 months: Initially 500 micrograms/kg once daily (max. per dose 5 mg) for up to 4 months, doses up to 10 mg daily may be required in malabsorption states
      - Child 1-17 years: 5 mg daily for 4 months (until term in pregnant women), doses up to 15 mg daily may be required in malabsorption states
  - **Folate supplementation in neonates**
    - **BY MOUTH**
      - Neonate: 50 micrograms once daily.

- **Prevention of neural tube defects (in those at a low risk of conceiving a child with a neural tube defect see Neural tube defects (prevention in pregnancy) p. 660)**
  - **BY MOUTH**
  - **Females of childbearing potential**: 400 micrograms daily, to be taken before conception and until week 12 of pregnancy
- **Prevention of neural tube defects (in those in the high-risk group who wish to become pregnant or who are at risk of becoming pregnant see Neural tube defects (prevention in pregnancy) p. 660)**
  - **BY MOUTH**
  - **Females of childbearing potential**: 5 mg daily, to be taken before conception and until week 12 of pregnancy
**Prevention of neural tube defects (in those with sickle-cell disease)**
- **BY MOUTH**
- Females of childbearing potential: 5 mg daily, patient should continue taking their normal dose of folic acid 5 mg daily (or increase the dose to 5 mg daily) before conception and continue this throughout pregnancy

**Prevention of methotrexate side-effects in severe Crohn’s disease**
- **BY MOUTH**
- Child: 5 mg once weekly, dose to be taken on a different day to methotrexate dose

**Prophylaxis of folate deficiency in dialysis**
- **BY MOUTH**
- Child 1 month–11 years: 250 micrograms/kg once daily (max. per dose 10 mg)
- Child 12–17 years: 5–10 mg once daily

**Haemolytic anaemia**
- **BY MOUTH**
- Child 1 month–11 years: 2.5–5 mg once daily
- Child 12–17 years: 5–10 mg once daily

**Prevention of methotrexate side-effects in juvenile idiopathic arthritis**
- **BY MOUTH**
- Child: 1 mg daily, alternatively 5 mg once weekly, dose to be adjusted according to local guidelines, weekly dose to be taken on a different day to methotrexate dose

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### VITAMINS AND TRACE ELEMENTS

#### Cyanocobalamin

**29-Mar-2019**

**INDICATIONS AND DOSE**
- **Vitamin B12 deficiency of dietary origin**
  - **BY MOUTH**
  - Child: 50–105 micrograms daily in 1–3 divided doses

**PRESCRIBING AND DISPENSING INFORMATION**
Currently available brands of the tablet may not be suitable for vegans.

**NATIONAL FUNDING/ACCESS DECISIONS**
NHS restrictions. Cyanocobalamin solution and Cytamina® injection are not prescribable in NHS primary care.

**LESS SUITABLE FOR PRESCRIBING**
Cyanocobalamin is less suitable for prescribing.

#### Hydroxocobalamin

**20-Jul-2017**

**INDICATIONS AND DOSE**
- **Macrocytic anaemia without neurological involvement**
  - **BY INTRAMUSCULAR INJECTION**
  - Child: Initially 0.25–1 mg once daily on alternate days for 1–2 weeks, then 0.25 mg once weekly until blood count normal, then 1 mg every 2–3 months

**Macrocytic anaemia with neurological involvement**
- **BY INTRAMUSCULAR INJECTION**
- Child: Initially 1 mg once daily on alternate days until no further improvement, then 1 mg every 2–3 months

**Prophylaxis of macrocytic anaemias associated with vitamin B12 deficiency**
- **BY INTRAMUSCULAR INJECTION**
- Child: 1 mg every 2–3 months

**Leber’s optic atrophy**
- **BY INTRAMUSCULAR INJECTION**
- Child: Initially 1 mg daily for 2 weeks, then 1 mg twice weekly until no further improvement, then 1 mg every 1–3 months

**Congenital transcobalamin II deficiency**
- **BY INTRAMUSCULAR INJECTION**

- Neonate: 1 mg 3 times a week for 1 year, then reduced to 1 mg once weekly, adjusted as appropriate.

- Child: 1 mg 3 times a week for 1 year, then reduced to 1 mg once weekly, adjusted as appropriate.

**Methylmalonic acidemia and homocystinuria**
- **BY INTRAMUSCULAR INJECTION**
- Child: Initially 1 mg daily for 5–7 days, then adjusted according to response to up to 1 mg 1–2 times a week, this is the maintenance dose

**Methylmalonic acidemia, maintenance once intramuscular response established**
- **BY MOUTH**
- Child: 5–10 mg 1–2 times a week, some children do not respond to oral route
Iron overload

Overview
Severe tissue iron overload can occur in aplastic and other refractory anaemias, mainly as the result of repeated blood transfusions. It is a particular problem in refractory anaemias with hyperplastic bone marrow, especially thalassaemia major, where excessive iron absorption from the gut and inappropriate iron therapy can add to the tissue siderosis.

Iron overload associated with haemochromatosis can be treated with repeated venesection. Venesection may also be used for patients who have received multiple transfusions and whose bone marrow has recovered. Where venesection is contra-indicated, and in thalassaemia, the long-term administration of the iron chelating compound desferrioxamine mesilate p. 598 is useful. Desferrioxamine mesilate (up to 2 g per unit of blood) may also be given at the time of blood transfusion, provided that the desferrioxamine mesilate is not added to the blood and is not given through the same line as the blood (but the two may be given through the same cannula).

Iron excretion induced by desferrioxamine mesilate is enhanced by ascorbic acid p. 652 (vitamin C) daily by mouth; it should be given separately from food since it also enhances iron absorption. Ascorbic acid should not be given to children with cardiac dysfunction; in children with normal cardiac function ascorbic acid should be introduced 1 month after starting desferrioxamine mesilate.

Desferrioxamine mesilate infusion can be used to treat aluminium overload in dialysis patients; theoretically 100 mg of desferrioxamine binds with 4.1 mg of aluminium.

ANTIDOTES AND CHELATORS

Deferasirox

Drug action
Deferasirox is an oral iron chelator.

Indications and dose
Transfusion-related chronic iron overload when desferrioxamine is contra-indicated or inadequate in patients with beta thalassaemia major who receive frequent blood transfusions (7 mL/kg/month or more of packed red blood cells) (specialist use only)

By mouth
Child 2–5 years: Initially 7–21 mg/kg once daily, dose adjusted according to serum-ferritin concentration and amount of transfused blood—consult product literature, then adjusted in steps of 3.5–7 mg/kg every 3–6 months, maintenance dose adjusted according to serum-ferritin concentration; maximum 28 mg/kg per day; Usual maximum 21 mg/kg

Transfusion-related chronic iron overload in patients with beta thalassaemia major who receive frequent blood transfusions (7 mL/kg/month or more of packed red blood cells) (specialist use only)

By mouth
Child 6–17 years: Initially 7–21 mg/kg once daily, dose adjusted according to serum-ferritin concentration and amount of transfused blood—consult product literature, then adjusted in steps of 3.5–7 mg/kg every
Iron overload

3–6 months, maintenance dose adjusted according to serum-ferritin concentration; maximum 28 mg/kg per day; usual maximum 21 mg/kg

Transfusion-related chronic iron overload when desferrioxamine is contra-indicated or inadequate in patients with beta thalassaemia major who receive infrequent blood transfusions (less than 7 ml/kg/month of packed red blood cells) [specialist use only]

Transfusion-related chronic iron overload when desferrioxamine is contra-indicated or inadequate in patients with other anaemias (specialist use only)

- **BY MOUTH**
  - Child 2–17 years: Initially 7–21 mg/kg once daily, dose adjusted according to serum–ferritin concentration and amount of transfused blood—consult product literature, then adjusted in steps of 3.5–7 mg/kg every 3–6 months, maintenance dose adjusted according to serum–ferritin concentration; maximum 28 mg/kg per day; usual maximum 21 mg/kg

Chronic iron overload when desferrioxamine is contra-indicated or inadequate in non-transfusion-dependent thalassaemia syndromes (specialist use only)

- **BY MOUTH**
  - Child 10–17 years: Initially 7 mg/kg once daily, maintenance dose adjusted according to serum–ferritin concentration and liver–iron concentration (consult product literature); maximum 7 mg/kg per day

- **CAUTIONS** History of liver cirrhosis—not recommended in conditions which may reduce life expectancy (e.g. high-risk myelodysplastic syndromes)—platelet count less than 50 x 10^10/litre; risk of gastrointestinal ulceration and haemorrhage, unexpected cytopaenia—consider treatment interruption

- **INTERACTIONS** → Appendix 1: iron chelators

- **SIDE-EFFECTS**
  - **Common or very common** Constipation; diarrhoea; gastrointestinal discomfort; headache; nausea; skin reactions; urine abnormalities; vomiting
  - **Uncommon** Anxiety; cataract; cholelithiasis; deafness; dizziness; fatigue; fever; gastrointestinal disorders; gastrointestinal haemorrhage (including fatal cases); hepatic disorders; laryngeal pain; maculopathy; oedema; renal tubular disorders; sleep disorder
  - **Rare or very rare** Optic neuritis
  - **Frequency not known** Acute kidney injury; alopecia; anaemia aggravated; angioedema; hypersensitivity vasculitis; metabolic acidosis; nephritis tubulointerstitial; nephrolithiasis; neutropenia; pancreatitis acute; pancytopenia; renal tubular necrosis; severe cutaneous adverse reactions (SCARs); thrombocytopenia

- **PREGNANCY** Manufacturer advises avoid unless essential—toxicity in animal studies.

- **BREAST FEEDING** Manufacturer advises avoid—present in milk in animal studies.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution in moderate impairment; avoid in severe impairment.

- **Dose adjustments** Manufacturer advises reduce initial dose considerably then gradually increase to max. 50% of normal dose in moderate impairment.

- **RENAL IMPAIRMENT** Manufacturer advises avoid if estimated creatinine clearance less than 60 ml/minute. Dose adjustments Manufacturer advises reduce dose if serum–creatinine increased above age–appropriate limits or creatinine clearance less than 90 ml/minute on 2 consecutive occasions—consult product literature.

- **MONITORING REQUIREMENTS**
  - Manufacturer advises monitoring of the following patient parameters: baseline serum creatinine twice and creatinine clearance once before initiation of treatment, weekly in the first month after treatment initiation or modification, then monthly thereafter; proteinuria before treatment initiation then monthly thereafter, and other markers of renal tubular function as needed; liver function before treatment initiation, every 2 weeks during the first month of treatment, then monthly thereafter; eye and ear examinations before treatment and annually during treatment; serum–ferritin concentration monthly.
  - Manufacturer advises monitor liver–iron concentration every three months in children with non-transfusion-dependent thalassaemia syndromes when serum ferritin is <800 micrograms/litre.
  - Manufacturer advises monitor body–weight, height, and sexual development before treatment and then annually thereafter.

- **DIRECTIONS FOR ADMINISTRATION** For film–coated tablets, manufacturer advises tablets may be crushed and sprinkled on to soft food (yoghurt or apple sauce), then administered immediately.

- **PATIENT AND CARER ADVICE** Patient or carers should be given advice on how to administer deferasirox tablets.

- **NATIONAL FUNDING/ACCESS DECISIONS**

**Scottish Medicines Consortium (SMC) decisions**

The Scottish Medicines Consortium has advised (June 2017) that deferasirox (Exjade®) is accepted for restricted use within NHS Scotland for the treatment of chronic iron overload associated with the treatment of rare acquired or inherited anaemias requiring recurrent blood transfusions. It is not recommended for patients with myelodysplastic syndromes.

- Patients with myelodysplastic syndromes, the commonly cause of transfusion–dependent anaemia, were poorly represented in the clinical trial population and the economic case was not demonstrated in this group.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Dose</th>
<th>Pack</th>
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<td>Exjade</td>
<td>Novartis Pharmaceuticals UK Ltd</td>
<td>90 mg</td>
<td>30 tablet</td>
<td>£126.00</td>
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<tr>
<td>Deferasirox 360 mg</td>
<td>Exjade 360 mg tablets</td>
<td>30 tablet</td>
<td>£504.00</td>
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**Deferiprone**

- **DRUG ACTION** Deferiprone is an oral iron chelator.

- **INDICATIONS AND DOSE**
  - Treatment of iron overload in patients with thalassaemia major in whom desferrioxamine is contra–indicated or is inadequate
  - **BY MOUTH**
    - Child 6–17 years: 25 mg/kg 3 times a day; maximum 100 mg/kg per day

- **CONTRA-INDICATIONS** History of agranulocytosis or recurrent neutropenia

- **INTERACTIONS** → Appendix 1: deferiprone

- **SIDE-EFFECTS**
  - **Common or very common** Abdominal pain (reducing dose and increasing gradually may improve tolerance); agranulocytosis; appetite increased; arthralgia; diarrhoea (reducing dose and increasing gradually may improve tolerance); fatigue; headache; nausea (reducing dose and increasing gradually may improve tolerance); neutropenia; pain; proteinuria; skin reaction; vomiting

**Blood and nutrition**
Iron overload

- urine discolouration - vomiting (reducing dose and increasing gradually may improve tolerance)

■ Frequency not known Skin reactions - zinc deficiency

■ CONCEPTION AND CONTRACEPTION Manufacturer advises avoid before intended conception—teratogenic and embryotoxic in animal studies. Contraception advised in females of child-bearing potential.

■ PREGNANCY Manufacturer advises avoid during pregnancy—teratogenic and embryotoxic in animal studies.

■ BREAST FEEDING Manufacturer advises avoid—no information available.

■ HEPATIC IMPAIRMENT Manufacturer advises monitor liver function—interrupt treatment if persistent elevation in serum alanine aminotransferase.

■ RENAL IMPAIRMENT Manufacturer advises caution—no information available.

■ MONITORING REQUIREMENTS Monitor neutrophil count weekly and discontinue treatment if neutropenia develops.

■ PATIENT AND CARER ADVICE Blood disorders Patients or their carers should be told how to recognise signs of neutropaenia and advised to seek immediate medical attention if symptoms such as fever or sore throat develop.

■ MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution

- Oral solution
  - CAUTIONARY AND ADVISORY LABELS 14
    - Ferriprox (Swedish Orphan Biovitrum Ltd)
    - Desferal 500 mg per ml
    - Desferal 100mg/ml oral solution sugar-free | 500 ml (PN) £152.39 DT = £152.39

- Tablet
  - CAUTIONARY AND ADVISORY LABELS 14
    - Ferriprox (Swedish Orphan Biovitrum Ltd)
    - Desferal 500 mg
    - Desferal 500mg tablets | 100 tablet (PN) £152.39 DT = £152.39
    - Desferal 1 gram
    - Desferal 1000mg tablets | 50 tablet (PN) £175.25 DT = £175.25

■ Desferrioxamine mesilate (Deferoxamine Mesilate)

■ INDICATIONS AND DOSE

- Iron poisoning
  - BY CONTINUOUS INTRAVENOUS INFUSION
  - Neonate: Initially up to 15 mg/kg/hour, max. 80 mg/kg in 24 hours, dose to be reduced after 4–6 hours, in severe cases, higher doses may be given on advice from the National Poisons Information Service.
  - Child: Initially up to 15 mg/kg/hour, max. 80 mg/kg in 24 hours, dose to be reduced after 4–6 hours, in severe cases, higher doses may be given on advice from the National Poisons Information Service

- Aluminiun overload in dialysis patients
  - BY INTRAVENOUS INFUSION
  - Child: 5 mg/kg once weekly

- Chronic iron overload (low iron overload)
  - BY SUBCUTANEOUS INFUSION
  - Child: Initially up to 30 mg/kg 3–7 times a week, to be given over 8–12 hours, the dose should reflect the degree of iron overload

- Chronic iron overload (established overload)
  - BY SUBCUTANEOUS INFUSION
  - Child: 20–50 mg/kg daily

■ UNLICENSED USE
- When used for iron poisoning Licensed for use in children (age range not specified by manufacturer).

■ CAUTIONS
- Aluminnum-related encephalopathy (may exacerbate neurological dysfunction)

■ INTERACTIONS
- Appendix 1: iron chelators

■ SIDE-EFFECTS
- Common or very common Arthralgia - bone disorder - fever - growth retardation - headache - muscle complaints - nausea - skin reactions

- Uncommon Abdominal pain - asthm a - deafness - neurosensory - tinnitus - vomiting

- Rare or very rare Angioedema - blood disorder - cataract - diarrhoea - dizziness - encephalopathy - eye disorders - hypersensitivity - hypotension (more common when given too rapidly by intravenous injection) - increased risk of infection - nerve disorders - nervous system disorder - paraesthesia - respiratory disorders - shock - tachycardia - thrombocytopenia - vision disorders

- Frequency not known Acute kidney injury - hypocalcaemia - leucopenia - renal tubular disorder - seizure - urine red

■ PREGNANCY
- Teratogenic in animal studies. Manufacturer advises use only if potential benefit outweighs risk.

■ BREAST FEEDING
- Manufacturer advises use only if potential benefit outweighs risk—no information available.

■ RENAL IMPAIRMENT
- Use with caution.

■ MONITORING REQUIREMENTS
- Eye and ear examinations before treatment and at 3-month intervals during treatment.

- Monitor body-weight and height in children at 3-month intervals—risk of growth retardation with excessive doses.

■ DIRECTIONS FOR ADMINISTRATION
- For full details and warnings relating to administration, consult product literature.

- When used for Chronic iron overload or Aluminium overload in dialysis patients For intravenous or subcutaneous infusion, reconstitute powder with Water for Injection to a concentration of 100 mg/ml; dilute with Glucose 5% or Sodium Chloride 0.9%. In haemodialysis or haemo-filtration administer over the last hour of dialysis (may be given via the dialysis fistula). Intrapertitoneal: may be added to dialysis fluid. In CAPD give prior to the last exchange of the day.

■ PATIENT AND CARER ADVICE
- Medicines for Children leaflet: Desferasirox for removing excess iron www.medicinesforchildren.org.uk/desferasirox-removing-excess-iron-0

■ MEDICINAL FORMS
- There can be variation in the licensing of different medicines containing the same drug.

- Powder for solution for injection
  - Desferrioxamine mesilate (Non-proprietary)
    - Desferrioxamine mesilate 500 mg: Desferal 500mg powder for solution for injection vials | 10 vial (PN) £179.50
    - Desferrioxamine mesilate 2 gram: Desferal 2g powder for solution for injection vials | 10 vial (PN) £179.50
    - Desferal (Novartis Pharmaceuticals UK Ltd)
      - Desferrioxamine mesilate 500 mg: Desferal 500mg powder for solution for injection vials | 10 vial (PN) £46.63
3 Neutropenia and stem cell mobilisation

3.1 Neutropenia

Neutropenia

Management

Recombinant human granulocyte-colony stimulating factor (rH-G-CSF) stimulates the production of neutrophils and may reduce the duration of chemotherapy-induced neutropenia and thereby reduce the incidence of associated sepsis; there is as yet no evidence that it improves overall survival. Filgrastim below (unglycosylated rH-G-CSF) and lenograstim p. 600 (glycosylated rH-G-CSF) have similar effects; both have been used in a variety of clinical settings, including cytotoxic-induced neutropenia, and neutropenia following bone marrow transplantation, but they do not have any clear-cut routine indications. In congenital neutropenia filgrastim usually increases the neutrophil count with an appropriate clinical response. Prolonged use may be associated with an increased risk of myeloid malignancy.

Treatment with granulocyte-colony stimulating factors should only be prescribed by those experienced in their use.

Neonatal neutropenia

Filgrastim has been used to treat sepsis-induced neutropenia in preterm neonates. There is no clear evidence that granulocyte-colony stimulating factors improve survival or long-term outcomes.

IMMUNOSTIMULANTS > GRANULOCYTE-COLONY STIMULATING FACTORS

Granulocyte-colony stimulating factors

- **DRUG ACTION** Recombinant human granulocyte-colony stimulating factor (rH-G-CSF) stimulates the production of neutrophils.
- **CAUTIONS** Malignant myeloid conditions · pre-malignant myeloid conditions · risk of splenomegaly and rupture—spleen size should be monitored · sickle-cell disease
- **CAUTIONS, FURTHER INFORMATION**
- **SIDE-EFFECTS**
  - Common or very common Arthralgia · cutaneous vasculitis · dyspnoea · haemoptysis · headache · hypersensitivity · leucocytosis · pain · spleen abnormalities · thrombocytopenia
  - Uncommon Acute febrile neutrophilic dermatosis · capillary leak syndrome · hypoxia · pulmonary oedema · respiratory disorders · sickle cell anaemia with crisis
- **PREGNANCY** Manufacturers advise avoid—toxicity in animal studies.
- **BREAST FEEDING** There is no evidence for the use of granulocyte-colony stimulating factors during breast-feeding and manufacturers advise avoiding their use.

***Filgrastim***

(Recombinant human granulocyte-colony stimulating factor; G-CSF)

- **INDICATIONS AND DOSE**
  - Reduction in duration of neutropenia and incidence of febrile neutropenia in cytotoxic chemotherapy for malignancy (except chronic myeloid leukaemia and myelodysplastic syndromes) (specialist use only)
  - **BY SUBCUTANEOUS INJECTION, OR BY INTRAVENOUS INFUSION**
    - Child: 5 micrograms/kg daily until neutrophil count in normal range, usually for up to 14 days (up to 38 days in acute myeloid leukaemia), to be started at least 24 hours after cytotoxic chemotherapy. Preferably given by subcutaneous injection; if given by intravenous infusion, administer over 30 minutes
  - Reduction in duration of neutropenia (and associated sequelae) in myeloablative therapy followed by bone-marrow transplantation (specialist use only)
    - **BY SUBCUTANEOUS INJECTION, OR BY INTRAVENOUS INFUSION**
      - Child: 10 micrograms/kg daily, to be started at least 24 hours following cytotoxic chemotherapy and within 24 hours of bone-marrow infusion, then adjusted according to neutrophil count—consult product literature, doses administered over 30 minutes or 24 hours via intravenous route and over 24 hours via subcutaneous route
  - Mobilisation of peripheral blood progenitor cells for autologous infusion, used alone (specialist use only)
    - **BY SUBCUTANEOUS INJECTION, OR BY INTRAVENOUS INFUSION**
      - Child: 10 micrograms/kg daily for 5–7 days, to be administered over 24 hours if given by subcutaneous infusion
  - Mobilisation of peripheral blood progenitor cells for autologous infusion, used following adjunctive myelosuppressive chemotherapy—to improve yield (specialist use only)
    - **BY SUBCUTANEOUS INJECTION**
      - Child: 5 micrograms/kg daily until neutrophil count in normal range, to be started the day after completing chemotherapy, for timing of leucopheresis, consult product literature
  - Mobilisation of peripheral blood progenitor cells in normal donors for allogeneic infusion (specialist use only)
    - **BY SUBCUTANEOUS INJECTION**
      - Child 16–17 years: 10 micrograms/kg daily for 4–5 days, for timing of leucopheresis, consult product literature
  - Severe congenital neutropenia and history of severe or recurrent infections (distinguish carefully from other haematological disorders) (specialist use only)
    - **BY SUBCUTANEOUS INJECTION**
      - Child: Initially 12 micrograms/kg daily, adjusted according to response, can be given in single or divided doses, consult product literature and local protocol

- **MONITORING REQUIREMENTS**
  - Full blood counts including differential white cell and platelet counts should be monitored.
  - Spleen size should be monitored during treatment—risk of splenomegaly and rupture.

- **MONITORING REQUIREMENTS**
  - Full blood counts including differential white cell and platelet counts should be monitored.
  - Spleen size should be monitored during treatment—risk of splenomegaly and rupture.
Severe cyclic neutropenia, or idiopathic neutropenia and
history of severe or recurrent infections (distinguish
carefully from other haematological disorders)
(specialist use only)

- By subcutaneous injection
  - Child: Initially 5 micrograms/kg daily, adjusted
    accordingly to response, can be given in single or
divided doses, consult product literature and local protocol

Persistent neutropenia in HIV infection (specialist use
only)

- By subcutaneous injection
  - Child: Initially 1 microgram/kg daily, subsequent doses
    increased as necessary until neutrophil count in
    normal range, then adjusted to maintain neutrophil
    counts in normal range—consult product literature;
    maximum 4 micrograms/kg per day

Neonatal neutropenia (specialist use only)

- By subcutaneous injection
  - Neonate: 10 micrograms/kg daily, to be discontinued if
    white cell count exceeds 50 x 10^9/litre.

Glycogen storage disease type 1b (specialist use only)

- By subcutaneous injection
  - Child: Initially 5 micrograms/kg daily, dose to be
    adjusted as necessary

● Unlicensed use
  Not licensed for treatment of glycogen
  storage disease or neonatal neutropenia.

● Contra-indications
  Severe congenital neutropenia
  (Kostmann’s syndrome) with abnormal cytogenetics

● Cautions
  Osteoporotic bone disease (monitor bone
  density if given for more than 6 months) - secondary acute
  myeloid leukaemia

● Side-effects
  - Common or very common
    - Anaemia, diarrhoea, dysuria,
      haemorrhage, hepatomegaly, hyperuricaemia,
      hypotension, rash, urolithiasis, uric acid urolithiasis.
  - Uncommon
    - Fluid imbalance, graft versus host disease,
      peripheral vascular disease, pseudogout, rheumatoid arthritis,
      urate urolithiasis.

● Monitoring requirements
  Regular morphological and
cytogenetic bone-marrow examinations recommended in
severe congenital neutropenia (possible risk of
myelodysplastic syndromes or leukaemia).

● Directions for administration
  For subcutaneous or intravenous infusion, dilute with Glucose 5% to
a concentration of not less than 15 micrograms/mL; to dilute
to a concentration of 2–15 micrograms/mL, add albumin
solution (human albumin solution) to produce a final
albumin solution of 2 mg/mL; not compatible with Sodium
Chloride solutions.

● Prescribing and dispensing information
  Filgrastim is a biological medicine. Biological medicines must be
prescribed and dispensed by brand name, see Biological
medicines and Biosimilar medicines, under Guidance on
prescribing p. 1.

  1 million units of filgrastim solution for injection
  contains 10 micrograms filgrastim.

● Medicinal forms
  There can be variation in the licensing of
different medicines containing the same drug.

  Solution for injection
  - Accofil (Accord Healthcare Ltd) ▼
    - Filgrastim 60 mega u per 1 ml
      Accofil 30 million units/0.5ml solution
      for injection pre-filled syringes | 5 pre-filled disposable
      injection (POM) £284.20
    - Filgrastim 96 mega u per 1 ml
      Accofil 48 million units/0.5ml solution
      for injection pre-filled syringes | 5 pre-filled disposable
      injection (POM) £455.70
  - Neupogen (Amgen Ltd)
    - Filgrastim 30 mega u per 1 ml
      Neupogen 30 million units/1ml solution
      for injection vials | 5 vial (POM) £263.52
  - Neupogen Singleject (Amgen Ltd)
    - Filgrastim 60 mega u per 1 ml
      Neupogen Singleject 30 million
      units/0.5ml solution for injection
      pre-filled syringes | 1 pre-filled disposable
      injection (POM) £52.70
    - Filgrastim 96 mega u per 1 ml
      Neupogen Singleject 48 million
      units/0.5ml solution for injection
      pre-filled syringes | 1 pre-filled disposable
      injection (POM) £84.06
  - Nivestim (Pfizer Ltd)
    - Filgrastim 60 mega u per 1 ml
      Nivestim 30 million units/0.5ml solution
      for injection pre-filled syringes | 5 pre-filled disposable
      injection (POM) £246.50
    - Nivestim 12 million units
      0.2ml solution for injection
      pre-filled syringes | 5 pre-filled disposable
      injection (POM) £153.00
    - Filgrastim 96 mega u per 1 ml
      Nivestim 48 million units/0.5ml solution
      for injection pre-filled syringes | 5 pre-filled disposable
      injection (POM) £395.25
  - Zarzio (Sandoz Ltd)
    - Filgrastim 60 mega u per 1 ml
      Zarzio 30 million units/0.5ml solution
      for injection pre-filled syringes | 5 pre-filled disposable
      injection (POM) £250.75
    - Filgrastim 96 mega u per 1 ml
      Zarzio 48 million units/0.5ml solution
      for injection pre-filled syringes | 5 pre-filled disposable
      injection (POM) £399.50

Lenograstim
(Recombinant human granulocyte-colony
stimulating factor; rHuG-CSF)

● Indications and dose
  Reduction in the duration of neutropenia and associated
  complications following bone-marrow transplantation for
  non-myeloid malignancy (specialist use only)
  - Reduction in the duration of neutropenia and associated
    complications following peripheral stem cell
    transplantation for non-myeloid malignancy (specialist
    use only)
  - By intravenous infusion, or by subcutaneous injection
    - Child 2-17 years: 150 micrograms/m^2 daily until
      neutrophil count stable in acceptable range (max.
      28 days), to be started the day after transplantation.
    - Intravenous infusion to be given over 30 minutes

  Reduction in the duration of neutropenia and associated
  complications following treatment with cytotoxic
  chemotherapy associated with a significant incidence of
  febrile neutropenia (specialist use only)
  - By subcutaneous injection
    - Child 2-17 years: 150 micrograms/m^2 daily until
      neutrophil count stable in acceptable range (max.
      28 days), to be started on the day after completion of
      chemotherapy

  Mobilisation of peripheral blood progenitor cells
  for harvesting and subsequent infusion, used alone
  (specialist use only)
  - By subcutaneous injection
    - Child 2-17 years: 10 micrograms/kg daily for 4–6 days
      (5–6 days in healthy donors)

  Mobilisation of peripheral blood progenitor cells, used
  following adjunctive myelosuppressive chemotherapy
  (to improve yield) (specialist use only)
  - By subcutaneous injection
    - Child 2-17 years: 150 micrograms/m^2 daily until
      neutrophil count stable in acceptable range, to be
      started 1–5 days after completion of chemotherapy, for
      timing of leukopheresis, consult product literature

● Unlicensed use
  Not licensed for use in children for
cytotoxic-induced neutropenia, mobilisation of peripheral
blood progenitor cells (monotherapy or adjunctive
therapy), or following peripheral stem cells
transplantation.

● Side-effects
  - Common or very common
    - Abdominal pain - asthenia
thrombocythaemia in patients at risk of thrombo-
anagrelide below reduces platelets in essential
Platelet disorders

Idiopathic thrombocytopenic purpura
Acute idiopathic thrombocytopenic purpura is usually self-
limited in children. A corticosteroid, such as prednisolone
p. 458, is sometimes used if idiopathic thrombocytopenic
purpura does not resolve spontaneously or if it is associated
with severe cutaneous symptoms or mucous membrane
bleeding; corticosteroid treatment should not be continued
longer than 14 days regardless of the response.

Immunoglobulin preparations may be used in idiopathic
thrombocytopenic purpura or where a temporary rapid rise
in platelets is needed, as in pregnancy or pre-operatively;
they are often used in preference to a corticosteroid. Anti-D
(RhD) immunoglobulin p. 794 is licensed for the management
of idiopathic thrombocytopenic purpura.

Other therapies that have been tried under specialist
supervision in refractory idiopathic thrombocytopenic
purpura include: azathioprine p. 536, cyclophosphamide
p. 555, vincristine sulfate p. 570, and cyclosporin p. 537.
Rituximab p. 550 [unlicensed] is also used in specialist
centres but experience of its use in children is limited. For
patients with chronic severe thrombocytopenia refractory to
other therapy, tranexamic acid p. 83 may be given to reduce
the severity of haemorrhage.

Eltrombopag p. 602 and romiplostim p. 603 are
thrombopoietin receptor agonists. They are licensed for the
treatment of chronic immune (idiopathic) thrombocytopenic
purpura in children who are refractory to other treatments,
such as corticosteroids or immunoglobulins. Eltrombopag
is an oral preparation and romiplostim is an injection which is
made biosynthetically by recombinant DNA technology; they
should both be used under the supervision of a specialist.

Splenectomy is considered in chronic thrombocytopenic
purpura if a satisfactory platelet count is not achieved with
regular immunoglobulin infusions, if there is a relapse on
withdrawing or reducing the dose of corticosteroid, and if
other therapies are considered inappropriate.

Essential thrombocythaemia
Anagrelide below reduces platelets in essential
thrombocythaemia in patients at risk of thrombo-
haemorrhagic events who have not responded adequately to
other drugs or who cannot tolerate other drugs.

4.1 Essential thrombocythaemia

Other drugs used for Essential thrombocythaemia
Hydroxycarbamide, p. 572

ANTITHROMBOTIC DRUGS > CYCLIC AMP
PHOSPHODIESTERASE III INHIBITORS

<table>
<thead>
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<th>Anagrelide</th>
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- **INDICATIONS AND DOSE**
  - Essential thrombocythaemia in patients at risk of
    thrombo-haemorrhagic events who have not responded adequately to
    other drugs or who cannot tolerate other drugs (initiated under specialist supervision)
    - By mouth
      - Child 7-17 years: Initially 500 micrograms daily, dose to be
        adjusted at weekly intervals according to response, increased in steps of 500 micrograms daily; usual dose
        1–3 mg daily in divided doses (max. per dose 2.5 mg); maximum 10 mg per day

- **SIDE-EFFECTS**
  - Not licensed for use in children.
  - **CAUTIONS**
    - Cardiovascular disease—assess cardiac function before and regularly during treatment - concomitant use of
drugs that prolong QT-interval—assess cardiac function before and regularly during treatment - risk factors for QT-
interval prolongation—assess cardiac function before and regularly during treatment
  - **INTERACTIONS**
    - Appendix 1: anagrelide
  - **SIDE-EFFECTS**
    - Common or very common: Anaemia - arthralgia - asthma - chest pain - chills - confusion - congestive heart failure
      - constipation - depression - dry mouth - dysphoria - erectile dysfunction - fever - haemorrhage - hypertension
      - insomnia - malaise - memory loss - myalgia - nervousness - oedema - pain - pancreatitis - pancytopenia - pneumonia
      - pulmonary hypertension - respiratory disorders - sensation abnormal - syncope - thrombocytenia - weight changes
    - Rare or very rare: Angina pectoris - cardiomyopathy - coordination abnormal - drowsiness - dysarthria - influenza
      - like illness - myocardial infarction - nocturia - pericardial effusion - postural hypotension - renal failure - tinnitus - vasodilation - vision disorders
    - Frequency not known: Hepatitis - nephritis - tubulointerstitial

- **CONCEPTION AND CONTRACEPTION**
  - Effective contraception required during treatment.

- **PREGNANCY**
  - Manufacturer advises avoid (toxicity in
    animal studies).

- **BREAST FEEDING**
  - Manufacturer advises avoid—present in
    milk in animal studies.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises use with
    caution in mild impairment; avoid in moderate-to-severe
    impairment or if serum transaminases exceed 5 times the
    upper limit of normal.

- **RENAL IMPAIRMENT**
  - Manufacturer advises avoid if
    estimated glomerular filtration rate less than
    50 mL/minute/1.73 m²
### 4.2 Immune thrombocytopenia

**ANTHAEMORRHAGICS > THROMBOPOIETIN RECEPTOR AGONISTS**

#### Eltrombopag

**INDICATIONS AND DOSE**

**Chronic immune (idiopathic) thrombocytopenic purpura in patients refractory to other treatments (such as corticosteroids or immunoglobulins) (under expert supervision)**

- **By mouth**
  - Child 1-5 years: Initially 25 mg once daily, dose to be adjusted to achieve a platelet count of $50 \times 10^{9}$/litre or more—consult product literature for dose adjustments, discontinue if inadequate response after 4 weeks treatment at maximum dose; maximum 75 mg per day.
  - Child 6-17 years: Initially 50 mg once daily, dose to be adjusted to achieve a platelet count of $50 \times 10^{9}$/litre or more—consult product literature for dose adjustments, discontinue if inadequate response after 4 weeks treatment at maximum dose; maximum 75 mg per day.
  - Child 6-17 years (patients of East Asian origin): Initially 25 mg once daily, dose to be adjusted to achieve a platelet count of $50 \times 10^{9}$/litre or more—consult product literature for dose adjustments, discontinue if inadequate response after 4 weeks treatment at maximum dose; maximum 75 mg per day.

**SIDE-EFFECTS**

- **Common or very common**
  - Alopecia
  - Anaemia
  - Appetite decreased
  - Asthenia
  - Cough
  - Depression
  - Diarrhoea
  - Dry eye
  - Dry mouth
  - Fever
  - Gastrointestinal discomfort
  - Gastrointestinal disorders
  - Haemolytic anaemia
  - Hepatic disorders
  - Hyperbilirubinemia
  - Increased risk of infection
  - Malaise
  - Menorrhagia
  - Muscle complaints
  - Nasal complaints
  - Nausea
  - Oral disorders
  - Oropharyngeal complaints
  - Pain
  - Peripheral oedema
  - QT interval prolongation
  - Sensation abnormal
  - Skin reactions
  - Sleep disorder
  - Sweats
  - Vertigo
  - Vision disorders
  - Vomiting

- **Uncommon**
  - Anisocytosis
  - Arrhythmias
  - Balance impaired
  - Cardiovascular disorder
  - Cataract
  - Chest pain
  - Cyanosis
  - Drowsiness
  - Ear pain
  - Electrolyte imbalance
  - Embolism and thrombosis
  - Eosinophilia
  - Excessive tearing
  - Eye inflammation
  - Eye pain
  - Feeling hot
  - Feeling jittery
  - Food poisoning
  - Gout
  - Haemorrhage
  - Headaches
  - Hemiparesis
  - Increased leucocytes
  - Lens opacity
  - Mood altered
  - Muscle weakness
  - Myocardial infarction
  - Nephritis
  - Lupus
  - Nerve disorders
  - Nocturia
  - Rectosigmoid cancer
  - Renal failure
  - Retinal pigment epitheliopathy
  - Sinus disorder
  - Sleep apnoea
  - Speech disorder
  - Sunburn
  - Thrombocytopenia
  - Tremor
  - Urine abnormalities
  - Vasodilatation
  - Wound inflammation

**CONCEPTION AND CONTRACEPTION**

Ensure effective contraception during treatment.

**PREGNANCY**

Avoid—toxicity in animal studies.

**BREAST FEEDING**

Manufacturer advises avoid.

**HEPATIC IMPAIRMENT**

Manufacturer advises consider avoiding.

**Dose adjustments**

- When used for idiopathic thrombocytopenic purpura: Manufacturer advises initial dose reduction to $25 \text{ mg}$ once daily and wait at least 3 weeks before upwards titration of dose.

**RENAL IMPAIRMENT**

Use with caution.

**MONITORING REQUIREMENTS**

- Manufacturer advises monitor liver function before treatment, every two weeks when adjusting the dose, and monthly thereafter.
- Manufacturer advises regular ophthalmological examinations for cataract formation.
- Manufacturer advises peripheral blood smear prior to initiation to establish baseline level of cellular morphologic abnormalities; once stabilised, full blood count with white blood cell count differential should be performed monthly.
- For idiopathic thrombocytopenic purpura, manufacturer advises monitor full blood count including platelet count and peripheral blood smears every week during treatment until a stable platelet count is reached ($50 \times 10^{9}$/litre or more for at least 4 weeks), then monthly thereafter; monitor platelet count weekly for 4 weeks following treatment discontinuation.

**EFFECT ON LABORATORY TESTS**

Eltrombopag is highly coloured and can cause serum discoloration and interference with total bilirubin and creatinine testing. If laboratory results are inconsistent with clinical observations, manufacturer advises re-testing using another method to help determine the validity of the result.

**DIRECTIONS FOR ADMINISTRATION**

Each dose should be taken at least 4 hours before or after any dairy products (or foods containing calcium), indigestion remedies, or medicines containing aluminium, calcium, iron, magnesium, zinc, or selenium to reduce possible interference with absorption.

**PATIENT AND CARER ADVICE**

Patient counselling is advised on how to administer eltrombopag tablets.
Romiplostim

28-Jan-2019

**DRUG ACTION**
Romiplostim is an Fc–peptide fusion protein that binds to and activates the thrombopoietin (TPO) receptor, thereby increasing platelet production.

**INDICATIONS AND DOSE**
Chronic immune (idiopathic) thrombocytopenic purpura in patients refractory to other treatments (such as corticosteroids or immunoglobulins) (under expert supervision)

- **BY SUBCUTANEOUS INJECTION**
  - Child 1–17 years: Initially 1 microgram/kg once weekly, adjusted in steps of 1 microgram/kg once weekly (max. per dose 10 micrograms/kg once weekly) until a stable platelet count of 50×10⁹/litre or more is reached, consult product literature for further details of dose adjustments; reassess bodyweight every 12 weeks, discontinue treatment if inadequate response after 4 weeks at maximum dose

**CAUTIONS**
Risk factors for thromboembolism

**SIDE-EFFECTS**
- Common or very common Anaemia, angiodema, arthralgia, asthenia, bone marrow disorders, chills, constipation, cough, diarrhoea, dizziness, embolism and thrombosis, eye inflammation, fever, flushing, gastrointestinal discomfort, headaches, hypersensitivity, increased risk of infection, influenza-like illness, muscle complaints, nausea, oropharyngeal pain, pain, palpitations, peripheral oedema, peripheral swelling, sensation abnormal, skin reactions, sleep disorders
- Uncommon Alopecia, appetite decreased, chest pain, clonus, dehydration, depression, dry throat, dysphagia, dyspnoea, erythromelalgia, eye disorders, eye pruritus, feeling hot, feeling jittery, gastrooesophageal reflux disease, gout, haemorrhage, hair growth abnormal, hypotension, irritability, leucocytosis, malaise, muscle weakness, myocardial infarction, nasal complaints, neoplasms, oral disorders, peripheral ischaemia, peripheral neuropathy, photosensitivity reaction, pleuritic pain, portal vein thrombosis, skin nodule, splenomegaly, taste altered, thrombocytosis, tooth discoloration, vertigo, vision disorders, vomiting, weight changes

**PREGNANCY**
Manufacturer advises avoid—toxicity in animal studies.

**BREAST FEEDING**
Manufacturer advises avoid—no information available.

**HEPATIC IMPAIRMENT**
Manufacturer advises caution; consider avoiding in moderate to severe impairment (risk of thromboembolic complications).

**RENAL IMPAIRMENT**
Manufacturer advises caution—no information available.

**MONITORING REQUIREMENTS**
- Manufacturer advises monitor full blood count and peripheral blood smears for morphological abnormalities before and during treatment.
- Manufacturer advises monitor platelet count weekly until platelet count reaches 50×10⁹/litre or more for at least 4 weeks without dose adjustment, then monthly thereafter.
- Manufacturer advises monitor platelet count following treatment discontinuation—risk of bleeding.

**PATIENT AND CARER ADVICE**
Driving and skilled tasks
Manufacturer advises that patients and their carers should be counselled on the effects on driving and the performance of skilled tasks—increased risk of dizziness.

**NATIONAL FUNDING/ACCESS DECISIONS**
Scottish Medicines Consortium (SMC) decisions
SMC No. SMC2126
The Scottish Medicines Consortium has advised (February 2019) that romiplostim (Nplate®) is accepted for restricted use within NHS Scotland for the treatment of chronic immune (idiopathic) thrombocytopenic purpura (ITP) in patients aged one year and older who are refractory to other treatments (e.g. corticosteroids, immunoglobulins). Romiplostim is restricted to those with severe symptomatic ITP or those with a high risk of bleeding.

**All Wales Medicines Strategy Group (AWMSG) decisions**
AWMSG No. 2468
The All Wales Medicines Strategy Group has advised (October 2017) that eltrombopag (Revolade®) is accepted for restricted use within NHS Scotland for the treatment of chronic immune (idiopathic) thrombocytopenic purpura (ITP) in patients aged 1 year to 17 years who have severe symptomatic ITP or a high risk of bleeding, and are refractory to other treatments (e.g. corticosteroids, immunoglobulins). This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland, or a list price that is equivalent or lower.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Tablet**
- **Revolade®** (Novartis Pharmaceuticals UK Ltd)
  - **Eltrombopag (as Eltrombopag olamine) 25 mg** Revolade 25 mg tablets | 28 tablet vial £770.00 DT = £770.00
  - **Eltrombopag (as Eltrombopag olamine) 50 mg** Revolade 50 mg tablets | 28 tablet vial £1,540.00 DT = £1,540.00
  - **Eltrombopag (as Eltrombopag olamine) 75 mg** Revolade 75 mg tablets | 28 tablet vial £2,310.00 DT = £2,310.00

**PATIENT AND CARER ADVICE**
Informed consent
Manufacturer advises that patients and their carers should be counselled on the effects on driving and the performance of skilled tasks—increased risk of dizziness.

**NATIONAL FUNDING/ACCESS DECISIONS**
Scottish Medicines Consortium (SMC) decisions
SMC No. SMC2126
The Scottish Medicines Consortium has advised (February 2019) that romiplostim (Nplate®) is accepted for restricted use within NHS Scotland for the treatment of chronic immune (idiopathic) thrombocytopenic purpura (ITP) in patients aged one year and older who are refractory to other treatments (e.g. corticosteroids, immunoglobulins). Romiplostim is restricted to those with severe symptomatic ITP or those with a high risk of bleeding.

**All Wales Medicines Strategy Group (AWMSG) decisions**
AWMSG No. 3103
The All Wales Medicines Strategy Group has advised (March 2019) that romiplostim (Nplate®) is recommended as an option for use within NHS Wales for the treatment of chronic immune (idiopathic) thrombocytopenic purpura in patients from 1 year of age up to 18 years of age who are refractory to other treatments (e.g. corticosteroids, immunoglobulins). This recommendation applies only in circumstances where the approved Patient Access Scheme (PAS) is utilised or where the list/contract price is equivalent or lower than the PAS price.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**
- **Nplate (Amgen Ltd)**
  - **Romiplostim 125 microgram** Nplate 125 microgram powder for solution for injection vials | 1 vial (125 µg) £241.00
Nutrition and metabolic disorders

1 Acid-base imbalance

1.1 Metabolic acidosis

ALKALISING DRUGS

Trometamol
(Tris(hydroxymethyl)aminomethane, THAM)

- Indications and dose
  - Metabolic acidosis
    - By intravenous infusion
    - Child: To be administered at an amount appropriate to the body base deficit

- Unlicensed use
  - Unlicensed preparation.

- Contra-indications
  - Anuria: chronic respiratory acidosis

- Cautions
  - Extravasation can cause severe tissue damage

- Side-effects
  - Hepatic necrosis (following administration via umbilical vein) (in neonates) • hyperkalaemia (in renal impairment) • hypoglycaemia • respiratory depression

- Side-effects, further information
  - Respiratory support may be required because trometamol induces respiratory depression.

- Pregnancy
  - Limited information available, hypoglycaemia may harm fetus.

- Breast feeding
  - No information available.

- Renal impairment
  - Use with caution, may cause hyperkalaemia.

- Medicinal forms
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for infusion

- Solution for infusion
  - Tris (imported (Germany))
    - Trometamol 36.34 mg per 1 ml Tris 36.34% solution for infusion 20ml ampoules | 10 ampoules

2 Fluids and electrolyte imbalances

Fluids and electrolytes

Electrolyte replacement therapy
The electrolyte concentrations (intravenous fluid) table and the electrolyte content (gastro-intestinal secretions) table may be helpful in planning replacement electrolyte therapy; faeces, vomit, or aspiration should be saved and analysed where possible if abnormal losses are suspected.

Oral preparations for fluid and electrolyte imbalance
Sodium and potassium salts, may be given by mouth to prevent deficiencies or to treat established deficiencies of mild or moderate degree.

Oral potassium
Compensation for potassium loss is especially necessary:

- in children in whom secondary hyperaldosteronism occurs, e.g. renal artery stenosis, renal tubule disorder, the nephrotic syndrome, and severe heart failure;
- in children with excessive losses of potassium in the faeces, e.g. chronic diarrhoea associated with intestinal malabsorption or laxative abuse;
- in those taking digoxin or anti-arrhythmic drugs, where potassium depletion may induce arrhythmias.

Measures to compensate for potassium loss may be required during long-term administration of drugs known to induce potassium loss (e.g. corticosteroids). Potassium supplements are seldom required with the small doses of diuretics given to treat hypertension; potassium-sparing diuretics (rather than potassium supplements) are recommended for prevention of hypokalaemia due to diuretics such as furosemide p. 142 or the thiazides when these are given to eliminate oedema.

If potassium salts are used for the prevention of hypokalaemia, then doses of potassium chloride p. 623 daily by mouth are suitable in patients taking a normal diet. Smaller doses must be used if there is renal insufficiency to reduce the risk of hyperkalaemia.

Potassium salts cause nausea and vomiting and poor compliance is a major limitation to their effectiveness (small divided doses may minimise gastric irritation); when appropriate, potassium-sparing diuretics are preferable. When there is established potassium depletion larger doses may be necessary, the quantity depending on the severity of any continuing potassium loss (monitoring of plasma-potassium concentration and specialist advice would be required). Potassium depletion is frequently associated with chloride depletion and with metabolic alkalosis, and these disorders require correction.

Management of hyperkalaemia
Acute severe hyperkalaemia calls for urgent treatment with intravenous infusion of soluble insulin (0.3–0.6 units/kg/hour in neonates and 0.05–0.2 units/kg/hour in children over 1 month) with glucose p. 611 0.5–1 g/kg/hour (5–10 mL/kg of glucose 10%; 2.5–5 mL/kg of glucose 20% via a central venous catheter may also be considered). If insulin cannot be used, salbutamol p. 158 can be given by intravenous injection, but it has a slower onset of action and may be less effective for reducing plasma-potassium concentration.

Calcium gluconate p. 614 is given by slow intravenous injection to manage cardiac excitability caused by hyperkalaemia.

The correction of causal or complicating acidosis with sodium bicarbonate infusion p. 607 should be considered (important: preparations of sodium bicarbonate and calcium salts should not be administered in the same line—risk of precipitation). Intravenous furosemide can also be given but is less effective in children with renal impairment. Drugs exacerbating hyperkalaemia should be reviewed and stopped as appropriate; dialysis may occasionally be required.

Ion-exchange resins may be used to remove excess potassium in mild hyperkalaemia or in moderate hyperkalaemia when there are no ECG changes. Calcium polystyrene sulfonate is preferred unless plasma-calcium concentrations are high.

Oral sodium and water
Sodium chloride p. 610 is indicated in states of sodium depletion. In preterm neonates in the first few weeks of life and in chronic conditions associated with mild or moderate degrees of sodium depletion, e.g. in salt-losing bowel or renal disease, oral supplements of sodium chloride may be sufficient. Sodium chloride solutions suitable for use by mouth in neonates are available from ‘special-order’ manufacturers or specialist importing companies, they should be used with care because they are hypertonic. Supplementation with sodium chloride may be required to
replace losses in children with cystic fibrosis particularly in warm weather.

**Oral rehydration therapy (ORT)**

Diarrhoea in children is usually self-limiting, however, in children under 6 months of age, and more particularly in those under 3 months, symptoms of dehydration may be less obvious and there is a risk of rapid and severe deterioration. Intestinal absorption of sodium and water is enhanced by glucose (and other carbohydrates). Replacement of fluid and electrolytes lost through diarrhoea can therefore be achieved by giving solutions containing sodium, potassium, and glucose or another carbohydrate such as rice starch.

Oral rehydration solutions should:
- enhance the absorption of water and electrolytes;
- replace the electrolyte deficit adequately and safely;
- contain an alkalinising agent to counter acidosis;
- be slightly hypo-osmolar (about 250 mmol/litre) to prevent the possible induction of osmotic diarrhoea;
- be simple to use in hospital and at home;
- be palatable and acceptable, especially to children;
- be readily available.

It is the policy of the World Health Organization (WHO) to promote a single oral rehydration solution but to use it flexibly (e.g. by giving extra water between drinks of oral rehydration solution to moderately dehydrated infants).

The WHO oral rehydration salts formulation contains sodium chloride 2.6 g, potassium chloride 1.5 g, sodium citrate 2.9 g, anhydrous glucose 13.5 g. It is dissolved in sufficient water to produce 1 litre (providing Na+ 75 mmol, K+ 20 mmol, Cl− 65 mmol, citrate 10 mmol, glucose 75 mmol/litre). This formulation is recommended by the WHO and the United Nations Children’s fund, but it is not commonly used in the UK.

Oral rehydration solutions used in the UK are lower in sodium (50–60 mmol/litre) than the WHO formulation since, in general, patients suffer less severe sodium loss.

Rehydration should be rapid over 3 to 4 hours (except in hypernatraemic dehydration in which case rehydration should occur more slowly over 12 hours). The patient should be reassessed after initial rehydration and if still dehydrated rapid fluid replacement should continue.

Once rehydration is complete further dehydration is prevented by encouraging the patient to drink normal volumes of an appropriate fluid and by replacing continuing losses with an oral rehydration solution; in infants, breastfeeding or formula feeds should be offered between oral rehydration drinks.

**Oral bicarbonate**

Sodium bicarbonate is given by mouth for chronic acidotic states such as uraemic acidosis or renal tubular acidosis. The dose for correction of metabolic acidosis is not predictable and the response must be assessed. For severe metabolic acidosis, sodium bicarbonate can be given intravenously. Sodium supplements may increase blood pressure or cause fluid retention and pulmonary oedema in those at risk; hypokalaemia may be exacerbated.

Sodium bicarbonate p. 607 may affect the stability or absorption of other drugs if administered at the same time. If possible, allow 1–2 hours before administering other drugs orally.

Where hyperchloraemic acidosis is associated with potassium deficiency, as in some renal tubular and gastrointestinal disorders it may be appropriate to give oral potassium bicarbonate, although acute or severe deficiency should be managed by intravenous therapy.

**Parenteral preparations for fluid and electrolyte imbalance**

**Electrolytes and water**

Solutions of electrolytes are given intravenously, to meet normal fluid and electrolyte requirements or to replenish substantial deficits or continuing losses when it is not possible or desirable to use the oral route. When intravenous administration is not possible, fluid (as sodium chloride 0.9% p. 610 or glucose 5% p. 611) can also be given subcutaneously by hypodermoclysis.

In an individual patient the nature and severity of the electrolyte imbalance must be assessed from the history and clinical and biochemical examination. Sodium, potassium, chloride, magnesium, phosphate, and water depletion can occur singly and in combination with or without disturbances of acid-base balance.

Isotonic solutions may be infused safely into a peripheral vein. Solutions more concentrated than plasma, for example 15% glucose, are best given through an indwelling catheter positioned in a large vein.

**Maintenance fluid requirements** in children are usually derived from the relationship that exists between body-weight and metabolic rate; the figures in the table below may be used as a guide outside the neonatal period. The glucose requirement is that needed to minimise gluconeogenesis from amino acids obtained as substrate from muscle breakdown. Maintenance fluids are intended only to provide hydration for a short period until enteral or parenteral nutrition can be established.

It is usual to meet these requirements by using a standard solution of sodium chloride with glucose p. 611. Solutions containing 20 mmol/litre of potassium chloride p. 623 meet usual potassium requirements when given in the suggested volumes; adjustments may be needed if there is an inability to excrete fluids or electrolytes, excessive renal loss or continuing extra-renal losses. The exact requirements depend upon the nature of the clinical situation and types of losses incurred.

**Fluid requirements for children over 1 month:**

<table>
<thead>
<tr>
<th>Body-weight</th>
<th>24-hour fluid requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10 kg</td>
<td>100 ml/kg</td>
</tr>
<tr>
<td>10–20 kg</td>
<td>100 ml/kg for the first 10 kg + 50 ml/kg for each 1 kg body-weight over 10 kg</td>
</tr>
<tr>
<td>Over 20 kg</td>
<td>100 ml/kg for the first 10 kg + 50 ml/kg for each 1 kg body-weight between 10–20 kg + 20 ml/kg for each 1 kg body-weight over 20 kg (max. 2 litres in females, 2.5 litres in males)</td>
</tr>
</tbody>
</table>

**Important** The baseline fluid requirements shown in the table should be adjusted to take account of factors that reduce water loss (e.g. increased diuretic hormone, renal failure, hypothermia, and high ambient humidity) or increase water loss (e.g. pyrexia or burns).

**Replacement therapy:** initial intravenous replacement fluid is generally required if the child is over 10% dehydrated, or if 5–10% dehydrated and oral or enteral rehydration is not tolerated or possible. Oral rehydration is adequate, if tolerated, in the majority of those less than 10% dehydrated. Subsequent fluid and electrolyte requirements are determined by clinical assessment of fluid balance.

**Intravenous sodium**

**Intravenous** sodium chloride in isotonic (0.9%) solution provides the most important extracellular ions in near physiological concentrations and is indicated in sodium depletion. It may be given for initial treatment of acute fluid loss and to replace ongoing gastro-intestinal losses from the upper gastro-intestinal tract. Intravenous sodium chloride is commonly given as a component of maintenance and replacement therapy, usually in combination with other electrolytes and glucose.

**Chronic hypernatraemia** should ideally be corrected by fluid restriction. However, if sodium chloride is required, the
deficit should be corrected slowly to avoid the risk of osmotic demyelination syndrome; the rise in plasma sodium concentration should be no more than 10 mmol/litre in 24 hours.

Sodium chloride with glucose solutions are indicated when there is combined water and sodium depletion. A 1:1 mixture of isotonic sodium chloride and 5% glucose allows some of the water (free of sodium) to enter body cells which suffer most from dehydration while the sodium salt with a volume of water determined by the normal plasma Na⁺ remains extracellular.

Combined sodium, potassium, chloride, and water depletion may occur, for example, with severe diarrhoea or persistent vomiting; replacement is carried out with sodium chloride intravenous infusion 0.9% and glucose intravenous infusion 5% with potassium as appropriate. Combined sodium lactate (Hartmann’s solution) can be used instead of isotonic sodium chloride solution during or after surgery, or in the initial management of the injured or wounded.

**Compound sodium lactate** (Hartmann’s solution) is the initial treatment for the correction of severe hypokalaemia and when sufficient potassium cannot be taken by mouth. Glucose solutions are used to correct and prevent hypoglycaemia and to provide a source of energy in those too ill to be fed adequately by mouth; glucose solutions are a key component of parenteral nutrition. Glucose solutions are given with insulin for the emergency management of hyperkalaemia. They are also given, after correction of hyperglycaemia, during treatment of diabetic ketoacidosis, when they must be accompanied by continuous insulin infusion.

**Intervenous potassium**

Potassium chloride with sodium chloride intravenous infusion p. 609 is the initial treatment for the correction of severe hypokalaemia and when sufficient potassium cannot be taken by mouth. Repeated measurements of plasma potassium concentration are necessary to determine whether further infusions are required and to avoid the development of hyperkalaemia, which is especially likely in renal impairment.

Initial potassium replacement therapy should not involve glucose infusions, because glucose may cause a further decrease in the plasma-potassium concentration.

**Bicarbonate and trometamol**

Sodium bicarbonate is used to control severe metabolic acidosis (pH < 7.1) particularly that caused by loss of bicarbonate (as in renal tubular acidosis or from excessive gastro-intestinal losses). Mild metabolic acidosis associated with volume depletion should first be managed by appropriate fluid replacement because acidosis usually resolves as tissue and renal perfusion are restored. In more severe metabolic acidosis or when the acidosis remains unresponsive to correction of anoxia or hypovolaemia,
sodium bicarbonate below (1.26%) can be infused over 3–4 hours with plasma-pH and electrolyte monitoring. In severe shock, for example in cardiac arrest, metabolic acidosis can develop without sodium depletion; in these circumstances sodium bicarbonate is best given intravenously as a small volume of hypertonic solution, such as 8.4%; plasma pH and electrolytes should be monitored. For chronic acidotic states, sodium bicarbonate can be given by mouth. Trometamol p. 604 (tris(hydroxymethyl)aminomethane, THAM), an organic buffer, corrects metabolic acidosis by causing an increase in urinary pH and an osmotic diuresis. It is indicated when sodium bicarbonate is unsuitable as in carbon dioxide retention, hypernatremia, or renal impairment. It is also used during cardiac bypass surgery and, very rarely, in cardiac arrest.

**Plasma and plasma substitutes**

Albumin solution p. 615, prepared from whole blood, contain soluble proteins and electrolytes but no clotting factors, blood group antibodies, or plasma cholinesterases; they may be given without regard to the recipient’s blood group.

Albumin is usually used after the acute phase of illness to correct a plasma-volume deficit; hypoalbuminemia itself is not an appropriate indication. The use of albumin solution in acute plasma or blood loss may be wasteful; plasma substitutes are more appropriate. Concentrated albumin solution may also be used to obtain a diuresis in hypoalbuminemic patients (e.g. in nephrotic syndrome).

Recent evidence does not support the previous view that the use of albumin increases mortality.

**Plasma substitutes**

Gelatin p. 616 is a macromolecular substance that is metabolised slowly. Gelatin may be used at the outset to expand and maintain blood volume in shock arising from conditions such as burns or septicemia; it may also be used as an immediate short-term measure to treat haemorrhage until blood is available. Gelatin is rarely needed when shock is due to sodium and water depletion because, in these circumstances, the shock responds to water and electrolyte repletion; see also the management of shock.

Plasma substitutes should not be used to maintain plasma volume in conditions such as burns or peritonitis where there is loss of plasma protein, water, and electrolytes over periods of several days or weeks. In these situations, plasma or plasma protein fractions containing large amounts of albumin should be given.

Large volumes of some plasma substitutes can increase the risk of bleeding through depletion of coagulation factors.

**Parenteral preparations for fluid and electrolyte imbalance**

**Electrolytes and water**

Neonates lose water through the skin and nose, particularly if preterm or if the skin is damaged. The basic fluid requirement for a term baby in average ambient humidity is 40–60 mL/kg/day plus urinary losses. Preterm babies have very high transepidermal losses particularly in the first few days of life; they may need more fluid replacement than full term babies and up to 180 mL/kg/day may be required. Local guidelines for fluid management in the neonatal period should be consulted.

**Intravenous sodium**

The sodium requirement for most healthy neonates is 3 mmol/kg daily. Preterm neonates, particularly below 30 weeks gestation, may require up to 6 mmol/kg daily. Hypernatremia may be caused by excessive renal loss of sodium; it may also be dilutional and restriction of fluid intake may be appropriate. Sodium supplementation is likely to be required if the serum sodium concentration is significantly reduced.

**Bicarbonate**

**Sodium bicarbonate**

- **INDICATIONS AND DOSE**
  - Chronic acidotic states such as uraemic acidosis or renal tubular acidosis
    - By mouth
  - Neonate: Initially 1–2 mmol/kg daily in divided doses, adjusted according to response.
  - Child: Initially 1–2 mmol/kg daily in divided doses, adjusted according to response.
  - Severe metabolic acidosis
    - By slow intravenous injection, or by intravenous infusion
  - Child: Administer an amount appropriate to the body base deficit, to be given by slow intravenous injection of a strong solution (up to 8.4%), or by continuous intravenous infusion of a weaker solution (usually 1.26%)
  - Renal hyperkalaemia
    - By slow intravenous injection
  - Neonate: 1 mmol/kg daily.
  - Child: 1 mmol/kg daily

- **Persistent cyanotic spell in a child with congenital heart disease despite optimal use of 100% oxygen and propranolol**
  - By intravenous infusion
  - Child: 1 mmol/kg, dose given to correct acidosis (or dose calculated according to arterial blood gas results), sodium bicarbonate 4.2% intravenous infusion is appropriate for a child under 1 year and sodium bicarbonate 8.4% intravenous infusion in children over 1 year

- **CONTRA-INDICATIONS**
  - With oral use Salt restricted diet

- **CAUTIONS**
  - Respiratory acidosis

- **INTERACTIONS**
  - Appendix 1: sodium bicarbonate

- **SIDE-EFFECTS**
  - With intravenous use Skin exfoliation · soft tissue necrosis · ulcer
  - With oral use Abdominal cramps · burping · flatulence · hypokalaemia · metabolic alkalosis

- **HEPATIC IMPAIRMENT**
  - With oral use Manufacturer advises caution in cirrhosis. Salt restriction will be covered in the prelims.

- **MONITORING REQUIREMENTS**
  - With intravenous use Plasma-pH and electrolytes should be monitored.

- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use For peripheral infusion dilute 8.4% solution at least 1 in 10. For central line infusion dilute 1 in 5 with Glucose 5% or 10% or Sodium Chloride 0.9%. Extravasation can cause severe tissue damage.
  - With oral use Sodium bicarbonate may affect the stability or absorption of other drugs if administered at the same time.
PATIENT AND CARER ADVICE

With intravenous use

- Sodium bicarbonate (Non-proprietary) 84 mg per 1 ml
  - Solution for infusion 
  - Usual strength Sodium bicarbonate 84 mg per 1 ml
  - Potassium chloride with calcium chloride and sodium chloride and sodium lactate (Ringer’s solution)
  - Dosed according to the deficit or daily maintenance requirements (consult product literature)

- Potassium chloride with calcium chloride dihydrate and sodium chloride (Non-proprietary)
  - Potassium chloride 300 microgram per 1 ml
  - Calcium chloride 320 microgram per 1 ml
  - Sodium chloride 8.6 mg per 1 ml
  - Ringers solution for injection provides the following ions (in mmol/litre), Ca²⁺: 2.2, K⁺: 4, Na⁺: 147, Cl⁻: 156.

- Potassium chloride with calcium chloride dihydrate and sodium chloride (Non-proprietary)
  - Polyflex Ringers solution for infusion 500ml bottles | 1 bottle £6.89

- Potassium chloride with calcium chloride and sodium chloride and sodium lactate
  - Compound sodium lactate intravenous infusion contains Na⁺ 131 mmol, K⁺ 5 mmol, Ca²⁺ 2 mmol, HCO₃⁻ (as lactate) 29 mmol, Cl⁻ 111 mmol/litre.

 INFORMATION

- INDICATIONS AND DOSE
  - For prophylaxis, and replacement therapy, requiring the use of sodium chloride and lactate, with minimal amounts of calcium and potassium
    - BY INTRAVENOUS INFUSION
    - Child: (consult product literature)

- INTERACTIONS
  - Appendix 1: calcium salts - potassium chloride
    - Compound sodium lactate intravenous infusion contains Na⁺ 131 mmol, K⁺ 5 mmol, Ca²⁺ 2 mmol, HCO₃⁻ (as lactate) 29 mmol, Cl⁻ 111 mmol/litre.

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.
Potassium chloride with glucose

The properties listed below are those particular to the combination only. For the properties of the components please consider, potassium chloride p. 623, glucose p. 611.

- **INDICATIONS AND DOSE**
  - **Electrolyte imbalance**
  - Child: Dosed according to the deficit or daily maintenance requirements

- **INTERACTIONS** → Appendix 1: potassium chloride

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Potassium chloride 0.3% contains 40 mmol each of K⁺ and Cl⁻/litre or 0.15% contains 20 mmol each of K⁺ and Cl⁻/litre with 5% of anhydrous glucose.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion, solution for infusion

**Infusion**
- Potassium chloride with glucose (Non-proprietary)
  - Potassium chloride 3 mg per 1 ml, Glucose anhydrous 50 mg per 1 ml Potassium chloride 0.3% (potassium 20mmol/500ml) / Glucose 5% infusion 500ml bags | 1 bag $0.67-£3.11
  - Potassium chloride 0.3% (potassium 40mmol/1litre) / Glucose 5% infusion 1litre bags | 1 bag $0.67-£3.11
  - Potassium chloride 2 mg per 1 ml, Glucose anhydrous 50 mg per 1 ml Steriflex No.29 potassium chloride 0.2% (potassium 27mmol/litre) / Glucose 5% infusion 1litre bags | 1 bag $2.20
  - Potassium chloride 0.15% (potassium 10mmol/500ml) / Glucose 5% infusion 500ml bags | 1 bag $1.30

Potassium chloride with sodium chloride

The properties listed below are those particular to the combination only. For the properties of the components please consider, potassium chloride p. 623, sodium chloride p. 610.

- **INDICATIONS AND DOSE**
  - **Electrolyte imbalance**
  - Child: Dosed according to the deficit or daily maintenance requirements

- **INTERACTIONS** → Appendix 1: potassium chloride

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Concentration of potassium chloride to be specified by the prescriber (usually K⁺ 10–40 mmol/litre).

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion, solution for infusion

**Infusion**
- Potassium chloride with glucose and sodium chloride (Non-proprietary)
  - Sodium chloride 1.8 mg per 1 ml, Potassium chloride 3 mg per 1 ml, Glucose anhydrous 40 mg per 1 ml Potassium chloride 0.3% (potassium 20mmol/500ml) / Glucose 4% / Sodium chloride 0.18% infusion 500ml bags | 1 bag $0.67-£3.11
  - Potassium chloride 0.3% (potassium 40mmol/litre) / Glucose 4% / Sodium chloride 0.18% infusion 1litre bags | 1 bag $2.20
  - Potassium chloride 1.5 mg per 1 ml, Sodium chloride 50 mg per 1 ml Potassium chloride 1.5% (potassium 20mmol/500ml) / Glucose 5% / sodium chloride 40 mmol/500ml bags | 1 bag $1.30

Potassium chloride with potassium bicarbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, potassium chloride p. 623.

- **INDICATIONS AND DOSE**
  - **Potassium depletion**
  - Child: Dosed according to the deficit or daily maintenance requirements (consult product literature)

- **INTERACTIONS** → Appendix 1: potassium chloride

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Each Sando-K® tablet contains potassium 470 mg (12 mmol of K⁺) and chloride 285mg (8 mmol of Cl⁻).

**PATIENT AND CARER ADVICE**
- Medicines for Children leaflet: Potassium chloride for potassium depletion www.medicinesforchildren.org.uk/potassium-chloride-potassium-depletion

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Effervescent tablet**
- CAUTIONARY AND ADVISORY LABELS 13, 21
  - Sando-K (HK Pharma Ltd)
    - Potassium bicarbonate 400 mg, Potassium chloride 600 mg Sando-K effervescent tablets | 100 tablet N £9.95 DT = £9.95

Potassium chloride with sodium bicarbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, potassium chloride p. 623, sodium chloride p. 610.

- **INDICATIONS AND DOSE**
  - **Electrolyte imbalance**

- **INTERACTIONS** → Appendix 1: potassium chloride

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Potassium chloride 0.15% (potassium 10mmol/500ml) / Glucose 4% / Sodium chloride 0.18% infusion 500ml bags | 1 bag $0.67-£3.11
  - Potassium chloride 1.8 mg per 1 ml, Potassium chloride 2 mg per 1 ml, Glucose anhydrous 40 mg per 1 ml Steriflex No.30 potassium chloride 0.2% (potassium 13.3mmol/500ml) / Glucose 4% / sodium chloride 0.18% infusion 500ml bags | 1 bag $1.67
  - Potassium chloride 1.5 mg per 1 ml, Sodium chloride 4.5 mg per 1 ml Intravenous potassium chloride 0.15% (potassium 10mmol/500ml) / glucose 5% / sodium chloride 0.45% infusion 500ml bags | 1 bag $2.00

Potassium chloride with sodium bicarbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, potassium chloride p. 623, sodium chloride p. 610.

- **INDICATIONS AND DOSE**

- **INTERACTIONS** → Appendix 1: potassium chloride

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Potassium chloride 0.15% with sodium chloride 0.9% contains K⁺ 20 mmol, Na⁺ 150 mmol, and Cl⁻ 170 mmol/litre or potassium chloride 0.3% with sodium chloride 0.9% contains K⁺ 40 mmol, Na⁺ 150 mmol, and Cl⁻ 190 mmol/litre.
**Blood and nutrition**

**CHLORIDE**

With intravenous use

- **Dilutional hyponatraemia**
  - Reduced fluid loss

**MEDICINAL FORMS**

- **Potassium chloride with sodium chloride (Non-proprietary)**
  - Potassium chloride 3 mg per 1 mL, Sodium chloride 9 mg per 1 mL
  - Potassium chloride 0.3% (potassium 20mmol/500ml) / Sodium chloride 0.9% infusion 500ml bags | 1 bag £0.5
  - Potassium chloride 1.5 mg per 1 mL, Sodium chloride 9 mg per 1 mL
  - Potassium chloride 0.15% (potassium 20mmol/litre) / Sodium chloride 0.9% infusion 1 litre bags | 1 bag £0.5
  - Potassium chloride 0.9% infusion 500ml bags | 1 bag £0.30–£0.67
  - Potassium chloride 2 mg per 1 mL, Sodium chloride 9 mg per 1 mL
  - Steriflex No.28 potassium chloride 0.2% (potassium 13.3mmol/500ml) / Sodium chloride 0.9% infusion 500ml bags | 1 bag £0.67

- **Sodium chloride (Non-proprietary)**
  - Potassium chloride 1.5 mg per 1 mL, Sodium chloride 9 mg per 1 mL
  - Sodium chloride 0.9% infusion 500ml bags | 1 bag £0.5
  - Sodium chloride 0.9% infusion 1 litre bags | 1 bag £0.20

**SIDE-EFFECTS**

- With intravenous use
  - Chills · fever · hypervolaemia · hypotension · local reaction · localised pain · paraesthesia · skin reactions · tremor · vascular irritation · venous thrombosis
  - With oral use
    - Abdominal cramps · acidosis hyperchlaemic · diarrhoea · generalised oedema · hypertension · hypotension · irritability · muscle complaints · nausea · vomiting

**MONITORING REQUIREMENTS**

- During parenteral hydration, fluids and electrolytes should be monitored closely and any disturbance corrected by slow infusion of an appropriate solution.

**PRESCRIBING AND DISPENSING INFORMATION**

- With intravenous use
  - Sodium chloride 0.9% intravenous infusion contains Na⁺ and Cl⁻ each 150 mmol/litre. The term ‘normal saline’ should not be used to describe sodium chloride intravenous infusion 0.9%; the term ‘physiological saline’ is acceptable but it is preferable to give the composition (i.e. sodium chloride intravenous infusion 0.9%).
  - With oral use
    - Each Slow Sodium® tablet contains approximately 10 mmol each of Na⁺ and Cl⁻; ES®G tablets can be crushed before administration.

- The RCPhC and NPPG recommend that, when a liquid special of sodium chloride is required, the following strength is used: 5 mmol/mL.

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Sodium chloride for hyponatraemia
- With systemic use
  - www.medicinesforchildren.org.uk/sodium-chloride-hyponatraemia

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, solution for injection, infusion, solution for infusion.

**Modified-release tablet**

<table>
<thead>
<tr>
<th>CAUTIONARY AND ADVISORY LABELS 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow Sodium® (HK Pharma Ltd)</td>
</tr>
<tr>
<td>Sodium chloride 600 mg</td>
</tr>
<tr>
<td>Slow Sodium 600mg tablets</td>
</tr>
<tr>
<td>100 tablet (£0.43)</td>
</tr>
<tr>
<td>Solution for injection</td>
</tr>
<tr>
<td><em>Sodium chloride (Non-proprietary)</em></td>
</tr>
<tr>
<td>Sodium chloride 9 mg per 1 mL</td>
</tr>
</tbody>
</table>
| Sodium chloride 0.9% solution for injection 50ml ampoules | 25 vial (£0.92) £85.00–£85.01 DT = £85.01
| Sodium chloride 0.9% solution for injection 10ml ampoules | 10 ampoule (£0.92) £2.96–£3.70 DT = £2.96 | 20 ampoule (£30) £10.21
| 50 ampoule (£0.92) £25.50 | 100 ampoule (£20) £51.00
| Sodium chloride 0.9% solution for injection 20ml ampoules | 20 ampoule (£25) £18.93–£19.87
| Sodium chloride 0.9% solution for injection 5ml ampoules | 10 ampoule (£0.92) £2.07–£2.60 DT = £2.07
| Sodium chloride 0.9% solution for injection 5ml ampoules | 10 ampoule (£0.92) £2.24–£2.70 DT = £2.24 | 50 ampoule (£20) £22.00
| Sodium chloride 300 mg per 1 ml  |
| Sodium chloride 30% solution for solution 10ml ampoules | 10 ampoule (£0.43) £70.43 DT = £70.43

**Solution for infusion**

<table>
<thead>
<tr>
<th>Sodium chloride (Non-proprietary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium chloride 300 mg per 1 mL</td>
</tr>
</tbody>
</table>
| Sodium chloride 30% concentrate for solution for infusion 100ml vials | 10 vial (£5.80) £55.60 DT = £55.60
| Sodium chloride 30% concentrate for solution for infusion 50ml vials | 1 vial (£0.92) £14.63 DT = £14.63 | 10 vial (£20) £77.50 DT = £77.50
| Sodium chloride 30% concentrate for solution for infusion 10ml ampoules | 10 ampoule (£0.43) £70.40

**INDICATIONS AND DOSE**

- Chronic renal salt wasting
  - **BY MOUTH**
    - Child: 1–2 mmol/kg daily in divided doses, adjusted according to requirements
  - **INITIALLY BY MOUTH**
    - Neonate up to 36 weeks corrected gestational age: 2 mmol, dose to be administered in 100 mL of formula feed (consult dietician), alternatively (by mouth using modified-release tablets) 3–4 mmol, dose to be administered in 100 mL of breast milk (consult dietician).

- **Sodium replacement**
  - **BY MOUTH USING MODIFIED-RELEASE TABLETS**
    - Child: 1–2 mmol/kg daily in divided doses, adjusted according to requirements, higher doses may be needed in severe depletion
  - **BY INTRAVENOUS INSTILLATION**
    - Child: (consult local protocol)
  - Diluent for instillation of drugs to the bladder
  - (consult product literature)

**INDICATIONS AND DOSE**

- **Carbohydrate deficiency**
  - **BY MOUTH**
    - Child: 10–20 mmol/kg daily
  - **INITIALLY BY MOUTH**
    - Infants: 2–10 mmol/kg daily

**SIDE-EFFECTS**

- With intravenous use
  - Avoid excessive administration · cardiac failure · cardio-respiratory diseases · children receiving glucocorticoids · dilutional hyponatraemia · hepatic cirrhosis · hypertonstion · peripheral oedema · pulmonary oedema · reduced fluid loss · renal insufficiency · restrict intake in impaired renal function · toxoaemia of pregnancy

**MEDICINES FOR CHILDREN**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, solution for injection, infusion, solution for infusion.

**SIDE-EFFECTS**

- With intravenous use
  - Avoid excessive administration · cardiac failure · cardio-respiratory diseases · children receiving glucocorticoids · dilutional hyponatraemia · hepatic cirrhosis · hypertonstion · peripheral oedema · pulmonary oedema · reduced fluid loss · renal insufficiency · restrict intake in impaired renal function · toxoaemia of pregnancy

**MEDICAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, solution for injection, infusion, solution for infusion.

**SIDE-EFFECTS**

- With intravenous use
  - Avoid excessive administration · cardiac failure · cardio-respiratory diseases · children receiving glucocorticoids · dilutional hyponatraemia · hepatic cirrhosis · hypertonstion · peripheral oedema · pulmonary oedema · reduced fluid loss · renal insufficiency · restrict intake in impaired renal function · toxoaemia of pregnancy

**MEDICAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, solution for injection, infusion, solution for infusion.

**SIDE-EFFECTS**

- With intravenous use
  - Avoid excessive administration · cardiac failure · cardio-respiratory diseases · children receiving glucocorticoids · dilutional hyponatraemia · hepatic cirrhosis · hypertonstion · peripheral oedema · pulmonary oedema · reduced fluid loss · renal insufficiency · restrict intake in impaired renal function · toxoaemia of pregnancy

**MEDICAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, solution for injection, infusion, solution for infusion.
**Fluid and electrolyte imbalances**

During parenteral hydration, the properties listed below are those particular to the preparations available from special-order manufacturers include: solution for infusion and other preparations.

- **Sodium chloride (Non-proprietary)**
  - Sodium chloride 1.8 mg per 1 ml Polyfusor 0 sodium chloride 0.18% infusion 500ml bottles | 1 bottle (P) £3.98
  - Sodium chloride 4.5 mg per 1 ml Sodium chloride 0.45% infusion 500ml bags | 1 bag (P) £0.55
  - Sodium chloride 9 mg per 1 ml Sodium chloride 0.9% infusion 100ml bags | 1 bag (P) £0.55
  - Sodium chloride 9 mg per 1 ml Sodium chloride 0.9% infusion 250ml bags | 1 bag (P) £1.00
  - Sodium chloride 9 mg per 1 ml Sodium chloride 0.9% infusion 500ml bags | 1 bag (P) £1.00
  - Sodium chloride 9 mg per 1 ml Sodium chloride 0.9% infusion 1 litre bags | 1 bag (P) £1.00
  - Sodium chloride 18 mg per 1 ml Polyfusor SC sodium chloride 1.8% infusion 500ml bottles | 1 bottle (P) £3.98
  - Sodium chloride 27 mg per 1 ml Polyfusor SD sodium chloride 2.7% infusion 500ml bottles | 1 bottle (P) £3.98
  - Sodium chloride 50 mg per 1 ml Polyfusor SE sodium chloride 5% infusion 500ml bottles | 1 bottle (P) £3.98

Combination available: Potassium chloride with calcium chloride and sodium chloride and sodium lactate, p. 608 - Potassium chloride with calcium chloride dihydrate and sodium chloride, p. 608 - Potassium chloride with glucose and sodium chloride, p. 609 - Potassium chloride with sodium chloride, p. 609

**Sodium chloride with glucose**

The properties listed below are those particular to the combination only. For the properties of the components please consider, sodium chloride p. 610, glucose below.

- **INDICATIONS AND DOSE**
  - Combined water and sodium depletion
  - **BY INTRAVENOUS INFUSION**
    - Child: (consult product literature)

- **CAUTIONS**
  - **CAUTIONS, FURTHER INFORMATION** Sodium chloride 0.18% and glucose 4% intravenous infusion fluid should not be used for fluid replacement in children aged 16 years or less because of the risk of hypoglycaemia; availability of this infusion should be restricted to high dependency and intensive care units, and specialist wards, such as renal, liver, and cardiac units. Local guidelines on intravenous fluids should be consulted.

- **MONITORING REQUIREMENTS**
  - Maintenance fluid should accurately reflect daily requirements and close monitoring is required to avoid fluid and electrolyte imbalance.
  - During parenteral hydration, fluids and electrolytes should be monitored closely and any disturbance corrected by slow infusion of an appropriate solution.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for infusion and other preparations.
  - **Sodium chloride with glucose (Non-proprietary)**
    - Sodium chloride 4.5 mg per 1 ml, Glucose anhydrous 25 mg per 1 ml Sodium chloride 0.45% / Glucose 2.5% infusion 500ml Vial/No.10 bags | 1 bag (P) £2.40
    - Sodium chloride 1.8 mg per 1 ml, Glucose anhydrous 40 mg per 1 ml Glucose 4% / sodium chloride 0.18% infusion 500ml bottles | 1 bottle (P) £2.40
    - Sodium chloride 0.18% / Glucose 4% infusion 1 litre bottles | 1 bottle (P) £3.98

- **Sodium and chloride 0.18% / Glucose 4% infusion 1 litre bags | 1 bag (P) £1.47
  - Sodium chloride 9 mg per 1 ml, Glucose 50 mg per 1 ml Steriflex No.3 glucose 5% / sodium chloride 0.9% infusion 500ml bags | 1 bag (P) £2.34
  - Sodium chloride 4.5 mg per 1 ml, Glucose anhydrous 50 mg per 1 ml Steriflex No.4 glucose 5% / sodium chloride 0.45% infusion 500ml bags | 1 bag (P) £2.34
  - Sodium chloride 1.8 mg per 1 ml, Glucose anhydrous 100 mg per 1 ml Steriflex No.19 glucose 10% / sodium chloride 0.18% infusion 500ml bags | 1 bag (P) £2.34

**NUTRIENTS › Sugars**

**Glucose**

(Dextrose Monohydrate)

- **INDICATIONS AND DOSE**
  - **Establish presence of gestational diabetes**
    - **BY MOUTH**
      - Child: Test dose 75 g, anhydrous glucose to be given to the fasting patient and blood-glucose concentrations measured at intervals, to be given with 200–300 mL fluid
  - **Oral glucose tolerance test**
    - **BY MOUTH**
      - Child: Test dose 1.75 g/kg (max. per dose 75 g), anhydrous glucose to be given to the fasting patient and blood-glucose concentrations measured at intervals. To be given with 200–300 mL fluid

**Neonatal hypoglycaemia**

- **BY INTRAVENOUS INFUSION**
  - Neonate: 500 mg/kg/hour, to be administered as Glucose 10% intravenous infusion, an initial dose of 250 mg/kg over 5 minutes may be required if hypoglycaemia is severe enough to cause loss of consciousness or seizures.

**Hypoglycaemia**

- **BY INTRAVENOUS INFUSION**
  - Child: 500 mg/kg, to be administered as Glucose 10% intravenous infusion into a large vein through a large-gauge needle; care is required since this concentration is irritant especially if extravasation occurs

- **Energy source**
  - **BY INTRAVENOUS INFUSION**
  - Child: (consult product literature)

- **Water replacement**
  - **BY INTRAVENOUS INFUSION**
  - Child: The volume of glucose solution needed to replace deficits may vary (consult product literature)

- **Persistent cyanosis (in combination with propranolol)**
  - When blood glucose less than 3 mmol/litre (followed by morphine)
  - **BY INTRAVENOUS INFUSION**
  - Child: 200 mg/kg, to be administered as Glucose 10% intravenous infusion over 10 minutes

- **Management of diabetic ketoacidosis**
  - **BY INTRAVENOUS INFUSION**
  - Child: Glucose 5% or 10% should be added to replacement fluid once blood-glucose concentration falls below 14 mmol/litre

- **Dose equivalence and conversion**
  - 75 g anhydrous glucose is equivalent to Glucose BP 82.5 g.

- **CAUTIONS**
  - Do not give alone except when there is no significant loss of electrolytes - prolonged administration
Blood and nutrition

612 Fluid and electrolyte imbalances

of glucose solutions without electrolytes can lead to hyponatraemia and other electrolyte disturbances

> **SIDE-EFFECTS** Chills · electrolyte imbalance · fever · fluid imbalance · hypersensitivity · local reaction · localised pain · polyuria · rash · venous thrombosis

> **DIRECTIONS FOR ADMINISTRATION**
>

- With intravenous use Injections containing more than 10% glucose can be irritant and should be given into a central venous line; however, solutions containing up to 12.5% can be administered for a short period into a peripheral line.

> **PRESCRIBING AND DISPENSING INFORMATION** Glucose BP is the monohydrate but Glucose Intravenous Infusion BP is a sterile solution of anhydrous glucose or glucose monohydrate, potency being expressed in terms of anhydrous glucose.

> **EXCEPTIONS TO LEGAL CATEGORY**
>

- With intravenous use Prescription only medicine restriction does not apply to 50% solution where administration is for saving life in emergency.

> **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution, solution for injection, solution for infusion

> **Solution for infusion**
>

- **Glucose (Non-proprietary)**
  - Glucose anhydrous 200 mg per 1 ml Glucose 20% solution for infusion 100ml vials | 1 vial £0.14
  - Glucose anhydrous 500 mg per 1 ml Glucose 50% solution for infusion 20ml ampoules | 10 ampoule £12.00–£14.00 DT = £12.00

- Glucose 50% solution for infusion 50ml vials | 25 vial £50.00–£60.00 DT = £50.01

> **Oral solution**
>

- **Rapilose OTT** (Galen Ltd)
  - Glucose 250 mg per 1 ml Rapilose OTT solution | 300 ml £3.48

> **Oral gel**
>

- **Glucogel (BBi Healthcare Ltd)**
  - Glucose 400 mg per 1 gram Glucogel 40% gel original | 75 gram GSS £7.16 DT = £7.16 | 80 gram GSS £6.84

> **Infusion**
>

- **Glucose (Non-proprietary)**
  - Glucose anhydrous 50 mg per 1 ml Glucose 5% infusion 1 litre bags | 1 bag £0.32

  - Glucose 5% infusion 500ml bags | 1 bag £0.14

  - Glucose 5% infusion 100ml bags | 1 bag £0.09

  - Glucose 5% infusion 250ml bags | 1 bag £0.39

  - Glucose 5% infusion 1 litre bottles | 1 bottle £3.50

  - Glucose 5% infusion 50ml bags | 1 bag £0.10

  - Glucose 5% infusion 500ml bottles: | 1 bottle £2.60

  - Glucose anhydrous 100 mg per 1 ml Glucose 10% infusion 1 litre bags | 1 bag £0.64

  - Glucose 10% infusion 500ml bags | 1 bag £0.32

  - Glucose anhydrous 200 mg per 1 ml Steriflex No.31 glucose 20% infusion 500ml bags | 1 bag £0.24

  - Glucose 20% infusion 500ml polyethylene bottles | 10 bottle £40.21

  - Glucose anhydrous 500 mg per 1 ml Steriflex No.33 glucose 40% infusion 500ml bags | 1 bag £0.82

  - Glucose anhydrous 500 mg per 1 ml Steriflex No.34 glucose 50% infusion 500ml bags | 1 bag £3.11

  - Glucose anhydrous 700 mg per 1 ml Steriflex No.35 glucose 70% concentration for solution for infusion 500ml Vialflex bags | 1 bag £0.82

> **Combinations available:** Potassium chloride with glucose, p. 609 · Potassium chloride with glucose and sodium chloride, p. 609 · Sodium chloride with glucose, p. 611

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**ORAL REHYDRATION SALTS**

**Disodium hydrogen citrate with glucose, potassium chloride and sodium chloride**

(Formulated as oral rehydration salts)

> **INDICATIONS AND DOSE**
>

- **Fluid and electrolyte loss in diarrhoea**
  
  - **BY MOUTH**
  
    - Child 1-11 months: 1–1½ times usual feed volume to be given
    
    - Child 1-11 years: 200 ml, to be given after every loose motion
    
    - Child 12-17 years: 200–400 ml, to be given after every loose motion, dose according to fluid loss

> **DIRECTIONS FOR ADMINISTRATION**
>

- Reconstitute 1 sachet with 200ml of water (freshly boiled and cooled for infants); 5 sachets reconstituted with 1 litre of water provide Na+ 60 mmol, K+ 20 mmol, Cl− 60 mmol, citrate 10 mmol, and glucose 90 mmol.

> **PRESCRIBING AND DISPENSING INFORMATION**
>

- Flavours of oral powder formulations may include black currant, citrus, or natural.

> **PATIENT AND CARER ADVICE**
>

- After reconstitution any unused solution should be discarded no later than 1 hour after preparation unless stored in a refrigerator when it may be kept for up to 24 hours.

> **MEDICINAL FORMS**
>

- There can be variation in the licensing of different medicines containing the same drug.

> **Powder**
>

- **Dioralyte** (Sanofi)
  - Potassium chloride 300 mg, Sodium chloride 470 mg, Disodium hydrogen citrate 530 mg, Glucose 3.56 gram
  
  - Dioralyte oral powder sachets citrus | 20 sachet £0.67
  
  - Dioralyte oral powder sachets plain | 20 sachet £0.67
  
  - Dioralyte oral powder sachets blackcurrant | 20 sachet £0.67

> **Oral rehydration salts**
>

- www.medicinesforchildren.org.uk/oral-rehydration-salts

---

**Potassium chloride with rice powder, sodium chloride and sodium citrate**

(Formulated as oral rehydration salts)

> **INDICATIONS AND DOSE**
>

- **Fluid and electrolyte loss in diarrhoea**

  - **BY MOUTH**

    - Child 1-11 months: 1–1½ times usual feed volume to be given

    - Child 1-11 years: 200 ml, to be given after every loose motion

    - Child 12-17 years: 200–400 ml, to be given after every loose motion, dose according to fluid loss

> **UNLICENSED USE**
>

- Dioralyte Relief® not licensed for use in children under 3 months.

> **DIRECTIONS FOR ADMINISTRATION**
>

- Reconstitute 1 sachet with 200 ml of water (freshly boiled and cooled for infants); 5 sachets when reconstituted with 1 litre of water provide Na+ 60 mmol, K+ 20 mmol, Cl− 50 mmol and citrate 10 mmol.

> **PRESCRIBING AND DISPENSING INFORMATION**
>

- Flavours of oral powder formulations may include apricot, black currant, or raspberry.

> **PATIENT AND CARER ADVICE**
>

- Patients and carers should be advised how to reconstitute Dioralyte® Relief oral powder.
2.1 Calcium imbalance

2.1a Hypocalcaemia

ELECTROLYTES AND MINERALS > CALCIUM

Calcium salts

- CONTRA-INDICATIONS Conditions associated with hypercalcaemia (e.g. some forms of malignant disease) - conditions associated with hypocalcaemia (e.g. some forms of malignant disease)
- CAUTIONS History of nephrolithiasis - sarcoidosis
- SIDE-EFFECTS Uncommon Constipation · diarrhoea · hypocalcaemia · nausea
- RENAL IMPAIRMENT Use with caution. Risk of hypercalcaemia and renal calculi.

Calcium carbonate

- INDICATIONS AND DOSE Phosphate binding in renal failure and hyperphosphataemia
  - BY MOUTH
    - Child 1–11 months: 120 mg 3–4 times a day, dose to be adjusted as necessary, to be taken with feeds
    - Child 1–5 years: 300 mg 3–4 times a day, dose to be adjusted as necessary, to be taken prior to or with meals
    - Child 6–11 years: 600 mg 3–4 times a day, dose to be adjusted as necessary, to be taken prior to or with meals
    - Child 12–17 years: 1.25 g 3–4 times a day, dose to be adjusted as necessary, to be taken prior to or with meals
- Calcium deficiency
  - BY MOUTH
    - Neonate: 0.25 mmol/kg 4 times a day, adjusted according to response.
    - Child 1 month–4 years: 0.25 mmol/kg 4 times a day, adjusted according to response
    - Child 5–11 years: 0.2 mmol/kg 4 times a day, adjusted according to response
    - Child 12–17 years: 0.1 mmol 4 times a day, adjusted according to response
- INTERACTIONS → Appendix 1: calcium salts
Calcium carbonate with calcium lactate gluconate

The properties listed below are those particular to the combination only. For the properties of the components please consider, calcium carbonate p. 613.

**INDICATIONS AND DOSE**

### Calcium deficiency

- **BY MOUTH**
  - Neonate: 0.25 mmol/kg 4 times a day, adjusted according to response.
  - Child 1 month–4 years: 0.25 mmol/kg 4 times a day, adjusted according to response
  - Child 5–11 years: 0.2 mmol/kg 4 times a day, adjusted according to response
  - Child 12–17 years: 10 mmol 4 times a day, adjusted according to response

**INTERACTIONS** → Appendix 1: calcium salts

**PRESCRIBING AND DISPENSING INFORMATION** Each Sandocal® tablet contains 1 g calcium (Ca²⁺ 25 mmol); flavours of soluble tablet formulations may include orange.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Effervescent tablet

**INDICATIONS AND DOSE**

- **Acute hypocalcaemia**
  - Child: (consult product literature)

**CAUTIONS** Avoid in respiratory acidosis - avoid in respiratory failure

**INTERACTIONS** → Appendix 1: calcium salts

**SIDE-EFFECTS** Soft tissue calcification - taste unpleasant - vasodilation

**DIRECTIONS FOR ADMINISTRATION** Care should be taken to avoid extravasation.

**PRESCRIBING AND DISPENSING INFORMATION** Non proprietary Calcium chloride dihydrate 7.35%(calcium 20 mg or Ca" 500 micromol/mL); Calcium chloride dihydrate 10%(calcium 27.3 mg or Ca" 680 micromol/mL); Calcium chloride dihydrate 14.7%(calcium 40.1 mg or Ca" 1000 micromol/mL).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension

### Solution for injection

- **Calcium chloride (Non-proprietary)**
  - Calcium chloride dihydrate 100 mg per 1 ml
    - Calcium chloride 10% solution for injection 10ml pre-filled syringes | 1 pre-filled disposable syringe | £3.42 DT + £3.42
    - Calcium chloride dihydrate 147 mg per 1 ml
      - Calcium chloride 14.7% solution for injection 5ml ampoules | 10 ampoule PHS £120.98
      - Calcium chloride 14.7% solution for injection 10ml ampoules | 10 ampoule PHS £188.28 DT + £188.28
Calcium lactate

- **INDICATIONS AND DOSE**
  - **Calcium deficiency**
  - **BY MOUTH**
  - Neonate: 0.25 mmol/kg 4 times a day, adjusted according to response.
  - Child 1 month-4 years: 0.25 mmol/kg 4 times a day, adjusted according to response.
  - Child 5-11 years: 0.2 mmol/kg 4 times a day, adjusted according to response.
  - Child 12-17 years: 10 mmol 4 times a day, adjusted according to response.

- **INTERACTIONS**  
  - Appendix 1: calcium salts

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

- **Tablet**
  - Calcium lactate (Non-proprietary) 84 tablet  
    - Calcium lactate 300 mg Calcium lactate 300mg tablets |  
      - 84 tablet £4.57  
      - 84 tablet £4.57

Calcium phosphate

- **INDICATIONS AND DOSE**
  - **Indications listed in combination monographs (available in the UK only in combination with other drugs)**
    - **BY MOUTH**
    - Child: Doses listed in combination monographs

**INTERACTIONS**  
- Appendix 1: calcium salts

**SIDE-EFFECTS**

Epi gastric pain, gastrointestinal disorder, hypercalciuria

**MEDICINAL FORMS**

No licensed medicines listed.

### 2.2 Low blood volume

**BLOOD AND RELATED PRODUCTS**

**PLASMA PRODUCTS**

#### Albumin solution

**Human Albumin Solution**

- **INDICATIONS AND DOSE**
  - Acute or sub-acute loss of plasma volume e.g., in burns, pancreatitis, trauma, and complications of surgery (with isotonic solutions) | Plasma exchange (with isotonic solutions) | Severe hypoalbuminaemia associated with low plasma volume and generalised oedema where salt and water restriction with plasma volume expansion are required (with concentrated solutions 20%) | Paracentesis of large volume ascites associated with portal hypertension (with concentrated solutions 20%) | Adjunct in the treatment of hyperbilirubinaemia by exchange transfusion in the newborn (with concentrated solutions 20%)
  - **BY INTRAVENOUS INFUSION**
  - Child: (consult product literature)

**CONTRA-INDICATIONS**

Cardiac failure, severe anaemia

**CAUTIONS**

Correct dehydration when administering concentrated solution - history of cardiac disease (administer slowly to avoid rapid rise in blood pressure and
cardiac failure, and monitor cardiovascular and respiratory function; history of circulatory disease (administer slowly to avoid rapid rise in blood pressure and cardiac failure, and monitor cardiovascular and respiratory function) - increased capillary permeability

- **SIDE-EFFECTS**
  - Rare or very rare Fever - flushing - nausea - shock - urticaria

- **MONITORING REQUIREMENTS** Plasma and plasma substitutes are often used in very ill patients whose condition is unstable. Therefore, close monitoring is required and fluid and electrolyte therapy should be adjusted according to the patient’s condition at all times.

- **PRESCRIBING AND DISPENSING INFORMATION** A solution containing protein derived from plasma, serum, or normal placentas; at least 95% of the protein is albumin. The solution may be isotonic (containing 3.5 – 5% protein) or concentrated (containing 15 – 25% protein).

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Infusion**
  - **Flexbumin** (Baxalta UK Ltd)
    - Albumin solution human 200 gram per 1 litre: Flexbumin 20% infusion 100ml bags | 1 bag (POM) N
  - **Albunorm** (Octapharma Ltd)
    - Solution for infusion: Flexible bag (POM)
  - **Albunorm** (Grifols UK Ltd)
    - Albumin solution human 50 mg per 1 ml
    - Albuinorm 5% solution for infusion 250ml bottles | 1 bottle (POM) £33.75
    - Albuinorm 5% solution for infusion 100ml bottles | 1 bottle (POM) £13.50
    - Albuinorm 5% solution for infusion 500ml bottles | 1 bottle (POM) £67.50
    - Albumin solution human 200 mg per 1 ml
    - Albuinorm 20% solution for infusion 100ml bottles | 1 bottle (POM) £54.00
    - Albuinorm 20% solution for infusion 500ml bottles | 1 bottle (POM) £27.00
  - **Alburex** (CSL Behring UK Ltd)
    - Albumin solution human 50 mg per 1 ml
    - Alburex 5% solution for infusion 500ml vials | 1 vial (POM) £50.00
  - **Alburex** (B.Braun Medical Ltd)
    - Albumin solution human 200 mg per 1 ml
    - Alburex 20% solution for infusion 100ml vials | 1 vial (POM) £40.00
  - **Albutein** (Grifols UK Ltd)
    - Albumin solution human 50 mg per 1 ml
    - Albutein 5% solution for infusion 500ml vials | 1 vial (POM) N
    - Albutein 5% solution for infusion 250ml vials | 1 vial (POM) N
  - **Albumeo** (Biotest (Bioitex Ltd))
    - Solution for infusion: Flexible vial (POM)
  - **Gelaspan** (B.Braun Medical Ltd)
    - Albumin solution human 50 mg per 1 ml
    - Human Albumin Biotest 5% solution for infusion 250ml vials | 1 vial (POM) N
    - Human Albumin Biotest 20% solution for infusion 500ml vials | 1 vial (POM) N
  - **Geliflex** (Grifols Ltd)
    - Albumin solution human 50 mg per 1 ml
    - Human albumin Geliflex 5% solution for infusion 500ml bottles | 1 bottle (POM) £42.75
    - Human albumin Geliflex 5% solution for infusion 250ml vials | 1 bottle (POM) £21.38
    - Human albumin Geliflex 5% solution for infusion 100ml bottles | 1 bottle (POM) £9.90
  - **Gelamine** (Biotest (Bioitex Ltd))
    - Albumin solution human 200 mg per 1 ml
    - Human albumin Gelamine 20% solution for infusion 500ml vials | 1 vial (POM) £23.40
    - Human albumin Gelamine 20% solution for infusion 250ml vials | 1 vial (POM) £14.80
    - Human albumin Gelamine 20% solution for infusion 100ml vials | 1 vial (POM) £6.50
  - **Gelaspan** (B.Braun Medical Ltd)
    - Albumin solution human 45 mg per 1 ml
    - Gelaspan 4.5% solution for infusion 250ml bottles | 1 bottle (POM) £27.51
    - Gelaspan 4.5% solution for infusion 500ml bottles | 1 bottle (POM) £55.02
  - **Gelaspan** (B.Braun Medical Ltd)
    - Albumin solution human 200 mg per 1 ml
    - Gelaspan 20% solution for infusion 100ml bottles | 1 bottle (POM) £54.00
    - Gelaspan 20% solution for infusion 500ml bottles | 1 bottle (POM) £27.00

- **PLASMA SUBSTITUTES**

- **Indications and Dose**
  - **Low blood volume in hypovolaemic shock, burns and cardiopulmonary bypass**
    - **By Intravenous Infusion**
      - Child: Initially 10–20 mL/kg, use 3.5–4% solution

- **Caution**
  - Cardiac disease - severe liver disease

- **Caution, Further Information**
  - The use of plasma substitutes in children requires specialist supervision due to the risk of fluid overload; use is best restricted to an intensive care setting.

- **Side-effects**
  - Rare or very rare Chill - dyspnoea - fever - hyperhidrosis - hypersensitivity - hypertension - hypotension - hypoxia - tachycardia - tremor - urticaria - wheezing

- **Pregnancy**
  - Manufacturer of Geloplasma® advises avoid at the end of pregnancy.

- **Hepatic Impairment**
  - Manufacturers advise avoid preparations that contain lactate (risk of impaired lactate metabolism).

- **Renal Impairment**
  - Use with caution in renal impairment.

- **Monitoring Requirements**
  - Urine output should be monitored. Care should be taken to avoid haemotocrit concentration from falling below 25–30% and the patient should be monitored for hypersensitivity reactions.

- Plasma and plasma substitutes are often used in very ill patients whose condition is unstable. Therefore, close monitoring is required and fluid and electrolyte therapy should be adjusted according to the patient’s condition at all times.

- **Prescribing and Dispensing Information**
  - The gelatin is partially degraded.
  - **Gelaspan®** contains succinylated gelatin (modified fluid gelatin, average molecular weight 26 500) 40 g, Na+ 151 mmol, K+ 4 mmol, Mg2+ 1 mmol, Cl− 103 mmol, Ca2+ 1 mmol, acetate 24 mmol/litre; **Gelofusine®** contains succinylated gelatin (modified fluid gelatin, average molecular weight 30 000) 40 g (4%), Na+ 154 mmol, Cl− 124 mmol/litre; **Geloplasma®** contains partially hydrolysed and succinylated gelatin (modified liquid gelatin) (as anhydrous gelatin) 30 g (3%), Na+ 150 mmol, K+ 5 mmol, Mg2+ 1.5 mmol, Cl− 100 mmol, lactate 30 mmol/litre; **Isoplex®** contains succinylated gelatin (modified fluid gelatin, average molecular weight 30 000) 40g (4%), Na+ 145 mmol, K+ 4 mmol, Mg2+ 0.9 mmol, Cl− 105 mmol, lactate 25mmol/litre; **Volplex®** contains succinylated gelatin (modified fluid gelatin, average molecular weight 30 000) 40 g (4%), Na+ 154 mmol, Cl− 125 mmol/litre.

- **Medicinal Forms**
  - There can be variation in the licensing of different medicines containing the same drug.

- **Infusion**
  - **Gelaspan** (B.Braun Medical Ltd)
    - Gelatin 40 mg per 1 ml: Gelaspan 4% infusion 500ml Ecobags | 1 bag (POM) £5.95 (Hospital only)
  - **Gelofusine** (B.Braun Medical Ltd)
    - Gelatin 40 mg per 1 ml: Gelofusine 4% infusion 1 litre Ecobags | 1 bag (POM) £9.31
    - Gelofusine 4% infusion 500ml Ecobags | 1 bag (POM) £4.97
  - **Geloplasma** (Fresenius Kabi Ltd)
    - Gelatin 30 mg per 1 ml: Geloplasma 3% infusion 500ml Freeflex bags | 1 box (POM) £57.50
  - **Volplex** (Kent Pharmaceuticals Ltd)
    - Gelatin 40 mg per 1 ml: Volplex 4% infusion 500ml bags | 10 bag (POM) £75.00 (Hospital only)
2.3 Magnesium imbalance

Magnesium imbalance

Overview
Magnesium is an essential constituent of many enzyme systems, particularly those involved in energy generation; the largest stores are in the skeleton.

Magnesium salts are not well absorbed from the gastrointestinal tract, which explains the use of magnesium sulfate p. 618 as an osmotic laxative.

Magnesium is excreted mainly by the kidneys and is therefore retained in renal failure, but significant hypomagnesaemia (causing muscle weakness and arrhythmias) is rare.

Hypomagnesaemia
Since magnesium is secreted in large amounts in the gastrointestinal fluid, excessive losses in diarrhoea, stoma or fistula are the most common causes of hypomagnesaemia; deficiency may also occur as a result of treatment with certain drugs. Hypomagnesaemia often causes secondary hypercalcaemia (with which it may be confused), particularly in neonates, and also hypokalaemia and hyponatraemia.

Symptomatic hypomagnesaemia is associated with a deficit of 0.5–1 mmol/kg. Magnesium is given initially by intravenous infusion or by intramuscular injection of magnesium sulfate; the intramuscular injection is painful. Plasma magnesium concentration should be measured to determine the rate and duration of infusion and the dose should be reduced in renal impairment. To prevent recurrence of the deficit, magnesium may be given by mouth in divided doses, but there is limited evidence of benefit. Magnesium aspartate below powder for oral solution is available as a licensed preparation.

Arrhythmias
Magnesium sulfate injection has also been recommended for the emergency treatment of serious arrhythmias, especially in the presence of hypokalaemia (when hypomagnesaemia may also be present) and when salvos of rapid ventricular tachycardia show the characteristic twisting wave front known as torsade de pointes.

2.3a Hypomagnesaemia

ELECTROLYTES AND MINERALS > MAGNESIUM

Magnesium aspartate

INDICATIONS AND DOSE
Treatment and prevention of magnesium deficiency

BY MOUTH
Child 2-3 years: 4.5 mmol daily, given as one level 5 mL spoonful of Magnaspartate® powder.
Child 4-9 years: 4.5 mmol daily, given as a 5 mL level spoonful of Magnaspartate® powder, alternatively 10 mmol daily, given as 1 sachet of Magnaspartate® powder.
Child 10-17 years: 10 mmol daily, given as 1 sachet of Magnaspartate® powder.

CONTRA-INDICATIONS
Disorders of cardiac conduction

INTERAKTIONS
Appendix 1: magnesium

SIDE-EFFECTS

Uncommon
Diarrhoea - faeces soft
Rare or very rare
Fatigue - hypermagnesaemia
Frequency not known
Gastrointestinal irritation

SIDE-EFFECTS, FURTHER INFORMATION
Side-effects generally occur at higher doses; if side-effects (such as diarrhoea) occur, consider interrupting treatment and restarting at a reduced dose.

Overdose
Symptoms of hypermagnesaemia may include nausea, vomiting, flushing, thirst, hypotension, drowsiness, confusion, reflexes absent (due to neuromuscular blockade), respiratory depression, speech slurred, diplopia, muscle weakness, arrhythmias, coma, and cardiac arrest.

RENAL IMPAIRMENT
Avoid in severe impairment (estimated glomerular filtration rate less than 30 mL/minute/1.73m²).

DIRECTIONS FOR ADMINISTRATION
Dissolve sachet contents in 50–200 mL water, tea or orange juice and take immediately.

PRESCRIBING AND DISPENSING INFORMATION
Magnaspartate® contains magnesium aspartate 6.5 g (10 mmol Mg²⁺)/sachet.

PATIENT AND CARER ADVICE
Patients and carers should be given advice on how to administer magnesium aspartate powder.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: powder

Powder
EXCIPIENTS: May contain Sucrose

Magnaspartate® (Kofa Healthcare) 243 mg Magnaspartate® 243mg (magnesium 10mmol) oral powder sachets | 10 sachet £9.95 DT + £18.95

Magnesium glycero-phosphate

INDICATIONS AND DOSE
Hypomagnesaemia

BY MOUTH
Child 1 month-11 years: Initially 0.2 mmol/kg 3 times a day, dose to be adjusted as necessary, dose expressed as Mg²⁺.
Child 12-17 years: Initially 4–8 mmol 3 times a day, dose to be adjusted as necessary, dose expressed as Mg²⁺.

DOSE EQUIVALENCE AND CONVERSION
Magnesium glycero-phosphate 1 g is approximately equivalent to Mg²⁺ 4 mmol or magnesium 97 mg.

NEOMAG® CHEWABLE TABLETS

Hypomagnesaemia

BY MOUTH
Child 4-11 years: Initially 1 tablet twice daily, dose to be adjusted according to the serum total magnesium level
Child 12-17 years: Initially 1 tablet 3 times a day, dose to be adjusted according to the serum total magnesium level

DOSE EQUIVALENCE AND CONVERSION
Each Neomag® chewable tablet contains Mg²⁺ 4 mmol or magnesium 97 mg.

UNLICENSED USE
Preparations other than Neomag® are not licensed for use.

INTERAKTIONS
Appendix 1: magnesium

SIDE-EFFECTS
Diarrhoea - hypermagnesaemia

Overdose
Symptoms of hypermagnesaemia may include nausea, vomiting, flushing, thirst, hypotension, drowsiness, confusion, reflexes absent (due to neuromuscular blockade), respiratory depression, speech

BNFC 2019–2020

Volplex (Kent Pharmaceuticals Ltd)
Gelatin 40 mg per 1 ml Volplex 4% infusion 500ml bags | 10 bag £47.00 (Hospital only)
Blood and nutrition

MEDICINAL FORMS

- Suspension, oral solution, powder
- Different medicines containing the same drug. Forms available

NEOMAG® CHEWABLE TABLETS

- Manufacturer advises avoid in severe impairment.

MONITORING REQUIREMENTS

- Manufacturer advises to monitor serum magnesium levels every 3–6 months.

DIRECTIONS FOR ADMINISTRATION

- Tablet
  - Magnesium (as Magnesium glycerophosphate) 97.2 mg: 50 tablet £13.89 DT = £22.77
  - Magnesium (as Magnesium glycerophosphate) 19.44 mg per 1 ml LiquaMag GP (magnesium 121.25mg/5ml (5mmol/5ml) oral solution sugar-free) = 200 ml £49.99
  - MagnaPhos (TriOn Pharma Ltd) Magnesium (as Magnesium glycerophosphate) 19.44 mg per 1 ml MagnaPhos 91.2mg/5ml (4mmol/5ml) oral solution = 200 ml £97.84
  - Magnesium (as Magnesium glycerophosphate) 24.25 mg per 1 ml MagnaPhos 121.25mg/5ml (5mmol/5ml) oral solution = 200 ml £137.87 DT = £197.84

- Chewable tablet

EXCIPIENTS: May contain Aspartame

Magnesium (as Magnesium glycerophosphate) 97.2 mg Magnesium (as Magnesium glycerophosphate) 19.44 mg per 1 ml Magnesium (as Magnesium glycerophosphate) 24.25 mg per 1 ml Magnesium (as Magnesium glycerophosphate) 97.2 mg

Torsade de pointes

- Bayesian inference

DOSE EQUIVALENT AND CONVERSION

MagnaPhos

- Magnus sulfate

INDICATIONS AND DOSE

Severe acute asthma | Continuing respiratory deterioration in anaphylaxis

- By Intravenous infusion
- Child 2–17 years: 40 mg/kg (max. per dose 2 g), to be given over 20 minutes

Persistent pulmonary hypertension of the newborn

- Initially by Intravenous infusion
- Neonate: Initially 200 mg/kg, to be given over 20–30 minutes, then (by continuous intravenous infusion) 20–75 mg/kg/hour for up to 5 days if response occurs after initial dose (to maintain plasma magnesium concentration between 3.5–5.5 mmol/litre).

Hypomagnesaemia

- By Intravenous infusion
- Neonate: 100 mg/kg every 6–12 hours as required, to be given over at least 10 minutes.

- Child 1 month–11 years: 50 mg/kg every 12 hours as required, to be given over at least 10 minutes
- Child 12–17 years: 1 g every 12 hours as required, to be given over at least 10 minutes

Hypomagnesaemia maintenance (e.g. in intravenous nutrition)

- By Intravenous infusion, or by Intramuscular injection
- Child: 50–100 mg/kg daily; maximum 5 g per day

Neonatal hypocalcaemia

- By deep Intramuscular injection, or by Intravenous infusion
- Neonate: 100 mg/kg every 12 hours for 2–3 doses.

Torsade de pointes

- By Intravenous infusion
- Child: 25–50 mg/kg (max. per dose 2 g), to be given over 10–15 minutes, dose may be repeated once if necessary (consult local protocol)

SIDE-EFFECTS Electrolyte imbalance

- Overdose Symptoms of hypomagnesaemia may include nausea, vomiting, flushing, thirst, hypotension, drowsiness, confusion, reflexes absent (due to neuromuscular blockade), respiratory depression, speech slurred, diplopia, muscle weakness, arrhythmias, coma, and cardiac arrest.

PREGNANCY

- When used for Neonatal hypocalcaemia or Hypomagnesaemia or Torsade de pointes or Severe acute asthma or Continuing respiratory deterioration in anaphylaxis Sufficient amount may cross the placenta in mothers treated with high doses e.g. in pre-eclampsia, causing hypotonia and respiratory depression in newborns.

HEPATIC IMPAIRMENT

- Avoid in hepatic coma if risk of renal failure.

RENAL IMPAIRMENT

- Increased risk of toxicity.

- Avoid or reduce dose.

UNLICENSED USE Unlicensed indication in severe acute asthma and continuing respiratory deterioration in anaphylaxis.

INTERACTIONS Appendix 1: magnesium

SIDE-EFFECTS Electrolyte imbalance

- Overdose Symptoms of hypomagnesaemia may include nausea, vomiting, flushing, thirst, hypotension, drowsiness, confusion, reflexes absent (due to neuromuscular blockade), respiratory depression, speech slurred, diplopia, muscle weakness, arrhythmias, coma, and cardiac arrest.

PREGNANCY

- When used for Neonatal hypocalcaemia or Hypomagnesaemia or Torsade de pointes or Severe acute asthma or Continuing respiratory deterioration in anaphylaxis Sufficient amount may cross the placenta in mothers treated with high doses e.g. in pre-eclampsia, causing hypotonia and respiratory depression in newborns.

HEPATIC IMPAIRMENT

- Avoid in hepatic coma if risk of renal failure.

RENAL IMPAIRMENT

- Increased risk of toxicity.

- Avoid or reduce dose.

MONITORING REQUIREMENTS Monitor blood pressure, respiratory rate, urinary output and for signs of overdosage (loss of patellar reflexes, weakness, nausea, sensation of warmth, flushing, drowsiness, double vision, and slurred speech).
### Hyperphosphataemia

#### 2.4 Phosphate imbalance

#### Phosphate imbalance

##### Oral phosphate supplements p. 621 may be required in addition to Vitamin D in children with hypophosphataemic vitamin D-resistant rickets, see also Vitamin D, under Vitamins p. 646.

Phosphate infusion is occasionally needed in phosphate deficiency arising from use of parenteral nutrition deficient in phosphate supplements; phosphate depletion also occurs in severe diabetic ketoacidosis. It is difficult to provide detailed guidelines for the treatment of severe hypophosphataemia because the extent of total body deficits and response to therapy are difficult to predict. High doses of phosphate may result in a transient serum elevation followed by redistribution into intracellular compartments or bone tissue. It is recommended that severe hypophosphataemia be treated intravenously as large doses of oral phosphate may cause diarrhoea; intestinal absorption may be unreliable and dose adjustment may be necessary.

Phosphate is not the first choice for the treatment of hypercalcaemia because of the risk of precipitation of calcium phosphate in the kidney and other tissues. If used, the child should be well hydrated and electrolytes monitored.

#### Phosphate-binding agents

Calcium-containing preparations are used as phosphate-binding agents in the management of hyperphosphataemia complicating renal failure. Aluminium-containing preparations are rarely used as phosphate-binding agents and can cause aluminium accumulation.

Sevelamer hydrochloride is licensed for the treatment of hyperphosphataemia in adults on haemodialysis or peritoneal dialysis. Although experience is limited in children, sevelamer hydrochloride may be useful when hypercalcaemia prevents the use of calcium carbonate p. 613.

#### Phosphate supplements in neonates

Phosphate deficiency may occur in very low-birthweight infants and may compromise bone growth if not corrected. Parenterally fed infants may be at risk of phosphate deficiency due to the limited solubility of phosphate. Some units routinely supplement expressed breast milk with phosphate, although the effect on the osmolarity of the milk should be considered.
**ELECTROLYTES AND MINERALS**

## Calcium

**Calcium acetate**

- **INDICATIONS AND DOSE**
  - **PHOSEX® TABLETS**
    - Phosphate binding in renal failure and hyperphosphataemia
  - **BY MOUTH**
    - Child: Dose to be adjusted according to requirements of patient, dose to be taken with meals (consult product literature)

- **INTERACTIONS**
  - Appendix 1: calcium salts

- **SIDE-EFFECTS**
  - Uncommon

**DIRECTIONS FOR ADMINISTRATION**

**Uncommon side-effects**

- **SIDE-EFFECTS**

- **EXCIPIENTS:** May contain Propylene glycol 250 mg (equivalent to calcium 250 mg or Ca²⁺ 6.2 mmol).

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Calcium salts for kidney disease www.medicinesforchildren.org.uk/calcium-salts-kidney-disease-0

**PHOSEX® TABLETS**

- Patients or carers should be given advice on how to administer Phosex® tablets.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

- **Tablet**
  - CAUTIONARY AND ADVISORY LABELS 25
    - Phosex (Pharmacosmos UK Ltd)
      - Calcium acetate 1 gram
      - Phosex® tablets contain calcium acetate 1 g (equivalent to calcium 250 mg or Ca²⁺ 6.2 mmol).

**PHOSPHATE BINDERS**

## Sevelamer

### Sevelamer

- **INDICATIONS AND DOSE**
  - **RENAGEL®**
    - Hyperphosphataemia in patients on haemodialysis or peritoneal dialysis
  - **BY MOUTH**
    - Child 12–17 years: Initially 0.8–1.6 g 3 times a day, dose to be given with meals and adjusted according to serum-phosphate concentration

- **RENELA® 2.4G ORAL POWDER SACHETS**
  - Hyperphosphataemia in chronic kidney disease
  - **BY MOUTH**
    - Child 6–17 years (body surface area 0.75–1.1 m²): Initially 2.4 g daily in 3 divided doses, dose to be taken with meals and adjusted according to serum-phosphate concentration every 2–4 weeks—consult product literature
    - Child 6–17 years (body surface area 1.2 m² and above): Initially 4.8 g daily in 3 divided doses, dose to be taken with meals and adjusted according to serum-phosphate concentration every 2–4 weeks—consult product literature

**CAUTIONS**

- Gastro-intestinal disorders

**SIDE-EFFECTS**

- Common or very common Constipation • diarrhoea • gastrointestinal discomfort • gastrointestinal disorders • nausea • vomiting

**FREQUENCY NOT KNOWN**

- Skin reactions

**PRECAUTIONS**

- Manufacturer advises use only if potential benefit outweighs risk.

**BREAST FEEDING**

- Renvela 2.4G oral powder sachets

**RENELA® 800MG TABLETS**

- Patients and carers should be advised on how to administer powder for oral suspension.

**NATIONAL FUNDING/ACCESS DECISIONS**

**RENELA® 2.4G ORAL POWDER SACHETS**

- Scottish Medicines Consortium (SMC) decisions
  - The Scottish Medicines Consortium has advised (February 2018) that sevelamer carbonate (Renela®) is accepted for restricted use within NHS Scotland as second-line management of hyperphosphataemia in paediatric patients (greater than 6 years of age and a Body Surface Area greater than 0.75 m²) with chronic kidney disease receiving haemodialysis.

**RENELA® 800MG TABLETS**

- Scottish Medicines Consortium (SMC) decisions
  - The Scottish Medicines Consortium has advised (April 2011) that sevelamer carbonate (Renela®) is accepted for restricted use within NHS Scotland for the second-line management of hyperphosphataemia in adults receiving haemodialysis.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

- **Powder**
  - CAUTIONARY AND ADVISORY LABELS 13
    - Renela (Sanofi)
      - Sevelamer carbonate 2.4 gram
      - Renela 2.4g oral powder sachets
      - sugar-free | 60 sachet
  - **Tablet**
    - CAUTIONARY AND ADVISORY LABELS 25
      - Exipients: May contain Propylene glycol
      - Renagel (Sanofi)
        - Sevelamer 800 mg Renagel 800mg tablets

**UNLICENSED USE**

- **RENAGEL®** Not licensed for use in children under 18 years.

**CONTRA-INDICATIONS**

- Bowel obstruction
2.4b Hypophosphataemia

DRUGS AFFECTING BONE STRUCTURE AND MINERALISATION > MONOCLONAL ANTIBODIES

Burosumab

- **DRUG ACTION** Burosumab is a human monoclonal antibody that inhibits the activity of fibroblast growth factor 23, thereby increasing renal tubular reabsorption of phosphate and increasing serum concentration of vitamin D.

- **INDICATIONS AND DOSE** X-linked hypophosphataemia with radiographic evidence of bone disease in children and adolescents with growing skeletons (initiated by a specialist)
  - **BY SUBCUTANEOUS INJECTION**
    - Child 1-17 years: Initially 0.4 mg/kg, subsequent doses adjusted according to response and administered every 2 weeks. Dose may be increased in steps of 0.4 mg/kg at intervals of at least 4 weeks up to a maximum of 2 mg/kg (maximum dose 90 mg)—consult product literature; usual maintenance 0.8 mg/kg every 2 weeks (max. per dose 90 mg), to be administered into the arm, abdomen, buttock or thigh, each dose should be rounded to the nearest 10 mg.

- **CONTRA-INDICATIONS** Concurrent use of oral phosphate or vitamin D analogues—discontinue 1 week before initiation of burosumab.

- **SIDE-EFFECTS**
  - Common or very common Dizziness, headache, myalgia, pain in extremity, rash, tooth ache, toothache.
  - PREGNANCY Manufacturer advises avoid—toxicity in animal studies.
  - BREAST FEEDING Manufacturer advises avoid—no information available.
  - RENAL IMPAIRMENT Manufacturer advises avoid in severe impairment—no information available.

- **MONITORING REQUIREMENTS**
  - Manufacturer advises monitor fasting serum-phosphate concentration before treatment initiation, every 2 weeks for the first month, every 4 weeks for the following 2 months, 4 weeks after dose adjustment, and as appropriate thereafter—target the lower end of the normal reference range for age to decrease the risk of ectopic mineralisation. Periodic measurement of post-prandial serum-phosphate concentration is also advised.
  - Manufacturer advises monitor for signs and symptoms of nephrocalcinosis at treatment initiation, every 6 months for the first 12 months, and annually thereafter. Also monitor plasma alkaline phosphatases, calcium, parathyroid hormone, and creatinine every 6 months (every 3 months for children aged 1–2 years) or as indicated, and urine calcium and phosphate every 3 months.

- **DIRECTIONS FOR ADMINISTRATION** Maximum volume per injection site is 1.5 mL. If a volume over 1.5 mL is required on a given dosing day, manufacturer advises the total volume should be split and given at 2 different injection sites.

- **HANDLING AND STORAGE** Manufacturer advises store in a refrigerator (2-8°C).

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NATIONAL FUNDING/ACCESS DECISIONS

**NICE decisions**

- Burosumab for treating X-linked hypophosphataemia in children and young people (October 2018) NICE HST8
  - Burosumab (Crysvita®) is recommended, within its marketing authorisation, for treating X-linked hypophosphataemia with radiographic evidence of bone disease in children aged 1 year and over, and in young people with growing bones. It is recommended only if the manufacturer provides burosumab according to the commercial arrangement.
  - www.nice.org.uk/guidance/hst8

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **EXCipients:** May contain Polysorbates, sorbitol
  - Crysvita (Kyowa Kirin Ltd)▼
    - **Burosumab 10 mg per 1 ml** Crysvita 10mg/1ml solution for injection vials | 1 vial (£92)
    - **Burosumab 20 mg per 1 ml** Crysvita 20mg/1ml solution for injection vials | 1 vial (£98)
    - **Burosumab 30 mg per 1 ml** Crysvita 30mg/1ml solution for injection vials | 1 vial (£97)

**LAXATIVES > OSMOTIC LAXATIVES**

Phosphate

- **INDICATIONS AND DOSE** Hypophosphataemia | Hypophosphataemic rickets | Osteomalacia
  - **BY MOUTH USING EFFERVESCENT TABLETS**
    - Neonate: 1 mmol/kg daily in 1–2 divided doses, dose can be taken as a supplement in breast milk—caution advised as solubility in breast milk is limited to 1.2 mmol in 100 mL if calcium also added, contact pharmacy department for details.
    - Child 1 month–4 years: 2–3 mmol/kg daily in 2–4 divided doses, dose to be adjusted as necessary, dose can be taken as a supplement in breast milk—caution advised as solubility in breast milk is limited to 1.2 mmol in 100 mL if calcium also added, contact pharmacy department for details; maximum 48 mmol per day
    - Child 5–17 years: 2–3 mmol/kg daily in 2–4 divided doses, dose to be adjusted as necessary; maximum 97 mmol per day
  - **BY INTRAVENOUS INFUSION**
    - Neonate: 1 mmol/kg daily, dose to be adjusted as necessary.
    - Child 1 month–1 year: 0.7 mmol/kg daily, dose to be adjusted as necessary
    - Child 2–17 years: 0.4 mmol/kg daily, dose to be adjusted as necessary

**IMPORTANT SAFETY INFORMATION**

Some phosphate injection preparations also contain potassium. For peripheral intravenous administration the concentration of potassium should not usually exceed 40 mmol/litre. The infusion solution should be thoroughly mixed. Local policies on avoiding inadvertent use of potassium concentrate should be followed. The potassium content of some phosphate preparations may also limit the rate at which they may be administered.

**CAUTIONS**

- **GENERAL CAUTIONS** Cardiac disease, dehydration, diabetes mellitus, sodium and potassium concentrations of preparations

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622 Fluid and electrolyte imbalances

SPECIFIC CAUTIONS
• With intravenous use Avoid extravasation • severe tissue necrosis

SIDE-EFFECTS

GENERAL SIDE-EFFECTS
• Common or very common Diarrhoea
• Frequency not known Nausea

SPECIFIC SIDE-EFFECTS
• With intravenous use Acute kidney injury • extravasation necrosis • hypocalcaemia • hypotension • metastatic calcification • oedema
• With oral use Abdominal distress

SIDE-EFFECTS, FURTHER INFORMATION Diarrhoea is a common side-effect and should prompt a reduction in dosage.

RENAI IMPAIRMENT
Dose adjustments Reduce dose.
Monitoring Monitor closely in renal impairment.

MONITORING REQUIREMENTS It is essential to monitor closely plasma concentrations of calcium, phosphate, potassium, and other electrolytes—excessive doses of phosphates may cause hypocalcaemia and metastatic calcification.

DIRECTIONS FOR ADMINISTRATION
• With intravenous use Dilute in infusion with Sodium Chloride 0.9% or 0.45% or Glucose 5% or 10%. Administration rate of phosphate should not exceed 0.05 mmol/kg/hour. In emergencies in intensive care faster rates may be used—seek specialist advice.

PRESCRIBING AND DISPENSING INFORMATION Phosphate Sandoz® contains sodium dihydrogen phosphate anhydrous (anhydrous sodium acid phosphate) 1.936 g, sodium bicarbonate 350 mg, potassium bicarbonate 315 mg, equivalent to phosphorus 500 mg (phosphate 16.1 mmol), sodium 468.8 mg (Na+ 20.4 mmol), potassium 123 mg (K+ 3.1 mmol); Polyfusor NA® contains Na+ 162 mmol/litre, K+ 19 mmol/litre, PO4 3- 100 mmol/litre; non-proprietary potassium dihydrogen phosphate injection (potassium acid phosphate) 13.6% may contain 1 mmol/mL phosphate, 1 mmol/mL potassium.


MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: infusion, solution for infusion

Effervescent tablet
CAUTIONARY AND ADVISORY LABELS 13
• Phosphate Sandoz (HK Pharma Ltd) Sodium dihydrogen phosphate anhydrous 1.936 gram Phosphate Sandoz effervescent tablets 100 tablet 15.19.39 DT £13.39

Solution for infusion
• Phosphate (Non-proprietary) Potassium dihydrogen phosphate 136 mg per 1 ml Potassium dihydrogen phosphate 13.6% (potassium 10 mmol/10 ml) solution for infusion 10 ml ampoules 10 ampoule 101.96 DT £101.96

Infusion
• Phosphate (Non-proprietary) Potassium dihydrogen phosphate 1.295 gram per 1 litre, Disodium hydrogen phosphate anhydrous 5.75 gram per 1 litre Polyfusor NA phosphates infusion 500ml bottles 1 bottle 15.15

2.5 Potassium imbalance
2.5a Hyperkalaemia

Other drugs used for Hyperkalaemia Calcium gluconate, p. 614 • Insulin, p. 471

ANTIDOTES AND CHELATORS • CATION EXCHANGE RESINS

Calcium polystyrene sulfonate

INDICATIONS AND DOSE Hyperkalaemia associated with anuria or severe oliguria, and in dialysis patients
• BY MOUTH
  • Child: 0.5–1 g/kg daily in divided doses; maximum 60 g per day
  • BY RECTUM
  • Neonate: 0.5–1 g/kg daily, irrigate colon to remove resin after 8–12 hours.

• CONTRA-INDICATIONS Hyperparathyroidism • metastatic carcinoma • multiple myeloma • obstructive bowel disease • reduced gut motility (in neonates) • sarcoidosis

CAUTIONS Impaction of resin with excessive dosage or inadequate dilution

INTERACTIONS Appendix 1: polystyrene sulfonate

SIDE-EFFECTS Appetite decreased • constipation (discontinue—avoid magnesium-containing laxatives) • diarrhoea • electrolyte imbalance • epigastric discomfort • gastrointestinal disorders • gastrointestinal necrosis (in combination with sorbitol) • hypercalcaemia (in dialysed patients and occasionally in those with renal impairment) • increased risk of infection • nausea • vomiting

PREGNANCY Manufacturers advise use only if potential benefit outweighs risk—no information available.

BREAST FEEDING Manufacturers advise use only if potential benefit outweighs risk—no information available.

MONITORING REQUIREMENTS Monitor for electrolyte disturbances (stop if plasma-potassium concentration below 5 mmol/litre).

DIRECTIONS FOR ADMINISTRATION
• With rectal use Mix each 1 g of resin with 5 mL of water or 10% glucose.

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: enema

Powder
CAUTIONARY AND ADVISORY LABELS 13, 21 (Sorbisterit® powder only)
EXCIPIENTS: May contain Sucrose
• Calcium Resonium (Sandoz)
Calcium polystyrene sulfonate 999.34 mg per 1 gram Calcium Resonium powder sugar-free 300 gram 182.16 DT £182.16
Sodium polystyrene sulfonate

- **INDICATIONS AND DOSE**
  - Hyperkalaemia associated with anuria or severe oliguria, and in dialysis patients
    - **BY MOUTH**
      - Child: 0.5–1 g/kg daily in divided doses; maximum 60 g per day
    - **BY RECTUM**
      - Neonate: 0.5–1 g/kg daily, irrigate colon to remove resin after 8–12 hours.
      - Child: 0.5–1 g/kg daily, irrigate colon to remove resin after 8–12 hours; maximum 30 g per day

- **CONTRA-INDICATIONS**
  - Obstructive bowel disease • reduced gut motility (in neonates)
  - **CAUTIONS**
    - Congestive heart failure • hypertension • impaction of resin with excessive dosage or inadequate dilution • oedema
  - **INTERACTIONS** → Appendix 1: polystyrene sulfonate

- **SIDE-EFFECTS**
  - Appetite decreased • nausea • vomiting • constipation (discontinue - avoid magnesium-containing laxatives)
  - diaphoresis • electrolyte imbalance • epigastric discomfort • gastrointestinal disorders • increased risk of infection • nausea • necrosis (in combination with sorbitol) • vomiting

- **PREGNANCY**
  - Manufacturers advise use only if potential benefit outweighs risk - no information available.

- **BREAST FEEDING**
  - Manufacturers advise use only if potential benefit outweighs risk - no information available.

- **RENA L IMPAIRMENT**
  - Use with caution.

- **MONITORING REQUIREMENTS**
  - Monitor for electrolyte disturbances (stop if plasma-potassium concentration below 5 mmol/litre).

- **DIRECTIONS FOR ADMINISTRATION**
  - **BY INTRAVENOUS INFUSION**
    - With rectal use: Mix each 1 g of resin with 5 mL of water or 10% glucose.
    - With oral use: Administer dose (powder) in a small amount of water or honey - do not give with fruit juice or squash, which have a high potassium content.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Forms available from special-order manufacturers include: oral suspension
    - **Powder**
      - Resonium A (Sanofi)
      - Sodium polystyrene sulfonate 999.34 mg per 1 gram
      - Effervescent tablet
      - Sodium polystyrene sulfonate 999.34 mg per 1 gram: Resonium A powder sugar-free

Potassium chloride

- **INDICATIONS AND DOSE**
  - Prevention of hypokalaemia (patients with normal diet)
    - **BY MOUTH**
      - Child: 1–2 mmol/kg daily; usual maximum: 50 mmol
  - **Electrolyte imbalance**
    - **BY INTRAVENOUS INFUSION**
      - Neonate: 1–2 mmol/kg daily, dose dependent on deficit or the daily maintenance requirements.
        - **BY MOUTH**
          - Neonate: 0.5–1 mmol/kg twice daily; total daily dose may alternatively be given in 3 divided doses, dose to be adjusted according to plasma-potassium concentration.
          - Child: 0.5–1 mmol/kg twice daily, total daily dose may alternatively be given in 3 divided doses, dose to be adjusted according to plasma-potassium concentration.

- **CONTRA-INDICATIONS**
  - Plasma-potassium concentration above 5 mmol/litre

- **CAUTIONS**
  - With intravenous use: seek specialist advice in very severe potassium depletion or difficult cases
  - With oral use: Cardiac disease • hiatus hernia (with modified-release preparations) • history of peptic ulcer (with modified-release preparations) • intestinal stricture (with modified-release preparations)

- **INTERACTIONS** → Appendix 1: potassium chloride

- **SIDE-EFFECTS**
  - Abdominal pain • diarrhoea • flatulence • nausea • vomiting
  - **RENA L IMPAIRMENT**
    - Avoid in severe impairment.
  - **DIRECTIONS FOR ADMINISTRATION**
    - To be dissolved in water before administration.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - These tablets do not contain chloride.

**Potassium bicarbonate with potassium acid tartrate**

- **INDICATIONS AND DOSE**
  - Hyperchloraemic acidosis associated with potassium deficiency (as in some renal tubular and gastrointestinal disorders)
    - **BY MOUTH**
      - Child: (consult product literature)
  - **CONTRA-INDICATIONS**
    - Hypokalaemia • plasma-potassium concentration above 5 mmol/litre
  - **CAUTIONS**
    - Cardiac disease

**Electrolytes and minerals > Potassium**

**2.5b Hypokalaemia**

**SIDE-EFFECTS**
- Abdominal pain • diarrhoea • flatulence • nausea • vomiting

**RENA L IMPAIRMENT**
- Avoid in severe impairment.

**DIRECTIONS FOR ADMINISTRATION**
- To be dissolved in water before administration.

**PRESCRIBING AND DISPENSING INFORMATION**
- These tablets do not contain chloride.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Effervescent tablet**
- CAUTIONARY AND ADVISORY LABELS 13, 21
  - Potassium bicarbonate with potassium acid tartrate (Non-proprietary)
    - Potassium acid tartrate 300 mg, Potassium bicarbonate 500 mg: Potassium (potassium 6.5 mmol) effervescent tablets BPC 1968 | 56 tablet £81.27 DT = £90.99

**IMPORTANT SAFETY INFORMATION**

**SAFE PRACTICE**
- Potassium overdose can be fatal. Ready-mixed infusion solutions containing potassium should be used. Exceptionally, if potassium chloride concentrate is used for preparing an infusion, the infusion solution should be thoroughly mixed. Local policies on avoiding inadvertent use of potassium chloride concentrate should be followed.

**CONTRA-INDICATIONS**
- Plasma-potassium concentration above 5 mmol/litre

**CAUTIONS**
- With intravenous use: seek specialist advice in very severe potassium depletion or difficult cases
- With oral use: Cardiac disease • hiatus hernia (with modified-release preparations) • history of peptic ulcer (with modified-release preparations) • intestinal stricture (with modified-release preparations)

**INTERACTIONS** → Appendix 1: potassium chloride

**SIDE-EFFECTS**
- Cardiac disease

**SPECIFIC SIDE-EFFECTS**
- Hyperkalaemia

**ELECTROLYTES AND MINERALS > POTASSIUM**

**INDICATIONS AND DOSE**
- Hyperkalaemia associated with potassium deficiency (in renal patients with normal diet)
RENAL IMPAIRMENT  Avoid in severe impairment.
Dose adjustments  Smaller doses must be used in the prevention of hypokalaemia, to reduce the risk of hyperkalaemia.
Monitoring  Close monitoring required in renal impairment—high risk of hyperkalaemia.

MONITORING REQUIREMENTS
- Regular monitoring of plasma-potassium concentration is essential in those taking potassium supplements.
- With intravenous use ECG monitoring should be performed in difficult cases.

DIRECTIONS FOR ADMINISTRATION
- With oral use Potassium salts are preferably given as a liquid (or effervescent) preparation, rather than modified-release tablets; they should be given as the chloride (the use of effervescent potassium tablets BPC 1968 should be restricted to hyperchloreaemic states).
- With intravenous use Potassium chloride concentrate must be diluted with not less than 50 times its volume of sodium chloride intravenous infusion 0.9% or other suitable diluent and mixed well.
- Ready-mixed infusion solutions should be used when possible. For peripheral intravenous infusion, the concentration of potassium should not usually exceed 40 mmol/L. Potassium infusions should be given slowly over at least 2–3 hours and at a rate not exceeding 0.2 mmol/kg/hour with specialist advice and ECG monitoring in difficult cases. Higher concentrations of potassium chloride or faster infusion rates may be given in very severe depletion, but require specialist advice.

PRESCRIBING AND DISPENSING INFORMATION  Kay-Cee-L® contains 1 mmol/mL each of K+ and Cl−. Potassium Tablets Do not confuse Effervescent Potassium Tablets BPC 1968 with effervescent potassium chloride tablets. Effervescent Potassium Tablets BPC 1968 do not contain chloride ions and their use should be restricted to hyperchloreaemic states.

PATIENT AND CARER ADVICE  Patient or carers should be given advice on how to administer potassium chloride modified-release tablets.
- Salt substitutes A number of salt substitutes which contain significant amounts of potassium chloride are readily available as health food products (e.g. LoSalt® and Ruthmol®). These should not be used by patients with renal failure as potassium intoxication may result.
- LESS SUITABLE FOR PRESCRIBING  Modified-release tablets are less suitable for prescribing. Modified-release preparations should be avoided unless effervescent tablets or liquid preparations inappropriate.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: modified-release tablet, oral solution, solution for injection, infusion, solution for infusion.

Modified-release tablet  CAUTIONARY AND ADVISORY LABELS 25, 27
- Potassium chloride (Imported)  Potassium chloride 600 mg Kaleorid LP 600mg tablets | 30 tablets [PSM] £
  Duro-K 600mg tablets | 100 tablet [PSM] £
Solution for infusion  Potassium chloride (Non-proprietary)  Potassium chloride 150 mg per 1 ml Potassium chloride 15% (potassium 20mmol/10ml) solution for infusion 10ml ampoules | 10 ampoule [PSM] £10.00 | 20 ampoule [PSM] £6.50–£10.70

Potassium chloride 200 mg per 1 ml Potassium chloride 20% (potassium 13.3mmol/5ml) solution for infusion 5ml ampoules | 10 ampoule £0.00
Potassium chloride 20% (potassium 27mmol/10ml) solution for infusion 10ml ampoules | 10 ampoule £133.38

Oral solution  CAUTIONARY AND ADVISORY LABELS 21
- Kay-Cee-L (Geistslich Sons Ltd)  Potassium chloride 75 mg per 1 ml Kay-Cee-L syrup sugar-free | 500 ml £18.77 DT = £18.77

Infusion
- Potassium chloride (Non-proprietary)  Potassium chloride 30 mg per 1 ml Potassium chloride 3% (potassium 40mmol/10ml) infusion 100ml bags | 1 bag £0.00
Potassium chloride 3% (potassium 20mmol/50ml) infusion 50ml bags | 1 bag £0.00

3 Metabolic disorders

Metabolic disorders

Use of medicines in metabolic disorders
Metabolic disorders should be managed under the guidance of a specialist. As many preparations are unlicensed and may be difficult to obtain, arrangements for continued prescribing and supply should be made in primary care. General advice on the use of medicines in metabolic disorders can be obtained from: Alder Hey Children’s Hospital, Medicines Information Centre (0151) 252 5381 and Great Ormond Street Hospital for Children, pharmacy (020) 7405 9200

Urea cycle disorders
Sodium benzoate p. 636 and sodium phenylbutyrate p. 637 are used in the management of urea cycle disorders. Both, either singly or in combination, are indicated as adjunctive therapy in all patients with neonatal-onset disease and in those with late-onset disease who have a history of hyperammonaemic encephalopathy. Sodium benzoate is also used in non-ketotic hyperglycaemia.

The long-term management of urea cycle disorders includes oral maintenance treatment with sodium benzoate and sodium phenylbutyrate combined with a low protein diet and other drugs such as arginine p. 635 or citrulline p. 636, depending on the specific disorder.

Emergency management
For further information on the emergency management of urea cycle disorders consult the British Inherited Metabolic Disease Group (BIMDG) website at: www.bimdg.org.uk.

3.1 Acute porphyrias

Acute porphyrias 01-Oct-2017

Overview
The acute porphyrias (acute intermittent porphyria, variegate porphyria, hereditary coproporphyria, and 5-aminolaevulinic acid dehydratase deficiency porphyria) are hereditary disorders of haem biosynthesis; they have a prevalence of about 1 in 75 000 of the population.

Great care must be taken when prescribing for patients with acute porphyria, since certain drugs can induce acute porphyric crises. Since acute porphyrias are hereditary,
relatives of affected individuals should be screened and advised about the potential danger of certain drugs. Where there is no safe alternative, drug treatment for serious or life-threatening conditions should not be withheld from patients with acute porphyria. Where possible, the clinical situation should be discussed with a porphyria specialist for advice on how to proceed and monitor the patient. In the UK clinical advice can be obtained from the National Acute Porphyria Service or from the UK Porphyria Medicines Information Service (UKPMIS)—see details below.

Haem arginate p. 626 is administered by short intravenous infusion as haem replacement in moderate, severe, or unremitting acute porphyria crises.

In the United Kingdom the National Acute Porphyria Service (NAPS) provides clinical support and treatment with haem arginate from two centres (University Hospital of Wales and King’s College Hospital). To access the service telephone (029) 2074 7747 and ask for the Acute Porphyria Service.

Drugs unsafe for use in acute porphyrias

The following list contains drugs on the UK market that have been classified as ‘unsafe’ in porphyria because they have been shown to be porphyrinogenic in animals or in vitro, or have been associated with acute attacks in patients. Absence of a drug from the following lists does not necessarily imply that the drug is safe. For many drugs no information about porphyrinogenicity is available.

An up-to-date list of drugs considered safe in acute porphyrias is available from the UKPMIS, see Useful resources below.

Further information may be obtained from: porphyria.eu/ and also from:

The UK Porphyria Medicines Information Service (UKPMIS)
University Hospital of Wales
CF14 4XW
Cardiff
(029) 2074 2979/3877

Quite modest changes in chemical structure can lead to changes in porphyrinogenicity but where possible general statements have been made about groups of drugs; these should be checked first.

Unsafe Drug Groups (check first)

- Anabolic steroids
- Antidepressants, MAOIs (contact UKPMIS for advice)
- Antidepressants, Tricyclic and related (contact UKPMIS for advice)
- Barbiturates (includes primidone and thiopental)
- Contraceptives, hormonal (for detailed advice contact UKPMIS or a porphyria specialist)
- Hormone replacement therapy (for detailed advice contact UKPMIS or a porphyria specialist)
- Imidazole antifungals (applies to oral and intravenous use; topical antifungals are thought to be safe due to low systemic exposure)
- Non-nucleoside reverse transcriptase inhibitors (contact UKPMIS for advice)
- Progestogens (for detailed advice contact UKPMIS or a porphyria specialist)
- Protease inhibitors (contact UKPMIS for advice)
- Sulfonamides (includes co-trimoxazole and sulfasalazine)
- Sulfonylureas (glipizide and glimepiride are thought to be safe)
- Taxanes (contact UKPMIS for advice)
- Triazole antifungals (applies to oral and intravenous use; topical antifungals are thought to be safe due to low systemic exposure)

Unsafe Drugs (check groups above first)

- Aceclofenac
- Alcohol
- Amiodarone
- Aprepitant
- Artemether with lumefantrine
- Bexarotene
- Bosantan
- Busulfan
- Carbamazepine
- Chloral hydrate (although evidence of hazard is uncertain, manufacturer advises avoid)
- Chloramphenicol
- Chloroform (small amounts in medicines probably safe)
- Clemastine
- Clindamycin
- Cocaine
- Danazol
- Dapsone
- Diliazem
- Disopyramide
- Disulfiram
- Ergometrine
- Ergotamine
- Erythromycin
- Etamsylate
- Ethosuximide
- Etomidate
- Flutamide
- Fosaprepitant
- Fosphenytoin
- Griseofulvin
- Hydralazine
- Ilosafamide
- Indapamide
- Isomethene mucate
- Isoniazid (safety uncertain, contact UKPMIS for advice)
- Ketamine
- Mefenamic acid (safety uncertain, contact UKPMIS for advice)
- Meprobamate
- Mehyldopa
- Metolazone
- Metopropone
- Milnepristone
- Minoxidil (safety uncertain, contact UKPMIS for advice)
- Mitoxane
- Nalidixic acid
- Nitrazepam
- Nitrofurantoin
- Orphenadrine
- Oxcarbazepine
- Oxybutynin
- Pentazocine
- Pentoxifylline
- Pergolide
- Phenoxbenzamine
- Phenotoin
- Pivmecillinam
- Pizotifen
- Porfimer
- Raloxifene
- Rifabutin (safety uncertain, contact UKPMIS for advice)
- Rifampicin
- Riluzole
- Risperidone
- Spinonolactone
- Sulfinpyrazone
- Tamoxifen
- Temoporfin
- Thiopeta
- Tiagabine
3.2 Carnitine deficiency

AMINO ACIDS AND DERIVATIVES

Levo carnitine

(Carnitine)

- INDICATIONS AND DOSE
  Primary carnitine deficiency due to inborn errors of metabolism
  - BY MOUTH
    - Neonate: Up to 200 mg/kg daily in 2–4 divided doses.
    - Child: Up to 200 mg/kg daily in 2–4 divided doses; maximum 3 g per day
    - Initially by intravenous infusion
  - Neonate; Initially 100 mg/kg, to be administered over 30 minutes, followed by (by continuous intravenous infusion) 4 mg/kg/hour.

- UNLICENSED USE
  Not licensed for use by intravenous infusion. Tablets, chewable tablets, and oral liquid (30%) not licensed in children under 12 years. Paediatric oral solution (30%) not licensed in children under 12 years. Not licensed for use in organic acidaemias.

- CAUTIONS
  Diabetes mellitus

- SIDE-EFFECTS
  Rare or very rare Abdominal cramps - diarrhoea - nausea - skin oedema abnormal - vomiting

SIDE-EFFECTS, FURTHER INFORMATION
Sides-effects may be dose-related—monitor tolerance during first week and after any dose increase.

- PREGNANCY
  Appropriate to use; no evidence of teratogenicity in animal studies.

- RENAL IMPAIRMENT
  Accumulation of metabolites may occur with chronic oral administration in severe impairment.

- MONITORING REQUIREMENTS
  Monitoring of free and acyl carnitine in blood and urine recommended.

- DIRECTIONS FOR ADMINISTRATION
  For intravenous infusion, dilute injection with Sodium Chloride 0.9% or Glucose 5% or 10%.

- PRESCRIBING AND DISPENSING INFORMATION
  When used for Organic acidaemias Levocarnitine is used in the treatment of some organic acidaemias; however, use in fatty acid oxidation is controversial.

- PATIENT AND CARETAKER ADVICE
  Medicines for Children leaflet: Carnitine for metabolic disorders www.medicinesforchildren.org.uk/carnitine-metabolic-disorders-0
3.3a Cystinosis

Nephropathic cystinosis

AMINO ACIDS AND DERIVATIVES

Mercaptamine

(Cysteamine)

**INDICATIONS AND DOSE**

Nephropathic cystinosis (specialist use only)

**BY MOUTH**

- Neonate: Initially one-sixth to one-quarter of the expected maintenance dose, increased gradually over 4–6 weeks to avoid intolerance, maintenance 1.3 g/m² daily in 4 divided doses.
- Child 1 month–11 years (body-weight up to 50 kg): Initially one-sixth to one-quarter of the expected maintenance dose, increased gradually over 4–6 weeks to avoid intolerance, maintenance 1.3 g/m² daily in 4 divided doses.
- Child 12–17 years (body-weight up to 50 kg): Initially one-sixth to one-quarter of the expected maintenance dose, increased gradually over 4–6 weeks to avoid intolerance, maintenance 1.3 g/m² daily in 4 divided doses.
- Child 12–17 years (body-weight 50 kg and above): Initially one-sixth to one-quarter of the expected maintenance dose, increased gradually over 4–6 weeks to avoid intolerance, maintenance 2 g daily in 4 divided doses.

Corneal cystine crystal deposits in patients with cystinosis (specialist use only)

- TO THE EYE
- Child 2–17 years: Apply 1 drop 4 times a day, to be applied to both eyes (minimum 4 hours between doses); dose may be reduced according to response (minimum daily dose 1 drop in each eye)

**DOSE EQUIVALENCE AND CONVERSION**

- With oral use

**INDICATIIONS AND DOSE**

Nephropathic cystinosis (specialist use only)

**ORAL SOLUTION**

- Levocarnitine (Non-proprietary)
  - L-Carnitine 300 mg per 1 ml
  - Carnitor 1g chewable tablets | 10 tablet $35.00
- L-Carnitine 100 mg per 1 ml
  - Carnitor oral single dose 1g solution $18.00
- L-Carnitine 250 mg Bio-Carnitine 250 mg capsules | 10 capsule $35.00

**SAFETY PRACTICE**

- mercaptamine-eye-drops-ocular-symptoms-cystinosis

**SIDE-EFFECTS**

- With oral use
  - Dry mouth
  - Dry eyes
  - Eye discomfort
  - Eye disorders
  - Vision blurred
  - Nausea
  - Skin reactions
  - Vomiting

**CAUTIONS**

- When used by eye
  - Contact lens wearers

**DIRECTIONS FOR ADMINISTRATION**

- With oral use
  - Dose of phosphate supplement may need to be adjusted if transferring from phosphocysteamine to mercaptamine.

**PRESCRIBING AND DISPENSING INFORMATION**

- Mercaptamine has been confused with mercaptopurine; care must be taken to ensure the correct drug is prescribed and dispensed.

**ALLERGY AND CROSS-SENSITIVITY**

- Contra-indicated if history of hypersensitivity to penicillamine.

**PREGNANCY**

- With oral use
  - Manufacturer advises avoid—teratogenic and toxic in animal studies.

**BREAST FEEDING**

- With oral use
  - Manufacturer advises avoid—no information available.

**CONTACT LENS WEARING**

- Both eyes
  - Contact lens wearers
  - Assessment should be made
  - Patient should refer to product literature.

**HANDLING AND STORAGE**

- Prolonged storage in room temperature—refrigerated
  - Manufacturer advises store in a refrigerator (2–8°C)—after opening store at room temperature up to 25°C for up to 7 days; protect from light.

**PATIENT AND CARER ADVICE**


**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

- With oral use
  - The Scottish Medicines Consortium has advised (November 2017) that mercaptamine (Procasby®) is not recommended for use within NHS Scotland for the treatment of proven nephropathic cystinosis.

**1.3 g/m² is approximately equivalent to 50 mg/kg.**
3.4 Fabry’s disease

ENZYMES

Agalsidase alfa

- **DRUG ACTION** Agalsidase alfa, an enzyme produced by recombinant DNA technology are licensed for long-term enzyme replacement therapy in Fabry’s disease (a lysosomal storage disorder caused by deficiency of alpha-galactosidase A).

- **INDICATIONS AND DOSE**
  - **Fabry’s disease (specialist use only)**
    - **BY INTRAVENOUS INFUSION**
      - Child 7-17 years: 1 mg/kg every 2 weeks
  - **INTERACTIONS** → Appendix 1: agalsidase
  - **SIDE-EFFECTS**
    - **Common or very common** Arrhythmias - asthenia - chest discomfort - chills - cough - diarrhea - dizziness - dyspnoea - excessive tearing - fever - flushing - gastrointestinal discomfort - headache - hoarseness - hypersomnia - hypertension - increased risk of infection - influenza like illness - joint disorders - malaise - musculoskeletal discomfort - myalgia - nausea - oedema - pain - palpitations - peripheral oedema - peripheral swelling - rhinorrhoea - sensation abnormal - skin reactions - taste altered - temperature sensation altered - throat complaints - tremor - vomiting
    - **Uncommon** Altered smell sensation - angioedema - hypersensitivity - sensation of pressure
    - **Frequency not known** Heart failure - hyperhidrosis - hypotension - myocardial ischaemia
  - **SIDE-EFFECTS, FURTHER INFORMATION** Infusion-related reactions; manage by slowing the infusion rate, or minimise by pre-treatment with an antihistamine, antipyretic, or corticosteroid — consult product literature.
  - **PREGNANCY** Use with caution.
  - **BREAST FEEDING** Use with caution — no information available.
  - **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion, given intermittently in Sodium Chloride 0.9%, reconstitute initially with Water for Injections (5 mg in 1.1 mL, 35 mg in 7.2 mL) to produce a solution containing 5 mg/mL. Dilute with Sodium Chloride 0.9% (for doses less than 35 mg dilute with at least 50 mL; doses 35 – 70 mg dilute with at least 100 mL; doses 70 – 100 mg dilute with at least 250 mL; doses greater than 100 mg dilute with 500 mL) and give through an in-line low protein-binding 0.2 micron filter at an initial rate of no more than 15 mg/hour; for subsequent infusions, infusion rate may be increased gradually once tolerance has been established.
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Solution for infusion**
  - **Replagal** (Shire Pharmaceuticals Ltd)
    - Agalsidase alfa 1 mg per 1 mL Replagal 3.5mg/3.5ml solution for infusion vials | 1 vial £1,040.94
  - **Agalsidase beta**
    - **DRUG ACTION** Agalsidase beta, an enzyme produced by recombinant DNA technology are licensed for long-term enzyme replacement therapy in Fabry’s disease (a lysosomal storage disorder caused by deficiency of alpha-galactosidase A).

- **INDICATIONS AND DOSE**
  - **Fabry’s disease (specialist use only)**
    - **BY INTRAVENOUS INFUSION**
      - Child 8-17 years: 1 mg/kg every 2 weeks
  - **INTERACTIONS** → Appendix 1: agalsidase
  - **SIDE-EFFECTS**
    - **Uncommon** Dysphagia - ear discomfort - eye pruritus - influenza like illness - malaise - peripheral coldness - tremor
    - **Frequency not known** Anaphylactoid reaction - hypersensitivity vasculitis - hypoxia
  - **SIDE-EFFECTS, FURTHER INFORMATION** Infusion-related reactions; manage by slowing the infusion rate, or minimise by pre-treatment with an antihistamine, antipyretic, or corticosteroid — consult product literature.
  - **PREGNANCY** Use with caution.
  - **BREAST FEEDING** Use with caution — no information available.
  - **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion, given intermittently in Sodium Chloride 0.9%, reconstitute initially with Water for Injections (5 mg in 1.1 mL, 35 mg in 7.2 mL) to produce a solution containing 5 mg/mL. Dilute with Sodium Chloride 0.9% (for doses less than 35 mg dilute with at least 50 mL; doses 35 – 70 mg dilute with at least 100 mL; doses 70 – 100 mg dilute with at least 250 mL; doses greater than 100 mg dilute with 500 mL) and give through an in-line low protein-binding 0.2 micron filter at an initial rate of no more than 15 mg/hour; for subsequent infusions, infusion rate may be increased gradually once tolerance has been established.
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Powder for solution for infusion**
  - **Fabrazyme** (Genzyme Therapeutics Ltd)
    - Agalsidase beta 5 mg Fabrazyme 5mg powder for solution for infusion vials | 1 vial £315.08
    - Agalsidase beta 35 mg Fabrazyme 35mg powder for solution for infusion vials | 1 vial £2,196.59
3.5 Gaucher’s disease

**Other drugs used for Gaucher’s disease** Migalastat, p. 633

### ENZYMES

#### Imiglucerase

**DRUG ACTION** Imiglucerase is an enzyme produced by recombinant DNA technology that is administered as enzyme replacement therapy for non-neurological manifestations of type I or type III Gaucher’s disease, a familial disorder affecting principally the liver, spleen, bone marrow, and lymph nodes.

#### Indications and dose

**Gaucher’s disease type I (specialist use only)**

- **By intravenous infusion**
  - Neonate: Initially 60 units/kg every 2 weeks, adjusted according to response, doses as low as 30 units/kg once every 2 weeks may be appropriate.
  - Child: Initially 60 units/kg every 2 weeks, adjusted according to response, doses as low as 30 units/kg once every 2 weeks may be appropriate

**Gaucher’s disease type III (specialist use only)**

- **By intravenous infusion**
  - Neonate: Initially 60–120 units/kg every 2 weeks, adjusted according to response.
  - Child: Initially 60–120 units/kg every 2 weeks, adjusted according to response

#### Side-effects

- **Common or very common** Angioedema - cough - dyspnoea - hypersensitivity - skin reactions
- **Uncommon** Abdominal cramps - arthralgia - back pain - chest discomfort - chills - cyanosis - diarrhoea - dizziness - fatigue - fever - flushing - headache - hypotension - nausea - paraesthesia - tachycardia - vomiting
- **Pregnancy** Manufacturer advises use with caution - limited information available.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

Migalastat for treating Fabry disease (February 2017) NICE HS74

Migalastat is recommended, within its marketing authorisation, as an option for treating Fabry disease in people over 16 years of age with an amenable mutation, only if migalastat is provided with the discount agreed in the patient access scheme, and only if enzyme replacement therapy would otherwise be offered.

www.nice.org.uk/guidance/hst4

**Scottish Medicines Consortium (SMC) decisions**

The Scottish Medicines Consortium (November 2016) has advised that migalastat (Galafold®) is accepted for restricted use within NHS Scotland for long-term treatment of adults and adolescents aged 16 years and older with a confirmed diagnosis of Fabry disease (α-galactosidase A deficiency) and who have an amenable mutation—consult SMC advice for full details of restriction.

#### MEDICINAL FORMS

**There can be variation in the licensing of different medicines containing the same drug.**

**Capsule**

- **Galafold (Amicus Therapeutics UK Ltd)**
- **Migalastat (as Migalastat hydrochloride)** 123 mg Galafold 123mg capsules | 14 capsule | £16,153.85
**Velaglucerase alfa**

**DRUG ACTION** Velaglucerase alfa is an enzyme produced by recombinant DNA technology that is administered as enzyme replacement therapy for the treatment of type I Gaucher’s disease.

**INDICATIONS AND DOSE**

**Type I Gaucher’s disease (specialist use only)**
- **BY INTRAVENOUS INFUSION**
  - Child 4–17 years: Initially 60 units/kg every 2 weeks; adjusted according to response to 15–60 units/kg every 2 weeks

**SIDE-EFFECTS, FURTHER INFORMATION** Infusion-related reactions are very common; manage by slowing the infusion rate, or interrupting the infusion, or minimise by pre-treatment with an antihistamine, antipyretic, or corticosteroid—consult product literature.

**PREGNANCY** Manufacturer advises use with caution—limited information available.

**BREAST FEEDING** Manufacturer advises use with caution—no information available.

**MONITORING REQUIREMENTS** Monitor plasma-methionine concentration before and during treatment—interrupt treatment if symptoms of cerebral oedema occur.

**DIRECTIONS FOR ADMINISTRATION** Powder should be mixed with water, juice, milk, formula, or food until completely dissolved and taken immediately; measuring spoons are provided to measure 1 g, 150 mg, and 100 mg of Cystadane® powder.

**PRESCRIBING AND DISPENSING INFORMATION** Betaine should be used in conjunction with dietary restrictions and may be given with supplements of Vitamin B₁₂, pyridoxine, and folate under specialist advice.

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

SMC No. 407/07

The Scottish Medicines Consortium has advised (August 2010) that betaine anhydrous (Cystadane®) is accepted for restricted use within NHS Scotland for the adjunctive treatment of homocystinuria involving deficiencies or defects in cystathionine beta-synthase, 5,10-methylene-tetrahydrofolate reductase, or cobalamin cofactor metabolism in patients who are not responsive to pyridoxine treatment.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral solution

**Powder for solution for infusion**

**ELECTROLYTES** May contain Sodium
- **VPRIV (Shire Pharmaceuticals Ltd)**

| Velaglucerase alfa 400 unit VPRIV 400 units powder for solution for infusion vials | 1 vial | £1,410.20 |

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**3.6 Homocystinuria**

**METHYL DONORS**

**Betaine**

**INDICATIONS AND DOSE**

Adjuvantive treatment of homocystinuria involving deficiencies or defects in cystathionine beta-synthase, 5,10-methylene-tetrahydrofolate reductase, or cobalamin cofactor metabolism (specialist use only)
- **BY MOUTH**
  - Neonate: Initially 50 mg/kg twice daily (max. per dose 75 mg/kg), adjusted according to response; maximum 150 mg/kg per day.
  - Child 1 month–9 years: Initially 50 mg/kg twice daily (max. per dose 75 mg/kg), adjusted according to response; maximum 150 mg/kg per day.
  - Child 10–17 years: 3 g twice daily (max. per dose 10 g), adjusted according to response; maximum 20 g per day

**SIDE-EFFECTS**

- Uncommon Abdominal discomfort, agitation, alopecia, appetite decreased, brain oedema, diarrhoea, glossitis, irritability, nausea, skin reactions, urinary incontinence, vomiting
- **PREGNANCY** Manufacturer advises avoid unless essential—limited information available.
- **BREAST FEEDING** Manufacturer advises caution—no information available.
- **MONITORING REQUIREMENTS** Monitor plasma-methionine concentration before and during treatment—interrupt treatment if symptoms of cerebral oedema occur.
- **DIRECTIONS FOR ADMINISTRATION** Powder should be mixed with water, juice, milk, formula, or food until completely dissolved and taken immediately; measuring spoons are provided to measure 1 g, 150 mg, and 100 mg of Cystadane® powder.

**ENZYMES**

**Asfotase alfa**

**DRUG ACTION** Asfotase alfa is a human recombinant tissue-nonspecific alkaline phosphatase that promotes mineralisation of the skeleton.

**INDICATIONS AND DOSE**

Paediatric-onset hypophosphatasia (initiated by a specialist)
- **BY SUBCUTANEOUS INJECTION**
  - Neonate: 2 mg/kg 3 times a week, alternatively 1 mg/kg 6 times a week, dosing frequency depends on body-weight—consult product literature for further information.
  - Child: 2 mg/kg 3 times a week, alternatively 1 mg/kg 6 times a week, dosing frequency depends on body-weight—consult product literature for further information

**CAUTIONS** Hypersensitivity reactions

**FURTHER INFORMATION**

Reactions, including signs and symptoms consistent with anaphylaxis, have occurred within minutes of administration and can occur in patients.
on treatment for more than one year; if these reactions occur, manufacturer advises immediate discontinuation of treatment and initiation of appropriate medical treatment. For information on re-administration, consult product literature.

- **SIDE-EFFECTS**
  - Common or very common: Bruising tendency - chills - cutis laxa - fever - headache - hypersensitivity - irritability - lipohypertrophy - myalgia - nausea - oral hypoaesthesia - pain - skin reactions - vasodilatation

SIDE-EFFECTS, FURTHER INFORMATION: Injection-site reactions including hypertrophy, induration, skin discoloration, and cellulitis may occur, particularly in patients receiving treatment 6 times a week. Manufacturer advises rotation of injection sites to manage these reactions; interrupt treatment if severe reactions occur and administer appropriate medical therapy.

- **PREGNANCY**
  - Manufacturer advises avoid—no information available.

- **BREAST FEEDING**
  - Manufacturer advises avoid—no information available.

- **MONITORING REQUIREMENTS**
  - Manufacturer advises monitor serum parathyroid hormone and calcium concentrations—supplements of calcium and oral vitamin D may be required.
  - Manufacturer advises periodic ophthalmological examination and renal ultrasounds.
  - Manufacturer advises monitor for increased intracranial pressure (including fundoscopy for signs of papilloedema) periodically in patients below 5 years of age—prompt intervention required if increased intracranial pressure develops.

- **DIRECTIONS FOR ADMINISTRATION**
  - Manufacturer advises max. 1 mL per injection site; administer multiple injections if more than 1 mL is required—consult product literature.

- **HANDLING AND STORAGE**
  - Manufacturer advises store in a refrigerator (2–8 °C).

- **PATIENT AND CARER ADVICE**
  - Injection guides: The manufacturer has produced injection guides for patients and carers to support training given by health care professionals.

- **NATIONAL FUNDING/ACCESS DECISIONS**

- **NICE decisions**
  - Asfotase alfa for treating paediatric-onset hypophosphatasia (August 2017) NICE HST6
    - Asfotase alfa is recommended as an option for treating paediatric-onset hypophosphatasia only:
      - for people who meet the criteria for treatment within the managed access arrangement (see section 4.18 of the guidance), and
      - for the duration of this arrangement and in line with the other conditions it specifies, and
      - when the manufacturer provides asfotase alfa with the confidential commercial terms agreed with NHS England.
    - Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

 www.nice.org.uk/guidance/HST6

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution, oral drops

- **Tablet**
  - Ubidecarenone (Non-proprietary)
    - Ubidecarenone 30 mg | Co-enzyme Q10 30mg tablets | 30 tablet £7.23 | 90 tablet £20.16

- **Oral drops**
  - Ubicor (Imported (Italy))
    - Ubidecarenone 5 mg per 1 ml | Ubicor 5mg/ml oral drops | 10 ml £20.24 [%]

- **Chewable tablet**
  - Ubidecarenone (Non-proprietary)
    - Ubidecarenone 25 mg | Coenzyme Q10 25mg chewable tablets sugar-free | 250 tablet £22.94 [%]

- **Capsule**
  - BioActive Q10 Uniquinol (Pharma Nord (UK) Ltd)
    - Ubidecarenone 30 mg | BioActive Q10 Uniquinol 30mg capsules | 60 capsule £11.06 | 150 capsule £22.11
    - Ubidecarenone 100 mg | BioActive Q10 Uniquinol 100mg capsules | 60 capsule £29.23 | 150 capsule £53.14

  - Super Bio-Quinone (Pharma Nord (UK) Ltd)
    - Ubidecarenone 30 mg | Super Bio-Quinone Q10 30mg capsules | 30 capsule £4.96 | 60 capsule £9.73 | 150 capsule £17.71

3.8 Mitochondrial disorders

**VITAMINS AND TRACE ELEMENTS**

- **Ubidecarenone**
  - (Ubiquinone; Co-enzyme Q10)

- **INDICATIONS AND DOSE**
  - Mitochondrial disorders
    - **BY MOUTH**
      - Neonate: Initially 5 mg 1–2 times a day, adjusted according to response, dose too be taken with food, increased if necessary up to 200 mg daily.
      - Child: Initially 5 mg 1–2 times a day, adjusted according to response, dose to be taken with food, increased if necessary up to 300 mg daily

- **UNLICENSED USE**
  - Not licensed.

- **CAUTIONS**
  - May reduce insulin requirement in diabetes mellitus

- **SIDE-EFFECTS**
  - Common or very common: Diarrhoea - dyspepsia - nausea
  - Rare or very rare: Agitation - dizziness - headache - irritability

- **HEPATIC IMPAIRMENT**
  - Dose adjustments: Reduce dose in moderate and severe impairment.

- **PATIENT AND CARER ADVICE**

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution, oral drops
3.9 Mucopolysaccharidosis

ENZYMES

Elosulfase alfa

**DRUG ACTION** Elosulfase alfa is an enzyme produced by recombinant DNA technology that provides replacement therapy in conditions caused by N-acetylgalactosamine-6-sulfatase (GALNS) deficiency.

- **INDICATIONS AND DOSE**
  - **Mucopolysaccharidosis IVA (specialist use only)**
    - By intravenous infusion
    - Neonate: 2 mg/kg once weekly.
  - Child: 2 mg/kg once weekly

- **CAUTIONS** Infusion-related reactions
  - Infusion-related reactions may occur; manufacturer advises these may be minimised by pre-treatment with an antihistamine and antipyretic, given 30–60 minutes before treatment. If reaction is severe, stop infusion and start appropriate treatment. Caution and close monitoring is advised during re-administration following a severe reaction.

- **SIDE-EFFECTS**
  - Common or very common: Abdominal pain, chills, diarrhea, dizziness, dyspnoea, fever, headache, hypersensitivity, infusion-related reaction, myalgia, nausea, oropharyngeal pain, vomiting.
  - Pregnancy: Manufacturer advises use only if potential benefit outweighs risk—present in milk in animal studies.
  - Breast feeding: Manufacturer advises use only if necessary, store at 2–8°C for max. 24 hours, followed by up to 24 hours at 23–27°C.

- **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion (Vimizim®), give intermittently in Sodium chloride 0.9%; body-weight under 25 kg, dilute requisite dose to final volume of 100 ml infusion fluid and mix gently, give over 4 hours through in-line filter (0.2 micron) initially at a rate of 3 ml/hour, then increase to a rate of 6 ml/hour after 15 minutes, then increase gradually if tolerated every 15 minutes by 6 ml/hour to max. 36 ml/hour; body-weight 25 kg or over, dilute requisite dose to final volume of 250 ml and mix gently, give over 4 hours through in-line filter (0.2 micron) initially at a rate of 6 ml/hour, then increase to a rate of 12 ml/hour after 15 minutes, then increase gradually if tolerated every 15 minutes by 12 ml/hour to max. 72 ml/hour.

- **HANDLING AND STORAGE** Manufacturer advises store in a refrigerator at 2–8°C. After dilution use immediately or, if necessary, store at 2–8°C for max. 24 hours, followed by up to 24 hours at 23–27°C.

- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks: Manufacturer advises patients and carers should be counselled about the effects on driving and performance of skilled tasks—increased risk of dizziness.

- **NATIONAL FUNDING/ACCESS DECISIONS**

  - Elosulfase alfa for treating mucopolysaccharidosis type Iva (December 2015) NICE HST2
  - Elosulfase alfa, within its marketing authorisation, is recommended for funding for treating mucopolysaccharidosis type IVA (MPS IVA) according to the conditions in the managed access agreement for elosulfase alfa.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Solution for infusion**
  - EXCIPIENTS: May contain Polysorbates, sorbitol
  - ELECTROLYTES: May contain Sodium
  - Vimizim (BioMarin Europe Ltd)

- Elosulfase alfa 1 mg per 1 ml Vimizim 5mg/5ml concentrate for solution for infusion vials | 1 vial (HED) £750.00

Galsulfase

- **DRUG ACTION** Galsulfase is a recombinant form of human N-acetylgalactosamine-4-sulfatase.

- **INDICATIONS AND DOSE**

  - **Mucopolysaccharidosis VI (specialist use only)**
    - By intravenous infusion
    - Child 5–17 years: 1 mg/kg once weekly

- **CAUTIONS** Acute febrile illness (consider delaying treatment) – acute respiratory illness (consider delaying treatment) – infusion-related reactions can occur – respiratory disease.

- **SIDE-EFFECTS** Abdominal pain, apnoea, chest pain, chills, conjunctivitis, corneal opacity, dyspnoea, ear pain, face oedema, hypertension, increased risk of infection, infusion-related reaction, malaise, nasal congestion, reflexes absent, umbilical hernia.

- **SIDE-EFFECTS, FURTHER INFORMATION** Infusion-related reactions often occur, they can be managed by slowing the infusion rate or interrupting the infusion, and can be minimised by pre-treatment with an antihistamine and an antipyretic. Recurrent infusion-related reactions may require pre-treatment with a corticosteroid—consult product literature for details.

- **PREGNANCY** Manufacturer advises avoid unless essential.

- **BREAST FEEDING** Manufacturer advises avoid—no information available.

- **DIRECTIONS FOR ADMINISTRATION** For intravenous infusion, dilute requisite dose with Sodium Chloride 0.9% to a final volume of 250 mL and mix gently; infuse through a 0.2 micron in-line filter; give approx. 2.5% of the total volume over 1 hour, then infuse remaining volume over next 3 hours; if body-weight under 20 kg and at risk of fluid overload, dilute requisite dose in 100 mL Sodium Chloride 0.9% and give over at least 4 hours.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Solution for infusion**
  - Naglazyme (BioMarin Europe Ltd)
  - Galsulfase 1 mg per 1 ml Naglazyme 5mg/5ml solution for infusion vials | 1 vial (HED) £820.00

Idursulfase

- **DRUG ACTION** Idursulfase is an enzyme produced by recombinant DNA technology licensed for long-term replacement therapy in mucopolysaccharidosis II (Hunter syndrome), a lysosomal storage disorder caused by deficiency of iduronate-2-sulfatase.

- **INDICATIONS AND DOSE**

  - **Mucopolysaccharidosis II (specialist use only)**
    - By intravenous infusion
    - Child 5–17 years: 500 micrograms/kg once weekly
**Laronidase**

**Drug Action** Laronidase is an enzyme produced by recombinant DNA technology licensed for long-term replacement therapy in the treatment of non-neurological manifestations of mucopolysaccharidosis I, a lysosomal storage disorder caused by deficiency of alpha-L-iduronidase.

**Indications and Dose**

Non-neurological manifestations of mucopolysaccharidosis I (specialist use only)
- By intravenous infusion
- Child: 100 units/kg once weekly

**Caution** Infusion-related reactions can occur

**Side-Effects**
- Common or very common Abdominal pain, alopecia, anaphylactic reaction, angioedema, chills, cough, diarrhoea, dizziness, dyspnoea, fatigue, fever, flushing, headache, hypotension, influenza, joint disorders, nausea, pain, pallor, paraesthesia, peripheral coldness, respiratory disorders, restlessness, skin reactions, sweat changes, tachycardia, temperature sensation altered, vomiting
- Frequency not known Cyanosis, hypoxia, oedema

**Side-Effects, Further Information** Infusion-related reactions often occur, they can be managed by slowing the infusion rate or interrupting the infusion, and can be minimised by pre-treatment with an antihistamine and an anti-inflammatory. Recurrent infusion-related reactions may require pre-treatment with a corticosteroid—consult product literature for details.

**Pregnancy** Manufacturer advises avoid unless essential—no information available.

**Breast Feeding** Manufacturer advises avoid—no information available.

**Monitoring Requirements** Monitor immunoglobulin G (IgG) antibody concentration.

**Directions for Administration** For intravenous infusion, dilute with Sodium Chloride 0.9%; body-weight under 20 kg, dilute to 100 mL, body-weight over 20 kg dilute to 250 mL; give through in-line filter (0.22 micron) initially at a rate of 2 units/kg/hour then increase gradually every 15 minutes to max. 43 units/kg/hour.

**Medicinal Forms** There can be variation in the licensing of different medicines containing the same drug.

**Solution for Infusion**
- Elaprase (Shire Pharmaceuticals Ltd) £ 1.985.00

**Miglustat**

**Drug Action** Miglustat is an inhibitor of glucosylceramide synthase.

**Indications and Dose**

Treatment of progressive neurological manifestations of Niemann-Pick type C disease (under expert supervision)
- By mouth
  - Child 4-11 years (body surface area up to 0.48 m²): 100 mg once daily
  - Child 4-11 years (body surface area 0.48-0.73 m²): 100 mg twice daily
  - Child 4-11 years (body surface area 0.74-0.88 m²): 100 mg 3 times a day
  - Child 4-11 years (body surface area 0.89-1.25 m²): 200 mg twice daily
  - Child 4-11 years (body surface area 1.26 m² and above): 200 mg 3 times a day
  - Child 12-17 years: 200 mg 3 times a day

**Side-Effects**
- Common or very common Appetite decreased, asthenia, chills, constipation, depression, diarrhoea, dizziness, flatulence, gastrointestinal discomfort, headache, insomnia, libido decreased, malaise, muscle spasms, muscle weakness, nausea, peripheral neuropathy, sensation abnormal, thrombocytopenia, tremor, vomiting, weight decreased
- Frequency not known Growth retardation

**Conception and Contraception** Effective contraception must be used during treatment. Men should avoid fathering a child during and for 3 months after treatment.

**Pregnancy** Manufacturer advises avoid—toxicity in animal studies.

**Breast Feeding** Manufacturer advises avoid—no information available.

**Hepatic Impairment** Manufacturer advises caution (no information available).

**Renal Impairment** Avoid if estimated glomerular filtration less than 30 mL/minute/1.73 m². Child under 12 years—consult product literature.
DIRECTIONS FOR ADMINISTRATION

Monitor immunoglobulin G (IgG) antibody concentration.
▶ Monitor closely if respiratory dysfunction.
▶ Monitor closely if cardiac dysfunction.

MONITORING REQUIREMENTS

> Monitor cognitive and neurological function.
> Monitor growth and platelet count in Niemann–Pick type C disease.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Capsule

Zavesca (Actelion Pharmaceuticals UK Ltd)
Miglustat 100 mg Zavesca 100 mg capsules | 84 capsule (POM) £3,934.17 (Hospital only)

BREAST FEEDING

SIDE-EFFECTS

Cluster headache. Hypersensitivity reactions: flushing, skin reactions, dyspnoea, rhinitis, rash, fever, vomiting.

CAUTIONS

Cardiac dysfunction, infusion-related reactions—consult product literature.

ENZYMES

3.11 Pompe disease

Alglucosidase alfa

DRUG ACTION

Alglucosidase alfa is an enzyme produced by recombinant DNA technology licensed for long-term replacement therapy in Pompe disease, a lysosomal storage disorder caused by deficiency of acid alpha-glucosidase.

INDICATIONS AND DOSE

Pompe disease (specialist use only)
▶ BY INTRAVENOUS INFUSION

Neonate: 20 mg/kg every 2 weeks.
Child: 20 mg/kg every 2 weeks

CAUTIONS

Cardiac dysfunction, infusion-related reactions—consult product literature.

SIDE-EFFECTS

Common or very common

Anxiety, arthralgia, chest discomfort, chill, cough, cyanosis, diarrhea, dizziness, fatigue, feeling hot, fever, flushing, hyperhidrosis, hypotension, irritability, local swelling, muscle complaints, nausea, oedema, pallor, paraesthesia, respiratory disorders, skin reactions, throat complaints, tremor, vomiting.

Frequency not known

Abdominal pain, angioedema, apnoea, arthralgia, cardiac arrest, dyspnoea, excessive tearing, eye inflammation, eye pain, granulocytopenia, leucopenia, photophobia, thrombocytopenia.

INTERACTIONS

Further information

Infusion-related reactions are very common, calling for use of antihistamine, antipyretic, or corticosteroid; consult product literature for details.

PREGNANCY

Toxicity in animal studies, but treatment should not be withheld.

BREAST FEEDING

Manufacturer advises avoid—no information available.

MONITORING REQUIREMENTS

Monitor closely if cardiac dysfunction.
Monitor closely if respiratory dysfunction.
Monitor immunoglobulin G (IgG) antibody concentration.

DIRECTIONS FOR ADMINISTRATION

For intravenous infusion, reconstitute 50 mg with 10.3 mL water for injections to produce 5 mg/mL solution; gently rotate vial without shaking; dilute requisite dose with Sodium Chloride 0.9% to give a final concentration of 0.5–4 mg/mL; give through a low protein-binding in-line filter (0.2 micron) at an initial rate of 1 mg/kg/hour increased by 2 mg/kg/hour every 30 minutes to max. 7 mg/kg/hour.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for infusion

Myozyme (Genzyme Therapeutics Ltd)
Alglucosidase alfa 50 mg Myozyme 50 mg powder for concentrate for solution for infusion vials | 1 vial (POM) £356.06 (Hospital only)

3.12 Tyrosinaemia type I

ENZYME INHIBITORS

4-HYDROXYPHENYLPYRUVATE DIOXYGENASE INHIBITORS

Nitisinone (NTBC)

INDICATIONS AND DOSE

Hereditary tyrosinaemia type I (in combination with dietary restriction of tyrosine and phenylalanine) (specialist use only)
▶ BY MOUTH

Neonate: Initially 500 micrograms/kg twice daily, adjusted according to response; maximum 2 mg/kg per day.
Child: Initially 500 micrograms/kg twice daily, adjusted according to response; maximum 2 mg/kg per day.

INTERACTIONS

Appendix 1: nitisinone

SIDE-EFFECTS

Common or very common

Corneal opacity, eye inflammation, eye pain, granulocytopenia, leucopenia, photophobia, thrombocytopenia.

Uncommon

Leucocytosis, skin reactions.

PREGNANCY

Manufacturer advises avoid unless potential benefit outweighs risk—toxicity in animal studies.

BREAST FEEDING

Manufacturer advises avoid—adverse effects in animal studies.

PRE-TREATMENT SCREENING

Slit-lamp examination of eyes recommended before treatment.

MONITORING REQUIREMENTS

Monitor liver function regularly.

DIRECTIONS FOR ADMINISTRATION

Capsules can be opened and the contents suspended in a small amount of water or formula diet and taken immediately.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Orfadin (Swedish Orphan Biovitrum Ltd)
Nitisinone 2 mg Nitisinone 2 mg capsules | 60 capsule (POM) £423.00
Nitisinone 5 mg Nitisinone 5 mg capsules | 60 capsule (POM) £845.25
Nitisinone 10 mg Nitisinone 10 mg capsules | 60 capsule (POM) £1,546.50

Orfadin (Swedish Orphan Biovitrum Ltd)
Nitisinone 2 mg Orfadin 2 mg capsules | 60 capsule (POM) £356.00
Nitisinone 5 mg Orfadin 5 mg capsules | 60 capsule (POM) £1,127.00
Nitisinone 10 mg Orfadin 10 mg capsules | 60 capsule (POM) £2,062.00

Nitisinone 20 mg Orfadin 20 mg capsules | 60 capsule (POM) £4,512.00
3.13 Urea cycle disorders

**AMINO ACIDS AND DERIVATIVES**

<table>
<thead>
<tr>
<th>Arginine</th>
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<td><strong>INDICATIONS AND DOSE</strong></td>
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| Acute hyperammonaemia in carbamylphosphate synthetase deficiency (specialist use only) / Acute hyperammonaemia in ornithine transcarbamylase deficiency (specialist use only)  
**BY INTRAVENOUS INFUSION** |
| Neonate: 6 mg/kg/hour. |
| Child (body-weight up to 40 kg): 6 mg/kg/hour |
| Child (body-weight 40 kg and above): 4 mg/kg/hour |
| Maintenance treatment of hyperammonaemia in carbamylphosphate synthetase deficiency (specialist use only) / Maintenance treatment of hyperammonaemia in ornithine transcarbamylase deficiency (specialist use only)  
**BY MOUTH** |
| Neonate: 100–200 mg/kg daily in 3–4 divided doses, dose to be taken with feeds. |
| Child (body-weight up to 20 kg): 100–200 mg/kg daily in 3–4 divided doses, dose to be given with feeds or meals |
| Child (body-weight 20 kg and above): 2.5–6 g/m² daily in 3–4 divided doses, dose to be taken with meals; maximum 6 g per day |
| Acute hyperammonaemia in citrullinaemia (specialist use only) / Acute hyperammonaemia in arginosuccinic aciduria (specialist use only)  
**BY INTRAVENOUS INFUSION** |
| Neonate: Initially 300 mg/kg, to be administered over 90 minutes, followed by 12.5 mg/kg/hour, to be administered over 24 hours (maximum 25 mg/kg/hour thereafter). |
| Child (body-weight up to 40 kg): Initially 300 mg/kg, to be administered over 90 minutes, followed by 12.5 mg/kg/hour, to be administered over 24 hours (maximum 25 mg/kg/hour thereafter) |
| Child (body-weight 40 kg and above): 21 mg/kg/hour |
| Maintenance treatment of hyperammonaemia in citrullinaemia (specialist use only) / Maintenance treatment of hyperammonaemia in arginosuccinic aciduria (specialist use only)  
**BY MOUTH** |
| Neonate: 100–300 mg/kg daily in 3–4 divided doses, dose to be taken with feeds. |
| Child (body-weight up to 20 kg): 100–300 mg/kg daily in 3–4 divided doses, dose to be taken with feed or meals |
| Child (body-weight 20 kg and above): 2.5–6 g/m² daily in 3–4 divided doses, dose to be taken with meals; maximum 6 g per day |
| **CONTRA-INDICATIONS** Not to be used in the treatment of arginase deficiency |
| **SIDE-EFFECTS** Acidosis hyperchloraemic - flushing, headache, hypotension, nausea, numbness, vomiting |
| **PREGNANCY** No information available. |
| **BREAST FEEDING** No information available. |
| **MONITORING REQUIREMENTS** Monitor plasma pH and chloride. |

**DIRECTIONS FOR ADMINISTRATION** For intravenous infusion, dilute to a max. concentration of 50 mg/mL with glucose 10%.

**PRESCRIBING AND DISPENSING INFORMATION** Powder to be prescribed as a borderline substance (ACBS). For use as a supplement in urea cycle disorders other than arginase deficiency, such as hyperammonaemia types I and II, citrullinaemia, arginosuccinic aciduria, and deficiency of N-acetyl glutamate synthetase.

**PATIENT AND CARER ADVICE** Medicines for Children leaflet: Arginine for urea cycle disorders  
www.medicinesforchildren.org.uk/arginine-urea-cycle-disorders-0

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral solution, solution for infusion

- **Tablet**  
  - Arginine (Non-proprietary)  
  - L-Arginine 500 mg / L-Arginine 500 mg tablets | 60 tablet £3.86  
  - L-Arginine 1 gram / L-Arginine 1 g tablets | 90 tablet £11.59

- **Solution for infusion**  
  - Arginine (Non-proprietary)  
  - L-Arginine monohydrochloride 210.7 mg per 1 ml / L-Arginine-Hydrochlorid 21% concentrate for solution for infusion 20ml ampoules | 5 ampoule €0.81

- **Capsule**  
  - Arginine (Non-proprietary)  
  - L-Arginine 500 mg / L-Arginine 500 mg capsules | 30 capsule £4.02

- **Powder**  
  - Arginine (Non-proprietary)  
  - L-Arginine 1 gram per 1 gram / L-Arginine powder | 100 gram £45.81

---

<table>
<thead>
<tr>
<th>Carglumic acid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDICATIONS AND DOSE</strong></td>
</tr>
</tbody>
</table>
| Hyperammonaemia due to N-acetylglutamate synthase deficiency (under expert supervision)  
**BY MOUTH** |
| Neonate: Initially 50–125 mg/kg twice daily, to be taken immediately before feeds, dose adjusted according to plasma–ammonia concentration; maintenance 5–50 mg/kg twice daily, the total daily dose may alternatively be given in 3–4 divided doses |
| Child: Initially 50–125 mg/kg twice daily, to be taken immediately before food, dose adjusted according to plasma–ammonia concentration; maintenance 5–50 mg/kg twice daily, the total daily dose may alternatively be given in 3–4 divided doses |

**Hyperammonaemia due to organic aciduria (under expert supervision)  
**BY MOUTH** |
| Neonate: Initially 50–125 mg/kg twice daily, to be taken immediately before feeds, dose adjusted according to plasma–ammonia concentration; the total daily dose may alternatively be given in 3–4 divided doses |
| Child: Initially 50–125 mg/kg twice daily, to be taken immediately before food, dose adjusted according to plasma–ammonia concentration; the total daily dose may alternatively be given in 3–4 divided doses |

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**IMPORTANT SAFETY INFORMATION**

**EMERGENCY MANAGEMENT OF UREA CYCLE DISORDERS**

For further information on the emergency management of urea cycle disorders consult the British Inherited Metabolic Disease Group (BIMDG) website at www.bimdg.org.uk.
Blood and nutrition

BENZOATES

Sodium benzoate

- **INDICATIONS AND DOSE**
  - **Acute hyperammonaemia due to urea cycle disorder (specialist use only)**
    - **BY INTRAVENOUS INFUSION**
    - Neonate: Initially 250 mg/kg, to be administered over 90 minutes, followed by 10 mg/kg/hour, adjusted according to response.
    - Child: Initially 250 mg/kg, to be administered over 90 minutes, followed by 10 mg/kg/hour, adjusted according to response.

- **SIDE-EFFECTS**
  - **Metabolic acidosis • oxalate metabolism abnormal • polyneuropathy (long term use)**
  - **PREGNANCY** No information available.
  - **BREAST FEEDING** No information available.

- **MEDICINAL FORMS**
  - No licensed medicines listed.
DRUGS FOR METABOLIC DISORDERS > AMMONIA LOWERING DRUGS

Glycerol phenylbutyrate 13-Sep-2018

- **DRUG ACTION** Glycerol phenylbutyrate is a nitrogen-binding agent that provides an alternative vehicle for waste nitrogen excretion.

- **INDICATIONS AND DOSE**

  **Urea cycle disorders (specialist use only)**
  - **BY MOUTH, OR BY GASTROSTOMY TUBE, OR BY NASOGASTRIC TUBE**

  **Neonate (body surface area up to 1.3 m²):** Initially 9.4 g/m² daily in divided doses, usual maintenance 5.3–12.4 g/m² daily in divided doses, each dose should be rounded up to the nearest 0.1 mL and given with each feed. For dose adjustments based on individual requirements—consult product literature.

  **Child 1–2 years (body surface area up to 1.3 m²):** Initially 9.4 g/m² daily in divided doses, usual maintenance 5.3–12.4 g/m² daily in divided doses, each dose should be rounded up to the nearest 0.5 mL and given with each meal. For dose adjustments based on individual requirements—consult product literature.

  **Child 2–7 years (body surface area 1.3 m² and above):** Initially 9.4 g/m² daily in divided doses, usual maintenance 5.3–12.4 g/m² daily in divided doses, each dose should be rounded up to the nearest 0.5 mL and given with each meal. For dose adjustments based on individual requirements—consult product literature.

  **DOSE EQUIVALENCE AND CONVERSION**

  - 1 mL of liquid contains 1.1 g of glycerol phenylbutyrate.
  - For patients switching from sodium phenylbutyrate or sodium benzoate—consult product literature.

- **IMPORTANT SAFETY INFORMATION**

  **EMERGENCY MANAGEMENT OF UREA CYCLE DISORDERS**
  For further information on the emergency management of urea cycle disorders consult the British Inherited Metabolic Disease Group (BIMDG) website at www.bimdorg.org.uk.

- **CONTRA-INDICATIONS** Treatment of acute hyperammonaemia

- **CAUTIONS** Intestinal malabsorption • pancreatic insufficiency

- **INTERACTIONS** → Appendix 1: glycerol phenylbutyrate

- **SIDE-EFFECTS**
  - **Common or very common** Appetite abnormal • constipation • diarrhoea • dizziness • fatigue • food aversion • gastrointestinal discomfort • gastrointestinal disorders • headache • menstrual cycle irregularities • nausea • oral disorders • peripheral oedema • skin reactions • tremor • vomiting
  - **Uncommon** Akathisia • alopecia • biliary colic • bladder pain • burping • confusion • depressed mood • drowsiness • dry mouth • dysphonia • epistaxis • fever • gastrointestinal infection viral • hot flush • hyperhidrosis • hypoaluminaemia • hypokalaemia • hypothyroidism • joint swelling • muscle spasms • nasal congestion • oropharyngeal pain • pain • paraesthesia • plantar fasciitis • speech disorder • taste altered • throat irritation • ventricular arrhythmia • weight changes
  - **Frequency not known** Anaemia • nail ridging • thrombocytosis

- **PREGNANCY** Manufacturer advises avoid unless essential—toxicity in animal studies.

- **BREAST FEEDING** Manufacturer advises avoid—no information available.

- **HEPATIC IMPAIRMENT** Manufacturer advises caution (risk of increased exposure).

- **DIRECTIONS FOR ADMINISTRATION** Manufacturer advises may be added to a small amount of apple sauce, ketchup, or squash puree and used within 2 hours. For administration advice via nasogastric or gastrostomy tube—consult product literature.

- **HANDLING AND STORAGE** Manufacturer advises discard contents of bottle 14 days after opening.

- **PATIENT AND CARER ADVICE**

  **Driving and skilled tasks** Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness.

- **NATIONAL FUNDING/ACCESS DECISIONS**

  **Scottish Medicines Consortium (SMC) decisions**

  SMC No. 1342/18
  The Scottish Medicines Consortium has advised (August 2018) that glycerol phenylbutyrate (Ravicti®) is accepted for use within NHS Scotland as an adjunctive therapy for chronic management of adult and paediatric patients aged 2 months and older with urea cycle disorders who cannot be managed by dietary protein restriction and or amino acid supplementation alone. Glycerol phenylbutyrate must be used with dietary protein restriction and, in some cases, dietary supplements. This advice is contingent upon the continuing availability of the patient access scheme in NHS Scotland or a list price that is equivalent or lower.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  **Liquid**
  - Ravicti (Swedish Orphan Biovitrum Ltd) ➤
  - Glycerol phenylbutyrate 1.1 gram per 1 ml
  - Ravicti 1.1g/ml oral liquid | 25 ml [Pos] £61.00

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**Sodium phenylbutyrate**

- **INDICATIONS AND DOSE**

  **Acute hyperammonaemia due to urea cycle disorders (specialist use only)**
  - **BY INTRAVENOUS INFUSION**

  - **Neonate:** Initially 250 mg/kg, to be administered over 90 minutes, followed by 10 mg/kg/hour, adjusted according to response.

  - **Child:** Initially 250 mg/kg, to be administered over 90 minutes, followed by 10 mg/kg/hour, adjusted according to response

  **Maintenance treatment of hyperammonaemia due to urea cycle disorders (specialist use only)**
  - **BY MOUTH**

  - **Neonate:** Up to 250 mg/kg daily in 3–4 divided doses, with feeds.

  - **Child (body-weight up to 20 kg):** Up to 250 mg/kg daily in 3–4 divided doses, with feeds or meals

  - **Child (body-weight 20 kg and above):** 5 g/m² daily in 3–4 divided doses, with meals; maximum 12 g per day
3.14 Wilson’s disease

Other drugs used for Wilson’s disease Penicillamine, p. 639

ANTIDOTES AND CHELATORS > COPPER ABSORPTION INHIBITORS

Zinc acetate

• DRUG ACTION Zinc prevents the absorption of copper in Wilson’s disease.

• INDICATIONS AND DOSE
  Wilson’s disease (initiated under specialist supervision)
  • BY MOUTH
    • Child 1-5 years: 25 mg twice daily
    • Child 6-15 years (body-weight up to 57 kg): 25 mg 3 times a day
    • Child 6-15 years (body-weight 57 kg and above): 50 mg 3 times a day
    • Child 16-17 years: 50 mg 3 times a day
  DOSE EQUIVALENCE AND CONVERSION
  • Doses expressed as elemental zinc.

• PHARMACOKINETICS
  • Symptomatic Wilson’s disease patients should be treated initially with a chelating agent because zinc has a slow onset of action. When transferring from chelating treatment to zinc maintenance therapy, chelating treatment should be co-administered for 2–3 weeks until zinc produces its maximal effect.

• CAUTIONS
  • Portal hypertension (risk of hepatic decompensation when switching from chelating agent)
  • Drug interactions: copper absorption

• SIDE-EFFECTS
  • Common or very common
    • Epigastric discomfort (usually transient)
  • Uncommon
    • Leucopenia

• CAUTIONARY AND ADVISORY LABELS
  • Zinc prevents the absorption of copper in Wilson’s disease.

• MEDICAL FORMS
  • There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, solution for infusion
  • Granules
    • Ammonaps (Swedish Orphan Biovitrum Ltd)
      Sodium phenylbutyrate 940 mg per 1 gram Ammonaps 940mg/g granules sugar-free | 266 gram | £860.00 D + £860.00
    • Pheburane (Lucane Pharma Ltd)
      Sodium phenylbutyrate 483 mg per 1 gram Pheburane 483mg/g granules | 174 gram | £331.00
  • Tablet
    • Ammonaps (Swedish Orphan Biovitrum Ltd)
      Sodium phenylbutyrate 500 mg Ammonaps 500mg tablets | 250 tablet | £493.00 D + £493.00
  • Capsule
    • CAUTIONARY AND ADVISORY LABELS 23
      • Wilzin (Recordati Rare Diseases UK Ltd)
        Zinc (as Zinc acetate) 25 mg Wilzin 25mg capsules | 250 capsule | £132.00
        Zinc (as Zinc acetate) 50 mg Wilzin 50mg capsules | 250 capsule | £242.00
Penicillamine

**Drug Action** Penicillamine aids the elimination of copper ions in Wilson's disease (hepatolenticular degeneration).

**Indications and Dose**

**Wilson's disease**
- **By Mouth**
  - Child 1 month–11 years: 20 mg/kg daily in 2–3 divided doses, to be taken 1 hour before food; maximum 2 g per day
  - Child 12–17 years: Initially 20 mg/kg daily in 2–3 divided doses, maintenance 0.75–1 g daily, to be taken 1 hour before food; maximum 2 g per day

**Cystinuria**
- **By Mouth**
  - Child: 20–30 mg/kg daily in 2–3 divided doses, lower doses may be used initially and increased gradually, doses to be adjusted to maintain 24-hour urinary cystine below 1 mmol/litre, maintain adequate fluid intake, to be taken 1 hour before food; maximum 3 g per day

**Contra-Indications** Lupus erythematosus

**Side-Effects**
- Common or very common: Proteinuria, thrombocytopenia
- Rare or very rare: Alopecia, breast enlargement (males and females), connective tissue disorders, haematuria (discontinue immediately if cause unknown), hypersensitivity, oral disorders, skin reactions
- Frequency not known: Agranulocytosis, aplastic anaemia, appetite decreased, fever, glomerulonephritis, Goodpasture's syndrome, haemolytic anaemia, increased risk of infection, jaundice, cholestatic, leucopenia, lupus-like syndrome, myasthenia gravis, nausea, nephrotic syndrome, neurological deterioration in Wilson's disease, neutropenia, pancreatitis, polymyositis, pulmonary haemorrhage, rash (consider dose reduction), respiratory disorders, Stevens-Johnson syndrome, taste loss (mineral deficiency in Wilson's disease), taste changes, vomiting, yellow nail syndrome

**Allergy and Cross-Sensitivity** Patients who are hypersensitive to penicillin may react rarely to penicillamine.

**Pregnancy** Fetal abnormalities reported rarely; avoid if possible.

**Breast Feeding** Manufacturer advises avoid unless potential benefit outweighs risk—no information available.

**Renal Impairment**
- Dose adjustments: Reduce dose and monitor renal function or avoid (consult product literature).

**Monitoring Requirements**
- Consider withdrawal if platelet count falls below 120 000/mm³ or white blood cells below 2500/mm³ or if 3 successive falls within reference range (can restart at reduced dose when counts return to within reference range but permanent withdrawal necessary if recurrence of leucopenia or thrombocytopenia).
- Monitor urine for proteinuria.
- Monitor blood and platelet count regularly.

**Patient and Carer Advice** Counselling on the symptoms of blood disorders is advised. Warn patient and carers to tell doctor immediately if sore throat, fever, infection, non-specific illness, unexplained bleeding and bruising, purpura, mouth ulcers, or rashes develop.

**Medicinal Forms**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

**Tablet**
- **Cautionary and Advisory Labels**: 6, 22
  - Penicillamine (Non-proprietary)
    - Penicillamine 125 mg: Penicillamine 125 mg tablets | 56 tablet 🇬🇧 £6.00 DT = £4.00
    - Penicillamine 250 mg: Penicillamine 250 mg tablets | 56 tablet 🇬🇧 £6.67 DT = £4.88

**Trientine dihydrochloride**

**Indications and Dose**

**Wilson's disease in patients intolerant of penicillamine**
- **By Mouth**
  - Child 2–11 years: Initially 0.6–1.5 g daily in 2–4 divided doses, adjusted according to response, to be taken before food
  - Child 12–17 years: 1.2–2.4 g daily in 2–4 divided doses, adjusted according to response, to be taken before food

**Interactions** → Appendix 1: trientine

**Side-Effects**
- Rare or very rare: Anaemia
- Frequency not known: Gastrointestinal disorders, nausea, neurological deterioration in Wilson's disease, rash

**Pregnancy** Teratogenic in animal studies—use only if benefit outweighs risk.
- Monitoring: Monitor maternal and neonatal serum-copper concentrations.

**Prescribing and Dispensing Information** Trientine is not an alternative to penicillamine for rheumatoid arthritis or cystinuria. Penicillamine-induced systemic lupus erythematosus may not resolve on transfer to trientine.

**Medicinal Forms**
- There can be variation in the licensing of different medicines containing the same drug.

**Capsule**
- **Cautionary and Advisory Labels**: 6, 22
  - Trientine dihydrochloride (Non-proprietary)
    - Trientine dihydrochloride 300 mg: Trientine dihydrochloride 300 mg capsules | 100 capsule 🇬🇧 £13.00 DT = £13.00

4 Mineral and trace elements deficiencies

4.1 Zinc deficiency

**Zinc deficiency**

**Overview**
Zinc supplements should not be given unless there is good evidence of deficiency (hypoproteinaemia spuriously lowers plasma zinc concentration) or in zinc-losing conditions. Zinc deficiency can occur as a result of inadequate diet or malabsorption; excessive loss of zinc can occur in trauma, burns, and protein-losing conditions. A zinc supplement is given until clinical improvement occurs, but it may need to be continued in severe malabsorption, metabolic disease, or in zinc-losing states.

Zinc is used in the treatment of Wilson's disease and acrodermatitis enteropathica, a rare inherited abnormality of zinc absorption.
Parenteral nutrition regimens usually include trace amounts of zinc, see also Intravenous nutrition below. If necessary, further zinc can be added to intravenous feeding regimens.

**ELECTROLYTES AND MINERALS > ZINC**

**Zinc sulfate**

- **INDICATIONS AND DOSE**
  - **Zinc deficiency or supplementation in zinc-losing conditions**
    - BY MOUTH USING EFFERVESCENT TABLETS
  - Neonate: 1 mg/kg daily, dose expressed as elemental zinc, to be dissolved in water and taken after food.
  - Child (body-weight up to 10 kg): 22.5 mg daily, dose to be adjusted as necessary, to be dissolved in water and taken after food, dose expressed as elemental zinc.
  - Child (body-weight 10–30 kg): 22.5 mg 1–3 times a day, dose to be adjusted as necessary, to be dissolved in water and taken after food, dose expressed as elemental zinc.
  - Child (body-weight 31 kg and above): 45 mg 1–3 times a day, dose to be adjusted as necessary, to be dissolved in water and taken after food, dose expressed as elemental zinc.
  - **Acrodermatitis enteropathica**
    - BY MOUTH USING EFFERVESCENT TABLETS
    - Neonate: 0.5–1 mg/kg twice daily, dose to be adjusted as necessary, total daily dose may alternatively be given in 3 divided doses, dose expressed as elemental zinc.
    - Child: 0.5–1 mg/kg twice daily, dose to be adjusted as necessary, total daily dose may alternatively be given in 3 divided doses, dose expressed as elemental zinc.

- **UNLICENSED USE** Solvazinc® is not licensed for use in acrodermatitis enteropathica.
- **INTERACTIONS** → Appendix 1: zinc
- **SIDE-EFFECTS** Diarrhoea, gastritis, gastrointestinal discomfort, nausea, vomiting
- **PREGNANCY** Crosses placenta; risk theoretically minimal, but no information available.
- **BREAST FEEDING** Present in milk; risk theoretically minimal, but no information available.
- **RENAL IMPAIRMENT** Accumulation may occur in acute renal failure.
- **PRESCRIBING AND DISPENSING INFORMATION** Each Solvazinc® tablet contains zinc sulfate monohydrate 125 mg (45 mg zinc).

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - Effervescent tablet
  - CAUTIONARY AND ADVISORY LABELS 13, 21
  - Solvazinc® (Galens Ltd)
    - Zinc sulfate monohydrate 125 mg. Solvazinc 125mg effervescent tablets sugar-free | 80 tablet [P] £17.20 DT + £17.20

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### 5 Nutrition (intravenous)

#### Overview

When adequate feeding through the alimentary tract is not possible, nutrients may be given by intravenous infusion. This may be in addition to oral or enteral tube feeding—supplemental parenteral nutrition, or may be the sole source of nutrition—total parenteral nutrition (TPN). Complete enteral starvation is undesirable and total parenteral nutrition is a last resort.

Indications for parenteral nutrition include prematurity; severe or prolonged disorders of the gastro-intestinal tract; preparation of undernourished patients for surgery, chemotherapy, or radiation therapy; major surgery, trauma, or burns; prolonged coma or inability to eat; and some patients with renal or hepatic failure. The composition of proprietary preparations used in children is given under Proprietary Infusion Fluids for Parenteral Feeding p. 641.

Parenteral nutrition requires the use of a solution containing amino acids, glucose, lipids, electrolytes, trace elements, and vitamins. This is now commonly provided by the pharmacy in the form of an amino-acid, glucose, electrolyte bag, and a separate lipid infusion or, in older children a single ‘all-in-one’ bag. If the patient is able to take small amounts by mouth, vitamins may be given orally.

The nutrition solution is infused through a central venous catheter inserted under full surgical precautions.

Alternatively, infusion through a peripheral vein may be used for supplementary as well as total parenteral nutrition, depending on the availability of peripheral veins; factors prolonging cannula life and preventing thrombophlebitis include the use of soft polyurethane paediatric cannulas and use of nutritional solutions of low osmolality and neutral pH. Nutritional fluids should be given by a dedicated intravenous line; if not possible, compatibility with any drugs or fluids should be checked as precipitation of components may occur. Extravasation of parenteral nutrition solution can cause severe tissue damage and injury; the infusion site should be regularly monitored.

Before starting intravenous nutrition the patient should be clinically stable and renal function and acid-base status should be assessed. Appropriate biochemical tests should have been carried out beforehand and serious deficits corrected. Nutritional and electrolyte status must be monitored throughout treatment. The nutritional components of parenteral nutrition regimens are usually increased gradually over a number of days to prevent metabolic complications and to allow metabolic adaptation to the infused nutrients. The solutions are usually infused over 24 hours but this may be gradually reduced if long-term nutrition is required. Home parenteral nutrition is usually infused over 12 hours overnight.

Complications of long-term parenteral nutrition include gall bladder sludging, gall stones, cholestasis and abnormal liver function tests. For details of the prevention and management of parenteral nutrition complications, specialist literature should be consulted.

**Protein** (nitrogen) is given as mixtures of essential and non-essential synthetic L-amino acids. Ideally, all essential amino acids should be included with a wide variety of non-essential ones to provide sufficient nitrogen together with electrolytes. Solutions vary in their composition of amino acids; they often contain an energy source (usually glucose) and electrolytes. Solutions for use in neonates and children under 1 year of age are based on the amino acid profile of umbilical cord blood (Primene®) or breast milk (Vaminolact®) and contain amino acids that are essential in this age group; these amino acids may not be present in sufficient quantities in preparations designed for older children and adults.

**Energy** requirements must be met if amino acids are to be utilised for tissue maintenance. An appropriate energy to protein ratio is essential and requirements will vary depending on the child’s age and condition. A mixture of carbohydrate and fat energy sources (usually 30–50% as fat) gives better utilisation of amino acids than glucose alone.

Glucose p. 611 is the preferred source of carbohydrate, but frequent monitoring of blood glucose is required particularly during initiation and build-up of the regimen; insulin may be necessary. Glucose above a concentration of 12.5% must be
**Proprietary Infusion Fluids for Parenteral Feeding**

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Nitrogen g/litre</th>
<th>1.2 Energy kJ/litre</th>
<th>Electrolytes</th>
<th>Other components/litre</th>
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<tr>
<td>ClinOleic 20% (Baxter Healthcare Ltd)</td>
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</table>

1 1000 kcal = 4200kJ; 1000 kJ = 238.8 kcal. All entries are Prescription-only medicines.
2 Excludes protein- or amino acid-derived energy

Infused through a central venous catheter to avoid thrombosis; the maximum concentration of glucose that should normally be infused in fluid restricted children is 20–25%.

In parenteral nutrition regimens, it is necessary to provide adequate phosphate in order to allow phosphorylation of glucose and to prevent hypophosphataemia. Neonates, particularly preterm neonates, and young children also require phosphorus and calcium to ensure adequate bone mineralisation. The compatibility and solubility of calcium and phosphorus salts is complex and unpredictable; precipitation is a risk and specialist pharmacy advice should be sought.

Fat (lipid) emulsions have the advantages of a high energy to fluid volume ratio, neutral pH, and iso-osmolarity with plasma, and provide essential fatty acids. Several days of adaptation may be required to attain maximal utilisation. Reactions include occasional febrile episodes (usually only with 20% emulsions) and rare anaphylactic responses. Interference with biochemical measurements such as those for blood gases and calcium may occur if samples are taken before fat has been cleared. Regular monitoring of plasma cholesterol and triglyceride is necessary to ensure clearance from the plasma, particularly in conditions where fat metabolism may be disturbed e.g. infection. Emulsions containing 20% or 30% fat should be used in neonates as they are cleared more efficiently. Additives should not be mixed with fat emulsions unless compatibility is known.

Electrolytes are usually provided as the chloride salts of potassium and sodium. Acetate salts can be used to reduce the amount of chloride infused; hyperchloraemic acidosis or hypochloraemic alkalosis can occur in preterm neonates or children with renal impairment.

**Administration**

Because of the complex requirements relating to parenteral nutrition full details relating to administration have been omitted. In all cases specialist pharmacy advice, product literature and other specialist literature should be consulted.
NUTRIENTS > PARENTERAL NUTRITION

Parenteral nutrition supplements

- INDICATIONS AND DOSE
  - Supplement in intravenous nutrition
  - By intravenous infusion, or by slow intravenous injection
  - Child: (consult product literature)

Dipeptiven 20g/100ml concentrate for solution for infusion bottles

Amino acid supplement for hypertensive or hypermetabolic states

- By intravenous infusion
- Child: 300–400 mg/kg daily, dose not to exceed 20% of total amino acid intake

- CAUTIONS
  - Because of the complex requirements relating to parenteral nutrition, full details relating to administration have been omitted. In all cases specialist pharmacy advice, product literature, and other specialist literature should be consulted. Compatibility with the infusion solution must be ascertained before adding supplementary preparations. Additives should not be mixed with fat emulsions unless compatibility is known.

Cernevit solution for injection vials and diluent

 Dilute solution in 5 mL water for injections.

Peditrace solution for infusion 10ml ampoules

Reduced biliary excretion - reduced biliary excretion in cholestatic liver disease - reduced biliary excretion in markedly reduced urinary excretion (careful biochemical monitoring required) - total parenteral nutrition exceeding one month

Cautions, further information

- Total parenteral nutrition exceeding one month. Measure serum manganese concentration and check liver function before commencing treatment and regularly during treatment, discontinue if manganese concentration raised or if cholestasis develops.

- Directions for administration
  - Because of the complex requirements relating to parenteral nutrition, full details relating to administration have been omitted. In all cases specialist pharmacy advice, product literature, and other specialist literature should be consulted. Compatibility with the infusion solution must be ascertained before adding supplementary preparations. Additives should not be mixed with fat emulsions unless compatibility is known.

Cernevit solution for injection vials and diluent

- Dissolve in 5 mL water for injections.

Peditrace solution for infusion 10ml ampoules

For addition to Vaminolact®, Vamin Electrolyte-Free solutions, and glucose intravenous infusions.

Additrace solution for infusion 10ml ampoules

For addition to Vamin solutions and glucose intravenous infusions.

Dipeptiven 20g/100ml concentrate for solution for infusion bottles

For addition to infusion solutions containing amino acids.

Addiphos® vials

For addition to Vamin® solutions and glucose intravenous infusions.

Decan concentrate for solution for infusion 40ml bottles

For addition to infusion solutions.

Solivito n powder for solution for infusion vials

Solvito N® powder for reconstitution contains biotin 60 micrograms, cyanocobalamin 5 micrograms, folic acid 400 micrograms, glycine 300 micrograms, nicotinamide 40 mg, pyridoxine hydrochloride 4.9 mg, riboflavin sodium phosphate 4.9 mg, sodium ascorbate 1.13 mg, sodium pantothenate 16.5 mg, thiamine mononitrate 3.1 mg.

Vitlipid n adult emulsion for injection 10ml ampoules

Vitlipid N® adult emulsion contains vitamin A 330 units, ergocalciferol 20 units, dl-alpha tocopherol 1 unit, phenytoin sodium 15 micrograms/mL.

For adults and children over 11 years.

Vitlipid n infant emulsion for injection 10ml ampoules

Vitlipid N® infant emulsion contains vitamin A 230 units, ergocalciferol 40 units, dl-alpha tocopherol 0.7 unit, phenytoin sodium 20 micrograms/mL.

- Medicinal forms
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for infusion

Solution for injection

- Cernevit (Baxter Healthcare Ltd)
  - Cyanocobalamin 6 microgram, Biotin 69 microgram, Folic Acid 414 microgram, Thiamine 3.51 mg, Riboflavin (as Riboflavin sodium phosphate) 4.14 mg, Pyridoxine (as Pyridoxine hydrochloride) 4.53 mg, Pantothenic acid (as Diphosphatidylglycerol) 17.25 mg, Nicotinamide 46 mg, Ascorbic acid 125 mg, Alpha tocopherol 11.2 unit, Colecalciferol 220 unit, Retinol 3500 unit

Solution for infusion

- Parenteral nutrition supplements (Non-proprietary)
  - Sodium glycerophosphate 216 mg per 1 ml
  - Sodium glycerophosphate 4.32g/20ml concentrate for solution for infusion vials | 1 vial (BNFC) £5.60

- Additrace (Fresenius Kabi Ltd)
  - Sodium molybdate 4.85 microgram per 1 ml, Chromic chloride 5.33 microgram per 1 ml, Sodium selenite 10.5 microgram per 1 ml, Potassium iodide 16.6 microgram per 1 ml, Manganese chloride 99 microgram per 1 ml, Sodium fluoride 210 microgram per 1 ml, Copper chloride 340 microgram per 1 ml, Ferric chloride 544 microgram per 1 ml, Zinc chloride 1.36 mg per 1 ml

- Dipeptiven (Fresenius Kabi Ltd)
  - N2-L-alanyl-L-glutamine 200 mg per 1 ml

Solutions and glucose intravenous infusions.

- Prescribing and dispensing information
  - Cernevit solution contains dl-alpha tocopherol 11.2 units, ascorbic acid 125 mg, biotin 69 micrograms, colecalciferol 220 units, cyanocobalamin 5 micrograms, folic acid 414 micrograms, glycine 250 mg, nicotinamide 46 mg, pantothenic acid (as diphosphatidylglycerol) 17.25 mg, pyridoxine hydrochloride 5.5 mg, retinol (as palmitate) 3500 units, riboflavin (as dehidrated sodium phosphate) 4.14 mg, thiamine (as carbonamiylase tetrahydrate) 3.51 mg.

Peditrace solution for infusion 10ml vials

For use in neonates (when kidney function established, usually second day of life), infants, and children.

Peditrace® solution contains traces of Zn²⁺, Cu²⁺, Mn²⁺, Se⁴⁺, F⁻, I⁻.

Aditrace solution for infusion 10ml ampoules

For patients over 40 kg.

Aditrace® solution contains traces of Fe³⁺, Zn²⁺, Cu²⁺, Mn²⁺, F⁻, Co²⁺, Se⁴⁺, Mo⁶⁺, Cr³⁺.

Dipeptiven 20g/100ml concentrate for solution for infusion bottles

Dipeptiven® solution contains N(2)-L-alanyl-L-glutamine 200 mg/mL (providing L-alanine 82 mg, L-glutamine 134.6 mg).

Addiphos® vials

Addiphos® sterile solution contains phosphate 40 mmol, K⁺ 30 mmol, Na⁺ 30 mmol/20 mL.

Decan concentrate for solution for infusion 40ml bottles

For patients over 40 kg.

Decan® solution contains traces elements Fe³⁺, Zn²⁺, Cu²⁺, Mn²⁺, F⁻, Co²⁺, I⁻, Se⁴⁺, Mo⁶⁺, Cr³⁺.

Solivito n powder for solution for infusion vials

Solivito N® powder for reconstitution contains biotin 60 micrograms, cyanocobalamin 5 micrograms, folic acid 400 micrograms, glycine 300 micrograms, nicotinamide 40 mg, pyridoxine hydrochloride 4.9 mg, riboflavin sodium phosphate 4.9 mg, sodium ascorbate 113 mg, sodium pantothenate 16.5 mg, thiamine mononitrate 3.1 mg.

Vitlipid n adult emulsion for injection 10ml ampoules

Vitlipid N® adult emulsion contains vitamin A 330 units, ergocalciferol 20 units, dl-alpha tocopherol 1 unit, phenytoin sodium 15 micrograms/mL.

For adults and children over 11 years.

Vitlipid n infant emulsion for injection 10ml ampoules

Vitlipid N® infant emulsion contains vitamin A 230 units, ergocalciferol 40 units, dl-alpha tocopherol 0.7 unit, phenytoin sodium 20 micrograms/mL.
6 Nutrition (oral)

Enteral nutrition

Overview

Children have higher nutrient requirements per kg bodyweight, different metabolic rates, and physiological responses compared to adults. They have low nutritional stores and are particularly vulnerable to growth and nutritional problems during critical periods of development. Major illness, operations, or trauma impose increased nutritional problems during critical periods of development. Most children receiving enteral feeds for a child. Expert advice from a dietician should be sought before prescribing enteral feeds for a child.

Infant formula feeds

Child 0–12 months. Term infants with normal gastro-intestinal function are given either breast milk or normal infant formula during the first year of life. The energy intake is between 150 mL and 200 mL/kg/day. Infant milk formulas are based on whey- or casein-dominant protein, lactose with or without maltodextrin, amylose, vegetable oil and milk fat. The composition of all normal and soya infant formulas have to meet the European Community Regulations 2006/141/EC; the composition of other enteral and specialist feeds has to meet the Commission Directive (1999/21/EC) on Dietary Foods for Special Medical Purposes.

A high-energy feed, which contains 9–11% of energy derived from protein can be used for infants who fail to grow adequately. Alternatively, energy supplements may be added to normal infant formula to achieve a higher energy content (but this will reduce the protein to energy ratio) or the normal infant formula concentration may be increased slightly. Care should be taken not to present an osmotic load (with or without added medium chain triglyceride (MCT) oil) or the normal energy density of formula to increase the energy density. Even when nutritionally complete feeds are given, water and electrolyte balance should be monitored.

Choosing the best formula for children depends on several factors including: nutritional requirements, gastrointestinal function, underlying disease, nutrient restrictions, age, and feed characteristics (nutritional composition, viscosity, osmolality, availability and cost). Children have specific dietary requirements and in many situations liquid feeds prepared for adults are totally unsuitable and should not be given. Additional vitamins may also be needed.

Most feeds for enteral use contain protein derived from cows’ milk or soya. Elemental feeds containing protein hydrolysates or free amino acids can be used for children who have diminished ability to break down protein, for example in inflammatory bowel disease or pancreatic insufficiency. Even when nutritionally complete feeds are given, water and electrolyte balance should be monitored. Haematological and biochemical parameters should also be monitored, particularly in the clinically unstable child. Extra minerals (e.g. magnesium and zinc) may be needed in patients where gastro-intestinal secretions are being lost. Additional vitamins may also be needed.

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Nutrition (oral) 643

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Clinical Conditions such as renal and liver diseases. When used without the supervision of a paediatric dietician, and because of their flexibility; disadvantages include their complexity and preparation difficulties. Modular feeds should not be used without the supervision of a paediatric dietician.

Specialised formula

Highly specialised formulae are designed to meet the specific requirements in various clinical conditions such as renal and liver diseases. When using these formulas, both the biochemical status of the child and their growth parameters need to be monitored.

Feed thickeners

Carob based thickeners may be used to thicken feeds for infants under 1 year with significant gastro-oesophageal reflux. Breast-fed infants can be given the thickener mixed to a paste with water or breast-milk prior to feeds.

Pre-thickened formula

Milk-protein- or casein-dominant infant formula, which contains small quantities of pre-gelatinized starch, is recommended primarily for infants with mild gastro-oesophageal reflux. Pre-thickened formula is prepared in the same way as normal infant formula and flows through a standard teat. The feeds do not thicken on standing but thicken in the stomach when exposed to acid pH.

Starched based thickeners can be used to thicken liquids and feeds for children over 1 year of age with dysphagia.

Dietary supplements for oral use

Three types of prescribable fortified dietary supplements are available: fortified milk and non-milk tasting (juice-style) drinks, and fortified milk-based semi-solid preparations. The recommended daily quantity is age-dependent. The following is a useful guide: 1–2 years, 200 kcal (840 kJ); 3–5 years, 400 kcal (1680 kJ); 6–11 years, 600 kcal (2520 kJ); and over 12 years, 800 kcal (3360 kJ). Supplements containing 1.5 kcal/mL are high in protein and should not be used for children under 3 years of age. Many supplements are high in sugar or maltodextrin; care should be taken to prevent prolonged contact with teeth. Ideally supplements should be administered after meals or at bedtime so as not to affect appetite.

Products for metabolic diseases

There is a large range of disease-specific infant formulas and amino acid-based supplements available for use in children with metabolic diseases (see under specific metabolic diseases). Some of these formulas are nutritionally incomplete and supplementation with vitamins and other nutrients may be necessary. Many of the product names are similar; to prevent metabolic complications in children who cannot tolerate specific amino acids it is important to ensure the correct supplement is supplied.

Enteral feeding tubes

Care is required in choosing an appropriate formulation of a drug for administration through a nasogastric narrow-bore feeding tube or through a percutaneous endoscopic gastrostomy (PEG) or jejunostomy tube. Liquid preparations (or soluble tablets) are preferred; injection solutions may also be suitable for administration through an enteral tube.

If a solid formulation of a medicine needs to be given, it should be given as a suspension of particles fine enough to pass through the tube. It is possible to crush many immediate-release preparations should not be crushed.

Enteral feeds may affect the absorption of drugs and it is therefore important to consider the timing of drug administration in relation to feeds. If more than one drug needs to be given, they should be given separately and the tube should be flushed with water after each drug has been given.

Clearing blockages

Carbonated (sugar-free) drinks may be marginally more effective than water in unblocking feeding tubes, but mildly acidic liquids (such as pineapple juice or cola-based drinks) can coagulate protein in feeds, causing further blockage. If these measures fail to clear the enteral feeding tube, an alkaline solution containing pancreatic enzymes may be introduced into the tube (followed after at least 5 minutes by water). Specific products designed to break up blockages caused by formula feeds are also available.
6.1 Special diets

Nutrition in special diets

Overview

These are preparations that have been modified to eliminate a particular constituent from a food or that are nutrient mixtures formulated as food substitutes for children who either cannot tolerate or cannot metabolise certain common constituents of food.

Coeliac disease

Coeliac disease is caused by an abnormal immune response to gluten. For management and further information, see Coeliac disease p. 27.

Phenylketonuria

Phenylketonuria (hyperphenylalaninaemia, PKU), which results from the inability to metabolise phenylalanine, is managed by restricting dietary intake of phenylalanine to a small amount sufficient for tissue building and repair.

Aspartame (used as a sweetener in some foods and medicines) contributes to the phenylalanine intake and may affect control of phenylketonuoria. If alternatives are unavailable, children with phenylketonuria should not be denied access to appropriate medication; the amount of aspartame consumed can be taken into account in the management of the condition. Where the presence of aspartame in a preparation is specified in the product literature, aspartame is listed as an excipient in the relevant product entry in BNF for Children; the child or carer should be informed of this.

Some rare forms of phenylketonuria are caused by a deficiency of tetrahydrobiopterin. Treatment involves oral supplementation of tetrahydrobiopterin p. 646; in some severe cases, the addition of the neurotransmitter precursors, levodopa and 5-hydroxytryptophan, is also necessary.

Sapropterin dihydrochloride below, a synthetic form of tetrahydrobiopterin p. 646, is licensed as an adjunct to dietary restriction of phenylalanine in the management of patients with phenylketonuria and tetrahydrobiopterin deficiency.

Products for metabolic diseases

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6.1a Phenylketonuria

DRUGS FOR METABOLIC DISORDERS

TETRAHYDROBIOPTERIN AND DERIVATIVES

Sapropterin dihydrochloride

14-Sep-2018

INDICATIONS AND DOSE

Phenylketonuria (adjunct to dietary restriction of phenylalanine) (specialist use only)

- BY MOUTH
  - Child 4–17 years: Initially 10 mg/kg once daily, adjusted according to response; usual dose 5–20 mg/kg once daily, dose to be taken preferably in the morning

Tetrahydrobiopterin deficiency (adjunct to dietary restriction of phenylalanine) (specialist use only)

- BY MOUTH
  - Neonate: Initially 2–5 mg/kg once daily, adjusted according to response, dose to be taken preferably in the morning, the total daily dose may alternatively be given in 2–3 divided doses; maximum 20 mg/kg per day
  - Child: Initially 2–5 mg/kg once daily, adjusted according to response, dose to be taken preferably in the morning, the total daily dose may alternatively be given in 2–3 divided doses; maximum 20 mg/kg per day

CAUTIONS

- History of convulsions
- Appendix 1: Sapropterin

SIDE-EFFECTS

- Common or very common Abdominal pain - cough - diarrhoea - headache - laryngeal pain - nasal congestion - vomiting
- Frequency not known Hypersensitivity

PREGNANCY

Manufacturer advises caution—consider only if strict dietary management inadequate.

BREAST FEEDING

Manufacturer advises avoid—no information available.

HEPATIC IMPAIRMENT

Manufacturer advises caution (no information available).

RENAL IMPAIRMENT

Manufacturer advises caution—no information available.

MONITORING REQUIREMENTS

- Monitor blood-phenylalanine concentration before and after first week of treatment—if unsatisfactory response increase dose at weekly intervals to max. dose and monitor blood-phenylalanine concentration weekly; discontinue treatment if unsatisfactory response after 1 month.
- Monitor blood-phenylalanine and tyrosine concentrations 1–2 weeks after dose adjustment and during treatment.

DIRECTIONS FOR ADMINISTRATION

Tablets should be dissolved in water and taken within 20 minutes.

PRESCRIBING AND DISPENSING INFORMATION

Sapropterin is a synthetic form of tetrahydrobiopterin.

PATIENT AND CARER ADVICE

Patient or carers should be given advice on how to administer sapropterin dihydrochloride dispersible tablets.

NATIONAL FUNDING/ACCESS DECISIONS

Scottish Medicines Consortium (SMC) decisions

SMC No. 558/09

The Scottish Medicines Consortium has advised (August 2018) that sapropterin dihydrochloride (Kuvan®) is not recommended for use within NHS Scotland for the treatment of hyperphenylalaninaemia in adults and paediatric patients of all ages with phenylketonuria (who have been shown to be responsive to such treatment) as the economic case was not demonstrated.
Vitamin deficiency

7 Vitamin deficiency

Vitamins

Overview

Vitamins are used for the prevention and treatment of specific deficiency states or where the diet is known to be inadequate; they may be prescribed in the NHS to prevent or treat deficiency but not as dietary supplements. Except for iron-deficiency anaemia, a primary vitamin or mineral deficiency due to simple dietary inadequacy is rare in the developed world. Some children may be at risk of developing deficiencies because of an inadequate intake, impaired vitamin synthesis or malabsorption in disease states such as cystic fibrosis and Crohn’s disease.

The use of vitamins as general ‘pick-me-ups’ is of unproven value and, the ‘fad’ for mega-vitamin therapy with water-soluble vitamins, such as ascorbic acid p. 652 and pyridoxine hydrochloride p. 650, is unscientific and can be harmful. Many vitamin supplements are described as ‘multivitamin’ but few contain the whole range of essential vitamins and many contain relatively high amounts of vitamins A and D. Care should be taken to ensure the correct dose is not exceeded.

Dietary reference values for vitamins are available in the Department of Health publication:


Dental patients

It is unjustifiable to treat stomatitis or glossitis with mixtures of vitamin preparations; this delays diagnosis and correct treatment.

Most patients who develop a nutritional deficiency despite an adequate intake of vitamins have malabsorption and if this is suspected the patient should be referred to a medical practitioner.

Vitamin A

Deficiency of vitamin A p. 649 (retinol) is associated with ocular defects (particularly xerophthalmia) and an increased susceptibility to infections, but deficiency is rare in the UK (even in disorders of fat absorption).

Vitamin A supplementation may be required in children with liver disease, particularly cholestatic liver disease, due to the malabsorption of fat soluble vitamins. In those with complete biliary obstruction an intramuscular dose once a month may be appropriate.

Preterm neonates have low plasma concentrations of vitamin A and are usually given vitamin A supplements, often as part of an oral multivitamin preparation once enteral feeding has been established.

Vitamin B group

Deficiency of the B vitamins, other than vitamin B12, is rare in the UK and is usually treated by preparations containing thiamine p. 650 (B1), and riboflavin (B2). Other members (or substances traditionally classified as members) of the vitamin B complex such as aminobenzoic acid, biotin, choline, inositol nicotinate, and pantothenic acid or panthenol may be included in vitamin B preparations, but there is no evidence of their value as supplements; however, they can be used in the management of certain metabolic disorders. Anaphylaxis has been reported with parental B vitamins.

As with other vitamins of the B group, pyridoxine hydrochloride (B6) deficiency is rare, but it may occur during isoniazid p. 382 therapy or penicillamine p. 639 treatment in Wilson’s disease and is characterised by peripheral neuritis. High doses of pyridoxine hydrochloride are given in some metabolic disorders, such as hyperoxaluria, cystathioninuria and homocystinuria; folic acid p. 594 supplementation may also be beneficial in these disorders. Pyridoxine hydrochloride is also used in sideroblastic anaemia. Rarely, seizures in the neonatal period or during infancy respond to pyridoxine hydrochloride treatment; pyridoxine hydrochloride should be tried in all cases of early-onset intractable seizures and status epilepticus. Pyridoxine hydrochloride has been tried for a wide variety of other disorders, but there is little sound evidence to support the claims of efficacy.

A number of mitochondrial disorders may respond to treatment with certain B vitamins but these disorders require specialist management. Thiamine is used in the treatment of maple syrup urine disease, mitochondrial respiratory chain defects and, together with riboflavin, in the treatment of congenital lactic acidosis; riboflavin is also used in glutaric acidemias and cytochrome oxidase deficiencies; biotin is used in carboxylase defects.

Folic acid and vitamin B12 are used in the treatment of megaloblastic anaemia. Folinic acid p. 575 (available as calcium folinate) is used in association with cytotoxic therapy.
**Vitamin C**

Vitamin C (ascorbic acid) therapy is essential in scurvy, but less florid manifestations of vitamin C deficiency have been reported. Vitamin C is used to enhance the excretion of iron one month after starting desferrioxamine mesilate p. 598 therapy; it is given separately from food as it also enhances iron absorption. Vitamin C is also used in the treatment of some inherited metabolic disorders, particularly mitochondrial disorders; specialist management of these conditions is required.

Severe scurvy causes gingival swelling and bleeding margins as well as petechiae on the skin. This is, however, exceedingly rare and a child with these signs is more likely to have leukaemia. Investigation should not be delayed by a trial period of vitamin treatment.

Claims that vitamin C ameliorates colds or promotes wound healing have not been proved.

**Vitamin D**

The term Vitamin D is used for a range of compounds including ergocalciferol p. 656 (calciferol, vitamin D₂), colecalciferol p. 654 (vitamin D₃), dihydroxycholecalciferol, alfalcacidol p. 653 (1α-hydroxycholecalciferol), and calcitriol p. 653 (1,25-dihydroxycholecalciferol).

Asymptomatic vitamin D deficiency is common in the United Kingdom; symptomatic deficiency may occur in certain ethnic groups, particularly as rickets or hypocalcaemia, and rarely in association with malabsorption. The amount of vitamin D required in infancy is related to the stores built up in utero and subsequent exposure to sunlight. The amount of vitamin D in breast milk varies and some breast-fed babies, particularly if preterm or born to vitamin D deficient mothers, may become deficient. Most formula milk and supplement feeds contain adequate vitamin D to prevent deficiency.

Simple, nutritional vitamin D deficiency can be prevented by oral supplementation of ergocalciferol (calciferol, vitamin D₂) or colecalciferol (vitamin D₃) daily, using multi–vitamin drops, preparations of vitamins A and D, manufactured ‘special’ solutions, or as calcium and ergocalciferol tablets (although the calcium and other vitamins in supplements are unnecessary); excessive supplementation may cause hypercalcaemia.

Inadequate bone mineralisation can be caused by a deficiency, or a lack of action of vitamin D or its active metabolite. In childhood this causes bowing and distortion of bones (rickets). In nutritional vitamin D deficiency rickets, initial high doses of ergocalciferol or colecalciferol should be reduced to supplemental doses after 8–12 weeks, as there is a significant risk of hypercalcaemia. However, calcium supplements are recommended if there is hypocalcaemia or evidence of a poor dietary calcium intake. A single large dose of ergocalciferol p. 656 or colecalciferol p. 654 can also be effective for the treatment of nutritional vitamin D deficiency rickets.

Poor bone mineralisation in neonates and young children may also be due to inadequate intake of phosphate or calcium particularly during long-term parenteral nutrition—supplementation with phosphate or calcium may be required.

*Hyppophosphataemic* rickets occurs due to abnormal phosphate excretion; treatment with high doses of oral phosphate, and hydroxylated (activated) forms of vitamin D allow bone mineralisation and optimise growth.

Nutritional deficiency of vitamin D is best treated with colecalciferol or ergocalciferol. Preparations containing calcium and colecalciferol are also occasionally used in children where there is evidence of combined calcium and vitamin D deficiency. Vitamin D deficiency caused by intestinal malabsorption or chronic liver disease usually requires vitamin D in pharmacological doses; the hypocalcaemia of *hypoparathyroidism* often requires higher doses in order to achieve normocalcaemia and alfacalcidol p. 653 is generally preferred.

Vitamin D supplementation is often given in combination with calcium supplements for persistent hypocalcaemia in neonates, and in chronic renal disease.

Vitamin D requires hydroxylation, by the kidney and liver, to its active form therefore the hydroxylated derivatives alfacalcidol or calcitriol p. 653 should be prescribed if patients with *severe liver or renal impairment* require vitamin D therapy. Alfacalcidol is generally preferred in children as there is more experience of its use and appropriate formulations are available. Calcitriol is unlicensed for use in children and is generally reserved for those with severe liver disease.

Paricalcitol p. 657, a synthetic vitamin D analogue, is licensed for the prevention and treatment of secondary hyperparathyroidism associated with chronic kidney disease.

**Vitamin E**

The daily requirement of vitamin E (tocopherol) has not been well defined. Vitamin E supplements are given to children with fat malabsorption such as in cystic fibrosis and cholestatic liver disease. In children with abetalipoproteinemia abnormally low vitamin E concentrations may occur in association with neuromuscular problems; this usually responds to high doses of vitamin E. Some neonatal units still administer a single intramuscular dose of vitamin E at birth to preterm neonates to reduce the risk of complications; no trials of long-term outcome have been carried out. The intramuscular route should also be considered in children with severe liver disease when response to oral therapy is inadequate.

Vitamin E has been tried for various other conditions but there is little scientific evidence of its value.

**Vitamin K**

Vitamin K is necessary for the production of blood clotting factors and proteins necessary for the normal calcification of bone.

Because vitamin K is fat soluble, children with fat malabsorption, especially in biliary obstruction or hepatic disease, may become deficient. For oral administration to prevent vitamin K deficiency in malabsorption syndromes, a water-soluble synthetic vitamin K derivative, menadiol sodium phosphate p. 658 can be used if supplementation with phytomenadione p. 659 by mouth has been insufficient.

Oral coumarin anticoagulants act by interfering with vitamin K metabolism in the hepatic cells and their effects can be antagonised by giving vitamin K; see advice on the use of vitamin K in haemorrhage.

**Multivitamins**

Multivitamin supplements are used in children with vitamin deficiencies and also in malabsorption conditions such as cystic fibrosis or liver disease. Supplementation is not required if nutrient enriched feeds are used; consult a dietician for further advice.

**Vitamin K deficiency bleeding**

Neonates are relatively deficient in vitamin K and those who do not receive supplements of vitamin K are at risk of serious bleeding including intracranial bleeding. The Chief Medical Officer and the Chief Nursing Officer have recommended that all newborn babies should receive vitamin K to prevent vitamin K deficiency bleeding (previously termed haemorrhagic disease of the newborn). An appropriate regimen should be selected after discussion with parents in the antenatal period.

Vitamin K (as phytomenadione) may be given by a single intramuscular injection at birth; this prevents vitamin K deficiency bleeding in virtually all babies.
Alternatively, in healthy babies who are not at particular risk of bleeding disorders, vitamin K may be given by mouth, and arrangements must be in place to ensure the appropriate regimen is followed. Two doses of a colloidal (mixed micelle) preparation of phytomenadione should be given by mouth in the first week, the first dose being given at birth and the second dose at 4–7 days. For exclusively breast-fed babies, a third dose of colloidal phytomenadione is given by mouth at 1 month of age; the third dose is omitted in formula-fed babies because formula feeds contain adequate vitamin K. An alternative regimen is to give one dose of phytomenadione by mouth at birth (using the contents of a phytomenadione capsule) to protect from the risk of vitamin K deficiency bleeding in the first week; for exclusively breast-fed babies, further doses of phytomenadione are given by mouth (using the contents of a phytomenadione capsule) at weekly intervals for 12 weeks.

**VITAMINS AND TRACE ELEMENTS**

**MULTIVITAMINS**

### Vitamins A and D

- **INDICATIONS AND DOSE**
  - Prevention of vitamin A and D deficiency
    - **BY MOUTH**
      - Child: 1 capsule daily, 1 capsule contains 4000 units vitamin A and 400 units (10 micrograms) vitamin D

- **UNLICENSED USE** Not licensed in children under 6 months of age.

- **SIDE-EFFECTS**
  - Overdose: Prolonged excessive ingestion of vitamins A and D can lead to hypervitaminosis.

- **PRESCRIBING AND DISPENSING INFORMATION** This drug contains vitamin D; consult individual vitamin D monographs.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Capsule
    - **Vitamins a and d (Non-proprietary)**
      - Vitamin D 400 unit, Vitamin A 4000 unit
  - **EXCIPIENTS**: May contain Arachis (peanut) oil, sucrose

### Vitamins A, B group, C and D

- **INDICATIONS AND DOSE**
  - Prevention of deficiency
    - **BY MOUTH USING CAPSULES**
      - Child 1-11 years: 1 capsule daily
      - Child 12-17 years: 2 capsules daily
  - Cystic Fibrosis: prevention of deficiency
    - **BY MOUTH USING CAPSULES**
      - Child 1-7 years: 2–3 capsules daily

**ABIDEC MULTIVITAMIN DROPS**

- **PREVENTION OF DEFICIENCY**
  - **BY MOUTH USING ORAL DROPS**
  - Preterm neonate: 0.6 mL daily.
  - Neonate: 0.3 mL daily.
  - Child 1-11 months: 0.3 mL daily
  - Child 1-7 years: 0.6 mL daily

**CYSTIC FIBROSIS: PREVENTION OF DEFICIENCY**

- **BY MOUTH USING ORAL DROPS**
  - Child 1-11 months: 0.6 mL daily
  - Child 1-7 years: 1.2 mL daily

**UNLICENSED USE** Dalivit® not licensed for use in children under 6 weeks.

**PRESCRIBING AND DISPENSING INFORMATION** This drug contains vitamin D; consult individual vitamin D monographs.

- To avoid potential toxicity, the content of all vitamin preparations, particularly vitamin A, should be considered when used together with other supplements.

- Vitamin A concentration of preparations varies.

<table>
<thead>
<tr>
<th>ABIDEC MULTIVITAMIN DROPS®</th>
<th>Contains 1333 units of vitamin A (as palmitate) per 0.6 mL dose.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DALIVIT ORAL DROPS®</td>
<td>Contains 5000 units of vitamin A (as palmitate) per 0.6 mL dose.</td>
</tr>
</tbody>
</table>

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Oral drops**

- **EXCIPIENTS**: May contain Arachis (peanut) oil, sucrose

- **Abidec Multivitamin (Omega Pharma Ltd)**
  - Nicotinamide 1333 microgram per 1 mL, Pyridoxine hydrochloride 1333 microgram per 1 mL, Riboflavin 1333 microgram per 1 mL, Thiamine hydrochloride 1.67 mg per 1 mL, Ascorbic acid 66.7 mg per 1 mL, Ergocalciferol 667 iu per 1 mL, Retinol (as Vitamin A palmitate) 2222 iu per 1 mL
  - Abidec Multivitamin drops | 25 mL (GSK) £3.68

- **Dalivit (Boston Healthcare Ltd)**
  - Riboflavin 667 microgram per 1 mL, Pyridoxine 833 microgram per 1 mL, Thiamine 1667 microgram per 1 mL, Nicotinamide 8.3 mg per 1 mL, Ascorbic acid 81 mg per 1 mL, Ergocalciferol 667 iu per 1 mL, Retinol (as Vitamin A palmitate) 2222 iu per 1 mL
  - Dalivit oral drops | 25 mL (GSK) £5.60

**Capsule**

- **Vitamins a, b group, c and d (Non-proprietary)**
  - Riboflavin 500 microgram, Thiamine hydrochloride 1 mg, Nicotinamide 7.5 mg, Ascorbic acid 15 mg, Vitamin D 300 unit, Vitamin A 2500 unit
  - Dalivit capsules | 1000 capsule £48.20 DT = £15.48

### Vitamins A, C and D

The properties listed below are those particular to the combination only. For the properties of the components please consider, vitamin A p. 649, ascorbic acid p. 652.

- **INDICATIONS AND DOSE**
  - Prevention of vitamin deficiency
    - **BY MOUTH**
      - Child 1 month-4 years: 5 drops daily, 5 drops contain vitamin A approx. 700 units, vitamin D approx. 300 units (7.5 micrograms), ascorbic acid approx. 20 mg

- **INTERACTIONS** → Appendix 1: Ascorbic acid - vitamin A

- **PRESCRIBING AND DISPENSING INFORMATION** This drug contains vitamin D; consult individual vitamin D monographs.

- Available free of charge to children under 4 years in families on the Healthy Start Scheme, or alternatively may be available direct to the public—further information for healthcare professionals can be accessed at...
VITAMINS AND TRACE ELEMENTS

Vitamin A (Retinol)

**INDICATIONS AND DOSE**

Vitamin A deficiency

- **BY MOUTH**
  - Neonate: 5000 units daily, higher doses may be used initially for treatment of severe deficiency.
  - Child 1-11 months: 5000 units daily, to be taken with or after food, higher doses may be used initially for treatment of severe deficiency.
  - Child 1-7 years: 10 000 units daily, to be taken with or after food, higher doses may be used initially for treatment of severe deficiency.

Prevention of deficiency in complete biliary obstruction

- **BY INTRAMUSCULAR INJECTION**
  - Neonate: 50 000 units once a month.
  - Child 1-11 months: 50 000 units once a month.

**UNLICENSED USE** Preparations containing only vitamin A are not licensed.

**INTERACTIONS** Appendix 1: vitamin A

**SIDE-EFFECTS**

Overdose Massive overdose can cause rough skin, dry hair, an enlarged liver, and increases in erythrocyte sedimentation rate, serum calcium and serum alkaline phosphatase concentration.

Pregnancy Excessive doses may be teratogenic. In view of evidence suggesting that high levels of vitamin A may cause birth defects, women who are (or may become) pregnant are advised not to take vitamin A supplements (including tablets and fish liver oil drops), except on the advice of a doctor or an antenatal clinic; nor should they eat liver or products such as liver paté or liver sausage.

Breastfeeding Theoretical risk of toxicity in infants of mothers taking large doses.

Monitoring requirements Treatment is sometimes initiated with very high doses of vitamin A and the child should be monitored closely; very high doses are associated with acute toxicity.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral drops, solution for injection

**Solution for injection**

- Vitamin A (Imported)
  - Retinol (as Vitamin A palmitate) 50000 unit per 1 ml Aquasol A
  - Parenteral 100,000 units/2ml solution for injection vials
  - 1 vial £6
  - Nepal Vitamin A 100,000 units/2ml solution for injection ampoules
  - 6 ampoule £20

**Oral drops**

- Arovit (Imported (Italy))
  - Vitamin A 150000 unit per 1 ml Arovit 150,000 units/ml drops
  - 7.5 ml £6

Combinations available: Vitamins A, C, and D, p. 648

**VITAMINS AND TRACE ELEMENTS**

Biotin (Vitamin H)

**INDICATIONS AND DOSE**

Isolated carboxylase defects

- **BY MOUTH, OR BY SLOW INTRAVENOUS INJECTION**
  - Neonate: 5 mg once daily, adjusted according to response; maintenance 10–50 mg daily, higher doses may be required.

  - Child: 10 mg once daily, adjusted according to response; maintenance 10–50 mg daily, increased if necessary up to 100 mg daily.

Defects of biotin metabolism

- **BY MOUTH, OR BY SLOW INTRAVENOUS INJECTION**
  - Neonate: Initially 10 mg once daily, adjusted according to response; maintenance 5–20 mg daily, higher doses may be required.

  - Child: Initially 10 mg once daily, adjusted according to response; maintenance 5–20 mg daily, higher doses may be required.

**PREGNANCY** No information available.

**BREAST FEEDING** No information available.

**DIRECTIONS FOR ADMINISTRATION** For administration by mouth, tablets may be crushed and mixed with food or drink.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Biotin for metabolic disorders www.medicinesforchildren.org.uk/biotin metabolic disorders-0

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral suspension, oral solution

**Solution for injection**

- Biodermin (Imported (Italy))
  - Biotin 5 mg per 1 ml Biodermin 5mg/1ml solution for injection vials
  - 10 vial £9

**Tablet**

- Biotisan (Imported (Germany))
  - Biotin 10 mg Biotisan 10 mg tablet FORTE tablets
  - 30 tablet £9

- Biotess (Essential HealthCare Ltd)
  - Biotin 5 mg Biotess 5mg tablets
  - 30 tablet £13.81

- OroB7 (Rhodes Pharma Ltd)
  - Biotin 5 mg OroB7 5mg tablets
  - 30 tablet £33.99
**Pyridoxine hydrochloride**  
*(Vitamin B₆)*

### Indications and Dose

####isoniazid-induced neuropathy (prophylaxis)
- **By mouth**
  - Neonate: 5 mg daily.
  - Child 1 month–11 years: 5–10 mg daily
  - Child 12–17 years: 10 mg daily

####isoniazid-induced neuropathy (treatment)
- **By mouth**
  - Neonate: 5–10 mg daily.
  - Child 1 month–11 years: 10–20 mg 2–3 times a day
  - Child 12–17 years: 30–50 mg 2–3 times a day

####Prevention of penicillamine-induced neuropathy in Wilson's disease
- **By mouth**
  - Child: 50–100 mg 1–2 times a day

####Pyridoxine-dependent seizures
- **Initially by intravenous injection**
  - Neonate: Test dose 50–100 mg, repeated if necessary, if responsive, followed by an oral maintenance dose; (by mouth) maintenance 50–100 mg once daily, dose to be adjusted as necessary.
  - Child 1 month–11 years: Test dose 50–100 mg daily, if responsive, followed by an oral maintenance dose, (by mouth) maintenance 20–50 mg 1–2 times a day, dose to be adjusted as necessary, (by mouth) increased if necessary up to 30 mg/kg daily, alternatively (by mouth) increased if necessary up to 1 g daily

####Unlicensed Use
- Not licensed for prophylaxis of penicillamine-induced neuropathy in Wilson's disease.
- Not licensed for use in children.

####Caution
- With intravenous use: risk of cardiovascular collapse (with intravenous injection—resuscitation facilities must be available and monitor closely)

####Side-effects
- **Peripheral neuritis**
- **Overdose** Overdose may induce toxic effects.

####Medicinal Forms
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: capsule, oral suspension, oral solution, solution for injection.

####Tablet
- **Pyridoxine hydrochloride (Non-proprietary)**
  - Pyridoxine hydrochloride 10 mg Pyridoxine 10 mg tablets | 28 tablet (P) £16.95 DT = £16.95
  - Pyridoxine hydrochloride 20 mg Pyridoxine 20 mg tablets | 500 tablet (P) £
  - Pyridoxine hydrochloride 50 mg Pyridoxine 50 mg tablets | 28 tablet (P) £16.31 DT = £15.75

####Solution for injection
- **Pyridoxine hydrochloride (Non-proprietary)**
  - Pyridoxine hydrochloride 50 mg per 1 ml Vitamin B6 100 mg/2ml solution for injection ampoules | 10 ampoule (P) £

  - **Sicovit (Imported—Romania)**
  - Pyridoxine hydrochloride 25 mg per 1 ml Sicovit B6 50 mg/2ml solution for injection vials | 5 vial (P) £

####Oral solution
- **PyriDose (Trion Pharma Ltd)**
  - Pyridoxine hydrochloride 20 mg per 1 ml PyriDose 100 mg/5ml oral solution | 100 ml £29.86 DT = £36.79

####Capsule
- **Pyridoxine hydrochloride (Non-proprietary)**
  - Pyridoxine hydrochloride 100 mg Vitamin B6 100 mg capsules | 100 capsule (P) | 120 capsule £5.50

**Riboflavin**  
*(Riboflavin; Vitamin B₂)*

### Indications and Dose

####Metabolic diseases
- **By mouth**
  - Neonate: 50 mg 1–2 times a day, adjusted according to response.
  - Child: 50–100 mg 1–2 times a day, adjusted according to response to up to 400 mg daily

####Unlicensed Use
- Not licensed in children.

####Side-effects
- Urine discolouration
- **Pregnancy** Crosses the placenta but no adverse effects reported, information at high doses limited.
- **Breast Feeding** Present in breast milk but no adverse effects reported, information at high doses limited.

####Medicinal Forms
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, modified-release tablet, capsule, oral suspension, oral solution.

####Modified-release tablet
- **Riboflavin (Non-proprietary)**
  - Riboflavin 100 mg Vitamin B2 100 mg modified-release tablets | 60 tablet £4.46

####Tablet
- **Riboflavin (Non-proprietary)**
  - Riboflavin 100 mg Vitamin B2 100 mg tablets | 100 tablet £

####Capsule
- **Riboflavin (Non-proprietary)**
  - Riboflavin 50 mg Riboflavin 50 mg capsules | 30 capsule £3.13
  - B-2-50 (Bio-Tech Pharmacal Inc)
  - Riboflavin 50 mg B-2-50 capsules | 100 capsule £
  - E-B2 (Ennogen Healthcare Ltd)
  - Riboflavin 100 mg E-B2 100 mg capsules | 30 capsule £9.20

**Thiamine**  
*(Vitamin B₁)*

### Indications and Dose

####Maple syrup urine disease
- **By mouth**
  - Neonate: 5 mg/kg daily, dose to be adjusted as necessary.
  - Child: 5 mg/kg daily, dose to be adjusted as necessary

####Metabolic disorders | Congenital lactic acidosis
- **Initially by mouth, or by intravenous infusion**
  - Neonate: 50–200 mg once daily, dose to be adjusted as necessary, the total dose may alternatively be given in 2–3 divided doses, administer intravenous infusion over 30 minutes.
  - Child: 100–300 mg once daily, dose to be adjusted as necessary, the total dose may alternatively be given in 2–3 divided doses, administer intravenous infusion over 30 minutes, (by mouth) increased if necessary up to 2 g daily.
Vitamin B complex

**INDICATIONS AND DOSE**

**Treatment of deficiency**
- **By Mouth**
  - Child 1-11 months: 5 mL 3 times a day, this dose is for Vigranon B® syrup.
  - Child 1-11 years: 10 mL 3 times a day, this dose is for Vigranon B® syrup.
  - Child 12–17 years: 10–15 mL 3 times a day, this dose is for Vigranon B® syrup.

**Prophylaxis of deficiency**
- **By Mouth Using Syrup**
  - Child 1-11 months: 5 mL once daily, this dose is for Vigranon B® syrup.

**PRESCRIBING AND DISPENSING INFORMATION**

- **CAUTIONS**
  - Anaphylaxis may occasionally follow injection.
  - Breast Feeding
    - Severely thiamine-deficient mothers should avoid breast-feeding as toxic methyl-glyoxal present in milk.
- **PREScribing and dispensing information**
  - With intravenous use
    - Some preparations may contain phenol as a preservative.
  - Thiamine HYDROCHLORIDE 100 mg
  - Thiamine hydrochloride 50 mg
  - Thiamine hydrochloride 25 mg
  - Thiamine hydrochloride 100 mg
  - Thiamine hydrochloride 50 mg
  - Thiamine hydrochloride 25 mg

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

<table>
<thead>
<tr>
<th>Modified-release tablet</th>
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<tbody>
<tr>
<td>Thiamine (Non-proprietary)</td>
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<tr>
<td>Thiamine hydrochloride 100 mg</td>
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<td>Thiamine hydrochloride 50 mg</td>
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<td>Thiamine hydrochloride 25 mg</td>
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<td>Thiamine hydrochloride 100 mg</td>
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<td>Thiamine hydrochloride 50 mg</td>
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<tr>
<th>Solution for injection</th>
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<tr>
<td>Thiamine (Imported)</td>
</tr>
<tr>
<td>Thiamine hydrochloride 50 mg per 1 ml</td>
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<tr>
<td>Thiamine hydrochloride 100 mg per 1 ml</td>
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</tbody>
</table>

**INDICATIONS AND DOSE**

**ORAL Solution**

- **Vigranon-B** (Wallace Manufacturing Chemists Ltd)
  - Pyridoxine hydrochloride 400 microgram per 1 ml, Riboflavin sodium phosphate 548 microgram per 1 ml, Dexamethasone 600 microgram per 1 ml, Thiamine hydrochloride 1 mg per 1 ml, Nicotinamide 4 mg per 1 ml | 150 ml (P) £26.00 |

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Multivitamin preparations for vitamin deficiency
  - www.medicinesforchildren.org.uk/multivitamin-preparations-vitamin-deficiency

**KETOVITE® LIQUID**

- Ketovite® liquid may be mixed with milk, cereal, or fruit juice.

**KETOVITE® TABLETS**

- Tablets may be crushed immediately before use.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Vitamins with minerals and trace elements**

**INDICATIONS AND DOSE**

**ORAL Solution**

- **KETOVITE® LIQUID**
  - Prevention of vitamin deficiency in disorders of carbohydrate or amino-acid metabolism | Adjunct in restricted, specialised, or synthetic diets
  - **By Mouth**
    - Child: 5 mL daily, dose adjusted according to condition, diet, or age, use with Ketovite® Tablets for complete vitamin supplementation.

- **KETOVITE® TABLETS**
  - Prevention of vitamin deficiency in disorders of carbohydrate or amino-acid metabolism | Adjunct in restricted, specialised, or synthetic diets
  - **By Mouth**
    - Child: 1 tablet 3 times a day, dose adjusted according to condition, diet, or age, use with Ketovite® Liquid for complete vitamin supplementation.

**UNLICENSED USE**

- Not licensed in children.

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM advice (September 2007)**

- Although potentially serious allergic adverse reactions may rarely occur during, or shortly after, parenteral administration, the CHM has recommended that:
  - This should not preclude the use of parenteral thiamine in patients where this route of administration is required, particularly in patients at risk of Wernicke-Korsakoff syndrome where treatment with thiamine is essential;
  - Intravenous administration should be by infusion over 30 minutes;
  - Facilities for treating anaphylaxis (including resuscitation facilities) should be available when parenteral thiamine is administered.

**NATIONAL FUNDING/ACCESS DECISIONS**

- **NHS restrictions**
  - Vigranon B® syrup is not prescribable in NHS primary care.

- **LESS suitable for prescribing**
  - Vitamin B compound tablets, vitamin B compound strong tablets, and Vigranon B® syrup are less suitable for prescribing.

**MEdICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**ORAL Solution**

- **Vigranon-B** (Wallace Manufacturing Chemists Ltd)
  - Pyridoxine hydrochloride 400 microgram per 1 ml, Riboflavin sodium phosphate 548 microgram per 1 ml, Dexamethasone 600 microgram per 1 ml, Thiamine hydrochloride 1 mg per 1 ml, Nicotinamide 4 mg per 1 ml | 150 ml (P) £26.00 |

**Vigranon B®**

- Use with thiamine is essential; parenteral thiamine is administered.

**BNFC 2019–2020**
Ascorbic acid (Vitamin C)

**INDICATIONS AND DOSE**

**Treatment of scurvy**
- **BY MOUTH**
  - Child: 1 month–3 years: 125–250 mg daily in 1–2 divided doses
  - Child: 4–11 years: 250–500 mg daily in 1–2 divided doses
  - Child: 12–17 years: 0.5–1 g daily in 1–2 divided doses

Adjunct to desferrioxamine (to enhance the excretion of iron 1 month after treatment)
- **BY MOUTH**
  - Child: 100–200 mg daily, to be taken 1 hour before food

**Metabolic disorders | Tyrosinaemia type III | Transient tyrosinaemia of the newborn | Glutathione synthase deficiency | Hawkinsuria**
- **BY MOUTH**
  - Neonate: 50–200 mg daily, dose to be adjusted as necessary.
  - Child: 200–400 mg daily in 1–2 divided doses, dose to be adjusted as necessary, increased if necessary up to 1 g daily

**UNLICENSED USE** Not licensed for metabolic disorders.

**CONTRA-INDICATIONS** Hyperoxaluria.

**CAUTIONS**

**CAUTIONS, FURTHER INFORMATION**

Iron overload Ascorbic acid should not be given to patients with cardiac dysfunction.

In patients with normal cardiac function ascorbic acid should be introduced 1 month after starting desferrioxamine.

**INTERACTIONS | Appendix 1: ascorbic acid**

**SIDE-EFFECTS** Diarrhoea | gastrointestinal disorder | hyperoxaluria | oxalate nephrolithiasis | polyuria

**PRESCRIBING AND DISPENSING INFORMATION** It is rarely necessary to prescribe more than 100 mg daily except early in the treatment of scurvy.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, oral suspension, oral solution

**Tablet**

- **Ketovite** (Essential Pharmaceuticals Ltd)
  - Biotin 170 microgram, Folic acid 250 microgram, Pyridoxine hydrochloride 330 microgram, Acetomenaphthone 500 microgram, Riboflavin 1 mg, Thiamine hydrochloride 1 mg, Calcium pantothenate 1.16 mg, Nicotinamide 3.3 mg, Alpha tocopherol acetate 5 mg, Ascorbic acid 16.6 mg, Inositol 50 mg
  - Ketovite tablets | 100 tablet

**Capsule**

- **Forceval** (Forum Health Products Ltd)
  - Cyanocobalamin 3 microgram, Selenium 50 microgram, Biotin 100 microgram, Iodine 140 microgram, Chromium 400 microgram, Molybdenum 250 microgram, Folic acid 600 microgram, Phosphorus 77 mg, Calcium 100 mg, Ergocalciferol 400 unit, Vitamin A 2500 unit
  - Forceval capsules | 15 capsule

**Expiry Date**

- 15 months

**VITAMINS AND TRACE ELEMENTS | VITAMIN C**
Alfacalcidol
(1α-Hydroxycholecalciferol)

**INDICATIONS AND DOSE**

- Hypophosphataemic rickets
- Persistent hypocalcaemia due to hypoparathyroidism or pseudohypoparathyroidism

- **BY MOUTH, OR BY INTRAVENOUS INJECTION**
  - Child 1 month-11 years: 25–50 nanograms/kg once daily, dose to be adjusted as necessary; maximum 1 microgram per day
  - Child 12-17 years: 1 microgram once daily, dose to be adjusted as necessary

**SIDE-EFFECTS**

- Rash pustular
- Abdominal discomfort
- Arrhythmia
- Muscle weakness
- Sensory disorder
- Urinary disorders

**INTERACTIONS**

- Alfacalcidol 2 microgram per 1 ml One-Alpha 2 micrograms/ml oral drops sugar-free | 10 ml PFS £21.30 DT + £21.30

**CAPSULE**

- **EXCipients:** May contain Alcohol, propylene glycol
  - Alfacalcidol 2 microgram per 1 ml One-Alpha 2 micrograms/ml oral drops sugar-free | 10 ml PFS £21.30 DT + £21.30

**UNLICENSED USE**

- Not licensed for use in children.

**CAUTIONS**

- Nephrolithiasis - take care to ensure correct dose in infants

**SIDE-EFFECTS**

- Common or very common: Abdominal discomfort - hyperphosphataemia - rash pustular
- Uncommon: Asthenia - diarrhoea - malaise - myalgia - urolithiasis
- Rare or very rare: Dizziness
- Frequency not known: Confusion - renal impairment

**RENAIMPERATION**

- Monitor plasma-calcium concentration in renal impairment.

**DIRECTIONS FOR ADMINISTRATION**

- For injection, shake ampoule for at least 5 seconds before use, and give over 30 seconds.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

- Solution for injection
  - **EXCipients:** May contain Alcohol, propylene glycol
  - **One-Alpha (LEO Pharma)**
    - Alfacalcidol 2 microgram per 1 ml One-Alpha 2 micrograms/ml oral drops sugar-free | 10 ml PFS £21.30 DT + £21.30

**Calcitriol**
(1,25-Dihydroxycholecalciferol)

**INDICATIONS AND DOSE**

- Vitamin D dependent rickets
- Hypophosphataemic rickets
- Persistent hypocalcaemia due to hypoparathyroidism
- Pseudo-hypoparathyroidism (limited experience)

- **BY MOUTH**
  - Child 1 month-11 years: Initially 15 nanograms/kg once daily (max. per dose 250 nanograms), increased in steps of 5 nanograms/kg daily (max. per dose 250 nanograms) if required, dose to be increased every 2–4 weeks
  - Child 12-17 years: Initially 250 nanograms once daily, increased in steps of 5 nanograms/kg daily (max. per dose 250 nanograms) if required, dose to be increased every 2–4 weeks; usual dose 0.5–1 microgram daily

**UNLICENSED USE**

- Take care to ensure correct dose in infants

**SIDE-EFFECTS**

- Common or very common: Urinary tract infection
- Frequency not known: Abdominal pain upper - apathy - arrhythmia - dehydration - drowsiness - fever - growth retardation - muscle weakness - paralytic ileus - polydipsia - psychiatric disorder - sensory disorder - urinary disorders - weight decreased

**RENAIMPERATION**

- Monitor plasma-calcium, phosphate, and creatinine during dosage titration.
- Monitor plasma-calcium concentration in patients receiving high doses.

**DIRECTIONS FOR ADMINISTRATION**

- Contents of capsule may be administered by oral syringe.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

- **ORAL SOLUTION**
  - Calcitriol (Non-proprietary)
    - Calcitriol 1 microgram per 1 ml Rocaltrol 1 micrograms/ml oral solution sugar-free | 10 ml PFS £
Cautions: 

There can be variation in the licensing of

Renal Impairment: 

Monitoring: Monitor plasma-calcium concentration in renal impairment.

Monitoring Requirements: Monitor plasma-calcium concentration in patients receiving high doses.

Directions for Administration: 

INVITA D3® Oral Solution: May be mixed with a small amount of milk or cold or lukewarm food immediately before administration.

Indications and Dose: Prevention of vitamin D deficiency

By Mouth: 

Child: 400 units daily

Renal Impairment: 

Monitoring: Monitor plasma-calcium concentration in renal impairment.

Monitoring Requirements: Monitor plasma-calcium concentration in patients receiving high doses.

Directions for Administration: 

INVITA D3® Oral Solution: May be mixed with a small amount of milk or cold or lukewarm food immediately before administration.

Medicinal Forms: There can be variation in the licensing of different medicines containing the same drug. Licenses available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution, oral drops

Tablet: 

Colecaciferol (Non-proprietary) 

Colecaciferol 10000 unit E-D 10,000 unit tablets | 30 tablet £95.00
Colecaciferol 20000 unit E-D 20,000 unit tablets | 30 tablet £95.90
Iso D3 (Nutri Advanced Ltd)
Colecaciferol 2000 unit Iso D 2,000 unit tablets | 90 tablet £16.72
Stexerol-D3 (Kyowa Kirin Ltd)
Colecaciferol 1000 unit Stexerol-D 1,000 unit tablets | 28 tablet £2.35 D + £2.25
Colecaciferol 25000 unit Stexerol-D 25,000 unit tablets | 12 tablet £17.00 D + £17.00
SunVit-D3 (SunVit-D3 Ltd)
Colecaciferol 400 unit SunVit-D 3,000 unit tablets | 60 tablet £16.16
Colecaciferol 2000 unit SunVit-D 2,000 unit tablets | 28 tablet £3.99
Colecaciferol 3000 unit SunVit-D 3,000 unit tablets | 28 tablet £5.49
Colecaciferol 5000 unit SunVit-D 5,000 unit tablets | 28 tablet £4.99
Colecaciferol 10000 unit SunVit-D 10,000 unit tablets | 28 tablet £6.99
Colecaciferol 20000 unit SunVit-D 20,000 unit tablets | 28 tablet £4.40
Colecaciferol 50000 unit SunVit-D 50,000 unit tablets | 15 tablet £19.99

Oral Drops: 

Colecaciferol 1000 unit per 1 ml D Drops 1000 oral drops sugar-free | 30 ml £6.12
Colecaciferol 2000 unit per 1 ml Vigantol 20,000 units/ml oral drops | 10 ml £3.45
E-D3 (Enogen Healthcare Ltd)
Colecaciferol 2000 unit per 1 ml E-D 2,000 units/ml oral drops sugar-free | 20 ml £6.99
Fultium-D3 (Intercess Pharmaceuticals Ltd)
Colecaciferol 2740 unit per 1 ml Fultium-D 3,740 units/ml oral drops sugar-free | 25 ml £10.70 DT + £10.70
Invita D3 (Consilient Health Ltd)
Colecaciferol 2400 unit per 1 ml Invita D 3,400 units/ml oral drops sugar-free | 20 ml £9.80
Sapvit-D3 (Stirling Anglican Pharmaceuticals Ltd)
Colecaciferol 14400 unit per 1 ml Sapvit-D 14,400 units/ml oral drops sugar-free | 12.5 ml £3.85 DT + £3.85
SunVit-D3 (SunVit-D3 Ltd)
Colecaciferol 2000 unit per 1 ml SunVit-D 2,000 units/ml oral drops sugar-free | 20 ml £6.20
Thorens (Galen Ltd)
Colecaciferol 10000 unit per 1 ml Thorens 10,000 units/ml oral drops sugar-free | 10 ml £5.85 DT + £5.85

Oral Solution: 

CAUTIONARY AND ADVISORY LABELS: 21

Colecaciferol (Non-proprietary) 

Colecaciferol 3000 unit per 1 ml Colecaciferol 3,000 units/ml oral solution | 100 ml £14.00 DT + £14.00
E-D 15,000 units/5ml oral solution | 50 ml £5
Colecaciferol 10000 unit per 1 ml Zyman 10,000 units/ml oral solution | 10 ml £8
Colecaciferol 2000 unit per 1 ml Afciferol 3,000 units/ml liquid | 100 ml £18.00
Baby D (Kofka Healthcare)
Colecaciferol 1000 unit per 1 ml Baby D 1,000 units/ml oral solution | 30 ml £4.50
E-D3 (Enogen Healthcare Ltd)
Colecaciferol 1000 unit per 1 ml E-D 1,000 units/ml oral solution | 15 ml £3
Invita D3 (Consilient Health Ltd)
Colecaciferol 25000 unit per 1 ml Invita D 25,000 units/1ml oral solution sugar-free | 3 ampoule £4.45 DT + £4.45
Colecaciferol 50000 unit per 1 ml Invita D 50,000 units/1ml oral solution sugar-free | 3 ampoule £6.25 DT + £6.25
E-D3 (Synergy Biologics Ltd)
Colecaciferol 2000 unit per 1 ml Pro D 2,000 units/ml liquid | 50 ml £16.80 | 100 ml £22.50
Colecalciferol with calcium carbonate

The properties listed below are those particular to the combination only. For the properties of the components please consider, colecalciferol p. 654, calcium carbonate p. 613.

**INDICATIONS AND DOSE**

Prevention and treatment of vitamin D and calcium deficiency

**BY MOUTH**

- Child: Dosed according to the deficit or daily maintenance requirements (consult product literature)

**UNLICENSED USE** *Adcal-D®* and *Calcice®* are not licensed for use in children under 12 years. *Calcichew-D®, Calcichew-D® Forte, Calci chew-D®* and *Kalcidos-D®* not licensed for use in children (age range not specified by manufacturers). *Accrete D3®* and *Natecal D3®* not licensed for use in children under 18 years.

**INTERACTIONS** → Appendix 1: calcium salts - vitamin D substances

**PRESCRIBING AND DISPENSING INFORMATION** *Accrete D3®* contains calcium carbonate 1.5 g (calcium 600 mg or Ca2+ 15 mmol), colecalciferol 10 micrograms (400 units); *Adcal- D3®* tablets contain calcium carbonate 1.5 g (calcium 600 mg or Ca2+ 15 mmol), colecalciferol 10 micrograms (400 units); *Cact®* D3 contains calcium carbonate 1.25 g (calcium 500 mg or Ca2+ 12.5 mmol), colecalciferol 11 micrograms (440 units)/sachet; *Calcio®* contains calcium carbonate 1.25 g (calcium 500 mg or Ca2+ 12.5 mmol), colecalciferol 10 micrograms (800 units); *Natecal D3®* contains calcium carbonate 1.5 g (calcium 600 mg or Ca2+ 15 mmol), colecalciferol 10 micrograms (400 units); consult product literature for details of other available products.
Flavours of chewable and soluble forms may include orange, lemon, aniseed, peppermint, molasses, or tutti-frutti.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Effervescent granules**
- Colecalciferol with calcium carbonate (Non-proprietary) 880 unit Colecalciferol 880 unit / Calcium carbonate 2.5 g effervescent granules sachets | 24 sachet
- Cacit D (Theramex HQ UK Ltd) 750 mg, Colecalciferol 440 unit Cacit D effervescent granules sachets | 30 sachet DT £4.06 DT £4.06

**Effervescent tablet**
- Adcal-D (Kyoa Kirin Ltd) Calcium carbonate 2.5 gram, Colecalciferol 440 unit 60 tablet £2.95 DT £2.95
- Accre D3 (Internis Pharmaceuticals Ltd) Calcium carbonate 1.25 gram, Colecalciferol 200 unit 56 tablet £5.99 DT £5.99

**Tablet**
- EXCIPIENTS: May contain Propylene glycol
  - Accre D3 (Internis Pharmaceuticals Ltd) Calcium carbonate 1.5 gram, Colecalciferol 400 unit Accre D3 tablets | 60 tablet £2.95 DT £2.95
  - Adcal-D (Kyoa Kirin Ltd) Calcium carbonate 750 mg, Colecalciferol 200 unit Adcal-D 112 tablet £2.95 DT £2.95
  - Calcichew D (Takeda UK Ltd) Calcium carbonate 1.25 gram, Colecalciferol 400 unit Calcichew D 100 tablet £7.43 DT £7.43

**Chewable tablet**
- EXCIPIENTS: May contain Aspartame
  - Colecalciferol with calcium carbonate (Non-proprietary) Calcium carbonate 1.5 gram, Colecalciferol 400 unit 56 tablet £3.65 DT £3.65 | 112 tablet £7.49
  - Accre D3 One a Day (Internis Pharmaceuticals Ltd) Calcium carbonate 1.5 gram, Colecalciferol 880 unit Accre D3 One a Day 1000 mg/880 unit chewable tablets | 30 tablet DT £2.95 DT £2.95

**INDICATIONS AND DOSE**
- Chewable forms with calcium salts and colecalciferol or ergocalciferol should be dispensed or directed that when calciferol is prescribed or demanded, substances with the strength (expressed in micrograms or milligrams per day) not clear, the intention of the prescriber with respect to the strength (expressed in micrograms or milligrams per tablet) should be ascertained.

**INTERACTIONS** → Appendix 1: calcium salts - vitamin D substances

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Powder**
- Calcium carbonate 3.1 gram, Colecalciferol 800 unit Calfovit D3 oral powder sachets | 30 sachet DT £4.32 DT £4.32

**Ergocalciferol** (Calciferol; Vitamin D₂)

**INDICATIONS AND DOSE**
- Nutritional vitamin-D deficiency rickets
  - BY MOUTH
  - Child 1-5 months: 3000 units daily, dose to be adjusted as necessary
  - Child 6 months-11 years: 6000 units daily, dose to be adjusted as necessary
  - Child 12-17 years: 10 000 units daily, dose to be adjusted as necessary

- Prevention of rickets
  - BY MOUTH
  - Neonate: 400 units daily.

- Child: 400–600 units daily

- Vitamin D deficiency in intestinal malabsorption or in chronic liver disease
  - BY MOUTH, OR BY INTRAMUSCULAR INJECTION
  - Child 1-11 years: 10 000–25 000 units daily, dose to be adjusted as necessary
  - Child 12-17 years: 10 000–40 000 units daily, dose to be adjusted as necessary

**CAUTIONS** Take care to ensure correct dose in infants

**INTERACTIONS** → Appendix 1: vitamin D substances

**RENAL IMPAIRMENT** Monitoring Monitor plasma-calcium concentration in renal impairment.

**MONITORING REQUIREMENTS** Monitor plasma-calcium concentration in patients receiving high doses.

**PRESCRIBING AND DISPENSING INFORMATION** The BP directs that when calciferol is prescribed or demanded, colecalciferol or ergocalciferol should be dispensed or supplied.

When the strength of the tablets ordered or prescribed is not clear, the intention of the prescriber with respect to the strength (expressed in micrograms or milligrams per tablet) should be ascertained.
**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: tablet, capsule, oral suspension, oral solution, solution for injection.

**Tablet**
- Ergocalciferol 12.5 microgram (Einnogen Healthcare Ltd)
- Ergocalciferol 125 microgram (Cubic Pharmaceuticals Ltd)
- Ergocalciferol 10 microgram (Cubic Pharmaceuticals Ltd)

**Capsule**
- Ergocalciferol 1.25 mg (Cubic Pharmaceuticals Ltd)
- Ergocalciferol 12.5 microgram (Cubic Pharmaceuticals Ltd)
- Ergocalciferol 15 microgram (Cubic Pharmaceuticals Ltd)

**Oral solution**
- Ergocalciferol 1 microgram per 1 ml (Einnogen Healthcare Ltd)
- Ergocalciferol 10 microgram per 1 ml (Einnogen Healthcare Ltd)
- Ergocalciferol 3000 unit per 1 ml (Cubic Pharmaceuticals Ltd)

**Ergocalciferol with calcium lactate and calcium phosphate**
*(Calcium and vitamin D)*

The properties listed below are those particular to the combination only. For the properties of the components please consider, ergocalciferol p. 656, calcium lactate p. 615.

**INDICATIONS AND DOSE**
- Prevention of calcium and vitamin D deficiency
- Treatment of calcium and vitamin D deficiency
- **BY MOUTH**
- Child: (consult product literature)

**UNLICENSED USE** Calcium and Ergocalciferol tablets not licensed for use in children under 6 years.

**INTERACTIONS** → Appendix 1: calcium salts - vitamin D substances

**DIRECTIONS FOR ADMINISTRATION** Tablets may be crushed before administration, or may be chewed.

**PRESCRIBING AND DISPENISING INFORMATION** Each tablet contains calcium lactate 300 mg, calcium phosphate 150 mg (calcium 97 mg or Ca²⁺ 2.4 mmol), ergocalciferol 10 micrograms (400 units).

**PATIENT AND CARER ADVICE** Patient or carers should be given advice on how to administer calcium and ergocalciferol tablets.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**
- Ergocalciferol with calcium lactate and calcium phosphate (Non-proprietary)
- Ergocalciferol 10 microgram, Calcium phosphate 150 mg, Calcium lactate 300 mg (Cubic Pharmaceuticals Ltd) 28 tablet pack £25.55

**Side-effects**
- Abdominal pain
- Asthenia
- Electrolyte imbalance
- Gastrointestinal discomfort
- Malaise
- Muscle cramps
- Nausea
- Palpitations
- Peripheral oedema
- Pruritus
- Pneumonia
- Taste altered
- Tinnitus
- Unusual tiredness

**Contra-indications**
- Preterm neonates (in neonates)
- Predisposition to thrombosis

**CAUTIONS**
- **PREGNANCY**
- Manufacturer advises caution, no evidence of harm in animal studies.
- **BREAST FEEDING**
- Manufacturer advises use only if potential benefit outweighs risk - no information available.

**VITAMINS AND TRACE ELEMENTS**

**VITAMIN E**

**Alpha tocopherol**
*(Tocopherol)*

**INDICATIONS AND DOSE**
- Vitamin E deficiency because of malabsorption in congenital or hereditary chronic cholestasis
- **BY MOUTH USING ORAL SOLUTION**
- Neonate: 17 mg/kg daily, dose to be adjusted as necessary.
- Child: 17 mg/kg daily, dose to be adjusted as necessary

**CONTRA-INDICATIONS**
- Preterm neonates (in neonates)
- Predisposition to thrombosis

**CAUTIONS**
- Abdominal pain
- Diarrhoea
- Alopecia - asthenia - headache - skin reactions
- Frequency not known

**SIDE-EFFECTS**
- Abdominal pain
- Diarrhoea
- Alopecia - asthenia - headache - skin reactions
- Frequency not known

**PREGNANCY**
- Manufacturer advises caution, no evidence of harm in animal studies.

**BREAST FEEDING**
- Manufacturer advises use only if potential benefit outweighs risk - no information available.

**HEPATIC IMPAIRMENT**
- Manufacturer advises caution.

**RENAL IMPAIRMENT**
- Manufacturer advises caution. Risk of renal toxicity due to polyethylene glycol content.

**Monitoring**
- Manufacturer advises monitor closely in renal impairment.
Alpha tocopheryl acetate (Tocopherol)

**INDICATIONS AND DOSE**

**Vitamin E deficiency**
- BY MOUTH
  - Neonate: 10 mg/kg once daily.
  - Child: 2–10 mg/kg daily, increased if necessary up to 20 mg/kg daily.

**Malabsorption in cystic fibrosis**
- BY MOUTH
  - Child 1–11 months: 50 mg once daily, dose to be adjusted as necessary, to be taken with food and pancreatic enzymes.
  - Child 1–11 years: 100 mg once daily, dose to be adjusted as necessary, to be taken with food and pancreatic enzymes.
  - Child 12–17 years: 200–600 mg once daily, dose to be adjusted as necessary, to be taken with food and pancreatic enzymes.

**Vitamin E deficiency in cholestasis and severe liver disease**
- BY MOUTH
  - Neonate: 10 mg/kg daily.
  - Child: 10 mg/kg once daily (max. per dose 100 mg).

**Malabsorption in abetalipoproteinaemia**
- BY MOUTH
  - Neonate: 100 mg/kg once daily.
  - Child: 50–150 mg/kg once daily.

**CAUTIONS**
- Increased risk of necrotising enterocolitis in neonate weighing less than 1.5 kg or in a preterm neonate (in neonates) - predisposition to thrombosis.

**INTERACTIONS** → Appendix 1: vitamin E substances.

**SIDE-EFFECTS**
- Abdominal pain (more common at high doses) - bleeding tendency, diarrhoea (more common at high doses), increased risk of thrombosis.

**PREGNANCY**
- No evidence of safety of high doses.

**BREAST FEEDING**
- Excreted in milk; minimal risk, although caution with large doses.

**MONITORING REQUIREMENTS**
- Increased bleeding tendency in vitamin K deficient patients or those taking anticoagulants (prothrombin time and INR should be monitored).

**DIRECTIONS FOR ADMINISTRATION**
- Consider dilution of oral suspension for use in neonates due to high osmolality.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Oral solution**
- **Vedrop** (Recordati Rare Diseases UK Ltd)
  - D-alpha tocopherol (as Tocofersolan) 50 mg per 1 ml
  - Oral solution sugar-free | 20 ml £4.55 DT + £4.55
  - Oral solution sugar-free | 60 ml £16.65

**VITAMINS AND TRACE ELEMENTS** ➔ **VITAMIN K**

Menadioni sodium phosphate

**INDICATIONS AND DOSE**

**Supplementation in vitamin K malabsorption**
- BY MOUTH
  - Child 1–11 years: 5–10 mg daily, dose to be adjusted as necessary.
  - Child 12–17 years: 10–20 mg daily, dose to be adjusted as necessary.

**CONTRA-INDICATIONS**
- Infants, neonates.

**CAUTIONS**
- G6PD deficiency (risk of haemolysis) - vitamin E deficiency (risk of haemolysis).

**PREGNANCY**
- Avoid in late pregnancy and labour unless benefit outweighs risk of neonatal haemolytic anaemia, hyperbilirubinaemia, and kernicterus in neonate.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: chewable tablet, solution for injection.

**Solution for injection**
- **Alpha tocopheryl acetate (Non-proprietary)**
  - Alpha tocopherol acetate 200 unit capsules | 100 capsule £11.99
  - Alpha tocopherol acetate 200 unit capsules | 300 capsule £33.99

**Oral solution**
- **EXCIPIENTS:** May contain Sucrose
  - **Alpha tocopheryl acetate (Non-proprietary)**
    - Alpha tocopherol acetate 100 mg | 100 ml £2.45

**Chewable tablet**
- **E-Tabs** (Ennogen Healthcare Ltd)
  - Alpha tocopherol acetate 100 mg | 100 capsule £19.80
  - Alpha tocopherol acetate 100 mg | 100 capsule £39.60

**Capsule**
- **Alpha tocopheryl acetate (Non-proprietary)**
  - Alpha tocopherol 75 unit capsules | 100 capsule £13.05
  - Alpha tocopherol 200 unit capsules | 30 capsule £30.05
  - Bio-E-Vitamin 200 unit capsules | 150 capsule £9.40
  - Alpha tocopherol 400 unit capsules | 30 capsule £15.12
  - E-Caps (Ennogen Healthcare Ltd)
    - Alpha tocopherol 75 unit capsules | 100 capsule £109.50
    - Alpha tocopherol 100 unit capsules | 30 capsule £84.40
  - Alpha tocopherol 200 unit capsules | 30 capsule £89.50
  - Alpha tocopherol 400 unit capsules | 30 capsule £128.50
  - Alpha tocopherol 1000 unit capsules | 30 capsule £130.20
  - **Nutra-E** (TriOn Pharma Ltd)
    - Alpha tocopherol 75 unit capsules | 100 capsule £5.86
    - Alpha tocopherol 200 unit capsules | 100 capsule £12.88
    - Alpha tocopherol 400 unit capsules | 100 capsule £18.82
    - Vita-E (Typharm Ltd)
      - Alpha tocopherol 75 unit capsules | 100 capsule £6.99
      - Alpha tocopherol 200 unit capsules | 30 capsule £5.35
      - Alpha tocopherol 400 unit capsules | 30 capsule £7.99
      - Alpha tocopherol 1000 unit capsules | 100 capsule £21.85
**Phytomenadione** (Vitamin K<sub>1</sub>)

**INDICATIONS AND DOSE**

**Neonatal prophylaxis of vitamin-K deficiency bleeding**
- **BY INTRAVENOUS INJECTION**
  - Preterm neonate: 400 micrograms/kg (max. per dose 1 mg) for 1 dose, to be given at birth, the intravenous route may be used in preterm neonates with very low birth-weight if intramuscular injection is not possible, however, it may not provide the prolonged protection of the intramuscular injection, any neonate receiving intravenous vitamin K should be given subsequent oral doses.

- **Neonate: 1 mg for 1 dose, to be given at birth.**

**Neonatal hypoprothrombinaemia | Vitamin-K deficiency bleeding**
- **BY INTRAVENOUS INJECTION**
  - **Neonate: 1 mg every 8 hours if required.**

**Neonatal biliary atresia and liver disease**
- **BY MOUTH**
  - **Neonate: 1 mg daily.**

**Reversal of coumarin anticoagulation when continued anticoagulation required or if no significant bleeding—seek specialist advice**
- **BY INTRAVENOUS INJECTION**
  - **Child: 15–30 micrograms/kg (max. per dose 1 mg) for 1 dose, dose may be repeated as necessary**

**Reversal of coumarin anticoagulation when anticoagulation not required or if significant bleeding—seek specialist advice | Treatment of haemorrhage associated with vitamin-K deficiency—seek specialist advice**
- **BY INTRAVENOUS INJECTION**
  - **Child: 250–300 micrograms/kg (max. per dose 10 mg) for 1 dose**

**KONAKION® MM PAEDIATRIC**

**Neonatal prophylaxis of vitamin-K deficiency bleeding in healthy babies who are not at risk of bleeding disorders**
- **BY MOUTH**
  - **Neonate: Initially 2 mg for 1 dose at birth, then 2 mg after 4–7 days.**

**Neonatal prophylaxis of vitamin-K deficiency bleeding in healthy babies who are not at risk of bleeding disorders (exclusively breast fed babies)**
- **BY MOUTH**
  - **Neonate: Initially 2 mg for 1 dose at birth, then 2 mg after 4–7 days for a further 1 dose, then 2 mg for a further 1 dose 1 month after birth.**

**CAUTIONS**
- Intravenous injections should be given very slowly—risk of vascular collapse

**KONAKION® MM PAEDIATRIC** Parenteral administration in premature infant or neonate of less than 2.5 kg (increased risk of kernicterus).

**PREGNANCY** Use if potential benefit outweighs risk.

**BREAST FEEDING** Present in milk.

**HEPATIC IMPAIRMENT**

**DIRECTIONS FOR ADMINISTRATION**
- With oral use in neonates The contents of one capsule should be administered by cutting the narrow tubular tip off and squeezing the liquid contents into the mouth; if the baby spits out the dose or is sick within three hours of administration a replacement dose should be given.

**KONAKION® MM PAEDIATRIC** Konakion® MM Paediatric may be administered by mouth or by intramuscular injection or by intravenous injection. For intravenous injection, may be diluted with Glucose 5% if necessary.

**KONAKION® MM** Konakion® MM may be administered by slow intravenous injection or by intravenous infusion in glucose 5%; not for intramuscular injection.

**MEDICINAL FORMS**

- **Tablet**
  - Menadiol (Non-proprietary)
    - Menadiol sodium phosphate (as menadiol phosphate) 10mg
      - Menadiol 10mg tablets | 100 tablet £204.49 DT + £204.49

**NEOKAY**

**Neonatal prophylaxis of vitamin-K deficiency bleeding in healthy babies who are not at particular risk of bleeding disorders**
- **BY MOUTH**
  - **Neonate: 1 mg for 1 dose at birth (to protect from the risk of vitamin K deficiency bleeding in the first week).**

**Neonatal prophylaxis of vitamin-K deficiency bleeding in healthy babies who are not at particular risk of bleeding disorders (exclusively breast-fed babies)**
- **BY MOUTH**
  - **Neonate: Initially 1 mg for 1 dose at birth, then 1 mg every week for 12 weeks.**

**MEDICINAL FORMS**

- **Tablet**
  - Menadiol (Neceuticals Ltd)
    - Menadiol sodium phosphate (as menadiol phosphate) 300 micrograms/kg (max. per dose 1 mg) for 1 dose
      - Menadiol 10mg tablets | 100 capsule £34.00

- **K-Cap** (Transdermal Ltd)

- **NeoKay** (Neceuticals Ltd)

**Solution for injection**

**EXCIPIENTS:** May contain Glycocholic acid, lecithin

- **Phytomenadione 10 mg per 1mL** Konakion MM Paediatric 2mg/0.2ml solution for injection ampoules | 5 ampoule £71.71 DT + £71.71

**Capsule**

- **K-Cap (Transdermal Ltd)**

- **NeoKay (Neceuticals Ltd)**

**Phytomenadione 1mg** NeoKay 1mg capsules | 12 capsule £95 DT + £3.95

**Phytomenadione 10mg** NeoKay 1mg capsules | 30 capsule £158.80

**Phytomenadione 1 mg** NeoKay 1mg capsules | 10 capsule £34.00
7.1 Neural tube defects (prevention in pregnancy)

Neural tube defects (prevention in pregnancy) 01-Aug-2017

Description of condition
Neural tube defects represent a group of congenital defects, caused by incomplete closure of the neural tube within 28 days of conception. The most common forms are anencephaly, spina bifida and encephalocele.

The main risk factors are maternal folate deficiency, maternal vitamin B₁₂ deficiency, previous history of having an infant with a neural tube defect, smoking, diabetes, obesity, and use of antiepileptic drugs. For information on smoking cessation see Smoking cessation p. 304.

Prevention in pregnancy
Pregnant women or women who wish to become pregnant should be advised to take supplementation with folic acid p. 594 before conception and until week 12 of pregnancy.

A higher daily dose (see folic acid) is recommended for women at a high risk of conceiving a child with a neural tube defect, including women who have previously had an infant with a neural tube defect, who are receiving antiepileptic medication (see Epilepsy p. 195), or who have diabetes or sickle-cell disease.

Useful Resources
www.nice.org.uk/guidance/cg62

www.nice.org.uk/guidance/cg156
Chapter 10
Musculoskeletal system

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1 Arthritis

Juvenile idiopathic arthritis

Management
Rheumatic diseases require symptomatic treatment to relieve pain, swelling, and stiffness, together with treatment to control and suppress disease activity. Treatment of juvenile idiopathic arthritis may involve non-steroidal anti-inflammatory drugs p. 674 (NSAIDs), a disease modifying anti-rheumatic drug (DMARD) such as methotrexate p. 563 or a cytokine modulator, and intra-articular, intravenous, or oral corticosteroids.

Rheumatic disease, suppressing drugs

Overview
Certain drugs, such as methotrexate p. 563, cytokine modulators, and sulfasalazine p. 33, are used to suppress the disease process in juvenile idiopathic arthritis (juvenile chronic arthritis); these drugs are known as disease modifying antirheumatic drugs (DMARDs). In children, DMARDs should be used under specialist supervision. Some children with juvenile idiopathic arthritis do not require DMARDs. Methotrexate is effective in juvenile idiopathic arthritis; sulfasalazine is an alternative but should be avoided in systemic-onset juvenile idiopathic arthritis. Gold and penicillamine p. 639 are no longer used. Cytokine modulators have a role in polyarticular juvenile idiopathic arthritis.

Unlike NSAIDs, DMARDs can affect the progression of disease but they may require 3–6 months of treatment for a full therapeutic response. Response to a DMARD may allow the dose of the NSAID to be reduced. DMARDs can improve not only the symptoms of inflammatory joint disease but also extra-articular manifestations. They reduce the erythrocyte sedimentation rate and C-reactive protein.

Antimalarials
The antimalarial hydroxychloroquine sulfate p. 662 is rarely used to treat juvenile idiopathic arthritis. Hydroxychloroquine sulfate can also be useful for systemic or discoid lupus erythematosus, particularly involving the skin and joints, and in sarcoidosis.

Retinopathy rarely occurs provided that the recommended doses are not exceeded. Mepacrine hydrochloride is used on rare occasions to treat discoid lupus erythematosus [unlicensed].

Drugs affecting the immune response
Methotrexate, given as a once weekly dose, is the DMARD of choice in the treatment of juvenile idiopathic arthritis and also has a role in juvenile dermatomyositis, vasculitis, uveitis, systemic lupus erythematosus, localised scleroderma, and sarcoidosis; for these indications it is given by the subcutaneous, oral, or rarely, the intramuscular route. Absorption from intramuscular or subcutaneous routes may be more predictable than from the oral route; if the oral route is ineffective subcutaneous administration is generally preferred. Folic acid may reduce mucosal or gastro-intestinal side-effects of methotrexate. The dosage regimen for folic acid p. 594 has not been established—in children over 2 years a weekly dose [unlicensed indication], may be given on a different day from the methotrexate.

Azathioprine p. 536 may be used in children for vasculitis which has failed to respond to other treatments, for the management of severe cases of systemic lupus erythematosus and other connective tissue disorders, in conjunction with corticosteroids for patients with severe or progressive renal disease, and in cases of polymyositis which are resistant to corticosteroids. Azathioprine has a corticosteroid-sparing effect in patients whose corticosteroid requirements are excessive. Ciclosporin p. 537 is rarely used in juvenile idiopathic arthritis, connective tissue diseases, vasculitis, and uveitis; it may be considered if the condition has failed to respond to other treatments.

Cytokine modulators
Cytokine modulators should be used under specialist supervision.

Adalimumab p. 665, etanercept p. 667, and infliximab p. 35 inhibit the activity of tumour necrosis factor alpha (TNF-α). Adalimumab can be used for the management of active polyarticular juvenile idiopathic arthritis and enthesitis-related arthritis. Etanercept is licensed for the treatment of the following subtypes of juvenile idiopathic arthritis: polyarticular juvenile idiopathic arthritis in children who have had an inadequate response to methotrexate or who cannot tolerate it, oligoarthritis in children who have had an inadequate response to methotrexate or who cannot tolerate it, psoriatic arthritis in children over 12 years who have had an inadequate response to methotrexate or cannot tolerate it, and enthesitis-related arthritis in children over 12 years who have had an inadequate response to conventional therapy or cannot tolerate it. Infliximab has been used in...
refractory polyarticular juvenile idiopathic arthritis [unlicensed indication] when other treatments, such as etanercept, have failed.

Abatacept p. 664 prevents the full activation of T-lymphocytes; it can be used for the management of active polyarticular juvenile idiopathic arthritis. Abatacept is not recommended for use in combination with TNF inhibitors. Canakinumab p. 543 inhibits the activity of interleukin-1 beta (IL-1β) and is licensed for the treatment of active systemic juvenile idiopathic arthritis in children over 2 years, when there has been an inadequate response to NSAIDs and systemic corticosteroids.

Tocilizumab p. 663 antagonises the actions of interleukin-6; it can be used for the management of active systemic juvenile idiopathic arthritis when there has been an inadequate response to NSAIDs and systemic corticosteroids and polyarticular juvenile idiopathic arthritis when there has been an inadequate response to methotrexate. Tocilizumab can be used in combination with methotrexate, or as monotherapy if methotrexate is not tolerated or is contra-indicated. Tocilizumab is not recommended for use with other cytokine modulators.

Sulfasalazine
Sulfasalazine has a beneficial effect in suppressing the inflammatory activity associated with some forms of juvenile idiopathic arthritis; it is generally not used in systemic-onset disease.

Other drugs used for Arthritis

- Cyclophosphamide, p. 555
- Diclofenac sodium, p. 676
- Etoricoxib, p. 677
- Flurbiprofen, p. 678
- Ibuprofen, p. 679
- Indometacin, p. 681
- Mefenamic acid, p. 682
- Meloxicam, p. 683
- Naproxen, p. 683
- Piroxicam, p. 684

DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS

Hydroxychloroquine sulfate

- **INDICATIONS AND DOSE**
  - Active rheumatoid arthritis (including juvenile idiopathic arthritis) (administered on expert advice) | Systemic and discoid lupus erythematosus (administered on expert advice) | Dermatological conditions caused or aggravated by sunlight (administered on expert advice)
    - **BY MOUTH**
      - Child: 5–6.5 mg/kg once daily (max. per dose 400 mg), dose given based on ideal body-weight

- **UNLICENSED USE** Plaquenil® not licensed for use in children for dermatological conditions caused or aggravated by sunlight.

- **CAUTIONS** Acute porphyrias p. 624 | diabetes (may lower blood glucose) | G6PD deficiency | may aggravate myasthenia gravis | may exacerbate psoriasis | neurological disorders (especially in those with a history of epilepsy—may lower seizure threshold) | severe gastro-intestinal disorders.

- **CAUTIONS, FURTHER INFORMATION**
  - Screening for retinopathy. A review group convened by the Royal College of Ophthalmologists has updated guidelines on screening for chloroquine and hydroxychloroquine retinopathy (Hydroxychloroquine and Chloroquine Retinopathy: Recommendations on Screening 2018). There are no reports of hydroxychloroquine retinopathy in patients under the age of 18 years, or evidence for screening paediatric patients for drug toxicity. However, the guideline recommends long-term users of hydroxychloroquine under the age of 18 years who otherwise satisfy the screening criteria should be referred for screening.

- **INTERACTIONS** Appendix 1: hydroxychloroquine

- **SIDE-EFFECTS**
  - Common or very common Abdominal pain | appetite decreased | diarrhoea | emotional lability | headache | nausea | skin reactions | vision disorders | vomiting
  - Uncommon Alopecia | corneal oedema | dizziness | eye disorders | hair colour changes | nervousness | neuromuscular dysfunction | retinopathy | seizure | tinnitus | vertigo
  - Frequency not known Acute hepatic failure | agranulocytosis | anaemia | angioedema | bone marrow disorders | bronchospasm | cardiac conduction disorders | cardiomyopathy | hearing loss | hypoglycaemia | leucopenia | movement disorders | muscle weakness | myopathy | photosensitivity reaction | psychosis | reflexes absent | severe cutaneous adverse reactions (SCARs) | thrombocytopenia | tremor | ventricular hypertrophy

- **OVERDOSE** Hydroxychloroquine is very toxic in overdosage; overdosage is extremely hazardous and difficult to treat. Urgent advice from the National Poisons Information Service is essential. Life-threatening features include arrhythmias (which can have a very rapid onset) and convulsions (which can be intractable).

- **PREGNANCY** It is not necessary to withdraw an antimalarial drug during pregnancy if the rheumatic disease is well controlled; however, the manufacturer of hydroxychloroquine advises avoiding use.

- **BREAST FEEDING** Avoid—risk of toxicity in infant.

- **HEPATIC IMPAIRMENT** Caution in moderate to severe hepatic impairment.

- **RENAI IMPAIRMENT** Manufacturer advises caution.

- **PRESCRIBING AND DISPENSING INFORMATION** To avoid excessive dosage in obese patients, the dose of hydroxychloroquine should be calculated on the basis of ideal body-weight.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

- **Tablet**
  - **CAUTIONARY AND ADVISORY LABELS** 21
    - Hydroxychloroquine sulfate (Non-proprietary)
    - Hydroxychloroquine sulfate 200 mg Hydrochloroquine 200mg tablets | 60 tablet [PBN] £32.49 DT = £3.70
    - Quinoric (Bristol Laboratories Ltd)
      - Hydroxychloroquine sulfate 200 mg Quinoric 200mg tablets | 60 tablet [PBN] £4.75 DT = £0.70

IMMUNOSUPPRESSANTS > INTERLEUKIN INHIBITORS

Anakinra

- **INDICATIONS AND DOSE** Cryopyrin-associated periodic syndromes (specialist use only)
  - **BY SUBCUTANEOUS INJECTION**
    - Child 8 months–17 years (body-weight 10 kg and above): 1–2 mg/kg daily, for severe cryopyrin–associated periodic syndromes, usual maintenance is 3–4 mg/kg daily, up to a maximum of 8 mg/kg daily
    - Still's disease (specialist use only)
      - **BY SUBCUTANEOUS INJECTION**
        - Child 8 months–17 years (body-weight 10–49 kg): 1–2 mg/kg daily, increased if necessary up to 4 mg/kg daily
        - Child 8 months–17 years (body-weight 50 kg and above): 100 mg daily, increased if necessary up to 4 mg/kg daily
CONTRA-INDICATIONS Active infection - neutropenia (absolute neutrophil count less than 1.5 × 10^9/litre)—do not initiate - pre-existing malignancy

CAUTIONS Elderly - history of asthma (increased risk of serious infection) - history of recurrent infection - predisposition to infection

INTERACTIONS → Appendix 1: anakinra

SIDE-EFFECTS
- Common or very common: Headache - infection - neutropenia - thrombocytopenia
- Uncommon: Skin reactions
- Frequency not known: Hepatitis

SIDE-EFFECTS, FURTHER INFORMATION Neutropenia reported commonly—discontinue if neutropenia develops.

PREGNANCY Manufacturer advises avoid.

BREAST FEEDING Manufacturer advises avoid—no information available.

HEPATIC IMPAIRMENT Manufacturer advises caution in severe impairment.

RENAL IMPAIRMENT: Manufacturer advises caution in moderate impairment.

Dose adjustments: Manufacturer advises consider alternate day dosing in severe impairment.

PRE-TREATMENT SCREENING: Manufacturer advises patients should be screened for latent tuberculosis and viral hepatitis prior to initiation of treatment.

MONITORING REQUIREMENTS
- Manufacturer advises monitor neutrophil count before treatment, then every month for 6 months, then every 3 months thereafter.
- When used for Cryopyrin-associated periodic syndromes: Manufacturer advises monitor for CNS inflammation (including ear and eye tests) 3 months after starting treatment, then every 6 months until effective treatment doses have been identified, then yearly thereafter.
- When used for Still's disease: Manufacturer advises consider routine monitoring of hepatic enzymes during the first month of treatment.

PRESCRIBING AND DISPENSING INFORMATION
- When used for Cryopyrin-associated periodic syndromes or Still's disease: The manufacturer of Kineret® has provided a Guide for Healthcare Professionals.

PATIENT AND CARER ADVICE
Blood disorders: Patients should be instructed to seek medical advice if symptoms suggestive of neutropenia (such as fever, sore throat, bruising or, bleeding) develop.

When used for Still's disease: A patient card and patient booklet should be provided.

When used for Cryopyrin-associated periodic syndromes: A patient booklet should be provided.

NATIONAL FUNDING/ACCESS DECISIONS
Scottish Medicines Consortium (SMC) decisions
SMC No. 05/02
The Scottish Medicines Consortium has advised (November 2002) that anakinra (Kineret®) is not recommended for the treatment of rheumatoid arthritis within NHS Scotland.

SMC No. SMC2104
The Scottish Medicines Consortium has advised (October 2018) that anakinra (Kineret®) is accepted for use within NHS Scotland for the treatment of Still’s disease, as monotherapy or in combination with other anti-inflammatory drugs and disease-modifying anti-rheumatic drugs.

Tocilizumab

INDICATIONS AND DOSE
Active systemic juvenile idiopathic arthritis [in combination with methotrexate or alone if methotrexate inappropriate, in children who have had an inadequate response to NSAIDs and systemic corticosteroids]
- BY INTRAVENOUS INFUSION
  - Child 2–17 years (body-weight up to 30 kg): 12 mg/kg every 2 weeks, for dose adjustments in patients with liver enzyme abnormalities, or low absolute neutrophil or platelet count—consult product literature, review treatment if no improvement within 6 weeks
  - Child 2–17 years (body-weight 30 kg and above): 8 mg/kg every 2 weeks, for dose adjustments in patients with liver enzyme abnormalities, or low absolute neutrophil or platelet count—consult product literature, review treatment if no improvement within 6 weeks

Polyarticular juvenile idiopathic arthritis [in combination with methotrexate or alone if methotrexate inappropriate, in children who have had an inadequate response to methotrexate]
- BY INTRAVENOUS INFUSION
  - Child 2–17 years (body-weight up to 30 kg): 10 mg/kg every 4 weeks, for dose adjustments in patients with liver enzyme abnormalities, or low absolute neutrophil or platelet count—consult product literature, review treatment if no improvement within 12 weeks
  - Child 2–17 years (body-weight 30 kg and above): 8 mg/kg every 4 weeks, for dose adjustments in patients with liver enzyme abnormalities, or low absolute neutrophil or platelet count—consult product literature, review treatment if no improvement within 12 weeks

ROACTEMRA® PRE-FILLED SYRINGE
Polyarticular juvenile idiopathic arthritis [in combination with methotrexate or alone if methotrexate inappropriate, in children who have had an inadequate response to methotrexate]
- BY SUBCUTANEOUS INJECTION
  - Child 2–17 years (body-weight up to 30 kg): 162 mg every 3 weeks, administer to abdomen, thigh or upper arm, for dose adjustments in patients with liver enzyme abnormalities, or low absolute neutrophil or platelet count—consult product literature, review treatment if no improvement within 12 weeks
  - Child 2–17 years (body-weight 30 kg and above): 162 mg every 2 weeks, administer to abdomen, thigh or upper arm, for dose adjustments in patients with liver enzyme abnormalities, or low absolute neutrophil or platelet count—consult product literature, review treatment if no improvement within 12 weeks

CONTRA-INDICATIONS Do not initiate if absolute neutrophil count less than 2 × 10^9/litre - severe active infection

CAUTIONS History of diverticulitis - history of intestinal ulceration - history of recurrent or chronic infection (interrupt treatment if serious infection occurs) - low absolute neutrophil count - low platelet count - predisposition to infection (interrupt treatment if serious infection occurs)
Musculoskeletal system

PATIENT AND CARER ADVICE

HANDLING AND STORAGE

With subcutaneous use
DIRECTIONS FOR ADMINISTRATION

▶ Manufacturer advises monitor for demyelinating
▶ Manufacturer advises monitor lipid pro

HEPATIC IMPAIRMENT

With subcutaneous use
Manufacturer advises monitor renal function closely in moderate-to-severe impairment—no information available.

PRE-TREATMENT SCREENING

Tuberculosis Patients should be evaluated for tuberculosis before treatment.

MONITORING REQUIREMENTS

Manufacturer advises monitor lipid profile 4–8 weeks after starting treatment and then as indicated.

Manufacturer advises monitor for demyelinating disorders.

Manufacturer advises monitor hepatic transaminases, and neutrophil and platelet count at the time of the second administration, and then as indicated.

DIRECTIONS FOR ADMINISTRATION

With intravenous use For intravenous infusion, manufacturer advises for body-weight less than 30 kg, give intermittently in Sodium chloride 0.9%, dilute requisite dose to a volume of 50 ml with infusion fluid and give over 1 hour; body-weight 30 kg or greater, give intermittently in Sodium chloride 0.9%, dilute requisite dose to a volume of 100 ml with infusion fluid and give over 1 hour.

With subcutaneous use For subcutaneous injection, manufacturer advises rotate injection site and avoid skin that is tender, damaged or scarred. Patients may self-administer RoActemra®, after appropriate training in subcutaneous injection technique.

PRESCRIBING AND DISPENSING INFORMATION

Manufacturer advises to record the brand name and batch number after each administration.

HANDLING AND STORAGE

Manufacturer advises protect from light and store in a refrigerator (2–8 °C)—consult product literature for further information regarding storage conditions outside refrigerator and after preparation of the infusion.

PATIENT AND CARER ADVICE

Manufacturer advises patients and their carers should be advised to seek immediate medical attention if symptoms of infection occur, or if symptoms of diverticular perforation such as abdominal pain, haemorrhage, or fever accompanying change in bowel habits occur.

An alert card should be provided.

Driving and skilled tasks Manufacturer advises patients should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness.

NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions

Tocilizumab for the treatment of systemic juvenile idiopathic arthritis (December 2011) NICE TA238

Tocilizumab (RoActemra®) is recommended for the treatment of systemic juvenile idiopathic arthritis in children aged 2 years and older who have not responded adequately to NSAIDs, systemic corticosteroids and methotrexate, if the manufacturer makes tocilizumab available with the discount agreed as part of the patient access scheme.

Tocilizumab is not recommended for the treatment of systemic juvenile idiopathic arthritis in children whose disease continues to respond to methotrexate or who have not been treated with methotrexate.

Patients currently receiving tocilizumab for systemic juvenile idiopathic arthritis who do not meet these criteria should have the option to continue treatment until it is considered appropriate to stop.

www.nice.org.uk/guidance/ta238

Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis (December 2015) NICE TA373

Tocilizumab (RoActemra®) is recommended as an option for treatment of polyarticular juvenile idiopathic arthritis (JIA), including polyarticular-onset, polyarticular-course and extended oligoarticular JIA in children 2 years and older whose disease has responded inadequately to previous therapy with methotrexate and if the manufacturer provides tocilizumab with the discounts agreed in the patient access schemes.

www.nice.org.uk/guidance/ta373

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Solution for injection

RoActemra (Roche Products Ltd)

Tocilizumab 180 mg per 1 ml RoActemra 162mg/0.9ml solution for injection pre-filled pen | 4 pre-filled disposable injection £913.12 DT + £913.12 RoActemra 162mg/0.9ml solution for injection pre-filled syringes | 4 pre-filled disposable injection £913.12 DT + £913.12 (Hospital only)

Solution for infusion

ELECTROLYTES: May contain Sodium

RoActemra (Roche Products Ltd)

Tocilizumab 20 mg per 1 ml RoActemra 400mg/20ml concentrate for solution for infusion vials | 1 vial £512.00 (Hospital only) Tocilizumab 200mg/10ml concentrate for solution for infusion vials | 1 vial £256.00 (Hospital only) Tocilizumab 80mg/4ml concentrate for solution for infusion vials | 1 vial £162.40 (Hospital only)

IMMUNOSUPPRESSANTS > T-CELL ACTIVATION INHIBITORS

Abatacept

00-Dec-2017

INDICATIONS AND DOSE

Moderate-to-severe dose polyarticular juvenile idiopathic arthritis (specialist use only)

BY INTRAVENOUS INFUSION

Child 6–17 years (body-weight up to 75 kg): 10 mg/kg every 2 weeks for 3 doses, then 10 mg/kg every 4 weeks, review treatment if no response within 6 months

Child 6–17 years (body-weight 75–100 kg): 750 mg every 2 weeks for 3 doses, then 750 mg every 4 weeks, review treatment if no response within 6 months

Child 6–17 years (body-weight ≥101 kg and above): 1 g every 2 weeks for 3 doses, then 1 g every 4 weeks, review treatment if no response within 6 months

CONTRA-INDICATIONS

Severe infection
MEDICINAL FORMS

Abatacept, adalimumab, etanercept and tocilizumab for NICE funding/decision decisions

DIRECTIONS FOR ADMINISTRATION

PREGNANCY

CONCEPTION AND CONTRACEPTION

Rare or very rare Pelvic inflammatory disease - respiratory malignancy

CONCEPTION AND CONTRACEPTION Effective contraception required during treatment and for 14 weeks after last dose.

PREGNANCY Manufacturer advises avoid unless essential.

PREGNANCY Breastfeeding Present in milk in animal studies - manufacturer advises avoid breastfeeding during treatment and for 14 weeks after last dose.

DIRECTIONS FOR ADMINISTRATION For intravenous infusion, given intermittently in Sodium chloride 0.9%; reconstitute each vial with 10 mL water for injections using the silicone-free syringe provided; dilute requisite dose in Sodium Chloride 0.9% to 100 mL (using the same silicone-free syringe and give over 20 minutes through a low protein-binding filter (pore size 0.2–1.2 micron).

NATIONAL FUNDING/ACCESS DECISIONS

NICE decisions

Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis (December 2015) NICE TA373

Abatacept is recommended as options for treating polyarticular juvenile idiopathic arthritis (JIA), including polyarticular-onset, polyarticular-course and extended oligoarticular JIA in patients 6 years and older whose disease has responded inadequately to other disease-modifying anti-rheumatic drugs (DMARDs) including at least 1 tumour necrosis factor (TNF) inhibitor, only if the manufacturer provides abatacept with the discounts agreed in the patient access schemes.

www.nice.org.uk/TA373

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Solution for injection

Orencia (Bristol-Myers Squibb Pharmaceuticals Ltd)

Abatacept 125 mg per 1 mL Orencia 125mg/1ml solution for injection pre-filled syringes | 4 pre-filled disposable injection $1.20960 DT + $1.20960 (Hospital only)

Orencia Clickject (Bristol-Myers Squibb Pharmaceuticals Ltd)

Abatacept 125 mg per 1 mL Orencia Clickject 125mg/1ml solution for injection pre-filled pen | 4 pre-filled disposable injection $1.20960 DT + $1.20960

Powder for solution for infusion

ELECTROLYTES: May contain Sodium

Orencia (Bristol-Myers Squibb Pharmaceuticals Ltd)

Abatacept 250 mg Orencia 250mg powder for concentrate for solution for infusion vials | 1 vial $302.40 (Hospital only)

IMMUNOSUPPRESSANTS TUMOR NECROSIS FACTOR ALPHA (TNF-α) INHIBITORS

Adalimumab

INDICATIONS AND DOSE

Plaque psoriasis (initiated by a specialist)

BY SUBCUTANEOUS INJECTION

Child 4-17 years (body-weight 15-29 kg): Initially 20 mg once weekly for 2 doses, then 20 mg every 2 weeks, review treatment if no response within 16 weeks

Child 4-17 years (body-weight 30 kg and above): Initially 40 mg once weekly for 2 doses, then 40 mg every 2 weeks, review treatment if no response within 16 weeks

Polyarticular juvenile idiopathic arthritis (initiated by a specialist)

BY SUBCUTANEOUS INJECTION

Child 2-17 years (body-weight 10-29 kg): 20 mg every 2 weeks, review treatment if no response within 12 weeks

Child 2-17 years (body-weight 30 kg and above): 40 mg every 2 weeks, review treatment if no response within 12 weeks

Enthesitis-related arthritis (initiated by a specialist)

BY SUBCUTANEOUS INJECTION

Child 6-17 years (body-weight 15-29 kg): 20 mg every 2 weeks

Child 6-17 years (body-weight 30 kg and above): 40 mg every 2 weeks

Crohn’s disease (initiated by a specialist)

BY SUBCUTANEOUS INJECTION

Child 6-17 years (body-weight up to 40 kg): Initially 40 mg, then 20 mg after 2 weeks; maintenance 20 mg every 2 weeks, increased if necessary to 20 mg once weekly, review treatment if no response within 12 weeks

Child 6-17 years (body-weight 40 kg and above): Initially 80 mg, then 40 mg after 2 weeks; maintenance 40 mg every 2 weeks, increased if necessary to 40 mg once weekly, alternatively 80 mg every 2 weeks, review treatment if no response within 12 weeks

Crohn’s disease (accelerated regimen) (initiated by a specialist)

BY SUBCUTANEOUS INJECTION

Child 6-17 years (body-weight up to 40 kg): Initially 80 mg, then 40 mg after 2 weeks; maintenance 20 mg every 2 weeks, increased if necessary to 20 mg once weekly, review treatment if no response within 12 weeks

Child 6-17 years (body-weight 40 kg and above): Initially 160 mg, dose can alternatively be given as divided injections over 2 days, then 80 mg after 2 weeks; maintenance 40 mg every 2 weeks, then increased if necessary to 40 mg once weekly, alternatively 80 mg every 2 weeks, review treatment if no response within 12 weeks

Hidradenitis suppurativa (initiated by a specialist)

BY SUBCUTANEOUS INJECTION

Child 12-17 years (body-weight 30 kg and above): Initially 80 mg, followed by 40 mg after 1 week, then maintenance 40 mg every 2 weeks; increased if necessary to 40 mg once weekly, alternatively 80 mg every 2 weeks, review treatment if no response within 12 weeks; if treatment interrupted—consult product literature

continued→
**Uveitis (initiated by a specialist)**

- **BY SUBCUTANEOUS INJECTION**
  - Child 2-17 years (body-weight up to 30 kg): Initially 40 mg, then 20 mg after 1 week; maintenance 20 mg every 2 weeks
  - Child 2-17 years (body-weight 30 kg and above): Initially 80 mg, then 40 mg after 1 week; maintenance 40 mg every 2 weeks

**CONTRA-INDICATIONS**
Moderate or severe heart failure
- severe infection

**CAUTIONS**
Children should be brought up to date with current immunisation schedule before initiating therapy
- demyelinating disorders (risk of exacerbation)
- development of malignancy
- do not initiate until active infections are controlled (discontinue if new serious infection develops)
- hepatitis B virus—monitor for active infection
- history of malignancy
- mild heart failure
- (discontinue if symptoms develop or worsen)
- predisposition to infection

**CAUTIONS, FURTHER INFORMATION**
- **Tuberculosis**
  - Active tuberculosis should be treated with standard treatment for at least 2 months before starting adalimumab. Patients who have previously received adequate treatment for tuberculosis can start adalimumab but should be monitored every 3 months for possible recurrence. In patients without active tuberculosis but who were previously not treated adequately, chemoprophylaxis should ideally be completed before starting adalimumab. In patients at high risk of tuberculosis who cannot be assessed by tuberculin skin test, chemoprophylaxis can be given concurrently with adalimumab.

**INTERACTIONS**
Appendix 1: monoclonal antibodies

**SIDE-EFFECTS**
- **Common or very common**
  - Agranulocytosis
  - alopecia
  - anaemia
  - anxiety
  - arthralgias
  - arterial occlusion
  - asthma
  - broken nails
  - chest pain
  - coagulation disorder
  - connective tissue disorders
  - cough
  - dehydration
  - depression
  - dyspnoea
  - electrolyte imbalance
  - embolism and thrombosis
  - eye inflammation
  - fever
  - flushing
  - gastrointestinal discomfort
  - gastrointestinal disorders
  - haemorrhage
  - headaches
  - healing impaired
  - hyperglycaemia
  - hypersensitivity
  - hypertension
  - increased risk of infection
  - insomnia
  - leucocytosis
  - leucopenia
  - mood altered
  - muscle spasms
  - musculoskeletal pain
  - nausea
  - neoplasms
  - nerve disorders
  - neutropenia
  - oedema
  - renal impairment
  - seasonal allergy
  - sensation abnormal
  - sepsis
  - skin reactions
  - sweat changes
  - thrombocytopenia
  - vasculitis
  - vertigo
  - vision disorders
  - vomiting

- **Uncommon**
  - Aortic aneurysm
  - congestive heart failure
  - deafness
  - demyelinating disorders
  - dysphagia
  - erectile dysfunction
  - gallbladder disorders
  - hepatic disorders
  - inflammation
  - lupus erythematosus
  - meningitis viral
  - myocardial infarction
  - nocturia
  - pancreatitis
  - respiratory disorders
  - rhabdomyolysis
  - sarcoidosis
  - solid organ neoplasms
  - stroke
  - tinnitus
  - tremor

- **Rare or very rare**
  - Cardiac arrest
  - pancytopenia
  - Stevens-Johnson syndrome

**SIDE-EFFECTS, FURTHER INFORMATION**
Associated with infections, sometimes severe, including tuberculosis, septicemia, and hepatitis B reactivation.

**CONCEPTION AND CONTRACEPTION**
Manufacturer advises effective contraception required during treatment and for at least 5 months after last dose.

**PREGNANCY**
Manufacturer advises use only if potential benefit outweighs risk.

**BREAST FEEDING**
Manufacturer advises can be used—excreted in breast milk at very low concentrations (limited information available).

**PRE-TREATMENT SCREENING**
Tuberculosis
Manufacturer advises patients should be evaluated for active and latent tuberculosis before treatment.

**MONITORING REQUIREMENTS**
- Manufacturer advises monitor for infection before, during, and for 4 months after treatment.
- Manufacturer advises monitor for non-melanoma skin cancer before and during treatment, especially in patients with a history of PUVA treatment for psoriasis or extensive immunosuppressant therapy.
- For uveitis, manufacturer advises patients should be assessed for pre-existing or developing central demyelinating disorders before and at regular intervals during treatment.

**PRESCRIBING AND DISPENSING INFORMATION**
Adalimumab is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1.

**PATIENT AND CARER ADVICE**
When used to treat *hidradenitis suppurativa*, patients and their carers should be advised to use a daily topical antiseptic wash on lesions during treatment with adalimumab.

Tuberculosis patients and their carers should be advised to seek medical attention if symptoms suggestive of tuberculosis (e.g. persistent cough, weight loss, or, and fever) develop.

Blood disorders Patients and their carers should be advised to seek medical attention if symptoms suggestive of blood disorders (such as fever, sore throat, bruising, or bleeding) develop.

Alert card
An alert card should be provided.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**
- Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis (December 2015) NICE TA373
  - Adalimumab is recommended as an option for treating polyarticular juvenile idiopathic arthritis (JIA), including polyarticular-onset, polyarticular-course and extended oligoarticular JIA in patients 2 years and older whose disease has responded inadequately to 1 or more disease-modifying antirheumatic drugs (DMARDs) and for treating enthesitis-related JIA in patients 6 years and older whose disease has responded inadequately to, or who are intolerant of, conventional therapy.
  - [www.nice.org.uk/guidance/ta373](http://www.nice.org.uk/guidance/ta373)

- Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people (July 2017) NICE TA455
  - Adalimumab is recommended as an option for treating plaque psoriasis in children and young people aged 4 years or older, only if the disease:
    - is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and
    - has not responded to standard systemic therapy, such as ciclosporin, methotrexate or phototherapy, or these options are contra-indicated or not tolerated.
  - Stop treatment at 16 weeks if the psoriasis has not responded adequately. An adequate response is defined as a 75% reduction in the PASI score from the start of treatment.
  - Patients currently receiving adalimumab who do not meet the above criteria and whose treatment was started within the NHS before this guidance was published, should have the option to continue treatment until they and their clinician consider it appropriate to stop.
  - [www.nice.org.uk/guidance/ta455](http://www.nice.org.uk/guidance/ta455)

**Scottish Medicines Consortium (SMC) decisions**
The Scottish Medicines Consortium has advised (April 2015) that adalimumab (Humira®) is accepted for restricted use.
within NHS Scotland for the treatment of active enthesitis-related arthritis in children 6 years of age and over who have had an inadequate response to, or who are intolerant of, conventional therapy, and is used within specialist rheumatology services (including those working within the network for paediatric rheumatology).

The Scottish Medicines Consortium has advised (June 2017) that adalimumab (Humira®) is accepted for use within NHS Scotland for the treatment of active moderate-to-severe hidradenitis suppurativa (HS) (acne inversa) in adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy.

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

**CAUTIONARY AND ADVISORY LABELS**

- **Humira** (AbbVie Ltd)
  - Adalimumab 50 mg per 1 ml Humira 40mg/0.4ml solution for injection pre-filled syringes | 2 pre-filled disposable injection (POD) £633.85
  - Adalimumab 40mg/0.8ml solution for injection pre-filled pen | 2 pre-filled disposable injection (POD) £633.85

- **Humira** (Biogen Idec Ltd)
  - Imraldi 40mg/0.8ml solution for injection pre-filled syringes | 2 pre-filled disposable injection (POD) £633.85

**Etanercept**

### INDICATIONS AND DOSE

**BENEPAVL® SOLUTION FOR INJECTION**

Polyarthritis in children who have had an inadequate response to methotrexate or who cannot tolerate it

- By subcutaneous injection
  - Child 2-7 years: 800 micrograms/kg once weekly (max. per dose 50 mg), consider discontinuation if no response after 4 months

Psoriatic arthritis in adolescents who have had an inadequate response to methotrexate or who cannot tolerate it

- By subcutaneous injection
  - Child 12-17 years: 800 micrograms/kg once weekly (max. per dose 50 mg), consider discontinuation if no response after 4 months

**Chronic, severe plaque psoriasis in children who have had an inadequate response to other systemic therapies or phototherapies or who cannot tolerate them**

- By subcutaneous injection
  - Child 6-17 years: 800 micrograms/kg once weekly (max. per dose 50 mg) for up to 24 weeks, discontinue if no response after 12 weeks

**Enbrel® POWDER AND SOLVENT FOR SOLUTION FOR INJECTION**

Polyarthritis in children who have had an inadequate response to methotrexate or who cannot tolerate it

- By subcutaneous injection
  - Child 2-7 years: 400 micrograms/kg twice weekly (max. per dose 25 mg), to be given at an interval of 3—4 days between doses, alternatively 800 micrograms/kg once weekly (max. per dose 50 mg), consider discontinuation if no response after 4 months

Psoriatic arthritis in adolescents who have had an inadequate response to methotrexate or who cannot tolerate it

- By subcutaneous injection
  - Child 12-17 years: 400 micrograms/kg twice weekly (max. per dose 25 mg), to be given at an interval of 3—4 days between doses, alternatively 800 micrograms/kg once weekly (max. per dose 50 mg), consider discontinuation if no response after 4 months

**Chronic, severe plaque psoriasis in children who have had an inadequate response to other systemic therapies or phototherapies or who cannot tolerate them**

- By subcutaneous injection
  - Child 6-17 years: 800 micrograms/kg once weekly (max. per dose 50 mg) for up to 24 weeks, discontinue if no response after 12 weeks
**ENBREL<sup>®</sup> SOLUTION FOR INJECTION**

**Polyarthritis in children who have had an inadequate response to methotrexate or who cannot tolerate it**

- Extended oligoarthritis in children who have had an inadequate response to methotrexate or who cannot tolerate it
  - **BY SUBCUTANEOUS INJECTION**
    - Child 2-17 years: 400 micrograms/kg twice weekly (max. per dose 25 mg), to be given at an interval of 3–4 days between doses, alternatively 800 micrograms/kg once weekly (max. per dose 50 mg), consider discontinuation if no response after 4 months

**Psoriatic arthritis in adolescents who have had an inadequate response to methotrexate or who cannot tolerate it**

- **BY SUBCUTANEOUS INJECTION**
  - Child 12-17 years: 400 micrograms/kg twice weekly (max. per dose 25 mg), to be given at an interval of 3–4 days between doses, alternatively 800 micrograms/kg once weekly (max. per dose 50 mg), consider discontinuation if no response after 4 months

**Chronic, severe plaque psoriasis in children who have had an inadequate response to other systemic therapies or phototherapies or who cannot tolerate them**

- **BY SUBCUTANEOUS INJECTION**
  - Child 6-17 years: 800 micrograms/kg once weekly (max. per dose 50 mg) for up to 24 weeks, discontinue if no response after 12 weeks

**CONTRA-INDICATIONS**

- Active infection
- Avoid injections containing benzyl alcohol in neonates

**CAUTIONS**

- Children should be brought up to date with current immunisation schedule before initiating therapy
- Development of malignancy
- Diabetes mellitus
- Heart failure (risk of exacerbation)
- Hepatitis B virus—monitor for active infection
- Hepatitis C infection (monitor for worsening infection)
- History of blood disorders
- History of malignancy
- History or increased risk of demyelinating disorders
- Predisposition to infection (avoid if predisposition to septicemia)
- Significant exposure to herpes zoster virus—interrupt treatment and consider varicella–zoster immunoglobulin

**CAUTIONS, FURTHER INFORMATION**

- **Tuberculosis**
  - Active tuberculosis should be treated with standard treatment for at least 2 months before starting etanercept. Patients who have previously received adequate treatment for tuberculosis can start etanercept but should be monitored every 3 months for possible recurrence. In patients without active tuberculosis but who were previously not treated adequately, chemoprophylaxis should ideally be completed before starting etanercept. In patients at high risk of tuberculosis who cannot be assessed by tuberculin skin test, chemoprophylaxis can be given concurrently with etanercept.

**INTERACTIONS**

- **Appendix 1**: etanercept

**SIDE-EFFECTS**

- **Common or very common**
  - Cystitis
  - Fever
  - Hypersensitivity
  - Increased risk of infection
  - Pain
  - Skin reactions
  - Swelling
- **Uncommon**
  - Abscess
  - Bursitis
  - Cholecystitis
  - Diarrhoea
  - Endocarditis
  - Eye inflammation
  - Gastritis
  - Hepatic disorders
  - Myositis
  - Neoplasms
  - Respiratory disorders
  - Sepsis
  - Skin ulcers
  - Thrombocytopenia
  - Vasculitis
- **Rare or very rare**
  - Anaemia
  - Bone marrow disorders
  - Congestive heart failure
  - Cutaneous lupus erythematosus
  - Demyelination
  - Leucopenia
  - Lupus-like syndrome
  - Nerve disorders
  - Neutropenia
  - Sarcoidosis
  - Seizure
  - Severe cutaneous adverse reactions (SCARs)
  - Transverse myelitis

- **Frequency not known**
  - Abdominal pain
  - Depression
  - Dermatomyositis exacerbated
  - Headache
  - Hepatitis B reactivation
  - Inflammatory bowel disease
  - Macrophage activation syndrome
  - Nausea
  - Personality disorder
  - Post procedural infection
  - Type 1 diabetes mellitus
  - Vomiting

**SIDE-EFFECTS, FURTHER INFORMATION**

- Associated with infections, sometimes severe, including tuberculosis, septicemia, and hepatitis B reactivation.

**CONCEPTION AND CONTRACEPTION**

- Manufacturer advises effective contraception required during treatment and for 3 weeks after last dose.

**PREGNANCY**

- Avoid—limited information available.

**BREAST FEEDING**

- Manufacturer advises avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT**

- Manufacturer advises caution in moderate to severe alcoholic hepatitis.

**PRE-TREATMENT SCREENING**

- Tuberculosis: Patients should be evaluated for tuberculosis before treatment.

**MONITORING REQUIREMENTS**

- Monitor for skin cancer before and during treatment, particularly in those at risk (including patients with psoriasis or a history of PUVA treatment).

**PRESCRIBING AND DISPENSING INFORMATION**

- Etanercept is a biological medicine. Biological medicines must be prescribed and dispensed by brand name, see Biological medicines and Biosimilar medicines, under Guidance on prescribing p. 1.

**BENEPALI<sup>®</sup> SOLUTION FOR INJECTION**

- Manufacturer advises patients requiring less than the full 50 mg dose should not receive Benepali<sup>®</sup>-if an alternate dose is required, other etanercept formulations providing this option should be used.

**PATIENT AND CARER ADVICE**

- Blood disorders: Patients and their carers should be advised to seek medical attention if symptoms suggestive of blood disorders (such as fever, sore throat, bruising, or bleeding) develop.

- Tuberculosis: Patients and their carers should be advised to seek medical attention if symptoms suggestive of tuberculosis (e.g. persistent cough, weight loss, and fever) develop.

- Alert card: An alert card should be provided.

- Medicines for Children leaflet: Etanercept for juvenile idiopathic arthritis www.medicinesforchildren.org.uk/etanercept-juvenile-idiopathic-arthritis

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

- Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis (December 2015)

**NICE TA373**

- Etanercept is recommended as an option for treating:
  - Polyarticular juvenile idiopathic arthritis (JIA), including polyarticular-onset, polyarticular-course and extended oligoarticular JIA, in patients 2 years and over whose disease has responded inadequately to, or who are intolerant of, methotrexate;
  - Enthesitis-related JIA in patients 12 years and over whose disease has responded inadequately to, or who are intolerant of, conventional therapy;
  - Psoriatic JIA in patients 12 years and over whose disease has responded inadequately to, or who are intolerant of, methotrexate.

- **www.nice.org.uk/TA373**

- Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people (July 2017)

- Etanercept is recommended as an option for treating plaque psoriasis in children and young people aged 6 years and older, only if the disease:
is severe, as defined by a total Psoriasis Area and
Severity Index (PASI) of 10 or more, and
has not responded to standard systemic therapy, such as
ciclosporin, methotrexate or phototherapy, or these
options are contra-indicated or not tolerated.
If the psoriasis has not responded adequately, stop
treatment at 12 weeks. An adequate response is defined as a
75% reduction in PASI score from the start of treatment.
Patients currently receiving etanercept who do not meet
the above criteria and whose treatment was started within
the NHS before this guidance was published, should have
the option to continue treatment until they and their
clinician consider it appropriate to stop.

www.nice.org.uk/guidance/TA445

Scottish Medicines Consortium (SMC) decisions
The Scottish Medicines Consortium has advised (February 2013) that etanercept (Enbrel<sup>®</sup>) is accepted for restricted
use within NHS Scotland for the treatment of polyarthritis
(rheumatoid factor positive or negative) and extended oligoarthritis in children and adolescents from the age of
2 years who have had an inadequate response to or are
intolerant of methotrexate, psoriatic arthritis in adolescents
from the age of 12 years who have had an inadequate response to or are intolerant of methotrexate,
and enthesitis-related arthritis in adolescents from the age of
12 years who have had an inadequate response to or are
intolerant of conventional therapy. It is further restricted
to use within specialist rheumatology services (including
those working within the network for paediatric
rheumatology).

MEDICINAL FORMS There can be variation in the licensing of
different medicines containing the same drug.

Solution for injection

CAUTIONARY AND ADVISORY LABELS 10

* BENEPALI (Biogen Idec Ltd)
  - Etanercept 50 mg per 1 ml BENEPALI 50mg/1ml solution for injection pre-filled syringes | 4 pre-filled disposable injection [PDP] £656.00 DT
  - £715.00
  BENEPALI 50mg/1ml solution for injection pre-filled pen | 4 pre-filled disposable injection [PDP] £656.00

* ENBREL (Pfizer Ltd)
  - Etanercept 50 mg per 1 ml ENBREL 50mg/1ml solution for injection pre-filled syringes | 4 pre-filled disposable injection [PDP] £715.00 DT
  - £715.00 (Hospital only)
  ENBREL 25mg/0.5ml solution for injection pre-filled syringes | 4 pre-filled disposable injection [PDP] £357.50 DT + £357.50 (Hospital only)

* ENBREL MYCLIC (Pfizer Ltd)
  - Etanercept 50 mg per 1 ml ENBREL MYCLIC 50mg/1ml solution for injection pre-filled MyClic pen | 4 pre-filled disposable injection [PDP] £715.00 (Hospital only)
  ENBREL MYCLIC 25mg/0.5ml solution for injection pre-filled MyClic pen | 4 pre-filled disposable injection [PDP] £357.50 (Hospital only)

Powder and solvent for solution for injection

CAUTIONARY AND ADVISORY LABELS 10

EXCIPIENTS: May contain Benzyl alcohol

* ENBREL (Pfizer Ltd)
  - Etanercept 10 mg ENBREL Paediatric 10mg powder and solvent for solution for injection vials | 4 vial [PDP] £143.00 (Hospital only)
  - Etanercept 25 mg ENBREL 25mg powder and solvent for solution for injection vials | 4 vial [PDP] £357.50 (Hospital only)

Golimumab

INDICATIONS AND DOSE

Polyarticular juvenile idiopathic arthritis (initiated by a specialist)
BYSUBCUTANEOUS INJECTION
Child (body-weight 40 kg and above): 50 mg once a
month, on the same date each month, review
treatment if no response after 3–4 doses

CONTRA-INDICATIONS Moderate or severe heart failure - severe active infection

CAUTIONS Active infection (do not initiate until active
infections are controlled; discontinue if new serious
infection develops until infection controlled) - children
should be brought up to date with current immunisation
schedule before initiating therapy - demyelinating
neuropathies (risk of exacerbation) - hepatitis B virus—monitor
for active infection - history of development of malignancy
- mild heart failure (discontinue if symptoms develop or
worsen) - predisposition to infection - risk factors for
dysplasia or carcinoma of the colon—screen for dysplasia
regularly

CAUTIONS, FURTHER INFORMATION
- Tuberculosis Active tuberculosis should be treated with
standard treatment for at least 2 months before starting
golimumab. Patients who have previously received
adequate treatment for tuberculosis can start golimumab
but should be monitored every 3 months for possible
recurrence. In patients without active tuberculosis but
who were previously not treated adequately,
chemoprophylaxis should ideally be completed before
starting golimumab. In patients at high risk of tuberculosis
who cannot be assessed by tuberculin skin test,
chemoprophylaxis can be given concurrently with
golimumab. Patients who have tested negative for latent
tuberculosis, and those who are receiving or who have
completed treatment for latent tuberculosis, should be
monitored closely for symptoms of active infection.

INTERACTIONS ➤ Appendix 1: monoclonal antibodies

SIDE-EFFECTS
- Common or very common Abscess - alopecia - anaemia -
asthenia - asthma - bone fracture - chest discomfort -
depression - dizziness - fever - gastrointestinal discomfort -
gastrointestinal disorders - gastrointestinal inflammatory
orders - headache - hypersensitivity - hypertension -
increased risk of infection - insomnia - nausea -
paraesthesia - respiratory disorders - skin reactions -
stomatitis

- Uncommon Arrhythmia - balance impaired - bone marrow
orders - breast disorder - cholelithiasis - constipation -
eye inflammation - eye irritation - flushing - goitre -
hyperthyroidism - hypothyroidism - leucopenia - liver
order - menstrual disorder - myocardial ischaemia -
neoplasms - sepsis - thrombocytopenia - thrombosis -
thyroid disorder - vision disorders

- Rare or very rare Bladder disorder - congestive heart failure -
demyelination - healing impaired - hepatitis B
reactivation - lupus-like syndrome - Raynaud’s
phenomenon - renal disorder - sarcoidosis - taste altered -
vasculitis

SIDE-EFFECTS, FURTHER INFORMATION Associated with
infections, sometimes severe, including tuberculosis,
septicemia, and hepatitis B reactivation.

CONCEPTION AND CONTRACEPTION Manufacturer advises
adequate contraception during treatment and for at least
6 months after last dose.

PREGNANCY Use only if essential.

BREAST FEEDING Manufacturer advises avoid during and
for at least 6 months after treatment—present in milk in
animal studies.

HEPATIC IMPAIRMENT Manufacturer advises caution (no
information available).

PRE-TREATMENT SCREENING Tuberculosis Patients should be evaluated for tuberculosis
before treatment.

MONITORING REQUIREMENTS Monitor for infection before,
during, and for 5 months after treatment.

DIRECTIONS FOR ADMINISTRATION Missed dose If dose administered more than 2 weeks late,
subsequent doses should be administered on the new
monthly due date.
● **PATIENT AND CARER ADVICE**

**Tuberculosis** All patients and their carers should be advised to seek medical attention if symptoms suggestive of tuberculosis (e.g. persistent cough, weight loss, and fever) develop.

**Blood disorders** Patients and their carers should be advised to seek medical attention if symptoms suggestive of blood disorders (such as fever, sore throat, bruising, or bleeding) develop.

Alert card An alert card should be provided.

● **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

| CAUTIONARY AND ADVISORY LABELS | 10 |
| Simponi (Merck Sharp & Dohme Ltd) |
| Gollumab 100 mg per 1 ml Simponi 50mg/0.5ml solution for injection pre-filled pen | 1 pre-filled disposable injection (PFS) |
| £762.97 DT = £762.97 |
| Simponi 50mg/0.5ml solution for injection pre-filled syringes | 1 pre-filled disposable injection (PFS) £762.97 DT = £762.97 |
| Simponi 100mg/1ml solution for injection pre-filled pen | 1 pre-filled disposable injection (PFS) £1,525.94 DT = £1,525.94 |

2 **Neuromuscular disorders**

**Neuromuscular disorders**

**Drugs that enhance neuromuscular transmission**

Anticholinesterases are used as first-line treatment in *ocular myasthenia gravis* and as an adjunct to immunosuppressant therapy for *generalised myasthenia gravis*.

Corticosteroids are used when anticholinesterases do not control symptoms completely. A second-line immunosuppressant such as azathioprine p. 536 is frequently used to reduce the dose of corticosteroid.

Plasmapheresis or infusion of intravenous immunoglobulin [unlicensed indication] may induce temporary remission in severe relapses, particularly where bulbar or respiratory function is compromised or before thymectomy.

**Anticholinesterases**

Anticholinesterase drugs enhance neuromuscular transmission in voluntary and involuntary muscle in myasthenia gravis. Excessive dosage of these drugs can impair neuromuscular transmission and precipitate cholinergic crises by causing a depolarising block. This may be difficult to distinguish from a worsening myasthenic state.

Muscarinic side-effects of anticholinesterases include increased sweating, increased salivary and gastric secretions, increased gastro-intestinal and uterine motility, and bradycardia. These parasympathomimetic effects are antagonised by atropine sulfate p. 837.

Neostigmine p. 672 produces a therapeutic effect for up to 4 hours. Its pronounced muscarinic action is a disadvantage, and simultaneous administration of an antimuscarinic drug such as atropine sulfate or propantheline bromide p. 64 may be required to prevent colic, excessive salivation, or diarrhoea. In severe disease neostigmine can be given every 2 hours. In infants, neostigmine by either subcutaneous or intramuscular injection is preferred for the short-term management of myasthenia.

Pyridostigmine bromide p. 673 is less powerful and slower in action than neostigmine but it has a longer duration of action. It is preferable to neostigmine because of its smoother action and the need for less frequent dosage. It is particularly preferred in patients whose muscles are weak on waking. It has a comparatively mild gastrointestinal effect but an antimuscarinic drug may still be required. It is inadvisable to use excessive doses because acetylcholine receptor down regulation may occur. Immunosuppressant therapy may be considered if high doses of pyridostigmine bromide are needed.

Neostigmine and pyridostigmine bromide should be given to neonates 30 minutes before feeds to improve sucking.

Neostigmine is also used to reverse the actions of the non-depolarising neuromuscular blocking drugs.

**Immunosuppressant therapy**

A course of corticosteroids is an established treatment in severe cases of myasthenia gravis and may be particularly useful when antibodies to the acetylcholine receptor are present in high titre. Short courses of high-dose (‘pulsed’) methylprednisolone p. 458 followed by maintenance therapy with oral corticosteroids may also be useful.

Corticosteroid treatment is usually initiated under specialist supervision. Transient but very serious worsening of symptoms can occur in the first 2–3 weeks, especially if the corticosteroid is started at a high dose. Once remission has occurred (usually after 2–6 months), the dose of prednisolone p. 458 should be reduced slowly to the minimum effective dose.

**Skeletal muscle relaxants**

The drugs described are used for the relief of chronic muscle spasm or spasticity associated with neurological damage; they are not indicated for spasm associated with minor injuries. They act principally on the central nervous system with the exception of dantrolene, which has a peripheral site of action. They differ in action from the muscle relaxants used in anaesthesia, which block transmission at the neuromuscular junction.

The underlying cause of spasticity should be treated and any aggravating factors (e.g. pressure sores, infection) remedied. Skeletal muscle relaxants are effective in most forms of spasticity except the rare alpha variety. The major disadvantage of treatment with these drugs is that reduction in muscle tone can cause a loss of splinting action of the spastic leg and trunk muscles and sometimes lead to an increase in disability.

Dantrolene sodium p. 848 acts directly on skeletal muscle and produces fewer central adverse effects. It is generally used in resistant cases. The dose should be increased slowly.

Baclofen p. 673 inhibits transmission at spinal level and also depresses the central nervous system. The dose should be increased slowly to avoid the major side-effects of sedation and muscular hypotonia (other adverse events are uncommon).

Diazepam p. 226 has undoubted efficacy in some children. Sedation and occasionally extensor hypotonus are disadvantages. Other benzodiazepines also have muscle-relaxant properties.
2.1 Muscular dystrophy

**DRUGS FOR NEUROMUSCULAR DISORDERS**

### Ataluren

**DRUG ACTION** Ataluren restores the synthesis of dystrophin by allowing ribosomes to read through premature stop codons that cause incomplete dystrophin synthesis in nonsense mutation Duchenne muscular dystrophy.

**INDICATIONS AND DOSE** Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene, in ambulatory patients (initiated by a specialist)
- **BY MOUTH**
  - Child 2–17 years (body-weight 12 kg and above): (consult product literature)

**INTERACTIONS** → Appendix 1: ataluren

**SIDE-EFFECTS**
- Common or very common: Appetite decreased, constipation, cough, enuresis, fever, fatigue, gastrointestinal discomfort, haemorrhage, headache, hypotension, hypertryglyceridaemia, nausea, pain, rash erythematous, vomiting, weight decreased

**PREGNANCY** Manufacter advises avoid—xicity in animal studies.

**BREAST FEEDING** Manufacturer advises discontinue breastfeeding—present in milk in animal studies.

**RENAI IMPAIRMENT** Manufacturer advises close monitoring—safety and efficacy not established.

**MONITORING REQUIREMENTS** Manufacturer advises monitor renal function at least every 6–12 months, and cholesterol and triglyceride concentrations at least annually.

**DIRECTIONS FOR ADMINISTRATION** Manufacturer advises the contents of each sachet should be mixed with at least 30 ml of liquid (water, milk, fruit juice), or 3 tablespoons of semi-solid food (yoghurt or apple sauce).

**PATIENT AND CARER ADVICE** Manufacturer advises patients should maintain adequate hydration during treatment.

**Missed doses** Manufacturer advises if a morning or midday dose is more than 3 hours late, or an evening dose is more than 6 hours late, the missed dose should not be taken and the next dose should be taken at the normal time.

**NATIONAL FUNDING/ACCESS DECISIONS**

**Nice decisions**
- Ataluren for treating Duchenne muscular dystrophy with a nonsense mutation in the dystrophin gene (July 2016)

**NICE** Ataluren, within its marketing authorisation, is recommended for treating Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene in people aged 5 years and older who can walk, only when:
  - the manufacturer provides ataluren with the discount agreed in the patient access scheme, and
  - the conditions under which ataluren is made available are set out in the managed access agreement between the manufacturer and NHS England, which should include the conditions set out in sections 5.12–5.15 and 5.23 of the guidance.

Patients whose treatment was started within the NHS before this guidance was published should have the option to continue treatment, without change to their funding arrangements, until they and their NHS clinician consider it appropriate to stop.

www.nice.org.uk/guidance/HST3

**Scottish Medicines Consortium (SMC) decisions**

The Scottish Medicines Consortium has advised (April 2016) that ataluren (Translarna®) is not recommended for use within NHS Scotland for the treatment of Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene, in ambulatory patients aged 5 years and older as the economic case was not demonstrated.

**All Wales Medicines Strategy Group (AWMSG) decisions**

AWMSG No. 940 The All Wales Medicines Strategy Group has advised (August 2016) that the NICE HST advice for ataluren (Translarna®) for the treatment of Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene, in ambulatory patients aged 5 years and older should be implemented within NHS Wales.

AWMSG No. 3911 The All Wales Medicines Strategy Group has advised (April 2019) that ataluren (Translarna®) is recommended for use within NHS Wales for the treatment of Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene, in ambulatory patients aged from 2 years up to 5 years. This recommendation applies only in circumstances where the approved Patient Access Scheme (PAS) is utilised or where the list/contract price is equivalent or lower than the PAS price.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Granules**
- Translarna (PTC Therapeutics Ltd)

  Ataluren 125 mg Translarna 125mg granules for oral suspension sachets 30 sachet
  - £2,532.00

  Ataluren 250 mg Translarna 250mg granules for oral suspension sachets 30 sachet
  - £5,064.00

  Ataluren 1 gram Translarna 1,000mg granules for oral suspension sachets 30 sachet
  - £20,256.00

**Nusinersen**

**DRUG ACTION** Nusinersen is an antisense oligonucleotide that increases the production of survival motor neurone (SMN) protein, thereby helping to compensate for the defect in the SMN1 gene found in 5q spinal muscular atrophy.

**INDICATIONS AND DOSE**
- **5q spinal muscular atrophy (initiated by a specialist)**
- **BY INTRATHecal INJECTION**

**NICE decisions**
- Nusinersen for treating 5q spinal muscular atrophy (initiated by a specialist) (April 2019)

**NICE** Nusinersen is recommended for use for the treatment of 5q spinal muscular atrophy (initiated by a specialist) for use within NHS England for the treatment of 5q spinal muscular atrophy resulting from a nonsense mutation in the SMN1 gene found in ambulatory patients aged 2 years to 21 years.

**Indications**
- Child: Initially 12 mg for 4 doses on days 0, 14, 28 and 63, then 12 mg every 4 months, for advice on missed doses—consult product literature.

**UNLICENSED USE** Licensed for use in children (age range not specified by manufacturer).

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: NUSINERSEN (SPINRAZA®): REPORTS OF COMMUNICATING HYDROCEPHALUS NOT RELATED TO Meningitis OR BLEEDING (JULY 2018)**

Communicating hydrocephalus not related to meningitis or bleeding has been reported in patients treated with Spinraza®. Patients and caregivers should be informed about the signs and symptoms of hydrocephalus before Spinraza® is started and should be instructed to seek medical attention in case of: persistent vomiting or headache, unexplained decrease in consciousness, and
in children increase in head circumference. Patients with signs and symptoms suggestive of hydrocephalus should be further investigated by a physician with expertise in its management.

- **CAUTIONS** Risk factors for renal toxicity—monitor urine protein (preferably using a first morning urine specimen) - risk factors for thrombocytopenia and coagulation disorders—monitor platelet and coagulation profile before treatment
- **PREGNANCY** Manufacturer advises use only if potential benefit outweighs risk.
- **BREAST FEEDING** Amount probably too small to be harmful.

### Neostigmine

*(Neostigmine methylsulfate)*

#### INDICATIONS AND DOSE

**Treatment of myasthenia gravis**

- **BY MOUTH**
  - Neonate: Initially 1–2 mg, then 1–5 mg every 4 hours, given 30 minutes before feeds.
  - Child 1 month–5 years: Initially 7.5 mg, dose repeated at suitable intervals throughout the day, total daily dose 15–90 mg
  - Child 6–11 years: Initially 15 mg, dose repeated at suitable intervals throughout the day, total daily dose 15–90 mg
  - Child 12–17 years: Initially 15–30 mg, dose repeated at suitable intervals throughout the day, total daily dose 75–300 mg, the maximum that most patients can tolerate is 180 mg daily
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Neonate: 150 micrograms/kg every 6–8 hours, to be given 30 minutes before feeds, then increased if necessary up to 300 micrograms/kg every 4 hours.
  - Child 1 month–11 years: 200–500 micrograms, dose repeated at suitable intervals throughout the day
  - Child 11 years–17 years: Dose repeated at suitable intervals throughout the day
- **Reversal of non-depolarising (competitive) neuromuscular blockade**
  - **BY INTRAVENOUS INJECTION**
    - Neonate: 50 micrograms/kg, to be given over 1 minute after or with glycopyrronium or atropine, followed by 25 micrograms/kg if required.
    - Child 1 month–11 years: 50 micrograms/kg (max. per dose 2.5 mg), to be given over 1 minute after or with glycopyrronium or atropine, then 25 micrograms/kg if required
    - Child 12–17 years: 50 micrograms/kg (max. per dose 2.5 mg), to be given over 1 minute after or with glycopyrronium or atropine, then 25 micrograms/kg (max. per dose 2.5 mg) if required

#### Appendix 1: neostigmine

- **UNLICENSED USE**
  - In neonates Dose for treatment of myasthenia gravis by subcutaneous or intramuscular injection is unlicensed.
- **CAUTIONS**
  - With intravenous use glycopyrronium or atropine should also be given when reversing neuromuscular blockade
- **INTERACTIONS**
- **SIDE-EFFECTS**
- **RENAI IMPAIRMENT**
  - Dose adjustments May need dose reduction.
- **DIRECTIONS FOR ADMINISTRATION** For intravenous injection, give undiluted or dilute with Glucose 5% or Sodium Chloride 0.9%.
2.3 Spasticity

Other drugs used for Spasticity Dantrolene sodium, p. 848 - Diazepam, p. 226

Spasticity

2.3 Spasticity

Pyridostigmine bromide

**INDICATIONS AND DOSE**

**Myasthenia gravis**

- Initially by mouth

- Neonate: Initially 1–1.5 mg/kg, dose repeated throughout the day, then (by mouth using immediate-release medicines) increased if necessary up to 10 mg, to be increased gradually and given 30–60 minutes before feeds.

- Child 1 month–11 years: Initially 1–1.5 mg/kg daily, then (by mouth using immediate-release medicines) increased to 7 mg/kg daily in 6 divided doses, to be increased gradually; (by mouth using immediate-release medicines) usual dose 30–360 mg daily in divided doses.

- Child 12–17 years: 30–120 mg, dose repeated throughout the day; (by mouth using immediate-release medicines) usual dose 300–600 mg daily in divided doses, consider immunosuppressant therapy if total daily dose exceeds 360 mg, down-regulation of acetylcholine receptors possible if total daily dose exceeds 450 mg.

**INTERACTIONS** → Appendix 1: pyridostigmine

**SIDE-EFFECTS** Gastrointestinal hypermotility - muscle cramps - rash

**RENAL IMPAIRMENT**

Dose adjustments Reduce dose; excreted by kidney.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

**Solution for injection**

- Neostigmine (Non-proprietary)

  Neostigmine metilsulfate 2.5 mg per 1 ml Neostigmine 2.5mg/1ml solution for injection ampoules | 10 ampoule £5.45–£7.72 DT = £6.13

- Tablet

  Neostigmine (Non-proprietary)

  Neostigmine bromide 15 mg Neostigmine 15mg tablets | 140 tablet £120.52 DT = £120.52

**Drug Action** Pyridostigmine bromide has weaker muscarinic action than neostigmine.

**MUSCLE RELAXANTS > CENTRALLY ACTING**

**Baclofen**

**INDICATIONS AND DOSE**

**Chronic severe spasticity of voluntary muscle**

- **BY MOUTH**

  - Child 1 month–7 years: Initially 300 micrograms/kg daily in 4 divided doses, increased gradually at weekly intervals until satisfactory response; maintenance 0.75–2 mg/kg daily in divided doses, review treatment if no benefit within 6 weeks of achieving maximum dose; maximum 40 mg per day.

  - Child 8–17 years: Initially 300 micrograms/kg daily in 4 divided doses, increased gradually at weekly intervals until satisfactory response; maintenance 0.75–2 mg/kg daily in divided doses, review treatment if no benefit within 6 weeks of achieving maximum dose; maximum 60 mg per day.

  **Severe chronic spasticity of cerebral or spinal origin unresponsive to oral antispastic drugs (oral therapy not tolerated) (specialist use only)**

- **BY INTRATECHAL INJECTION**

  - Child 4–17 years: Test dose 25–50 micrograms, to be given over at least 1 minute via catheter or lumbar puncture, then increased in steps of 25 micrograms (max. per dose 100 micrograms), not more often than every 24 hours to determine initial maintenance dose; maintenance 25–200 micrograms daily, adjusted according to response, dose-titration phase, most often using infusion pump (implanted into chest wall or abdominal wall tissues) to establish maintenance dose retaining some spasticity to avoid sensation of paralysis.

**IMPORTANT SAFETY INFORMATION**

Consult product literature for details on test dose and titration—important to monitor patients closely in appropriately equipped and staffed environment during screening and immediately after pump implantation. Resuscitation equipment must be available for immediate use. Treatment with continuous pump-administered intrathecal baclofen should be initiated within 3 months of a satisfactory response to intrathecal baclofen testing.

**CONTRA-INDICATIONS**

- With intrathecal use Local infection - systemic infection

- With oral use Avoid oral route in active peptic ulceration

**CAUTIONS**

**GENERAL CAUTIONS** Diabetes - epilepsy - history of peptic ulcer - hypertonic bladder sphincter - psychiatric illness - respiratory impairment

**SPECIFIC CAUTIONS**

- With intrathecal use Coagulation disorders - malnutrition (increased risk of post-surgical complications) - previous spinal fusion procedure

**INTERACTIONS** → Appendix 1: baclofen

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- Common or very common Confusion - constipation - depression - diarrhoea - dizziness - drowsiness - dry mouth - euphoric mood - hallucination - headache - hyperhidrosis - hypotension - nausea - paraesthesia - skin reactions - urinary disorders - vision disorders - vomiting

- Uncommon Bradycardia - hypothermia

- Rare or very rare Withdawal syndrome
SPECIFIC SIDE-EFFECTS

- Common or very common
  - With intrathecal use: Anxiety, appetite decreased, asthenia, chills, dyspnoea, fever, hyperventilation, insomnia, neuromuscular dysfunction, oedema, pain, pneumonia, respiratory disorders, seizure, sexual dysfunction
  - With oral use: Fatigue, gastrointestinal disorder, muscle weakness, myalgia, respiratory depression, sleep disorders

- Uncommon
  - With intrathecal use: Alopecia, deep vein thrombosis, dehydration, flushing, hypertension, hypoguesia, ileus, memory loss, pallor, paranoia, suicidal tendencies

- Rare or very rare
  - With oral use
    - Abdominal pain
    - Erectile dysfunction
    - Hepatic function abnormal
    - Hyperthermia, psychiatric reactions and convulsions; to exacerbate spasticity, and hyperactive state
  - With intrathecal use
    - Alopecia
    - Anxiety
    - depression
    - Hypertension
    - Hypogeusia
    - Myalgia
    - Oedema
    - Rash
    - Respiratory disorders
    - Seizure
    - Fever
    - Myalgia
    - Paranoia
    - Scoliosis
    - Sialorrhea
    - Sleep
    - Tinnitus
    - Urticaria
    - Pneumonia

- Frequency not known
  - With intrathecal use: Scoliosis
- PREGNANCY
  - Manufacturer advises use only if potential benefit outweighs risk (toxicity in animal studies).
- BREAST FEEDING
  - Present in milk—amount probably too small to be harmful.
- HEPATIC IMPAIRMENT
  - With oral use: Manufacturer advises use with caution—no information available.
- RENAL IMPAIRMENT
  - Excreted by the kidney.
  - Dose adjustments
    - With oral use: Risk of toxicity—use smaller oral doses and if necessary increase dosage interval; if estimated glomerular filtration rate less than 15 mL/minute/1.73 m² use mouth by only potential benefit outweighs risk.
- TREATMENT CESSATION
  - Avoid abrupt withdrawal (risk of hyperactive state, may exacerbate spasticity, and precipitate autonomic dysfunction including hyperthermia, psychiatric reactions and convulsions; to minimise risk, discontinue by gradual dose reduction over at least 1–2 weeks (longer if symptoms occur)).
- PRESCRIBING AND DISPENSING INFORMATION
  - Flavours of oral liquid formulations may include raspberry.
- PATIENT AND CARER ADVICE
  - Medicines for Children leaflet: Baclofen for muscle spasm
    - www.medicinesforchildren.org.uk/baclofen-muscle-spasm
  - Driving and skilled tasks
    - Drowsiness may affect performance of skilled tasks (e.g., driving); effects of alcohol enhanced.
- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution for injection

Tablet

CAUTIONARY AND ADVISORY LABELS 2, 8, 21

EXCIPIENTS: May contain Gluten

- Baclofen (Non-proprietary)
  - Baclofen 10 mg Baclofen 10mg tablets | 84 tablet $9.99 DT + $1.21
  - Lioresal (Novartis Pharmaceuticals UK Ltd)
  - Baclofen 10 mg Lioresal 10mg tablets | 100 tablet $14.86

Solution for injection

- Baclofen (Non-proprietary)
  - Baclofen 50 microgram per 1 ml Baclofen 50 micrograms/1ml solution for injection ampoules | 10 ampoule $25.00
  - Lioresal (Novartis Pharmaceuticals UK Ltd)
  - Baclofen 50 microgram per 1 ml Lioresal intrathecal 50micrograms/1ml solution for injection ampoules | 1 ampoule $3.16

Solution for infusion

- Baclofen (Non-proprietary)
  - Baclofen 500 microgram per 1 ml Baclofen 10mg/20ml solution for infusion ampoules | 1 ampoule $50.00
  - Baclofen 2 mg per 1 ml Baclofen 40mg/20ml solution for infusion ampoules | 1 ampoule $250.00

Baclofen 10mg/5ml solution for infusion ampoules | 10 ampoule $50.00

- Lioresal (Novartis Pharmaceuticals UK Ltd)
  - Baclofen 500 microgram per 1 ml Lioresal Intrathecal 10mg/20ml solution for infusion ampoules | 1 ampoule $70.01
  - Baclofen 2 mg per 1 ml Lioresal Intrathecal 10mg/5ml solution for infusion ampoules | 1 ampoule $70.01

Oral solution

CAUTIONARY AND ADVISORY LABELS 2, 8, 21

- Baclofen (Non-proprietary)
  - Baclofen 1 mg per 1 ml Baclofen 5mg/5ml oral solution sugar free sugar-free | 300 ml $13.45 DT + $4.12
  - Lioresal (Novartis Pharmaceuticals UK Ltd)
  - Baclofen 1 mg per 1 ml Lioresal 5mg/5ml liquid sugar-free | 300 ml $10.31 DT + $4.12
  - Lyflex (Chemidex Pharma Ltd)
  - Baclofen 1 mg per 1 ml Lyflex 5mg/5ml oral solution sugar-free | 300 ml $7.95 DT + $4.12

3 Pain and inflammation in musculoskeletal disorders

Non-steroidal anti-inflammatory drugs

Therapeutic effects

In single doses non-steroidal anti-inflammatory drugs (NSAIDs) have analgesic activity comparable to that of paracetamol p. 278 but paracetamol is preferred.

In regular full dosage NSAIDs have both a lasting analgesic and an anti-inflammatory effect which makes them particularly useful for the treatment of continuous or regular pain associated with inflammation.

Choice

Differences in anti-inflammatory activity between NSAIDs are small, but there is considerable variation in individual response and tolerance of these drugs. A large proportion of children will respond to any NSAID; of the others, those who do not respond to one may well respond to another. Pain relief starts soon after taking the first dose and a full analgesic effect should normally be obtained within a week, whereas an anti-inflammatory effect may not be achieved (or may not be clinically assessable) for up to 3 weeks. However, in juvenile idiopathic arthritis NSAIDs may take 4–12 weeks to be effective. If appropriate responses are not obtained within these times, another NSAID should be tried. The availability of appropriate formulations needs to be considered when prescribing NSAIDs for children.

NSAIDs reduce the production of prostaglandins by inhibiting the enzyme cyclo-oxygenase. They vary in their selectivity for inhibiting different types of cyclo-oxygenase; selective inhibition of cyclo-oxygenase-2 is associated with less gastro-intestinal intolerance. However, in children gastro-intestinal symptoms are rare in those taking NSAIDs for short periods. The role of selective inhibitors of cyclo-oxygenase-2 is undetermined in children.

Ibuprofen p. 679 and naproxen p. 683 are propionic acid derivatives used in children.

Ibuprofen combines anti-inflammatory, analgesic, and antipyretic properties. It has fewer side-effects than other NSAIDs but its anti-inflammatory properties are weaker. Naproxen combines good efficacy with a low incidence of side-effects.

Diclofenac sodium p. 676, diclofenac potassium p. 675, indometacin p. 681, mefenamic acid p. 682, and piroxicam p. 684 have properties similar to those of propionic acid derivatives:

Diclofenac sodium and diclofenac potassium are similar in efficacy to naproxen.
Indomethacin has an action equal to or superior to that of naproxen, but with a high incidence of side-effects including headache, dizziness, and gastro-intestinal disturbances. It is rarely used in children and should be reserved for when other NSAIDs have been unsuccessful.

Mefenamic acid has minor anti-inflammatory properties. It has occasionally been associated with diarrhoea and haemolytic anaemia which require discontinuation of treatment.

Piroxicam is as effective as naproxen and has a long duration of action which permits once-daily administration. However, it has more gastro-intestinal side-effects than most other NSAIDs, and is associated with more frequent serious skin reactions.

Meloxicam p. 683 is a selective inhibitor of cyclo-oxygenase-2. Its use may be considered in adolescents intolerant to other NSAIDs.

Ketorolac trometamol 10–15 mg can be used for the short-term management of postoperative pain.

Etoricoxib p. 677, a selective inhibitor of cyclo-oxygenase-2, is licensed for the relief of pain in osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, and acute gout in children aged 16 years and over.

**Dental and orofacial pain**

Most mild to moderate dental pain and inflammation is effectively relieved by ibuprofen, diclofenac potassium or diclofenac sodium.

**NSAIDs and cardiovascular events**

The risk of cardiovascular events secondary to NSAID use is undetermined in children. In adults, all NSAID use (including cyclo-oxygenase-2 selective inhibitors) can, to varying degrees, be associated with a small increased risk of thrombotic events (e.g. myocardial infarction and stroke) independent of baseline cardiovascular risk factors or duration of NSAID use; however, the greatest risk may be in those patients receiving high doses long term. A small increased thrombotic risk cannot be excluded in children.

In adults, cyclo-oxygenase-2 selective inhibitors, diclofenac (150 mg daily) and ibuprofen (2.4 g daily) are associated with an increased risk of thrombotic events. The increased risk for diclofenac is similar to that of etoricoxib. Naproxen (in adults, 1 g daily) is associated with a lower thrombotic risk, and lower doses of ibuprofen (in adults, 1.2 g daily or less) have not been associated with an increased risk of myocardial infarction.

The lowest effective dose of NSAID should be prescribed for the shortest period of time to control symptoms, and the need for long-term treatment should be reviewed periodically.

**NSAIDs and gastro-intestinal events**

All NSAIDs are associated with gastro-intestinal toxicity. In adults, evidence on the relative safety of NSAIDs indicates differences in the risks of serious upper gastro-intestinal side-effects—piroxicam and ketorolac trometamol are associated with the highest risk; indomethacin, diclofenac, and naproxen are associated with intermediate risk, and ibuprofen with the lowest risk (although high doses of ibuprofen have been associated with intermediate risk). Selective inhibitors of cyclo-oxygenase-2 are associated with a lower risk of serious upper gastro-intestinal side-effects than non-selective NSAIDs.

Children appear to tolerate NSAIDs better than adults and gastro-intestinal side-effects are less common although they do still occur and can be significant; use of gastro-protective drugs may be necessary.

**Asthma**

All NSAIDs have the potential to worsen asthma, either acutely or as a gradual worsening of symptoms; consider both prescribed NSAIDs and those that are purchased over the counter.

**Advanced Pharmacy Services**

Children taking NSAIDs may be eligible for the Medicines Use Review service provided by a community pharmacist. For further information, see Advanced Pharmacy Services in Guidance on prescribing p. 1.

**ANALGESICS > NON-STEROIDAL ANTI-INFLAMMATORY DRUGS**

**Diclofenac potassium**

**INDICATIONS AND DOSE**

Pain and inflammation in rheumatic disease and other musculoskeletal disorders

- **BY MOUTH**
  - Child 14-17 years: 75–100 mg daily in 2–3 divided doses

Postoperative pain

- **BY MOUTH**
  - Child 9-13 years (body-weight 35 kg and above): Up to 2 mg/kg daily in 3 divided doses; maximum 100 mg per day
  - Child 14-17 years: 75–100 mg daily in 2–3 divided doses

Fever in ear, nose, or throat infection

- **BY MOUTH**
  - Child 9–17 years (body-weight 35 kg and above): Up to 2 mg/kg daily in 3 divided doses; maximum 100 mg per day

**UNLICENSED USE** Voltarol® Rapid not licensed for use in children under 14 years or in fever.

**CONTRA-INDICATIONS** Active gastro-intestinal bleeding, active gastro-intestinal ulceration - cerebrovascular disease, history of gastro-intestinal bleeding related to previous NSAID therapy, history of gastro-intestinal perforation related to previous NSAID therapy, history of recurrent gastro-intestinal haemorrhage (two or more distinct episodes), history of recurrent gastro-intestinal ulceration (two or more distinct episodes), ischaemic heart disease — mild to severe heart failure — peripheral arterial disease

**CAUTIONS** Allergic disorders — cardiac impairment (NSAIDs may impair renal function) — coagulation defects — connective-tissue disorders — Crohn’s disease (may be exacerbated) — history of cardiac failure — hypertension — left ventricular dysfunction — oedema — risk factors for cardiovascular events — ulcerative colitis (may be exacerbated)

**INTERACTIONS** > Appendix 1: NSAIDs

**SIDE-EFFECTS**

- **Common or very common** Appetite decreased — diarrhoea — dizziness — gastro-intestinal discomfort — gastro-intestinal disorders — headache — nausea — skin reactions — vertigo — vomiting
- **Uncommon** Chest pain — heart failure — myocardial infarction — palpitations
- **Rare or very rare** Acute kidney injury — agranulocytosis — alopecia — anaemia — angioedema — anxiety — aplastic anaemia — asthma — confusion — constipation — depression — drowsiness — dyspnoea — erectile dysfunction — fatigue — haemolytic anaemia — haemorrhage — hearing impairment — hepatic disorders — hypersensitivity — hypertension — hypotension — inflammatory bowel disease — irritable bowel syndrome — leucopenia — memory loss — meningitis aseptic (patients with connective-tissue disorders such as systemic lupus erythematosus may be especially susceptible) — nephritis tubulointerstitial — nephrotic syndrome — oedema — oesophageal disorder — oral disorders — pancreatitis — photosensitivity reaction — pneumonitis — proteinuria —
性疾病

MEDICINAL FORMS

l RENAL IMPAIRMENT
l BREAST FEEDING
l ALLERGY AND CROSS-SENSITIVITY

▶ Frequency not known Hallucination - malaise - optic neuritis

SIDE EFFECTS, FURTHER INFORMATION For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs.

l ALLERGY AND CROSS-SENSITIVITY Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

l PREGNANCY

Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

l BREAST FEEDING

Use with caution during breast-feeding. Amount in milk too small to be harmful.

l HEPATIC IMPAIRMENT

Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

l RENAL IMPAIRMENT

Avoid if possible or use with caution. Avoid in severe impairment.

Dose adjustments The lowest effective dose should be used for the shortest possible duration.

Monitoring In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

l PATIENT AND CARER ADVICE

Medicines for Children leaflet: Diclofenac for pain and inflammation www.medicinesforchildren.org.uk/diclofenac-pain-and-inflammation

l MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Tablet

CAUTIONARY AND ADVISORY LABELS 21

l Diclofenac potassium (Non-proprietary)

Diclofenac potassium 25 mg Diclofenac potassium 25mg tablets | 28 tablet PIP £3.87 DT = £3.87

Diclofenac potassium 50 mg Diclofenac potassium 50mg tablets | 28 tablet PIP £7.41 DT = £7.41

Voltarol Rapid (Novartis Pharmaceuticals UK Ltd)

Diclofenac potassium 50 mg Voltarol Rapid 50mg tablets | 30 tablet PIP £7.94

Diclofenac sodium 22-Sep-2016

l INDICATIONS AND DOSE

Pain and inflammation in rheumatic disease including juvenile idiopathic arthritis

▶ BY MOUTH USING IMMEDIATE-RELEASE MEDICINES

Child 6 months-17 years: 1.5–2.5 mg/kg twice daily, total daily dose may alternatively be given in 3 divided doses; maximum 150 mg per day

Postoperative pain

▶ BY RECTUM

Child 6 months-17 years (body-weight 8-11 kg): 12.5 mg twice daily for maximum 4 days

Child 6 months-17 years (body-weight 12 kg and above): 1 mg/kg 3 times a day (max. per dose 50 mg) for maximum 4 days

Inflammation | Mild to moderate pain

▶ BY MOUTH USING IMMEDIATE-RELEASE MEDICINES, OR BY RECTUM

Child 6 months-17 years: 0.3–1 mg/kg 3 times a day (max. per dose 50 mg)

DICLOMAX RETARD ◊

Pain and inflammation

▶ BY MOUTH

Child 12-17 years: 1 capsule once daily

DICLOMAX SR ◊

Pain and inflammation

▶ BY MOUTH

Child 12-17 years: 1 capsule 1–2 times a day

MOTIFENE ◊

Pain and inflammation

▶ BY MOUTH

Child 12-17 years: 1 tablet 1–2 times a day

VOLTAROL ® 75MG SR TABLETS

Pain and inflammation

▶ BY MOUTH

Child 12-17 years: 1 capsule once daily

VOLTAROL ® RETARD

Pain and inflammation

▶ BY MOUTH

Child 12-17 years: 1 tablet once daily

VOLTAROL ® SOLUTION FOR INJECTION

Postoperative pain

▶ BY INTRAVENOUS INFUSION, OR BY DEEP INTRAMUSCULAR INJECTION

Child 2-17 years: 0.3–1 mg/kg 1–2 times a day for maximum 2 days, for intramuscular injection, to be injected into the gluteal muscle; maximum 150 mg per day

l UNLICENSED USE


l CONTRA-INDICATIONS

Active gastro-intestinal bleeding - active gastro-intestinal ulceration - avoid injections containing benzyl alcohol in neonates (in neonates) - avoid suppositories in proctitis - cerebrovascular disease - history of gastro-intestinal bleeding related to previous NSAID therapy - history of gastro-intestinal perforation related to previous NSAID therapy - history of recurrent gastro-intestinal haemorrhage (two or more distinct episodes) - history of recurrent gastro-intestinal ulceration (two or more distinct episodes) - ischaemic heart disease - mild to severe heart failure - peripheral arterial disease

With intravenous use: Dehydration - history of asthma - history of confirmed or suspected cerebrovascular bleeding - history of haemorrhagic diathesis - hypovolaemia - operations with high risk of haemorrhage

l CAUTIONS

Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - coagulation defects - connective-tissue disorders - Crohn’s disease (may be exacerbated) - history of cardiac failure - hypertension - left ventricular dysfunction - oedema - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated)

l INTERACTIONS Appendix 1: NSAIDs

l SIDE-EFFECTS

GENERAL SIDE-EFFECTS

Common or very common Appetite decreased - diarrhoea - dizziness - gastrointestinal discomfort - gastrointestinal
disorders • headache • nausea • rash (discontinue) • vertigo • vomiting
  ▶ **Uncommon**  Chest pain • heart failure • myocardial infarction • palpitations
  ▶ **Rare or very rare**  Acute kidney injury • agranulocytosis • alopecia • anaemia • angioedema • anxiety • aplastic anaemia • asthma • chest pain • confusion • constipation • depression • drowsiness • dyspnoea • erectile dysfunction • fatigue • haemolytic anaemia • haemorrhage • hearing impairment • heart failure • hepatic disorders • hypersensitivity • hypertension • hypotension • irritability • leucopenia • memory loss • meningitis aseptic (patients with connective-tissue disorders such as systemic lupus erythematosus may be especially susceptible) • myocardial infarction • nephritis tubulointerstitial • nephrotic syndrome • oedema • oesophageal disorder • oral disorders • palpitations • pancreatitis • photosensitivity reaction • pneumonia • proteinuria • psychiatric disorder • renal papillary necrosis • seizure • sensation abnormal • severe cutaneous adverse reactions (SCARs) • shock • skin reactions • sleep disorders • stroke • taste altered • thrombocytopenia • tinnitus • tremor • vasculitis • vision disorders
  ▶ With rectal use  Ulcerative colitis aggravated
  ▶ Frequency not known  Fertility decreased female • fluid retention • hallucination • malaise • optic neuritis • platelet aggregation inhibition

**SPECIFIC SIDE-EFFECTS**
• With parenteral use  Injection site necrosis

**SIDE-EFFECTS, FURTHER INFORMATION**  For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs p. 674

**ALLERGY AND CROSS-SENSITIVITY**  Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

**PREGNANCY**  Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero) and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

**BREAST FEEDING**  Use with caution during breast-feeding. Amount in milk too small to be harmful.

**HEPATIC IMPAIRMENT**  Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

**RENAL IMPAIRMENT**  Avoid if possible or use with caution. Avoid in severe impairment.
• With intravenous use  Contra-indicated in moderate or severe renal impairment.

**Dose adjustments**  The lowest effective dose should be used for the shortest possible duration.

**Monitoring**  In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

**DIRECTIONS FOR ADMINISTRATION**  For **intravenous infusion**, dilute 75 mg with 100–500 mL. Glucose 5% or Sodium Chloride 0.9% (previously buffered with 0.5 mL Sodium Bicarbonate 8.4% solution or with 1 mL Sodium Bicarbonate 4.2% solution); give over 30–120 minutes.

**PATIENT AND CARER ADVICE**  Medicines for Children leaflet; Diclofenac for pain and inflammation www.medicinesforchildren.org.uk/diclofenac-pain-and-inflammation

**MEDICINAL FORMS**  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: dispersible tablet, oral suspension, oral solution

**Modified-release tablet**

**Gastro-resistant tablet**

**Diclofenac sodium (Non-proprietary)**
• **Diclofenac sodium 25 mg**  Diclofenac sodium 25 mg gastro-resistant tablets | 28 tablet (PO) £3.87–£8.99 DT = £1.77 | 84 tablet (PO) £1.50–£26.97
• **Diclofenac sodium 50 mg**  Diclofenac sodium 50 mg gastro-resistant tablets | 28 tablet (PO) £4.97 DT = £1.89 | 84 tablet (PO) £2.48–£15.00

**Dicloflex (Dexel-Pharma Ltd)**
• **Diclofenac sodium 25 mg**  Dicloflex 25 mg gastro-resistant tablets | 84 tablet (PO) £4.42
• **Diclofenac sodium 50 mg**  Dicloflex 50 mg gastro-resistant tablets | 28 tablet (PO) £2.75 DT = £1.89 (Hospital only) | 84 tablet (PO) £8.05

**Fenactol (Discovery Pharmaceuticals)**
• **Diclofenac sodium 50 mg**  Fenactol 50 mg gastro-resistant tablets | 100 tablet (PO) £3.70

**Suppository**
• **Econac (Advanz Pharma)**
  • **Diclofenac sodium 100 mg**  Econac 100mg suppositories | 10 suppository (PO) £3.04 DT = £3.64
• **Voltarol (Novartis Pharmaceuticals UK Ltd)**
  • **Diclofenac sodium 12.5 mg**  Voltarol 12.5mg suppositories | 10 suppository (PO) £0.70 DT = £0.70
• **Diclofenac sodium 25 mg**  Voltarol 25mg suppositories | 10 suppository (PO) £1.24 DT = £1.24
• **Diclofenac sodium 50 mg**  Voltarol 50mg suppositories | 10 suppository (PO) £2.04 DT = £2.04
• **Diclofenac sodium 100 mg**  Voltarol 100mg suppositories | 10 suppository (PO) £3.64 DT = £3.64

**Solution for injection**
  • **EXCIPIENTS:**  May contain Benzyl alcohol, propylene glycol
• **Voltarol (Novartis Pharmaceuticals UK Ltd)**
  • **Diclofenac sodium 25 mg per 1 ml**  Voltarol 75mg/3ml solution for injection ampoules | 10 ampoule (PO) £3.91 DT = £3.91

**Modified-release capsule**

**Diclofenac sodium 25 mg**  Diclofenac sodium 25 mg gastro-resistant capsules | 28 capsule (PO) £8.20 DT = £8.20

**Dicloflex SR**
• **Diclofenac sodium 75 mg**  Diclofenac sodium 75 mg gastro-resistant capsules | 56 capsule (PO) £11.40 DT = £11.40
• **Motifene (Daichi Sankyo UK Ltd)**
• **Diclofenac sodium 75 mg**  Motifene 75mg modified-release capsules | 56 capsule (PO) £8.00 DT = £8.00

**Etoricoxib**

**INDICATIONS AND DOSE**

**Pain and inflammation in osteoarthritis**
• **BY MOUTH**
  • Child 16–17 years: 30 mg once daily, increased if necessary to 60 mg once daily

**Pain and inflammation in rheumatoid arthritis**

**Ankylosing spondylitis**
• **BY MOUTH**
  • Child 16–17 years: 60 mg once daily, increased if necessary to 90 mg once daily

**Acute gout**
• **BY MOUTH**
  • Child 16–17 years: 120 mg once daily for maximum 8 days

**CONTRA-INDICATIONS**  Active gastro-intestinal bleeding • active gastro-intestinal ulceration • cerebrovascular
disease · inflammatory bowel disease · ischaemic heart disease · mild to severe heart failure · peripheral arterial disease · uncontrolled hypertension (persistently above 140/90 mmHg)

**CAUTIONS** Allergic disorders · cardiac impairment (NSAIDs may impair renal function) · coagulation defects · connective-tissue disorders · Crohn’s disease (may be exacerbated) · dehydration · history of cardiac failure · hypertension · left ventricular dysfunction · oedema · risk factors for cardiovascular events · ulcerative colitis (may be exacerbated)

**INTERACTIONS** → Appendix 1: NSAIDs

**SIDE-EFFECTS**

- **Common or very common** Arrhythmias · asthenia · bronchospasm · constipation · diarrhoea · dizziness · fluid retention · gastrointestinal discomfort · gastrointestinal disorders · headache · hypertension · increased risk of infection · influenza like illness · nausea · oedema · oral ulceration · palpitations · skin reactions · vomiting

- **Uncommon** Alertness decreased · anaemia · angina pectoris · anxiety · appetite abnormal · cerebrovascular insufficiency · chest pain · congestive heart failure · conjunctivitis · cough · depression · drowsiness · dry mouth · dyspnoea · flushing · haemorrhage · hallucination · hyperkalaemia · hypersensitivity · insomnia · irritable bowel syndrome · leucopenia · myocardial infarction · pancreatitis · proteinuria · renal failure (more common in patients with pre-existing renal impairment) · sensation abnormal · taste altered · thrombocytopenia · tinnitus · vasculitis · vertigo · vision blurred · weight increased

- **Rare or very rare** Angioedema · confusion · hepatic disorders · muscle complaints · severe cutaneous adverse reactions (SCARs) · shock

- **Frequency not known** Nephritis tubulointerstitial · nephropathy

SIDE-EFFECTS, FURTHER INFORMATION For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs.

**ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

**CONCEPTION AND CONTRACEPTION** Caution—long-term use of some NSAIDs is associated with reduced female fertility, which is reversible on stopping treatment.

**PREGNANCY** Manufacturer advises avoid (teratogenic in animal studies). Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

**BREAST FEEDING** Use with caution during breast-feeding. Manufacturer advises avoid—present in milk in animal studies.

**HEPATIC IMPAIRMENT** Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment (no information available).

Dose adjustments Manufacturer advises max. 60 mg once daily in mild impairment; max. 30 mg once daily in moderate impairment.

**RENAL IMPAIRMENT** Avoid if possible or use with caution. Avoid if estimated glomerular filtration rate less than 30 mL/minute 1.73 m².

Dose adjustments The lowest effective dose should be used for the shortest possible duration.

**Monitoring** In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

**MONITORING REQUIREMENTS** Monitor blood pressure before treatment, 2 weeks after initiation and periodically during treatment.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- Etoricoxib (Non-proprietary)
  - Etoricoxib 30 mg | 28 tablet | £96.00
  - Etoricoxib 60 mg | 28 tablet | £20.11
  - Etoricoxib 90 mg | 28 tablet | £22.96
  - Etoricoxib 120 mg | 7 tablet | £3.03

- Arcoxia (Merck Sharp & Dohme Ltd)
  - Arcoxia 30 mg | 28 tablet | £13.99 DT
  - Arcoxia 60 mg | 28 tablet | £24.11 DT
  - Arcoxia 90 mg | 28 tablet | £6.03

**Flurbiprofen**

**INDICATIONS AND DOSE**

Pain and inflammation in rheumatic disease and other musculoskeletal disorders | Migraine | Postoperative analgesia | Mild to moderate pain

→ BY MOUTH

- Child 12-17 years: 150–200 mg daily in 2–4 divided doses, then increased to 300 mg daily, dose to be increased only in acute conditions

**Dysmenorrhoea**

→ BY MOUTH

- Child 12-17 years: Initially 100 mg, then 50–100 mg every 4–6 hours; maximum 300 mg per day

**CONTRA-INDICATIONS** Active gastro-intestinal bleeding · active gastro-intestinal ulceration · history of gastro-intestinal bleeding related to previous NSAID therapy · history of gastro-intestinal perforation related to previous NSAID therapy · history of recurrent gastro-intestinal haemorrhage (two or more distinct episodes) · history of recurrent gastro-intestinal ulceration (two or more distinct episodes) · severe heart failure

**CAUTIONS** Allergic disorders · cardiac impairment (NSAIDs may impair renal function) · cerebrovascular disease · coagulation defects · connective-tissue disorders · Crohn’s disease (may be exacerbated) · heart failure · ischaemic heart disease · peripheral arterial disease · risk factors for cardiovascular events · ulcerative colitis (may be exacerbated) · uncontrolled hypertension

**INTERACTIONS** → Appendix 1: NSAIDs

**SIDE-EFFECTS** Agranulocytosis · angioedema · aplastic anaemia · asthma · bronchospasm · confusion · constipation · Crohn’s disease · depression · diarrhoea · dizziness · drowsiness · dyspnoea · fatigue · fertility decreased female · gastrointestinal discomfort · gastrointestinal disorders · haemolytic anaemia · haemorrhage · hallucination · headache · heart failure · hepatic disorders · hypersensitivity · hypertension · malaise · meningeitis aseptic (patients with connective-tissue disorders such as systemic lupus erythematosus may be especially susceptible) · nausea · nephritis · tubulointerstitial · nephropathy · neutropenia · oedema · optic neuritis · oral ulceration · pancreatitis · paraesthesia · photosensitivity reaction · platelet aggregation inhibition · renal failure (more common in patients with pre-existing renal impairment) · respiratory tract reaction · severe
cutaneous adverse reactions (SCARs) • skin reactions • stroke • thrombocytopenia • tinnitus • vertigo • visual impairment • vomiting

SIDE-EFFECTS, FURTHER INFORMATION
For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs. p. 674

ALLERGY AND CROSS-SENSITIVITY
Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

PREGNANCY
Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

BREAST FEEDING
Use with caution during breast-feeding. Small amount present in milk—manufacturer advises avoid.

HEPATIC IMPAIRMENT
Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

RENAL IMPAIRMENT
Avoid if possible or use with caution. Deterioration in renal function has also been reported after topical use.

Avoid in severe impairment.

Dose adjustments The lowest effective dose should be used for the shortest possible duration.

Monitoring In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Table

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<tr>
<td>CAUTIONARY AND ADVISORY LABELS</td>
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<td>Flurbiprofen (Non-proprietary)</td>
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| Flurbiprofen 50 mg Flurbiprofen 50mg tablets | 10 tablet | £21.30
| Flurbiprofen 100 mg Flurbiprofen 100mg tablets | 100 tablet | £38.10-£77.21 DT + £70.78

Ibuprofen

INDICATIONS AND DOSE

Pain and inflammation in musculoskeletal disorders

- Child 10-11 years: 300 mg 3 times a day, maximum daily dose to be given in 3–4 divided doses; maximum 30 mg/kg per day; maximum 2.4 g per day
- Child 12-17 years: Initially 300–400 mg 3–4 times a day; increased if necessary up to 600 mg 4 times a day; maintenance 200–400 mg 3 times a day, may be adequate

Pain and inflammation

- BY MOUTH USING MODIFIED-RELEASE MEDICINES
  - Child 12-17 years: 1.6 g once daily, dose preferably taken in the early evening, increased to 2.4 g daily in 2 divided doses, dose to be increased only in severe cases

Pain and inflammation in rheumatic disease including juvenile idiopathic arthritis

- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
  - Child 3 months-17 years: 30–40 mg/kg daily in 3–4 divided doses; maximum 2.4 g per day

Pain and inflammation in systemic juvenile idiopathic arthritis

- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
  - Child 3 months-17 years: Up to 60 mg/kg daily in 4–6 divided doses; maximum 2.4 g per day

Post-immunisation pyrexia in infants (on doctor’s advice only)

- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES
  - Child 2-3 months: 50 mg for 1 dose, followed by 50 mg after 6 hours if required

UNLICENSED USE

- With intravenous use in neonates Orphan licence for the injection for closure of ductus arteriosus in premature neonates less than 34 weeks corrected gestational age.
- With oral use Not licensed for use in children under 3 months or body-weight under 5 kg. Maximum dose for systemic juvenile idiopathic arthritis is unlicensed.

CONTRA-INDICATIONS
Active gastro-intestinal bleeding • active gastro-intestinal ulceration • history of gastro-intestinal bleeding related to previous NSAID therapy • history of gastro-intestinal perforation related to previous NSAID therapy • history of recurrent gastro-intestinal ulceration (two or more distinct episodes) • history of recurrent gastro-intestinal ulceration (two or more distinct episodes) • severe heart failure • varicella infection

- With intravenous use Active bleeding (especially intracranial or gastro-intestinal); coagulation defects • ductal-dependent congenital heart disease; known or suspected necrotising enterocolitis; life-threatening infection • marked un conjugated hyperbilirubinemia • pulmonary hypertension • thrombocytopenia

CAUTIONS
Cardiac impairment (NSAIDs may impair renal function) • cerebrovascular disease • coagulation defects • connective-tissue disorders • Crohn’s disease (may be exacerbated) • heart failure • ischaemic heart disease • peripheral arterial disease • risk factors for cardiovascular events • risk factors for cardiovascular events • ulcerative colitis (may be exacerbated) • uncontrolled hypertension

- With intravenous use May mask symptoms of infection (in neonates)

CAUTIONS, FURTHER INFORMATION
- High-dose ibuprofen A small increase in cardiovascular risk, similar to the risk associated with cyclo-oxygenase-2 inhibitors and diclofenac, has been reported with high-dose ibuprofen (≥ 2.4 g daily); use should be avoided in patients with established ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, congestive heart failure (New York Heart Association classification II-III), and uncontrolled hypertension.

INTERACTIONS→ Appendix 1: NSAIDs
SIDE-EFFECTS

GENERAL SIDE-EFFECTS

- Rare or very rare Gastrointestinal disorders (very common in neonates) - haemorrhage (very common in neonates) - thrombocytopenia (very common in neonates)
- Frequency not known Fluid retention (very common in neonates)

SPECIFIC SIDE-EFFECTS

- Common or very common
  - With intravenous use Intraventricular haemorrhage; neutropenia (in neonates) - periventricular leukomalacia (in neonates) - renal impairment (in neonates)
- Uncommon
  - With oral use Gastrointestinal discomfort - headache - hypersensitivity - nausea - rash (discontinue) - skin reactions
- Rare or very rare
  - With oral use Acute kidney injury - agranulocytosis - anaemia - angioedema - constipation - diarrhoea - dyspepsia - leucopenia - liver disorder - meningitis asptic (patients with connective-tissue disorders such as systemic lupus erythematosus may be especially susceptible) - oedema - oral ulceration - pancytopenia - renal papillary necrosis - severe cutaneous adverse reactions (SCARs) - shock - vomiting
- Frequency not known
  - With oral use Asthma - Crohn’s disease - fertility decreased female - heart failure - hypertension - increased risk of arterial thromboembolism - renal failure (more common in patients with pre-existing renal impairment) - respiratory disorders - respiratory tract reaction

SIDE-EFFECTS, FURTHER INFORMATION
For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs. p. 674

Overdose
Overdosage with ibuprofen may cause nausea, vomiting, epigastric pain, and tinnitus, but more serious toxicity is very uncommon. Charcoal, activated followed by symptomatic measures are indicated if more than 100 mg/kg has been ingested within the preceding hour.

For details on the management of poisoning, see Emergency treatment of poisoning p. 859.

ALLERGY AND CROSS-SENSITIVITY
Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

PREGNANCY
Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

BREAST FEEDING
Use with caution during breast-feeding. Amount too small to be harmful but some manufacturers advise avoid.

HEPATIC IMPAIRMENT
With oral use Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

RENAL IMPAIRMENT
With intravenous use in neonates Avoid if possible in severe impairment.
- With oral use Avoid if possible or use with caution. Avoid in severe impairment.

Dose adjustments
- With intravenous use in neonates Use lowest effective dose.
- With oral use The lowest effective dose should be used for the shortest possible duration.

Monitoring
In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

MONITORING REQUIREMENTS

DIRECTIONS FOR ADMINISTRATION
- With intravenous use in neonates For slow intravenous injection, give over 15 minutes, preferably undiluted. May be diluted with Glucose 5% or Sodium Chloride 0.9%.

PRESCRIBING AND DISPENSING INFORMATION
With oral use Flavours of syrup may include orange.
- With topical use Caution—topical preparations not generally suitable for children.

PATIENT AND CARER ADVICE

PROFESSION SPECIFIC INFORMATION
Dental practitioners’ formulary: Ibuprofen Oral Suspension Sugar-free may be prescribed. Ibuprofen Tablets may be prescribed.

EXCEPTIONS TO LEGAL CATEGORY
Oral preparations can be sold to the public in certain circumstances.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

Effervescent granules

CAUTIONARY AND ADVISORY LABELS 13, 21

ELECTROLYTES: May contain Sodium
- Brufen (Mylan)
  - Ibuprofen 600 mg Brufen 600 mg effervescent granules sachets | 20 sachet DT = £6.80 DT = £6.80
- Modified-release tablet
CAUTIONARY AND ADVISORY LABELS 25, 27
- Brufen Retard (Mylan)
  - Ibuprofen 800 mg Brufen Retard 800 mg tablets | 56 tablet DT = £7.74 DT = £7.74

Pain and inflammation in musculoskeletal disorders

Tablet

CAUTIONARY AND ADVISORY LABELS 21
- Ibuprofen (Non-proprietary)
  - Ibuprofen 200 mg Ibuprofen 200 mg tablets | 84 tablet DT = £3.29
  - Ibuprofen 200 mg caplets | 16 tablet DT = £0.25 | 24 tablet DT = £0.79
  - Ibuprofen 400 mg Ibuprofen 400 mg tablets film coated | 24 tablet DT = £0.75 DT = £0.88 | 84 tablet DT = £4.20 DT = £3.08
  - Ibuprofen 400 mg caplets | 24 tablet DT = £0.88
  - Ibuprofen 600 mg Ibuprofen 600 mg tablets | 250 tablet DT = £9.17
  - Ibuprofen 600 mg Brufen 600 mg tablets | 84 tablet DT = £4.11 DT = £4.03
  - Ibuprofen 600 mg tablets film coated | 84 tablet DT = £4.03 DT = £4.03
- Brufen (Mylan)
  - Ibuprofen 400 mg Brufen 400 mg tablets | 60 tablet DT = £4.90
  - Ibuprofen 600 mg Brufen 600 mg tablets | 60 tablet DT = £7.34
- Feminax Express (Bayer Plc)
  - Ibuprofen (as Ibuprofen lysine) 200 mg Feminax Express 342 mg tablets | 8 tablet DT = £1.76 | 16 tablet DT = £2.67
- Nurofen Express (Reckitt Benckiser Healthcare (UK) Ltd)
  - Ibuprofen (as Ibuprofen lysine) 200 mg Nurofen Express 684 mg tablets | 24 tablet DT = £6.14

Nurofen Joint & Back Pain Relief (Reckitt Benckiser Healthcare (UK) Ltd)
- Ibuprofen (as Ibuprofen sodium dihydrate) 200 mg Nurofen Joint & Back Pain Relief 256 mg caplets | 16 tablet DT = £2.44
  - Nurofen Joint & Back Pain Relief 256 mg tablets | 16 tablet DT = £2.30
- Nurofen Max Strength Joint & Back Pain Relief 512 mg tablets | 24 tablet DT = £5.82
- Nurofen Migraine Pain (Reckitt Benckiser Healthcare (UK) Ltd)
  - Ibuprofen (as Ibuprofen lysine) 200 mg Nurofen Migraine Pain 342 mg tablets | 12 tablet DT = £2.09

Oral suspension

CAUTIONARY AND ADVISORY LABELS 21
- Ibuprofen (Non-proprietary)
  - Ibuprofen 20 mg per 1 ml Ibuprofen 100mg/5ml oral suspension sugar free sugar-free | 500 ml DT = £7.15
**Pain and inflammation in musculoskeletal disorders**

**Indomethacin**

**Indications and Dose**

**Symptomatic ductus arteriosus**

By intravenous infusion

- Neonate: Initially 100–200 micrograms/kg for 1 dose, followed by 100 micrograms/kg after 24 hours for 2 doses, at 24-hour intervals, doses to be given over 20–30 minutes, if residual patency present, 100 micrograms/kg to be given for a further 3 doses at 24-hour intervals.

**Relief of pain and inflammation in rheumatic diseases including juvenile idiopathic arthritis**

- By mouth using immediate-release medicines
- Child: 0.5–1 mg/kg twice daily, higher doses may be used under specialist supervision

**Unlicensed use**

- With oral use Not licensed for use in children.

**Contra-indications**

- With intravenous use Bleeding (especially with active intracranial haemorrhage or gastro-intestinal bleeding); coagulation defects; necrotising enterocolitis; thrombocytopenia; untreated infection
- With oral use Active gastro-intestinal bleeding - active gastro-intestinal ulceration - history of gastro-intestinal bleeding related to previous NSAID therapy - history of gastro-intestinal perforation related to previous NSAID therapy - history of recurrent gastro-intestinal haemorrhage (two or more distinct episodes) - history of recurrent gastro-intestinal ulceration (two or more distinct episodes) - severe heart failure

**Caution**

**General Caution**

- Heart failure

**Specific Caution**

- With intravenous use Inhibition of platelet aggregation (monitor for bleeding); may induce hypotension - may mask symptoms of infection - may reduce urine output by 50% or more and precipitate renal impairment especially if extracelluar volume depleted; sepsis
- With oral use Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - cerebrovascular disease - coagulation defects - connective-tissue disorders - Crohn's disease (may be exacerbated) - epilepsy - ischaemic heart disease - peripheral arterial disease - psychiatric disturbances - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated) - uncontrolled hypertension

**Interactions**

- Appendix 1: NSAIDs

**Side-effects**


**Side-effects, Further Information**

For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs, p. 674

**Allergy and Cross-sensitivity**

Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

**Pregnancy**

- With oral use Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

**Breast Feeding**

- With oral use Amount probably too small to be harmful—manufacturers advise avoid. Use with caution during breast-feeding.

**Hepatic Impairment**

- With intravenous use in neonates Increased risk of gastro-intestinal bleeding and fluid retention. Avoid in severe impairment.
- With oral use Use with caution; there is an increased risk of gastro-intestinal bleeding and fluid retention. Avoid in severe liver disease.
Mefenamic acid

**INDICATIONS AND DOSE**

- Indometacin 50 mg – £0.15
- Indometacin 25 mg – £0.03
- £33.15

**CONTRA-INDICATIONS**

- Contra-indicated in
  - Meningitis aseptic (patients with connective-tissue disorders such as systemic lupus erythematosus may show a possible exacerbation of symptoms in asthma, see Non-proprietary).
  - Acute porphyrias
  - Menorrhagia
  - Trauma

**SIDE-EFFECTS, FURTHER INFORMATION**

- There can be variation in the licensing of special-order manufacturers include: oral suspension (Chemidex Pharma Ltd)

**EXCIPIENTS:** May contain Ethanol

**MEDICAL FORMS**

- Solution
- Capsule
- Tablet

**CAUTIONARIO AND ADVISORY LABELS**

- Use with caution during breast-feeding.

**WARNINGS AND CAUTIONS**

- For further information, see Non-proprietary.

**FOR INFORMATION**

- For details on the management of poisoning, see Non-proprietary.

**PATIENT AND CARER ADVICE**

- Mefenamic acid (Non-proprietary)

**SIDE-EFFECTS**

- Dizziness
- Drowsiness
- Headache
- Sleeplessness
- Vomiting
- Diarrhoea
- Urinary frequency
- Micturition (discontinue)

**INTERACTIONS**

- Avoid if possible or use with caution.

**MEDICATION FORMS**

- Onset of liver damage, monitor liver function; in severe impairment, avoid in severe impairment.

**RENAI INSUFFICIENCY**

- Use with caution.

**HEPATIC IMPAIRMENT**

- Use with caution.

**BREAST FEEDING**

- Use with caution during breast-feeding.

**PREGNANCY**

- Use with caution during breast-feeding.

**ALLERGY AND CROSS-SENSITIVITY**

- Avoid if possible or use with caution.

**CAUTIONARY AND ADVISORY LABELS**

- Avoid if possible or use with caution. Avoid in
  - Severe heart disease
  - Severe ischaemic heart disease
  - Severe tissue disorders
  - Severe allergy and cross-sensitivity
  - Severe renal impairment
  - Severe hepatic disorders
  - Severe bone marrow disorders
  - Severe anaemia
  - Severe dyspnoea
  - Severe dysuria
  - Severe gastrointestinal discomfort
  - Severe eye irritation
  - Severe allergic disorders
  - Menorrhagia

**MEDICAL INSTRUCTIONS**

- Use with caution during breast-feeding.

**MENORRHAGIA**

- Anticontraception

**FOR INFORMATION**

- For details on the management of poisoning, see Non-proprietary.

**OESOPHASAL REFUX**

- Avoid if possible or use with caution.

**CONTRA-INDICATIONS**

- Avoid if possible or use with caution.

**MEDICAL FORMS**

- Onset of liver damage, monitor liver function; in severe impairment, avoid in severe impairment.

**RENAI INSUFFICIENCY**

- Use with caution.

**HEPATIC IMPAIRMENT**

- Use with caution.

**BREAST FEEDING**

- Use with caution during breast-feeding.

**PREGNANCY**

- Use with caution during breast-feeding.

**ALLERGY AND CROSS-SENSITIVITY**

- Avoid if possible or use with caution.

**CAUTIONARY AND ADVISORY LABELS**

- Avoid if possible or use with caution. Avoid in
  - Severe heart disease
  - Severe ischaemic heart disease
  - Severe tissue disorders
  - Severe allergy and cross-sensitivity
  - Severe renal impairment
  - Severe hepatic disorders
  - Severe bone marrow disorders
  - Severe anaemia
  - Severe dyspnoea
  - Severe dysuria
  - Severe gastrointestinal discomfort
  - Severe eye irritation
  - Severe allergic disorders
  - Menorrhagia

**MEDICAL INSTRUCTIONS**

- Use with caution during breast-feeding.

**MENORRHAGIA**

- Anticontraception

**FOR INFORMATION**

- For details on the management of poisoning, see Non-proprietary.

**OESOPHASAL REFUX**

- Avoid if possible or use with caution.
Meloxicam

04-Nov-2016

- **INDICATIONS AND DOSE**
  - **Exacerbation of osteoarthritis (short-term)**
    - **BY MOUTH**
    - Child 16-17 years: 7.5 mg once daily, then increased if necessary up to 15 mg once daily
  - **Pain and inflammation in rheumatic disease**
    - **Ankylosing spondylitis**
    - **BY MOUTH**
    - Child 16-17 years: 15 mg once daily, then reduced to 7.5 mg once daily if required
  - **Relief of pain and inflammation in juvenile idiopathic arthritis and other musculoskeletal disorders in children intolerant to other NSAIDs**
    - **BY MOUTH**
    - Child 12-17 years (body-weight up to 50 kg): 7.5 mg once daily
    - Child 12-17 years (body-weight 50 kg and above): 15 mg once daily

- **UNLICENSED USE** Not licensed for use in children under 16 years.

- **CONTRA-INDICATIONS** Active gastro-intestinal bleeding - active gastro-intestinal ulceration - history of gastrointestinal bleeding related to previous NSAID therapy - history of gastro-intestinal perforation related to previous NSAID therapy - history of recurrent gastro-intestinal haemorrhage (two or more distinct episodes) - history of recurrent gastro-intestinal ulceration (two or more distinct episodes) - severe heart failure

- **CAUTIONS** Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - cerebrovascular disease - coagulation defects - connective-tissue disorders - Crohn's disease (may be exacerbated) - heart failure - ischaemic heart disease - peripheral arterial disease - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated) - uncontrolled hypertension

- **INTERACTIONS** → Appendix 1: NSAIDs

- **SIDE-EFFECTS**
  - **Common or very common** Constipation - diarrhoea - gastrointestinal discomfort - gastrointestinal disorders - headache - nausea - vomiting
  - **Uncommon** Anaemia - angioedema - burping - dizziness - drowsiness - electrolyte imbalance - fluid retention - flushing - haemorrhage - hepatic disorders - hypersensitivity - oedema - skin reactions - stomatitis - vertigo
  - **Rare or very rare** Acute kidney injury - asthma - conjunctivitis - leucopenia - mood altered - nightmare - palpitations - severe cutaneous adverse reactions (SCARs) - thrombocytopenia - tinnitus - vision disorders
  - **Frequency not known** Agranulocytosis - confusion - fertility decreased female - heart failure - increased risk of arterial thromboembolism - nephritis tubulointerstitial - nephrotic syndrome - photosensitivity reaction - renal necrosis

**SIDE-EFFECTS, FURTHER INFORMATION** For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs. p. 674

- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID— which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

**PREGNANCY** Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

**BREAST FEEDING** Use with caution during breast-feeding.

**HEPATIC IMPAIRMENT** Use with caution during breast-feeding.

**RENAI IMPAIRMENT** Avoid if possible or use with caution. Avoid if estimated glomerular filtration rate less than 25 mL/minute/1.73 m².

**SIDE-EFFECTS** Thromboembolism - angioedema - urticaria - photosensitivity reaction - nausea - vomiting - diarrhoea - vertigo.

**CAUTIONS** Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - cerebrovascular disease - coagulation defects - connective-tissue disorders - Crohn's disease (may be exacerbated) - heart failure - ischaemic heart disease - peripheral arterial disease - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated) - uncontrolled hypertension

**INTERACTIONS** → Appendix 1: NSAIDs

**SIDE-EFFECTS** Agranulocytosis - alopecia - angioedema - aplastic anaemia - asthma - cognitive impairment - concentration impaired - confusion - constipation - corneal

Naproxen

01-Mar-2019

- **INDICATIONS AND DOSE**
  - **Pain and inflammation in musculoskeletal disorders**
    - **Dysmenorrhoea**
      - **BY MOUTH**
      - Child: 5 mg/kg twice daily; maximum 1 g per day
  - **Pain and inflammation in juvenile idiopathic arthritis**
    - **BY MOUTH**
    - Child 2-17 years: 5–7.5 mg/kg twice daily; maximum 1 g per day

- **UNLICENSED USE** Not licensed for use in children under 5 years for juvenile idiopathic arthritis. Not licensed for use in children under 16 years for musculoskeletal disorders or dysmenorrhoea.

- **CONTRA-INDICATIONS** Active gastro-intestinal bleeding - active gastro-intestinal ulceration - history of gastro-intestinal bleeding related to previous NSAID therapy - history of gastro-intestinal perforation related to previous NSAID therapy - history of recurrent gastro-intestinal haemorrhage (two or more distinct episodes) - history of recurrent gastro-intestinal ulceration (two or more distinct episodes) - severe heart failure

- **CAUTIONS** Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - cerebrovascular disease - coagulation defects - connective-tissue disorders - Crohn's disease (may be exacerbated) - heart failure - ischaemic heart disease - peripheral arterial disease - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated) - uncontrolled hypertension

**INTERACTIONS** → Appendix 1: NSAIDs

**SIDE-EFFECTS** Agranulocytosis - alopecia - angioedema - aplastic anaemia - asthma - cognitive impairment - concentration impaired - confusion - constipation - corneal
MEDICINAL FORMS

RENAL IMPAIRMENT

ALLERGY AND CROSS-SENSITIVITY

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

SIDE-EFFECTS, FURTHER INFORMATION

ALLERGY AND CROSS-SENSITIVITY
Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

PREGNANCY
Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

BREAST FEEDING
Use with caution during breast-feeding. Amount too small to be harmful but manufacturer advises avoid.

HEPATIC IMPAIRMENT
Manufacturer advises caution in mild to moderate impairment; avoid in severe impairment.

Dose adjustments
Manufacturer advises consider dose reduction in mild to moderate impairment.

RENAI IMPAIRMENT
Avoid if possible or use with caution. Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

Dose adjustments
The lowest effective dose should be used for the shortest possible duration.

Monitoring
In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

EXCEPTIONS TO LEGAL CATEGORY
Can be sold to the public for the treatment of primary dysmenorrhoea in women aged 15–50 years subject to max. single dose of 500 mg, max. daily dose of 750 mg for max. 3 days, and a max. pack size of 9 × 250 mg tablets.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

Gastro-resistant tablet

CAUTIONARY AND ADVISORY LABELS 5, 25

Naproxen 375 mg Naprosyn EC 375mg tablets | 56 tablet £6.42 DT = £27.62
Naproxen 500 mg Naprosyn EC 500mg tablets | 56 tablet £8.56 DT = £44.10

Naproxen EC (Noumed Life Sciences Ltd)
Naproxen 250 mg Naproxen EC 250mg gastro-resistant tablets | 56 tablet £7.51 DT = £17.23
Naproxen 375 mg Naprex EC 375mg gastro-resistant tablets | 56 tablet £8.70 DT = £27.62
Naproxen 500 mg Naproxen EC 500mg gastro-resistant tablets | 56 tablet £14.10

Tablet

CAUTIONARY AND ADVISORY LABELS 21

Naproxen (Non-proprietary)
Naproxen 250 mg Naproxen 250mg tablets | 28 tablet £8.62 DT = £19.15 | 56 tablet £17.00
Naproxen 500 mg Naproxen 500mg tablets | 28 tablet £15.16 DT = £32.71 | 56 tablet £27.60

Naprosyn (Atnahs Pharma UK Ltd)
Naproxen 250 mg Naproxen 250mg tablets | 56 tablet £4.29
Naproxen 500 mg Naproxen 500mg tablets | 56 tablet £8.56

Oral suspension

Naproxen (Non-proprietary)
Naproxen 25 mg per 1 ml Naproxen 25mg/ml oral suspension sugar free suspension | 100 ml £110.00 DT = £191.00
Naproxen 25 mg per 1 ml Naproxen 50mg/ml oral suspension sugar free suspension | 100 ml £100.00 DT = £180.00 DT = £191.00
Naproxen 50 mg per 1 ml Naproxen 50mg/ml oral suspension | 100 ml £40.00 DT = £40.03 DT = £45.03

Effervescent tablet

Stirlesemcent (Stirling Anglian Pharmaceuticals Ltd)
Naproxen 250 mg Stirlesemcent 250mg effervescent tablets sugar-free | 20 tablet £52.72 DT = £52.72

Piroxicam

INDICATIONS AND DOSE

Relief of pain and inflammation in juvenile idiopathic arthritis

BY MOUTH

Child 6–17 years (body-weight up to 15 kg): 5 mg daily
Child 6–17 years (body-weight 15–25 kg): 10 mg daily
Child 6–17 years (body-weight 26–45 kg): 15 mg daily
Child 6–17 years (body-weight 46 kg and above): 20 mg daily

UNLICENSED USE
Not licensed for use in children.

IMPORTANT SAFETY INFORMATION

CHMP ADVICE—PIROXICAM (JUNE 2007)

The CHMP has recommended dual restrictions on the use of piroxicam because of the increased risk of gastrointestinal side effects and serious skin reactions. The CHMP has advised that:

• piroxicam should be initiated only by physicians experienced in treating inflammatory or degenerative rheumatic diseases
• piroxicam should not be used as first-line treatment in adults, use of piroxicam should be limited to the symptomatic relief of osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis
• piroxicam dose should not exceed 20 mg daily
• piroxicam should no longer be used for the treatment of acute painful and inflammatory conditions
• treatment should be reviewed 2 weeks after initiating piroxicam, and periodically thereafter
• concomitant administration of a gastro-protective agent should be considered.

Topical preparations containing piroxicam are not affected by these restrictions.

CONTRA-INDICATIONS
Active gastro-intestinal bleeding - active gastro-intestinal ulceration - history of gastro-intestinal bleeding - history of gastro-intestinal
perforation - history of gastro-intestinal ulceration - inflammatory bowel disease - severe heart failure

- **CAUTIONS**
  - Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - cerebrovascular disease - coagulation defects - connective-tissue disorders - Crohn’s disease (may be exacerbated) - heart failure - ischaemic heart disease - peripheral arterial disease - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated) - uncontrolled hypertension

- **INTERACTIONS** – Appendix 1: NSAIDs

- **SIDE-EFFECTS**
  - **Common or very common**
    - Anaemia - appetite decreased - constipation - diarrhoea - dizziness - drowsiness - eosinophilia - gastrointestinal discomfort - gastrointestinal disorders - headache - hyperglycaemia - leucopenia - nausea - oedema - rash (discontinue) - skin reactions - thrombocytopenia - tinnitus - vertigo - vomiting - weight changes
  - **Uncommon**

**SIDE-EFFECTS, FURTHER INFORMATION**

For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs. p. 674

- **ALLERGY AND CROSS-SENSITIVITY**
  - Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.
  - **PREGNANCY**
    - Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.
  - **BREAST FEEDING**
    - Use with caution during breast-feeding. Amount too small to be harmful.
  - **HEPATIC IMPAIRMENT**
    - Use with caution; there is an increased risk of gastro-intestinal bleeding and fluid retention. Avoid in severe liver disease.
  - **RENAL IMPAIRMENT**
    - Avoid if possible or use with caution. Dose adjustments The lowest effective dose should be used for the shortest possible duration. Monitoring In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.
  - **DIRECTIONS FOR ADMINISTRATION**
    - Piroxicam orodispersible tablets can be taken by placing on the tongue and allowing to dissolve or by swallowing. Piroxicam orodispersible tablets may be halved to give 10 mg dose [unlicensed].
  - **LESS SUITABLE FOR PRESCRIBING**
    - Piroxicam is less suitable for prescribing.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Orodispensible tablet**
    - **CAUTIONARY AND ADVISORY LABELS** 10, 21
    - **EXCIPIENTS:** May contain Aspartame
      - **Feldene Melt** (Pfizer Ltd)
        - Piroxicam 20 mg Feldene Melt 20mg tablets sugar-free |
        - 30 tablet container PT 10.53 DT £10.53
  - **Capsule**
    - **CAUTIONARY AND ADVISORY LABELS** 21
      - **Feldene (Non-proprietary)**
        - Piroxicam 10 mg Piroxicam 10mg capsules | 56 capsule container PT 16.82 DT £4.90
        - Piroxicam 20 mg Piroxicam 20mg capsules | 28 capsule container PT 5.76 DT £4.47
      - **Feldene** (Pfizer Ltd)
        - Piroxicam 10 mg Feldene 10mg capsules | 30 capsule container PT 3.86
        - Piroxicam 20 mg Feldene 20 capsules | 30 capsule container PT 7.71

## 4 Soft tissue and joint disorders

### 4.1 Local inflammation of joints and soft tissue

Other drugs used for Local inflammation of joints and soft tissue

Dexamethasone, p. 455 · Prednisolone, p. 458

### CORTICOSTEROIDS

#### Corticosteroids, inflammatory disorders

**Systemic corticosteroids**

In children with rheumatic diseases corticosteroids should be reserved for specific indications (e.g. when other therapies are unsuccessful or while waiting for DMARDS to take effect) and should be used only under the supervision of a specialist.

Systemic corticosteroids may be considered for the management of juvenile idiopathic arthritis in systemic disease or when several joints are affected. Systemic corticosteroids may also be considered in severe, possibly life-threatening conditions such as systemic lupus erythematosus, systemic vasculitis, juvenile dermatomyositis, Behçet’s disease, and polyarticular joint disease.

In severe conditions, short courses (‘pulses’) of high dose intravenous methylprednisolone p. 458 or a pulsed oral corticosteroid may be particularly effective for providing rapid relief, and has fewer long-term adverse effects than continuous treatment.

Corticosteroid doses should be reduced with care because of the possibility of relapse if the reduction is too rapid. If complete discontinuation of corticosteroids is not possible, consideration should be given to alternate-day (or alternate high-dose, low-dose) administration; on days when no corticosteroid is given, or a lower dose is given, an additional dose of a NSAID may be helpful. In some conditions, alternative treatment using an antimalarial or concomitant use of an immunosuppressant drug, such as azathioprine p. 536, methotrexate p. 563 or cyclophosphamide p. 555 may prove useful; in less severe conditions treatment with a NSAID alone may be adequate.

Administration of corticosteroids may result in suppression of growth and may affect the development of puberty. The risk of corticosteroid-induced osteoporosis should be considered for those on long-term corticosteroid...
Corticosteroids are injected locally for an anti-inflammatory effect. In inflammatory conditions of the joints, including juvenile idiopathic arthritis, they are given by intra-articular injection as monotherapy, or as an adjunct to long-term therapy to reduce swelling and deformity in one or a few joints. Asceptic precautions (e.g. a no-touch technique) are essential, as is a clinician skilled in the technique; infected areas should be avoided and general anaesthesia, or local anaesthesia, or conscious sedation should be used. Occasionally an acute inflammatory reaction develops after an intra-articular or soft-tissue injection of a corticosteroid. This may be a reaction to the microcrystalline suspension of the corticosteroid used, but must be distinguished from sepsis introduced into the injection site.

Triamcinolone hexacetonide p. 687 [unlicensed] is preferred for intra-articular injection because it is almost insoluble and has a long-acting (depot) effect. Triamcinolone acetonide below and methylprednisolone may also be considered for intra-articular injection into larger joints, whilst hydrocortisone acetate p. 456 should be reserved for smaller joints or for soft-tissue injections. Intra-articular corticosteroid injections can cause flushing and, in adults, may affect the hyaline cartilage. Each joint should usually be treated no more than 3–4 times in one year.

A smaller amount of corticosteroid may also be injected directly into soft tissues for the relief of inflammation in conditions such as tennis or golfer’s elbow or compression neurapathies, which occur rarely in children. In tendinitis, injections should be made into the tendon sheath and not directly into the tendon (due to the absence of a true tendon sheath and a high risk of rupture, the Achilles tendon should not be injected). Corticosteroid injections are also injected into soft tissues for the treatment of skin lesions.

Hydrocortisone

**INDICATIONS AND DOSE**

**HYDROCORTISAB**

**Local inflammation of joints and soft-tissues**

- **BY INTRA-ARTICULAR INJECTION**
  - Child 1 month–11 years: 5–30 mg, select dose according to size of child and joint; where appropriate dose may be repeated at intervals of 21 days. Not more than 3 joints should be treated on any one day, for details consult product literature
  - Child 12–17 years: 5–50 mg, select dose according to size of patient and joint; where appropriate dose may be repeated at intervals of 21 days. Not more than 3 joints should be treated on any one day, for details consult product literature

**SIDE-EFFECTS** Myocardial rupture (following recent myocardial infarction)

**INTERACTIONS** → Appendix 1: corticosteroids

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for injection**

- Hydrocortisab (Advanc Pharma) Hydrocortisone acetate 25 mg per 1 ml Hydrocortisab 25mg/1ml suspension for injection ampoules | 10 ampoule £68.72 DT = £68.72

Methylprednisolone

**INDICATIONS AND DOSE**

**DEPO-MEDRONE**

**Local inflammation of joints and soft tissues**

- **BY INTRA-ARTICULAR INJECTION**
  - Child: (consult product literature)

**SIDE-EFFECTS** Angioedema, cataract, confusion - delusions - depressed mood - diarrhoea - dizziness - drug dependence - dyslipidaemia - embolism and thrombosis - epidural lipomatosis - gastrointestinal disorders - glucose tolerance impaired - hallucination - hepatitis - hiccups - hypopituitarism - increased insulin requirement - intracranial pressure increased - memory loss - metabolic acidosis - muscle weakness - myalgia - neuropathic arthropathy - peripheral oedema - psychiatric disorder - schizophrenia exacerbated - sterile abscess - suicidal ideation - vision loss - withdrawal syndrome

**PATIENT AND CARER ADVICE** Patient counselling is advised for methylprednisolone tablets and injections (steroid card).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for injection**

**CAUTIONARY AND ADVISORY LABELS**

- **DEPO-MEDRONE** (Pfizer Ltd)
  - Methylprednisolone acetate 40 mg per 1 ml Depo-Medrone 40mg/1ml suspension for injection vials | 1 vial £3.44 DT = £3.44 | 10 vial £34.04
  - Depo-Medrone 80mg/2ml suspension for injection vials | 1 vial £6.18 DT = £6.18 | 10 vial £61.39
  - Depo-Medrone 120mg/3ml suspension for injection vials | 1 vial £8.96 DT = £8.96 | 10 vial £88.81

Triamcinolone acetonide

**INDICATIONS AND DOSE**

**ADCORTYL** INTRA-ARTICULAR/INTRADERMAL

**Local inflammation of joints and soft tissues**

- **BY INTRA-ARTICULAR INJECTION**
  - Child 1–17 years: 2 mg/kg (max. per dose 15 mg), for details consult product literature, dose applies for larger joints. For doses above 15 mg use Kenalog® Intra-articular/Intramuscular. If appropriate repeat treatment for relapse.

**KENALOG** VIALS

**Local inflammation of joints and soft tissues**

- **BY INTRA-ARTICULAR INJECTION**
  - Child 1–17 years: 2 mg/kg, for details consult product literature, if appropriate repeat treatment for relapse, higher doses than usual maximum have been used; Usual maximum 40 mg

**UNLICENSED USE** Not licensed for use in children under 6 years.

**INTERACTIONS** → Appendix 1: corticosteroids

**PATIENT AND CARER ADVICE** Patient counselling is advised for triamcinolone acetonide injection (steroid card).
Soft tissue disorders

4.2 Soft tissue disorders

Soft-tissue and musculoskeletal disorders

The management of children with soft-tissue injuries and strains, and musculoskeletal disorders, may include temporary rest together with the local application of heat or cold, local massage and physiotherapy. For pain relief, paracetamol p. 278 is often adequate and should be used first. Alternatively, the lowest effective dose of a NSAID (e.g. ibuprofen p. 679) can be used. If pain relief with either drug is inadequate, both paracetamol (in a full dose appropriate for the child) and a low dose of a NSAID may be required.

Extravasation

Local guidelines for the management of extravasation should be followed where they exist or specialist advice sought.

Extravasation injury follows leakage of drugs or intravenous fluids from the veins or inadvertent administration into the subcutaneous or subdermal tissue. It must be dealt with promptly to prevent tissue necrosis.

Acidic or alkaline preparations and those with an osmolarity greater than that of plasma can cause extravasation injury; excipients including alcohol and polyethylene glycol have also been implicated. Cytotoxic drugs commonly cause extravasation injury. Very young children are at increased risk. Those receiving anticoagulants are more likely to lose blood into surrounding tissues if extravasation occurs, while those receiving sedatives or analgesics may not notice the early signs or symptoms of extravasation.

Extravasation prevention

Precautions should be taken to avoid extravasation; ideally, drugs likely to cause extravasation injury should be given through a central line and children receiving repeated doses of hazardous drugs peripherally should have the cannula re-sited at regular intervals. Attention should be paid to the manufacturers’ recommendations for administration. Placing a glyceryl trinitrate p. 137 patch or using glyceryl trinitrate ointment distal to the cannula may improve the patency of the vessel in children with small veins or in those whose veins are prone to collapse. Children or their carers should be asked to report any pain or burning at the site of injection immediately.

Extravasation management

If extravasation is suspected the infusion should be stopped immediately but the cannula should not be removed until after an attempt has been made to aspirate the area (through the cannula) or localise and neutralise the offending substance; one approach is to localise and neutralise the substance whereas another is to spread and dilute it. The first method may be appropriate following extravasation of vesicant drugs and involves administration of an antidote (if available) and the application of cold compresses 3–4 times a day (consult specialist literature for details of specific antidotes). Spreading and diluting the offending substance involves infiltrating the area with physiological saline, applying warm compresses, elevating the affected limb, and administering hyaluronidase p. 688. A saline flush-out technique (involving flushing the subcutaneous tissue with physiological saline) may be effective but requires specialist advice. Hyaluronidase should not be administered following extravasation of vesicant drugs (unless it is either specifically indicated or used in the saline flush-out technique).
**Enzymes used in soft-tissue disorders**

Hyaluronidase is used for the management of extravasation.

### ENZYMES

#### Hyaluronidase

**INDICATIONS AND DOSE**

**Extravasation**
- **BY LOCAL INFILTRATION**
- Child: (consult product literature)

**UNLICENSED USE** Licensed for use in children, but age range not specified by the manufacturer.

**CONTRA-INDICATIONS** Avoid sites where infection is present - avoid sites where malignancy is present - do not apply direct to cornea - not for anaesthesia in unexplained premature labour - not for intravenous administration - not to be used to enhance the absorption and dispersion of dopamine and/or alpha-adrenoceptor agonists - not to be used to reduce swelling of bites - not to be used to reduce swelling of stings.

**CAUTIONS** Infants (control speed and total volume and avoid overhydration especially in renal impairment).

**SIDE-EFFECTS** Oedema - periorbital oedema.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**
- **Hyaluronidase (Non-proprietary)**
  - **Hyaluronidase 1500 unit** Hyaluronidase 1,500 unit powder for solution for injection ampoules | 10 ampoule £13.55
**Chapter 11**

**Eye**

**Eye treatment: drug administration**

Drugs are most commonly administered to the eye by topical application as eye drops or eye ointments. When a higher drug concentration is required within the eye, a local injection may be necessary.

Eye-drop dispenser devices are available to aid the instillation of eye drops from plastic bottles and some are prescribable on the NHS (consult Drug Tariff—see Appliances and Reagents). Product-specific devices may be supplied by manufacturers—contact individual manufacturers for further information. They are particularly useful for children in whom normal application is difficult, for the visually impaired, or otherwise physically limited patients.

**Eye drops and eye ointments**

Eye drops are generally instilled into the pocket formed by gently pulling down the lower eyelid and keeping the eye closed for as long as possible after application; in neonates and infants it may be more appropriate to administer the drop in the inner angle of the open eye. One drop is all that is needed; instillation of more than one drop at a time should be discouraged because it may increase systemic side-effects. A small amount of eye ointment is applied similarly; the ointment melts rapidly and blinking helps to spread it.

When two different eye-drop preparations are used at the same time of day, dilution and overflow can occur when one immediately follows the other. The carer or child should therefore leave an interval of at least 5 minutes between the two; the interval should be extended when eye drops with a prolonged contact time, such as gels and suspensions, are used. Eye ointment should be applied after drops. Both drops and ointment can cause transient blurred vision; children should be warned, where appropriate, not to perform skilled tasks (e.g. cycling or driving) until vision is clear.

Systemic effects may arise from absorption of drugs into the general circulation from conjunctival vessels or from the nasal mucosa after the excess preparation has drained down through the tear ducts. The extent of systemic absorption following ocular administration is highly variable; nasal drainage of drugs is associated with eye drops much more often than with eye ointments. Pressure on the lacrimal punctum for at least a minute after applying eye drops reduces nasolacrimal drainage and therefore decreases systemic absorption from the nasal mucosa.

Also see warnings relating to eye drops and contact lenses.

**Eye lotions**

These are solutions for the irrigation of the conjunctival sac. They act mechanically to flush out irritants or foreign bodies as a first-aid treatment. Sterile sodium chloride 0.9% solution p. 697 is usually used. Clean water will suffice in an emergency.

**Other preparations administered to the eye**

Subconjunctival injection may be used to administer anti-infective drugs, mydriatics, or corticosteroids for conditions not responding to topical therapy; intracameral and intravitreal routes can also beused to administer certain drugs, for example antibacterials. These injections should only be used under specialist supervision.

Drugs such as antimicrobials and corticosteroids may be administered systemically to treat susceptible eye conditions.

**Ophthalmic Specials**

The Royal College of Ophthalmologists and the UK Ophthalmic Pharmacy Group have produced the Ophthalmic Specials Guidance to help prescribers and pharmacists manage and restrict the use of unlicensed eye preparations. 'Specials' should only be prescribed in situations where a licensed product will not be suitable for a child’s needs. The Ophthalmic Specials Guidance can be accessed on the Royal College of Ophthalmologists website (www.rcophth.ac.uk). The guidance will be reviewed every six months to ensure the most accurate and up-to-date information is available.

**Preservatives and sensitisers**

Information on preservatives and substances identified as skin sensitisers is provided under Excipients statements in preparation entries. Very rarely, cases of corneal calcification have been reported with the use of phosphate-containing eye drops in patients with significantly damaged corneas—consult product literature for further information.

**Eye preparations: control of microbial contamination**

Preparations for the eye should be sterile when issued. Care should be taken to avoid contamination of the contents during use.

Eye drops in multiple-application containers for domiciliary use should not be used for more than 4 weeks after first opening (unless otherwise stated by the manufacturer).

Multiple application eye drops for use in hospital wards are normally discarded 1 week after first opening—local practice may vary. Individual containers should be provided for each patient. A separate container should be supplied for each eye.
only if there are special concerns about contamination. Containers used before an eye operation should be discarded at the time of the operation and fresh supplies dispensed postoperatively. A fresh supply should also be provided upon discharge from hospital; in specialist ophthalmology units, it may be acceptable to issue containers that have been dispensed to the patient on the day of discharge.

In **out-patient departments** single-application containers should be used; if multiple-application containers are used, they should be discarded after single use within one clinical session.

In **eye surgery** single-application containers should be used if possible; if a multiple-application container is used, it should be discarded after single use. Preparations used during intra-ocular procedures and others that may penetrate into the anterior chamber must be isotonic and without preservatives and buffered if necessary to a neutral pH. Specially formulated fluids should be used for intra-ocular surgery; intravenous infusion preparations are not usually suitable for this purpose (Hartmann’s solution may be used in some oculic surgery). For all surgical procedures, a previously unopened container is used for each patient.

### Contact lenses

For cosmetic reasons many people prefer to wear contact lenses rather than spectacles; contact lenses are also sometimes required for medical indications. Visual defects are corrected by either rigid (‘hard’ or gas permeable) lenses or soft (hydrogel or silicone hydrogel—in adults only) lenses; soft lenses are the most popular type, because they are initially the most comfortable, but they may not give the best vision. Lenses should usually be worn for a specified number of hours each day and removed for sleeping. The risk of infectious and non-infectious keratitis is increased by extended continuous contact lens wear, which is not recommended, except when medically indicated.

Contact lenses require meticulous care. Poor compliance with directions for use, and with daily cleaning and disinfection, can result in complications including ulcerative keratitis or conjunctivitis. One-day disposable lenses, which are worn only once and therefore require no disinfection or cleaning, are becoming increasingly popular.

*Acanthamoeba keratitis*, a painful and sight-threatening condition, is associated with ineffective lens cleaning and disinfection, the use of contaminated lens cases, or tap water coming into contact with the lenses. The condition is especially associated with the use of soft lenses (including frequently replaced lenses) and should be treated by specialists.

### Contact lenses and drug treatment

Special care is required in prescribing eye preparations for contact lens users. Some drugs and preservatives in eye preparations can accumulate in hydrogel lenses and may induce toxic and adverse reactions. Therefore, unless medically indicated, the lenses should be removed before instillation of the eye preparation and not worn during the period of treatment. Alternatively, unpreserved drops can be used. Eye drops may, however, be instilled while patients are wearing rigid corneal contact lenses. Ointment preparations should never be used in conjunction with contact lens wear; oily eye drops should also be avoided.

Many drugs given systemically can also have adverse effects on contact lens wear. These include oral contraceptives (particularly those with a higher oestrogen content), drugs which reduce blink rate (e.g. anxiolytics, hypnotics, antihistamines, and muscle relaxants), drugs which reduce lacrimation (e.g. antihistamines, antimuscarinics, fenfluramines and related drugs, some beta-blockers, diuretics, and tricyclic antidepressants), and drugs which increase lacrimation (including epinephrine hydrochloride p. 125 and hyaluronic acid hydrochloride p. 118). Other drugs that may affect contact lens wear are isotretinoin p. 780 (can cause conjunctival inflammation), aspirin p. 93 (salicylic acid appears in tears and can be absorbed by contact lenses—leading to irritation), and rifampicin p. 379 and sulfasalazine p. 33 (can discolor lenses).

## 1 Allergic and inflammatory eye conditions

### Eye, allergy and inflammation

#### Corticosteroids

Corticosteroids administered locally to the eye or given by mouth are effective for treating anterior segment inflammation, including that which results from surgery. *Topical corticosteroids* should normally only be used under expert supervision; three main dangers are associated with their use:

- a ‘red eye’, when the diagnosis is unconfirmed, may be due to herpes simplex virus, and a corticosteroid may aggravate the condition, leading to corneal ulceration, with possible damage to vision and even loss of the eye.
- Bacterial, fungal, and amoebic infections pose a similar hazard;
- ‘Steroid glaucoma’ can follow the use of corticosteroid eye preparations in susceptible individuals;
- a ‘steroid cataract’ can follow prolonged use.

Products combining a corticosteroid with an antimicrobial are used after ocular surgery to reduce inflammation and prevent infection: use of combination products is otherwise rarely justified.

*Systemic corticosteroids* may be useful for ocular conditions. The risk of producing a ‘steroid cataract’ increases with the dose and duration of corticosteroid use.

#### Eye care, other anti-inflammatory preparations

Eye drops containing *antihistamines*, such as antazoline with xylometazoline below as *Otrivine-Antistin*®, azelastine hydrochloride p. 691, epinastine hydrochloride p. 691, ketotifen p. 691, and olopatadine p. 691, can be used for allergic conjunctivitis.

Sodium cromoglicate p. 692 and nedocromil sodium eye drops p. 692 may be useful for vernal keratoconjunctivitis and other allergic forms of conjunctivitis. Lodoxamide eye drops p. 691 are used for allergic conjunctival conditions including seasonal allergic conjunctivitis.

### 1.1 Allergic conjunctivitis

#### ANTIHISTAMINES

##### Antazoline with xylometazoline

- **INDICATIONS AND DOSE**
  - **Allergic conjunctivitis**
    - **TO THE EYE**
    - Child 12-17 years: Apply 2–3 times a day for maximum 7 days
  
- **CAUTIONS** Angle-closure glaucoma, cardiovascular disease, diabetes mellitus, hypertension, hyperthyroidism, phaeochromocytoma, urinary retention

- **INTERACTIONS** → Appendix 1: antihistamines, sedating sympathomimetics, vasoconstrictor
Azelastine hydrochloride

- **INDICATIONS AND DOSE**
  - Seasonal allergic conjunctivitis
    - TO THE EYE
    - Child 4-17 years: Apply twice daily, increased if necessary to 4 times a day
  - Perennial conjunctivitis
    - TO THE EYE
    - Child 12-17 years: Apply twice daily; increased if necessary to 4 times a day, maximum duration of treatment 6 weeks

- **INTERACTIONS** → Appendix 1: antihistamines, non-sedating

- **SIDE-EFFECTS**
  - Common or very common Eye irritation, taste altered

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate
    - Otrivine Antistin (Thea Pharmaceuticals Ltd)
      - Xylometazoline hydrochloride 500 microgram per 1 ml, Antazoline sulfate 5 mg per 1 ml Otrivine Antistin 0.9%/0.03% eye drops | 10 ml (£3.35 DT + £3.35

Epinastine hydrochloride

- **INDICATIONS AND DOSE**
  - Seasonal allergic conjunctivitis
    - TO THE EYE
    - Child 12-17 years: Apply twice daily for maximum 8 weeks

- **SIDE-EFFECTS**
  - Common or very common Eye discomfort
  - Uncommon Dry eye, eye disorders, headache, nasal irritation, rhinitis, taste altered, visual impairment

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate
    - Optilast (Meda Pharmaceuticals Ltd)
      - Azelastine hydrochloride 500 microgram per 1 ml Optilast 0.05% eye drops | 8 ml (£6.40 DT + £6.40

Ketotifen

- **INDICATIONS AND DOSE**
  - Seasonal allergic conjunctivitis
    - TO THE EYE
    - Child 3-17 years: Apply twice daily

- **INTERACTIONS** → Appendix 1: antihistamines, sedating

- **SIDE-EFFECTS**
  - Common or very common Eye discomfort, eye disorders, eye inflammation
  - Uncommon Conjunctival haemorrhage, drowsiness, dry eye, dry mouth, headache, skin reactions, vision disorders
  - Frequency not known Asthma exacerbated, facial swelling, oedema

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - EXCIPIENTS: May contain Benzalkonium chloride
      - Ketofall (Scope Ophthalmics Ltd)
        - Ketotifen (as Ketotifen hydrogen fumarate) 250 microgram per 1 ml Ketotifen 0.25mg/ml eye drops 0.4ml unit dose | 30 unit dose (£6.95 DT + £6.95
      - Zaditen (Thea Pharmaceuticals Ltd)
        - Ketotifen (as Ketotifen fumarate) 250 microgram per 1 ml Zaditen 250micrograms/ml eye drops | 5 ml (£7.80 DT + £7.80

Olopatadine

- **INDICATIONS AND DOSE**
  - Seasonal allergic conjunctivitis
    - TO THE EYE
    - Child 3-47 years: Apply twice daily for maximum 4 months

- **SIDE-EFFECTS**
  - Common or very common Asthenia, dry eye, eye discomfort, headache, nasal dryness, taste altered
  - Uncommon Dizziness, eye disorders, eye inflammation, increased risk of infection, numbness, skin reactions, vision disorders
  - Frequency not known Drowsiness, dyspnoea, malaise, nausea, vomiting

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - EXCIPIENTS: May contain Benzalkonium chloride
      - Zaditen (Novartis Pharmaceuticals UK Ltd)
        - Olopatadine (as Olopatadine hydrochloride) 1 mg per 1 ml Olopatadine 40 micrograms/ml eye drops | 4 ml (£3.00 DT + £3.00

- MAST-CELL STABILISERS

Lodoxamide

- **INDICATIONS AND DOSE**
  - Allergic conjunctivitis
    - TO THE EYE
    - Child 4-17 years: Apply 4 times a day, improvement of symptoms may sometimes require treatment for up to 4 weeks

- **SIDE-EFFECTS**
  - Common or very common Dry eye, eye discomfort, eye disorders, vision disorders
  - Uncommon Corneal deposits, dizziness, eye inflammation, headache, nausea
  - Rare or very rare Nasal complaints, rash, taste altered

- **EXCEPTIONS TO LEGAL CATEGORY**
  - Lodoxamide 0.1% eye drops can be sold to the public for treatment of allergic conjunctivitis in adults and children over 4 years.
**Corticosteroids**

**Betamethasone**

- **Drug action**: Betamethasone has very high glucocorticoid activity and insignificant mineralocorticoid activity.

- **Indications and dose**: Local treatment of inflammation (short-term)
  - **To the eye using eye drop**: Apply every 1–2 hours until control then reduce frequency

- **Side-effects**: Common or very common: Eye discomfort, eye strain, taste altered

- **Medicinal forms**: No licensed medicines listed.

**Sodium cromoglicate**

- **Indications and dose**: Allergic conjunctivitis, Seasonal keratoconjunctivitis
  - **To the eye**: Apply 4 times a day

- **Side-effects**: Common or very common: Eye discomfort

- **Medicinal forms**: There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops, eye ointment, ear/eye/nose drops.

**Dexamethasone**

- **Drug action**: Dexamethasone has very high glucocorticoid activity and insignificant mineralocorticoid activity.

- **Indications and dose**: Local treatment of inflammation (short-term)
  - **To the eye using eye drop**: Apply every 4–6 times a day

- **Side-effects**: Common or very common: Eye discomfort, taste altered

- **Medicinal forms**: There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops, eye ointment, ear/eye/nose drops.

**Nedocromil sodium**

- **Indications and dose**: Seasonal and perennial conjunctivitis
  - **To the eye**: Apply 2–4 times a day, alternatively apply at night when used in combination with eye drops

- **Side-effects**: Common or very common: Eye discomfort

- **Medicinal forms**: There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops, eye ointment, ear/eye/nose drops.

**1.2 Inflammatory eye conditions**

Other drugs used for inflammatory eye conditions

Adalimumab, p. 665
Fluorometholone

**INDICATIONS AND DOSE**

Local treatment of inflammation (short term)

- TO THE EYE
- Child: Apply every 1–2 hours until controlled then reduce frequency

**SIDE-EFFECTS**

Cataract, eye discomfort, eye disorders, eye infection, eye inflammation, rash, taste altered, vision disorders

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate, polysorbates

- FML Liquifilm (Allergan Ltd)

Fluorometholone 1 mg per 1 ml

FML Liquifilm 0.1% ophthalmic suspension | 5 ml | £1.71 DT = £1.71 | 10 ml | £2.95 DT = £2.95

**INDICATIONS AND DOSE**

Local treatment of eye inflammation and bacterial infection (short-term)

- TO THE EYE USING EYE DROP
- Child: Apply 4–6 times a day, may be administered every 30–60 minutes in severe conditions until controlled, then reduce frequency

**SIDE-EFFECTS**

Cataract, eye infection, eye inflammation, rash, taste altered, vision disorders

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate, polysorbates

- FML Liquifilm (Allergan Ltd)

Fluorometholone 1 mg per 1 ml

FML Liquifilm 0.1% ophthalmic suspension | 5 ml | £1.71 DT = £1.71 | 10 ml | £2.95 DT = £2.95

**INDICATIONS AND DOSE**

Local treatment of inflammation (short-term)

- TO THE EYE
- Child: 2–17 years: Apply every 1 hour for 24–48 hours, then reduced to 2–4 times a day

**SIDE-EFFECTS**

Cataract, eye discomfort, eye disorders, eye infection, eye inflammation, rash, taste altered, vision disorders

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

EXCIPIENTS: May contain Polysorbates

- FML Liquifilm (Allergan Ltd)

Fluorometholone 1 mg per 1 ml

FML Liquifilm 0.1% ophthalmic suspension | 5 ml | £1.71 DT = £1.71 | 10 ml | £2.95 DT = £2.95

**INDICATIONS AND DOSE**

Local treatment of inflammation (short-term)

- TO THE EYE
- Child: Apply every 1 hour for 24–48 hours, then reduced to 2–4 times a day

**SIDE-EFFECTS**

Cataract, eye discomfort, eye disorders, eye infection, eye inflammation, rash, taste altered, vision disorders

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate, polysorbates

- FML Liquifilm (Allergan Ltd)

Fluorometholone 1 mg per 1 ml

FML Liquifilm 0.1% ophthalmic suspension | 5 ml | £1.71 DT = £1.71 | 10 ml | £2.95 DT = £2.95

**INDICATIONS AND DOSE**

Local treatment of inflammation (short-term)

- TO THE EYE
- Child: Apply every 1 hour for 24–48 hours, then reduced to 2–4 times a day

**SIDE-EFFECTS**

Cataract, eye discomfort, eye disorders, eye infection, eye inflammation, rash, taste altered, vision disorders

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

EXCIPIENTS: May contain Polysorbates

- FML Liquifilm (Allergan Ltd)

Dexamethasone 1 mg per 1 ml

Dexamethasone 0.1% eye drops | 5 ml | £1.42 DT = £1.42 | 10 ml | £2.80 DT = £2.80

**COMBINATIONS WITH ANTI-INFECTIVES**

- Pred Forte (Bausch & Lomb UK Ltd)

Prednisolone sodium phosphate 5 mg per 1 ml

Predsol 0.5% eye drops | 10 ml | £2.00 DT = £2.00

**CORTICOSTEROIDS**

Betamethasone with neomycin

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 692, neomycin sulfate p. 714.

**INDICATIONS AND DOSE**

Local treatment of eye inflammation and bacterial infection (short-term)

- TO THE EYE USING EYE DROP
- Child: (consult product literature)

**INTERACTIONS**

Appendix 1: corticosteroids - neomycin

**LESS SUITABLE FOR PRESCRIBING**

Betamethasone with neomycin eye-drops are less suitable for prescribing.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye drops solution**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate

- Predsol (RPH Pharmaceuticals AB)

Prednisolone sodium phosphate 5 mg per 1 ml

Predsol 0.5% eye drops | 10 ml | £2.00 DT = £2.00

**Dexamethasone with framycetin sulfate and gramicidin**

The properties listed below are those particular to the combination only. For the properties of the components please consider, dexamethasone p. 692, framycetin sulfate p. 713.

**INDICATIONS AND DOSE**

Local treatment of inflammation (short-term)

- TO THE EYE
- Child: Apply 4–6 times a day, may be administered every 30–60 minutes in severe conditions until controlled, then reduce frequency

**SIDE-EFFECTS**

Cataract, eye discomfort, eye disorders, eye infection, eye inflammation, rash, taste altered, vision disorders

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye drops solution**

EXCIPIENTS: May contain Polysorbates

- Sofradex (Sanofi)

Gramicidin 50 microgram per 1 ml, Dexamethasone (as Dexamethasone sodium metasulfobenzoate) 500 microgram per 1 ml, Framycetin sulfate 5 mg per 1 ml

Sofradex ear/eye drops | 8 ml | £7.50

**COMBINATIONS WITH ANTI-INFECTIVES**

- Betnesol-N ear/eye/nose drops

Betnesol-N ear/eye/nose drops | 10 ml | £2.39 DT = £2.39

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye/nose drops solution**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate

- Betnesol-N (RPH Pharmaceuticals AB)

Betnesol-N ear/eye/nose drops | 10 ml | £2.39 DT = £2.39

**COMBINATIONS WITH ANTI-INFECTIVES**

- Bepanthen-N ear/eye/nose drops

Bepanthen-N ear/eye/nose drops | 10 ml | £3.00 DT = £3.00

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye drops solution**

EXCIPIENTS: May contain Polysorbates

- Sofradex (Sanofi)

Gramicidin 50 microgram per 1 ml, Dexamethasone (as Dexamethasone sodium metasulfobenzoate) 500 microgram per 1 ml, Framycetin sulfate 5 mg per 1 ml

Sofradex ear/eye drops | 8 ml | £7.50

**COMBINATIONS WITH ANTI-INFECTIVES**

- Betnesol-N ear/eye/nose drops

Betnesol-N ear/eye/nose drops | 10 ml | £2.39 DT = £2.39

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye drops solution**

EXCIPIENTS: May contain Polysorbates

- Sofradex (Sanofi)

Gramicidin 50 microgram per 1 ml, Dexamethasone (as Dexamethasone sodium metasulfobenzoate) 500 microgram per 1 ml, Framycetin sulfate 5 mg per 1 ml

Sofradex ear/eye drops | 8 ml | £7.50

**COMBINATIONS WITH ANTI-INFECTIVES**

- Betnesol-N ear/eye/nose drops

Betnesol-N ear/eye/nose drops | 10 ml | £2.39 DT = £2.39

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye drops solution**

EXCIPIENTS: May contain Polysorbates

- Sofradex (Sanofi)

Gramicidin 50 microgram per 1 ml, Dexamethasone (as Dexamethasone sodium metasulfobenzoate) 500 microgram per 1 ml, Framycetin sulfate 5 mg per 1 ml

Sofradex ear/eye drops | 8 ml | £7.50

**COMBINATIONS WITH ANTI-INFECTIVES**

- Betnesol-N ear/eye/nose drops

Betnesol-N ear/eye/nose drops | 10 ml | £2.39 DT = £2.39

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye drops solution**

EXCIPIENTS: May contain Polysorbates

- Sofradex (Sanofi)

Gramicidin 50 microgram per 1 ml, Dexamethasone (as Dexamethasone sodium metasulfobenzoate) 500 microgram per 1 ml, Framycetin sulfate 5 mg per 1 ml

Sofradex ear/eye drops | 8 ml | £7.50

**COMBINATIONS WITH ANTI-INFECTIVES**

- Betnesol-N ear/eye/nose drops

Betnesol-N ear/eye/nose drops | 10 ml | £2.39 DT = £2.39

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.
**Dexamethasone with hypromellose, neomycin and polymyxin B sulfate**

The properties listed below are those particular to the combination only. For the properties of the components please consider, dexamethasone p. 692, neomycin sulfate p. 714.

### Drug Action

Ciclosporin inhibits production and release of lymphokines, thereby suppressing cell-mediated immune response.

### Indications and Dose

**Local treatment of inflammation (short-term)**

- **Child:** Apply every 30–60 minutes until controlled, then reduced to 4–6 times a day

**Local treatment of inflammation (short-term)**

- **Child:** Apply 3–4 times a day, alternatively, apply at night when used with eye drops

### Interactions

- **Appendix 1: corticosteroids - neomycin**
- **Less suitable for prescribing:** Dexamethasone with neomycin and polymyxin B sulfate is less suitable for prescribing.

### Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug.

**Eye ointment**

- **Excipients:** May contain Hydroxybenzoates (parabens), woolfat and related substances (including lanolin)
- **Dexamethasone 1 mg per 1 gram, Neomycin (as Neomycin sulfate) 3500 unit per 1 gram, Polymyxin B sulfate 6000 unit per 1 gram** Maxitrol eye ointment | 3.5 gram | £1.44

**Eye drops**

- **Excipients:** May contain Benzalkonium chloride, polysorbites
- **Maxitrol (Novartis Pharmaceuticals UK Ltd)**
- **Dexamethasone 1 mg per 1 ml, Hypromellose 5 mg per 1 ml, Neomycin (as Neomycin sulfate) 3500 unit per 1 ml, Polymyxin B sulfate 6000 unit per 1 ml** Maxitrol eye drops | 5 ml | £1.68

### Immunosuppressants > Calcineurin Inhibitors and Related Drugs

**Ciclosporin (Cyclosporin)**

**Drug Action**

Ciclosporin inhibits production and release of lymphokines, thereby suppressing cell-mediated immune response.

### Indications and Dose

**Verkazia ®**

**Severe vernal keratoconjunctivitis (initiated by a specialist)**

- **Child 4-17 years:** Apply 1 drop 4 times a day, to be applied to the affected eye(s) during the vernal keratoconjunctivitis season, if signs and symptoms persist after the end of the season, treatment may be continued at the recommended dose or decreased to 1 drop twice daily once adequate control is achieved. Once resolved, treatment should be discontinued, and re-initiated upon recurrence

### Contra-Indications

- **Active or suspected ocular or peri-ocular infection**
- **History of ocular herpes—no information available**

### Interactions

- **Appendix 1: ciclosporin**

### Side-Effects

- **Cough • eye discomfort • eye disorders • eye inflammation • headache • increased risk of infection • vision blurred**

### Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **Verkazia (Santen UK Ltd)**
- **Ciclosporin 1 mg per 1 ml** Verkazia 0.1% eye drops 0.3ml unit dose | 120 unit dose | £288.00

### Dexamethasone and Related Drugs

**Pregnancy**

Manufacturer advises avoid unless potential benefit outweighs risk—no information available.

**Breast Feeding**

Manufacturer advises avoid—limited information.

**Monitoring Requirements**

Manufacturer advises regular eye examinations when used for more than 12 months (efficacy and safety have not been studied beyond 12 months).

**Directions for Administration**

Manufacturer advises keep eyes closed for 2 minutes after using eye drops to increase local drug action and reduce systemic absorption.

**Patient and Carer Advice**

Driving and skilled tasks: Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of blurred vision.

**National Funding/Access Decisions**

**Scottish Medicines Consortium (SMC) decisions**

SMC No. SMC2111

The Scottish Medicines Consortium has advised (December 2018) that ciclosporin 1 mg/ml (0.1%) eye drops emulsion (Verkazia ®) is accepted for use within NHS Scotland for the treatment of severe vernal keratoconjunctivitis in patients from 4 to 17 years of age.

**All Wales Medicines Strategy Group (AWMSG) decisions**

AWMSG No. 2908

The All Wales Medicines Strategy Group has advised (March 2019) that ciclosporin (Verkazia ®) is recommended as an option for use within NHS Wales for the treatment of severe vernal keratoconjunctivitis in patients from 4 years of age up to 18 years of age.

### Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **Verkazia (Santen UK Ltd)**
- **Ciclosporin 1 mg per 1 ml** Verkazia 0.1% eye drops 0.3ml unit dose | 120 unit dose | £288.00

### 1.2a Anterior uveitis

**Antimuscarinics**

**Antimuscarinics (eye)**

- **Children under 3 months owing to the possible association between cycloplegia and the development of amblyopia - darkly pigmented iris is more resistant to pupillary dilatation and caution should be exercised to avoid overdosage - mydriasis can precipitate acute angle-closure glaucoma (usually in those who are predisposed to the condition because of a shallow anterior chamber) - neonates at increased risk of systemic toxicity (in neonates)**

**Side-Effects**

- Dizziness • photophobia • skin reactions • tachycardia

**Patient and Carer Advice**

Patients may not be able to undertake skilled tasks until vision clears after mydriasis.

### Atropine sulfate

**Indications and Dose**

**Cycloplegia**

- **To the eye using eye drop**
- **Child 3 months-17 years:** Apply twice daily for 3 days, before procedure
Cyclopentolate hydrochloride

- **INDICATIONS AND DOSE**

  Cycloplegia
  - TO THE EYE
  - Child: Apply 1 drop, 30–60 minutes before examination, using 1% eye drops.
  - Child: Apply 1 drop, 30–60 minutes before examination, using 0.5% eye drops.

  Uveitis
  - TO THE EYE
  - Child: Apply 1 drop 2–4 times a day, using 0.5% eye drops (1% for deeply pigmented eyes).

- **INTERACTIONS** → Appendix 1: atropine

- **SIDE-EFFECTS**

  Abdominal distension - arrhythmias - behaviour abnormal - cardio-respiratory distress - conjunctivitis (on prolonged administration) - constipation - dry mouth - eye oedema (on prolonged administration) - flushing - gastrointestinal disorders - hyperaemia (on prolonged administration) - mydriasis - palpitations - psychotic disorder - staggering - urinary disorders - vomiting

  SIDE-EFFECTS, FURTHER INFORMATION

  Systemic side-effects can occur.

- **PRESCRIBING AND DISPENSING INFORMATION**

  Although multi-dose atropine sulphate eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS**

  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops

  **Eye drops**

  - Atropine sulfate (Non-proprietary)
    - Atropine sulfate 10 mg per 1 ml: Atropine 1% eye drops.
    - 10 ml: £131.88 DT + £131.87
  - Atropine sulfate (Bausch & Lomb UK Ltd)
    - Atropine sulfate 10 mg per 1 ml: Minims atropine sulfate 1% eye drops 0.5ml unit dose.
    - 20 unit dose: £15.10 DT + £15.10

  Homatropine hydrobromide

- **INDICATIONS AND DOSE**

  Anterior uveitis
  - TO THE EYE
  - Child 3 months: Apply 1 drop daily, alternatively apply 1 drop once daily on alternate days, adjusted according to response, only 0.5% eye drops to be used.
  - Child 2-17 years: Apply 1 drop twice daily, adjusted according to response.

- **UNLICENSED USE**

  Not licensed for use in children under 3 months.

- **INTERACTIONS** → Appendix 1: homatropine

- **MEDICINAL FORMS**

  Forms available from special-order manufacturers: eye drops

  **Eye drops**

  - Atropine sulfate (Non-proprietary)
    - Atropine sulfate 10 mg per 1 ml: Atropine 1% eye drops.
    - 10 ml: £131.88 DT + £131.87
  - Atropine sulfate (Bausch & Lomb UK Ltd)
    - Atropine sulfate 10 mg per 1 ml: Minims atropine sulfate 1% eye drops 0.5ml unit dose.
    - 20 unit dose: £15.10 DT + £15.10

  Cyclodrinate

  - Cyclodrinate aqueous solution 0.5% (Bausch & Lomb UK Ltd)
    - 20 minims: £11.68 DT + £11.68
  - Cyclodrinate 0.5% solution (Bausch & Lomb UK Ltd)
    - 5 ml: £8.08 DT + £8.08
  - Cyclodrinate solution 0.5% (Bausch & Lomb UK Ltd)
    - 5 ml: £8.08 DT + £8.08

  Acetylcysteine

- **INDICATIONS AND DOSE**

  Tear deficiency | Impaired or abnormal mucus production
  - TO THE EYE
  - Child: Apply 3–4 times a day.

- **SIDE-EFFECTS**

  Eye discomfort - eye redness

  Ocular lubricants

  Acetylcysteine

  - **INDICATIONS AND DOSE**

  Tear deficiency | Impaired or abnormal mucus production
  - TO THE EYE
  - Child: Apply 3–4 times a day.

  - **SIDE-EFFECTS**

  Eye discomfort - eye redness
**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: effervescent tablet, granules, eye drops.

**Eye drops**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate.

- **Ibut (Rayner Pharmaceuticals Ltd)**
- **Acetyl cysteine 50 mg per 1 ml** Ibut 5% eye drops | 10 ml (Pat) £16.90 DT = £16.30

**Blephagel**

TO THE EYE

Dry eye conditions

**INDICATIONS AND DOSE**

- TO THE EYE
- Child: Apply 3–4 times a day or when required

**UNLICENSED USE** Some preparations not licensed for use in children.

**PRESCRIBING AND DISPENSING INFORMATION** Synthetic high molecular weight polymers of acrylic acid cross-linked with either allyl ethers of sucrose or allyl ethers of pentaerythritol.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Eye gel**

EXCIPIENTS: May contain Benzalkonium chloride, cetrimide, disodium edetate.

- **Blephagel** (Thea Pharmaceuticals Ltd)
  - Carbomer 0.6 mg per 1 gram Blephagel 0.36% eye gel preservative free | 30 gram £7.53
- **Liquivisc** (Thea Pharmaceuticals Ltd)
  - Carbomer 974P 2.5 mg per 1 gram Liquivisc 0.25% eye gel | 10 gram £4.50 DT = £4.50

**Eye drops**

- **GelTears** (Bausch & Lomb UK Ltd)
  - Carbomer 980 2 mg per 1 gram GelTears 0.2% gel | 10 gram (Pat) £2.80 DT = £2.80
- **Viscoatears** (Bausch & Lomb UK Ltd)
  - Carbomer 980 2 mg per 1 gram Viscotears 2mg/g liquid gel | 10 gram (Pat) £1.59 DT = £2.80

**Hydroxypropyl guar with polyethylene glycol and propylene glycol**

(Formulated as an ocular lubricant)

**MEDICINAL FORMS** No licensed medicines listed.

**Hypermellose**

**INDICATIONS AND DOSE**

Tear deficiency

- TO THE EYE
- Child: Apply as required

**PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose hypermellose eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **Artificial tears** (Bausch & Lomb UK Ltd)
  - Hydroxypropylcellulose 4.4 mg per 1 ml Minims artificial tears 0.44% eye drops 0.5ml unit dose | 20 unit dose (Pat) £9.33 DT = £9.33

**MEDICINAL FORMS**

- **Celluvisc** (Allergan Ltd)
  - Celluvisc 1% eye drops 0.4ml unit dose | 30 unit dose (Pat) £3.00 DT = £3.00 | 60 unit dose (Pat) £10.95
- **Carmellose sodium 5 mg per 1 ml** Celluvisc 0.5% eye drops 0.4ml unit dose | 30 unit dose (Pat) £4.80 DT = £4.80 | 90 unit dose (Pat) £15.53
- **Ocu-Lube Carmellose** (Sai-Meds Ltd)
  - Ocu-Lube Carmellose 0.5% eye drops preservative free | 10 ml £7.49
- **Optive** (Allergan Ltd)
  - Optive 0.5% eye drops | 10 ml £7.49
- **Optive Plus** (Allergan Ltd)
  - Optive Plus 0.5% eye drops | 10 ml £7.49
- **Tearvis** (Sai-Meds Ltd)
  - Tearvis 1% eye drops | 10 ml £8.49
  - Tearvis 0.5% eye drops | 10 ml £7.49

**Hypermellose (Non-proprietary)**

- **Hypermellose 3 mg per 1 ml** Hypermellose 0.3% eye drops | 10 ml (Pat) £1.21 DT = £1.45 | 10 ml £0.99 DT = £1.45

**Hypermellose**

**INDICATIONS AND DOSE**

Tear deficiency

- TO THE EYE
- Child: Apply as required

**PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose hypermellose eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**MEDICINAL FORMS**

- **Celluvisc (Allergan Ltd)**
  - Celluvisc 1% eye drops 0.4ml unit dose | 30 unit dose (Pat) £3.00 DT = £3.00 | 60 unit dose (Pat) £10.95
- **Carmellose sodium 5 mg per 1 ml** Celluvisc 0.5% eye drops 0.4ml unit dose | 30 unit dose (Pat) £4.80 DT = £4.80 | 90 unit dose (Pat) £15.53
- **Ocu-Lube Carmellose** (Sai-Meds Ltd)
  - Ocu-Lube Carmellose 0.5% eye drops preservative free | 10 ml £7.49
- **Optive** (Allergan Ltd)
  - Optive 0.5% eye drops | 10 ml £7.49
- **Tearvis** (Sai-Meds Ltd)
  - Tearvis 1% eye drops | 10 ml £8.49
  - Tearvis 0.5% eye drops | 10 ml £7.49

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops.

**EXCIPIENTS:** May contain Benzalkonium chloride, cetrimide, disodium edetate.

- **Hypermellose**
  - Hypermellose 3 mg per 1 ml Hypermellose 0.3% eye drops | 10 ml (Pat) £1.21 DT = £1.45 | 10 ml £0.99 DT = £1.45
**PATIENT AND CARER ADVICE**

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye ointment**

- Paraffin, yellow, soft (Non-proprietary)

  - Liquid paraffin 100 mg per 1 gram, Wool fat 100 mg per 1 gram
  - Yellow soft paraffin 800 mg per 1 gram
  - Simple eye ointment

**Polyvinyl alcohol**

**INDICATIONS AND DOSE**

Tear deficiency

- TO THE EYE
- Child: Apply as required

**PRESCRIBING AND DISPENSING INFORMATION**

Although multi-dose polyvinyl alcohol eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops

**Eye drops**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate, Artelac Single Dose Unit 0.32% eye drops 0.5ml unit dose | 30 unit dose £16.95 DT = £16.65 | 60 unit dose £32.85 Artelac 0.32% eye drops | 10 ml  £4.99 DT = £4.99

**Hydrocor**

Hydrocor 0.3% eye drops 0.4ml unit dose preservative free | 30 unit dose £5.75

**Isopto Plain**

Hydrocor 5 mg per 1 ml IsotoPLAIN 0.5% eye drops | 10 ml  £0.81 DT = £0.81

**Tear-Lac**

Hydrocor 3 mg per 1 ml Tear-Lac Hydrocor 0.3% eye drops preservative free | 10 ml  £5.80

**Liquifilm Tears**

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate, Liquifilm Tears 1.4% eye drops 0.4ml unit dose preservative free | 30 unit dose £5.35

**Refresh Ophthalmic**

Polyvinyl alcohol 14 mg per 1 ml Refresh Ophthalmic 1.4% eye drops 0.4ml unit dose | 30 unit dose £2.25

**Sno Tears**

Polyvinyl alcohol 14 mg per 1 ml Sno Tears 1.4% eye drops | 10 ml  £1.06

**Retinol palmitate with white soft paraffin and light liquid paraffin and liquid paraffin and**

Liquid paraffin with white soft paraffin and wool alcohols

**INDICATIONS AND DOSE**

Dry eye conditions

- TO THE EYE
- Child: Apply as required, best suited for application before sleep

**PATIENT AND CARER ADVICE**

May cause temporary visual disturbance. Should not be used during contact lens wear.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye ointment**

- Liquidparaffin with white soft paraffin and wool alcohols (Non-proprietary)

  Xailin Night eye ointment preservative free | 5 gram £2.54

**Lacrilex**

Wool alcohols 2 mg per 1 gram, Liquid paraffin 425 mg per 1 gram Lactri-lube eye ointment | 3.5 gram £3.01 | 5 gram £3.98

**Paraffin, yellow, soft**

**INDICATIONS AND DOSE**

Eye surface lubrication

- TO THE EYE
- Child: Apply every 2 hours as required

**PATIENT AND CARER ADVICE**

Ophthalmic preparations may cause temporary visual disturbance. Should not be used during contact lens wear.

**Sodium chloride**

**INDICATIONS AND DOSE**

Tear deficiency | Ocular lubricants and astringents | Irrigation, including first-aid removal of harmful substances | Intra-ocular or topical irrigation during surgical procedures

- TO THE EYE
- Child: Apply as required, use 0.9% eye preparations

**PRESCRIBING AND DISPENSING INFORMATION**

Although multi-dose sodium chloride eye drops commonly contain preservatives, preservative-free unit dose vials may be available.
**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops, eye ointment, irrigation.

**Eye drops**
- **Saline** (Bausch & Lomb UK Ltd)
  - Sodium chloride 9 mg per 1 ml
  - Unit dose: £0.44

**Sodium hyaluronate and trehalose**

**INDICATIONS AND DOSE**

**Dry eye conditions**
- **Child:** Apply as required.
- **Adult:** Apply up to 4 times a day.

**PRESCRIBING AND DISPENSING INFORMATION** Some preparations are contained in units which are resealable and may be used for up to 12 hours. Although multi-dose sodium hyaluronate eye drops commonly contain preservatives, preservative-free units are available.

**INDICATIONS AND DOSE**

**Eye drops**
- **Lubristil** (Rayner Pharmaceuticals Ltd)
  - Lubristil 0.15% eye gel 0.4ml unit dose preservative free: £1.20

**Sodium hyaluronate**

**INDICATIONS AND DOSE**

**Dry eye conditions**
- **Child:** Apply up to 4 times a day.

**PRESCRIBING AND DISPENSING INFORMATION** Sodium hyaluronate and trehalose preparations do not contain preservatives; multi-dose preparation can be used for up to 3 months.

**INDICATIONS AND DOSE**

**Eye drops**
- **Thealoz Duo** (Thea Pharmaceuticals Ltd)
  - Thealoz Duo eye drops preservative free: £2.97

**Eye infections**

**Eye infections**

Most acute superficial eye infections can be treated topically. Blepharitis and conjunctivitis are often caused by staphylococci; keratitis and endophthalmitis may be bacterial, viral, or fungal.

Bacterial **blepharitis** is treated by lid hygiene and application of antibacterial eye drops to the conjunctival sac or to the lid margins. Systemic treatment may be required and may be necessary for 3 months or longer.

Most cases of acute bacterial conjunctivitis are self-limiting; where treatment is appropriate, antibacterial eye drops or an eye ointment are used. A poor response might indicate viral or allergic conjunctivitis or antibiotic resistance.

**Corneal ulcer** and **keratitis** require specialist treatment, usually under inpatient care, and may call for intensive topical, subconjunctival, or systemic administration of antimicrobials.

**Endophthalmitis** is a medical emergency which also calls for specialist management and requires intravitreal administration of antimicrobials; concomitant systemic therapy may be necessary.

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**Emergency ophthalmic preparations**

- **Ocusan** (Aegyphiis Pharma S.r.o.)
  - Ocusan 0.2% eye drops 0.5ml unit dose: £0.80

- **Optive Fusion** (Allergan Ltd)
  - Optive Fusion 0.1% eye drops: £0.41

- **Oxyal** (Bausch & Lomb UK Ltd)
  - Oxyal 0.25% eye drops: £0.45

- **Vismed** (TRB Chemidica (UK) Ltd)
  - Vismed Gel Multi 0.3% eye drops preservative free: £0.81

- **Xaillin HA** (Visufarma UK Ltd)
  - Xaillin HA 0.2% eye drops: £1.72
treatment is required in some cases. Surgical intervention, such as vitrectomy, is sometimes indicated.

See reference to the treatment of crab lice of the eyelashes.

**Antibacterials for eye infections**

Bacterial eye infections are generally treated topically with eye drops and eye ointments. Systemic administration is sometimes appropriate in blepharitis.

Chloramphenicol p. 701 has a broad spectrum of activity and is the drug of choice for superficial eye infections.

Chloramphenicol eye drops are well tolerated and the recommendation that chloramphenicol eye drops should be avoided because of an increased risk of aplastic anaemia is not well founded.

Other antibacterials with a broad spectrum of activity include the quinolones, ciprofloxacin p. 700, levofloxacin p. 700, moxifloxacin p. 700, and ofloxacin p. 701; the aminoglycosides, gentamicin below and tobramycin p. 700 are also active against a wide variety of bacteria. Gentamicin, tobramycin, quinolones (except moxifloxacin), and polymyxin B are effective for infections caused by *Pseudomonas aeruginosa*.

Ciprofloxacin eye drops are licensed for corneal ulcers; intensive application (especially in the first 2 days) is required throughout the day and night.

Azithromycin eye drops p. 700 are licensed for trachomatous conjunctivitis caused by *Chlamydia trachomatis* and for purulent bacterial conjunctivitis. *Trachoma* which results from chronic infection with *Chlamydia trachomatis* can be treated with azithromycin by mouth [unlicensed indication].

Fusidic acid is useful for staphylococcal infections.

Propamidine isetionate p. 701 is of little value in bacterial infections but is used by specialists to treat the rare, but potentially sight-threatening, condition of *actinomadura keratitis* [unlicensed indication].

Other antibacterial eye drops may be prepared aseptically in a specialist manufacturing unit from material supplied for injection.

**With corticosteroids**

Many antibacterial preparations also incorporate a corticosteroid but such mixtures should *not* be used unless a patient is under close specialist supervision. In particular they should not be prescribed for undiagnosed ‘red eye’ which is sometimes caused by the herpes simplex virus and may be difficult to diagnose.

**Administration**

Frequency of application depends on the severity of the infection and the potential for irreversible ocular damage; antibacterial eye preparations are usually administered as follows:

- **Eye drops**, apply 1 drop at least every 2 hours in severe infection then reduce frequency as infection is controlled and continue for 48 hours after healing. For less severe infection 3–4 times daily is generally sufficient.
- **Eye ointment**, apply either at night (if eye drops used during the day) or 3–4 times daily (if eye ointment used alone).

**Antifungals for eye infections**

Fungal infections of the cornea are rare. Orbital mycosis is rarer, and when it occurs it is usually because of direct spread of infection from the paranasal sinuses. Debility or immunosuppression can encourage fungal proliferation. The spread of infection through blood occasionally produces metastatic endophthalmitis. Many different fungi are capable of producing ocular infection; they can be identified by appropriate laboratory procedures.

Antifungal preparations for the eye are not generally available. Treatment will normally be carried out at specialist centres, but requests for information about supplies of preparations not available commercially should be addressed to the Strategic Health Authority (or equivalent in Scotland or Northern Ireland), or to the nearest hospital ophthalmology unit, or to Moorfields Eye Hospital, 162 City Road, London EC1V 2PD (tel. (020) 7253 3411) or www.moorfields.nhs.uk.

**Antivirals for eye infections**

Herspes simplex infections producing, for example, dendritic corneal ulcers can be treated with aciclovir p. 702. Aciclovir eye ointment is used in combination with systemic treatment for ophthalmic zoster.

Also see systemic treatment of CMV retinitis.

**Antibacterials for eye infections in neonates**

Antibacterial eye drops are used to treat acute bacterial conjunctivitis in neonates (ophthalmia neonatorum); where possible the causative microorganism should be identified. Chloramphenicol eye drops are used to treat mild conjunctivitis; more serious infections also require a systemic antibacterial. Failure to respond to initial treatment requires further investigation; chlamydial infection is one of the most frequent causes of neonatal conjunctivitis and should be considered. Azithromycin eye drops are licensed to treat trachomatous conjunctivitis caused by *Chlamydia trachomatis* and purulent bacterial conjunctivitis in neonates. However, as there is a risk of simultaneous infection at other sites in neonates and children under 3 months presenting with conjunctivitis caused by *Chlamydia trachomatis*, systemic treatment with oral erythromycin p. 341 is required. *Gonococcal eye infections* are treated with a single-dose of parenteral cefotaxime p. 330 or ceftriaxone p. 332. Gentamicin eye drops together with appropriate systemic antibacterials are used in the treatment of *pseudomonal eye infections*; high-strength gentamicin eye drops (1.5% [unlicensed]) are available for severe infections.

### 3.1 Bacterial eye infection

**ANTIBACTERIALS > AMINOGLYCOSIDES**

**Gentamicin**

- **INDICATIONS AND DOSE**
  - **Bacterial eye infections**
    - **TO THE EYE**
      - **Child:** Apply 1 drop at least every 2 hours in severe infection, reduce frequency as infection is controlled and continue for 48 hours after healing, frequency of eye drops depends on the severity of the infection and the potential for irreversible ocular damage; for less severe infection 3–4 times daily is generally sufficient

- **INTERACTIONS** → Appendix 1: aminoglycosides

- **PRESCRIBING AND DISPENSING INFORMATION** Eye drops may be sourced as a manufactured special or from specialist importing companies.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops

  **Ear/eye drops solution**

  **EXCIPIENTS:** May contain Benzalkonium chloride

  **Gentamicin (Non-proprietary)**

  Gentamicin (as Gentamicin sulfate) 3 mg per 1 ml Gentamicin 0.3% ear/eye drops | 10 ml | £2.63 DT + £2.47

  **BNFC 2019–2020**
700 Eye infections

Tobramycin

- INDICATIONS AND DOSE
  - Local treatment of infections
  - TO THE EYE
    - Child 1-17 years: Apply twice daily for 6–8 days
  - Local treatment of infections (severe infection)
  - TO THE EYE
    - Child 1-17 years: Apply 4 times a day for first day, then apply twice daily for 5–7 days

- INTERACTIONS → Appendix 1: aminoglycosides
- MEDICINAL FORMS
  - No licensed medicines listed

AZITHROMYCIN > MACROLIDES

Azithromycin

- INDICATIONS AND DOSE
  - Trachomatous conjunctivitis caused by Chlamydia trachomatis
  - Purulent bacterial conjunctivitis
  - TO THE EYE
    - Child: Apply twice daily for 3 days, review if no improvement after 3 days of treatment

- INTERACTIONS → Appendix 1: macrolides
- SIDE-EFFECTS
  - Common or very common
    - Eye discomfort
  - Uncommon
    - Eye allergy

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - Azyter (Thea Pharmaceuticals Ltd)
      - Azithromycin dihydrate 15 mg per 1 gram Azyter 15mg/g eye drops 0.25g unit dose | 6 unit dose [POM] £6.99 DT = £6.99

ANTIBACTERIALS > QUINOLONES

Ciprofloxacin

- INDICATIONS AND DOSE
  - Superficial bacterial eye infection
  - TO THE EYE USING EYE DROP
    - Child: Apply 4 times a day for maximum duration of treatment 21 days
  - TO THE EYE USING EYE OINTMENT
    - Child 1-17 years: Apply 1.25 centimetres 3 times a day for 2 days, then apply 1.25 centimetres twice daily for 5 days
  - Superficial bacterial eye infection (severe infection)
  - TO THE EYE USING EYE DROP
    - Child: Apply every 2 hours during waking hours for 2 days, then apply 4 times a day for maximum duration of treatment 21 days
  - Corneal ulcer
  - TO THE EYE USING EYE DROP
    - Child: Apply every 15 minutes for 6 hours, then apply every 30 minutes for the remainder of day 1, then apply every 1 hour on day 2, then apply every 4 hours on days 3–14, maximum duration of treatment 21 days, to be administered throughout the day and night
  - TO THE EYE USING EYE OINTMENT
    - Child 1-17 years: Apply 1.25 centimetres every 1–2 hours for 2 days, then apply 1.25 centimetres every 4 hours for the next 12 days, to be administered throughout the day and night

- INTERACTIONS → Appendix 1: quinolones

Levofloxacin

- INDICATIONS AND DOSE
  - Local treatment of eye infections
  - TO THE EYE
    - Child 1-17 years: Apply every 2 hours for first 2 days, to be applied maximum 8 times a day, then apply 4 times a day for 3 days

- INTERACTIONS → Appendix 1: quinolones
- PREGNANCY
  - Manufacturer advises use only if potential benefit outweighs risk.
- BREAST FEEDING
  - Manufacturer advises use only if potential benefit outweighs risk.
- PRESCRIBING AND DISPENSING INFORMATION
  - Although multi-dose levofloxacin eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - EXCIPIENTS: May contain Benzalkonium chloride
      - Ciprofloxacin (as Ciprofloxacin hydrochloride) 3 mg per 1 ml Ciloxan 0.3% eye drops | 5 ml [POM] £4.70 DT = £4.70

Moxifloxacin

- INDICATIONS AND DOSE
  - Local treatment of infections
  - TO THE EYE
    - Child: Apply 3 times a day continue treatment for 2–3 days after infection improves; review if no improvement within 5 days

- CAUTIONS
  - Not recommended for neonates (in neonates)
- INTERACTIONS → Appendix 1: quinolones
- SIDE-EFFECTS
  - Rare or very rare
    - Laryngeal pain
    - Nasal discomfort

- MEDICINAL FORMS
  - There can be variation in the licensing of different medicines containing the same drug.
  - Eye drops
    - EXCIPIENTS: May contain Benzalkonium chloride
      - Moxifloxacin (as Moxifloxacin hydrochloride) 5 mg per 1 ml Moxivig 0.5% eye drops | 5 ml [POM] £3.80 DT = £3.80
**Ofloxacin**

**INDICATIONS AND DOSE**

**Local treatment of infections**

- **TO THE EYE**
  - Child 1–17 years: Apply every 2–4 hours for the first 2 days, then reduced to 4 times a day for maximum 10 days treatment

**CAUTIONS**

- Corneal ulcer (risk of corneal perforation) - epithelial defect (risk of corneal perforation)
- **INTERACTIONS** → Appendix 1: quinolones

**SIDE-EFFECTS**

- Oropharyngeal swelling - tongue swelling
- **PREGNANCY** Manufacturer advises use only if benefit outweighs risk (systemic quinolones have caused arthropathy in animal studies).

**BREAST FEEDING**

- Manufacturer advises avoid.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- EXCIPIENTS: May contain Benzalkonium chloride
- **Exocin** (Allergan Ltd)
  - Ofloxacin 3 mg per 1 ml Excin 0.3% eye drops | 5 ml [POM] £2.17 DT = £2.17

**ANTIBACTERIALS > OTHER**

**Chloramphenicol**

**DRUG ACTION**

- Chloramphenicol is a potent broad-spectrum antibiotic.

**INDICATIONS AND DOSE**

**Superficial eye infections**

- **TO THE EYE USING EYE DROP**
  - Child: Apply 1 drop every 2 hours then reduce frequency as infection is controlled and continue for 48 hours after healing, frequency dependent on the severity of the infection. For less severe infection 3–4 times daily is generally sufficient
  - **TO THE EYE USING EYE OINTMENT**
  - Child: Apply daily, to be applied at night (if eye drops used during the day), alternatively apply 3–4 times a day, if ointment used alone

**INTERACTIONS** → Appendix 1: chloramphenicol

**SIDE-EFFECTS**

- Angioedema - bone marrow disorders - eye stinging - fever - paraesthesia - skin reactions
- **PREGNANCY** Avoid unless essential—no information on topical use but risk of ‘neonatal grey-baby syndrome’ with oral use in third trimester.

**BREAST FEEDING**

- Avoid unless essential— theoretical risk of bone-marrow toxicity.

**PRESCRIBING AND DISPENSING INFORMATION**

- Although multi-dose chloramphenicol eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**PATIENT AND CARER ADVICE**

- Medicines for Children leaflet: Chloramphenicol for eye infections www.medicinesforchildren.org.uk/chloramphenicol-eye-infections-0

**EXCEPTIONS TO LEGAL CATEGORY**

- Chloramphenicol 0.5% eye drops (in max. pack size 10 ml) and 1% eye ointment (in max. pack size 4 g) can be sold to the public for treatment of acute bacterial conjunctivitis in adults and children over 2 years; max. duration of treatment 5 days.

**Fusidic acid**

16 Jun 2017

**INDICATIONS AND DOSE**

**Staphylococcal eye infections**

- **TO THE EYE**
  - Child: Apply twice daily

**INTERACTIONS** → Appendix 1: fusidic acid

**SIDE-EFFECTS**

- Common or very common—Dry eye - eye discomfort - vision blurred
- Uncommon—Crying on application - skin reactions - watering eye
- Frequency not known—Angioedema - eye inflammation

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Modified-release drops**

- EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate
- **Fusidic acid 10 mg per 1 gram** Fusidic acid 1% modified-release eye drops | 5 gram [POM] £29.06 DT = £29.06

**ANTIPROTOZOAALs**

**Propamidine isetionate**

**INDICATIONS AND DOSE**

**Acanthamoeba keratitis infections (specialist use only)**

**Local treatment of eye infections**

- **TO THE EYE USING EYE OINTMENT**
  - Child: Apply 1–2 times a day
  - **TO THE EYE USING EYE DROP**
  - Child: Apply up to 4 times a day

**UNLICENSED USE**

- Not licensed for acanthamoeba keratitis infections.

**SIDE-EFFECTS**

- Eye discomfort - vision blurred

**PREGNANCY**

- Manufacturer advises avoid unless essential—no information available.

**BREAST FEEDING**

- Manufacture advises avoid unless essential—no information available.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Eye ointment**

- **Golden Eye (dibrompropamidine)** (Cambridge Healthcare Supplies Ltd)
  - Dibrompropamidine isetionate 1.5 mg per 1 gram Golden Eye 0.15% ointment | 5 gram [P] £3.98 DT = £3.98
**Eye procedures**

**Mydriatics and cycloplegics**

**Overview**

Antimuscarinics dilate the pupil and paralyse the ciliary muscle; they vary in potency and duration of action.

Short-acting, relatively weak mydriatics, such as tropicamide below 0.5% (action lasts for 4–6 hours), facilitate the examination of the fundus of the eye.

Cyclopentolate hydrochloride or homatropine hydrobromide p. 695 (action up to 3 days) can also be used and may be preferred because they have a shorter duration of action.

**ANTIMUSCARINICS**

### Tropicamide

**INDICATIONS AND DOSE**

**Fundoscopy**

- TO THE EYE
- Child: 0.5% eye drops to be applied 20 minutes before examination.

**INTERACTIONS**

- Appendix 1: tropicamide
- SIDE-EFFECTS: Eye erythema, eye irritation (on prolonged administration), eye pain, headache, hypotension, nausea, syncope, vision blurred

**PRESCRIBING AND DISPENSING INFORMATION**

Although multi-dose tropicamide eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **EXCipients:** May contain Benzalkonium chloride
  - **Brolene (Propamidine)** (Sanofi)  Propamidine isetionate 1 mg per 1 ml  Brolene 0.1% eye drops 10 ml £2.80 DT + £2.80
  - **Golden Eye (propamidine)** (Cambridge Healthcare Supplies Ltd)  Propamidine isetionate 1 mg per 1 ml  Golden Eye 0.1% drops 10 ml £3.62 DT + £2.80

### 3.2 Viral eye infection

#### 3.2a Ophthalmic herpes simplex

**ANTIVIRALS > NUCLEOSIDE ANALOGUES**

**Aciclovir**

**(Aцикловир)**

**INDICATIONS AND DOSE**

Herpes simplex infection (local treatment)

- TO THE EYE USING EYE OINTMENT
- Child: Apply 1 centimetre 5 times a day continue for at least 3 days after complete healing

**INTERACTIONS**

- Appendix 1: aciclovir

**SIDE-EFFECTS**

- Common or very common  Eye inflammation - eye pain

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Aciclovir eye ointment for herpes-simplex-infection www.medicinesforchildren.org.uk/aciclovir-eye-ointment-herpes-simplex-infection-0

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Eye ointment**

- **Zovirax** (GlaxoSmithKline UK Ltd)  Aciclovir 30 mg per 1 gram  Zovirax 3% ophthalmic ointment 4.5 gram £9.34 DT £9.34

### Povidone-iodine

**INDICATIONS AND DOSE**

Cutaneous peri-ocular and conjunctival antisepsis before ocular surgery

- TO THE EYE
- Neonate: Apply, leave for 2 minutes, then irrigate thoroughly with sodium chloride 0.9%.
- Child: Apply, leave for 2 minutes, then irrigate thoroughly with sodium chloride 0.9%

**CONTRA-INDICATIONS**

Concomitant use of ocular antimicrobial drugs - concomitant use of ocular formulations containing mercury-based preservatives preterm neonates

**SIDE-EFFECTS**

- Rare or very rare  Eye erythema - punctate keratitis
- Frequency not known  Cytotoxicity - eye discoloration - hypothyroidism (in neonates)

**PRESCRIBING AND DISPENSING INFORMATION**

Although multi-dose povidone iodine eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops, eye lotion

**Eye drops**

- **EXCipients:** May contain Benzalkonium chloride, edetic acid (edta)
  - **Mydriacyl** (Alcon Eye Care Ltd)  Tropicamide 10 mg per 1 ml  Mydriacyl 1% eye drops 5 ml £1.60
  - **Tropicamide** (Bausch & Lomb UK Ltd)  Tropicamide 5 mg per 1 ml  Minims tropicamide 0.5% eye drops 0.5 ml unit dose 20 unit dose £11.18
  - **Tropicamide** (Bausch & Lomb UK Ltd)  Tropicamide 10 mg per 1 ml  Minims tropicamide 1% eye drops 0.5 ml unit dose 20 unit dose £11.31

**IODINE PRODUCTS**

**Povidone-Iodine 50 mg per 1 ml**

- **Brolene** (Propamidine)  Propamidine isetionate 1 mg per 1 ml  Brolene 0.1% eye drops 10 ml £2.80 DT £2.80

**Zovirax**

- **EXCipients:** May contain Benzalkonium chloride, edetic acid (edta)
  - **Tropicamide** (Alcon Eye Care Ltd)  Tropicamide 10 mg per 1 ml  Zovirax 3% ophthalmic ointment 4.5 gram £9.34 DT £9.34

**IODINE PRODUCTS**

**Povidone-Iodine 50 mg per 1 ml**

- **Brolene** (Propamidine)  Propamidine isetionate 1 mg per 1 ml  Brolene 0.1% eye drops 10 ml £2.80 DT £2.80

**Zovirax**

- **EXCipients:** May contain Benzalkonium chloride, edetic acid (edta)
  - **Tropicamide** (Alcon Eye Care Ltd)  Tropicamide 10 mg per 1 ml  Zovirax 3% ophthalmic ointment 4.5 gram £9.34 DT £9.34

**IODINE PRODUCTS**

**Povidone-Iodine 50 mg per 1 ml**

- **Brolene** (Propamidine)  Propamidine isetionate 1 mg per 1 ml  Brolene 0.1% eye drops 10 ml £2.80 DT £2.80

**Zovirax**

- **EXCipients:** May contain Benzalkonium chloride, edetic acid (edta)
  - **Tropicamide** (Alcon Eye Care Ltd)  Tropicamide 10 mg per 1 ml  Zovirax 3% ophthalmic ointment 4.5 gram £9.34 DT £9.34
**DIAGNOSTIC AGENTS** > **DYES**

**Fluorescein sodium**

- **INDICATIONS AND DOSE**
  - Detection of lesions and foreign bodies
  - **TO THE EYE**
  - Child: Use sufficient amount to stain damaged areas

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Although multi-dose fluorescein eye drops commonly contain preservatives, preserve-free unit dose vials may be available.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  **Eye drops**
  - Fluorescein sodium (Bausch & Lomb UK Ltd)
  - Fluorescein sodium 10 mg per 1 ml
    - Minimum fluorescein sodium 1% eye drops 0.5 ml unit dose | 20 unit dose £9.25
  - Fluorescein sodium 20 mg per 1 ml
    - Minimum fluorescein sodium 2% eye drops 0.5 ml unit dose | 20 unit dose £9.25

**MIOTICS** > **PARASYMPATHOMIMETICS**

**Acetylcholine chloride**

- **INDICATIONS AND DOSE**
  - Cataract surgery | Penetrating keratoplasty | Iridectomy | Anterior segment surgery requiring rapid complete miosis
  - **TO THE EYE**
  - Child: (consult product literature)

- **UNLICENSED USE**
  - Not licensed for use in children.

- **CAUTIONS**
  - Asthma | Gastro-intestinal spasm | Heart failure | Hyperthyroidism | Peptic ulcer | Urinary-tract obstruction

- **SIDE-EFFECTS**
  - Bradycardia | Corneal decompensation | Corneal oedema | Dyspnœa | Flushing | Hyperhidrosis | Hypotension

- **PREGNANCY**
  - Avoid unless potential benefit outweighs risk—no information available.

- **BREAST FEEDING**
  - Avoid unless potential benefit outweighs risk—no information available.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  **Irrigation**
  - Miochol-E (Bausch & Lomb UK Ltd)
    - Acetylcholine chloride 20 mg
      - Miochol-E 20 mg powder and solvent for solution for intraocular irrigation vials | 1 vial (Packet) £7.28
    - Miochel (Parmigina S.p.A.)
      - Acetylcholine chloride 20 mg
        - Miochel 20 mg powder and solvent for solution for intraocular irrigation ampoules | 6 ampoule (Packet) £4.68 (Hospital only)

**SYMPATHOMIMETICS** > **Vasoconstrictor**

**Phenylephrine hydrochloride**

- **INDICATIONS AND DOSE**
  - **MYDRIASIS**
    - **TO THE EYE**
    - Child: Apply 1 drop, to be administered before procedure, a drop of proparacaine topical anaesthetic may be applied to the eye a few minutes before using phenylephrine to prevent stinging

- **CONTRA-INDICATIONS**
  - 10% strength eye drops in children • 10% strength eye drops in neonates (in neonates) • Aneurysms • Cardiovascular disease • Hypertension • Thyrotoxicosis

- **CAUTIONS**
  - Asthma • Corneal epithelial damage • Darkly pigmented iris is more resistant to pupillary dilatation and caution should be exercised to avoid overdosage • Diabetes (avoid eye drops in long standing diabetes • Mydriasis can precipitate acute angle-closure glaucoma in the very few children who are predisposed to the condition because of a shallow anterior chamber • Neonates are at an increased risk of systemic toxicity • Ocular hyperaemia • Susceptibility to angle-closure glaucoma

- **INTERACTIONS**
  - Appendix 1: sympathomimetics, vasoconstrictor

- **SIDE-EFFECTS**
  - Arrhythmias • Conjunctivitis allergic • Eye discomfort • Hypertension • Myocardial infarction (usually after use of 10% strength in patients with pre-existing cardiovascular disease • Palpitations • Periorbital pallor • Vision disorders

- **PREGNANCY**
  - Use only if potential benefit outweighs risk.

- **BREAST FEEDING**
  - Use only if potential benefit outweighs risk—no information available.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Although multi-dose phenylephrine eye drops commonly contain preservatives, preserve-free unit dose vials may be available.

- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks: Patients should be warned not to undertake skilled tasks (e.g. driving) until vision clears after mydriasis.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops

  **Eye drops**
  - EXCIPIENTS: May contain Disodium edetate, sodium metabisulphite
    - Phenylephrine hydrochloride (Bausch & Lomb UK Ltd)
      - Phenylephrine hydrochloride 25 mg per 1 ml
        - Minimum phenylephrine hydrochloride 2.5% eye drops 0.5 ml unit dose | 20 unit dose £11.87

**4.1 Post-operative pain and inflammation**

**Eye, surgical and peri-operative drug use**

**Ocular peri-operative drugs**

Drugs used to prepare the eye for surgery and drugs that are injected into the anterior chamber at the time of surgery are included here.

Sodium hyaluronate p. 698 is used during surgical procedures on the eye.

Apraclonidine p. 710, an alpha-adrenoceptor agonist, reduces intra-ocular pressure possibly by reducing the production of aqueous humour. It is used for short-term treatment only.

**Balanced Salt Solution** is used routinely in intra-ocular surgery.

Povidone–iodine p. 702 is used for peri-ocular and conjunctival antisepsis before ocular surgery to support postoperative infection control.

**Ocular local anaesthetics**

Oxybuprocaine hydrochloride p. 704 and tetracaine p. 704 are widely used topical local anaesthetics. Proparacaine hydrochloride p. 704 causes less initial stinging and is useful for children. Oxybuprocaine hydrochloride or a combined preparation of lidocaine hydrochloride p. 852 and fluorescein sodium above is used for tonometry. Tetracaine produces a more profound anaesthesia and is suitable for use before
minor surgical procedures, such as the removal of corneal sutures. It has a temporary disruptive effect on the corneal epithelium. Lidocaine hydrochloride, with or without adrenaline/epinephrine p. 138, is injected into the eyelids for minor surgery. Local anaesthetics should never be used for the management of ocular symptoms. Local anaesthetic eye drops should be avoided in preterm neonates because of the immaturity of the metabolising enzyme system.

ANAESTHETICS, LOCAL

Fluorescein with lidocaine

- **INDICATIONS AND DOSE**
  - **Local anaesthesia**
    - **TO THE EYE**
      - Child: Apply as required

- **CONTRA-INDICATIONS** Avoid in pre-term neonates (immature metabolising enzyme system)
- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose lidocaine and fluorescein eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Eye drops**
    - Lidocaine and Fluorescein (Bausch & Lomb UK Ltd)
      - Fluorescein sodium 2.5 mg per 1 ml, Lidocaine hydrochloride 40 mg per 1 ml
      - Minims lidocaine and fluorescein eye drops 0.5ml unit dose | 20 unit dose [PPO] £11.69

Oxybuprocaine hydrochloride
(Benoxinate hydrochloride)

- **INDICATIONS AND DOSE**
  - **Local anaesthesia**
    - **TO THE EYE**
      - Child: Apply as required

- **CONTRA-INDICATIONS** Avoid in preterm neonates
- **INTERACTIONS** → Appendix 1: anaesthetics, local
- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose oxybuprocaine eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Eye drops**
    - Oxybuprocaine hydrochloride (Bausch & Lomb UK Ltd)
      - Oxybuprocaine hydrochloride 4 mg per 1 ml
      - Minims oxybuprocaine hydrochloride 0.4% eye drops 0.5ml unit dose | 20 unit dose [PPO] £10.56

Proxymetacaine hydrochloride

- **INDICATIONS AND DOSE**
  - **Local anaesthetic**
    - **TO THE EYE**
      - Child: Apply as required

- **CONTRA-INDICATIONS** Avoid in preterm neonates
- **INTERACTIONS** → Appendix 1: anaesthetics, local
- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose proxymetacaine eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Eye drops**
    - Proxymetacaine (Bausch & Lomb UK Ltd)
      - Proxymetacaine hydrochloride 5 mg per 1 ml
      - Minims proxymetacaine 0.5% eye drops 0.5ml unit dose | 20 unit dose [PPO] £12.12

### Tetracaine
(AMETHOCAINE)

- **INDICATIONS AND DOSE**
  - **Local anaesthetic**
    - **TO THE EYE**
      - Child: Apply as required

- **UNLICENSED USE** Not licensed for use in neonates.
- **CONTRA-INDICATIONS** Avoid in preterm neonates
- **INTERACTIONS** → Appendix 1: anaesthetics, local
- **SIDE-EFFECTS** Dermatitis - eye disorders - eye inflammation - paraesthesia
- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose tetracaine eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Eye drops**
    - Tetracaine (Bausch & Lomb UK Ltd)
      - Tetracaine hydrochloride 5 mg per 1 ml
      - Minims tetracaine hydrochloride 0.5% eye drops 0.5ml unit dose | 20 unit dose [PPO] £10.57 DT = £10.57
      - Tetracaine hydrochloride 10 mg per 1 ml
      - Minims tetracaine hydrochloride 1% eye drops 0.5ml unit dose | 20 unit dose [PPO] £10.57 DT = £10.57

### DICLOFENAC SODIUM

- **INDICATIONS AND DOSE**
  - **Non-steroidal anti-inflammatory drugs**
    - **Inhibition of intra-operative miosis during cataract surgery (but does not possess intrinsic mydriatic properties)**
    - **Postoperative inflammation in cataract surgery, strabismus surgery, argon laser trabecuoplasty**
    - **TO THE EYE**
      - Child: (consult product literature)

- **UNLICENSED USE** Not licensed for use in children.
- **INTERACTIONS** → Appendix 1: NSAIDs
- **SIDE-EFFECTS**
  - Rare or very rare
    - Asthma exacerbated - dyspnoea - eye disorders - eye inflammation - hypersensitivity - oedema - skin reactions
  - Frequency not known
    - Eye discomfort - rhinitis - vision blurred

- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose diclofenac sodium eye drops commonly contain preservatives, preservative-free unit dose vials may be available.
### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **EXCIPIENTS:** May contain benzalkonium chloride, disodium edetate, propylene glycol
- Voltarol Ophtha (Thea Pharmaceuticals Ltd)
- Diclofenac sodium 1 mg per 1 ml Voltarol Ophtha 0.1% eye drops 0.3ml unit dose | 5 unit dose (POM) £4.00 DT = £4.00 | 40 unit dose (POM) £32.00 DT = £32.00
- Voltarol Ophtha Multidose (Thea Pharmaceuticals Ltd)
- Diclofenac sodium 1 mg per 1 ml Voltarol Ophtha Multidose 0.1% eye drops | 5 ml (POM) £6.68 DT = £6.68

### ALLERGY AND CROSS-SENSITIVITY

- Frequency not known
- **Common or very common**

### SIDE-EFFECTS

- **TO THE EYE**
- Child: (consult product literature)

### INTERACTIONS

→ Appendix 1: NSAIDs

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### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **EXCIPIENTS:** May contain benzalkonium chloride, disodium edetate
- Ketorolac trometamol (Non-proprietary)
- Ketorolac trometamol 5 mg per 1 ml Ketorolac 0.5% eye drops | 5 ml (POM) £3.00–£3.99 DT = £3.00
- Acular (Allergan Ltd)
  - Ketorolac trometamol 5 mg per 1 ml Acular 0.5% eye drops | 5 ml (POM) £3.00 DT = £3.00

### ALLERGY AND CROSS-SENSITIVITY

- Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

### SIDE-EFFECTS

- **Common or very common**
- Eye discomfort - haemorrhage
- Frequency not known

### INTERACTIONS

→ Appendix 1: NSAIDs

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### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

- **EXCIPIENTS:** May contain benzalkonium chloride, disodium edetate
- Ketorolac trometamol (Non-proprietary)
- Ketorolac trometamol 5 mg per 1 ml Ketorolac 0.5% eye drops | 5 ml (POM) £3.00–£3.99 DT = £3.00
- Acular (Allergan Ltd)
  - Ketorolac trometamol 5 mg per 1 ml Acular 0.5% eye drops | 5 ml (POM) £3.00 DT = £3.00

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### Flurbiprofen

**06-Sep-2016**

**INDICATIONS AND DOSE**

Inhibition of intra-operative miosis (but does not possess intrinsic mydriatic properties) | Control of anterior segment inflammation following postoperative and post-laser trabeculoplasty when corticosteroids contra-indicated

- **TO THE EYE**
- Child: (consult product literature)

**UNLICENSED USE**

- Not licensed for use in children.

**INTERACTIONS**

→ Appendix 1: NSAIDs

**SIDE-EFFECTS**

- **Common or very common**
  - Eye discomfort
  - Haemorrhage
- Frequency not known

**ALLERGY AND CROSS-SENSITIVITY**

- Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

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### Ketorolac trometamol

**13-Aug-2018**

**INDICATIONS AND DOSE**

Prophylaxis and reduction of inflammation and associated symptoms following ocular surgery

- **TO THE EYE**
- Child: (consult product literature)

**UNLICENSED USE**

- Not licensed for use in children.

**INTERACTIONS**

→ Appendix 1: NSAIDs

**SIDE-EFFECTS**

- **Common or very common**
  - Eye discomfort
  - Eye disorders
  - Eye infection
  - Eye inflammation
  - Headache
  - Hypersensitivity
  - Keratopathy
  - Retinal haemorrhage
  - Vision disorders
- **Uncommon**
  - Dry eye
- **Frequency not known**
  - Asthma exacerbated
  - Bronchospasm

**ALLERGY AND CROSS-SENSITIVITY**

- Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

### 5 Glaucoma and ocular hypertension

#### Glaucoma

**Overview**

Glaucoma describes a group of disorders characterised by a loss of visual field associated with cupping of the optic disc and optic nerve damage and is generally associated with raised intra-ocular pressure.

Glaucoma is rare in children and should always be managed by a specialist. Primary congenital glaucoma is the most common form of glaucoma in children, followed by secondary glaucomas, such as following hereditary anterior segment malformations; juvenile open-angle glaucoma is less common and usually occurs in older children.

Treatment of glaucoma is determined by the pathophysiology and usually involves controlling raised intra-ocular pressure with surgery. Drug therapy is generally supportive, and can be used temporarily, pre- or post-operatively, or both, to reduce intra-ocular pressure. In secondary glaucomas, drug therapy is often used first-line, and long-term treatment may be required. Drugs that reduce intra-ocular pressure by different mechanisms are available for managing glaucoma. A topical beta-blocker or a prostaglandin analogue can be used. It may be necessary to combine these drugs or add others, such as carbonic anhydrase inhibitors, or miotics to control intra-ocular pressure.

Children with an acute form of glaucoma (usually presenting with pain in older children, a cloudy cornea, and may be associated with a previous history of controlled glaucoma or recent intra-ocular surgery) need immediate referral for specialist ophthalmic assessment and treatment.

**Beta-blockers for glaucoma**

Topical application of a beta-blocker to the eye reduces intra-ocular pressure effectively in primary and secondary glaucomas, probably by reducing the rate of production of aqueous humour.

**Prostaglandin analogues for glaucoma**

The prostaglandin analogues latanoprost p. 710, and travoprost, and the synthetic prostamide, bimatoprost, increase uveoscleral outflow and subsequently reduce intra-ocular pressure. They are used to reduce intra-ocular pressure. Only latanoprost (Xalatan® and certain non-proprietary preparations of latanoprost) is licensed for use in children. Children receiving prostaglandin analogues should be managed by a specialist.

**Sympathomimetics for glaucoma**

Apraclonidine p. 710 is an alpha-2 adrenoceptor agonist that lowers intra-ocular pressure by reducing aqueous humour formation. Eye drops containing apraclonidine 0.5% are used for a short period to delay laser treatment or surgery for glaucoma in patients not adequately controlled by another
drug; eye drops containing 1% are used for control of intraocular pressure after anterior segment laser surgery.

Brimonidine tartrate, an alpha-2-adrenoceptor agonist, is thought to lower intra-ocular pressure by reducing aqueous humour formation and increasing uveoscleral outflow.

Carbonic anhydrase inhibitors and systemic drugs for glaucoma

The carbonic anhydrase inhibitors, acetazolamide p. 707, brinzolamide p. 708, and dorzolamide p. 708, reduce intra-ocular pressure by reducing aqueous humour production. Systemic use of acetazolamide also produces weak diuresis.

Acetazolamide is given by mouth or, rarely in children, by intravenous injection (intramuscular injections are painful because of the alkaline pH of the solution). It is used as an adjunct to other treatment for reducing intra-ocular pressure. Acetazolamide is not generally recommended for long-term use.

Dorzolamide and brinzolamide are topical carbonic anhydrase inhibitors. They are unlicensed in children but are used in those resistant to beta-blockers or those in whom beta-blockers are contra-indicated. They are used alone or as an adjunct to a topical beta-blocker. Brinzolamide can also be used as an adjunct to a prostaglandin analogue. Systemic absorption can rarely cause sulfonamide-like side-effects and may require discontinuation if severe.

Metabolic acidosis can occur in children using topical carbonic anhydrase inhibitors; symptoms may include poor feeding and lack of weight gain.

Miotics for glaucoma

Miotics act by opening up the inefficient drainage channels in the trabecular meshwork. Pilocarpine p. 709 is a miotic used pre- and post-operatively in goniotomy and trabeculotomy; it is used occasionally for aphakic glaucoma.

BETA-ADRENOCORTICOTROPIN BLOCKERS

Betaxolol

- **INDICATIONS AND DOSE**
  - Primary and secondary glaucomas
    - TO THE EYE
    - Child: Apply twice daily

- **UNLICENSED USE** Not licensed for use in children.
- **CONTRA-INDICATIONS** Also consider contra-indications listed for systemically administered beta blockers. Heart block.
- **CAUTIONS** Patients with corneal disease

- **INTERACTIONS** → Appendix 1: beta blockers, selective
- **SIDE-EFFECTS**
  - Common or very common Eye discomfort
  - Rare or very rare Cataract
  - Frequency not known Angioedema

- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose (Betaxolol) eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

**EXCIPIENTS:** May contain Benzalkonium chloride, disodium edetate

- **Betoptic** (Novartis Pharmaceuticals UK Ltd)
  - Betaxolol (as Betaxolol hydrochloride) 2.5 mg per 1 ml
  - Betaxolol 0.25% suspension eye drops | 5 ml (£9.24) £2.66 DT = £2.66
  - Betaxolol 0.25% eye drops suspension 0.25ml unit dose | 50 unit dose (£3.66) £12.77 DT = £13.77

- **Betaxolol (as Betaxolol hydrochloride) 5 mg per 1 ml**
  - Betaxolol 0.5% eye drops | 5 ml (£8.90) £1.90 DT = £1.90

Levobunolol hydrochloride

- **INDICATIONS AND DOSE**
  - Primary and secondary glaucomas
  - TO THE EYE
  - Child: Apply 1–2 times a day

- **UNLICENSED USE** Not licensed for use in children.
- **CONTRA-INDICATIONS** Also consider contra-indications listed for systemically administered beta blockers.
- **CAUTIONS** Patients with corneal disease

- **INTERACTIONS** → Appendix 1: beta blockers, non-selective
- **SIDE-EFFECTS**
  - Common or very common Eye discomfort
  - Frequency not known Dry eye

- **PRESCRIBING AND DISPENSING INFORMATION** Although multi-dose (Levobunolol) eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

**EXCIPIENTS:** May contain Benzalkonium chloride, disodium edetate

- **Betagan** (Allergan Ltd)
  - Betagan Unit Dose
  - Levo B (Allergan Ltd)
  - Betoptic (Novartis Pharmaceuticals UK Ltd)
  - Levobunolol hydrochloride 5 mg per 1 ml
  - Levobunolol 0.5% eye drops | 5 ml (£8.98) £1.90 DT = £1.90

Timolol maleate

- **INDICATIONS AND DOSE**
  - Primary congenital and primary juvenile glaucoma, for a transitional period, before surgery or following failed surgery
  - TO THE EYE
  - Child: (consult product literature)

- **Timoptol-La**
  - Reduction of intra-ocular pressure in primary and secondary glaucoma
  - TO THE EYE
  - Child: Apply once daily
Acetazolamide

INDICATIONS AND DOSE

Glaucoma

- BY MOUTH USING MODIFIED-RELEASE MEDICINES
- Child 12–17 years: 250–500 mg daily

CARBONIC ANHYDRASE INHIBITORS

TIOPREP®

Reduction of intra-ocular pressure primary and secondary glaucomas
- TO THE EYE
- Child: Apply once daily, to be applied in the morning

- UNLICENSED USE Not licensed for use in children.
- CONTRA-INDICATIONS Also consider contra-indications listed for systemically administered beta blockers.
- bradycardia - heart block
- CAUTIONS Consider also cautions listed for systemically administered beta blockers.
- patients with corneal disease
- INTERACTIONS Appendix 1: beta blockers, non-selective
- SIDE-EFFECTS
- Common or very common Eye discomfort - eye disorders - eye inflammation - vision disorders
- Rare or very rare Angioedema

SIDE-EFFECTS, FURTHER INFORMATION Systemic absorption can follow topical application to the eyes; consider side effects listed for systemically administered beta blockers.

- BREAST FEEDING Manufacturer advises avoidance.

- NATIONAL FUNDING/ACCESS DECISIONS

TIOPREP® Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (February 2014) that timolol gel eye drops (Tioprep®) are accepted for restricted use within NHS Scotland for the reduction of elevated intraocular pressure in patients with ocular hypertension or chronic open angle glaucoma who have proven sensitivity to preservatives.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Eye gel

EXCIPIENTS: May contain Benzodiazecinium bromide

- Timoptol-LA (Santen UK Ltd)
- Timolol (as Timolol maleate) 2.5 mg per 1 ml
  - Timolol-LA 0.25% ophthalmic gel-forming solution | 2.5 ml (POD) £3.12 DT = £3.12
- Timolol (as Timolol maleate) 5 mg per 1 ml
  - Timolol-LA 0.5% ophthalmic gel-forming solution | 2.5 ml (POD) £3.12 DT = £3.12

Eye drops

EXCIPIENTS: May contain Benzalkonium chloride

- Timolol maleate (Non-proprietary)
- Timolol (as Timolol maleate) 2.5 mg per 1 ml
  - Timolol 0.25% eye drops | 5 ml (POD) £0.98 DT = £0.98
- Timolol (as Timolol maleate) 5 mg per 1 ml
  - Timolol 0.5% eye drops | 5 ml (POD) £1.00 DT = £1.00
  - Eysano (Aspire Pharma Ltd)
  - Timolol (as Timolol maleate) 2.5 mg per 1 ml
  - Eysano 2.5mg/ml eye drops | 5 ml (POD) £8.45 DT = £8.45
  - Timolol (as Timolol maleate) 5 mg per 1 ml
  - Eysano 5mg/ml eye drops | 5 ml (POD) £9.65 DT = £9.65
- Timolol (Santen UK Ltd)
- Timolol (as Timolol maleate) 2.5 mg per 1 ml
  - Timolol 0.25% eye drops | 5 ml (POD) £3.12 DT = £3.12
  - Timolol (as Timolol maleate) 5 mg per 1 ml
  - Timolol 0.5% eye drops | 5 ml (POD) £3.12 DT = £3.12
- Tiopex (Thea Pharmaceuticals Ltd)
- Timolol (as Timolol maleate) 1 mg per 1 gram
  - Tiopex 1mg/g eye gel 0.4% unit dose | 30 unit dose (POD) £7.49 DT = £7.49

Combinations available: Dorzolamide with timolol, p. 709

Glaucoma

- BY MOUTH USING MODIFIED-RELEASE MEDICINES
- Child 12–17 years: 250–500 mg daily

Allergic and cross-sensitivity

Contra-indicated if history of sulfonamide hypersensitivity.

Epilepsy

- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES, OR BY SLOW INTRAVENOUS INJECTION
- Neonate: Initially 2.5 mg/kg 2–3 times a day, followed by maintenance 5–7 mg/kg 2–3 times a day.

- Child 1 month–11 years: Initially 2.5 mg/kg 2–3 times a day, followed by maintenance 5–7 mg/kg 2–3 times a day; maximum 750 mg per day
- Child 12–17 years: 250 mg 2–4 times a day

Raised intracranial pressure

- BY MOUTH USING IMMEDIATE-RELEASE MEDICINES, OR BY SLOW INTRAVENOUS INJECTION
- Child 1 month–11 years: Initially 8 mg/kg 3 times a day, then increased if necessary up to 100 mg/kg daily

- UNLICENSED USE Not licensed for the treatment of glaucoma.
- CONTRA-INDICATIONS Adrenocortical insufficiency - hyperchloraemic acidosis - hypokalaemia - hypernatraemia - long-term administration in chronic angle-closure glaucoma

CAUTIONS Avoid extravasation at injection site (risk of necrosis) - diabetes mellitus - impaired alveolar ventilation (risk of acidosis) - not generally recommended for long-term use - pulmonary obstruction (risk of acidosis) - renal calculi

- INTERACTIONS Appendix 1: acetazolamide
- SIDE-EFFECTS

GENERAL SIDE-EFFECTS

- Rare or very rare
- Common or very common

SPECIFIC SIDE-EFFECTS

- Uncommon
- Rare or very rare

- With oral use: Osteomalacia
- With oral use: Ataxia - hyperglycaemia - hypoglycaemia - renal tubular necrosis

- Frequency not known

SIDE-EFFECTS, FURTHER INFORMATION Acetazolamide is a sulfonamide derivative; blood disorders, rashes, and other sulfonamide-related side-effects occur occasionally — patients should be told to report any unusual skin rash.

If electrolyte disturbances and metabolic acidosis occur, these can be corrected by administering bicarbonate.

- ALLERGY AND CROSS-SENSITIVITY Contra-indicated if history of sulfonamide hypersensitivity.
708 Glaucoma and ocular hypertension

- **PREGNANCY** Manufacturer advises avoid, especially in first trimester (toxicity in animal studies).
- **BREAST FEEDING** Amount too small to be harmful.
- **HEPATIC IMPAIRMENT** Manufacturer advises avoid.
- **RENAL IMPAIRMENT** Avoid—risk of metabolic acidosis.
- **MONITORING REQUIREMENTS** Monitor blood count and plasma electrolyte concentrations with prolonged use.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution.

**Tablet**

- **CAUTIONARY AND ADVISORY LABELS 3**
  - Acetazolamide (Non-proprietary)
    - Acetazolamide 250 mg Acetazolamide 250mg tablets | 112 tablet (£75.36 DT + £12.81)
  - **Powder for solution for injection**
    - Diamox (Advanz Pharma)
      - Acetazolamide 500 mg Diamox Sodium Parenteral 500mg powder for solution for injection vials | 1 vial (£14.76)
  - **Modified-release capsule**
    - Diamox SR (Advanz Pharma)
      - Acetazolamide 250 mg Diamox SR 250mg capsules | 30 capsule (£16.66 DT + £16.66)
    - Etyazox (Teva UK Ltd)
      - Acetazolamide 250 mg Etyazox 250mg modified-release capsules | 30 capsule (£16.60 DT + £16.66)

**Brinzolamide**

- **INDICATIONS AND DOSE**
  - Reduction of intra-ocular pressure in primary and secondary glaucoma either as adjunct to beta-blockers or prostaglandin analogues or used alone if unresponsive to beta-blockers or if beta-blockers contra-indicated
  - **TO THE EYE**
    - Child: Apply 3 times a day
  - Raised intra-ocular pressure in primary and secondary glaucoma as adjunct to a beta-blocker
  - **TO THE EYE**
    - Child: Apply twice daily

- **UNLICENSED USE** Not licensed for use in children.
- **CONTRA-INDICATIONS** Hyperchloraemic acidosis
- **CAUTIONS** Renal tubular immaturity or abnormality—risk of metabolic acidosis—systemic absorption follows topical application
- **INTERACTIONS**
  - Appendix 1: dorzolamide
- **SIDE-EFFECTS**
  - **Common or very common** Eye discomfort, eye disorders - taste altered - vision disorders
  - **Rare or very rare** Alopecia - angina pectoris - drowsiness - irritability - optic nerve disorder - respiratory disorders - tinnitus
  - **Frequency not known** Appetite decreased - arthralgia - asthma - hypertension - malaise - peripheral oedema - tremor - urinary frequency increased - vertigo

**SIDE-EFFECTS, FURTHER INFORMATION** Systemic absorption can rarely cause sulfonamide-like side-effects and may require discontinuation if severe.
- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated if history of sulfonamide hypersensitivity.
- **PREGNANCY** Avoid—toxicity in animal studies.
- **BREAST FEEDING** Use only if benefit outweighs risk.
- **HEPATIC IMPAIRMENT** Manufacturer advises avoid—no information available.
- **RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- **PREScribing AND Dispensing INFORMATION** Although multi-dose dorzolamide eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**Dorzolamide**

- **INDICATIONS AND DOSE**
  - Raised intra-ocular pressure in primary and secondary glaucoma used alone in patients unresponsive to beta-blockers or if beta-blockers contra-indicated
  - **TO THE EYE**
    - Child: Apply 3 times a day
  - Raised intra-ocular pressure in primary and secondary glaucoma as adjunct to a beta-blocker
  - **TO THE EYE**
    - Child: Apply twice daily

- **UNLICENSED USE** Not licensed for use in children.
- **CONTRA-INDICATIONS** Hyperchloraemic acidosis
- **CAUTIONS** Chronic corneal defects - history of intra-ocular surgery - history of renal calculi - immature renal tubules (neonates and infants) — risk of metabolic acidosis - low endothelial cell count - systemic absorption follows topical application
- **INTERACTIONS**
  - Appendix 1: dorzolamide
- **SIDE-EFFECTS**
  - **Common or very common** Asthenia - eye discomfort - eye disorders - eye inflammation - headache - nausea - paraesthesia - taste bitter - vision disorders
  - **Rare or very rare** Angioedema - bronchospasm - dizziness - dry mouth - dyspnoea - epistaxis - local reaction - pain - severe cutaneous adverse reactions (SCARs) - skin reactions - throat irritation - urolithiasis

**SIDE-EFFECTS, FURTHER INFORMATION** Systemic absorption can cause sulfonamide-like side-effects and may require discontinuation if severe.
- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated if history of sulfonamide hypersensitivity.
- **PREGNANCY** Manufacturer advises avoid—toxicity in animal studies.
- **BREAST FEEDING** Manufacturer advises avoid—no information available.
- **HEPATIC IMPAIRMENT** Manufacturer advises caution—no information available.
- **RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

**EXCIPIENTS:** May contain Benzalkonium chloride, disodium edetate.
Dorzolamide with timolol

The properties listed below are those particular to the combination only. For the properties of the components please consider, dorzolamide p. 708, timolol maleate p. 706.

**INDICATIONS AND DOSE**

- Raised intra-ocular pressure in open-angle glaucoma
- When beta-blockers alone not adequate
- Raised intra-ocular pressure in pseudo-exfoliative glaucoma when beta-blockers alone not adequate

- **INTERACTIONS**
  - To the eye
  - Child: Apply twice daily

- **SIDE-EFFECTS**
  - Bradycardia
  - Bronchospasm
  - Conjunctival vascular congestion
  - Gastrointestinal upset
  - Hypersalivation
  - Nausea
  - Retinal detachment
  - Retinal detachment has occurred in those with chronic simple glaucoma and those receiving long-term treatment with a miotic.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Although multi-dose dorzolamide with timolol eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

- **UNLICENSED USE**
  - Not licensed for use in children.

- **MEDIACIN FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**EYE DROPS**

**EXCIPIENTS:**
- May contain Benzalkonium chloride
- Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Dorzolamide 20mg/ml eye drops | 5 ml (£47.28) = £22.20 DT = £22.20
- Pilocarpine hydrochloride 1% eye drops | 10 ml (£47.28) = £22.20
- Pilocarpine hydrochloride 2% eye drops | 10 ml (£47.28) = £22.27 DT = £22.77
- Pilocarpine hydrochloride 4% eye drops | 10 ml (£47.28) = £28.40 DT = £28.40
- Pilocarpine nitrate (Bausch & Lomb UK Ltd)
- Pilocarpine nitrate 20 mg per 1 ml
- Minims pilocarpine nitrate 2% eye drops 0.5ml unit dose | 20 unit dose (£12.47) = £12.47

**DORZOLAMIDE WITH TIMOLOL**

- Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Timolol (as Timolol maleate) 5 mg per 1 ml
- Timolol 5mg/ml eye drops | 5 ml (£77.70) = £27.16 TD = £22.04
- Cosopt (Santen UK Ltd)
- Timolol (as Timolol maleate) 5 mg per 1 ml, Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Cosopt 20mg/ml | 5mg/ml eye drops | 5 ml (£77.70) = £10.05 TD = £2.04
- Cosopt iMulti (Santen UK Ltd)
- Timolol (as Timolol maleate) 5 mg per 1 ml, Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Cosopt iMulti 20mg/ml | 5mg/ml eye drops | 10 ml (£77.70) = £28.00
- Eylando (Aspire Pharma Ltd)
- Timolol (as Timolol maleate) 5 mg per 1 ml, Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Eylando 20mg/ml | 5mg/ml eye drops | 5 ml (£77.70) = £14.29

**Pilocarpine**

- **DRUG ACTION**
  - Pilocarpine acts by opening the inefficient drainage channels in the trabecular meshwork.

- **INDICATIONS AND DOSE**
  - Raised intra-ocular pressure
  - TO THE EYE
  - Child 1 month-1 year: Apply 1 drop 3 times a day, doses are for 0.5% or 1% solution

**MEDIACIN FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**EYE DROPS**

**EXCIPIENTS:**
- May contain Benzalkonium chloride
- Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Dorzolamide 20mg/ml eye drops | 5 ml (£47.28) = £22.28
- Eyelido (Aspire Pharma Ltd)
- Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Eyelido 20mg/ml eye drops | 5 ml (£47.28) = £12.09
- Trusopt (Santen UK Ltd)
- Dorzolamide (as Dorzolamide hydrochloride) 20 mg per 1 ml
- Trusopt 20mg/ml eye drops 0.2ml unit dose preservative free | 60 unit dose (£38.09) = £12.09
- Trusopt 20mg/ml eye drops | 5 ml (£47.28) = £6.33 TD = £2.38

**PATIENT AND CARER ADVICE**

- Driving and skilled tasks
  - Blurred vision may affect performance of skilled tasks (e.g. driving) particularly at night or in reduced lighting.
PROSTAGLANDIN ANALOGUES AND PROSTAMIDES

**Latanoprost**

**INDICATIONS AND DOSE**

Reduction of intra-ocular pressure in raised intra-ocular pressure and glaucoma

- **TO THE EYE**
  - Child: Apply once daily, to be administered preferably in the evening

**SIDE-EFFECTS**

- **Common or very common** Eye discoloration - eye discomfort - eye disorders - eye inflammation - vision disorders
- **Uncommon** Dry eye - rash
- **Rare or very rare** Asthma - chest pain - dyspnoea - unstable angina
- **Frequency not known** Arthralgia - dizziness - headache - myalgia - ophthalmic herpes simplex - palpitations

**PREGNANCY**

Manufacturer advises avoid.

**BREAST FEEDING**

May be present in milk - manufacturer advises avoid.

**MONITORING REQUIREMENTS**

Monitor for changes to eye coloration.

**PRESCRIBING AND DISPENSING INFORMATION**

Although multi-dose latanoprost eye drops commonly contain preservatives, preservative-free unit dose vials may be available.

**PATIENT AND CARER ADVICE**

Changes in eye colour Before initiating treatment, patients should be warned of a possible change in eye colour as a possible difference in the brown pigment in the iris can occur, which may be permanent; particular care is required in those with mixed coloured irides and those receiving treatment to one eye only. Changes in eyelashes and vellus hair may also occur, and patients should also be advised to avoid repeated contact of the eye drop solution with skin as this can lead to hair growth or skin pigmentation.

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: LATANOPROST (XALATAN®): INCREASED REPORTING OF EYE IRRITATION SINCE REFORMULATION (JULY 2015)**

Following reformulation of Xalatan®, to allow for long-term storage at room temperature, there has been an increase in the number of reports of eye irritation from across the EU. Patients should be advised to tell their health professional promptly (within a week) if they experience eye irritation (e.g. excessive watering) severe enough to make them consider stopping treatment. Review treatment and prescribe a different formulation if necessary.

- **CONTRA-INDICATIONS** Active herpetic simplex keratitis - history of recurrent herpetic keratitis associated with prostaglandin analogues
- **CAUTIONS** Aphakia - asthma - children less than 1 year—limited information available - history of herpetic keratitis - history of significant ocular viral infections - peri-operative period of cataract surgery - preterm neonates less than 36 weeks gestational age - no information available - pseudophakia with torn posterior lens capsule or anterior chamber lenses - risk factors for cystoid macular oedema - risk factors for iritis - risk factors for uveitis

**UNLICENSED USE**

0.5% drops are not licensed for use

- **SIDE-EFFECTS**
  - **Common or very common** Eye disorders
  - **Uncommon** Bradycardia - conjunctival haemorrhage - diarrhoea - dry eye - eye discomfort - eye inflammation - gastrointestinal discomfort - irritability - libido decreased - nasal dryness - palpitations - postural hypotension - sensation abnormal - sleep disorders - syncope - vision disorders - vomiting

**SYMPATHOMIMETICS > ALPHA2-ADRENERGIC AGONISTS**

**Apraclonidine**

**DRUG ACTION** Apraclonidine is an alpha2-adrenergic agonist that lowers intra-ocular pressure by reducing aqueous humour formation. It is a derivative of clonidine.

**INDICATIONS AND DOSE**

Control or prevention of postoperative elevation of intra-ocular pressure after anterior segment laser surgery

- **TO THE EYE**
  - Child: Apply 1 drop, 1 hour before laser procedure, then 1 drop, immediately after completion of procedure, 1% eye drops to be administered

**Short-term adjunctive treatment of chronic glaucoma in patients not adequately controlled by another drug**

- **TO THE EYE**
  - Child 12-17 years: Apply 1 drop 3 times a day usually for maximum 1 month, 0.5% eye drops to be administered, may not provide additional benefit if patient already using two drugs that suppress the production of aqueous humour

**UNLICENSED USE**

0.5% drops are not licensed for use in children under 12 years. 1% drops are not licensed for use in children.

**CONTRA-INDICATIONS** History of severe or unstable and uncontrolled cardiovascular disease

**CAUTIONS** Cerebrovascular disease - depression - heart failure - history of angina - hypertension - loss of effect may occur over time - Raynaud’s syndrome - recent myocardial infarction - reduction in vision in end-stage glaucoma (suspend treatment) - severe coronary insufficiency - thromboangiitis obliterans - vasovagal attack

**INTERACTIONS** Appendix 1: apraclonidine

**SIDE-EFFECTS**

- **Common or very common** Eye disorders
- **Uncommon** Bradycardia - conjunctival haemorrhage - diarrhoea - dry eye - eye discomfort - eye inflammation - gastrointestinal discomfort - irritability - libido decreased - nasal dryness - palpitations - postural hypotension - sensation abnormal - sleep disorders - syncope - vision disorders - vomiting

**NATIONAL FUNDING/ACCESS DECISIONS**

**MONOPOST®**

**Scottish Medicines Consortium (SMC) decisions**

The Scottish Medicines Consortium has advised (June 2013) that Monopost® is accepted for restricted use within NHS Scotland for the reduction of elevated intra-ocular pressure in patients with open-angle glaucoma and ocular hypertension who have proven sensitivity to benzalkonium chloride.
Optic neuropathy 711

- **Rare or very rare** Chest pain · dry mouth · fatigue · headache · hyperhidrosis · pain in extremity · pruritus · taste altered · temperature sensation altered

**SIDE-EFFECTS, FURTHER INFORMATION** Since absorption may follow topical application, systemic effects may occur—see clonidine hydrochloride p. 103.

**Ocular intolerance** Manufacturer advises withdrawal if eye pruritus, ocular hyperaemia, increased lacrimation, or oedema of the eyelids and conjunctiva occur.

- **PREGNANCY** Manufacturer advises avoid—no information available.
- **BREAST FEEDING** Manufacturer advises avoid—no information available.
- **HEPATIC IMPAIRMENT** Manufacturer advises use with caution (no information available).
- **RENA L IMPAIRMENT** Manufacturer advises use with caution—no information available.
- **PATIENT AND CARER ADVICE**
  - Driving and skilled tasks Drowsiness may affect performance of skilled tasks (e.g. driving).

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Eye drops**

  - **Excipients:** May contain Benzalkonium chloride
  - **Iopidine** (Novartis Pharmaceuticals UK Ltd)
    - **Apraclonidine** (as Apraclonidine hydrochloride) 5 mg per 1 ml Iopidine 5mg/ml eye drops | 5 ml £10.88 DT = £0.88
    - **Apraclonidine** (as Apraclonidine hydrochloride) 10 mg per 1 ml Iopidine 1% eye drops 0.25ml unit dose | 24 unit dose £77.85 DT = £77.85

6 Retinal disorders

6.1 Optic neuropathy

**DRUGS FOR METABOLIC DISORDERS > ANTIOXIDANTS**

**Idebenone**

- **Drug Action** Idebenone is a nootropic and antioxidant that is thought to act by restoring cellular ATP generation, thereby reactivating retinal ganglion cells.

- **INDICATIONS AND DOSE**
  - **Leber’s Hereditary Optic Neuropathy (initiated by a specialist)**
    - **By mouth**
    - Child 12-17 years: 300 mg 3 times a day

**SIDE-EFFECTS**

- **Common or very common** Cough · diarrhoea · increased risk of infection · pain
- **Frequency not known** Agranulocytosis · anaemia · anxiety · appetite decreased · azotaemia · delirium · dizziness · dyspepsia · hallucination · headache · hepatitis · leucopenia · malaise · movement disorders · nausea · neutropenia · poriomania · seizure · skin reactions · stupor · thrombocytopenia · urine discolouration · vomiting

**SIDE-EFFECTS, FURTHER INFORMATION** The metabolites of idebenone may cause red-brown discolouration of the urine. This effect is harmless, but the manufacturer advises caution as this may mask colour changes due to other causes (e.g. renal or blood disorders).
Chapter 12
Ear, nose and oropharynx

Ear

Otitis externa

Otitis externa is an inflammatory reaction of the lining of the ear canal usually associated with an underlying seborrhoeic dermatitis or eczema; it is important to exclude an underlying chronic otitis media before treatment is commenced. Many cases recover after thorough cleansing of the external ear canal by suction or dry mopping.

Secondary infection in otitis externa may be of bacterial, fungal, or viral origin. If infection is present, a topical anti-inflammatory which is not used systemically (such as neomycin sulfate p. 714 or flucloxicin) may be used, but for only about a week because excessive use may result in fungal infections that are difficult to treat. Sensitivity to the anti-inflammatory or solvent may occur and resistance to antibacterials is a problem with prolonged use. Aluminium acetate ear drops are also effective against bacterial infection and inflammation of the ear. Chloramphenicol p. 715 may be used, but the ear drops contain propylene glycol and cause hypersensitivity reactions in about 10% of patients.

In view of reports of ototoxicity, manufacturers contraindicate treatment with topical aminoglycosides or polymyxins in children with a perforated tympanic membrane (eardrum) or patent grommet. However, some specialists do use these drops cautiously in the presence of a perforation or patent grommet in children with chronic suppurative otitis media and when other measures have failed for otitis externa; treatment should be considered only by specialists in the following circumstances:

- drops should only be used in the presence of obvious infection;
- treatment should be for no longer than 2 weeks;
- the carer and child should be counselled on the risk of ototoxicity and given justification for the use of these topical antibiotics;
- baseline audiometry should be performed, if possible, before treatment is commenced.

Clinical expertise and judgement should be used to assess the risk of treatment versus the benefit to the patient in such circumstances.

A solution of acetic acid 2% acts as an antifungal and antibacterial in the external ear canal. It may be used to treat mild otitis externa but in severe cases an anti-inflammatory preparation with or without an anti-infective drug is required. A proprietary preparation containing acetic acid 2% (EarCalm® spray) is on sale to the public for children over 12 years.

For severe pain associated with otitis externa, a simple analgesic, such as paracetamol p. 278 or ibuprofen p. 679, can be used. A systemic antibacterial can be used if there is spreading cellulitis or if the patient is systemically unwell.

When a resistant staphylococcal infection (a boil) is present in the external auditory meatus, flucloxacillin p. 357 is the drug of choice; oral ciprofloxacin p. 714 or a systemic aminoglycoside may be needed for pseudomonal infections, particularly in children with diabetes or compromised immunity.

The skin of the pinna adjacent to the ear canal is often affected by eczema. Topical corticosteroid creams and ointments are then required, but prolonged use should be avoided.

Otitis media

Acute otitis media

Acute otitis media is a self-limiting condition that mainly affects children. It is characterised by inflammation in the middle ear associated with effusion and accompanied by the rapid onset of signs and symptoms of an ear infection. The infection can be caused by viruses or bacteria; often both are present simultaneously.

Children with acute otitis media usually present with symptoms such as ear pain, rubbing of the ear, fever, irritability, crying, poor feeding, restlessness at night, cough, or rhinorrhoea. Symptoms usually improve within 3 to 7 days without antibacterial drugs. The use of antibacterials...
generally does not prevent common complications of acute otitis media such as short-term hearing loss, perforated eardrum, or recurrent infection. Acute complications such as mastoiditis, meningitis, intracranial abscess, sinus thrombosis, and facial nerve paralysis, are rare. Children and their carers should be given advice about the usual duration of acute otitis media, self-care of symptoms such as pain and fever with paracetamol or ibuprofen p. 679, and when to seek medical help. In children aged 3 years and over who do not have a perforated eardrum, pain can be relieved with anaesthetic ear drops in addition to oral analgesics [unlicensed use]. Children and their carers should be reassured that antibacterial drugs are usually not required.

An immediate antibacterial drug should be given if the child is systemically very unwell, has signs or symptoms of a more serious illness, or is at high risk of complications such as significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis, and young children who were born prematurely. An immediate antibacterial drug can also be considered if otorrhoea is present, or in children under 2 years of age with bilateral otitis media. See **Antibacterial therapy for otitis media** in Ear infections, antibacterial therapy p. 315.

Children with acute otitis media associated with a severe systemic infection or acute complications should be referred to hospital.

**Otitis media with effusion**

Otitis media with effusion (glue ear) occurs in about 10% of children and in 90% of children with cleft palates. Antimicrobials, corticosteroids, decongestants, and antihistamines have little place in the routine management of otitis media with effusion. If glue ear persists for more than a month or two, the child should be referred for assessment and follow up because of the risk of long-term hearing impairment which can delay language development. Untreated or resistant glue ear may be responsible for some types of chronic otitis media.

**Chronic otitis media**

Opportunistic organisms are often present in the debris, keratin, and necrotic bone of the middle ear and mastoid in children with chronic otitis media. The mainstay of treatment is thorough cleansing with aural microsuction, which may completely resolve long-standing infection. Cleansing may be followed by topical treatment as for otitis externa; this is particularly beneficial for discharging ears or infections of the mastoid cavity. Acute exacerbations of chronic infection may require treatment with an oral antibacterial; a swab should be taken to identify infecting organisms and antibacterial sensitivity.

In view of reports of ototoxicity, manufacturers contraindicate topical treatment with ototoxic antibacterials in the presence of a tympanic perforation or patent grommet. Ciprofloxacin p. 714 or ofloxacin eye drops p. 701 used in the ear [unlicensed use] or ear drops [both unlicensed; available from ‘special-order’ manufacturers or specialist importing companies] are an effective alternative to such ototoxic ear drops for chronic otitis media in patients with perforation of the tympanic membrane.

However, some specialists do use ear drops containing **aminoglycosides or polymyxins** [unlicensed indications] cautiously in children with chronic suppurative otitis media and perforation of the tympanic membrane, if the otitis media has failed to settle with systemic antibacterials; treatment should be considered only by specialists in the following circumstances:

- drops should only be used in the presence of obvious infection;
- treatment should be for no longer than 2 weeks;
- the carer and child should be counselled on the risk of ototoxicity and given justification for the use of these topical antibiotics;
- baseline audiometry should be performed, if possible, before treatment is commenced.

Clinical expertise and judgement should be used to assess the risk of treatment versus the benefit to the patient in such circumstances. It is considered that the pus in the middle ear associated with otitis media also carries a risk of ototoxicity.

**Removal of ear wax**

Ear wax (cerumen) is a normal bodily secretion which provides a protective film on the meatal skin and need only be removed if it causes hearing loss or interferes with a proper view of the ear drum.

Ear wax causing discomfort or impaired hearing may be softened using simple remedies such as olive oil ear drops or almond oil ear drops; sodium bicarbonate ear drops p. 718 are also effective, but may cause dryness of the ear canal. If the wax is hard and impacted, the drops can be used twice daily for several days and this may reduce the need for mechanical removal of the wax. The child should lie with the affected ear uppermost for 5 to 10 minutes after a generous amount of the softening remedy has been introduced into the ear. Proprietary preparations containing organic solvents can irritate the meatal skin, and in most cases the simple remedies indicated above are just as effective and less likely to cause irritation. Docusate sodium p. 718 or urea hydrogen peroxide p. 718 are ingredients in a number of proprietary preparations for softening ear wax.

If necessary, wax may be removed by irrigation with water (warmed to body temperature). Ear irrigation is generally best avoided in young children, in children unable to cooperate with the procedure, in children who have had otitis media in the last six weeks, in otitis externa, in children with cleft palate, a history of ear drum perforation, or previous ear surgery. A child who has hearing in one ear only should not have that ear irrigated because even a very slight risk of damage is unacceptable in this situation.

**Administration**

To administer ear drops, lay the child down with the head turned to one side; for an infant pull the earlobe back and down, for an older child pull the earlobe back and up.

1 Otitis externa

**ANTIBACTERIALS › AMINOGLYCOSIDES**

**Framycetin sulfate**

- **INDICATIONS AND DOSE**
  - Bacterial infection in otitis externa
  - TO THE EAR
  - Child: (consult product literature)

- **CONTRA-INDICATIONS** Perforated tympanic membrane

- **CAUTIONS** Avoid prolonged use

- **SIDE-EFFECTS** Local reaction

- **MEDICINAL FORMS** No licensed medicines listed.

Combinations available: Dexamethasone withframycetin sulfate and gramicidin, p. 693
**Gentamicin**

**INDICATIONS AND DOSE**

**Bacterial infection in otitis externa**
- **TO THE EAR**
- **Child:** Apply 2–3 drops 4–5 times a day, (including a dose at bedtime)

**CONTRA-INDICATIONS**
- Patent grommet (although may be used by specialists, see Ear p. 712) • perforated tympanic membrane (although may be used by specialists, see Ear p. 712)
- **CAUTIONS** Avoid prolonged use
- **INTERACTIONS** → Appendix 1: neomycin
- **SIDE-EFFECTS** Local reaction

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: eye drops 

**Ear/eye drops solution**
- Excipients: May contain benzalkonium chloride
- Gentamicin (Non-proprietary)
- Gentamicin (as Gentamicin sulfate) 3 mg per 1 ml
  - Gentamicin 0.3% ear/eye drops 10 ml £2.63 DT = £2.47

**Gentamicin with hydrocortisone**

**INDICATIONS AND DOSE**

**Eczematous inflammation in otitis externa**
- **TO THE EAR**
- **Child:** Apply 2–4 drops 4–5 times a day, (including a dose at bedtime)

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

See Corticosteroids, general use p. 450.

**CONTRA-INDICATIONS**
- Patent grommet (although may be used by specialists, see Ear p. 712) • perforated tympanic membrane (although may be used by specialists, see Ear p. 712)
- **CAUTIONS** Avoid prolonged use
- **SIDE-EFFECTS** Local reaction
- **PATIENT AND CARER ADVICE**

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Ear drops**
- Excipients: May contain benzalkonium chloride, disodium edetate
- Gentamicin with hydrocortisone (Non-proprietary)
  - Gentamicin (as Gentamicin sulfate) 3 mg per 1 ml
  - Hydrocortisone acetate 10 mg per 1 ml
  - Gentamicin 0.3% / Hydrocortisone acetate 1% ear drops 10 ml £29.86 DT = £29.66

**Neomycin sulfate**

**INDICATIONS AND DOSE**

**Bacterial infection in otitis externa**
- **TO THE EAR**
- **Child:** (consult product literature)

**CONTRA-INDICATIONS**
- Patent grommet (although may be used by specialists, see Ear p. 712) • perforated tympanic membrane (although may be used by specialists, see Ear p. 712)
- **CAUTIONS** Avoid prolonged use
- **INTERACTIONS** → Appendix 1: neomycin
- **SIDE-EFFECTS** Local reaction

**MEDICINAL FORMS**
- No licensed medicines listed.

**Antibacterials → Quinolones**

**Ciprofloxacin**

**INDICATIONS AND DOSE**

**Acute otitis externa**
- **TO THE EAR**
- **Child 1-17 years:** Apply 0.25 mL, twice daily for 7 days, each 0.25 mL dose contains 0.5 mg ciprofloxacin

**CAUTIONS**
- Known (or at risk of) perforated tympanic membrane
- **INTERACTIONS** → Appendix 1: quinolones
- **SIDE-EFFECTS**
  - Uncommon Ear pruritus
  - **HANDLING AND STORAGE** Manufacturer advises discard any ampoules remaining 8 days after opening the pouch.
  - **PATIENT AND CARER ADVICE**
    - Medicines for Children leaflet: Ciprofloxacin drops for infection www.medicinesforchildren.org.uk/ciprofloxacin-drops-infection

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions
- SMC No. 1320/18
  - The Scottish Medicines Consortium has advised (April 2018) that ciprofloxacin ear drops (Cetraxal®) are recommended for use within NHS Scotland for the treatment of acute otitis externa in adults and children over 1 year with an intact tympanic membrane, caused by ciprofloxacin susceptible microorganisms when off-label or unlicensed ciprofloxacin formulations would otherwise be used.

All Wales Medicines Strategy Group (AWMSG) decisions
- AWMSG No. 1343
  - The All Wales Medicines Strategy Group has advised (July 2018) that ciprofloxacin (Cetraxal®) is recommended as an option for use within NHS Wales for the treatment of acute otitis externa in adults and children older than 1 year with an intact tympanic membrane, caused by ciprofloxacin susceptible microorganisms.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Ear drops**
- Cetraxal (Aspire Pharma Ltd)
  - Ciprofloxacin (as Ciprofloxacin hydrochloride) 2 mg per 1 ml
  - Cetraxal 2 mg/ml ear drops 0.25 ml unit dose 15 unit dose £6.01 DT = £6.01

**Combinations available:**
- Ciprofloxacin with dexamethasone, p. 716 • Ciprofloxacin with flucloxacillin acetate, p. 716
ANTIBACTERIALS › OTHER

Chloramphenicol

• **DRUG ACTION** Chloramphenicol is a potent broad-spectrum antibiotic.

• **INDICATIONS AND DOSE**
  - **Bacterial infection in otitis externa**
    - TO THE EAR
    - Child: Apply 2–3 drops 2–3 times a day

• **CAUTIONS** Avoid prolonged use

• **INTERACTIONS** → Appendix 1: chloramphenicol

• **SIDE-EFFECTS**
  - Blood disorder
  - Bone marrow depression

• **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: Chloramphenicol ear drops are less suitable for prescribing.

• **MEDICINAL FORMS**
  - **Ear drops**
    - Chloramphenicol 100 mg per 1 ml
      - 10 ml [P] £10.32 DT = £26.32
    - Chloramphenicol 100 mg per 1 ml
      - 10 ml [P] £13.10 DT = £34.31

• **LESS SUITABLE FOR PRESCRIBING** Chloramphenicol ear drops are less suitable for prescribing.

• **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

- **Ear drops**
  - EXCIPIENTS: May contain Propylene glycol
    - Chloramphenicol (Non-proprietary)
      - Chloramphenicol 50 mg per 1 ml
        - Chloramphenicol 5% ear drops
          - 10 ml [P] £7.01 DT = £19.20
      - Chloramphenicol 100 mg per 1 ml
        - Chloramphenicol 10% ear drops
          - 10 ml [P] £9.46 DT = £25.77

ANTIFUNGALS › IMIDAZOLE ANTIFUNGALS

Clotrimazole

• **INDICATIONS AND DOSE**
  - **Fungal infection in otitis externa**
    - TO THE EAR
    - Child: Apply 2–3 times a day continue for at least 14 days after disappearance of infection

• **INTERACTIONS** → Appendix 1: antifungals, azoles

• **SIDE-EFFECTS**
  - Local reaction

• **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: Clotrimazole for fungal infections

- www.medicinesforchildren.org.uk/clotrimazole-fungal-infections

• **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

- **Liquid**
  - Canesten (clotrimazole) (Bayer Plc)
    - Clotrimazole 10 mg per 1 ml
      - Canesten 1% solution
        - 20 ml [P] £2.53 DT = £6.85

CORTICOSTEROIDS

Betamethasone

• **INDICATIONS AND DOSE**

- **BETNESOL®**
  - Eczematous inflammation in otitis externa
    - TO THE EAR
    - Child: Apply 2–3 drops every 2–3 hours, reduce frequency when relief obtained

- **VISTAMETHASONE®**
  - Eczematous inflammation in otitis externa
    - TO THE EAR
    - Child: Apply 2–3 drops every 3–4 hours, reduce frequency when relief obtained

- **CONTRA-INDICATIONS** Avoid alone in the presence of untreated infection (combine with suitable anti-infective)

- **CAUTIONS** Avoid prolonged use

- **INTERACTIONS** → Appendix 1: corticosteroids

- **SIDE-EFFECTS**

Flumetasone pivalate with clioquinol

• **INDICATIONS AND DOSE**
  - **Eczematous inflammation in otitis externa**
  - **Mild bacterial or fungal infections in otitis externa**

  - TO THE EAR
  - Child 2–17 years: 2–3 drops twice daily for 7–10 days, to be instilled into the ear

IMPORTANT SAFETY INFORMATION

MHRA/CHM ADVICE: CORTICOSTEROIDS; RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

See Corticosteroids, general use p. 450.

- **CONTRA-INDICATIONS** Iodine sensitivity

- **CAUTIONS** Avoid prolonged use • manufacturer advises avoid in perforated tympanic membrane (but used by specialists for short periods)

- **SIDE-EFFECTS** Parasthesia • skin reactions

- **PATIENT AND CARER ADVICE** Clioquinol stains skin and clothing

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  - **Ear drops**
    - Flumetasone pivalate with clioquinol (Non-proprietary)
      - Flumetasone pivalate 200 microgram per 1 ml, Clioquinol 10 mg per 1 ml
      - Flumetasone 0.2% / Clioquinol 1% ear drops
        - 7.5 ml [P] £11.34 DT = £31.34
        - 10 ml [P] £15.13 DT = £45.13

Prednisolone

• **INDICATIONS AND DOSE**
  - **Eczematous inflammation in otitis externa**

    - TO THE EAR
    - Child: Apply 2–3 drops every 2–3 hours, frequency to be reduced when relief obtained

- **CONTRA-INDICATIONS** Avoid alone in the presence of untreated infection (combine with suitable anti-infective)

- **CAUTIONS** Avoid prolonged use

- **INTERACTIONS** → Appendix 1: corticosteroids

- **SIDE-EFFECTS** Local reaction
Corticosteroids > Corticosteroid combinations with anti-infectives

Betamethasone with neomycin

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 715, neomycin sulphate p. 714.

**Indications and dose**
Eccematous inflammation in otitis externa
- To the ear using ear drops
  - Child: Apply 2–3 drops 3–4 times a day

**Contra-indications**
Patent grommet (although may be used by specialists, see Ear p. 712).

**Cautions**
Avoid prolonged use

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: Cilodex ear drops and Cilodex ear drops solution.

Betamethasone (as Betamethasone sodium phosphate) 1 mg per 1 ml
Betnesol-N ear drops
Betnesol-N ear drops solution

**Excipients:** May contain Benzalkonium chloride, disodium edetate.

**National funding/access decisions**
The Scottish Medicines Consortium (SMC) has advised (July 2017) that dexamethasone with ciprofloxacin (Cilodex®) is accepted for restricted use within NHS Scotland for the treatment of acute otitis media in patients with tympanostomy tubes (AOMT).

**Ciprofloxacin with fluocinolone acetonide**

The properties listed below are those particular to the combination only. For the properties of the components please consider, ciprofloxacin, p. 714.

**Indications and dose**
- Acute otitis externa | Acute otitis media in patients with tympanostomy tubes
  - To the ear
  - Child: Apply 4 drops twice daily for 7 days

**Acute otitis externa**
- Child 1-5 years: Apply 4 drops twice daily for 7 days

**Important safety information**
MHRA/CHM advice: Corticosteroids: Rare risk of central serous choriorétinopathy with local as well as systemic administration (August 2017)
See Corticosteroids, general use p. 450.

**Contra-indications**
Fungal ear infections - viral ear infections

**Interactions**
- Appendices 1: fluocinolone - quinolones

**Side-effects**
- Common or very common Ear discomfort
- Uncommon Crying - dizziness - fatigue - flushing - headache - hearing impairment - increased risk of infection - irritability - otorrhoea - paraesthesia - skin reactions - taste altered - vomiting

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug.

Ear drops

Excipients: May contain Benzalkonium chloride, disodium edetate.

Betamethasone with neomycin

Corticosteroids, general use

**PATIENT AND CARER ADVICE**
Manufacturer advises counselling on administration.

**Important safety information**
MHRA/CHM advice: Corticosteroids: Rare risk of central serous choriorétinopathy with local as well as systemic administration (August 2017)
See Corticosteroids, general use p. 450.

**Contra-indications**
Fungal ear infections - viral ear infections

**Interactions**
- Appendix 1: fluocinolone - quinolones

**Side-effects**
- Common or very common Ear discomfort - taste altered
- Uncommon Crying - dizziness - fatigue - flushing - headache - hearing impairment - increased risk of infection - irritability - otorrhoea - paraesthesia - skin reactions - taste altered - vomiting

**Medicinal forms**
There can be variation in the licensing of different medicines containing the same drug.

Ear drops

Excipients: May contain Benzalkonium chloride, disodium edetate.

Betamethasone with neomycin

Corticosteroids, general use

**Side-effects**
- Rare or very rare Dizziness - headache - hearing loss - tinnitus

**Further information**
Manufacturer advises further evaluation of underlying conditions if otorrhoea persists after a full course, or if at least two episodes of otorrhoea occur within 6 months.

**Pregnancy**
Manufacturer advises use only if potential benefit outweighs risk — no information available.

**Breast feeding**
Manufacturer advises caution — no information available.

**Ear discomfort**

- Acute otitis externa
- Otitis externa
- Ear infection fungal
- Otorrhoea
- Paraesthesia
- Skin reactions
- Taste altered
- Vomiting

**Further information**
Manufacturer advises further evaluation of underlying conditions if otorrhoea persists after a full course, or if at least two episodes of otorrhoea occur within 6 months.

**Pregnancy**
Manufacturer advises use only if potential benefit outweighs risk — limited information available.

**Breast feeding**
Manufacturer advises caution.

**Ear discomfort**

- Acute otitis externa
- Otitis externa
- Ear infection fungal
- Otorrhoea
- Paraesthesia
- Skin reactions
- Taste altered
- Vomiting

**Further information**
Manufacturer advises further evaluation of underlying conditions if otorrhoea persists after a full course, or if at least two episodes of otorrhoea occur within 6 months.

**Pregnancy**
Manufacturer advises use only if potential benefit outweighs risk — limited information available.

**Breast feeding**
Manufacturer advises caution.

**Ear discomfort**

- Acute otitis externa
- Otitis externa
- Ear infection fungal
- Otorrhoea
- Paraesthesia
- Skin reactions
- Taste altered
- Vomiting

**Further information**
Manufacturer advises further evaluation of underlying conditions if otorrhoea persists after a full course, or if at least two episodes of otorrhoea occur within 6 months.

**Pregnancy**
Manufacturer advises use only if potential benefit outweighs risk — limited information available.

**Breast feeding**
Manufacturer advises caution.
Dexamethasone with framycetin sulfate and gramicidin

The properties listed below are those particular to the combination only. For the properties of the components please consider, dexamethasone p. 455, framycetin sulfate p. 713.

**INDICATIONS AND DOSE**

- **Eczematous inflammation in otitis externa**
  - **TO THE EAR**
  - **Child:** 2–3 drops 3–4 times a day

**IMPORTANT SAFETY INFORMATION**

- **MHRA/CHM ADVICE:** CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)
  - See Corticosteroids, general use p. 450.

**CAUTIONS**
- Avoid prolonged use

**INTERACTIONS**
- Appendix 1: corticosteroids

**LESS SUITABLE FOR PRESCRIBING**
- Sofradex® is less suitable for prescribing.

**MEDICINAL FORMS**
- No licensed medicines listed.

Dexamethasone with glacial acetic acid and neomycin sulfate

The properties listed below are those particular to the combination only. For the properties of the components please consider, dexamethasone p. 455, neomycin sulfate p. 714.

**INDICATIONS AND DOSE**

- **Eczematous inflammation in otitis externa**
  - **TO THE EAR**
  - **Child:** 2–3 drops 3–4 times a day

**IMPORTANT SAFETY INFORMATION**

- **MHRA/CHM ADVICE:** CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)
  - See Corticosteroids, general use p. 450.

**CONTRA-INDICATIONS**
- Patent grommet (although may be used by specialists, see Ear p. 712) - perforated tympanic membrane (although may be used by specialists, see Ear p. 712)

**CAUTIONS**
- Avoid prolonged use

**INTERACTIONS**
- Appendix 1: corticosteroids - neomycin

**SIDE-EFFECTS**
- Paraesthesia - skin reactions - vision blurred

Hydrocortisone with neomycin and polymyxin B sulfate

The properties listed below are those particular to the combination only. For the properties of the components please consider, hydrocortisone p. 456, neomycin sulfate p. 714.

**INDICATIONS AND DOSE**

- **Bacterial infection in otitis externa**
  - **TO THE EAR**
  - **Child:** 3–17 years: Apply 3 drops 3–4 times a day for 7 days (review treatment if there is no clinical improvement)

**IMPORTANT SAFETY INFORMATION**

- **MHRA/CHM ADVICE:** CORTICOSTEROIDS: RARE RISK OF CENTRAL SEROUS CHORIORETINOPATHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)
  - See Corticosteroids, general use p. 450.

**INTERACTIONS**
- Appendix 1: corticosteroids - neomycin - polymyxins

**RENAL IMPAIRMENT**
- Manufacturer advises avoid prolonged, unsupervised use.

**Dose adjustments**
- Manufacturer advises reduce dose.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Spray**

- **EXCIPIENTS:** May contain hydroxybenzoates (parabens)
  - Otomize® (Teva UK Ltd)
  - Dexamethasone 1 mg per 1 gram, Neomycin sulfate 5 mg per 1 gram, Acetic acid glacial 20 mg per 1 gram
  - Otomize ear spray
  - 5 ml
  - £3.27

**DERMATOLOGICAL DRUGS**

Aluminium acetate

**INDICATIONS AND DOSE**

- **Inflammation in otitis externa**
  - **TO THE EAR**
  - **Child:** To be inserted into meatus or apply on a ribbon gauze dressing or sponge wick which should be kept saturated with the ear drops

**UNLICENSED USE**
- Not licensed for use in children.

**DIRECTIONS FOR ADMINISTRATION**
- For ear drops 8% - dilute 8 parts aluminium acetate ear drops (13%) with 5 parts purified water. Must be freshly prepared.

**MEDICINAL FORMS**
- Forms available from special-order manufacturers include: ear drops
2 Removal of earwax

**BICARBONATE**

**Sodium bicarbonate**

***INDICATIONS AND DOSE***

- Removal of ear wax (with 5% ear drop solution)
  - TO THE EAR
  - Child: (consult product literature)

***INTERACTIONS*** → Appendix 1: sodium bicarbonate

***SIDE-EFFECTS***

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Ear drops**
  - Sodium bicarbonate (Non-proprietary)
    - Sodium bicarbonate 50 mg per 1 ml
    - Sodium bicarbonate 5% ear drops | 10 ml £1.23–£1.25
  - KliarVax Sodium Bicarbonate (Essential-Healthcare Ltd)
    - Sodium bicarbonate 50 mg per 1 ml
    - KliarVax Sodium Bicarbonate ear drops | 10 ml £0.97

**SOFTENING DRUGS**

**Almond oil**

***INDICATIONS AND DOSE***

- Removal of ear wax
  - TO THE EAR
  - Child: Allow drops to warm to room temperature before use (consult product literature)

***DIRECTIONS FOR ADMINISTRATION*** The patient should lie with the affected ear uppermost for 5 to 10 minutes after a generous amount of the softening remedy has been introduced into the ear.

***MEDICINAL FORMS*** There can be variation in the licensing of different medicines containing the same drug.

- Liquid
  - Almond oil (Non-proprietary)
    - Almond oil 1 ml per 1 ml
      - Almond oil liquid | 50 ml £0.95 DT = £0.95
      - 70 ml £0.85 | 200 ml £2.68

**Docusate sodium** 20-Apr-2016

***INDICATIONS AND DOSE***

- Removal of ear wax
  - Child: 1-17 years: (consult product literature)

***INTERACTIONS*** → Appendix 1: docusate sodium

***SIDE-EFFECTS*** Skin reactions

***LESS SUITABLE FOR PRESCRIBING*** Ear drops less suitable for prescribing.

***MEDICINAL FORMS*** There can be variation in the licensing of different medicines containing the same drug.

- **Ear drops**
  - Docusate sodium 5 mg per 1 ml
    - Molcer ear drops | 15 ml £5.60
  - Waxsol (Meda Pharmaceuticals Ltd)
    - Docusate sodium 5 mg per 1 ml
      - Waxsol ear drops | 10 ml £1.95 DT = £1.95

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**Olive oil**

***INDICATIONS AND DOSE***

- Removal of ear wax
  - TO THE EAR
  - Child: Apply twice daily for several days (if wax is hard and impacted)

***DIRECTIONS FOR ADMINISTRATION*** The patient should lie with the affected ear uppermost for 5 to 10 minutes after a generous amount of the softening remedy has been introduced into the ear. Allow ear drops to warm to room temperature before use.

***MEDICINAL FORMS*** There can be variation in the licensing of different medicines containing the same drug.

- **Spray**
  - Earol (HL Healthcare Ltd)
    - Earol olive oil ear spray | 10 ml
  - **Ear drops**
    - Olive oil (Non-proprietary)
      - Olive oil ear drops | 10 ml £1.35–£1.42
    - Arjun (Arjun Products Ltd)
      - Arjun ear drops | 10 ml £1.26
    - Cerumol (olive oil) (Thorton & Ross Ltd)
      - Cerumol olive oil ear drops | 10 ml
    - KliarVax (Essential-Healthcare Ltd)
      - KliarVax Olive Oil ear drops | 10 ml £0.97
    - Oleax (JR Biomedical Ltd)
      - Oleax ear drops | 15 ml £1.40
    - Olive oil (Thorton & Ross Ltd)
      - Care olive oil ear drops | 10 ml £1.42
    - St George’s (St George’s Medical Ltd)
      - Olive oil ear drops | 10 ml £1.40 | 20 ml £2.70

**Urea hydrogen peroxide**

***INDICATIONS AND DOSE***

- Softening and removal of ear wax
  - TO THE EAR
  - Child: (consult product literature)

***PATIENT AND CARER ADVICE*** The patient should lie with the affected ear uppermost for 5 to 10 minutes after a generous amount of the softening remedy has been introduced into the ear.

***LESS SUITABLE FOR PRESCRIBING*** Urea-hydrogen peroxide ear drops are less suitable for prescribing.

***MEDICINAL FORMS*** There can be variation in the licensing of different medicines containing the same drug.

- **Ear drops**
  - Exterol (Dermal Laboratories Ltd)
    - Urea hydrogen peroxide 50 mg per 1 gram
      - Exterol 9% ear drops | 8 ml £1.75 DT = £2.89
  - Otex (Thornton & Ross Ltd)
    - Urea hydrogen peroxide 50 mg per 1 gram
      - Otex 9% ear drops | 8 ml £2.89

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**Nose**

**Rhinitis**

Rhinitis is often self-limiting. Many nasal preparations contain sympathomimetic drugs which can give rise to rebound congestion (rhinitis medicamentosa) and may damage the nasal cilia. Sodium chloride 0.9% solution p. 610 may be used as a douche or ‘sniff’ following endonasal surgery.
Administration
To administer nasal drops, lay the child face-upward with the neck extended, instil the drops, then sit the child up and tilt the head forward.

Drugs used in nasal allergy
Mild allergic rhinitis is controlled by antihistamines (see under Antihistamines, allergen immunotherapy and allergic emergencies p. 174) or topical nasal corticosteroids; systemic nasal decongestants are not recommended for use in children. Topical nasal decongestants can be used for a short period to relieve congestion and allow penetration of a topical nasal corticosteroid.

More persistent symptoms can be relieved by topical nasal corticosteroids; sodium cromoglicate p. 725 is an alternative, but may be less effective. The topical antihistamine, azelastine hydrochloride p. 722, is useful for controlling breakthrough symptoms in allergic rhinitis. Azelastine hydrochloride is less effective than nasal corticosteroids, but probably more effective than sodium cromoglicate. In seasonal allergic rhinitis (e.g. hay fever), treatment should begin 2 to 3 weeks before the season commences and may have to be continued for several months; continuous long-term treatment may be required in perennial rhinitis.

Montelukast p. 168 is less effective than topical nasal corticosteroids; it can be used in children with seasonal allergic rhinitis (unresponsive to other treatments) and concomitant asthma.

Children with disabling symptoms of seasonal rhinitis (e.g. students taking important examinations), may be treated with oral corticosteroids for short periods. Oral corticosteroids may also be used at the beginning of a course of treatment with a corticosteroid spray to relieve severe mucosal oedema and allow the spray to penetrate the nasal mucosa.

Sometimes allergic rhinitis is accompanied by vasomotor rhinitis. In this situation, the addition of topical nasal ipratropium bromide p. 722 can reduce watery rhinorrhoea.

Corticosteroids
Corticosteroid nasal preparations should be avoided in the presence of untreated nasal infections, after nasal surgery (until healing has occurred) and in pulmonary tuberculosis.

Systemic absorption may follow nasal administration particularly if high doses are used or if treatment is prolonged; for cautions and side-effects of systemic corticosteroids. The risk of systemic effects may be greater with nasal drops than with nasal sprays; drops are administered incorrectly more often than sprays. The height of children receiving prolonged treatment with nasal corticosteroids should be monitored; if growth is slowed, referral to a paediatrician should be considered.

Nasal polyps
Short-term use of corticosteroid nasal drops helps to shrink nasal polyps; to be effective, the drops must be administered with the child in the 'head down' position. A short course of a systemic corticosteroid may be required initially to shrink large polyps. A corticosteroid nasal spray can be used to maintain the reduction in swelling and also for the initial treatment of small polyps.

Pregnancy
If a pregnant woman cannot tolerate the symptoms of allergic rhinitis, treatment with nasal beclometasone dipropionate p. 723, budesonide p. 724, fluticasone p. 724, or sodium cromoglicate may be considered.

Topical nasal decongestants
Sodium chloride 0.9% given as nasal drops or spray may relieve nasal congestion by helping to liquefy mucus secretions in children with rhinitis. In infants, 1–2 drops of sodium chloride 0.9% solution in each nostril before feeds will help relieve congestion and allow more effective suckling.

Inhalation of warm moist air may be useful in the treatment of symptoms of acute nasal congestion in infants and children, but the use of boiling water for steam inhalation is dangerous for children and should not be recommended. Volatile substances such as menthol and eucalyptus may encourage inhalation of warm moist air (see also Aromatic inhalations, cough preparations and systemic nasal decongestants p. 191).

Topical nasal decongestants containing sympathomimetics can cause rebound congestion (rhinitis medicamentosa) following prolonged use (more than 7 days), and are therefore of limited value in the treatment of nasal congestion.

Ephedrine hydrochloride p. 720 nasal drops is the least likely of the sympathomimetic nasal decongestants to cause rebound congestion and can provide relief for several hours. The more potent sympathomimetic drugs oxymetazoline and xylometazoline hydrochloride p. 721 are more likely to cause a rebound effect.

Non-allergic watery rhinorrhoea often responds well to treatment with the antimuscarinic ipratropium bromide.

Recurrent, persistent bleeding may respond to the use of a sympathomimetic nasal spray; if infection is present, chlorhexidine and neomycin (Naseptin ®) cream may be effective.

Nasal preparations for infection
There is no evidence that topical anti-infective nasal preparations have any therapeutic value in rhinitis; see elimination of nasal staphylococci. In children, acute complications such as peri-orbital cellulitis require hospital treatment.

Nasal staphylococci
Elimination of organisms such as staphylococci from the nasal vestibule can be achieved by the use of a cream containing chlorhexidine and neomycin (Naseptin ®), but re-colonisation frequently occurs. Coagulase-positive staphylococci are present in the noses of 40% of the population.

A nasal ointment containing mupirocin p. 722 is also available; it should probably be held in reserve for resistant infections. In hospitals or in care establishments, mupirocin nasal ointment should be reserved for the eradication (in both patients and staff) of nasal carriage of meticillin-resistant Staphylococcus aureus (MRSA). A sample should be taken 2 days after treatment to confirm eradication. The course may be repeated if the sample is positive (and the throat is not colonised). To avoid the development of resistance, the treatment course should not exceed 7 days and the course should not be repeated on more than one occasion. If the MRSA strain is mupirocin-resistant or does not respond after 2 courses, consider alternative products such as chlorhexidine and neomycin cream.

For eradication of MRSA also consult local infection control policy. See also MRSA p. 375.
1 Nasal congestion

SYMPATHOMIMETICS > VASOCONSTRICTOR

Ephedrine hydrochloride

- INDICATIONS AND DOSE
  Nasal congestion | Sinusitis affecting the maxillary antrum
  - BY INTRanasAL ADMINISTRATION
  - Child 12–17 years: Apply 1–2 drops up to 4 times a day as required for a maximum of 7 days, to be instilled into each nostril, administer ephedrine 0.5% nasal drops

IMPORTANT SAFETY INFORMATION

CHM/MHRA ADVICE
The CHM/MHRA has stated that non-prescription cough and cold medicines containing ephedrine can be considered for up to 5 days’ treatment in children aged 6–12 years after basic principles of best care have been tried; these medicines should not be used in children under 6 years of age.

- CAUTIONS
  Avoid excessive or prolonged use - cardiovascular disease - diabetes mellitus - hypertension - hypothyroidism

- INTERACTIONS
  Appendix 1: sympathomimetics, vasoconstrictor

- SIDE-EFFECTS
  - Common or very common
  - Anxiety, headache, insomnia, nausea
  - Frequency not known
    - Appetite decreased, arrhythmia, circulation impaired, dermatitis, dizziness, drug dependence, dry mouth, dyspnoea, hallucination, hyperglycaemia, hyperhidrosis, hypersalivation, hypertension, hypokalaemia, hypotension, irritability, muscle weakness, mydriasis, pain, palpitations, paranoia, piloerection, rebound congestion, syncope, thirst, tremor, urinary disorders, vasoconstriction, vasodilation, vomiting
  - PREGNANCY
    - Manufacturer advises avoid
  - BREAST FEEDING
    - Present in milk; manufacturer advises avoid - irritability and disturbed sleep reported

- PRESCRIBING AND DISPENSING INFORMATION
  For nasal drops, the BP directs that if no strength is specified 0.5% drops should be supplied.

- PROFESSION SPECIFIC INFORMATION
  Dental practitioners’ formulation
  Ephedrine nasal drops may be prescribed.

- EXCEPTIONS TO LEGAL CATEGORY
  Ephedrine nasal drops can be sold to the public provided no more than 180 mg of ephedrine base (or salts) are supplied at one time, and pseudoephedrine salts are not supplied at the same time; for conditions that apply to supplies made at the request of a patient, see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition).

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: nasal drops

  Nasal drops
    - Ephedrine hydrochloride (Non-proprietary)
      Ephedrine hydrochloride 5 mg per 1 ml Ephedrine 0.5% nasal drops | 10 ml | £1.90–£1.94 DT = £1.90
      Ephedrine hydrochloride 10 mg per 1 ml Ephedrine 1% nasal drops | 10 ml | £1.94–£2.01 DT = £1.94

Pseudoephedrine hydrochloride

- INDICATIONS AND DOSE
  Congestion of mucous membranes of upper respiratory tract
  - BY MOUTH
    - Child 6–11 years: 30 mg 3–4 times a day
    - Child 12–17 years: 60 mg 3–4 times a day

- IMPORTANT SAFETY INFORMATION
  Children under 6 years should not be given over-the-counter cough and cold medicines containing pseudoephedrine.

  - CAUTIONS
    - Diabetes - heart disease - hypertension - hypothyroidism - raised intra-ocular pressure
  - INTERACTIONS
    - Appendix 1: sympathomimetics, vasoconstrictor
  - SIDE-EFFECTS
    - Angle closure glaucoma, anxiety, arrhythmias, circulation impaired, dry mouth, hallucination, headache, hypertension, irritability, nausea, palpitations, psychiatric disorder, skin reactions, sleep disorders, tremor, urinary retention, vomiting
  - PREGNANCY
    - Deferential closure of the abdominal wall (gastrochisis) reported very rarely in newborns after first trimester exposure
  - BREAST FEEDING
    - May suppress lactation; avoid if lactation not well established or if milk production insufficient
  - HEPATIC IMPAIRMENT
    - Manufacturer advises caution in severe impairment
  - RENAL IMPAIRMENT
    - Use with caution in mild to moderate renal impairment. Manufacturer advises avoid in severe renal impairment.
  - LESS SUITABLE FOR PRESCRIBING
    - Pseudoephedrine hydrochloride is less suitable for prescribing
  - EXCEPTIONS TO LEGAL CATEGORY
    - Galpseud® and Sudafed® can be sold to the public provided no more than 720 mg of pseudoephedrine salts are supplied, and ephedrine base (or salts) are not supplied at the same time; for details see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition).

- MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

  Oral solution
  - EXCIPIENTS: May contain Alcohol
    - Galpseud (Thornton & Ross Ltd) Pseudoephedrine hydrochloride 6 mg per 1 ml Galpseud 30mg/5ml linctus sugar-free | 2000 ml [GR] £14.00
    - Sudafed Non-Drowsy Decongestant (McNeil Products Ltd) Pseudoephedrine hydrochloride 6 mg per 1 ml Sudafed Decongestant 30mg/5ml liquid | 100 ml [GR] £2.22

  Tablet
  - Galpseud (Thornton & Ross Ltd) Pseudoephedrine hydrochloride 60 mg Galpseud 60mg tablets | 24 tablet [PIN] £2.25 | 100 tablet [PIN] £5.42 DT = £5.42
    - Sudafed Non-Drowsy Decongestant (McNeil Products Ltd) Pseudoephedrine hydrochloride 60 mg Sudafed Decongestant 60mg tablets | 12 tablet [PIN] £2.43
Xylometazoline hydrochloride

**INDICATIONS AND DOSE**

<table>
<thead>
<tr>
<th>Nasal congestion</th>
</tr>
</thead>
<tbody>
<tr>
<td>BY INTRanasAL ADMINISTRATION USING NASAL DROPS</td>
</tr>
<tr>
<td>Child 6–11 years: 1–2 drops 1–2 times a day as required for maximum duration of 5 days, 0.05% solution to be administered into each nostril</td>
</tr>
<tr>
<td>Child 12–17 years: 2–3 drops 2–3 times a day as required for maximum duration of 7 days, 0.1% solution to be administered into each nostril</td>
</tr>
<tr>
<td>BY INTRanasAL ADMINISTRATION USING NASAL SPRAY</td>
</tr>
<tr>
<td>Child 12–17 years: 1 spray 1–3 times a day as required for maximum duration of 7 days, to be administered into each nostril</td>
</tr>
</tbody>
</table>

**INDICATIONS AND DOSE**

**NASAL CONGESTION**

- **BY INTRanasAL ADMINISTRATION USING NASAL DROPS**
  - Child 6–11 years: 1–2 drops 1–2 times a day as required for maximum duration of 5 days, 0.05% solution to be administered into each nostril.
  - Child 12–17 years: 2–3 drops 2–3 times a day as required for maximum duration of 7 days, 0.1% solution to be administered into each nostril.

**INDICATIONS AND DOSE**

**NASAL SPRAY**

- Child 12–17 years: 1 spray 1–3 times a day as required for maximum duration of 7 days, to be administered into each nostril.

**CAUTIONS**

- Angle-closure glaucoma.
- Avoid excessive or prolonged use.
- Cardiovascular disease.
- Diabetes mellitus.
- Hypertension.
- Hypothyroidism.
- Rebound congestion.

**SIDE-EFFECTS**

**CARDIOVASCULAR**

- Headache.
- Hypersensitivity.
- Nasal dryness.
- Nausea.
- Paraesthesia.

**VISUAL IMPAIRMENT**

- Visual impairment.

**FURTHER INFORMATION**

- Rebound congestion: Symptomimetic drugs are of limited value in the treatment of nasal congestion because they can, following prolonged use (more than 7 days), give rise to rebound congestion (rhinitis medicamentosa) on withdrawal, due to a secondary vasodilatation with a subsequent temporary increase in nasal congestion. This in turn tempts the further use of the decongestant, leading to a vicious cycle of events.

**INTERACTIONS**

- Appendix 1: sympathomimetics, vasoconstrictor.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Spray**

- **Otrivine** (GlaxoSmithKline Consumer Healthcare)
  - Xylometazoline hydrochloride 1 mg per 1 ml
  - Otrivine Congestion Relief 0.1% nasal spray | 10 ml | £3.05 DT = £2.18
  - Otrivine Adult Measured Dose Sinusitis spray | 10 ml | £2.62 DT = £1.28
  - Otrivine Allergy Relief 0.1% nasal spray | 10 ml | £2.62 DT = £1.28
  - Otrivine Adult nasal spray | 10 ml | £2.18 DT = £1.18
  - Otrivine Adult Dose Mometasone 0.1% nasal spray | 10 ml | £2.62 DT = £1.28

- **Sudafed Congestion Relief** (McNeil Products Ltd)
  - Xylometazoline hydrochloride 1 mg per 1 ml
  - Sudafed Congestion Relief 0.1% nasal spray | 10 ml | £3.46 DT = £2.18

- **Sudafed Non-Drowsy Decongestant** (McNeil Products Ltd)
  - Xylometazoline hydrochloride 1 mg per 1 ml
  - Sudafed Blocked Nose 0.1% spray | 15 ml | £1.76

**Sudafed Sinus-Ease** (McNeil Products Ltd)

- Xylometazoline hydrochloride 1 mg per 1 ml
- Sudafed Sinus-Ease 0.1% nasal spray | 15 ml | £2.80

**Nasal drops**

- **Otrivine** (GlaxoSmithKline Consumer Healthcare)
  - Xylometazoline hydrochloride 500 microgram per 1 ml
  - Otrivine adult drops | 10 ml | £1.91 DT = £1.91

- **Xylometazoline hydrochloride 1 mg per 1 ml**
  - Otrivine Adult 0.1% nasal drops | 10 ml | £2.18 DT = £2.18

2 Nasal infection

**Sinusitis (acute)**

**Description of condition**

Sinusitis is an inflammation of the mucosal lining of the paranasal sinuses. Acute sinusitis (rhinosinusitis) is a self-limiting condition usually triggered by a viral upper respiratory tract infection such as the ‘common cold’.

Occasionally, acute sinusitis may become complicated by a bacterial infection (see Antibacterial therapy for acute sinusitis in Nose infections, antibacterial therapy p. 317).

Children with acute sinusitis, particularly young children, often present with non-specific symptoms in the upper respiratory tract, including nasal blockage or congestion, discoloured nasal discharge, or cough during the day or night.

Symptoms usually improve within 2 to 3 weeks without requiring treatment.

Rarely, acute sinusitis may lead to orbital, intracranial or skeletal complications (e.g. periorbital cellulitis, symptoms or signs of meningitis).

**Aims of treatment**

Treatment is aimed at managing symptoms including pain, fever, and nasal congestion as well as treatment of bacterial infection if present.

**Treatment**

Children presenting with symptoms for around 10 days or less, should be given advice about the usual duration of acute sinusitis, self-care of pain or fever with paracetamol p. 278 or ibuprofen p. 679, and when to seek medical help. Children and their carers should be reassured that antibiotics are usually not required.

Children (over the age of 12) presenting with symptoms for around 10 days or more with no improvement could be considered for treatment with a high-dose nasal corticosteroid, such as mometasone furoate p. 725 [unlicensed use] or fluticasone p. 724 [unlicensed use] for 14 days.

If the child is systemically very unwell, has signs and symptoms of a more serious illness or condition, or is at high-risk of complications, an immediate antibiotic could be offered if deemed appropriate. (see Antibacterial therapy for acute sinusitis in Nose infections, antibacterial therapy p. 317).

Children presenting with symptoms of acute sinusitis associated with a severe systemic infection or with orbital or intracranial complications should be referred to hospital.

**Useful Resources**


www.nice.org.uk/guidance/ng79
722 Nasal inflammation, nasal polyps and rhinitis

ANTIBACTERIALS > AMINOGLYCOSIDES

Chlorhexidine with neomycin

- **INDICATIONS AND DOSE**
  - **Eradication of nasal carriage of staphylococci**
  - **BY INTRANASAL ADMINISTRATION**
  - **Child**: Apply 2–3 times a day for 5 days
  - **Preventing nasal carriage of staphylococci**
  - **BY INTRANASAL ADMINISTRATION**
  - **Child**: Apply twice daily

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**: May contain Arachis (peanut) oil, cetostearyl alcohol (including cetyl and stearyl alcohol).
  - **Naseptin (Alliance Pharmaceuticals Ltd)**
    - Chlorhexidine hydrochloride 1 mg per 1 gram, Neomycin sulfate 5 mg per 1 gram
    - Naseptin nasal cream | 15 gram (POD) £1.99 DT = £1.99

- **SIDE-EFFECTS**
  - Common or very common
    - **Skin reactions**
  - **PREGNANCY**
    - Manufacturer advises avoid unless potential benefit outweighs risk—no information available.
  - **BREAST FEEDING**
    - No information available.
  - **RENAL IMPAIRMENT**
    - Manufacturer advises caution when mupirocin ointment used in moderate or severe impairment because it contains macrogols (polyethylene glycol).

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Nasal ointment**
    - **Betabond (GlaxoSmithKline UK Ltd)**
      - Mupirocin (as Mupirocin calcium) 20 mg per 1 gram
    - **Bactroban 2% nasal ointment | 3 gram (POD)** £4.24 DT = £4.24

ANTIBACTERIALS > OTHER

Mupirocin

- **INDICATIONS AND DOSE**
  - **BACTROBAN NASAL ©**
    - **For eradication of nasal carriage of staphylococci, including meticillin-resistant Staphylococcus aureus (MRSA)**
    - **BY INTRANASAL ADMINISTRATION**
    - **Child**: Apply 2–3 times a day for 5 days; a sample should be taken 2 days after treatment to confirm eradication. Course may be repeated once if sample positive (and throat not colonised), dose to be applied to the inner surface of each nostril

- **SIDE-EFFECTS**
  - Common or very common
    - **Skin reactions**
  - **PREGNANCY**
    - Manufacturer advises avoid unless potential benefit outweighs risk—no information available.
  - **BREAST FEEDING**
    - No information available.
  - **RENAL IMPAIRMENT**
    - Manufacturer advises caution when mupirocin ointment used in moderate or severe impairment because it contains macrogols (polyethylene glycol).

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

ANTIBACTERIALS > OTHER

Betamethasone with neomycin

- **INDICATIONS AND DOSE**
  - **Nasal infection**
    - **BY INTRANASAL ADMINISTRATION USING NASAL DROPS**
    - **Child**: Apply 2–3 drops 2–3 times a day, to be applied into each nostril

- **INTERACTIONS**
  - **Appendix 1: corticosteroids • neomycin**
  - **LESS SUITABLE FOR PRESCRIBING**
    - Betamethasone with neomycin nasal-drops are less suitable for prescribing; there is no evidence that topical anti-infective nasal preparations have any therapeutic value in rhinitis or sinusitis.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**Ear/eye/nose drops solution**

**EXCIPIENTS**: May contain Benzalkonium chloride, disodium edetate

- **Betnesol-N (RPH Pharmaceuticals AB)**
  - Betamethasone (as Betamethasone sodium phosphate) 1 mg per 1 ml, Neomycin sulfate 5 mg per 1 ml
  - Betnesol-N ear/eye/nose drops | 10 ml (POD) £2.39 DT = £2.39

3 Nasal inflammation, nasal polyps and rhinitis

Other drugs used for Nasal inflammation, nasal polyps and rhinitis

Desloratadine, p. 177 • Fexofenadine hydrochloride, p. 178 • Ketotifen, p. 182 • Rupatadine, p. 179

ANTIHISTAMINES > NON-SEDATING

Azelastine hydrochloride

- **INDICATIONS AND DOSE**
  - **Allergic rhinitis**
    - **BY INTRANASAL ADMINISTRATION**
    - **Child 6-17 years**: 1 spray twice daily, to be administered into each nostril
  - **DOSE EQUIVALENCE AND CONVERSION**
    - 1 spray equivalent to 140 micrograms.

- **INTERACTIONS**
  - **Appendix 1: antihistamines, non-sedating**
  - **SIDE-EFFECTS**
    - Common or very common
      - **Taste bitter (if applied incorrectly)**
    - **Uncommon**
      - Epistaxis • nasal complaints

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**Spray**

- **Rhinolast (Meda Pharmaceuticals Ltd)**
  - Azelastine hydrochloride 140 microgram per 1 actuation
  - Rhinolast 140 microgram/dose nasal spray | 22 ml (POD) £10.50 DT = £10.50

Combinations available: Fluticasone with azelastine, p. 725

ANTIMUSCARINICS

Ipratropium bromide

- **INDICATIONS AND DOSE**
  - **Rhinorrhoea associated with allergic and non-allergic rhinitis**
    - **BY INTRANASAL ADMINISTRATION**
    - **Child 12-17 years**: 2 sprays 2–3 times a day, dose to be sprayed into each nostril
  - **DOSE EQUIVALENCE AND CONVERSION**
    - 1 metered spray of nasal spray = 21 micrograms.

- **CAUTIONS**
  - Avoid spraying near eyes • bladder outflow obstruction • cystic fibrosis • susceptibility to angle-closure glaucoma

- **INTERACTIONS**
  - **Appendix 1: ipratropium**
CORTICOSTEROIDS

Nasal inflammation, nasal polyps and rhinitis

SIDE-EFFECTS
- Common or very common: Epistaxis, gastrointestinal motility disorder, headache, nasal complaints, throat complaints
- Uncommon: Corneal oedema, eye disorders, eye pain, nausea, respiratory disorders, stomatitis, vision disorders
- Rare or very rare: Palpitations

ALLERGY AND CROSS-SENSITIVITY
Contra-indicated in patients with hypersensitivity to atropine or its derivatives.

PREGNANCY
Manufacturer advises only use if potential benefit outweighs the risk.

BREAST FEEDING
No information available—manufacturer advises only use if potential benefit outweighs risk.

PATIENT AND CARER ADVICE
Patients or carers should be counselled on appropriate administration technique and warned against accidental contact with the eye (due to risk of ocular complications).

SIDE-EFFECTS
Driving and skilled tasks
Manufacturer advises patients and carers should be counselled on the effects on driving and performance of skilled tasks—increased risk of dizziness and vision disorders.

INTERACTIONS
Appendix 1: corticosteroids

Corticosteroids (intranasal)

IMPORTANT SAFETY INFORMATION
MHRA/CHM ADVICE: CORTICOSTEROIDS; RARE RISK OF CENTRAL SEROUS CHIORETINOPTHY WITH LOCAL AS WELL AS SYSTEMIC ADMINISTRATION (AUGUST 2017)

Central serous chorioretinopathy is a retinal disorder that has been linked to the systemic use of corticosteroids. Recently, it has also been reported after local administration of corticosteroids via inhaled and intranasal, epidural, intra-articular, topical dermal, and periocular routes. The MHRA recommends that patients should be advised to report any blurred vision or other visual disturbances with corticosteroid treatment given by any route; consider referral to an ophthalmologist for evaluation of possible causes if a patient presents with vision problems.

CAUTIONS
Avoid after nasal surgery (until healing has occurred)- avoid in pulmonary tuberculosis- avoid in the presence of untreated nasal infections- patients transferred from systemic corticosteroids may experience exacerbation of some symptoms

CAUTIONS, FURTHER INFORMATION
- Systemic absorption: Systemic absorption may follow nasal administration particularly if high doses are used or if treatment is prolonged; therefore also consider the cautions and side-effects of systemic corticosteroids. The risk of systemic effects may be greater with nasal drops than with nasal sprays; drops are administered incorrectly more often than sprays.

SIDE-EFFECTS
- Common or very common: Altered smell sensation, epistaxis, headache, nasal complaints, taste altered, throat irritation
- Rare or very rare: Glaucoma, nasal septum perforation (more common following nasal surgery), vision blurred

MEXICAN FORMS
There can be variation in the licensing of different medicines containing the same drug.

Spray
EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate
- Ipratropium bromide 21 microgram per 1 dose Rinatec, nasal spray 180 dose $6.54 DT + $6.54

Beclometasone dipropionate (Beclometasone dipropionate)

INDICATIONS AND DOSE
Prophylaxis and treatment of allergic and vasomotor rhinitis
- BY INTRANASAL ADMINISTRATION
- Child 6-17 years: 100 micrograms twice daily, dose to be administered into each nostril, reduced to 50 micrograms twice daily, dose to be administered into each nostril, dose to be reduced when symptoms controlled; maximum 400 micrograms per day

INTERACTIONS
Appendix 1: corticosteroids

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Spray
EXCIPIENTS: May contain Benzalkonium chloride, polysorbates
- Beclometasone dipropionate (Non-proprietary) Beclometasone dipropionate 50 microgram per 1 dose Beclometasone 50micrograms/dose nasal spray 200 dose $3.02 DT = $3.02
- Beconase (GlaxoSmithKline UK Ltd, Omega Pharma Ltd) Beclometasone dipropionate 50 microgram per 1 dose Beconase Aqueous 50micrograms/dose nasal spray 200 dose $2.63 DT = $3.02
- Nasobec (Teva UK Ltd) Beclometasone dipropionate 50 microgram per 1 dose Nasobec Aqueous 50micrograms/dose nasal spray 200 dose $3.06 DT = $3.02

Betamethasone

INDICATIONS AND DOSE
BETNESOL®
Non-infected inflammatory conditions of nose
- BY INTRANASAL ADMINISTRATION
- Child: Apply 2–3 drops 2–3 times a day, dose to be applied into each nostril

VISTAMETHASONE®
Non-infected inflammatory conditions of nose
- BY INTRANASAL ADMINISTRATION
- Child: Apply 2–3 drops twice daily, dose to be applied into each nostril

INTERACTIONS
Appendix 1: corticosteroids

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Ear, eye/nose drops solution
EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate
- Betnesol (RPH Pharmaceuticals AB) Betamethasone sodium phosphate 1 mg per 1 ml BETNESOL 0.1% eye/ear/nose drops 5 ml $1.02 | 10 ml $1.16 DT = $2.32
12
Ear, nose and oropharynx

MEDICINAL FORMS

- Rare or very rare different medicines containing the same drug.
- Rhinocort
- Aircort (Imported (Italy))
- Budeflam Aquanase (Imported (South Africa))
- EXCIPIENTS: May contain Disodium edetate, polysorbates, potassium
- Rhinitis
- BY INTRANASAL ADMINISTRATION
- Child 12-17 years: 128 micrograms once daily, dose to be administered into each nostril; reduced to 64 micrograms once daily when control achieved.
- Nasal polyps
- BY INTRANASAL ADMINISTRATION
- Child 12-17 years: 100 micrograms twice daily for up to 3 months, dose to be administered into each nostril

Rhinitis

- BY INTRANASAL ADMINISTRATION
- Child 12-17 years: 64 micrograms twice daily, dose to be administered into each nostril

Nasal polyps

- BY INTRANASAL ADMINISTRATION
- Child 12-17 years: 64 micrograms twice daily, dose to be administered into each nostril

SIDE-EFFECTS

- Rare or very rare Adrenal suppression

INTERACTIONS

- Appendix 1: corticosteroids

SIDE-EFFECTS, FURTHER INFORMATION
Nasal ulceration occurs commonly with nasal preparations containing fluticasone furoate.

INTERACTIONS

- Appendix 1: corticosteroids

SIDE-EFFECTS

- Adrenal suppression

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Spray

EXCIPIENTS: May contain Disodium edetate, polysorbates, potassium

- Budelam Aquanase (Imported (South Africa))
- Budesonide 100 microgram per 1 dose Budelam Aquanase 100micrograms/dose nasal spray | 120 dose £26
- Aircort (Imported (Italy))
- Budesonide 100 microgram per 1 dose Aircort 100micrograms/dose nasal spray | 200 dose £44
- Benacort (McNeil Products Ltd)
- Budesonide 64 microgram per 1 dose Benacort 64micrograms nasal spray | 120 dose £55.83 DT = £4.77
- Rhinocort (Johnson & Johnson Ltd)
- Budesonide 64 microgram per 1 dose Rhinocort Aqua 64 nasal spray | 120 dose £3.77 DT = £4.77

PROPHYLAXIS AND TREATMENT OF ALLERGIC RHINITIS AND PERENNIAL RHINITIS

- BY INTRANASAL ADMINISTRATION
- Child 6-11 years: 27.5 micrograms once daily, dose to be sprayed into each nostril, then increased if necessary to 55 micrograms once daily, dose to be sprayed into each nostril, reduced to 27.5 micrograms once daily, to be sprayed into each nostril, dose to be reduced once control achieved; use minimum effective dose
- Child 12-17 years: 55 micrograms once daily, dose to be sprayed into each nostril, reduced to 27.5 micrograms once daily, to be sprayed into each nostril, dose to be reduced once control achieved; use minimum effective dose

DOSE EQUIVALENCE AND CONVERSION

- For Avamys spray: 1 spray equivalent to 27.5 micrograms.

INTERACTIONS

- Appendix 1: corticosteroids

SIDE-EFFECTS

- Adrenal suppression

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Spray

EXCIPIENTS: May contain Benzalkonium chloride, disodium edetate, polysorbates

- Avamys (GliaoxSmithKline UK Ltd)
- Fluticasone furoate 27.5 microgram per 1 dose Avamys 27.5micrograms/dose nasal spray | 120 dose £6.44 DT = £6.44
- Fludinonise GlaxoSmithKline Consumer Healthcare, GlaxoSmithKline UK Ltd
- Fludinonise propionate 50 microgram per 1 dose Fludinonise 50micrograms/dose aqueous nasal spray | 150 dose £11.01 DT = £7.26
- Nasofan (Teva UK Ltd)
- Fludinonise propionate 50 microgram per 1 dose Nasofan 50micrograms/dose aqueous nasal spray | 150 dose £8.04 DT = £7.26

Nasal drops

EXCIPIENTS: May contain Polysorbates

- Fludinonise (GliaoxSmithKline UK Ltd)
- Fludinonise propionate 400 microgram Fludinonise Nasule 400microgram/unit dose nasal drops | 28 unit dose £12.99 DT = £11.99
Fluticasone with azelastine
The properties listed below are those particular to the combination only. For the properties of the components please consider, fluticasone p. 724, azelastine hydrochloride p. 691.

**INDICATIONS AND DOSE**
- Moderate to severe seasonal and perennial allergic rhinitis, if monotherapy with antihistamine or corticosteroid is inadequate
- **BY INTRanasal ADMINISTRATION**
  - Child 12-17 years: 1 spray twice daily, dose to be administered into each nostril

**INTERACTIONS** → Appendix 1: corticosteroids

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.
- **Spray**
  - **Nasacort** (Sanofi) Fluticasone propionate 50 microgram per 1 actuation, Azelastine hydrochloride 117 microgram per 1 actuation
  - **Dymista** (Meda Pharmaceuticals Ltd) Mometasone furoate (Non-proprietary) 50 microgram per 1 dose, azelastine hydrochloride 117 microgram per 1 actuation

**SIDE-EFFECTS, FURTHER INFORMATION**
- Nasal ulceration occurs commonly with preparations containing mometasone furoate.
- *Mometasone furoate (Non-proprietary)* Mometasone furoate nasal spray | 140 dose vial £7.30 GT + £1.71
- *Nasonex* (Merck Sharp & Dohme Ltd) Mometasone furoate 50 microgram per 1 dose spray | 120 dose vial £13.80 GT + £1.80

**Triamcinolone acetonide**

**INDICATIONS AND DOSE**
- **Prophylaxis and treatment of allergic rhinitis**
- **BY INTRanasal ADMINISTRATION**
  - Child 2-5 years: 55 micrograms once daily, dose to be sprayed into each nostril
  - Child 6-11 years: 55 micrograms once daily, dose to be sprayed into each nostril; reduced to 55 micrograms once daily, dose to be sprayed into each nostril, reduce dose when control achieved; maximum duration of treatment 3 months
  - Child 12-17 years: 110 micrograms once daily, dose to be sprayed into each nostril, reduced to 55 micrograms once daily, dose to be sprayed into each nostril, reduce dose when control achieved

**UNLICENSED USE**
- Not licensed for use in children under 6 years.

**INTERACTIONS** → Appendix 1: corticosteroids

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.
- **Spray**
  - **Nasacort** (Sanofi) Triamcinolone acetonide 55 microgram per 1 dose
  - **Dymista** (Meda Pharmaceuticals Ltd) Mometasone furoate (Non-proprietary) 50 microgram per 1 dose

**Mast-Cell Stabilisers**

**Sodium cromoglicate**
(Sodium cromoglycate)

**INDICATIONS AND DOSE**
- **Prophylaxis of allergic rhinitis**
- **BY INTRanasal ADMINISTRATION**
  - Child: 1 spray 2–4 times a day, to be administered into each nostril

**SIDE-EFFECTS**
- Rare or very rare Bronchospasm (transient)
- Frequency not known Local reaction

**MEDICINAL FORMS**
- No licensed medicines listed.

**Oropharynx**

**1 Dry mouth**

**Treatment of dry mouth**

**Overview**
Dry mouth (xerostomia) may be caused by drugs with antimuscarinic (anticholinergic) side-effects (e.g. antispasmodics and sedating antihistamines), by irradiation of the head and neck region or by damage to or disease of the salivary glands. Children with a persistently dry mouth may develop a burning or scalded sensation and have poor oral hygiene; they may develop dental caries, periodontal disease, and oral infections (particularly candidiasis). Dry mouth may be relieved in many patients by simple measures such as frequent sips of cool drinks or sucking pieces of ice or sugar-free fruit pastilles. Sugar-free chewing gum stimulates salivation in patients with residual salivary function.

Artificial saliva can provide useful relief of dry mouth. A properly balanced artificial saliva should be of a neutral pH and contain electrolytes (including fluoride) to correspond approximately to the composition of saliva. The acidic pH of some artificial saliva products may be inappropriate.
Artificial saliva products

- **Artificial saliva products**
  
  **AS SALIVA ORTHANA® LOZENGES**
  Mucin 65 mg, xylitol 59 mg, in a sorbitol basis, pH neutral

- **INDICATIONS AND DOSE**
  Dry mouth as a result of having (or having undergone) radiotherapy (ACBS) | Dry mouth as a result of sicca syndrome (ACBS)
  - **BY MOUTH**
  - Child: 1 lozenge as required, allow to dissolve slowly in the mouth

**PRESCRIBING AND DISPENSING INFORMATION**
AS Saliva Orthana® lozenges do not contain fluoride.
AS Saliva Orthana lozenges (A.S Pharma Ltd)
30 lozenges | NHS indicative price = £3.50 • Drug Tariff (Part VIII C) price = £3.50

**AS SALIVA ORTHANA® SPRAY**
Gastric mucin (porcine) 3.5%, xylitol 2%, sodium fluoride 4.2 g/litre, with preservatives and flavouring agents, pH neutral.

- **INDICATIONS AND DOSE**
  Symptomatic treatment of dry mouth
  - **BY MOUTH**
  - Child: Apply 2–3 sprays as required, spray onto oral and pharyngeal mucosa

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary
AS Saliva Orthana® Oral Spray may be prescribed.

**BIOXTRA® GEL**
Lactoperoxidase, lactoferrin, lysozyme, whey colostrum, xylitol and other ingredients.

- **INDICATIONS AND DOSE**
  Dry mouth as a result of having (or having undergone) radiotherapy | Dry mouth as a result of sicca syndrome
  - **BY MOUTH**
  - Child: Apply as required, apply to oral mucosa

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary
BioXtra® Gel may be prescribed.
BioXtra Dry Mouth oral gel (R.L.S. Products Ltd)
40 ml | NHS indicative price = £3.94 • Drug Tariff (Part IXa)

**BIOTENE ORALBALANCE®**
Lactoperoxidase, lactoferrin, lysozyme, glucose oxidase, xylitol in a gel basis

- **INDICATIONS AND DOSE**
  Symptomatic treatment of dry mouth
  - **BY MOUTH**
  - Child: Apply as required, apply to gums and tongue

**PATIENT AND CARER ADVICE**
Avoid use with toothpastes containing detergents (including foaming agents).

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary
Biotene Oralbalance® Saliva Replacement Gel may be prescribed as Artificial Saliva Gel.

Biotene Oralbalance dry mouth saliva replacement gel (GlaxoSmithKline Consumer Healthcare) Glucose oxidase 12000 unit, Lactoferrin 12 mg, Lactoperoxidase 1200 unit, Muramidase 12 mg 50 gram | NHS indicative price = £4.46 • Drug Tariff (Part IXa)

**GLANDOSANE®**
Carmellose sodium 500 mg, sorbitol 1.5 g, potassium chloride 60 mg, sodium chloride 42.2 mg, magnesium chloride 2.6 mg, calcium chloride 7.3 mg, and dipotassium hydrogen phosphate 17.1 mg/50 g, pH 5.75.

- **INDICATIONS AND DOSE**
  Dry mouth as a result of having (or having undergone) radiotherapy (ACBS) | Dry mouth as a result of sicca syndrome (ACBS)
  - **BY MOUTH**
  - Child: Apply as required, spray onto oral and pharyngeal mucosa

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary
Glandosane® Aerosol Spray may be prescribed.

Glandosane synthetic saliva spray lemon (Fresenius Kabi Ltd)
50 ml | NHS indicative price = £5.68 • Drug Tariff (Part IXa)

Glandosane synthetic saliva spray natural (Fresenius Kabi Ltd)
50 ml | NHS indicative price = £5.68 • Drug Tariff (Part IXa)

Glandosane synthetic saliva spray peppermint (Fresenius Kabi Ltd)
50 ml | NHS indicative price = £5.68 • Drug Tariff (Part IXa)

**ORALIEVE MOISTURISING MOUTH SPRAY**
aqua, glycerin, xylitol, poloxamer 407, sodium benzoate, monosodium phosphate, xanthan gum, aroma, disodium phosphate, benzoic acid, whey protein, lactoferrin, lactoperoxidase, potassium thiocyanate, glucose oxidase, SLS free, alcohol free, pH 5.8

Oralieve moisturising mouth spray (Oralieve UK)
50 ml | NHS indicative price = £4.95 • Drug Tariff (Part IXa)

**ORALIEVE GEL**
Symptomatic treatment of dry mouth
- **BY MOUTH**
- Child: Apply as required, particularly at night, to oral mucosa

**PRESCRIBING AND DISPENSING INFORMATION**
Contains traces of milk protein and egg white protein.

**SST®**
Sugar-free, citric acid, malic acid and other ingredients in a sorbitol base.

- **INDICATIONS AND DOSE**
  Symptomatic treatment of dry mouth
  - **BY MOUTH**
  - Child: 1 tablet as required, allow tablet to dissolve slowly in the mouth

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary
May be prescribed as Saliva Stimulating Tablets.

**SALIVEZE®**
Carmellose sodium (sodium carboxymethylcellulose), calcium chloride, magnesium chloride, potassium chloride, sodium chloride, and dibasic sodium phosphate, pH neutral

- **INDICATIONS AND DOSE**
  Dry mouth as a result of having (or having undergone) radiotherapy (ACBS) | Dry mouth as a result of sicca syndrome (ACBS)
  - **BY MOUTH**
  - Child: Apply 1 spray as required, spray onto oral mucosa
2 Oral hygiene

Mouthwashes and other preparations for oropharyngeal use

Lozenges and sprays
There is no convincing evidence that antiseptic lozenges and sprays have a beneficial action and they sometimes irritate and cause sore tongue and sore lips. Some of these preparations also contain local anaesthetics which relieve pain but may cause sensitisation.

Mouthwashes and gargarces
Superficial infections of the mouth are often helped by warm mouthwashes which have a mechanical cleansing effect and cause some local hyperaemia. However, to be effective, they must be used frequently and vigorously. Mouthwashes may not be suitable for children under 7 years (risk of the solution being swallowed); the mouthwash or dental gel may be applied using a cotton bud.

A warm saline mouthwash is ideal and can be prepared either by dissolving half a teaspoonful of salt in a glassful of warm water or by diluting compound sodium chloride p. 610 mouthwash with an equal volume of warm water.

Mouthwashes containing an oxidising agent, such as hydrogen peroxide p. 728, may be useful in the treatment of acute ulcerative gingivitis (Vincent’s infection) since the organisms involved are anaerobes. It also has a mechanical cleansing effect arising from frothing when in contact with oral debris. Concentrations greater than 1.5% in children may cause ulceration and tissue damage.

Chlorhexidine below is an effective antiseptic which has the advantage of inhibiting plaque formation on the teeth. It does not, however, completely control plaque deposition and is not a substitute for effective toothbrushing. Moreover, chlorhexidine preparations do not penetrate significantly into stagnation areas and are therefore of little value in the control of dental caries or of periodontal disease once pocketing has developed. Chlorhexidine preparations are of little value in the control of acute necrotising ulcerative gingivitis. With prolonged use, chlorhexidine causes reversible brown staining of teeth and tongue. Chlorhexidine may be incompatible with some ingredients in toothpaste, causing an unpleasant taste in the mouth; rinse the mouth thoroughly with water between using toothpaste and chlorhexidine-containing products.

Chlorhexidine can be used as a mouthwash, spray or gel for secondary infection in mucosal ulceration and for controlling gingivitis, as an adjunct to other oral hygiene measures. These preparations may also be used instead of toothbrushing where there is a painful periodontal condition (e.g. primary herpetical stomatitis) or if the patient has a haemorrhagic disorder, or is disabled. Chlorhexidine mouthwash is used in the prevention of oral candidiasis in immunocompromised patients. Chlorhexidine mouthwash reduces the incidence of alveolar osteitis following tooth extraction. Chlorhexidine mouthwash should not be used for the prevention of endocarditis in children undergoing dental procedures.

ANTISEPTICS AND DISINFECTANTS

Chlorhexidine

**INDICATIONS AND DOSE**

**Oral hygiene and plaque inhibition | Oral candidiasis | Gingivitis | Management of apthous ulcers**

- **BY MOUTH USING MOUTHWASH**
  - Child: Rinse or gargle 10 mL twice daily (rinse or gargle for about 1 minute)

**Oral hygiene and plaque inhibition and gingivitis**

- **BY MOUTH USING DENTAL GEL**
  - Child: Apply 1–2 times a day, to be brushed on the teeth

**Oral candidiasis | Management of apthous ulcers**

- **BY MOUTH USING DENTAL GEL**
  - Child: Apply 1–2 times a day, to affected areas

**Oral hygiene and plaque inhibition | Oral candidiasis | Gingivitis | Management of apthous ulcers**

- **BY MOUTH USING OROMUCOSAL SPRAY**
  - Child: Apply up to 12 sprays twice daily as required, to be applied tooth, gingival, or ulcer surfaces

**Bladder irrigation and catheter patency solutions**

- **BY INTRAVESICAL INSTILLATION**
  - Child: (consult product literature)

**UNLICENSED USE**

- With oral (topical) use Corsodyl® not licensed for use in children under 12 years (unless on the advice of a healthcare professional).

**SIDE-EFFECTS**

- Common or very common
  - With oromucosal use Dry mouth • hypersensitivity • oral disorders • taste altered • tongue discolouration • tooth discoloration

**SIDE-EFFECTS, FURTHER INFORMATION** If desquamation occurs with mucosal irritation, discontinue treatment.

**PATIENT AND CARER ADVICE**

- With oral (topical) use Chlorhexidine gluconate may be incompatible with some ingredients in toothpaste; rinse...
the mouth thoroughly with water between using toothpaste and chlorhexidine-containing product.

**PROFESSION SPECIFIC INFORMATION**

**Dental practitioners’ formulary**
- With oral (topical) use Corsodyl® dental gel may be prescribed as Chlorhexidine Gluconate Gel; Corsodyl® mouthwash may be prescribed as Chlorhexidine Mouthwash; Corsodyl® oral spray may be prescribed as Chlorhexidine Oral Spray.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Dental gel**
- Corsodyl® (GlaxoSmithKline Consumer Healthcare)
- Chlorhexidine gluconate 10 mg per 1 gram: Chlorhexidine 1% dental gel sugar-free | 50 gram | £1.56 DT = £1.56

**Irrigation**
- Chlorhexidine (Non-proprietary)
  - Chlorhexidine gluconate 0.2% mouthwash aniseed | 300 ml | £2.09 DT = £4.18
  - Chlorhexidine gluconate 0.2% mouthwash mouthwash | 300 ml | £2.44 DT = £4.18
  - Chlorhexidine gluconate 0.2% mouthwash peppermint | 300 ml | £2.57 DT = £4.18
  - Chlorhexidine gluconate 0.2% mouthwash alcohol free | 300 ml | £2.06 DT = £4.18
- Corsodyl® (GlaxoSmithKline Consumer Healthcare)
- Chlorhexidine gluconate 0.2% mouthwash | 100 ml | £1.56 DT = £3.12
- Uro-Tainer (chlorhexidine) (B.Braun Medical Ltd)
- Chlorhexidine acetate 200 microgram per 1 ml: Uro-Tainer chlorhexidine 1:5000 catheter maintenance solution | 100 ml | £2.70

**Mouthwash**
- Chlorhexidine (Non-proprietary)
  - Chlorhexidine gluconate 2 mg per 1 ml: Chlorhexidine gluconate 0.2% mouthwash | 300 ml | £2.09 DT = £4.18
  - Chlorhexidine gluconate 0.2% mouthwash | 300 ml | £2.44 DT = £4.18
  - Chlorhexidine gluconate 0.2% mouthwash plain | 300 ml | £2.57 DT = £4.18
  - Chlorhexidine gluconate 0.2% mouthwash alcohol free | 300 ml | £2.06 DT = £4.18
- Corsodyl® (GlaxoSmithKline Consumer Healthcare)
- Chlorhexidine gluconate 2 mg per 1 ml: Corsodyl 0.2% mouthwash aniseed | 300 ml | £2.44 DT = £4.18
- Corsodyl® Mint 0.2% mouthwash | 300 ml | £2.57 DT = £4.18
- Chlorhexidine 0.2% mouthwash alcohol free | 300 ml | £2.06 DT = £4.18
- Curasept (Curaprox (UK) Ltd)
- Chlorhexidine gluconate 2 mg per 1 ml: Curasept 0.2% oral rinse | 200 ml | £1.56 DT = £3.12

**Irrigation solution**
- Chlorhexidine (Non-proprietary)
  - Chlorhexidine gluconate 200 microgram per 1 ml: Chlorhexidine acetate 0.02% irrigation solution 1 litre bottles | 1 bottle | £0.99 DT = £1.98
  - Chlorhexidine acetate 500 microgram per 1 ml: Chlorhexidine acetate 0.05% irrigation solution 1 litre bottles | 1 bottle | £2.87 DT = £5.74

**Hexetidine 06-Aug-2018**

**INDICATIONS AND DOSE**

**Oral hygiene**
- By mouth using mouthwash
- Child 12-17 years: Rinse or gargle 15 mL 2–3 times a day, to be used undiluted

**SIDE-EFFECTS**
- Rare: anaesthesia, taste altered
- Frequency not known: Cough, dry mouth, dysphagia, dryness, nausea, salivary gland enlargement, vomiting

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Mouthwash**
- Oraldene (McNeil Products Ltd)
  - Hexetidine 1 mg per 1 ml: Oraldene 0.1% mouthwash peppermint sugar-free | 200 ml | £2.92 DT = £2.92

**Hydrogen peroxide**

**DRUG ACTION** Hydrogen peroxide is an oxidising agent.

**INDICATIONS AND DOSE**

**Oral hygiene (with hydrogen peroxide 6%)**
- By mouth using mouthwash
- Child: Rinse or gargle 15 mL 2–3 times a day for 2–3 minutes, to be diluted in half a tumblerful of warm water

**Peroxyl®**

**Oral hygiene**
- By mouth using mouthwash
- Child 6–17 years: Rinse or gargle 10 mL 3 times a day for about 1 minute, for maximum 7 days, to be used after meals and at bedtime

**PRESCRIBING AND DISPENSING INFORMATION**
- When prepared extemporaneously, the BP states Hydrogen Peroxide Mouthwash, BP consists of hydrogen peroxide 6% solution (= approx. 20 volume) BP.

**HANDLING AND STORAGE** Hydrogen peroxide bleaches fabric.

**PROFESSION SPECIFIC INFORMATION**

**Dental practitioners’ formulary**
- Hydrogen Peroxide Mouthwash may be prescribed.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: liquid

**Mouthwash**
- Peroxyl (Colgate-Palmolive (UK) Ltd)
  - Hydrogen peroxide 15 mg per 1 ml: Peroxyl 1.5% mouthwash sugar-free | 300 ml | £2.94 DT = £2.94

**Sodium bicarbonate with sodium chloride**

**INDICATIONS AND DOSE**

**Oral hygiene**
- By mouth using mouthwash
- Child: (consult product literature)

**DIRECTIONS FOR ADMINISTRATION** For mouthwash, extemporaneous preparations should be prepared according to the following formula: sodium chloride 1.5 g, sodium bicarbonate 1 g, concentrated peppermint emulsion 2.5 mL, double-strength chloroform water 50 mL, water to 100 mL. To be diluted with an equal volume of warm water prior to administration.

**PRESCRIBING AND DISPENSING INFORMATION**
- Flavours of mouthwash may include peppermint.

**PROFESSION SPECIFIC INFORMATION**
- Dental practitioners’ formulary
- Compound sodium chloride mouthwash may be prescribed.

**MEDICINAL FORMS** Forms available from special-order manufacturers include: mouthwash

**Sodium chloride**

**INDICATIONS AND DOSE**

**Oral hygiene**
- By mouth using mouthwash
- Child: Rinse or gargle as required

**DIRECTIONS FOR ADMINISTRATION** Extemporaneous mouthwash preparations should be prepared according to the following formula: sodium chloride 1.5 g, sodium...
bicarbonate 1 g, concentrated peppermint emulsion 2.5 mL, double-strength chloroform water 50 mL, water to 100 mL. To be diluted with an equal volume of warm water.

**PRESCRIBING AND DISPENSING INFORMATION** No mouthwash preparations available—when prepared extemporaneously, the BP states Sodium Chloride Mouthwash, Compound, BP consists of sodium bicarbonate 1%, sodium chloride 1.5% in a suitable vehicle with peppermint flavour.

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary Compound Sodium Chloride Mouthwash may be prescribed.

**MEDICINAL FORMS** No licensed medicines listed.

## 2.1 Dental caries

### Fluoride imbalance

**Overview**
Availability of adequate fluoride confers significant resistance to dental caries. It is now considered that the topical action of fluoride on enamel and plaque is more important than the systemic effect.

When the fluoride content of drinking water is less than 700 micrograms per litre (0.7 parts per million), daily administration of fluoride tablets or drops provides suitable supplementation. Systemic fluoride supplements should not be prescribed without reference to the fluoride content of the local water supply. Infants need not receive fluoride supplements until the age of 6 months.

Dentifrices which incorporate sodium fluoride or monofluorophosphate are also a convenient source of fluoride.

Individuals who are either particularly caries prone or medically compromised may be given additional protection by use of fluoride rinses or by application of fluoride gels. Rinses may be used daily or weekly; daily use of a less concentrated rinse is more effective than weekly use of a more concentrated one. High-strength gels must be applied regularly under professional supervision; extreme caution is necessary to prevent children from swallowing any excess. Less concentrated gels are available for home use. Varnishes are also available and are particularly valuable for young or disabled children since they adhere to the teeth and set in the presence of moisture.

### VITAMINS AND TRACE ELEMENTS

#### Sodium fluoride

**INDICATIONS AND DOSE**

**Prophylaxis of dental caries for water content less than 300 micrograms/litre (0.3 parts per million) of fluoride ion**
- BY MOUTH USING TABLETS
  - Child 6 months-2 years: 250 micrograms daily, doses expressed as fluoride ion (F⁻)
  - Child 3-5 years: 500 micrograms daily, doses expressed as fluoride ion (F⁻)
  - Child 6-17 years: 1 mg daily, doses expressed as fluoride ion (F⁻)

**Prophylaxis of dental caries for water content between 300 and 700 micrograms/litre (0.3-0.7 parts per million) of fluoride ion**
- BY MOUTH USING TABLETS
  - Child 3-5 years: 250 micrograms daily, doses expressed as fluoride ion (F⁻)

**Prophylaxis of dental caries for water content above 700 micrograms/litre (0.7 parts per million) of fluoride ion**
- Child 6 months-17 years: Supplements not advised

**SIDE-EFFECTS**
Dental fluorosis

**DIRECTIONS FOR ADMINISTRATION**
Tablets should be sucked or dissolved in the mouth and taken preferably in the evening. For mouthwash, rinse mouth for 1 minute and then spit out.

**CONTRA-INDICATIONS**
Not for areas where drinking water is fluoridated

**PRESCRIBING AND DISPENSING INFORMATION**
Flavours of oral tablet formulations may include orange.

**PATIENT AND CARER ADVICE**
Mouthwash Avoid eating, drinking, or rinsing mouth for 15 minutes after use.

**PROFESSION SPECIFIC INFORMATION**
Dental practitioners’ formulary
Tablets may be prescribed as Sodium Fluoride Tablets.
Oral drops may be prescribed as Sodium Fluoride Oral Drops.
Mouthwashes may be prescribed as Sodium Fluoride Mouthwash 0.05% or Sodium Fluoride Mouthwash 2%. 

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**Dental caries 729**

**Prophylaxis of dental caries for water content above 700 micrograms/litre (0.7 parts per million) of fluoride ion**
- Child 6 months-17 years: Supplements not advised

**Prophylaxis of dental caries for individuals who are caries prone or medically compromised**
- BY MOUTH USING MOUTHWASH
  - Child 6-17 years: Rinse or gargle 10 mL daily

**DOSE EQUIVALENCE AND CONVERSION**
- Sodium fluoride 2.2 mg provides approx. 1 mg fluoride ion.
- These doses reflect the recommendations of the British Dental Association, the British Society of Paediatric Dentistry and the British Association for the Study of Community Dentistry (Br Dent J 1997; 182: 6–7).

**COLGATE DURAPHAT® 2800PPM FLUORIDE TOOTHPASTE**

**Prophylaxis of dental caries**
- BY MOUTH USING PASTE
  - Child 10-17 years: Apply 1 centimetre twice daily, to be applied using a toothbrush

**COLGATE DURAPHAT® 5000PPM FLUORIDE TOOTHPASTE**

**Prophylaxis of dental caries**
- BY MOUTH USING PASTE
  - Child 16-17 years: Apply 2 centimetres 3 times a day, to be applied after meals using a toothbrush

**EN-DE-KAY® FLUORINSE**

**Prophylaxis of dental caries for individuals who are caries prone or medically compromised**
- BY MOUTH USING MOUTHWASH
  - Child 8-17 years: 5 drops daily, dilute 5 drops to 10 mL of water, alternatively 20 drops once weekly, dilute 20 drops to 10 mL.
Ear, nose and oropharynx

pain, to reduce in diagnosis in each case as the majority of these lesions
de carcinoma, dermatological disorders, nutritional
Ulceration of the oral mucosa may be caused by trauma
Oral ulceration and inflammation

than infection. Children with an unexplained mouth ulcer of more
are prescribable on form FP
Dental information
Fluoride mouthwash, oral drops, tablets and toothpaste are prescribable on form FP10D (GP14 in Scotland, WP10D in Wales.
There are also arrangements for health authorities to supply fluoride tablets in the course of pre-school dental schemes, and they may also be supplied in school dental schemes.
Fluoride gels are not prescribable on form FP10D (GP14 in Scotland, WP10D in Wales).

MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.
Tablet
- Endekay (Manx Healthcare Ltd)
  Sodium fluoride 1.1 mg Endekay Flutabs 3-6 Years 1.1mg tablets | 200 tablet (T) £2.38 DT + £2.38
- Sodium fluoride 2.2 mg Endekay Flutabs 6+ Years 2.2mg tablets | 200 tablet (T) £2.38 DT + £2.38

Paste
- Sodium fluoride (Non-proprietary)
  Fluoride (as Sodium fluoride) 2.8 mg per 1 gram Sodium fluoride 0.619% dental paste sugar free sugar-free | 75 ml (G03) £3.26 DT + £3.26
  Fluoride (as Sodium fluoride) 5 mg per 1 gram Sodium fluoride 1.1% dental paste sugar free sugar-free | 51 gram (G04) £6.50 DT + £6.50
- Colgate Duraphat (Colgate-Palmolive (UK) Ltd)
  Fluoride (as Sodium fluoride) 2.8 mg per 1 gram Colgate Duraphat 2000ppm fluoride toothpaste sugar-free | 75 ml (G03) £3.26 DT + £3.26
  Fluoride (as Sodium fluoride) 5 mg per 1 gram Colgate Duraphat 5000ppm fluoride toothpaste sugar-free | 51 gram (G04) £6.50 DT + £6.50

Mouthwash
- Sodium fluoride (Non-proprietary)
  Sodium fluoride 500 microgram per 1 ml Sodium fluoride 0.05% mouthwash sugar free sugar-free | 250 ml (G03) £1.51
- Colgate FluorGard (Colgate-Palmolive (UK) Ltd)
  Sodium fluoride 500 microgram per 1 ml Colgate FluorGard 0.05% daily rinse mouthwash sugar-free | 400 ml £2.99
  Colgate FluorGard 0.05% daily rinse sugar-free | 400 ml (G04) £2.99
- Endekay (Manx Healthcare Ltd)
  Sodium fluoride 500 microgram per 1 ml Endekay 0.05% daily fluoride mouthwash sugar-free | 250 ml (G03) £1.51 DT + £1.51 sugar-free | 500 ml (G03) £2.45

Oral ulceration and inflammation

Ulceration and inflammation
Ulceration of the oral mucosa may be caused by trauma (physical or chemical), recurrent aphthae, infections, carcinoma, dermatological disorders, nutritional deficiencies, gastro-intestinal disease, haematopoietic disorders, and drug therapy. It is important to establish the diagnosis in each case as the majority of these lesions require specific management in addition to local treatment. Local treatment aims to protect the ulcerated area, to relieve pain, to reduce inflammation, or to control secondary infection. Children with an unexplained mouth ulcer of more than 3 weeks’ duration require urgent referral to hospital to exclude oral cancer in adults or secondary causes such as leukaemia.

Simple mouthwashes
A saline mouthwash may relieve the pain of traumatic ulceration. The mouthwash is made up with warm water and used at frequent intervals until the discomfort and swelling subsides.

Antiseptic mouthwashes
Secondary bacterial infection may be a feature of any mucosal ulceration; it can increase discomfort and delay healing. Use of chlorhexidine mouthwash p. 727 is often beneficial and may accelerate healing of recurrent aphthae.

Corticosteroids
Topical corticosteroid therapy may be used for some forms of oral ulceration. In the case of aphthous ulcers it is most effective if applied in the ‘prodromal’ phase. Thrush or other types of candidiasis are recognised complications of corticosteroid treatment.

Hydrocortisone oromucosal tablets p. 456 are allowed to dissolve next to an ulcer and are useful in recurrent aphthae and erosive lichenoid lesions.

Local analgesics
Local analgesics have a limited role in the management of oral ulceration. When applied topically their action is of a relatively short duration so that analgesia cannot be maintained continuously throughout the day. When local anaesthetics are used in the mouth, care must be taken not to produce anaesthesia of the pharynx before meals as this might lead to choking.

Benzydamine hydrochloride p. 731 and flurbiprofen p. 678 are non-steroidal anti-inflammatory drugs (NSAIDs).

Benzydamine hydrochloride mouthwash or spray may be useful in reducing the discomfort associated with a variety of ulcerative conditions. It has also been found to be effective in reducing the discomfort of tonsillitis and post-irritation mucositis. Some patients find the full-strength mouthwash causes some stinging and, for them, it should be diluted with an equal volume of water. Flurbiprofen lozenges are licensed for the relief of sore throat in adolescents.

Choline salicylate p. 732 is a derivative of salicylic acid and has some analgesic action. The dental gel may provide relief for recurrent aphthae, but excessive application or confinement under a denture irritates the mucosa and can itself cause ulceration in adults and children over 16 years of age.

Other preparations
Doxycycline p. 364 rinsed in the mouth may be of value for recurrent aphthous ulceration.

Periodontitis
Low-dose doxycycline (Periostat®) is licensed as an adjunct to scaling and root planing for the treatment of periodontitis; a low dose of doxycycline reduces collagenase activity without inhibiting bacteria associated with periodontitis.

For anti-infectives used in the treatment of destructive (refractory) forms of periodontal disease, see under Oropharyngeal infections, antibacterial therapy p. 733. See also Mouthwashes and other preparations for oropharyngeal use p. 727 for mouthwashes used for oral hygiene and plaque inhibition.

Dental information
Fluoride mouthwash, oral drops, tablets and toothpaste are prescribable on form FP10D (GP14 in Scotland, WP10D in Wales.
There are also arrangements for health authorities to supply fluoride tablets in the course of pre-school dental schemes, and they may also be supplied in school dental schemes.
Fluoride gels are not prescribable on form FP10D (GP14 in Scotland, WP10D in Wales).
ANAESTHETICS, LOCAL

Lidocaine hydrochloride (Lignocaine hydrochloride)

- **INDICATIONS AND DOSE**
  - **Dental practice**
    - **BY BUCCAL ADMINISTRATION USING OINTMENT**
    - Child: Rub gently into dry gum
  - **LARYNGOJET®**
  - Anaesthesia of mucous membranes of oropharynx, trachea, or respiratory tract
    - **TO MUCOUS MEMBRANES**
      - Child: Up to 3 mg/kg (max. per dose 200 mg), to be given as a single dose sprayed, instilled (if a cavity) or applied with a swab; reduce dose according to size, age, and condition of child
  - **XYLOCAINE®**
  - Bronchoscopy | Laryngoscopy | Oesophagoscopy | Endotracheal intubation
    - **TO MUCOUS MEMBRANES**
      - Child: Up to 3 mg/kg

- **CAUTIONS** Can damage plastic cuffs of endotracheal tubes
- **INTERACTIONS** → Appendix 1: antiarrhythmics
- **ALLERGY AND CROSS-SENSITIVITY**
  - Hypersensitivity and cross-sensitivity
    - Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, meptivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.
- **PREGNANCY** Crosses the placenta but not known to be harmful in animal studies—use if benefit outweighs risk.
- **BREAST FEEDING** Present in milk but amount too small to be harmful.
- **HEPATIC IMPAIRMENT** Caution—increased risk of side-effects.
- **RENAL IMPAIRMENT** Possible accumulation of lidocaine and active metabolite; caution in severe impairment.
- **PROFESSION SPECIFIC INFORMATION**
  - Dental practitioners’ formulary
    - Lidocaine ointment 5% may be prescribed. Spray may be prescribed as Lidocaine Spray 10%.
  - **XYLOCAINE®** May be prescribed as lidocaine spray 10%.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: ointment
  - **Spray**
    - Xylocaine (Aspen Pharma Trading Ltd)
      - Lidocaine 10 mg per 1 actuation
    - Xylocaine 10mg/dose spray sugar-free | 50 ml £6.29 DT = £6.29
  - **Ointment**
    - Lidocaine hydrochloride (Non-proprietary)
      - Lidocaine hydrochloride 50 mg per 1 gram
      - Lidocaine 5% ointment 15 gram £3.00 DT = £6.18

ANAESTHETICS, LOCAL

Flurbiprofen

- **INDICATIONS AND DOSE**
  - **Relief of sore throat**
    - **BY MOUTH USING LOZENGES**
      - Child 12-17 years: 1 lozenge every 3–6 hours for maximum 3 days, allow lozenge to dissolve slowly in the mouth; maximum 5 lozenges per day

- **INTERACTIONS** → Appendix 1: NSAIDs
- **SIDE-EFFECTS** Oral ulceration (move lozenge around mouth) · taste altered
- **ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of
asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Lozenges**
    - Strefen (Reckitt Benckiser Healthcare (UK) Ltd)
  - Flurbiprofen 8.75 mg Strefen Honey and Lemon 8.75mg lozenges | 16 lozenges (P) £3.23 DT + £3.23

**CORTICOSTEROIDS**

- **Betamethasone**
  - **INDICATIONS AND DOSE**
    - **Oral ulceration**
      - TO THE LESION USING SOLUBLE TABLETS
      - Child 12-17 years: 500 micrograms 4 times a day, to be dissolved in 20 mL water and rinsed around the mouth; not to be swallowed
  - **UNLICENSED USE** Betamethasone soluble tablets not licensed for use as mouthwash or in oral ulceration.
  - **CONTRA-INDICATIONS** Untreated local infection
  - **INTERACTIONS** → Appendix 1: corticosteroids
  - **PATIENT AND CARER ADVICE** Patient counselling is advised
  - **PROFESSION SPECIFIC INFORMATION**
    - Dental practitioners’ formulary

- **Hydrocortisone**
  - **INDICATIONS AND DOSE**
    - **Mild oral and perioral lesions**
      - TO THE LESION USING BUCCAL TABLET
      - Child 12-17 years: 500 micrograms 4 times a day, to be swallowed
  - **SIDE-EFFECTS** Bronchospasm

**SALICYLIC ACID AND DERIVATIVES**

- **Choline salicylate**
  - **INDICATIONS AND DOSE**
    - **Mild oral and perioral lesions**
      - TO THE LESION
      - Child 16-17 years: Apply 0.5 inch, with gentle massage, not more often than every 3 hours
  - **CONTRA-INDICATIONS** Children under 16 years
  - **PRESCRIBING AND DISPENSING INFORMATION** When prepared extemporaneously, the BP states Choline Salicylate Dental Gel, BP consists of choline salicylate 8.7% in a flavoured gel basis.
  - **PROFESSION SPECIFIC INFORMATION**
    - Dental practitioners’ formulary

**Salicylic acid with rhubarb extract**

- **INDICATIONS AND DOSE**
  - **Mild oral and perioral lesions**
    - TO THE LESION
    - Child 16-17 years: Apply 3–4 times a day maximum duration 7 days
  - **CONTRA-INDICATIONS** Children under 16 years
  - **PRESCRIPTION ADVICE**
    - Reye’s syndrome The CHM has advised that topical oral pain relief products containing salicylate salts should not be used in children under 16 years, as a cautionary measure due to the theoretical risk of Reye’s syndrome.
    - The CHM has advised that topical oral pain relief products containing salicylate salts should not be used in children under 16 years, as a cautionary measure due to the theoretical risk of Reye’s syndrome.
    - Salicylic acid products should not be used near the eyes or on sensitive skin areas.
    - Salicylic acid products should not be used near the eyes or on sensitive skin areas.
    - Salicylates may give rise to salicylate poisoning

**IMPORTANT SAFETY INFORMATION**

- **MHRA/CHM ADVICE: HYDROCORTISONE MUCO-ADHESIVE BUCCAL TABLETS SHOULD NOT BE USED OFF-LABEL FOR ADRENAL INSUFFICIENCY IN CHILDREN DUE TO SERIOUS RISKS (DECEMBER 2018)**

- The MHRA has received reports of off-label use of hydrocortisone muco-adhesive buccal tablets for adrenal insufficiency in children.
- Healthcare professionals are advised that:
  - Hydrocortisone muco-adhesive buccal tablets are indicated only for local use in the mouth for aphthous ulceration and should not be used to treat adrenal insufficiency;
  - substitution of licensed oral hydrocortisone formulations with muco-adhesive buccal tablets can result in insufficient cortisol absorption and, in stress situations, life-threatening adrenal crisis;
- only hydrocortisone products licensed for adrenal replacement therapy should be used.

- **CONTRA-INDICATIONS** Untreated local infection
- **INTERACTIONS** → Appendix 1: corticosteroids
- **PROFESSION SPECIFIC INFORMATION**
  - Dental practitioners’ formulary
    - Mucoadhesive buccal tablets may be prescribed as Hydrocortisone Oromucosal Tablets.
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
    - **Muco-adhesive buccal tablet**
      - Hydrocortisone (Non-proprietary)
      - Hydrocortisone (as Hydrocortisone sodium succinate) 2.5 mg Hydrocortisone 2.5mg muco-adhesive buccal tablets sugar free sugar-free | 20 tablet (P) £7.94 DT + £7.80
Oropharyngeal infections

4 Oropharyngeal bacterial infections

Oropharyngeal infections, antibacterial therapy

Pericoronitis
Antibacterial required only in presence of systemic features of infection, or of trismus, or persistent swelling despite local treatment.

- Metronidazole p. 344, or alternatively, amoxicillin p. 351
- **Suggested duration of treatment** 3 days or until symptoms resolve.

Gingivitis (acute necrotising ulcerative)
Antibacterial required only if systemic features of infection.

- Metronidazole, or alternatively, amoxicillin
- **Suggested duration of treatment** 3 days or until symptoms resolve.

Abscess (periapical or periodontal)
Antibacterial required only in severe disease with cellulitis or if systemic features of infection.

- Amoxicillin, or alternatively, metronidazole
- **Suggested duration of treatment** 5 days.

Periodontitis
Antibacterial used as an adjunct to debridement in severe disease or disease unresponsive to local treatment alone.

- Metronidazole, or alternatively in adults and children over 12 years, doxycycline p. 364

Sore throat (acute)
Acute sore throat is usually triggered by a viral infection and is self-limiting. Symptoms can last for around 1 week, and most people will improve within this time without treatment with antibiotics, regardless of the cause.

**Note**: Antibacterial therapy is required only in patients with severe systemic symptoms, signs, and symptoms of a more serious illness or condition, or those at high risk of complications. Patients with severe systemic infection or severe suppurative complications such as peri-tonsillar abscess (quinsy), acute otitis media, acute sinusitis or cellulitis should be referred to hospital.

- Phenoxymethylpenicillin p. 350
- **Suggested duration of treatment** 5 to 10 days.
- If penicillin-allergic, clarithromycin p. 340 (or erythromycin p. 341)
- **Suggested duration of treatment** 5 days.

Antibacterial therapy is required only in patients with severe systemic symptoms, signs, and symptoms of a more serious illness or condition, or those at high risk of complications. Patients with severe systemic infection or severe suppurative complications such as peri-tonsillar abscess (quinsy), acute otitis media, acute sinusitis or cellulitis should be referred to hospital.

- Phenoxymethylpenicillin p. 350
- **Suggested duration of treatment** 5 to 10 days.
- If penicillin-allergic, clarithromycin p. 340 (or erythromycin p. 341)
- **Suggested duration of treatment** 5 days.

5 Oropharyngeal fungal infections

Oropharyngeal fungal infections

Overview
Fungal infections of the mouth are usually caused by *Candida* spp. (candidiasis or candidosis). Different types of oropharyngeal candidiasis are managed as follows:

**Thrush**
Acute pseudomembranous candidiasis (thrush), is usually an acute infection but it may persist for months in patients receiving inhaled corticosteroids, cytotoxics, or broad-spectrum antibacterials. Thrush also occurs in patients with serious systemic disease associated with reduced immunity such as leukaemia, other malignancies, and HIV infection. Any predisposing condition should be managed appropriately. When thrush is associated with corticosteroid inhalers, rinsing the mouth with water (or cleaning a child’s teeth) immediately after using the inhaler may avoid the problem. Treatment with nystatin p. 734 or miconazole...
below may be needed. Fluconazole p. 389 is effective for unresponsive infections or if a topical antifungal drug cannot be used. Topical therapy may not be adequate in immunocompromised children and an oral triazole antifungal is preferred.

**Acute erythematous candidiasis**
Acute erythematous (atrophic) candidiasis is a relatively uncommon condition associated with corticosteroid and broad-spectrum antibacterial use and with HIV disease. It is usually treated with fluconazole.

**Angular cheilitis**
Angular cheilitis (angular stomatitis) is characterised by soreness, erythema and fissuring at the angles of the mouth. It may represent a nutritional deficiency or it may be related to orofacial granulomatosis or HIV infection. Both yeasts (*Candida spp.*) and bacteria (*Staphylococcus aureus* and beta-haemolytic streptococci) are commonly involved as infecting, infective factors. While the underlying cause is being identified and treated, it is often helpful to apply miconazole cream or fusidic acid ointment p. 371; if the angular cheilitis is unresponsive to treatment, hydrocortisone with miconazole cream or ointment p. 767 can be used.

**Immunocompromised patients**
See advice on prevention of fungal infections under Immunocompromised children in Antifungals, systemic use p. 385.

Antiseptic mouthwashes can have a role in the prevention of oral candidiasis in immunocompromised children.

**Drugs used in oropharyngeal candidiasis**
Nystatin is not absorbed from the gastro-intestinal tract and is applied locally (as a suspension) to the mouth for treating local fungal infections. Miconazole is used by local application (as an oral gel) in the mouth but it is also absorbed to the extent that potential interactions need to be considered. Miconazole also has some activity against Gram-negative bacteria including streptococci and staphylococci. In neonates, nystatin oral suspension or miconazole oral gel is used for the treatment of oropharyngeal candidiasis; to prevent re-infection it is important to ensure that the mother’s breast nipples and the teats of feeding bottles are cleaned adequately.

Fluconazole given by mouth is reliably absorbed; it is used for infections that do not respond to topical therapy or when infection is severe. Nystatin may be used in neonates, but it is not licensed for use in this patient group. Itraconazole p. 390 can be used for fluconazole-resistant infections.

If candidal infection fails to respond after 1 to 2 weeks of treatment with antifungal drugs the child should be sent for treatment with antifungal drugs. Persistent infection may also be caused by re-infection from the genito-urinary or gastro-intestinal tract.

### ANTIFUNGALS > IMIDAZOLE ANTIFUNGALS

#### Miconazole

**02-Apr-2019**

**INDICATIONS AND DOSE**

**Oral candidiasis**

- **Neonate:** 1 mL 2–4 times a day treatment should be continued for at least 7 days after lesions have healed or symptoms have cleared, to be smeared around the inside of the mouth after feeds.

- **Child 1–2 months:** 1.25 mL 4 times a day treatment should be continued for at least 7 days after lesions have healed or symptoms have cleared, to be smeared around the inside of the mouth after feeds.

- **Child 2–7 years:** 2.5 mL 4 times a day treatment should be continued for at least 7 days after lesions have healed or symptoms have cleared, to be smeared around the inside of the mouth after feeds.

- **Appendix**

  - **INTERACTIONS** → Appendix 1: antifungals, azoles

#### Fluconazole given by mouth is reliably absorbed; it is used for infections that do not respond to topical therapy or when infection is severe.

**Intestinal candidiasis**

- **BY MOUTH USING ORAL GEL**

- **Child 4 months–17 years:** 5 mg/kg 4 times a day (max. per dose 250 mg) treatment should be continued for at least 7 days after lesions have healed or symptoms have cleared.

- **UNLICENSED USE** Not licensed for use in children under 4 months of age or during first 5–6 months of life of an infant born pre-term.

- **CONTRA-INDICATIONS** Infants with impaired swallowing reflex

- **CAUTIONS** Avoid in Acute porphyrias p. 624

- **INTERACTIONS** → Appendix 1: antifungals, azoles

- **SIDE-EFFECTS**

  - **Uncommon** Skin reactions

  - **Frequency not known** Angioedema

- **PREGNANCY** Manufacturer advises avoid if possible—toxicity at high doses in animal studies.

- **BREAST FEEDING** Manufacturer advises caution—no information available.

- **HEPATIC IMPAIRMENT** Manufacturer advises avoid.

- **DIRECTIONS FOR ADMINISTRATION** Oral gel should be held in mouth, after food.

- **PRESCRIBING AND DISPENSING INFORMATION** Flavours of oral gel may include orange.

- **PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer miconazole oromucosal gel.

- **PROFESSION SPECIFIC INFORMATION**

  - **Dental practitioners’ formulary** Miconazole Oromucosal Gel may be prescribed.

- **EXCEPTIONS TO LEGAL CATEGORY** 15-g tube of oral gel can be sold to the public.

**CAUTIONARY AND ADVISORY LABELS**

- **9**

**Oral gel**

- **Daktarin** (Johnson & Johnson Ltd, Janssen-Cilag Ltd)

- **Miconazole 20 mg per 1 gram**

  - **DT = £ 3.78**
  - **DT = £ 3.78**
  - **sugar-free**
  - **sugar-free**
  - **15 gram**
  - **80 gram**

**ANTIFUNGALS > POLYENE ANTIFUNGALS**

**Nystatin**

- **15-Feb-2017**

- **INDICATIONS AND DOSE**

  - **Oral candidiasis**

    - **BY MOUTH**

      - **Neonate:** 100 000 units 4 times a day usually for 7 days, and continued for 48 hours after lesions have resolved, to be given after feeds.

      - **Child:** 100 000 units 4 times a day usually for 7 days, and continued for 48 hours after lesions have resolved

- **UNLICENSED USE** Nystatin may be used in neonates, but it is not licensed for use in this patient group.

- **CAUTIONS** Contact with eyes and mucous membranes should be avoided.

- **SIDE-EFFECTS** Abdominal distress, angioedema, diarrhoea, face oedema, nausea, sensitisation, skin reactions, Stevens-Johnson syndrome, vomiting.
PATIENT AND CARER ADVICE
Counselling advised with oral suspension (use of pipette, hold in mouth, after food).
Medicines for Children leaflet: Nystatin for Candida infection
www.medicinesforchildren.org.uk/nystatin-candida-infection

PROFESSION SPECIFIC INFORMATION
Dental practitioners’ formulary
Nystatin Oral Suspension may be prescribed.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

CAUTIONARY AND ADVISORY LABELS
EXCIPIENTS: May contain Ethanol

Nystatin (Non-proprietary)
Nystatin 100000 unit per 1 ml Nystatin 100,000 units/ml oral suspension 30 ml £2.43 DT = £2.03

6 Oropharyngeal viral infections

Oropharyngeal viral infections

Management
Viral infections are the most common cause of a sore throat. It is usually a self-limiting condition which does not benefit from anti-infective treatment. Adequate analgesia may be all that is required.

Children with varicella–zoster infection often develop painful lesions in the mouth and throat. Benzydamine hydrochloride p. 731 may be used to provide local analgesia. Chlorhexidine mouthwash or gel p. 727 will control plaque accumulation if toothbrushing is painful and will also help to control secondary infection in general.

In severe herpetic stomatitis systemic aciclovir p. 420 or valaciclovir p. 422 may be used for oral lesions associated with herpes zoster. Aciclovir and valaciclovir are also used to prevent frequently recurring herpes simplex lesions of the mouth particularly when associated with the initiation of erythema multiforme. See the treatment of labial herpes simplex infections.
## Skin conditions, management

### Topical preparations

When prescribing topical preparations for the treatment of skin conditions in children, the site of application, the condition being treated, and the child’s (and carer’s) preference for a particular vehicle all need to be taken into consideration.

### Vehicles

The British Association of Dermatologists list of preferred unlicensed dermatological preparations (specials) is available at [www.bad.org.uk](http://www.bad.org.uk).

The vehicle in topical preparations for the skin affects the degree of hydration, has a mild anti-inflammatory effect, and aids the penetration of the active drug. Therefore, the vehicle, as well as the active drug, should be chosen on the basis of their suitability for the child’s skin condition.

**Applications** are usually viscous solutions, emulsions, or suspensions for application to the skin (including the scalp) or nails.

**Collodions** are painted on the skin and allowed to dry to leave a flexible film over the site of application.

**Creams** are emulsions of oil and water and are generally well absorbed into the skin. They may contain an antimicrobial preservative unless the active ingredient or basis is intrinsically bactericidal and fungicidal. Generally, creams are cosmetically more acceptable than ointments because they are less greasy and easier to apply.

**Gels** consist of active ingredients in suitable hydrophilic or hydrophobic bases; they generally have a high water content. Gels are particularly suitable for application to the face and scalp.

**Lotions** have a cooling effect and may be preferred to ointments or creams for application over a hairy area. Lotions in alcoholic basis can sting if used on broken skin. **Shake lotions** (such as calamine lotion) contain insoluble powders which leave a deposit on the skin surface.

**Ointments** are greasy preparations which are normally anhydrous and insoluble in water, and are more occlusive than creams. They are particularly suitable for chronic, dry lesions. The most commonly used ointment bases consist of soft paraffin or a combination of soft, liquid, and hard paraffin. Some ointment bases have both hydrophilic and lipophilic properties; they may have occlusive properties on the skin surface, encourage hydration, and also be miscible with water; they often have a mild anti-inflammatory effect. **Water-soluble ointments** contain macrogols which are freely soluble in water and are therefore readily washed off; they have a limited but useful role where ready removal is desirable.

**Paste**s are stiff preparations containing a high proportion of finely powdered solids such as zinc oxide and starch suspended in an ointment. They are used for circumscribed lesions such as those which occur inlichen simplex, chronic eczema, or psoriasis. They are less occlusive than ointments and can be used to protect inflamed, lichenified, or excoriated skin.

**Dusting powders** are used only rarely. They reduce friction between opposing skin surfaces. Dusting powders should not be applied to moist areas because they can cake and abrade the skin. Talc is a lubricant but it does not absorb moisture; it can cause respiratory irritation. Starch is less lubricant but absorbs water.

**Dilution**

The BP directs that creams and ointments should not normally be diluted but that should dilution be necessary care should be taken, in particular, to prevent microbial contamination. The appropriate diluent should be used and heating should be avoided during mixing; excessive dilution may affect the stability of some creams. Diluted creams should normally be used within 2 weeks of preparation.

### Suitable quantities for prescribing

**Suitable quantities of dermatological preparations to be prescribed for specific areas of the body**

<table>
<thead>
<tr>
<th>Area of body</th>
<th>Creams and Ointments</th>
<th>Lotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>15–30 g</td>
<td>100 ml</td>
</tr>
<tr>
<td>Both hands</td>
<td>25–50 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Scalp</td>
<td>50–100 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Both arms or both legs</td>
<td>100–200 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Trunk</td>
<td>400 g</td>
<td>500 ml</td>
</tr>
<tr>
<td>Groins and genitalia</td>
<td>15–25 g</td>
<td>100 ml</td>
</tr>
</tbody>
</table>

These amounts are usually suitable for children 12-18 years for twice daily application for 1 week; smaller quantities will be required for children under 12 years. These recommendations do not apply to corticosteroid preparations.
Excipients and sensitisation

Excipients in topical products rarely cause problems. If a patch test indicates allergy to an excipient, products containing the substance should be avoided (see also Anaphylaxis). The following excipients in topical preparations are associated, rarely, with sensitisation; the presence of these excipients is indicated in the entries for topical products. See also Excipients, under General Guidance.

- Beeswax
- Benzyl alcohol
- Butylated hydroxyanisole
- Butylated hydroxytoluene
- Cetostearyl alcohol (including cetyl and stearyl alcohol)
- Chlorocresol
- Edetic acid (EDTA)
- Ethylenediamine
- Fragrances
- Hydroxybenzoates (parabens)
- Imidurea
- Isopropyl palmitate
- N-(2-Chloroallyl)hexaminium chloride (quaternium 15)
- Polysorbates
- Propylene glycol
- Sodium metabisulfite
- Sorbic acid
- Wool fat and related substances including lanolin (purified versions of wool fat have reduced the problem)

Neonates

Caution is required when prescribing topical preparations for neonates—their large body surface area in relation to body mass increases susceptibility to toxicity from systemic absorption of substances applied to the skin. Topical preparations containing potentially sensitising substances such as corticosteroids, aminoglycosides, iodine, and parasiticidal drugs should be avoided. Preparations containing alcohol should be avoided because they can dehydrate the skin, cause pain if applied to raw areas, and the alcohol can cause necrosis. In preterm neonates, the skin is more fragile and offers a poor barrier, especially in the first fortnight after birth. Preterm infants, especially if below 32 weeks corrected gestational age, may also require special measures to maintain skin hydration.

Emollients

Emollients hydrate the skin, soften the skin, act as barrier to water and external irritants, and are indicated for all dry or scaling disorders. Their effects are short-lived and they should be applied frequently even after improvement occurs. They are useful in dry and eczematous disorders, and to a lesser extent in psoriasis; they should be applied immediately after washing or bathing to maximise the effect of skin hydration. The choice of an appropriate emollient will depend on the severity of the condition, the child’s (or carer’s) preference, and the site of application. Ointments may exacerbate acne and folliculitis. Some ingredients rarely cause sensitisation and this should be suspected if an eczematous reaction occurs. The use of aqueous cream as a leave-on emollient may increase the risk of skin reactions, particularly in eczema.

Preparations such as aqueous cream and emulsifying ointment can be used as soap substitutes for handwashing and in the bath; the preparation is rubbed on the skin before rinsing off completely. The addition of a bath oil may also be helpful.

Urea is occasionally used with other topical agents such as corticosteroids to enhance penetration of the skin.

Emollient bath and shower preparations

In dry skin conditions soap should be avoided.

The quantities of bath additives recommended for older children are suitable for an adult-size bath. Proportionately less should be used for a child-size bath or a washbasin; recommended bath additive quantities for younger children reflect this.

MHRA/CHM advice (updated December 2018): Emollients:

New information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients

Emollients are an important and effective treatment for chronic dry skin disorders and people should continue to use these products. However, healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk. There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it cannot be excluded with paraffin-free emollients. A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days.

Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it.

Barrier preparations

Barrier preparations often contain water-repellent substances such as dimeticon p. 752, natural oils, and paraffins, to help protect the skin from abrasion and irritation; they are used to protect intact skin around stomas and pressure sores, and as a barrier against nappy rash. In neonates, barrier preparations which do not contain potentially sensitising excipients are preferred. Where the skin has broken down, barrier preparations have a limited role in protecting adjacent skin. Barrier preparations with zinc oxide or titanium salts are used to aid healing of uninfected, excoriated skin.

Nappy rash (Dermatitis)

The first line of treatment is to ensure that nappies are changed frequently and that tightly fitting water-proof pants are avoided. The rash may clear when left exposed to the air and a barrier preparation, applied with each nappy change, can be helpful. A mild corticosteroid such as hydrocortisone 0.5% or 1% p. 762 can be used if inflammation is causing discomfort, but it should be avoided in neonates. The barrier preparation should be applied after the corticosteroid preparation to prevent further damage. Preparations containing hydrocortisone should be applied for no more than a week; the hydrocortisone should be discontinued as soon as the inflammation subsides. The occlusive effect of nappies and waterproof pants may increase absorption of corticosteroids (see cautions). If the rash is associated with candidal infection, a topical antifungal such as clotrimazole cream p. 748 can be used. Topical antibacterial preparations can be used if bacterial infection is present; treatment with
an oral antibacterial may occasionally be required in severe or recurrent infection. Hydrocortisone may be used in combination with antimicrobial preparations if there is considerable inflammation, erosion, and infection.

Emollients for neonates

In the neonate, a preservative-free paraffin-based emollient hydrates the skin without affecting the normal skin flora; substances such as olive oil are also used. The development of blisters (epidermolysis bullosa) or ichthyosis may be alleviated by applying liquid and white soft paraffin ointment while awaiting dermatological investigation.

Dermatological Drugs \(\Rightarrow\) BARRIER PREPARATIONS

**Barrier creams and ointments**

- **INDICATIONS AND DOSE**
  - For use as a barrier preparation
  - To the skin
  - Child: (consult product literature)

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **EXCIPIENTS:** May contain Woolfat and related substances (including lanolin)
      - Barrier creams and ointments (Non-proprietary)
        - Cetostearyl alcohol 20 mg per 1 gram, Zinc oxide 75 mg per 1 gram, Beeswax white 100 mg per 1 gram, Arachis oil 305 mg per 1 gram, Castor oil 500 mg per 1 gram, Zinc and Castor oil ointment | 30 gram (GSL) £5.14–£5.19
        - Zinc and Castor oil cream | 100 gram (GSL) £1.46
      - **Metanium** (Thornton & Ross Ltd)
        - Titanium salicylate 30 mg per 1 gram, Titanium peroxide 50 mg per 1 gram, Titanium dioxide 200 mg per 1 gram
        - Metanium Nappy Rash ointment | 30 gram (GSL) £2.24 DT + £2.24
  - **Spray**
    - CAUTIONARY AND ADVISORY LABELS: 15
    - **EXCIPIENTS:** May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), hydroxybenzoates (parabens), woolfat and related substances (including lanolin)
      - **Sprilox** (M L Overridge Ltd)
        - Dimeticone 10.4 mg per 1 gram, Zinc oxide 125 mg per 1 gram, Spiron aerosol spray | 115 gram (GSL) £8.90 DT + £8.90
  - **Cream**
    - **EXCIPIENTS:** May contain Beeswax, butylated hydroxyanisole, butylated hydroxytoluene, cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol, fragrances, hydroxybenzoates (parabens), propylene glycol, woolfat and related substances (including lanolin)
      - **Conotrane** (LEO Pharma)
        - Benzalkonium chloride 1 mg per 1 gram, Dimeticone 220 mg per 1 gram
        - Conotrane cream | 100 gram (GSL) £0.88 DT + £0.88
      - **Drapolene** (Supra Enterprises Ltd)
        - Benzalkonium chloride 100 microgram per 1 gram, Cetrime 2 mg per 1 gram
        - Drapoline cream | 100 gram (GSL) £1.76
      - **Siopel** (Derma UK Ltd)
        - Cetrime 3 mg per 1 gram, Dimeticone 1000 100 mg per 1 gram
        - Siopel cream | 50 gram (GSL) £4.65
      - **Sudocrem** (Yeovil Uk Ltd)
        - Benzyl cinnamate 1.5 mg per 1 gram, Benzyl alcohol 3.9 mg per 1 gram, Benzyl benzoate 10.1 mg per 1 gram, Wool fat hydrous 40 mg per 1 gram, Zinc oxide 152.5 mg per 1 gram
        - Sudocrem antiseptic healing cream | 30 gram (GSL) £1.45
      - **Tretinol** (Deakin Chemist, London)
        - Benzyl cinnamate 1.5 mg per 1 gram

**Dermatological Drugs \(\Rightarrow\) EMOLLIENTS**

Emollient bath and shower products, antimicrobial-containing

- **INDICATIONS AND DOSE**
  - **DERMOL** ® 200 SHOWER EMOLLIENT
  - Dry and pruritic skin conditions including eczema and dermatitis
    - To the skin
    - Child: To be applied to the skin or used as a soap substitute
  - **DERMOL** ® 600 BATH EMOLLIENT
  - Dry and pruritic skin conditions including eczema and dermatitis
    - To the skin
    - Child 1-2 years: 15–30 mL/bath, not to be used undiluted
    - Child 2-17 years: 5–10 mL/bath, not to be used undiluted
  - **DERMOL** ® WASH EMULSION
  - Dry and pruritic skin conditions including eczema and dermatitis
    - To the skin
    - Child: To be applied to the skin or used as a soap substitute
  - **EMULSIDERM** ®
  - Dry skin conditions including eczema and ichthyosis
    - To the skin
    - Child 1-2 years: 5–10 mL/bath, alternatively, to be rubbed into dry skin until absorbed
    - Child 2-17 years: 7–30 mL/bath, alternatively, to be rubbed into dry skin until absorbed
  - **OLIATUM** ® PLUS
  - Topical treatment of eczema, including eczema at risk from infection
    - To the skin
    - Child 6-11 months: 1 mL/bath, not to be used undiluted
    - Child 1-7 years: 2–3 capfuls/bath, not to be used undiluted

**IMPORTANT SAFETY INFORMATION**

These preparations make skin and surfaces slippery—particular care is needed when bathing.

MHRA/CVM ADVICE (UPDATED DECEMBER 2018): EMOLLIENTS: NEW INFORMATION ABOUT RISK OF SEVERE AND FATAL BURNS WITH PARAFFIN-CONTAINING AND PARAFFIN-FREE EMOLLIENTS

See Emollient and barrier preparations p. 737.

- **DIRECTIONS FOR ADMINISTRATION**
  - Emollient bath additives should be added to bath water; hydration can be improved by soaking in the bath for 10–20 minutes. Some bath emollients can be applied to wet skin undiluted and rinsed off. Emollient preparations contained in tubes should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Preparations containing an antibacterial should be avoided unless infection is present or is a frequent complication.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**Bath additive**

- **CAUTIONARY AND ADVISORY LABELS: 15**
  - **EXCIPIENTS:** May contain Acetylated lanolin alcohols, isopropyl palmitate, polysorbates
Emollient bath and shower products, paraffin-containing

**INDICATIONS AND DOSE**

**AQUAMAX® WASH**

**Dry skin conditions**
- TO THE SKIN
  - Child: To be applied to wet or dry skin and rinse

**CETRABEN® BATH**

**Dry skin conditions, including eczema**
- TO THE SKIN
  - Neonate: 0.5 capful/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1 month–11 years: 0.5–1 capful/bath, alternatively, to be applied to wet skin and rinse
  - Child 12–17 years: 1–2 capfuls/bath, alternatively, to be applied to wet skin and rinse

**DERMALO®**

**Dermatitis | Dry skin conditions, including ichthyosis**
- TO THE SKIN
  - Neonate: 5 mL/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1 month–11 years: 5–10 mL/bath, alternatively, to be applied to wet skin and rinse
  - Child 12–17 years: 15–20 mL/bath, alternatively, to be applied to wet skin and rinse

**DOUBLEBASE® EMOLLIENT BATH ADDITIVE**

**Dry skin conditions including dermatitis and ichthyosis**
- TO THE SKIN
  - Neonate: 5–10 mL/bath.
  - Child 1 month–11 years: 5–10 mL/bath
  - Child 12–17 years: 15–20 mL/bath

**DOUBLETAB® EMOLLIENT SHOWER GEL**

**Dry, chapped, or itchy skin conditions**
- TO THE SKIN
  - Child: To be applied to wet or dry skin and rinse, or apply to dry skin after showering

**DERMAL 600® (Dermal Laboratories Ltd)**

Benzalkonium chloride 5 mg per 1 gram, Isopropyl myristate 250 mg per 1 gram, Liquid paraffin 250 mg per 1 gram
Dermal 600 bath emollient | 600 mL | £7.55

**EMULSIDERM® (Dermal Laboratories Ltd)**

Benzalkonium chloride 5 mg per 1 gram, Isopropyl myristate 250 mg per 1 gram, Liquid paraffin 250 mg per 1 gram
Emulsiderm emollient | 200 mL | £3.85 | 1000 mL | £12.90

**OILATUM PLUS** (GlaxoSmithKline Consumer Healthcare)

Triclosan 20 mg per 1 gram, Benzalkonium chloride 1 mg per 1 gram, Chlorhexidine hydrochloride 1 mg per 1 gram, Isopropyl myristate 25 mg per 1 gram
Oilatum Plus bath additive | 500 mL | £12.22

**Dry skin conditions including eczema, xeroderma, and ichthyosis**
- TO THE SKIN
  - Neonate: 5 mL/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1 month–11 years: 5–10 mL/bath, alternatively, to be applied to wet skin and rinse
  - Child 12–17 years: 15 mL/bath, alternatively, to be applied to wet skin and rinse

**E45® WASH CREAM**

Endogenous and exogenous eczema, xeroderma, and ichthyosis
- TO THE SKIN
  - Child: To be used as a soap substitute

**HYDROMOL® BATH AND SHOWER EMOLLIENT**

**Dry skin conditions | Eczema | Ichthyosis**
- TO THE SKIN
  - Neonate: 0.5 capful/bath, alternatively apply to wet skin and rinse.
  - Child 1 month–11 years: 0.5–2 capfuls/bath, alternatively apply to wet skin and rinse
  - Child 12–17 years: 1–3 capfuls/bath, alternatively apply to wet skin and rinse

**LPL 63.4®**

**Dry skin conditions**
- TO THE SKIN
  - Neonate: 0.5 capful/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1 month–11 years: 0.5–2 capfuls/bath, alternatively, to be applied to wet skin and rinse
  - Child 12–17 years: 1–3 capfuls/bath, alternatively, to be applied to wet skin and rinse

**OILATUM® EMOLLIENT BATH ADDITIVE**

**Dry skin conditions including dermatitis and ichthyosis**
- TO THE SKIN
  - Neonate: 0.5 capful/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1 month–11 years: Apply 0.5–2 capfuls/bath, alternatively, to be applied to wet skin and rinse
  - Child 12–17 years: 1–3 capfuls/bath, alternatively, to be applied to wet skin and rinse

**OILATUM® JUNIOR BATH ADDITIVE**

**Dry skin conditions including dermatitis and ichthyosis**
- TO THE SKIN
  - Neonate: 0.5 capful/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1 month–11 years: 0.5–2 capfuls/bath, alternatively, to be applied to wet skin and rinse
  - Child 12–17 years: 1–3 capfuls/bath, alternatively, to be applied to wet skin and rinse

**QV® BATH OIL**

**Dry skin conditions including eczema, psoriasis, ichthyosis, and pruritus**
- TO THE SKIN
  - Neonate: 5 mL/bath, alternatively, to be applied to wet skin and rinse.
  - Child 1–11 months: 5 mL/bath, alternatively, to be applied to wet skin and rinse
  - Child 1–17 years: 10 mL/bath, alternatively, to be applied to wet skin and rinse
**DIRECTIONS FOR ADMINISTRATION**

Emollient bath additives should be added to bath water; hydration can be improved by soaking in the bath for 10–20 minutes. Some bath emollients can be applied to wet skin undiluted and rinsed off. Emollient preparations contained in tubes should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Bath additive**

**CAUTIONARY AND ADVISORY LABELS**

**EXCIPIENTS:**

- May contain Acetylated lanolin alcohols, ceteareth alcohol (including cetyl and stearyl alcohol), fragrances, isopropyl palmitate
- Cetraben (Genus Pharmaceuticals Ltd)
- Liquid paraffin light 828 mg per 1 gram Cetraben emollient 82.8% bath additive | 500 ml (GSL) £5.75 DT = £5.75
- Dermal (Dermal Laboratories Ltd)
- Acetylated wool alcohols 50 mg per 1 gram, Liquid paraffin 650 mg per 1 gram Dermal bath emollient | 500 ml (GSL) £3.44
- Doublebase (Dermal Laboratories Ltd)
- Liquid paraffin 650 mg per 1 gram Doublebase emollient bath additive | 500 ml (GSL) £5.45 DT = £5.45
- E45 emollient bath (Forum Health Products Ltd)
- Liquid paraffin bath oil | 250 ml (ACBS) £3.30 | 500 ml (ACBS) £5.29
- Hydromol (Alliance Pharmaceuticals Ltd)
- Isopropyl myristate 378 mg per 1 ml Hydromol Bath & Shower emollient | 350 ml £3.91 | 500 ml £4.46 | 1000 ml £8.87
- LPL (Huxley Europe Ltd)
- Liquid paraffin light 634 mg per 1 ml LPL 63.4 bath additive and emollient | 500 ml £3.10 DT = £3.27
- Olatum (GlaxoSmithKline Consumer Healthcare)
- Liquid paraffin light 634 mg per 1 ml Olatum Bath Formula | 150 ml (GSL) £2.95 DT = £2.95 | 300 ml (GSL) £5.02 DT = £5.02
- Olatum Junior (GlaxoSmithKline Consumer Healthcare)
- Liquid paraffin light 634 mg per 1 ml Olatum Junior bath additive | 150 ml (GSL) £2.95 DT = £2.95 | 250 ml (GSL) £4.44 DT = £4.75 | 300 ml (GSL) £5.02 DT = £5.02 | 600 ml (GSL) £6.67 DT = £6.67
- QV (Crawford Healthcare Ltd)
- Liquid paraffin light 850.9 mg per 1 gram QV 85.09% bath oil | 500 ml £2.93 | 500 ml £4.79
- Zerolatum (Thornton & Ross Ltd)
- Acetylated wool alcohols 50 mg per 1 gram, Liquid paraffin 650 mg per 1 gram Zerolatum Bath emollient | 500 ml £4.79
- Gel

**CAUTIONARY AND ADVISORY LABELS**

**EXCIPIENTS:**

- May contain Butylated hydroxytoluene, propylene glycol, Glycerol
- Doublebase (Dermal Laboratories Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram Doublebase emollient shower gel | 200 gram (P) £5.21

**Wash**

**CAUTIONARY AND ADVISORY LABELS**

**EXCIPIENTS:**

- May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), Hydroxybenzoates (parabens), polysorbates
- Aquamax (Intrapharm Laboratories Ltd)
- Aquamax wash | 250 gram £2.99
- E45 emollient wash (Forum Health Products Ltd)
- E45 emollient wash cream | 250 ml (ACBS) £3.30
- QV Gentle (Crawford Healthcare Ltd)
- QV Gentle wash | 250 ml £3.19 | 500 ml £5.32

**IMPORTANT SAFETY INFORMATION**

These preparations make the skin and surfaces slippery—particular care is needed when bathing.

MHRA/CHM ADVICE (UPDATED DECEMBER 2018): EMOLLIENTS:

- NEW INFORMATION ABOUT RISK OF SEVERE AND FATAL BURNS WITH PARAFFIN-CONTAINING AND PARAFFIN-FREE EMOLLIENTS

See Emollient and barrier preparations p. 737.

**DIRECTIONS FOR ADMINISTRATION**

Emollient bath additives should be added to bath water; hydration can be improved by soaking in the bath for 10–20 minutes. Some bath emollients can be applied to wet skin undiluted and rinsed off. Emollient preparations contained in tubes should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Bath additive**

**CAUTIONARY AND ADVISORY LABELS**

**EXCIPIENTS:**

- May contain Acetylated lanolin alcohols, ceteareth alcohol (including cetyl and stearyl alcohol), fragrances, isopropyl palmitate
- Cetraben (Genus Pharmaceuticals Ltd)
- Liquid paraffin light 828 mg per 1 gram Cetraben emollient 82.8% bath additive | 500 ml (GSL) £5.75 DT = £5.75
- Dermal (Dermal Laboratories Ltd)
- Acetylated wool alcohols 50 mg per 1 gram, Liquid paraffin 650 mg per 1 gram Dermal bath emollient | 500 ml (GSL) £3.44
- Doublebase (Dermal Laboratories Ltd)
- Liquid paraffin 650 mg per 1 gram Doublebase emollient bath additive | 500 ml (GSL) £5.45 DT = £5.45
- E45 emollient bath (Forum Health Products Ltd)
- Liquid paraffin bath oil | 250 ml (ACBS) £3.30 | 500 ml (ACBS) £5.29
- Hydromol (Alliance Pharmaceuticals Ltd)
- Liquid paraffin light 378 mg per 1 ml Hydromol Bath & Shower emollient | 350 ml £3.91 | 500 ml £4.46 | 1000 ml £8.87
- QV (Crawford Healthcare Ltd)
- Liquid paraffin light 850.9 mg per 1 gram QV 85.09% bath oil | 500 ml £2.93 | 500 ml £4.79
- Zerolatum (Thornton & Ross Ltd)
- Acetylated wool alcohols 50 mg per 1 gram, Liquid paraffin 650 mg per 1 gram Zerolatum Bath emollient | 500 ml £4.79
- Gel

**CAUTIONARY AND ADVISORY LABELS**

**EXCIPIENTS:**

- May contain Butylated hydroxytoluene, propylene glycol, Glycerol
- Doublebase (Dermal Laboratories Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram Doublebase emollient shower gel | 200 gram (P) £5.21

**Wash**

**CAUTIONARY AND ADVISORY LABELS**

**EXCIPIENTS:**

- May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), Hydroxybenzoates (parabens), polysorbates
- Aquamax (Intrapharm Laboratories Ltd)
- Aquamax wash | 250 gram £2.99
- E45 emollient wash (Forum Health Products Ltd)
- E45 emollient wash cream | 250 ml (ACBS) £3.30
- QV Gentle (Crawford Healthcare Ltd)
- QV Gentle wash | 250 ml £3.19 | 500 ml £5.32

**IMPORTANT SAFETY INFORMATION**

These preparations make the skin and surfaces slippery—particular care is needed when bathing.

MHRA/CHM ADVICE (UPDATED DECEMBER 2018): EMOLLIENTS:

- NEW INFORMATION ABOUT RISK OF SEVERE AND FATAL BURNS WITH PARAFFIN-CONTAINING AND PARAFFIN-FREE EMOLLIENTS

See Emollient and barrier preparations p. 737.
Emollient bath and shower products, tar-containing

**INSTRUCTIONS AND DOSE**

**POLYTAR EMOLLIENT**

**Psoriasis, eczema, atopic and pruritic dermatoses**

▲ TO THE SKIN

▲ Child: 2–4 capfuls/bath, add 15–30 mL to an adult-size bath and proportionally less for a child’s bath; soak for 20 minutes

**PSORIDERM EMULSION**

**Psoriasis**

▲ TO THE SKIN

▲ Child: Up to 30 mL/bath, use 30 mL in adult-size bath, and proportionally less for a child’s bath, soak for 5 minutes

**IMPORTANT SAFETY INFORMATION**

These preparations make skin and surfaces slippery—particular care is needed when bathing.


**DIRECTIONS FOR ADMINISTRATION**

Emollient bath additives should be added to bath water; hydration can be improved by soaking in the bath for 10–20 minutes. Some bath emollients can be applied to wet skin undiluted and rinsed off. Emollient preparations contained in tubs should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Cream**

CAUTIONARY AND ADVISORY LABELS 15

EXCipients: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol)

▲**Dermol** (Dermal Laboratories Ltd)

Benzalkonium chloride 1 mg per 1 gram, Chlorhexidine hydrochloride 1 mg per 1 gram, Isopropyl myristate 100 mg per 1 gram, Liquid paraffin 100 mg per 1 gram Dermol cream | 100 gram | £2.86 | 500 gram | £6.03

**Liquid**

CAUTIONARY AND ADVISORY LABELS 15

EXCipients: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol)

▲**Dermol 500** (Dermal Laboratories Ltd)

Benzalkonium chloride 1 mg per 1 gram, Chlorhexidine hydrochloride 1 mg per 1 gram, Isopropyl myristate 25 mg per 1 gram, Liquid paraffin 25 mg per 1 gram Dermol 500 lotion | 500 mL | £8.04

**Emollient creams and ointments, colloidal oatmeal-containing**

**INSTRUCTIONS AND DOSE**

**Endogenous and exogenous eczema | Xeroderma | Ichthyosis**

▲ TO THE SKIN

▲ Child: (consult product literature)

**IMPORTANT SAFETY INFORMATION**


**DIRECTIONS FOR ADMINISTRATION**

Emollients should be applied immediately after washing or bathing to maximise the effect of skin hydration. Emollient preparations contained in tubs should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Cream and lotion**

CAUTIONARY AND ADVISORY LABELS 15

EXCipients: May contain Benzyl alcohol, Cetostearyl alcohol (including cetyl and stearyl alcohol), Isopropyl palmitate

▲**Aveeno** (Johnson & Johnson Ltd)

Aveeno lotion | 500 mL (ACBS) | £6.66

Aveeno cream | 100 mL (ACBS) | £3.97 | 300 mL (ACBS) | £6.80 | 500 mL (ACBS) | £6.47

**Emollient creams and ointments, antimicrobial-containing**

**INSTRUCTIONS AND DOSE**

**Dem and pruritic skin conditions including eczema and dermatitis**

▲ TO THE SKIN

▲ Child: To be applied to the skin or used as a soap substitute

**IMPORTANT SAFETY INFORMATION**

These preparations make skin and surfaces slippery—particular care is needed when bathing.


**DIRECTIONS FOR ADMINISTRATION**

Emollients should be applied immediately after washing or bathing to maximise the effect of skin hydration. Emollient preparations contained in tubs should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Cream**

CAUTIONARY AND ADVISORY LABELS 15

EXCipients: May contain Benzyl alcohol, Cetostearyl alcohol (including cetyl and stearyl alcohol), Isopropyl palmitate

▲**Aveeno** (Johnson & Johnson Ltd)

Aveeno lotion | 500 mL (ACBS) | £6.66

Aveeno cream | 100 mL (ACBS) | £3.97 | 300 mL (ACBS) | £6.80 | 500 mL (ACBS) | £6.47

**Emollient cream**

**Soya oil 833.5 mg per 1 gram** Zeroneum 83.35% bath additive | 500 mL £4.48
Emollient creams and ointments, paraffin-containing

**Indications and Dose**

Dry skin conditions | Eczema | Psoriasis | Ichthyosis | Pruritus

- To the skin
- Child: (consult product literature)

**Important Safety Information**

MHRA/CHM Advice (Updated December 2018): Emollients

New Information about Risk of Severe and Fatal Burns

MHRA/CHM Advice (Updated December 2018): Emollients

- Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

**Medicinal Forms**

There may be variation in the licensing of different medicines containing the same drug.

**Spray**

- CAUTIONARY AND ADVISORY LABELS 15
- Dermastem (Alliance Pharmaceuticals Ltd)
- Emollin (Leatherhead Medical Ltd)
- Emolfin aerosol spray | 150 ml £4.00 | 240 ml £6.39

**Gel**

- CAUTIONARY AND ADVISORY LABELS 15
- AproDerm (Isopropyl myristate / liquid paraffin) (Fontus Health Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram AproDerm gel | 100 gram £1.99 DT = £2.65 | 500 gram £3.99 DT = £5.83
- Doublebase (Dermal Laboratories Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram Doublebase Daylvee gel | 100 gram | £2.65 DT = £2.65 | 500 gram £6.29 DT = £5.83
- Doublebase gel | 100 gram | £2.65 DT = £2.65 | 500 gram | £5.83 DT = £5.83 | 1000 gram | £10.98
- Doublebase emollient wash gel | 200 gram | £5.21
- Doublebase emollient shower gel | 200 gram | £5.21
- Exmalatum (Ascot Laboratories Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram Exmalatum gel | 500 gram £2.85 DT = £5.83
- HypoBase (Aspire Pharma Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram HypoBase gel | 500 gram £5.83 DT = £5.83
- Myrítica (Galenn Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram Myrítica gel | 100 gram £2.12 DT = £2.65 | 500 ml £4.66
- Zerodouble (Thornton & Ross Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram Zerodouble gel | 100 gram £2.25 DT = £2.65 | 500 gram £4.90 DT = £5.83
- Isomol (Dermato Logical Ltd)
- Isopropyl myristate 150 mg per 1 gram, Liquid paraffin 150 mg per 1 gram isomol gel | 100 gram £1.99 DT = £2.65 | 500 gram £2.92 DT = £5.83

**Cream**

- CAUTIONARY AND ADVISORY LABELS 15
- Aquamol (Thornton & Ross Ltd)
- Aquamol cream | 50 gram £1.22 | 500 gram £6.40
- Cetraben (Thornton & Ross Ltd)
- Liquid paraffin light 105 mg per 1 gram, White soft paraffin 132 mg per 1 gram Cetraben cream | 50 gram £1.40 | 150 gram £3.98 | 500 gram £5.99 | 1000 gram £11.62
- Diprobase (Bayer Plc)
- Diprobase cream | 50 gram £1.28 | 500 gram £6.32
- E45 (Forum Health Products Ltd)
- Wool fat 10 mg per 1 gram, Liquid paraffin light 126 mg per 1 gram, White soft paraffin 145 mg per 1 gram E45 cream | 50 gram GSL £1.93 | 125 gram GSL £3.22 | 350 gram GSL £5.81 | 500 gram GSL £5.99
- Enopen (Enningen Healthcare Ltd)
- Liquid paraffin light 105 mg per 1 gram, White soft paraffin 132 mg per 1 gram Enopen cream | 50 gram £1.40 | 150 gram £3.98 | 500 gram £5.99 | 1000 gram £11.62
- Epaderm (Mohnlycke Health Care Ltd)
- Epaderm cream | 50 gram £3.71 | 150 gram £3.58 | 500 gram £7.01
- Epimask cream (Dermato Logical Ltd)
- Epimask cream | 100 gram £0.75 | 500 gram £2.49
- ExCetra (Dermato Logical Ltd)
- Liquid paraffin light 105 mg per 1 gram, White soft paraffin 132 mg per 1 gram ExCetra cream | 100 gram £1.75 | 500 gram £2.95
- ExmaQS (Ascot Laboratories Ltd)
- Liquid paraffin light 60 mg per 1 gram, White soft paraffin 150 mg per 1 gram ExmaQS cream | 500 gram £2.95
- Exmalatum (Ascot Laboratories Ltd)
- Liquid paraffin light 105 mg per 1 gram, White soft paraffin 150 mg per 1 gram Exmalatum cream | 500 gram £4.25
- Lipobase (LEO Pharma)
- Lipobase cream | 50 gram | £1.46
- Outilum (GlaxoSmithKline Consumer Healthcare)
- Liquid paraffin light 60 mg per 1 gram, White soft paraffin 150 mg per 1 gram Outilum cream | 150 gram GSL £3.06 DT + £3.06 | 500 ml GSSL £5.28 DT + £5.28
- Outilum Junior (GlaxoSmithKline Consumer Healthcare)
- Liquid paraffin light 60 mg per 1 gram, White soft paraffin 150 mg per 1 gram Outilum Junior cream | 150 gram GSSL £3.06 DT + £3.06 | 350 ml GSSL £4.65 DT + £4.65 | 500 ml GSSL £5.28 DT + £5.28
- Soffen (Vitame Ltd)
- Liquid paraffin light 105 mg per 1 gram, White soft paraffin 132 mg per 1 gram Soffen cream | 500 gram £4.79
- Unguentum M (Almirall Ltd)
- Unguentum M cream | 100 gram GSSL £2.78 | 500 gram GSSL £8.48
- ZeroAQ5 (Thornton & Ross Ltd)
- ZeroAQ5 emollient cream | 500 gram £3.29
- ZeroBase (Thornton & Ross Ltd)
- Liquid paraffin 110 mg per 1 gram ZeroBase 11% cream | 50 gram £1.04 | 500 gram £5.26
- Zerocream (Thornton & Ross Ltd)
- Liquid paraffin 126 mg per 1 gram, White soft paraffin 145 mg per 1 gram Zerocream | 50 gram £1.17 | 500 gram £4.08
- Zeroguent (Thornton & Ross Ltd)
- White soft paraffin 40 mg per 1 gram, Soya oil 50 mg per 1 gram, Liquid paraffin light 80 mg per 1 gram Zeroguent cream | 100 gram £2.33 | 500 gram £6.99

**Ointment**

- CAUTIONARY AND ADVISORY LABELS 15
- EXCIPIENTS: May contain Ceteostearyl alcohol (including cetyl) and stearyl alcohol), polyesters
- Emollient creams and ointments, paraffin-containing (Non-proprietary)
- Liquid paraffin 200 mg per 1 gram, Emulsifying wax 300 mg per 1 gram, White soft paraffin 500 mg per 1 gram Emulsifying ointment | 100 gram GSSL £6.09
- Liquid paraffin 500 mg per 1 gram, White soft paraffin 500 mg per 1 gram White soft paraffin 50% / Liquid paraffin 50% ointment | 250 gram £1.92 | 500 gram £3.22 | 500 gram £4.32 DT + £4.57 | 500 gram £4.57 DT + £4.57
- Magnesium sulfate dried 5 mg per 1 gram, Phenoxyethanol 10 mg per 1 gram, Wool alcohols ointment 500 mg per 1 gram Aquaderm Hydrous ointment | 500 gram £4.15
- Hydrous ointment | 500 gram GSSL £7.00
- White soft paraffin 1 mg per 1 gram, White soft paraffin solid | 500 gram GSSL £5.08 DT + £4.00 | 4500 gram GSSL £22.50-£36.00
- Yellow soft paraffin 1 mg per 1 gram Yellow soft paraffin solid | 15 gram GSSL £1.12 | 500 gram GSSL £39.80 DT + £39.80 | 4500 gram GSSL £21.56
Dry and scaling skin disorders

**DERMATONICS ONCE HEEL BALM®**

**Dry skin on soles of feet**

- TO THE SKIN
- Child 12–17 years: Apply once daily

**E45® ITCH RELIEF CREAM**

- Dry, scaling, and itching skin
- TO THE SKIN
- Child: Apply twice daily

**EUCERIN® INTENSIVE CREAM**

- Dry skin conditions including eczema, ichthyosis, xeroderma, and hyperkeratosis
- TO THE SKIN
- Child: Apply twice daily, to be applied thinly and rubbed into area

**EUCERIN® INTENSIVE LOTION**

- Dry skin conditions including eczema, ichthyosis, xeroderma, and hyperkeratosis
- TO THE SKIN
- Child: Apply twice daily, to be applied sparingly and rubbed into area

**FLEXITOL®**

- Dry skin on soles of feet and heels
- TO THE SKIN
- Child 12–17 years: Apply 1–2 times a day

**HYDROMOL® INTENSIVE**

- Dry, scaling, and itching skin
- TO THE SKIN
- Child: Apply twice daily, to be applied thinly

**IMUERM® EMOLLIENT**

- Dry skin conditions including eczema, psoriasis or dermatitis
- TO THE SKIN
- Child: Apply to skin or use as a soap substitute

**NUTRAPLUS®**

- Dry, scaling, and itching skin
- TO THE SKIN
- Child: Apply 2–3 times a day

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**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE (UPDATED DECEMBER 2018): EMOLLIENTS: NEW INFORMATION ABOUT RISK OF SEVERE AND FATAL BURNS WITH PARAFFIN-CONTAINING AND PARAFFIN-FREE EMOLLIENTS

See Emollient and barrier preparations p. 737.

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**DRUG ACTION** Urea is a keratin softener and hydrating agent used in the treatment of dry, scaling conditions (including ichthyosis) and may be useful in elderly patients.

**INDICATIONS AND DOSE**

- AQUADRATE®
- Dry, scaling, and itching skin
  - TO THE SKIN
  - Child: Apply twice daily, to be applied thinly

- BALNEUM® CREAM
- Dry skin conditions
  - TO THE SKIN
  - Child: Apply twice daily

- BALNEUM® PLUS CREAM
- Dry, scaling, and itching skin
  - TO THE SKIN
  - Child: Apply twice daily

- CALMURID®
- Dry, scaling, and itching skin
  - TO THE SKIN
  - Child: Apply twice daily, apply a thick layer for 3–5 minutes, massage into area, and remove excess. Can be diluted with aqueous cream (life of diluted cream is 14 days). Half-strength cream can be used for 1 week if stinging occurs

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**EMOLLIENTS, UREA-CONTAINING**

- **DIRECTIONS FOR ADMINISTRATION** Emollients should be applied immediately after washing or bathing to maximise the effect of skin hydration. Emollient preparations contained in tubes should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient. Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Cream**
  - CAUTIONARY AND ADVISORY LABELS 15
  - EXCIPIENTS: May contain benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), hydroxybenzoates (parabens), isopropyl palmitate, polysorbates, propylene glycol, woad and related substances (including lanolin)

  - **Aquadrate (Alliance Pharmaceuticals Ltd)**
    - Urea 100 mg per 1 gram Aquadrate 10% cream | 30 gram £1.64 | 100 gram £4.40
    - Balneum (Almirall Ltd)
      - Balneum cream | 50 gram £2.85 | 500 gram £9.97
      - Balneum Plus (Almirall Ltd)
        - Lauromacrocols 30 mg per 1 gram, Urea 50 mg per 1 gram Balneum Plus cream | 100 gram £3.29 DT = £4.28 | 500 gram £14.99 DT = £14.99

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**INDICATIONS AND Dose**

- AQUADRATE®
- Dry, scaling, and itching skin
  - TO THE SKIN
  - Child: Apply twice daily, to be applied thinly

- BALNEUM® CREAM
- Dry skin conditions
  - TO THE SKIN
  - Child: Apply twice daily

- BALNEUM® PLUS CREAM
- Dry, scaling, and itching skin
  - TO THE SKIN
  - Child: Apply twice daily

- CALMURID®
- Dry, scaling, and itching skin
  - TO THE SKIN
  - Child: Apply twice daily, apply a thick layer for 3–5 minutes, massage into area, and remove excess. Can be diluted with aqueous cream (life of diluted cream is 14 days). Half-strength cream can be used for 1 week if stinging occurs


2 Infections of the skin

Skin infections

Antibacterial preparations for the skin

Topical antibacterial preparations are used to treat localised bacterial skin infections caused by Gram-positive organisms (particularly by staphylococci or streptococci). Systemic antibacterial treatment is more appropriate for deep-seated infections (particularly by staphylococci or streptococci). Systemic antibacterials are used to treat wounds infected with anaerobic bacteria. Superficial bacterial infection of the skin may be treated with a topical antiseptic such as povidone-iodine p. 303.

Problems associated with the use of topical antibacterials include bacterial resistance, contact sensitisation, and superinfection. In order to minimise the development of resistance, antibacterials used systemically (e.g. fusidic acid p. 371) should not generally be chosen for topical use. Resistant organisms are more common in hospitals, and whenever possible swabs should be taken for bacteriological examination before beginning treatment.

Neomycin sulfate p. 746 applied topically may cause sensitisation and cross-sensitivity with other aminoglycoside antibacterials such as gentamicin p. 322 may occur. Topical antibacterials applied over large areas can cause systemic toxicity; otoxicity with neomycin sulfate and with polymyxins p. 747 is a particular risk for neonates and children with renal impairment. Superficial bacterial infection of the skin may be treated with a topical antiseptic such as povidone-iodine p. 784 which also softens crusts, or hydrogen peroxide 1% cream p. 786.

Bacterial infections such as impetigo and folliculitis can be treated with a short course of topical fusidic acid; mupirocin p. 748 should be used only to treat meticillin-resistant Staphylococcus aureus.

For extensive or long-standing impetigo, an oral antibacterial such as flexifloxacin p. 357 (or clarithromycin p. 340 in children with penicillin-allergy) should be used. A mild antiseptic may help to soften crusts. Mild antiseptics may be useful in reducing the spread of infection, but there is little evidence to support the use of topical antiseptics alone in the treatment of impetigo.

Cellulitis, a rapidly spreading deeply seated inflammation of the skin and subcutaneous tissue, requires systemic antibacterial treatment. Lower leg infections or infections spreading around wounds are almost always cellulitis. Erysipelas, a superficial infection with clearly defined edges (and often affecting the face), is also treated with a systemic antibacterial.

Staphylococcal scaled-skin syndrome requires urgent treatment with a systemic antibacterial, such as fluclaxacillin.

Mupirocin is not related to any other antibacterial in use; it is effective for skin infections, particularly those due to Gram-positive organisms but it is not indicated for pseudomonal infection. Although Staphylococcus aureus strains with low-level resistance to mupirocin are emerging, it is generally useful in infections resistant to other antibacterials. To avoid the development of resistance, mupirocin or fusidic acid should not be used for longer than 10 days and local microbiology advice should be sought before using it in hospital. In the presence of mupirocin-resistant MRSA infection, a topical antiseptic, such as povidone-iodine, chlorhexidine p. 785, or alcohol, can be used; their use should be discussed with the local microbiologist.

Mupirocin ointment contains macrogols; extensive absorption of macrogols through the mucous membranes or through application to thin or damaged skin may result in renal toxicity, especially in neonates. Mupirocin nasal ointment is formulated in a paraffin base and may be more suitable for the treatment of MRSA-infected open wound in neonates.

Metronidazole gel p. 746 is used topically in children to reduce the odour associated with anaerobic infections and for the treatment of periorificial rosacea; oral metronidazole is used to treat wounds infected with anaerobic bacteria. Silver sulfadiazine p. 747 is licensed for the prevention and treatment of infection in burns but the use of appropriate dressings may be more effective. Systemic effects may occur following extensive application of silver sulfadiazine; its use is not recommended in neonates.

Antibacterial preparations also used systemically

Fusidic acid is a narrow-spectrum antibacterial used for staphylococcal infections. Fusidic acid has a role in the treatment of impetigo.

An ointment containing fusidic acid is used in the fissures of angular cheilitis when associated with staphylococcal infection. See Oropharyngeal fungal infections p. 733 for further information on angular cheilitis.

Metronidazole is used topically to treat rosacea and to reduce the odour associated with anaerobic infections; oral metronidazole is used to treat wounds infected with anaerobic bacteria.

Antifungal preparations for the skin

Most localised fungal infections are treated with topical preparations. To prevent relapse, local antifungal treatment should be continued for 1–2 weeks after the disappearance of all signs of infection. Systemic therapy is necessary for scalp infection or if the skin infection is widespread, disseminated or intractable; although topical therapy may be used to treat some nail infections, systemic therapy is more effective. Specimens of scale, nail or hair should be sent for mycological examination before starting treatment, unless the diagnosis is certain.

Dermatophytes

Ringworm infection can affect the scalp (tinea capitis), body (tinea corporis), groin (tinea cruris), hand (tinea manus), foot (tinea pedis, athlete’s foot), or nail (tinea unguium, onychomycosis). Tinea capitis is a common childhood...
infection that requires systemic treatment with an oral antifungal; additional application of a topical antifungal, during the early stages of treatment, may reduce the risk of transmission. A topical antifungal can also be used to treat asymptomatic carriers of scalp ringworm.

Tinea corporis and tinea pedis infections in children respond to treatment with a topical imidazole (clotrimazole p. 748, econazole nitrate p. 748, or miconazole p. 749) or terbinafine cream p. 750. Nystatin p. 734 is less effective against tinea.

Compound benzoic acid ointment (Whitfield’s ointment) has been used for ringworm infections but it is cosmetically less acceptable than proprietary preparations. Antifungal dusting powders are of little therapeutic value in the treatment of fungal skin infections and may cause skin irritation; they may have some role in preventing re-infection.

Antifungal treatment may not be necessary in asymptomatic children with tinea infection of the nails. If treatment is necessary, a systemic antifungal is more effective than topical therapy. However, topical application of toconazole p. 749 may be useful for treating early onychomycosis when involvement is limited to mild distal disease, or for superficial white onychomycosis, or where there are contra-indications to systemic therapy. Chronic paronychia on the fingers (usually due to a candidal infection) should be treated with topical clotrimazole or nystatin, but these preparations should be used with caution in children who suck their fingers. Chronic paronychia of the toes (usually due to dermatophyte infection) can be treated with topical terbinafine.

Pityriasis versicolor

Pityriasis (tinea) versicolor can be treated with ketoconazole shampoo p. 749 or selenium sulfide shampoo. Topical imidazole antifungals such as clotrimazole, econazole nitrate and miconazole or topical terbinafine are alternatives, but large quantities may be required.

If topical therapy fails, or if the infection is widespread, pityriasis versicolor is treated systemically with an azole antifungal. Relapse is common, especially in the immunocompromised.

Candidiasis

Candidal skin infections can be treated with topical imidazole antifungals clotrimazole p. 748, econazole nitrate p. 748, or miconazole p. 749; topical terbinafine p. 750 is an alternative. Topical application of nystatin p. 734 is also effective for candidiasis but it is ineffective against dermatoophytosis. Refractory candidiasis requires systemic treatment generally with a triazole such as fluconazole p. 389; systemic treatment with griseofulvin p. 394 or terbinafine is not appropriate for refractory candidiasis. See the treatment of oral candidiasis and for the management of nappy rash.

Angular cheilitis

Miconazole cream is used in the fissures of angular cheilitis when associated with Candida.

Compound topical preparations

Combination of an imidazole and a mild corticosteroid (such as hydrocortisone 1% p. 762) may be of value in the treatment of eczematous intertrigo and, in the first few days only, of a severely inflamed patch of ringworm. Combination of a mild corticosteroid with either an imidazole or nystatin may be of use in the treatment of intertriginous eczema associated with candida.

Antiviral preparations for the skin

Aciclovir cream p. 753 is used for the treatment of initial and recurrent labial, cutaneous, and genital herpes simplex infections in children; treatment should begin as early as possible. Systemic treatment is necessary for buccal or vaginal infections or if cold sores recur frequently.

Herpes labialis

Aciclovir cream can be used for the treatment of initial and recurrent labial herpes simplex infections (cold sores). It is best applied at the earliest possible stage, usually when prodromal changes of sensation are felt in the lip and before vesicles appear. Penciclovir cream is also licensed for the treatment of herpes labialis; it needs to be applied more frequently than aciclovir cream.

Parasiticidal preparations for the skin

| Suitable quantities of parasiticidal preparations |
|---|---|---|---|---|
| Area of body | Skin creams | Lotions | Cream rinses |
| Scalp | Skin creams | 50–100 mL | |
| Body | Skin creams | 50–100 mL | |
| Body (scabies) | 30–60 g | 100 mL | |
| Body (crab lice) | 30–60 g | 100 mL | |

These amounts are usually suitable for a child 12–17 years for single application.

Scabies

Permethrin p. 752 is used for the treatment of scabies (Sarcoptes scabiei); malathion p. 752 can be used if permethrin is inappropriate.

Benzyl benzoate is an irritant and should be avoided in children; it is less effective than malathion and permethrin. Ivermectin p. 398 (available from ‘special-order’ manufacturers or specialist importing companies) by mouth has been used, in combination with topical drugs, for the treatment of hyperkeratotic (crusted or ‘Norwegian’) scabies that does not respond to topical treatment alone.

Application

Although acaricides have traditionally been applied after a hot bath, this is not necessary and there is even evidence that a hot bath may increase absorption into the blood, removing them from their site of action on the skin. All members of the affected household should be treated simultaneously. Treatment should be applied to the whole body including the scalp, neck, face, and ears. Particular attention should be paid to the webs of the fingers and toes and lotion brushed under the ends of nails. It is now recommended that malathion and permethrin should be applied twice, one week apart; in the case of benzyl benzoate in adults, up to 3 applications on consecutive days may be needed. It is important to warn users to reapply treatment to the hands if they are washed. Patients with hyperkeratotic scabies may require 2 or 3 applications of acaricide on consecutive days to ensure that enough penetrates the skin crusts to kill all the mites.

Itching

The itch and eczema of scabies persists for some weeks after the infestation has been eliminated and treatment for pruritus and eczema may be required. Application of crotamiton p. 775 can be used to control itching after treatment with more effective acaricides. A topical corticosteroid may help to reduce itch and inflammation after scabies has been treated successfully; however, persistent symptoms suggest that scabies eradication was not successful. Oral administration of a sedating antihistamine at night may also be useful.

Head lice

Dimeticon p. 752 is effective against head lice (Pediculus humanus capitis) and acts on the surface of the organism. Malathion, an organophosphorus insecticide, is an alternative, but resistance has been reported. Benzyl benzoate is licensed for the treatment of head lice but it is not recommended for use in children.

Head lice infestation (pediculosis) should be treated using lotion or liquid formulations only if live lice are present.
Shampoos are diluted too much in use to be effective. A contact time of 8–12 hours or overnight treatment is recommended for lotions and liquids; a 2-hour treatment is not sufficient to kill eggs.

In general, a course of treatment for head lice should be 2 applications of product 7 days apart to kill lice emerging from any eggs that survive the first application. All affected household members should be treated at the same time.

**MHRA/CHM advice: Head lice eradication products: risk of serious burns if treated hair is exposed to open flames or other sources of ignition (March 2018)**

Some products for the eradication of head lice infestations are combustible/flammable when on the hair and can ignite and cause serious harm in the presence of an open flame or other source of ignition such as when lighting cigarettes.

Patients and carers should be advised on the safe and correct use of head lice eradication treatments and if appropriate, should be advised that they should not smoke around treated hair and that it should be kept away from open flames or other sources of ignition, including in the morning after overnight application until hair is washed.

**Wet combing methods**

Head lice can be mechanically removed by combing wet hair meticulously with a plastic detection comb (probably for at least 30 minutes each time) over the whole scalp at 4-day intervals for a minimum of 2 weeks, and continued until no lice are found on 3 consecutive sessions; hair conditioner or vegetable oil can be used to facilitate the process. Several devices for the removal of head lice such as combs and topical solutions, are available and some are prescribable on the NHS.

The Drug Tariffs can be accessed online at:

- National Health Service Drug Tariff for England and Wales: [www.ppa.org.uk/ppa/edit_intro.htm](http://www.ppa.org.uk/ppa/edit_intro.htm)
- Health and Personal Social Services for Northern Ireland Drug Tariff: [www.hsbusines.hscni.net/services/2034.htm](http://www.hsbusines.hscni.net/services/2034.htm)

**Crab lice**

Permethrin and malathion are used to eliminate crab lice (*Pthirus pubis*); permethrin is not licensed for treatment of crab lice in children under 18 years. An aqueous preparation should be applied, allowed to dry naturally and washed off after 12 hours; a second treatment is needed after 7 days to kill lice emerging from surviving eggs. All surfaces of the body should be treated, including the scalp, neck, and face (paying particular attention to the eyebrows and other facial hair). A different insecticide should be used if a course of treatment fails.

**Parasiticidal preparations**

Dimeticone p. 752 coats head lice and interferes with water balance in lice by preventing the excretion of water; it is less active against eggs and treatment should be repeated after 7 days.

Malathion p. 752 is recommended for scabies, head lice and crab lice. The risk of systemic effects associated with 1–2 applications of malathion is considered to be very low; however, except in the treatment of hyperkeratotic scabies in children, applications of malathion liquid repeated at intervals of less than 1 week or application for more than 3 consecutive weeks should be avoided since the likelihood of eradication of lice is not increased.

Permethrin p. 752 is effective for scabies. It is also active against head lice but the formulation and licensed methods of application of the current products make them unsuitable for the treatment of head lice. Permethrin is also effective against crab lice but it is not licensed for this purpose in children under 18 years.
**ANTIBACTERIALS > POLYMIXINS**

### Polymixins

- **INDICATIONS AND DOSE**
  - **Bacterial skin infections**
    - **Child**: Apply twice daily, may be applied more frequently if required

- **SIDE-EFFECTS**
  - Sensitisation

- **MEDICINAL FORMS**
  - No licensed medicines listed.

**ANTIBACTERIALS > SULFONAMIDES**

### Silver sulfadiazine

- **INDICATIONS AND DOSE**
  - **Prophylaxis and treatment of infection in burn wounds**
    - **Child**: Apply daily, may be applied more frequently if very exudative

For conservative management of finger-tip injuries

- **INTERACTIONS**
  - Appendices 1: polymyxins

Adjunct to prophylaxis of infection in skin graft donor sites and extensive abrasions

- **SIDE-EFFECTS**
  - Leucopenia - skin reactions

- **ALLERGY AND CROSS-SENSITIVITY**
  - Contra-indicated in patients with sensitivity to sulfonamides.

- **PREGNANCY**
  - Risk of neonatal haemolysis and methaemoglobinemia in third trimester.

- **BREAST FEEDING**
  - Small risk of kernicterus in jaundiced infants and of haemolysis in G6PD-deficient infants.
ANTIFUNGALS > IMIDAZOLE ANTIFUNGALS

Clotrimazole

**INDICATIONS AND DOSE**

Fungal skin infections
- **TO THE SKIN**
  - **Child:** Apply 2–3 times a day

**CAUTIONS**

Contact with eyes and mucous membranes should be avoided

**INTERACTIONS**

→ Appendix 1: antifungals, azoles

**SIDE-EFFECTS**

Oedema - pain - paraesthesia - skin reactions - syncope

**PREGNANCY**

Minimal absorption from skin; not known to be harmful.

**PRESCRIBING AND DISPENSING INFORMATION**

Spray may be useful for application of clotrimazole to large or hairy areas of the skin.

**PATIENT AND CARER ADVICE**

Medicines for Children leaflet: Clotrimazole for fungal infections

www.medicinesforchildren.org.uk/clotrimazole-fungal-infections

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Cream**

**EXCIPIENTS:** May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates, propylene glycol

- **Flamazine (Smith & Nephew Healthcare Ltd)**
  - Sulfadiazine silver 10 mg per 1 gram Flamazine 1% cream |
    - 20 gram (£2.91) |
    - 50 gram (£3.85 DT = £3.65) |
    - 250 gram (£10.32 DT = £10.32) |
    - 500 gram (£18.27 DT = £18.27)

**Econazole nitrate**

**INDICATIONS AND DOSE**

Fungal skin infections
- **TO THE SKIN**
  - **Child:** Apply twice daily

**SIDE-EFFECTS**

- Common or very common: Pain, skin reactions
- Uncommon: Swelling
- Frequency not known: Angioedema

**PREGNANCY**

Treatment should be discontinued if side-effects are severe.

**PRESCRIBING AND DISPENSING INFORMATION**

Avoid contact with eyes and mucous membranes

**CAUTIONS**

Avoid contact with eyes and mucous membranes

**SIDE-EFFECTS**

- Common or very common: Pain, skin reactions
- Uncommon: Swelling
- Frequency not known: Angioedema

**PREGNANCY**

Minimal absorption from skin; not known to be harmful.

**Other drugs used for Fungal skin infections**
Griseofulvin, p. 394 - Hydrocortisone with clotrimazole, p. 766
Ketoconazole

02-Apr-2019

- **INDICATIONS AND DOSE**
  - **Treatment of seborrhoeic dermatitis and dandruff**
    - TO THE SKIN USING SHAMPOO
    - Child 12-17 years: Apply twice weekly for 2–4 weeks, leave preparation on for 3–5 minutes before rinsing
  - **Prophylaxis of seborrhoeic dermatitis and dandruff**
    - TO THE SKIN USING SHAMPOO
    - Child 12-17 years: Apply once daily for maximum 5 days, leave preparation on for 3–5 minutes before rinsing
  - **Treatment of pityriasis versicolor**
    - TO THE SKIN USING SHAMPOO
    - Child 12-17 years: Apply once daily for up to 3 days before sun exposure, leave preparation on for 3–5 minutes before rinsing

- **CONTRA-INDICATIONS** Acute porphyrias p. 624
- **CAUTIONS** Avoid contact with eyes - avoid contact with mucous membranes
- **INTERACTIONS** Appendix 1: antifungals, azoles
- **SIDE-EFFECTS**
  - Common or very common
  - Skin reactions
  - Uncommon
  - Alopecia - angioedema - excessive tearing - folliculitis - hair changes
  - Rare or very rare
  - Eye irritation - taste altered
- **EXCEPTIONS TO LEGAL CATEGORY**
  - For Seborrhoeic dermatitis and dandruff Can be sold to the public for the prevention and treatment of dandruff and seborrhoeic dermatitis of the scalp as a shampoo formulation containing ketoconazole maximum 2%, in a pack containing maximum 120 mL and labelled to show a maximum frequency of application of once every 3 days.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension
  - **Shampoo**
    - Ketoconazole 20 mg per 1 gram
    - 120 mL (£3.36 DT - £3.36)
    - Dandravil (Transdermal Ltd)
    - Ketoconazole 20 mg per 1 gram
    - 120 mL (£3.39 DT - £3.36)
  - **Cream**
    - Ketoconazole 2% cream
    - 15 gram (£2.51) 30 gram (£1.82 DT - £1.82)
    - Gyno-Daktarin (Janssen-Cilag Ltd)
    - Miconazole nitrate 20 mg per 1 gram
    - 15 g (£4.33 DT - £4.33)
      - Gyno-Pevaryl (Janssen-Cilag Ltd, Thornton & Ross Ltd)

- **UNLICENSED USE** Licensed for use in children (age range not specified by manufacturer).
- **CAUTIONS** Avoid in Acute porphyrias p. 624 - contact with eyes and mucous membranes should be avoided
- **INTERACTIONS** Appendix 1: antifungals, azoles
- **SIDE-EFFECTS**
  - Uncommon
  - Skin reactions
  - Frequency not known
- **PREGNANCY** Absorbed from the skin in small amounts; manufacturer advises caution.
- **BREAST FEEDING** Manufacturer advises caution—no information available.
- **PROFESSION SPECIFIC INFORMATION**
  - Dental practitioners’ formulary
  - Miconazole cream may be prescribed.
- **INTERNATIONAL FUNDING/ACCESS DECISIONS**
  - NHS restrictions Daktarin® powder and Daktarin® cream 15 g is not prescribable in NHS primary care.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**
    - Daktarin® powder and Daktarin® cream
    - 15 g (£2.95 DT - £2.95)
    - Gyno-Daktarin 2% vaginal cream
    - 78 gram (£4.33 DT - £4.33)
  - **Paint**
    - Tioconazole 283 mg per 1 mL
    - Ticogal 283mg/ml medicated nail lacquer
      - 12 mL (£27.38 - £28.74 DT - £28.74)
    - Trosyl (Pfizer Ltd)
    - Tioconazole 283 mg per 1 mL
      - Trosyl 283mg/ml nail solution
      - 12 mL (£27.38 DT - £28.74)

Tioconazole

02-Apr-2019

- **INDICATIONS AND DOSE**
  - **Fungal nail infections**
    - By transungual application
    - Child: Apply twice daily usually for up to 6 months (may be extended to 12 months), apply to nails and surrounding skin

- **UNLICENSED USE** Licensed for use in children (age range not specified by manufacturer).
- **CAUTIONS** Contact with eyes and mucous membranes should be avoided - use with caution if child likely to suck affected digits
- **SIDE-EFFECTS**
  - Common or very common
  - Peripheral oedema
  - Uncommon
  - Skin reactions
  - Frequency not known
  - Nail disorder - pain - paraesthesia - peri-orbital oedema
- **PREGNANCY** Manufacturer advises avoid.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Paint**
    - Tioconazole (Non-proprietary)
    - Tioconazole 283 mg per 1 mL
      - Ticogal 283mg/ml medicated nail lacquer
      - 12 mL (£27.38 - £28.74 DT - £28.74)
    - Trosyl (Pfizer Ltd)
    - Tioconazole 283 mg per 1 mL
      - Trosyl 283mg/ml nail solution
      - 12 mL (£27.38 DT - £28.74)

Miconazole

02-Apr-2019

- **INDICATIONS AND DOSE**
  - **Fungal skin infections**
    - TO THE SKIN
    - Neonate: Apply twice daily continuing for 10 days after lesions have healed.
ANTIFUNGALS

Amorolfine

**INDICATIONS AND DOSE**

**Fungal nail infections**
- By transungual application
  - Child 1 month-11 years: Apply 1–2 times a week for 6 months to treat finger nails and for toe nails 9–12 months (review at intervals of 3 months), apply to infected nails after filing and cleansing, allow to dry for approximately 3 minutes
  - Child 12-17 years: Apply 1–2 times a week for 6 months to treat finger nails and for toe nails 9–12 months (review at intervals of 3 months), apply to infected nails after filing and cleansing, allow to dry for approximately 3 minutes
- Child 17 years (body-weight 10-19 kg): 62.5 mg once daily for 2-4 weeks
- Child 17 years (body-weight 20-39 kg): 125 mg once daily for 2-4 weeks
- Child 17 years (body-weight 40 kg and above): 250 mg once daily for 2-4 weeks

**SIDE-EFFECTS**
- Rare or very rare
  - Nail discolouration
  - Skin reactions
- Uncommon
  - Photosensitivity reaction
  - Malaise

**INTERACTIONS**
- Table 1: terbinafine

**MEDICINAL FORMS**

**Medicated nail lacquer**

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Strength</th>
<th>Price (UK)</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loceryl</td>
<td>5%</td>
<td>£7.26</td>
<td>5 ml (Pom)</td>
</tr>
<tr>
<td>Loceryl</td>
<td>5%</td>
<td>£7.08</td>
<td>5 ml (Pom)</td>
</tr>
<tr>
<td>Omicur</td>
<td>5%</td>
<td>£9.09</td>
<td>5 ml (Pom)</td>
</tr>
</tbody>
</table>

**Terbinaine**

**INDICATIONS AND DOSE**

**Tinea pedis**
- TO THE SKIN USING CREAM
  - Child: Apply 1–2 times a day for up to 1 week, to be applied thinly
- BY MOUTH USING TABLETS
  - Child 1 month-11 years (body-weight 10-19 kg): 62.5 mg once daily for 2–6 weeks
  - Child 1-17 years (body-weight 20-39 kg): 125 mg once daily for 2–6 weeks
  - Child 17 years (body-weight 40 kg and above): 250 mg once daily for 2-6 weeks

**Tinea corporis**
- TO THE SKIN USING CREAM
  - Child: Apply 1–2 times a day for up to 1–2 weeks, to be applied thinly, review treatment after 2 weeks
- BY MOUTH USING TABLETS
  - Child 17 years (body-weight 10-19 kg): 62.5 mg once daily for 4 weeks
  - Child 17 years (body-weight 20-39 kg): 125 mg once daily for 4 weeks
  - Child 17 years (body-weight 40 kg and above): 250 mg once daily for 4 weeks

**SIDE-EFFECTS**
- Rare or very rare
  - Nausea
  - Smell altered
  - Tinnitus

**INTERACTIONS**
- Table 1: terbinafine

**UNLICENSED USE**
- Not licensed for use in children under 12 years.
- Avoid contact with ears.
- Avoid contact with eyes and mucous membranes.

**PATIENT AND CARER ADVICE**

- Avoid nail varnish or artificial nails during treatment.
- Avoid contact with ears.
- Avoid contact with eyes and mucous membranes.

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**Tinea cruris**

- TO THE SKIN USING CREAM
  - Child: Apply 1–2 times a day for up to 1–2 weeks, to be applied thinly, review treatment after 2 weeks

**Tinea capitis**

- BY MOUTH USING TABLETS
  - Child 1-17 years (body-weight 10-19 kg): 62.5 mg once daily for 4 weeks
  - Child 17 years (body-weight 20-39 kg): 125 mg once daily for 4 weeks
  - Child 17 years (body-weight 40 kg and above): 250 mg once daily for 4 weeks

**Dermatophyte infections of the nails**

- BY MOUTH USING TABLETS
  - Child 1-17 years (body-weight 10-19 kg): 62.5 mg once daily for 6 weeks-3 months (occasionally longer in toenail infections)
  - Child 17 years (body-weight 20-39 kg): 125 mg once daily for 6 weeks-3 months (occasionally longer in toenail infections)
  - Child 17 years (body-weight 40 kg and above): 250 mg once daily for 6 weeks-3 months (occasionally longer in toenail infections)

**Cutaneous candidiasis| Pityriasis versicolor**

- TO THE SKIN USING CREAM
  - Child: Apply 1–2 times a day for 2 weeks, to be applied thinly, review treatment after 2 weeks

**SIDE-EFFECTS**
- Rare or very rare
  - Nausea
  - Smell altered
  - Tinnitus

**INTERACTIONS**
- Table 1: terbinafine

**UNLICENSED USE**
- Not licensed for use in children.

**CAUTIONS**
- With oral use autoimmune disease (risk of lupus-erythematosus-like effect)
- With topical use contact with eyes and mucous membranes.

**SPECIFIC SIDE-EFFECTS**
- Metabolic disturbance
- Gastrointestinal symptoms
- Skin reactions
- Skin reactions

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**Terbinafine**

**INDICATIONS AND DOSE**

23-Apr-2018
### ANTIMYCOTICS AND ANTIFUNGALS

#### Develasome

**INDICATIONS AND DOSE**
- **TREATMENT**
  - **TREATMENT OF TINEA PEDIS**
    - CHILD: Apply twice daily, continuing for 7 days after lesions have healed
  - **PREVENTION OF TINEA PEDIS**
    - CHILD: Apply once daily

**SIDE-EFFECTS**
- Rare or very rare Skin irritation, hypersensitivity, skin reactions

**CAUTIONS**
- Avoid broken skin, contact with eyes should be avoided, contact with mucous membranes should be avoided

**LICENSED USE**
- Mycopharma licensed for use in children (age range not specified by manufacturer)

**UNLICENSED USE**
- Mycopharma licensed for use in children

**LICENSED USE**
- Mycopharma licensed for use in children

**UNLICENSED USE**
- Mycopharma licensed for use in children

### ANTISEPTICS AND DISINFECTANTS

#### INDECOXOATES

**Indecoxoate with zinc undecenoate**

**INDICATIONS AND DOSE**
- **TREATMENT**
  - **TO THE SKIN**
    - CHILD: Apply twice daily, continuing for 7 days after lesions have healed
  - **PREVENTION**
    - CHILD: Apply once daily

**SIDE-EFFECTS**
- Rare or very rare Skin irritation

**LICENSED USE**
- Mycopharma licensed for use in children (age range not specified by manufacturer)

**UNLICENSED USE**
- Mycopharma licensed for use in children

**LICENSED USE**
- Mycopharma licensed for use in children

**UNLICENSED USE**
- Mycopharma licensed for use in children

### ANTISEPTICS AND DISINFECTANTS

#### Chlorhexidine with nystatin

**INDICATIONS AND DOSE**
- **TREATMENT**
  - **TO THE SKIN**
    - CHILD: Apply 2–3 times a day, continuing for 7 days after lesions have healed

**SIDE-EFFECTS**
- Hypersensitivity - skin reactions
2.3 Parasitic skin infections

PARASITICIDES

Dimeticone

- **INDICATIONS AND DOSE**
  - Head lice
    - Child: Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight)

- **UNLICENSED USE**: Not licensed for use in children under 6 months except under medical supervision.

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: HEAD LICE ERADICATION PRODUCTS: RISK OF SERIOUS BURNS IF TREATED HAIR IS EXPOSED TO OPEN FLAMES OR OTHER SOURCES OF IGNITION (MARCH 2018)

See Skin infections p. 744.

- **CAUTIONS**: Avoid contact with eyes - children under 6 months, medical supervision required

**SIDE-EFFECTS**

- Alopecia - dryness - eye irritation
- Hypersensitivity - skin reactions

- **UNLICENSED USE**: Not licensed for use in children under 6 months except under medical supervision.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

- **Liquid**
  - Hedrin (Thornton & Ross Ltd)
  - Dimeticone 40 mg per 1 gram
  - Lyclear (dimeticone) (Omega Pharma Ltd)

**Cutaneous spray solution**

- Hedrin (Thornton & Ross Ltd)
- Dimeticone 40 mg per 1 gram

**Malathion**

- **INDICATIONS AND DOSE**
  - Head lice
    - Child: Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, remove by washing after 12 hours

  - Crab lice
    - Child: Apply once weekly for 2 doses, apply preparation over whole body, allow to dry naturally, wash off after 12 hours or overnight

  - Scabies
    - Child: Apply once weekly for 2 doses, apply preparation over whole body, wash off after 24 hours, if hands are washed with soap within 24 hours, they should be retreated

- **UNLICENSED USE**: Not licensed for use in children under 6 months except under medical supervision.

**IMPORTANT SAFETY INFORMATION**

MHRA/CHM ADVICE: HEAD LICE ERADICATION PRODUCTS: RISK OF SERIOUS BURNS IF TREATED HAIR IS EXPOSED TO OPEN FLAMES OR OTHER SOURCES OF IGNITION (MARCH 2018)

See Skin infections p. 744.

- **CAUTIONS**: Alcoholic lotions not recommended for head lice in children with severe eczema or asthma, or for scabies or crab lice - avoid contact with eyes - children under 6 months, medical supervision required - do not use lotion more than once a week for 5 consecutive weeks - do not use on broken or secondarily infected skin

- **SIDE-EFFECTS**: Angioedema - eye swelling - hypersensitivity - skin reactions

- **PRESCRIBING AND DISPENSING INFORMATION**
  - For scabies, manufacturer recommends application to the body but not necessarily to the head and neck. However, application should be extended to the scalp, neck, face, and ears.

- **MEDIcINAL FORMS**: There can be variation in the licensing of different medicines containing the same drug.

**Liquid**

- Excipients: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), fragrances, hydroxybenzoates (parabens)
- Derbac-M (G.R. Lane Health Products Ltd)
- Malathion 5 mg per 1 gram
- Dimeticone 40 mg per 1 gram

**Permethrin**

- **INDICATIONS AND DOSE**
  - Scabies
    - Child: Apply once weekly for 2 doses, apply 5% preparation over whole body including face, neck, scalp and ears then wash off after 8–12 hours. If hands are washed with soap within 8 hours of application, they should be treated again with cream

- **UNLICENSED USE**: Dermal Cream (scabies), not licensed for use in children under 2 months; not licensed for treatment of crab lice in children under 18 years. Creme Rinse (head
2.4 Viral skin infections

**ANTIVIRALS**

**Aciclovir**

(Acyclovir)

- **INDICATIONS AND DOSE**
  - **Herpes simplex infection (local treatment)**
    - **Child:** Apply 5 times a day for 5–10 days, to be applied to lesions approximately every 4 hours, starting at first sign of attack
  - **Unlicensed use**—Cream licensed for use in children (age range not specified by manufacturer).

- **CAUTIONS**
  - Avoid cream coming in to contact with eyes and mucous membranes

- **INTERACTIONS**— Appendix 1: aciclovir

- **SIDE-EFFECTS**
  - **Uncommon**—Skin reactions

- **PREGNANCY**
  - Limited absorption from topical aciclovir preparations.

- **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: Aciclovir cream for herpes
  - www.medicinesforchildren.org.uk/aciclovir-cream-herpes-

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**3 Inflammatory skin conditions**

**3.1 Eczema and psoriasis**

**Eczema**

**Types and management**

The main types of eczema (dermatitis) in children are atopic, irritant and allergic contact; different types may co-exist. *Atopic eczema* is the most common type and it usually involves dry skin as well as infection and lichenification caused by scratching and rubbing. *Seborrheic dermatitis* is also common in infants.

Management of eczema involves the removal or treatment of contributory factors; known or suspected irritants and contact allergens should be avoided. Rarely, ingredients in topical medicinal products may sensitise the skin; *BNF for Children* lists active ingredients together with excipients that have been associated with skin sensitisation.

Skin dryness and the consequent irritant eczema requires emollients applied regularly (at least twice daily) and liberally to the affected area; this can be supplemented with bath or shower emollients. The use of emollients should continue even if the eczema improves or if other treatment is being used.

**Topical corticosteroids** are also required in the management of eczema; the potency of the corticosteroid should be appropriate to the severity and site of the condition, and the age of the child. Mild corticosteroids are generally used on the face and on flexures; the more potent corticosteroids are generally required for use on lichenified areas of eczema or for severe eczema on the scalp, limbs, and trunk. Treatment should be reviewed regularly, especially if a potent corticosteroid is required. In children with frequent flares (2–3 per month), a topical corticosteroid can be applied on 2 consecutive days each week to prevent further flares.

Bandages (including those containing ichthammol with zinc oxide p. 767) are sometimes applied over topical corticosteroids or emollients to treat eczema of the limbs. Dry-wrap dressings can be used to provide a physical barrier to help prevent scratching and improve retention of emollients. Wet elasticated viscose stockinette is used for ‘wet-wrap’ bandaging over topical corticosteroids or emollients to cool the skin and relieve itching, but there is an increased risk of infection and excessive absorption of the corticosteroid; ‘wet-wrap’ bandaging should be used under specialist supervision.
See Wound management products and elasticated garments for details of elasticated viscose stockinet tubular bandages and garments, and silk clothing.


Infection
Bacterial infection (commonly with Staphylococcus aureus and occasionally with Streptococcus pyogenes) can exacerbate eczema. A topical antibacterial may be used for small areas of mild infection; treatment should be limited to a short course (typically 1 week) to reduce the risk of drug resistance or skin sensitisation. Associated eczema is treated simultaneously with a topical corticosteroid which can be combined with a topical antimicrobial.

Eczema involving moderate to severe, widespread, or recurrent infection requires the use of a systemic antibacterial that is active against the infecting organism. Preparations that combine an antiseptic with an emollient application and with a bath emollient can also be used; antiseptic shampoos can be used on the scalp.

Intertriginous eczema commonly involves candida and bacteria; it is best treated with a mild or moderately potent topical corticosteroid combined with a suitable antimicrobial drug.

Widespread herpes simplex infection may complicate atopic eczema (eczema herpeticum) and treatment under specialist supervision with a systemic antiviral drug is indicated. Secondary bacterial infection often exacerbates eczema herpeticum.

Management of other features of eczema
Lichenification, which results from repeated scratching, is treated initially with a potent corticosteroid. Bandages containing ichthammol p. 757 (to reduce pruritus) and other substances such as zinc oxide can be applied over the corticosteroid or emollient. Coal tar and ichthammol can be useful in some cases of chronic eczema. Discoid eczema, with thickened plaques in chronic atopic eczema, is usually treated with a topical antiseptic preparation, a potent topical corticosteroid, and paste bandages containing ichthammol with zinc oxide.

A non-sedating antihistamine may be of some value in relieving severe itching or urticaria associated with eczema. A sedating antihistamine can be used at night if itching causes sleep disturbance, but a large dose may be needed and drowsiness may persist on the following day.

Exudative (‘weeping’) eczema requires a potent corticosteroid initially; infection may also be present and require specific treatment. Potassium permanganate solution p. 784 (1 in 10,000) can be used as a soak in exudating eczema for its antiseptic and astringent effects; treatment should be stopped when exudation stops.

Severe refractory eczema is best managed under specialist supervision; it may require phototherapy or drugs that act on the immune system.

Seborrhoeic dermatitis
Seborrhoeic dermatitis (seborrhoeic eczema) is associated with species of the yeast Malassezia. Infantile seborrhoeic dermatitis affects particularly the body folds, nappy area and scalp; it is treated with emollients and mild topical corticosteroids with suitable antimicrobials. Infantile seborrhoeic dermatitis affecting the scalp (cradle cap) is treated by hydrating the scalp using natural oils and the use of mild shampoo.

In older children, seborrhoeic dermatitis affects the scalp, paranasal areas, and eyebrows. Shampoos active against the yeast (including those containing ketoconazole p. 749 and coal tar) and combinations of mild topical corticosteroids with suitable antimicrobials are used to treat older children.

Medicated bandages
Zinc paste bandages (see Wound management products and elasticated garments) are used with coal tar or ichthammol in chronic lichenified skin conditions such as chronic eczema (ichthammol often being preferred since its action is considered to be milder). They are also used with calamine in milder eczematous skin conditions.

Psoriasis
Management
Psoriasis is characterised by epidermal thickening and scaling. It commonly affects extensor surfaces and the scalp. For mild psoriasis, reassurance and treatment with an emollient may be all that is necessary. Guttate psoriasis is a distinctive form of psoriasis that characteristically occurs in children and young adults, often following a streptococcal throat infection or tonsillitis.

Occasionally psoriasis is provoked or exacerbated by drugs such as lithium, chloroquine and hydroxychloroquine, beta-blockers, non-steroidal anti-inflammatory drugs, and ACE inhibitors. Psoriasis may not occur until the drug has been taken for weeks or months.

Emollients, in addition to their effects on dryness, scaling and cracking, may have an antiproliferative effect in psoriasis. They are particularly useful in inflammatory psoriasis and in chronic stable plaque psoriasis.

For chronic stable plaque psoriasis on extensor surfaces of trunk and limbs preparations containing coal tar are moderately effective, but the smell is unacceptable to some children. Vitamin D and its analogues are effective and cosmetically acceptable alternatives to preparations containing coal tar or dithranol p. 768. Dithranol is an effective topical antipsoriatic agent but it irritates and stains the skin and it should be used only under specialist supervision. Adverse effects of dithranol are minimised by using a ‘short-contact technique’ and by starting with low concentration preparations. Tazarotene, a topical retinoid for the treatment of mild to moderate plaque psoriasis, is not recommended for use in children under 18 years. These medications can irritate the skin particularly in the flexures and they are not suitable for the more inflammatory forms of psoriasis; their use should be suspended during an inflammatory phase of psoriasis. The efficacy and the irritancy of each substance varies between patients. If a substance irritates significantly, it should be stopped or the concentration reduced; if it is tolerated, its effects should be assessed after 4 to 6 weeks and treatment continued if it is effective.

Widespread unstable psoriasis of erythrodermic or generalised pustular type requires urgent specialist assessment. Initial topical treatment should be limited to using emollients frequently and generously. More localised acute or subacute inflammatory psoriasis with hot, spreading or itchy lesions, should be treated topically with emollients or with a corticosteroid of moderate potency.

Scalp psoriasis is usually scaly, and the scale may be thick and adherent. This requires softening with an emollient ointment, cream, or oil and usually combined with salicylic acid p. 791 as a keratolytic.

Some preparations for psoriasis affecting the scalp combine salicylic acid with coal tar or sulfur. The preparation should be applied generously and left on for at least an hour, often more conveniently overnight, before washing it off. If a corticosteroid lotion or gel is required (e.g. for itch), it can be used in the morning.

Flexural psoriasis can be managed with short-term use of a mild potency topical corticosteroid. Calcipotriol p. 773 or tacalcitol p. 774 can be used in the longer term; calcipotriol p. 773 is more likely to cause irritation in flexures and should be avoided. Low-strength tar preparations can also be used.
Facial psoriasis can be treated with short-term use of a mild topical corticosteroid; if this is ineffective, calcitriol, tacalcitol, or a low-strength tar preparation can be used.

Calcipotriol and tacalcitol are analogues of vitamin D that affect cell division and differentiation. Calcitriol is an active form of vitamin D. Vitamin D and its analogues are used as first-line treatment for plaque psoriasis; they do not smell or stain and they may be more acceptable than tar or dithranol products. Of the vitamin D analogues, tacalcitol and calcitriol are less likely to irritate.

Coal tar p. 768 has anti-inflammatory properties that are useful in chronic plaque psoriasis; it also has antiscaling properties. Contact of coal tar products with normal skin is not normally harmful and preparations containing coal tar can be used for widespread small lesions; however, irritation, contact allergy, and sterile folliculitis can occur. Leave-on preparations that remain in contact with the skin, such as creams or ointments, containing up to 6% coal tar may be used on children 1 month to 2 years; leave-on preparations containing coal tar 10% may be used on children over 2 years with more severe psoriasis. Tar baths and tar shampoos may also be helpful.

Dithranol is effective for chronic plaque psoriasis. Its major disadvantages are irritation (for which individual susceptibility varies) and staining of skin and of clothing. Dithranol is not generally suitable for widespread small lesions nor should it be used in the flexures or on the face. Proprietary preparations are more suitable for home use; they are usually washed off after 20–30 minutes (‘short contact’ technique). Specialist nurses may apply intensive treatment with dithranol paste which is covered by stockinette dressings and usually retained overnight. Dithranol should be discontinued if even a low concentration causes acute inflammation; continued use can result in the psoriasis becoming unstable.

A topical corticosteroid is not generally suitable for long-term use or as the sole treatment of extensive chronic plaque psoriasis; any early improvement is not usually maintained and there is a risk of the condition deteriorating or of precipitating an unstable form of psoriasis e.g. erythrodermic psoriasis or generalised pustular psoriasis on withdrawal. Topical use of potent corticosteroids on widespread psoriasis can also lead to systemic as well as local side-effects. However, topical corticosteroids used short-term may be appropriate to treat psoriasis in specific sites such as the face or flexures with a mild corticosteroid, and psoriasis of the scalp, palms, and soles with a potent corticosteroid. Very potent topical corticosteroids should only be used under specialist supervision.

Combining the use of a corticosteroid with another specific topical treatment may be beneficial in chronic plaque psoriasis; the drugs may be used separately at different times of the day or used together in a single formulation. Eczema co-existing with psoriasis may be treated with a corticosteroid, or coal tar, or both.

Phototherapy

Phototherapy is available in specialist centres under the supervision of a dermatologist. Narrow band ultraviolet B (UVB) radiation is usually effective for chronic stable psoriasis and for guttate psoriasis. It can be considered for children with moderately severe psoriasis in whom topical treatment has failed, but it may irritate inflammatory psoriasis. The use of phototherapy and photochemotherapy in children is limited by concerns over carcinogenicity and premature ageing.

Photochemotherapy combining long-wave ultraviolet A radiation with a psoralen (PUVA) is available in specialist centres under the supervision of a dermatologist. The psoralen, which enhances the effect of irradiation, is administered either by mouth or topically. PUVA is effective in most forms of psoriasis, including the localised palmoplantar pustular psoriasis. Early adverse effects include phototoxicity and pruritus. Higher cumulative doses exaggerate skin ageing, increase the risk of dysplastic and neoplastic skin lesions especially squamous cancer, and pose a theoretical risk of cataracts.

Phototherapy combined with coal tar, dithranol, topical vitamin D or vitamin D analogues, or oral acitretin, allows reduction of the cumulative dose of phototherapy required to treat psoriasis.

Systemic treatment

Systemic treatment is required for severe, resistant, unstable or complicated forms of psoriasis, and it should be initiated only under specialist supervision. Systemic drugs for psoriasis include acitretin and drugs that affect the immune response (see Eczema and psoriasis, drugs affecting the immune response below).

Acitretin p. 772, a metabolite of etretinate, is a retinoid (vitamin A derivative); it is prescribed by specialists. The main indication of acitretin is severe psoriasis resistant to other forms of therapy. It is also used in disorders of keratinisation such as severe Darier’s disease (keratosis follicularis), and some forms of ichthyosis. Although a minority of cases of psoriasis respond well to acitretin alone, it is only moderately effective in many cases; adverse effects are a limiting factor. A therapeutic effect occurs after 2 to 4 weeks and the maximum benefit after 4 months.

Consideration should be given to stopping acitretin if the response is inadequate after 4 months at the optimum dose. Continuous treatment for longer than 6 months is not usually necessary in psoriasis. However, some patients, particularly those with severe ichthyosis, may benefit from longer treatment, provided that the lowest effective dose is used, patients are monitored carefully for adverse effects, and the need for treatment is reviewed regularly. Topical preparations containing keratolytics should normally be stopped before administration of acitretin. Liberal use of emollients should be encouraged and topical corticosteroids can be continued if necessary.

Acitretin is teratogenic; in females of child-bearing age, the possibility of pregnancy must be excluded before treatment and effective contraception must be used during treatment and for at least 3 years afterwards (oral progestogen-only contraceptives not considered effective).

Topical treatment

The vitamin D and analogues, calcipotriol p. 773, calcitriol p. 773, and tacalcitol p. 774 are used for the management of plaque psoriasis. They should be avoided by those with calcium metabolism disorders, and used with caution in generalised pustular or erythrodermic exfoliative psoriasis (enhanced risk of hypercalcaemia).

Eczema and psoriasis, drugs affecting the immune response

Overview

Drugs affecting the immune response are used for eczema or psoriasis. Pimecrolimus p. 770 by topical application is licensed for mild to moderate atopic eczema. Tacrolimus p. 770 is licensed for topical use in moderate to severe atopic eczema. Both are drugs whose long-term safety is still being evaluated and they should not usually be considered first-line treatment unless there is a specific reason to avoid or reduce the use of topical corticosteroids. Treatment with topical pimecrolimus or topical tacrolimus should be initiated only by prescribers experienced in treating atopic eczema.

Topical corticosteroids have a role in eczema and a limited role in psoriasis. A systemic corticosteroid such as prednisolone p. 458 may be used in severe refractory eczema.
Systemic drugs acting on the immune system are generally used by specialists in a hospital setting. Ciclosporin p. 537 by mouth can be used for severe psoriasis and for severe eczema. Azathioprine p. 536 or mycophenolate mofetil p. 544 are also used for severe refractory eczema in children. Methotrexate p. 563 can be used for severe resistant psoriasis; the dose is given once weekly and adjusted according to severity of the condition and biochemical measurements. Folic acid p. 594 should be given to reduce the possibility of methotrexate toxicity [unlicensed indication]. Folic acid can be given once weekly on a different day to the methotrexate; alternative regimens may be used in some settings.

Etanercept p. 667 (a cytokine modulator) is licensed in children over 6 years of age for the treatment of severe plaque psoriasis that is inadequately controlled by other systemic treatments and photochemotherapy, or when these other treatments cannot be used because of intolerance or contra-indications.

Adalimumab p. 665 (a cytokine modulator) is licensed in children over 4 years for the treatment of severe chronic plaque psoriasis that is inadequately controlled by other topical treatments and phototherapies, or when these treatments are inappropriate.

CORTICOSTEROIDS

Topical corticosteroids

Overview

Topical corticosteroids are used for the treatment of inflammatory conditions of the skin (other than those arising from an infection), particularly eczema, contact dermatitis, insect stings, and eczema of scabies. Corticosteroids suppress the inflammatory reaction during use; they are not curative and on discontinuation a rebound exacerbation of the condition may occur. They are generally used to relieve symptoms and suppress signs of the disorder when other measures such as emollients are ineffective.

Children, especially infants, are particularly susceptible to side-effects. However, concern about the safety of topical corticosteroids in children should not result in the child being undertreated. The aim is to control the condition as well as possible; inadequate treatment will perpetuate the condition. Carers of young children should be advised that treatment should not necessarily be reserved to ‘treat only the worst areas’ and they may need to be advised that patient information leaflets may contain inappropriate advice for the child’s condition.

In an acute flare-up of atopic eczema, it may be appropriate to use more potent formulations of topical corticosteroids for a short period to regain control of the condition.

Topical corticosteroids are not recommended in the routine treatment of urticaria; treatment should only be initiated and supervised by a specialist. Topical corticosteroids may worsen ulcerated or secondarily infected lesions. They should not be used indiscriminately in pruritus (where they will only benefit if inflammation is causing the itch) and are not recommended for acne vulgaris.

Systemic or very potent topical corticosteroids should be avoided or given only under specialist supervision in psoriasis because, although they may suppress the psoriasis in the short term, relapse or vigorous rebound occurs on withdrawal (sometimes precipitating severe psutular psoriasis). Topical use of potent corticosteroids on widespread psoriasis can lead to systemic as well as to local side-effects. It is reasonable, however, to prescribe a mild topical corticosteroid for a short period (2–4 weeks) for flexural and facial psoriasis, and to use a more potent corticosteroid such as betamethasone p. 758 or fluocinonide p. 761 for psoriasis of the scalp, palms, or soles.

In general, the most potent topical corticosteroids should be reserved for recalcitrant dermatoses such as chronic discoid lupus erythematosus, lichen simplex chronicus, hypertrophic lichen planus, and palmoplantar pustulosis.

Potent corticosteroids should generally be avoided on the face and skin flexures, but specialists occasionally prescribe them for use on these areas in certain circumstances.

When topical treatment has failed, intrallesional corticosteroid injections may be used. These are more effective than the very potent topical corticosteroid preparations and should be reserved for severe cases where there are localised lesions such as keloid scars, hypertrophic lichen planus, or localised alopecia areata.

Perioral lesions

Hydrocortisone cream 1% p. 762 can be used for up to 7 days to treat uninfected inflammatory lesions on the lips. Hydrocortisone with miconazole cream or ointment p. 767 is useful where infection by susceptible organisms and inflammation co-exist, particularly for initial treatment (up to 7 days) e.g. in angular cheilitis. Organisms susceptible to miconazole include Candida spp. and many Gram-positive bacteria including streptococci and staphylococci.

Choice

Water-miscible corticosteroid creams are suitable for moist or weeping lesions whereas ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. Lotions may be useful when minimal application to a large or hair-bearing area is required or for the treatment of exudative lesions. Occlusive polythene or hydrocolloid dressings increase absorption, but also increase the risk of side-effects; they are therefore used only under supervision on a short-term basis for areas of very thick skin (such as the palms and soles). Disposable nappies and tight fitting pants also increase the risk of side-effects by increasing absorption of the corticosteroid. The inclusion of urea or salicylic acid p. 791 also increases the penetration of the corticosteroid.

In the BNF for Children, topical corticosteroids for the skin are categorised as ‘mild’, ‘moderately potent’, ‘potent’ or ‘very potent’; the least potent preparation which is effective should be chosen but dilution should be avoided whenever possible.

Topical hydrocortisone is usually used in children under 1 year of age. Moderately potent and potent topical corticosteroids should be used with great care in children and for short periods (1–2 weeks) only. A very potent corticosteroid should be initiated under the supervision of a specialist.

Appropriate topical corticosteroids for specific conditions are:

- insect bites and stings—mild corticosteroid such as hydrocortisone 1% cream;
- inflamed nappy rash causing discomfort in infant over 1 month—mild corticosteroid such as hydrocortisone 0.5% or 1% for up to 7 days (combined with antimicrobial if infected);
- mild to moderate eczema, flexural and facial eczema or psoriasis—mild corticosteroid such as hydrocortisone 1%;
- severe eczema of the face and neck—moderately potent corticosteroid for 3–5 days only, if not controlled by a mild corticosteroid;
- severe eczema on the trunk and limbs—moderately potent or potent corticosteroid for 1–2 weeks only, switching to a less potent preparation as the condition improves;
- eczema affecting area with thickened skin (e.g. soles of feet)—potent topical corticosteroid in combination with urea or salicylic acid (to increase penetration of corticosteroid).
Absorption through the skin
*Mild* and *moderately potent* topical corticosteroids are associated with few side-effects but particular care is required when treating neonates and infants, and in the use of *potent* and *very potent* corticosteroids. Absorption through the skin can rarely cause adrenal suppression and even Cushing’s syndrome, depending on the area of the body being treated and the duration of treatment. Absorption of corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on the face or genital area), from corticosteroid is greatest from severely inflamed skin, thin skin (especially on 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Skin

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment

Cream

**CAUTIONARY AND ADVISORY LABELS** 28

**Beclometasone dipropionate (Non-proprietary)**

Beclometasone dipropionate 250 microgram per 1 gram Beclometasone 0.025% cream | 30 gram [POM] £68.00 DT = £68.00

Ointment

**CAUTIONARY AND ADVISORY LABELS** 28

**Beclometasone dipropionate (Non-proprietary)**

Beclometasone dipropionate 250 microgram per 1 gram Beclometasone 0.025% ointment | 30 gram [POM] £68.00 DT = £68.00

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**Alclometasone dipropionate** 21-Dec-2017

**INDICATIONS AND DOSE**

**Inflammatory skin disorders such as eczemas**

→ **TO THE SKIN**

Child: Apply 1–2 times a day, to be applied thinly

**POTENCY**

Alclometasone dipropionate cream 0.05%; moderate

**UNLICENSED USE**

Licensed for use in children (age range not specified by manufacturer).

**SIDE-EFFECTS**

Vasodilation

**PATIENT AND CARER ADVICE**

Patients or carers should be counselled on the application of alclometasone dipropionate cream.

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

Cream

**CAUTIONARY AND ADVISORY LABELS** 28

EXCIPIENTS: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol, propylene glycol

**Alclometasone dipropionate (Non-proprietary)**

Alclometasone dipropionate 500 microgram per 1 gram Boots Derma Care Eczema & Dermatitis Flare-Up 0.05% cream | 15 gram [P]

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**Betamethasone dipropionate** (Betamethasone dipropionate)

**INDICATIONS AND DOSE**

**Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids / Psoriasis**

→ **TO THE SKIN**

Child: Apply 1–2 times a day, to be applied thinly

**POTENCY**

Betamethasone dipropionate cream and ointment 0.025%; potent.

**UNLICENSED USE**

Not licensed for use in children under 1 year.

**INTERACTIONS** → Appendix 1: corticosteroids

**SIDE-EFFECTS**

Vasodilation - vision blurred

**INDICATIONS AND DOSE**

Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids / Psoriasis

→ **TO THE SKIN**

Child: Apply 1–2 times a day, to be applied thinly

**POTENCY**

Betamethasone valerate 0.25% cream and ointment: moderate. Betamethasone valerate 0.1% cream, lotion, ointment, and scalp application: potent. Betamethasone valerate 0.12% foam: potent. Betamethasone dipropionate 0.05% cream, lotion, and ointment: potent.

**UNLICENSED USE**

Betacap®, Betnovate® and Betnovate-RD® are not licensed for use in children under 1 year. Bettamousse® is not licensed for use in children under 6 years.

**CAUTIONS**

Use of more than 100 g per week of 0.1% preparation likely to cause adrenal suppression

**INTERACTIONS** → Appendix 1: corticosteroids

**SIDE-EFFECTS**

Vasodilation

**PATIENT AND CARER ADVICE**

Patient counselling is advised for betamethasone cream, ointment, scalp application and foam (application).

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment

Foam

**CAUTIONARY AND ADVISORY LABELS** 15, 28

EXCIPIENTS: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates, propylene glycol

**Bettamousse** (RPH Pharmaceuticals AB)

Betamethasone (as Betamethasone valerate) 1 mg per 1 gram Betamethasone 0.1% cutaneous foam | 100 gram [POM] £9.75 DT = £9.75

Cream

**CAUTIONARY AND ADVISORY LABELS** 28

EXCIPIENTS: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol

**Betamethasone (Non-proprietary)**

Betamethasone (as Betamethasone valerate) 1 mg per 1 gram Betamethasone valerate 0.1% cream | 15 gram [POM] £3.00 | 30 gram [POM] £5.99 DT = £1.61 | 100 gram [POM] £11.99 DT = £5.37

**Audavate** (Auden McKenzie (Pharma Division) Ltd, Actavis UK Ltd)

Betamethasone (as Betamethasone valerate) 250 microgram per 1 gram Audavate RD 0.025% cream | 100 gram [POM] £2.99 DT = £1.15

Betamethasone (as Betamethasone valerate) 1 mg per 1 gram Audavate 0.1% cream | 30 gram [POM] £1.14 DT = £1.61 | 100 gram [POM] £3.24 DT = £5.37

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This length can be measured in terms of a **fingertip unit** (the distance from the tip of the adult index finger to the first crease). One fingertip unit (approximately 500 mg from a tube with a standard 5 mm diameter nozzle) is sufficient to cover an area that is twice that of the flat adult handprint (palm and fingers). Mixing topical preparations on the skin should be avoided where possible; several minutes should elapse between application of different preparations.

‘Wet-wrap bandaging’ increases absorption into the skin, but should be initiated only by a dermatologist and application supervised by a healthcare professional trained in the technique.

**PRESCRIBING AND DISPENSING INFORMATION**

The potency of each topical corticosteroid should be included on the label with the directions for use. The label should be attached to the container (for example, the tube) rather than the outer packaging.

**PATIENT AND CARER ADVICE**

Patients or carers should be given advice on how to administer corticosteroid creams and ointments. If a patient is using topical corticosteroids of different potencies, the patient should be told when to use each corticosteroid. Patients and their carers should be reassured that side effects such as skin thinning and systemic effects rarely occur when topical corticosteroids are used appropriately.
Calcipotriol with betamethasone
March 2017

The properties listed below are those particular to the combination only. For the properties of the components please consider, calcipotriol p. 773, betamethasone p. 454, 758.

- INDICATIONS AND DOSE

**DOVOBET® GEL**

Scalp psoriasis
- TO THE SKIN
  - Child 12–17 years (specialist use only): Apply 1–4 g once daily usual duration of therapy 4 weeks; if necessary, treatment may be continued beyond 4 weeks or repeated, on the advice of a specialist, shampoo off after leaving on scalp overnight or during day, when different preparations containing calcipotriol used together, maximum total calcipotriol 3.75 mg in any one week

**Mild to moderate plaque psoriasis**
- TO THE SKIN
  - Child 12–17 years (specialist use only): Apply once daily for up to 4 weeks; if necessary, treatment may be continued beyond 4 weeks or repeated, on the advice of a specialist, apply to maximum 30% of body surface, when different preparations containing calcipotriol used together, max. total calcipotriol 3.75 mg in any one week; maximum 75 g per week

**DOVOBET® OINTMENT**

Stable plaque psoriasis
- TO THE SKIN
  - Child 12–17 years (specialist use only): Apply once daily for up to 4 weeks; if necessary, treatment may be continued beyond 4 weeks or repeated, on the advice of a specialist, apply to maximum 30% of body surface, when different preparations containing calcipotriol used together, max. total calcipotriol 3.75 mg in any one week; maximum 75 g per week

- **UNLICENSED USE** Dovobet® not licensed for use in children.

- **CONTRA-INDICATIONS**

  **ENSTILAR®** Erythrodermic psoriasis - pustular psoriasis

- **INTERACTIONS**
  - Appendix 1: corticosteroids - vitamin D substances

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**Ointment**

- CLOBETASOL (Bayer)
  - Calcipotriol (as Calcipotriol hydrate) 50 microgram per 1 gram, Betamethasone (as Betamethasone dipropionate) 500 microgram per 1 gram Dovobet ointment | 30 gram | £19.84 DT = £19.84 | 60 gram | £39.68 | 120 gram | £73.86

**Gel**

- CLOBETASOL (Bayer)
  - Calcipotriol (as Calcipotriol monohydrate) 50 microgram per 1 gram, Betamethasone (as Betamethasone dipropionate) 500 microgram per 1 gram Dovobet gel | 60 gram | £37.21 DT = £37.21 | 120 gram | £69.31

**Calcipotriol with betamethasone**

- **INDICATIONS AND DOSE**

  Short-term treatment only of severe resistant inflammatory skin disorders such as recalcitrant eczemas unresponsive to less potent corticosteroids

  - TO THE SKIN
    - Child 1–17 years: Apply 1–2 times a day for up to 4 weeks, to be applied thinly

  **POTENCY**

  - Clobetasol propionate 0.05% cream, foam, ointment, scalp application, and shampoo: very potent.

- **UNLICENSED USE** Dermovate® not licensed for use in children under 1 year.

- **PATIENT AND CARER ADVICE**

  - Patients or carers should be given advice on how to administer clobetasol propionate foam, liquid (scalp application), cream, ointment and shampoo.
Scalp application Patients or carers should be advised to apply foam directly to scalp lesions (foam begins to subside immediately on contact with skin).

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment, paste.
  - Cream
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol, propylene glycol.
    - **Eumovate (GlaxoSmithKline Consumer Healthcare, GlaxoSmithKline UK Ltd)**
      - **Clotetasone butyrate 500 microgram per 1 gram**
        - Eumovate
        - **Cream**
          - **Eczema and Dermatitis:** 0.05% cream | 15 gram
          - **Psoriasis:** 0.1% cream | 15 gram
          - **Diflucortolone valerate**
          - **Cream**
        - **Dermovate (GlaxoSmithKline UK Ltd)**
          - **Clotetasone butyrate 500 microgram per 1 gram**
            - **Dermovate**
            - **Cream**
          - **Nerisone (Meadow Laboratories Ltd)**
            - **Clotetasone butyrate 500 microgram per 1 gram**
              - **Nerisone Forte**
    - **Ointment**
      - **CAUTIONARY AND ADVISORY LABELS**
      - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol, propylene glycol.
      - **ClobaDerm (Auden McKenzie (Pharma Division) Ltd)**
        - **Clotetasone butyrate 500 microgram per 1 gram**
          - **ClobaDerm**
          - **Ointment**
      - **Clobetasol propionate 500 microgram per 1 gram**
        - **Clobetasol propionate 500 microgram per 1 gram**
    - **Liquid**
      - **CAUTIONARY AND ADVISORY LABELS**
      - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol, propylene glycol.
      - **Eumovate (GlaxoSmithKline UK Ltd)**
        - **Clotetasone butyrate 500 microgram per 1 gram**
          - **Eumovate**
          - **Cream**
      - **Dermovate (GlaxoSmithKline UK Ltd)**
        - **Clotetasone butyrate 500 microgram per 1 gram**
          - **Dermovate**
          - **Cream**
      - **Clobetasol propionate 500 microgram per 1 gram**
        - **Clobetasol propionate 500 microgram per 1 gram**

- **INDICATIONS AND DOSE**
  - **Eczemas and dermatitis of all types**
  - **Maintenance between courses of more potent corticosteroids**
  - **TO THE SKIN**
    - Child: Apply 1–2 times a day, to be applied thinly
  - **POTENCY**
    - Clotetasone butyrate 0.05% cream and ointment: moderate.
  - **UNLICENSED USE** Licensed for use in children (age range not specified by manufacturer).
  - **PATIENT AND CARER ADVICE** Patients or carers should be advised on the application of clotetasone butyrate containing preparations.
  - **EXCEPTIONS TO LEGAL CATEGORY** Cream can be sold to the public for short-term symptomatic treatment and control of patches of eczema and dermatitis (but not seborrhoeic dermatitis) in adults and children over 12 years provided pack does not contain more than 15 g.
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment,
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
    - **Cream**
      - **CAUTIONARY AND ADVISORY LABELS**
      - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
      - **Nerisone (Meadow Laboratories Ltd)**
        - **Diflucortolone valerate 1 mg per 1 gram**
          - **Nerisone Forte**
    - **Cream**
      - **CAUTIONARY AND ADVISORY LABELS**
      - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
      - **Nerisone (Meadow Laboratories Ltd)**
        - **Diflucortolone valerate 1 mg per 1 gram**
          - **Nerisone Forte**

**Diflucortolone valerate**

- **INDICATIONS AND DOSE**
  - **Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids (using 0.3% diflucortolone valerate)**
  - **Short-term treatment of severe exacerbations (using 0.1% diflucortolone valerate)**
  - **Psoriasis (using 0.3% diflucortolone valerate)**
  - **TO THE SKIN**
    - Child 1 month–3 years: Apply 1–2 times a day for up to 2 weeks, reducing strength as condition responds, to be applied thinly
    - Child 4–17 years: Apply 1–2 times a day for up to 2 weeks, reducing strength as condition responds, to be applied thinly; maximum 60 g per week
  - **Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids (using 0.1% diflucortolone valerate)**
  - **Psoriasis (using 0.1% diflucortolone valerate)**
  - **TO THE SKIN**
    - Child: Apply 1–2 times a day for up to 4 weeks, to be applied thinly
  - **POTENCY**
    - Diflucortolone valerate 0.1% cream and ointment: potent.
    - Diflucortolone valerate 0.3% cream and ointment: very potent.
  - **UNLICENSED USE** Nerisone® licensed for use in children (age range not specified by manufacturer); Nerisone Forte® not licensed for use in children under 4 years.
  - **PRESCRIBING AND DISPENSING INFORMATION** Patients or carers should be advised on application of diflucortolone valerate containing preparations.
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
      - **Diflucortolone valerate 3 mg per 1 gram**
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
      - **Diflucortolone valerate 3 mg per 1 gram**
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
      - **Diflucortolone valerate 3 mg per 1 gram**

**Clotetasone butyrate**

- **INDICATIONS AND DOSE**
  - **Eczemas and dermatitis of all types**
  - **Maintenance between courses of more potent corticosteroids**
  - **TO THE SKIN**
    - Child: Apply 1–2 times a day, to be applied thinly
  - **POTENCY**
    - Clotetasone butyrate 0.05% cream and ointment: moderate.
  - **UNLICENSED USE** Licensed for use in children (age range not specified by manufacturer).
  - **PATIENT AND CARER ADVICE** Patients or carers should be advised on the application of clotetasone butyrate containing preparations.
  - **EXCEPTIONS TO LEGAL CATEGORY** Cream can be sold to the public for short-term symptomatic treatment and control of patches of eczema and dermatitis (but not seborrhoeic dermatitis) in adults and children over 12 years provided pack does not contain more than 15 g.
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
      - **Diflucortolone valerate 3 mg per 1 gram**
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
      - **Diflucortolone valerate 3 mg per 1 gram**
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), disodium edetate, hydroxybenzoates (parabens).
    - **Nerisone (Meadow Laboratories Ltd)**
      - **Diflucortolone valerate 1 mg per 1 gram**
        - **Nerisone Forte**
      - **Diflucortolone valerate 3 mg per 1 gram**

**BNFC 2019–2020**
Fludroxycortide
(Flurandrenolone)

**INDICATIONS AND DOSE**

- **Inflammatory skin disorders such as eczemas**
  - **TO THE SKIN**
  - **Child:** Apply 1–2 times a day, to be applied thinly

**POTENCY**

- Fludroxycortide 0.0125% cream and ointment: moderate

**HAELAN® TAPE**

- Chronic localised recalcitrant dermatoses (but not acute or weeping)
  - **TO THE SKIN**
  - **Child:** Cut tape to fit lesion, apply to clean, dry skin shorn of hair, usually for 12 hours daily

**UNLICENSED USE**

- Licensed for use in children (age range not specified by manufacturer).

**SIDE-EFFECTS**

- Cushing’s syndrome - increased risk of infection - vasodilation

**PATIENT AND CARER ADVICE**

- Patients or carers should be counselled on application of fludroxycortide cream and ointment.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Ointment**

- **CAUTIONARY AND ADVISORY LABELS** 28

- **EXCIPIENTS:** May contain Propylene glycol, woolfat and related substances (including lanolin)
  - **Synalar** (Reig Jofre UK Ltd)
    - Flucinolone acetonide 62.5 microgram per 1 gram Synalar 1 in 4 Dilution 0.00625% ointment | 50 gram (£84) £4.84 DT = £4.84
    - Flucinolone acetonide 250 microgram per 1 gram Synalar 0.025% ointment | 30 gram (£14.14) £4.14 DT = £4.14 | 100 gram (£111.75) £11.75 DT = £11.75

**Cream**

- **CAUTIONARY AND ADVISORY LABELS** 28

- **EXCIPIENTS:** May contain Beeswax, cetostearyl alcohol (including cetyl and stearyl alcohol), polyborates, propylene glycol
  - **Synalar** (Reig Jofre UK Ltd)
    - Flucinolone acetonide 62.5 microgram per 1 gram Synalar 1 in 4 Dilution 0.00625% cream | 50 gram (£84) £4.84 DT = £4.84
    - Flucinolone acetonide 250 microgram per 1 gram Synalar 0.025% cream | 30 gram (£14.14) £4.14 DT = £4.14 | 100 gram (£111.75) £11.75 DT = £11.75

**Gel**

- **CAUTIONARY AND ADVISORY LABELS** 28

- **EXCIPIENTS:** May contain Hydroxybenzoates (parabens), propylene glycol
  - **Synalar** (Reig Jofre UK Ltd)
    - Flucinolone acetonide 250 microgram per 1 gram Synalar 0.025% gel | 30 gram (£5.56) £5.56 DT = £5.56 | 60 gram (£10.02) £10.02 DT = £10.02

**Combinations available:** Flucinolone acetonide with clioquinol, p. 765
  - Fluocinolone acetonide with neomycin, p. 765

Fluocinolone acetonide

**INDICATIONS AND DOSE**

- **Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids**

**Psoriasis**

- **TO THE SKIN**
  - **Child:** Apply 1–2 times a day, to be applied thinly

**POTENCY**

- Fluocinolone acetonide 0.025% cream, gel, and ointment: potent.
- Fluocinolone acetonide 0.00625% cream and ointment: moderate.
- Fluocinolone acetonide 0.0025% cream: mild.

**INTERACTIONS**

- Appendix 1: fluorocinolone

**SIDE-EFFECTS**

- Vasodilation

**PRESCRIBING AND DISPENSING INFORMATION**

- Gel is useful for application to the scalp and other hairy areas.

**PATIENT AND CARER ADVICE**

- Patient counselling is advised for fluorocinolone acetonide cream, gel and ointment (application).
Fluticasone

**INDICATIONS AND DOSE**
Severe inflammatory skin disorders such as dermatitis and eczemas unresponsive to less potent corticosteroids
- **Psoriasis**
  - **Child 1–2 months:** Apply 1–2 times a day, to be applied thinly
  - **Child 3 months–17 years:** Apply 1–2 times a day, to be applied thinly

**POTENCY**
- Fluticasone cream 0.05%: potent.
- Fluticasone ointment 0.005%: potent.

**UNLICENSED USE**
Not licensed for use in children under 3 months.

**INTERACTIONS**
Appendix 1: corticosteroids

**PATIENT AND CARER ADVICE**
Patients or carers should be given advice on application of fluticasone creams and ointments.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Cream**

- **Fluticasone (Non-proprietary)**
  - Fluticasone propionate 50 microgram per 1 gram
  - Cutivate (GlaxoSmithKline UK Ltd)
  - Fluticasone propionate 500 microgram per 1 gram
  - Cutivate (GlaxoSmithKline UK Ltd)

**Ointment**

- **Fluticasone (Non-proprietary)**
  - Fluticasone propionate 50 microgram per 1 gram
  - Cutivate (GlaxoSmithKline UK Ltd)
  - Fluticasone propionate 500 microgram per 1 gram

Hydrocortisone

**DRUG ACTION**
Hydrocortisone has equal glucocorticoid and mineralocorticoid activity.

**INDICATIONS AND DOSE**
Mild inflammatory skin disorders such as eczemas
- **TO THE SKIN**
  - Child: Apply 1–2 times a day, to be applied thinly

**Nappy rash**
- **TO THE SKIN**
  - Child: Apply 1–2 times a day for no longer than 1 week, discontinued as soon as the inflammation subsides

**POTENCY**
- Hydrocortisone cream and ointment 0.5 to 2.5%: mild

**INTERACTIONS**
Appendix 1: corticosteroids

**SIDE-EFFECTS**
Vasodilation

**PRESCRIBING AND DISPENSING INFORMATION**
When hydrocortisone cream or ointment is prescribed and no strength is stated, the 1% strength should be supplied. Although Diaderm™ contains only 0.1% hydrocortisone, the formulation is designed to provide a clinical activity comparable to that of Hydrocortisone Cream 1% BP.

**PATIENT AND CARER ADVICE**
Patient counselling is advised for hydrocortisone cream and ointment (application).

**PROFESSION SPECIFIC INFORMATION**

**Dental practitioners’ formulary**
Hydrocortisone Cream 1% 15 g may be prescribed.

**EXCEPTIONS TO LEGAL CATEGORY**
Skin creams and ointments containing hydrocortisone (alone or with other ingredients) can be sold to the public for the treatment of allergic contact dermatitis, irritant dermatitis, insect bite reactions and mild to moderate eczema in patients over 10 years, to be applied sparingly over the affected area 1–2 times daily for max. 1 week. Over-the-counter hydrocortisone preparations should not be sold without medical advice for children under 10 years or for pregnant women; they should not be sold for application to the face, anogenital region, broken or infected skin (including cold sores, acne, and athlete’s foot).

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment

**Cream**

- **Fluticasone (Non-proprietary)**
  - Fluticasone 5 mg per 1 gram
  - Hydrocortisone 0.5% cream
  - 15 gram (PSt) £44.00 DT = £1.01 | 30 gram (PSt) £2.02–£88.00
  - Hydrocortisone 10 mg per 1 gram
  - 15 gram (PSt) £10.50 DT = £0.94 | 30 gram (PSt) £23.83 DT = £1.88
  - 50 gram (PSt) £36.12 DT = £3.13
  - Hydrocortisone 25 mg per 1 gram
  - Hydrocortisone 2.5% cream
  - 15 gram (PSt) £44.00 DT = £4.15 | 30 gram (PSt) £10.74–£88.00
  - **Dioderm (Dermal Laboratories Ltd)**
    - Hydrocortisone 1 mg per 1 gram
    - Dioderm 0.1% cream
    - 30 gram (PSt) £2.39 DT = £2.39
    - **Mildison Lipocream (LEO Pharma)**
      - Hydrocortisone 10 mg per 1 gram
      - Mildison Lipocream 1% cream
      - 30 gram (PSt) £1.71 DT = £1.88

**Ointment**

- **Fluticasone (Non-proprietary)**
  - Fluticasone 5 mg per 1 gram
  - Hydrocortisone 0.5% ointment
  - 15 gram (PSt) £44.00 DT = £5.94 | 30 gram (PSt) £12.00–£88.00
  - Hydrocortisone 10 mg per 1 gram
  - Hydrocortisone 1% ointment
  - 15 gram (PSt) £10.50 DT = £1.17 | 30 gram (PSt) £3.31 DT = £2.14
  - 50 gram (PSt) £36.12 DT = £3.57
  - Hydrocortisone 25 mg per 1 gram
  - Hydrocortisone 2.5% ointment
  - 15 gram (PSt) £44.00 DT = £24.57 | 30 gram (PSt) £49.14–£88.00

**Combinations available:**

Hydrocortisone butyrate

**INDICATIONS AND DOSE**
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids | Psoriasis

- **TO THE SKIN**
  - Child 1–17 years: Apply 1–2 times a day, to be applied thinly

**POTENCY**
- Hydrocortisone butyrate 0.1% cream, liquid, and ointment: potent

**PATIENT AND CARER ADVICE**
Patients or carers should be given advice on how to administer hydrocortisone butyrate lotion, cream, ointment and scalp lotion.

Medicines for Children leaflet: Hydrocortisone (topical) for eczema www.medicinesforchildren.org.uk/hydrocortisone-topical-eczema
Mometasone furoate

• INDICATIONS AND DOSE
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids
▶ TO THE SKIN
▶ Child 1 month-1 year: Apply once daily, to be applied thinly (to scalp in case of lotion)
▶ Child 2-17 years: Apply once daily, to be applied thinly
POTENCY
▶ Mometasone furoate 0.1% cream, ointment, and scalp lotion: potent.

• UNLICENSED USE Not licensed for use in children under 2 years.
• INTERACTIONS ▶ Appendix 1: corticosteroids

Corticosteroids > Corticosteroid combinations with anti-infectives

Betamethasone with clioquinol

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 756.

• INDICATIONS AND DOSE
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids
▶ TO THE SKIN
▶ Child: (consult product literature)
POTENCY
▶ Betamethasone (as valerate) 0.1% with clioquinol cream and ointment: potent.

• UNLICENSED USE Betamethasone and clioquinol preparations is not licensed for use in children under 1 year.
• INTERACTIONS ▶ Appendix 1: corticosteroids
• PATIENT AND CARER ADVICE Stains clothing. Patients or carers should be counselled on application of betamethasone with clioquinol preparations.

Betamethasone with clotrimazole

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 454, clotrimazole p. 748.

• INDICATIONS AND DOSE
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids
▶ TO THE SKIN
▶ Child: (consult product literature)
POTENCY
▶ Betamethasone dipropionate 0.064% (=betamethasone 0.5%) with clotrimazole cream: potent.

• UNLICENSED USE Lotriderm® not licensed for use in children under 12 years.
• INTERACTIONS ▶ Appendix 1: antifungals, azoles - corticosteroids
• PATIENT AND CARER ADVICE Patients or carers should be given advice on how to administer betamethasone with clotrimazole cream.
Betamethasone with fusidic acid

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 758, fusidic acid p. 371.

**INDICATIONS AND DOSE**
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids | Psoriasis
- TO THE SKIN
- Child: (consult product literature)

**POTENCY**
- Betamethasone (as valerate) 0.1% with fusidic acid cream: potent.

**LICENSED USE**
Betamethasone with neomycin (Non-proprietary)
Betamethasone (as Betamethasone valerate) 1 mg per 1 gram, Neomycin sulfate 5 mg per 1 gram
- Ointment
- Cream

**INTERACTIONS**
- Appendix 1: corticosteroids • fusidic acid

**PATIENT AND CARER ADVICE**
Patients or carers should be counselled on application of betamethasone with fusidic acid preparations.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Cream**
- CAUTIONARY AND ADVISORY LABELS 2B
- BETAMETHASONE (as Betamethasone valerate) 1 mg per 1 gram, Fusidic acid 20 mg per 1 gram
- Lotriderm (Merck Sharp & Dohme Ltd) £6.84 DT + £6.34

**Betamethasone with neomycin**

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 758, neomycin sulfate p. 746.

**INDICATIONS AND DOSE**
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids | Psoriasis
- TO THE SKIN
- Child: 1–2 times a day, to be applied thinly

**POTENCY**
- Betamethasone (as valerate) 0.1% with neomycin cream and ointment: potent.

**LICENSED USE**
Betamethasone and neomycin preparations not licensed for use in children under 2 years.

**INTERACTIONS**
- Appendix 1: corticosteroids • neomycin

**PATIENT AND CARER ADVICE**
Patient counselling is advised for betamethasone with neomycin cream and ointment (application).

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Ointment**
- CAUTIONARY AND ADVISORY LABELS 2B
- BETAMETHASONE (as Betamethasone valerate) 1 mg per 1 gram
- Neomycin sulfate 5 mg per 1 gram
- Neomycin 5 mg per 1 gram
- Betamethasone valerate 0.1% / Neomycin 0.5% ointment
- 50 mg £8.88 DT + £31.56 | 100 mg £97.00 DT + £104.52

**Cream**
- CAUTIONARY AND ADVISORY LABELS 2B
- BETAMETHASONE (as Betamethasone valerate) 1 mg per 1 gram
- Neomycin sulfate 5 mg per 1 gram
- Neomycin 5 mg per 1 gram
- Betamethasone valerate 0.1% / Neomycin 0.5% cream
- 50 mg £8.88 DT + £31.56 | 100 mg £97.00 DT + £104.52

**Betamethasone with salicylic acid**

The properties listed below are those particular to the combination only. For the properties of the components please consider, betamethasone p. 758, salicylic acid p. 791.

**INDICATIONS AND DOSE**
DIPROSALIC ® OINTMENT
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids | Psoriasis
- TO THE SKIN
- Child: Apply 1–2 times a day, max. 60 g per week

**POTENCY**
- Betamethasone (as dipropionate) 0.05% with salicylic acid 3%: potent.

**DIPROSALIC ® SCALP APPLICATION**
Severe inflammatory skin disorders such as eczemas unresponsive to less potent corticosteroids | Psoriasis
- TO THE SKIN
- Child: Apply 1–2 times a day, apply a few drops

**POTENCY**
- Betamethasone (as dipropionate) 0.05% with salicylic acid 2%: potent.

**INTERACTIONS**
- Appendix 1: corticosteroids

**PATIENT AND CARER ADVICE**
DIPROSALIC ® OINTMENT Patients or carers should be counselled on application of betamethasone and salicylic acid preparations.

DIPROSALIC ® SCALP APPLICATION Patients or carers should be counselled on application of betamethasone and salicylic acid scalp application.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Ointment**
- DIPROSALIC ® OINTMENT
- DIPROSALIC ® SCALP APPLICATION

**Cream**
- CAUTIONARY AND ADVISORY LABELS 2B
- BETAMETHASONE (as Betamethasone valerate) 1 mg per 1 gram, Salicylic acid 20 mg per 1 gram
- £0.50 DT + £6.38 | 60 gram £12.76
- £0.65 DT + £6.38 | 60 gram £12.45 DT + £12.76

**Liquid**
- CAUTIONARY AND ADVISORY LABELS 2B
- BETAMETHASONE (as Betamethasone dipropionate) 500 microgram per 1 ml, Salicylic acid 20 mg per 1 ml
- £0.05/2% scalp application | 100 ml £10.10 DT + £10.10
Clobetasol propionate with neomycin sulfate and nystatin

The properties listed below are those particular to the combination only. For the properties of the components please consider, clobetasol propionate p. 759, neomycin sulfate p. 746.

- **INDICATIONS AND DOSE**
  - Short-term treatment only of severe resistant inflammatory skin disorders such as calcified, chronic eczemas associated with infection and unresponsive to less potent corticosteroids | Psoriasis associated with infection
  - **TO THE SKIN**
  - Child: (consult product literature)
  - **POTENCY**
  - Clobetasol propionate 0.05% with neomycin sulfate and nystatin cream and ointment: very potent.

- **UNLICENSED USE**
  - Clobetasol with neomycin and nystatin preparations not licensed for use in children under 2 years.

- **INTERACTIONS**
  - Appendix 1: neomycin

- **PATIENT AND CARER ADVICE**
  - Patients or carers should be advised on application of clobetasol propionate, neomycin sulfate and nystatin containing preparations.

- **M EDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS**
    - **EXCIPIENTS:** May contain Cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol, disodium edetate, hydroxybenzoates (parabens), polysorbates, propylene glycol

Clobetasone butyrate with nystatin and oxytetracycline

The properties listed below are those particular to the combination only. For the properties of the components please consider, clobetasone butyrate p. 760, oxytetracycline p. 367.

- **INDICATIONS AND DOSE**
  - Steroid-responsive dermatoses where candidal or bacterial infection is present
  - **TO THE SKIN**
  - Child: (consult product literature)
  - **POTENCY**
  - Clobetasone butyrate 0.05% with nystatin and oxytetracycline cream: moderate.

- **INTERACTIONS**
  - Appendix 1: tetracyclines

- **PATIENT AND CARER ADVICE**
  - Stains clothing.

- **M EDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream

Fluocinolone acetonide with clioquinol

The properties listed below are those particular to the combination only. For the properties of the components please consider, fluocinolone acetonide p. 761.

- **INDICATIONS AND DOSE**
  - Inflammatory skin disorders such as eczemas associated with infection | Psoriasis associated with infection
  - **TO THE SKIN**
  - Child: Apply 1–2 times a day, to be applied thinly, reducing strength as condition responds
  - **POTENCY**
  - Clioquinol 3% with fluocinolone acetonide 0.025% cream and ointment: potent.

- **INTERACTIONS**
  - Appendix 1: fluocinolone

- **PATIENT AND CARER ADVICE**
  - Patient counselling is advised for clioquinol with fluocinolone acetonide cream and ointment (application). Ointment stains clothing.

- **M EDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

Fluocinolone acetonide with neomycin

The properties listed below are those particular to the combination only. For the properties of the components please consider, fluocinolone acetonide p. 761, neomycin sulfate p. 746.

- **INDICATIONS AND DOSE**
  - Inflammatory skin disorders such as eczemas associated with infection | Psoriasis associated with infection
  - **TO THE SKIN**
  - Child 1–11 months: Apply 1–2 times a day, to be applied thinly, reducing strength as condition responds
  - Child 1–17 years: Apply 1–2 times a day, to be applied thinly, reducing strength as condition responds
  - **POTENCY**
  - Fluocinolone acetonide 0.025% with neomycin 0.5% cream and ointment: potent.

- **INTERACTIONS**
  - Appendix 1: fluocinolone, neomycin

- **PATIENT AND CARER ADVICE**
  - Patients or carers should be counselled on the application of fluocinolone acetonide with neomycin preparations.
Hydrocortisone with benzalkonium chloride, dimeticone and nystatin

The properties listed below are those particular to the combination only. For the properties of the components please consider, hydrocortisone p. 762, dimeticone p. 752.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Ointment**
- CAUTIONARY AND ADVISORY LABELS 28
- EXCIPIENTS: May contain Propylene glycol, woolfat and related substances (including lanolin)
  - Synalar N (Reig Jofre UK Ltd)
  - Fluocinolone acetate 250 microgram per 1 gram, Neomycin sulfate 5 mg per 1 gram Synalar N ointment | 30 gram £4.36

**INTERACTIONS** → Appendix 1: corticosteroids

**PATIENT AND CARER ADVICE** Patients or carers should be advised on application of benzalkonium with dimeticone and hydrocortisone and nystatin preparations.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Cream**
- CAUTIONARY AND ADVISORY LABELS 28
- EXCIPIENTS: May contain Butylated hydroxyanisole, cetostearyl alcohol (including cetyl and stearyl alcohol), hydroxybenzoates (parabens), sodium metabisulfite, sorbic acid
  - Timodine (Alliance Pharmaceuticals Ltd)
  - Benzalkonium chloride 1 mg per 1 gram, Hydrocortisone 5 mg per 1 gram, Dimeticone 350 100 mg per 1 gram, Nystatin 100000 unit per 1 gram Timodine cream | 30 gram £3.37

**INDICATIONS AND DOSE**
- Mild inflammatory skin disorders such as eczemas associated with infection
  - TO THE SKIN
  - Child: Apply 3 times a day until lesion has healed, to be applied thinly
- POTENCY
  - Benzalkonium with dimeticone, hydrocortisone acetate 0.5%, and nystatin cream: mild

**INTERACTIONS** → Appendix 1: corticosteroids

**PATIENT AND CARER ADVICE** Patients or carers should be advised on application of benzalkonium with dimeticone and hydrocortisone and nystatin preparations.

Hydrocortisone with chlorhexidine hydrochloride and nystatin

The properties listed below are those particular to the combination only. For the properties of the components please consider, hydrocortisone p. 762, chlorhexidine p. 785.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Ointment**
- CAUTIONARY AND ADVISORY LABELS 28
- EXCIPIENTS: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates
  - Hydrocortisone with chlorhexidine hydrochloride and nystatin
    - (Non-proprietary)
    - Chlorhexidine acetate 10 mg per 1 gram, Hydrocortisone 10 mg per 1 gram, Nystatin 100000 unit per 1 gram
    - Nystatin 100,000 units/g / Chlorhexidine acetate 1% / Hydrocortisone 1% ointment | 30 gram £5.29 DT = £5.29

**Cream**
- CAUTIONARY AND ADVISORY LABELS 28
- EXCIPIENTS: May contain Benzy alcohol, cetoesteryl alcohol (including cetyl and stearyl alcohol), polysorbates
  - Hydrocortisone with chlorhexidine hydrochloride and nystatin
    - (Non-proprietary)
    - Hydrocortisone 5 mg per 1 gram, Chlorhexidine hydrochloride 10 mg per 1 gram, Nystatin 100000 unit per 1 gram
    - Nystatin 100,000 units/g / Chlorhexidine hydrochloride 1% / Hydrocortisone 0.5% cream | 30 gram £5.29 DT = £5.29

**INDICATIONS AND DOSE**
- Mild inflammatory skin disorders such as eczemas (associated with fungal infection)
  - TO THE SKIN
  - Child: (consult product literature)
- POTENCY
  - Clotrimazole with hydrocortisone 1% cream: mild

**INTERACTIONS** → Appendix 1: antifungals, azoles - corticosteroids

**PATIENT AND CARER ADVICE** Patients or carers should be given advice on how to administer clotrimazole with hydrocortisone cream.

**EXCEPTIONS TO LEGAL CATEGORY** A 15-g tube is on sale to the public for the treatment of athlete’s foot and fungal infection of skin folds with associated inflammation in patients 10 years and over.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Cream**
- CAUTIONARY AND ADVISORY LABELS 28
- EXCIPIENTS: May contain Benzyl alcohol, cetoesteryl alcohol (including cetyl and stearyl alcohol)
  - Canesten HC (Bayer Plc)
  - Clotrimazole 10 mg per 1 gram, Hydrocortisone 10 mg per 1 gram Canesten HC cream | 30 gram £2.42 DT = £2.42

Hydrocortisone with fusidic acid

The properties listed below are those particular to the combination only. For the properties of the components please consider, hydrocortisone p. 762, fusidic acid p. 371.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Ointment**
- CAUTIONARY AND ADVISORY LABELS 28
  - Hydrocortisone with fusidic acid cream: mild

**INDICATIONS AND DOSE**
- Mild inflammatory skin disorders such as eczemas
  - TO THE SKIN
  - Child: To be applied thinly (consult product literature)
- POTENCY
  - Hydrocortisone with fusidic acid cream: mild

**INTERACTIONS** → Appendix 1: corticosteroids - fusidic acid

**PATIENT AND CARER ADVICE** Patients or carers should be advised on application of hydrocortisone with fusidic acid preparations.
Hydrocortisone with miconazole

The properties listed below are those particular to the combination only. For the properties of the components please consider, hydrocortisone p. 762, miconazole p. 749.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **EXCIPIENTS**: May contain Butylated hydroxyanisole, cetostearyl alcohol (including cetyl and stearyl alcohol), polymers, potassium sorbate
    - Fucidin H (Fusidic acid / Hydrocortisone) (LEO Pharma)
      - Hydrocortisone acetate 10 mg per 1 gram, Fusidic acid 20 mg per 1 gram Fucidin H cream | 30 gram (POM) £6.02 DT = £6.02
      - 60 gram (POM) £12.05 DT = £12.05
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **EXCIPIENTS**: May contain Butylated hydroxyanisole, cetostearyl alcohol (including cetyl and stearyl alcohol), polysorbates, potassium sorbate
    - Ichthammol (Non-proprietary)
      - Hydrocortisone 10 mg per 1 gram, Miconazole nitrate 20 mg per 1 gram Ichthammol ointment | 30 gram (POM) £5.01 DT = £5.01

- **INDICATIONS AND DOSE**
  - **Mild inflammatory skin disorders such as eczemas associated with infections**
    - **TO THE SKIN**
    - **Child**: (consult product literature)
  - **POTENCY**
    - Hydrocortisone 1% with miconazole cream and ointment: mild

- **INTERACTIONS** → Appendix 1: antifungals, azoles · corticosteroids
- **PATIENT AND CARER ADVICE** Patients or carers should be advised on application of hydrocortisone with miconazole preparations.
- **PROFESSION SPECIFIC INFORMATION**
  - **Dental practitioners’ formulary**
    - May be prescribed as Miconazole and Hydrocortisone Cream or Ointment for max. 28 days.
  - **EXCEPTIONS TO LEGAL CATEGORY** A 15-g tube of hydrocortisone with miconazole cream is on sale to the public for the treatment of athlete’s foot and candidal intertrigo in children over 10 years.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **Terra-Cortril** (Intrapharm Laboratories Ltd)
      - Hydrocortisone 10 mg per 1 gram, Oxymetazoline (as Oxymetazoline hydrochloride) 30 mg per 1 gram Terra-Cortril ointment | 30 gram (POM) £5.01 DT = £5.01

**DERMATOLOGICAL DRUGS** → **ANTI-INFECTIVES**

**Ichthammol**

- **INDICATIONS AND DOSE**
  - **Chronic lichenified eczema**
    - **TO THE SKIN**
    - **Child**: 1-17 years: Apply 1–3 times a day

- **UNLICENSED USE** No information available.
- **SIDE-EFFECTS** Skin irritation

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **Terra-Cortril** (Intrapharm Laboratories Ltd)
      - Hydrocortisone 10 mg per 1 gram, Oxymetazoline (as Oxymetazoline hydrochloride) 30 mg per 1 gram Terra-Cortril ointment | 30 gram (POM) £5.01 DT = £5.01
  - **Cream**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **EXCIPIENTS**: May contain Butylated hydroxyanisole, disodium edetate
    - **Daktacort** (Janssen-Cilag Ltd)
      - Hydrocortisone 10 mg per 1 gram, Miconazole nitrate 20 mg per 1 gram Daktacort ointment | 30 gram (POM) £2.50 DT = £2.50

**Ichthammol with zinc oxide**

The properties listed below are those particular to the combination only. For the properties of the components please consider, ichthammol above.

- **INDICATIONS AND DOSE**
  - **Chronic lichenified eczema**
    - **TO THE SKIN**
    - **Child**: (consult product literature)

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: ointment, paste
  - **Liquids**
    - **Ichthammol (Non-proprietary)**
      - Ichthammol 1 mg per 1 mg Ichthammol liquid | 100 gram (GSS) £12.86 DT = £12.86 | 500 gram (GSS) £41.47

- **CONTRA-INDICATIONS** Children under 12 years

**Hydrocortisone with oxytetracycline**

The properties listed below are those particular to the combination only. For the properties of the components please consider, hydrocortisone p. 762, oxytetracycline p. 367.

- **INDICATIONS AND DOSE**
  - **Mild inflammatory skin disorders such as eczemas**
    - **TO THE SKIN**
    - **Child 12-17 years**: (consult product literature)
  - **POTENCY**
    - Hydrocortisone 1% with oxytetracycline ointment: mild

- **INTERACTIONS** → Appendix 1: corticosteroids · tetracyclines
- **PREGNANCY** Tetracyclines should not be given to pregnant women. Effects on skeletal development have been documented when tetracyclines have been used in the first trimester in animal studies. Administration during the second or third trimester may cause discoloration of the child’s teeth.
- **BREAST FEEDING** Tetracyclines should not be given to women who are breast-feeding (although absorption and therefore discoloration of teeth in the infant is probably usually prevented by chelation with calcium in milk).
- **PATIENT AND CARER ADVICE** Patients should be given advice on the application of hydrocortisone with oxytetracycline ointment.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **Terra-Cortril** (Intrapharm Laboratories Ltd)
      - Hydrocortisone 10 mg per 1 gram, Oxymetazoline (as Oxymetazoline hydrochloride) 30 mg per 1 gram Terra-Cortril ointment | 30 gram (POM) £5.01 DT = £5.01

- **INTERACTIONS** → Appendix 1: corticosteroids · tetracyclines
- **PREGNANCY** Tetracyclines should not be given to pregnant women. Effects on skeletal development have been documented when tetracyclines have been used in the first trimester in animal studies. Administration during the second or third trimester may cause discoloration of the child’s teeth.
- **BREAST FEEDING** Tetracyclines should not be given to women who are breast-feeding (although absorption and therefore discoloration of teeth in the infant is probably usually prevented by chelation with calcium in milk).
- **PATIENT AND CARER ADVICE** Patients should be given advice on the application of hydrocortisone with oxytetracycline ointment.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Ointment**
    - **CAUTIONARY AND ADVISORY LABELS** 28
    - **Terra-Cortril** (Intrapharm Laboratories Ltd)
      - Hydrocortisone 10 mg per 1 gram, Oxymetazoline (as Oxymetazoline hydrochloride) 30 mg per 1 gram Terra-Cortril ointment | 30 gram (POM) £5.01 DT = £5.01

**DERMATOLOGICAL DRUGS** → **ANTI-INFECTIVES**

**Ichthammol**

- **INDICATIONS AND DOSE**
  - **Chronic lichenified eczema**
    - **TO THE SKIN**
    - **Child**: 1-17 years: Apply 1–3 times a day

- **UNLICENSED USE** No information available.
- **SIDE-EFFECTS** Skin irritation

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: ointment, paste
  - **Liquids**
    - **Ichthammol (Non-proprietary)**
      - Ichthammol 1 mg per 1 mg Ichthammol liquid | 100 gram (GSS) £12.86 DT = £12.86 | 500 gram (GSS) £41.47

**Ichthammol with zinc oxide**

The properties listed below are those particular to the combination only. For the properties of the components please consider, ichthammol above.

- **INDICATIONS AND DOSE**
  - **Chronic lichenified eczema**
    - **TO THE SKIN**
    - **Child**: (consult product literature)
DERMATOLOGICAL DRUGS > ANTRACEN

**Dithranol**
*(Anthralin)*

- **INDICATIONS AND DOSE**
  - **Subacute and chronic psoriasis**
  - **TO THE SKIN**
  - Child: (consult product literature)
  - **DITHROCREAM®**
  - **Subacute and chronic psoriasis**
  - **TO THE SKIN**
  - Child: For application to skin or scalp, 0.1–0.5% cream suitable for overnight treatment, 1–2% cream for maximum 1 hour (consult product literature)
  - **MICANOL®**
  - **Subacute and chronic psoriasis**
  - **TO THE SKIN**
  - Child: Apply once daily, for application to skin or scalp, to be applied for up to 30 minutes, apply 1% cream, if necessary 3% cream can be used under medical supervision

- **UNLICENSED USE**
  - **MICANOL®** Micanol® licensed for use in children, but not recommended for infants or young children (age range not specified by manufacturer).
  - **DITHROCREAM®** Dithrocream® is licensed for use in children (age range not specified by manufacturer).

- **CONTRA-INDICATIONS**
  - Acute and pustular psoriasis - hypersensitivity

- **CAUTIONS**
  - Avoid sensitive areas of skin - avoid use near eyes

- **SIDE-EFFECTS**
  - Skin reactions

- **PREGNANCY**
  - No adverse effects reported.

- **BREAST FEEDING**
  - No adverse effects reported.

- **DIRECTIONS FOR ADMINISTRATION**
  - When applying dithranol, hands should be protected by gloves or they should be washed thoroughly afterwards. Dithranol should be applied to chronic extensor plaques only, carefully avoiding normal skin.
  - **MICANOL®** At the end of contact time, use plenty of lukewarm (not hot) water to rinse off cream; soap may be used after the cream has been rinsed off; use shampoo before applying cream to scalp and if necessary after cream has been rinsed off.

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Treatment should be started with a low concentration such as dithranol 0.1%, and the strength increased gradually every few days up to 3%, according to tolerance.

- **PATIENT AND CARER ADVICE**
  - Dithranol can stain the skin, hair and fabrics.

- **EXCEPTIONS TO LEGAL CATEGORY**
  - Prescription only medicine if dithranol content more than 1%, otherwise may be sold to the public.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: ointment

- **Cream**

  - **CAUTIONARY AND ADVISORY LABELS**
  - **28 EXCipients:** May contain cetostearyl alcohol (including cetyl and stearyl alcohol), chlorocresol
  - **Dithrocream** (Dermal Laboratories Ltd)

  - **Dithranol 5 mg per 1 gram** Dithrocream 0.5% cream | 50 gram £4.66 DT + £4.66
  - **Dithranol 10 mg per 1 gram** Dithrocream 1% cream | 50 gram £5.42 DT + £5.42
  - **Dithranol 20 mg per 1 gram** Dithrocream 2% cream | 50 gram £6.79 DT + £6.79

  - Combinations available: **Coal tar with dithranol and salicylic acid**, p. 769

**Dithranol with salicylic acid and zinc oxide**

The properties listed below are those particular to the combination only. For the properties of the components please consider, dithranol above, salicylic acid p. 791.

- **INDICATIONS AND DOSE**
  - **Subacute and chronic psoriasis**
  - **TO THE SKIN**
  - Child: (consult local protocol)

- **MEDICINAL FORMS**
  - Forms available from special-order manufacturers include: ointment, paste

DERMATOLOGICAL DRUGS > TARS

**Coal tar**

- **INDICATIONS AND DOSE**
  - **Psoriasis | Chronic atopic eczema**
  - **TO THE SKIN USING PASTE**
  - Child: Apply 1–3 times a day, start application with low-strength preparations
  - **TO THE SKIN**
  - Child: 100 mL/bath, to be added to an adult sized bath; add proportionally less for a child’s bath. Use Coal Tar Solution BP

  - **ALPHOSYL 2 IN 1® SHAMPOO**

  - **Psoriasis | Seborrhoeic dermatitis | Scaling | Itching**
  - **TO THE SKIN**
  - Child: Apply every 2–3 days

  - **Dandruff**
  - **TO THE SKIN**
  - Child: Apply 1–2 times a week as required

  - **EXOREX® LOTION**

  - **Psoriasis**
  - **TO THE SKIN**
  - Child: Apply 2–3 times a day, to be applied to skin or scalp; can be diluted with a few drops of water before applying

  - **PSORIDERM® SCALP LOTION**

  - **Scalp psoriasis**
  - **TO THE SKIN**
  - Child: As required

- **CONTRA-INDICATIONS**
  - Avoid broken or inflamed skin - avoid eye area - avoid genital area - avoid mucosal areas - avoid rectal area - infection - sore, acute, or pustular psoriasis

- **CAUTIONS**
  - Application to face - application to skin flexures

- **SIDE-EFFECTS**
  - Photosensitivity reaction - skin reactions

- **PRESCRIBING AND DISPENSING INFORMATION**
  - Coal Tar Solution BP contains coal tar 20%, Strong Coal Tar Solution BP contains coal tar 40%.

- **HANDLING AND STORAGE**
  - Use suitable chemical protection gloves for extemporaneous preparation. May stain skin, hair and fabric.
PATIENT AND CARER ADVICE  May stain skin, hair and fabric.

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: cream, ointment, paste

Cutaneous emulsion  EXCIPIENTS: May contain Hydroxybenzoates (parabens)
  
  Exorex  (Teva UK Ltd)
  
  Coal tar solution 50 mg per 1 gram  Exorex lotion | 100 ml | GSK £8.11 DT + £16.24
  
  Shampoo  EXCIPIENTS: May contain Fragrances, hydroxybenzoates (parabens)
  
  Alphosyl 2 in 1  (Omega Pharma Ltd)
  
  Coal tar solution 50 mg per 1 gram  Alphosyl 2 in 1 shampoo | 250 ml | GSK £5.49 DT + £5.49
  
  Neutrogena T/Gel Therapeutic  (Johnson & Johnson Ltd)
  
  Coal tar extract 20 mg per 1 gram  Neutrogena T/Gel Therapeutic shampoo | 125 ml | GSK £3.90 DT + £3.90 | 250 ml | GSK £5.86 DT + £5.86
  
  Polytar Scalp  (GlaxoSmithKline Consumer Healthcare)
  
  Coal tar solution 40 mg per 1 ml  Polytar Scalp shampoo | 150 ml | GSK £3.46 DT + £3.46
  
  Psoriderm  (Dermal Laboratories Ltd)
  
  Coal tar solution 25 mg per 1 ml  Psoriderm shampoo | 250 ml | £4.74 DT + £4.74

Coal tar with coconut oil and salicylic acid

The properties listed below are those particular to the combination only. For the properties of the components please consider, coal tar p. 768, salicylic acid p. 791.

INDICATIONS AND DOSE
  
  Scaly scalp disorders: Psoriasis | Seborrhoeic dermatitis | Dandruff | Cradle cap
  
  Child: Apply daily as required

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Shampoo  
  
  Capasal  (Dermal Laboratories Ltd)
  
  Salicylic acid 5 mg per 1 gram, Coal tar distilled 10 mg per 1 gram, Coconut oil 10 mg per 1 gram  Capasal Therapeutic shampoo | 250 ml | £4.69

Coal tar with dithranol and salicylic acid

The properties listed below are those particular to the combination only. For the properties of the components please consider, coal tar p. 768, dithranol p. 768, salicylic acid p. 791.

INDICATIONS AND DOSE
  
  Subacute and chronic psoriasis
  
  Child: Apply up to twice daily

UNLICENSED USE  Psorin® is licensed for use in children (age range not specified by manufacturer).

MEDICINAL FORMS  Forms available from special-order manufacturers include: ointment

Coal tar with lecithin

The properties listed below are those particular to the combination only. For the properties of the components please consider, coal tar p. 768.

INDICATIONS AND DOSE
  
  Psoriasis
  
  TO THE SKIN
  
  Child: Apply 1–2 times a day, cream to be applied to the skin or scalp

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Cream  EXCIPIENTS: May contain Isopropyl palmitate, propylene glycol
  
  Psoriderm  (Dermal Laboratories Ltd)
  
  Lecithin 4 mg per 1 gram, Coal tar distilled 60 mg per 1 gram  Psoriderm cream | 225 ml | £9.42 DT + £9.42

Coal tar with salicylic acid and precipitated sulfur

The properties listed below are those particular to the combination only. For the properties of the components please consider, coal tar p. 768, salicylic acid p. 791.

INDICATIONS AND DOSE
  
  CCOOIS® OINTMENT
  
  Scaly scalp disorders including psoriasis, eczema, seborrhoeic dermatitis and dandruff
  
  TO THE SKIN USING SCALP OINTMENT
  
  Child 6–11 years: Medical supervision required
  
  Child 12–17 years: Apply once weekly as required, alternatively (to the skin) apply daily for the first 3–7 days (if severe), shampoo off after 1 hour

SEBCO® OINTMENT
  
  Scaly scalp disorders including psoriasis, eczema, seborrhoeic dermatitis and dandruff
  
  TO THE SKIN USING SCALP OINTMENT
  
  Child 6–11 years: Medical supervision required
  
  Child 12–17 years: Apply as required, alternatively apply daily for the first 3–7 days (if severe), shampoo off after 1 hour

MEDICINAL FORMS  There can be variation in the licensing of different medicines containing the same drug.

Ointment  EXCIPIENTS: May contain Cetostearyl alcohol (including cetyl and stearyl alcohol)
  
  CCoos (RPH Pharmaceuticals AB)
  
  Coal tar solution 120 mg per 1 gram  CCoos ointment | 40 gram | £6.22 | 100 gram | GSK £11.69
  
  Sebco (Derma UK Ltd)
  
  Coal tar solution 120 mg per 1 gram  Sebco ointment | 40 gram | GSK £6.20 | 100 gram | GSK £11.67
Coal tar with zinc oxide

The properties listed below are those particular to the combination only. For the properties of the components please consider, coal tar p. 768.

**INDICATIONS AND DOSE**

Psoriasis | Chronic atopic eczema

▶ **TO THE SKIN**

Child: Apply 1–2 times a day

**MEDICINAL FORMS**

Forms available from special-order manufacturers include: ointment, paste

**IMMUNOSUPPRESSANTS** > CALCINEURIN INHIBITORS AND RELATED DRUGS

Pimecrolimus

**INDICATIONS AND DOSE**

Short-term treatment of mild to moderate atopic eczema (including flares) when topical corticosteroids cannot be used (initiated by a specialist)

▶ **TO THE SKIN**

Child 2–17 years: Apply twice daily until symptoms resolve (stop treatment if eczema worsens or no response after 6 weeks)

**CONTRA-INDICATIONS** Application to malignant or potentially malignant skin lesions - application under occlusion - congenital epidermal barrier defects - contact with eyes - contact with mucous membranes - generalised erythroderma - immunodeﬁciency - infection at treatment site

**CAUTIONS**

Alcohol consumption (risk of facial ﬂushing and skin irritation) - avoid other topical treatments except emollients at treatment site - UV light (avoid excessive exposure to sunlight and sunlamps)

**INTERACTIONS** ▶ Appendix 1: pimecrolimus

**SIDE-EFFECTS**

▶ Common or very common | Increased risk of infection

▶ Rare or very rare | Skin discolouration

▶ Frequency not known | Skin papilloma

**PREGNANCY**

Manufacturer advises avoid; toxicity in animal studies following systemic administration.

**BREAST FEEDING**

Manufacturer advises caution; ensure infant does not come in contact with treated areas.

**NATIONAL FUNDING/ACCESS DECISIONS**

NICE decisions

Tacrolimus and pimecrolimus for atopic eczema (August 2004) NICE TA82

Topical pimecrolimus is an option for atopic eczema not controlled by maximal topical corticosteroid treatment or if there is a risk of important corticosteroid side-effects (particularly skin atrophy).

Topical pimecrolimus is recommended for moderate atopic eczema on the face and neck of children aged 2–16 years. Pimecrolimus should be used within its licensed indications.

www.nice.org.uk/TA82

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

Cream

CAUTIONARY AND ADVISORY LABELS 4, 11, 28

EXCIPIENTS: May contain Benzyl alcohol, cetostearyl alcohol (including cetyl and stearyl alcohol), propylene glycol

▶ Elidel (Meda Pharmaceuticals Ltd)

Pimecrolimus 10 mg per 1 gram Elidel 1% cream | 30 gram £37.41 DT + £37.41 | 60 gram £72.30 DT + £72.30 | 100 gram £100.07 DT + £100.07

Tacrolimus

**DRUG ACTION**

Tacrolimus is a calcineurin inhibitor.

**INDICATIONS AND DOSE**

Short-term treatment of moderate to severe atopic eczema (including flares) in patients unresponsive to, or intolerant of conventional therapy (initiated by a specialist)

▶ **TO THE SKIN**

Child 2–17 years: Apply twice daily for up to 3 weeks (consider other treatment if eczema worsens or if no improvement after 2 weeks), 0.03% ointment to be applied thinly, then reduced to once daily until lesion clears

Child 16–17 years: Apply twice daily until lesion clears (consider other treatment if eczema worsens or no improvement after 2 weeks), initially 0.1% ointment to be applied thinly, reduce frequency to once daily or strength of ointment to 0.03% if condition allows

Prevention of flares in patients with moderate to severe atopic eczema and 4 or more flares a year who have responded to initial treatment with topical tacrolimus (initiated by a specialist)

▶ **TO THE SKIN**

Child 2–15 years: Apply twice daily, 0.03% ointment to be applied thinly, with an interval of 2–3 days between applications, use short-term treatment regimen during an acute flare; review need for preventative therapy after 1 year

Child 16–17 years: Apply twice weekly, 0.1% ointment to be applied thinly, with an interval of 2–3 days between applications, use short-term treatment regimen during an acute flare; review need for preventative therapy after 1 year

**CONTRA-INDICATIONS** Application to malignant or potentially malignant skin lesions - application under occlusion - congenital epidermal barrier defects - contact with eyes - avoid contact with mucous membranes - congenital epidermal barrier defects - generalised erythroderma - immunodeﬁciency - infection at treatment site

**CAUTIONS**

UV light (avoid excessive exposure to sunlight and sunlamps)

**INTERACTIONS** ▶ Appendix 1: tacrolimus

**SIDE-EFFECTS**

▶ Common or very common | Alcohol intolerance - increased risk of infection - sensation abnormal - skin reactions

▶ Uncommon | Lymphadenopathy

▶ Frequency not known | Malignancy - neoplasms

**ALLERGY AND CROSS-SENSITIVITY**

Contra-indicated if history of hypersensitivity to macrolides.

**PREGNANCY**

Manufacturer advises avoid unless essential; toxicity in animal studies following systemic administration.

**BREAST FEEDING**

Avoid—present in breast milk (following systemic administration).
**INHIBITORS**

- **Medicinal forms**
  - **National Funding/Access decisions**
    - **NICE decisions**
      - Tacrolimus and pimecrolimus for atopic eczema (August 2004) NICE TA82
        
        Tacrolimus is an option for atopic eczema not controlled by maximal topical corticosteroid treatment or if there is a risk of important corticosteroid side-effects (particularly skin atrophy).

      - **Topical tacrolimus** is recommended as an option for the second-line treatment for moderate to severe atopic eczema in adults and children over 2 years. Tacrolimus should be used within its licensed indications.

      - **Cautionary and advisory labels**
        - **by subcutaneous injection** (specialist use only)
          - **Photochemotherapy**, or when these treatments cannot respond to other systemic treatments or moderate-to-severe plaque psoriasis that has not responded to other systemic treatments or those over 17 years of age.

      - **Interactions**
        - **appendix 1: monoclonal antibodies**
          - **Uncommon**

      - **Side-effects**
        - **Common or very common**
          - **Arthralgia**
          - **Headache**
          - **Diarrhoea**
          - **Dizziness**
          - **Increased risk of infection**
          - **Myalgia**
          - **Nausea**
          - **Oropharyngeal pain**
          - **Skin reactions**
          - **Vomiting**

      - **Contra-indications**
        - **Active tuberculosis** should be treated with adequate treatment for tuberculosis can start ustekinumab but should be monitored every 3 months for possible recurrence. In patients without active tuberculosis but who were previously not treated adequately, chemoprophylaxis should ideally be completed before starting ustekinumab. In patients at high risk of tuberculosis who cannot be assessed by tuberculin skin test, chemoprophylaxis can be given concurrently with ustekinumab.

      - **Contraindications**
        - **Active infection**

      - **Caution**
        - **Development of malignancy**

      - **FURTHER INFORMATION**
        - **Tuberculosis**
          - **Active tuberculosis** should be treated with standard treatment for at least 2 months before starting ustekinumab. Patients who have previously received adequate treatment for tuberculosis can start ustekinumab but should be monitored every 3 months for possible recurrence. In patients without active tuberculosis but who were previously not treated adequately, chemoprophylaxis should ideally be completed before starting ustekinumab. In patients at high risk of tuberculosis who cannot be assessed by tuberculin skin test, chemoprophylaxis can be given concurrently with ustekinumab.

      - **Monitors**
        - **for signs and symptoms of exfoliative dermatitis** or erythrodermic psoriasis.

      - **Pregnancy**
        - **Avoid.**

      - **Breast-feeding**
        - **Manufacturer advises avoid—present in milk in animal studies.**

      - **Pre-treatment screening**
        - **Tuberculosis** Patients should be evaluated for tuberculosis before treatment.

      - **Monitoring requirements**
        - **Monitor** for signs and symptoms of exfoliative dermatitis

      - **National funding/access decisions**
        - **NICE decisions**
          - **Adalimumab, etanercept and ustekinumab** for treating plaque psoriasis in children and young people (July 2017) NICE TA455

          Ustekinumab is recommended as an option for treating plaque psoriasis in children and young people aged 12 years or older, only if the disease:

        - **is severe, as defined by a total PASI of 10 or more**,
11-Sep-2018

● has not responded to standard systemic therapy, such as ciclosporin, methotrexate or phototherapy, or these options are contra-indicated or not tolerated.

If the psoriasis has not responded adequately, stop treatment at 16 weeks. An adequate response is defined as a 75% reduction in PASI score from the start of treatment. Patients currently receiving ustekinumab who do not meet the above criteria and whose treatment was started within the NHS before this guidance was published, should have the option to continue treatment until they and their clinician consider it appropriate to stop.

www.nice.org.uk/guidance/TA455

RETINOID AND RELATED DRUGS

Acitretin

11-Sep-2018

● INDICATIONS AND DOSE

Severe extensive psoriasis resistant to other forms of therapy (under expert supervision) | Palmarplantar pustular psoriasis (under expert supervision) | Severe congenital ichthyosis (under expert supervision)

▸ BY MOUTH
- Child 1 month–11 years: 0.5 mg/kg once daily; increased if necessary to 1 mg/kg once daily, to be taken with food or milk, careful monitoring of musculoskeletal development required; maximum 35 mg per day
- Child 12–17 years: Initially 25–30 mg daily for 2–4 weeks, then adjusted according to response to 25–50 mg daily, increased to up to 75 mg daily, dose only increased to 75 mg daily for short periods in psoriasis

Severe Darier’s disease (keratosis follicularis) (under expert supervision)

▸ BY MOUTH
- Child 1 month–11 years: 0.5 mg/kg once daily; increased if necessary to 1 mg/kg once daily, to be taken with food or milk, careful monitoring of musculoskeletal development required; maximum 35 mg per day
- Child 12–17 years: Initially 10 mg daily for 2–4 weeks, then adjusted according to response to 25–50 mg daily

Harlequin ichthyosis (under expert supervision)

▸ BY MOUTH
- Neonate: 0.5 mg/kg once daily; increased if necessary to 1 mg/kg once daily, to be taken with food or milk, careful monitoring of musculoskeletal development required.

● CONTRA-INDICATIONS

Hyperlipidaemia

● CAUTIONS

Avoid excessive exposure to sunlight and unsupervised use of sunlamps - diabetes (can alter glucose tolerance - initial frequent blood glucose checks) - do not donate blood during and for 2 years after stopping therapy (teratogenic risk) - in children use only in exceptional circumstances and monitor growth parameters and bone development (premature epiphyseal closure reported) - investigate atypical musculoskeletal symptoms

● INTERACTIONS

▸ Appendix 1: retinoids

● SIDE-EFFECTS

▸ Common or very common Abdominal pain - arthralgia - brittle nails - conjunctivitis - diarrhoea - dry mouth - gastrointestinal disorder - haemorrhage - hair texture abnormal - headache - increased risk of infection - mucosal abnormalities - myalgia - nausea - oral disorders - peripheral oedema - skin reactions - thirst - vomiting - xerophthalmia

▸ Uncommon Dizziness - hepatic disorders - photosensitivity reaction - vision disorders

▸ Rare or very rare Bone pain - exostosis - idiopathic intracranial hypertension - peripheral neuropathy

▸ Frequency not known Angioedema - capillary leak syndrome - drowsiness - dysphonia - flushing - glucose tolerance impaired - granuloma - hearing impairment - hyperhidrosis - malaise - pyogenic granuloma - retinoic acid syndrome - taste altered - tinnitus

SIDE-EFFECTS, FURTHER INFORMATION

Exostosis Skeletal hyperostosis and extra-osseous calcification reported following long-term treatment with etretinate (of which acitretin is a metabolite) and premature epiphyseal closure in children.

Benign intracranial hypertension Discontinue if severe headache, nausea, vomiting, or visual disturbances occur.

● CONCEPTION AND CONCEPTION

Effective contraception must be used.

Pregnancy prevention In females of child-bearing potential (including those with a history of infertility), exclude pregnancy up to 3 days before treatment, every month during treatment, and every 1–3 months for 3 years after stopping treatment. Treatment should be started on day 2 or 3 of menstrual cycle. Females of child-bearing age must practise effective contraception for at least 1 month before starting treatment, during treatment, and for at least 3 years after stopping treatment. Females should be advised to use at least 1 method of contraception, but ideally they should use 2 methods of contraception. Oral progesteron-only contraceptives are not considered effective. Barrier methods should not be used alone but can be used in conjunction with other contraceptive methods. Females should be advised to seek medical attention immediately if they become pregnant during treatment or within 3 years of stopping treatment. They should also be advised to avoid alcohol during treatment and for 2 months after stopping treatment.

▸ PREGNANCY

Avoid—teratogenic.

▸ BREAST FEEDING

Avoid.

▸ HEPATIC IMPAIRMENT

Manufacturer advises avoid in severe impairment.

▸ RENAL IMPAIRMENT

Avoid in severe impairment; increased risk of toxicity.

● MONITORING REQUIREMENTS

▸ Monitor serum-triglyceride and serum-cholesterol concentrations before treatment, 1 month after starting, then every 3 months.

▸ Check liver function at start, at least every 4 weeks for first 2 months and then every 3 months.

● PRESCRIBING AND DISPENSING INFORMATION

Prescribing for women of child-bearing potential Each prescription for acitretin should be limited to a supply of up to 30 days’ treatment and dispensed within 7 days of the date stated on the prescription.

● PATIENT AND CARER ADVICE

Females of child-bearing potential must be advised on pregnancy prevention. A patient information leaflet should be provided.
Eczema and psoriasis

**Salicylic Acid with zinc oxide**

**INDICATIONS AND DOSE**

**Hyperkeratotic skin disorders**
- **TO THE SKIN**
- **Child:** Apply twice daily

**CAUTIONS**
- Avoid broken skin - avoiding inflamed skin

**SIDE-EFFECTS**
- Skin reactions

**PRESCRIBING AND DISPENSING INFORMATION**
- Zinc and Salicylic Acid Paste is also referred to as Lassar’s Paste. When prepared extemporaneously, the BP states Zinc and Salicylic Acid Paste, BP (Lassar’s Paste) consists of zinc oxide 24%, salicylic acid 2%, starch 24%, white soft paraffin 50%.

**MEDICINAL FORMS**
- Forms available from special-order manufacturers include: paste

**VITAMINS AND TRACE ELEMENTS**

**Calcipotriol**

**INDICATIONS AND DOSE**

**Plaque psoriasis**
- **TO THE SKIN USING OINTMENT**
- **Child 6-11 years:** Apply twice daily, when preparations used together maximum total calcipotriol 2.5 mg in any one week (e.g. scalp solution 20 mL with ointment 30 g); maximum 50 g per week
- **Child 12-17 years:** Apply twice daily, when preparations used together maximum total calcipotriol 3.75 mg in any one week (e.g. scalp solution 30 mL with ointment 45 g); maximum 75 g per week

**Scalp psoriasis**
- **TO THE SKIN USING SCALP LOTION**
- **Child 6-11 years (specialist use only):** Apply twice daily, when preparations used together maximum total calcipotriol 2.5 mg in any one week (e.g. scalp solution 20 mL with ointment 30 g); maximum 30 mL per week
- **Child 12-17 years (specialist use only):** Apply twice daily, when preparations used together maximum total calcipotriol 3.75 mg in any one week (e.g. scalp solution 30 mL with ointment 45 g); maximum 45 mL per week

**UNLICENSED USE**
- Calcipotriol ointment and scalp solution not licensed for use in children.

**CONTRA-INDICATIONS**
- Calcium metabolism disorders

**Calcitriol**

(1,25-Dihydroxycholecalciferol)

**INDICATIONS AND DOSE**

**Mild to moderate plaque psoriasis**
- **TO THE SKIN**
- **Child 12-17 years:** Apply twice daily, not more than 35% of body surface to be treated daily; maximum 30 g per day

**CONTRA-INDICATIONS**
- Do not apply under occlusion - patients with calcium metabolism disorders

**CAUTIONS**
- Avoid excessive exposure to sunlight and sunlamps - avoid on face - erythrodermic exfoliative psoriasis (enhanced risk of hypercalcaemia) - generalised pustular psoriasis (enhanced risk of hypercalcaemia)

**INTERACTIONS**
- Appendix 1: vitamin D substances

**SIDE-EFFECTS**
- Common or very common
- Skin reactions
- Uncommon
- Increased risk of infection
- Rare or very rare
  - Hypercalcaemia
  - Hypercalciuria
  - Phototoxicity

**PREGNANCY**
- Manufacturers advise avoid unless essential.

**BREAST FEEDING**
- No information available.

**HEPATIC IMPAIRMENT**
- Manufacturers advise avoid in severe impairment (no information available).

**RENAL IMPAIRMENT**
- Manufacturers advise avoid in severe impairment.

**ADVICE**
- Patient information leaflet for Dovonex® ointment advises liberal application. However, patients should be advised of maximum recommended weekly dose.
- Hands should be washed thoroughly after application to avoid inadvertent transfer to other body areas.

**PRESCRIBING AND DISPENSING INFORMATION**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, liquid, ointment, paste. There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, liquid, ointment, paste.
4 Perspiration

4.1 Hyperhidrosis

Hyperhidrosis

Overview

Aluminium chloride hexahydrate p. 775 is a potent antiperspirant used in the treatment of axillary, palmar, and plantar hyperhidrosis. Aluminium salts are also incorporated in preparations used for minor fungal skin infections associated with hyperhidrosis.

In more severe cases specialists use tap water or glycopyrronium bromide below (as a 0.05% solution) in the iontophoretic treatment of hyperhidrosis of palms and soles. Botox® contains botulinum toxin type A complex p. 265 and is available for use intradermally for severe hyperhidrosis of the axillae unresponsive to topical antiperspirant or other antihydrotic treatment; intradermal treatment is unlikely to be tolerated by most children and should be administered under hospital specialist supervision.

ANTIMUSCARINICS

Glycopyrronium bromide (Glycopyrrolate)

13-Sep-2017

INDICATIONS AND DOSE

Iontophoretic treatment of hyperhidrosis

TO THE SKIN

Child: Only 1 site to be treated at a time, maximum 2 sites treated in any 24 hours, treatment not to be repeated within 7 days (consult product literature).

CONTRA-INDICATIONS

Infections affecting the treatment site

CONTRA-INDICATIONS, FURTHER INFORMATION Contra-indications applicable to systemic use should be considered; however, glycopyrronium is poorly absorbed and systemic effects unlikely with topical use.

CAUTIONS

CAUTIONS, FURTHER INFORMATION Cautions applicable to systemic use should be considered; however, glycopyrronium is poorly absorbed and systemic effects unlikely with topical use.

INTERACTIONS

INTERACTIONS → Appendix 1: glycopyrronium

SIDE-EFFECTS

Abdominal discomfort - eating disorder - pain - paraesthesia

SIDE-EFFECTS, FURTHER INFORMATION The possibility of systemic side-effects should be considered; however, glycopyrronium is poorly absorbed and systemic effects are unlikely with topical use.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

Powder for solution for iontophoresis

Glycopyrronium bromide (Non-proprietary)

Glycopyrronium bromide 1 mg per 1 mg Glycopyrronium bromide powder for solution for iontophoresis | 3 gram £327.00 DT = £327.00
In pruritus ani, the underlying cause such as faecal soiling, eczema, psoriasis, or haemorrhoid infection should be treated.

Other drugs used for Pruritus
Alimemazine tartrate, p. 180
Cetirizine hydrochloride, p. 176
Chlorphenamine maleate, p. 180
Hydroxyzine hydrochloride, p. 181
Levocetirizine hydrochloride, p. 178

Antipruritics

Calamine with zinc oxide

5 Pruritus

Topical local antipruritics

Overview
Pruritus may be caused by systemic disease (such as obstructive jaundice, endocrine disease, chronic renal disease, iron deficiency, and certain malignant diseases), skin disease (such as eczema, psoriasis, urticaria, and scabies), drug hypersensitivity, or as a side-effect of opioid analgesics. Where possible, the underlying cause should be treated. Local antipruritics have a role in the treatment of pruritus in palliative care. Pruritus caused by cholestasis generally requires a bile acid sequestrant.

An emollient may be of value where the pruritus is associated with dry skin. Preparations containing calamine or crotamiton below are sometimes used but are of uncertain value.

A topical preparation containing dexamethasone 5% p. 776 is licensed for the relief of pruritus in eczema in children over 12 years; it can cause drowsiness and there may be a risk of sensitisation.

Topical antihistamines and local anaesthetics are only marginally effective and occasionally cause sensitisation. For insect stings and insect bites, a short course of a topical corticosteroid is appropriate. Short-term treatment with a sedating antihistamine may help in insect stings and in intractable pruritus where sedation is desirable. Calamine preparations are of little value for the treatment of insect stings or bites.

Crotamiton

- **INDICATIONS AND DOSE**
  - **Pruritus (including pruritus after scabies)**
    - **TO THE SKIN**
      - Child 1 month–2 years (on doctor’s advice only): Apply once daily
      - Child 3–17 years: Apply 2–3 times a day
  - **CONTRA-INDICATIONS**
    - Acute exudative dermatoses
  - **CAUTIONS**
    - Avoid use in buccal mucosa - avoid use near eyes - avoid use on broken skin - avoid use on very inflamed skin - use on doctor’s advice for children under 5 years
  - **PREGNANCY**
    - Manufacturer advises avoid, especially during the first trimester—no information available.
**Rosacea and Acne**

**Rosacea and Acne**

Acne vulgaris in children

Acne vulgaris commonly affects children around puberty and occasionally affects infants. Treatment of acne should be commenced early to prevent scarring; lesions may worsen before improving. The choice of treatment depends on age, severity, and whether the acne is predominantly inflammatory or comedonal.

**Mild to moderate acne** is generally treated with topical preparations, such as benzoyl peroxide p. 779, azelaic acid p. 779, and retinoids.

**For moderate to severe inflammatory acne** or where topical preparations are not tolerated or are ineffective or where application to the site is difficult, systemic treatment with oral antibacterials may be effective. Co-cyprindol p. 777 (cyprome acetate with ethinylestradiol) has anti-androgenic properties and may be useful in young women with acne refractory to other treatments.

Severe acne, acne unresponsive to prolonged courses of oral antibacterials, acne with scarring, or acne associated with psychological problems calls for early referral to a consultant dermatologist who may prescribe oral isotretinoin p. 780.

**Acne in neonates and infants**

Inflammatory papules, pustules, and occasionally comedones may develop at birth or within the first month; most neonates with acne do not require treatment. Acne developing at 3–6 months of age may be more severe and persistent; lesions are usually confined to the face. Topical preparations containing benzoyl peroxide (at the lowest strength possible to avoid irritation), adapalene p. 779, or tretinoin p. 574 may be used if treatment for infantile acne is necessary. In infants with inflammatory acne, oral erythromycin p. 341 is used because topical preparations for acne are not well tolerated. In cases of erythromycin-resistant acne, oral isotretinoin can be given on the advice of a consultant dermatologist.

**Acne: topical preparations**

In mild to moderate acne, comedones and inflamed lesions respond well to benzoyl peroxide or topical retinoids. Alternatively, topical application of an antibacterial such as erythromycin or clindamycin p. 778 may be effective for inflammatory acne. However, topical antibacterials are probably no more effective than benzoyl peroxide and may promote the emergence of resistant organisms. If topical preparations prove inadequate, oral preparations may be needed. The choice of product and formulation (gel, solution, lotion, or cream) is largely determined by skin type, patient preference, and previous usage of acne products.

**Benzoyl peroxide and azelaic acid**

Benzoyl peroxide is effective in mild to moderate acne. Both comedones and inflamed lesions respond well to benzoyl peroxide. The lower concentrations seem to be as effective as higher concentrations in reducing inflammation. It is usual to start with a lower strength and to increase the concentration of benzoyl peroxide gradually. The usefulness of benzoyl peroxide washes is limited by the short time the products are in contact with the skin. Adverse effects include local skin irritation, particularly when therapy is initiated, but the scaling and redness often subside with a reduction in benzoyl peroxide concentration, frequency, and area of application. If the acne does not respond after 2 months then use of a topical antibacterial should be considered.

Azeleic acid has antimicrobial and anticomomedonal properties. It may be used as an alternative to benzoyl peroxide or to a topical retinoid for treating mild to moderate comedonal acne, particularly of the face; azeleic acid is less likely to cause local irritation than benzoyl peroxide.

**Topical antibacterials for acne**

In the treatment of mild to moderate inflammatory acne, topical antibacterials may be no more effective than topical benzoyl peroxide or tretinoin. Topical antibacterials are probably best reserved for children who wish to avoid oral antibacterials or who cannot tolerate them.

Topical preparations of erythromycin and clindamycin may be used to treat *inflamed lesions* in mild to moderate acne when topical benzoyl peroxide or tretinoin is ineffective or poorly tolerated. Topical benzoyl peroxide, azeleic acid, or retinoids used in combination with an antibacterial (topical or systemic) may be more effective than an antibacterial used alone. Topical antibacterials can produce mild irritation of the skin, and on rare occasions
cause sensitisation; gastro-intestinal disturbances have been reported with topical clindamycin.

Antibacterial resistance of *Propionibacterium acnes* is increasing; there is cross-resistance between erythromycin and clindamycin. To avoid development of resistance:

- when possible use non-antibiotic antimicrobials (such as benzoyl peroxide or azelaic acid);
- avoid concomitant treatment with different oral and topical antibacterials;
- if a particular antibacterial is effective, use it for repeat courses if needed (short intervening courses of benzoyl peroxide or azelaic acid may eliminate any resistant *propionibacteria*);
- do not continue treatment for longer than necessary (but treatment with a topical preparation should be continued for at least 6 months).

**Topical retinoids and related preparations for acne**

Topical tretinoin, its isomer isotretinoin, and adapalene (a retinoid-like drug), are useful for treating comedones and inflammatory lesions in mild to moderate acne. Patients should be warned that some redness and skin peeling can occur initially but settles with time. If undue irritation occurs, the frequency of application should be reduced or treatment suspended until the reaction subsides; if irritation persists, discontinue treatment. Several months of treatment may be needed to achieve an optimal response and the treatment should be continued until no new lesions develop.

Tretinoin can be used under specialist supervision to treat infantile acne; adapalene can also be used.

**Other topical preparations for acne**

A topical preparation of nicotinamide p. 782 is available for inflammatory acne.

**Acne: oral preparations**

**Oral antibacterials for acne**

Oral antibacterials may be used in *moderate to severe inflammatory acne* when topical treatment is not adequately effective or is inappropriate. Concomitant antimcomedonal treatment with topical benzoyl peroxide or azelaic acid may also be required.

Tetracyclines should not be given to children under 12 years. In children over 12 years, either oxytetracycline p. 367 or tetracycline p. 367 is usually given for acne. If there is no improvement after the first 3 months another oral antibacterial should be used. Maximum improvement usually occurs after 4 to 6 months but in more severe cases treatment may need to be continued for 2 years or longer.

Doxycycline p. 364 and lymecycline p. 366 are alternatives to tetracycline in children over 12 years.

Although minocycline p. 366 is as effective as other tetracyclines for acne, it is associated with a greater risk of lupus erythematosus-like syndrome. Minocycline sometimes causes irreversible pigmentation.

Erythromycin is an alternative for the management of moderate to severe acne with inflamed lesions, but *propionibacteria* strains resistant to erythromycin are becoming widespread and this may explain poor response. In cases of erythromycin-resistant *P. acnes* in infants, oral isotretinoin may be used on the advice of a consultant dermatologist.

Concomitant use of different topical and systemic antibacterials is undesirable owing to the increased likelihood of the development of bacterial resistance.

**Hormone treatment for acne**

Co-cyprindiol below (cyproterone acetate with ethinyloestradiol) contains an anti-androgen. It is no more effective than an oral broad-spectrum antibacterial but is useful in females of child-bearing age who also wish to receive oral contraception.

Improvement of acne with co-cyprindiol probably occurs because of decreased sebum secretion which is under androgen control. Some females with moderately severe hirsutism may also benefit because hair growth is also androgen-dependent.

**Oral retinoid for acne**

The retinoid isotretinoin p. 780 reduces sebum secretion. It is used for the systemic treatment of nodulo-cystic and conglobate acne, severe acne, acne with scarring, or for acne which has not responded to an adequate course of a systemic antibacterial. Isotretinoin is used for the treatment of severe infantile acne resistant to erythromycin p. 341.

Isotretinoin is a toxic drug that should be prescribed only by, or under the supervision of, a consultant dermatologist. It is given for at least 16 weeks; repeat courses are not normally required. The drug is teratogenic and must not be given to females of child-bearing age unless they practise effective contraception (oral progestogen-only contraceptives not considered effective) and then only after detailed assessment and explanation by the physician. They must also be registered with a pregnancy prevention programme.

Although a causal link between isotretinoin use and psychiatric changes (including suicidal ideation) has not been established, the possibility should be considered before initiating treatment; if psychiatric changes occur during treatment, isotretinoin should be stopped, the prescriber informed, and specialist psychiatric advice should be sought.

**Rosacea**

The adult form of rosacea rarely occurs in children. Persistent or repeated use of potent topical corticosteroids may cause periorificial rosacea (steroid acne). The pustules and papules of rosacea may be treated for at least 6 weeks with a topical metronidazole p. 746 preparation, or a systemic antibacterial such as erythromycin, or for a child over 12 years, oxytetracycline p. 367. Tetracyclines are contra-indicated in children under 12 years of age.

**6.1 Acne**

**ANTI-ANDROGENS**

**Co-cyprindiol**

- **INDICATIONS AND DOSE**
  - Moderate to severe acne in females of child-bearing age refractory to topical therapy or oral antibacterials
  - Moderately severe hirsutism
  - **BY MOUTH**
  - Females of childbearing potential: 1 tablet daily for 21 days, to be started on day 1 of menstrual cycle; subsequent courses repeated after a 7-day interval (during which withdrawal bleeding occurs), time to symptom remission, at least 3 months; review need for treatment regularly

- **CONTRA-INDICATIONS**
  - Acute porphyrias p. 624 - gallstones
  - Heart disease associated with pulmonary hypertension or risk of embolus - history during pregnancy of cholestatic jaundice - history during pregnancy of chorea - history during pregnancy of phephigoid gestations - history during pregnancy of pruritus - history of breast cancer but can be used after 5 years if no evidence of disease and non-hormonal methods unacceptable - history of haemolytic uraemic syndrome - migraine with aura - personal history of venous or arterial thrombosis - presence or history of liver tumours - sclerosing treatment for varicose veins - severe or multiple risk factors for arterial disease or for venous thromboembolism - systemic lupus erythematosus with (or unknown) antiphospholipid antibodies - transient
cerebral ischaemic attacks without headaches - undiagnosed vaginal bleeding

- **CAUTIONS** Active trophoblastic disease (until return to normal of urine- and plasma-gonadotrophin concentration) – seek specialist advice • arterial disease • gene mutations associated with breast cancer (e.g., BRCA 1) • history of severe depression especially if induced by hormonal contraceptive • hyperprolactinaemia – seek specialist advice • inflammatory bowel disease including Crohn’s disease • migraine • personal or family history of hypertriglyceridaemia (increased risk of pancreatitis) • risk factors for venous thromboembolism • sickle-cell disease • undiagnosed breast mass

**CAUTIONS, FURTHER INFORMATION**

- Venous thromboembolism There is an increased risk of venous thromboembolism in women taking co-cyprindiol, particularly during the first year of use. The incidence of venous thromboembolism is 1.5–2 times higher in women using co-cyprindiol than in women using combined oral contraceptives containing levonorgestrel, but the risk may be similar to that associated with use of combined oral contraceptives containing third generation progestogens (desogestrel and gestodene) or drospirenone. Women requiring co-cyprindiol may have an inherently increased risk of cardiovascular disease.

- **INTERACTIONS** → Appendix 1: combined hormonal contraceptives

- **SIDE-EFFECTS**
  - Rare or very rare Cholelithiasis • photosensitivity reaction • systemic lupus erythematosus (SLE)
  - **Frequency not known** Abdominal cramps • amenorrhoea (on discontinuation) • breast abnormalities • cervical erosion • chest pain • contact lens intolerance • depression • fluid retention • headache • hepatic impairment • hepatic neoplasia • hypertension • irritability • leg cramps • libido disorder • lipid metabolism change • menstrual disorder • nausea • nervousness • skin reactions • thrombosis (more common when factor V Leiden present or in blood groups A, B, and AB) • visual impairment • vomiting • vulvovaginal disorders

- **PREGNANCY** Avoid—risk of feminisation of male fetus with cyproterone.

- **BREAST FEEDING** Manufacturer advises avoid; possibility of anti-androgen effects in neonate with cyproterone.

- **HEPATIC IMPAIRMENT** Manufacturer advises avoid in severe impairment (until liver function returns to normal.)

- **PRESCRIBING AND DISPENSING INFORMATION** A mixture of cyproterone acetate and ethinylestradiol in the mass proportions 2000 parts to 35 parts, respectively.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Tablet**

- **Co-cyprindiol (Non-proprietary)**
  - Ethinylestradiol 35 microgram, Cyproterone acetate 2 mg Co-cyprindiol 2000microgram/35microgram tablets | £13.70
  - Clairette (Stragen UK Ltd) Ethinylestradiol 35 microgram, Cyproterone acetate 2 mg Clairette 2000/35 tablets | £13.70
  - Dianeette (Bayer Plc) Ethinylestradiol 35 microgram, Cyproterone acetate 2 mg Dianeette tablets | £13.70
  - Teragezza (Morningside Healthcare Ltd) Ethinylestradiol 35 microgram, Cyproterone acetate 2 mg Teragezza 2000microgram/35microgram tablets | £13.70

**INDICATIONS AND DOSE**

- **Acne vulgaris**
  - To the skin
  - Child: Apply twice daily, to be applied thinly

**ZINDACLIN® GEL**

- **Acne vulgaris**
  - To the skin
  - Child: Apply twice daily, to be applied thinly

**INTERACTIONS** → Appendix 1: clindamycin

**SIDE-EFFECTS**

- **Common or very common** Skin reactions
  - **Frequency not known** Abdominal pain • antibiotic associated colitis • folliculitis gram-negative • gastrointestinal disorder

**PATIENT AND CARER ADVICE** Patients and their carers should be advised to discontinue and contact a doctor immediately if severe, prolonged or bloody diarrhoea develops.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Gel**
  - **Zindacin** (Crawford Healthcare Ltd) Clindamycin (as Clindamycin phosphate) 10 mg per 1 gram Zindacin 1% gel | £8.66
  - **Dalacin T** (Pfizer Ltd) Clindamycin (as Clindamycin phosphate) 10 mg per 1 ml Dalacin T 1% topical solution | £0.16
    - Dalacin T 1% topical solution | £0.23
  - **Zindaclin** (LEO Pharma) Clindamycin (as Clindamycin phosphate) 10 mg per 1 ml Zindaclin | £0.34
    - Zindaclin 1% topical solution | £0.39

**SOLUTION**

- **Dalacin T**
  - **Zineryt** (LEO Pharma) Clindamycin (as Clindamycin phosphate) 10 mg per 1 ml Zineryt | £2.02

**LOTION**

- **Zineryt** (LEO Pharma) Clindamycin (as Clindamycin phosphate) 10 mg per 1 ml Zineryt | £2.02

**Erythromycin with zinc acetate**

The properties listed below are those particular to the combination only. For the properties of the components please consider, erythromycin p. 341.

- **INDICATIONS AND DOSE**
  - **Acne vulgaris**
    - To the skin
    - Child: Apply twice daily

- **CAUTIONS** Some manufacturers advise preparations containing alcohol are not suitable for use with benzoyl peroxide

- **INTERACTIONS** → Appendix 1: macrolides

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Liquid**
  - **Zineryt** (LEO Pharma) Erythromycin 40 mg per 1 ml Erythromycin 12 mg per 1 ml Erythromycin and zinc acetate lotion | £0.20
## Benzoyl peroxide

### INDICATIONS AND DOSE

**Acne vulgaris**
- **TO THE SKIN**
  - Child 12-17 years: Apply 1–2 times a day, preferably apply after washing with soap and water, start treatment with lower-strength preparations

**Infantile acne**
- **TO THE SKIN**
  - Child 1 month-1 year: Apply 1–2 times a day, start treatment with lower-strength preparations

### UNLICENSED USE
Not licensed for use in treatment of infantile acne.

### CAUTIONS
Avoid contact with broken skin - avoid contact with eyes - avoid contact with mouth - avoid contact with mucous membranes - avoid excessive exposure to sunlight

### SIDE-EFFECTS
- Common or very common: Skin reactions
- Frequency not known: Facial swelling

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

<table>
<thead>
<tr>
<th>Type</th>
<th>Excipients</th>
<th>Concentration</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cream</td>
<td>May contain Cetostearyl alcohol (including cetyl and stearyl alcohols), fragrances, isopropyl palmitate, propylene glycol</td>
<td>5% gel 50 g (4.13 DT)</td>
<td>13% of prescriptions</td>
</tr>
<tr>
<td>Gel</td>
<td>May contain Fragrances, propylene glycol</td>
<td>5% gel 50 g (5.44 DT)</td>
<td>14% of prescriptions</td>
</tr>
</tbody>
</table>

### SIDE-EFFECTS, FURTHER INFORMATION
Reduce frequency or suspend use until skin irritation subsides and reintroduce at reduced frequency.

### PATIENT AND CARER ADVICE
May bleach fabrics and hair.

### Benzoyl peroxide with clindamycin

The properties listed below are those particular to the combination only. For the properties of the components please consider, benzoyl peroxide above, clindamycin p. 778.

### INDICATIONS AND DOSE

**Acne vulgaris**
- **TO THE SKIN**
  - Child 12-17 years: Apply once daily, dose to be applied in the evening

### INTERACTIONS
- Appendix 1: clindamycin

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

<table>
<thead>
<tr>
<th>Type</th>
<th>Excipients</th>
<th>Concentration</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gel</td>
<td>Duac (Stiefel Laboratories (UK) Ltd)</td>
<td>10 mg per 1 gram</td>
<td>13% of prescriptions</td>
</tr>
<tr>
<td></td>
<td>Clindamycin (as Clindamycin phosphate) 10 mg per 1 gram</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benzoyl peroxide 30 mg per 1 gram Duac Once Daily gel (3% and 1%)</td>
<td>11.14 DT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clindamycin (as Clindamycin phosphate) 10 mg per 1 gram</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benzoyl peroxide 50 mg per 1 gram Duac Once Daily gel (5% and 1%)</td>
<td>11.14 DT</td>
<td></td>
</tr>
</tbody>
</table>

## Azelaic acid

### INDICATIONS AND DOSE

**FINACEA®**

**Facial acne vulgaris**
- **TO THE SKIN**
  - Child 12-17 years: Apply twice daily

### CAUTIONS
Avoid contact with eyes - avoid contact with mouth - avoid contact with mucous membranes

### SIDE-EFFECTS
- Uncommon: Skin reactions
- Rare or very rare: Asthma exacerbated - chelitis
- Frequency not known: Angioedema - eye swelling

### MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

<table>
<thead>
<tr>
<th>Type</th>
<th>Excipients</th>
<th>Concentration</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cream</td>
<td>May contain Propylene glycol</td>
<td>5% gel 30 g</td>
<td>14% of prescriptions</td>
</tr>
<tr>
<td>Gel</td>
<td>May contain Disodium edetate, polysorbates, propylene glycol</td>
<td>5% gel 30 g</td>
<td>14% of prescriptions</td>
</tr>
</tbody>
</table>

### RETINOIDS AND RELATED DRUGS

## Adapalene

### INDICATIONS AND DOSE

**Mild to moderate acne vulgaris**
- **TO THE SKIN**
  - Child 12-17 years: Apply once daily, apply thinly in the evening

**Infantile acne**
- **TO THE SKIN**
  - Child 1 month-1 year: Apply once daily, apply thinly in the evening

### UNLICENSED USE
Not licensed for use in infantile acne.

### CAUTIONS
Avoid accumulation in angles of the nose - avoid excessive exposure to sunlight - avoid contact with mucous membranes - use in severe acne involving large areas - caution in sensitive areas such as the neck

### INTERACTIONS
- Appendix 1: retinoids

### CONCEPTION AND CONTRACEPTION
Females of child-bearing age must use effective contraception (oral progestogen-only contraceptives not considered effective).

### PREGNANCY
Avoid.

### BREAST FEEDING
Amount of drug in milk probably too small to be harmful; ensure infant does not come in contact with treated areas.
Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

Cream

**CAUTIONARY AND ADVISORY LABELS**

- Adapalene (Non-proprietary)
  - Adapalene 1 mg per 1 gram: Differin 0.1% cream | 45 gram (POM) £16.43 DT = £16.43
  - Differin (Galderma (UK) Ltd): Adapalene 1 mg per 1 gram | 45 gram (POM) £16.43 DT = £16.43

Gel

**CAUTIONARY AND ADVISORY LABELS**

- Adapalene (Non-proprietary)
  - Adapalene 1 mg per 1 gram: Differin 0.1% gel | (POM) £15.85
- Differin (Galderma (UK) Ltd): Adapalene 1 mg per 1 gram | (POM) £16.43 DT = £16.43

Patient and carer advice

- Please consider, adapalene p.
- Combination only. For the properties of the components different medicines containing the same drug.

Indications and dose

**Acne vulgaris**

- **TO THE SKIN**
  - Child 9–17 years: Apply once daily, to be applied thinly in the evening

- **INTERACTIONS** → Appendix 1: retinoids
- **CONCEPTION AND CONTRACEPTION** Females of childbearing age must use effective contraception (oral progestogen-only contraceptives not considered effective).
- **PATIENT AND CARER ADVICE** Gel may bleach clothing and hair.
- **NATIONAL FUNDING/ACCESS DECISIONS**
  - Scottish Medicines Consortium (SMC) decisions
  - The Scottish Medicines Consortium has advised (March 2014) that Epiduo® should be restricted for use in mild to moderate facial acne when monotherapy with benzoyl peroxide or adapalene is inappropriate.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Gel**

**CAUTIONARY AND ADVISORY LABELS**

- Epiduo (Galderma (UK) Ltd): Adapalene 1 mg per 1 gram, Benzoyl peroxide 25 mg per 1 gram Epiduo 0.1%/2.5% gel | 45 gram (POM) £19.53 DT = £19.53

Isotretinoin

**INDICATIONS AND DOSE**

**Topical treatment of mild to moderate acne**

- **TO THE SKIN**
  - Child: Apply 1–2 times a day, to be applied thinly

- **UNLICENSED USE**
  - With oral use Not licensed for use in infantile acne.

**IMPORTANT SAFETY INFORMATION**

**MHRA/CHM ADVICE: ISOTRETINOIN (ROACCUTANE®): RARE REPORTS OF ERECTILE DYSFUNCTION AND DECREASED LIBIDO (OCTOBER 2017)**

An EU-wide review has concluded that on rare occasions, oral isotretinoin, indicated for severe acne, may cause sexual side-effects, including erectile dysfunction and decreased libido.

**CONTRA-INDICATIONS**

- With oral use Hyperlipidaemia - hypervitaminosis A
- With topical use Perioral dermatitis - rosacea

**CAUTIONS**

- With oral use avoid blood donation during treatment and for at least 1 month after treatment - diabetes - dry eye syndrome (associated with risk of keratitis) - history of depression - monitor for depression
- With topical use allow peeling (resulting from other irritant treatments) to subside before using a topical retinoid - alternating a preparation that causes peeling with a topical retinoid may give rise to contact dermatitis (reduce frequency of retinoid application) - avoid accumulation in angles of the nose - avoid contact with eyes, nostrils, mouth and mucous membranes, eczematous, broken or sunburned skin - avoid exposure to UV light (including sunlight, solariums) - avoid in severe acne involving large areas - avoid use of topical retinoids with abrasive cleaners, comedogenic or astringent cosmetics - caution in sensitive areas such as the neck - personal or familial history of skin cancer

**INTERACTIONS** → Appendix 1: retinoids

**SIDE-EFFECTS**

**GENERAL SIDE-EFFECTS**

- Common or very common Skin reactions
  - Rare or very rare Photosensitivity reaction

**SPECIFIC SIDE-EFFECTS**

- Common or very common
  - With oral use Alopecia - anaemia - arthralgia - back pain - cheilitis - dry eye - eye discomfort - eye inflammation - haemorrhage - headache - increased risk of infection - myalgia - nasal dryness - neutropenia - proteinuria - skin fragility (trauma may cause blistering) - thrombocytopenia - thrombocytosis
  - Rare or very rare
  - With oral use Anxiety - arthritis - behaviour abnormal - bone disorders - bronchospasm - cataract - corneal opacity - depression - diabetes mellitus - dizziness - drowsiness - dry throat - gastrointestinal disorders - glomerulonephritis - hair changes - hearing impairment - hepatitis - hoarseness -
Patent and Carer Advice

Monitoring Requirements

Breast Feeding

With oral use Rhadomyolysis • severe cutaneous adverse reactions (SCARs)

Side-effects, Further Information

Risk of pancreatitis if triglycerides above 9 mmol/litre—discontinue if uncontrolled hypertriglyceridaemia or pancreatitis.

Discontinue treatment if skin peeling severe or haemorrhagic diarrhoea develops.

Visual disturbances require expert referral and possible withdrawal.

Psychiatric side-effects could require expert referral.

\* Conception and Contraception

Pregnancy prevention

With oral use Effective contraception must be used. In women of child-bearing potential, exclude pregnancy up to 5 days before treatment (start treatment on day 2 or 3 of menstrual cycle), every month during treatment (unless there are compelling reasons to indicate that there is no risk of pregnancy), and 5 weeks after stopping treatment—perform pregnancy test in the first 3 days of the menstrual cycle. Women must practise effective contraception for at least 1 month before starting treatment, during treatment, and for at least 1 month after stopping treatment. Women should be advised to use at least 1 method of contraception, but ideally they should use 2 methods of contraception. Oral progestogen-only contraceptives are not considered effective. Barrier methods should not be used alone, but can be used in conjunction with other contraceptive methods. Each prescription for isotretinoin should be limited to a supply of up to 30 days’ treatment and dispensed within 7 days of the date stated on the prescription; repeat prescriptions or faxed prescriptions are not acceptable. Women should be advised to discontinue treatment and to seek prompt medical attention if they become pregnant during treatment or within 1 month of stopping treatment.

With topical use Effective contraception (oral progestogen-only contraceptives not considered effective).

Pregnancy Contra-indicated in pregnancy (teratogenic).

Breast Feeding Avoid.

Hepatic Impairment

With oral use Manufacturer advises avoid—limited information available.

Renal Impairment

Dose adjustments With oral use In severe impairment, reduce initial dose and increase gradually, if necessary, up to 1 mg/kg daily as tolerated.

Monitoring Requirements

With oral use Measure hepatic function and serum lipids before treatment, 1 month after starting and then every 3 months (reduce dose or discontinue if transaminase or serum lipids persistently raised).

Prescribing and Dispensing Information

Isotretinoin is an isomer of tretinoin.

Patient and Carer Advice

With oral use Warn patient to avoid wax epilation (risk of epidermal stripping), dermabrasion, and laser skin treatments (risk of scarring) during treatment and for at least 6 months after stopping; patient should avoid exposure to UV light (including sunlight) and use sunscreen and emollient (including lip balm) preparations from the start of treatment. Patients and carers should be told how to recognise signs and symptoms of psychiatric disorders such as depression, anxiety, and rarely suicidal thoughts.

With topical use Patients should be warned that some redness and skin peeling can occur initially but settles with time. If undue irritation occurs, the frequency of application should be reduced or treatment suspended until the reaction subsides; if irritation persists, discontinue treatment. Several months of treatment may be needed to achieve an optimal response and the treatment should be continued until no new lesions develop. If sun exposure is unavoidable, an appropriate sunscreen or protective clothing should be used.

\* Medicinal Forms

There can be variation in the licensing of different medicines containing the same drug.

Capsule

CAUTIONARY AND ADVISORY LABELS 10, 11, 21

- Isotretinoin (non-proprietary)

- Isotretinoin 5 mg Isotretinoin 5mg capsules | 30 capsule £10.10–£10.15 | 56 capsule £14.78 DT = £14.78
- Isotretinoin 10 mg Isotretinoin 10mg capsules | 30 capsule £14.54 DT = £14.54
- Isotretinoin 20 mg Isotretinoin 20mg capsules | 30 capsule £20.60 DT = £16.65 | 56 capsule £31.08–£37.85
- Isotretinoin 40 mg Isotretinoin 40mg capsules | 30 capsule £38.98 DT = £38.98

- Roaccutane (Roche Products Ltd)

- Isotretinoin 10 mg Roaccutane 10mg capsules | 30 capsule £14.54 DT = £14.54
- Isotretinoin 20 mg Roaccutane 20mg capsules | 30 capsule £20.02 DT = £16.65

- Isotretinoin with Erythromycin

The properties listed below are those particular to the combination only. For the properties of the components please consider, isotretinoin p. 780, erythromycin p. 341.

Indications and dose

Topical treatment of mild to moderate acne

- To the skin

- Child: (consult product literature)

Interactions

Appendix 1: macrolides - retinoids

Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

Gel

CAUTIONARY AND ADVISORY LABELS 11

EXCIPIENTS: May contain Butylated hydroxytoluene

- Isotrexin (Stiefel Laboratories (UK) Ltd)

- Isotrexin 500 microgram per 1 gram, Erythromycin 20 mg per 1 gram Isotrexin gel | 30 gram £7.47 DT = £7.47

Tretinoin with Clindamycin

The properties listed below are those particular to the combination only. For the properties of the components please consider, tretinoin p. 574, clindamycin p. 778.

Indications and dose

Facial acne

- To the skin

- Child 12-17 years: Apply daily, (to be applied thinly at bedtime)

Contra-indications

Perioral dermatitis - personal or familial history of skin cancer - rosacea

Cautions

Allow peeling (resulting from other irritant treatments) to subside before using a topical retinoid - alternating a preparation that causes peeling with a topical retinoid may give rise to contact dermatitis (reduce frequency of retinoid application) - avoid accumulation in angles of the nose - avoid contact with eyes, nostrils,
Scalp and hair conditions

782 Scalp and hair conditions

Overview
The detergent action of shampoo removes grease (sebum) from hair. Prepubertal children produce very little grease and require shampoo less frequently than adults. Shampoos can be used as vehicles for medicinal products, but their usefulness is limited by the short time the product is in contact with the scalp and by their irritant nature. Oils and ointments are very useful for scaly, dry scalp conditions; if a greasy appearance is cosmetically

Tretinoin with erythromycin
The properties listed below are those particular to the combination only. For the properties of the components please consider, tretinoin p. 574, erythromycin p. 341.

● INDICATIONS AND DOSE
  Acne
  ▶ TO THE SKIN
  ▶ Child: Apply 1–2 times a day, apply thinly

● CONTRA-INDICATIONS
  Perioral dermatitis · personal or familial history of skin cancer · rosacea

● CAUTIONS
  Allow peeling (resulting from other irritant treatments) to subside before using a topical retinoid · alternating a preparation that causes peeling with a topical retinoid may give rise to contact dermatitis (reduce frequency of retinoid application) · avoid accumulation in angles of the nose · avoid contact with eyes, nostrils, mouth and mucous membranes, eczematous, broken or sunburned skin · avoid exposure to UV light (including sunlight, sunlamps) · avoid in severe acne involving large areas · avoid use of topical retinoids with abrasive cleaners, comedogenic or astringent cosmetics · caution in sensitive areas such as the neck

● INTERACTIONS
  ▶ Appendix 1: clindamycin · retinoids

● SIDE-EFFECTS
  Dry skin (discontinue if severe) · eye irritation · oedema · photosensitivity reaction · skin pigmentation change (transient) · skin reactions

● CONCESSION AND CONTRACEPTION
  Females of child-bearing age must use effective contraception (oral progestogen-only contraceptives not considered effective).

● PREGNANCY
  Contra-indicated in pregnancy.

● BREAST FEEDING
  Amount of drug in milk after topical application probably too small to be harmful; ensure infant does not come in contact with treated areas.

● PATIENT AND CARER ADVICE
  If sun exposure is unavoidable, an appropriate sunscreen or protective clothing should be used. Patients and carers should be warned that some redness and skin peeling can occur initially but settles with time. If undue irritation occurs, the frequency of application should be reduced or treatment suspended until the reaction subsides; if irritation persists, discontinue treatment. Several months of treatment may be needed to achieve an optimal response and the treatment should be continued until no new lesions develop. If sun exposure is unavoidable, an appropriate sunscreen or protective clothing should be used.

● MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

  Liquid
  CAUTIONARY AND ADVISORY LABELS 11
  ▶ Aknemycin Plus (Almirall Ltd)
  Tretinoin 250 microgram per 1 gram, Erythromycin 40 mg per 1 gram Aknemycin Plus solution | 25 ml £7.05 DT + £7.05

VITAMINS AND TRACE ELEMENTS > VITAMIN B GROUP

Nicotinamide

● INDICATIONS AND DOSE
  Inflammatory acne vulgaris
  ▶ TO THE SKIN
  ▶ Child: Apply twice daily, reduced to once daily or on alternate days, dose reduced if irritation occurs

● UNLICENSED USE
  Licensed for use in children (age range not specified by manufacturer).

● CAUTIONS
  Avoid contact with eyes · avoid contact with mucous membranes (including nose and mouth) · reduce frequency of application if excessive dryness, irritation or peeling

● SIDE-EFFECTS
  Paraesthesia · skin reactions

● MEDICINAL FORMS
  There can be variation in the licensing of different medicines containing the same drug.

  Gel
  ▶ Freedom (Dendron Ltd)
  Nicotinamide 40 mg per 1 gram Freedom Treatment 4% gel | 25 gram £5.56
  ▶ Nicam (Dermal Laboratories Ltd)
  Nicotinamide 40 mg per 1 gram Nicam 4% gel | 60 gram £7.10
unacceptable, the preparation may be applied at night and washed out in the morning. Alcohol-based lotions are rarely used in children; alcohol causes painful stinging on broken skin and the fumes may exacerbate asthma.

Itchy, inflammatory, eczematous scalp conditions may be relieved by a simple emollient oil such as olive oil or coconut oil (arachis oil (ground nut oil, peanut oil) is best avoided in children under 5 years). In more severe cases a topical corticosteroid may be required. Preparations containing coal tar are used for the common scaly scalp conditions of childhood including seborrhoeic dermatitis, dandruff (a mild form of seborrhoeic dermatitis), and psoriasis; salicylic acid p. 791 is used as a keratolytic in some scalp preparations.

Shampoos containing antimicrobials such as selenium below or ketoconazole p. 749 are used for seborrhoeic dermatitis and dandruff in which yeast infection is complicated, and for tinea capitis (ringworm of the scalp). Bacterial infection affecting the scalp (usually secondary to eczema, head lice, or ringworm) may be treated with shampoos containing antimicrobials such as pyrithione zinc, cetrime, or povidone-iodine p. 784

In neonates and infants, cradle cap (which is also a form of seborrhoeic eczema) can be treated by massaging coconut oil or olive oil into the scalp; a bland emollient such as emulsifying ointment can be rubbed onto the affected area once or twice daily before bathing and a mild shampoo used.

Other drugs used for Scalp and hair conditions Coal tar, p. 768 - Coal tar with lacticin, p. 769 - Coal tar with salicylic acid and precipitated sulfur, p. 769

**VITAMINS AND TRACE ELEMENTS**

**Selenium**

- **INDICATIONS AND DOSE**
  - **Seborrhoeic dermatitis** | Dandruff
    - To the skin using shampoo
    - Child 5-17 years: Apply twice weekly for 2 weeks, then apply once weekly for 2 weeks, then apply as required

- **Pityriasis versicolor**
  - To the skin using shampoo
  - Child 5-17 years: Apply once daily for 7 days, apply to the affected area and leave on for 10 minutes before rinsing off. The course may be repeated if necessary. Diluting with a small amount of water prior to application can reduce irritation

- **UNLICENSED USE**
  - The use of selenium sulfide shampoo as a lotion for the treatment of pityriasis (tinea) versicolor is an unlicensed indication.

- **INTERACTIONS**
  - Appendix 1: selenium

- **PATIENT AND CARER ADVICE**
  - With topical use Avoid using 48 hours before or after applying hair colouring, straightening or waving preparations.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

Shampoo

- **Excipients**: May contain Fragrances
- **Selsun (Chattem (U.K.) Ltd)**
  - Selenium sulfide 25 mg per 1 ml | Selsun 2.5% shampoo | 50 ml (£)
  - £1.61 DT = £1.61 | 100 ml (£) | £2.15 DT = £2.15 | 150 ml (£) | £3.06 DT = £3.06

**Skin cleansers, antiseptics and desloughing agents**

**Skin cleansers, antiseptics and desloughing agents**

**Skin cleansers and antiseptics**

Soap or detergent is used with water to cleanse intact skin but they can irritate infantile skin; emollient preparations such as aqueous cream or emulsifying ointment can be used in place of soap or detergent for cleansing dry or irritated skin.

An antiseptic is used for skin that is infected or that is susceptible to recurrent infection. Detergent preparations containing chlorhexidine p. 785 or povidone-iodine p. 784, which should be thoroughly rinsed off, are used. Emollients may also contain antiseptics.

Antiseptics such as chlorhexidine or povidone-iodine are used on intact skin before surgical procedures; their antiseptic effect is enhanced by an alcoholic solvent. Antiseptic solutions containing cetrimide can be used if a detergent effect is also required. Preparations containing alcohol, and regular use of povidone-iodine, should be avoided on neonatal skin.

Hydrogen peroxide p. 786, an oxidising agent, is available as a cream and can be used for superficial bacterial skin infections.

For irrigating ulcers or wounds, lukewarm sterile sodium chloride 0.5% solution p. 697 is used but tap water is often appropriate.

Potassium permanganate p. 784 solution 1 in 10 000, a mild antiseptic with astringent properties, can be used as a
Skin cleansers, antiseptics and desloughing agents

**Desloughing agents**
Alginates, hydrogel, and hydrocolloid dressings are effective in wound debridement. Sterile larvae (maggots) (available from BioMonde) are also used for managing sloughing wounds and are prescribable on the NHS. Desloughing solutions and creams are of little clinical value. Substances applied to an open area are easily absorbed and perilesional skin is easily sensitised.

**ANTISEPTICS AND DISINFECTANTS**

### Potassium permanganate

**INDICATIONS AND DOSE**
Cleansing and deodorising suppurating eczematous reactions and wounds
- TO THE SKIN
- Child: For wet dressings or baths, use approximately 0.01% (1 in 10 000) solution

**CAUTIONS** Irritant to mucous membranes

**DIRECTIONS FOR ADMINISTRATION** Potassium permanganate 0.1% solution to be diluted 1 in 10 to provide a 0.01% (1 in 10 000) solution. With potassium permanganate tablets for solution, 1 tablet dissolved in 4 litres of water provides a 0.01% (1 in 10 000) solution.

**PATIENT AND CARER ADVICE** Can stain clothing, skin and nails (especially with prolonged use).

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: liquid

- **Tablet for cutaneous solution**
  - EN-Potab (Enogen Healthcare Ltd)
  - Potassium permanganate 400 mg EN-Potab 400mg tablets for cutaneous solution | 30 tablet | £9.12
  - Permitabs (Alliance Pharmaceuticals Ltd)
  - Potassium permanganate 400 mg Permitabs 400mg tablets for cutaneous solution | 30 tablet | £9.25

**ANTISEPTICS AND DISINFECTANTS >> ALCOHOL DISINFECTANTS**

### Alcohol

(Industrial methylated spirit)

**INDICATIONS AND DOSE**
Skin preparation before injection
- TO THE SKIN
- Child: As required

**CONTRA-INDICATIONS** Neonates

**CAUTIONS** Avoid broken skin - flammable - patients have suffered severe burns when diathermy has been preceded by application of alcoholic skin disinfectants

**PRESCRIBING AND DISPENSING INFORMATION** Industrial methylated spirits defined by the BP as a mixture of 19 volumes of ethyl alcohol of an appropriate strength with 1 volume of approved wood naphtha.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

- **Liquid**
  - Alcohol (Non-proprietary)
    - Industrial methylated spirit 70% | 600 ml £6.56–£7.01

### Povidone-iodine

**INDICATIONS AND DOSE**
Skin disinfection
- TO THE SKIN
- Child: (consult product literature)

**BETADINE ® DRY POWDER SPRAY**
Skin disinfection, particularly minor wounds and infections
- TO THE SKIN
- Child 2-17 years: Not for use in serous cavities (consult product literature)

**VIDENE ® SOLUTION**
Skin disinfection
- TO THE SKIN
- Child: Apply undiluted in pre-operative skin disinfection and general antisepsis

**VIDENE ® SURGICAL SCRUB ®**
Skin disinfection
- TO THE SKIN
- Child: Use as a pre-operative scrub for hand and skin disinfection

**VIDENE ® TINCTURE**
Skin disinfection
- TO THE SKIN
- Child: Apply undiluted in pre-operative skin disinfection

**CONTRA-INDICATIONS** Concomitant use of lithium - corrected gestational age under 32 weeks - infants body-weight under 1.5 kg - regular use in neonates

**VIDENE ® TINCTURE** Neonates

**CAUTIONS**

- Broken skin - large open wounds

**CAUTIONS, FURTHER INFORMATION**

- Large open wounds The application of povidone–iodine to large wounds or severe burns may produce systemic adverse effects such as metabolic acidosis, hypernatraemia and impairment of renal function.

**VIDENE ® TINCTURE** Procedures involving hot wire cautery and diathermy

**SIDE-EFFECTS**

- Rare or very rare Eye erythema - punctate keratitis
- Frequency not known Cytotoxicity - eye discolouration - hypothyroidism (in neonates)

**PREGNANCY** Sufficient iodine may be absorbed to affect the fetal thyroid in the second and third trimester.

**BREAST FEEDING** Avoid regular or excessive use.

**RENAL IMPAIRMENT** Avoid regular application to inflamed or broken skin or mucosa.

**EFFECT ON LABORATORY TESTS** May interfere with thyroid function tests.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: liquid

**Spray**
- Betadine (Aspire Pharma Ltd)
  - Povidone-iodine 25 mg per 1 gram Betadine 2.5% dry powder spray | 100 ml | £9.95

**Liquid**

- **CAUTIONARY AND ADVISORY LABELS** 15 (Only for use with alcoholic solutions)
  - Videne (Ecolab Healthcare Division)
    - Povidone-iodine 75 mg per 1 ml Videne 7.5% surgical scrub solution | 500 ml | £7.97

soak for exudative eczematous areas; treatment should be stopped when the skin becomes dry.
Chlorhexidine gluconate with isopropyl alcohol

The properties listed below are those particular to the combination only. For the properties of the components please consider, chlorhexidine above.

**INDICATIONS AND DOSE**

- To the skin
- Child: 2 months–17 years (consult product literature)

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: liquid

**Liquid**

- CAUTIONARY AND ADVISORY LABELS 15
- Chlordex Prep (Carefusion U.K. Ltd)
- Chlorhexidine gluconate 20 mg per 1 ml, isopropyl alcohol
  - 700 ml per 1 litre Chlordex Prep with Tint solution 10.5ml applicators | 25 applicator GSE £17.50 DT + £17.50
  - Chlorhexidine Prep with Tint solution 25ml applicators | 25 applicator GSE £19.00 DT + £19.00
  - Chlorhexidine Prep solution 3ml applicators | 25 applicator GSE £21.25 DT + £21.25
  - Chlorhexidine Prep solution 1.5ml applicators | 20 applicator GSE £11.00 DT + £11.00
  - Chlorhexidine Prep with Tint solution 3ml applicators | 25 applicator GSE £22.31 DT + £22.31
  - Chlorhexidine Prep solution 0.67ml applicators | 200 applicator GSE £60.00 DT + £60.00
  - Chlorhexidine Prep solution 10.5ml applicators | 25 applicator GSE £73.00 DT + £73.00
  - Chlorhexidine Prep with Tint solution 5ml applicators | 25 applicator GSE £96.00 DT + £96.00
  - Chlorhexidine Prep with Tint solution 10ml applicators | 25 applicator GSE £119.00 DT + £119.00

**SIDE-EFFECTS**

Skin reactions
786 Skin cleansers, antiseptics and desloughing agents

Chlorhexidine with cetrimide

The properties listed below are those particular to the different medicines containing the same drug.

**INDICATIONS AND DOSE**

- **Skin disinfection such as wound cleansing and obstetrics**
  - **TO THE SKIN**
  - **Child:** To be used undiluted

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**
    - **Savlon** (Glanzsmithline Consumer Healthcare)
    - Chlorhexidine gluconate 1 mg per 1 gram, Cetrimide 5 mg per 1 gram, Savlon antiseptic cream | 15 gram (P) £0.90 | 30 gram (P) £1.19 | 60 gram (P) £1.91 | 300 gram (P) £2.78
  - **Sterets Tisept**
    - Chlorhexidine acetate 150 microgram per 1 ml, Cetrimide 1.5 mg per 1 ml, Sterets Tisept solution 3 ml sachets | 10 bottle (P) £6.85 DT = £6.85

**DIETHYL PHALATE WITH METHYL SALICYLATE**

**INDICATIONS AND DOSE**

- **Skin preparation before injection**
  - **TO THE SKIN**
  - **Child:** Apply to the area to be disinfected

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.
  - **Liquid**
    - **Sterets Tisept** (Molynlycke Health Care Ltd)
      - Chlorhexidine gluconate 150 microgram per 1 ml, Cetrimide 1.5 mg per 1 ml, Sterets Tisept solution 25ml sachets | 25 sachet (P) £0.53 DT = £0.33
    - Sterets Tisept solution 100ml sachets | 10 sachet (P) £6.85 DT = £6.85

**HYDROGEN PEROXIDE**

**DRUG ACTION**

Hydrogen peroxide is an oxidising agent.

**INDICATIONS AND DOSE**

- **CRYSTACIDE®**
  - **Superficial bacterial skin infection**
  - **TO THE SKIN**
  - **Child:** Apply 2–3 times a day for up to 3 weeks

**UNLICENSED USE**

Licensed for use in children (age range not specified by manufacturer).

**CAUTIONS**

Avoid on eyes - avoid on healthy skin - incompatible with products containing iodine or potassium permanganate

**PRESCRIBING AND DISPENSING INFORMATION**

The BP directs that when hydrogen peroxide is prescribed, hydrogen peroxide solution 6% (20s) should be dispensed.

Strong solutions of hydrogen peroxide which contain 27% (90 vols) and 30% (100 vols) are only for the preparation of weaker solutions.

**HANDLING AND STORAGE**

Hydrogen peroxide bleaches fabric.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.
  - **Cream**
    - **EXCIPIENTS:** May contain Edetic acid (edta), propylene glycol
    - **Crystacide (Reig Jofre UK Ltd)**
      - Hydrogen peroxide 10 mg per 1 gram Crystacide 1% cream | 25 gram (P) £8.07 DT = £8.07 | 40 gram (P) £11.62

**PROFLAVINE**

**INDICATIONS AND DOSE**

- **Infected wounds**
  - **Infected burns**
  - **TO THE SKIN**
  - **Child:** (consult product literature)

**PATIENT AND CARER ADVICE**

Stains clothing.

**MEDICINAL FORMS**

- Forms available from special-order manufacturers include: liquid

**IRRIGATION SOLUTIONS**

- There can be variation in the licensing of different medicines containing the same drug.
  - **Sodium chloride 0.9% irrigation solution 20ml**
    - **NHS indicative price = £0.71 - Drug Tariff (Part IXa)**
  - **Irriclens sodium chloride 0.9% irrigation solution aerosol spray (Convatec Ltd)**
    - Sodium chloride 9 mg per 1 ml 240 ml - NHS indicative price = £3.60 - Drug Tariff (Part IXa)
  - **Normasol sodium chloride 0.9% irrigation solution 100ml sachets (Molynlycke Health Care Ltd)**
    - Sodium chloride 9 mg per 1 ml 10 unit dose - NHS indicative price = £7.97 - Drug Tariff (Part IXa)
  - **Normasol sodium chloride 0.9% irrigation solution 25ml sachets (Molynlycke Health Care Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £6.46 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml Clinipod unit dose (Mayors Healthcare Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £4.80 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml ISO-POD unit dose (St Georges Medical Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £5.84 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml Sal-e Pods unit dose (Mayors Healthcare Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £4.99 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml Salipod unit dose (Ennogen Healthcare Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £4.80 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose (Sai-Meds Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £5.60 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml Sterowash unit dose (Steroplast Healthcare Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £5.40 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml unit dose (C D Medical Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £5.60 - Drug Tariff (Part IXa)
  - **Sodium chloride 0.9% irrigation solution 20ml unit dose (St Georges Medical Ltd)**
    - Sodium chloride 9 mg per 1 ml 25 unit dose - NHS indicative price = £5.84 - Drug Tariff (Part IXa)
8.1 Minor cuts and abrasions

Minor cuts and abrasions

Management

Many preparations traditionally used to manage minor burns, and abrasions have fallen out of favour. Preparations containing camphor and sulphonamides should be avoided. Preparations such as magnesium sulfate paste are now rarely used to treat carbuncles and boils as these are best treated with antibiotics.

Cetrime is used to treat minor cuts and abrasions and proflavine p. 786 may be used to treat infected wounds or burns, but its use has now been largely superseded by other antiseptics or suitable antibacterials. The effervescent effect of hydrogen peroxide p. 786 is used to clean minor cuts and abrasions.

Flexible collodion (see castor oil with collodion and colophony below) may be used to seal minor cuts and wounds that have partially healed; skin tissue adhesives are used similarly, and also for additional suture support.

DERMATOLOGICAL DRUGS 》 COLLODIONS

Castor oil with collodion and colophony

- **INDICATIONS AND DOSE**
  - Used to seal minor cuts and wounds that have partially healed
    - TO THE SKIN
    - Child: (consult product literature)

- **ALLERGY AND CROSS-SENSITIVITY**
  - Contra-indicated if patient has an allergy to collodion in elastic adhesive plasters and tape.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

Flexible collodion
  - Castor oil with collodion and colophony (Non-proprietary)
  - Castor oil 25 mg per 1 ml, Collodion 25 mg per 1 ml, Collodion methylated 950 microitre per 1 ml Flexible collodion methylated
    - 100 ml £13.81–£14.09
    - 500 ml £29.47

Skin adhesives

- **SKIN ADHESIVES**

  - **Derma+Flex skin adhesive** (Chemence Ltd)
    - 0.5 ml - NHS indicative price = £5.36 - Drug Tariff (Part IXa)

  - **Dermabond ProPen skin adhesive** (Ethicon Ltd)
    - 0.5 ml - NHS indicative price = £18.64 - Drug Tariff (Part IXa)

  - **Histoacryl skin adhesive** (B. Braun Medical Ltd)
    - 0.5 ml - NHS indicative price = £6.72 - Drug Tariff (Part IXa)

  - **Histoacryl skin adhesive** (B. Braun Medical Ltd)
    - 0.5 ml - NHS indicative price = £6.50 - Drug Tariff (Part IXa)

  - **Indermil skin adhesive** (Coviden (UK) Commercial Ltd)
    - 0.5 gram - NHS indicative price = £6.50 - Drug Tariff (Part IXa)

  - **LiquiBand flow control tissue adhesive** (Advanced Medical Solutions Ltd)
    - 0.5 gram - NHS indicative price = £5.50 - Drug Tariff (Part IXa)

  - **LiquiBand tissue adhesive** (Advanced Medical Solutions Ltd)
    - 0.5 gram - NHS indicative price = £5.50 - Drug Tariff (Part IXa)

9 Skin disfigurement

Camouflagers

Overview

Disfigurement of the skin can be very distressing to patients and may have a marked psychological effect. In skilled hands, or with experience, camouflagage cosmetics can be very effective in concealing scars and birthmarks. The depigmented patches in vitiligo are also very disfiguring and camouflagage creams are of great cosmetic value.

Opaque cover foundation or cream is used to mask skin pigment abnormalities; careful application using a combination of dark- and light-coloured cover creams set with powder helps to minimise the appearance of skin deformities.

Borderline substances

The preparations marked ‘ACBS’ can be prescribed on the NHS for postoperative scars and other deformities and as adjunctive therapy in the relief of emotional disturbances due to disfiguring skin disease, such as vitiligo.

Camouflages

- **CAMOFLAUGES**

  - **Covermark classic foundation** (Derma UK Ltd)
    - 15 ml (ACBS) - NHS indicative price = £11.86

  - **Covermark finishing powder** (Derma UK Ltd)
    - 25 gram (ACBS) - NHS indicative price = £11.86

  - **Covermark removing cream** (Derma UK Ltd)
    - 200 ml - No NHS indicative price available

  - **Dermablend Dermasmooth Corrective Foundation** (Vichy)
    - 30 ml - No NHS indicative price available

  - **Dermacolor Creme Effectiv** (Kryolan UK Ltd)
    - 50 ml - NHS indicative price = £5.73

  - **Dermacolor body camouflage** (Kryolan UK Ltd)
    - 50 ml - NHS indicative price = £8.94

  - **Dermacolor camouflage creme** (Kryolan UK Ltd)
    - 30 gram - NHS indicative price = £11.00

  - **Dermacolor cleansing cream** (Kryolan UK Ltd)
    - 75 gram - No NHS indicative price available

  - **Dermacolor fixing powder** (Kryolan UK Ltd)
    - 60 gram (ACBS) - NHS indicative price = £9.85

  - **Keromask finishing powder** (Bellavia Ltd)
    - 20 gram (ACBS) - NHS indicative price = £6.27

  - **Keromask masking cream** (Bellavia Ltd)
    - 15 ml (ACBS) - NHS indicative price = £6.27

  - **Veil cover cream** (Thomas Blake Cosmetic Creams Ltd)
    - 19 gram (ACBS) - NHS indicative price = £22.42

  - **Veil finishing powder** (Thomas Blake Cosmetic Creams Ltd)
    - 35 gram (ACBS) - NHS indicative price = £24.58

10 Sun protection and photodamage

Sunscreen

Sunscreen preparations

Solar ultraviolet irradiation can be harmful to the skin. It is responsible for disorders such as polymorphic light eruption,
solar urticaria, and it provokes the various cutaneous porphyrias. It also provokes (or at least aggravates) skin lesions of lupus erythematosus and may aggravate some other dermatoses. Certain drugs, such as demeclocycline, phenothiazines, or amiiodarone, can cause photosensitivity. All these conditions (as well as sunburn) may occur after relatively short periods of exposure to the sun. Solar ultraviolet irradiation may provoke attacks of recurrent relatively short periods of exposure to the sun. Solar dermatoses.

Certain drugs, such as demeclocycline, lesions of porphyrias. It also provokes (or at least aggravates) skin reactions and photodermatoses. Both UVA and UVB contribute to long-term photodamage and to the changes responsible for skin cancer and ageing.

Sunscreen preparations contain substances that protect the skin against UVA and UVB radiation, but they are no substitute for covering the skin and avoiding sunlight. Protective clothing and sun avoidance (rather than the use of sunscreen preparations) are recommended for children under 6 months of age.

The sun protection factor (SPF, usually indicated in the preparation title) provides guidance on the degree of protection offered against UVB; it indicates the multiples of protection provided against burning, compared with unprotected skin; for example, an SPF of 8 should enable a child to remain 8 times longer in the sun without burning. However, in practice users do not apply sufficient sunscreen product and the protection is lower than that found in experimental studies. Some manufacturers use a star rating system to indicate the protection against UVA relative to protection against UVB for sunscreen products. However, the usefulness of the star rating system remains controversial. The EU Commission (September 2006) has recommended that the UVA protection factor for a sunscreen should be at least one-third of the sun protection factor (SPF); products that achieve this requirement will be labelled with a UVA logo alongside the SPF classification.

Preparations that also contain reflective substances, such as titanium dioxide, provide the most effective protection against UVA.

Sunscreen preparations may rarely cause allergic reactions. For optimum photoprotection, sunscreen preparations should be applied thickly and frequently (approximately 2 hourly). In photodermatoses, they should be used from spring to autumn. As maximum protection from sunlight is desirable, preparations with the highest SPF should be prescribed.

The European Commission Cosmetic Products Regulation (EC) 1223/2009 requires the use of INCI (International Nomenclature of Cosmetic Ingredients) for cosmetics and sunscreens. This table includes the rINN and the INCI synonym for the active ingredients of sunscreen preparations in the BNFC

Borderline substances

Antelios® XL SPF 50+ Melt-in cream; Senscse® Ultra; Uvistat® Lipscreen SPF 50; and Uvistat® Sunscreen SPF 30 and 50 (see Borderline substances) cannot be prescribed on the NHS except for skin protection against ultraviolet radiation in abnormal cutaneous photosensitivity. Preparations with SPF less than 30 should not normally be prescribed.

Photodamage

Overview

Actinic keratoses occur very rarely in healthy children; actinic cheilitis may occur on the lips of adolescents following excessive sun exposure. Diclofenac gel (Solaraze®) and topical preparations of fluouracil are licensed for the treatment of actinic keratoses but they are not licensed for use in children. In children with photosensitivity disorders, such as erythropoietic protoporphyria, specialists may use betacarotene below, mepacrine, chloroquine or hydroxochloroquine to reduce skin reactions.

VITAMINS AND TRACE ELEMENTS > VITAMIN A

Betacarotene

Drug Action

Betacarotene is a precursor to vitamin A.

Indications and Dose

Management of photosensitivity reactions in erythropoietic protoporphyria (specialist use only)

By Mouth

Child 1–4 years: 60–90 mg daily, to be given as a single dose or in divided doses

Child 5–8 years: 90–120 mg daily, to be given as a single dose or in divided doses

Child 9–11 years: 120–150 mg daily, to be given as a single dose or in divided doses

Child 12–15 years: 150–180 mg daily, to be given as a single dose or in divided doses

Child 16–17 years: 180–300 mg daily, to be given as a single dose or in divided doses

Unlicensed Use

Not licensed.

Caution

Monitor vitamin A intake

Caution, Further Information

Protection not total—avoid strong sunlight and use sunscreen preparations; generally 2–6 weeks of treatment (resulting in yellow coloration of palms and soles) necessary before increasing exposure to sunlight; dose should be adjusted according to level of exposure to sunlight.

Side Effects

Rare or very rare Arthralgia > skin reactions

Frequency not known Diarrhoea

Pregnancy

Partially converted to vitamin A, but does not give rise to abnormally high serum concentration; manufacturer advises use only if potential benefit outweighs risk.

Breast Feeding

Use with caution—present in milk.

Ingredient nomenclature in sunscreen preparations

<table>
<thead>
<tr>
<th>rINN</th>
<th>INCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>amiloxate</td>
<td>isoamyl p-methoxycinnamate</td>
</tr>
<tr>
<td>avobenzene</td>
<td>butyl methoxydibenzoylmethane</td>
</tr>
<tr>
<td>bemotrizinol</td>
<td>bis-ethylhexyloxyphenol methoxyphenyl triazine</td>
</tr>
<tr>
<td>bisoctizole</td>
<td>methylene bis-benzotriazolyl tetramethylbutylphenol</td>
</tr>
<tr>
<td>ecamsule</td>
<td>terephthalydine dicamphor sulfuric acid</td>
</tr>
<tr>
<td>ensulizole</td>
<td>phenylbenzimidazole sulfuric acid</td>
</tr>
<tr>
<td>enzacanem</td>
<td>4-methylbenzilene camphor</td>
</tr>
<tr>
<td>octinoxate</td>
<td>octyl (or ethylhexyl) methoxycinnamate</td>
</tr>
</tbody>
</table>

The European Commission Cosmetic Products Regulation (EC) 1223/2009 requires the use of INCI (International Nomenclature of Cosmetic Ingredients) for cosmetics and sunscreens. This table includes the rINN and the INCI synonym for the active ingredients of sunscreen preparations in the BNFC.
12 Warts and calluses

Warts and calluses

Overview

Warts (verruca vulgaris) are common, benign, self-limiting, and usually asymptomatic. They are caused by a human papillomavirus, which most frequently affects the hands, feet (plantar warts), and the anogenital region; treatment usually relies on local tissue destruction and is required only if the warts are painful, unsightly, persistent, or cause distress. In immunocompromised children, warts may be more difficult to eradicate.

Preparations of salicylic acid p. 791, formaldehyde p. 790, glutaraldehyde p. 790 or silver nitrate p. 790 are used for the removal of warts on hands and feet. Salicylic acid is a useful keratolytic which may be considered first-line in the treatment of warts; it is also suitable for the removal of corns and callouses. Preparations of salicylic acid in a collodion basis are available but some patients may develop an allergy to colophony in the formulation; collodion should be avoided in children allergic to elastic adhesive plaster. Cryotherapy causes pain, swelling, and blistering, and may be no more effective than topical salicylic acid in the treatment of warts.

Anogenital warts

Anogenital warts (condylomata acuminata) in children are often asymptomatic and require only a simple barrier preparation. If treatment is required it should be supervised by a hospital specialist. Persistent warts on genital skin may require treatment with cryotherapy or other forms of physical ablation under general anaesthesia.

Podophyllotoxin below (the major active ingredient of podophyllum), or imiquimod p. 791 are used to treat external anogenital warts; these preparations can cause considerable irritation of the treated area and are therefore suitable only for children who are able to co-operate with the treatment.

ANTINEOPLASTIC DRUGS > PLANT ALKALOIDS

Podophyllotoxin

INDICATIONS AND DOSE

CONDYLINE ®

Condylomata acuminata affecting the penis or the female external genitalia

TO THE LESION

Child 2–17 years (initiated under specialist supervision):
Apply twice daily for 3 consecutive days, treatment may be repeated at weekly intervals if necessary for a total of five 3–day treatment courses, direct medical supervision for lesions in the female and for lesions greater than 4 cm² in the male, maximum 50 single applications (“loops”) per session (consult product literature)

WARTICON ® CREAM

Condylomata acuminata affecting the penis or the female external genitalia

TO THE LESION

Child 2–17 years (initiated under specialist supervision):
Apply twice daily for 3 consecutive days, treatment may be repeated at weekly intervals if necessary for a total of four 3-day treatment courses, direct medical supervision for lesions greater than 4 cm²
WARTICON® LIQUID

Condylomata acuminata affecting the penis or the female external genitalia

- TO THE LESION
- Child 2-17 years (initiated under specialist supervision): Apply twice daily for 3 consecutive days, treatment may be repeated at weekly intervals if necessary for a total of four 3-day treatment courses, direct medical supervision for lesions greater than 4 cm², maximum 50 single applications (‘loops’) per session (consult product literature)

- UNLICENSED USE Not licensed for use in children.
- CAUTIONS Avoid normal skin - avoid open wounds - keep away from face - very irritant to eyes
- SIDE-EFFECTS Balanoposthitis - skin irritation
- PREGNANCY Avoid.
- BREAST FEEDING Avoid.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Cream
EXCIPIENTS: May contain Butylated hydroxyanisole, cetostearyl alcohol (including cetyl and stearyl alcohol), hydroxybenzoates (parabens), sorbic acid
- Warticon (Phoenix Labs Ltd)
  Podophyllotoxin 1.5 mg per 1 gram Warticon 0.15% cream | 5 gram PSM £17.83 DT = £17.83

Liquid
CAUTIONARY AND ADVISORY LABELS 15
- Condyline (Takeda UK Ltd)
  Podophyllotoxin 5 mg per 1 ml Condyline 0.5% solution | 3.5 ml PSM £14.49 DT = £14.49
  Podophyllotoxin 5 mg per 1 ml Warticon 0.5% solution | 3 ml PSM £14.86 DT = £14.86

ANTISEPTICS AND DISINFECTANTS ☑ ALDEHYDES AND DERIVATIVES

Formaldehyde

- INDICATIONS AND DOSE
  Warts, particularly plantar warts
  - TO THE LESION
  - Child: Apply twice daily

- UNLICENSED USE Licensed for use in children (age range not specified by manufacturer).
- CAUTIONS Impaired peripheral circulation - not suitable for application to anogenital region - not suitable for application to face - not suitable for application to large areas - patients with diabetes at risk of neuropathic ulcers - protect surrounding skin and avoid broken skin - significant peripheral neuropathy
- SIDE-EFFECTS Asthma - cough - dysphagia - eye irritation - increased risk of infection - laryngospasm - skin reactions

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: liquid

Liquid
- Formaldehyde (Non-proprietary)
  Formaldehyde 40 mg per 1 ml Formaldehyde 4% solution | 1000 ml £3.90 DT = £3.90
  Formaldehyde 350 mg per 1 gram Formaldehyde solution | 500 ml £7.24 DT = £7.24 | 2000 ml £18.72

Glutaraldehyde

- INDICATIONS AND DOSE
  Warts, particularly plantar warts
  - TO THE LESION
  - Child: Apply twice daily

- UNLICENSED USE Licensed for use in children (age range not specified by manufacturer).
- CAUTIONS Not for application to anogenital areas - not for application to face - not for application to mucosa - protect surrounding skin
- SIDE-EFFECTS Rare or very rare Severe cutaneous adverse reactions (SCARs)
  Frequency not known Rash - skin irritation (discontinue if severe)

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Paint
- Glutarol (Dermal Laboratories Ltd)
  Glutaraldehyde 100 mg per 1 ml Glutarol 10% cutaneous solution | 10 ml P | £2.07 DT = £2.07

ANTISEPTICS AND DISINFECTANTS ☑ OTHER

Silver nitrate

- INDICATIONS AND DOSE
  Common warts
  - TO THE LESION
  - Child: Apply every 24 hours for up to 3 applications, apply moistened caustic pencil tip for 1–2 minutes. Instructions in proprietary packs generally incorporate advice to remove dead skin before use by gentle filing and to cover with adhesive dressing after application
  Verrucas
  - TO THE LESION
  - Child: Apply every 24 hours for up to 6 applications, apply moistened caustic pencil tip for 1–2 minutes. Instructions in proprietary packs generally incorporate advice to remove dead skin before use by gentle filing and to cover with adhesive dressing after application
  Umbilical granulomas
  - TO THE SKIN
  - Child: Apply moistened caustic pencil tip (usually containing silver nitrate 40%) for 1–2 minutes, protect surrounding skin with soft paraffin

- UNLICENSED USE No age range specified by manufacturer.
- CAUTIONS Avoid broken skin - not suitable for application to ano-genital region - not suitable for application to face - not suitable for application to large areas - protect surrounding skin
- SIDE-EFFECTS Rare or very rare Argyria - methaemoglobinaemia
- PATIENT AND CARER ADVICE Patients should be advised that silver nitrate may stain fabric.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Stick
- Avoca (Bray Group Ltd)
  Silver nitrate 400 mg per 1 gram Avoca 40% silver nitrate pencils | 1 applicator P £1.13 DT = £1.13
  Silver nitrate 750 mg per 1 gram Avoca 75% silver nitrate applicators | 100 applicator P £47.82
  Avoca 75% silver nitrate applicators with thick handles | 50 applicator P £47.19
  Silver nitrate 950 mg per 1 gram Avoca 95% silver nitrate applicators | 100 applicator P £51.17
  Avoca 95% silver nitrate pencils | 1 applicator P £2.56 DT = £3.08
Salicylic acid

**INDICATIONS AND DOSE**

**OCCLUSAL®**

- **Common and plantar warts**
  - **TO THE LESION**
  - **Child:** Apply daily, treatment may need to be continued for up to 3 months

- **VERRUGON®**

- **For plantar warts**
  - **TO THE LESION**
  - **Child:** Apply daily, treatment may need to be continued for up to 3 months

**UNLICENSED USE**

- Not licensed for use in children under 2 years.
- **CAUTIONS**
  - Avoid broken skin
  - Impaired peripheral circulation
  - Not suitable for application to anogenital region
  - Not suitable for application to face
  - Not suitable for application to large areas
  - Patients with diabetes at risk of neuropathic ulcers

**SIDE-EFFECTS**

- **Skin irritation**
- **PATIENT AND CARER ADVICE**
  - Advise patient to apply carefully to wart and to protect surrounding skin (e.g., with soft paraffin or specially designed plaster); rub wart surface gently with felt or pumice stone once weekly.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.
- **Ointment**
  - Verrugon (Optima Consumer Health Ltd)
  - Salicylic acid 500 mg per 1 gram Verrugon complete 50% ointment 6 gram £4.44 DT = £4.44

- **Liquid**
  - Occlusal (Alliance Pharmaceuticals Ltd)
  - Salicylic acid 260 mg per 1 ml Occlusal 26% solution 10 ml £3.56 DT = £3.56

Salicylic acid with lactic acid

The properties listed below are those particular to the combination only. For the properties of the components please consider, salicylic acid above.

**INDICATIONS AND DOSE**

**CUPLEX®**

- **Plantar and mosaic warts | Corns | Calluses**
  - **TO THE LESION**
  - **Child:** 2–17 years: Apply once daily, treatment may need to be continued for up to 3 months

**DUOFILM®**

- **Plantar and mosaic warts**
  - **TO THE LESION**
  - **Child:** Apply daily, treatment may need to be continued for up to 3 months

**SALACTOL®**

- **Warts, particularly plantar warts | Verrucas | Corns | Calluses**
  - **TO THE LESION**
  - **Child:** Apply daily, treatment may need to be continued for up to 3 months

**SALATAC®**

- **Warts | Verrucas | Corns | Calluses**
  - **TO THE LESION**
  - **Child:** Apply daily, treatment may need to be continued for up to 3 months
PRESCRIBING AND DISPENSING INFORMATION
Preparations of salicylic acid in a collodion basis (Cuplex® and Salactol®) are available but some patients may develop an allergy to colophony in the formulation.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Paint
- **Duofilm** (GlaxoSmithKline UK Ltd)
  - Lactic acid 150 mg per 1 gram, Salicylic acid 167 mg per 1 gram | 15 ml [P] £2.25 DT = £2.25
- **Salactol** (Dermal Laboratories Ltd)
  - Lactic acid 167 mg per 1 gram, Salicylic acid 167 mg per 1 gram | 10 ml [P] £1.71 DT = £1.71

Gel
- **Salatac** (Dermal Laboratories Ltd)
  - Lactic acid 40 mg per 1 gram, Salicylic acid 120 mg per 1 gram | 8 gram [P] £2.98 DT = £2.98
Chapter 14
Vaccines

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1 Immunoglobulin therapy

IMMUNE SERA AND IMMUNOGLOBULINS > IMMUNOGLOBULINS

Immunoglobulins 04-Oct-2017

Passive immunity

Immunity with immediate protection against certain infective organisms can be obtained by injecting preparations made from the plasma of immune individuals with adequate levels of antibody to the disease for which protection is sought. The duration of this passive immunity varies according to the dose and the type of immunoglobulin. Passive immunity may last only a few weeks; when necessary, passive immunisation can be repeated. Antibodies of human origin are usually termed immunoglobulins. The term antiserum is applied to material prepared in animals. Because of serum sickness and other allergic-type reactions that may follow injections of antiserum, this therapy has been replaced wherever possible by the use of immunoglobulins. Reactions are theoretically possible after injection of human immunoglobulins but reports of such reactions are very rare.

Two types of human immunoglobulin preparation are available, normal immunoglobulin p. 796 and disease-specific immunoglobulins.

Human immunoglobulin is a sterile preparation of concentrated antibodies (immune globulins) recovered from pooled human plasma or serum obtained from outside the UK, tested and found non-reactive for hepatitis B surface antigen and for antibodies against hepatitis C virus and human immunodeficiency virus (types 1 and 2). A global shortage of human immunoglobulin and the rapidly increasing range of clinical indications for treatment with immunoglobulins has resulted in the need for a Demand Management programme in the UK, for further information consult www.ivig.nhs.uk and Clinical Guidelines for Immunoglobulin Use, www.gov.uk/dh.


Availability

Normal immunoglobulin for intramuscular administration is available from some regional Public Health laboratories for protection of contacts and the control of outbreaks of hepatitis A, measles, and rubella only. For other indications, subcutaneous or intravenous normal immunoglobulin should be purchased from the manufacturer.

Disease-specific immunoglobulins are available from some regional Public Health laboratories, with the exception of tetanus immunoglobulin p. 798 which is available from BPL, hospital pharmacies, or blood transfusion departments. Rabies immunoglobulin p. 798 is available from the Specialist and Reference Microbiology Division, Public Health England, Colindale. Hepatitis B immunoglobulin p. 796 required by transplant centres should be obtained commercially.

In Scotland all immunoglobulins are available from the Scottish National Blood Transfusion Service (SNBTS).

In Wales all immunoglobulins are available from the Welsh Blood Service (WBS).

In Northern Ireland all immunoglobulins are available from the Northern Ireland Blood Transfusion Service (NIBTS).

Normal immunoglobulin

Human normal immunoglobulin (‘HNIG’) is prepared from pools of at least 1000 donations of human plasma; it contains immunoglobulin G (IgG) and antibodies to hepatitis A, measles, mumps, rubella, varicella, and other viruses that are currently prevalent in the general population.

Uses

Normal immunoglobulin (containing 10–18% protein) is administered by intramuscular injection for the protection of susceptible contacts against hepatitis A virus (infectious hepatitis), measles and, to a lesser extent, rubella. Injection of immunoglobulin produces immediate protection lasting for several weeks.

Normal immunoglobulin (containing 3–12% protein) for intravenous administration is used as replacement therapy for children with congenital agammaglobulinaemia and hypogammaglobulinaemia, and for the short-term treatment of idiopathic thrombocytopenic purpura and Kawasaki disease; it is also used for the prophylaxis of infection following bone-marrow transplantation and in children with symptomatic HIV infection who have recurrent bacterial infections. Normal immunoglobulin for replacement therapy may also be given intramuscularly or subcutaneously, but intravenous formulations are normally preferred.

Intravenous immunoglobulin is also used in the treatment of Guillain-Barré syndrome as an alternative to plasma exchange.

The dose of normal immunoglobulin used as replacement therapy in patients with immunodeficiencies is not the same as the dose required for treatment of acute conditions. For Kawasaki disease a single dose by intravenous infusion should be given with concomitant aspirin p. 93 within 10 days of onset of symptoms (but children with a delayed diagnosis may also benefit).

For guidance on the use of intravenous normal immunoglobulin and alternative therapies for other conditions, consult Clinical Guidelines for Immunoglobulin Use (www.gov.uk/dh).

Hepatitis A

Hepatitis A vaccine p. 821 is recommended for individuals at risk of infection including those visiting areas where the disease is highly endemic (all countries excluding Northern and Western Europe, North America, Japan, Australia, and
New Zealand). In unimmunised individuals, transmission of hepatitis A is reduced by good hygiene. Intramuscular normal immunoglobulin is no longer recommended for prophylaxis in travellers.

Public Health England recommends the use of normal immunoglobulin in addition to hepatitis A vaccine for prevention of infection in close contacts (of confirmed cases of hepatitis A) who have chronic liver disease (including chronic hepatitis B or C infection), or HIV infection (with a CD4 count < 200 cells per microlitre), or who are immunosuppressed; normal immunoglobulin should be given as soon as possible, preferably within 14 days of exposure to the primary case. However, normal immunoglobulin can still be given to contacts with chronic liver disease up to 28 days after exposure to the primary case. Hepatitis A vaccine can be given at the same time, but it should be given at a separate injection site.

Measles
Intravenous or subcutaneous normal immunoglobulin may be given to prevent or attenuate an attack of measles in individuals who do not have adequate immunity. Children with compromised immunity who have come into contact with measles should receive intravenous or subcutaneous normal immunoglobulin as soon as possible after exposure. It is most effective if given within 72 hours but can be effective if given within 6 days.

Subcutaneous or intramuscular normal immunoglobulin should also be considered for the following individuals if they have been in contact with a confirmed case of measles or with a person associated with a local outbreak:
- non-immune pregnant women
- infants under 9 months

Further advice should be sought from the Centre for Infections, Public Health England (tel. (020) 8200 6868).

Varicella-zoster immunoglobulin
Varicella-zoster immunoglobulin p. 798 (VZIG) is recommended for individuals who are at increased risk of severe varicella (neonates, pregnant women, and immunosuppressed individuals with normal immunity who are not in the above categories and who have not been fully immunised against measles), can be given measles, mumps and rubella vaccine, live p. 826 for prophylaxis following exposure to measles.

Rubella
Intramuscular immunoglobulin after exposure to rubella does not prevent infection in non-immune contacts and is not recommended for protection of pregnant women exposed to rubella. It may, however, reduce the likelihood of a clinical attack which may possibly reduce the risk to the fetus. Risk of intra-uterine transmission is greatest in the first 11 weeks of pregnancy, between 16 and 20 weeks there is minimal risk of deafness only, after 20 weeks there is no increased risk. Intramuscular normal immunoglobulin p. 796 should be used only if termination of pregnancy would be unacceptable to the pregnant woman—it should be given as soon as possible after exposure. Serological follow-up of recipients is essential to determine if the woman has become infected despite receiving immunoglobulin.

For routine prophylaxis against rubella, see measles, mumps and rubella vaccine, live p. 826.

Disease-specific immunoglobulins
Specific immunoglobulins are prepared by pooling the plasma of selected human donors with high levels of the specific antibody required. For further information, see Immunoglobulin Handbook (www.gov.uk/phe).

There are no specific immunoglobulins for hepatitis A, measles, or rubella—normal immunoglobulin is used in certain circumstances. There is no specific immunoglobulin for mumps; neither normal immunoglobulin nor measles, mumps and rubella vaccine, live is effective as postexposure prophylaxis.

Hepatitis B immunoglobulin
Disease-specific hepatitis B immunoglobulin p. 796 (HBIG) is available for use in association with hepatitis B vaccine for the prevention of infection in infants born to mothers who have become infected with this virus in pregnancy or who are high-risk carriers (see hepatitis B vaccine). Hepatitis B immunoglobulin will not inhibit the antibody response when given at the same time as hepatitis B vaccine but should be given at different sites.

An intravenous and preparation of hepatitis B immunoglobulin is licensed for the prevention of hepatitis B recurrence in HBV-DNA negative patients who have undergone liver transplantation for liver failure caused by the virus.

Rabies immunoglobulin
Following exposure of an unimmunised individual to an animal in or from a country where the risk of rabies is high the site of the bite should be washed with soapy water and specific rabies immunoglobulin p. 798 of human origin administered. All of the dose should be injected around the site of the wound; if this is difficult or the wound has completely healed it can be given in the anterolateral thigh (remote from the site used for vaccination).

Rabies vaccine p. 827 should also be given intramuscularly at a different site (for details see rabies vaccine). If there is delay in giving the rabies immunoglobulin, it should be given within 7 days of starting the course of rabies vaccine.

Tetanus immunoglobulin
For the management of tetanus-prone wounds, tetanus immunoglobulin p. 798 should be used in addition to wound cleansing and, where appropriate, antibacterial prophylaxis and a tetanus-containing vaccine. Tetanus immunoglobulin, together with metronidazole p. 344 and wound cleansing, should also be used for the treatment of established cases of tetanus.

Varicella-zoster immunoglobulin
Varicella-zoster immunoglobulin p. 798 (VZIG) is recommended for individuals who are at increased risk of severe varicella (neonates, pregnant women, and immunosuppressed individuals with normal immunity who are not in the above categories and who have not been fully immunised against measles, mumps and rubella vaccine). Varicella-zoster virus immunoglobulin G antibody less than 150 mIU/mL and who have no antibodies to varicella-zoster virus and who have significant exposure to chickenpox (varicella) or shingles (herpes zoster) during the infectious period.

Immunosuppressed children receiving regular intravenous immunoglobulin replacement therapy only require varicella-zoster immunoglobulin if the most recent dose was administered more than 3 weeks before exposure. Immunosuppressed children on long-term aciclovir p. 420 or valaciclovir prophylaxis p. 422 will require a temporary increase in their dose following exposure; for children within 12 months of a stem cell transplant, varicella-zoster immunoglobulin should also be considered.


Anti-D (Rh0) immunoglobulin

- INDICATIONS AND DOSE
- To rhesus-negative woman for prevention of Rh(D) sensitisation, following birth of rhesus-positive infant
  - By deep intramuscular injection
  - Females of childbearing potential: 500 units, dose to be administered immediately or within 72 hours; for transplacental bleed of over 4 mL fetal red cells, extra 100–125 units per mL fetal red cells, subcutaneous route used for patients with bleeding disorders
To rhesus-negative woman for prevention of Rh(D) sensitisation, following any potentially sensitising episode (e.g. stillbirth, abortion, amniocentesis) up to 20 weeks' gestation

- **BY DEEP INTRAMUSCULAR INJECTION**
- Females of childbearing potential: 250 units per episode, dose to be administered immediately or within 72 hours, subcutaneous route used for patients with bleeding disorders

To rhesus-negative woman for prevention of Rh(D) sensitisation, following any potentially sensitising episode (e.g. stillbirth, abortion, amniocentesis) after 20 weeks' gestation

- **BY DEEP INTRAMUSCULAR INJECTION**
- Females of childbearing potential: 500 units per episode, dose to be administered immediately or within 72 hours, subcutaneous route used for patients with bleeding disorders

To rhesus-negative woman for prevention of Rh(D) sensitisation, antenatal prophylaxis

- **BY DEEP INTRAMUSCULAR INJECTION**
- Females of childbearing potential: 500 units, dose to be given at weeks 28 and 34 of pregnancy, if infant rhesus-positive, a further dose is still needed immediately or within 72 hours of delivery, subcutaneous route used for patients with bleeding disorders

To rhesus-negative woman for prevention of Rh(D) sensitisation, following Rh(D) incompatible blood transfusion

- **BY DEEP INTRAMUSCULAR INJECTION**
- Females of childbearing potential: 100–125 units per mL of transfused rhesus-positive red cells, subcutaneous route used for patients with bleeding disorders

RPHOPHYLAC®

To rhesus-negative woman for prevention of Rh(D) sensitisation, following birth of rhesus-positive infant

- **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
- Females of childbearing potential: 1000–1500 units, dose to be administered immediately or within 72 hours; for large transplacental bleed, extra 100 units per mL fetal red cells (preferably by intravenous injection), intravenous route recommended for patients with bleeding disorders

To rhesus-negative woman for prevention of Rh(D) sensitisation, following any potentially sensitising episode (e.g. abortion, amniocentesis, choriionic villous sampling) up to 12 weeks' gestation

- **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
- Females of childbearing potential: 1000 units per episode, dose to be administered immediately or within 72 hours, intravenous route recommended for patients with bleeding disorders, higher doses may be required after 12 weeks gestation

To rhesus-negative woman for prevention of Rh(D) sensitisation, antenatal prophylaxis

- **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
- Females of childbearing potential: 1500 units, dose to be given between weeks 28–30 of pregnancy; if infant rhesus-positive, a further dose is still needed immediately or within 72 hours of delivery, intravenous route recommended for patients with bleeding disorders

To rhesus-negative woman for prevention of Rh(D) sensitisation, following Rh(D) incompatible blood transfusion

- **BY INTRAVENOUS INJECTION**
- Females of childbearing potential: 50 units per mL of transfused rhesus-positive blood, alternatively 100 units per mL of erythrocyte concentrate, intravenous route recommended for patients with bleeding disorders

- **CONTRA-INDICATIONS** Treatment of idiopathic thrombocytopenia purpura in rhesus negative patients - treatment of idiopathic thrombocytopenia purpura in splenectomised patients

- **CAUTIONS** Immunoglobulin A deficiency - possible interference with live virus vaccines

**CAUTIONS, FURTHER INFORMATION**

- MMR vaccine MMR vaccine may be given in the postpartum period with anti-D (Rh) immunoglobulin injection provided that separate syringes are used and the products are administered into different limbs. If blood is transfused, the antibody response to the vaccine may be inhibited—measure rubella antibodies after 6–8 weeks and revaccinate if necessary.

- **INTERACTIONS** Appendix 1: immunoglobulins

- **SIDE-EFFECTS**
  - Uncommon Chills, fever, headache, malaise, skin reactions
  - Rare or very rare Arthralgia, dyspnoea, hypersensitivity, hypotension, nausea, tachycardia, vomiting
  - Frequency not known Intravascular haemolysis

**HANDLING AND STORAGE**

Care must be taken to store all immunological products under the conditions recommended in the product literature, otherwise the preparation may become ineffective. Refrigerated storage is usually necessary; many immunoglobulins need to be stored at 2–8°C and not allowed to freeze. Immunoglobulins should be protected from light. Opened multidose vials must be used within the period recommended in the product literature.

**NATIONAL FUNDING/ACCESS DECISIONS**

**NICE decisions**

- Routine antenatal anti-D prophylaxis for rhesus-negative women (August 2008) NICE TA156 Routine antenatal anti-D prophylaxis should be offered to all non-sensitised pregnant women who are rhesus negative.
  - www.nice.org.uk/TA156

**MEDICINAL FORMS**

There can be variation in the licensing of different medicines containing the same drug.

**Solution for Injection**

- **D-Gam (Bio Products Laboratory Ltd)** Anti-D (RHO) immunoglobulin 500 unit D-Gam Anti-D immunoglobulin 500 unit solution for injection vials | 1 vial £38.25
- Anti-D (RHO) immunoglobulin 1500 unit D-Gam Anti-D immunoglobulin 1,500 unit solution for injection vials | 1 vial £58.00
- **Rphophylac (CSL Behring UK Ltd)** Anti-D (RHO) immunoglobulin 750 unit per 1 ml Rphophylac 1,500units/2ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £46.30
Hepatitis B immunoglobulin

**INDICATIONS AND DOSE**

**Prophylaxis against hepatitis B infection**
- **BY INTRAMUSCULAR INJECTION**
  - Neonate: 200 units, dose to be administered as soon as possible after exposure; ideally within 12–48 hours, but no later than 7 days after exposure.
  - Child 1 month–4 years: 200 units, dose to be administered as soon as possible after exposure; ideally within 12–48 hours, but no later than 7 days after exposure.
  - Child 5–9 years: 300 units, dose to be administered as soon as possible after exposure; ideally within 12–48 hours, but no later than 7 days after exposure.
  - Child 10–17 years: 500 units, dose to be administered as soon as possible after exposure; ideally within 12–48 hours, but no later than 7 days after exposure.

**Prevention of transmitted infection at birth**
- **BY INTRAVENOUS INFUSION**
  - Neonate: 200 units, dose to be administered as soon as possible after birth; for full details consult Immunisation against Infectious Disease (www.dh.gov.uk).
- **BY INTRAMUSCULAR INJECTION**
  - Neonate: (consult product literature).

**Prophylaxis against hepatitis B infection, after exposure to hepatitis B virus-contaminated material**
- **BY INTRAVENOUS INFUSION**
  - Child: Dose to be administered as soon as possible after exposure, but no later than 72 hours (consult product literature).

**Prophylaxis against re-infection of transplanted liver**
- **BY INTRAVENOUS INFUSION**
  - Child: (consult product literature).

**CAUTIONS**
- IgA deficiency • interference with live virus vaccines

**INTERACTIONS**
- Appendix 1: immunoglobulins

**SIDE-EFFECTS**
- Uncommon: Abdominal pain upper • headache
- Rare or very rare: Cardiac discomfort • fatigue • hypersensitivity • hypertension • hypotension • muscle spasms • nasopharyngitis • oropharyngeal pain • palpitations • skin reactions

**PRESCRIBING AND DISPENSING INFORMATION**
- Vials containing 200 units or 500 units (for intramuscular injection), available from selected Public Health England and NHS laboratories (except for Transplant Centres), also available from BPL.

**HANDLING AND STORAGE**
- Care must be taken to store all immunological products under the conditions recommended in the product literature, otherwise the preparation may become ineffective. Refrigerated storage is usually necessary; many immunoglobulins need to be stored at 2–8°C and not allowed to freeze. Immunoglobulins should be protected from light. Opened multidose vials must be used within the period recommended in the product literature.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Hepatitis B immunoglobulin (Non-proprietary)**
  - Hepatitis B immunoglobulin human 500 unit solution for injection vials | 1 vial (£400.00)
  - Zutebra (Biotest (UK) Ltd) Zutebra 500units/1ml solution for injection pre-filled syringes | 5 syringe (£1,500.00)

**Solution for infusion**
- **Hepact CP (Biotest (UK) Ltd)**
  - Hepatitis B immunoglobulin human 50 unit per 1 ml | 1 vial (£55.00)
  - Hepact CP 100units/2ml solution for infusion vials | 1 vial (£1,100.00)
  - Hepact CP 500units/10ml solution for infusion vials | 1 vial (£2,750.00)
  - Omri-Hep-B (Imported (Israel)) Hepatitis B immunoglobulin human 50 unit per 1 ml Omri-Hep-B 500units/100ml solution for infusion vials | 1 vial (£200.00)

**Normal immunoglobulin**

**INDICATIONS AND DOSE**
- **To control outbreaks of hepatitis A**
  - **BY DEEP INTRAMUSCULAR INJECTION**
  - Child 1 month–9 years: 250 mg
  - Child 10–17 years: 500 mg

- **Rubella in pregnancy, prevention of clinical attack**
  - **BY DEEP INTRAMUSCULAR INJECTION**
  - Females of childbearing potential: 750 mg

- **Antibody deficiency syndromes**
  - **BY SUBCUTANEOUS INFUSION**
  - Child: (consult product literature)

- **Kawasaki disease (with concomitant aspirin)**
  - **BY INTRAVENOUS INFUSION**
  - Child: 2 g/kg daily for 1 dose, treatment should be given within 10 days of onset of symptom (but children with a delayed diagnosis may also benefit)

- **SUBGAM®**
  - **Hepatitis A prophylaxis in outbreaks**
  - **BY INTRAMUSCULAR INJECTION**
  - Child 1 month–9 years: 500 mg
  - Child 10–17 years: 750 mg

**UNLICENSED USE**
- **SUBGAM®** Subgamm® is not licensed for prophylactic use, but due to difficulty in obtaining suitable immunoglobulin products, Public Health England recommends intramuscular use for prophylaxis against Hepatitis A or rubella.

**CONTRA-INDICATIONS**
- Patients with selective IgA deficiency who have known antibody against IgA

- **PRIVIGEN®** Hyperprolinaemia (contains L-proline)
- **FLEBOGAMMA® DIF** Hereditary fructose intolerance (contains sorbitol)
- **HIZENTRA®** Hyperprolinaemia (contains L-proline)
- **GAMMAPLEX®** Hereditary fructose intolerance (contains sorbitol)

**CAUTIONS**
- **GENERAL CAUTIONS** Agammaglobulinaemia with or without IgA deficiency • hypogammaglobulinaemia with or without IgA deficiency • interference with live virus vaccines

**SPECIFIC CAUTIONS**
- With intravenous use: Ensure adequate hydration • obesity • renal insufficiency • risk factors for arterial or venous thromboembolic events • thrombophilic disorders

**CAUTIONS, FURTHER INFORMATION**
- Interference with live virus vaccines: Normal immunoglobulin may interfere with the immune response to live virus
vaccines which should therefore only be given at least 3 weeks before or 3 months after an injection of normal immunoglobulin (this does not apply to yellow fever vaccine since normal immunoglobulin does not contain antibody to this virus).

**OCTAGAM** Falsely elevated results with blood glucose testing systems (contains maltose)

**INTERACTIONS** Appendix 1: immunoglobulins

**SIDE-EFFECTS**

**Common or very common**
- With intramuscular use Chills
- With subcutaneous use Diarrhoea, dizziness, drowsiness, fatigue, gastrointestinal discomfort, headaches, hypotension, local reaction, myalgia, nausea, pain, skin reactions
- Rare or very rare
  - With intramuscular use Abdominal pain, arthralgia, musculoskeletal stiffness, myalgia, peripheral coldness, tremor
  - Frequency not known
    - With intramuscular useChestdiscomfort, dyspnoea, facial swelling, fever, flushing, hyperhidrosis, hypertension, hypotension, malaise, oral paraesthesia, pallor, paraesthesia, tachycardia, vomiting
    - With intravenous use Embolism and thrombosis, gastrointestinal discomfort, haemolytic anaemia, myocardial infarction, stroke

**SIDE-EFFECTS, FURTHER INFORMATION**

Adverse reactions are more likely to occur in patients receiving normal immunoglobulin for the first time, or following a prolonged period between treatments, or when a different brand of normal immunoglobulin is administered.

**MONITORING REQUIREMENTS** Monitor for acute renal failure; consider discontinuation if renal function deteriorates. Intravenous preparations with added sucrose have been associated with cases of renal dysfunction and acute renal failure.

**DIRECTIONS FOR ADMINISTRATION**

Preparations for subcutaneous use may be administered by intramuscular injection if subcutaneous route not possible; intramuscular route not for patients with thrombocytopenia or other bleeding disorders.

**GAMUNEX** Use Glucose 5% intravenous infusion if dilution prior to infusion is required.

**KIOVIG** Use Glucose 5% intravenous infusion if dilution prior to infusion is required.

**PRESCRIBING AND DISPENSING INFORMATION**

Antibody titres can vary widely between normal immunoglobulin preparations from different manufacturers—formulations are not interchangeable; patients should be maintained on the same formulation throughout long-term treatment to avoid adverse effects.

**HANDLING AND STORAGE**

Care must be taken to store all immunological products under the conditions recommended in the product literature, otherwise the preparation may become ineffective. Refrigerated storage is usually necessary; many immunoglobulins need to be stored at 2–8°C and not allowed to freeze. Immunoglobulins should be protected from light. Opened multidose vials must be used within the period recommended in the product literature.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

**ELECTROLYTES:** May contain Sodium

- **Hizentra** (CSL Behring UK Ltd)
  - Normal immunoglobulin human 200 mg per 1 ml Hizentra 2g/10ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £108.00

- **Subgam** (Bio Products Laboratory Ltd)
  - Normal immunoglobulin human 160 mg per 1 ml Subgam 1.5g/9.375ml solution for injection vials | 1 vial (P09) £75.00
  - Subgam 4g/25ml solution for injection vials | 1 vial (P09) £200.00
  - Subgam 2g/12.5ml solution for injection vials | 1 vial (P09) £100.00
  - Subgam 4g/6.25ml solution for injection vials | 1 vial (P09) £50.00
  - Subgam 75mg/4.6875ml solution for injection vials | 1 vial (P09) £37.50

**Solution for infusion**

**EXCIPIENTS:** May contain Glucose, maltose, sorbitol, sucrose

- **Normal immunoglobulin (Non-proprietary)**
  - Normal immunoglobulin human 100 mg per 1 ml Normal immunoglobulin human 5g/50ml solution for infusion vials | 1 vial (P09) £690.00
  - Normal immunoglobulin human 2.5g/25ml solution for infusion vials | 1 vial (P09) £50.00
  - Normal immunoglobulin human 20g/200ml solution for infusion vials | 1 vial (P09) £980.00
  - Normal immunoglobulin human 10g/100ml solution for infusion vials | 1 vial (P09) £500.00
  - Normal immunoglobulin human 30g/300ml solution for infusion vials | 1 vial (P09) £1,020.00

- **Flebogammadif** (Grifols UK Ltd)
  - Normal immunoglobulin human 50 mg per 1 ml Flebogamma Dif 1g/200ml solution for infusion vials | 1 vial (P09) £100.00
  - Flebogamma Dif 2.5g/50ml solution for infusion vials | 1 vial (P09) £127.50
  - Flebogamma Dif 5g/100ml solution for infusion vials | 1 vial (P09) £225.00
  - Flebogamma Dif 500mg/10ml solution for infusion vials | 1 vial (P09) £30.00
  - Flebogamma Dif 2g/400ml solution for infusion vials | 1 vial (P09) £1,020.00

- **Gammaplex** (Bio Products Laboratory Ltd)
  - Normal immunoglobulin human 50 mg per 1 ml Gammaplex 1g/200ml solution for infusion vials | 1 vial (P09) £41.00 (Hospital only)
  - Gammaplex 5g/100ml solution for infusion vials | 1 vial (P09) £209.00 (Hospital only)
  - Gammaplex 20g/400ml solution for infusion vials | 1 vial (P09) £836.00 (Hospital only)

- **Gamunex** (Grifols UK Ltd)
  - Normal immunoglobulin human 100 mg per 1 ml Gamunex 10g/50ml solution for infusion vials | 1 vial (P09) £125.50
  - Gamunex 10g/100ml solution for infusion vials | 1 vial (P09) £225.00
  - Gamunex 10g/200ml solution for infusion vials | 1 vial (P09) £470.00
  - Gamunex 10g/400ml solution for infusion vials | 1 vial (P09) £980.00

- **Hizentra** (CSL Behring UK Ltd)
  - Normal immunoglobulin human 200 mg per 1 ml Hizentra 2g/10ml solution for infusion vials | 1 vial (P09) £108.00
  - Hizentra 2g/5ml solution for infusion vials | 1 vial (P09) £54.00
  - Hizentra 4g/20ml solution for infusion vials | 1 vial (P09) £216.00

- **Kiovig** (Baxalta UK Ltd)
  - Normal immunoglobulin human 100 mg per 1 ml Kiovig 5g/50ml solution for infusion vials | 1 vial (P09) £245.00
  - Kiovig 20g/200ml solution for infusion vials | 1 vial (P09) £980.00
  - Kiovig 10g/100ml solution for infusion vials | 1 vial (P09) £490.00
  - Kiovig 30g/300ml solution for infusion vials | 1 vial (P09) £1,470.00
  - Kiovig 2.5g/25ml solution for infusion vials | 1 vial (P09) £122.50
  - Kiovig 1g/10ml solution for infusion vials | 1 vial (P09) £49.00

- **Octagam** (Octapharma Ltd)
  - Normal immunoglobulin human 50 mg per 1 ml Octagam 5g/200ml solution for infusion vials | 1 bottle (P03) £480.00 (Hospital only)
  - Octagam 5g/100ml solution for infusion vials | 1 bottle (P03) £240.00 (Hospital only)
  - Normal immunoglobulin human 100 mg per 1 ml Octagam 10g/100ml solution for infusion vials | 1 bottle (P03) £690.00 (Hospital only)
Tetanus immunoglobulin

- **INDICATIONS AND DOSE**
  - **Post-exposure prophylaxis**
    - **By intramuscular injection**
    - **Child:** Initially 250 units, then increased to 500 units, dose is only increased if more than 24 hours have elapsed or there is risk of heavy contamination or following burns
  - **Treatment of tetanus infection**
    - **By intramuscular injection**
    - **Child:** 150 units/kg, dose may be given over multiple sites

- **CAUTIONS**
  - IgA deficiency - interference with live virus vaccines
- **INTERACTIONS**
  - → Appendix 1: immunoglobulins
- **SIDE-EFFECTS**
  - Rare or very rare: Anaphylactic reaction - hypotension
  - Frequency not known: Arthralgia - chest pain - dizziness - dyspnoea - face oedema - oral disorders - tremor

- **HANDLING AND STORAGE**
  - Care must be taken to store all immunological products under the conditions recommended in the product literature, otherwise the preparation may become ineffective. **Refrigerated storage** is usually necessary; many immunoglobulins need to be stored at 2–8°C and not allowed to freeze. Immunoglobulins should be protected from light. Opened multidose vials must be used within the period recommended in the product literature.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Solution for injection**
    - **Tetanus immunoglobulin (Non-proprietary)**
      - Tetanus immunoglobulin human 250 unit
      - Tetanus immunoglobulin human 250 unit solution for injection vials | 1 vial (POM) £170.00

Varicella-zoster immunoglobulin (Antivariella-zoster Immunoglobulin)

- **INDICATIONS AND DOSE**
  - **Prophylaxis against varicella infection**
    - **By deep intramuscular injection**

- **Solution for injection**
  - **Rabies immunoglobulin (Non-proprietary)**
    - Rabies immunoglobulin human 500 unit
      - Rabies immunoglobulin human 500 unit solution for injection vials | 1 vial (POM) £800.00

Rabies immunoglobulin

- **INDICATIONS AND DOSE**
  - **Post-exposure prophylaxis for rabies infection**
    - **By local infiltration, or by intramuscular injection**
    - **Child:** 20 units/kg, dose administered by infiltration in and around the cleansed wound; if the wound not visible or healed or if infiltration of whole volume not possible, give remainder by intramuscular injection into anterolateral thigh (remote from vaccination site)

- **CAUTIONS**
  - IgA deficiency - interference with live virus vaccines
- **INTERACTIONS**
  - → Appendix 1: immunoglobulins
- **SIDE-EFFECTS**
  - Rare or very rare: Arthralgia - chills - fatigue - fever - headache - hypersensitivity - hypotension - influenza like illness - malaise - nausea - skin reactions - tachycardia - vomiting

- **PRESCRIBING AND DISPENSING INFORMATION**
  - The potency of individual batches of rabies immunoglobulin from the manufacturer may vary; potency may also be described differently by different manufacturers. It is therefore critical to know the potency of the batch to be used and the weight of the patient in order to calculate the specific volume required to provide the necessary dose.
  - Available from Specialist and Reference Microbiology Division, Public Health England (also from BPL).

- **HANDLING AND STORAGE**
  - Care must be taken to store all immunological products under the conditions recommended in the product literature, otherwise the preparation may become ineffective. **Refrigerated storage** is usually necessary; many immunoglobulins need to be stored at 2–8°C and not allowed to freeze. Immunoglobulins should be protected from light. Opened multidose vials must be used within the period recommended in the product literature.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - **Solution for injection**
    - **Tetanus immunoglobulin (Non-proprietary)**
      - Tetanus immunoglobulin human 250 unit
      - Tetanus immunoglobulin human 250 unit solution for injection vials | 1 vial (POM) £170.00

Octagam 10% 20g/200ml solution for infusion bottles | 1 bottle (POM) £1,380.00 (Hospital only)
Octagam 10% 5g/50ml solution for infusion bottles | 1 bottle (POM) £345.00 (Hospital only)
Octagam 10% 2g/20ml solution for infusion vials | 1 vial (POM) £138.00 (Hospital only)
- **Panzyga** (Octapharma Ltd)
  - Normal immunoglobulin human 100 mg per 1 ml
  - Panzyga 10g/100ml solution for infusion bottles | 1 bottle (POM) £586.50 (Hospital only)
  - Panzyga 2g/20ml solution for infusion bottles | 1 bottle (POM) £1,173.00 (Hospital only)
  - Panzyga 5g/50ml solution for infusion bottles | 1 vial (POM) £293.25 (Hospital only)
- **Privigen** (CSL Behring UK Ltd)
  - Normal immunoglobulin human 100 mg per 1 ml
  - Privigen 5g/50ml solution for infusion vials | 1 vial (POM) £270.00
  - Privigen 20g/200ml solution for infusion vials | 1 vial (POM) £1,080.00
  - Privigen 10g/100ml solution for infusion vials | 1 vial (POM) £540.00
  - Privigen 2.5g/25ml solution for infusion vials | 1 vial (POM) £135.00

Varicella-zoster immunoglobulin

- **INDICATIONS AND DOSE**
  - **Prophylaxis against varicella infection**
    - **By deep intramuscular injection**

- **Solution for injection**
  - **Rabies immunoglobulin (Non-proprietary)**
    - Rabies immunoglobulin human 500 unit
      - Rabies immunoglobulin human 500 unit solution for injection vials | 1 vial (POM) £800.00
Post-exposure prophylaxis

Immune sera and immunoglobulins

Botulism antitoxin

**Drug Action** A preparation containing the specific antitoxin globulins that have the power of neutralising the toxins formed by types A, B, and E of *Clostridium botulinum.*

**Indications and Dose**
- **Post-exposure prophylaxis of botulism**
- **Child:** (consult product literature)

**Side-effects** Hypersensitivity

**Side-effects, further information** It is essential to read the contra-indications, warnings, and details of sensitivity tests on the package insert. Prior to treatment checks should be made regarding previous administration of any antitoxin and history of any allergic condition, e.g. asthma, hay fever, etc.

**Pre-treatment screening** All patients should be tested for sensitivity (diluting the antitoxin if history of allergy).

**Prescribing and dispensing information** Available from local designated centres, for details see TOXBASE (requires registration) www.toxbase.org. For supplies outside working hours apply to other designated centres or to the Public Health England Colindale duty doctor (Tel (020) 8200 6868). For major incidents, obtain supplies from Centre for Infections (Tel (020) 8200 6868) or in Northern Ireland from Public Health Laboratory, Belfast City Hospital (Tel (028) 9032 9241). For supplies outside working hours apply to other designated centres or to the Public Health England Colindale duty doctor (Tel (020) 8200 6868). For major incidents, obtain supplies from Centre for Infections (Tel (020) 8200 6868) or in Northern Ireland from Public Health Laboratory, Belfast City Hospital (Tel (028) 9032 9241).

**Medicinal forms** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Varicella-Zoster** (Bio Products Laboratory Ltd)
  - Varicella-Zoster immunoglobulin human 250 mg
  - Varicella-Zoster immunoglobulin human 250mg solution for injection vials
    - 1 vial £60.00

**3 Tuberculosis diagnostic test**

**Diagnostic agents**

Tuberculin purified protein derivative (Tuberculin PPD)

**Indications and dose**
- **Mantoux test**
  - **Child:** 2 units for one dose
  - **Mantoux test (if first test is negative and a further test is considered appropriate)**
    - **Child:** 10 units for 1 dose

**Dose equivalence and conversion**
- 2 units is equivalent to 0.1 mL of 20 units/mL strength.
- 10 units is equivalent to 0.1 mL of 100 units/mL strength.

**Medicinal forms** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Diphtheria antitoxin (Non-proprietary)**
  - Diphtheria antitoxin 1000 unit per 1 mL Antidiphtheria serum
  - 10,000 units/10 mL solution for injection ampoules
  - 1 ampoule £30.00

**Prescribing and dispensing information** Available from Centre for Infections (Tel (020) 8200 6868) or in Northern Ireland from Public Health Laboratory, Belfast City Hospital (Tel (028) 9032 9241).
Vaccines and HIV infection

HIV-positive children with or without symptoms can receive the following live vaccines:
- MMR (but avoid if immunity significantly impaired), varicella-zoster vaccine against chickenpox (but avoid if immunity significantly impaired—consult product literature; use of normal immunoglobulin should be considered after exposure to measles and varicella–zoster immunoglobulin considered after exposure to chickenpox or herpes zoster), rotavirus; and the following inactivated vaccines:
  - anthrax, cholera (oral), diphtheria, haemophilus influenzae type b, hepatitis A, hepatitis B, human papillomavirus, influenza (injection), meningococcal, pertussis, pneumococcal, poliomyelitis (inactivated poliomyelitis vaccine is now used instead of oral poliomyelitis vaccine for routine immunisation of children), rabies, tetanus, tick-borne encephalitis, typhoid (injection).

HIV-positive children should **not** receive:
- BCG, influenza nasal spray (unless stable HIV infection and receiving antiretroviral therapy), typhoid (oral), yellow fever (if yellow fever risk is unavoidable, specialist advice should be sought).

The above advice differs from that for other immunocompromised patients; Immunisation of HIV infected Children issued by Children’s HIV Association (CHIVA) are available at [www.chiva.org.uk](http://www.chiva.org.uk).

Vaccines and asplenia

The following vaccines are recommended for asplenic patients, those with splenic dysfunction or complement disorders, depending on the age at which their condition is diagnosed:
- Haemophilus influenzae type b with meningococcal group C vaccine p. 818;
- Influenza vaccine p. 825;
- Meningococcal groups A with C and W135 and Y vaccine p. 819 and meningococcal group B vaccine (rDNA, component, adsorbed) p. 818;
- pneumococcal polysaccharide vaccine.

**Children first diagnosed under 1 year of age** should be vaccinated according to the Immunisation Schedule. Additionally, one dose of meningococcal groups A with C and W135 and Y vaccine should be given during infancy followed by a second dose at least one month apart. Two months following the routine 12 month booster vaccines, give a dose of meningococcal groups A with C and W135 and Y vaccine and an additional dose of 13-valent pneumococcal polysaccharide vaccine. An additional dose of haemophilus influenzae type b with meningococcal group C vaccine and 23-valent pneumococcal polysaccharide vaccine should be given after the second birthday. The influenza vaccine should be administered annually in children aged 6 months or older.

**Children first diagnosed between 1 and 2 years of age** should be vaccinated according to the Immunisation Schedule, including the 12 month boosters. Two months after the routine 12 month booster vaccines, give a dose of meningococcal groups A with C and W135 and Y vaccine and an additional dose of 13-valent pneumococcal polysaccharide vaccine. An additional dose of haemophilus influenzae type b with meningococcal group C vaccine and 23-valent pneumococcal polysaccharide vaccine should be given after the second birthday. The influenza vaccine should be administered annually.

**Children first diagnosed over 2 years of age** should be vaccinated according to the Immunisation Schedule, including the 12 month boosters. The child should receive one additional booster dose of haemophilus influenzae type
**Routine immunisation schedule**

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Vaccine given and dose schedule (for details of dose, see under individual vaccines)</th>
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| **Neonates at risk only** | ▶ Bacillus Calmette-Guérin vaccine p. 817 (at birth, see BCG vaccine p. 802)  
▶ Hepatitis B vaccine p. 822 (at birth, see Hepatitis B vaccine p. 805) |
| **8 weeks** | ▶ Diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine p. 816 (*Inflanrix hexa*®). First dose  
▶ Meningococcal group B vaccine (rDNA, component, adsorbed) p. 818 (*Bexsero*®). First dose  
▶ Pneumococcal polysaccharide conjugate vaccine (adsorbed) p. 819 (*Prevenar 13*®). First dose  
▶ Rotavirus vaccine p. 827 (*Rotarix*®). First dose |
| **12 weeks** | ▶ Diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine (*Inflanrix hexa*®). Second dose  
▶ Rotavirus vaccine (*Rotarix*®). Second dose |
| **16 weeks** | ▶ Diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine (*Inflanrix hexa*®). Third dose  
▶ Meningococcal group B vaccine (rDNA, component, adsorbed) (*Bexsero*®). Second dose  
▶ Pneumococcal polysaccharide conjugate vaccine (adsorbed) (*Prevenar 13*®). Second dose |
| **1 year (on or after first birthday)** | ▶ Measles, mumps and rubella vaccine, live p. 826 (*MMR VaxPRO*® or *Priorix*®). First dose  
▶ Meningococcal group B vaccine (rDNA, component, adsorbed) (*Bexsero*®). Single booster dose  
▶ Pneumococcal polysaccharide conjugate vaccine (adsorbed) (*Prevenar 13*®). Single booster dose  
▶ Haemophilus influenzae type b with meningococcal group C vaccine p. 818 (*Menitorix*®). Single booster dose |
| **2-10 years on 31st August 2019 (including children in reception class and school years 1, 2, 3, 4, 5, and 6)** | ▶ Influenza vaccine p. 825 Each year from September. Note: live attenuated influenza nasal spray is recommended (*Fluenz Tetra®*). If contra-indicated and child is in clinical risk group, use inactivated influenza vaccine (see Influenza vaccine p. 806) |
| **3 years and 4 months, or soon after** | ▶ Diphtheria with pertussis, poliomyelitis vaccine and tetanus p. 816 (*Repevax*®). Single booster dose.  
▶ Measles, mumps and rubella vaccine, live (*MMR VaxPRO*® or *Priorix*®). Second dose |
| **11-14 years (females only). First dose of HPV vaccine will be offered to females aged 12-13 years of age in England, Wales, and Northern Ireland, and 11-13 years of age in Scotland. For females aged 15 years and older, see Human papillomavirus vaccine p. 805.** | ▶ Human papillomavirus vaccines p. 824 (*Gardasil*®), 2 doses; second dose 6-24 months after first dose. If a 3-dose course of HPV vaccine has been started, where possible, the course should be completed (2 doses less than 6 months apart does not provide long-term protection). Only *Gardasil*® is offered as part of the national immunisation programme. Therefore for those females who started the schedule with *Cervarix*®, but did not complete the vaccination course, the course can be completed with *Gardasil*®. Ideally one vaccine should be used for the entire course.  
▶ Meningococcal groups A with C and W135 and Y vaccine p. 819 (*Nimenrix®* or *Menveo®*). Single booster dose |
▶ Measles, mumps and rubella vaccine, live (*MMR VaxPRO*® or *Priorix*®). Second dose  
▶ Note: Can be given at the same time as the dose of meningococcal groups A with C and W135 and Y vaccine at 13-15 years of age. |
| **13-18 years** | ▶ Acellular pertussis-containing vaccine administered as diphtheria with pertussis, poliomyelitis vaccine and tetanus (*Boostrix-IPV*®). 1 dose from the 16th week of pregnancy, preferably after the fetal anomaly scan (weeks 18-20)  
▶ Influenza vaccine (inactivated). Single dose administered from September, regardless of the stage of pregnancy (see Influenza vaccine p. 806) |

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**Vaccines and antisera availability**

*Anthrax vaccine and yellow fever vaccine, live p. 829, botulism antitoxin p. 799, diphtheria antitoxin p. 799, and snake and spider venom antitoxins are available from local designated holding centres. For antivenom, see Emergency Treatment of Poisoning. Enquiries for vaccines not available commercially can also be made to:*

Vaccines and Countermeasures Response Department  
Public Health England  
Wellington House  
133–155 Waterloo Road  
London  
SE1 8UG  
vaccinesupply@phe.gov.uk

In Scotland information about availability of vaccines can be obtained from a Specialist in Pharmaceutical Public Health.

In Wales enquiries for vaccines not available commercially should be directed to:

Welsh Medicines Information Centre  
University Hospital of Wales  
Cardiff  
CF14 4XW  
(029) 2074 2979
Vaccines

In Northern Ireland:
Pharmacy and Medicines Management Centre
Northern Health and Social Care Trust
Beech House
Antrim Hospital Site
Bush Road
Antrim
BT41 2RL
rphps.admin@northerntrust.hscni.net
For further details of availability, see under individual vaccines.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at:

Immunisation schedule 23-Apr-2019
Routine immunisations, sources of information
The following recommendations reflect advice produced by Public Health England. Recommendations specific to each vaccine can be found in Immunisation against infectious disease– the ‘Green Book’. Public Health England at:

The immunisation schedule reflects advice from ‘The complete routine immunisation schedule’ produced by Public Health England (2018). For the most up to date immunisation schedule see: www.gov.uk/government/publications/the-complete-routine-immunisation-schedule


Vaccines for the immunisation schedule should be obtained from ImmForm at: www.immform.dh.gov.uk

Preterm birth
Babies born preterm should receive all routine immunisations based on their actual date of birth. The risk of apnoea following vaccination is increased in preterm babies, particularly in those born at or before 28 weeks gestational age. If babies at risk of apnoea are in hospital at the time of their first immunisation, they should be monitored for respiratory complications for 48–72 hours after immunisation. If a baby develops apnoea, bradycardia, or desaturation after the first immunisation, the second immunisation should also be given in hospital with similar monitoring.

Individuals with unknown or incomplete immunisation history
For children born in the UK who present with an inadequate or unknown immunisation history, investigation into immunisations received should be carried out. Outstanding doses should be administered where the routine childhood immunisation schedule has not been completed.


Anthrax vaccine
Overview
Anthrax vaccine is rarely required for children.

Useful Resources

BCG vaccine
Overview
BCG (Bacillus Calmette-Guérin vaccine p. 817) is a live attenuated strain derived from Mycobacterium bovis which stimulates the development of hypersensitivity to M. tuberculosis. Bacillus Calmette-Guérin vaccine should be given intradermally by operators skilled in the technique.

The expected reaction to successful Bacillus Calmette-Guérin vaccine is induration at the site of injection followed by a local lesion which starts as a papule and then ulcerates and subsides. If a baby develops apnoea, bradycardia, or desaturation after the first immunisation, the second immunisation should also be given in hospital with similar monitoring.

Individuals with unknown or incomplete immunisation history
For children born in the UK who present with an inadequate or unknown immunisation history, investigation into immunisations received should be carried out. Outstanding doses should be administered where the routine childhood immunisation schedule has not been completed.

Botulism antitoxin

Overview

A polyvalent botulism antitoxin p. 799 is available for the post-exposure prophylaxis of botulism and for the treatment of persons thought to be suffering from botulism. It specifically neutralises the toxins produced by *Clostridium botulinum* types A, B, and E. It is not effective against infantile botulism as the toxin (type A) is seldom, if ever, found in the blood in this type of infection.

Hypersensitivity reactions are a problem. It is essential to read the contra-indications, warnings, and details of sensitivity tests on the package insert. Prior to treatment checks should be made regarding previous administration of any antitoxin and history of any allergic condition, e.g. asthma, hay fever, etc. All patients should be tested for sensitivity (diluting the antitoxin if history of allergy).

Useful Resources

Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Cholera vaccine

Overview

Oral cholera vaccine p. 817 contains inactivated Inaba (including El-Tor biotype) and Ogawa strains of *Vibrio cholerae*, serotype O1 together with recombinant B-subunit of the cholera toxin produced in Inaba strains of *V. cholerae*, serotype O1.

Oral cholera vaccine is licensed for children from 2 years of age who are travelling to endemic or epidemic areas on the basis of current recommendations. Immunisation should be completed at least one week before potential exposure. However, there is no requirement for cholera vaccination for international travel. After a full risk assessment, immunisation can be considered for the following children:

- children travelling with remote itineraries in areas where cholera epidemics are occurring and there is limited access to medical care;
- children travelling to potential cholera risk areas, for whom vaccination is considered potentially beneficial.

For dosing schedule, see cholera vaccine. Immunisation with cholera vaccine does not provide complete protection and all travellers to a country where cholera exists should be warned that scrupulous attention to food, water, and personal hygiene is essential.

All suspected cases of cholera must be notified to the local health protection unit. Where there is a community level outbreak, specialist advice should be sought from Public Health England (tel. 020 8200 4400) or, in Scotland, Health Protection Scotland (tel. 0140 300 1191).

Contacts

Contacts of children with cholera should maintain high standards of personal hygiene to avoid becoming infected. Cholera vaccine should not be used in the management of contacts of cases or in controlling the spread of infection.

Useful Resources


Diphtheria vaccine

Overview

Diphtheria vaccines are prepared from the toxin of *Corynebacterium diphtheriae* and adsorption on aluminium hydroxide or aluminium phosphate improves antigenicity. The vaccine stimulates the production of the protective antitoxin. The quantity of diphtheria toxoid in a preparation determines whether the vaccine is defined as ‘high dose’ or ‘low dose’. Vaccines containing the higher dose of diphtheria toxoid are used for primary immunisation of children under 10 years of age. Vaccines containing the lower dose of diphtheria toxoid are used for primary immunisation in adults and children over 10 years. Single-antigen diphtheria vaccine is not available and adsorbed diphtheria vaccine is given as a combination product containing other vaccines.

For primary immunisation of children aged between 2 months and 10 years vaccination is recommended usually in the form of 3 doses (separated by 1-month intervals) of diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine p. 816 (*Infanrix hexa®*) (see Immunisation schedule). In unimmunised individuals aged over 10 years the primary course comprises of 3 doses of adsorbed diphtheria [low dose], *tetanus* and *poliomyelitis* (inactivated) vaccine.
A booster dose should be given 3 years after the primary course (this interval can be reduced to a minimum of 1 year if the primary course was delayed). Children under 10 years should receive either adsorbed diphtheria, tetanus, pertussis (acellular, component) and poliomyelitis (inactivated) vaccine or adsorbed diphtheria [low dose], tetanus, pertussis (acellular, component) and poliomyelitis (inactivated) vaccine. Individuals aged over 10 years should receive adsorbed diphtheria [low dose], tetanus, and poliomyelitis (inactivated) vaccine.

A second booster dose, of adsorbed diphtheria [low dose], tetanus and poliomyelitis (inactivated) vaccine, should be given 10 years after the previous booster dose (this interval can be reduced to a minimum of 5 years if previous doses were delayed). For children who have been vaccinated following a tetanus-prone wound, see tetanus vaccines.

Travel
Those intending to travel to areas with a risk of diphtheria infection should be fully immunised according to the UK schedule. If more than 10 years have lapsed since completion of the UK schedule, a dose of adsorbed diphtheria [low dose], tetanus and poliomyelitis (inactivated) vaccine should be administered.

Contacts
Advice on the management of cases of diphtheria, carriers, contacts and outbreaks must be sought from health protection units. The immunisation history of infected children and their contacts should be determined; those who have been incompletely immunised should complete their immunisation and fully immunised individuals should receive a reinforcing dose. Also see advice on antibacterial treatment to prevent a secondary case of diphtheria in a non-immune child.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Haemophilus influenzae type B conjugate vaccine

Overview
Haemophilus influenzae type b (Hib) vaccine is made from capsular polysaccharide; it is conjugated with a protein such as tetanus toxoid to increase immunogenicity, especially in young children. Haemophilus influenzae type b vaccine immunisation is given in combination with diphtheria, tetanus, pertussis, hepatitis B and poliomyelitis vaccine (Infanrix hexa®), as a component of the primary course of childhood immunisation (see Immunisation schedule). For infants under 1 year, the course consists of 3 doses of a vaccine containing Haemophilus influenzae type b component with an interval of 1 month between doses. A booster dose of Haemophilus influenzae type b vaccine (combined with meningococcal group C conjugate vaccine) should be given at 1 year of age, on or after the child’s first birthday.

Children 1–10 years who have not been immunised against Haemophilus influenzae type b need to receive only 1 dose of Haemophilus influenzae type b vaccine (combined with meningococcal group C conjugate vaccine). However, if a primary course of immunisation has not been completed, children born before August 2017 should be given 3 doses of the combined vaccine they were started on. The risk of infection falls sharply in older children and the vaccine is not normally required for children over 10 years.

Haemophilus influenzae type b vaccine may be given to those over 10 years who are considered to be at increased risk of invasive H. influenzae type b disease (such as those with sickle-cell disease or complement deficiency, or those receiving treatment for malignancy).

Invasive Haemophilus influenzae type b disease
After recovery from infection, unimmunised and partially immunised index cases under 10 years of age should complete their age-specific course of immunisation.

Previously vaccinated cases under 10 years of age should be given an additional dose of haemophilus influenzae type b vaccine (combined with meningococcal group C conjugate vaccine) if Hib antibody concentrations are low or if it is not possible to measure antibody concentrations. Index cases of any age with asplenia or splenic dysfunction should complete their immunisation according to the recommendations below; fully vaccinated cases with asplenia or splenic dysfunction should be given an additional dose of haemophilus influenzae type b vaccine (combined with meningococcal group C conjugate vaccine) if they received their previous dose over 1 year ago.

Also see use of rifampicin p. 379 in the prevention of secondary cases of Haemophilus influenzae type b disease.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Hepatitis A vaccine

Overview
Hepatitis A vaccine p. 821 is prepared from formaldehyde-inactivated hepatitis A virus grown in human diploid cells. Immunisation is recommended for:

- residents of homes for those with severe learning difficulties;
- children with haemophilia or other conditions treated with plasma-derived clotting factors;
- children with severe liver disease;
- children travelling to high-risk areas;
- adolescents who are at risk due to their sexual behaviour;
- parenteral drug abusers.

Immunisation should be considered for:

- children with chronic liver disease including chronic hepatitis B or chronic hepatitis C;
- prevention of secondary cases in close contacts of confirmed cases of hepatitis A, within 14 days of exposure to the primary case (within 8 weeks of exposure to the primary case where there is more than 1 contact in the household).

A booster dose of hepatitis A vaccine is usually given 6–12 months after the initial dose. A second booster dose can be given 20 years after the previous booster dose to those who continue to be at risk. Specialist advice should be sought on re-immunisation of immunocompromised individuals.

In children under 16 years, a single dose of the combined vaccine Ambirix® can be used to provide rapid protection against hepatitis A. Public Health England recommends the
use of intramuscular normal immunoglobulin p. 796 in addition to hepatitis A vaccine for prevention of infection in close contacts (of confirmed cases of hepatitis A) who have chronic liver disease or HIV infection, or who are immunosuppressed. For further guidance, see Immunoglobulins p. 793.

Post-exposure prophylaxis is not required for healthy children under 1 year of age, so long as all those involved in nappy changing are vaccinated against hepatitis A. However, children 2–12 months of age can be given a dose of hepatitis A vaccine if it is not possible to vaccinate their carers, or if the child becomes a source of infection to others [unlicensed use]; in these cases, if the child goes on to require long-term protection against hepatitis A after the first birthday, the full course of 2 doses should be given.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Hepatitis B vaccine
Overview
Hepatitis B vaccine p. 822 contains inactivated hepatitis B virus surface antigen (HBsAg) adsorbed onto an adjuvant. It is made biosynthetically using recombinant DNA technology.

From August 2017, vaccination against hepatitis B is recommended as part of the routine immunisation schedule. Primary immunisation (see Routine immunisation schedule) requires 3 doses, given at intervals of 1 month from the age of 2 months, to be given as part of the combined diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine p. 816 (Infanrix hexa®).

As part of the selective neonatal immunisation programme, vaccination is recommended for neonates whose mothers have had acute hepatitis B during pregnancy or who are positive for hepatitis B surface antigen (regardless of e-antigen markers). Hepatitis B vaccination is started immediately after birth with a dose of the monovalent hepatitis B vaccine (no later than 24 hours after delivery), followed by a second dose at 4 weeks; the routine immunisation combination vaccine (Infanrix hexa®) at weeks 8, 12 and 16; and a further dose of the monovalent hepatitis B vaccine at one year of age.

Neonates born to highly infectious mothers should also receive hepatitis B immunoglobulin p. 796 at the same time as the first dose of monovalent hepatitis B vaccine, but administered at a different site—more detailed guidance is given in the handbook Immunisation against Infectious Disease www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18.

Following significant exposure to hepatitis B (e.g. through needle-stick injury or unprotected sex) and for pre-exposure prophylaxis in high-risk groups, ‘an accelerated schedule’ using the single, monovalent hepatitis B vaccine is recommended immediately, with the second dose given 1 month after the initial dose, and the third dose given 2 months after the initial dose. For those at continued high risk following exposure, a fourth dose should be given 12 months after the first dose. More detailed guidance is given in the handbook Immunisation against Infectious Disease.

Specific hepatitis B immunoglobulin can also be indicated for use with the vaccine in those accidentally inoculated and in neonates at special risk of infection. If hepatitis B immunoglobulin is indicated, it should be given as soon as possible, ideally at the same time or within 24 hours of the first dose of vaccine, but not after seven days have elapsed since exposure. See also hepatitis B immunoglobulin in Immunoglobulins p. 793.

In the UK, groups at high-risk of hepatitis B include:
- parenteral drug misusers, their sexual partners, and household contacts; other drug misusers who are likely to ‘progress’ to injecting;
- adolescents who are at risk from their sexual behaviour;
- close family contacts of an individual with chronic hepatitis B infection;
- children with haemophilia, those receiving regular blood transfusions or blood products, and carers responsible for the administration of such products;
- children with chronic renal failure including those on haemodialysis. Children receiving haemodialysis should be monitored for antibodies annually and re-immunised if necessary. Home carers (of dialysis patients) should be vaccinated;
- children with chronic liver disease
- patients of day-care or residential accommodation for those with severe learning difficulties;
- children in custodial institutions;
- children travelling to areas of high or intermediate prevalence who are at increased risk or who plan to remain there for lengthy periods;
- families adopting children from countries with a high or intermediate prevalence of hepatitis B;
- foster carers and their families.

Following a primary course of immunisation, most children do not require a reinforcing dose of a hepatitis B-containing vaccine. A single booster dose should be offered to healthcare workers around five years after primary immunisation, to patients on renal dialysis with anti-HBs levels below 10mIU/mL, and at the time of a subsequent significant exposure.

Immunisation does not eliminate the need for commonsense precautions for avoiding the risk of infection from known carriers by the routes of infection which have been clearly established, consult Guidance for Clinical Health Care Workers: Protection against Infection with Blood-borne Viruses (available at www.dh.gov.uk). Accidental inoculation of hepatitis B virus-infected blood into a wound, incision, needle-prick, or abrasion may lead to infection, whereas it is unlikely that indirect exposure to a carrier will do so.

A combined hepatitis A and B vaccine p. 821 is also available.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Human papillomavirus vaccine
Overview
Human papillomavirus vaccine is available as a bivalent vaccine (Cervarix®) or a quadrivalent vaccine (Gardasil®). Since 2012, only Gardasil® is offered as part of the national immunisation programme. Cervarix® is licensed for use in
Vaccines

Vaccines

806 Vaccination

Influenza vaccine

Overview

While most viruses are antigenically stable, the influenza viruses A and B (especially A) are constantly altering their antigenic structure, as indicated by changes in the haemagglutinins (H) and neuraminidases (N) on the surface of the viruses. It is essential that influenza vaccine p. 825 in use contain the H and N components of the prevalent strain or strains recommended each year by the World Health Organization.

The influenza vaccines recommended for immunisation in children are the standard egg-grown quadrivalent influenza vaccine (inactivated), and the live attenuated influenza vaccine. The choice of vaccine is dependent on the child’s age and contra-indications.

The ideal time for immunisation is between September and early November.

Immunisation is recommended for children at high risk from influenza, and to reduce transmission of infection.

Annual immunisation is strongly recommended for children (including infants that were preterm or low birth-weight) aged 6 months and over with the following conditions:

- chronic respiratory disease;
- chronic heart disease;
- chronic liver disease;
- chronic renal disease at stage 3, 4 or 5;
- chronic neurological disease;
- complement disorders;
- diabetes mellitus;
- immunosuppression because of disease (including asplenia or splenic dysfunction) or treatment (including prolonged systemic corticosteroid treatment for over 1 month at dose equivalents of prednisolone p. 458: child under 20 kg, 1 mg/kg or more daily; child over 20 kg, 20 mg or more daily), and chemotherapy;
- HIV infection (regardless of immune status);
- morbid obesity (BMI of 40 kg/m² and above).

Annual influenza vaccine is also recommended for:

- children of specific ages see Immunisation schedule p. 802;
- all pregnant females (including those who become pregnant during the flu season);
- children living in long-stay facilities;
- carers of children whose welfare may be at risk if the carer falls ill;
- household contacts of immunocompromised individuals.

Children aged 6 months to less than 2 years of age in clinical risk groups should be offered the standard egg-grown quadrivalent inactivated influenza vaccine.

Children aged 2–17 years of age (including those in clinical risk groups) should be offered the live attenuated influenza vaccine administered as a nasal spray (Fluenz tetra®). The live attenuated vaccine is thought to provide broader protection than inactivated vaccines. If the child is in a clinical risk group and the live attenuated vaccine is contra-indicated or otherwise unsuitable, offer standard egg-grown quadrivalent inactivated influenza vaccine.

Children aged 6 months to less than 9 years of age in clinical risk groups who have not had the influenza vaccine previously should be offered two doses of the appropriate influenza vaccine, four weeks apart.

In the 2019/2020 national influenza immunisation programme, annual influenza vaccine will be offered to all children aged 2–10 years on 31st August 2019 (including those in reception class and school years 1, 2, 3, 4, 5, and 6). For the management of influenza, see Influenza p. 443.


Useful Resources


Useful Resources

Japanese encephalitis vaccine 14-Nov-2018

Overview
Japanese encephalitis is a mosquito-borne viral encephalitis caused by a Flavivirus. Japanese encephalitis vaccine p. 826 (IXIARO) is an inactivated vaccine adsorbed onto an adjuvant. It is recommended for children who are going to reside in an area where Japanese encephalitis is endemic or epidemic. Children travelling to South and South-East Asia and the Far East should be immunised if staying for a month or longer in endemic areas during the transmission season. Other children travelling with shorter exposure periods should also be immunised if the risk is considered sufficient.

The primary immunisation course of 2 doses should be completed at least one week before potential exposure to Japanese encephalitis virus.

Children (aged 2 months and over) at ongoing risk (such as long-term travellers), should receive a single booster dose 12 months after the primary immunisation course. For other children travelling, a single booster dose should be given within 12–24 months after primary immunisation, before potential re-exposure to the Japanese encephalitis virus.

Cases of Japanese encephalitis should be managed with supportive treatment.

Up-to-date information on the risk of Japanese encephalitis in specific countries can be obtained from the National Travel Health Network and Centre.

Useful Resources
National Travel Health Network and Centre nathnc.net

Measles, Mumps and Rubella vaccine

Overview
Measles vaccine has been replaced by a combined measles, mumps and rubella vaccine, live p. 826 (MMR vaccine).

A combined measles, mumps and rubella vaccine, live (MMR vaccine) aims to eliminate measles, mumps, and rubella (German measles) and congenital rubella syndrome. Every child should receive two doses of measles, mumps and rubella vaccine, live by entry to primary school, unless there is a valid contra-indication. Measles, mumps and rubella vaccine, live should be given irrespective of previous measles, mumps, or rubella infection or vaccination.

The first dose of measles, mumps and rubella vaccine, live is given to children at 1 year of age, on or after their first birthday. A second dose is given before starting school at 3 years and 4 months of age, or soon after (see Immunisation Schedule).

Children presenting for pre-school booster who have not received the first dose of measles, mumps and rubella vaccine, live should be given a dose of measles, mumps and rubella vaccine, live followed 3 months later by a second dose.

At school-leaving age or at entry into further education, MMR immunisation should be offered to individuals of both sexes who have not received 2 doses during childhood. In those who have received only a single dose of MMR in childhood, a second dose is recommended to achieve full protection. If 2 doses of measles, mumps and rubella vaccine, live are required, the second dose should be given one month after the initial dose.

Measles, mumps and rubella vaccine, live should be used to protect against rubella in seronegative women of childbearing age (see Immunisation Schedule); unimmunised healthcare workers who might put pregnant women and other vulnerable groups at risk of rubella or measles should be vaccinated. Measles, mumps and rubella vaccine, live may also be offered to previously unimmunised and seronegative post-partum women (see measles, mumps and rubella vaccine, live)—vaccination a few days after delivery is important because about 60% of congenital abnormalities from rubella infection occur in babies of women who have borne more than one child. Immigrants arriving after the age of school immunisation are particularly likely to require vaccination.

Contacts
Measles, mumps and rubella vaccine, live may also be used in the control of outbreaks of measles and should be offered to susceptible children aged over 6 months who are contacts of a case, within 3 days of exposure to infection. Children immunised before 12 months of age should still receive two doses of measles, mumps and rubella vaccine, live at the recommended ages. If one dose of measles, mumps and rubella vaccine, live has already been given to a child, then the second dose may be brought forward to at least one month after the first, to ensure complete protection. If the child is under 18 months of age and the second dose is given within 3 months of the first, then the routine dose before starting school at 3 years and 4 months of age (or soon after) should still be given. Children aged under 9 months for whom avoidance of measles infection is particularly important (such as those with history of recent severe illness) can be given normal immunoglobulin p. 796 after exposure to measles; routine MMR immunisation should then be given after at least 3 months at the appropriate age.

Measles, mumps and rubella vaccine, live is not suitable for prophylaxis following exposure to mumps or rubella since the antibody response to the mumps and rubella components is too slow for effective prophylaxis.

Children with impaired immune response should not receive live vaccines (for advice on HIV). If they have been exposed to measles infection they should be given normal immunoglobulin.

Travel
Unimmunised travellers, including children over 6 months, to areas where measles is endemic or epidemic should receive measles, mumps and rubella vaccine, live. Children immunised before 12 months of age should still receive two doses of measles, mumps and rubella vaccine, live at the recommended ages. If one dose of measles, mumps and rubella vaccine, live has already been given to a child, then the second dose should be brought forward to at least one month after the first, to ensure complete protection. If the child is under 18 months of age and the second dose is given within 3 months of the first, then the routine dose before starting school at 3 years and 4 months of age (or soon after) should still be given.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
Meningococcal vaccine
Overview
Almost all childhood meningococcal disease in the UK is caused by *Neisseria meningitidis* serogroups B and C. **Meningococcal group C conjugate vaccine** protects only against infection by serogroup C and **meningococcal group B vaccine** protects only against infection by serogroup B. The risk of meningococcal disease declines with age—immunisation is not generally recommended after the age of 25 years.

Tetravalent meningococcal vaccines that cover serogroups A, C, W and Y are available. Although the duration of protection has not been established, the **meningococcal groups A, C, W135, and Y conjugate vaccine** is likely to provide longer-lasting protection than the unconjugated meningococcal polysaccharide vaccine. The antibody response to serogroup C in unconjugated meningococcal polysaccharide vaccines in young children may be suboptimal [not currently available in the UK].

**Meningococcal group B vaccines**, Bexsero® and Trumenba®, are licensed in the UK against infection caused by *Neisseria meningitidis* serogroup B. The use of Bexsero® is recommended in the Immunisation Schedule. Bexsero® contains 3 recombinant *Neisseria meningitidis* serogroup B proteins and the outer membrane vesicles from the NZ 98/254 strain, in order to achieve broad protection against *Neisseria meningitidis* serogroup B. Trumenba® contains 2 recombinant *Neisseria meningitidis* serogroup B proteins. The proteins are adsorbed onto an aluminium compound to stimulate an enhanced immune response.

Childhood immunisation
**Meningococcal group C conjugate vaccine** provides long-term protection against infection by serogroup C of *Neisseria meningitidis*. Immunisation consists of 1 dose given at 12 months of age (as the haemophilus influenzae type b with meningococcal group C vaccine p. 818) and a second dose given at 13–15 years of age (as the meningococcal groups A with C and W135 and Y vaccine p. 819) (see Immunisation Schedule).

**Meningococcal group B vaccine** provides protection against infection by serogroup B of *Neisseria meningitidis*. Immunisation consists of 1 dose given at 2 months of age, a second dose at 4 months of age, and a booster dose at 12 months of age (see Immunisation Schedule above).

Unimmunised children aged under 12 months should be given 1 dose of meningococcal group B vaccine (rDNA, component, adsorbed) p. 818 followed by a second dose two months later. They should then be vaccinated according to the Immunisation Schedule (ensuring at least a two month interval between doses of meningococcal group B vaccines). Unimmunised children aged 12–23 months should be given 2 doses of meningococcal group B vaccine (rDNA, component, adsorbed) separated by an interval of two months if they have received less than 2 doses in the first year of life. Unimmunised children aged 2–9 years should be given a single dose of meningococcal group C vaccine (as the haemophilus influenzae type b with meningococcal group C vaccine), followed by a booster dose of meningococcal groups A with C and W135 and Y vaccine at 13–15 years of age.

From 2015, unimmunised individuals aged 10–25 years, including those aged under 25 years who are attending university for the first time, should be given a single dose of meningococcal groups A with C and W135 and Y vaccine; a booster dose is not required.

Children with confirmed serogroup C disease, who have previously been immunised with meningococcal group C vaccine, should be offered meningococcal group C conjugate vaccine before discharge from hospital.

Travel
Individuals travelling to countries of risk should be immunised with meningococcal groups A, C, W135, and Y conjugate vaccine, even if they have previously received meningococcal group C conjugate vaccine. If an individual has recently received meningococcal group C conjugate vaccine, an interval of at least 4 weeks should be allowed before administration of the tetravalent (meningococcal groups A, C, W135, and Y) vaccine.

Vaccination is particularly important for those living or working with local people or visiting an area of risk during outbreaks.

Immunisation recommendations and requirements for visa entry for individual countries should be checked before travelling, particularly to countries in Sub-Saharan Africa, Asia, and the Indian sub-continent where epidemics of meningococcal outbreaks and infection are reported. Country-by-country information is available from the National Travel Health Network and Centre (www.nathnac.org/).

Proof of vaccination with the tetravalent (meningococcal groups A, C, W135, and Y) vaccine is required for those travelling to Saudi Arabia during the Hajj and Umrah pilgrimages (where outbreaks of the W135 strain have occurred).

Contacts
For advice on the immunisation of laboratory workers and close contacts of cases of meningococcal disease in the UK and on the role of the vaccine in the control of local outbreaks, consult Guidelines for Public Health Management of Meningococcal Disease in the UK at www.gov.uk/phe. Also see antibacterial prophylaxis for prevention of secondary cases of meningococcal meningitis.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Pertussis vaccine
Overview
**Pertussis vaccine** is given as a combination preparation containing other vaccines. Acellular vaccines are derived from highly purified components of *Bordetella pertussis*. Primary immunisation against pertussis (whooping cough) requires 3 doses of an acellular pertussis-containing vaccine (see Immunisation schedule), given at intervals of 1 month from the age of 2 months. All children up to the age of 10 years should receive primary immunisation with a combination vaccine of diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine p. 816 (Infanrix hexa®).

A booster dose of an acellular pertussis-containing vaccine should ideally be given 3 years after the primary course, although, the interval can be reduced to 1 year if the primary course was delayed.

Children aged 1–10 years who have not received a pertussis-containing vaccine as part of their primary immunisation should be offered 1 dose of a suitable pertussis-containing vaccine; after an interval of at least 1 year, a booster dose of a suitable pertussis-containing vaccine should be given. Immunisation against pertussis is
not routinely recommended in individuals over 10 years of age.

**Vaccination of pregnant women against pertussis**

In response to the pertussis outbreak, the UK health departments introduced a temporary programme (October 2012) to vaccinate pregnant women against pertussis, and this programme will continue until further notice. The aim of the programme is to boost the levels of pertussis-specific antibodies that are transferred, through the placenta, from the mother to the fetus, so that the newborn is protected before routine immunisation begins at 2 months of age.

Pregnant women should be offered a single dose of acellular pertussis-containing vaccine (as adsorbed diphtheria [low dose], tetanus, pertussis [acellular, component] and poliomyelitis (inactivated) vaccine; *Boostrix-IPV®*) between 16 and 32 weeks of pregnancy.

Public Health England has advised (2016) that the vaccine is probably best offered on or after the fetal anomaly scan at around 18–20 weeks. Pregnant women should be offered a single dose of acellular pertussis-containing vaccine up to the onset of labour if they missed the opportunity for vaccination at 16–32 weeks of pregnancy. A single dose of acellular pertussis-containing vaccine may also be offered to new mothers, who have never previously been vaccinated against pertussis, until the child receives the first vaccination.

While this programme is in place, women who become pregnant again should be offered vaccination during each pregnancy to maximise transplacental transfer of antibody.

**Contacts**

Vaccination against pertussis should be considered for close contacts of cases with pertussis who have been offered antibacterial prophylaxis. Unimmunised or partially immunised contacts under 10 years of age should complete their vaccination against pertussis. A booster dose of an acellular pertussis-containing vaccine is recommended for contacts aged over 10 years who have not received a pertussis-containing vaccine in the last 5 years and who have not received adsorbed diphtheria [low dose], tetanus, and poliomyelitis (inactivated) vaccine in the last month.

**Side-effects**

Local reactions do not contra-indicate further doses.

The vaccine should not be withheld from children with a history to a preceding dose of:
- fever, irrespective of severity;
- persistent crying or screaming for more than 3 hours;
- severe local reaction, irrespective of extent.

**Useful Resources**

Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: [www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book](http://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book)

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### Pneumococcal vaccine

**Overview**

The pneumococcal polysaccharide conjugate vaccine (adsorbed) p. 819 and the pneumococcal polysaccharide vaccine p. 820 protect against infection with *Streptococcus pneumoniae* (pneumococcus). Both vaccines contain polysaccharide from capsular pneumococci. The pneumococcal polysaccharide vaccine contains purified polysaccharide from 23 capsular types of pneumococcus, whereas the pneumococcal polysaccharide conjugate vaccine (adsorbed) contains polysaccharide from either 10 capsular types (*Synflorix®*) or 13 capsular types (*Prevenar 13®*). Both vaccines are inactivated.

*Prevenar 13®* is the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) used in the childhood Immunisation schedule p. 802. The schedule consists of 3 doses given at separate intervals.

The 23-valent pneumococcal polysaccharide vaccine is recommended for children aged 2 years and over in the following at-risk groups:

- asplenia or splenic dysfunction (including homozgyous sickle cell disease and coeliac syndrome which could lead to splenic dysfunction);
- chronic respiratory disease (including severe asthma treated with continuous or frequent use of a systemic corticosteroid);
- chronic heart disease;
- chronic renal disease;
- chronic liver disease;
- diabetes mellitus requiring insulin or oral hypoglycaemic drugs;
- immunosuppression because of disease (e.g. HIV infection, and genetic disorders affecting the immune system) or treatment (including prolonged systemic corticosteroid treatment for over 1 month at dose equivalents of prednisolone: *child under 20 kg, 1 mg/kg or more daily; child over 20 kg, 20 mg or more daily, and chemotherapy*);
- presence of cochlear implant;
- conditions where leakage of cerebrospinal fluid may occur.

Where possible, the vaccine should be given at least 2 weeks (ideally 4–6 weeks) before splenectomy, chemotherapy, or radiotherapy; children and their parents, or carers should be given advice about the increased risk of pneumococcal infection. If it is not possible to vaccinate at least 2 weeks before splenectomy, chemotherapy, or radiotherapy, the vaccine should be given at least 2 weeks after the splenectomy, and at least 3 months after completion of chemotherapy or radiotherapy. For children with leukaemia or who have had a bone marrow transplant, refer to Chapter 25, Pneumococcal, in *Immunisation against infectious disease– The Green Book* for vaccination advice. A patient card and information leaflet for patients with asplenia are available from the Department of Health or in Scotland from the Scottish Government, Health Protection Division (Tel (0131) 244 2879).

**Choice of vaccine**

Vaccination regimens may differ depending on the child’s age, risk of pneumococcal disease, vaccination history, and immune status. Children in at-risk groups may require additional protection.

**Children with unknown or incomplete vaccination histories**

Unimmunised or partially immunised children who present late for vaccination and before the age of 1 year should receive 2 doses of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) 2 months apart, and a further dose on their first birthday, at least 2 months after the previous dose (intervals can be reduced to 1 month to allow the immunisation schedule to be completed promptly).

Children aged between 1 year and under 2 years of age who are unimmunised or partially immunised should receive a single dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed).

**Children diagnosed with at-risk conditions under 2 years of age**

Children under 1 year in at-risk group should receive the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) according to the Immunisation schedule p. 802.

Those who present late for vaccination should be immunised according to ‘Children with unknown or incomplete vaccination histories’ above. A single dose of the 23-valent
pneumococcal polysaccharide vaccine should then be given at 2 years of age, at least 2 months after the last dose of 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed).

Children under 2 years who are severely immunocompromised or those with asplenia, splenic dysfunction, or complement disorders, should have an additional dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed), given at least 2 months after the routine dose due on their first birthday. A single dose of the 23-valent pneumococcal polysaccharide vaccine should then be given at 2 years of age, at least 2 months after the last dose of 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed).

Children diagnosed with at-risk conditions from 2 years to under 10 years of age

Children diagnosed or first presenting with an at-risk condition aged 2 years to under 10 years of age who have completed their routine immunisation schedule should receive a single dose of the 23-valent pneumococcal polysaccharide vaccine, at least 2 months after the last dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed).

Children previously unvaccinated or partially vaccinated with the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) should receive a single dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed), followed by a single dose of the 23-valent pneumococcal polysaccharide vaccine at least 2 months later.

Severely immunocompromised children may have a sub-optimal immunological response to the vaccine and should be given an additional dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed), even if they are fully vaccinated. This should be followed by a single dose of the 23-valent pneumococcal polysaccharide vaccine, at least 2 months after the last dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed). If the 23-valent pneumococcal polysaccharide vaccine has already been given, the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) should be given at least 6 months after.

Children diagnosed with at-risk conditions aged 10 years and over

Children diagnosed or first presenting with an at-risk condition should be given a single dose of the 23-valent pneumococcal polysaccharide vaccine. No additional doses should be given.

Severely immunocompromised individuals should be given a single dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) followed by the 23-valent pneumococcal polysaccharide vaccine at least 2 months later, irrespective of their previous pneumococcal vaccinations. The 23-valent pneumococcal polysaccharide vaccine has already been given, the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed) should be given at least 6 months after.

For further information on vaccination in patients with asplenia, see Vaccination, general principles p. 800.

Revaccination

In children with higher concentrations of antibodies to pneumococcal polysaccharides, revaccination with the 23-valent pneumococcal polysaccharide vaccine more commonly produces side effects (e.g. chills, asthenia, and myalgia). Revaccination is therefore not recommended, except for children in whom the antibody concentration is likely to decline rapidly (e.g. asplenia, splenic dysfunction and chronic renal disease), where revaccination is recommended every 5 years.

Management of cases

For the management of cases, contacts and outbreaks, refer to Chapter 25, Pneumococcal, in Immunisation against infectious disease – ‘The Green Book’.

Useful Resources


Poliomyelitis vaccine

Overview

Two types of poliomyelitis vaccines (containing strains of poliovirus types 1, 2, and 3) are available, inactivated poliomyelitis vaccines (for injection) and live (oral) poliomyelitis vaccines. Inactivated poliomyelitis vaccines, only available in combined preparation, is recommended for routine immunisation; it is given by injection and contains inactivated strains of human poliovirus types 1, 2 and 3.

A course of primary immunisation consists of 3 doses of a combined preparation containing inactivated poliomyelitis vaccines starting at 2 months of age with intervals of 1 month between doses (see Immunisation schedule). A course of 3 doses should also be given to all unimmunised children; no child should remain unimmunised against poliomyelitis.

Two booster doses of a preparation containing inactivated poliomyelitis vaccines are recommended, the first before school entry and the second before leaving school (see Immunisation schedule). Further booster doses should be given every 10 years only to individuals at special risk.

Live (oral) poliomyelitis vaccines is no longer available for routine use; its use may be considered during large outbreaks, but advice should be sought from Public Health England. The live (oral) vaccine poses a very rare risk of vaccine-associated paralytic polio because the attenuated strain of the virus can revert to a virulent form. For this reason the live (oral) vaccine must not be used for immunosuppressed individuals or their household contacts. The use of inactivated poliomyelitis vaccines removes the risk of vaccine-associated paralytic polio altogether.

Travel

Unimmunised travellers to areas with a high incidence of poliomyelitis should receive a full 3-dose course of a preparation containing inactivated poliomyelitis vaccines. Those who have not been vaccinated in the last 10 years should receive a booster dose of adsorbed diphtheria [low dose], tetanus and poliomyelitis (inactivated) vaccine. Information about countries with a high incidence of poliomyelitis can be obtained from www.travax.nhs.uk/ or from the National Travel Health Network and Centre, (www.nathnac.org/).

Useful Resources

Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
Rabies vaccine

Overview
Rabies vaccine p. 827 contains inactivated rabies virus cultivated in either human diploid cells or purified chick embryo cells; vaccines are used for pre- and postexposure prophylaxis.

Pre-exposure prophylaxis
Immunisation should be offered to children at high risk of exposure to rabies—where there is limited access to prompt medical care for those living in areas where rabies is enzootic, for those travelling to such areas for longer than 1 month, and for those on shorter visits who may be exposed to unusual risk. Transmission of rabies by humans has not been recorded but it is advised that those caring for children with the disease should be vaccinated.

Up-to-date country-by-country information on the incidence of rabies can be obtained from the National Travel Health Network and Centre (www.nathnac.org/) and, in Scotland, from Health Protection Scotland (www.hps.scot.nhs.uk/).

Immunisation against rabies requires 3 doses of rabies vaccine, with further booster doses for those who remain at frequent risk.

Post-exposure management
Following potential exposure to rabies, the wound or site of exposure (e.g. mucous membrane) should be cleansed under running water and washed for several minutes with soapy water as soon as possible after exposure. Disinfectant and a simple dressing can be applied, but suturing should be delayed because it may increase the risk of introducing rabies virus into the nerves.

Post-exposure prophylaxis against rabies depends on the level of risk in the country, the nature of exposure, and the individual’s immunity. In each case, expert risk assessment and advice on appropriate management should be obtained from the local Public Health England Centre or Public Health England’s Virus Reference Department, Colindale (tel. (020) 8200 4400) or the PHE Colindale Duty Doctor (tel. (020) 8200 6868), in Wales from the Public Health Wales local Health Protection Team or Public Health Wales Virus Reference Laboratory (tel. (029) 2074 7747), in Scotland from the local on-call infectious diseases consultant, and in Northern Ireland from the Public Health Agency Duty Room (tel. (028) 9055 3997/(028) 9063 2662) or the Regional Virology Service (tel. (028) 9024 0503).

There are no specific contra-indications to the use of rabies vaccine for post-exposure prophylaxis and its use should be considered whenever a child has been attacked by an animal in a country where rabies is enzootic, even if there is no direct evidence of rabies in the attacking animal. Because of the potential consequences of untreated rabies exposure and because rabies vaccination has not been associated with fetal abnormalities, pregnancy is not considered a contra-indication to post-exposure prophylaxis.

For post-exposure prophylaxis of fully immunised individuals (who have previously received pre-exposure or post-exposure prophylaxis with cell-derived rabies vaccine), 2 doses of cell-derived vaccine are likely to be sufficient; the first dose is given on day 0 and the second dose is given between day 3–7. Rabies immunoglobulin p. 798 is not necessary in such cases.

Post-exposure treatment for unimmunised individuals (or those whose prophylaxis is possibly incomplete) comprises 5 doses of rabies vaccine given over 1 month (on days 0, 3, 7, 14, and the fifth dose is given between day 28–30); also, depending on the level of risk (determined by factors such as the nature of the bite and the country where it was sustained), rabies immunoglobulin is given to unimmunised individuals on day 0 or within 7 days of starting the course of rabies vaccine. The immunisation course can be discontinued if it is proved that the child was not at risk.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at:


Rotavirus vaccine

Overview
Rotavirus vaccine p. 827 is a live, oral vaccine that protects young children against gastro-enteritis caused by rotavirus infection. The recommended schedule consists of 2 doses, the first at 2 months of age, and the second at 3 months of age (see Immunisation schedule). The first dose of rotavirus vaccine must be given between 6–15 weeks of age and the second dose should be given after an interval of at least 4 weeks; the vaccine should not be started in children 15 weeks of age or older. Ideally, the full course should be completed before 16 weeks of age to provide protection before the main burden of disease, and to avoid a temporal association between vaccination and intussusception; the course must be completed before 24 weeks of age.

The rotavirus vaccine virus is excreted in the stool and may be transmitted to close contacts; however, vaccination of those with immunosuppressed close contacts may protect the contacts from wild-type rotavirus disease and outweigh any risk from transmission of vaccine virus. Carers of a recently vaccinated baby should be advised of the need to wash their hands after changing the baby’s nappies.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at:


Smallpox vaccine

Overview
Limited supplies of smallpox vaccine are held at the Specialist and Reference Microbiology Division, Public Health England Colindale (Tel. (020) 8200 4400) for the exclusive use of workers in laboratories where pox viruses (such as vaccinia) are handled.

If a wider use of the vaccine is being considered, Guidelines for smallpox response and management in the post-eradication era should be consulted at www.gov.uk/phe.

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at:
**Tetanus vaccine**

**Overview**

Tetanus vaccine contains a cell-free purified toxin of *Clostridium tetani* adsorbed on aluminium hydroxide or aluminium phosphate to improve antigenicity.

Primary immunisation for children under 10 years consists of 3 doses of a combined preparation containing adsorbed tetanus vaccine, with an interval of 1 month between doses. Following routine childhood vaccination, 2 booster doses of a preparation containing adsorbed tetanus vaccine are recommended, the first before school entry and the second before leaving school (see Immunisation Schedule).

The recommended schedule of tetanus vaccination not only gives protection against tetanus in childhood but also gives the basic immunity for subsequent booster doses. In most circumstances, a total of 5 doses of tetanus vaccine is considered sufficient for long term protection.

For primary immunisation of adults and children over 10 years previously unimmunised against tetanus, 3 doses of adsorbed diptheria [low dose], tetanus and poliomyelitis (inactive) vaccine are given with an interval of 1 month between doses.

When an individual presents for a booster dose but has been vaccinated following a tetanus-prone wound, the vaccine preparation administered at the time of injury should be determined. If this is not possible, the booster should still be given to ensure adequate protection against all antigens in the booster vaccine.

Very rarely, tetanus has developed after abdominal surgery; patients awaiting elective surgery should be advised about tetanus immunisation and immunised if necessary.

Parenteral drug abuse is also associated with tetanus; those abusing drugs by injection should be vaccinated if their immunisation status is not known or who have been fully immunised but are now immunocompromised (see Immunisation Schedule).

All laboratory staff should be offered a primary course if unimmunised.

**Wounds**

Wounds are considered to be tetanus-prone if they are sustained more than 6 hours before surgical treatment or at any interval after injury and are puncture-type (particularly if contaminated with soil or manure) or show much devitalised tissue or are septic or are compound fractures or contain foreign bodies. All wounds should receive thorough cleansing.

- For clean wounds: fully immunised individuals (those who have received a total of 5 doses of a tetanus-containing vaccine at appropriate intervals) and those whose primary immunisation is complete (with boosters up to date), do not require tetanus vaccine; individuals whose primary immunisation is incomplete or whose boosters are not up to date require a reinforcing dose of a tetanus-containing vaccine (followed by further doses as required to complete the schedule); non-immunised individuals (or those whose immunisation status is not known or who have been fully immunised but are now immunocompromised) should be given a dose of the appropriate tetanus-containing vaccine immediately (followed by completion of the full course of the vaccine if records confirm the need)

- For tetanus-prone wounds: management is as for clean wounds with the addition of a dose of tetanus immunoglobulin given at a different site; in fully immunised individuals and those whose primary immunisation is complete (with boosters up to date) the immunoglobulin is needed only if the risk of infection is especially high (e.g. contamination with manure).

Antibacterial prophylaxis (with benzylpenicillin, co-amoxiclav, or metronidazole) may also be required for tetanus-prone wounds.

**Useful Resources**

Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

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**Tick-borne encephalitis vaccine**

**Overview**

Tick-borne encephalitis vaccine, inactivated p. 828 contains inactivated tick-borne encephalitis virus cultivated in chick embryo cells. It is recommended for immunisation of those at risk working in, or visiting, high-risk areas (see International Travel). Those working, walking or camping in warm forested areas of Central and Eastern Europe, Scandinavia, Northern and Eastern China, and some parts of Japan, particularly from April to November when ticks are most prevalent, are at greatest risk of tick-borne encephalitis. For full protection, 3 doses of the vaccine are required; booster doses are required every 3–5 years for those still at risk. Ideally, immunisation should be completed at least one month before travel.

**Useful Resources**

Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

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**Typhoid vaccine**

**Overview**

Typhoid vaccine p. 820 is available as Vi capsular polysaccharide (from *Salmonella typhi*) vaccine for injection and as live, attenuated *Salmonella typhi* vaccine for oral use.

Typhoid immunisation is advised for children travelling to:

- areas where typhoid is endemic and whose planned activities put them at higher risk (country-by-country information is available from the National Travel Health Network and Centre);
- endemic areas where frequent or prolonged exposure to poor sanitation and poor food hygiene is likely.

Capsular polysaccharide typhoid vaccine is given as a single dose, usually by intramuscular injection. Children under 2 years [unlicensed] may respond suboptimally to the vaccine, but children aged between 1–2 years should be immunised if the risk of typhoid fever is considered high (immunisation is not recommended for infants under 12 months). A single booster dose should be given at 3-year intervals in children over 2 years of age who remain at risk from typhoid fever.

Oral typhoid vaccine is a live, attenuated vaccine contained in an enteric-coated capsule recommended in children aged 6 years and over. One capsule taken on
Varicella-zoster vaccine

Overview
Varicella-zoster vaccine p. 828 (live) is licensed for immunisation against varicella (chickenpox) in seronegative individuals. It is not recommended for routine use in children but can be given to seronegative healthy children over 1 year who come into close contact with individuals at high risk of severe varicella infection.

Rarity, the varicella-zoster vaccine virus has been transmitted from the vaccinated individual to close contacts. Therefore, contact with the following should be avoided if a vaccine-related cutaneous rash develops within 4–6 weeks of the first or second dose:
- varicella-susceptible pregnant females;
- individuals at high risk of severe varicella, including those with immunodeficiency or those receiving immunosuppressive therapy.

Varicella-zoster immunoglobulin p. 798 is used to protect susceptible children at increased risk of severe varicella infection (see Immunoglobulins p. 793).

Useful Resources
Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at:

Yellow fever vaccine

Overview
Yellow fever vaccine, live p. 829 is an attenuated preparation of yellow fever virus grown in chick eggs. Yellow fever vaccine, live is recommended for:
- children aged 9 months or older who are travelling to, or living in areas or countries with a risk of yellow fever transmission;
- children aged 9 months or older who are travelling to, or living in countries that require an International Certificate of Vaccination or Prophylaxis (ICVP) for entry (information about countries at risk of yellow fever is available from the National Health Network and Centre). Children aged under 9 months are at risk of vaccine-associated encephalitis, with the risk being inversely proportional to age. Children aged under 6 months should not be vaccinated. Children aged 6–9 months should only be vaccinated if a detailed risk assessment, and vaccination is generally only recommended if the risk of yellow fever transmission is high (such as during epidemics/outbreaks). If travel is unavoidable, seek expert advice on whether to vaccinate.

A single-dose of yellow fever vaccine, live confers life-long immunity against yellow fever disease. Immunisation should be performed at least 10 days before travelling to an endemic area to allow protective immunity to develop and for the ICVP (if required) to become valid.

Reinforcing immunisation is not needed, except for a small subset of children at continued risk who may not have developed long-term protection from their initial yellow fever vaccine, live vaccination—seek expert advice.

Yellow fever vaccine, live should be avoided in HIV-infected and immunosuppressed children. If the yellow fever risk is unavoidable, consult the Children’s HIV Association of UK and Ireland (www.chiva.org.uk/guidelines/immunisation) or other specialist advice.

All suspected cases of yellow fever must be notified to the local health protection unit. Where there is a community level outbreak, specialist advice should be sought from Public Health England (tel. 020 8200 4400) or, in Scotland, Health Protection Scotland (tel. 0140 300 1191).

Useful Resources
Chapter 33 National Travel Health Network and Centre
nathnet.net

Vaccines for travel

Immunisation for travel
See advice on Malaria, treatment p. 407.
No special immunisation is required for travellers to the United States, Europe, Australia, or New Zealand, although all travellers should have immunity to tetanus and poliomyelitis (and childhood immunisations should be up to date); Tick-borne encephalitis vaccine is recommended for immunisation of those working in, or visiting, high-risk areas. Certain special precautions are required in non-European areas surrounding the Mediterranean, in Africa, the Middle East, Asia, and South America.

Travellers to areas that have a high incidence of poliomyelitis or tuberculosis should be immunised with the appropriate vaccine; in the case of poliomyelitis previously immunised travellers may be given a booster dose of a preparation containing inactivated poliomyelitis vaccine. BCG immunisation is recommended for travellers aged under 16 years proposing to stay for longer than 3 months (or in close contact with the local population) in countries with an incidence of tuberculosis greater than 40 per 100 000 (list of countries where the incidence of tuberculosis is greater than 40 cases per 100 000 is available from www.gov.uk/pha); it should preferably be given 3 months or more before departure.

Yellow fever immunisation is recommended for travel to the endemic zones of Africa and South America. Many countries require an International Certificate of Vaccination
Vaccines

from individuals arriving from, or who have been travelling through, endemic areas; other countries require a certificate from all entering travellers (consult the Department of Health handbook, *Health Information for Overseas Travel*, www.dh.gov.uk).

Immunisation against *meningococcal meningitis* is recommended for a number of areas of the world. Protection against *hepatitis A* is recommended for travellers to high-risk areas outside Northern and Western Europe, North America, Japan, Australia and New Zealand. Hepatitis A vaccine is recommended and it is likely to be effective even if given shortly before departure; Public Health England recommends travellers can be vaccinated with hepatitis A vaccine up to the day of travel, and no longer recommends the use of normal immunoglobulin for travel prophylaxis. Special care must also be taken with food hygiene.

*Hepatitis B* vaccine is recommended for those travelling to areas of high or intermediate prevalence who intend to seek employment as healthcare workers or who plan to remain there for lengthy periods and who may therefore be at increased risk of acquiring infection as the result of medical or dental procedures carried out in those countries. Short-term tourists or business travellers are not generally at increased risk of infection but may put themselves at risk by their sexual behaviour when abroad.

Prophylactic immunisation against *rabies* is recommended for travellers to enzootic areas on long journeys or to areas out of reach of immediate medical attention.

Travellers who have not had a *tetanus* booster in the last 10 years and are visiting areas where medical attention may not be accessible should receive a booster dose of adsorbed diphtheria [low dose], tetanus and poliomyelitis (inactivated) vaccine, even if they have received 5 doses of a tetanus-containing vaccine previously.

*Typhoid vaccine* is indicated for travellers to countries where typhoid is endemic, but the vaccine is no substitute for personal precautions.

There is no requirement for cholera vaccination as a condition for entry into any country, but *oral cholera vaccine* should be considered for backpackers and those travelling to situations where the risk is greatest (e.g. refugee camps). Regardless of vaccination, travellers to areas where cholera is endemic should take special care with food hygiene.

Advice on *diphtheria*, on *Japanese encephalitis*, and on *tick-borne encephalitis* is included in *Health Information for Overseas Travel*.

**Food hygiene**

In areas where sanitation is poor, good food hygiene is important to help prevent hepatitis A, typhoid, cholera, and other diarrhoeal diseases (including travellers’ diarrhoea). Food should be freshly prepared and hot, and uncooked vegetables (including green salads) should be avoided; only fruits which can be peeled should be eaten. Only suitable bottled water, or tap water that has been boiled or treated with sterilising tablets, should be used for drinking.

**Information on health advice for travellers**

Health professionals and travellers can find the latest information on immunisation requirements and precautions for avoiding disease while travelling from: www.nathnac.org.

The handbook, *Health Information for Overseas Travel* (2010), which draws together essential information for healthcare professionals regarding health advice for travellers, can also be obtained from this website. Immunisation requirements change from time to time, and information on the current requirements for any particular country may be obtained from the embassy or legation of the appropriate country or from:

**National Travel Health Network and Centre**

UCLH NHS Foundation Trust
3rd Floor Central,
250 Euston Road,
London, NW1 2PG
Tel: 0845 602 6712
(Monday and Friday: 9–11 a.m. and 1–2 p.m. Tuesday to Thursday: 9–11 a.m. and 1–3:30 p.m. For healthcare professionals only) www.travelhealthpro.org.uk/

**Travel Medicine Team**

Health Protection Scotland
Meridian Court,
5 Cadogan Street,
Glasgow, G2 6QG
Tel: (0141) 300 1130
(2–4 p.m. Monday to Wednesday, 9:30–11:30 a.m. Friday; for registered TRAVAX users only) www.travax.nhs.uk

(TRAVAX is free for NHS Scotland users (registration required); subscription fee may be payable for users outside NHS Scotland)

**Welsh Assembly Government**

Tel (029) 2082 5397
(9 a.m.–5:30 p.m. weekdays)

**Department of Health, Social Services and Public Safety**

Castle Buildings,
Stormont,
Belfast, BT4 3Q
Tel: (028) 9052 2118
(9 a.m.–5 p.m. weekdays) www.dhsspsni.gov.uk

**VACCINES**

**IMPORANT SAFETY INFORMATION**

MHRA/CHM ADVICE (UPDATED NOVEMBER 2017)

Following reports of death in neonates who received a live attenuated vaccine after exposure to a tumor necrosis factor alpha (TNF-a) inhibitor in utero, the MHRA has issued the following advice:

- any infant who has been exposed to immunosuppressive treatment from the mother either in utero during pregnancy or via breastfeeding should have any live attenuated vaccination deferred for as long as a postnatal influence on the immune status of the infant remains possible;
- in the case of infants who have been exposed to TNF-a inhibitors and other immunosuppressive biological medicines in utero, PHE advise that any live attenuated vaccination (e.g. BCG vaccine) should be deferred until the infant is age 6 months;
- PHE advise if there is any doubt as to whether an infant due to receive a live attenuated vaccine may be immunosuppressed due to the mother’s therapy, including exposure through breast-feeding, specialist advice should be sought.

**CONTRA-INDICATIONS**

**CONTRA-INDICATIONS, FURTHER INFORMATION**

- Impaired immune response Severeley immunosuppressed patients should not be given live vaccines (including those with severe primary immunodeficiency).

**CAUTIONS**

Acute illness • minor illnesses

CAUTIONS, FURTHER INFORMATION Vaccination may be postponed if the individual is suffering from an acute illness; however, it is not necessary to postpone immunisation in patients with minor illnesses without fever or systemic upset.

- Impaired immune response and drugs affecting immune response Immune response to vaccines may be reduced in
immunosuppressed patients and there is also a risk of generalised infection with live vaccines.

Specialist advice should be sought for those being treated with high doses of corticosteroids (dose equivalents of prednisolone: adults, at least 40 mg daily for more than 1 week; children, 2 mg/kg or more or 40 mg) daily for at least 1 week or 1 mg/kg daily for 1 month), or other immunosuppressive drugs, and those being treated for malignant conditions with chemotherapy or generalised radiotherapy. Live vaccines should be postponed until at least 3 months after stopping high-dose systemic corticosteroids and at least 6 months after stopping other immunosuppressive drugs or generalised radiotherapy (at least 12 months after discontinuing immunosuppressants following bone-marrow transplantation).


- Predisposition to neurological problems When there is a personal or family history of febrile convulsions, there is an increased risk of these occurring during fever from any cause including immunisation, but this is not a contra-indication to immunisation. In children who have had a low-grade seizure associated with fever without neurological deterioration, immunisation is recommended; advice on the management of fever (see Post-immunisation Pyrexia in Infants) should be given before immunisation. When a child has had a convulsion not associated with fever, and the neurological condition is not deteriorating, immunisation is recommended. Children with stable neurological disorders (e.g. spina bifida, congenital brain abnormality, and peri-natal hypoxic-ischaemic encephalopathy) should be immunised according to the recommended schedule when they are at least 1 year old.

- When there is a still evolving neurological problem, including poorly controlled epilepsy, immunisation should be deferred and the child referred to a specialist. Immunisation is recommended if a cause for the neurological disorder is identified. If a cause is not identified, immunisation should be deferred until the condition is stable.

- SIDE-EFFECTS
  - Common or very common Appetite decreased · arthralgia · diarrhoea · dizziness · fatigue · fever · headache · irritable bowel syndrome · lymphadenopathy · malaise · myalgia · nausea · skin rashes · vomiting
  - Uncommon Hypersensitivity

- ALLERGY AND CROSS-SENSITIVITY Contra-indicated in patients with a confirmed anaphylactic reaction to a preceding dose of a vaccine containing the same antigens or vaccine component (such as antibiotics in viral vaccines).

- PREGNANCY Live vaccines should not be administered routinely to pregnant women because of the theoretical risk of fetal infection but where there is a significant risk of exposure to disease, the need for vaccination usually outweighs any possible risk to the fetus. Termination of pregnancy following inadvertent immunisation is not recommended. There is no evidence of risk from vaccinating pregnant women with inactivated viral or bacterial vaccines or toxoids.

- BREAST FEEDING Although there is a theoretical risk of live vaccine being present in breast milk, vaccination is not contra-indicated for women who are breast-feeding if the theoretical risk of exposure to disease is significant and the risk of disease is high. There is no evidence of risk from vaccinating women who are breast-feeding, with inactivated viral or bacterial vaccines or toxoids.

- DIRECTIONS FOR ADMINISTRATION If alcohol or disinfectant is used for cleansing the skin it should be allowed to evaporate before vaccination to prevent possible inactivation of live vaccines.

- When 2 or more live vaccines are required (and are not available as a combined preparation), they can be administered at any time before or after each other at different sites, preferably in a different limb; if more than one injection is to be given in the same limb, they should be administered at least 2.5 cm apart. See also Bacillus Calmette-Guérin vaccine p. 817, and Cautions, further information in measles, mumps and rubella vaccine, live p. 826.

- Vaccines should not be given intravenously. Most vaccines are given by the intramuscular route, although some are given by either the intradermal, deep subcutaneous, or oral route. The intramuscular route should not be used in patients with bleeding disorders such as haemophilia or thrombocytopenia, vaccines usually given by the intramuscular route should be given by deep subcutaneous injection instead.

- The Department of Health has advised against the use of jet guns for vaccination owing to the risk of transmitting blood-borne infections, such as HIV.

- Particular attention should be paid to instructions on the use of diluents. Vaccines which are liquid suspensions or are reconstituted before use should be adequately mixed to ensure uniformity of the material to be injected.

- HANDLING AND STORAGE Care must be taken to store all vaccines under the conditions recommended in the product literature, otherwise the preparation may become ineffective. Refrigerated storage is usually necessary: many vaccines need to be stored at 2°C–8°C and not allowed to freeze. Vaccines should be protected from light. Reconstituted vaccines and opened multidose vials must be used within the period recommended in the product literature. Unused vaccines should be disposed of by incineration at a registered disposal contractor.

VACCINES ▶ BACTERIAL AND VIRAL VACCINES, COMBINED

Diphtheria with haemophilus influenzae type b vaccine, pertussis, poliomyelitis and tetanus

- INDICATIONS AND DOSE
  - Primary immunisation
    - By intramuscular injection
      - Child 2 months–9 years: 0.5 mL every month for 3 doses
  - UNLICENSED USE Infanrix-IPV+Hib® not licensed for use in children over 36 months; Pediacel® not licensed in children over 4 years. However, the Department of Health recommends that these be used for children up to 10 years.

- SIDE-EFFECTS
  - Common or very common Crying abnormal · drowsiness · restlessness
  - Uncommon Cough · extensive swelling of vaccinated limb · increased risk of infection · rhinorrhoea
  - Frequency not known Angioedema · apnoea · hypotonic-hyporesponsiveness episode · seizure

SIDE-EFFECTS, FURTHER INFORMATION The incidence of local and systemic reactions is lower with acellular pertussis vaccines than with whole-cell pertussis vaccines used previously.

Compared with primary vaccination, injection site reactions are more common with booster doses of vaccines containing acellular pertussis.
Diphtheria with pertussis, poliomyelitis and tetanus vaccine

**INDICATIONS AND DOSE**

**First booster dose**
- **BY INTRAMUSCULAR INJECTION**
  - Child 3-9 years: 0.5 mL, to be given 3 years after primary immunisation

**Vaccination of pregnant women against pertussis (using low dose vaccines)**
- **BY INTRAMUSCULAR INJECTION**
  - Females of childbearing potential: 0.5 mL for 1 dose

**SIDE-EFFECTS**
- **Common or very common** Abdominal pain - drowsiness - extensive swelling of vaccinated limb
- **Uncommon** Apathy - asthma - chills - dry throat - oral herpes - pain - paraesthesia - sleep disorder
- **Frequency not known** Angioedema - asthma - hypotonic-hyporesponsive episode - seizure

**SIDE-EFFECTS, FURTHER INFORMATION** The incidence of local and systemic reactions is lower with acellular pertussis vaccines than with whole-cell pertussis vaccines used previously.

Compared with primary vaccination, injection site reactions are more common with booster doses of vaccines containing acellular pertussis.

Public Health England has advised (2016) that the vaccine should not be withheld from children with a history to a preceding dose of: fever, irrespective of severity; hypotonic-hyporesponsive episodes; persistent crying or screaming for more than 3 hours; severe local reaction, irrespective of extent.

**PREGNANCY** Contra-indicated in pregnant women with a history of encephalopathy of unknown origin within 7 days of previous immunisation with a pertussis-containing vaccine. Contra-indicated in pregnant women with a history of transient thrombocytopenia or neurological complications following previous immunisation against diphtheria or tetanus.

**PRESCRIBING AND DISPENSING INFORMATION** Pregnant women should be vaccinated using low dose vaccines (brands may include *Boostrix-IPV* or *Repevax*).

Available as part of childhood immunisation schedule from health organisations or ImmForm.

Available for vaccination of pregnant women from ImmForm.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for injection**
- **EXCIPIENTS:** May contain Neomycin, polymyxin b, streptomycin
- **Boostrix-IPV** *(GlaxoSmithKline UK Ltd)*
  - *Boostrix-IPV* suspension for injection 0.5mL pre-filled syringes | 1 pre-filled disposable injection (PBS) £22.74 DT = £20.00
- **Repevax** *(Sanofi Pasteur)*
  - *Repevax* vaccine suspension for injection 0.5mL pre-filled syringes | 1 pre-filled disposable injection (PBS) £20.00 DT = £20.00

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Diphtheria with tetanus, pertussis, hepatitis B, poliomyelitis and haemophilus influenzae type b vaccine

**INDICATIONS AND DOSE**

**Primary immunisation**
- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child 2 months: 0.5 mL for 1 dose

**Primary immunisation (second dose)**
- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child 3 months: 0.5 mL for 1 dose, preferably administer at a different injection site to that of first dose

**Primary immunisation (third dose)**
- **BY DEEP INTRAMUSCULAR INJECTION**
  - Child 4 months: 0.5 mL for 1 dose, preferably administer at a different injection site to that of second dose

**SIDE-EFFECTS**
- **Common or very common** Anxiety - crying abnormal
**Bacillus Calmette-Guérin vaccine**

*Infanrix Hexa* vaccine powder and suspension for suspension for injection

**MEDICINAL FORMS** Available as part of childhood schedule from health organisations or ImmForm.

**PRESCRIBING AND DISPENSING INFORMATION** Available from health organisations or direct from ImmForm www.immform.gov.uk (SSI brand, multidose vial with diluent).

**CONTRA-INDICATIONS** Generalised septic skin conditions - neonate in household contact with known or suspected case of active tuberculosis

**CONTRA-INDICATIONS, FURTHER INFORMATION** A lesion-free site should be used to administer BCG vaccine to patients with eczema.

**CAUTIONS** When BCG is given to infants, there is no need to delay routine primary immunisations. No further vaccination should be given in the arm used for BCG vaccination for at least 3 months because of the risk of regional lymphadenitis.

**INTERACTIONS** Appendix 1: live vaccines

**SIDE-EFFECTS**

- Rare or very rare Increased risk of infection - osteitis

**PRE-TREATMENT SCREENING** Apart from children under 6 years, any person being considered for BCG immunisation must first be given a skin test for hypersensitivity to tuberculin protein (see tuberculin purified protein derivative p. 799). A skin test is not necessary for a child under 6 years provided that the child has not stayed for longer than 3 months in a country with an incidence of tuberculosis greater than 40 per 100 000, the child has not had contact with a person with tuberculosis, and there is no family history of tuberculosis within the last 5 years.

**INDICATIONS AND DOSE**

**Immunisation against tuberculosis**

- **BY INTRADERMAL INJECTION**
  - Neonate: 0.05 mL, to be injected at insertion of deltoid muscle onto humerus (keloid formation more likely with sites higher on arm); tip of shoulder should be avoided.
  - Child 1-11 months: 0.05 mL, to be injected at insertion of deltoid muscle onto humerus (keloid formation more likely with sites higher on arm); tip of shoulder should be avoided.
  - Child 1-17 years: 0.1 mL, to be injected at insertion of deltoid muscle onto humerus (keloid formation more likely with sites higher on arm); tip of shoulder should be avoided.

**CONTRA-INDICATIONS** Acute gastro-intestinal illness

**INTERACTIONS** Appendix 1: cholera vaccine

**SIDE-EFFECTS**

- Uncommon Gastrointestinal discomfort - gastrointestinal disorders

**DIRECTIONS FOR ADMINISTRATION** Intradermal injection technique: Skin is stretched between thumb and forefinger and needle (size 25G or 26G) inserted (bevel upwards) for about 3 mm into superficial layers of dermis (almost parallel with surface). Needle should be short with short bevel (can usually be seen through epidermis during insertion). Tense raised blanched bleb showing tips of hair follicles is sign of correct injection; 7 mm bleb = 0.1 mL injection, 3 mm bleb = 0.05 mL injection; if considerable resistance not felt, needle too deep and should be removed and reinserted before giving more vaccine.

**Medicines**

- **Rare or very rare** Angioedema • anaphylaxis • hypotonic-hyperopic responsiveness episode • seizure • swelling • thrombocytopenia

- **Uncommon** Cough • drowsiness • extensive swelling of vaccinated limb • increased risk of infection

- **Very rare** Angioedema • anaphylaxis • hypotonic-hyperopic responsiveness episode • seizure • swelling • thrombocytopenia

- **Uncommon or very rare** Different medicines containing the same drug.
medicines should be avoided for 1 hour before and after vaccination.

**PATIENT AND CARER ADVICE** Counselling on administration advised. Immunisation with cholera vaccine does not provide complete protection and all travellers to a country where cholera exists should be warned that scrupulous attention to food, water, and personal hygiene is essential.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

### Haemophilus influenzae type b with meningococcal group C vaccine

**INDICATIONS AND DOSE**
- **Booster dose** (for infants who have received primary immunisation with a vaccine containing *Haemophilus influenzae type b* component) and primary immunisation against *Neisseria meningitidis*  
  - **BY INTRAMUSCULAR INJECTION**  
  - Child 12-13 months: 0.5 mL for 1 dose
- **Immunisation against *Neisseria meningitidis* in an unimmunised patient**  
  - **BY INTRAMUSCULAR INJECTION**  
  - Child 1-9 years: 0.5 mL for 1 dose

**Booster dose** (for children who have not been immunised against *Haemophilus influenzae type b*)  
- **Booster dose after recovery from *Haemophilus influenzae type b* disease** (for index cases previously vaccinated, with low Hib antibody concentration or if it is not possible to measure antibody concentration)  
  - **BY INTRAMUSCULAR INJECTION**  
  - Child 1-9 years: 0.5 mL for 1 dose

**Booster dose** (for patients diagnosed with asplenia, splenic dysfunction or complement deficiency at under 2 years of age)  
- **BY INTRAMUSCULAR INJECTION**  
  - Child 2-17 years: 0.5 mL for 1 dose, this booster dose should be given after the second birthday, this is the second dose of *Haemophilus influenzae type b* vaccine combined with meningococcal group C conjugate vaccine (the first dose is given during the routine immunisation schedule)

**Booster dose** (for patients diagnosed with asplenia, splenic dysfunction or complement deficiency at over 2 years of age)  
- **BY INTRAMUSCULAR INJECTION**  
  - Child 2-17 years: 0.5 mL for 1 dose, this booster dose should be followed 2 months later by one dose of meningococcal A, C, W135, and Y conjugate vaccine (in patients from 11 years of age, this interval can be reduced to one month)

**UNLICENSED USE** Not licensed for use in patients over 2 years.

**SIDE-EFFECTS**
- Common or very common Drowsiness
- Uncommon Crying
- Rare or very rare Abdominal pain · Insomnia

**FREQUENCY NOT KNOWN** Apnoea (in neonates) · Fibrile seizure · Meningism (but no evidence that vaccine causes meningococcal C meningitis) · Muscle tone decreased

**PRESCRIBING AND DISPENSING INFORMATION** Available as part of the childhood immunisation schedule from ImmForm.

**Meningococcal group B vaccine (rDNA, component, adsorbed)**

**INDICATIONS AND DOSE**
- **BEXSERO®**  
  - Immunisation against *Neisseria meningitidis*, primary immunisation  
    - **BY DEEP INTRAMUSCULAR INJECTION**  
      - Child 2 months: 0.5 mL for 1 dose, injected preferably into deltoid region (or anterolateral thigh in infants), for information about the use of paracetamol for prophylaxis of post-immunisation pyrexia, see paracetamol p. 278.
      - Child 4 months: 0.5 mL for 1 dose, injected preferably into deltoid region (or anterolateral thigh in infants), for information about the use of paracetamol for prophylaxis of post-immunisation pyrexia, see paracetamol p. 278.
  - **Immunisation against *Neisseria meningitidis*, primary immunisation booster dose**  
    - **BY DEEP INTRAMUSCULAR INJECTION**  
      - Child 12-23 months: 0.5 mL for 1 dose, injected preferably into deltoid region (or anterolateral thigh in infants)

- **Immunisation against *Neisseria meningitidis*, primary immunisation (in unimmunised patients)**  
  - **BY DEEP INTRAMUSCULAR INJECTION**  
    - Child 6-11 months: 0.5 mL for 2 doses, separated by an interval of at least 2 months; booster dose of 0.5 mL given between 1–2 years of age and at least 2 months after completion of primary immunisation, injected preferably into deltoid region (or anterolateral thigh in infants)
    - Child 2-10 years: 0.5 mL for 2 doses, separated by an interval of at least 2 months. Injected preferably into deltoid region (or anterolateral thigh in infants)
    - Child 11-17 years: 0.5 mL for 2 doses, separated by an interval of at least 1 month. Injected preferably into deltoid region

**TRUMENBA®**  
- Immunisation against *Neisseria meningitidis*, primary immunisation  
  - **BY INTRAMUSCULAR INJECTION**  
    - Child 10–17 years: 0.5 mL for 2 doses, separated by an interval of 6 months, alternatively 0.5 mL for 2 doses, separated by an interval of at least 1 month, followed by 0.5 mL as a third dose, given at least 4 months after the second dose, injected preferably into deltoid region, a booster dose should be considered for individuals at continued risk—consult product literature
MENINGOCOCCAL GROUP C VACCINE

INDICATIONS AND DOSE

Patients with confirmed serogroup C disease (who have previously been immunised)

BY INTRAMUSCULAR INJECTION

Child 1-17 years: 0.5 mL for 1 dose, dose to be given before discharge from hospital

SIDE-EFFECTS

Common or very common Anxiety, cough, crying, drowsiness, gastrointestinal discomfort, hypothermia, increased risk of infection, pain, sleep disorders

Uncommon Asthenia, chills, eyelid oedema, flushing, joint stiffness, musculoskeletal stiffness, nasal congestion, oedema, respiratory disorders, seizures, sensation abnormal, syncope

Rare or very rare Circulatory collapse, influenza-like illness

Frequency not known Angioedema, apnoea, dyspnoea, hypotonic-hyporesponsiveness episode, immune thrombocytopenic purpura, meningitis (but no evidence that vaccine causes meningococcal C meningitis), Stevens-Johnson syndrome

PRESCRIBING AND DISPENSING INFORMATION

Available as part of childhood immunisation schedule from www.immunform.dh.gov.uk

MEDICINAL FORMS

There can be a variation in the licensing of different medicines containing the same drug.

Suspension for injection

Nimenrix (Pfizer Ltd)

Nimenrix vaccine powder and solvent for solution for injection 0.5 mL prefilled vials (250) = £30.00

Primary immunisation against Neisseria meningitidis in those at risk of exposure to prevent invasive disease

BY INTRAMUSCULAR INJECTION

Child 3-11 months: 0.5 mL every month for 2 doses, dose preferably injected into deltoid region

Child 1-17 years: 0.5 mL for 1 dose, dose preferably injected into deltoid region

Patients attending university for the first time (who have not received the routine meningococcal groups A with C and W135 Y conjugate vaccine over the age of 10 years)

BY INTRAMUSCULAR INJECTION

Child 16-17 years: 0.5 mL for 1 dose

NIMENRIX

Primary immunisation against Neisseria meningitidis

Child 13-15 years: 0.5 mL for 1 dose, to be injected preferably into deltoid region

Immunisation against Neisseria meningitidis in an unimmunised patient

BY INTRAMUSCULAR INJECTION

Child 10-17 years: 0.5 mL for 1 dose, booster dose is not required

Immunisation against Neisseria meningitidis in those at risk of exposure

BY INTRAMUSCULAR INJECTION

Child 1-17 years: 0.5 mL for 1 dose, to be injected preferably into deltoid region (or anterolateral thigh in child ≥12 months), then 0.5 mL after 1 year if required for 1 dose, second dose should be considered in those who continue to be at risk of Neisseria meningitidis serogroup A infection

Patients attending university for the first time (who have not received the routine meningococcal groups A with C and W135 Y conjugate vaccine over the age of 10 years)

BY INTRAMUSCULAR INJECTION

Child 16-17 years: 0.5 mL for 1 dose

UNLICENSED USE

MENVEO ® Menveo ® is not licensed for use in children under 2 years.

SIDE-EFFECTS

Common or very common Crying abnormal, drowsiness, eating disorder

Uncommon Seizures, vascular disorders

Frequency not known Extensive swelling of vaccinated limb - hypotonic-hyporesponsiveness episode

Meningococcal groups A with C and W135 and Y vaccine

INDICATIONS AND DOSE

MENVEO ®, PREVENAR 13 ®, Pneumococcal polysaccharide conjugate vaccine (adsorbed)

Vaccines
Vaccines

Primary immunisation against pneumococcal infection [second dose]
▶ By Intramuscular Injection
- Child 4 months: 0.5 mL for 1 dose, anterolateral thigh is preferred site of injection in infants under 1 year

Primary immunisation against pneumococcal infection [booster dose]
▶ By Intramuscular Injection
- Child 1 year: 0.5 mL for 1 dose, anterolateral thigh is preferred site of injection in infants under 1 year; deltoid muscle is preferred in older children

Immunisation against pneumococcal infection [in patients who are unimmunised or partially immunised]
▶ By Intramuscular Injection
- Child 3-11 months: 0.5 mL for 2 doses, given 2 months apart (interval may be reduced to 1 month to ensure immunisation schedule is completed), followed by 0.5 mL for 1 dose on their first birthday, given at least 2 months after the last dose. Anterolateral thigh is preferred site of injection in infants under 1 year
- Child 12-23 months: 0.5 mL for 1 dose, deltoid muscle is preferred site of injection in children

Immunisation against pneumococcal infection [immunised patients at increased risk]
▶ By Intramuscular Injection
- Child 14 months-17 years: 0.5 mL for 1 dose, given at least 2 months after primary immunisation booster dose, deltoid muscle is preferred site of injection in children

Immunisation against pneumococcal infection [unimmunised or partially immunised patients at increased risk]
▶ By Intramuscular Injection
- Child 3-11 months: 0.5 mL for 2 doses, given 2 months apart (interval may be reduced to 1 month to ensure immunisation schedule is completed), followed by 0.5 mL for 1 dose on their first birthday, given at least 2 months after the last dose, followed by 0.5 mL for 1 dose, given at least 2 months after the last dose. Anterolateral thigh is preferred site of injection in infants under 1 year
- Child 1-9 years: 0.5 mL for 1 dose, an additional dose is recommended (at least 2 months later) in those who are severely immunocompromised. Deltoid muscle is preferred site of injection in children
- Child 10-17 years: 0.5 mL for 1 dose, deltoid muscle is preferred site of injection in children

**SYNFLORIX®**

Immunisation against pneumococcal infection
▶ By Intramuscular Injection
- Child 6 weeks-4 years: Deltoid muscle is preferred site of injection in young children; anterolateral thigh is preferred site in infants (consult product literature)

- **UNLICENSED USE**
  - PREVENAR 13®: The dose in BNF publications may differ from that in product literature.

- **SIDE-EFFECTS**
  - Common or very common: Drowsiness
  - Uncommon: Apnoea - crying abnormal - extensive swelling of vaccinated limb
  - Rare or very rare: Angioedema - hypotonic-hyporesponsiveness episode - Kawasaki disease - seizure

- **PRESCRIBING AND DISPENSING INFORMATION**
  - PREVENAR 13®: Available as part of childhood immunisation schedule from ImnForm www.imnform.dh.gov.uk.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Suspension for injection
    - Prevenar (Pfizer Ltd)
      - Prevenar 13 vaccine suspension for injection 0.5mL pre-filled syringes | 1 pre-filled disposable injection £49.10 | 10 pre-filled disposable injection £491.00
    - Synflorix (GliaoSmithKline UK Ltd)
      - Synflorix vaccine suspension for injection 0.5mL pre-filled syringes | 1 pre-filled disposable injection £27.60

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**Pneumococcal polysaccharide vaccine**

01-May-2019

- **INDICATIONS AND DOSE**
  - Immunisation against pneumococcal infection [in patients at increased risk]
    - By Intramuscular Injection
      - Child 2-17 years: 0.5 mL for 1 dose, dose should be administered at least 2 months after the last dose of the 13-valent pneumococcal polysaccharide conjugate vaccine (adsorbed), deltoid muscle is preferred site of injection in children and adults

  - Immunisation against pneumococcal infection [revaccination; booster dose in patients with no spleen, splenic dysfunction or chronic kidney disease]
    - By Intramuscular Injection
      - Child 7-17 years: 0.5 mL every 5 years, deltoid muscle is preferred site of injection in children and adults

- **SIDE-EFFECTS**
  - Angioedema - arthritis - asthma - chills - febrile seizure - haemolytic anaemia - injected limb mobility decreased - leucocytosis - lymphadenitis - nerve disorders - paraesthesia - peripheral oedema - thrombocytopenia

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.
  - Solution for injection
    - Pneumococcal polysaccharide vaccine (Non-proprietary)
      - Pneumococcal polysaccharide vaccine solution for injection 0.5mL vials | 1 vial £18.32
    - Pneumovax 23 (Merck Sharp & Dohme Ltd)
      - Pneumovax 23 solution for injection 0.5mL pre-filled syringes | 1 pre-filled disposable injection £16.80

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**Typhoid vaccine**

- **INDICATIONS AND DOSE**
  - Immunisation against typhoid fever in children at high risk of typhoid fever
    - By Intramuscular Injection
      - Child 12-23 months: 0.5 mL for 1 dose, dose should be given at least 2 weeks before potential exposure to typhoid infection, response may be suboptimal

  - Immunisation against typhoid fever
    - By Intramuscular Injection
      - Child 2-17 years: 0.5 mL for 1 dose, dose should be given at least 2 weeks before potential exposure to typhoid infection
        - By Mouth
          - Child 6-17 years: 1 capsule every 2 days for 3 doses (on days 1, 3, and 5)

- **UNLICENSED USE**
  - With intramuscular use: Not licensed for use in children under 2 years.

- **CONTRA-INDICATIONS**
  - With oral use: Acute gastro-intestinal illness

- **INTERACTIONS**
  - Appendix 1: live vaccines
**SIDE-EFFECTS**
- Common or very common
  - With oral use: Gastrointestinal discomfort, influenza-like illness
- Rare or very rare
  - With oral use: Asthenia, back pain, chills, flatulence, paraesthesia

**DIRECTIONS FOR ADMINISTRATION**
Capsule should be taken one hour before a meal. Swallow as soon as possible after placing in mouth with a cold or lukewarm drink.

**HANDLING AND STORAGE**
It is important to store capsules in a refrigerator.

**PATIENT AND CARER ADVICE**
Patients or carers should be given advice on how to administer and store typhoid vaccine capsules.

**MEDICINAL FORMS**
There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- Typhim Vi (Sanofi Pasteur)
  - Salmonella typhi Vi capsular polysaccharide 50 microgram per 1 ml Typhim Vi 25micrograms/0.5ml vaccine solution for injection pre-filled syringes | 1 pre-filled disposable injection (POM) £11.16 DT = £11.16 | 10 pre-filled disposable injection (POM) £111.60 DT = £11.60

**Gastro-resistant capsule**

**CAUTIONARY AND ADVISORY LABELS**
- 25

**Vaccines**

**Hepatitis A and B vaccine**
The properties listed below are those particular to the combination only. For the properties of the components please consider, hepatitis A vaccine below, hepatitis B vaccine p. 822.

**INDICATIONS AND DOSE**

**AMBIRIX**

**Immunisation against hepatitis A and hepatitis B infection (primary course)**
- **BY INTRAMUSCULAR INJECTION**
  - Child 1-15 years: Initially 1 mL for 1 dose, then 1 mL after 6–12 months for 1 dose, the deltoid region is the preferred site of injection; anterolateral thigh is the preferred site in infants; not to be injected into the buttock (vaccine efficacy reduced), subcutaneous route used for patients with bleeding disorders (but immune response may be reduced)

**TWINRIX**

**Immunisation against hepatitis A and hepatitis B infection (primary course)**
- **BY INTRAMUSCULAR INJECTION**
  - Child 1-15 years: Initially 0.5 mL every month for 2 doses, then 0.5 mL after 5 months for 1 dose, the deltoid region is the preferred site of injection; anterolateral thigh is the preferred site in infants; not to be injected into the buttock (vaccine efficacy reduced), subcutaneous route used for patients with bleeding disorders (but immune response may be reduced)

**Precautions**
- Rare or very rare
- Common or very common

**AMBIRIX**

**Immunisation against hepatitis A and hepatitis B infection (primary course)**
- **BY INTRAMUSCULAR INJECTION**
  - Child 1-15 years: Initially 0.5 mL for 1 dose, then 0.5 mL after 6–12 months, dose given as booster; booster dose may be delayed by up to 3 years if not given after recommended interval following primary dose, the deltoid region is the preferred site of injection. The subcutaneous route may be continued...
used for patients with bleeding disorders; not to be injected into the buttock (vaccine efficacy reduced)

HAVRIX MONODOSE

Immunisation against hepatitis A infection
- **BY INTRAMUSCULAR INJECTION**
  - Child 1-15 years: Initially 0.5 mL for 1 dose, then 0.5 mL after 6–12 months, dose given as booster; booster dose may be delayed by up to 3 years if not given after recommended interval following primary dose, the deltoid region is the preferred site of injection. The subcutaneous route may be used for patients with bleeding disorders
  - Child 16–17 years: Initially 1 mL for 1 dose, then 1 mL after 6–12 months, dose given as booster; booster dose may be delayed by up to 3 years if not given after recommended interval following primary dose, the deltoid region is the preferred site of injection. The subcutaneous route may be used for patients with bleeding disorders

VAQTA ® PEDIATRIC

Immunisation against hepatitis A infection
- **BY INTRAMUSCULAR INJECTION**
  - Child 17 years: Initially 0.5 mL for 1 dose, then 0.5 mL after 6–18 months, dose given as booster, the deltoid region is the preferred site of injection. The subcutaneous route may be used for patients with bleeding disorders (but immune response may be reduced)

- **SIDE-EFFECTS**
  - **Uncommon** Anxiety · asthenia · cough · crying · drowsiness · gastrointestinal discomfort · nasal complaints · pain · sleep disorders
  - **Rare or very rare** Allergic rhinitis · asthma · ataxia · burping · chest pain · constipation · dehydration · ear pain · eyelid crusting · feeling hot · flushing · gait abnormal · gastrointestinal disorders · infantile spitting up · influenza like illness · musculoskeletal stiffness · oropharyngeal pain · paraesthesia · respiratory tract congestion · sneezing · sensation of tightness · sweat changes · synovitis
  - **Frequency not known** Guillain-Barre syndrome · thrombocytopenia

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

Suspension for injection
EXCIPIENTS: May contain Neomycin
- **Avarix** (Sanofi Pasteur)
  - Avarix vaccine suspension for injection 0.5 mL pre-filled syringes | 1 pre-filled disposable injection £21.72 | 10 pre-filled disposable injection £217.20
- **Havrix** (GlaxoSmithKline UK Ltd)
  - Havrix Monodose vaccine suspension for injection 1 mL pre-filled syringes | 1 pre-filled disposable injection £22.14 DT + £22.14 |
  - 10 pre-filled disposable injection £221.43
  - Havrix Junior Monodose vaccine suspension for injection 0.5 mL pre-filled syringes | 1 pre-filled disposable injection £16.77 |
  - 10 pre-filled disposable injection £167.68
- **VAQTA** (Merck Sharp & Dohme Ltd)
  - VAQTA Paediatric vaccine suspension for injection 0.5 mL pre-filled syringes | 1 pre-filled disposable injection £14.74

- **Hepatitis A with typhoid vaccine**

The properties listed below are those particular to the combination only. For the properties of the components please consider, hepatitis A vaccine p. 821, typhoid vaccine p. 820.

- **INDICATIONS AND DOSE**

HEPATYRIX ®

Immunisation against hepatitis A and typhoid infection (primary course)
- **BY INTRAMUSCULAR INJECTION**
  - Child 15–17 years: 1 mL for 1 dose, the deltoid region is the preferred site of injection; not to be injected into the buttock (vaccine efficacy reduced). The subcutaneous route may be used for patients with bleeding disorders, booster dose given using single component vaccines

VIATIM ®

Immunisation against hepatitis A and typhoid infection (primary course)
- **BY INTRAMUSCULAR INJECTION**
  - Child 16–17 years: 1 mL for 1 dose, the deltoid region is the preferred site of injection; not to be injected into the buttock (vaccine efficacy reduced). The subcutaneous route may be used for patients with bleeding disorders, booster dose given using single component vaccines

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

Suspension for injection
EXCIPIENTS: May contain Neomycin
- **VIATIM** (Sanofi Pasteur)
  - VIATIM vaccine suspension for injection 1 mL pre-filled syringes | 1 pre-filled disposable injection £35.76 DT + £35.76

- **Hepatitis B vaccine**

- **INDICATIONS AND DOSE**

ENGERIX B ®

Immunisation against hepatitis B infection
- **BY INTRAMUSCULAR INJECTION**
  - Neonate: 10 micrograms for 1 dose, then 10 micrograms after 1 month for 1 dose, followed by 10 micrograms after 5 months for 1 dose, anterolateral thigh is preferred site in neonates; not to be injected into the buttock (vaccine efficacy reduced), this dose should not be given to neonates born to hepatitis B surface antigen positive mother.

  - Child 1 month–15 years: 10 micrograms for 1 dose, then 10 micrograms after 1 month for 1 dose, followed by 10 micrograms after 5 months for 1 dose, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)
  - Child 16–17 years: 20 micrograms for 1 dose, then 20 micrograms after 1 month for 1 dose, followed by 20 micrograms after 5 months for 1 dose, deltoid muscle is preferred site of injection; not to be injected into the buttock (vaccine efficacy reduced)

Immunisation against hepatitis B infection (accelerated schedule)
- **BY INTRAMUSCULAR INJECTION**
  - Neonate: 10 micrograms every month for 3 doses, followed by 10 micrograms after 10 months for 1 dose, anterolateral thigh is preferred site in neonates; not to
be injected into the buttock (vaccine efficacy reduced), this dose should not be given to neonates born to hepatitis B surface antigen positive mother.

- **Child 1 month-15 years:** 10 micrograms every month for 3 doses, followed by 10 micrograms after 10 months for 1 dose, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)
- **Child 16-17 years:** 20 micrograms every month for 3 doses, followed by 20 micrograms after 10 months for 1 dose, deltoid muscle is preferred site of injection; not to be injected into the buttock (vaccine efficacy reduced)

### Immunisation against hepatitis B infection, alternative accelerated schedule

- **By intramuscular injection**

- **Child 11-15 years:** 20 micrograms for 1 dose, followed by 20 micrograms after 6 months, this schedule is not suitable if high risk of infection between doses or if compliance with second dose uncertain, deltoid muscle is preferred site of injection; not to be injected into the buttock (vaccine efficacy reduced)
- **Child 16-17 years:** 20 micrograms every month for 3 doses, followed by 20 micrograms after 4 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)

### Immunisation against hepatitis B infection for neonates born to hepatitis B surface antigen positive mother

- **By intramuscular injection**

- **Neonate:** 10 micrograms once a month for 3 doses, first dose to be given at birth with hepatitis B immunoglobulin injection (separate site), followed by 10 micrograms after 10 months for 1 dose, anterolateral thigh is preferred site in neonates; not to be injected into the buttock (vaccine efficacy reduced).

### Immunisation against hepatitis B infection (in renal insufficiency, including haemodialysis patients)

- **By intramuscular injection**

- **Neonate:** 10 micrograms every month for 2 doses, followed by 10 micrograms after 5 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, anterolateral thigh is preferred site in neonates; not to be injected into the buttock (vaccine efficacy reduced), this dose should not be given to neonates born to hepatitis B surface antigen positive mother.
- **Child 1 month-15 years:** 10 micrograms every month for 2 doses, followed by 10 micrograms after 5 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)
- **Child 16-17 years:** 40 micrograms every month for 3 doses, followed by 40 micrograms after 4 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, deltoid muscle is preferred site of injection; not to be injected into the buttock (vaccine efficacy reduced)

### Immunisation against hepatitis B infection (in renal insufficiency, including haemodialysis patients (accelerated schedule))

- **By intramuscular injection**

- **Neonate:** 10 micrograms every month for 3 doses, followed by 10 micrograms after 10 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, anterolateral thigh is preferred site in neonates; not to be injected into the buttock (vaccine efficacy reduced), this dose should not be given to neonates born to hepatitis B surface antigen positive mother.
- **Child 1 month-15 years:** 10 micrograms every month for 3 doses, followed by 10 micrograms after 10 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)

### Immunisation against hepatitis B infection (including pre-haemodialysis and haemodialysis patients)

- **By intramuscular injection**

- **Child 15-17 years:** 20 micrograms every month for 3 doses, followed by 20 micrograms after 4 months for 1 dose, immunisation schedule and booster doses may need to be adjusted in those with low antibody concentration, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)

### HBVAXPRO®

### Immunisation against hepatitis B infection

- **By intramuscular injection**

- **Neonate:** 5 micrograms for 1 dose, followed by 5 micrograms after 1 month for 1 dose, then 5 micrograms after 5 months for 1 dose, booster doses may be required in immunocompromised patients with low antibody concentration, anterolateral thigh is preferred site in neonates; not to be injected into the buttock (vaccine efficacy reduced), dose not to be used for neonate born to hepatitis B surface antigen positive mother.
- **Child 1 month-15 years:** 5 micrograms for 1 dose, followed by 5 micrograms after 1 month for 1 dose, then 5 micrograms after 5 months for 1 dose, booster doses may be required in immunocompromised patients with low antibody concentration, deltoid muscle is preferred site of injection in adults and older children; anterolateral thigh is preferred site in infants; not to be injected into the buttock (vaccine efficacy reduced)
- **Child 16-17 years:** 10 micrograms every month for 1 dose, followed by 10 micrograms after 1 month for 1 dose, then 10 micrograms after 5 months for 1 dose, booster doses may be required in immunocompromised patients with low antibody concentration, deltoid muscle is preferred site of injection in adults and older children; not to be injected into the buttock (vaccine efficacy reduced)

### Immunisation against hepatitis B infection (accelerated schedule)

- **By intramuscular injection**

- **Neonate:** 5 micrograms every month for 3 doses, followed by 5 micrograms after 10 months for 1 dose, booster doses may be required in immunocompromised patients with low antibody concentration, anterolateral thigh is preferred site in neonates; not to be injected into the buttock (vaccine efficacy reduced), dose not to be used for neonate born to hepatitis B surface antigen positive mother.
- **Child 1 month-15 years:** 5 micrograms every month for 3 doses, followed by 5 micrograms after 10 months for 1 dose, booster doses may be required in immunocompromised patients with low antibody concentration, deltoid muscle is preferred site of injection in older children; anterolateral thigh is preferred site in infants and young children; not to be injected into the buttock (vaccine efficacy reduced)
thigh is preferred site in infants; not to be injected into the buttck (vaccine efficacy reduced)

- Child 16–17 years: 10 micrograms every month for 3 doses, followed by 10 micrograms after 10 months for 1 dose, booster doses may be required in immunocompromised patients with low antibody concentration, deltoid muscle is preferred site of injection in older children; not to be injected into the buttck (vaccine efficacy reduced)

Neonate born to hepatitis B surface antigen-positive mother

- By intramuscular injection

- Neonate: 5 micrograms every month for 3 doses, first dose given at birth with hepatitis B immunoglobulin injection (separate site), followed by 5 micrograms after 10 months for 1 dose, anterolateral thigh is preferred site in neonates; not to be injected into the buttck (vaccine efficacy reduced)

### Chronic haemodialysis patients

- By intramuscular injection

- Child 16–17 years: 40 micrograms every month for 2 doses, followed by 40 micrograms after 5 months for 1 dose, booster doses may be required in those with low antibody concentration, deltoid muscle is preferred site of injection in older children; not to be injected into the buttck (vaccine efficacy reduced)

### Side-effects

- Common or very common: Drowsiness - gastrointestinal disorder
- Rare or very rare: Influenza like illness

### Medicinal forms

There can be variation in the licensing of different medicines containing the same drug.

#### Suspension for injection

EXCIPIENTS: May contain Thiomersal

- Engerix B (GlaxoSmithKline UK Ltd)
- Hepatitis B virus surface antigen 20 microgram per ml Engerix B 10micrograms/0.5ml vaccine suspension for injection pre-filled syringes | 1 pre-filled disposable injection | £8.95 DT = £8.95
- Hepatitis B 20micrograms/1ml vaccine suspension for injection pre-filled syringes | 1 pre-filled disposable injection | £12.99 DT + £12.99 | 10 pre-filled disposable injection | £129.92
- Fendrix (GlaxoSmithKline UK Ltd)
- Hepatitis B virus surface antigen 40 microgram per ml Fendrix 20micrograms/0.5ml vaccine suspension for injection pre-filled syringes | 1 pre-filled disposable injection | £27.60 DT = £27.60
- HBVAXPRO (Merck Sharp & Dohme Ltd)
- Hepatitis B virus surface antigen 10 microgram per ml HBVAXPRO 5micrograms/0.5ml vaccine suspension for injection pre-filled syringes | 1 pre-filled disposable injection | £8.95 DT = £8.95
- Hepatitis B virus surface antigen 10 microgram per ml HBVAXPRO 40micrograms/1ml vaccine suspension for injection vials | 1 vial | £38.10 DT = £38.10

### Human papillomavirus vaccines

#### Cervarix®

Prevention of pre-malignant genital lesions and cervical cancer

- By intramuscular injection

- Child 9–14 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if second dose administered earlier than 5 months after the first, a third dose should be administered, dose to be administered into deltoid region, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 15–17 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 9–14 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 15–17 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

#### Gardasil®

Prevention of pre-malignant genital (cervical, vulvar and vaginal) and anal lesions, cervical and anal cancers, and genital warts

- By intramuscular injection

- Child 9–14 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 15–17 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 9–14 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 15–17 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

#### Indications and dose

**Prevention of pre-malignant genital lesions and cervical cancer**

- By intramuscular injection

- Child 9–14 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if second dose administered earlier than 5 months after the first, a third dose should be administered, dose to be administered into deltoid region, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.

- Child 15–17 years (female): 0.5 mL for 1 dose, followed by 0.5 mL after 5–7 months for 1 dose, if the second dose is administered earlier than 6 months after the first dose, a third dose should be administered, dose to be administered preferably into deltoid region or higher anterolateral thigh, if the course is interrupted, it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years or more.
Influenza vaccine

25-Oct-2018

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Suspension for injection**
- **Cervarix** (GlaxoSmithKline UK Ltd) Cervarix vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £80.50
- **Gardasil** (Merck Sharp & Dohme Ltd) Gardasil vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £86.50 OT = £86.50

**VACCINES**

- **FLUENZ TETRA** (AstraZeneca UK Ltd) Fluenz Tetra vaccine nasal suspension 0.5ml pre-filled syringes

**INDICATIONS AND DOSE**

- **Annual immunisation against seasonal influenza**
  - **BY INTRAMUSCULAR INJECTION**
    - Child 6 months-17 years: 0.5 mL for 1 dose
  - **BY INTRANASAL ADMINISTRATION**
    - Child 2-17 years: 0.1 mL for 1 dose, dose to be administered into each nostril

- **Annual immunisation against seasonal influenza (for children in clinical risk groups who have not received seasonal influenza vaccine previously)**
  - **BY INTRAMUSCULAR INJECTION**
    - Child 6 months-8 years: 0.5 mL for 1 dose, followed by 0.5 mL for 1 dose, after at least 4 weeks
  - **BY INTRANASAL ADMINISTRATION**
    - Child 2-8 years: 0.1 mL for 1 dose, followed by 0.1 mL for 1 dose, after at least 4 weeks. 0.1 mL dose to be administered to each nostril

- **UNLICENSED USE** The Joint Committee on Vaccination and Immunisation advises offering a second dose of vaccine for annual immunisation against seasonal influenza to children in clinical risk groups only.

- **CONTRA-INDICATIONS** Preparations marketed by Pfizer, or CSL Biotherapies in child under 5 years—increased risk of febrile convulsions

- **FLUENZ TETRA** Active wheezing - comitant use with antiviral therapy for influenza - comitant use with salicylates - severe asthma

- **CONTRA-INDICATIONS, FURTHER INFORMATION**

- **CONTRA-INDICATIONS**
  - Concomitant use with antiviral therapy for influenza
  - Avoid influenza antiviral agents for at least 2 weeks after immunisation; avoid immunisation for at least 48 hours after stopping the influenza antiviral agent.

- **CAUTIONS** Increased risk of fever in child 5–9 years with preparations marketed by Pfizer or CSL Biotherapies—use alternative influenza vaccine if available

- **INTERACTIONS** Appendix 1: live vaccines

- **SIDE-EFFECTS**
  - Common or very common
    - With intramuscular use: Chills, hyperhidrosis, induration, local reactions, pain
    - With intranasal use: Nasal complaints
  - Uncommon
    - With intranasal use: Epistaxis, face oedema
    - Frequency not known
      - With intramuscular use: Angioedema, encephalomyelitis, extensive swelling of vaccinated limb, febrile seizure, nerve disorders, nervous system disorder, parasthesia, shock, syncope, thrombocytopenia, vasculitis
      - With intranasal use: Guillain–Barre syndrome

- **ALLERGY AND CROSS-SENSITIVITY** Individuals with a history of egg allergy can be immunised with either an egg free influenza vaccine, if available, or an influenza vaccine with an ovalbumin content less than 120 nanograms/mL (facilities should be available to treat anaphylaxis). Vaccines with an ovalbumin content more than 120 nanograms/mL or where content is not stated should not be used in individuals with egg allergy. If an influenza vaccine containing ovalbumin is being considered in those with a history of anaphylaxis to egg or egg allergy with uncontrolled asthma, these individuals should be referred to a specialist in hospital.

- **PREGNANCY** Inactivated vaccines not known to be harmful.

- **FLUENZ TETRA** Avoid in pregnancy.

- **BREAST FEEDING** Inactivated vaccines not known to be harmful.

- **FLUENZ TETRA** Avoid in breast-feeding.

- **PRESCRIBING AND DISPENSING INFORMATION** The available preparations are not licensed for use in all age-groups—further information can be found in the product literature for the individual vaccines.

- **FLUARIX TETRA** Ovalbumin content less than 100 nanograms/mL.

- **PATIENT AND CARER ADVICE**

- **FLUENZ TETRA** Avoid close contact with severely immunocompromised patients for 1–2 weeks after vaccination.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Spray**
  - **EXCIPIENTS:** May contain Gelatin, gentamicin
    - **Fluenz TETRA** (AstraZeneca UK Ltd) Fluenz Tetra vaccine nasal suspension for injection 0.5ml pre-filled syringes | 1 unit dose £118.00

- **Suspension for injection**
    - **EXCIPIENTS:** May contain Gentamicin, kanamycin, neomycin, polymyxin b
      - **Influenza vaccine (non-proprietary)**
    - **Trivalent influenza vaccine (split virion, inactivated)**
      - High Dose suspension for injection 0.5ml pre-filled syringes | 5 pre-filled disposable injection (PFS) £20.00
      - Influenza vaccine (split virion, inactivated) suspension for injection 0.5ml pre-filled syringes | 10 pre-filled disposable injection (PFS) £65.90
    - **Quadrivalent influenza vaccine (split virion, inactivated)**
      - Suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £8.00 | 10 pre-filled disposable injection (PFS) £80.00
      - Influenza Tetra MYL vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £8.00 | 10 pre-filled disposable injection (PFS) £80.00
      - Influenza MYL vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £6.59 | 10 pre-filled disposable injection (PFS) £65.90
    - **Flud (Seqirus Vaccines Ltd)** Flud vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £9.79 | 10 pre-filled disposable injection (PFS) £97.90
    - **Fluarix Tetra** (GlaxoSmithKline UK Ltd)
      - Fluarix Tetra vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £9.94 | 10 pre-filled disposable injection (PFS) £99.40
    - **Flucelvax Tetra** (Seqirus Vaccines Ltd)
      - Flucelvax Tetra vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £9.94 | 10 pre-filled disposable injection (PFS) £99.40
    - **Imuvac** (Mylan)
      - Imuvac vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £6.59 | 10 pre-filled disposable injection (PFS) £65.90
    - **Influvac Sub-unit** (Mylan)
      - Influvac Sub-unit vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £5.22 | 10 pre-filled disposable injection (PFS) £52.20
      - Influvac Sub-unit Tetra vaccine suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection (PFS) £9.94 | 10 pre-filled disposable injection (PFS) £99.40
Japanese encephalitis vaccine

**Indications and dose**

**Immunisation against Japanese encephalitis**
- **By intramuscular injection**
  - Child 2-35 months: 0.25 mL every 28 days for 2 doses, alternatively 0.25 mL every 7 days for 2 doses, anterolateral thigh may be used as the injection site in infants; deltoid muscle is preferred site in older children, immunisation should be completed at least 1 week before potential exposure
  - Child 3-17 years: 0.5 mL every 28 days for 2 doses, alternatively 0.5 mL every 7 days for 2 doses, deltoid muscle is preferred site in older children, immunisation should be completed at least 1 week before potential exposure

**First booster**
- **By intramuscular injection**
  - Child 12 months: live vaccine should not be given second may be considered.

**Unlicensed use**

- When used for immunisation against Japanese encephalitis The rapid schedule administered at days 0 and 7 is not licensed in children or the elderly.

**Side-effects**

- Abdominal pain · cough · influenza like illness

**Pregnancy**

- Although manufacturer advises avoid because of limited information, miscarriage has been associated with Japanese encephalitis virus infection acquired during the first 2 trimesters of pregnancy.

**Medicinal forms**

- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- Japanese encephalitis GCVC vaccine (non-proprietary)
  - Japanese encephalitis GCVC vaccine solution for injection 1ml vials |
  - 1 vial (Valneva UK Ltd)
  - Japanese encephalitis GCVC vaccine solution for injection 20ml vials |
  - 1 vial (Valneva UK Ltd)
  - Japanese encephalitis GCVC vaccine solution for injection 10ml vials |
  - 1 vial (Valneva UK Ltd)

**Suspension for injection**

- Ixiaro vaccine suspension for injection 0.5ml pre-filled syringes |
  - 1 pre-filled disposable injection (Post) £59.50

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Measles, mumps and rubella vaccine, live

**Indications and dose**

**Primary immunisation against measles, mumps, and rubella (first dose)**
- **By intramuscular injection, or by deep subcutaneous injection**
  - Child 12-13 months: 0.5 mL for 1 dose

**Primary immunisation against measles, mumps, and rubella (second dose)**
- **By intramuscular injection, or by deep subcutaneous injection**
  - Child 40 months-5 years: 0.5 mL for 1 dose

Rubella immunisation (in seronegative women, susceptible to rubella and in unimmunised, seronegative women, post-partum)

- By intramuscular injection, or by deep subcutaneous injection
  - Females of childbearing potential: (consult product literature or local protocols)

Children presenting for pre-school booster, who have not received the primary immunisation (first dose)

- Immunisation for patients at school-leaving age or at entry into further education, who have not completed the primary immunisation course
  - Control of measles outbreak
  - Immunisation for patients travelling to areas where measles is endemic or epidemic, who have not completed the primary immunisation

**Unlicensed use**

- Not licensed for use in children under 9 months.

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**Important safety information**

**MMR vaccination and bowel disease or autism**

Reviews undertaken on behalf of the CSM, the Medical Research Council, and the Cochrane Collaboration, have not found any evidence of a link between MMR vaccination and bowel disease or autism. The Chief Medical Officers have advised that the MMR vaccine is the safest and best way to protect children against measles, mumps, and rubella. Information (including fact sheets and a list of references) may be obtained from www.dh.gov.uk/imunication.

**Caution**

- Antibody response to measles component may be reduced after immunoglobulin administration or blood transfusion– leave an interval of at least 3 months before MMR immunisation

**Caution, further information**

- Administration with other vaccines MMR vaccine should not be administered on the same day as yellow fever vaccine; there should be a 4-week minimum interval between the vaccines. When protection is rapidly required, the vaccines can be given at any interval and an additional dose of MMR may be considered.

- MMR and varicella-zoster vaccine can be given on the same day or separated by a 4-week minimum interval. When protection is rapidly required, the vaccines can be given at any interval and an additional dose of the vaccine given second may be considered.

**Interactions**

- Appendix 1: live vaccines

**Side-effects**

- Uncommon: Angioedema · arthritis · ataxia · cough · encephalopathy · eye inflammation · meningitis aseptic · nerve deafness · nerve disorders · ocular motor nerve paralysis · oedema · panniculitis · papillitis · paraesthesia · regional lymphadenopathy · respiratory disorders · seizures · Stevens-Johnson syndrome · subacute sclerosing panencephalitis · syncope · throat pain · thrombocytopenia · vasculitis

**Side-effects, further information**

- Malaise, fever, or a rash can occur after the first dose of MMR vaccine—most commonly about a week after vaccination and lasting about 2 to 3 days.

- Febrile seizures occur rarely to 11 days after MMR vaccination (the incidence is lower than that following measles infection).
Vaccination 827

MMR vaccination, usually within 6 weeks of the first dose. The risk of idiopathic thrombocytopenic purpura after MMR vaccine is much less than the risk after infection with wild measles or rubella virus. Children who develop idiopathic thrombocytopenic purpura within 6 weeks of the first dose of MMR should undergo serological testing before the second dose is due; if the results suggest incomplete immunity against measles, mumps or rubella then a second dose of MMR is recommended. Samples should be sent to the Virus Reference Laboratory of the Health Protection Agency.

**Frequency of side effects** Adverse reactions are considerably less frequent after the second dose of MMR vaccine than after the first.

- **ALLERGY AND CROSS-SENSITIVITY** MMR vaccine can be given safely even when the child has had an anaphylactic reaction to food containing egg. Dislike of eggs, refusal to eat egg, or confirmed anaphylactic reactions to egg-containing food is not a contra-indication to MMR vaccination. Children with a confirmed anaphylactic reaction to the MMR vaccine should be assessed by a specialist.

- **CONCEPTION AND CONTRACEPTION** Exclude pregnancy before immunisation. Avoid pregnancy for at least 1 month after vaccination.

- **PRESCRIBING AND DISPENSING INFORMATION** Available as part of childhood immunisation schedule from health organisations or Immunform www.immunform.dh.gov.uk.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for suspension for injection** EXCIPIENTS: May contain Gelatin, neomycin

- M-M-RVAXPRO (Merck Sharp & Dohme Ltd)

  M-M-RVAXPRO vaccine powder and solvent for suspension for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection £11.00

**Powder and solvent for solution for injection** EXCIPIENTS: May contain Neomycin

- Priorix (GliaoxSmithKline UK Ltd)

  Priorix vaccine powder and solvent for solution for injection 0.5ml pre-filled syringes | 1 pre-filled disposable injection £7.64

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**Rabies vaccine**

- **INDICATIONS AND DOSE**

  **Pre-exposure prophylaxis**

  - BY INTRAMUSCULAR INJECTION
  - Child: 1 mL for 2 doses (on days 0 and 7), followed by 1 mL for 1 dose (on day 28), to be administered in deltoid region or anterolateral thigh in infants, for those at continuous risk, measure plasma-concentration of antirabies antibodies every 6 months and give a booster dose if the titre is less than 0.5 units/mL, final dose may be given from day 21, if insufficient time before travel

  **Pre-exposure prophylaxis booster dose (for patients at frequent risk of exposure)**

  - BY INTRAMUSCULAR INJECTION
  - Child: 1 mL after 1 year for 1 dose, to be given 1 year after primary course is completed, then 1 mL every 3–5 years, to be administered in deltoid region or anterolateral thigh in infants, the frequency of booster doses may alternatively be determined according to plasma-concentration of antirabies antibodies

  **Pre-exposure prophylaxis booster dose (for patients at infrequent risk of exposure)**

  - BY INTRAMUSCULAR INJECTION
  - Child: 1 mL for 1 dose, to be given 10 years after primary course is completed, administered in deltoid region or anterolateral thigh in infants

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**Post-exposure prophylaxis of fully immunised individuals (who have previously received pre-exposure or post-exposure prophylaxis with cell-derived rabies vaccine)**

- BY INTRAMUSCULAR INJECTION

  - Child (administered on expert advice): 1 mL for 1 dose, followed by 1 mL after 3–7 days for 1 dose, to be administered in deltoid region or anterolateral thigh in infants, rabies immunoglobulin is not necessary

  **Post-exposure treatment for unimmunised individuals (or those whose prophylaxis is possibly incomplete)**

  - BY INTRAMUSCULAR INJECTION

  - Child (administered on expert advice): 1 mL 5 times a month for 1 month, doses should be given on days 0, 3, 7, 14, and the fifth dose is given between day 28–30, to be administered in deltoid region or anterolateral thigh in infants, depending on the level of risk (determined by factors such as the nature of the bite and the country where it was sustained), rabies immunoglobulin is given to unimmunised individuals on day 0 or within 7 days of starting the course of rabies vaccine, the immunisation course can be discontinued if it is proved that the individual was not at risk

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**Rotavirus vaccine**

- **DRUG ACTION** Rotavirus vaccine is a live, oral vaccine that protects young children against gastro-enteritis caused by rotavirus infection.

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**INTERACTIONS** → Appendix 1: rabies vaccine

**SIDE-EFFECTS**

- **Common or very common** Asthenia · gastrointestanal discomfort

- **Rare or very rare** Angioedema · chills · encephalitis · Guillain-Barre syndrome · hyperhidrosis · paraesthesia · syncope · vertigo

**PREGNANCY** Because of the potential consequences of untreated rabies exposure and because rabies vaccination has not been associated with fetal abnormalities, pregnancy is not considered a contra-indication to post-exposure prophylaxis. Immunisation against rabies is indicated during pregnancy if there is substantial risk of exposure to rabies and rapid access to post-exposure prophylaxis is likely to be limited.

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**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Powder and solvent for suspension for injection** EXCIPIENTS: May contain Neomycin

- Rabies vaccine (Non-proprietary) Rabies vaccine powder and solvent for suspension for injection 1ml vials | 1 vial £0.84

**Powder and solvent for solution for injection** EXCIPIENTS: May contain Neomycin

- Rabipur (GliaoxSmithKline UK Ltd) Rabipur vaccine powder and solvent for solution for injection 1ml vials | 1 vial £34.56

Rabipur vaccine powder and solvent for solution for injection 1ml pre-filled syringes | 1 pre-filled disposable injection £34.56

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**Post-exposure prophylaxis of fully immunised individuals (who have previously received pre-exposure or post-exposure prophylaxis with cell-derived rabies vaccine)**

- BY INTRAMUSCULAR INJECTION

  - Child (administered on expert advice): 1 mL for 1 dose, followed by 1 mL after 3–7 days for 1 dose, to be administered in deltoid region or anterolateral thigh in infants, rabies immunoglobulin is not necessary

  **Post-exposure treatment for unimmunised individuals (or those whose prophylaxis is possibly incomplete)**

  - BY INTRAMUSCULAR INJECTION

  - Child (administered on expert advice): 1 mL 5 times a month for 1 month, doses should be given on days 0, 3, 7, 14, and the fifth dose is given between day 28–30, to be administered in deltoid region or anterolateral thigh in infants, depending on the level of risk (determined by factors such as the nature of the bite and the country where it was sustained), rabies immunoglobulin is given to unimmunised individuals on day 0 or within 7 days of starting the course of

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**Rotavirus vaccine**

- **DRUG ACTION** Rotavirus vaccine is a live, oral vaccine that protects young children against gastro-enteritis caused by rotavirus infection.
be completed before 24 weeks of age (preferably before 16 weeks)

**CONTRA-INDICATIONS** History of intussusception - predisposition to intussusception - severe combined immunosuppression

**CONTRA-INDICATIONS, FURTHER INFORMATION**
- Immunosuppression With the exception of severe combined immunodeficiency (children born to mothers who received immunosuppressive biological therapy during pregnancy, see Important safety information), rotavirus vaccine is not contra-indicated in immunosuppressed patients—benefit from vaccination is likely to outweigh the risk, if there is any doubt, seek specialist advice.
- **CAUTIONS** Diarrhoea (postpone vaccination) - immunosuppressed close contacts - vomiting (postpone vaccination).

**CAUTIONS, FURTHER INFORMATION** The rotavirus vaccine virus is excreted in the stool and may be transmitted to close contacts; however, vaccination of those with immunosuppressed close contacts may protect the contacts from wild-type rotavirus disease and outweigh any risk from transmission of vaccine virus.

**INTERACTIONS** → Appendix 1: live vaccines

**SIDE-EFFECTS**
- Frequency not known: Apreo - haematochezia

**PATIENT AND CARER ADVICE** The rotavirus vaccine virus is excreted in the stool and may be transmitted to close contacts; carers of a recently vaccinated baby should be advised of the need to wash their hands after changing the baby’s nappies.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Oral suspension**
- **Rotarix** (GlaxoSmithKline UK Ltd)
  - Rotarix vaccine live oral suspension 1.5ml pre-filled syringes | 1 unit dose £34.76
  - Rotarix vaccine live oral suspension 1.5ml tube | 1 tube £34.76

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**Varicella-zoster vaccine**

**INDICATIONS AND DOSE**

**VARILRIX®**

**Prevention of varicella infection (chickenpox)**
- **BY SUBCUTANEOUS INJECTION**
  - Child 1-17 years: 0.5 mL every 4–6 weeks for 2 doses, to be administered into the deltoid region or anterolateral thigh

**VARIVAX®**

**Prevention of varicella infection (chickenpox)**
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Child 1-12 years: 0.5 mL for 2 doses, interval of at least 4 weeks between each dose, to be administered into the deltoid region (or higher anterolateral thigh in young children)
  - Child 13-17 years: 0.5 mL for 2 doses, interval of 4–8 weeks between each dose, to be administered preferably into the deltoid region

**Prevention of varicella infection (chickenpox) in children with asymptomatic HIV infection**
- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
  - Child 1-12 years: 0.5 mL for 2 doses, interval of 12 weeks between each dose, to be administered into the deltoid region (or higher anterolateral thigh in young children)

**CAUTIONS** Post-vaccination close contact with susceptible individuals

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**Tick-borne encephalitis vaccine, inactivated**

**INDICATIONS AND DOSE**

**Initial immunisation against tick-borne encephalitis**
- **BY INTRAMUSCULAR INJECTION**
  - Child 1-15 years: 0.25 mL for 1 dose, followed by 0.25 mL after 1–3 months for 1 dose, then 0.25 mL after further 5–12 months for 1 dose, to achieve more rapid protection, second dose may be given 14 days after first dose, dose to be administered in deltoid region or anterolateral thigh in infants, in immunocompromised patients (including those receiving immunosuppressants), antibody concentration may be measured 4 weeks after second dose and dose repeated if protective levels not achieved

**Child 16-17 years: 0.5 mL for 1 dose, followed by 0.5 mL after 1–3 months for 1 dose, then 0.5 mL after further 5–12 months for 1 dose, to achieve more rapid protection, second dose may be given 14 days after first dose, dose to be administered in deltoid region, in immunocompromised patients (including those receiving immunosuppressants), antibody concentration may be measured 4 weeks after second dose and dose repeated if protective levels not achieved**

**Immunisation against tick-borne encephalitis, booster doses**
- **BY INTRAMUSCULAR INJECTION**
  - Child 1-17 years: First dose to be given within 3 years after initial course completed and then every 3–5 years, dose to be administered in deltoid region or anterolateral thigh in infants (consult product literature)

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**SIDE-EFFECTS**
- Common or very common: Restlessness - sleep disorder
- Uncommon: Chills - gastrointestinal discomfort
- Rare or very rare: Asthenia - dyspnoea - encephalitis - eye pain - gait abnormal - hyperhidrosis - influenza like illness - meningism - motor dysfunction - musculoskeletal stiffness - nerve disorders - oedema - pain - seizures - sensory disorder - tinnitus - vertigo - vision disorders

**ALLERGY AND CROSS-SENSITIVITY** Individuals with evidence of previous anaphylactic reaction to egg should not be given tick-borne encephalitis vaccine.

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**INTERACTIONS**
- Appendix 1: live vaccines
CAUTIONS, FURTHER INFORMATION Rarely, the varicella–zoster virus vaccine has been transmitted from the vaccinated individual to close contacts. Therefore, contact with the following should be avoided if a vaccine-related cutaneous rash develops within 4–6 weeks of the first or second dose:
- varicella–susceptible pregnant women;
- individuals at high risk of severe varicella, including those with immunodeficiency or those receiving immunosuppressive therapy.

Healthcare workers who develop a generalised poplar or vesicular rash on vaccination should avoid contact with patients until the lesions have crusted. Those who develop a localised rash after vaccination should cover the lesions and be allowed to continue working unless in contact with patients at high risk of severe varicella.

- Administration with MMR vaccine Varicella–zoster and MMR vaccines can be given on the same day or separated by a 4-week minimum interval. When protection is rapidly required, the vaccines can be given at any interval and an additional dose of the vaccine given second may be considered.
- INTERACTIONS → Appendix 1: live vaccines
- SIDE-EFFECTS
  - Uncommon Cough; drowsiness; increased risk of infection
  - Rare or very rare Abdominal pain; conjunctivitis; Kawasaki disease; seizure; stroke; thrombocytopenia; vasculitis
- CONCEPTION AND CONTRACEPTION Avoid pregnancy for 3 months after vaccination.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.
  - Powder and solvent for suspension for injection EXCIPIENTS: May contain Gelatin, neomycin
    - Varivax (Merck Sharp & Dohme Ltd) Varivax vaccine powder and solvent for suspension for injection 0.5ml vials | 1 vial £30.28
  - Powder and solvent for solution for injection EXCIPIENTS: May contain Neomycin
    - Varilrix (GlaxoSmithKline UK Ltd) Varilrix vaccine powder and solvent for solution for injection 0.5ml vials | 1 vial £27.31

Yellow fever vaccine, live

- INDICATIONS AND DOSE
  - Immunisation against yellow fever
    - BY DEEP SUBCUTANEOUS INJECTION
      - Child 6–8 months (administered on expert advice): Infants under 9 months should be vaccinated only if the risk of yellow fever is high and unavoidable (consult product literature or local protocols)
      - Child 9 months–17 years: 0.5 mL for 1 dose
  - IMPORTANT SAFETY INFORMATION
    - MHRA/CHM ADVICE: YELLOW FEVER VACCINE (STAMARIL®) AND FATAL ADVERSE REACTIONS: EXTREME CAUTION NEEDED IN PEOPLE WHO MAY BE IMMUNOSUPPRESSED (APRIL 2019)

The yellow fever vaccine (Stamaril®) has been associated with an increased risk of life-threatening reactions and must not be given to patients with a history of thymus dysfunction (including myasthenia gravis and thymoma), to patients that are immunosuppressed, or that have had a thymectomy. Prior to administering yellow fever vaccines, healthcare professionals are advised to familiarise themselves with any contra-indications and special precautions, and to defer vaccination if it is suspected that a patient is immunosuppressed, until specialist advice can be sought.

Healthcare professionals administering vaccines should consult information in the YF Vaccine Centre code of practice and strengthen protocols and checklists to avoid inappropriate administration.

- CONTRA-INDICATIONS Children under 6 months; history of thymus dysfunction
- CAUTIONS
- CAUTIONS, FURTHER INFORMATION
  - Administration with MMR vaccine Yellow fever and MMR vaccines should not be administered on the same day; there should be a 4-week minimum interval between the vaccines. When protection is rapidly required, the vaccines can be given at any interval and an additional dose of MMR may be considered.
  - INTERACTIONS → Appendix 1: live vaccines
  - SIDE-EFFECTS
    - Common or very common Asthenia; crying; drowsiness
    - Uncommon Abdominal pain
    - Rare or very rare Rhinitis; yellow fever vaccine-associated neurotropic disease; yellow fever vaccine-associated viscerotropic disease
  - Frequency not known Angioedema; influenza-like illness; paraesthesia

SIDE-EFFECTS, FURTHER INFORMATION Very rare vaccine-associated adverse effects may occur, such as viscerotropic disease (yellow-fever vaccine-associated viscerotropic disease, YEL-AVD), a syndrome which may include metabolic acidosis, muscle and liver cirrhosis, and multi-organ failure. Neurological disorders (yellow fever vaccine-associated neurotropic disease, YEL-AND) such as encephalitis have also been reported. These very rare adverse effects usually occur after the first dose of yellow fever vaccine in those with no previous immunity. Increased risk of fatal reactions reported in patients aged 60 years and older and those who are immunosuppressed.

- ALLERGY AND CROSS-SENSITIVITY Yellow fever vaccine should only be considered under the guidance of a specialist in individuals with evidence of previous anaphylactic reaction to egg.

- PREGNANCY Live yellow fever vaccine should not be given during pregnancy because there is a theoretical risk of fetal infection. Pregnant women should be advised not to travel to areas at high risk of yellow fever. If exposure cannot be avoided during pregnancy, then the vaccine should be given if the risk from disease in the mother outweighs the risk to the fetus from vaccination.

- BREAST FEEDING Avoid; seek specialist advice if exposure to virus cannot be avoided.

- MEDICINAL FORMS There can be variation in the licensing of different medicines containing the same drug.

Powder and solvent for suspension for injection
- Stamaril (Sanofi Pasteur) Stamaril vaccine powder and solvent for suspension for injection 0.5ml vials | 1 vial £39.72

22-May-2019
Chapter 15
Anaesthesia

General anaesthesia

Anaesthesia (general)

Overview
Several different types of drug are given together during general anaesthesia. Anaesthesia is induced with either a volatile drug given by inhalation or with an intravenously administered drug; anaesthesia is maintained with an intravenous or inhalational anaesthetic. Analgesics, usually short-acting opioids, are also used. The use of neuromuscular blocking drugs necessitates intermittent positive-pressure ventilation. Following surgery, anticholinesterases can be given to reverse the effects of neuromuscular blocking drugs; specific antagonists can be used to reverse central and respiratory depression caused by some drugs used in surgery. A local topical anaesthetic can be used to reduce pain at the injection site.

Individual requirements vary considerably and the recommended doses are only a guide. Smaller doses are indicated in ill, shocked, or debilitated children and in significant hepatic impairment, while robust individuals may require larger doses. The required dose of induction agent may be less if the patient has been premedicated with a sedative agent or if an opioid analgesic has been used.

Intravenous anaesthetics
Intravenous anaesthetics may be used either to induce anaesthesia or for maintenance of anaesthesia throughout surgery. Intravenous anaesthetics nearly all produce their effect in one arm-brain circulation time. Extreme care is required in surgery of the mouth, pharynx, or larynx where the airway may be difficult to maintain (e.g. in the presence of a tumour in the pharynx or larynx).

To facilitate tracheal intubation, induction is usually followed by a neuromuscular blocking drug or a short-acting opioid.

The doses of all intravenous anaesthetic drugs should be titrated to effect (except when using ‘rapid sequence induction’).

Total intravenous anaesthesia
This is a technique in which major surgery is carried out with all drugs given intravenously. Respiration can be spontaneous, or controlled with oxygen-enriched air. Neuromuscular blocking drugs can be used to provide relaxation and prevent reflex muscle movements. The main problem to overcome is the assessment of depth of anaesthesia. Target Controlled Infusion (TCI) systems can be used to titrate intravenous anaesthetic infusions to predicted plasma-drug concentrations; specific models with paediatric pharmacokinetic data should be used for children.

Drugs used for intravenous anaesthesia
Propofol p. 832, the most widely used intravenous anaesthetic, can be used for induction or maintenance of anaesthesia in children, but it is not commonly used in neonates. Propofol is associated with rapid recovery and less hangover effect than other intravenous anaesthetics. Propofol can also be used for sedation during diagnostic procedures.

Thiopental sodium p. 228 is a barbiturate that is used for induction of anaesthesia, but has no analgesic properties. Induction is generally smooth and rapid, but dose-related cardiovascular and respiratory depression can occur. Awakening from a moderate dose of thiopental sodium is rapid because the drug redistributes into other tissues, particularly fat. However, metabolism is slow and sedative effects can persist for 24 hours. Repeated doses have a cumulative effect particularly in neonates and recovery is much slower.

Etomidate p. 831 is an intravenous agent associated with rapid recovery without a hangover effect. Etomidate causes less hypotension than thiopental sodium and propofol during induction. It produces a high incidence of extraneous muscle movements, which can be minimised by an opioid analgesic or a short-acting benzodiazepine given just before induction.

Ketamine p. 846 causes less hypotension than thiopental sodium and propofol during induction. It is sometimes used in children requiring repeat anaesthesia (such as for serial burns dressings), however recovery is relatively slow and there is a high incidence of extraneous muscle movements. Ketamine can cause hallucinations, nightmares, and other transient psychotic effects; these can be reduced by a benzodiazepine such as diazepam p. 226 or midazolam p. 229.

Inhalational anaesthetics
Inhalational anaesthetics include gases and volatile liquids. Gaseous anaesthetics require suitable equipment for storage and administration. Volatile liquid anaesthetics are administered using calibrated vapourisers, using air, oxygen, or nitrous oxide-oxygen mixtures as the carrier gas. To prevent hypoxia, the inspired gas mixture should contain a minimum of 25% oxygen at all times. Higher concentrations of oxygen (greater than 30%) are usually required during inhalational anaesthesia when nitrous oxide p. 835 is being administered.

Volatile liquid anaesthetics
Volatile liquid anaesthetics can be used for induction and maintenance of anaesthesia, and following induction with an intravenous anaesthetic.

Isoflurane p. 834 is a volatile liquid anaesthetic. Heart rhythm is generally stable during isoflurane anaesthesia, but heart-rate can rise. Systemic arterial pressure and cardiac...
output can fall, owing to a decrease in systemic vascular resistance. Muscle relaxation occurs and the effects of muscle relaxant drugs are potentiated. Isoflurane is not recommended for induction of anaesthesia in infants and children of all ages because of the occurrence of cough, breath-holding, desaturation, increased secretions, and laryngospasm. Isoflurane is the preferred inhalational anaesthetic for use in obstetrics.

Desflurane p. 834 is a rapid acting volatile liquid anaesthetic; it is reported to have about one-fifth the potency of isoflurane. Emergence and recovery from anaesthesia are particularly rapid because of its low solubility. Desflurane is not recommended for induction of anaesthesia as it is irritant to the upper respiratory tract.

Sevoflurane p. 835 is a rapid acting volatile liquid anaesthetic and is more potent than desflurane. Emergence and recovery are particularly rapid, but slower than desflurane. Sevoflurane is non-irritant and is therefore often used for inhalational induction of anaesthesia.

Nitrous oxide
Nitrous oxide is used for maintenance of anaesthesia and, in sub-anaesthetic concentrations, for analgesia. For anaesthesia, it is commonly used in a concentration of 50 to 66% in oxygen as part of a balanced technique in association with other inhalational or intravenous agents. Nitrous oxide is unsatisfactory as a sole anaesthetic owing to lack of potency, but is useful as part of a combination of drugs since it allows a significant reduction in dosage.

For analgesia (without loss of consciousness), a mixture of nitrous oxide and oxygen containing 50% of each gas (Entonox® , Equanox® ) is used. Self-administration using a demand valve may be used in children who are able to self-regulate their intake (usually over 5 years of age) for painful dressing changes, as an aid to postoperative physiotherapy, for wound debridement and in emergency ambulances.

Nitrous oxide may have a deleterious effect if used in children with an air-containing closed space since nitrous oxide diffuses into such a space with a resulting increase in pressure. This effect may be dangerous in conditions such as pneumothorax, which may enlarge to compromise respiration, or in the presence of intracranial air after head injury, entrapped air following recent underwater dive, or recent intra-ocular gas injection.

Malignant hyperthermia
Malignant hyperthermia is a rare but potentially lethal complication of anaesthesia. It is characterised by a rapid rise in temperature, increased muscle rigidity, tachycardia, and acidosis. The most common triggers of malignant hyperthermia are the volatile anaesthetics. Suxamethonium chloride p. 840 has also been implicated, but malignant hyperthermia is more likely if it is given following a volatile anaesthetic. Volatile anaesthetics and suxamethonium chloride should be avoided during anaesthesia in children at high risk of malignant hyperthermia.

Dantrolene sodium p. 848 is used in the treatment of malignant hyperthermia.

Sedation, anaesthesia, and resuscitation in dental practice
Overview
Sedation for dental procedures should be limited to conscious sedation whenever possible. Nitrous oxide p. 835 alone and midazolam p. 229 are effective for many children.


Surgery and long-term medication
Overview
The risk of losing disease control on stopping long-term medication before surgery is often greater than the risk posed by continuing it during surgery. It is vital that the anaesthetist knows about all drugs that a patient is (or has been) taking.

Patients with adrenal atrophy resulting from long-term corticosteroid use may suffer a precipitous fall in blood pressure unless corticosteroid cover is provided during anaesthesia and in the immediate postoperative period.

Anaesthetists must therefore know whether a patient is, or has been, receiving corticosteroids (including high-dose inhaled corticosteroids).

Other drugs that should normally not be stopped before surgery include drugs for epilepsy, asthma, immunosuppression, and metabolic, endocrine and cardiovascular disorders (but see potassium sparing diuretics). Expert advice is required for children receiving antivirals for HIV infection. See general advice on surgery in children with diabetes in Diabetes, surgery and medical illness p. 466.

Children taking antiplatelet medication or an oral anticoagulant present an increased risk for surgery. In these circumstances, the anaesthetist and surgeon should assess the relative risks and decide jointly whether the antiplatelet or the anticoagulant drug should be stopped or replaced with heparin (unfractionated) p. 97 or low molecular weight heparin therapy.

Drugs that should be stopped before surgery include combined oral contraceptives, see Contraceptives, hormonal p. 512. If antidepressants need to be stopped, they should be withdrawn gradually to avoid withdrawal symptoms. Tricyclic antidepressants need not be stopped, but there may be an increased risk of arrhythmias and hypotension (and dangerous interactions with vasopressor drugs); therefore, the anaesthetist should be informed if they are not stopped.

Lithium should be stopped 24 hours before major surgery but the normal dose can be continued for minor surgery (with careful monitoring of fluids and electrolytes). Potassium-sparing diuretics may need to be withheld on the morning of surgery because hyperkalaemia may develop if renal perfusion is impaired or if there is tissue damage. Herbal medicines may be associated with adverse effects when given with anaesthetic drugs and consideration should be given to stopping them before surgery.

ANAESTHETICS, GENERAL > INTRAVENOUS

Etomidate

- INDICATIONS AND DOSE
  - Induction of anaesthesia
    - By slow intravenous injection
      - Child 1 month–14 years: 150–300 micrograms/kg (max. per dose 60 mg), to be administered over 30–60 seconds (60 seconds for children in whom hypotension might be hazardous), increased if necessary to 400 micrograms/kg
      - Child 15–17 years: 150–300 micrograms/kg (max. per dose 60 mg), to be administered over 30–60 seconds (60 seconds for children in whom hypotension might be hazardous)
**UNLICENSED USE** Hypnomidate® licensed for use in children (age range not specified by manufacturer). Etomidate-Lipuro® not licensed for children under 6 months except for imperative indications during inpatient treatment. Doses in BNF for Children may differ from those in the product literature.

**CAUTIONS** Acute circulatory failure (shock) · adrenal insufficiency · Avoid in Acute porphyrias p. 624 · cardiovascular disease · fixed cardiac output · hypovolaemia

**CAUTIONS, FURTHER INFORMATION**
- Adrenal insufficiency Etomidate suppresses adrenocortical function, particularly during continuous administration, and it should not be used for maintenance of anaesthesia. It should be used with caution in patients with underlying adrenal insufficiency, for example, those with sepsis.
- **INTERACTIONS** Appendix 1: etomidate
- **SIDE-EFFECTS**
  - **Common or very common** Apathy, hypotension, movement disorders, nausea, respiratory disorders, skin reactions, vascular pain, vomiting
  - **Uncommon** Arrhythmias, cough, hiccups, hypersalivation, hypertension, muscle rigidity, neuromuscular dysfunction, nystagmus, procedural complications
  - **Frequency not known** Adrenal insufficiency, atrioventricular block, cardiac arrest, embolism and thrombosis, seizures, shock, Stevens-Johnson syndrome, trismus

**SIDE-EFFECTS, FURTHER INFORMATION** Pain on injection Can be reduced by injecting into a larger vein or by giving an opioid analgesic just before induction.

**PREGNANCY** May depress neonatal respiration if used during delivery.

**BREAST FEEDING** Breast-feeding can be resumed as soon as mother has recovered sufficiently from anaesthesia.

**HEPATIC IMPAIRMENT**
- **Dose adjustments** Manufacturer advises reduce dose in liver cirrhosis.
- **DIRECTIONS FOR ADMINISTRATION** To be administered over 30–60 seconds (60 seconds in patients in whom hypotension might be hazardous).

**PATIENT AND CAREER ADVICE**
- **Driving and skilled tasks** Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risk of driving or undertaking skilled tasks afterwards. For a short general anaesthetic the risk extends to at least 24 hours after administration. Responsible persons should be available to take patients home. The dangers of taking alcohol should also be emphasised.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Etomidate 2 mg per 1 ml** Hypnomidate 20mg/10ml solution for injection ampoules | 1 ampoule (PSt) £6.30

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**Propofol**

**INDICATIONS AND DOSE**

**Induction of anaesthesia using 0.5% or 1% injection**
- **By slow intravenous injection**
  - Child 1 month–16 years: Usual dose 2.5–4 mg/kg, dose adjusted according to age, body-weight and response
  - Child 17 years: Usual dose 1.5–2.5 mg/kg, to be administered at a rate of 20–40 mg every 10 seconds until response

**Induction of anaesthesia using 2% injection**
- **By intravenous infusion**
  - Child 3–16 years: Usual dose 2.5–4 mg/kg, dose adjusted according to age, body-weight and response
  - Child 17 years: Usual dose 1.5–2.5 mg/kg, to be administered at a rate of 20–40 mg every 10 seconds until response

**Maintenance of anaesthesia using 1% injection**
- **By continuous intravenous infusion**
  - Child 1 month–16 years: Usual dose 9–15 mg/kg/hour, dose adjusted according to age, body-weight and response
  - Child 17 years: Usual dose 4–12 mg/kg/hour, adjusted according to response

**Maintenance of anaesthesia using 2% injection**
- **By continuous intravenous infusion**
  - Child 3–16 years: Usual dose 9–15 mg/kg/hour, dose adjusted according to age, body-weight and response
  - Child 17 years: Usual dose 4–12 mg/kg/hour, adjusted according to response

**Sedation of ventilated patients in intensive care using 1% or 2% injection**
- **By continuous intravenous infusion**
  - Child 16–17 years: Usual dose 0.3–4 mg/kg/hour, adjusted according to response

**Induction of sedation for surgical and diagnostic procedures using 0.5% or 1% injection**
- **By slow intravenous injection**
  - Child 1 month–16 years: Initially 1–2 mg/kg, dose and rate of administration adjusted according to desired level of sedation and response
  - Child 17 years: Initially 0.5–1 mg/kg, to be administered over 1–5 minutes, dose and rate of administration adjusted according to desired level of sedation and response

**Maintenance of sedation for surgical and diagnostic procedures using 0.5% injection**
- **Initially by intravenous infusion**
  - Child 17 years: Initially 1.5–4.5 mg/kg/hour, dose and rate of administration adjusted according to desired level of sedation and response, followed by (by slow intravenous injection) 10–20 mg, (if rapid increase in sedation required)

**Maintenance of sedation for surgical and diagnostic procedures using 1% injection**
- **Initially by intravenous infusion**
  - Child 1 month–16 years: Usual dose 1.5–9 mg/kg/hour, dose and rate of administration adjusted according to desired level of sedation and response, followed by (by slow intravenous injection) up to 1 mg/kg, (if rapid increase in sedation required)
  - Child 17 years: Initially 1.5–4.5 mg/kg/hour, dose and rate of administration adjusted according to desired level of sedation and response, followed by (by slow
### General anaesthesia

**Anaesthesia**

**Volatile halogenated anaesthetics**

**Important Safety Information**

- Should only be administered by, or under the direct supervision of, personnel experienced in its use, with adequate training in anaesthesia and airway management, and when resuscitation equipment is available.

#### Contra-indications

- Children under 16 years receiving intensive care.

#### Further Information

- Use in intensive care associated with a risk of propofol infusion syndrome (potentially fatal effects, including metabolic acidosis, arrhythmias, cardiac failure, rhabdomyolysis, hyperlipidaemia, hyperkalaemia, hepatomegaly, and renal failure).

### Interactions

- Appendix 1: propofol

### Side-effects

- Common or very common: Apnoea, arrhythmias, headache, hypotension, localised pain, nausea, vomiting.

- Uncommon: Thrombosis.

- Rare or very rare: Epileptiform seizure (may be delayed), pancreatitis, post-procedural complications, pulmonary oedema, sexual disinhibition, soft tissue necrosis, urine discoloration.

### Frequency not known

- Drug use disorders, dyskinesia, euphoric mood, heart failure, hepatomegaly, hyperkalaemia, hyperlipidaemia, metabolic acidosis, renal failure, respiratory depression, rhabdomyolysis.

### Side-effects, Further Information

- Bradycardia.

- Bradyarrhythmia may be profound and may be treated with intravenous lidocaine.

### Propofol infusion syndrome

- Prolonged infusion of propofol doses exceeding 4mg/kg/hour may result in potentially fatal effects, including metabolic acidosis, arrhythmias, cardiac failure, rhabdomyolysis, hyperlipidaemia, hyperkalaemia, hepatomegaly, and renal failure.

### Pregnancy

- May depress neonatal respiration if used during delivery.

### Dose adjustments

- Max. dose for maintenance of anaesthesia 6mg/kg/hour.

### Breastfeeding

- Breast-feeding can be resumed as soon as mother has recovered sufficiently from anaesthesia.

### Hepatic impairment

- Manufacturer advises caution.

### Renal impairment

- Use with caution.

### Monitoring requirements

- Monitor blood-lipid concentration if risk of fat overload or if sedation longer than 3 days.

### DIRECTIONS FOR ADMINISTRATION

- Shake before use; microbiological filter not recommended; may be administered via a Y-piece close to injection site co-administered with Glucose 5% or Sodium chloride 0.9%.

#### 0.5% Emulsion

- For injection or intermittent infusion; may be administered undiluted, or diluted with Glucose 5% or Sodium chloride 0.9%; dilute to a concentration not less than 1mg/ml. 1% Emulsion for injection or infusion; may be administered undiluted, or diluted with Glucose 5% (Diprivan®) or (Propofol-Lipuro®) or Sodium chloride 0.9% (Propofol-Lipuro®) only; dilute to a concentration not less than 2mg/ml; use within 6 hours of preparation. 2% Emulsion for infusion; do not dilute.

### Patient and Carer Advice

- Driving and skilled tasks.

### Medicinal forms

- There can be variation in the licensing of different medicines containing the same drug.

#### Emulsion for infusion

- **Propofol (Non-proprietary)**

  - **Propofol 10 mg per 1 ml** Propofol 500mg/50ml emulsion for infusion vials | 1 vial £15.00 (Hospital only)
  - **Propofol-Lipuro 1% emulsion for infusion 50ml vials** | 10 vial £97.56 (Hospital only)
  - **Propofol 1g/100ml emulsion for infusion vials** | 1 vial £15.00 (Hospital only)
  - **Propofol-Lipuro 1% emulsion for infusion 100ml vials** | 10 vial £186.64 (Hospital only)
  - **Propofol 20 mg per 1 ml** Propofol 1g/50ml emulsion for infusion vials | 1 vial £15.00 (Hospital only)
  - **Propofol-Lipuro 2% emulsion for infusion 50ml vials** | 10 vial £186.64 (Hospital only)
  - **Propofol (Aspen Pharma Trading Ltd)**
    - **Propofol 10 mg per 1 ml** Diprivan 1% emulsion for infusion 50ml pre-filled syringes | 1 pre-filled disposable injection £10.68
    - **Propofol 20 mg per 1 ml** Diprivan 2% emulsion for infusion 50ml pre-filled syringes | 1 pre-filled disposable injection £15.16
  - **Propoven (Fresenius Kabi Ltd)**
    - **Propofol 10 mg per 1 ml** Propoven 1% emulsion for infusion 50ml vials | 10 vial £210.60 (Hospital only)
    - **Propoven 10% emulsion for infusion 100ml vials** | 10 vial £241.50 (Hospital only)
    - **Propofol 20 mg per 1 ml** Propoven 2% emulsion for infusion 50ml vials | 10 vial £241.50 (Hospital only)

#### Emulsion for injection

- **Propofol (Non-proprietary)**

  - **Propofol 10 mg per 1 ml** Propofol 200mg/20ml emulsion for injection vials | 5 vial £20.00 (Hospital only)
  - **Propofol-Lipuro 1% emulsion for injection 20ml ampoules** | 5 ampoule £15.36 (Hospital only)
  - **Diprivan (Aspen Pharma Trading Ltd)**
    - **Propofol 10 mg per 1 ml** Diprivan 1% emulsion for injection 20ml ampoules | 5 ampoule £15.15
  - **Propofol-Lipuro (B.Braun Melsungen AG)**
    - **Propofol 5 mg per 1 ml** Propofol-Lipuro 0.5% emulsion for injection 20ml ampoules | 5 ampoule £23.90 (Hospital only)
  - **Propoven (Fresenius Kabi Ltd)**
    - **Propofol 10 mg per 1 ml** Propoven 1% emulsion for injection 20ml ampoules | 5 ampoule £15.15
adequate training in anaesthesia and airway
management, and when resuscitation equipment is
available.

- **CONTRA-INDICATIONS**  Susceptibility to malignant
hyperthermia
- **CAUTIONS**  Can trigger malignant hyperthermia -
neuromuscular disease (inhalational anaesthetics are very
rarely associated with hyperkalaemia, resulting in cardiac
arrhythmias and death) - raised intracranial pressure (can
increase cerebrospinal pressure)
- **SIDE-EFFECTS**
  - **Common or very common**  Agitation • apnoea • arrhythmias •
  chills • cough • dizziness • headache • hypersalivation •
  hypertension • hypotension • nausea • respiratory disorders •
  vomiting
  - **Uncommon**  Hyoxia
  - **Frequency not known**  Breath holding • cardiac arrest •
  haemorrhage • hepatic disorders • hyperkalaemia •
  malignant hyperthermia • Q-T interval prolongation •
  rhabdomyolysis • seizures
- **ALLERGY AND CROSS-SENSITIVITY**  Can cause
hepatotoxicity in those sensitised to halogenated
anaesthetics.
- **DIRECTIONS FOR ADMINISTRATION**  Volatile liquid
anaesthetics are administered using calibrated vapourisers,
using air, oxygen, or nitrous oxide–oxygen mixtures as the
carrier gas. To prevent hypoxia, the inspired gas mixture
should contain a minimum of 25% oxygen at all times.
- **DRIVING AND SKILLED TASKS**  Patients given sedatives and
analgesics during minor outpatient procedures should be
very carefully warned about the risks of driving or
undertaking skilled tasks afterwards. For a short general
anaesthetic, the risk extends to at least 24 hours after
administration. Responsible persons should be available to
take patients home. The dangers of taking alcohol should
also be emphasised.

### Isoflurane

- **INDICATIONS AND DOSE**
  - **Induction of anaesthesia (in oxygen or nitrous oxide–
  oxygen)** (but indication not recommended in infants and
  children of all ages)
    - **BY INHALATION**
      - Neonate: Initially 0.5 %, increased to 3 %, adjusted
        according to response, administered using specifically
        calibrated vaporiser.
      - Child: Initially 0.5 %, increased to 3 %, adjusted
        according to response, administered using specifically
        calibrated vaporiser
      - **Maintenance of anaesthesia (in nitrous oxide–oxygen)**
        - **BY INHALATION**
          - Neonate: 1 – 2.5 %, to be administered using specifically
            calibrated vaporiser; an additional 0.5 – 1% may be
            required when given with oxygen alone.
          - Child: 1 – 2.5 %, to be administered using specifically
            calibrated vaporiser; an additional 0.5 – 1% may be
            required when given with oxygen alone
    - **Maintenance of anaesthesia in caesarean section (in
      nitrous oxide–oxygen)**
      - **BY INHALATION**
        - Child: 0.5 – 0.75 %, to be administered using specifically
          calibrated vaporiser

- **INTERACTIONS**  → Appendix 1: volatile halogenated
  anaesthetics
- **SIDE-EFFECTS**
  - **Common or very common**  Coagulation disorder •
    conjunctivitis
  - **Uncommon**  Myalgia • myocardial infarction • myocardial
    ischaemia • vasodilation
- **FREQUENCY NOT KNOWN**  Abdominal pain • asthenia • heart
  failure • hypokalaemia • malaise • metabolic acidosis •
  pancreatitis acute • shock • skin reactions • ventricular
  dysfunction • visual acuity decreased
- **PREGNANCY**  May depress neonatal respiration if used
during delivery.
- **BREAST FEEDING**  Breast-feeding can be resumed as soon
  as mother has recovered sufficiently from anaesthesia.

- **MEDICINAL FORMS**  There can be variation in the licensing of
different medicines containing the same drug.
  **Inhalation vapour**
  - Desflurane (Non-proprietary)
    - Desflurane 1 ml per 1 ml Desflurane volatile liquid | 240 ml (Hospital only)

### Desflurane

- **INDICATIONS AND DOSE**
  - **Induction of anaesthesia (but not recommended)**
    - **BY INHALATION**
      - Child 12-17 years: 4 – 11 %, to be inhaled through
        specifically calibrated vaporiser
  - **Maintenance of anaesthesia (in nitrous oxide–oxygen)**
    - **BY INHALATION**
      - Neonate: 2 – 6 %, to be inhaled through a specifically
        calibrated vaporiser.
      - Child: 2 – 6 %, to be inhaled through a specifically
        calibrated vaporiser
  - **Maintenance of anaesthesia (in oxygen or oxygen–
    enriched air)**
    - **BY INHALATION**
      - Neonate: 2.5 – 8.5 %, to be inhaled through a specifically
        calibrated vaporiser.
      - Child: 2.5 – 8.5 %, to be inhaled through a specifically
        calibrated vaporiser
  - **INTERACTIONS**  → Appendix 1: volatile halogenated
    anaesthetics
  - **SIDE-EFFECTS**
    - **Common or very common**  Coagulation disorder •
      conjunctivitis
    - **Uncommon**  Myalgia • myocardial infarction • myocardial
      ischaemia • vasodilation
  - **IMPORTANCE SAFETY INFORMATION**
    - Isoflurane is not recommended for induction of
      anaesthesia in infants and children of all ages because of
      the occurrence of cough, breath-holding, desaturation,
      increased secretions, and laryngospasm.
Nitrous oxide

**INDICATIONS AND DOSE**

Maintenance of anaesthesia in conjunction with other anaesthetic agents

- **BY INHALATION**
  - Neonate: 50–66 %, to be administered using suitable anaesthetic apparatus in oxygen.
  - Child: 50–66 %, to be administered using suitable anaesthetic apparatus in oxygen.

Analgesia

- **BY INHALATION**
  - Neonate: Up to 50 %, to be administered using suitable anaesthetic apparatus in oxygen, adjusted according to the patient’s needs.
  - Child: Up to 50 %, to be administered using suitable anaesthetic apparatus in oxygen, adjusted according to the patient’s needs.

**CAUTIONS**

- Entrapped air following recent underwater dive · pneumothorax · presence of intracranial air after head injury · recent intra–ocular gas injection

**CAUTIONS, FURTHER INFORMATION**

Nitrous oxide may have a deleterious effect if used in patients with an air-containing closed space since nitrous oxide diffuses into such a space with a resulting increase in pressure. This effect may be dangerous in conditions such as pneumothorax, which may enlarge to compromise respiration, or in the presence of intracranial air after head injury, entrapped air following recent underwater dive, or recent intra–ocular gas injection.

**INTERACTIONS** → Appendix 1: nitrous oxide

**SIDE-EFFECTS**

- Abdominal distension · addiction · agranulocytosis · disorientation · dizziness · euphoria · mood · megaloblastic anaemia · middle ear damage · myeloneuropathy · nausea · paraesthesia · sedation · subacute combined cord degeneration · tinnitus · membrane perforation · vomiting

**SIDE-EFFECTS, FURTHER INFORMATION**

Exposure of patients to nitrous oxide for prolonged periods, either by continuous or by intermittent administration, may result in megaloblastic anaemia owing to interference with the action of vitamin B₁₂; neurological toxic effects can occur without preceding overt haematological changes. Depression of white cell formation may also occur.

**PREGNANCY**

- May depress neonatal respiration if used during delivery.

**BREAST FEEDING**

Breast-feeding can be resumed as soon as mother has recovered sufficiently from anaesthesia.

**MONITORING REQUIREMENTS**

- Assessment of plasma-vitamin B₁₂ concentration should be considered in those at risk of deficiency, including the elderly, those who have a poor, vegetarian, or vegan diet, and those with a history of anaemia.

**IMPORTANT SAFETY INFORMATION**

Nitrous oxide should only be administered by, or under the direct supervision of, personnel experienced in its use, with adequate training in anaesthesia and airway management, and when resuscitation equipment is available.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**INHALATION gas**

- **Nitrous oxide (Non-proprietary)**
  - Nitrous oxide 1 ml per 1 ml Nitrous oxide cylinders size E | 1800 litre P £
  - Medical Nitrous Oxide cylinders size D | 900 litre P £
  - Medical Nitrous Oxide cylinders size G | 9000 litre P £
  - Nitrous oxide cylinders size F | 3600 litre P £
  - Nitrous oxide cylinders size J | 18000 litre P £
  - Medical Nitrous Oxide cylinders size F | 3600 litre P £
  - Medical Nitrous Oxide cylinders size E | 1800 litre P £

**Sevoflurane**

**INDICATIONS AND DOSE**

Induction of anaesthesia (in oxygen or nitrous oxide–oxygen)

- **BY INHALATION**
  - Neonate: Up to 4 %, adjusted according to response, to be administered using specifically calibrated vaporiser.
  - Child: Initially 0.5–1 %, then increased to up to 8 %, increased gradually, according to response, to be administered using specifically calibrated vaporiser.

**Maintenance of anaesthesia (in oxygen or nitrous oxide–oxygen)**

- **BY INHALATION**
  - Neonate: 0.5–2 %, adjusted according to response, to be administered using specifically calibrated vaporiser.
  - Child: 0.5–3 %, adjusted according to response, to be administered using specifically calibrated vaporiser.

**CAUTIONS**

- Susceptibility to QT-interval prolongation

**INTERACTIONS** → Appendix 1: volatile halogenated anaesthetics

**SIDE-EFFECTS**

- Common or very common Drowsiness · fever · hypothermia
  - Uncommon Asthma · atrioventricular block · confusion
  - Frequency not known Dystonia · intracranial pressure increased · muscle rigidity · nephritis tubulointerstitial · oedema · pancreatitis

**PREGNANCY**

- May depress neonatal respiration if used during delivery.

**BREAST FEEDING**

Breast-feeding can be resumed as soon as mother has recovered sufficiently from anaesthesia.

**RENAL IMPAIRMENT** Use with caution.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.
1 Anaesthesia adjuvants

Pre-medication and peri-operative drugs

Drugs that affect gastric pH
Regurgitation and aspiration of gastric contents (Mendelson’s syndrome) can be a complication of general anaesthesia, particularly in obstetrics and in gastro-oesophageal reflux disease; prophylaxis against acid aspiration is not routinely used in children but may be required in high-risk cases.

An H₂-receptor antagonist can be used before surgery to increase the pH and reduce the volume of gastric fluid. It does not affect the pH of fluid already in the stomach and this limits its value in emergency procedures; an oral H₂-receptor antagonist can be given 1–2 hours before the procedure.

Antimuscarinic drugs
Antimuscarinic drugs are used (less commonly nowadays) as premedicants to dry bronchial and salivary secretions which are increased by intubation, upper airway surgery, or some inhalational anaesthetics. They are also used before or with neostigmine p. 672 to prevent bradyarrhythmia, excessive salivation, and other muscarinic actions of neostigmine.

They also prevent bradyarrhythmia and hypotension associated with drugs such as propofol p. 832 and suxamethonium chloride p. 840.

Atropine sulfate p. 837 is now rarely used for premedication but still has an emergency role in the treatment of vagotonic side-effects. Atropine sulfate may have a role in cardiopulmonary resuscitation.

Hyoscine hydrobromide p. 273 reduces secretions and also provides a degree of amnesia, sedation, and anti-emesis. Unlike atropine sulfate it may produce bradycardia rather than tachycardia.

Glycopyrronium bromide p. 838 reduces salivary secretions. When given intravenously it produces less tachycardia than atropine sulfate. It is widely used with neostigmine for reversal of non-depolarising muscle relaxants.

Glycopyrronium bromide or hyoscine hydrobromide are also used to control excessive secretions in upper airways or hypersalivation in palliative care and in children unable to control posture or with abnormal swallowing reflex; effective dose varies and tolerance may develop. The intramuscular route should be avoided if possible. Hyoscine hydrobromide transdermal patches may also be used.

Sedative drugs
Premedication
Fear and anxiety before a procedure (including the night before) can be minimised by using a sedative drug, usually a benzodiazepine. Premedication may also augment the action of anaesthetics and provide some degree of preoperative amnesia. The choice of drug depends on the individual, the nature of the procedure, the anaesthetic to be used, and other prevailing circumstances such as outpatients, obstetrics, and availability of recovery facilities.

The choice also varies between elective and emergency procedures. Oral administration is preferred if possible; the rectal route should only be used in exceptional circumstances.

Premedication can be given the night before major surgery; a further, smaller dose may be required before surgery. Alternatively, the first dose may be given on the day of the procedure.

Oral midazolam p. 229 is the most common premedicant for children; temazepam p. 847 may be used in older children. The antihistamine alimemazine tartrate p. 180 is occasionally used orally, but when given alone it may cause postoperative restlessness in the presence of pain.

Benzodiazepines
Benzodiazepines possess useful properties for premedication including relief of anxiety, sedation, and amnesia; short-acting benzodiazepines taken by mouth are the most common premedicants. Benzodiazepines are also used for sedation prior to clinical procedures and for sedation in intensive care.

Benzodiazepines may occasionally cause marked respiratory depression and facilities for its treatment are essential; flumazenil p. 887 is used to antagonise the effects of benzodiazepines.

Midazolam, a water-soluble benzodiazepine, is the preferred benzodiazepine for premedication and for sedation for clinical procedures in children. It has a fast onset of action, and recovery is faster than for other benzodiazepines.

Recovery may be longer in children with a low cardiac output, or after repeated dosing.

Midazolam can be given by mouth [unlicensed], but its bitter acidic taste may need to be disguised. It can also be given buccally [unlicensed indication] or intranasally [unlicensed]. Midazolam is associated with prolonged sedation when high doses are given or when it is used with certain other drugs. It can cause severe disinhibition and restlessness in some children. Midazolam is not recommended for prolonged sedation in neonates; drug accumulation is likely to occur.

Temazepam is given by mouth for premedication in older children and has a short duration of action. Anxiolytic and sedative effects last about 90 minutes, although there may be residual drowsiness. Temazepam is rarely used for dental procedures in children.

Lorazepam p. 228 produces more prolonged sedation than temazepam and it has marked amnesic effects. Peri-operative use of diazepam p. 226 is not recommended in children; onset and magnitude of response are unreliable, and paradoxical effects may occur. Diazepam is not used for dental procedures in children.

Antagonists for central and respiratory depression
Respiratory depression is a major concern with opioid analgesics and it may be treated by artificial ventilation or be reversed by an opioid antagonist. Naloxone hydrochloride p. 869 given intravenously immediately reverses opioid-induced respiratory depression but the dose may have to be repeated because of its short duration of action.

Intramuscular injection of naloxone hydrochloride produces a more gradual and prolonged effect but absorption may be erratic. Care is required in children requiring pain relief because naloxone hydrochloride also antagonises the analgesic effect of opioids.

Flumazenil is a benzodiazepine antagonist for the reversal of the central sedative effects of benzodiazepines after anaesthetic and similar procedures. Flumazenil has a shorter half-life and duration of action than diazepam or midazolam so patients may become resedated.

Neonates
Naloxone hydrochloride is used in newborn infants to reverse respiratory depression and sedation resulting from the use of opioids by the mother, usually for pain during labour. In neonates the effects of opioids may persist for up to 48 hours and in such cases naloxone hydrochloride is often given by intramuscular injection for its prolonged effect. In severe respiratory depression after birth, breathing should first be established (using artificial means if necessary) and naloxone hydrochloride administered only if use of opioids by the mother is thought to cause the respiratory depression; the infant should be monitored.
closely and further doses of naloxone hydrochloride administered as necessary.

**ANTIMUSCARINICS**

**Atropine sulfate**

- **INDICATIONS AND DOSE**
  - Brachyarrhythmia due to acute massive overdosage of beta-blockers
    - **BY INTRAVENOUS INJECTION**
      - Child: 40 micrograms/kg (max. per dose 3 mg)
  - Treatment of poisoning by organophosphorus insecticide or nerve agent (in combination with pralidoxime chloride)
    - **BY INTRAVENOUS INJECTION**
      - Child: 20 micrograms/kg every 5–10 minutes (max. per dose 2 mg) until the skin becomes flushed and dry, the pupils dilate, and bradycardia is abolished, frequency of administration dependent on the severity of poisoning
  - Premedication
    - **BY INTRAVENOUS INJECTION**
      - Neonate: 10 micrograms/kg, to be administered immediately before induction of anaesthesia.
      - Child 1 month–11 years: 20 micrograms/kg, to be administered immediately before induction of anaesthesia (minimum 100 micrograms, max. 600 micrograms)
      - Child 12–17 years: 300–600 micrograms, to be administered immediately before induction of anaesthesia
    - **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION**
      - Neonate: 10 micrograms/kg, to be administered 30–60 minutes before induction of anaesthesia.
      - Child 1 month–11 years: 10–30 micrograms/kg, to be administered 30–60 minutes before induction of anaesthesia (minimum 100 micrograms, max. 600 micrograms)
      - Child 12–17 years: 300–600 micrograms, to be administered 30–60 minutes before induction of anaesthesia
    - **BY MOUTH**
      - Neonate: 20–40 micrograms/kg, to be administered 1–2 hours before induction of anaesthesia.
      - Child: 20–40 micrograms/kg (max. per dose 900 micrograms), to be administered 1–2 hours before induction of anaesthesia
  - **Intra-operative bradycardia**
    - **BY INTRAVENOUS INJECTION**
      - Neonate: 10–20 micrograms/kg.
      - Child 1 month–11 years: 10–20 micrograms/kg
      - Child 12–17 years: 300–600 micrograms, larger doses may be used in emergencies
  - **Control of muscarinic side-effects of neostigmine in reversal of competitive neuromuscular block**
    - **BY INTRAVENOUS INJECTION**
      - Neonate: 20 micrograms/kg.
      - Child 1 month–11 years: 20 micrograms/kg (max. per dose 1.2 mg)
      - Child 12–17 years: 0.6–1.2 mg
  - **UNLICENSED USE** Not licensed for use in children under 12 years for intra-operative bradycardia or by intravenous route for premedication.
  - With oral use Not licensed for use by oral route.

**IMPORTANT SAFETY INFORMATION**

- With systemic use for Premedication Antimuscarinic drugs used for premedication to general anaesthesia should only be administered by, or under the direct supervision of, personnel experienced in their use.

- **INTERACTIONS** → Appendix 1: atropine

- **SIDE-EFFECTS**
  - Common or very common
    - With intravenous use Abdominal distension - anhidrosis - anxiety - arrhythmias - bronchial secretion decreased - dysphagia - gastrointestinal disorders - hallucination - hyperthermia - movement disorders - mydriasis - speech disorder - taste loss - thirst
  - Uncommon
    - With intravenous use Psychotic disorder

  - **PREGNANCY** Not known to be harmful; manufacturer advises caution.

  - **BREAST FEEDING** May suppress lactation; small amount present in milk—manufacturer advises caution.

- **MONITORING REQUIREMENTS**
  - Control of muscarinic side-effects of neostigmine in reversal of competitive neuromuscular block. Since atropine has a shorter duration of action than neostigmine, late unopposed bradycardia may result; close monitoring of the patient is necessary.

- **DIRECTIONS FOR ADMINISTRATION**
  - With oral use For administration by mouth, injection solution may be given orally.

- **EXCEPTIONS TO LEGAL CATEGORY**
  - With intramuscular use or intravenous use or subcutaneous use Prescription only medicine restriction does not apply where administration is for saving life in emergency.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension, oral solution, solution for injection, solution for infusion, eye drops, eye ointment

**Tablet**

- **Atropine sulfate (Non-proprietary)**
  - Atropine sulfate 600 microgram per 1 ml
    - Atropine 600microgram/tablet Atropine 600microgram/tablet | 28 tablet £5.92 DT = £5.92
  - **Solution for injection**
    - **Atropine sulfate (Non-proprietary)**
      - Atropine sulfate 100 microgram per 1 ml
        - Atropine 500micrograms/ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £13.00 | 10 pre-filled disposable injection £130.00
        - Atropine sulfate 200 microgram per 1 ml
          - Atropine 1mg/ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £7.29 | 10 pre-filled disposable injection £72.90
        - Atropine sulfate 300 microgram per 1 ml
          - Atropine 3mg/ml solution for injection pre-filled syringes | 1 pre-filled disposable injection £72.90
        - Atropine sulfate 400 microgram per 1 ml
          - Atropine 4mg/ml solution for injection ampolules | 10 ampoule £102.26 DT = £102.26
      - Atropine sulfate 600 microgram per 1 ml
        - Atropine 600micrograms/ml solution for injection ampolules | 10 ampoule £11.71 DT = £11.71
Glycopyrronium bromide
(Glycopyrrolate)

**INDICATIONS AND DOSE**

Premedication at induction
- **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
  - Neonate: 5 micrograms/kg.
  - Child 1 month–11 years: 4–8 micrograms/kg (max. per dose 200 micrograms)
  - Child 12–17 years: 200–400 micrograms, alternatively 4–5 micrograms/kg (max. per dose 400 micrograms)

*Intra-operative bradycardia*
- **BY INTRAVENOUS INJECTION**
  - Neonate: 10 micrograms/kg, repeated if necessary.
  - Child: 4–8 micrograms/kg (max. per dose 200 micrograms), repeated if necessary

*Control of muscarinic side-effects of neostigmine in reversal of non-depolarising neuromuscular block*
- **BY INTRAVENOUS INJECTION**
  - Neonate: 10 micrograms/kg.
  - Child 1 month–11 years: 10 micrograms/kg (max. per dose 500 micrograms)
  - Child 12–17 years: 10–15 micrograms/kg, alternatively, 200 micrograms per 1 mg of neostigmine to be administered

*Control of upper airways secretion | Hypersalivation*
- **BY MOUTH**
  - Child: 40–100 micrograms/kg 3–4 times a day (max. per dose 2 mg), adjusted according to response, dose to be administered using tablets or injection solution, see *Directions for administration*

- **BY SUBCUTANEOUS INFUSION**
  - Child 1 month–11 years: 12–40 micrograms/kg (max. per dose 1.2 mg) over 24 hours
  - Child 12–17 years: 0.6–1.2 mg/24 hours

- **BY SUBCUTANEOUS INJECTION, OR BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
  - Child 1 month–11 years: 4–10 micrograms/kg 4 times a day (max. per dose 200 micrograms) as required
  - Child 12–17 years: 200 micrograms every 4 hours as required

*SIALANAR® ORAL SOLUTION*

**Severe siaiolorrhoea (chronic pathological drooling)**
- **BY MOUTH**
  - Child 3-7 years: (consult product literature)

**UNLICENSED USE** Not licensed for use in control of upper airways secretion and hypersalivation.

**IMPORTANT SAFETY INFORMATION**

Antimuscarinic drugs used for premedication to general anaesthesia should only be administered by, or under the direct supervision of, personnel experienced in their use.

**CAUTIONS**

*SIALANAR® ORAL SOLUTION* Compromised blood-brain barrier—monitor for behavioural changes

**INTERACTIONS** ➔ Appendix 1: glycopyrronium

**SIDE-EFFECTS**
- Common or very common
  - With oral use Akathisia, anxiety, behaviour abnormal, bronchial secretion decreased, concentration impaired, crying, depressed mood, diarrhoea, fever, increased risk of infection, mood altered, nasal congestion
  - Uncommon
  - With oral use Breathlessness, dehydration, eye disorders, gastrointestinal disorders, insomnia, seizure, thirst
  - Frequency not known
  - With oral use Anhidrosis, dry eyes, dysphagia, epistaxis, speech disorder
  - With parenteral use Anhidrosis, bronchial secretion decreased, mydriasis

**PREGNANCY**

*SIALANAR® ORAL SOLUTION* Manufacturer advises avoid—no information available.

**BREAST FEEDING**

*SIALANAR® ORAL SOLUTION* Manufacturer advises avoid—no information available.

**RENAL IMPAIRMENT**

*SIALANAR® ORAL SOLUTION* Manufacturer advises avoid if estimated glomerular filtration rate is less than 30 mL/minute/1.73 m².

*Dose adjustments* Manufacturer advises reduce dose by 30% if estimated glomerular filtration rate is 30–89 mL/minute/1.73 m²—consult product literature.

**DIRECTIONS FOR ADMINISTRATION**

- With oral use for Control of upper airways secretion or Hypersalivation: For administration *by mouth*, injection solution may be given or crushed tablets suspended in water.

*SIALANAR® ORAL SOLUTION* Doses should be given at least 1 hour before or 2 hours after food, or at consistent times with respect to food if co-administration with food is required—high-fat food should be avoided; for administration by a nasogastric or feeding tube, flush with 10 mL of water immediately after dosing.

**PRESCRIBING AND DISPENSING INFORMATION**

- With oral use Tablets may be available on a named-patient basis from specialist importing companies.

**PATIENT AND CARER ADVICE**

*SIALANAR® ORAL SOLUTION* Manufacturer advises patients and their carers should be informed to stop treatment and seek medical advice if constipation, urinary retention, pneumonia, allergic reaction, pyrexia, or changes in behaviour occur; treatment should also be stopped and medical advice sought in very hot weather.

**NATIONAL FUNDING/ACCESS DECISIONS**

Scottish Medicines Consortium (SMC) decisions

The Scottish Medicines Consortium has advised (July 2017) that glycopyrronium bromide (Sialanar®) is accepted for use within NHS Scotland for the symptomatic treatment of severe siaiolorrhoea (chronic pathological drooling) in children and adolescents aged 3 years and older with chronic neurological disorders.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral solution

- **Tablet**
  - Glycopyrronium bromide (Non-proprietary)
    - Glycopyrronium bromide 1 mg Glycopyrronium bromide 1mg tablets | 30 tablet | £20.72 DT + £230.71
    - Glycopyrronium bromide 2 mg Glycopyrronium bromide 2mg tablets | 30 tablet | £254.24 DT + £254.24

**Solution for injection**

- **Glycopyrronium bromide (Non-proprietary)**
  - Glycopyrronium bromide 200 microgram per 1 ml Glycopyrronium bromide 200micrograms/1ml solution for injection ampoules | 10 ampoule | £5.72–£14.00 DT + £9.99
Neuromuscular blockade

Neuromuscular blocking drugs

Neuromuscular blocking drugs used in anaesthesia are also known as muscle relaxants. By specific blockade of the neuromuscular junction they enable light anaesthesia to be used with adequate relaxation of the muscles of the abdomen and diaphragm. They also relax the vocal cords and allow the passage of a tracheal tube. Their action differs from the muscle relaxants used in musculoskeletal disorders that act on the spinal cord or brain.

Children who have received a neuromuscular blocking drug should always have their respiration assisted or controlled until the drug has been inactivated or antagonised. They should also receive sufficient concomitant inhalational or intravenous anaesthetic or sedative drugs to prevent awareness.

Non-depolarising neuromuscular blocking drugs

Non-depolarising neuromuscular blocking drugs (also known as competitive muscle relaxants) compete with acetylcholine for receptor sites at the neuromuscular junction and their action can be reversed with anticholinesterases such as neostigmine. Non-depolarising neuromuscular blocking drugs can be divided into the aminosteroid group, comprising pancuronium bromide, atracurium besilate, and vecuronium bromide, and the benzylisoquinolinium group, comprising atracurium besilate and cisatracurium.

Non-depolarising neuromuscular blocking drugs have a slower onset of action than suxamethonium chloride. These drugs can be classified by their duration of action as short-acting (15–30 minutes), intermediate-acting (30–60 minutes), and long-acting (>60 minutes), although duration of action is dose-dependent. Drugs with a shorter or intermediate duration of action, such as atracurium besilate and vecuronium bromide, are more widely used than those with a longer duration of action, such as pancuronium bromide.

Non-depolarising neuromuscular blocking drugs have no sedative or anergic effects and are not considered to trigger malignant hyperthermia.

For patients receiving intensive care and who require tracheal intubation and mechanical ventilation, a non-depolarising neuromuscular blocking drug is chosen according to its onset of effect, duration of action, and side-effects. Rocuronium bromide, with a rapid onset of effect, may facilitate intubation. Atracurium besilate or cisatracurium may be suitable for longer-term neuromuscular blockade since their duration of action is not dependent on elimination by the liver or the kidneys.

Atracurium besilate, a mixture of 10 isomers, is a benzylisoquinolinium neuromuscular blocking drug with an intermediate duration of action. It undergoes non-enzymatic metabolism which is independent of liver and kidney function, thus allowing its use in children with hepatic or renal impairment. Cardiovascular effects are associated with significant histamine release; histamine release can be minimised by administering slowly or in divided doses over at least 1 minute. Neonates may be more sensitive to the effects of atracurium besilate and lower doses may be required.

Cisatracurium is a single isomer of atracurium besilate. It is more potent and has a slightly longer duration of action than atracurium besilate and provides greater cardiovascular stability because cisatracurium lacks histamine-releasing effects. In children aged 1 month to 12 years, cisatracurium has a shorter duration of action and produces faster spontaneous recovery.

Mivacurium, a benzylisoquinolinium neuromuscular blocking drug, has a short duration of action. It is metabolised by plasma cholinesterase and muscle paralysis is prolonged in individuals deficient in this enzyme. It is not associated with vagolytic activity or ganglionic blockade although histamine release can occur, particularly with rapid injection. In children under 12 years mivacurium has a faster onset, shorter duration of action, and produces more rapid spontaneous recovery.

Pancuronium bromide, an aminosteroid neuromuscular blocking drug, has a long duration of action and is often used in children receiving long-term mechanical ventilation in intensive care units. It lacks a histamine-releasing effect, but vagolytic and sympathomimetic effects can cause tachycardia and hypertension. The half-life of pancuronium bromide is prolonged in neonates; neonates should receive postoperative intermittent positive pressure ventilation.

Rocuronium bromide exerts an effect within 2 minutes and has the most rapid onset of any of the non-depolarising neuromuscular blocking drugs. It is an aminosteroid neuromuscular blocking drug with an intermediate duration of action. It is reported to have minimal cardiovascular effects; high doses produce mild vagolytic activity. In most children, the duration of action of rocuronium bromide may be shorter than in adults; however, in neonates and children under 2 years, usual doses may produce a more prolonged action.

Vecuronium bromide, an aminosteroid neuromuscular blocking drug, has an intermediate duration of action. It does not generally produce histamine release and lacks cardiovascular effects. In most children, the duration of action of vecuronium bromide may be shorter than in adults; however, in neonates and children under 2 years, usual doses may produce a more prolonged action.

Depolarising neuromuscular blocking drugs

Suxamethonium chloride has the most rapid onset of action of any of the neuromuscular blocking drugs and is ideal if fast onset and brief duration of action are required e.g. with tracheal intubation. Neonates and young children are less sensitive to suxamethonium chloride and a higher dose may be required. Unlike the non-depolarising neuromuscular blocking drugs, its action cannot be reversed and recovery is spontaneous; anticholinesterases such as neostigmine potentiate the neuromuscular block.

Suxamethonium chloride should be given after anaesthetic induction because paralysis is usually preceded by painful muscle fasciculations. Bradycardia may occur; premedication with atropine sulfate p. 837 reduces bradycardia as well as the excessive salivation associated with suxamethonium chloride use.

Prolonged paralysis may occur in dual block, which occurs with high or repeated doses of suxamethonium chloride and is caused by the development of a non-depolarising block following the initial depolarising block. Children with myasthenia gravis are resistant to suxamethonium chloride but can develop dual block resulting in delayed recovery. Prolonged paralysis may also occur in those with low or no histaminergic response to suxamethonium chloride.

Neuromuscular blockade 839
atypical plasma cholinesterase. Assisted ventilation should be continued until muscle function is restored.

**NEUROMUSCULAR BLOCKING DRUGS**

**DEPOLARISING**

**Suxamethonium chloride**

(Succinylcholine chloride)

- **DRUG ACTION** Suxamethonium acts by mimicking acetylcholine at the neuromuscular junction but hydrolysis is much slower than for acetylcholine; depolarisation is therefore prolonged, resulting in neuromuscular blockade.

- **INDICATIONS AND DOSE**

  - **Neuromuscular blockade (short duration) during surgery**
    - **BY INTRAVENOUS INJECTION**
      - Neonate: 2 mg/kg, produces 5–10 minutes neuromuscular blockade.
      - Child 1-11 months: 2 mg/kg
      - Child 1-17 years: 1 mg/kg
      - **BY INTRAMUSCULAR INJECTION**
        - Neonate: Up to 4 mg/kg, produces 10–30 minutes neuromuscular blockade.
        - Child 1-11 months: Up to 5 mg/kg
        - Child 1-11 years: Up to 4 mg/kg (max. per dose 150 mg)

  - **PHARMACOKINETICS**
    - Intramuscular injection has a duration of onset of 2–3 minutes.

- **SIDE-EFFECTS**
  - Bronchospasm
  - Cardiac arrest
  - Hypotension
  - Hypothermia (activity prolonged, lower doses required)
  - Myasthenia gravis (activity prolonged, lower doses required)
  - Myopathy (after prolonged use in intensive care)
  - Muscle weakness • myopathy (after prolonged use in intensive care)

- **CONTRA-INDICATIONS** Duchenne muscular dystrophy • family history of malignant hyperthermia • hyperkalaemia • low plasma-cholinesterase activity (including severe liver disease) • major trauma • neurological disease involving acute wasting of major muscle • personal or family history of congenital myotonic disease • prolonged immobilisation (risk of hyperkalaemia) • severe burns

- **CAUTIONS** Cardiac disease • neuromuscular disease • raised intra-ocular pressure (avoid in penetrating eye injury) • respiratory disease • severe sepsis (risk of hyperkalaemia)

- **INTERACTIONS**
  - Lamotrigine reduces risk of ventilatory depression
  - **Non-depolarising neuromuscular blocking drugs** should only be administered by, or under direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management.

**IMPORTANT SAFETY INFORMATION**

Should only be administered by, or under the direct supervision of, personnel experienced in its use.

- **CONTRA-INDICATIONS**
  - Duchenne muscular dystrophy • family history of malignant hyperthermia • hyperkalaemia • low plasma-cholinesterase activity (including severe liver disease) • major trauma • neurological disease involving acute wasting of major muscle • personal or family history of congenital myotonic disease • prolonged immobilisation (risk of hyperkalaemia) • severe burns

- **CAUTIONS** Cardiac disease • neuromuscular disease • raised intra-ocular pressure (avoid in penetrating eye injury) • respiratory disease • severe sepsis (risk of hyperkalaemia)

- **INTERACTIONS**
  - Lamotrigine reduces risk of ventilatory depression
  - **Non-depolarising neuromuscular blocking drugs** should only be administered by, or under direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management.

- **SIDE-EFFECTS**
  - **Common or very common**
    - Arrhythmias • flushing • muscle contractions involuntary • myoglobinuria • myoglobinuria • post procedural muscle pain • rash
  - **Rare or very rare**
    - Apnoea • cardiac arrest • hypersensitivity • malignant hyperthermia • respiratory disorders • trismus

  - **SIDE-EFFECTS, FURTHER INFORMATION**
    - Premedication with atropine reduces bradycardia associated with suxamethonium use.

- **ALLERGY AND CROSS-SENSITIVITY**
  - Allergic cross-reactivity between neuromuscular blocking drugs has been reported; caution is advised in cases of hypersensitivity to these drugs.

- **PREGNANCY**
  - Mildly prolonged maternal neuromuscular blockade may occur.

- **BREAST FEEDING**
  - Unlike to be present in breast milk in significant amounts (ionised at physiological pH). Breast-feeding may be resumed once the mother recovered from neuromuscular block.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution, particularly in end stage hepatic failure (increased risk of prolonged apnoea due to reduced hepatic synthesis of plasma cholinesterase).

- **DIRECTIONS FOR ADMINISTRATION**
  - With intravenous use For intravenous injection, give undiluted or dilute with Glucose 5% or Sodium Chloride 0.9%.

- **MEDICINAL FORMS**
  - There can be variation in the labelling of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

  - **Solution for injection**
    - Suxamethonium chloride (Non-proprietary) Suxamethonium chloride 50 mg per 1 ml Suxamethonium chloride 100mg/2ml solution for injection ampoules | 10 ampoule (£) £28.80–£50.00
    - Anectine (Aspen Pharma Trading Ltd) Suxamethonium chloride 50 mg per 1 ml Anectine 100mg/2ml solution for injection ampoules | 5 ampoule (£) £3.57

**NEUROMUSCULAR BLOCKING DRUGS**

**Non-depolarising**

**neuromuscular blocking drugs**

**IMPORTANT SAFETY INFORMATION**

Non-depolarising neuromuscular blocking drugs should only be administered by, or under direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management.

- **CAUTIONS**
  - Burns (resistance can develop, increased doses may be required) • cardiovascular disease (reduce rate of administration) • electrolyte disturbances (response unpredictable) • fluid disturbances (response unpredictable) • hypothermia (activity prolonged, lower doses required) • myasthenia gravis (activity prolonged, lower doses required) • neuromuscular disorders (response unpredictable)

- **SIDE-EFFECTS**
  - Common or very common
    - Flushing • hypotension
  - Uncommon
    - Bronchospasm • hypersensitivity • skin reactions
  - Rare or very rare
    - Muscle weakness • myopathy (after prolonged use in intensive care)

- **ALLERGY AND CROSS-SENSITIVITY**
  - Allergic cross-reactivity between neuromuscular blocking drugs has been reported; caution is advised in cases of hypersensitivity to these drugs.

- **PREGNANCY**
  - Non-depolarising neuromuscular blocking drugs are ionised at physiological pH and are therefore unlikely to cross the placenta in significant amounts.

- **BREAST FEEDING**
  - Non-depolarising neuromuscular blocking drugs are ionised at physiological pH and are unlikely to be present in milk in significant amounts. Breast-feeding may be resumed once the mother has recovered from neuromuscular block.
Atracurium besilate (Atracurium besilate)

**INDICATIONS AND DOSE**

**Neuromuscular blockade (short to intermediate duration) for surgery**
- **INITIALLY BY INTRAVENOUS INJECTION**
- **Neonate**: Initially 300–500 micrograms/kg, followed by (by intravenous injection) 100–200 micrograms/kg, repeated if necessary, alternatively (by intravenous infusion) 300–400 micrograms/kg/hour, adjusted according to response.
- **Child**: Initially 300–600 micrograms/kg, then (by intravenous injection) 100–200 micrograms/kg, repeated if necessary, alternatively (by intravenous injection) initially 300–600 micrograms/kg, followed by (by intravenous infusion) 300–600 micrograms/kg/hour, adjusted according to response.

**SIDE-EFFECTS**
- **Hypotension, skin flushing, and bronchospasm** is associated with histamine release by administering over a period of 5 minutes. Manufacturer advises minimising effects of histamine release by administering over 5 minutes in neonates with cardiovascular disease or sensitivity to histamine. Neonates may be more sensitive to the effects of atracurium and lower doses may be required.
- **DIRECTIONS FOR ADMINISTRATION** For continuous intravenous infusion, dilute to a concentration of 0.1–2 mg/mL with Glucose 5% or Sodium Chloride 0.9%; stability varies with diluent.
- **In neonates** Neonatal intensive care, dilute 60 mg/kg bodyweight to a final volume of 50 mL with Glucose 5% or Sodium Chloride 0.9%; minimum concentration of 500 micrograms/mL, maximum concentration of 5 mg/mL; an intravenous infusion rate of 0.1 mL/hour provides a dose of 120 micrograms/kg/hour.

**INTERACTIONS** → Appendix 1: neuromuscular blocking drugs, non-depolarising
- **SIDE-EFFECTS**
  - Rare or very rare Cardiac arrest, circulatory collapse, shock
  - Frequency not known Seizure
- **SIDE-EFFECTS, FURTHER INFORMATION** Hypotension, skin flushing, and bronchospasm is associated with histamine release. Manufacturer advises minimising effects of histamine release by administering over 1 minute in neonates with cardiovascular disease or sensitivity to histamine. Neonates may be more sensitive to the effects of atracurium and lower doses may be required.

**UNLICENSED USE**
- In neonates Not licensed for use in neonates.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Atracurium besilate** (Non-proprietary)
  - Atracurium besilate 2 mg per mL Atracurium besilate 250mg/25ml solution for injection vials | 1 vial (PODD) £16.50 (Hospital only)

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Cisatracurium

**INDICATIONS AND DOSE**

**Neuromuscular blockade (intermediate duration) during surgery**
- **INITIALLY BY INTRAVENOUS INJECTION**
  - **Child 1 month–1 year**: Initially 150 micrograms/kg, then (by intravenous injection) 30 micrograms/kg every 20 minutes as required
  - **Child 2–11 years**: Initially 150 micrograms/kg, 80–100 micrograms/kg if not for intubation, then (by intravenous injection) 20 micrograms/kg every 10 minutes as required, alternatively (by intravenous injection) initially 150 micrograms/kg, followed by (by intravenous infusion) 180 micrograms/kg/hour, (by intravenous infusion) reduced to 60–120 micrograms/kg/hour, adjusted according to response
  - **Child 12–17 years**: Initially 150 micrograms/kg, then (by intravenous injection) 30 micrograms/kg every 20 minutes as required, alternatively (by intravenous injection) initially 150 micrograms/kg, followed by (by intravenous infusion) 180 micrograms/kg/hour, (by intravenous infusion) reduced to 60–120 micrograms/kg/hour, adjusted according to response

**DOSES AT EXTREMES OF BODY-WEIGHT**
- To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

**INTERACTIONS** → Appendix 1: neuromuscular blocking drugs, non-depolarising
- **SIDE-EFFECTS**
  - Common or very common Bradycardia

**DIRECTIONS FOR ADMINISTRATION** For continuous intravenous infusion, dilute to a concentration of 0.1–2 mg/mL with Glucose 5% or Sodium Chloride 0.9%; solutions of 2 mg/mL and 5 mg/mL may be infused undiluted.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Cisatracurium** (Non-proprietary)
  - Cisatracurium (as Cisatracurium besilate) 2 mg per mL Cisatracurium besilate 20mg/10ml solution for injection ampoules | 5 ampoule (PODD) £33.75 (Hospital only) | 10 ampoule (PODD) £67.50
  - Cisatracurium besilate 20mg/10ml solution for injection ampoules | 5 vial (PODD) £33.75 | 10 vial (PODD) £33.86
  - Cisatracurium (as Cisatracurium besilate) 5 mg per mL Cisatracurium besilate 150mg/30ml solution for injection vials | 1 vial (PODD) £45.00 (Hospital only) | 1 vial (PODD) £26.43–£29.54

- **Nimbex** (Aspen Pharma Trading Ltd)
  - Cisatracurium (as Cisatracurium besilate) 2 mg per mL Nimbex 20mg/10ml solution for injection vials | 5 ampoule (PODD) £33.75
  - Cisatracurium (as Cisatracurium besilate) 5 mg per mL Nimbex Forte 150mg/30ml solution for injection vials | 1 vial (PODD) £13.09
Mivacurium

- **INDICATIONS AND DOSE**
  - Neuromuscular blockade (short duration) during surgery
    - **INITIALLY BY INTRAVENOUS INJECTION**
      - Child 2–5 months: Initially 150 micrograms/kg, then (by intravenous injection) 100 micrograms/kg every 6–9 minutes as required, alternatively (by intravenous infusion) 8–10 micrograms/kg/minute, (by intravenous infusion) adjusted in steps of 1 microgram/kg/minute every 3 minutes if required; (by intravenous infusion) usual dose 11–14 micrograms/kg/minute
      - Child 6 months–11 years: Initially 200 micrograms/kg, then (by intravenous injection) 100 micrograms/kg every 6–9 minutes as required, alternatively (by intravenous infusion) 8–10 micrograms/kg/minute, (by intravenous infusion) adjusted in steps of 1 microgram/kg/minute every 3 minutes if required; (by intravenous infusion) usual dose 11–14 micrograms/kg/minute
      - Child 12–17 years: Initially 70–250 micrograms/kg, then (by intravenous injection) 100 micrograms/kg every 15 minutes as required, alternatively (by intravenous infusion) 8–10 micrograms/kg/minute, (by intravenous infusion) adjusted in steps of 1 microgram/kg/minute every 3 minutes if required; (by intravenous infusion) usual dose 6–7 micrograms/kg/minute

- **DOSES AT EXTREMES OF BODY-WEIGHT**
  - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

- **CAUTIONS** Burns (low plasma cholinesterase activity; dose titration required)
- **INTERACTIONS** → Appendix 1: neuromuscular blocking drugs, non-depolarising
- **SIDE-EFFECTS**
  - Uncommon Tachycardia
- **HEPATIC IMPAIRMENT**
  - Dose adjustments Reduce dose in severe impairment.
- **RENAL IMPAIRMENT**
  - Dose adjustments Clinical effect prolonged in renal failure—reduce dose according to response.
- **DIRECTIONS FOR ADMINISTRATION**
  - For intravenous injection, give undiluted or dilute in Glucose 5% or Sodium Chloride 0.9%.
  - There can be variation in the licensing of different medicines containing the same drug.
  - Solution for injection
    - [Mivacurium (as Mivacurium chloride)] 2 mg per 1 ml
      - Mivacurium 10mg/5ml solution for injection ampoules | 5 ampoule | £13.95
      - Mivacurion 20mg/10ml solution for injection ampoules | 5 ampoule | £22.57

Rocuronium bromide

- **INDICATIONS AND DOSE**
  - Neuromuscular blockade (intermediate duration) during surgery
    - **INITIALLY BY INTRAVENOUS INJECTION**
      - Neonate: Initially 600 micrograms/kg, then (by intravenous injection) 150 micrograms/kg, repeated if necessary, alternatively (by intravenous infusion) 300–600 micrograms/kg/hour, adjusted according to response.
      - Child: Initially 600 micrograms/kg, then (by intravenous injection) 150 micrograms/kg, repeated if necessary, alternatively (by intravenous infusion) 300–600 micrograms/kg/hour first hour, then (by intravenous infusion), adjusted according to response

- **DOSES AT EXTREMES OF BODY-WEIGHT**
  - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

- **UNLICENSED USE**
  - Not licensed for use in children for assisted ventilation in intensive care.
- **INTERACTIONS** → Appendix 1: neuromuscular blocking drugs, non-depolarising
- **SIDE-EFFECTS**
  - Uncommon Procedural complications · tachycardia
  - Rare or very rare Angioedema · circulatory collapse · face oedema · malignant hyperthermia · paralysis · shock
- **HEPATIC IMPAIRMENT**
  - Dose adjustments Reduce dose.
- **RENAL IMPAIRMENT**
  - Dose adjustments Reduce maintenance dose; prolonged paralysis.
- **DIRECTIONS FOR ADMINISTRATION**
  - For continuous intravenous infusion or via drip tubing, may be diluted with Glucose 5% or Sodium Chloride 0.9%.

Pancuronium

- **INDICATIONS AND DOSE**
  - Neuromuscular blockade (long duration) during surgery
    - **BY INTRAVENOUS INJECTION**
      - Neonate: Initially 100 micrograms/kg, then 50 micrograms/kg, repeated if necessary.
      - Child: Initially 100 micrograms/kg, then 20 micrograms/kg, repeated if necessary.
  - **DOSES AT EXTREMES OF BODY-WEIGHT**
    - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.
**1.2 Neuromuscular blockade reversal**

**Neuromuscular blockade reversal**

**Anticholinesterases**

Anticholinesterases reverse the effects of the non-depolarising (competitive) neuromuscular blocking drugs such as pancuronium bromide but they prolong the action of the depolarising neuromuscular blocking drug suxamethonium chloride.

Neostigmine is used specifically for reversal of non-depolarising (competitive) blockade. It acts within one minute of intravenous injection and its effects last for 20 to 30 minutes; a second dose may then be necessary. Glycopyrronium bromide p. 838 or alternatively atropine sulfate, given before or with neostigmine, prevent bradycardia, excessive salivation, and other muscarinic effects of neostigmine.

Other drugs for reversal of neuromuscular blockade Sugammadex below is a modified gamma cyclodextrin which can be used in children for the routine reversal of neuromuscular blockade induced by rocuronium bromide.

**ANTICHOLINESTERASES**

**Neostigmine with glycopyrronium bromide**

The properties listed below are those particular to the combination only. For the properties of the components please consider, neostigmine p. 672, glycopyrronium bromide p. 838.

- **INDICATIONS AND DOSE**
  - **Reversal of non-depolarising neuromuscular blockade**
    - **BY INTRAVENOUS INJECTION**
    - Child: 0.02 mL/kilogram, repeated if necessary, alternatively dilute to 1 in 10 solution and give 0.2 mL/kg; maximum 2 mL per course
  - **INTERACTIONS** → Appendix 1: glycopyrronium · neostigmine
  - **DIRECTIONS FOR ADMINISTRATION** For intravenous injection, may be diluted with Sodium Chloride 0.9%, give over 10–30 seconds
  - **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Solution for injection**
  - **Neostigmine with glycopyrronium bromide (Non-proprietary)**
    - Glycopyrronium bromide 500 microgram per 1 mL Neostigmine methylsulfate 2.5 mg per 1 mL
    - Neostigmine 2.5mg/1ml / Glycopyrronium bromide 500micrograms/1ml solution for injection ampoules | 10 ampoule £11.50

**Sugammadex**

- **INDICATIONS AND DOSE**
  - **Routine reversal of neuromuscular blockade induced by rocuronium**
    - **BY INTRAVENOUS INJECTION**
    - Child 2-17 years: 2 mg/kg (consult product literature)

**IMPORTANT SAFETY INFORMATION**

Should only be administered by, or under the direct supervision of, personnel experienced in its use.

- **CAUTIONS** Cardiovascular disease (recovery may be delayed) · pre-existing coagulation disorders · recurrence of neuromuscular blockade—monitor respiratory function until fully recovered · use of anticoagulants (unrelated to surgery) · wait 24 hours before re-administering rocuronium

- **INTERACTIONS** → Appendix 1: sugammadex

- **SIDE-EFFECTS**
  - Common or very common Abdominal pain · arrhythmias · cough · dizziness · headache · nausea · procedural complications · skin reactions · taste altered · vomiting
  - Uncommon Hypersensitivity · Frequency not known Bronchospasm

- **PREGNANCY** Use with caution—no information available.

- **RENAL IMPAIRMENT** Avoid if estimated glomerular filtration rate less than 30 mL/minute/1.73 m².

- **DIRECTIONS FOR ADMINISTRATION** For intravenous injection dose may be diluted to a concentration of 10 mg/mL with Sodium Chloride 0.9%.

- **NATIONAL FUNDING/ACCESS DECISIONS**
  - Scottish Medicines Consortium (SMC) decisions
    - The Scottish Medicines Consortium, has advised (February 2013) that sugammadex (Bridion®) is accepted for restricted use within NHS Scotland for the routine reversal of neuromuscular blockade in high-risk patients only, or where prompt reversal of neuromuscular block is required.

- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

- **Solution for injection**
  - **Bridion (Merck Sharp & Dohme Ltd)**
    - Sugammadex (as Sugammadex sodium) 100 mg per 1 ml Bridion 500mg/5ml solution for injection vials | 10 vial £1,491.00 (Hospital only)
    - Bridion 200mg/2ml solution for injection vials | 10 vial £596.40 (Hospital only)

**1.3 Peri-operative analgesia**

**Peri-operative analgesia**

**Non-opioid analgesics**

Since non-steroidal anti-inflammatory drugs (NSAIDs) do not depress respiration, do not impair gastro-intestinal motility, and do not cause dependence, they may be useful alternatives or adjuncts to opioids for the relief of postoperative pain. NSAIDs may be inadequate for the relief of severe pain.

Diclofenac sodium p. 676, diclofenac potassium p. 675, ibuprofen p. 679, paracetamol p. 278, and ketorolac trometamol p. 844 are used to relieve postoperative pain in children; diclofenac sodium and paracetamol can be given parenterally and rectally as well as by mouth. Ketorolac trometamol is given by intravenous injection.
**Opioid analgesics**

Opioid analgesics are now rarely used as premedicants; they are more likely to be administered at induction. Pre-operative use of opioid analgesics is generally limited to children who require control of existing pain. The main side-effects of opioid analgesics are respiratory depression, cardiovascular depression, nausea, and vomiting; see general notes on opioid analgesics and their use in postoperative pain.

See the management of opioid-induced respiratory depression in Pre-medication and peri-operative drugs p. 836.

**Intra-operative analgesia**

Opioid analgesics given in small doses before or with induction reduce the dose requirement of some drugs used during anaesthesia.

Afentanil p. 845, fentanyl p. 286, and remifentanil p. 845 are particularly useful because they act within 1–2 minutes and have short durations of action. The initial doses of afentanil or fentanyl are followed either by successive intravenous injections or by an intravenous infusion; prolonged infusions increase the duration of effect.

In contrast to other opioids which are metabolised in the liver, remifentanil undergoes rapid metabolism by nonspecific blood and tissue esterases; its short duration of action allows prolonged administration at high dosage, without accumulation, and with little risk of residual postoperative respiratory depression. Remifentanil should not be given by intravenous injection intraoperatively, but it is well suited to continuous infusion; a supplementary analgesic is given before stopping the infusion of remifentanil.

**ANALGESICS > NON-Steroidal Anti-INFLAMMATORY DRUGS**

**Ketorolac trometamol**

13-Aug-2018

**INDICATIONS AND DOSE**

**Short-term management of moderate to severe acute postoperative pain only**

- **BY INTRAMUSCULAR INJECTION, OR BY INTRAVENOUS INJECTION**
  - Child 16–17 years (body-weight up to 50 kg): Initially 10 mg, then 10–30 mg every 4–6 hours as required for maximum duration of treatment 2 days, frequency may be increased to up to every 2 hours during initial postoperative period; maximum 60 mg per day
  - Child 16–17 years (body-weight 50 kg and above): Initially 10 mg, then 10–30 mg every 4–6 hours as required for maximum duration of treatment 2 days, frequency may be increased to up to every 2 hours during initial postoperative period; maximum 90 mg per day
  - **BY INTRAVENOUS INJECTION**
    - Child 6 months–15 years: Initially 0.5–1 mg/kg (max. per dose 15 mg), then 500 micrograms/kg every 6 hours (max. per dose 15 mg) as required for maximum duration of treatment 2 days; maximum 60 mg per day

**UNLICENSED USE** Not licensed for use in children under 16 years.

**CONTRA-INDICATIONS** Active or history of gastrointestinal bleeding - active or history of gastrointestinal ulceration - coagulation disorders - complete or partial syndrome of nasal polyposis - confirmed or suspected cerebrovascular bleeding - dehydration - following operations with high risk of haemorrhage or incomplete haemostasis - haemorrhagic diatheses - history of gastrointestinal perforation - hypovolaemia - severe heart failure

**CAUTIONS** Allergic disorders - cardiac impairment (NSAIDs may impair renal function) - cerebrovascular disease -

coagulation defects - connective-tissue disorders - Crohn’s disease (may be exacerbated) - heart failure - ischaemic heart disease - peripheral arterial disease - risk factors for cardiovascular events - ulcerative colitis (may be exacerbated) - uncontrolled hypertension

**INTERACTIONS** → Appendix 1: NSAIDs


**SIDE-EFFECTS, FURTHER INFORMATION** For information about cardiovascular and gastrointestinal side-effects, and a possible exacerbation of symptoms in asthma, see Non-steroidal anti-inflammatory drugs. p. 674

**ALLERGY AND CROSS-SENSITIVITY** Contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID—which includes those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID.

**PREGNANCY** Avoid unless the potential benefit outweighs the risk. Avoid during the third trimester (risk of closure of fetal ductus arteriosus in utero and possibly persistent pulmonary hypertension of the newborn); onset of labour may be delayed and duration may be increased.

**BREAST FEEDING** Amount too small to be harmful.

**HEPATIC IMPAIRMENT** Manufacturer advises caution—may increase risk of renal impairment; avoid in hepatic failure.

**RENAL IMPAIRMENT** Avoid if possible or use with caution. Avoid if serum creatinine greater than 160 micromol/litre.

**Dose adjustments** The lowest effective dose should be used for the shortest possible duration. Max. 60 mg daily by intramuscular injection or intravenous injection.

**Monitoring** In renal impairment monitor renal function; sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure.

**DIRECTIONS FOR ADMINISTRATION**

- With intravenous use. For intravenous injection, give over at least 15 seconds.

**MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- Ketorolac trometamol (Non-proprietary)
  - Ketorolac trometamol 30 mg per 1 ml Ketorolac 30mg/1ml solution for injection ampoules | 5 ampoules (£5.36) £17.60-22.00 DT (£5.36)

(Hospital only)
**Analgesics > Opioids**

### Alfentanil

**INDICATIONS AND DOSE**

**Assisted ventilation: analgesia and enhancement of anaesthesia for short procedures**
- BY INTRAVENOUS INJECTION

- Neonate: Initially 5–20 micrograms/kg, dose to be administered over 30 seconds; supplemental doses up to 10 micrograms/kg.
- Child: Initially 10–20 micrograms/kg, dose to be administered over 30 seconds; supplemental doses up to 10 micrograms/kg.

**Assisted ventilation: analgesia and enhancement of anaesthesia during maintenance of anaesthesia for longer procedures**
- BY INTRAVENOUS INFUSION

- Neonate: Initially 10–50 micrograms/kg, dose to be administered over 10 minutes, followed by 30–60 micrograms/kg/hour.
- Child: Initially 50–100 micrograms/kg, dose to be administered over 10 minutes, followed by 30–120 micrograms/kg/hour, usual dose with intravenous anaesthetic, 60 micrograms/kg/hour.

**DOSES AT EXTREMES OF BODY-WEIGHT**
- To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

**PHARMACOKINETICS**
- Half-life is prolonged in neonates and accumulation is likely with prolonged use. Clearance may be increased in children 1 month–12 years and higher infusion doses might be needed.

**CAUTIONS**
- CAUTIONS, FURTHER INFORMATION
  - Repeated intra-operative doses. Repeated intra-operative doses of alfentanil should be given with care since the resulting respiratory depression can persist postoperatively and occasionally it may become apparent for the first time postoperatively when monitoring of the patient might be less intensive.
- INTERACTIONS: Appendix 1: opioids

**SIDE-EFFECTS**
- Common or very common: Apnoea · Chills · Fatigue · Hypertension · Movement disorders · Muscle rigidity · Procedural complications
- Uncommon: Coma · Hiccups · Hypercapnia · Pain · Post procedural complications · Respiratory disorders
- Rare or very rare: Agitation · Crying · Epistaxis · Vascular pain
- Frequency not known: Cardiac arrest · Cough · Fever · Loss of consciousness · Seizure

**SIDE-EFFECTS, FURTHER INFORMATION**
- Alfentanil can cause muscle rigidity, particularly of the chest wall or jaw; this can be managed by the use of neuromuscular blocking drugs.

**BREAST FEEDING**
- Present in milk—withhold breast-feeding for 24 hours.

**HEPATIC IMPAIRMENT**
- Manufacturer advises caution.
- Dose adjustments: Manufacturer advises dose reduction and cautious titration.

**RENAL IMPAIRMENT**
- Avoid use or reduce dose; opioid effects increased and prolonged and increased cerebral sensitivity occurs.

**DIRECTIONS FOR ADMINISTRATION**
- 5 mg/mL injection to be diluted before use. For continuous or intermittent intravenous infusion dilute in Glucose 5% or Sodium Chloride 0.9%.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection

**Solution for injection**
- Alfentanil (Non-proprietary)
  - Alfentanil (as Alfentanil hydrochloride) 500 microgram per 1 ml
  - Alfentanil 1mg/2ml solution for injection ampoules | 10 ampoule | £5.95 + £6.34 (Hospital only) £14.90 (OD)
  - Alfentanil 25mg/50ml solution for injection vials | 1 vial | £27.80 (OD)
  - Alfentanil 5mg/10ml solution for injection ampoules | 10 ampoule | £21.95 + £6.34 (Hospital only) £23.19 (OD)

- Rapifen (Piramal Critical Care Ltd)
  - Rapifen (as Alfentanil hydrochloride) 500 microgram per 1 ml
  - Rapifen 5mg/10ml solution for injection ampoules | 5 ampoule | £14.50 (OD)
  - Rapifen 1mg/2ml solution for injection ampoules | 10 ampoule | £6.34 + £6.34 (OD)

- Alfentanil (as Alfentanil hydrochloride) 5 mg per 1 ml
  - Alfentanil 5mg/1ml solution for injection ampoules | 10 ampoule | £23.19 (Hospital only) £23.19 (OD)

**Remifentanil**

**INDICATIONS AND DOSE**

**Analgesia and enhancement of anaesthesia at induction (initial bolus injection)**
- BY INTRAVENOUS INJECTION

- Child 12–17 years: Initially 0.25–1 microgram/kg, dose to be administered over at least 30 seconds, if child is to be intubated more than 8 minutes after start of intravenous infusion, initial bolus intravenous injection dose is not necessary

**Analgesia and enhancement of anaesthesia at induction with or without initial bolus dose**
- BY INTRAVENOUS INFUSION

- Child 12–17 years: 30–60 micrograms/kg/hour, if child is to be intubated more than 8 minutes after start of intravenous infusion, initial bolus intravenous injection dose is not necessary

**Assisted ventilation: analgesia and enhancement of anaesthesia during maintenance of anaesthesia (initial bolus injection)**
- BY INTRAVENOUS INJECTION

- Child 1 month–11 years: Initially 0.1–1 microgram/kg, dose to be administered over at least 30 seconds (omitted if not required)
- Child 12–17 years: Initially 0.1–1 microgram/kg, dose to be administered over at least 30 seconds (omitted if not required)

**Assisted ventilation: analgesia and enhancement of anaesthesia during maintenance of anaesthesia with or without initial bolus dose**
- BY INTRAVENOUS INFUSION

- Neonate: 24–60 micrograms/kg/hour, additional doses of 1 microgram/kg can be given by intravenous injection during the intravenous infusion.

- Child 1 month–11 years: 3–78 micrograms/kg/hour, dose to be administered according to anaesthetic technique and adjusted according to response, continued →
additional doses can be given by intravenous injection during the intravenous infusion
- Child 12-17 years: 3–120 micrograms/kg/hour, dose to be administered according to anaesthetic technique and adjusted according to response, additional doses can be given by intravenous injection during the intravenous infusion

**Spontaneous respiration: analgesia and enhancement of anaesthesia during maintenance of anaesthesia**
- **BY INTRAVENOUS INFUSION**
- Child 12-17 years: Initially 2.4 micrograms/kg/hour, adjusted according to response; usual dose 1.5–6 micrograms/kg/hour

**DOSES AT EXTREMES OF BODY-WEIGHT**
- To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

**SIDE-EFFECTS**
- Frequency not known
- Uncommon

**CONTRA-INDICATIONS**
- Anaesthesia in conscious patients

**INTERACTIONS**
- Appendix 1: opioids

**SIDE-EFFECTS**
- Common or very common: Apnoea, muscle rigidity, post-procedural complications
- Uncommon: Hypoxia
- Rare or very rare: Cardiac arrest
- Frequency not known: Agitation, atrioventricular block, hypertension, seizure

**SIDE-EFFECTS, FURTHER INFORMATION**
- In contrast to other opioids which are metabolised in the liver, remifentanil undergoes rapid metabolism by plasma esterases; it has short duration of action which is independent of dose and duration of infusion.
- **Muscle rigidity**
- Remifentanil can cause muscle rigidity that can be managed by the use of neuromuscular blocking drugs.

**PREGNANCY**
- No information available.

**BREAST FEEDING**
- Avoid breast-feeding for 24 hours after administration—present in milk in animal studies.

**HEPATIC IMPAIRMENT**
- Manufacturer advises caution in severe impairment (limited information available).

**RENAL IMPAIRMENT**
- **Dose adjustments** No dose adjustment necessary in renal impairment.

**DIRECTIONS FOR ADMINISTRATION**
- With intravenous use: For intravenous injection, reconstitute to a concentration of 1 mg/mL; for continuous intravenous infusion, dilute further with glucose 5% or sodium chloride 0.9% to a concentration of 20–25 micrograms/mL for child 1–12 years or 20–250 micrograms/mL (usually 50 micrograms/mL) for child 12–18 years.

**PRESCRIBING AND DISPENSING INFORMATION**
- Remifentanil should not be given by intravenous injection intra-operatively, but is well suited to continuous infusion; a supplementary analgesic is given before stopping the infusion of remifentanil.

**M EDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Powder for solution for injection**
- **Remifentanil (as Remifentanyl hydrochloride) 1 mg**
  - Remifentanil 1 mg powder for concentrate for solution for injection vials | 5 vial (Hospital only) £25.60
  - Remifentanil 1 mg powder for concentrate for solution for injection vials | 5 vial (Hospital only) £31.13

- **Remifentanil (as Remifentanyl hydrochloride) 2 mg**
  - Remifentanil 2 mg powder for concentrate for solution for injection vials | 5 vial (Hospital only) £31.13

- **Remifentanil (as Remifentanyl hydrochloride) 5 mg**
  - Remifentanil 5 mg powder for concentrate for solution for injection vials | 5 vial (Hospital only) £127.90

**SIDE-EFFECTS, FURTHER INFORMATION**
- Agitation
- Atrioventricular block
- Hypertension
- Hypoxia
- Apnoea

**ANTAGONISTS**
- Opioid
- Non-opioid analgesia

**ANAESTHETICS, GENERAL**
- NMDA RECEPTOR ANTAGONISTS

**1.4 Peri-operative sedation**

**Conscious sedation for clinical procedures**

**Overview**
- Sedation of children during diagnostic and therapeutic procedures is used to reduce fear and anxiety, to control pain, and to minimise excessive movement. The choice of sedative drug will depend upon the intended procedure and whether the child is cooperative; some procedures are safer and more successful under anaesthesia.
- Midazolam p. 229 and chloral hydrate p. 302 are suitable for sedating children for painless procedures, such as imaging. For painful procedures, alternative choices include nitrous oxide p. 835, local anaesthesia, ketamine below, or concomitant use of sedation with opioid or non-opioid analgesia.

**Ketamine**

**INDICATIONS AND DOSE**

**Induction and maintenance of anaesthesia for short procedures**
- **BY INTRAMUSCULAR INJECTION**
- Neonate: 4 mg/kg, adjusted according to response, a dose of 4 mg/kg usually produces 15 minutes of surgical anaesthesia.

- Child: 4–13 mg/kg, adjusted according to response, a dose of 4 mg/kg sufficient for some diagnostic procedures, a dose of 10 mg/kg usually produces 12–25 minutes of surgical anaesthesia

- **BY INTRAVENOUS INJECTION**
- Neonate: 1–2 mg/kg, adjusted according to response, to be given over at least 60 seconds, a dose of 1–2 mg/kg produces 5–10 minutes of surgical anaesthesia.

- Child 1 month–11 years: 1–2 mg/kg, adjusted according to response, to be given over at least 60 seconds, a dose of 1–2 mg/kg produces 5–10 minutes of surgical anaesthesia.

- Child 12-17 years: 1–4.5 mg/kg, adjusted according to response, to be given over at least 60 seconds, a dose of 2 mg/kg usually produces 5–10 minutes of surgical anaesthesia

**Induction and maintenance of anaesthesia for long procedures**
- **INITIALLY BY INTRAVENOUS INJECTION**
- Neonate: Initially 0.5–2 mg/kg, followed by (by continuous intravenous infusion) 8 micrograms/kg/minute, adjusted according to response, doses up to 30 micrograms/kg/minute may be used to produce deep anaesthesia.
Hypnotics, sedatives and anxiolytics > Benzodiazepines

## Temazepam

### Indications and dose

Premedication before surgery or investigatory procedures

- **By mouth**
  - Child 12-17 years: 10–20 mg, to be taken 1 hour before procedure

### Unlicensed use

Tablets not licensed for use in children.

### Contraindications

- CNS depression.
- Compromised airway.
- Hyperkinesia.
- Obsessional state.
- Phobic states.
- Respiratory depression.

### Caution

- Hypoaalbuminaemia.
- Muscle weakness.
- Organic brain changes.

### Side-effects

- Paradoxical effects: A paradoxical increase in hostility and aggression may be reported by patients taking benzodiazepines. The effects range from talkativeness and excitement to aggressive and antisocial acts. Adjustment of the dose (up or down) sometimes attenuates the impulses. Increased anxiety and perceptual disorders are other paradoxical effects.

### Interactions

- **Appendix 1: temazepam**

### Side-effects

- Drug abuse.
- Dry mouth.
- Hypersalivation.
- Speech slurred.

### Breast feeding

- Benzodiazepines are present in milk, and should be avoided if possible during breast-feeding.

### Renal impairment

- Benzodiazepines are present in milk, and should be avoided if possible during breast-feeding.

### Patient and carer advice

- Driving and skilled tasks: Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risk of driving or undertaking skilled tasks afterwards. For a short general anaesthetic the risk extends to at least 24 hours after administration. Responsible persons should be available to take patients home. The dangers of taking alcohol should also be emphasised.

- For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including ketamine, see Drugs and driving under Guidance on prescribing p. 1.

## Medicinal forms

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection.

### Solution for injection

- **Ketamine (non-proprietary)**
  - Ketamine (as Ketamine hydrochloride) 10 mg per 1 ml
  - Curamed 50mg/5ml solution for injection ampoules | 10 ampoules £9.00 (Hospital only)
  - Ketamine (as Ketamine hydrochloride) 50 mg per 1 ml
  - Ketamine 500mg/10ml solution for injection vials | 10 vial £30.00 (Hospital only)
  - Ketamin 100mg/2ml solution for injection ampoules | 10 ampoules £9.00 (Hospital only)

### HYPNOTICS, SEDATIVES AND ANXIOLYTICS

### BENZODIAZEPINES

- **Benzodiazepines**
  - Temazepam Tablets and Oral Solution may be prescribed.

### Important safety information

Ketamine should only be administered by, or under the direct supervision of, personnel experienced in its use, with adequate training in anaesthesia and airway management, and when resuscitation equipment is available.

### Contraindications

- Acute porphyrias p. 624 - eclampsia - head trauma - hypertension - pre-eclampsia - raised intracranial pressure - severe cardiac disease - stroke

### Caution

- Acute circulatory failure (shock).
- Cardiovascular disease.
- Dehydration.
- Fixed cardiac output.
- Hallucinations.
- Head injury.
- Hypertension.
- Hypovolaemia.
- Increased cerebrospinal fluid pressure.
- Intracranial mass lesions.
- Nightmares.
- Predisposition to seizures.
- Psychotic disorders.
- Increased intraocular pressure.
- Respiratory tract infection.
- Thyroid dysfunction.

### Interactions

- Appendix 1: ketamine

### Side-effects

- Common or very common: Anxiety.
- Behavioural abnormal.
- Confusion.
- Diplopia.
- Hallucination.
- Muscle tone increased.
- Nausea.
- Nystagmus.
- Skin reactions.
- Sleep disorders.
- Tonic clonic movements.
- Vomiting.

### Rare or very rare

- Apnoea.
- Cystitis.
- Cystitis haemorrhagic.
- Delirium.
- Dysphoria.
- Flashback.
- Hypersalivation.

### Frequency not known

- Drug-induced liver injury.

### Side-effects, further information

- Incidence of hallucinations can be reduced by premedicating with a benzodiazepine (such as midazolam).
- May depress neonatal respiration if used during delivery.

### Breastfeeding

- Avoid for at least 12 hours after last dose.

### Hepatic impairment

- Dose adjustments: Manufacturer advises consider dose reduction—increased risk of accumulation.

### Directions for administration

- For intravenous injection, dilute 100 mg/mL strength to a concentration of not more than 50 mg/mL with Glucose 5% or Sodium Chloride 0.9%. For continuous intravenous infusion, dilute to a concentration of 1 mg/mL with Glucose 5% or Sodium Chloride 0.9%; use microdrip infusion for maintenance of anaesthesia.

### Patient and carer advice

- Driving and skilled tasks: Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risk of driving or undertaking skilled tasks afterwards. For a short general anaesthetic the risk extends to at least 24 hours after administration. Responsible persons should be available to take patients home. The dangers of taking alcohol should also be emphasised.

- For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including ketamine, see Drugs and driving under Guidance on prescribing p. 1.

### Medicinal forms

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection.

### Solution for injection

- **Ketamine (non-proprietary)**
  - Ketamine (as Ketamine hydrochloride) 10 mg per 1 ml
  - Curamed 50mg/5ml solution for injection ampoules | 10 ampoules £9.00 (Hospital only)
  - Ketamine (as Ketamine hydrochloride) 50 mg per 1 ml
  - Ketamine 500mg/10ml solution for injection vials | 10 vial £30.00 (Hospital only)
  - Ketamin 100mg/2ml solution for injection ampoules | 10 ampoules £9.00 (Hospital only)

### CAUTIONS

- Hypoaalbuminaemia.
- Muscle weakness.
- Organic brain changes.

### Side-effects, further information

- Paradoxical effects: A paradoxical increase in hostility and aggression may be reported by patients taking benzodiazepines. The effects range from talkativeness and excitement to aggressive and antisocial acts. Adjustment of the dose (up or down) sometimes attenuates the impulses. Increased anxiety and perceptual disorders are other paradoxical effects.

### Interactions

- **Appendix 1: temazepam**

### Side-effects

- Drug abuse.
- Dry mouth.
- Hypersalivation.
- Speech slurred.

### Breast feeding

- Benzodiazepines are present in milk, and should be avoided if possible during breast-feeding.

### Renal impairment

- Benzodiazepines are present in milk, and should be avoided if possible during breast-feeding.

### Patient and carer advice

- Driving and skilled tasks: Patients given sedatives and analgesics during minor outpatient procedures should be very carefully warned about the risks of undertaking skilled tasks (e.g. driving) afterwards. Responsible persons should be available to take patients home afterwards. The dangers of taking alcohol should be emphasised.

### Profession specific information

Dental practitioners’ formulary.

Temazepam Tablets and Oral Solution may be prescribed.
### Local anaesthesia

#### Anaesthesia (local)

**Local anaesthetic drugs**

The use of local anaesthetics by injection or by application to mucous membranes to produce local analgesia is discussed in this section.

Local anaesthetic drugs act by causing a reversible block to conduction along nerve fibres. They vary widely in their potency, toxicity, duration of action, stability, solubility in...
water, and ability to penetrate mucous membranes. These factors determine their application, e.g. topical (surface), infiltration, peripheral nerve block, intravenous regional anaesthesia (Bier’s block), plexus, epidural (extradural), or spinal (intrathecal or subarachnoid) block. Local anaesthetics may also be used for postoperative pain relief, thereby reducing the need for analgesics such as opioids.

Bupivacaine hydrochloride p. 850 has a longer duration of action than other local anaesthetics. It has a slow onset of action, taking up to 30 minutes for full effect. It is often used in lumbar epidural blockade and is particularly suitable for continuous epidural analgesia in labour, or for postoperative pain relief. It is the principal drug used for spinal anaesthesia. Hyperbaric solutions containing glucose may be used for spinal block.

Levobupivacaine p. 852, an isomer of bupivacaine hydrochloride, has anaesthetic and analgesic properties similar to bupivacaine hydrochloride, but is thought to have fewer adverse effects.

Lidocaine hydrochloride p. 852 is effectively absorbed from mucous membranes and is a useful surface anaesthetic in concentrations up to 10%. Except for surface anaesthesia and dental anaesthesia, solutions should not usually exceed 1% in strength. The duration of the block (with adrenaline/epinephrine p. 854) is about 90 minutes.

Application of a mixture of lidocaine and prilocaine (EMLA®) under an occlusive dressing provides surface anaesthesia for 1–2 hours. EMLA® does not appear to be effective in providing local anaesthesia for heel lancing in neonates.

Prilocaine hydrochloride p. 856 is a local anaesthetic of low toxicity which is similar to lidocaine hydrochloride. Ropivacaine hydrochloride p. 857 is an amide-type local anaesthetic agent similar to bupivacaine hydrochloride. It is less cardiotoxic than bupivacaine hydrochloride, but also less potent.

Tetracaine p. 858, a para-aminobenzoic acid ester, is an effective local anaesthetic for topical application; a 4% gel is indicated for anaesthesia before venepuncture or venous cannulation. Tetracaine is effective for 4–6 hours after a single application in most children. It is not recommended prior to neonatal heel lancing.

Tetracaine is rapidly absorbed from mucous membranes and should never be applied to inflamed, traumatised, or highly vascular surfaces. It should never be used to provide anaesthesia for bronchoscopy or cystoscopy because lidocaine hydrochloride is a safer alternative.

Administration by injection

The dose of local anaesthetic depends on the injection site and the procedure used. In determining the safe dosage, it is important to take account of the rate of absorption and excretion, and of the potency. The child’s age, weight, physique, and clinical condition, and the vascularity of the administration site and the duration of administration, must also be considered.

Uptake of local anaesthetics into the systemic circulation determines their duration of action and produces toxicity. NHS Improvement has advised (September 2016) that, prior to administration, all injectable medicines must be drawn directly from their original ampoule or container into a syringe and should never be decanted into gallipots or open containers. This is to avoid the risk of medicines being confused with other substances, e.g. skin disinfectants, and to reduce the risk of contamination.

Great care must be taken to avoid accidental intravascular injection; local anaesthetic injections should be given slowly in order to detect inadvertent intravascular administration. When prolonged analgesia is required, a long-acting local anaesthetic is preferred to minimise the likelihood of cumulative systemic toxicity. Local anaesthesia around the oral cavity may impair swallowing and therefore increases the risk of aspiration.

Epidural anaesthesia is combined with general anaesthesia for certain surgical procedures in children.

Vasoconstrictors in combination with local anaesthetics

Local anaesthetics cause dilatation of blood vessels. The addition of a vasoconstrictor such as adrenaline/epinephrine to the local anaesthetic preparation diminishes local blood flow, slowing the rate of absorption and thereby prolonging the anaesthetic effect. Great care should be taken to avoid inadvertent intravenous administration of a preparation containing adrenaline/epinephrine, and it is not advisable to give adrenaline/epinephrine with a local anaesthetic injection in digits or appendages because of the risk of ischaemic necrosis.

Adrenaline/epinephrine must be used in a low concentration when administered with a local anaesthetic. Care must also be taken to calculate a safe maximum dose of local anaesthetic when using combination products. In children with severe hypertension or unstable cardiac rhythm, the use of adrenaline/epinephrine with a local anaesthetic may be hazardous. For these children an anaesthetic without adrenaline/epinephrine should be used.

Dental anaesthesia

Lidocaine hydrochloride is widely used in dental procedures; it is most often used in combination with adrenaline/epinephrine. Lidocaine hydrochloride 2% combined with adrenaline/epinephrine 1 in 80 000 (12.5 micrograms/mL) is a safe and effective preparation; there is no justification for using higher concentrations of adrenaline/epinephrine. The amide-type local anaesthetics articaine and mepivacaine hydrochloride p. 855 are also used in dentistry; they are available in cartridges suitable for dental use. Mepivacaine hydrochloride is available with or without adrenaline/epinephrine, and articaine is available with adrenaline/epinephrine. In children with severe hypertension or unstable cardiac rhythm, mepivacaine hydrochloride without adrenaline/epinephrine may be used. Alternatively, prilocaine hydrochloride with or without felypressin can be used but there is no evidence that it is any safer. Felypressin can cause coronary vasoconstriction when used at high doses; limit dose in children with coronary artery disease.

Toxicity induced by local anaesthesia

For management of toxicity see Severe local anaesthetic-induced cardiovascular toxicity below.

Severe local anaesthetic-induced cardiovascular toxicity

Overview

After injection of a bolus of local anaesthetic, toxicity may develop at any time in the following hour. In the event of signs of toxicity during injection, the administration of the local anaesthetic must be stopped immediately.

Cardiovascular status must be assessed and cardiopulmonary resuscitation procedures must be followed. In the event of local anaesthetic-induced cardiac arrest, standard cardiopulmonary resuscitation should be initiated immediately. Lidocaine must not be used as anti-arrhythmic therapy.

If the patient does not respond rapidly to standard procedures, 20% lipid emulsion such as Intralipid® [unlicensed indication] should be given intravenously at an initial bolus dose of 1.5 mL/kg over 1 minute, followed by an infusion of 15 mL/kg/hour. After 5 minutes, if cardiovascular stability has not been restored or circulation deteriorates, give a maximum of two further
bolus doses of 1.5 mL/kg over 1 minute, 5 minutes apart, and increase the infusion rate to 30 mL/kg/hour. Continue infusion until cardiovascular stability and adequate circulation are restored or maximum cumulative dose of 12 mL/kg is given.

Standard cardiopulmonary resuscitation must be maintained throughout lipid emulsion treatment. Propofol is not a suitable alternative to lipid emulsion.

Further advice on ongoing treatment should be obtained from the National Poisons Information Service.

Detailed treatment algorithms and accompanying notes are available at www.toxbase.org or can be found in the Association of Anaesthetists of Great Britain and Ireland safety guideline, Management of Severe Local Anaesthetic Toxicity and Management of Severe Local Anaesthetic Toxicity - Accompanying notes.

### Anaesthetics, Local

**Adrenaline with articaine hydrochloride**

(Carticaine hydrochloride with epinephrine)

[28-Mar-2017]

- **INDICATIONS AND DOSE**
  - **Infiltration anaesthesia in dentistry**
    - **BY REGIONAL ADMINISTRATION**
    - **Child 4-17 years:** Consult expert dental sources

- **DOSES AT EXTREMES OF BODY-WEIGHT**
  - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

**IMPORTANT SAFETY INFORMATION**

Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered parenterally unless adequate resuscitation equipment is available.

Adrenaline/epinephrine must be used in a low concentration when administered with a local anaesthetic. The total dose of adrenaline should not exceed 5 micrograms/kg (1 mL/kg of a 1 in 200 000 solution) and it is essential not to exceed a concentration of 1 in 200 000 (5 micrograms/mL) if more than 50 mL of the mixture is to be injected.

- **CONTRA-INDICATIONS**
  - Application to damaged skin
  - Application to the middle ear (may cause ototoxicity)
  - Complete heart block
  - Injection into infected tissues
  - Injection into inflamed tissues
  - Preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier’s block)

**CONTRA-INDICATIONS, FURTHER INFORMATION**

- **Injection site**
  - Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin.
  - Increased absorption into the blood increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

- **CAUTIONS**
  - Arrhythmias
  - Cardiovascular disease
  - Cerebrovascular disease
  - Children (consider dose reduction)
  - Cor pulmonale
  - Debilitated patients (consider dose reduction)
  - Diabetes mellitus
  - Epilepsy
  - Hypercalcaemia
  - Hyperreflexia
  - Hypertension
  - Hyperthyroidism
  - Hypokalaemia
  - Hypovolaemia
  - Impaired cardiac conduction
  - Impaired respiratory function
  - Ischaemic heart disease
  - Myasthenia gravis
  - Obstructive cardiomyopathy
  - Occlusive vascular disease
  - Organic brain damage
  - Phaeochromocytoma
  - Prostate disorders
  - Psychoneurosis
  - Severe angina
  - Shock
  - Susceptibility to angle-closure glaucoma

**CAUTIONS, FURTHER INFORMATION**

- **Use of vasconstrictors**
  - In patients with severe hypertension or unstable cardiac rhythm, the use of adrenaline with a local anaesthetic may be hazardous. For these patients an anaesthetic without adrenaline should be used.

- **INTERACTIONS**
  - **Appendix 1:** articaine
  - Sympathomimetics, vasconstrictor

- **SIDE-EFFECTS**
  - Face oedema
  - Gingivitis
  - Headache
  - Nausea
  - Sensation abnormal

**SIDE-EFFECTS, FURTHER INFORMATION**

Toxic effects after administration of local anaesthetics are a result of excessively high plasma concentrations; severe toxicity usually results from inadvertent intravascular injection.

The toxicity mainly involves the central nervous and cardiovascular systems. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.

- **ALLERGY AND CROSS-SENSITIVITY**
  - Hypersensitivity and cross-sensitivity

  - Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine.

  - Cross-sensitivity reactions may be avoided by using the alternative chemical type.

- **PREGNANCY**
  - Use only if potential benefit outweighs risk—no information available.

- **BREAST FEEDING**
  - Avoid breast-feeding for 48 hours after administration.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution (increased risk of toxicity in severe impairment).

- **RENAI IMPAIRMENT**
  - Manufacturers advise use with caution in severe impairment.

- **MONITORING REQUIREMENTS**
  - Consider monitoring blood pressure and ECG (advised with systemic adrenaline/epinephrine).

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

**EXCIPIENTS:** May contain Sulphites

- Septanest (Septodont Ltd)
  - Adrenaline (as Adrenaline acid tartrate) 10 microgram per 1 ml, Articaine hydrochloride 40 mg per 1 ml
  - Articaine hydrochloride 40 mg per 1 ml
  - Articaine hydrochloride 40 mg per 1 ml
  - Septanest 1 in 100,000 solution for injection cartridges 50 cartridge £24.95

**Bupivacaine hydrochloride**

[13-Jun-2018]

- **INDICATIONS AND DOSE**
  - **Surgical anaesthesia / Acute pain**
    - **BY REGIONAL ADMINISTRATION**
    - **Child:** Doses adjusted according to child’s physical status and nature of procedure, seek expert advice (consult product literature or local protocols)

- **DOSES AT EXTREMES OF BODY-WEIGHT**
  - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

**IMPORTANT SAFETY INFORMATION**

The licensed doses stated may not be appropriate in some settings and expert advice should be sought.

Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered
Bupivacaine hydrochloride 5 mg per 1 ml
Bupivacaine hydrochloride 2.5 mg per 1 ml

<table>
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<th>Concentration</th>
<th>Dose (mg/10 ml)</th>
<th>Duration of Action (minutes)</th>
<th>Volumes Available</th>
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<tr>
<td>Bupivacaine hydrochloride 5 mg per 1 ml</td>
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<td>15</td>
<td>20 ml Sure-Amp ampoules, 10 ml Polyamp Steripack ampoules</td>
</tr>
<tr>
<td>Bupivacaine hydrochloride 2.5 mg per 1 ml</td>
<td>25</td>
<td>12</td>
<td>10 ml Polyamp Steripack ampoules</td>
</tr>
</tbody>
</table>

### Important Safety Information

Adrenaline/epinephrine must be used in a low concentration when administered with a local anaesthetic. The total dose of adrenaline should not exceed 5 micrograms/kg (1 ml/kg of a 1 in 200 000 solution) and it is essential not to exceed a concentration of 1 in 200 000 (5 micrograms/mL) if more than 50 mL of the mixture is to be injected.

### Indications and Dose

**Surgical Anaesthesia**
- By Lumbar Epidural, or by Local Infiltration, or by Caudal Epidural
- Child 12-17 years: (consult product literature)

**Acute Pain Management**
- By Lumbar Epidural, or by Local Infiltration
- Child 1-17 years: (consult product literature)

### Contraindications

- Local anaesthetics should not be injected into inflamed or inflected tissues nor should they be applied to damaged skin. Injection site reaction site increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.
- Cardiovascular disease - cerebral atheroma - children (consider dose reduction) - debilitated patients (consider dose reduction) - epilepsy - hypertension - hypotension - hypovolaemia - impaired cardiac conduction - impaired respiratory function - myasthenia gravis - myocardial depression may be more severe and more resistant to treatment - shock
- Neurotoxicity
- Arachnoiditis - cardiac arrest - diplopia - nerve disorders - paraplegia - paresis - respiratory depression

### Side-Effects

- Toxic effects after administration of local anaesthetics are a result of excessive plasma concentrations; severe toxicity usually results from inadvertent intravascular injection.
- The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.

### Allergy and Cross-Sensitivity

- Hypersensitivity and cross-sensitivity
- Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levo-bupivacaine, lidocaine, meptivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

### Pregnancy

- Large doses during delivery can cause neonatal respiratory depression, hypotonia, and bradycardia after epidural block.
- Dose adjustments
- Use lower doses for intrathecal use during late pregnancy.

### Breast Feeding

- Amount too small to be harmful.

### Hepatic Impairment

- Manufacturer advises use with caution in advanced liver dysfunction.

### Renal Impairment

- Use with caution in severe impairment.

### Medicinal Forms

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, infusion, solution for infusion

### Solution for Injection

- Bupivacaine hydrochloride (Non-proprietary)
  - Bupivacaine hydrochloride 5 mg per 1 ml
  - Bupivacaine hydrochloride 2.5 mg per 1 ml

### Infusion

- **Bupivacaine hydrochloride (Non-proprietary)**
  - Bupivacaine hydrochloride 1 mg per 1 ml
  - Bupivacaine hydrochloride 2.5 mg per 1 ml
  - Bupivacaine hydrochloride 10 mg per 1 ml

### Indications and Dose

**Surgical Anaesthesia**
- By Lumbar Epidural, or by Local Infiltration, or by Caudal Epidural
- Child 12-17 years: (consult product literature)

**Acute Pain Management**
- By Lumbar Epidural, or by Local Infiltration
- Child 1-17 years: (consult product literature)

### Important Safety Information

- In patients with severe hypertension or unstable cardiac rhythm, the use of adrenaline with a local anaesthetic may be hazardous. For these patients an anaesthetic without adrenaline should be used.

### Interactions

- Appendix 1: Anaesthetics, Local - sympathomimetics, vasoconstrictor

### Medicinal Forms

- There can be variation in the licensing of different medicines containing the same drug.

### Solution for Injection

- **Bupivacaine with adrenaline (Non-proprietary)**
  - Adrenaline (as Adrenaline acid tartrate) 5 micrograms per 1 ml
  - Bupivacaine hydrochloride 2.5 mg per 1 ml

### Infusion

- **Bupivacaine hydrochloride (Non-proprietary)**
  - Bupivacaine hydrochloride 10 mg per 1 ml
  - Bupivacaine hydrochloride 20 mg per 1 ml

### Indications and Dose

**Surgical Anaesthesia**
- By Lumbar Epidural, or by Local Infiltration, or by Caudal Epidural
- Child 12-17 years: (consult product literature)

**Acute Pain Management**
- By Lumbar Epidural, or by Local Infiltration
- Child 1-17 years: (consult product literature)

### Important Safety Information

- Adrenaline/epinephrine must be used in a low concentration when administered with a local anaesthetic. The total dose of adrenaline should not exceed 5 micrograms/kg (1 ml/kg of a 1 in 200 000 solution) and it is essential not to exceed a concentration of 1 in 200 000 (5 micrograms/mL) if more than 50 mL of the mixture is to be injected.

### Contraindications

- Local anaesthetics should not be injected into inflamed or inflected tissues nor should they be applied to damaged skin. Injection site reaction site increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.
- Cardiovascular disease - cerebral atheroma - children (consider dose reduction) - debilitated patients (consider dose reduction) - epilepsy - hypertension - hypotension - hypovolaemia - impaired cardiac conduction - impaired respiratory function - myasthenia gravis - myocardial depression may be more severe and more resistant to treatment - shock
- Neurotoxicity
- Arachnoiditis - cardiac arrest - diplopia - nerve disorders - paraplegia - paresis - respiratory depression

### Side-Effects

- Toxic effects after administration of local anaesthetics are a result of excessive plasma concentrations; severe toxicity usually results from inadvertent intravascular injection.
- The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.

### Allergy and Cross-Sensitivity

- Hypersensitivity and cross-sensitivity
- Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levo-bupivacaine, lidocaine, meptivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

### Pregnancy

- Large doses during delivery can cause neonatal respiratory depression, hypotonia, and bradycardia after epidural block.
- Dose adjustments
- Use lower doses for intrathecal use during late pregnancy.

### Breast Feeding

- Amount too small to be harmful.

### Hepatic Impairment

- Manufacturer advises use with caution in advanced liver dysfunction.

### Renal Impairment

- Use with caution in severe impairment.

### Medicinal Forms

- There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, infusion, solution for infusion

### Solution for Injection

- **Bupivacaine hydrochloride (Non-proprietary)**
  - Bupivacaine hydrochloride 5 mg per 1 ml
  - Bupivacaine hydrochloride 2.5 mg per 1 ml

### Infusion

- **Bupivacaine hydrochloride (Non-proprietary)**
  - Bupivacaine hydrochloride 10 mg per 1 ml
  - Bupivacaine hydrochloride 20 mg per 1 ml
**Hypersensitivity** and cross-sensitivity

- **Frequency not known**

**SIDE-EFFECTS**
- Injection site
  - Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin.

**CONTRA-INDICATIONS, FURTHER INFORMATION**
- Application to the middle ear (can cause ototoxicity).
- Avoid injection into infected tissues.
- Avoid injection into inflamed tissues.
- Complete heart block.
- Preparations containing preservatives should not be used for caudal, epidural, or spinal block.

**CAUTIONS**
- Cardiovascular disease.
- Children.
- Decrease dose.
- Debilitated patients.
- Apparent increase in the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

**INTERACTIONS**
- Appendices: anaesthetics, local

**SIDE-EFFECTS**
- Common or very common
  - Anaemia.
  - Back pain.
  - Dizziness.
  - Fever.
  - Headache.
  - Hypotension.
  - Nausea.
  - Procedural pain.
  - Vomiting.

- Frequency not known
  - Angioedema.
  - Aponoea.
  - Arrhythmias.
  - Asthenia.
  - Atiroventricular block.
  - Bladder disorder.
  - Cardiac arrest.
  - Drowsiness.
  - Eye disorders.
  - Faecal incontinence.
  - Flushing.
  - Loss of consciousness.
  - Muscle twitching.
  - Muscle weakness.
  - Nerve disorders.
  - Neurological injury.
  - Oral hypoesthesia.
  - Paralysis.
  - Priapism.
  - Respiratory disorders.
  - Seizure.
  - Sensation abnormal.
  - Skin reactions.
  - Sneezing.
  - Sweaty.
  - Syncope.
  - Vomiting.

**SIDE-EFFECTS, FURTHER INFORMATION**
- The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems. Systemic toxicity can occur due to inadvertent intravascular injection. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.

**ALLERGY AND CROSS-SENSITIVITY**
- Hypersensitivity and cross-sensitivity
  - Reactions occur mainly with the ester-type local anaesthetics, such as tetracaine.
  - Reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine.
  - Cross-sensitivity reactions may be avoided by using the alternative chemical type.

**PREGNANCY**
- Large doses during delivery can cause neonatal respiratory depression, hypotonia, and bradycardia after epidural block.
- Avoid if possible in the first trimester—toxicity in animal studies. May cause fetal distress syndrome.
- Do not use for paracervical block in obstetrics.
- Do not use 7.5 mg/mL strength in obstetrics.

**BREAST FEEDING**
- Amount too small to be harmful.

**HEPATIC IMPAIRMENT**
- Manufacturer advises caution in patients with reduced hepatic blood flow

**DIRECTIONS FOR ADMINISTRATION**
- For 1.25 mg/mL concentration dilute standard solutions with sodium chloride 0.9%.

**PRESCRIBING AND DISPENSING INFORMATION**
- Levobupivacaine is an isomer of bupivacaine.

**INDICATIONS AND DOSE**
- **Surgical anaesthesia | Acute pain**
  - **By Regional Administration**
    - Child: Doses adjusted according to the child’s physical status and nature of procedure, seek expert advice (consult product literature or local protocols). DOSE AT EXTREMES OF BODY-WEIGHT
    - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

**UNLICENSED USE**
- Not licensed for use in children except for analgesia by ilioinguinal or iliohypogastric block.

**IMPORTANT SAFETY INFORMATION**
- The licensed doses stated may not be appropriate in some settings and expert advice should be sought.
- Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management.
- Should not be administered parenterally unless adequate resuscitation equipment is available.

**CONTRA-INDICATIONS**
- Application to the middle ear (can cause ototoxicity).
- Avoid injection into infected tissues.
- Avoid injection into inflamed tissues.
- Complete heart block.
- Preparations containing preservatives should not be used for caudal, epidural, or spinal block.
- For intravenous regional anaesthesia (Bier’s block).
- Should not be applied to damaged skin.

**MEDICINAL FORMS**
- There can be variation in the listing of different medicines containing the same drug.

**Solution for injection**
- Levobupivacaine (Non-proprietary)
  - Levobupivacaine (as Levobupivacaine hydrochloride) 2.5 mg per 1 ml
  - Levobupivacaine (as Levobupivacaine hydrochloride) 5 mg per 1 ml
  - Levobupivacaine (as Levobupivacaine hydrochloride) 7.5 mg per 1 ml
  - Levobupivacaine (as Levobupivacaine hydrochloride) 10 mg per 1 ml
  - Chirocaine (AbbVie Ltd)
  - Chirocaine (as Levobupivacaine hydrochloride) 2.5 mg per 1 ml
  - Chirocaine (as Levobupivacaine hydrochloride) 5 mg per 1 ml
  - Chirocaine (as Levobupivacaine hydrochloride) 7.5 mg per 1 ml

**Infusion**
- Levobupivacaine (Non-proprietary)
  - Levobupivacaine (as Levobupivacaine hydrochloride) 0.25 mg/mL strength in obstetrics.
  - Levobupivacaine (as Levobupivacaine hydrochloride) 0.5 mg/mL strength in obstetrics.
  - Levobupivacaine (as Levobupivacaine hydrochloride) 1 mg/mL strength in obstetrics.
  - Chirocaine (AbbVie Ltd)
  - Chirocaine (as Levobupivacaine hydrochloride) 2.5 mg per 1 ml
  - Chirocaine (as Levobupivacaine hydrochloride) 5 mg per 1 ml

**Lidocaine hydrochloride**

- **Infiltration anaesthesia**
  - **By Local Infiltration**
    - Neonate: Up to 3 mg/kg, dose to be given according to patient’s weight and nature of procedure, dose may be repeated not more often than every 4 hours, 3 mg/kg equivalent to 0.3 mL/kg of 1% solution.
    - Child 1 month–11 years: Up to 3 mg/kg, dose to be given according to patient’s weight and nature of procedure, dose may be repeated not more often than every 4 hours, 3 mg/kg equivalent to 0.3 mL/kg of 1% solution.
    - Child 12–17 years: (max. per dose 200 mg), dose to be given according to child’s weight and nature of procedure, dose may be repeated not more often than every 4 hours.
DOSES AT EXTREMES OF BODY-WEIGHT

- When used by local infiltration To avoid excessive dosage in obese patients, weight-based doses for non-emergency indications may need to be calculated on the basis of ideal body-weight.

Intravenous regional anaesthesia and nerve block

- By Regional Administration
- Child: Seek expert advice

Dental anaesthesia

- By Regional Administration
- Child: Seek expert advice

Pain relief (in anal fissures, haemorrhoids, pruritus ani, pruritus vulvae, herpes zoster, or herpes labialis) | Lubricant in cystoscopy | Lubricant in proctoscopy

- To the skin using ointment
- Child: Apply 1–2 mL as required, avoid long-term use

LMX 4

Anaesthesia before venous cannulation or venepuncture

- TO THE SKIN
- Child 1-2 months: Apply up to 1 g, apply thick layer to small area (2.5 cm × 2.5 cm) of non-irritated skin at least 30 minutes before procedure; may be applied under an occlusive dressing; max. application time 60 minutes, remove cream with gauze and perform procedure after approximately 5 minutes
- Child 3-11 months: Apply up to 1 g, apply thick layer to small area (2.5 cm × 2.5 cm) of non-irritated skin at least 30 minutes before procedure; may be applied under an occlusive dressing; max. application time 4 hours, remove cream with gauze and perform procedure after approximately 5 minutes
- Child 1-17 years: Apply 1–2.5 g, apply thick layer to small area (2.5 cm × 2.5 cm) of non-irritated skin at least 30 minutes before procedure; may be applied under an occlusive dressing; max. application time 5 hours, remove cream with gauze and perform procedure after approximately 5 minutes

IMPORTANT SAFETY INFORMATION

- When used by local infiltration
  The licensed doses stated may not be appropriate in some settings and expert advice should be sought. Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered parenterally unless adequate resuscitation equipment is available.

CONTRA-INDICATIONS

- When used by regional administration
  All grades of atrioventricular block - application to the middle ear (can cause ototoxicity) - avoid injection into infected tissues - avoid injection into inflamed tissues - preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier’s block) - should not be applied to damaged skin - severe myocardial depression - sino-atrial disorders

CONTRA-INDICATIONS, FURTHER INFORMATION

- When used by regional administration
  Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin. Increased absorption into the blood increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

CAUTIONS

- When used by regional administration
  Acute porphyrias p. 624 (consider infusion with glucose for its anti-porphyrinogenic effects) - congestive cardiac failure (consider lower dose) - post cardiac surgery (consider lower dose) - children (consider dose reduction) - debilitated patients (consider dose reduction) - epilepsy - hypovolaemia - impaired cardiac conduction - impaired respiratory function - myasthenia gravis - shock

INTERACTIONS → Appendix 1: antidiarrhoeics

SIDE-EFFECTS Anxiety - arrhythmias - atiroventricular block - cardiac arrest - circulatory collapse - confusion - dizziness - drowsiness - euphoric mood - headache - hypotension (may lead to cardiac arrest) - loss of consciousness - methaemoglobinemia - muscle twitching - myocardial contractility decreased - nausea - neurological effects - nystagmus - pain - psychosis - respiratory disorders - seizure - sensation abnormal - temperature sensation altered - tinnitus - tremor - vision blurred - vomiting

SIDE-EFFECTS, FURTHER INFORMATION

Toxic effects The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems.

Methaemoglobinemia

Methylthioninium chloride can be used for the acute symptomatic treatment of drug-induced methaemoglobinemia.

ALLERGY AND CROSS-SENSITIVITY

- Hypersensitivity and cross-sensitivity
  Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, meptivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

PREGNANCY

Crosses the placenta but not known to be harmful in animal studies—use if benefit outweighs risk. When used as a local anaesthetic, large doses can cause fetal bradycardia; if given during delivery can also cause neonatal respiratory depression, hypotonia, or bradycardia after paracervical or epidural block.

BREAST FEEDING

Present in milk but amount too small to be harmful.

HEPATIC IMPAIRMENT

Caution—increased risk of side-effects.

RENAL IMPAIRMENT

Possible accumulation of lidocaine and active metabolite; caution in severe impairment.

MONITORING REQUIREMENTS

- With systemic use
  Monitor ECG and have resuscitation facilities available.

MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: solution for injection, ointment.

Solution for injection

- Lidocaine hydrochloride (Non-proprietary)
  Lidocaine hydrochloride 5 mg per 1 ml
  Lidocaine 50mg/10ml (0.5%) solution for injection ampoules | 10 ampoule (£0.70)
  Lidocaine hydrochloride 10 mg per 1 ml
  Lidocaine 100mg/10ml (1%) solution for injection ampoules | 10 ampoule (£0.70)
  £1.15–£1.21
  Lidocaine 100mg/10ml (1%) solution for injection ampoules | 10 ampoule (£0.70)
  £4.00–£4.40
  Lidocaine 200mg/20ml (3%) solution for injection vials | 10 vial (£0.70)
  £19.00–£22.00
  Lidocaine 200mg/20ml (3%) solution for injection ampoules | 10 ampoule (£0.70)
  £7.00–£11.00
  Lidocaine 50mg/5ml (1%) solution for injection ampoules | 10 ampoule (£0.70)
  £2.59–£12.00
  Lidocaine 200mg/20ml (3%) solution for injection Mini-Plasco ampoules | 20 ampoule (£0.70)
  £12.00
  Lidocaine 50mg/5ml (1%) solution for injection Mini-Plasco ampoules | 20 ampoule (£0.70)
  £6.50
  Lidocaine 50mg/5ml (1%) solution for injection Sure-Amp ampoules | 20 ampoule (£0.70)
  £8.00
Lidocaine hydrochloride 20 mg per 1 ml
Lidocaine 100mg/5ml (2%) solution for injection ampoules | 10 ampoule £2.70–£12.00 DT | £2.70
Lidocaine 400mg/20ml (2%) solution for injection vials | 10 vial £19.50–£23.00 DT | £23.00
Lidocaine 200mg/10ml (2%) solution for injection Mini-Plasco ampoules | 20 ampoule £14.95
Lidocaine 400mg/20ml (2%) solution for injection Mini-Plasco ampoules | 20 ampoule £12.00 DT | £12.00
Lidocaine 100mg/5ml (2%) solution for injection Mini-Plasco ampoules | 20 ampoule £7.50
Lidocaine 400mg/20ml (2%) solution for injection ampoules | 10 ampoule £8.00–£11.40 DT | £11.40

Cream
EXCIPIENTS: May contain Benzyl alcohol, propylene glycol
- LMX 4 (Ferndale Pharmaceuticals Ltd)
  Lidocaine 40 mg per 1 gram
  LMX 4 cream | 5 gram £2.98 DT | £2.98
- Vagisil medicated (Combe International Ltd)
  Lidocaine 20 mg per 1 gram
  Vagisil 2% medicated cream | 30 gram £2.99 DT | £2.99

Ointment
- Lidocaine hydrochloride (Non-proprietary)
- Lidocaine hydrochloride 50 mg per 1 gram
  Lidocaine 5% ointment | 15 gram £9.00 DT | £6.18

## Lidocaine with adrenaline

The properties listed below are those particular to the combination only. For the properties of the components please consider, lidocaine hydrochloride p. 852, adrenaline/epinephrine p. 138.

### INDICATIONS AND DOSE

**Local anaesthesia**
- BY LOCAL INFILTRATION
- Child 12-17 years: Dosage according to the type of nerve block required (consult product literature)

### IMPORTANT SAFETY INFORMATION

Adrenaline/epinephrine must be used in a low concentration when administered with a local anaesthetic. The total dose of adrenaline should not exceed 5 micrograms/kg (1 mg/L of a 1 in 200 000 solution) and it is essential not to exceed a concentration of 1 in 200 000 (5 micrograms/mL) if more than 50 mL of the mixture is to be injected.

### INTERACTIONS

- Appendix 1: antiarrhythmics, sympathomimetics, vasoconstrictor

### PROFESSION SPECIFIC INFORMATION

**Dental information**

A variety of lidocaine injections with adrenaline is available in dental cartridges.

Consult expert dental sources for specific advice in relation to dose of lidocaine for dental anaesthesia.

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

EXCIPIENTS: May contain Sulphites
- Lignospan Special (Septodont Ltd)
  Adrenaline (as Adrenaline acid tartrate) 12.5 microgram per 1 ml
  Lidocaine hydrochloride 20 mg per 1 ml
  Lignospan Special 2% injection 2.2ml cartridges | 50 cartridge £21.95
  Lignospan Special 2% injection 1.8ml cartridges | 50 cartridge £21.95
- REXOCaine (Henry Schein Ltd)
  Adrenaline (as Adrenaline acid tartrate) 12.5 microgram per 1 ml
  Lidocaine hydrochloride 20 mg per 1 ml
  REXOCaine 2% injection 2.2ml cartridges | 50 cartridge £23.29

### INDICATIONS AND DOSE

**Anaesthesia and disinfection in dental practice**

- TO MUCOUS MEMBRANES USING OROMUCOSAL SPRAY
  - Child 4-17 years: 10–20 mg, no more than 30 mg should be applied to the same quadrant of the buccal cavity—consult product literature, dose expressed as lidocaine

**Anaesthesia in dental practice**

- TO MUCOUS MEMBRANES USING DENTAL GEL
  - Child 4-17 years: Apply 100–500 mg, use cotton pellet for application to dried mucosa, dose expressed as weight of gel

**DOSE EQUIVALENCE AND CONVERSION**

- 1 metered dose of Xylonor® spray is equivalent to 10 mg of lidocaine.
- 2 millimetres of Xylonor® gel is approximately equivalent to 100 mg of gel (approximately equivalent to 5 mg of lidocaine).

### CAUTIONS

Sepsis (risk of rapid systemic absorption) - traumatised mucosa (risk of rapid systemic absorption)

### INTERACTIONS

- Appendix 1: antiarrhythmics

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

**Oromucosal gel**

- Xylonor (Septodont Ltd)
  Cetrimide 1.5 mg per 1 gram
  Lidocaine 50 mg per 1 gram
  Xylonor 5% gel sugar-free | 15 gram £4.00

**Spray**

- Xylonor (Septodont Ltd)
  Cetrimide 100 microgram per 1 gram
  Lidocaine 10 mg per 1 gram
  Xylonor 10% spray sugar-free | 36 gram £20.15

## Lidocaine with phenylephrine

The properties listed below are those particular to the combination only. For the properties of the components please consider, lidocaine hydrochloride p. 852, phenylephrine hydrochloride p. 127.

### INDICATIONS AND DOSE

**Anaesthesia before nasal surgery, endoscopy, laryngoscopy, or removal of foreign bodies from the nose**

- BY INTRANASAL ADMINISTRATION
- Child 12-17 years: Up to 8 sprays

### INTERACTIONS

- Appendix 1: antiarrhythmics - sympathomimetics, vasoconstrictor

### MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug.

**Spray**

- Lidocaine with phenylephrine (Non-proprietary)
  Phenylephrine hydrochloride 5 mg per 1 ml
  Lidocaine hydrochloride 50 mg per 1 ml
  Xylocaine (2%) 50 mg/5 ml | 50 ml £12.90 DT | £12.90

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**854 Local anaesthesia**

**Lidocaine with cetrizine**

The properties listed below are those particular to the combination only. For the properties of the components please consider, lidocaine hydrochloride p. 852.

### INDICATIONS AND DOSE

**Anaesthesia and disinfection in dental practice**

- TO MUCOUS MEMBRANES USING OROMUCOSAL SPRAY
  - Child 4-17 years: 10–20 mg, no more than 30 mg should be applied to the same quadrant of the buccal cavity—consult product literature, dose expressed as lidocaine

**Anaesthesia in dental practice**

- TO MUCOUS MEMBRANES USING DENTAL GEL
  - Child 4-17 years: Apply 100–500 mg, use cotton pellet for application to dried mucosa, dose expressed as weight of gel

**DOSE EQUIVALENCE AND CONVERSION**

- 1 metered dose of Xylonor® spray is equivalent to 10 mg of lidocaine.
- 2 millimetres of Xylonor® gel is approximately equivalent to 100 mg of gel (approximately equivalent to 5 mg of lidocaine).

### CAUTIONS

Sepsis (risk of rapid systemic absorption) - traumatised mucosa (risk of rapid systemic absorption)

### INTERACTIONS

- Appendix 1: antiarrhythmics
Lidocaine with prilocaine

The properties listed below are those particular to the combination only. For the properties of the components please consider, lidocaine hydrochloride p. 852, prilocaine hydrochloride p. 856.

- **INDICATIONS AND DOSE**
  - Anaesthesia before minor skin procedures including venepuncture
  - **TO THE SKIN**
  - Neonate: Apply up to 1 g for maximum 1 hour before procedure, to be applied under occlusive dressing, shorter application time of 15–30 minutes is recommended for children with atopic dermatitis (30 minutes before removal of mollusca); maximum 1 dose per day.
  - Child 1-2 months: Apply up to 1 g for maximum 1 hour before procedure, to be applied under occlusive dressing, shorter application time of 15–30 minutes is recommended for children with atopic dermatitis (30 minutes before removal of mollusca); maximum 1 dose per day.
  - Child 3-11 months: Apply up to 2 g for maximum 1 hour before procedure, to be applied under occlusive dressing, shorter application time of 15–30 minutes is recommended for children with atopic dermatitis (30 minutes before removal of mollusca); maximum 2 doses per day.
  - Child 1-11 years: Apply 1–5 hours before procedure, a thick layer should be applied under occlusive dressing, shorter application time of 15–30 minutes is recommended for children with atopic dermatitis (30 minutes before removal of mollusca); maximum 2 doses per day.
  - Child 12-17 years: Apply 1–5 hours before procedure (2–5 hours before procedures on large areas e.g. split skin grafting), a thick layer should be applied under occlusive dressing, shorter application time of 15–30 minutes is recommended for children with atopic dermatitis (30 minutes before removal of mollusca).
  - **Anaesthesia on genital skin before injection of local anaesthetics**
    - **TO THE SKIN**
    - Child 12-17 years: Apply under occlusive dressing for 15 minutes (males) or 60 minutes (females) before procedure.
  - **Anaesthesia before surgical treatment of lesions on genital mucosa**
    - **TO THE SKIN**
    - Child 12-17 years: Apply up to 10 g, to be applied 5–10 minutes before procedure, maximum dose should be proportionally reduced in adolescents with body-weight less than 20 kg.
  - **Anaesthesia before cervical curettage**
    - **TO THE SKIN**
    - Child 12-17 years: Apply 10 g in lateral vaginal fornices for 10 minutes.

- **CONTRA-INDICATIONS** Use in child less than 37 weeks corrected gestational age.
- **INTERACTIONS** → Appendix 1: anaesthetics, local - antihistamines
- **SIDE-EFFECTS**
  - Rare or very rare Methaemoglobinemia - skin reactions
- **PATIENT AND CARER ADVICE**
  - Medicines for Children leaflet: EMLA cream for local anaesthesia www.medicinesforchildren.org.uk/emla-cream-local-anaesthesia

Mepivacaine hydrochloride

- **INDICATIONS AND DOSE**
  - Infiltration anaesthesia and nerve block in dentistry
  - Child 3-17 years: Consult expert dental sources
  - **DOSES AT EXTREMES OF BODY-WEIGHT**
    - To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.
  - **IMPORTANT SAFETY INFORMATION**
    - Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered parenterally unless adequate resuscitation equipment is available.
  - **CONTRA-INDICATIONS** Application to the middle ear (can cause oto toxicity) - avoid injection into infected tissues - avoid injection into inflamed tissues - complete heart block - preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier’s block) - should not be applied to damaged skin.
  - **CAUTIONS** Cardiovascular disease - children (consider dose reduction) - debilitated patients (consider dose reduction) - epilepsy - hypovolaemia - impaired cardiac conduction - impaired respiratory function - myasthenia gravis - shock
  - **INTERACTIONS** → Appendix 1: anaesthetics, local
  - **SIDE-EFFECTS**
    - Common or very common Arrhythmias - dizziness - hypertension - hypotension - nausea - paraesthesia - vomiting
    - Uncommon Neurotoxicity
    - Rare or very rare Arachnoiditis - cardiac arrest - diplopia - nerve disorders - respiratory depression
  - **SIDE-EFFECTS, FURTHER INFORMATION** Toxic effects after administration of local anaesthetics are a result of excessively high plasma concentrations; severe toxicity usually results from inadvertent intravascular injection or too rapid injection. The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.
ALLERGY AND CROSS-SENSITIVITY

Hypersensitivity and cross-sensitivity. Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

PREGNANCY
Use with caution. Mepivacaine may cause nucleic acid damage in the developing embryo.

CONTRA-INDICATIONS
Acquired methaemoglobinaemia - anaemia - application to the middle ear (can cause ototoxicity); avoid injection into infected tissues - avoid injection into inflamed tissues - complete heart block - congenital methaemoglobinaemia - preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier's block) - should not be applied to damaged skin.

CONTRA-INDICATIONS, FURTHER INFORMATION
Injection site Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin. Increased absorption into the blood increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

CAUTIONS
Cardiovascular disease - children (consider dose reduction) - debilitated patients (consider dose reduction) - epilepsy - hypovolaemia - impaired cardiac conduction - impaired respiratory function - myasthenia gravis - neonates and infants under 6 months are particularly susceptible to methaemoglobinaemia (in neonates) - severe or untreated hypertension - shock.

INTERACTIONS
Appendix 1: anaesthetics, local - sympathomimetics, vasoconstrictor.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Solution for injection
- Scandonest plain (Septodont Ltd)
  Mepivacaine hydrochloride 30 mg per 1 ml Scandonest plain 3% solution for injection 2.2ml cartridges | 50 cartridge £21.95

Mepivacaine with adrenaline

The properties listed below are those particular to the combination only. For the properties of the components please consider, mepivacaine hydrochloride p. 855, adrenaline/epinephrine p. 138.

INDICATIONS AND DOSE

Infiltration anaesthesia and nerve block in dentistry
- By local infiltration
- Child: consult product literature.

IMPORTANT SAFETY INFORMATION
Adrenaline/epinephrine must be used in a low concentration when administered with a local anaesthetic. The total dose of adrenaline should not exceed 5 micrograms/kg (1 mL/kg of a 1 in 200 000 solution) and it is essential not to exceed a concentration of 1 in 200 000 (5 micrograms/mL) if more than 50 mL of the mixture is to be injected.

INTERACTIONS
Appendix 1: anaesthetics, local - sympathomimetics, vasoconstrictor.

MEDICINAL FORMS
There can be variation in the licensing of different medicines containing the same drug.

Solution for injection
EXCIPIENTS: May contain Sulphites
- Scandonest special (Septodont Ltd)
  Adrenaline 10 microgram per 1 ml, Mepivacaine hydrochloride 20 mg per 1 ml Scandonest special 2% solution for injection 2.2ml cartridges | 50 cartridge £21.95

Prilocaine hydrochloride

INDICATIONS AND DOSE

DOSES AT EXTREMES OF BODY-WEIGHT
To avoid excessive dosage in obese patients, dose should be calculated on the basis of ideal body-weight.

CITANEST 1% ®

Infiltration anaesthesia | Nerve block
- By regional administration
  - Child 6 months-11 years: Up to 5 mg/kg, dose adjusted according to site of administration and response; maximum 400 mg per course
  - Child 12-17 years: 100–200 mg/minute, alternatively, may be given in incremental doses; dose adjusted according to site of administration and response; maximum 400 mg per course

IMPORTANT SAFETY INFORMATION
Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered parenterally unless adequate resuscitation equipment is available.

CONTRA-INDICATIONS
Acquired methaemoglobinaemia - anaemia - application to the middle ear (can cause ototoxicity); avoid injection into infected tissues - avoid injection into inflamed tissues - complete heart block - congenital methaemoglobinaemia - preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier's block) - should not be applied to damaged skin.

CONTRA-INDICATIONS, FURTHER INFORMATION
Injection site Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin. Increased absorption into the blood increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

CAUTIONS
Cardiovascular disease - children (consider dose reduction) - debilitated patients (consider dose reduction) - epilepsy - hypovolaemia - impaired cardiac conduction - impaired respiratory function - myasthenia gravis - neonates and infants under 6 months are particularly susceptible to methaemoglobinaemia (in neonates) - severe or untreated hypertension - shock.

INTERACTIONS
Appendix 1: anaesthetics, local.

SIDE-EFFECTS

Common or very common
- Arrhythmias - dizziness - hypertension - hypotension - nausea - paraesthesia - vomiting
- Neurotoxicity
- Rare or very rare
- Cardiac arrest - methaemoglobinaemia - nerve disorders
- Frequency not known
- Diplopia - respiratory depression

SIDE-EFFECTS, FURTHER INFORMATION
Toxic effects. Toxic effects after administration of local anaesthetics are a result of excessively high plasma concentrations; severe toxicity usually results from inadvertent intravascular injection or too rapid injection. The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.

Methaemoglobinaemia
Methaemoglobinaemia can be treated with an intravenous injection of methyleneblue chloride.

ALLERGY AND CROSS-SENSITIVITY

Hypersensitivity and cross-sensitivity. Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

PREGNANCY
Large doses during delivery can cause neonatal respiratory depression, hypotonia, and bradycardia after epidural block. Avoid paracervical or pudendal block in obstetrics (neonatal methaemoglobinaemia reported).

Dose adjustments
Use lower doses for intrathecal use during late pregnancy.
Prilocaine hydrochloride With Felypressin
The properties listed below are those particular to the combination only. For the properties of the components please consider, prilocaine hydrochloride p. 856.

- **INDICATIONS AND DOSE**
  - **Dental anaesthesia**
  - **BY REGIONAL ADMINISTRATION**
  - **Child:** Consult expert dental sources for specific advice

- **INTERACTIONS** ➔ Appendix 1: anaesthetics, local

- **SIDE-EFFECTS**
  - Bradycardia, cardiac arrest, dizziness, drowsiness, hypotension, loss of consciousness, methaemoglobinaemia, myocardial contractility decreased, nervousness, respiratory arrest, seizure, tremor, vision blurred

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  **Solution for injection**
  - **Citasten (Aspen Pharma Trading Ltd)**
  - **Prilocaine hydrochloride 10 mg per 1 ml** Citasten 1% solution for injection 50ml vials | 1 vial (PSt) £5.06

Ropivacaine hydrochloride

- **INDICATIONS AND DOSE**
  - **Acute pain / Surgical anaesthesia**
  - **BY REGIONAL ADMINISTRATION**
  - **Child:** Adjust according to child’s physical status and nature of procedure, seek expert advice

  **DOSES AT EXTREMES OF BODY-WEIGHT**
  - To avoid excessive dosage in obese patients, dose may need to be calculated on the basis of ideal bodyweight.

- **UNLICENSED USE**
  - 2 mg/mL strength not licensed for use in children under 12 years except for acute pain management by caudal epidural block and continuous epidural infusion. 7.5 mg/mL and 10 mg/mL strengths not licensed for use in children under 12 years.

- **IMPORTANT SAFETY INFORMATION**
  - Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered parenterally unless adequate resuscitation equipment is available.

- **CONTRA-INDICATIONS**
  - Application to the middle ear (can cause ototoxicity), avoid injection into infected tissues, avoid injection into inflamed tissues, complete heart block, preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier’s block), should not be applied to damaged skin

- **CONTRA-INDICATIONS, FURTHER INFORMATION**
  - Injection site: Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin. Increased absorption into the blood increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

- **CAUTIONS**
  - Acute porphyrias p. 624, cardiovascular disease - children (consider dose reduction), debilitated patients (consider dose reduction), epilepsy, hypovolaemia, impaired cardiac conduction, impaired respiratory function, myasthenia gravis, shock

- **INTERACTIONS** ➔ Appendix 1: anaesthetics, local

- **SIDE-EFFECTS**
  - Common or very common: Arrhythmias, back pain, chill, cramping, dizziness, headache, hypertension, hypotension, nausea, sensation abnormal, urinary retention, vomiting
  - Uncommon: Anxiety, dyspnoea, hypothermia, neurotoxicity, syncope
  - Rare or very rare: Cardiac arrest
  - Frequency not known: Dyskinesia

SIDE-EFFECTS, FURTHER INFORMATION: Toxic effects after administration of local anaesthetics are a result of excessively high plasma concentrations; severe toxicity usually results from inadvertent intravascular injection. The systemic toxicity of local anaesthetics mainly involves the central nervous and cardiovascular systems. The onset of toxicity can be unpredictable and delayed. Monitor as per local protocol for at least 30 minutes after administration.

- **ALLERGY AND CROSS-SENSITIVITY**
  - Hypersensitivity and cross-sensitivity: Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

- **PREGNANCY**
  - Not known to be harmful. Do not use for paracervical block in obstetrics.

- **BREAST FEEDING**
  - Not known to be harmful.

- **HEPATIC IMPAIRMENT**
  - Manufacturer advises caution in severe impairment.

  **Dose adjustments**
  - Manufacturer advises consider dose reduction for repeat doses in severe impairment.

- **RENAL IMPAIRMENT**
  - Caution in severe impairment. Increased risk of systemic toxicity in chronic renal failure.

- **MEDICINAL FORMS**
  - There can be variation in the licensing of different medicines containing the same drug.

  **Solution for injection**
  - **Ropivacaine hydrochloride 10 mg per 1 ml** Naropin 10mg/1ml solution for injection ampoules | 10 ampoule (PSt) £15.90 (Hospital only)
  - **Ropivacaine hydrochloride 7.5 mg per 1 ml** Naropin 7mg/10ml solution for injection ampoules | 10 ampoule (PSt) £11.79
  - **Ropivacaine hydrochloride 2 mg per 1 ml** Naropin 2mg/10ml solution for injection ampoules | 5 ampoule (PSt) £12.79
  - **Ropivacaine hydrochloride 7.5 mg per 1 ml** Naropin 7mg/10ml solution for injection ampoules | 5 ampoule (PSt) £11.22

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Local anaesthesia 857

**Prilocaine with felypressin**

**Dose:** 10 mg per 1 ml

**Contraindications:**
- Hypersensitivity and cross-sensitivity, use with caution.
- **Children:** Not recommended for children under 8 years.

**Side-effects:**
- Common or very common: Loss of consciousness, cardiac arrest, respiratory arrest, cardiac dysrhythmias, hypotension, hypotension, tremor.
- Uncommon: Neurotoxicity, syncope.
- Rare or very rare: Seizure, respiratory arrest.

**Dosage:**
- **Children:** 1 mg/kg body weight.

**Interactions:**
- **Medicines containing the same drug:** Use with caution.

**Further information:**
- **Injection site:** Local anaesthetics should not be injected into inflamed or infected tissues nor should they be applied to damaged skin. Increased absorption into the blood increases the possibility of systemic side-effects, and the local anaesthetic effect may also be reduced by altered local pH.

**Caution:**
- Acute porphyrias, cardiovascular disease - children (consider dose reduction), debilitated patients (consider dose reduction), epilepsy, hypovolaemia, impaired cardiac conduction, impaired respiratory function, myasthenia gravis, shock.

**Allergy and cross-sensitivity:**
- Hypersensitivity and cross-sensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

**Pregnancy:**
- Not known to be harmful. Do not use for paracervical block in obstetrics.

**Breast feeding:**
- Not known to be harmful.

**Hepatic impairment:**
- Manufacturer advises caution in severe impairment.

**Renal impairment:**
- Caution in severe impairment. Increased risk of systemic toxicity in chronic renal failure.

**Medicinal forms:**
- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection:**
- **Naropin (Aspen Pharma Trading Ltd)**
  - **Prilocaine hydrochloride 2 mg per 1 ml** Naropin 2mg/10ml solution for injection ampoules | 10 ampoule (PSt) £15.00 (Hospital only)
  - **Prilocaine hydrochloride 7.5 mg per 1 ml** Naropin 7mg/10ml solution for injection ampoules | 10 ampoule (PSt) £25.00 (Hospital only)
  - **Prilocaine hydrochloride 10 mg per 1 ml** Naropin 10mg/10ml solution for injection ampoules | 10 ampoule (PSt) £30.00 (Hospital only)
  - **Naropin (Aspen Pharma Trading Ltd)**
    - **Ropivacaine hydrochloride 2 mg per 1 ml** Ropivacaine 20mg/10ml solution for injection ampoules | 10 ampoule (PSt) £16.50 (Hospital only)
    - **Ropivacaine hydrochloride 7.5 mg per 1 ml** Ropivacaine 7.5mg/10ml solution for injection ampoules | 10 ampoule (PSt) £25.00 (Hospital only)
    - **Ropivacaine hydrochloride 10 mg per 1 ml** Ropivacaine 10mg/10ml solution for injection ampoules | 10 ampoule (PSt) £30.00 (Hospital only)
    - **Naropin (Aspen Pharma Trading Ltd)**
      - **Ropivacaine hydrochloride 2 mg per 1 ml** Naropin 2mg/10ml solution for injection ampoules | 10 ampoule (PSt) £12.79
      - **Ropivacaine hydrochloride 7.5 mg per 1 ml** Naropin 7.5mg/10ml solution for injection ampoules | 10 ampoule (PSt) £11.79

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**Ropivacaine hydrochloride**

**Dose:** 2 mg/mL strength not licensed for use in children under 12 years except for acute pain management by caudal epidural block and continuous epidural infusion. 7.5 mg/mL and 10 mg/mL strengths not licensed for use in children under 12 years.

**Unlicensed use:**
- 2 mg/mL strength not licensed for use in children under 12 years except for acute pain management by caudal epidural block and continuous epidural infusion. 7.5 mg/mL and 10 mg/mL strengths not licensed for use in children under 12 years.

**Important safety information:**
- Should only be administered by, or under the direct supervision of, personnel experienced in their use, with adequate training in anaesthesia and airway management, and should not be administered parenterally unless adequate resuscitation equipment is available.

**Contra-indications:**
- Application to the middle ear (can cause ototoxicity), avoid injection into infected tissues, avoid injection into inflamed tissues, complete heart block, preparations containing preservatives should not be used for caudal, epidural, or spinal block, or for intravenous regional anaesthesia (Bier’s block), should not be applied to damaged skin.
Infusion
ELECTROLYTES: May contain Sodium

- **Ropivacaine hydrochloride (Non-proprietary)**
  Ropivacaine hydrochloride 2 mg per 1 ml Ropivacaine
  400mg/200ml infusion bags | 5 bag pack £75.55 (Hospital only) | 10 bag pack £137.00 (Hospital only)
- **Naropin** (Aspen Pharma Trading Ltd)
  Ropivacaine hydrochloride 2 mg per 1 ml Naropin 400mg/200ml infusion Polybags | 5 bag pack £86.70

**Tetracaine**
(Amethocaine)

- **INDICATIONS AND DOSE**
  Anaesthesia before venepuncture or venous cannulation
  → **TO THE SKIN**
  - Neonate: Apply contents of tube (or appropriate proportion) to site of venepuncture or venous cannulation and cover with occlusive dressing; remove gel and dressing after 30 minutes for venepuncture and after 45 minutes for venous cannulation.
  - Child 1 month–4 years: Apply contents of up to 1 tube (applied at separate sites at a single time or appropriate proportion) to site of venepuncture or venous cannulation and cover with occlusive dressing; remove gel and dressing after 30 minutes for venepuncture and after 45 minutes for venous cannulation.
  - Child 5–17 years: Apply contents of up to 5 tubes (applied at separate sites at a single time or appropriate proportion) to site of venepuncture or venous cannulation and cover with occlusive dressing; remove gel and dressing after 30 minutes for venepuncture and after 45 minutes for venous cannulation.

- **UNLICENSED USE**
  Not licensed for use in neonates.

- **CONTRA-INDICATIONS**
  Should not be applied to damaged skin

- **SIDE-EFFECTS**
  Oedema · skin reactions

SIDE-EFFECTS, FURTHER INFORMATION
The systemic toxicity of local anaesthetics mainly involves the central nervous system; systemic side effects unlikely as minimal absorption following topical application.

- **ALLERGY AND CROSS-SENSITIVITY**
  Hypersensitivity and cross-sensitivity
  Hypersensitivity reactions occur mainly with the ester-type local anaesthetics, such as tetracaine; reactions are less frequent with the amide types, such as articaine, bupivacaine, levobupivacaine, lidocaine, mepivacaine, prilocaine, and ropivacaine. Cross-sensitivity reactions may be avoided by using the alternative chemical type.

- **BREAST FEEDING**
  Not known to be harmful.

- **PATIENT AND CARER ADVICE**
  Medicines for Children leaflet: Tetracaine gel for local anaesthesia
  www.medicinesforchildren.org.uk/tetracaine-gel-local-anaesthesia

- **MEDICINAL FORMS**
  There can be variation in the licensing of different medicines containing the same drug.

**Gel**

- **EXCIPIENTS:** May contain Hydroxybenzoates (parabens)
- **Ametop** (Forum Health Products Ltd)
  Tetracaine 40 mg per 1 gram Ametop 4% gel | 1.5 gram pack £1.08
  DT + £1.08
**Chapter 16**

**Emergency treatment of poisoning**

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**Poisoning, emergency treatment**

**Overview**

These notes provide only an overview of the treatment of poisoning, and it is strongly recommended that either TOXBASE or the UK National Poisons Information Service be consulted when there is doubt about the degree of risk or about management.

Most childhood poisoning is accidental. Other causes include intentional overdose, drug abuse, iatrogenic and deliberate poisoning. The drugs most commonly involved in childhood poisoning are paracetamol, ibuprofen and aspirin, orally ingested creams, aspirin, iron preparations, cough medicines, and the contraceptive pill.

**Hospital admission**

Children who have features of poisoning should generally be admitted to hospital. Children who have taken poisons with delayed actions should also be admitted, even if they appear well. Delayed-action poisons include aspirin, iron, paracetamol, tricyclic antidepressants, and co-phenotrope (diphenoxylate with atropine, Lomotil®) p. 50; the effects of modified-release preparations are also delayed. A note of all relevant information, including what treatment has been given, should accompany the patient to hospital.

**Further information**

TOXBASE, the primary clinical toxicology database of the National Poisons Information Service, is available on the internet to registered users at www.toxbase.org (a backup site is available at www.toxbasebackup.org if the main site cannot be accessed). It provides information about routine diagnosis, treatment, and management of patients exposed to drugs, household products, and industrial and agricultural chemicals.

Specialist information and advice on the treatment of poisoning is available day and night from the National Poisons Information Service, is available on the internet to registered users at www.toxbase.org (a backup site is available at www.toxbasebackup.org if the main site cannot be accessed). It provides information about routine diagnosis, treatment, and management of patients exposed to drugs, household products, and industrial and agricultural chemicals.

Advice on laboratory analytical services can be obtained from TOXBASE or from the National Poisons Information Service. Help with identifying capsules or tablets may be available from a regional medicines information centre or from the National Poisons Information Service (out of hours).

**General care**

It is often impossible to establish with certainty the identity of the poison and the size of the dose. This is not usually important because only a few poisons (such as opioids, paracetamol, and iron) have specific antidotes; few patients require active removal of the poison. In most patients, treatment is directed at managing symptoms as they arise. Nevertheless, knowledge of the type and timing of poisoning can help in anticipating the course of events. All relevant information should be sought from the poisoned individual and from carers or parents. However, such information should be interpreted with care because it may not be complete or entirely reliable. Sometimes symptoms arise from other illnesses and patients should be assessed carefully. Accidents may involve domestic and industrial products (the contents of which are not generally known). The National Poisons Information Service should be consulted when there is doubt about any aspect of suspected poisoning.

**Respiration**

Respiration is often impaired in unconscious patients. An obstructed airway requires immediate attention. In the absence of trauma, the airway should be opened with simple measures such as chin lift or jaw thrust. An oropharyngeal or nasopharyngeal airway may be useful in patients with reduced consciousness to prevent obstruction, provided ventilation is adequate. Intubation and ventilation should be considered in patients whose airway cannot be protected or who have respiratory acidosis because of inadequate ventilation; such patients should be monitored in a critical care area.

Most poisons that impair consciousness also depress respiration. Assisted ventilation (either mouth-to-mouth or using a bag-valve-mask device) may be needed. Oxygen is not a substitute for adequate ventilation, although it should be given in the highest concentration possible in poisoning with carbon monoxide and irritant gases.

The potential for pulmonary aspiration of gastric contents should be considered.

**Blood pressure**

Hypotension is common in severe poisoning with central nervous system depressants; if severe, this may lead to irreversible brain damage or renal tubular necrosis. Hypotension should be corrected initially by raising the foot of the bed and administration of an infusion of either sodium chloride p. 610 or a colloid. Vasocostrictor sympathomimetics are rarely required and their use may be discussed with the National Poisons Information Service or a paediatric intensive care unit.

Fluid depletion without hypotension is common after prolonged coma and after aspirin poisoning due to vomiting, sweating, and hyperpnoea.

Hypertension, often transient, occurs less frequently than hypotension in poisoning; it may be associated with
sympathomimetic drugs such as amphetamines, phencyclidine, and cocaine.

**Heart**

Cardiac conduction defects and arrhythmias can occur in acute poisoning, notably with tricyclic antidepressants, some antipsychotics, and some antihistamines. Arrhythmias often respond to correction of underlying hypoxia, acidosis, or other biochemical abnormalities, but ventricular arrhythmias that cause serious hypotension require treatment. If the QT interval is prolonged, specialist advice should be sought because the use of some anti-arrhythmic drugs may be inappropriate. Supraventricular arrhythmias are seldom life-threatening and drug treatment is best withheld until the patient reaches hospital.

**Body temperature**

Hypothermia may develop in patients of any age who have been deeply unconscious for some hours, particularly following overdose with barbiturates or phenothiazines. It may be missed unless core temperature is measured using a low-reading rectal thermometer or by some other means. Hypothermia should be managed by prevention of further heat loss and appropriate rewarming as clinically indicated. Hyperthermia can develop in patients taking CNS stimulants; children and the elderly are also at risk when taking therapeutic doses of drugs with antimuscarinic properties. Hyperthermia is initially managed by removing all unnecessary clothing and using a fan. Sponging with tepid water will promote evaporation. Advice should be sought from the National Poisons Information Service on the management of severe hyperthermia resulting from conditions such as the serotonin syndrome.

Both hypothermia and hyperthermia require urgent hospitalisation for assessment and supportive treatment.

**Convulsions during poisoning**

Single short-lived convulsions (lasting less than 5 minutes) do not require treatment. If convulsions are protracted or recur frequently, lorazepam p. 228 or diazepam p. 226 (preferably as emulsion) should be given by slow intravenous injection into a large vein. Benzodiazepines should not be given by the intramuscular route for convulsions. If the intravenous route is not readily available, midazolam oromucosal solution p. 229 can be given by the buccal route or diazepam can be administered as a rectal solution.

**Methaemoglobinaemia**

Drug- or chemical-induced methaemoglobinaemia should be treated with methylthioninium chloride p. 870 if the methaemoglobin concentration is 30% or higher, or if symptoms of tissue hypoxia are present despite oxygen therapy. Methylthioninium chloride p. 870 reduces the ferric iron of methaemoglobin back to the ferrous iron of haemoglobin; in high doses, methylthioninium chloride can itself cause methaemoglobinaemia.

**Poison removal and elimination**

**Prevention of absorption**

Given by mouth, charcoal, activated p. 866 can adsorb many poisons in the gastro-intestinal system, thereby reducing their absorption. The sooner it is given the more effective it is, but it may still be effective up to 1 hour after ingestion of the poison—longer in the case of modified-release preparations or of drugs with antimuscarinic (anticholinergic) properties. It is particularly useful for the prevention of absorption of poisons that are toxic in small amounts, such as antidepressants.

A second dose may occasionally be required when blood-drug concentration continues to rise suggesting delayed drug release or delayed gastric emptying.

**Active elimination techniques**

Repeated doses of charcoal, activated by mouth may *enhance the elimination* of some drugs after they have been absorbed; repeated doses are given after overdosage with:

- Carbamazepine
- Dapsone
- Phenobarbital
- Quinine
- Theophylline

If vomiting occurs after dosing, it should be treated (e.g. with an antiemetic drug) since it may reduce the efficacy of charcoal treatment. In cases of intolerance, the dose may be reduced and the frequency increased but this may compromise efficacy.

Charcoal, activated should not be used for poisoning with petroleum distillates, corrosive substances, alcohols, malathion, cyanides and metal salts including iron and lithium salts.

Other techniques intended to enhance the elimination of poisons after absorption are only practicable in hospital and are only suitable for a small number of severely poisoned patients. Moreover, they only apply to a limited number of poisons. Examples include:

- haemodialysis for ethylene glycol, lithium, methanol, phenobarbital, salicylates, and sodium valproate;
- alkalisation of the urine for salicylates.

**Removal from the gastro-intestinal tract**

Gastric lavage is rarely required as benefit rarely outweighs risk; advice should be sought from the National Poisons Information Service if a significant quantity of iron or lithium has been ingested within the previous hour.

Whole bowel irrigation (by means of a bowel cleansing preparation) has been used in poisoning with certain modified-release or enteric-coated formulations, in severe poisoning with lithium salts, and if illicit drugs are carried in the gastro-intestinal tract (‘body-packing’). However, it is not clear that the procedure improves outcome and advice should be sought from the National Poisons Information Service.

The administration of laxatives alone has no role in the management of the poisoned child and is not a recommended method of gut decontamination. The routine use of a laxative in combination with charcoal, activated has mostly been abandoned. Laxatives should not be administered to young children because of the likelihood of fluid and electrolyte imbalance.

**Alcohol, acute intoxication**

Acute intoxication with alcohol (ethanol) is common in adults but also occurs in children. The features include ataxia, dysarthria, nystagmus, and drowsiness, which may progress to coma, with hypotension and acidosis. Aspiration of vomit is a special hazard and hypoglycaemia may occur. Patients are managed supportivey, with particular attention to maintaining a clear airway and measures to reduce the risk of aspiration of gastric contents. The blood glucose is measured and glucose given if indicated.

**Aspirin poisoning**

The main features of salicylate poisoning are hyperventilation, tinnitus, deafness, vasodilatation, and sweating. Coma is uncommon but indicates very severe poisoning. The associated acid–base disturbances are complex.

Treatment must be in hospital, where plasma salicylate, pH, and electrolytes can be measured; absorption of aspirin may be slow and the plasma-salicylate concentration may continue to rise for several hours, requiring repeated measurement. Plasma-salicylate concentration may not correlate with clinical severity in the young, and clinical and biochemical assessment is necessary. Generally, the clinical
severity of poisoning is less below a plasma-salicylate concentration of 500 mg/litre (3.6 mmol/litre), unless there is evidence of metabolic acidosis. Activated charcoal can be given within 1 hour of ingesting more than 125 mg/kg of aspirin. Fluid losses should be replaced and intravenous sodium bicarbonate may be given (ensuring plasma-potassium concentration is within the reference range) to enhance urinary salicylate excretion (optimum urinary pH 7.5–8.5).

Plasma-potassium concentration should be corrected before giving sodium bicarbonate as hypokalaemia may complicate alkalinaisation of the urine.

Haemodialysis is the treatment of choice for severe salicylate poisoning and should be considered when the plasma-salicylate concentration exceeds 700 mg/litre (5.1 mmol/litre) or in the presence of severe metabolic acidosis, convulsions, respiratory failure, pulmonary oedema or persistently high plasma-salicylate concentrations unresponsive to urinary alkalinaisation.

**Opioid poisoning**

Opioids (narcotic analgesics) cause varying degrees of coma, respiratory depression, and pinpoint pupils. The specific antidote naloxone hydrochloride p. 865 is indicated if there is coma or bradypnoea. Since naloxone has a shorter duration of action than many opioids, close monitoring and repeated injections are necessary according to the respiratory rate and depth of coma. When repeated administration of naloxone is required, it can be given by continuous intravenous infusion instead of the rate of infusion adjusted according to vital signs. All children should be observed for at least 6 hours after the last dose of naloxone. The effects of some opioids, such as buprenorphine, are only partially reversed by naloxone. Dextropropoxyphene and methadone have very long durations of action; patients may need to be monitored for long periods following large overdoses.

Naloxone reverses the opioid effects of dextropropoxyphene. The long duration of action of dextropropoxyphene calls for prolonged monitoring and further doses of naloxone may be required.

Norgestimate, a metabolite of dextropropoxyphene, also has cardiotoxic effects which may require treatment with sodium bicarbonate p. 607 or magnesium sulfate p. 618, or both. Arrhythmias may occur for up to 12 hours.

**Paracetamol poisoning**

In cases of intravenous paracetamol poisoning contact the National Poisons Information Service for advice on risk assessment and management.

Toxic doses of paracetamol may cause severe hepatocellular necrosis and, much less frequently, renal tubular necrosis. Nausea and vomiting, the only early features of poisoning, usually settle within 24 hours. Persistence beyond this time, often associated with the onset of right subcostal pain and tenderness, usually indicates development of hepatic necrosis. Liver damage is maximal 3–4 days after paracetamol overdose and may lead to encephalopathy, haemorrhage, hypoglycaemia, cerebral oedema, and death. Therefore, despite a lack of significant early symptoms, children who have taken an overdose of paracetamol should be transferred to hospital urgently.

To avoid underestimating the potentially toxic paracetamol dose ingested by obese children who weigh more than 110 kg, use a body-weight of 110 kg (rather than their actual body-weight) when calculating the total dose of paracetamol ingested (in mg/kg).

Acetylcysteine p. 870 protects the liver if infused up to, and possibly beyond, 24 hours of ingesting paracetamol. It is most effective if given within 8 hours of ingestion, after which effectiveness declines. Very rarely, giving acetylcysteine by mouth [unlicensed route] is an alternative if intravenous access is not possible—contact the National Poisons Information Service for advice.

Neonates less than 45 weeks corrected gestational age may be more susceptible to paracetamol-induced liver toxicity, therefore, treatment with acetylcysteine should be considered in all paracetamol overdoses, and advice should be sought from the National Poisons Information Service.

**Acute overdose**

Hepatotoxicity may occur after a single ingestion of more than 150 mg/kg paracetamol taken in less than 1 hour.

Rarely, hepatotoxicity may develop with single ingestions as low as 75 mg/kg of paracetamol taken in less than 1 hour. Children who have ingested 75 mg/kg or more of paracetamol in less than 1 hour should be referred to hospital. Administration of charcoal, activated p. 866 should be considered if paracetamol in excess of 150 mg/kg is thought to have been ingested within the previous hour.

Children at risk of liver damage and, therefore, requiring acetylcysteine, can be identified from a single measurement of the plasma-paracetamol concentration, related to the time from ingestion, provided this time interval is not less than 4 hours; earlier samples may be misleading. The concentration is plotted on a paracetamol treatment graph, with a reference line (‘treatment line’) joining plots of 100 mg/litre (0.66 mmol/litre) at 4 hours and 3.13 mg/litre (0.02 mmol/litre) at 24 hours. Acetylcysteine treatment should commence immediately in children:

- whose plasma-paracetamol concentration falls on or above the treatment line on the paracetamol treatment graph;
- who present 8–24 hours after taking an acute overdose of more than 150 mg/kg of paracetamol, even if the plasma-paracetamol concentration is not yet available; acetylcysteine treatment should commence if the plasma-paracetamol concentration is later reported to be below the treatment line on the paracetamol treatment graph, provided that the child is asymptomatic and liver function tests, serum creatinine and INR are normal.

The prognostic accuracy of a plasma-paracetamol concentration taken after 15 hours is uncertain, but a concentration on or above the treatment line on the paracetamol treatment graph should be regarded as carrying a serious risk of liver damage. If more than 15 hours have elapsed since ingestion, or there is doubt about appropriate management, advice should be sought from the National Poisons Information Service.

'Staggered' overdose, uncertain time of overdose, or therapeutic excess

A ‘staggered’ overdose involves ingestion of a potentially toxic dose of paracetamol over more than one hour, with the possible intention of causing self-harm. Therapeutic excess is the inadvertent ingestion of a potentially toxic dose of paracetamol during its clinical use. The paracetamol treatment graph is unreliable if a ‘staggered’ overdose is taken, if there is uncertainty about the time of the overdose, or if there is therapeutic excess. In these cases, children who have taken more than 150 mg/kg of paracetamol in any 24-hour period are at risk of toxicity and should be commenced on acetylcysteine immediately, unless it is more than 24 hours since the last ingestion, the patient is asymptomatic, the plasma-paracetamol concentration is undetectable, and liver function tests, serum creatinine and INR are normal.

Rarely, toxicity can occur with paracetamol doses between 75–150 mg/kg in any 24-hour period; for some children this may be within the licensed dose, but ingestion of a licensed dose of paracetamol is not considered an overdose. Clinical judgement of the individual case is necessary to determine whether to treat those who have ingested this amount of paracetamol.

Although there is some evidence suggesting that factors such as the use of liver enzyme-inducing drugs (e.g.
carbamazepine p. 200, efavirenz p. 429, nevirapine p. 430, phenobarbital p. 223, phenytoin p. 211, primidone p. 224, rifabutin p. 378, rifampicin p. 379, St John’s wort), chronic alcoholism, and starvation may increase the risk of hepatotoxicity, the CHM has advised that these should no longer be used in the assessment of paracetamol toxicity.

Significant toxicity is unlikely if, 24 hours or longer after the last paracetamol ingestion, the patient is asymptomatic, the plasma-paracetamol concentration is undetectable, and liver function tests, serum creatinine and INR are normal. Children with clinical features of hepatic injury such as jaundice or hepatic tenderness should be treated urgently with acetylcysteine. If there is uncertainty about a patient’s risk of toxicity after paracetamol overdose, treatment with acetylcysteine should be commenced. Advice should be sought from the National Poisons Information Service whenever necessary.

**Antidepressant poisoning**

**Tricyclic and related antidepressants**
Tricyclic and related antidepressants cause dry mouth, coma of varying degree, hypotension, hypothermia, hyperreflexia, extensor plantar responses, convulsions, respiratory failure, cardiac conduction defects, and arrhythmias. Dilated pupils and urinary retention also occur. Metabolic acidosis may complicate severe poisoning; delirium with confusion, agitation, and visual and auditory hallucinations are common during recovery.

Assessment in hospital is strongly advised in case of poisoning by tricyclic and related antidepressants but symptomatic treatment can be given before transfer.

Supportive measures to ensure a clear airway and adequate ventilation during transfer are mandatory. Intravenous lorazepam or intravenous diazepam (preferably in emulsion form) may be required to treat convulsions. Activated charcoal given within 1 hour of the overdose reduces absorption of the drug. Although arrhythmias are worrying, some will respond to correction of hypoxia and acidosis. The use of anti-arrhythmic drugs is best avoided, but intravenous infusion of sodium bicarbonate can arrest arrhythmias or prevent them in those with an extended QRS duration. Diazepam p. 226 given by mouth is usually adequate to sedate delirious patients but large doses may be required.

**Selective serotonin re-uptake inhibitors (SSRIs)**
Symptoms of poisoning by selective serotonin re-uptake inhibitors include nausea, vomiting, agitation, tremor, nystagmus, drowsiness, and sinus tachycardia; convulsions may occur. Rarely, severe poisoning results in the serotonin syndrome, with marked neuropsychiatric effects, neuromuscular hyperactivity, and autonomic instability; hyperthermia, rhabdomyolysis, renal failure, and coagulopathies may develop.

Management of SSRI poisoning is supportive. Activated charcoal given within 1 hour of the overdose reduces absorption of the drug. Convulsions can be treated with lorazepam p. 228, diazepam p. 226, or buccal midazolam p. 229 (see Convulsions). Contact the National Poisons Information Service for the management of hyperthermia or the serotonin syndrome.
Antimalarial poisoning
Overdosage with quinine, chloroquine, or hydroxychloroquine is extremely hazardous and difficult to treat. Urgent advice from the National Poisons Information Service is essential. Life-threatening features include arrhythmias (which can have a very rapid onset) and convulsions (which can be intractable).

Antipsychotic poisoning
Phenothiazines and related drugs
Phenothiazines cause less depression of consciousness and respiration than other sedatives. Hypotension, hypothermia, sinus tachycardia, and arrhythmias may complicate poisoning. Dystonic reactions can occur with therapeutic doses (particularly with prochlorperazine and trifluoperazine), and convulsions may occur in severe cases. Arrhythmias may respond to correction of hypoxia, acidosis, and other biochemical abnormalities, but specialist advice should be sought if arrhythmias result from a prolonged QT interval; the use of some anti-arrhythmic drugs can worsen such arrhythmias. Dystonic reactions are rapidly abolished by injection of drugs such as procyclidine hydrochloride p. 263 or diazepam (emulsion preferred).

Second-generation antipsychotic drugs
Features of poisoning by second-generation antipsychotic drugs include drowsiness, convulsions, extrapyramidal symptoms, hypotension, and ECG abnormalities (including prolongation of the QT interval). Management is supportive. Charcoal, activated p. 866 can be given within 1 hour of ingesting a significant quantity of a second-generation antipsychotic drug.

Benzodiazepine poisoning
Benzodiazepines taken alone cause drowsiness, ataxia, dysarthria, nystagmus, and occasionally respiratory depression, and coma. Charcoal, activated can be given within 1 hour of ingesting a significant quantity of benzodiazepine, provided the patient is awake and the airway is protected. Benzodiazepines potentiate the effects of other central nervous system depressants taken concomitantly. Use of the benzodiazepine antagonist flumazenil p. 867 [unlicensed indication] can be hazardous, particularly in mixed overdoses involving tricyclic antidepressants or in benzodiazepine-dependent patients. Flumazenil may prevent the need for ventilation, particularly in patients with severe respiratory disorders; it should be used on expert advice only and not as a diagnostic test in children with a reduced level of consciousness.

Beta blockers poisoning
Therapeutic overdosages with beta-blockers may cause lightheadedness, dizziness, and possibly syncope as a result of bradycardia and hypotension; heart failure may be precipitated or exacerbated. These complications are most likely in children with conduction system disorders or impaired myocardial function. Bradycardia is the most common arrhythmia caused by beta-blockers, but sotalol may induce ventricular tachyarrhythmias (sometimes of the torsade de pointes type). The effects of massive overdose can vary from one beta-blocker to another; propranolol overdose in particular may cause coma and convulsions. The early clinical features are non-specific and may include apathy and restlessness which could be confused with mental changes arising from the child’s depressive illness. Vomiting, diarrhoea, ataxia, weakness, dysarthria, muscle twitching, and tremor may follow. Severe poisoning is associated with convulsions, coma, renal failure, electrolyte imbalance, dehydration, and hypotension.

Emergency treatment of poisoning
Overdose with quinine, chloroquine, or hydroxychloroquine is extremely hazardous and difficult to treat. Urgent advice from the National Poisons Information Service is essential. Life-threatening features include arrhythmias (which can have a very rapid onset) and convulsions (which can be intractable).

Calcium-channel blockers poisoning
Features of calcium-channel blocker poisoning include nausea, vomiting, dizziness, agitation, confusion, and coma in severe poisoning. Metabolic acidosis and hyperglycaemia may occur. Verapamil and diltiazem have a profound cardiac depressant effect causing hypotension and arrhythmias, including complete heart block and asystole. The dihydropyridine calcium-channel blockers cause severe hypotension secondary to profound peripheral vasodilatation.

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Benzodiazepines taken alone cause drowsiness, ataxia, dysarthria, nystagmus, and occasionally respiratory depression, and coma. Charcoal, activated can be given within 1 hour of ingesting a significant quantity of benzodiazepine, provided the patient is awake and the airway is protected. Benzodiazepines potentiate the effects of other central nervous system depressants taken concomitantly. Use of the benzodiazepine antagonist flumazenil p. 867 [unlicensed indication] can be hazardous, particularly in mixed overdoses involving tricyclic antidepressants or in benzodiazepine-dependent patients. Flumazenil may prevent the need for ventilation, particularly in patients with severe respiratory disorders; it should be used on expert advice only and not as a diagnostic test in children with a reduced level of consciousness.

Benzodiazepine poisoning
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Stimulant-drug poisoning

Amphetamines
Amphetamines cause wakefulness, excessive activity, paranoia, hallucinations, and hypertension followed by exhaustion, convulsions, hyperthermia, and coma. The early stages can be treated with lorazepam p. 228; advice should be sought from the National Poisons Information Service. Later, tepid sponging, anticonvulsants, and artificial respiration may be needed.

Cocaine
Cocaine stimulates the central nervous system, causing agitation, dilated pupils, tachycardia, hypertension, hallucinations, hyperreflexia; cardiac effects include chest pain, myocardial infarction, and arrhythmias.

Initial treatment of cocaine poisoning involves cooling measures for hyperthermia (see Body temperature); agitation, hypertension and cardiac effects require specific treatment and expert advice should be sought.

Ecstasy
Ecstasy (methylenedioxymethamphetamine, MDMA) may cause severe reactions, even at doses that were previously tolerated. The most serious effects are delirium, coma, convulsions, ventricular arrhythmias, hyperthermia, rhabdomyolysis, acute renal failure, acute hepatitis, disseminated intravascular coagulation, adult respiratory distress syndrome, hypotension and intraocular haemorrhage; hyponatraemia has also been associated with ecstasy use and syndrome of inappropriate antidiuretic hormone secretion (SIADH) can occur.

Treatment of methylenedioxymethamphetamine poisoning is supportive, with diazepam to control persistent convulsions and close monitoring including ECG. For the management of agitation, seek specialist advice. Self-induced water intoxication should be considered in patients with ecstasy poisoning.

Liquid ecstasy’ is a term used for sodium oxybate (gamma-hydroxybutyrate, GHB), which is a sedative.

Theophylline poisoning

Theophylline and related drugs are often prescribed as modified-release formulations and toxicity can therefore be delayed. They cause vomiting (which may be severe and intractable), agitation, restlessness, dilated pupils, sinus tachycardia, and hyperglycaemia. More serious effects are haematemesis, convulsions, and supraventricular and ventricular arrhythmias. Severe hypokalaemia may develop rapidly.

Repeated doses of charcoal, activated p. 866 can be used to eliminate theophylline even if more than 1 hour has elapsed after ingestion and especially if a modified-release preparation has been taken (see also under Active Elimination Techniques). Ondansetron p. 271 may be effective for severe vomiting that is resistant to other antiemetics. Hypokalaemia is corrected by intravenous infusion of potassium chloride p. 623 and may be so severe as to require high doses under ECG monitoring. Convulsions should be controlled by intravenous administration of lorazepam or diazepam (see Convulsions). For the management of agitation associated with theophylline overdose, seek specialist advice.

Provided the child does not suffer from asthma, a short-acting beta-blocker can be administered intravenously to reverse severe tachycardia, hypokalaemia, and hyperglycaemia.

Cyanide poisoning

Oxygen should be administered to children with cyanide poisoning. The choice of antidote depends on the severity of poisoning, certainty of diagnosis, and the cause. Dicobalt edetate p. 866 is the antidote of choice when there is a strong clinical suspicion of severe cyanide poisoning, but it should not be used as a precautionary measure. Dicobalt edetate itself is toxic, associated with anaphylactoid reactions, and is potentially fatal if administered in the absence of cyanide poisoning. A regimen of sodium nitrite p. 866 followed by sodium thiosulfate p. 866 is an alternative if dicobalt edetate is not available.

Hydroxocobalamin p. 595 (Cyanokit®—no other preparation of hydroxocobalamin is suitable) can be considered for use in victims of smoke inhalation who show signs of significant cyanide poisoning.

Ethylene glycol and methanol poisoning

Fomepizole (available from “special-order” manufacturers or specialist importing companies) is the treatment of choice for ethylene glycol and methanol (methyl alcohol) poisoning. If necessary, ethanol (by mouth or by intravenous infusion) can be used, but with caution. Advice on the treatment of ethylene glycol and methanol poisoning should be obtained from the National Poisons Information Service. It is important to start antidote treatment promptly in cases of suspected poisoning with these agents.

Heavy metal poisoning

Heavy metal antidotes include succimer (DMSA) [unlicensed], unithiol (DMPS) [unlicensed], sodium calcium edetate [unlicensed], and dimercaprol. Dimercaprol in the management of heavy metal poisoning has been superseded by other chelating agents. In all cases of heavy metal poisoning, the advice of the National Poisons Information Service should be sought.

Noxious gases poisoning

Carbon monoxide
Carbon monoxide poisoning is usually due to inhalation of smoke, car exhaust, or fumes caused by blocked flues or incomplete combustion of fuel gases in confined spaces.

Immediate treatment of carbon monoxide poisoning is essential. The patient should be moved to fresh air, the airway cleared, and high-flow oxygen 100% administered as soon as available. Artificial respiration should be given as necessary and continued until adequate spontaneous breathing starts, or stopped only after persistent and efficient treatment of cardiac arrest has failed. The child should be admitted to hospital because complications may arise after a delay of hours or days. Cerebral oedema may occur in severe poisoning and is treated with an intravenous infusion of mannitol p. 143. Referral for hyperbaric oxygen treatment should be discussed with the National Poisons Information Service if the patient is pregnant or in cases of severe poisoning such as if the patient is or has been unconscious or has psychiatric or neurological features other than a headache or has myocardial ischaemia or an arrhythmia, or has a blood carboxyhaemoglobin concentration of more than 20%.

Sulfur dioxide, chlorine, phosgene, and ammonia

All of these gases can cause upper respiratory tract and conjunctival irritation. Pulmonary oedema, with severe breathlessness and cyanosis may develop suddenly up to 36 hours after exposure. Death may occur. Patients are kept under observation and those who develop pulmonary oedema are given oxygen. Assisted ventilation may be necessary in the most serious cases.
CS spray poisoning
CS spray, which is used for riot control, irritates the eyes (hence 'tear' gas) and the respiratory tract; symptoms normally settle spontaneously within 15 minutes. If symptoms persist, the patient should be removed to a well-ventilated area, and the exposed skin washed with soap and water after removal of contaminated clothing. Contact lenses should be removed and rigid ones washed (soft ones should be discarded). Eye symptoms should be treated by irrigating the eyes with physiological saline (or water if saline is not available) and advice sought from an ophthalmologist. Patients with features of severe poisoning, particularly respiratory complications, should be admitted to hospital for symptomatic treatment.

Nerve agents poisoning
Treatment of nerve agent poisoning is similar to organophosphorus insecticide poisoning, but advice must be sought from the National Poisons Information Service. The risk of cross-contamination is significant; adequate decontamination and protective clothing for healthcare personnel are essential. In emergencies involving the release of nerve agents, kits ('NAAS pods') containing pralidoxime chloride p. 867 can be obtained through the Ambulance Service from the National Blood Service (or the Welsh Blood Service in South Wales or designated hospital pharmacies in Northern Ireland and Scotland—see TOXBASE for list of designated centres).

Pesticide poisoning
Organophosphorus insecticides
Organophosphorus insecticides are usually supplied as powders or dissolved in organic solvents. All are absorbed through the bronchi and intact skin as well as through the gut and inhibit cholinesterase activity, thereby prolonging and intensifying the effects of acetylcholine. Toxicity between different compounds varies considerably, and onset may be delayed after skin exposure.

Anxiety, restlessness, dizziness, headache, miosis, nausea, hypersalivation, vomiting, abdominal colic, diarrhoea, bradycardia, and sweating are common features of organophosphorus poisoning. Muscle weakness and fasciculation may develop and progress to generalised flaccid paralysis, including the ocular and respiratory muscles. Convulsions, coma, pulmonary oedema with copious bronchial secretions, hypoxia, and arrhythmias occur in severe cases. Hyperglycaemia and glycosuria without ketonuria may also be present.

Further absorption of the organophosphorus insecticide should be prevented by moving the child to fresh air, removing soiled clothing, and washing contaminated skin. In severe poisoning it is vital to ensure a clear airway, frequent removal of bronchial secretions, and adequate ventilation and oxygenation; gastric lavage may be considered provided that the airway is protected. Atropine sulfate p. 837 will reverse the muscarinic effects of acetylcholine and is given by intravenous injection until the skin becomes flushed and dry, the pupils dilate, and bradycardia is abolished.

Pralidoxime chloride, a cholinesterase reactivator, is used as an adjunct to atropine sulfate in moderate or severe poisoning. It improves muscle tone within 30 minutes of administration. Pralidoxime chloride is continued until the patient has not required atropine sulfate for 12 hours. Pralidoxime chloride can be obtained from designated centres, the names of which are held by the National Poisons Information Service.

Snake bites and animal stings
Snake bites
Envenoming from snake bite is uncommon in the UK. Many exotic snakes are kept, some illegally, but the only indigenous venomous snake is the adder (Vipera berus). The bite may cause local and systemic effects. Local effects include pain, swelling, bruising, and tender enlargement of regional lymph nodes. Systemic effects include early anaphylactic symptoms (transient hypotension with syncope, angioedema, urticaria, abdominal colic, diarrhoea, and vomiting), with later persistent or recurrent hypotension, ECG abnormalities, spontaneous systemic bleeding, coagulopathy, adult respiratory distress syndrome, and acute renal failure. Fatal envenoming is rare but the potential for severe envenoming must not be underestimated.

Early anaphylactic symptoms should be treated with adrenaline/epinephrine p. 138. Indications for European viper snake venom antiserum treatment p. 871 include systemic envenoming, especially hypotension, ECG abnormalities, vomiting, haemostatic abnormalities, and marked local envenoming such that after bites on the hand or foot, swelling extends beyond the wrist or ankle within 4 hours of the bite. For those children who present with clinical features of severe envenoming (e.g. shock, ECG abnormalities, or local swelling that has advanced from the foot to above the knee or from the hand to above the elbow within 2 hours of the bite), a higher initial dose of the European viper snake venom antiserum is recommended; if symptoms of systemic envenoming persist contact the National Poisons Information Service.

Adrenaline/epinephrine injection must be immediately to hand for treatment of anaphylactic reactions to the European viper snake venom antiserum.

European viper snake venom antiserum is available for bites by certain foreign snakes and spiders, stings by scorpions and fish. For information on identification, management, and for supply in an emergency, telephone the National Poisons Information Service. Whenever possible the TOXBASE entry should be read, and relevant information collected, before telephoning the National Poisons Information Service.

Insect stings
Stings from ants, wasps, hornets, and bees cause local pain and swelling but seldom cause severe direct toxicity unless many stings are inflicted at the same time. If the sting is in the mouth or on the tongue local swelling may threaten the upper airway. The stings from these insects are usually treated by cleaning the area with a topical antiseptic. Bee stings should be removed as quickly as possible.

Anaphylactic reactions require immediate treatment with intramuscular adrenaline/epinephrine: self-administered (or administered by a carer) intramuscular adrenaline/epinephrine (e.g. EpiPen®) is the best first-aid treatment for patients with severe hypersensitivity. An inhaled bronchodilator should be used for asthmatic reactions, see also the management of anaphylaxis. A short course of an oral antihistamine or a topical corticosteroid may help to reduce inflammation and relieve itching. A vaccine containing extracts of bee and wasp venom can be used to reduce the risk of anaphylaxis and systemic reactions in patients with systemic hypersensitivity to bee or wasp stings.

Marine stings
The severe pain of weeverfish (Trachinus virens) and Portuguese man-of-war stings can be relieved by immersing the stung area immediately in uncomfortably hot, but not scalding, water (not more than 45°C). People stung by jellyfish and Portuguese man-of-war around the UK coast should be removed from the sea as soon as possible. Adherent tentacles should be lifted off carefully (wearing gloves or using tweezers) or washed off with seawater. Alcoholic solutions, including suntan lotions, should not be applied because they can cause further discharge of stinging hairs. Ice packs can be used to reduce pain.
Other poisons
Consult either the National Poisons Information Service day and night or TOXBASE. The National Poisons Information Service (Tel: 0344 892 0111) will provide specialist advice on all aspects of poisoning day and night.

1 Active elimination from the gastro-intestinal tract

ANTIDOTES AND CHELATORS

Charcoal, activated

- **INDICATIONS AND DOSE**
  Reduction of absorption of poisons in the gastro-intestinal system
  - BY MOUTH
    - Neonate: 1 g/kg,
    - Child 1-month-11 years: 1 g/kg (max. per dose 50 g)
    - Child 12-17 years: 50 g
  - Active elimination of poisons
    - BY MOUTH
      - Neonate: 1 g/kg every 4 hours, dose may be reduced and the frequency increased if not tolerated, reduced dose may compromise efficacy.
      - Child 1-month-11 years: 1 g/kg every 4 hours (max. per dose 50 g), dose may be reduced and the frequency increased if not tolerated, reduced dose may compromise efficacy.
      - Child 12-17 years: Initially 50 g, then 50 g every 4 hours, reduced if not tolerated to 25 g every 2 hours, alternatively 12.5 g every 1 hour, reduced dose may compromise efficacy.

- **CAUTIONS** Comatose patient (risk of aspiration—ensure airway is protected) or drowsy patient (risk of aspiration—ensure airway protected) or reduced gastrointestinal motility (risk of obstruction).
- **SIDE-EFFECTS** Bezoar · constipation · diarrhoea · gastrointestinal disorders
- **DIRECTIONS FOR ADMINISTRATION** Suspension or reconstituted powder may be mixed with soft drinks (e.g. caffeine-free diet cola) or fruit juices to mask the taste.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.
  - **Oral suspension**
    - **Charcodote** (Teva UK Ltd)
      - Activated charcoal 200 mg per 1 ml Charcodote 200mg/ml oral suspension sugar-free | 250 ml [P] £11.48
    - **Carbonix** (Kent Pharmaceuticals Ltd)
      - Activated charcoal 813 mg per 1 gram Carbonix 81.3% granules sugar-free | 50 gram [P] £11.90

2 Chemical toxicity

2.1 Cyanide toxicity

ANTIDOTES AND CHELATORS

Dicobalt edetate

- **INDICATIONS AND DOSE**
  Severe poisoning with cyanides
  - BY INTRAVENOUS INJECTION
    - Child: Consult the National Poisons Information Service

- **CAUTIONS** Owing to toxicity to be used only for definite cyanide poisoning when patient tending to lose, or has lost, consciousness
- **SIDE-EFFECTS** Reflex tachycardia · vomiting
- **EXCEPTIONS TO LEGAL CATEGORY** Prescription only medicine restriction does not apply where administration is for saving life in emergency.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  - **Solution for injection**
    - **Dicobalt edetate (Non-proprietary)**
      - Dicobalt edetate 15 mg per 1 ml Dicobalt edetate 300mg/20ml solution for injection ampoules | 6 ampoule (£11.72) DT = £11.72

Sodium nitrite

- **INDICATIONS AND DOSE**
  Poisoning with cyanides (used in conjunction with sodium thiosulfate)
  - BY INTRAVENOUS INJECTION
    - Child: Consult the National Poisons Information Service

- **SIDE-EFFECTS** Arrhythmias · dizziness · headache · hypotension · palpitations
- **EXCEPTIONS TO LEGAL CATEGORY** Prescription only medicine restriction does not apply where administration is for saving life in emergency.
- **MEDICINAL FORMS** There can be variation in the licensing of different medicines containing the same drug.

  - **Solution for injection**
    - **Sodium nitrite (Non-proprietary)**
      - Sodium nitrite 30 mg per 1 ml Sodium nitrite 300mg/10ml solution for injection vials | 1 vial (£0.5)

Sodium thiosulfate

- **INDICATIONS AND DOSE**
  Poisoning with cyanides
  - BY INTRAVENOUS INJECTION
    - Child: Consult the National Poisons Information Service

- **DOSE EQUIVALENCE AND CONVERSION**
  - 12.5 g equates to 50 mL of a 25% solution or 25 mL of a 50% solution.
- **EXCEPTIONS TO LEGAL CATEGORY** Prescription only medicine restriction does not apply where administration is for saving life in emergency.
2.2 Organophosphorus toxicity

Other drugs used for Organophosphorus toxicity
Atropine sulfate, p. 837

ANTIDOTES AND CHELATORS

Pralidoxime chloride

- **INDICATIONS AND DOSE**
  Adjunct to atropine in the treatment of poisoning by organophosphorus insecticide or nerve agent
  - **BY INTRAVENOUS INFUSION**
    - **Child:** Initially 30 mg/kg, to be given over 20 minutes, followed by 8 mg/kg/hour; maximum 12 g per day
  - **UNLICENSED USE**
    Pralidoxime chloride doses may differ from those in product literature.
  - **CONTRA-INDICATIONS**
    Poisoning with carbamates - poisoning with organophosphorus compounds without anticholinesterase activity
  - **CAUTIONS**
    Myasthenia gravis
  - **SIDE-EFFECTS**
    Dizziness, drowsiness, headache, hyperventilation, muscle weakness, nausea, tachycardia, visual impairment
  - **RENAL IMPAIRMENT**
    Use with caution.
  - **DIRECTIONS FOR ADMINISTRATION**
    The loading dose may be administered by intravenous injection (diluted to a concentration of 50 mg/mL with water for injections) over at least 5 minutes if pulmonary oedema is present or if it is not practical to administer an intravenous infusion.
    For intravenous infusion, reconstitute each vial with 20 mL water for injections, then dilute to a concentration of 10–20 mg/mL with Sodium Chloride 0.9%.
  - **PRESCRIBING AND DISPENSING INFORMATION**
    Available from designated centres for organophosphorus insecticide poisoning or from the National Blood Service (or Welsh Ambulance Services for Mid West and South East Wales)—see TOXBASE for list of designated centres.
  - **EXCEPTIONS TO LEGAL CATEGORY**
    Prescription only medicine restriction does not apply where administration is for saving life in emergency.
  - **MEDICINAL FORMS**
    There can be variation in the licensing of different medicines containing the same drug.
    - Protosan Chloride (Imported (United States))
    - Pralidoxime chloride 1 gram Protosan Chloride 1g powder for solution for injection vials | 6 vial

Flumazenil

- **INDICATIONS AND DOSE**
  Reversal of sedative effects of benzodiazepines
  - **BY INTRAVENOUS INJECTION**
    - **Neonate:** 10 micrograms/kg every 1 minute if required, dose to be administered over 15 seconds.
    - **Child:** 10 micrograms/kg every 1 minute (max. per dose 200 micrograms) if required, dose to be administered over 15 seconds; maximum 1 mg per course; maximum 50 micrograms/kg per course
  - **UNLICENSED USE**

IMPORTANT SAFETY INFORMATION
Flumazenil should only be administered by, or under the direct supervision of, personnel experienced in its use.

- **CONTRA-INDICATIONS**
  Life-threatening condition (e.g. raised intracranial pressure, status epilepticus) controlled by benzodiazepines
- **CAUTIONS**
  Avoid rapid injection following major surgery - avoid rapid injection in high-risk or anxious patients - benzodiazepine dependence (may precipitate withdrawal symptoms) - children - ensure neuromuscular blockade cleared before giving - head injury (rapid reversal of benzodiazepine sedation may cause convulsions) - history of panic disorders (risk of recurrence) - prolonged benzodiazepine therapy for epilepsy (risk of convulsions) - short-acting (repeat doses may be necessary) - benzodiazepine effects may persist for at least 24 hours
- **SIDE-EFFECTS**
  - **Common or very common**
    Anxiety, diplopia, dry mouth, eye disorders, flushing, headache, hiccups, hyperhidrosis, hyperventilation, hypotension, insomnia, nausea, palpitations, paraesthesia, speech disorder, tremor, vertigo, vomiting
  - **Uncommon**
    Abnormal hearing, arrhythmias, chest pain, chills, cough, dyspnoea, nasal congestion, seizure (more common in patients with epilepsy)
- **Frequency not known**
  Withdrawal syndrome
- **PREGNANCY**
  Not known to be harmful.
- **BREAST FEEDING**
  Avoid breast-feeding for 24 hours.
3.2 Digoxin toxicity

ANTIDOTES AND CHELATORS ➔ ANTIBODIES

Digoxin-specific antibody

- INDICATIONS AND DOSE
  Treatment of known or strongly suspected life-threatening digoxin toxicity associated with ventricular arrhythmias or bradycardia unresponsive to atropine and when measures beyond the withdrawal of digoxin and correction of any electrolyte abnormalities are considered necessary
  - BY INTRAVENOUS INFUSION
  - Child: Serious cases of digoxin toxicity should be discussed with the National Poisons Information Service (consult product literature)

- MEDICINAL FORMS
  - Solution for injection
    - Flumazenil (Non-proprietary)
      - Flumazenil 100 microgram per 1 ml Flumazenil 500 micrograms/5ml solution for injection ampoules
      - 5 ampoule | £7.24 (Hospital only) | 5 ampoule | £65.50–£70.00 | 10 ampoule | £140.00

3.3 Heparin toxicity

ANTIDOTES AND CHELATORS

Protamine sulfate

- INDICATIONS AND DOSE
  Overdosage with intravenous injection or intravenous infusion of unfractionated heparin (less than 30 minutes lapsed since overdose)
    - BY INTRAVENOUS INJECTION
    - Child: 1 mg (max. per dose 50 mg), to be administered at a rate not exceeding 5 mg/minute, to neutralise each 100 units of unfractionated heparin
  Overdosage with intravenous injection or intravenous infusion of unfractionated heparin (if 30–60 minutes lapsed since overdose)
    - BY INTRAVENOUS INJECTION
    - Child: 500–750 micrograms (max. per dose 50 mg), to be administered at a rate not exceeding 5 mg/minute, to neutralise each 100 units of unfractionated heparin

- MEDICINAL FORMS
  - Solution for injection
    - Protamine sulfate (Non-proprietary)
      - Protamine sulfate 10 mg per 1 ml Protamine sulfate 100mg/10ml solution for injection ampoules
      - 5 ampoule | £4.10
      - Protamine sulfate 50mg/5ml solution for injection ampoules
      - 10 ampoule | £49.55
3.4 Opioid toxicity

**OPIOID RECEPTOR ANTAGONISTS**

### Naloxone hydrochloride

#### INDICATIONS AND DOSE

**Overdosage with opioids**
- **BY INTRAVENOUS INJECTION**
  - Neonate: Initially 100 micrograms/kg, if no response, repeat at intervals of 1 minute to a max. of 2 mg, then review diagnosis; further doses may be required if respiratory function deteriorates, doses can be given by subcutaneous or intramuscular routes but only if intravenous route is not feasible; intravenous administration has more rapid onset of action.
  - Child: Using an infusion pump, adjust rate according to response (initially, rate may be set at 60% of the initial resuscitative intravenous injection dose per hour). The initial resuscitative intravenous injection dose is that which maintained satisfactory ventilation for at least 15 minutes.

**Reversal of postoperative respiratory depression**
- **INITIALLY BY INTRAVENOUS INJECTION**
  - Neonate: 1 microgram/kg, repeated every 2–3 minutes if required.
  - Child: Using an infusion pump, adjust rate according to response (initially, rate may be set at 60% of the initial resuscitative intravenous injection dose per hour). The initial resuscitative intravenous injection dose is that which maintained satisfactory ventilation for at least 15 minutes.

**Reversal of postoperative respiratory depression**
- **BY INTRAMUSCULAR INJECTION**
  - Neonate: 200 micrograms, alternatively 60 micrograms/kg, to be given as a single dose at birth.

#### PHARMACOKINETICS
- Naloxone has a short duration of action; repeated doses or infusion may be necessary to reverse effects of opioids with longer duration of action.

#### UNLICENSED USE
- Naloxone doses in BNF may differ from those in product literature.

#### IMPORTANT SAFETY INFORMATION

**SAFE PRACTICE**
- Doses used in acute opioid overdosage may not be appropriate for the management of opioid-induced respiratory depression and sedation in those receiving palliative care and in chronic opioid use.

**CAUTIONS**
- Cardiovascular disease or those receiving cardiotoxic drugs (serious adverse cardiovascular effects reported) • maternal physical dependence on opioids (may precipitate withdrawal in newborn) • pain • physical dependence on opioids (precipitates withdrawal)
- **FURTHER INFORMATION**
  - Titrated dose In postoperative use, the dose should be titrated for each patient in order to obtain sufficient respiratory response; however, naloxone antagonises analgesia.

**SIDE-EFFECTS**
- **Common or very common**
  - Arrhythmias • dizziness • headache • hypertension • hypotension • nausea • vomiting
  - **Uncommon**
    - Diarrhoea • dry mouth • hyperhidrosis • hyperventilation • inflammation localised • pain • tremor • vomiting • respiratory depression
  - **Rare or very rare**
    - Anxiety • cardiac arrest • erythema multiforme • pulmonary oedema • seizure
  - **Frequency not known**
    - Analgesia reversed • asthenia • chills • death • dyspnoea • fever • irritability • nasal complaints • piloerection • yawning

**PREGNANCY**
- Use only if potential benefit outweighs risk.

**BREAST FEEDING**
- Not orally bioavailable.

**DIRECTIONS FOR ADMINISTRATION**
- With intravenous use For continuous intravenous infusion, dilute to a concentration of up to 200 micrograms/mL with Glucose 5% or Sodium Chloride 0.9%.

**MEDICINAL FORMS**
- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**
- **Naloxone hydrochloride (Non-proprietary)**
  - Naloxone hydrochloride 20 microgram per 1 ml
  - Naloxone 40 micrograms/2 ml solution for injection ampoules | 10 ampoule [Price] £55.00
  - Naloxone hydrochloride dihydrate 400 microgram per 1 ml
  - Naloxone 400 micrograms/1 ml solution for injection ampoules | 10 ampoule [Price] £36.05–£53.70 DT + £40.79
  - Naloxone hydrochloride 1 mg per 1 ml
  - Naloxone 2 mg/2 ml solution for injection pre-filled syringes | 1 pre-filled disposable injection [Price] £16.80
3.5 Paracetamol toxicity

**Antidotes and Chelators**

**Acetylcysteine**

- **Indications and Dose**
  - **Paracetamol Overdose**
    - **By Intravenous Infusion**
      - Neonate: Initially 150 mg/kg over 1 hour, dose to be administered in 3 mL/kg glucose 5%, followed by 50 mg/kg over 4 hours, dose to be administered in 7 mL/kg glucose 5%, then 100 mg/kg over 16 hours, dose to be administered in 14 mL/kg glucose 5%.
      - Child (body-weight up to 20 kg): Initially 150 mg/kg over 1 hour, dose to be administered in 3 mL/kg glucose 5%, followed by 50 mg/kg over 4 hours, dose to be administered in 7 mL/kg glucose 5%, then 100 mg/kg over 16 hours, dose to be administered in 14 mL/kg glucose 5%.
      - Child (body-weight 20 kg up to 100 kg): Initially 150 mg/kg over 1 hour, dose to be administered in 100 mL glucose 5%, followed by 50 mg/kg over 4 hours, dose to be administered in 250 mL glucose 5%, then 100 mg/kg over 16 hours, dose to be administered in 500 mL glucose 5%.
      - Child (body-weight 40 kg and above): 150 mg/kg over 1 hour, dose to be administered in 200 mL Glucose Intravenous Infusion 5%, then 50 mg/kg over 4 hours, to be started immediately after completion of first infusion, dose to be administered in 500 mL Glucose Intravenous Infusion 5%, then 100 mg/kg over 16 hours, to be started immediately after completion of second infusion, dose to be administered in 1 litre Glucose Intravenous Infusion 5%.

**Meconium Ileus**

- **By Mouth**
  - Neonate: 200–400 mg up to 3 times a day if required.

**Treatment of distal intestinal obstructive syndrome**

- **By mouth**
  - Child 1 month–1 year: 0.4–3 g as a single dose
  - Child 2–6 years: 2–3 g as a single dose
  - Child 7-17 years: 4–6 g as a single dose

**Prevention of distal intestinal obstruction syndrome**

- **By mouth**
  - Child 1 month–1 year: 100–200 mg 3 times a day
  - Child 2-11 years: 200 mg 3 times a day
  - Child 12-17 years: 200–400 mg 3 times a day

**Doses at Extremes of Body-weight**

- To avoid excessive dosage in obese patients, a ceiling weight of 110 kg should be used when calculating the dose for paracetamol overdose.

- **Unlicensed Use**
  - With oral use Not licensed for use in meconium ileus or for distal intestinal obstructive syndrome in children with cystic fibrosis.

**Important Safety Information**

MHRA/CHM Advice: Intravenous Acetylcysteine for Paracetamol Overdose: Reminder of Authorised Dose Regimen; Possible Need for Continued Treatment (January 2017)

The authorised dose regimen for acetylcysteine in paracetamol overdose is 3 consecutive intravenous infusions given over a total of 21 hours.

**Continued Treatment**

The authorised dose regimen for acetylcysteine in paracetamol overdose is 3 consecutive intravenous infusions given over a total of 21 hours.

- **CAUTIONS**
  - With intravenous use asthma (see Side-effects for management of asthma but do not delay acetylcysteine treatment). Atopy may slightly increase INR - may slightly increase prothrombin time.
  - With oral use Asthma - history of peptic ulceration.

- **Side-effects**

- **Side-effects, Further Information**
  - Anaphylactoid reactions (with intravenous use) can be managed by suspending treatment and initiating appropriate management. Treatment may then be restarted at lower rate.

- **Directions for Administration**
  - With oral use For oral administration, use oral granules or dilute injection solution (200 mg/mL) to a concentration of 50 mg/mL; orange or blackcurrant juice or cola drink may be used as a diluent to mask the bitter taste.
  - With intravenous use Glucose 5% is preferred fluid; Sodium Chloride 0.9% is an alternative if glucose 5% unsuitable.

- **Medicinal Forms**
  - There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: effervescent tablet, granules.

**Granules**

CAUTIONARY AND ADVISORY LABELS: 13

- **A-CYS** (Ennogen Healthcare Ltd)
  - Acetylcysteine 200 mg A-CYS 200mg granules sachets | 20 sachets
  - £75.00

**Solution for infusion**

**Electrolytes**

- May contain Sodium

- **Acetylcysteine (Non-proprietary)**
  - Acetylcysteine 200 mg per 1 mL
  - Acetylcysteine 2g/10ml solution for infusion ampoules | 10 ampoule £21.26–£24.99 DT = £21.26
  - **Parvolex** (Phoenix Labs Ltd)
  - Acetylcysteine 200 mg per 1 mL
  - Parvolex 2g/10ml concentrate for solution for infusion ampoules | 10 ampoule £22.50 DT = £21.26

4. Methaemoglobinemia

**Antidotes and Chelators**

**Methylthioninium chloride**

(Methylene blue)

- **Indications and Dose**
  - Drug- or chemical-induced methaemoglobinemia
    - **By Slow Intravenous Injection**
      - Neonate: Seek advice from National Poisons Information Service.
      - Child 1–2 months: Seek advice from National Poisons Information Service.
      - Child 3 months–17 years: Initially 1–2 mg/kg, then 1–2 mg/kg after 30–60 minutes if required, to be given over 5 minutes, seek advice from National Poisons Information Service if further repeat doses are required; maximum 7 mg/kg per course.
**ANITOXINS > IMMUNE SERA AND IMMUNOGLOBULINS > ANTITOXINS**

### European viper snake venom antiserum

**INDICATIONS AND DOSE**

*Systemic envenomming from snake bites > Marked local envenomming*

- **BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION**
- **Child:** Initially 10 mL for 1 dose, then 10 mL after 1–2 hours if required, the second dose should only be given if symptoms of systemic envenomming persist after the first dose, if symptoms of systemic

---

**5 Snake bites**

**IMMUNE SERA AND IMMUNOGLOBULINS > ANTITOXINS**

**European viper snake venom antiserum**

- **CAUTIONS**
  - Children under 3 months (more susceptible to methaemoglobinemia from high doses of methylthioninium) - chlorate poisoning (reduces efficacy of methylthioninium) - G6PD deficiency (seek advice from National Poisons Information Service) - methaemoglobinemia due to treatment of cyanide poisoning with sodium nitrite (seek advice from National Poisons Information Service) - pulse oximetry may give false estimation of oxygen saturation
- **INTERACTIONS**
  - Appendix 1: methylthioninium chloride
- **SIDE-EFFECTS**
  - Common or very common: Abdominal pain, anxiety, chest pain, dizziness, headache, hyperhidrosis, nausea, pain in extremity, paraesthesia, skin reactions, taste altered, urinary discoulouration, vomiting
  - Frequency not known: Aphasia, arrhythmias, confusion, faeces discoloured, fever, haemolytic anaemia, hyperbilirubinaemia (in infants), hypertension, injection site necrosis, mydriasis, tremor
- **PREGNANCY**
  - No information available, but risk to fetus of untreated methaemoglobinemia likely to be significantly higher than risk of treatment.
- **BREAST FEEDING**
  - Manufacturer advises avoid breastfeeding for up to 6 days after administration—no information available.
- **RENAL IMPAIRMENT**
  - Dose adjustments: Use with caution in severe impairment; dose reduction may be required.
- **DIRECTIONS FOR ADMINISTRATION**
  - For intravenous injection, may be diluted with Glucose 5% to minimise injection-site pain; not compatible with Sodium Chloride 0.9%.

**MEDICINAL FORMS**

- There can be variation in the licensing of different medicines containing the same drug.

**Solution for injection**

- **European viper snake venom antiserum (Non-proprietary)**
  - European viper snake venom antiserum 100 mg per 1 ml Viper venom antiserum, European (equine) 1g/10ml solution for injection vials | 1 vial (BNF)
Appendix 1

Interactions

Changes have been made to the interactions content in BNF publications. For more information, see www.bnf.org/new-bnf-interactions/.

Two or more drugs given at the same time can exert their effects independently or they can interact. Interactions may be beneficial and exploited therapeutically; this type of interaction is not within the scope of this appendix. Many interactions are harmless, and even those that are potentially harmful can often be managed, allowing the drugs to be used safely together. Nevertheless, adverse drug interactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA), through the Yellow Card Scheme (see Adverse reactions to drugs p. 14), as for other adverse drug reactions.

Potentially harmful drug interactions may occur in only a small number of patients, but the true incidence is often hard to establish. Furthermore the severity of a harmful interaction is likely to vary from one patient to another.

Patients at increased risk from drug interactions include the elderly and those with impaired renal or hepatic function.

Interactions can result in the potentiation or antagonism of one drug by another, or result in another effect, such as renal impairment. Drug interactions may develop either through pharmacokinetic or pharmacodynamic mechanisms.

Pharmacodynamic interactions
These are interactions between drugs which have similar or antagonistic pharmacological effects or side-effects. They might be due to competition at receptor sites, or occur between drugs acting on the same physiological system. They are usually predictable from a knowledge of the pharmacology of the interacting drugs; in general, those demonstrated with one drug are likely to occur with related drugs.

Pharmacokinetic interactions
These occur when one drug alters the absorption, distribution, metabolism, or excretion of another, thus increasing or decreasing the amount of drug available to produce its pharmacological effects. Pharmacokinetic interactions occurring with one drug do not necessarily occur uniformly across a group of related drugs.

Affecting absorption
The rate of absorption and the total amount absorbed can both be altered by drug interactions. Delayed absorption is rarely of clinical importance unless a rapid effect is required (e.g. when giving an analgesic). Reduction in the total amount absorbed, however, can result in ineffective therapy.

Affecting distribution
Due to changes in protein binding: To a variable extent most drugs are loosely bound to plasma proteins. Protein-binding sites are non-specific and one drug can displace another thereby increasing the proportion free to diffuse from plasma to its site of action. This only produces a detectable increase in effect if it is an extensively bound drug (more than 90%) that is not widely distributed throughout the body. Even so displacement rarely produces more than transient potentiation because this increased concentration of free drug will usually be eliminated.

Displacement from protein binding plays a part in the potentiating of warfarin by sulfonamides but these interactions become clinically relevant mainly because warfarin metabolism is also inhibited.

Induction or inhibition of drug transporter proteins: Drug transporter proteins, such as P-glycoprotein, actively transport drugs across biological membranes. Transporters can be induced or inhibited, resulting in changes in the concentrations of drugs that are substrates for the transporter. For example, rifampicin induces P-glycoprotein, particularly in the gut wall, resulting in decreased plasma concentrations of digoxin, a P-glycoprotein substrate.

Affecting metabolism
Many drugs are metabolised in the liver. Drugs are either metabolised by phase I reactions (oxidation, reduction, or hydrolysis) or by phase II reactions (e.g. glucuronidation).

Phase I reactions are mainly carried out by the cytochrome P450 family of isoenzymes, of which CYP3A4 is the most important isoenzyme involved in the metabolism of drugs. Induction of cytochrome P450 isoenzymes by one drug can increase the rate of metabolism of another, resulting in lower plasma concentrations and a reduced effect. On withdrawal of the inducing drug, plasma concentrations increase and toxicity can occur.

Conversely when one drug inhibits cytochrome P450 isoenzymes, it can decrease the metabolism of another, leading to higher plasma concentrations, resulting in an increased effect with a risk of toxicity.

Isoenzymes of the hepatic cytochrome P450 system interact with a wide range of drugs. With knowledge of which isoenzymes are involved in a drug’s metabolism, it is possible to predict whether certain pharmacokinetic interactions will occur. For example, carbamazepine is a potent inducer of CYP3A4, ketoconazole is potent inhibitor of CYP3A4, and midazolam is a substrate of CYP3A4. Carbamazepine reduces midazolam concentrations, and it is therefore likely that other drugs that are potent inducers of CYP3A4 will interact similarly with midazolam. Ketoconazole, however, increases midazolam concentrations, and it can be predicted that other drugs that are potent inhibitors of CYP3A4 will interact similarly.

Less is known about the enzymes involved in phase II reactions. These include UDP-glucurononyltransferases which, for example, might be induced by rifampicin, resulting in decreased metabolism of mycophenolate (a substrate for this enzyme) to its active form, mycophenolic acid.

Affecting renal excretion
Drugs are eliminated through the kidney both by glomerular filtration and by active tubular secretion. Competition occurs between those which share active transport mechanisms in the proximal tubule. For example, salicylates and some other NSAIDs delay the excretion of methotrexate; serious methotrexate toxicity is possible. Changes in urinary pH can also affect the reabsorption of a small number of drugs, including methenamine.
Relative importance of interactions

Levels of severity: Most interactions have been assigned a severity; this describes the likely effect of an unmanaged interaction on the patient.

Severe—the result may be a life-threatening event or have a permanent detrimental effect.

Moderate—the result could cause considerable distress or partially incapacitate a patient; they are unlikely to be life-threatening or result in long-term effects.

Mild—the result is unlikely to cause concern or incapacitate the majority of patients.

Unknown—used for those interactions that are predicted, but there is insufficient evidence to hazard a guess at the outcome.

Levels of evidence: Most interactions have been assigned a rating to indicate the weight of evidence behind the interaction.

Study—for interactions where the information is based on formal study including those for other drugs with same mechanism (e.g. known inducers, inhibitors, or substrates of cytochrome P450 isoenzymes or P-glycoprotein).

Anecdotal—interactions based on either a single case report or a limited number of case reports.

Theoretical—interactions that are predicted based on sound theoretical considerations. The information may have been derived from in vitro studies or based on the way other members in the same class act.

Action messages: Each interaction describes the effect that occurs, and the action to be taken, either based on manufacturer’s advice from the relevant Summary of Product Characteristics or advice from a relevant authority (e.g. MHRA). An action message is only included where the combination is to be avoided, where a dose adjustment is required, or where specific administration requirements (e.g. timing of doses) are recommended. Pharmacodynamic interactions, with the exception of interactions with drugs that may prolong the QT interval, do not have an action message included as these will depend on individual patient circumstances.

Appendix 1 structure

1. **Drugs**
   - Drugs are listed alphabetically. If a drug is a member of a drug class, all interactions for that drug will be listed under the drug class entry; in this case the drug entry provides direction to the relevant drug class where its interactions can be found.
   - Within a drug or drug class entry, interactions are listed alphabetically by the interacting drug or drug class. The interactions describe the effect that occurs, and the action to be taken, either based on manufacturer’s advice from the relevant Summary of Product Characteristics or advice from a relevant authority (e.g. MHRA). An action message is only included where the combination is to be avoided, where a dose adjustment is required, or where specific administration requirements (e.g. timing of doses) are recommended. If two drugs have a pharmacodynamic effect in addition to a pharmacokinetic interaction, a cross-reference to the relevant pharmacodynamic effect table is included at the end of the pharmacokinetic message.

2. **Drug classes**
   - The drugs that are members of a drug class are listed underneath the drug class entry in a blue box. Interactions for the class are then listed alphabetically by the interacting drug or drug class. If the interaction only applies to certain drugs in the class, these drugs will be shown in brackets after the drug class name.

3. **Supplementary information**
   - If a drug has additional important information to be considered, this is shown in a blue box underneath the drug or drug class entry. This information might be food and lifestyle advice (including smoking and alcohol consumption), relate to the pharmacology of the drug or applicability of interactions to certain routes of administration, or it might be advice about separating administration times.

4. **Pharmacodynamic effects**
   - Tables at the beginning of Appendix 1 cover pharmacodynamic effects. If a drug is included in one or more of these tables, this will be indicated at the top of the list of interactions for the drug or drug class. In addition to the list of interactions for a drug or drug class, these tables should always be consulted.
   - Each table describes the relevant pharmacodynamic effect and lists those drugs that are commonly associated with the effect. Concurrent use of two or more drugs from the same table is expected to increase the risk of the pharmacodynamic effect occurring. Please note these tables are not exhaustive.
TABLE 1
Drugs that cause hepatotoxicity

The following is a list of some drugs that cause hepatotoxicity (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>alcohol (beverage)</td>
<td>aclacinomycin</td>
<td>dactinomycin</td>
<td>isoniazid</td>
<td>micafungin</td>
</tr>
<tr>
<td>alectinib</td>
<td>demeclocycline</td>
<td>itraconazole</td>
<td>leflunomide</td>
<td>minocycline</td>
</tr>
<tr>
<td>asparaginase</td>
<td>dantrolene</td>
<td>fluconazole</td>
<td>lenalidomide</td>
<td>oxytetracycline</td>
</tr>
<tr>
<td>atorvastatin</td>
<td>didanosine</td>
<td>fluocinolone</td>
<td>lomitapide</td>
<td>paracetamol</td>
</tr>
<tr>
<td>bedaquiline</td>
<td>doxycycline</td>
<td>fluconazole</td>
<td>lymecycline</td>
<td>pegaspargase</td>
</tr>
<tr>
<td>carbamazepine</td>
<td>flucloxacillin</td>
<td>flucloxacillin</td>
<td>mercaptopurine</td>
<td>pravastatin</td>
</tr>
<tr>
<td>clavulanic acid</td>
<td>fluvastatin</td>
<td>fluvastatin</td>
<td>methotrexate</td>
<td>rosuvastatin</td>
</tr>
<tr>
<td>crisantaspase</td>
<td></td>
<td></td>
<td></td>
<td>simvastatin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>streptozocin</td>
</tr>
</tbody>
</table>

TABLE 2
Drugs that cause nephrotoxicity

The following is a list of some drugs that cause nephrotoxicity (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>aceclofenacin</td>
<td>acetaminophen</td>
<td>diclofenac</td>
<td>etodolac</td>
<td>methotrexate</td>
</tr>
<tr>
<td>aciclovir</td>
<td>acetaminophen</td>
<td>etoricoxib</td>
<td>etoricoxib</td>
<td>nabumetone</td>
</tr>
<tr>
<td>adefovir</td>
<td>acetaminophen</td>
<td>flurbiprofen</td>
<td>foscarnet</td>
<td>naproxen</td>
</tr>
<tr>
<td>amikacin</td>
<td>acetylsalicylic acid</td>
<td>ganciclovir</td>
<td>gentamicin</td>
<td>neomycin</td>
</tr>
<tr>
<td>amphotericin</td>
<td>acetylsalicylic acid</td>
<td>ibuprofen</td>
<td>ibuprofen</td>
<td>oxaliplatin</td>
</tr>
<tr>
<td>bacitracin</td>
<td>acetylsalicylic acid</td>
<td>ifosfamide</td>
<td>ifosfamide</td>
<td>parecoxib</td>
</tr>
<tr>
<td>capreomycin</td>
<td>acetylsalicylic acid</td>
<td>indometacin</td>
<td>indometacin</td>
<td>pemetrexed</td>
</tr>
<tr>
<td>carboplatin</td>
<td>acetylsalicylic acid</td>
<td>ketoprofen</td>
<td>ketoprofen</td>
<td>penicillamine</td>
</tr>
<tr>
<td>cefadroxil</td>
<td>acetylsalicylic acid</td>
<td>ketorolac</td>
<td>ketorolac</td>
<td>pentamidine</td>
</tr>
<tr>
<td>cefalexin</td>
<td>acetylsalicylic acid</td>
<td>mefenamic acid</td>
<td>mefenamic acid</td>
<td>piroxicam</td>
</tr>
<tr>
<td>cefotaxime</td>
<td>acetylsalicylic acid</td>
<td>meloxicam</td>
<td>meloxicam</td>
<td>polymyxins</td>
</tr>
<tr>
<td>cefradine</td>
<td>acetylsalicylic acid</td>
<td></td>
<td></td>
<td>streptomycin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>streptozocin</td>
</tr>
</tbody>
</table>

TABLE 3
Drugs with anticoagulant effects

The following is a list of drugs that have anticoagulant effects. Concurrent use of two or more drugs from this list might increase the risk of bleeding; concurrent use of drugs with antiplatelet effects (see table of drugs with antiplatelet effects) might also increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>acenocoumarol</td>
<td>dabigatran</td>
<td>fondaparinux</td>
<td>rivaroxaban</td>
<td>warfarin</td>
</tr>
<tr>
<td>alteplase</td>
<td>dalteparin</td>
<td>heparin (unfractionated)</td>
<td>streptokinase</td>
<td>tenecteplase</td>
</tr>
<tr>
<td>apixaban</td>
<td>danaparoid</td>
<td>nicotinic acid</td>
<td>tenecteplase</td>
<td>tinzaparin</td>
</tr>
<tr>
<td>argatroban</td>
<td>edoxaban</td>
<td>omega-3-acid ethyl esters</td>
<td>urokinase</td>
<td></td>
</tr>
<tr>
<td>bivalirudin</td>
<td>enoxaparin</td>
<td>phenindione</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 4
Drugs with antiplatelet effects

The following is a list of drugs that have antiplatelet effects (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase the risk of bleeding; concurrent use of drugs with antiplatelet effects (see table of drugs with anticoagulant effects) might also increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>aceclofenacin</td>
<td>atorvastatin</td>
<td>diclofenac</td>
<td>etoricoxib</td>
<td>ketorolac</td>
</tr>
<tr>
<td>anagrelide</td>
<td>atorvastatin</td>
<td>dipyridamole</td>
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<td>mefenamic acid</td>
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<tr>
<td>aspirin</td>
<td>bevacizumab</td>
<td>duloxetine</td>
<td>flurbiprofen</td>
<td>meloxicam</td>
</tr>
<tr>
<td>bevacizumab</td>
<td>cangrelor</td>
<td>epoprostenol</td>
<td>fluoroxime</td>
<td>nabumetone</td>
</tr>
<tr>
<td>cantreplomab</td>
<td>celecoxib</td>
<td>epifibatide</td>
<td>ibritinib</td>
<td>naproxen</td>
</tr>
<tr>
<td>cilostazol</td>
<td>cilostazol</td>
<td>escitalopram</td>
<td>ibuprofen</td>
<td>parecoxib</td>
</tr>
<tr>
<td>clopidogrel</td>
<td>clopidogrel</td>
<td>etodolac</td>
<td>iloprost</td>
<td>paroxetine</td>
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<tr>
<td>dapsoneptine</td>
<td>dapsoneptine</td>
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<td>indometacin</td>
<td>piroxicam</td>
</tr>
<tr>
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<td>inotersen</td>
<td>prasugrel</td>
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<tr>
<td></td>
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<td>ketoprofen</td>
<td>regorafenib</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<td>asparagin</td>
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</tbody>
</table>

TABLE 5
Drugs that cause thromboembolism

The following is a list of some drugs that cause thromboembolism (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>bleomycin</td>
<td>eptifibatide</td>
<td>ketorolac</td>
<td>mefenamic acid</td>
<td>sertraline</td>
</tr>
<tr>
<td>cyclophosphamide</td>
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<td>pentostatin</td>
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</tr>
<tr>
<td>darboepotin alfa</td>
<td>eptifibatide</td>
<td>pomalidomide</td>
<td>nabumetone</td>
<td>tenoxicam</td>
</tr>
<tr>
<td>doxorubicin</td>
<td>eptifibatide</td>
<td>rapamycin</td>
<td>naproxen</td>
<td>tiapronectic acid</td>
</tr>
<tr>
<td>epoetin alfa</td>
<td>eptifibatide</td>
<td>raloxifene</td>
<td>parecoxib</td>
<td>ticagrelor</td>
</tr>
<tr>
<td>epoetin beta</td>
<td>eptifibatide</td>
<td>tamoxifen</td>
<td>paroxetine</td>
<td>tirolibine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>thalidomide</td>
<td>piroxicam</td>
<td>tolfenamic acid</td>
</tr>
<tr>
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<td></td>
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<td>prasugrel</td>
<td>trastuzumab emtansine</td>
</tr>
<tr>
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<td>venlafaxine</td>
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<td></td>
<td></td>
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<td>vortioxetine</td>
</tr>
</tbody>
</table>

TABLE 6
Drugs that cause thromboembolism

The following is a list of some drugs that cause thromboembolism (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>bleomycin</td>
<td>eptifibatide</td>
<td>ketorolac</td>
<td>mefenamic acid</td>
<td>sertraline</td>
</tr>
<tr>
<td>cyclophosphamide</td>
<td>eptifibatide</td>
<td>pentostatin</td>
<td>meloxicam</td>
<td>sulindac</td>
</tr>
<tr>
<td>darboepotin alfa</td>
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<td>pomalidomide</td>
<td>nabumetone</td>
<td>tenoxicam</td>
</tr>
<tr>
<td>doxorubicin</td>
<td>eptifibatide</td>
<td>rapamycin</td>
<td>naproxen</td>
<td>tiapronectic acid</td>
</tr>
<tr>
<td>epoetin alfa</td>
<td>eptifibatide</td>
<td>raloxifene</td>
<td>parecoxib</td>
<td>ticagrelor</td>
</tr>
<tr>
<td>epoetin beta</td>
<td>eptifibatide</td>
<td>tamoxifen</td>
<td>paroxetine</td>
<td>tirolibine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>thalidomide</td>
<td>piroxicam</td>
<td>tolfenamic acid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tibolone</td>
<td>prasugrel</td>
<td>trastuzumab emtansine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>regorafenib</td>
<td>venlafaxine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>vortioxetine</td>
</tr>
</tbody>
</table>
### TABLE 6
**Drugs that cause bradycardia**
The following is a list of drugs that cause bradycardia (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>acebutolol</td>
<td>carvedilol</td>
<td>fentanyl</td>
<td>nadolol</td>
<td>selegiline</td>
<td>sotalol</td>
<td></td>
</tr>
<tr>
<td>alectinib</td>
<td>celiprolol</td>
<td>fingolimod</td>
<td>nebivolol</td>
<td>sotufenil</td>
<td>thalidomide</td>
<td></td>
</tr>
<tr>
<td>alfentanil</td>
<td>cisatracurium</td>
<td>flecainide</td>
<td>neostigmine</td>
<td>timolol</td>
<td>tizanidine</td>
<td></td>
</tr>
<tr>
<td>amiodarone</td>
<td>clonidine</td>
<td>galantamine</td>
<td>pasireotide</td>
<td>tizanidine</td>
<td>verapamil</td>
<td></td>
</tr>
<tr>
<td>apraclonidine</td>
<td>crizotinib</td>
<td>ivabradine</td>
<td>pindolol</td>
<td>tizanidine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>atenolol</td>
<td>diltiazem</td>
<td>labetalol</td>
<td>propranolol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>betaxolol</td>
<td>donepezil</td>
<td>levobunolol</td>
<td>pyridostigmine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bisoprolol</td>
<td>esmolol</td>
<td>methadone</td>
<td>remifentanil</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>brimonidine</td>
<td></td>
<td>metoprolol</td>
<td>rivastigmine</td>
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</tr>
</tbody>
</table>

### TABLE 7
**Drugs that cause first dose hypotension**
The following is a list of some drugs that can cause first-dose hypotension (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
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<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
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<tr>
<td>alfuzosin</td>
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<td>isosorbide dinitrate</td>
<td>prazosin</td>
<td>trandolapril</td>
<td></td>
</tr>
<tr>
<td>azilsartan</td>
<td>fosinopril</td>
<td>isosorbide mono nitrate</td>
<td>quinapril</td>
<td>valsartan</td>
<td></td>
</tr>
<tr>
<td>candesartan</td>
<td>glyceryl trinitrate</td>
<td>losartan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>captopril</td>
<td>imidapril</td>
<td>olmesartan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>doxazosin</td>
<td>in doramin</td>
<td>perindopril</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enalapril</td>
<td>irbesartan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 8
**Drugs that cause hypotension**
The following is a list of some drugs that cause hypotension (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

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<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>risperidone</td>
<td></td>
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<td>alcohol (beverage)</td>
<td>chlorpromazine</td>
<td>haloperidol</td>
<td>molsyslyte</td>
<td>roтинове</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>aliskiren</td>
<td>chlortalidone</td>
<td>hydrochloride</td>
<td>moxonidine</td>
<td>rotitogine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>clevidine</td>
<td>hydrochlorothiazide</td>
<td>nadolol</td>
<td>sacbitril</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>clomipramine</td>
<td>hydroflumethiazide</td>
<td>nebulinol</td>
<td>sapatroprin</td>
<td></td>
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<td>indapamide</td>
<td>nivalandril</td>
<td>seveflurane</td>
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<td></td>
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<td>nitrous oxide</td>
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<td>ketamine</td>
<td>olanzapine</td>
<td>sulpiride</td>
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<td></td>
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<tr>
<td>atenolol</td>
<td>dosulepin</td>
<td>labetalol</td>
<td>olmesartan</td>
<td>tadalafil</td>
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<td>avanafil</td>
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<td>paliperidone</td>
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<td>levodopa</td>
<td>perindopril</td>
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<td>phenelzine</td>
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<td>lisinopril</td>
<td>pindolol</td>
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<tr>
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<td>ertugliflozin</td>
<td>lofexidine</td>
<td>pramipexole</td>
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<td>bromidinone</td>
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<td>losartan</td>
<td>prazosin</td>
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<td>bromocriptine</td>
<td>esmolol</td>
<td>loxapine</td>
<td>prochlorperazine</td>
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<td>bumetanide</td>
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<td>promazine</td>
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<td>methoxyflurane</td>
<td>propanolol</td>
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<tr>
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<td>flupeptinol</td>
<td>methyldopa</td>
<td>prazosin</td>
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<td>candesartan</td>
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<td>metolazone</td>
<td>quetiapine</td>
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<td>captopril</td>
<td>fosinopril</td>
<td>metoprolol</td>
<td>quinaglide</td>
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<tr>
<td>cariprazine</td>
<td>furosemide</td>
<td>methyldopa</td>
<td>quinapril</td>
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<td></td>
</tr>
<tr>
<td>carvedilol</td>
<td>glyceryl trinitrate</td>
<td>molazone</td>
<td>ramipril</td>
<td></td>
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<tr>
<td>celiprolol</td>
<td>guanethidine</td>
<td>metoprolol</td>
<td>rosigluat</td>
<td></td>
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</tr>
</tbody>
</table>
The following is a list of some drugs that prolong the QT interval (note that this list is not exhaustive). Concurrent use of two or more drugs that are associated with QT prolongation should be avoided. Increasing age, female sex, cardiac disease, and some metabolic disturbances (notably hypokalaemia) predispose to QT prolongation—concurrent use of drugs that reduce serum potassium might further increase this risk (see table of drugs that reduce serum potassium).

Drugs that are not known to prolong the QT interval but are predicted (by the manufacturer) to increase the risk of QT prolongation include: domperidone, fingoilmol, granisetron, ivabradine, metlofloxine, mizolastine, palonosetron, and intravenous pentamidine. Most manufacturers advise avoiding concurrent use with drugs that prolong the QT interval.

TABLE 9
Drugs that prolong the QT interval
The following is a list of some drugs that prolong the QT interval (note that this list is not exhaustive). Concurrent use of two or more drugs that are associated with QT prolongation should be avoided. Increasing age, female sex, cardiac disease, and some metabolic disturbances (notably hypokalaemia) predispose to QT prolongation—concurrent use of drugs that reduce serum potassium might further increase this risk (see table of drugs that reduce serum potassium).

TABLE 10
Drugs with antimuscarinic effects
The following is a list of some drugs that have antimuscarinic effects (note that this list is not exhaustive). Concurrent use of two or more drugs from this list might increase the risk of these effects occurring. Drugs with antimuscarinic effects decrease the absorption of levodopa.

TABLE 11
Drugs with CNS depressant effects
The following is a list of some drugs with CNS depressant effects (note that this list is not exhaustive). Concurrent use of two or more drugs from this list might increase the risk of CNS depressant effects, such as drowsiness, which might affect the ability to perform skilled tasks (see ‘Drugs and Driving’ in Guidance on Prescribing p. 1).
### Table 12: Drugs that cause peripheral neuropathy
The following is a list of some drugs that cause peripheral neuropathy (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>amiodarone</td>
<td>didanosine</td>
<td>isoniazid</td>
<td>phenytoin</td>
<td>videsine</td>
<td>bupropion</td>
<td>fluoxetine</td>
<td>methadone</td>
</tr>
<tr>
<td>bortezomib</td>
<td>disulfiram</td>
<td>lamivudine</td>
<td>stavudine</td>
<td>vinfunine</td>
<td>citalopram</td>
<td>fluvoxamine</td>
<td>methylthioninium chloride</td>
</tr>
<tr>
<td>brentuximab vedotin</td>
<td>docetaxel</td>
<td>metronidazole</td>
<td>thalidomide</td>
<td>vinorelbine</td>
<td>buspirone</td>
<td>folate</td>
<td>mianserin</td>
</tr>
<tr>
<td>cabazitaxel</td>
<td>eribulin</td>
<td>nitrofurantoin</td>
<td>venlafaxine</td>
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<td></td>
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<tr>
<td>cisplatin</td>
<td>fosphenytoin</td>
<td>paclitaxel</td>
<td>vortioxetine</td>
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<tr>
<td>escitalopram</td>
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</tbody>
</table>

### Table 13: Drugs that cause serotonin syndrome
The following is a list of some drugs that cause serotonin syndrome (note that this list is not exhaustive). See 'Serotonin Syndrome' and 'Monoamine-Oxidase Inhibitors' under Antidepressant drugs p. 241 for more information and for specific advice on avoiding monoamine-oxidase inhibitors during and after administration of other serotonergic drugs.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>almotriptan</td>
<td>fentanyl</td>
<td>methadone</td>
<td>pethidine</td>
<td>tapentadol</td>
<td>bupropion</td>
<td>fluoxetine</td>
<td>methylthioninium chloride</td>
<td>pentoxyfylline</td>
<td></td>
</tr>
<tr>
<td>buspirone</td>
<td>fluvoxamine</td>
<td>methylphenidate</td>
<td>tramadol</td>
<td>cabozantinib</td>
<td>citalopram</td>
<td>folate</td>
<td>methyldopa</td>
<td>tramuloin</td>
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</tr>
<tr>
<td>citalopram</td>
<td></td>
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<td>clomipramine</td>
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<td>clonidine</td>
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<td></td>
<td>doxepin</td>
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<tr>
<td>dapoxetine</td>
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<tr>
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</tbody>
</table>

### Table 14: Antidiabetic drugs
The following is a list of antidiabetic drugs (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase the risk of hypoglycaemia.

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<tr>
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</tr>
</thead>
<tbody>
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<td>acarbose</td>
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<td>glimepiride</td>
<td>lixisenatide</td>
<td>saxagliptin</td>
<td>alogliptin</td>
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<td>metformin</td>
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<td>ertugliflozin</td>
<td>glipizide</td>
<td>nateglinide</td>
<td>sitagliptin</td>
<td>dapagliflozin</td>
<td>glibenclamide</td>
<td>pioglitazone</td>
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<td>linagliptin</td>
<td>repaglinide</td>
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<td>gliclazide</td>
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</table>

### Table 15: Drugs that cause myelosuppression
The following is a list of some drugs that cause myelosuppression (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

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<td>olanizumab</td>
<td>sulfadiazine</td>
<td>amsacrine</td>
<td>gefitinib</td>
<td>olaparib</td>
<td>sulfamethoxazole</td>
<td></td>
</tr>
<tr>
<td>anakinra</td>
<td>chlorambucil</td>
<td>gefitinib</td>
<td>osalazine</td>
<td>sulfasalazine</td>
<td>asparaginase</td>
<td>cladribine</td>
<td>paclitaxel</td>
<td>sunitinib</td>
<td></td>
</tr>
<tr>
<td>azathioprine</td>
<td>cladribine</td>
<td>gencitabine</td>
<td>oxaliplatin</td>
<td>temozolomide</td>
<td>bevacizumab</td>
<td>clofarabine</td>
<td>peginterferon alfa</td>
<td>temsirolimus</td>
<td></td>
</tr>
<tr>
<td>balsalazide</td>
<td>clofarabine</td>
<td>hydroxyccarboxamide</td>
<td>oxaliplatin</td>
<td>thalidomide</td>
<td>belinumab</td>
<td>clozpine</td>
<td>peginterferon alfa</td>
<td>thiotepa</td>
<td></td>
</tr>
<tr>
<td>belinumab</td>
<td>cytarabine</td>
<td>idarubicin</td>
<td>pemetrexed</td>
<td>topotecan</td>
<td>bendamustine</td>
<td>daunorubicin</td>
<td>peginterferon alfa</td>
<td>tramectidine</td>
<td></td>
</tr>
<tr>
<td>bevacizumab</td>
<td>dacarbazine</td>
<td>idelalisib</td>
<td>pentamidene</td>
<td>trastuzumab</td>
<td>bleomycin</td>
<td>daclabazine</td>
<td>pergolide</td>
<td>treosulfan</td>
<td></td>
</tr>
<tr>
<td>blinatumomab</td>
<td>daclabazine</td>
<td>ivofoamid</td>
<td>pentostatin</td>
<td>valganciclovir</td>
<td>bortezomib</td>
<td>dactinomycin</td>
<td>interferon alfa</td>
<td>vinblasticine</td>
<td></td>
</tr>
<tr>
<td>bortezomib</td>
<td>dasatinib</td>
<td>interferon beta</td>
<td>pixantrone</td>
<td>vincristine</td>
<td>bosutinib</td>
<td>daouorubicin</td>
<td>interferon beta</td>
<td>vincristine</td>
<td></td>
</tr>
<tr>
<td>brentuximab vedotin</td>
<td>daouorubicin</td>
<td>irinotecan</td>
<td>pomalidomide</td>
<td>vinorelbine</td>
<td>busulfan</td>
<td>decitabine</td>
<td>interferon alfa</td>
<td>vinorelbine</td>
<td></td>
</tr>
<tr>
<td>cabazitaxel</td>
<td>deforpron</td>
<td>lefunomide</td>
<td>praline</td>
<td>zidovudine</td>
<td>cabozantinib</td>
<td>docetaxel</td>
<td>interferon beta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cabezatcinob</td>
<td>doxorubicin</td>
<td>lenalidomide</td>
<td>pramiquina</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>canakinumab</td>
<td>epirubicin</td>
<td>lineozol</td>
<td>procarbazine</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>capectabine</td>
<td>eribulin</td>
<td>lomustine</td>
<td>propylthiouracil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carbidoxazole</td>
<td>estramustine</td>
<td>melphalan</td>
<td>pyrimethamine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carboplotin</td>
<td>ethosuximide</td>
<td>mercaptapurine</td>
<td>raltux indeed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carfilzomib</td>
<td>etoposide</td>
<td>methotrexate</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>mitomycin</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>mitotane</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>mycophenolate</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>nelfarbin</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>nilotinib</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ong</td>
<td>raltuxinde</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 16
Drugs that increase serum potassium

The following is a list of some drugs that increase serum potassium concentrations (note that this list is not exhaustive). Concurrent use of two or more drugs from this list might increase the risk of hyperkalaemia (hyperkalaemia is particularly notable when ACE inhibitors or angiotensin-II receptor antagonists are given with spironolactone or eplerenone).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>aceclofenac</td>
<td>diclofenac</td>
</tr>
<tr>
<td>aliskiren</td>
<td>drosipirenone</td>
</tr>
<tr>
<td>amlodipine</td>
<td>enalapril</td>
</tr>
<tr>
<td>azilsartan</td>
<td>enoxaparin</td>
</tr>
<tr>
<td>candesartan</td>
<td>eplerenone</td>
</tr>
<tr>
<td>captopril</td>
<td>eplerenone alfa</td>
</tr>
<tr>
<td>celecoxib</td>
<td>eplinid alfa</td>
</tr>
<tr>
<td>ciclosporin</td>
<td>eposartan</td>
</tr>
<tr>
<td>dalteparin</td>
<td>etodolac</td>
</tr>
<tr>
<td>darbepoetin alfa</td>
<td>etoricoxib</td>
</tr>
<tr>
<td>dexibuprofen</td>
<td>flurbiprofen</td>
</tr>
<tr>
<td>dextroprofen</td>
<td></td>
</tr>
</tbody>
</table>

- heparin (unfractionated)
- ibuprofen
- imidapril
- indometacin
- irbesartan
- ketoprofen
- ketorolac
- lisinopril
- losartan
- mafenamic acid
- meloxicam
- nabumetone
- naproxen
- olmesartan
- parecoxib
- perindopril
- piroxicam
- potassium aminobenzoate
- potassium canrenoate
- potassium chloride
- quinapril
- ramipril
- spironolactone
- sulindac
- tacrolimus
- telmisartan
- tenoxicam
- tiaprofenic acid
- tizaniparin
terfenacin acid
tolvaptan
tranoldapril
triamterene
trimethoprim
valsartan

### TABLE 17
Drugs that reduce serum potassium

The following is a list of some drugs that reduce serum potassium concentrations (note that this list is not exhaustive and that other drugs can cause hypokalaemia in overdose). Concurrent use of two or more drugs from this list might increase the risk of hypokalaemia. Hypokalaemia can increase the risk of torsade de pointes, which might be additive with the effects of drugs that prolong the QT interval (see table of drugs that prolong the QT interval). Drugs that reduce serum potassium are predicted to increase the risk of digoxin toxicity.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>aminophylline</td>
<td>bumetidine</td>
</tr>
<tr>
<td>amphotericin</td>
<td>chlorothiazide</td>
</tr>
<tr>
<td>bamberterol</td>
<td>chlortalidone</td>
</tr>
<tr>
<td>beclometasone</td>
<td>deflazacort</td>
</tr>
<tr>
<td>bendroflumethiazide</td>
<td>dexamethasone</td>
</tr>
<tr>
<td>betamethasone</td>
<td>fluindroctisone</td>
</tr>
<tr>
<td>betesoside</td>
<td>formoterol</td>
</tr>
<tr>
<td>bumetanide</td>
<td>furosemide</td>
</tr>
<tr>
<td>chlortalidione</td>
<td>hydrochlorothiazide</td>
</tr>
<tr>
<td>clortalidone</td>
<td>hydrocortisone</td>
</tr>
<tr>
<td>citalopram</td>
<td>hydroflumethiazide</td>
</tr>
<tr>
<td>clomipramide</td>
<td>indacaterol</td>
</tr>
<tr>
<td>dapsoneide</td>
<td>indapamide</td>
</tr>
<tr>
<td>desmopressin</td>
<td>methylprednisolone</td>
</tr>
<tr>
<td>desoxibuprofen</td>
<td>metolazone</td>
</tr>
<tr>
<td>dextroprofen</td>
<td>olodaterol</td>
</tr>
<tr>
<td>diclofenac</td>
<td>prenisolone</td>
</tr>
<tr>
<td>doxepin</td>
<td>salbutamol</td>
</tr>
<tr>
<td>dosulepin</td>
<td>salmeterol</td>
</tr>
<tr>
<td>doxuloxine</td>
<td>terbutaline</td>
</tr>
<tr>
<td>eplerenone</td>
<td>theophylline</td>
</tr>
<tr>
<td>eplinid alfa</td>
<td></td>
</tr>
<tr>
<td>escalolopram</td>
<td></td>
</tr>
<tr>
<td>etodolac</td>
<td></td>
</tr>
<tr>
<td>etoricoxib</td>
<td></td>
</tr>
<tr>
<td>flurbiprofen</td>
<td></td>
</tr>
<tr>
<td>fluoxamine</td>
<td></td>
</tr>
<tr>
<td>furosemide</td>
<td></td>
</tr>
<tr>
<td>gabapentin</td>
<td></td>
</tr>
<tr>
<td>hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>hydroflumethiazide</td>
<td></td>
</tr>
<tr>
<td>imipramine</td>
<td></td>
</tr>
<tr>
<td>indapamide</td>
<td></td>
</tr>
<tr>
<td>indometacin</td>
<td></td>
</tr>
<tr>
<td>ketoprofen</td>
<td></td>
</tr>
<tr>
<td>ketorolac</td>
<td></td>
</tr>
<tr>
<td>mefenamic acid</td>
<td></td>
</tr>
<tr>
<td>meloxicam</td>
<td></td>
</tr>
<tr>
<td>nabumetone</td>
<td></td>
</tr>
<tr>
<td>naproxen</td>
<td></td>
</tr>
<tr>
<td>olmesartan</td>
<td></td>
</tr>
<tr>
<td>paracetamol</td>
<td></td>
</tr>
<tr>
<td>paroxetine</td>
<td></td>
</tr>
<tr>
<td>piroxicam</td>
<td></td>
</tr>
<tr>
<td>quinapril</td>
<td></td>
</tr>
<tr>
<td>ramipril</td>
<td></td>
</tr>
<tr>
<td>spironolactone</td>
<td></td>
</tr>
<tr>
<td>sulindac</td>
<td></td>
</tr>
<tr>
<td>tenoxicam</td>
<td></td>
</tr>
<tr>
<td>tiaprofenic acid</td>
<td></td>
</tr>
<tr>
<td>tolvaptan</td>
<td></td>
</tr>
<tr>
<td>trimethoprim</td>
<td></td>
</tr>
<tr>
<td>triamterene</td>
<td></td>
</tr>
<tr>
<td>xipamide</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 18
Drugs that cause hyponatraemia

The following is a list of some drugs that reduce sodium concentrations (note that this list is not exhaustive). Concurrent use of two or more drugs from this list might increase the risk of hyponatremia.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>aceclofenac</td>
<td>diclofenac</td>
</tr>
<tr>
<td>amlodipine</td>
<td>drosipirenone</td>
</tr>
<tr>
<td>amitriptyline</td>
<td>enalapril</td>
</tr>
<tr>
<td>carbamazepine</td>
<td>enoxaparin</td>
</tr>
<tr>
<td>celecoxib</td>
<td>eplerenone</td>
</tr>
<tr>
<td>chlorothiazide</td>
<td>eplerenone alfa</td>
</tr>
<tr>
<td>chlortalidone</td>
<td>eplinid alfa</td>
</tr>
<tr>
<td>clortalidone</td>
<td>eposartan</td>
</tr>
<tr>
<td>citalopram</td>
<td>etodolac</td>
</tr>
<tr>
<td>clomipramide</td>
<td>etoricoxib</td>
</tr>
<tr>
<td>dapsoneide</td>
<td>flurbiprofen</td>
</tr>
<tr>
<td>desmopressin</td>
<td>furosemide</td>
</tr>
<tr>
<td>doxepin</td>
<td>gabapentin</td>
</tr>
<tr>
<td>dosulepin</td>
<td>hydrochlorothiazide</td>
</tr>
<tr>
<td>doxuloxine</td>
<td>hydrocortisone</td>
</tr>
<tr>
<td>eplerenone</td>
<td>hydroflumethiazide</td>
</tr>
<tr>
<td>eplinid alfa</td>
<td>indacaterol</td>
</tr>
<tr>
<td>escalolopram</td>
<td>indapamide</td>
</tr>
<tr>
<td>etodolac</td>
<td>indometacin</td>
</tr>
<tr>
<td>etoricoxib</td>
<td>ketoprofen</td>
</tr>
<tr>
<td>flurbiprofen</td>
<td>ketorolac</td>
</tr>
<tr>
<td>furosemide</td>
<td>mefenamic acid</td>
</tr>
<tr>
<td>gabapentin</td>
<td>meloxicam</td>
</tr>
<tr>
<td>hydrochlorothiazide</td>
<td>metolazone</td>
</tr>
<tr>
<td>hydroflumethiazide</td>
<td>nabumetone</td>
</tr>
<tr>
<td>ibuprofen</td>
<td>naproxen</td>
</tr>
<tr>
<td>imidapril</td>
<td>nortriptyline</td>
</tr>
<tr>
<td>indometacin</td>
<td>paracetamol</td>
</tr>
<tr>
<td>irbesartan</td>
<td>paroxetine</td>
</tr>
<tr>
<td>ketoprofen</td>
<td>piroxicam</td>
</tr>
<tr>
<td>ketorolac</td>
<td>quinapril</td>
</tr>
<tr>
<td>ketorolac</td>
<td>ramipril</td>
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<tr>
<td>meloxicam</td>
<td>spironolactone</td>
</tr>
<tr>
<td>mefenamic acid</td>
<td>sulindac</td>
</tr>
<tr>
<td>meloxicam</td>
<td>tenoxicam</td>
</tr>
<tr>
<td>nabumetone</td>
<td>tiaprofenic acid</td>
</tr>
<tr>
<td>naproxen</td>
<td>tolvaptan</td>
</tr>
<tr>
<td>olmesartan</td>
<td>trimethoprim</td>
</tr>
<tr>
<td>paracetamol</td>
<td>triamterene</td>
</tr>
<tr>
<td>paroxetine</td>
<td>xipamide</td>
</tr>
</tbody>
</table>

### TABLE 19
Drugs that cause ototoxicity

The following is a list of some drugs that cause ototoxicity (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>amikacin</td>
<td>cisplatin</td>
</tr>
<tr>
<td>amikacin</td>
<td>furosemide</td>
</tr>
<tr>
<td>amikacin</td>
<td>gentamicin</td>
</tr>
<tr>
<td>amikacin</td>
<td>neomycin</td>
</tr>
<tr>
<td>amikacin</td>
<td>oxaliplatin</td>
</tr>
<tr>
<td>amikacin</td>
<td>streptomyacin</td>
</tr>
<tr>
<td>amikacin</td>
<td>telavancin</td>
</tr>
<tr>
<td>amikacin</td>
<td>tobramycin</td>
</tr>
<tr>
<td>amikacin</td>
<td>toremycin</td>
</tr>
<tr>
<td>amikacin</td>
<td>vancomecin</td>
</tr>
<tr>
<td>amikacin</td>
<td>vinblastine</td>
</tr>
<tr>
<td>amikacin</td>
<td>vincristine</td>
</tr>
<tr>
<td>amikacin</td>
<td>virdesine</td>
</tr>
<tr>
<td>amikacin</td>
<td>vinflunine</td>
</tr>
<tr>
<td>amikacin</td>
<td>vinorelbine</td>
</tr>
</tbody>
</table>

### TABLE 20
Drugs with neuromuscular blocking effects

The following is a list of some drugs with neuromuscular blocking effects (note that this list is not exhaustive). Concurrent use of two or more drugs from the list might increase this risk.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>amikacin</td>
<td>botulinus toxin type B</td>
</tr>
<tr>
<td>amikacin</td>
<td>cisplaticurum</td>
</tr>
<tr>
<td>amikacin</td>
<td>colistimethate</td>
</tr>
<tr>
<td>amikacin</td>
<td>gentamicin</td>
</tr>
<tr>
<td>amikacin</td>
<td>mivacurium</td>
</tr>
<tr>
<td>amikacin</td>
<td>neomycin</td>
</tr>
<tr>
<td>amikacin</td>
<td>pancuronium</td>
</tr>
<tr>
<td>amikacin</td>
<td>polymyxins</td>
</tr>
<tr>
<td>amikacin</td>
<td>runcuronium</td>
</tr>
<tr>
<td>amikacin</td>
<td>streptomyacin</td>
</tr>
<tr>
<td>amikacin</td>
<td>suxamethonium</td>
</tr>
<tr>
<td>amikacin</td>
<td>tobramycin</td>
</tr>
</tbody>
</table>
List of drug interactions

The following is an alphabetical list of drugs and their interactions, to avoid excessive cross-referencing each drug or group is listed twice: in the alphabetical list and also against the drug or group with which it interacts.

Abacavir
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to abacavir. (Moderate) Theoretical
- HIV-protease inhibitors (tipranavir) slightly decrease the exposure to abacavir. Avoid. (Severe) Study

Abatacept
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with abatacept. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Abatacept is predicted to increase the risk of generalised infection (possibly life-threatening) when given with monoclonal antibodies (golimumab). Avoid. (Severe) Theoretical

Abemaciclib
- Antiarhythmics (dronedarone) are predicted to increase the exposure to abemaciclib. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to abemaciclib. Avoid. (Severe) Study
- Antifungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study
- Aprepitant is predicted to increase the exposure to abemaciclib. (Moderate) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to abemaciclib. (Moderate) Study
- Cobicistat is predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study
- Crizotinib is predicted to increase the exposure to abemaciclib. (Moderate) Study
- Enzalutamide is predicted to markedly decrease the exposure to abemaciclib. Avoid. (Severe) Study
- Grapefruit juice is predicted to increase the exposure to abemaciclib. Avoid. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study
- Idelalisib is predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study
- Imatinib is predicted to increase the exposure to abemaciclib. (Moderate) Study
- Macrolides (clarithromycin) are predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study
- Macrolides (erythromycin) are predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study
- Mitotane is predicted to markedly decrease the exposure to abemaciclib. (Moderate) Study
- Nilotinib is predicted to increase the exposure to abemaciclib. (Moderate) Study
- Rifampicin is predicted to markedly decrease the exposure to abemaciclib. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to abemaciclib. Avoid. (Severe) Study

Abiraterone
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to abiraterone. Avoid. (Severe) Study
- Abiraterone is predicted to increase the exposure to beta blockers, selective (metoprolol). (Moderate) Study
- Abiraterone is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Enzalutamide is predicted to decrease the exposure to abiraterone. Avoid. (Severe) Study
- Mitotane is predicted to decrease the exposure to abiraterone. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to abiraterone. Avoid. (Severe) Study

Acarbose
- See table 7. p. 875 (first-dose hypotension)
- Acarbose decreases the concentration of digoxin. (Moderate) Study

Acetaminophen
- See NSAIDs

Acenocoumarol
- See coumarins

Acetazolamide
- See theophylline, non-sedating
- See antihistamines, non-sedating
- See NSAIDs
- See coumarins

Acrivastine
- See antihistamines, non-sedating

Acrizol
- See theophylline.

Adefovir
- See table 2. p. 874 (nephrotoxicity)
- See table 10. p. 876 (antimuscarinics)
- See NSIDs
- See monoclonal antibodies

Acrizol
- See theophylline.

Adefovir
- See table 2. p. 874 (nephrotoxicity)
Adefovir (continued)  
▶ Leflunomide is predicted to increase the exposure to adefovir.  
(Moderate) Theoretical  
▶ Teriflunomide is predicted to increase the exposure to adefovir.  
(Moderate) Study  
Adenosine → see antiarrhythmics  
Adrenaline/epinephrine → see sympathomimetics, vasoconstrictor  
Afatinib → see TABLE 15 p. 877 (myelosuppression)  
▶ Antiarhythmics (amiodarone, dronedarone) are predicted to increase the exposure to afatinib. Separate administration by 12 hours. (Moderate) Study  
▶ Antiepileptics (carbamazepine) are predicted to decrease the exposure to afatinib. (Moderate) Study  
▶ HIV-protease inhibitors (ritonavir) decrease the exposure to afatinib. (Moderate) Study  
Albendazole  
▶ Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the concentration of albendazole. (Moderate) Study  
▶ H₂-receptor antagonists (cimetidine) decrease the clearance of albendazole. (Moderate) Study  
▶ HIV-protease inhibitors (ritonavir) decrease the exposure to albendazole. (Moderate) Study  
Albendazole slightly decreases the exposure to levamisole and levamisole moderately decreases the exposure to albendazole. (Moderate) Study  
Alcohol (beverage) → see TABLE 1 p. 874 (hepatotoxicity), TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)  
▶ Alcohol (beverage) potentially increases the risk of visual disturbances when given with antiepileptics (retigabine). (Moderate) Study  
▶ Alcohol (beverage) potentially causes a disulfiram-like reaction when given with antifungals, azoles (itraconazole, ketoconazole). Avoid. (Moderate) Aneodyal  
▶ Alcohol (beverage) causes serious, potentially fatal, CNS depression when given with clonethiazole. Avoid. Severe Study → Also see TABLE 11 p. 876  
▶ Alcohol (beverage) (in those who drink heavily) potentially decreases the anticoagulant effect of coumarins. Severe Study  
▶ Alcohol (beverage) (excessive consumption) potentially increases the risk of gastrointestinal side-effects when given with dimethyl fumarate. Avoid. (Moderate) Theoretical  
▶ Alcohol (beverage) causes an extremely unpleasant systemic reaction when given with disulfiram. Avoid for at least 24 hours before and up to 14 days after stopping treatment. Severe Study  
▶ Alcohol (beverage) potentially causes a disulfiram-like reaction when given with griseofulvin. (Moderate) Aneodyal  
▶ Alcohol (beverage) potentially causes a disulfiram-like reaction when given with levamisole. (Moderate) Study  
▶ Alcohol (beverage) (excessive consumption) potentially increases the risk of lactic acidosis when given with metformin. Avoid excessive alcohol consumption. (Moderate) Theoretical  
▶ Alcohol (beverage) potentially causes a disulfiram-like reaction when given with metronidazole. Avoid for at least 48 hours stopping treatment. (Moderate) Study  
▶ Alcohol (beverage) causes rapid release of opioids (hydromorphone, morphine) (from extended-release preparatory) → Also see TABLE 11 p. 876  
▶ Alcohol (beverage) (in those who drink heavily) causes severe liver damage when given with paracetamol. Severe Study → Also see TABLE 1 p. 874  
▶ Alcohol (beverage) increases the risk of facial flushing and skin irritation when given with topical pimecrolimus. (Moderate) Study  
▶ Alcohol (beverage) potentially causes a disulfiram-like reaction when given with procarbazine. (Moderate) Aneodyal  
▶ Alcohol (beverage) potentially increases the concentration of retinoids (acitretin). Avoid and for 2 months after stopping acitretin. (Moderate) Study  
▶ Alcohol (beverage) increases the risk of facial flushing and skin irritation when given with topical tacrolimus. (Moderate) Study  
▶ Alcohol (beverage) potentially causes a disulfiram-like reaction when given with tinidazole. Avoid for 72 hours stopping treatment. (Moderate) Theoretical  
Aldosterone antagonists → see TABLE 18 p. 878 (hyponatraemia), TABLE 8 p. 875 (hypotension), TABLE 16 p. 878 (increased serum potassium)  
Eplerenone → spironolactone.  
▶ Antiarhythmics (amiodarone) are predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Theoretical  
▶ Antiarhythmics (dronedarone) are predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study  
▶ Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to eplerenone. Avoid. (Moderate) Theoretical → Also see TABLE 18 p. 878
Aldosterone antagonists — Alkylating agents 881

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to eplerenone. Avoid. (Severe) Study

- Apalutamide is predicted to decrease the exposure to eplerenone. Avoid or monitor. (Moderate) Study

- Aprepitant is predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Cobicistat is predicted to markedly increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Eplerenone very slightly increases the exposure to digoxin. (Mid) Study

- Enalaprilat is predicted to decrease the exposure to eplerenone. Avoid. (Moderate) Theoretical

- HIV-protease inhibitors are predicted to markedly increase the exposure to eplerenone. Avoid. (Severe) Study

- Idelalisib is predicted to markedly increase the exposure to eplerenone. Avoid. (Severe) Study

- Imatinib is predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Eplerenone potentially increases the concentration of lithium. Avoid. (Moderate) Theoretical

- Spironolactone potentially increases the concentration of lithium. (Moderate) Study

- Macrolides (azithromycin) are predicted to markedly increase the exposure to eplerenone. Avoid. (Severe) Study

- Macrolides (erythromycin) are predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Mitotane is predicted to decrease the exposure to eplerenone. Avoid. (Moderate) Theoretical

- Netupitant is predicted to decrease the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Nimotop is predicted to decrease the exposure to eplerenone. Avoid. (Severe) Study

- Rifampicin is predicted to decrease the exposure to eplerenone. Avoid. (Moderate) Theoretical

- St John's Wort is predicted to slightly decrease the exposure to eplerenone. Avoid. (Moderate) Study

- Alemtuzumab 
  - see monoclonal antibodies

- Alendronic acid 
  - see bisphosphonates

- Alfentanil 
  - see opioids

- Alfuzosin 
  - see alpha blockers

- Alimemazine 
  - see antihistamines, sedating

- Aminoglycosides 
  - see aminoglycosides

- Aliskiren is predicted to markedly increase the exposure to aliskiren. Avoid. (Severe) Study

- Antiarrhythmics (amiodarone, droxidopa) are predicted to increase the exposure to aliskiren. (Severe) Study

- Antidepressants (carbamazepine) decrease the exposure to aliskiren. (Moderate) Study

- Antifungals, azoles (itraconazole) markedly increase the exposure to aliskiren. Avoid. (Severe) Study

- Antifungals, azoles (ketoconazole) moderately increase the exposure to aliskiren. (Moderate) Study

- Calcium channel blockers (verapamil) moderately increase the exposure to aliskiren. (Moderate) Study

- Certitin is predicted to increase the exposure to aliskiren. (Moderate) Theoretical

- Ciclosporin markedly increases the exposure to aliskiren. Avoid. (Severe) Study

- Eliglustat is predicted to increase the exposure to aliskiren. Adjust dose. (Moderate) Study

- Grapefruit juice moderately decreases the exposure to aliskiren. Avoid. (Severe) Study

- HIV-protease inhibitors (ritonavir, saquinavir) are predicted to increase the exposure to aliskiren. (Moderate) Theoretical

- Lapatinib is predicted to increase the exposure to aliskiren. (Moderate) Theoretical

- Aliskiren slightly decreases the exposure to loop diuretics (furosemide). (Moderate) Study

- Aliskiren is predicted to increase the exposure to aliskiren. (Moderate) Study

- Mirabegron is predicted to increase the exposure to aliskiren. (Mid) Theoretical

- Paroxetine (with ritonavir and omeprazole) is predicted to increase the exposure to aliskiren. (Moderate) Study

- Pibrentasvir is predicted to decrease the exposure to aliskiren. (Moderate) Study

- Prasugrel is predicted to decrease the exposure to aliskiren. (Mid) Theoretical

- Ranolazine is predicted to increase the exposure to aliskiren. (Moderate) Theoretical

- Rifampicin decreases the exposure to aliskiren. (Moderate) Study

- St John's Wort decreases the exposure to aliskiren. (Moderate) Study

- Statins (atorvastatin) slightly to moderately increase the exposure to aliskiren. (Moderate) Study

- Velpatasvir is predicted to increase the exposure to aliskiren. (Moderate) Study

- Aliskiren is predicted to increase the exposure to aliskiren. Adjust with caution and adjust dose. (Moderate) Theoretical

- Alitretinoin 
  - see retinoids

- Antacids are predicted to decrease the absorption of estramustine. Avoid. (Moderate) Study

- Antifungals, azoles (isavuconazole) are predicted to increase the exposure to cyclophosphamide. (Moderate) Study

- Antifungals, azoles (itraconazole) increase the risk of busulfan toxicity when given with busulfan. Monitor and adjust dose. (Moderate) Study

- Antifungals, azoles (miconazole) are predicted to increase the concentration of busulfan. Use with caution and adjust dose. (Moderate) Theoretical

- Aprepitant is predicted to increase the exposure to ifosfamide. (Severe) Theoretical

- Oral calcium salts decrease the absorption of estramustine. (Severe) Study

- Fosaprepitant is predicted to increase the exposure to ifosfamide. (Severe) Theoretical

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with alkylating agents. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

- Metronidazole increases the risk of toxicity when given with busulfan. (Severe) Study

- Netupitant very slightly increases the exposure to cyclophosphamide. (Moderate) Study

- Netupitant is predicted to increase the exposure to ifosfamide. (Moderate) Study

- Bendamustine • busulfan • carmustine • chlorambucil • cyclophosphamide • dacarbazine • estramustine • ifosfamide • lomustine • melphalan • temozolomide • thiopeta • treosulfan

- Anticancer agents are predicted to increase the exposure to busulfan. Increase dose of busulfan. (Moderate) Study

FOOD AND LIFESTYLE

- Avoid apple juice and orange juice as they greatly decrease aliskiren concentrations and plasma renin activity.

- ACE Inhibitors increase the risk of renal impairment when given with aliskiren. Use with caution or avoid aliskiren in selected patients. (Severe) Study

- Angiotensin II receptor antagonists increase the risk of renal impairment when given with aliskiren. Use with caution or avoid aliskiren in selected patients. (Severe) Study

- Antiarrhythmics (amiodarone, droxidopa) are predicted to increase the exposure to aliskiren. (Severe) Study

- Antidepressants (carbamazepine) decrease the exposure to aliskiren. (Moderate) Study

- Spironolactone increases the concentration of digoxin. Monitor and adjust dose. (Moderate) Study

- HIV-protease inhibitors are predicted to markedly increase the exposure to eplerenone. Avoid. (Severe) Study

- Idelalisib is predicted to markedly increase the exposure to eplerenone. Avoid. (Severe) Study

- Imatinib is predicted to increase the exposure to eplerenone. Adjust eplerenone dose. (Severe) Study

- Eplerenone potentially increases the concentration of lithium. Avoid. (Moderate) Theoretical
Alkylating agents (continued)

- **Paracetamol** is predicted to decrease the clearance of busulfan. [Moderate] [Theoretical]
- **Cyclophosphamide** (high-dose) increases the risk of toxicity when given with **pentostatin**. Avoid. [Severe] Anecdotal → Also see TABLE 15, p. 877 → Also see TABLE 8, p. 874
- **Rolapitant** is predicted to increase the exposure to bendamustine. Avoid or monitor. [Moderate] [Study]
- **Cyclophosphamide** increases the risk of prolonged neuromuscular blockade when given with **suxamethonium**. [Moderate] [Study]

**Allopurinol**

- **ACE inhibitors** are predicted to increase the risk of hypersensitivity and haematological reactions when given with **allopurinol**. [Severe] Anecdotal
- **Allopurinol** potentially increases the risk of haematological toxicity when given with **azathioprine**. Adjust **azathioprine** dose. p. 536. [Severe] [Study]
- **Allopurinol** is predicted to decrease the effects of **capecilibine**. Avoid. [Severe] [Study]
- **Allopurinol** moderately increases the exposure to **didanosine**. Avoid. [Severe] [Study]
- **Allopurinol** potentially increases the risk of haematological toxicity when given with **mercaptoptilin**. Adjust **mercaptoptilin** dose. p. 562. [Severe] [Study]
- **Allopurinol** increases the risk of skin rash when given with **penicillins** (**amoxicillin, ampicillin**). [Moderate] [Study]
- **Allopurinol** is predicted to increase the risk of hyperuricemia when given with **pyrazinamide**. [Moderate] [Theoretical]
- **Thiadizide diuretics** are predicted to increase the risk of hypersensitivity reactions when given with **allopurinol**. [Severe] [Theoretical]

**Almotriptan** | see TABLE 13, p. 877 (serotonin syndrome)

- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** increase the exposure to **almotriptan**. [MED] [Study]
- **Cobicistat** increases the exposure to **almotriptan**. [MED] [Study]
- **Almotriptan** is predicted to increase the risk of vasoconstriction when given with **ergotamine**. Ergotamine should be taken at least 24 hours before or 6 hours after **almotriptan**. [Severe] [Theoretical]
- **HIV-protease inhibitors** increase the exposure to **almotriptan**. [MED] [Study]
- **Idelalisib** increases the exposure to **almotriptan**. [MED] [Study]
- **Macrolides (clarithromycin)** increase the exposure to **almotriptan**. [MED] [Study]

**Allopamitin** | see TABLE 14, p. 877 (anti-diabetic drugs)

**Alpha blockers** | see TABLE 7, p. 875 (first-dose hypotension), TABLE 8, p. 875 (hypotension)

- **Alfuzosin, doxazosin, indoramin, prazosin, tamsulosin, terazosin** are predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Antifungals, azoles (fluconazole, isavuconazole, posaconazole)** are predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to increase the exposure to **doxazosin**. [Moderate] [Study]
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to moderately increase the exposure to **alpha blockers (alfuzosin, tamsulosin)**. Use with caution or avoid. [Moderate] [Study]
- **Aprepitant** is predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Calcium channel blockers (diltiazem, verapamili)** are predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical] → Also see TABLE 8, p. 875
- **Cobicistat** is predicted to moderately increase the exposure to **alpha blockers (alfuzosin, tamsulosin)**. Use with caution or avoid. [Moderate] [Study]
- **Cobicistat** is predicted to increase the exposure to **doxazosin**. [Moderate] [Study]
- **Cobicistat** is predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **HIV-protease inhibitors** are predicted to moderately increase the exposure to **alpha blockers (alfuzosin, tamsulosin)**. Use with caution or avoid. [Moderate] [Study]
- **HIV-protease inhibitors** are predicted to increase the exposure to **doxazosin**. [Moderate] [Study]
- **Idelalisib** is predicted to moderately increase the exposure to **alpha blockers (alfuzosin, tamsulosin)**. Use with caution or avoid. [Moderate] [Study]
- **Idelalisib** is predicted to increase the exposure to **doxazosin**. [Moderate] [Study]
- **Imatinib** is predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Macrolides (clarithromycin)** are predicted to increase the exposure to **doxazosin**. [Moderate] [Study]
- **Macrolides (erythromycin)** are predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to **alpha blockers (alfuzosin, tamsulosin)**. Use with caution or avoid. [Moderate] [Study]
- **Monoamine oxidase A and B inhibitors, irreversible** are predicted to increase the effects of **indoramin**. Avoid. [Severe] [Theoretical] → Also see TABLE 8, p. 875
- **Netupitant** is predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Nilotinib** is predicted to increase the exposure to **tamsulosin**. [Moderate] [Theoretical]
- **Alpha blockers** cause significant hypotensive effects when given with **phosphodiesterase type-5 inhibitors**. Patient should be stabilised on first drug then second drug should be added at the lowest recommended dose. [Severe] [Study] → Also see TABLE 8, p. 875
- **Ribociclib** (high-dose) is predicted to increase the exposure to **alfuzosin**. Avoid. [Moderate] [Theoretical]
- **Alpha tocopherol** | see vitamin E substances
- **Alpha tocopheryl acetate** | see vitamin E substances
- **Alprazolam** | see TABLE 11, p. 876 (CNS depressant effects)
- **Antiarrhythmics (dronedaron)** are predicted to increase the exposure to **alprazolam**. [Severe] [Study]
- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to **alprazolam**. Adjust dose. [Moderate] [Theoretical] → Also see TABLE 11, p. 876
- **Antifungals, azoles (fluconazole, isavuconazole, posaconazole)** are predicted to increase the exposure to **alprazolam**. [Severe] [Study]
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** moderately increase the exposure to **alprazolam**. Avoid. [Moderate] [Study]
- **Antifungals, azoles (miconazole)** are predicted to increase the exposure to **alprazolam**. Use with caution and adjust dose. [Moderate] [Theoretical]
- **Aprepitant** is predicted to increase the exposure to **alprazolam**. [Severe] [Study]
- **Calcium channel blockers (diltiazem, verapamili)** are predicted to increase the exposure to **alprazolam**. [Severe] [Study]
- **Cobicistat** moderately increases the exposure to **alprazolam**. Adjust dose. [Moderate] [Theoretical]
- **Crizotinib** is predicted to increase the exposure to **alprazolam**. [Severe] [Study]
- **Enzalutamide** is predicted to decrease the exposure to **alprazolam**. Adjust dose. [Moderate] [Theoretical]
- **Fosaprepitant** is predicted to increase the exposure to **alprazolam**. [Moderate] [Study]
- **HIV-protease inhibitors** moderately increase the exposure to **alprazolam**. Avoid. [Moderate] [Study]
- **Idelalisib** moderately increases the exposure to **alprazolam**. Avoid. [Moderate] [Study]
- **Imatinib** is predicted to increase the exposure to **alprazolam**. [Severe] [Study]
- **Alprazolam** is predicted to increase the exposure to **tomitapride**. Separate administration by 12 hours. [Moderate] [Theoretical]
- **Macrolides (clarithromycin)** moderately increase the exposure to **alprazolam**. Avoid. [Moderate] [Study]
- **Macrolides (erythromycin)** are predicted to increase the exposure to **alprazolam**. [Severe] [Study]
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- Mitotane is predicted to decrease the exposure to alprazolam. Adjust dose. [Moderate] Theoretical
- Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to alprazolam. Monitor and adjust dose. [Moderate] Theoretical
- Neutrapen is predicted to increase the exposure to alprazolam. [Severe] Study
- Nilotinib is predicted to increase the exposure to alprazolam. [Severe] Study
- Rifampicin is predicted to decrease the exposure to alprazolam. Adjust dose. [Moderate] Theoretical
- SSRIs (fluvoxamine) moderately increase the exposure to alprazolam. Adjust dose. [Moderate] Study
- St John's Wort moderately decreases the exposure to alprazolam. [Moderate] Study
- Allopurinol (amfenetamine) see TABLE B p. 875 (hypotension)
- Alteplase see TABLE 3 p. 874 (anticoagulant effects)
- Aluminium hydroxide see antacids
- Amantadine see dopamine receptor agonists
- Ambrisantan
- Ciclosporin moderately increases the exposure to ambrisantan. Adjust ambrisantan dose. [Moderate] Study
- Rifampicin transiently increases the exposure to ambrisantan. [Moderate] Study
- Amfetamines see TABLE 13 p. 877 (serotonin syndrome)
- dexamfetamine - lisdexamfetamine
- Amfetamines are predicted to decrease the effects of apraclonidine. Avoid. [Severe] Theoretical
- Amfetamines are predicted to increase the risk of side-effects when given with atomoxetine. [Severe] Theoretical
- Dexamfetamine decreases the effects of guanethidine. [Severe] Study
- HIV-protase inhibitors (ritonavir, tipranavir) are predicted to increase the exposure to amfetamines. [Severe] Theoretical
- Moclomide is predicted to increase the risk of a hypertensive crisis when given with amfetamines. Avoid. [Severe] Theoretical
- Also see TABLE 13 p. 877
- Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the risk of a hypertensive crisis when given with amfetamines. Avoid and for 14 days after stopping the MAOI. [Severe] Anecdotal Also see TABLE 13 p. 877
- Monoamine-oxidase B inhibitors (rasagiline, selegiline) are predicted to increase the risk of severe hypertension when given with amfetamines. Avoid. [Severe] Theoretical Also see TABLE 13 p. 877
- Monoamine-oxidase B inhibitors (safinamide) are predicted to increase the risk of severe hypertension when given with amfetamines. Avoid. [Severe] Theoretical Also see TABLE 13 p. 877
- Monoamine-oxidase B inhibitors (safinamide) are predicted to increase the risk of severe hypertension when given with amfetamines. Avoid. [Severe] Theoretical Also see TABLE 13 p. 877
- Methylphenidate is predicted to increase the risk of cardiovascular side-effects when given with amfetamines. Avoid. [Severe] Theoretical Also see TABLE 13 p. 877
- Phenothiazines are predicted to decrease the effects of amfetamines and amfetamines are predicted to decrease the effects of phenothiazines. [Moderate] Study
- SSRIs (escitalopram, paroxetine) are predicted to increase the exposure to amfetamines. [Severe] Theoretical Also see TABLE 13 p. 877
- Aminoflurane see TABLE 9 p. 876 (QF-interval prolongation)
- Amikacin see aminoglycosides
- Amiloride see potassium-sparing diuretics
- Aminoglycosides see TABLE 2 p. 874 (nephrotoxicity), TABLE 19 p. 878 (ototoxicity), TABLE 20 p. 878 (neuromuscular blocking effects)
- amikacin - gentamicin - streptomycin - tobramycin
- Since systemic absorption can follow topical application, the possibility of interactions with topical gentamicin should be borne in mind.
- Since systemic absorption can follow topical application, the possibility of interactions with topical tobramycin should be borne in mind.
- Aminoglycosides are predicted to decrease the effects of apalasidase. Avoid. [Moderate] Theoretical
- Antifungals, azoles (micazole) potentially decrease the exposure to tobramycin. [Moderate] Anecdotal
- Ataluren is predicted to increase the risk of nephrotoxicity when given with intravenous aminoglycosides. Avoid. [Severe] Study
- Aminoglycosides increase the risk of hypocalcaemia when given with bisphophonates. [Moderate] Anecdotal Also see TABLE 2 p. 874
- Aminoglycosides potentially increase the concentration of digoxin. Monitor and adjust dose. [Mild] Study
- Loop diuretics increase the risk of nephrotoxicity when given with aminoglycosides. Avoid. [Moderate] Study Also see TABLE 19 p. 878
- Aminoglycosides are predicted to decrease the effects of neostigmine. [Moderate] Theoretical
- Aminoglycosides are predicted to decrease the effects of pyridostigmine. [Moderate] Theoretical
- Aminophylline see TABLE 17 p. 878 (reduced serum potassium)

FOOD AND LIFESTYLE Smoking can increase aminophylline clearance and increased doses of aminophylline are therefore required; dose adjustments are likely to be necessary if smoking started or stopped during treatment.
- Aciclovir increases the exposure to aminophylline. Monitor and adjust dose. [Severe] Anecdotal
- Aminophylline is predicted to decrease the efficacy of antiarrhythmics (adenosine). Separate administration by 24 hours. [Mild] Theoretical
- Antiepileptics (fosphenytoin) are predicted to decrease the exposure to aminophylline. Adjust dose. [Moderate] Study
- Antiepileptics (phenobarbital) are predicted to decrease the exposure to aminophylline. Adjust dose. [Moderate] Theoretical
- Antiepileptics (phenytoin) decrease the exposure to aminophylline. Adjust dose. [Moderate] Study
- Antiepileptics (primidone) are predicted to increase the clearance of aminophylline. Adjust dose. [Moderate] Theoretical
- Antiepileptics (stiripentol) are predicted to increase the exposure to aminophylline. Avoid. [Moderate] Theoretical
- Beta blockers, non-selective are predicted to increase the risk of bronchospasm when given with aminophylline. Avoid. [Severe] Theoretical
- Beta blockers, selective are predicted to increase the risk of bronchospasm when given with aminophylline. Avoid. [Severe] Theoretical
- Combined hormonal contraceptives are predicted to increase the exposure to aminophylline. Adjust dose. [Moderate] Theoretical
- Aminophylline increases the risk of agitation when given with doxapram. [Moderate] Study
- Esketamine is predicted to increase the risk of seizures when given with aminophylline. Avoid. [Severe] Theoretical
- H2 receptor antagonists see TABLE 10 p. 874 (hyperproteinaemia)
- HIV-protase inhibitors (ritonavir) decrease the exposure to aminophylline. Adjust dose. [Mild] Study
- Interferons are predicted to slightly increase the exposure to aminophylline. Adjust dose. [Mild] Theoretical
- Iron chelators (deferasirox) are predicted to increase the exposure to aminophylline. Avoid. [Moderate] Theoretical
- Isoniazid is predicted to affect the clearance of aminophylline. [Severe] Theoretical
- Leflunomide decreases the exposure to aminophylline. Adjust dose. [Mild] Study
- Aminophylline is predicted to decrease the concentration of lithium. [Moderate] Theoretical
- Macrolides (azithromycin) are predicted to increase the exposure to aminophylline. [Moderate] Theoretical
- Macrolides (clarithromycin) are predicted to decrease the exposure to aminophylline. Adjust dose. [Severe] Study
- Methotrexate is predicted to decrease the clearance of aminophylline. [Moderate] Theoretical
- Mexiletine is predicted to increase the exposure to aminophylline. Adjust dose. [Moderate] Theoretical
- Monoclonal antibodies (bilatuzumab) are predicted to transiently increase the exposure to aminophylline. Monitor and adjust dose. [Moderate] Theoretical
Aminophylline (continued)

- Monoclonal antibodies (sarilumab) potentially affect the exposure to aminophylline. Monitor and adjust dose. (Moderate) Theoretical
- Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to aminophylline. Monitor and adjust dose. (Moderate) Theoretical
- Pentoxifylline is predicted to increase the concentration of aminophylline. Use with caution or avoid. (Severe) Theoretical
- Thiopurines (azathioprine, mercaptopurine) are predicted to increase the exposure to aminophylline. Adjust dose. (Moderate) Theoretical
- Rifampicin decreases the exposure to aminophylline. Adjust dose. (Moderate) Study
- Aminophylline is predicted to slightly increase the exposure to ropivacaine. Avoid. (Moderate) Theoretical
- Rucaparib is predicted to increase the exposure to aminophylline. Monitor and adjust dose. (Moderate) Study
- SSRIs (fluvoxamine) moderately to markedly increase the exposure to aminophylline. Avoid. (Severe) Study
- St John's Wort is predicted to decrease the concentration of aminophylline. (Severe) Theoretical
- Symathomimetics, vasoconstrictor (ephedrine) increase the risk of side-effects when given with aminophylline. Avoid in children. (Moderate) Study
- Teriflunomide decreases the exposure to aminophylline. Adjust dose. (Moderate) Study
- Valaciclovir is predicted to increase the exposure to aminophylline. (Severe) Anecdotal

Aminosalicylic acid

- Aminosalicylic acid is predicted to increase the risk of methaemoglobinemia when given with topical amines. (Severe) Theoretical
- Aminosalicylic acid is predicted to increase the risk of methaemoglobinemia when given with dapsone. (Severe) Theoretical
- Amiodarone → see antiarrhythmics
- Amlodipine → see calcium channel blockers
- Amoxicillin → see penicillins
- Amphotericin → see Table 2 p. 874 (nephrotoxicity), Table 17 p. 878 (reduced serum potassium)
- Amphotericin increases the risk of toxicity when given with fluvoxamine. (Severe) Study
- Micafungin slightly increases the exposure to amphotericin. Avoid or monitor toxicity. (Moderate) Study
- Sodium stibogluconate increases the risk of cardiovascular side-effects when given with amphotericin. Separate administration by 14 days. (Severe) Study
- Ampicillin → see penicillins
- Amsacrine → see Table 15 p. 877 (myelosuppression)
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with amsacrine. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Anaesthetics, local → see Table 11 p. 876 (CNS depressant effects)

ROUTE-SPECIFIC INFORMATION: Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- Aminosalicylic acid is predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Theoretical
- Anaesthetics, local are predicted to increase the risk of cardiodepression when given with antihypertensives. (Severe) Theoretical → Also see Table 11 p. 876

- Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Theoretical → Also see Table 11 p. 876
- Antiepileptics (phenytoin) are predicted to decrease the exposure to ropivacaine. (Moderate) Theoretical
- Antimalarials (chloroquine, primaquine) are predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Theoretical
- Dapsone is predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Theoretical
- HIV-protease inhibitors (ritonavir) are predicted to decrease the exposure to ropivacaine. (Moderate) Theoretical
- Metoclopramide is predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Avoid. (Severe) Theoretical
- Nitrofurantoin is predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Theoretical
- Paracetamol is predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Avoid. (Severe) Theoretical
- Rifaximin is predicted to decrease the exposure to ropivacaine. (Moderate) Theoretical
- Sodium nitroprusside is predicted to increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Theoretical
- Sulfonamides potentially increase the risk of methaemoglobinemia when given with topical prilocaine. Use with caution or avoid. (Severe) Anecdotal
- Teriflunomide is predicted to decrease the exposure to ropivacaine. (Moderate) Theoretical
- Anagrelide → see Table 9 p. 876 (QT-interval prolongation), Table 4 p. 874 (antiplatelet effects)
- Combined hormonal contraceptives are predicted to increase the exposure to anagrelide. (Moderate) Theoretical
- Mexiletine is predicted to increase the exposure to anagrelide. (Moderate) Theoretical
- Quinolones (ciprofloxacin) are predicted to increase the exposure to anagrelide. (Moderate) Theoretical
- SSRIs (fluvoxamine) decrease the clearance of ropivacaine. Avoid prolonged use. (Moderate) Study
- Anakinra is predicted to increase the risk of generalised infection (possibly life-threatening) when given with etanercept. Avoid. (Severe) Theoretical
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with anakinra. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Anakinra is predicted to increase the risk of generalised infection (possibly life-threatening) when given with monoclonal antibodies (gilumab). Avoid. (Severe) Theoretical

Antiangiotensin-II receptor antagonists → see Table 7 p. 875 (first-dose hypotension), Table 8 p. 875 (hypotension), Table 16 p. 878 (increased serum potassium)

Azilsartan → candesartan → eprosartan → irbesartan → losartan → olmesartan → telmisartan → valsartan

- Angiotensin-II receptor antagonists increase the risk of renal impairment when given with aliskiren. Use with caution or avoid aliskiren in selected patients. (Severe) Study → Also see Table 8 p. 875 → Also see Table 16 p. 878
- Angiotensin-II receptor antagonists potentially increase the concentration of lithium. Monitor concentration and adjust dose. (Severe) Anecdotal
Antacids

- aluminium hydroxide - magnesium carbonate - magnesium trisilicate

**SEPARATION OF ADMINISTRATION** Antacids should preferably not be taken at the same time as other drugs since they might impair absorption. Antacids might damage enteric coatings designed to prevent dissolution in the stomach.

- Antacids are predicted to decrease the absorption of alkylation agents (estramusine). Avoid. [Moderate] Study
- Antacids decrease the absorption of antiepileptics ( gabapentin). Gabapentin should be taken 2 hours after antacids. [Moderate] Study
- Antacids decrease the absorption of antifungals, azoles (itraconazole) (capsule). Antacids should be taken 1 hour before or 2 hours after itraconazole. [Moderate] Study
- Antacids decrease the absorption of antifungals, azoles (ketocanozole). Separate administration by at least 2 hours. [Moderate] Study
- Antacids decrease the absorption of antihistamines, non-sedating (fexofenadine). Separate administration by 2 hours. [Mild] Study
- Antacids decrease the absorption of antimalarials (chloroquine). Separate administration by at least 4 hours. [Moderate] Study
- Antacids are predicted to decrease the absorption of antimalarials (propoquin). Separate administration by at least 2 hours. [Moderate] Study
- Antacids decrease the absorption of aspirin (high-dose). Separate administration by at least 2 hours. [Moderate] Study
- Antacids decrease the exposure to bictegravir. Separate administration by at least 2 hours. [Moderate] Study
- Antacids decrease the absorption of bisphosphonates (alendronic acid). Alendronic acid should be taken at least 30 minutes before antacids. [Moderate] Study
- Antacids are predicted to decrease the absorption of bisphosphonates (ibandronic acid). Avoid antacids for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical
- Antacids decrease the absorption of bisphosphonates (risedronate). Separate administration by at least 2 hours. [Moderate] Study
- Antacids decrease the absorption of bisphosphonates (sodium clonodronate). Avoid antacids for 2 hours before or 1 hour after sodium clonodronate. [Moderate] Study
- Antacids are predicted to decrease the absorption of bosutinib. Bosutinib should be taken at least 12 hours before antacids. [Moderate] Theoretical
- Antacids are predicted to decrease the absorption of ceritinib. Separate administration by 2 hours. [Moderate] Theoretical
- Oral aluminium hydroxide decreases the absorption of chenodeoxycholic acid. [Moderate] Study
- Antacids are predicted to decrease the absorption of cholic acid. Separate administration by 5 hours. [Mild] Theoretical
- Antacids are predicted to decrease the absorption of corticosteroids (deflazacort). Separate administration by 2 hours. [Moderate] Theoretical
- Antacids decrease the absorption of corticosteroids (dexamethasone). [Moderate] Study
- Antacids decrease the absorption of dasatinib. Separate administration by at least 2 hours. [Moderate] Study
- Aluminium hydroxide is predicted to decrease the absorption of deferiprone. Avoid. [Moderate] Theoretical
- Antacids decrease the absorption of digoxin. Separate administration by 2 hours. [Mild] Study
- Antacids are predicted to decrease the absorption of dipyridamole (immediate release tablets). [Moderate] Theoretical
- Antacids moderately decrease the exposure to dolutegravir. Dolutegravir should be taken 2 hours before or 6 hours after antacids. [Moderate] Study
- Antacids decrease the absorption of eltrombopag. Ettrombopag should be taken 2 hours before or 4 hours after antacids. [Severe] Study
- Antacids moderately decrease the exposure to elvitegravir. Separate administration by at least 4 hours. [Moderate] Study
- Antacids are predicted to decrease the absorption of erlotinib. Antacids should be taken 4 hours before or 2 hours after erlotinib. [Moderate] Theoretical
- Antacids are predicted to slightly to moderately decrease the exposure to fibrates (gemfibrozil). [Moderate] Study
- Antacids are predicted to slightly decrease the exposure to gefitinib. [Moderate] Theoretical
- Antacids are predicted to decrease the absorption of HIV-protease inhibitors (atazanavir). Atazanavir should be taken 2 hours before or 1 hour after antacids. [Severe] Theoretical
- Antacids are predicted to decrease the absorption of HIV-protease inhibitors (tipranavir). Separate administration by 2 hours. [Moderate] Study
- Antacids are predicted to decrease the absorption of hydroxychloroquine. Separate administration by at least 4 hours. [Moderate] Study
- Antacids decrease the absorption of iron (oral). Iron (oral) should be taken 1 hour before or 2 hours after antacids. [Moderate] Study
- Antacids are predicted to decrease the absorption of iron chelators (deferasirox). Avoid. [Moderate] Theoretical
- Antacids are predicted to decrease the absorption of lentinib. Avoid. [Moderate] Theoretical
- Antacids are predicted to decrease the exposure to ledipasvir. Separate administration by 4 hours. [Moderate] Theoretical
- Antacids decrease the exposure to mycophenolate. [Moderate] Study
- Antacids are predicted to decrease the absorption of nilotinib. Separate administration by at least 2 hours. [Moderate] Theoretical
- Magnesium trisilicate decreases the absorption of nitrofurantoin. [Moderate] Study
- Antacids are predicted to decrease the absorption of pazopanib. Pazopanib should be taken 1 hour before or 2 hours after antacids. [Moderate] Theoretical
- Antacids decrease the absorption of penicillamine. Separate administration by 2 hours. [Mild] Study
- Antacids decrease the absorption of phenothiazines. [Moderate] Anecdotal
- Antacids increase the risk of metabolic alkalosis when given with polystyrene sulfonate. [Severe] Anecdotal
- Antacids decrease the absorption of quinolones. Quinolones should be taken 2 hours before or 4 hours after antacids. [Moderate] Study
- Antacids slightly decrease the exposure to raltegravir. Avoid. [Moderate] Study
- Antacids decrease the absorption of rifampicin. Rifampicin should be taken 1 hour before antacids. [Moderate] Study
- Antacids are predicted to decrease the exposure to ripivirine. Antacids should be taken 2 hours before or 4 hours after ripivirine. [Severe] Theoretical
- Antacids slightly decrease the exposure to riociguat. Antacids should be taken 2 hours before or 1 hour after riociguat. [Mild] Study
- Antacids moderately decrease the absorption of statins (rosuvastatin). Separate administration by 2 hours. [Moderate] Study
- Antacids decrease the absorption of sulpiride. Separate administration by 2 hours. [Moderate] Study
- Antacids decrease the absorption of tetracyclines. Separate administration by 2 to 3 hours. [Moderate] Study
- Antacids are predicted to decrease the absorption of thyroid hormones (levothyroxine). Separate administration by at least 4 hours. [Moderate] Anecdotal
- Antacids are predicted to decrease the absorption of ursodeoxycholic acid. Separate administration by 2 hours. [Moderate] Theoretical
- Antacids are predicted to decrease the concentration of velpatasvir. Separate administration by 4 hours. [Moderate] Theoretical
- Antazoline → see antihistamines, sedating
- Anthracyclines → see TABLE 15 p. 877 (myelosuppression), TABLE 5 p. 874 (thromboembolism)
INTERACTIONS

Antiarrhythmics

Daunorubicin - doxorubicin - epirubicin - idarubicin - mitoxantrone - pimonidazole

**GENERAL INFORMATION**

Caution is necessary with concurrent use of cardioactive drugs, or drugs that reduce cardiac contractility.

- **Calcium channel blockers** (verapamil) moderately increase the exposure to doxorubicin. (Moderate) Study
- **Ciclosporin** increases the concentration of antiarrhythmics (daunorubicin, doxorubicin, epirubicin, idarubicin, mitoxantrone). (Severe) Study
- **H₂ receptor antagonists** (cimetidine) slightly increase the exposure to epirubicin. Avoid. (Moderate) Study
- **Leflunomide** is predicted to increase the exposure to antiarrhythmics (daunorubicin, doxorubicin, mitoxantrone). (Moderate) Study
- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with anthracyclines. Public Health England advises avoid (refer to **Green Book**). (Severe) Theoretical
- **Antiarrhythmics** are predicted to increase the risk of cardiotoxicity when given with monoclonal antibodies (trastuzumab, trastuzumab emtansine). Avoid. (Severe) Theoretical
- **Rolapitant** is predicted to increase the exposure to antiarrhythmics (doxorubicin, mitoxantrone). Avoid or monitor. (Moderate) Study
- **Teriflunomide** is predicted to increase the exposure to antiarrhythmics (daunorubicin, doxorubicin, mitoxantrone). (Moderate) Theoretical
- **Anti-D (Rh0) immunoglobulin** → see immunoglobulins

**Antithrombolytics** → see thrombolytics

**Antihistamines** → see antihistamines

**Antivirals** → see antivirals

**Anti-D (Rh0) immunoglobulin**

**Anti-D (Rh0) immunoglobulin** → see immunoglobulins

**Antithrombolytics** → see thrombolytics

**Antihistamines** → see antihistamines

**Antivirals** → see antivirals

**Adenosine - amiodarone - disopyramide - dronedarone - flecainide - lidocaine - propafenone**

- Amiodarone has a long half-life; there is potential for drug interactions to occur for several weeks (or even months) after treatment with it has been stopped.
- Since systemic absorption can follow topical application of lidocaine, the possibility of interactions should be borne in mind.

**Dronedarone** is predicted to increase the exposure to abemaciclib. (Moderate) Study

**Antiarrhythmics** (amiodarone, dronedarone) are predicted to increase the exposure to abemaciclib. Separate administration by 12 hours. (Moderate) Study

**Amiodarone** is predicted to decrease the effects of agalsidase. Avoid. (Moderate) Theoretical

**Amiodarone** is predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. (Severe) Theoretical

**Dronedarone** is predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. (Severe) Study

**Antiarrhythmics** (amiodarone, dronedarone) are predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. (Severe) Study

**Dronedarone** is predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. (Severe) Study

**Dronedarone** is predicted to increase the exposure to alpha blockers (tamsulosin). (Moderate) Theoretical

**Dronedarone** is predicted to increase the exposure to alprazolam. (Severe) Study

**Aminophylline** is predicted to decrease the efficacy of adenosine. Separate administration by 24 hours. (Mild) Theoretical

**Anaesthetics, local** are predicted to increase the risk of cardiodepression when given with antiarrhythmics. (Severe) Theoretical

**Antiarrhythmics** (propafenone) are predicted to increase the risk of cardiodepression when given with antiarrhythmics (amiodarone). Monitor and adjust dose. (Severe) Theoretical

**Antiarrhythmics** (amiodarone) increase the concentration of antiarrhythmics (flecainide). Adjust flecainide dose and monitor side effects. (Severe) Study → Also see TABLE 6 p. 875 → Also see TABLE 9 p. 876

**Antiarrhythmics** (propafenone) are predicted to increase the risk of cardiodepression when given with antiarrhythmics (lidocaine). (Moderate) Study

**Antiarrhythmics** (dronedarone) are predicted to increase the exposure to antiarrhythmics (propafenone). Monitor and adjust dose. (Moderate) Study

**Amiodarone** increases the risk of bradycardia when given with anticholinesterases, centrally acting. (Moderate) Anecdotal

**Antiepileptics** (clobazam, clobazam, phenobarbital, phenytoin, primidone) are predicted to decrease the efficacy of propafenone. (Moderate) Study

**Antiepileptics** (fosphenytoin, phenytoin) are predicted to decrease the exposure to lidocaine. (Severe) Anecdotal

**Antiepileptics** (clobazam, clobazam, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to antiarrhythmics (disopyramide, dronedarone). Avoid. (Severe) Study

**Amiodarone** is predicted to slightly increase the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor and adjust dose. (Severe) Study → Also see TABLE 12 p. 877

**Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure of disopyramide, dronedarone. (Moderate) Theoretical

**Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to disopyramide. Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876

**Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to disopyramide. Use with caution and adjust dose. (Severe) Theoretical

**Antifungals, azoles** (posaconazole) are predicted to increase the exposure to antiarrhythmics (disopyramide, dronedarone). Avoid. (Severe) Theoretical

**Dronedarone** is predicted to increase the exposure to antihistamines, non-sedating (fexofenadine, mizolastine). (Severe) Theoretical

**Dronedarone** is predicted to increase the exposure to antihistamines, non-sedating (fexofenadine, mizolastine). Avoid. (Moderate) Study

**Dronedarone** is predicted to increase the concentration of antimalarials (piperaquine). (Severe) Theoretical

**Dronedarone** is predicted to increase the exposure to apixaban. (Moderate) Theoretical

**Aprepitant** increases the exposure to dronedarone. (Severe) Theoretical

**Aprepitant** is predicted to increase the exposure to propafenone. Monitor and adjust dose. (Moderate) Study

**Dronedarone** is predicted to increase the exposure to axitinib. (Moderate) Theoretical

**Dronedarone** is predicted to increase the exposure to bedaquiline. Avoid prolonged use. (Mild) Theoretical → Also see TABLE 9 p. 876

**Antiarrhythmics** (amiodarone, disopyramide, dronedarone, flecainide, lidocaine) are predicted to increase the risk of cardiovascular side-effects when given with beta blockers, non-selective. Use with caution or avoid. (Severe) Study → Also see TABLE 6 p. 875 → Also see TABLE 9 p. 876

**Propafenone** is predicted to increase the risk of cardiovascular side-effects when given with beta blockers, non-selective (labetalol, levobunolol, nadolol, pindolol, sotalol). Use with caution or avoid. (Severe) Study

**Anthracyclines** (daunorubicin, doxorubicin, epirubicin, idarubicin, mitoxantrone)

**Anthracyclines** (daunorubicin, doxorubicin, epirubicin, idarubicin, mitoxantrone) are predicted to increase the risk of cardiotoxicity when given with antiepileptics (propafenone). Monitor and adjust dose. (Moderate) Study
- Propafenone increases the risk of cardiovascular side-effects when given with beta blockers, non-selective (propranolol). Use with caution or avoid. (Severe) Study

- Propafenone is predicted to increase the exposure to beta blockers, non-selective (timolol) and beta blockers, selective (metoprolol). Monitor and adjust dose. (Moderate) Study

- Propafenone is predicted to increase the exposure to beta blockers, selective (metoprolol). (Moderate) Study

- Propafenone is predicted to increase the exposure to beta blockers, selective (nebivolol) and beta blockers, selective (nebulol) are predicted to increase the risk of cardiovascular side-effects when given with propafenone. Avoid. (Severe) Theoretical

- Antiarrhythmics (amiodarone, disopyramide, dronedarone, flecainide, lidocaine) are predicted to increase the risk of cardiac arrhythmias. (Severe) Theoretical

- Bosentan is predicted to decrease the exposure to dronedarone. (Severe) Theoretical

- Dronedarone is predicted to increase the exposure to bosentan. Avoid or adjust dose. (Severe) Theoretical

- Calcium channel blockers (diltiazem, verapamil) increase the exposure to dronedarone and dronedarone increases the exposure to calcium channel blockers (diltiazem, verapamil). (Moderate) Study

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to propafenone. Monitor and adjust dose. (Moderate) Study

- Calcium channel blockers (diltiazem, verapamil) increase the risk of cardiovascular side-effects when given with flecainide. (Severe) Theoretical

- Dronedarone is predicted to increase the exposure to calcium channel blockers (amiodarone, dipyridamole, fesoterodine, propafenone). Monitor and adjust dose. (Moderate) Study

- Amiodarone is predicted to increase the risk of cardiovascular side-effects when given with calcium channel blockers (verapamil). Avoid. (Severe) Theoretical

- Disopyramide is predicted to increase the risk of cardiovascular side-effects when given with calcium channel blockers (verapamil). Avoid. (Severe) Theoretical

- Dronedarone is predicted to increase the exposure to ciclosporin. Avoid. (Severe) Study

- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to ciclosporin. (Severe) Theoretical

- Dronedarone increases the concentration of ciclosporin. Monitor and adjust dose. (Severe) Study

- Cobicistat potentially increases the concentration of antiarrhythmics (amiodarone, disopyramide, flecainide, lidocaine). (Severe) Theoretical

- Cobicistat very markedly increases the exposure to dronedarone. Avoid. (Severe) Study

- Cobicistat is predicted to increase the exposure to propafenone. Monitor and adjust dose. (Severe) Study

- Dronedarone is predicted to increase the exposure to cobimetinib. (Severe) Theoretical

- Dronedarone is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. (Severe) Study

- Dronedarone is predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor and adjust dose. (Moderate) Study

- Amiodarone increases the anticoagulant effect of coumarins. Avoid. (Severe) Study

- Propafenone increases the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Moderate) Study

- Crizotinib is predicted to increase the exposure to propafenone. Monitor and adjust dose. (Moderate) Study

- Dronedarone increases the exposure to dabigatran. Adjust dabigatran dose. (Moderate) Study

- Dronedarone slightly increases the exposure to dabigatran. Avoid. (Severe) Study

- Darifenacin is predicted to increase the concentration of flecainide. (Moderate) Theoretical

- Dronedarone is predicted to moderately increase the exposure to dasatinib. (Severe) Study → Also see TABLE 9 p. 876

- Antiarrhythmics (amiodarone, dronedarone) are predicted to moderately increase the exposure to digoxin. Monitor and adjust digoxin dose, p. 82. (Severe) Study → Also see TABLE 9 p. 875

- Propafenone increases the concentration of digoxin. Monitor and adjust dose. (Severe) Study

- Dronedarone increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study

- Dronedarone is predicted to increase the exposure to dopamine receptor agonists (bromocriptine). (Severe) Theoretical

- Dronedarone is predicted to increase the concentration of dopamine receptor agonists (caboergoline). (Severe) Theoretical

- Dronedarone is predicted to moderately increase the exposure to dutasteride. (HiId) Study

- Amiodarone slightly increases the exposure to edoxaban. Adjust edoxaban dose. (Severe) Study

- Dronedarone slightly increases the exposure to edoxaban. Adjust edoxaban dose. (Severe) Study

- Efavirenz is predicted to decrease the exposure to dronedarone. (Severe) Theoretical → Also see TABLE 9 p. 876

- Antiarrhythmics (dronedarone, propafenone) are predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study

- Dronedarone is predicted to moderately increase the exposure to encorafenib. (Moderate) Study → Also see TABLE 9 p. 876

- Enzalutamide is predicted to decrease the exposure to antiarrhythmics (disopyramide, dronedarone). Avoid. (Severe) Study

- Enzalutamide is predicted to decrease the efficacy of propafenone. (Moderate) Study

- Dronedarone is predicted to increase the risk of ergotism when given with ergometrine. (Severe) Theoretical

- Dronedarone is predicted to increase the risk of ergotism when given with ergonovine. (Severe) Theoretical

- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to erlotinib. (Severe) Theoretical

- Dronedarone is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study

- Dronedarone is predicted to increase the exposure to febuxostat. Adjust febuxostat dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. (HiId) Study

- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study

- Dronedarone is predicted to increase the exposure to gefitinib. (Severe) Theoretical

- Dronedarone potentially increases the exposure to glecaprevir. (Moderate) Theoretical

- Grapefruit juice increases the exposure to amiodarone. Avoid. (Moderate) Study
Antiarrhythmics (continued)

- **Grapefruit juice** moderately increases the exposure to dronedarone. Avoid. [Severe] Study
- **Grapefruit juice** increases the exposure to propafenone. Monitor and adjust dose. [Moderate] Study
- **Dronedarone** is predicted to increase the concentration of guanfacine. Adjust guanfacine dose, p. 237. [Moderate] Theoretical
- **H₂ receptor antagonists** (cemidetine) increase the exposure to amiodarone. [Moderate] Study
- **H₂ receptor antagonists** (cimetidine) slightly increase the exposure to flecainide. Monitor and adjust dose. [Mild] Study
- **H₂ receptor antagonists** (cimetidine) increase the exposure to lidocaine. Monitor and adjust dose. [Moderate] Study
- **Dronedarone** are predicted to increase the exposure to propafenone. Monitor and adjust dose. [Moderate] Theoretical
- **HIV-protease inhibitors** are predicted to increase the exposure to amiodarone. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **HIV-protease inhibitors** are predicted to increase the exposure to disopyramide. [Severe] Theoretical → Also see TABLE 9 p. 876
- **HIV-protease inhibitors** very markedly increase the exposure to dronedarone. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- **HIV-protease inhibitors** (ritonavir) are predicted to increase the exposure to flecainide. Avoid or monitor side effects. [Severe] Theoretical
- **HIV-protease inhibitors** are predicted to increase the exposure to lidocaine. Avoid. [Severe] Study
- **Dronedarone** are predicted to increase the exposure to propafenone. Adjust dose. [Moderate] Theoretical
- **HIV-protease inhibitors** are predicted to increase the exposure to amiodarone. Avoid. [Severe] Study
- **Dronedarone** are predicted to increase the exposure to propafenone. Monitor and adjust dose. [Moderate] Study
- **Amiodarone** is predicted to increase the exposure to ibritinib. Adjust ibritinib dose. [Severe] Theoretical
- **Dronedarone** is predicted to increase the exposure to ibritinib. Adjust ibritinib dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Dronedarone** is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. [Severe] Theoretical
- **Dronedarone** is predicted to increase the exposure to ivacaftor. Adjust ivacaftor or tezacaftor with ivacaftor p. 189 dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Dronedarone** is predicted to increase the exposure to lapatinib. [Moderate] Study → Also see TABLE 9 p. 876
- **Lediaparin** increases the risk of severe bradycardia or heart block when given with amiodarone. Refer to specialist literature. [Severe] Anecdotal
- **Letemovir** is predicted to increase the concentration of amiodarone. [Moderate] Theoretical
- **Amiodarone** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to lomitapide. Avoid. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to lurasidone. Adjust lurasidone dose. [Moderate] Study
- **Macrolides** (clarithromycin) very markedly increase the exposure to dronedarone. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- **Macrolides** (clarithromycin) are predicted to increase the exposure to propafenone. Monitor and adjust dose. [Severe] Study
- **Macrolides** (clarithromycin, erythromycin) are predicted to increase the exposure to lidocaine. [Moderate] Theoretical
- **Macrolides** (erythromycin) are predicted to moderately increase the exposure to dronedarone. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Macrolides** (erythromycin) are predicted to increase the exposure to propafenone. Monitor and adjust dose. [Moderate] Study
- **Mexiletine** increases the risk of torsade de pointes when given with antiarrhythmics. Avoid. [Severe] Theoretical
- **Dronedarone** is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. [Severe] Study
- **Dronedarone** is predicted to increase the exposure to midostaurin. [Moderate] Theoretical
- **Mitotane** is predicted to decrease the exposure to antiarrhythmics (disopyramide, dronedarone). Avoid. [Severe] Study
- **Mitotane** is predicted to decrease the efficacy of propafenone. [Moderate] Study
- **Dronedarone** increases the risk of neutropenia when given with monoclonal antibodies (brentuximab vedotin). Monitor and adjust dose. [Severe] Theoretical
- **Dronedarone** is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
- **Netupitant** is predicted to increase the exposure to propafenone. Monitor and adjust dose. [Moderate] Study
- **Nevirapine** is predicted to decrease the exposure to dronedarone. [Severe] Theoretical
- **Amiodarone** is predicted to increase the exposure to propafenone. Monitor and adjust dose. [Moderate] Study
- **Antiarrhythmics** (amiodarone, dronedarone) are predicted to increase the exposure to nintedanib. [Moderate] Study
- **NSAIDs** (celecoxib) are predicted to increase the exposure to antiarrhythmics (flecainide, propafenone). Monitor and adjust dose. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. [Moderate] Study
- **Amiodarone** is predicted to increase the concentration of opioids (fentanyl). [Moderate] Theoretical → Also see TABLE 6 p. 875
- **Dronedarone** is predicted to increase the exposure to opioids (methadone, sufentanil). [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Dronedarone** is predicted to increase the exposure to oxybutynin. [Mild] Theoretical
- **Antiarrhythmics** (amiodarone, dronedarone) are predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Dronedarone** is predicted to increase the exposure to pazopanib. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Propafenone** is predicted to increase the anticoagulant effect of phenindione. Monitor and adjust dose. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study → Also see TABLE 9 p. 876
- **Dronedarone** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). [Severe] Theoretical
- **Dronedarone** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Adjust dose. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Amiodarone** is predicted to increase the exposure to pibrentasvir. [Moderate] Theoretical
- **Dronedarone** potentially increases the exposure to pibrentasvir. [Moderate] Theoretical
- **Dronedarone** is predicted to increase the exposure to pimozone. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Dronedarone** is predicted to increase the exposure to quetiapine. Avoid. [Moderate] Study
- Quinolones (ciprofloxacin) slightly increase the exposure to lidocaine. (Mild) Study
- Dronedarone is predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876
- Amiodarone is predicted to increase the exposure to retinoids (alitretinoin). Adjust alitretinoin dose. (Moderate) Theoretical
- Ribocil (high-dose) is predicted to increase the exposure to amiodarone. Avoid. (Moderate) Theoretical → Also see TABLE 9 p. 876
- Dronedarone is predicted to increase the exposure to ribocil. (Moderate) Study → Also see TABLE 9 p. 876
- Rifampicin is predicted to decrease the exposure to antiarrhythmics (disopyramide, dronedarone). Avoid. (Severe) Study
- Rifampicin is predicted to decrease the efficacy of propafenone. (Moderate) Study
- Dronedarone is predicted to increase the exposure to rivaroxaban. Avoid. (Moderate) Theoretical
- Rolapitant is predicted to increase the exposure to propafenone. (Severe) Study
- Dronedarone is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical
- Dronedarone is predicted to increase the exposure to saxagliptin. (Mild) Study
- Amiodarone is predicted to increase the concentration of sirolimus. (Severe) Anecdotal
- Dronedarone increases the concentration of sirolimus. Monitor and adjust dose. (Moderate) Study
- Sofosbuvir is predicted to increase the risk of severe bradycardia or heart block when given with amiodarone. Refer to specialist literature. (Severe) Anecdotal
- SSRIs (fluvoxamine) are predicted to increase the exposure to propafenone. Monitor and adjust dose. (Moderate) Study
- Dronedarone is predicted to increase the exposure to SSRIs (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline). Theoretical → Also see TABLE 9 p. 876
- Dronedarone is predicted to increase the exposure to SSRIs (dopoxetine). Adjust dopoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to dronedarone. Avoid. (Severe) Theoretical
- Amiodarone is predicted to increase the risk of rhabdomyolysis when given with statins (atorvastatin). Monitor and adjust dose. (Moderate) Theoretical
- Dronedarone is predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. (Severe) Study
- Amiodarone is predicted to increase the exposure to statins (fluvastatin). (Severe) Theoretical
- Dronedarone slightly increases the exposure to statins (rosuvastatin). Adjust dose. (Severe) Study
- Amiodarone increases the risk of rhabdomyolysis when given with statins (simvastatin). Adjust simvastatin dose, p. 136. (Severe) Study
- Dronedarone is predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose, p. 136. (Severe) Study
- Amiodarone is predicted to increase the exposure to sulfonylureas. Use with caution and adjust dose. (Moderate) Study
- Dronedarone is predicted to increase the exposure to suniflumethion. Use with caution and adjust suniflumethion dose, p. 136. (Severe) Study
- Amiodarone is predicted to increase the concentration of tacrolimus. (Severe) Anecdotal
- Dronedarone is predicted to increase the concentration of tacrolimus. (Severe) Study
- Dronedarone is predicted to increase the exposure to taxanes (cabazitaxel). (Moderate) Theoretical
- Dronedarone is predicted to increase the exposure to taxanes (paclitaxel). (Severe) Theoretical
- Dronedarone is predicted to increase the concentration of temsirolimus. (Moderate) Theoretical
- Dronedarone is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
- Theophylline decreases the efficacy of adenosine. Separate administration by 24 hours. (Mild) Study
- Amiodarone is predicted to increase the risk of thyroid dysfunction when given with thyroid hormones. Avoid. (Moderate) Study
- Amiodarone is predicted to increase the exposure to ticagrelor. Use with caution or avoid. (Severe) Study
- Dronedarone given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study
- Dronedarone is predicted to increase the exposure to tolterodine. (Mild) Theoretical → Also see TABLE 9 p. 876
- Dronedarone is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study
- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to topotecan. (Severe) Study
- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the concentration of trametinib. (Moderate) Theoretical
- Dronedarone is predicted to increase the exposure to trazodone. (Moderate) Theoretical
- Dronedarone is predicted to increase the exposure to tricyclic antidepressants. Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876
- Propafenone is predicted to increase the concentration of tricyclic antidepressants. (Moderate) Theoretical → Also see TABLE 10 p. 876
- Dronedarone is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study
- Amiodarone is predicted to increase the concentration of vedolizumab. Avoid or monitor. (Moderate) Theoretical
- Amiodarone is predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. (Severe) Theoretical
- Dronedarone is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. (Severe) Study
- Dronedarone is predicted to increase the exposure to vinca alkaloids. (Severe) Theoretical → Also see TABLE 9 p. 876
- Dronedarone is predicted to increase the exposure to topotecan. Adjust dose. (Moderate) Study

Anticholinesterases, centrally acting
- Donepezil - galantamine - rivastigmine

- Antiarrhythmics (amiodarone) increase the risk of bradycardia when given with anticholinesterases, centrally acting. (Moderate) Anecdotal → Also see TABLE 6 p. 875
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to donepezil. (Mild) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate) Study
- Anticholinesterases, centrally acting are predicted to increase the risk of bradycardia when given with beta blockers, non-selective. (Moderate) Anecdotal → Also see TABLE 6 p. 875
- Anticholinesterases, centrally acting are predicted to increase the risk of bradycardia when given with beta blockers, selective. (Moderate) Anecdotal → Also see TABLE 6 p. 875
- Bupropion is predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate) Study
- Cobicistat is predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate) Study
- Enalaprilam is predicted to decrease the exposure to donepezil. (Mild) Study
- HIV-protease inhibitors are predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate) Study
- Idelalisib is predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate) Study
Anticholinesterases, centrally acting (continued)

- **Macrolides** (clarithromycin) are predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate Study)

- **Mirtazapine** is predicted to decrease the exposure to donepezil. (High Study)

- **Anticholinesterases, centrally acting** are predicted to decrease the effects of neuromuscular blocking drugs, non-depolarising. (Moderate) Theoretical → Also see TABLE 6 p. 875

- **Alcohol (beverage)** are predicted to decrease the exposure to donepezil. (High Study)

- **Anticholinesterases, centrally acting** increase the effects of suxamethonium. (Moderate) Theoretical

- **Terbutaline** is predicted to increase the exposure to galantamine. Monitor and adjust dose. (Moderate Study)

### Antiepileptics

- See TABLE 1 p. 874 (hepatotoxicity), TABLE 18 p. 878 (hyponatraemia), TABLE 15 p. 877 (myelosuppression), TABLE 12 p. 877 (peripheral neuropathy), TABLE 11 p. 876 (CNS depressive effects)


### Food and lifestyle

- Avoid taking milk, dairy products, carbonated drinks, fruit juices, or caffeine-containing food and drinks at the same time as stiripentol.

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to abacavir. (Moderate) Theoretical

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to abemaciclib. Avoid. (Severe Study)

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to abiraterone. Avoid. (Severe Study)

- **Acetazolamide** potentially increases the risk of toxicity when given with valproate. (Severe Study)

- **Acetazolamide** potentially increases the risk of overheating and dehydration when given with zonisamide. Avoid in children. (Severe) Theoretical

- **Carbamazepine** is predicted to decrease the exposure to abemaciclib. (Moderate) Study

- **Antiepileptics** (fosphenytoin, phenytoin) are predicted to decrease the exposure to agomelatine. (Moderate) Theoretical

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the concentration of albendazole. (Moderate) Study

- **Alcohol (beverage)** potentially increases the risk of visual disturbances when given with retigabine. (Moderate) Study

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to aldosterone antagonists (eplerenone). Avoid. (Moderate) Theoretical → Also see TABLE 18 p. 878

- **Carbamazepine** decreases the exposure to aliskiren. (Moderate) Study

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to alprazolam. Adjust dose. (Moderate) Study

- **Phenytoin** is predicted to decrease the exposure to amnopyridine. Adjust dose. (Moderate Theoretical → Also see TABLE 11 p. 876

- **Fosphenytoin** is predicted to decrease the exposure to amnopyridine. Adjust dose. (Moderate) Study

- **Phenytoin** is predicted to decrease the exposure to amnopyridine. Adjust dose. (Moderate) Theoretical

- **Phenytoin** decreases the exposure to amnopyridine. Adjust dose. (Moderate) Study

- **Primidone** is predicted to increase the clearance of amnopyridine. Adjust dose. (Moderate) Theoretical

- **Stiripentol** is predicted to increase the exposure to amnopyridine. Avoid. (Moderate) Theoretical

### Antiepileptics, centrally acting

- **Antiepileptics** (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to increase the risk of methaemoglobinemia when given with topical anaesthetics, local (prilocaine). Use with caution or avoid. (Severe Theoretical)

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to antihistamines (disopyramide, droxidopa). Avoid. (Severe Study)

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to antihistamines (amiodarone). Are predicted to slightly increase the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor and adjust dose. (Severe Study) → Also see TABLE 12 p. 877

- **Antiepileptics** (fosphenytoin, phenytoin) are predicted to decrease the exposure to antihistamines (lidocaine). (Severe Anecdotal)

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the efficacy of antihistamines (propafenone). (Moderate) Study

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to anticholinesterases, centrally acting (donepezil). (High Study)

- **Antiepileptics** (carbamazepine) decrease the concentration of antiepileptics (brivaracetam). (Moderate) Study

- **Antiepileptics** (fosphenytoin, phenytoin) decrease the concentration of antiepileptics (brivaracetam). (Moderate) Study

- **Antiepileptics** (lamotrigine) potentially increase the concentration of antiepileptics (carbamazepine) and antiepileptics (carbamazepine) decrease the concentration of antiepileptics (lamotrigine). Adjust lamotrigine dose and monitor carbamazepine concentration, p. 207, p. 200. (Moderate) Study

- **Antiepileptics** (phenobarbital) affect the concentration of antiepileptics (carbamazepine) and antiepileptics (carbamazepine) increase the concentration of antiepileptics (phenobarbital). Adjust dose. (Moderate) Study

- **Antiepileptics** (topiramate) increase the concentration of antiepileptics (carbamazepine, phenobarbital). Avoid in Dravet syndrome. (Severe Study)

- **Antiepileptics** (carbamazepine) slightly decrease the exposure to antiepileptics (eslicarbazepine, oxcarbazepine). Monitor and adjust dose. (Moderate) Study

- **Antiepileptics** (stiripentol) are predicted to increase the concentration of antiepileptics (fosphenytoin). (Severe Study)

- **Antiepileptics** (carbamazepine) affect the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) decrease the concentration of antiepileptics (carbamazepine). Monitor and adjust dose. (Severe Study)

- **Antiepileptics** (eslicarbazepine) increase the exposure to antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) decrease the exposure to antiepileptics (eslicarbazepine). Monitor and adjust dose. (Severe Study)

- **Antiepileptics** (valproate) affect the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) decrease the concentration of antiepileptics (valproate). (Severe) Study

- **Antiepileptics** (vigabatrin) decrease the concentration of antiepileptics (fosphenytoin, phenytoin). (High) Study

- **Antiepileptics** (fosphenytoin) decrease the concentration of antiepileptics (lamotrigine). Monitor and adjust lamotrigine dose, p. 207. (Moderate) Study

- **Antiepileptics** (phenobarbital, phenytoin, primidone) decrease the concentration of antiepileptics (lamotrigine). Monitor and
### Antiepileptics

**Antiepileptics** (valproate) increase the exposure to antiepileptics (lamotrigine). Adjust lamotrigine dose and monitor rash, p. 207. **Severe** Study

Antiepileptics (lamotrigine) are predicted to increase the concentration of antiepileptics (oxcarbazepine) and antiepileptics (oxcarbazepine) are predicted to decrease the concentration of antiepileptics (lamotrigine). Monitor side effects and adjust dose. **Moderate** Study

Antiepileptics (carbamazepine, fosphenytoin) are predicted to decrease the exposure to antiepileptics (perampanel). Monitor and adjust dose. **Moderate** Study

Antiepileptics (oxcarbazepine) decrease the concentration of antiepileptics (perampanel) and antiepileptics (perampanel) increase the concentration of antiepileptics (oxcarbazepine). Monitor and adjust dose. **Moderate** Study

Antiepileptics (phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to antiepileptics (perampanel). Monitor and adjust dose. **Moderate** Study

Antiepileptics (phenytoin) increase the concentration of antiepileptics (phenobarbital) and antiepileptics (phenobarbital) affect the concentration of antiepileptics (phenytoin). **Moderate** Study

Antiepileptics (fosphenytoin) increase the concentration of antiepileptics (phenobarbital, primidone) and antiepileptics (phenobarbital, primidone) affect the concentration of antiepileptics (fosphenytoin). **Moderate** Study

Antiepileptics (oxcarbazepine) are predicted to increase the concentration of antiepileptics (phenytoin). Monitor concentration and adjust dose. **Moderate** Study

Antiepileptics (stiripentol) are predicted to increase the concentration of antiepileptics (phenytoin). Avoid in Dravet syndrome. **Severe** Theoretical

Antiepileptics (carbamazepine) potentially decrease the concentration of antiepileptics (primidone) and antiepileptics (primidone) potentially decrease the concentration of antiepileptics (carbamazepine). Adjust dose. **Moderate** Aneodal

Antiepileptics (phenytoin) increase the concentration of antiepileptics (phenobarbital) and antiepileptics (phenobarbital, primidone) affect the concentration of antiepileptics (phenytoin). **Moderate** Study

Antiepileptics (valproate) affect the concentration of antiepileptics (primidone). Monitor and adjust dose. **Severe** Study

Antiepileptics (carbamazepine) slightly increase the clearance of antiepileptics (retigabine). **Moderate** Study

Antiepileptics (fosphenytoin, phenytoin) are predicted to slightly increase the clearance of antiepileptics (retigabine). **Moderate** Study

Antiepileptics (valproate) increase the exposure to antiepileptics (rufinamide). Adjust rufinamide dose, p. 212. **Moderate** Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to antiepileptics (tiagabine). Monitor and adjust tiagabine dose, p. 217. **Moderate** Study

Antiepileptics (fosphenytoin, phenytoin) decrease the concentration of antiepileptics (topiramate) and antiepileptics (topiramate) increase the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor and adjust dose. **Moderate** Study

Antiepileptics (phenobarbital, primidone) are predicted to decrease the concentration of antiepileptics (topiramate). **Mild** Study

Antiepileptics (phenobarbital) decrease the concentration of antiepileptics (valproate) and antiepileptics (valproate) increase the concentration of antiepileptics (phenobarbital). **Moderate** Study

Antiepileptics (topiramate) increase the concentration of antiepileptics (topiramate). **Severe** Study

Antiepileptics (carbamazepine) slightly to moderately decrease the concentration of antiepileptics (zonisamide) and antiepileptics (zonisamide) affect the concentration of antiepileptics (carbamazepine). Monitor and adjust dose. **Moderate** Study

Antiepileptics (fosphenytoin, phenytoin) slightly to moderately decrease the concentration of antiepileptics (zonisamide). Monitor and adjust dose. **Moderate** Study

Antiepileptics (phenobarbital, primidone) are predicted to decrease the concentration of antiepileptics (zonisamide). Monitor and adjust dose. **Moderate** Study

Antiepileptics (topiramate) potentially increase the risk of overheating and dehydration when given with antiepileptics (zonisamide). Avoid in children. **Severe** Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to very slightly increase the exposure to perampanel. **Mild** Study

Antifungals, azoles (miconazole) increase the risk of carbamazepine toxicity when given with carbamazepine. Monitor and adjust dose. **Severe** Aneodal

Antifungals, azoles (miconazole) increase the risk of phenytoin toxicity when given with fosphenytoin. Monitor and adjust dose. **Severe** Aneodal

Carbamazepine is predicted to decrease the efficacy of antifungals, azoles (flucanazole) and antifungals, azoles (fluconazole) increase the concentration of carbamazepine. Avoid or monitor carbamazepine concentration and adjust dose accordingly, p. 200. **Severe** Theoretical → Also see **TABLE 1** p. 874

Antifungals, azoles (fluconazole) increase the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. **Moderate** Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to antifungals, azoles. Avoid (itraconazole, posaconazole). **Severe** Study

Fosphenytoin very markedly decreases the exposure to antifungals, azoles (itraconazole). Avoid and for 14 days after stopping fosphenytoin. **Moderate** Study

Phenobarbital decreases the concentration of antifungals, azoles (itraconazole). Avoid and for 14 days after stopping phenobarbital. **Moderate** Study

Phenytoin very markedly decreases the exposure to antifungals, azoles (itraconazole). Avoid and for 14 days after stopping phenytoin. **Moderate** Study

Primidone is predicted to decrease the concentration of antifungals, azoles (itraconazole). **Moderate** Theoretical

Carbamazepine is predicted to decrease the efficacy of antifungals, azoles (itraconazole, voriconazole) and antifungals, azoles (itraconazole, voriconazole) increase the concentration of carbamazepine. Avoid or adjust dose. **Moderate** Theoretical → Also see **TABLE 1** p. 874

Carbamazepine is predicted to decrease the efficacy of antifungals, azoles (ketoconazole) and antifungals, azoles (ketoconazole) slightly increase the concentration of carbamazepine. Avoid or monitor carbamazepine concentration and adjust dose accordingly, p. 200. **Moderate** Study

Phenobarbital is predicted to decrease the concentration of antifungals, azoles (ketoconazole). Avoid. **Moderate** Study

Antiepileptics (fosphenytoin, phenytoin) decrease the exposure to antifungals, azoles (ketoconazole). Avoid. **Moderate** Study

Antiepileptics (ketoconazole) are predicted to decrease the concentration of antifungals, azoles (ketoconazole). Avoid. **Moderate** Study

Carbamazepine is predicted to decrease the efficacy of antifungals, azoles (ketoconazole) and antifungals, azoles (ketoconazole) increase the concentration of carbamazepine. Avoid or adjust dose. **Moderate** Theoretical

Phenobarbital is predicted to decrease the concentration of antifungals, azoles (ketoconazole). Avoid. **Moderate** Study

Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the exposure to antifungals, azoles (posaconazole). Avoid. **Moderate** Study

Carbamazepine is predicted to decrease the efficacy of antifungals, azoles (posaconazole) and antifungals, azoles (posaconazole) increase the concentration of carbamazepine. Avoid or adjust dose. **Moderate** Study
Antiepileptics (continued)

- the exposure to fosphenytoin. Avoid or adjust voriconazole dose and monitor phenytoin concentration, p. 392. [Moderate] Study

  - Fosphenytoin decreases the exposure to antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole) increase the exposure to phenytoin. Avoid or adjust voriconazole dose and monitor phenytoin concentration, p. 392, p. 211. [Moderate] Study

- Antiepileptics (phenobarbital, primidone) are predicted to decrease the concentration of antifungals, azoles (voriconazole). Avoid. [Moderate] Theoretical

  - Antihistamines, sedating (hydroxyzine) potentially increase the risk of overheating and dehydration when given with zonisamide. Avoid in children. [Severe] Theoretical

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to antimalarials (artemether) (with lumeferantrine). Avoid. [Severe] Study

  - Antimalarials (pyrimethamine) increase the risk of haematological toxicity when given with antiepileptics (fosphenytoin, phenytoin). [Severe] Study

  - Antimalarials (pyrimethamine) are predicted to increase the risk of haematological toxicity when given with antiepileptics (phenobarbital, primidone). [Severe] Theoretical

- Antiepileptics [carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone] are predicted to decrease the concentration of antimalarials (piperazine). Avoid. [Moderate] Theoretical

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) potentially increase the risk of toxicity when given with antimalarials (quinine). [Unknown] Study

- Apalutamide potentially decreases the exposure to valproate. [Mild] Theoretical

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to apixaban. Use with caution or avoid. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) moderately decrease the exposure to apremilast. Avoid. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to aprepitant. Avoid. [Moderate] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to apixaban. Adjust or adjust dose. [Moderate] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to apixaban. Avoid or adjust dose. [Moderate] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to bazedoxifene. [Moderate] Theoretical

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to bedaquiline. Avoid. [Severe] Study → Also see TABLE 11 p. 876

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to bedaquiline. Avoid. [Severe] Study → Also see TABLE 1 p. 874

- Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to beta blockers, non-selective (carvedilol, labetalol). [Moderate] Theoretical

  - Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to beta blockers, non-selective (propranolol). [Moderate] Study

  - Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to beta blockers, selective (acebutolol, bisoprolol, metoprolol, nebivolol). [Moderate] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to bictegravir. Avoid. [Moderate] Study

  - Oxcarbazepine is predicted to decrease the exposure to bictegravir. Avoid. [Moderate] Theoretical

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) slightly decrease the exposure to bortezomib. Avoid. [Severe] Study → Also see TABLE 12 p. 877

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) affect the exposure to bosentan. Avoid. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to very markedly decrease the exposure to bosutinib. Avoid. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to brigitinib. Avoid. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to bupropion. [Severe] Study

  - Valproate increases the exposure to bupropion. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to bupropion. Use with caution and adjust dose. [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) moderately decrease the exposure to cabozantinib. Avoid. [Moderate] Study

  - Antiepileptics (fosphenytoin, phenytoin) are predicted to moderately increase the clearance of caffeine citrate. Monitor and adjust dose. [Moderate] Study

  - Calcium channel blockers (diltiazem) increase the concentration of carbamazepine and carbamazepine is predicted to decrease the exposure to calcium channel blockers (diltiazem). Monitor concentrations and adjust dose. [Severe] Anecdotal

  - Calcium channel blockers (verapamil) increase the concentration of carbamazepine and carbamazepine is predicted to decrease the exposure to calcium channel blockers (verapamil). [Severe] Anecdotal

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to calcium channel blockers (diltiazem, verapamil). [Severe] Study

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cannabis extract. Avoid. [Severe] Theoretical → Also see TABLE 11 p. 876

  - Capcetabine increases the concentration of antiepileptics (fosphenytoin, phenytoin). [Severe] Anecdotal

  - Carbapenems decrease the concentration of valproate. Avoid. [Severe] Anecdotal

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to carbapenems. Avoid. [Severe] Anecdotal

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cariprazine. Avoid. [Severe] Theoretical → Also see TABLE 11 p. 876

  - Antiepileptics (carbamazepine, fosphenytoin, phenytoin) are predicted to decrease the concentration of caspofungin. Adjust caspofungin dose, p. 386. [Moderate] Theoretical

  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to ceritinib. Avoid. [Severe] Study

  - Antiepileptics (phenobarbital, primidone) are predicted to affect the efficacy of chenodeoxycholic acid. Monitor and adjust dose. [Moderate] Theoretical

  - Antiepileptics (phenobarbital, primidone) decrease the concentration of chlorpheniramine. [Moderate] Study

  - Intravenous chlorpheniramine increases the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) affect the concentration of intravenous chlorpheniramine. Monitor concentration and adjust dose. [Severe] Study

  - Chloroxazone affects the concentration of antiepileptics (fosphenytoin, phenytoin). [Severe] Study

  - Phenobarbital decreases the effects of cholic acid. Avoid. [Moderate] Study
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- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the concentration of ciclosporin. (Severe) Study
- Oxcarbazepine decreases the concentration of ciclosporin. (Severe) Aneodal
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to alter the effects of ciclosporin. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cobicistat. Monitor and adjust dose. (Moderate) Study
- Carbamazepine is predicted to increase the risk of haematological toxicity when given with oral claidobrine. (Moderate) Theoretical
- Clobazam potentially affects the concentration of antiepileptics (fosphenytoin, phenytoin). (Severe) Aneodal
- Stiripentol increases the concentration of clobazam. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to clomethiazole. Monitor and adjust dose. (Moderate) Study → Also see TABLE 11 p. 876
- Clonazepam potentially affects the concentration of antiepileptics (fosphenytoin, phenytoin). (Severe) Aneodal
- Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to clobazam. (Severe) Study
- Oxcarbazepine is predicted to decrease the concentration of cobicistat. (Severe) Theoretical
- Cobicistat is predicted to very slightly increase the exposure to perampanel. (MILD) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cobicistat. Avoid. (Severe) Aneodal
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ciclosporin. (Severe) Aneodal
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Study
- Combined hormonal contraceptives alter the exposure to lamotrigine. Adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ciclosporin. (Severe) Aneodal
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ciclosporin. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to alter the concentration of ciclosporin. (Severe) Aneodal
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ciclosporin. (Severe) Theoretical
- Carbamazepine decreases the effects of ciclosporin. Monitor and adjust dose. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ciclosporin. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ciclosporin. (Severe) Theoretical
- Carbamazepine is predicted to decrease the exposure to dabigatran. Avoid. (Severe) Study
- Phenytoin is predicted to decrease the exposure to dabigatran. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to dabrafenib. Avoid. (Moderate) Theoretical
- Danazol moderately increases the concentration of carbamazepine. Monitor and adjust dose. (Severe) Study
- Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to increase the risk of methaemoglobinemia when given with dapsone. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to darifenacin. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to dasabuvir. Avoid. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to dasatinib. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to slightly decrease the exposure to deltamethrin. Avoid. (Moderate) Study
- Lamotrigine is predicted to increase the risk of hyponatraemia when given with desmopressin. (Severe) Theoretical
- Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- Desogestrel is predicted to increase the exposure to lamotrigine. (Moderate) Study
- Diazoxide decreases the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the effects of diazoxide. Monitor concentration and adjust dose. (Moderate) Aneodal
- Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the concentration of digoxin. (Moderate) Aneodal
- Diazoxide increases the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to dolutegravir. Adjust dose. (Severe) Study
- Oxcarbazepine is predicted to decrease the exposure to dolutegravir. Adjust dose. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to doravirine. Avoid. (Severe) Study
- Oxcarbazepine is predicted to decrease the exposure to doravirine. Avoid. (Severe) Study
- Phenytoin is predicted to decrease the exposure to dolutegravir. (Moderate) Theoretical
- Carbamazepine is predicted to decrease the exposure to edoxaban. (Moderate) Study
- Phenytoin is predicted to decrease the exposure to edoxaban. (Moderate) Theoretical
- Antiepileptics (fosphenytoin, phenytoin) slightly decrease the exposure to efavirenz and efavirenz affects the concentration of antiepileptics (fosphenytoin, phenytoin). (Severe) Theoretical
- Carbamazepine slightly decreases the exposure to efavirenz and efavirenz slightly decreases the exposure to carbamazepine. (Severe) Study
- Phenobarbital is predicted to decrease the exposure to efavirenz and efavirenz affects the concentration of phenobarbital. (Severe) Theoretical
- Efavirenz is predicted to affect the efficacy of primidone and primidone is predicted to slightly decrease the exposure to efavirenz. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to elbasvir. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to elgilustat. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
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Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to encorafenib. [Severe] Theoretical

Enteral feeds decrease the absorption of phenytoin. [Severe]

Enzalutamide is predicted to slightly decrease the exposure to brivaracetam. [Moderate] Theoretical

Enzalutamide is predicted to decrease the exposure to erlotinib. Avoid or adjust erlotinib dose. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the effects of ergotamine. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to eslicarbazepine and oxcarbazepine. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to esketamine. Adjust dose. [Moderate] Theoretical → Also see TABLE 11 p. 876

Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the efficacy of etoposide. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of everolimus. Avoid or adjust dose. [Severe] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) moderately decrease the exposure to exemestane. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to fingolet. Avoid. [Moderate] Study

Fluorouracil increases the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. [Severe] Theoretical

Folates are predicted to decrease the concentration of antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone). Monitor concentration and adjust dose. [Severe] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to fosaprepitant. Avoid. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to glecaprevir. Avoid. [Severe] Study

Valproate potentially opposes the effects of glycerol phenylbutyrate. [Moderate] Theoretical

Grapefruit juice slightly increases the exposure to carbamazepine. Monitor and adjust dose. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study

Antiepileptics (phenobarbital, primidone) decrease the effects of griseofulvin. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of guanfacine. Adjust guanfacine dose, p. 237. [Moderate] Study → Also see TABLE 11 p. 876

Oxcarbazepine is predicted to decrease the concentration of guanfacine. Monitor and adjust guanfacine dose, p. 237. [Moderate] Theoretical

Guanfacine increases the concentration of valproate. Monitor and adjust dose. [Moderate] Study

H₂-receptor antagonists (cimetidine) transiently increase the concentration of carbaamazepine. Monitor concentration and adjust dose. [Severe] Study

H₂-receptor antagonists (cimetidine) increase the concentration of carbaamazepine. Monitor concentration and adjust dose. [Severe] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the concentration of haloperidol. Adjust dose. [Moderate] Study → Also see TABLE 11 p. 876

Haloperidol potentially increases the risk of overheating and dehydration when given with zonisamide. Avoid in children. [Severe] Theoretical

HIV-protease inhibitors are predicted to affect the exposure to antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) decrease the concentration of HIV-protease inhibitors. [Severe] Theoretical

HIV-protease inhibitors are predicted to affect the concentration of antiepileptics (phenobarbital, primidone) and antiepileptics (phenobarbital, primidone) are predicted to decrease the concentration of HIV-protease inhibitors. [Severe] Theoretical

HIV-protease inhibitors are predicted to increase the exposure to carbamazepine and carbamazepine is predicted to decrease the exposure to HIV-protease inhibitors. Monitor and adjust dose. [Severe] Theoretical

HIV-protease inhibitors (ritonavir) slightly decrease the exposure to lamotrigine. [Severe] Study

HIV-protease inhibitors are predicted to very slightly increase the exposure to perampanel. [Mild] Study

HIV-protease inhibitors (ritonavir) are predicted to decrease the concentration of valproate. [Severe] Anecdotal

Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the effects of hormone replacement therapy. [Moderate] Anecdotal

Hormone replacement therapy is predicted to alter the exposure to lamotrigine. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ibritinib. Avoid or adjust ibritinib dose. [Severe] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to idelalisib. Avoid. [Severe] Study

Idelalisib is predicted to very slightly increase the exposure to perampanel. [Mild] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to imatinib. Avoid. [Moderate] Study

Oxcarbazepine decreases the exposure to imatinib. Avoid. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to iron chelators (deferasirox). Monitor serum ferritin and adjust dose. [Moderate] Theoretical

Isoniazid increases the concentration of antiepileptics (fosphenytoin, phenytoin). [Moderate] Study → Also see TABLE 12 p. 877

Isoniazid markedly increases the concentration of carbamazepine and carbamazepine increases the risk of hepatotoxicity when given with isoniazid. Monitor concentration and adjust dose. [Severe] Study → Also see TABLE 1 p. 874

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ivabradine. Adjust dose. [Moderate] Theoretical
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ivacaftor. Avoid. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to isavuconazol. Avoid. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to lapatinib. Avoid. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ledipasvir. Avoid. [Severe] Theoretical
> Carbamazepine is predicted to decrease the exposure to ledipasvir. Avoid. [Severe] Study
> Antiepileptics (carbamazepine, phenobarbital, primidone) are predicted to decrease the concentration of levetiracetam. [Moderate] Theoretical
> Letermovir is predicted to decrease the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the concentration of letrozol. [Moderate] Theoretical
> Antiepileptics (fosphenytoin, phenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the effects of levedopa. [Moderate] Study
> Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to increase the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to lithium. [Severe] Anecdotal
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to lomitapide. Monitor and adjust dose. [Moderate] Theoretical
> Also see TABLE 11 p. 874
> Antiepileptics (fosphenytoin, phenytoin) decrease the effects of loop diuretics (furosemide). [Moderate] Study
> Lumacaftor is predicted to decrease the exposure to antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone). Avoid. [Severe] Theoretical
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to lurasidone. Avoid. [Moderate] Study → Also see TABLE 11 p. 876
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to maclentan. Avoid. [Severe] Study
> Macrolides (clarithromycin) slightly increase the concentration of carbamazepine. Monitor concentration and adjust dose. [Severe] Study
> Macrolides (erythromycin) are predicted to very slightly increase the exposure to perampanel. [Mild] Study
> Macrolides (erythromycin) markedly increase the concentration of carbamazepine. Monitor concentration and adjust dose. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to mycophenolate. Adjust dose. [Severe] Study
> Phenytoin is predicted to decrease the exposure to melatonin. [Moderate] Theoretical
> Levetiracetam decreases the clearance of methotrexate. [Severe] Anecdotal
> Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to metronidazole. [Moderate] Study
> Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the effects of metyrapone. Avoid. [Moderate] Study
> Phenytoin is predicted to increase the clearance of mexiletine. Monitor and adjust dose. [Moderate] Study
> Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to mianserin. [Moderate] Study → Also see TABLE 11 p. 876
> Carbamazepine markedly decreases the exposure to mianserin. Adjust dose. [Moderate] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to midazolam. Monitor and adjust dose. [Moderate] Study → Also see TABLE 11 p. 876
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to midostaurin. Avoid. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to mirzapine. Adjust dose. [Moderate] Study → Also see TABLE 11 p. 876
> Mitotane is predicted to decrease the exposure to perampanel. Monitor and adjust dose. [Moderate] Study
> Antiepileptics (carbamazepine, phenobarbital, primidone) are predicted to decrease the exposure to modafinil. [Mild] Theoretical
> Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the exposure to modafinil and modafinil is predicted to increase the concentration of antiepileptics (fosphenytoin, phenytoin, phenobarbital, phenytoin, primidone). Monitor concentration and adjust dose. [Moderate] Theoretical
> Antiepileptics (phenobarbital, primidone) are predicted to increase the effects of monoamine-oxidase A and B inhibitors, irreversible. [Severe] Theoretical
> Carbamazepine is predicted to increase the risk of severe toxic reaction when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical
> Carbamazepine is predicted to decrease the effects of monoclonal antibodies (brentuximab vedotin). [Severe] Theoretical
> Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to antiepileptics (fosphenytoin, phenytoin). Monitor and adjust dose. [Moderate] Theoretical
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to montelukast. [Mild] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to naloxegol. Avoid. [Moderate] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to slightly decrease the exposure to nateglinide. [Mild] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to netupitant. Avoid. [Severe] Study
> Carbamazepine is predicted to decrease the effects of (but acute use increases the effects of) neuromuscular blocking drugs, non-depolarising (atracurium, cisatracurium, pancuronium, rocuronium). Monitor and adjust dose. [Moderate] Study
> Antiepileptics (fosphenytoin, phenytoin) decrease the effects of (but acute use increases the effects of) neuromuscular blocking drugs, non-depolarising (atracurium, cisatracurium, pancuronium, rocuronium). [Moderate] Study
> Nevirapine is predicted to decrease the concentration of antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) and antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of nevirapine. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to nintedanib. Avoid. [Severe] Study
> Carbamazepine is predicted to decrease the exposure to nintedanib. [Moderate] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to nitoxime. Adjust dose. [Moderate] Theoretical
> Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
Antiepileptics (continued)

- Carbamazepine potentially decreases the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- Phenytoin is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to alaparin. Avoid. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ondansetron. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to opioids (alfentanil, fentanyl). (Moderate) Study → Also see TABLE 11 p. 876
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to opioids (methadone). Monitor and adjust dose. (Severe) Study → Also see TABLE 11 p. 876
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to phenytoin, primidone. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to omeprazole. Study → Also see TABLE 11 p. 876
- Carbamazepine decreases the concentration of opioids (tramadol). Adjust dose. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to osimertinib. Avoid. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to osphenfine. (Moderate) Study
- Oxycodone potentially increases the risk of overheating and dehydration when given with zonisamide. Avoid in children. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to palbociclib. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to paliperidone. Avoid. (Severe) Study → Also see TABLE 11 p. 876
- Valproate slightly increases the exposure to paliperidone. Adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to panobinostat. Avoid. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to paracetamol. (Moderate) Study → Also see TABLE 1 p. 874
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to pazopanib. Avoid. (Severe) Theoretical
- Valproate increases the risk of side-effects when given with penicillins (pimelicillin). Avoid. (Severe) Anecdotal
- Phenothiazines (chlorpromazine) decrease the concentration of antiepileptics (phenobarbital, primidone) and antiepileptics (phenobarbital, primidone) decrease the concentration of phenothiazines (chlorpromazine). (Moderate) Study → Also see TABLE 11 p. 876
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avancafil, tadafilaf). Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (sildenafil, vardenafa). (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately to markedly decrease the exposure to rifampicin and rifapicin. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to rilpivirine. Avoid. (Severe) Study

Also see TABLE 11
Antiepileptics – Antiepileptics

- Carbamazepine is predicted to decrease the concentration of rilpivirine. Avoid. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to risperidone. Adjust dose. (Moderate) Study → Also see TABLE 11 p. 876
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to rivaroxaban. Unless patient cannot be monitored for signs of thrombosis. Avoid or adjust rivaroxaban dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the concentration of sirolimus. Avoid. (Severe) Study
- Valproate is predicted to increase the exposure to selexipag. Adjust dose. (Moderate) Study
- Valproate is predicted to increase the exposure to sodium oxybate. Adjust sodium oxybate dose. (Moderate) Study
- Valproate is predicted to increase the effects of sodium phenylbutyrate. (Moderate) Anecdotal
- Antiepileptics (fosphenytoin, oxcarbazepine, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to sofosbuvir. Avoid. (Severe) Theoretical
- Carbamazepine is predicted to decrease the exposure to sofosbuvir. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to sofosbuvir. Avoid. (Severe) Study
- Carbamazepine is predicted to decrease the exposure to statins (simvastatin). Monitor and adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to statins (simvastatin, simvastatin). (Moderate) Anecdotal
- Carbamazepine moderately decreases the exposure to statins (simvastatin). Monitor and adjust dose. (Severe) Study → Also see TABLE 1 p. 874
- Eslicarbazepine moderately decreases the exposure to statins (simvastatin). Monitor and adjust dose. (Moderate) Study
- Sulfonamides (sulfadiazine) are predicted to increase the concentration of fosphenytoin. Monitor and adjust dose. (Moderate) Study
- Sulfonamides (sulfadiazine) increase the concentration of phenytoin. Monitor and adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to sumitabine. Avoid or adjust sumitabine dose. (Moderate) Study
- Antiepileptics (fosphenytoin, phenytoin) increase the effects of suxamethonium. Avoid. (Moderate) Study
- Carbamazepine increases the risk of prolonged neuromuscular blockade when given with suxamethonium. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the concentration of tacrolimus. Monitor and adjust dose. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. (Severe) Study → Also see TABLE 12 p. 877
- Fegatuf potentially increases the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. (Severe) Anecdotal
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, oxcarbazepine, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to tetracyclines (doxycycline). Monitor and adjust dose. (Moderate) Study → Also see TABLE 1 p. 874
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tezacaftor. Avoid. (Severe) Theoretical
- Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the exposure to theophylline. Adjust dose. (Moderate) Study
- Antiepileptics (phenobarbital, primidone) are predicted to increase the clearance of theophylline. Adjust dose. (Moderate) Theoretical
- Carbamazepine potentially increases the clearance of theophylline and theophylline decrease the exposure to carbamazepine. Adjust dose. (Moderate) Anecdotal
- Stiripentol is predicted to increase the exposure to theophylline. Avoid. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenytoin) are predicted to increase the risk of hypothyroidism when given with thyroid hormones. (Moderate) Study
- Antiepileptics (phenobarbital, primidone) are predicted to decrease the effects of thyroid hormones. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to ticagrelor. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tivozanib. Avoid. (Severe) Study
- Antiepileptics (fosphenytoin, phenytoin) moderately decrease the exposure to tivozanib. Avoid. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tofacitinib. Avoid. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tolvaptan. Use with caution or avoid depending on indication. (Severe) Study
- Antiepileptics (fosphenytoin, phenytoin) increase the clearance of topotecan. (Moderate) Study
Antiepileptics (continued)

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to toremifene. Adjust dose. (Moderate Study)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to trabectedin. Avoid. (Severe Theoretical) Also see TABLE 1 p. 874
- Carbamazepine decreases the concentration of trazodone. Adjust dose. (Moderate Study) Also see Anecdotal Study
- Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to tricyclic antidepressants. (Moderate Study)
- Carbamazepine decreases the exposure to tricyclic antidepressants. Adjust dose. (Moderate Study) Also see TABLE 18 p. 878
- Tricyclic antidepressants (clomipramine, imipramine) potentially increase the risk of overheating and dehydration when given with zonisamide. Avoid in children. (Severe Theoretical)
- Trimethoprim increases the concentration of antiepileptics (fosphenytoin, phenytoin). (Moderate Study)
- Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) decrease the efficacy of ulipristal. For FSHR guidance, see Contraceptives, interactions p. 516. (Severe Anecdotal)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vandetanib. Avoid. (Moderate Study)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to velpatavir. Avoid. (Severe Study)
- Oxcarbazepine is predicted to decrease the exposure to vemurafenib. Avoid. (Severe Theoretical)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to venetoclax. Avoid. (Severe Study)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vinca alkaloids (vinblastine, vincristine, vinodesine). (Severe Theoretical) Also see TABLE 1 p. 874 Also see TABLE 12 p. 877
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vinca alkaloids (vinflunine). Avoid. (Severe Theoretical) Also see TABLE 12 p. 877
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vismodegib. Avoid. (Moderate Theoretical)
- Antiepileptics (fosphenytoin, phenytoin) decrease the effects of vitamin D substances. (Moderate Study)
- Antiepileptics (phenobarbital, primidone) are predicted to decrease the effects of vitamin D substances. (Moderate Theoretical)
- Carbamazepine is predicted to decrease the effects of vitamin D substances. (Moderate Study)
- Antiepileptics (phenobarbital, primidone) potentially increase the risk of nephrotoxicity when given with volatile halogenated anaesthetics (methoxyflurane). Avoid. (Severe Theoretical) Also see TABLE 11 p. 876
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vortioxetine. Monitor and adjust dose. (Moderate Study)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of voxilaprevir. Avoid. (Severe Study)
- Oxcarbazepine is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe Theoretical)
- Valproate slightly increases the exposure to zidovudine. (Moderate Study)
- Carbamazepine moderately decreases the exposure to zolpidem. (Moderate Study)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to zopiclone. Adjust dose. (Moderate Study) Also see TABLE 11 p. 876
- Antifungals, azoles → see TABLE 1 p. 874 (Hepatotoxicity), TABLE 9 p. 876 (QT-interval prolongation)
- Since systemic absorption can follow topical application, the possibility of interactions with topical clotrimazole and ketoconazole should be borne in mind.
- In general, fluconazole interactions relate to multiple-dose treatment.
- The use of carbonated drinks, such as cola, improves irtraconazole, ketoconazole and posaconazole bioavailability.
- Interactions of miconazole apply to the oral gel formulation, as a sufficient quantity can be absorbed to cause systemic effects. Systemic absorption from intravaginal and topical formulations might also occur.
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to abemaciclib. (Moderate Study)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe Study)
- Antifungals, azoles (itraconazole, ketoconazole) are predicted to increase the exposure to afatinib. Separate administration by 12 hours. (Moderate Study)
- Alcohol (beverage) potentially causes a disulfiram-like reaction when given with ketoconazole. Avoid. (Moderate Anecdotal)
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. (Severe Study)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to aldosterone antagonists (eplerenone). Avoid. (Severe Study)
- Itraconazole markedly increases the exposure to aliskiren. Avoid. (Severe Study)
- Ketoconazole moderately increases the exposure to aliskiren. (Moderate Study)
- Itraconazole increases the risk of busulfan toxicity when given with alkylating agents (busulfan). Monitor and adjust dose. (Moderate Study)
- Miconazole is predicted to increase the concentration of alkylating agents (busulfan). Use with caution and adjust dose. (Moderate Theoretical)
- Isavuconazole is predicted to increase the exposure to alkylating agents (cyclophosphamide). (Moderate Study)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) increase the exposure to almitrtpian. (Mild Study)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to alpha blockers (alfuzosin, tamsulosin). Use with caution or avoid. (Moderate Study)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to alpha blockers (doxazosin). (Moderate Study)
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to alpha blockers (tamsulosin). (Moderate Theoretical)
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to alprazolam. (Severe Study)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) moderately increase the exposure to alprazolam. Avoid. (Moderate Study)
- Miconazole is predicted to increase the exposure to alprazolam. Use with caution and adjust dose. (Moderate Theoretical)
Antifungals, azoles

Miconazole potentially decreases the exposure to aminoglycosides (tobramycin). [Moderate] Anecdot al

Antacids decrease the absorption of itraconazole (capsule). Antacids should be taken 1 hour before or 2 hours after itraconazole. [Moderate] Study

Antacids decrease the absorption of ketoconazole. Separate administration by at least 2 hours. [Moderate] Study

Miconazole is predicted to increase the exposure to antihistamines (disopyramide). Use with caution and adjust dose. [Severe] Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to antihistamines (disopyramide). Avoid. [Severe] Theoretical

Posaconazole is predicted to increase the exposure to antihistamines (disopyramide, dronedarone). Avoid. [Severe] Study

Fluconazole is predicted to increase the exposure to antihistamines (dronedarone). [Severe] Theoretical → Also see TABLE 9 p. 876

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) very markedly increase the exposure to antihistamines (dronedarone). Avoid. [Severe] Study → Also see TABLE 9 p. 876

Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to antihistamines (propafenone). Monitor and adjust dose. [Moderate] Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to antihistamines (propafenone). Monitor and adjust dose. [Severe] Study

Antiepileptics (carbamazepine) are predicted to decrease the efficacy of fluconazole and fluconazole increases the concentration of antiepileptics (carbamazepine). Avoid or monitor carbamazepine concentration and adjust dose accordingly. p. 200. [Severe] Theoretical → Also see TABLE 1 p. 874

Antiepileptics (carbamazepine) are predicted to decrease the efficacy of ketoconazole and ketoconazole slightly increases the concentration of antiepileptics (carbamazepine). Avoid or monitor carbamazepine concentration and adjust dose accordingly. p. 200. [Moderate] Study

Antiepileptics (carbamazepine) are predicted to decrease the efficacy of posaconazole and posaconazole increases the concentration of antiepileptics (carbamazepine). Avoid. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to isavuconazole. Avoid. [Severe] Study

Antiepileptics (fosphenytoin) very markedly decrease the exposure to itraconazole. Avoid and for 14 days after stopping fosphenytoin. [Moderate] Study

Antiepileptics (fosphenytoin) decrease the exposure to voriconazole and voriconazole increases the exposure to antiepileptics (fosphenytoin). Avoid or adjust voriconazole dose and monitor phenytoin concentration, p. 392. [Moderate] Study

Antiepileptics (fosphenytoin, phenytoin) decrease the exposure to ketoconazole. Avoid. [Moderate] Study

Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the exposure to posaconazole. Avoid. [Moderate] Study

Antiepileptics (phenobarbital) decrease the concentration of itraconazole. Avoid and for 14 days after stopping phenobarbital. [Moderate] Study

Antiepileptics (phenobarbital) are predicted to decrease the concentration of ketoconazole. Avoid. [Moderate] Study

Antiepileptics (phenobarbital) are predicted to decrease the concentration of posaconazole. Avoid. [Moderate] Study

Antiepileptics (phenobarbital, primidone) are predicted to decrease the concentration of voriconazole. Avoid. [Moderate] Theoretical

Antiepileptics (phenytoin) very markedly decrease the exposure to itraconazole. Avoid and for 14 days after stopping phenytoin. [Moderate] Study

Antiepileptics (phenytoin) decrease the exposure to voriconazole and voriconazole increases the exposure to antiepileptics (phenytoin). Avoid or adjust voriconazole dose and monitor phenytoin concentration, p. 392, p. 211. [Moderate] Study

Antiepileptics (primidone) are predicted to decrease the concentration of itraconazole. [Moderate] Theoretical

Miconazole increases the risk of carbamazepine toxicity when given with antiepileptics (carbamazepine). Monitor and adjust dose. [Severe] Anecdot al

Miconazole increases the risk of phenytoin toxicity when given with antiepileptics (fosphenytoin). Monitor and adjust dose. [Severe] Anecdot al

Fluconazole increases the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. [Moderate] Study

Antiepileptics (Carbamazepine) are predicted to decrease the efficacy of antifungals, azoles (itraconazole, voriconazole) and antifungals, azoles (itraconazole, voriconazole) increase the concentration of antiepileptics (carbamazepine). Avoid or adjust dose. [Moderate] Theoretical → Also see TABLE 1 p. 874

Antiepileptics (primidone) are predicted to decrease the concentration of antifungals, azoles (ketocazolame, posaconazole). Avoid. [Moderate] Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to very slightly increase the exposure to antifungals (perampanel). [Moderate] Study

Miconazole increases the risk of phenytoin toxicity when given with antiepileptics (phenytoin). Monitor and adjust dose. [Severe] Anecdot al

Antifungals, azoles (fluconazole) are predicted to increase the exposure to antifungals, azoles (isavuconazole). Avoid or monitor side effects. [Severe] Study

Antifungals, azoles (posaconazole) are predicted to increase the exposure to antifungals, azoles (isavuconazole). Avoid. [Moderate] Study

Ketoconazole increases the exposure to antimalarials (mefloquine). [Moderate] Study

Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to antihistamines, non-sedating (mizolastine). Avoid. [Moderate] Theoretical

Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to antimalarials (mefloquine). [Moderate] Study

Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the exposure to antimalarials, non-sedating (mizolastine). Avoid. [Moderate] Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to antimalarials (mefloquine). [Moderate] Theoretical

Antifungals, azoles (fluconazole, itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to antimalarials (mefloquine). [Moderate] Theoretical

Antifungals, azoles (fluconazole, itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of antimalarials (piperperaquine). [Severe] Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to apalutamide. [Mild] Study → Also see TABLE 9 p. 876

Itraconazole is predicted to increase the exposure to apixaban. Avoid. [Severe] Theoretical

Ketoconazole slightly to moderately increases the exposure to apixaban. Avoid. [Severe] Study

Voriconazole is predicted to increase the exposure to apixaban. Avoid. [Moderate] Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to apreparant. [Moderate] Study

Fluconazole is predicted to increase the exposure to apreparant. [Moderate] Theoretical

Apreparant is predicted to increase the exposure to isavuconazole. [Moderate] Theoretical
### TABLE 9

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antifungals, azoles</strong> (itraconazole, ketoconazole, voriconazole)</td>
<td>Are predicted to increase the exposure to calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>(amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose.</td>
</tr>
<tr>
<td></td>
<td>(Moderate) Study</td>
</tr>
<tr>
<td><strong>Itraconazole</strong></td>
<td>Are predicted to increase the exposure to calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>(amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose.</td>
</tr>
<tr>
<td></td>
<td>(Moderate) Study</td>
</tr>
<tr>
<td><strong>Voriconazole</strong></td>
<td>Are predicted to increase the exposure to calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>(amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose.</td>
</tr>
<tr>
<td></td>
<td>(Moderate) Study</td>
</tr>
<tr>
<td><strong>Posaconazole</strong></td>
<td>Are predicted to increase the exposure to calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>(amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose.</td>
</tr>
<tr>
<td></td>
<td>(Moderate) Study</td>
</tr>
<tr>
<td><strong>Isavuconazole</strong></td>
<td>Are predicted to increase the exposure to calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>(amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose.</td>
</tr>
<tr>
<td></td>
<td>(Moderate) Study</td>
</tr>
<tr>
<td><strong>Miconazole</strong></td>
<td>Are predicted to increase the exposure to calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>(amlodipine, clopidogrel, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose.</td>
</tr>
<tr>
<td></td>
<td>(Moderate) Study</td>
</tr>
</tbody>
</table>

*Also see p. 876*
Antifungals, azoles – Antifungals, azoles

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to corticosteroids (betamethasone) (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to corticosteroids (budesonide, ciclesonide, deflazacort, desamethasone, fluocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study
- Miconazole is predicted to increase the concentration of corticosteroids (methylprednisolone). Monitor and adjust dose. [Moderate] Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor and adjust dose. [Moderate] Study
- Fluconazole increases the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Moderate] Study
- Itraconazole potentially increases the anticoagulant effect of coumarins. [Severe] Anecdotal
- Ketocnazole potentially increases the anticoagulant effect of coumarins (warfarin). Monitor INR and adjust dose. [Severe] Anecdotal
- Miconazole greatly increases the anticoagulant effect of coumarins. MHRA advises avoid unless INR can be monitored closely; monitor for signs of bleeding. [Severe] Study
- Voriconazole increases the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Moderate] Study
- Itraconazole is predicted to markedly increase the exposure to crizotinib. Avoid. [Moderate] Study → Also see TABLE 9 p. 876
- Itraconazole, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to dabigatran. Avoid. [Severe] Study
- Itraconazole, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to dabrafenib. Use with caution or avoid. [Moderate] Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to slightly increase the exposure to darifenacin. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to dasatinib. [Severe] Study → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to delamanid. [Severe] Study → Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to diazepam. Monitor and adjust dose. [Moderate] Study
- Didanosine (served) decreases the exposure to antifungals, azoles (itraconazole, ketoconazole). Separate administration by 2 hours. [Severe] Study → Also see TABLE 1 p. 874
- Isavuconazole slightly increases the exposure to digoxin. Monitor and adjust dose. [Moderate] Study
- Voriconazole is predicted to markedly increase the concentration of digoxin. Monitor and adjust dose. [Severe] Study
- Ketoconazole is predicted to markedly increase the concentration of digoxin. [Severe] Study
- Voriconazole is predicted to increase the concentration of digoxin. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole, posaconazole) increase the risk of QT-prolongation when given with domperidone. Avoid. [Severe] Study
- Antifungals, azoles (itraconazole, isavuconazole, posaconazole) are predicted to increase the exposure to dopamine receptor agonists (bromocriptine). [Severe] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) increase the exposure to dopamine receptor agonists (bromocriptine). [Severe] Study
- Itraconazole is predicted to increase the exposure to dopamine receptor agonists (pramipexole). Adjust dose. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to doxepin. [Severe] Study
- Ketocnazole moderately increases the exposure to drospirenone. [Severe] Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to moderately increase the exposure to dutasteride. [Mild] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical
- Itraconazole is predicted to slightly increase the exposure to edoxaban. Adjust edoxaban dose. [Severe] Study
- Efavirenz is predicted to decrease the exposure to isavuconazole. Avoid. [Severe] Theoretical
- Efavirenz slightly decreases the exposure to itraconazole. Avoid for 14 days after stopping efavirenz. [Moderate] Study
- Ketocnazole moderately decreases the exposure to ketoconazole. [Severe] Study
- Efavirenz slightly decreases the exposure to posaconazole. Avoid. [Moderate] Study
- Efavirenz moderately decreases the exposure to voriconazole and voriconazole slightly increases the exposure to efavirenz. Adjust dose. [Severe] Study → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to eledtriptan. Avoid. [Severe] Study
- Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the exposure to efavirenz. Avoid or adjust dose—consult product literature. [Severe] Study
- Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to moderately increase the exposure to encorafenib. [Moderate] Study → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to enfuvirtide. Avoid or monitor. [Severe] Study → Also see TABLE 9 p. 876
- Enzalutamide is predicted to decrease the exposure to isavuconazole. Avoid. [Severe] Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ergonovine. Avoid or monitor. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the risk of ergotism when given with ergonovine. [Severe] Theoretical
- Itraconazole, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the risk of ergotism when given with ergotamine. [Severe] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the risk of ergotism when given with ergotamine. Avoid. [Severe] Theoretical
- Miconazole is predicted to increase the exposure to ergotamine. Avoid. [Moderate] Theoretical
Antifungals, azoles (continued)

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to erlotinib. [Moderate] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. [Moderate] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to esketamine. Adjust dose. [Moderate] Study

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the concentration of everolimus. Avoid or adjust dose. [Moderate] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. [Severe] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole, posaconazole) are predicted to increase the exposure to fosaprepitant. [Moderate] Theoretical

> Posaconazole is predicted to increase the exposure to fosaprepitant. [Moderate] Study

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to gefitinib. [Moderate] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of guanfacine. Adjust guanfacine dose, p. 237. [Moderate] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to guanfacine. Adjust guanfacine dose, p. 237. [Moderate] Study

> H₂ receptor antagonists are predicted to decrease the absorption of itraconazole. Administer itraconazole capsules with a dry beverage. [Moderate] Study

> H₂ receptor antagonists are predicted to decrease the absorption of ketoconazole. Administer ketoconazole with an acidic beverage. [Moderate] Study

> H₂ receptor antagonists are predicted to decrease the absorption of ketoconazole. Avoid use of ketoconazole oral suspension. [Moderate] Study

> Itraconazole increases the concentration of haloperidol. [Moderate] Study

> Fluconazole slightly increases the exposure to HIV-protease inhibitors (tipranavir). Avoid or adjust dose. [Moderate] Study

> HIV-protease inhibitors are predicted to increase the exposure to isavuconazole. Avoid or monitor side effects. [Severe] Study

> HIV-protease inhibitors are predicted to increase the exposure to itraconazole. Use with caution and adjust dose. [Severe] Study

> HIV-protease inhibitors are predicted to increase the exposure to ketoconazole. Use with caution and adjust dose. [Moderate] Study

> Miconazole is predicted to increase the concentration of HIV-protease inhibitors. Use with caution and adjust dose. [Moderate] Theoretical

> Posaconazole is predicted to increase the concentration of HIV-protease inhibitors. [Moderate] Study

> HIV-protease inhibitors are predicted to affect the exposure to voriconazole and posaconazole potentially affects the exposure to HIV-protease inhibitors. [Severe] Study → Also see TABLE 9 p. 876

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ibritunib. Adjust ibritunib dose with moderate inhibitors of CYP3A4. [Severe] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to very markedly increase the exposure to ibritunib. Avoid potent inhibitors of CYP3A4 or adjust ibritunib dose. [Severe] Study

> Idelalisib is predicted to increase the exposure to isavuconazole. Avoid or monitor side effects. [Severe] Study

> Antifungals, azoles (fluconazole, posaconazole) are predicted to increase the exposure to imatinib. [Moderate] Study

> Imatinib is predicted to decrease the exposure to isavuconazole. [Moderate] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ivabradine. Adjust ivabradine dose. [Severe] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ivabradine. Avoid. [Severe] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole, posaconazole) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor or tezacaftor with ivacaftor, p. 189 dose with moderate inhibitors of CYP3A4. [Severe] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor, p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor, p. 189 dose with potent inhibitors of CYP3A4. [Severe] Study

> Lanthanum is predicted to decrease the absorption of ketoconazole. Separate administration by at least 2 hours. [Moderate] Theoretical

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to laptapinib. [Moderate] Study → Also see TABLE 9 p. 876

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to laptapinib. Avoid. [Severe] Study → Also see TABLE 9 p. 876

> Leternovir slightly decreases the exposure to voriconazole. [Moderate] Study

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to lorlatinib. Avoid. [Moderate] Study

> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to lorlatinib. Avoid or monitor side effects. [Moderate] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to lorlatinib. Avoid. [Severe] Study → Also see TABLE 1 p. 874

> Clotrimazole is predicted to increase the exposure to lorlatinib. Separate administration by 12 hours. [Moderate] Theoretical

> Lumacaftor is predicted to decrease the exposure to antifungals, azoles (itraconazole, ketoconazole, posaconazole, voriconazole). Avoid or monitor efficacy. [Moderate] Theoretical

> Lumacaftor is predicted to decrease the exposure to fluconazole. Adjust dose. [Mild] Theoretical

> Antifungals, azoles (fluconazole, isavuconazole) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose. [Moderate] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to lurasidone. Avoid. [Severe] Study

> Posaconazole moderately increases the exposure to lurasidone. Avoid. [Severe] Study

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to macitentan. [Moderate] Study

> Macrolides (clarithromycin) are predicted to increase the exposure to isavuconazole. Avoid or monitor side effects. [Severe] Study

> Macrolides (erythromycin) are predicted to increase the exposure to isavuconazole. [Moderate] Theoretical
Antifungals, azoles – Antifungals, azoles

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to maraviroc. Adjust dose. [Severe] Study
- Metoclopramide potentially decreases the absorption of posaconazole (oral suspension). [Moderate] Study
- Antifungals, azoles (fluconazole, itraconazole, ketoconazole) are predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. [Severe] Study
- Miconazole is predicted to increase the exposure to intravenous midazolam. Use with caution and adjust dose. [Moderate] Theoretical
- Miconazole is predicted to increase the exposure to oral midazolam. Avoid. [Severe] Study
- Antifungals, azoles (fluconazole, itraconazole, voriconazole) are predicted to increase the exposure to midostaurin. [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to monoclonal antibodies (trastuzumab emtansine). Avoid. [Severe] Theoretical
- Isavuconazole increases the exposure to mycophenolate. [Moderate] Study
- Antifungals, azoles (fluconazole, itraconazole, voriconazole) are predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to naloxegol. Avoid. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to netupitant. [Moderate] Study
- Netupitant is predicted to decrease the exposure to isavuconazole. [Moderate] Theoretical
- Fluconazole slightly to moderately increases the exposure to nevirapine. [Moderate] Study
- Nevirapine is predicted to decrease the exposure to isavuconazole. Avoid. [Severe] Theoretical
- Nevirapine moderately decreases the exposure to itraconazole. Avoid and for 14 days after stopping nevirapine. [Moderate] Study
- Nevirapine moderately decreases the exposure to ketoconazole. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to voriconazole and voriconazole increases the exposure to nevirapine. Monitor and adjust dose. [Severe] Theoretical
- Antifungals, azoles (fluconazole, posaconazole) are predicted to increase the exposure to nilotinib. [Moderate] Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to nilotinib. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to nilotinib. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to nitidasine. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to nitis Rin. Adjust dose. [Moderate] Theoretical
- Fluconazole moderately increases the exposure to NSAIDs (celecoxib). Adjust celecoxib dose. [Moderate] Study
- Voriconazole slightly increases the exposure to NSAIDs (diclofenac). Monitor and adjust dose. [Moderate] Study
- Voriconazole moderately increases the exposure to NSAIDs (ibuprofen). Adjust dose. [Moderate] Study
- Fluconazole increases the exposure to NSAIDs (paracetamol). Monitor and adjust dose. [Moderate] Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. [Moderate] Study
- Miconazole is predicted to increase the exposure to opioids (alfentanil). Use with caution and adjust dose. [Moderate] Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to opioids (methadone). Adjust dose. [Severe] Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to opioids (methadone, sufentanil). [Moderate] Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to omeprazole. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Fluconazole increases the exposure to omeprazole. Use with caution or avoid. [Moderate] Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to oxycodone. [Mild] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to oxycodone. [Mild] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to palbociclib. Adjust palbociclib dose. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. [Moderate] Study → Also see TABLE 9 p. 876
- Posaconazole is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to paripariphir. Avoid. [Severe] Study
- Posaconazole is predicted to increase the exposure to paritaprevir (with ritonavir and ombitasvir) and paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to posaconazole. Avoid. [Severe] Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to pazopanib. [Moderate] Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate] Study → Also see TABLE 9 p. 876
- Miconazole greatly increases the anticoagulant effect of phenindione. [Severe] Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. [Severe] Study → Also see TABLE 9 p. 876
Antifungals, azoles (continued)

- **Miconazole** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Use with caution and adjust dose. (Severe) Theoretical

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4. (Moderate) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. (Severe) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). (Severe) Theoretical

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Use with caution or avoid. (Severe) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Adjust dose. (Severe) Theoretical → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to pibrentasvir. (Moderate) Theoretical

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to pimozide. Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876

- **Miconazole** is predicted to increase the exposure to pimozide. Avoid. (Moderate) Theoretical

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to praziquantel. (Mild) Study

- **Proton pump inhibitors** decrease the absorption of itraconazole. Administer itraconazole capsules with an acidic beverage, p. 460. (Moderate) Study

- **Proton pump inhibitors** decrease the absorption of ketoconazole. Administer ketoconazole with an acidic beverage, p. 460. (Moderate) Study

- **Proton pump inhibitors** decrease the absorption of voriconazole. (Oral suspension). Avoid. (Moderate) Study

- Voriconazole increases the exposure to proton pump inhibitors (esomeprazole, omeprazole). Adjust dose. (Moderate) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to quetiapine. Avoid. (Severe) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ranolazine. Avoid. (Severe) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to reboxetine. (Mild) Study

- Miconazole is predicted to increase the concentration of reboxetine. Use with caution and adjust dose. (Moderate) Theoretical

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to regorafenib. Avoid. (Moderate) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to repaglinide. (Moderate) Study

- Antifungals, azoles (fluconazole, itraconazole, ketoconazole, miconazole, voriconazole) are predicted to increase the exposure to retinoids (tretinoin). Adjust all tretinoin dose. (Moderate) Theoretical

- Antifungals, azoles (fluconazole, ketoconazole, voriconazole) are predicted to increase the risk of tretinoin toxicity when given with retinoids (tretinoin). (Moderate) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ribociclib. (Moderate) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. (Moderate) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, posaconazole) increase the concentration of rifabutin and rifabutin decreases the concentration of antifungals, azoles (itraconazole, posaconazole). Avoid. (Severe) Study

- Fluconazole increases the risk of uveitis when given with rifabutin. Adjust dose. (Severe) Study

- Rifabutin is predicted to decrease the exposure to isavuconazole. Avoid. (Severe) Theoretical

- Ketoconazole is predicted to increase the concentration of rifabutin and rifabutin is predicted to decrease the concentration of ketoconazole. Avoid. (Severe) Theoretical

- Miconazole is predicted to increase the concentration of rifabutin. Use with caution and adjust dose. (Moderate)

- Rifabutin decreases the concentration of voriconazole and voriconazole increases the concentration of rifabutin. Avoid or adjust voriconazole dose, p. 390. (Severe) Study

- Rifampicin slightly decreases the exposure to fluconazole. Adjust dose. (Moderate) Study

- Rifampicin is predicted to decrease the exposure to isavuconazole. Avoid. (Severe) Study

- Rifampicin markedly decreases the exposure to itraconazole. Avoid and for 14 days after stopping rifampicin. (Moderate) Study

- Rifampicin markedly decreases the exposure to ketoconazole and ketoconazole potentially decreases the exposure to rifampicin. Avoid. (Moderate) Study

- Rifampicin is predicted to decrease the exposure to posaconazole. Avoid. (Moderate) Anecdotal

- Rifampicin markedly decreases the exposure to voriconazole. Avoid. (Moderate) Study

- Itraconazole is predicted to increase the exposure to riociguat. Avoid. (Moderate) Study

- Ketoconazole moderately increases the exposure to riociguat. Avoid. (Moderate) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to risperidone. Adjust dose. (Moderate) Study → Also see TABLE 9 p. 876

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to rivaroxaban. Avoid. (Severe) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to rituximab. (Moderate) Theoretical

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to rituximab. Adjust dose and monitor side effects. (Moderate) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to saxagliptin. (Mild) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to saxagliptin. (Moderate) Study

- Fluconazole is predicted to increase the exposure to selexipag. (Unknown) Theoretical

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) increase the concentration of sirolimus. Monitor and adjust dose. (Moderate) Study
Interactions | Appendix 1

Antifungals, azoles – Antifungals, azoles 905

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of sirolimus. Avoid. (Severe) Study
- Miconazole is predicted to increase the concentration of sirolimus. Monitor and adjust dose. (Moderate) Study
- Oral sodium bicarbonate decreases the absorption of ketoconazole. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to solifenacin. Adjust solifenacin or tomasulosin with solifenacin dose; avoid in hepatic and renal impairment. (Severe) Study
- Voriconazole is predicted to increase the exposure to SSRIs (citalopram). (Severe) Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to SSRIs (dopoxetine). Adjust dopoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to SSRIs. (atorvastatin). (Anecdotal) Theoretical
- Miconazole potentially increases the exposure to statins (atorvastatin). (Anecdotal) Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. (Severe) Study → Also see TABLE 1 p. 874
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to statins (atorvastatin). Avoid or adjust dose and monitor rhabdomyolysis. (Severe) Study → Also see TABLE 1 p. 874
- Antifungals, azoles (fluconazole, miconazole) are predicted to increase the exposure to statins (fluvastatin). (Severe) Theoretical → Also see TABLE 1 p. 874
- Isavuconazole is predicted to increase the exposure to statins (fluvastatin, rosuvastatin). (Moderate) Theoretical
- Miconazole is predicted to increase the exposure to statins (simvastatin). Avoid. (Severe) Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose, p. 136. (Suicide) Study → Also see TABLE 1 p. 874
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to statins (simvastatin). Avoid. (Severe) Study → Also see TABLE 1 p. 874
- Isavuconazole is predicted to increase the exposure to statins (fluvastatin, rosuvastatin). (Anecdotal) Theoretical
- Antifungals, azoles (fluconazole, miconazole) are predicted to increase the exposure to sulfonylureas. Use with caution and adjust dose. (Moderate) Study
- Voriconazole is predicted to increase the concentration of sulfonylureas. Use with caution and adjust dose. (Moderate) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to suntinib. (Moderate) Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to slightly increase the exposure to suntinib. Avoid or adjust suntinib dose. (Moderate) Study → Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the concentration of tacrolimus. (Severe) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of tacrolimus. Monitor and adjust dose. (Severe) Study
- Miconazole is predicted to increase the concentration of tacrolimus. Monitor and adjust dose. (Severe) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to taxanes (cabazitaxel). (Moderate) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the increase the exposure to taxanes (docetaxel). Use with caution and adjust dose. (Moderate) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to taxanes (docetaxel). Avoid or adjust dose. (Severe) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to taxanes (paclitaxel). (Severe) Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the concentration of temsirolimus. Avoid. (Severe) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of temsirolimus. Avoid. (Severe) Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to ticagrelor. Avoid. (Severe) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) given with a potent CYP2C19 inhibitor are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to tolterodine. (Mild) Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tolterodine. Avoid. (Severe) Study → Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study
- Antifungals, azoles (itraconazole, ketoconazole) are predicted to increase the exposure to topotecan. (Severe) Study
- Isavuconazole is predicted to increase the exposure to topotecan. (Moderate) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to toremifene. (Moderate) Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to trabectedin. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 1 p. 874
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of trametinib. (Moderate) Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to trazodone. (Moderate) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to trazodone. Avoid or adjust dose. (Moderate) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Severe) Study
Antifungals, azoles (continued)

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to vemurafenib. Severe
  - Theoretical
  - Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the exposure to venooclax. Avoid or adjust dose—consult product literature. Severe
  - Study
  - Also see TABLE 9 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the exposure to vinca alkaloids. Severe
  - Theoretical
  - Also see TABLE 1 p. 874 → Also see TABLE 9 p. 876
- Miconazole is predicted to increase the concentration of vinca alkaloids. Use with caution and adjust dose. Moderate
  - Theoretical
- Antifungals, azoles (clofotrimazole, ketoconazole) are predicted to decrease the exposure to vitamin D substances (colecalciferol). Moderate
  - Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to vitamin D substances (paricalcitol). Moderate
  - Study
- Fluconazole slightly increases the exposure to zidovudine. Moderate
  - Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to zopiclone. Adjust dose. Moderate
  - Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to zopiclone. Adjust dose. Moderate
  - Theoretical

Antihistamines, non-sedating → see TABLE 9 p. 876 (QT-interval prolongation)

acrivastine · azelastine · bilastine · cetirizine · desloratadine · fexofenadine · levocetirizine · loratadine · mizolastine · rupatadine

- Since systemic absorption can follow topical application, the possibility of interactions with topical azelastine should be borne in mind.
- Apple juice and orange juice decrease the exposure to fexofenadine.

Antacids decrease the absorption of fexofenadine. Separate administration by 2 hours. Mild
- Study

Antiarhythmics (dronedarone) are predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study

Antiarhythmics (dronedarone) are predicted to increase the exposure to antihistamines, non-sedating (fexofenadine, mizolastine). Severe
- Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to mizolastine. Avoid. Severe
- Study
- Antifungals, azoles (miconazole) are predicted to increase the exposure to mizolastine. Avoid. Moderate
- Theoretical

Aplutamide slightly decreases the exposure to fexofenadine. Mild
- Study
- Aprepitant is predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Aprepitant is predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Antihistamines, non-sedating are predicted to decrease the effects of betahistine. Moderate
- Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Certitinib is predicted to increase the exposure to fexofenadine. Moderate
- Theoretical

Cobicistat is predicted to increase the exposure to mizolastine. Avoid. Severe
- Study
- Cobicistat is predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Crizotinib is predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Crizotinib is predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Elaglutin is predicted to increase the exposure to fexofenadine. Adjust dose. Moderate
- Study
- Grapefruit juice slightly decreases the exposure to bilastine. Bilastine should be taken 1 hour before or 2 hours after grapefruit juice. Moderate
- Study
- Grapefruit juice increases the exposure to rupatadine. Avoid. Moderate
- Study
- HIV-protease inhibitors are predicted to increase the exposure to mizolastine. Avoid. Severe
- Study
- HIV-protease inhibitors are predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Idelalisib is predicted to increase the exposure to mizolastine. Avoid. Severe
- Study
- Idelalisib is predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Lapatinib is predicted to increase the exposure to fexofenadine. Moderate
- Theoretical
- Leflunomide is predicted to increase the exposure to fexofenadine. Moderate
- Theoretical
- Letemovir is predicted to increase the concentration of fexofenadine. Moderate
- Theoretical
- Macrolides (clarithromycin) are predicted to increase the exposure to mizolastine. Avoid. Severe
- Study
- Macrolides (clarithromycin, erythromycin) are predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Macrolides (erythromycin) are predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Mirabegron is predicted to increase the exposure to fexofenadine. Mild
- Theoretical
- Monoamine oxidase A and B inhibitors, irreversible are predicted to increase the risk of antimuscarinic side-effects when given with antihistamines, non-sedating. Avoid. Severe
- Theoretical
- Netupitant is predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Netupitant is predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Nilotinib is predicted to increase the exposure to mizolastine. Severe
- Theoretical
- Nilotinib is predicted to increase the exposure to rupatadine. Avoid. Moderate
- Study
- Pibrentasvir (with glecaprevir) is predicted to increase the exposure to fexofenadine. Moderate
- Study
- Pitolisant is predicted to increase the exposure to fexofenadine. Mild
- Theoretical
- Rifampicin is predicted to decrease the exposure to bilastine. Moderate
- Theoretical
- Rifampicin increases the clearance of fexofenadine. Moderate
- Study
- Teriflunomide is predicted to increase the exposure to fexofenadine. Moderate
- Study
- Velpatasvir is predicted to increase the exposure to fexofenadine. Severe
- Theoretical
- Venooclax is predicted to increase the exposure to fexofenadine. Moderate
- Theoretical

Antihistamines, sedating → see TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects), TABLE 10 p. 876 (antimuscarinics)

GENERAL INFORMATION Drugs with antimuscarinic effects might reduce the absorption of levodopa → see TABLE 10 p. 876

alimemazine · antazoline · buclizine · chlorphenamine · cinnarizine · Clemastine · cyclizine · cyproheptadine · doxylamine · hydroxyzine ·
Antihistamines, sedating – Antimalarials 907

**ROUTE-SPECIFIC INFORMATION** Since systemic absorption can follow topical application of ketotifen, the possibility of interactions should be borne in mind.

- **Hydroxyzine** potentially increases the risk of overheating and dehydration when given with antiepileptics (zonisamide). Avoid in children. ([Severe] Theoretical)
- **Antihistamines, sedating** are predicted to decrease the effects of beta-histine. ([Moderate] Theoretical)
- **Cyprophedantadine** decreases the effects of metapyrone. Avoid. ([Moderate] Study)
- **Monoamine-oxidase A and B inhibitors, irreversible** are predicted to increase the risk of antimuscarinic side-effects when given with antihistamines, sedating. Avoid. ([Severe] Theoretical)
- **Antihistamines, sedating** are predicted to decrease the efficacy of pitolisant. ([Moderate] Theoretical)
- **Cyprophedantadine** potentially decreases the effects of SSRI. ([Moderate] Anecdotal)

### Antimalarials
- **See TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)**
  - artemether · arteminol · atovaquone · chloroquine · lumeafantrine · mefloquine · piperaquine · primaquine · proguanil · pyrimethamine · quinine

**PHARMACOLOGY** Piperquine has a long half-life; there is a potential for drug interactions to occur for up to 3 months after treatment has been stopped.

- **Chloroquine** is predicted to decrease the effects of agalasidase. Avoid. ([Moderate] Theoretical)
- **Antimalarials** (chloroquine, primaquine) are predicted to increase the risk of methaemoglobinemia when given with topical anaesthetics, local (pilocaine). Use with caution or avoid. ([Severe] Theoretical)
- **Antacids** decrease the absorption of chloroquine. Separate administration by at least 4 hours. ([Moderate] Study)
- **Antacids** are predicted to decrease the absorption of proguanil. Separate administration by at least 2 hours. ([Moderate] Study)
- **Antihistamines, sedating** (dronedarone) are predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to artemether (with lumeafantrine). Avoid. ([Severe] Study)
- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of piperaquine. Avoid. ([Moderate] Theoretical)
- **Antiepileptics** (carbamazepine, phenobarbital, primidone) potentially increase the risk of toxicity when given with quinine. ([Unknown] Study)
- **Pyrimethamine** increases the risk of haematological toxicity when given with antiepileptics (fosphenytoin, phenytoin). ([Severe] Study)
- **Pyrimethamine** is predicted to increase the risk of haematological toxicity when given with antiepileptics (phenobarbital, primidone). ([Severe] Theoretical)
- **Antifungals, azoles** (fluconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Antifungals, azoles** (fluconazole, itraconazole, posaconazole, voriconazole) are predicted to increase the exposure to mefloquine. ([Moderate] Theoretical)
- **Antimalarials** (proguanil) are predicted to increase the risk of side-effects when given with antimalarials (pyrimethamine). ([Severe] Theoretical)
- **Aprepitant** is predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Mefloquine** is predicted to increase the risk of bradyardia when given with beta blockers, non-selective. ([Severe] Theoretical)
- **Mefloquine** is predicted to increase the risk of bradyardia when given with beta blockers, selective. ([Severe] Theoretical)
- **Mefloquine** is predicted to increase the risk of bradyardia when given with calcium channel blockers. ([Severe] Theoretical)

- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Calcium salts** (calcium carbonate) decrease the absorption of chloroquine. Separate administration by at least 4 hours. ([Moderate] Study)
- **Calcium salts** (calcium carbonate) are predicted to decrease the absorption of proguanil. Separate administration by at least 2 hours. ([Moderate] Study)
- **Chloroquine** decreases the efficacy of oral cholera vaccine. ([Severe] Theoretical)
- **Cobicistat** is predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Crizotinib** is predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Antimalarials** (chloroquine, primaquine) are predicted to increase the risk of methaemoglobinemia when given with dapsone. ([Severe] Theoretical)
- **Mefloquine** is predicted to increase the risk of bradyardia when given with digoxin. ([Severe] Theoretical)
- **Quinine increases the concentration of digoxin.** Monitor and adjust digoxin dose, p. 82. ([Severe] Anecdotal)
- **Efavirenz** decreases the concentration of artemether. ([Severe] Study) → Also see TABLE 9 p. 876
- **Efavirenz** moderately decreases the exposure to atovaquone. Avoid. ([Moderate] Study)
- **Efavirenz affects the exposure to proguanil. Avoid. ([Moderate] Study)
- **Enzalutamide** is predicted to decrease the exposure to artemether (with lumeafantrine). Avoid. ([Severe] Study)
- **Enzalutamide** is predicted to decrease the concentration of piperaquine. Avoid. ([Moderate] Theoretical)
- **Etravirine** decreases the exposure to artemether. ([Moderate] Study)
- **Grapefruit juice** increases the exposure to artemether. ([Unknown] Study)
- **Grapefruit juice** is predicted to increase the concentration of piperaquine. Avoid. ([Severe] Theoretical)
- **H1 receptor antagonists** (cimetidine) decrease the clearance of chloroquine. ([Moderate] Study)
- **H1 receptor antagonists** (cimetidine) slightly increase the exposure to quinine. ([Moderate] Study)
- **HIV-protease inhibitors** decrease the exposure to atovaquone. Avoid if boosted with ritonavir. ([Moderate] Study)
- **HIV-protease inhibitors** are predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **HIV-protease inhibitors** are predicted to decrease the exposure to proguanil. Avoid. ([Moderate] Study)
- **HIV-protease inhibitors** are predicted to affect the exposure to quinine. ([Severe] Study) → Also see TABLE 9 p. 876
- **Idealisib** is predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Imatinib** is predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Lanthanum** is predicted to decrease the absorption of chloroquine. Separate administration by at least 2 hours. ([Moderate] Theoretical)
- **Chloroquine** is predicted to decrease the exposure to laronidase. Avoid simultaneous administration. ([Severe] Theoretical)
- **Macrolides** (clarithromycin, erythromycin) are predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
- **Mepacrine** is predicted to increase the concentration of primaquine. Avoid. ([Moderate] Theoretical)
- **Pyrimethamine** is predicted to increase the risk of side-effects when given with mefloquine. ([Severe] Theoretical) → Also see TABLE 15 p. 877
- **Metoclopramide** decreases the concentration of atovaquone. Avoid. ([Moderate] Study)
- **Mitotane** is predicted to decrease the exposure to artemether (with lumeafantrine). Avoid. ([Moderate] Study)
- **Mitotane** is predicted to decrease the concentration of piperaquine. Avoid. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the concentration of piperaquine. ([Severe] Theoretical)
Antimalarials (continued)

▶ Nilotinib is predicted to increase the concentration of piperazine. (Severe) Theoretical
▶ Pyrimethamine is predicted to increase the risk of side-effects when given with pemetrexed. (Severe) Theoretical → Also see TABLE 15 p. 877
▶ Chloroquine is predicted to increase the risk of haematological toxicity when given with penicillinamide. Avoid. (Severe) Theoretical
▶ Chloroquine moderately decreases the exposure to praziquantel. Use with caution and adjust dose. (Moderate) Study
▶ Chloroquine decreases the efficacy of rabies vaccine. Avoid. (Moderate) Study
▶ Rifabutin slightly decreases the exposure to atovaquone. Avoid. (Moderate) Study
▶ Rifampicin moderately decreases the exposure to artemether (with lumefantrine). Avoid. (Severe) Study
▶ Rifampicin moderately decreases the exposure to atovaquone and atovaquone slightly increases the exposure to rifampicin. Avoid. (Moderate) Study
▶ Rifampicin moderately decreases the exposure to mefloquine. (Severe) Study
▶ Rifampicin is predicted to decrease the concentration of piperazine. Avoid. (Moderate) Theoretical
▶ Rifampicin decreases the exposure to quinine. (Severe) Study
▶ St John’s Wort is predicted to decrease the concentration of piperazine. Avoid. (Moderate) Theoretical
▶ Pyrimethamine increases the risk of side-effects when given with sulfonamides. (Severe) Study → Also see TABLE 15 p. 877
▶ Tetracyclines (tetracycline) decrease the concentration of atovaquone. (Moderate) Study
▶ Pyrimethamine increases the risk of side-effects when given with trimethoprim. (Severe) Study
▶ Pyrimethamine is predicted to increase the concentration of side-effects when given with zidovudine. (Severe) Theoretical → Also see TABLE 15 p. 877

Antithymocyte immunoglobulin (rabbit) → see immunoglobulins

Apalutamide → see TABLE 9 p. 876 (QT-interval prolongation)
▶ Apalutamide is predicted to decrease the exposure to aldosterone antagonists (episterone). Avoid or monitor. (Moderate) Study
▶ Apalutamide potentially decreases the exposure to antiepileptics (valproate). (Mild) Theoretical
▶ Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to apalutamide. (Mild) Study → Also see TABLE 9 p. 876
▶ Apalutamide slightly decreases the exposure to antihistamines, non-sedating (fexofenadine). (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to beta2 agonists (salmeterol). Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to bosutinib. Avoid or monitor. (Moderate) Study → Also see TABLE 9 p. 876
▶ Apalutamide is predicted to decrease the exposure to buspirone. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to calcium channel blockers (felodipine, lercanidipine). Avoid or monitor. (Moderate) Study
▶ Clopidogrel is predicted to increase the exposure to apalutamide. (Mild) Study
▶ Cobicistat is predicted to increase the exposure to apalutamide. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to colchicine. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to corticosteroids (budesonide, flucicasone). Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to coumarins. Avoid or monitor. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to dabigatran. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to darifenacin. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to dasatinib. Avoid or monitor. (Moderate) Study → Also see TABLE 9 p. 876
▶ Apalutamide is predicted to decrease the exposure to diazepam. Avoid or monitor. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to digoxin. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to everolimus. Avoid or monitor. (Moderate) Study
▶ Fibrates (gemfibrozil) are predicted to increase the exposure to apalutamide. (Mild) Study
▶ HIV- protease inhibitors are predicted to increase the exposure to apalutamide. (Mild) Study → Also see TABLE 9 p. 876
▶ Idelalisib is predicted to increase the exposure to apalutamide. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to ivacaftor. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to lomitapide. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to lurasidone. Avoid or monitor. (Moderate) Study
▶ Macrolides (clarithromycin) are predicted to increase the exposure to apalutamide. (Mild) Study → Also see TABLE 9 p. 876
▶ Apalutamide is predicted to decrease the exposure to maraviroc. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to methotrexate. (Mild) Study
▶ Apalutamide markedly decreases the exposure to midazolam. Avoid or monitor. (Severe) Study
▶ Apalutamide is predicted to decrease the exposure to moclobemide. Avoid or monitor. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to naloxegol. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to opioids (alfentanil, methadone). Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, sildenafil, vardenafil, tadalafil). Avoid or monitor. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to proton pump inhibitors (lansoprazole, rabeprazole). Avoid or monitor. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to quetiapine. Avoid or monitor. (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to sirolimus. Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to SSRIs (citalopram). Avoid or monitor. (Mild) Study → Also see TABLE 9 p. 876
▶ Apalutamide slightly decreases the exposure to statins (rosuvastatin). (Mild) Study
▶ Apalutamide is predicted to decrease the exposure to statins (simvastatin). Avoid or monitor. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to temsirolimus. Avoid or monitor. (Moderate) Study
▶ Apalutamide potentially decreases the exposure to thyroid hormones (levothyroxine). (Mild) Theoretical
▶ Apalutamide is predicted to decrease the exposure to ticagrelor. Monitor and adjust dose. (Moderate) Study
▶ Apalutamide is predicted to decrease the exposure to tolvaptan. Avoid or monitor. (Moderate) Study

Apixaban → see TABLE 3 p. 874 (anticoagulant effects)
▶ Antiarrhythmics (dronedarone) are predicted to increase the exposure to apixaban. (Moderate) Theoretical
▶ Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to apixaban. Use with caution or avoid. (Severe) Study
▶ Antifungals, azoles (itraconazole) are predicted to increase the exposure to apixaban. Avoid. (Severe) Theoretical
▶ Antifungals, azoles (ketoconazole) slightly to moderately increase the exposure to apixaban. Avoid. (Severe) Study
Antifungals, azoles (voriconazole) are predicted to increase the exposure to apixaban. Avoid. [Moderate] Theoretical
Calcium channel blockers (verapamil) are predicted to increase the exposure to apixaban. Avoid. [Moderate] Theoretical
Cobicistat is predicted to increase the exposure to apixaban. Avoid. [Moderate] Theoretical
Enzalutamide is predicted to moderately decrease the exposure to apixaban. Use with caution or avoid. [Severe] Study
HIV-protease inhibitors (ritonavir) are predicted to increase the exposure to apixaban. Avoid. [Severe] Theoretical
Macrolides (erythromycin) are predicted to increase the exposure to apixaban. [Moderate] Theoretical
Mitotane is predicted to moderately decrease the exposure to apixaban. Use with caution or avoid. [Severe] Study
Rifampin is predicted to moderately decrease the exposure to apixaban. Use with caution or avoid. [Severe] Study
St John’s Wort is predicted to decrease the exposure to apixaban. Use with caution or avoid. [Moderate] Theoretical
Apomorphine is predicted to markedly increase the exposure to aripiprazole. Avoid. [Moderate] Theoretical
Apriomin (tricyclic antidepressant) is predicted to increase the exposure to aripiprazole. Avoid. [Severe] Study
Amfebutamone is predicted to decrease the effects of apromelanotide. Avoid. [Severe] Study
Methylphenidate is predicted to decrease the effects of apromelanotide. Avoid. [Severe] Study
Sympathomimetics, inotropic are predicted to decrease the effects of apromelanotide. Avoid. [Severe] Study
Apremilast
Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) moderately decrease the exposure to apremilast. Avoid. [Severe] Study
Enzalutamide moderately decreases the exposure to apremilast. Avoid. [Severe] Study
Mitotane moderately decreases the exposure to apremilast. Avoid. [Severe] Study
Rifampin moderately decreases the exposure to apremilast. Avoid. [Severe] Study
St John’s Wort is predicted to decrease the exposure to apremilast. Avoid. [Severe] Study
Aprepitant
Aprepitant is predicted to increase the exposure to aripiprazole. Avoid. [Severe] Study
Aprepitant is predicted to increase the exposure to axitinib. [Moderate] Theoretical
Aprepitant is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical
Aprepitant is predicted to increase the exposure to beta, agonists (salmeterol). [Moderate] Study
Bosantan is predicted to decrease the exposure to apremilast. [Moderate] Study
Aprepitant is predicted to increase the exposure to bosutinib. Avoid or adjust dose. [Severe] Theoretical
Aprepitant is predicted to increase the exposure to buspirone. Use with caution and adjust dose. [Moderate] Study
Aprepitant is predicted to increase the exposure to cabozantinib. [Moderate] Theoretical
Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to apremilast and apremitap is predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). [Moderate] Study
Aprepitant is predicted to increase the exposure to calcium channel blockers (amiodarone, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
Aprepitant is predicted to increase the exposure to carbiprazine. Avoid. [Severe] Study
Aprepitant is predicted to increase the exposure to ceritinib. [Moderate] Theoretical
Aprepitant is predicted to increase the concentration of ciclosporin. [Severe] Study
Cobicistat is predicted to markedly increase the exposure to ciclosporin. [Severe] Study
Aprepitant is predicted to increase the exposure to cabemizinetin. [Severe] Theoretical
Aprepitant is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
Aprepitant is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, Interactions p. 516. [Severe] Study
Aprepitant is predicted to increase the exposure to oral corticosteroids (budesonide). [Moderate] Study
Aprepitant moderately increases the exposure to corticosteroids (dexamethasone). Monitor and adjust dose. [Moderate] Study
Aprepitant is predicted to increase the exposure to corticosteroids (fluticasone). [Moderate] Study
Aprepitant is predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor and adjust dose. [Moderate] Study
Aprepitant decreases the anticoagulant effect of coumarin. [Severe] Study
Aprepitant is predicted to slightly increase the exposure to darifenacin. [Moderate] Study
Aprepitant is predicted to increase the exposure to dasatinib. [Severe] Study
Aprepitant is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. [Severe] Theoretical
Aprepitant increases the risk of QT-prolongation when given with domperidone. Avoid. [Severe] Study
Aprepitant is predicted to increase the exposure to dopaminergic receptor agonists (bromocriptine). [Severe] Theoretical
Aprepitant is predicted to increase the concentration of dopamine receptor agonists (cabergoline). [Moderate] Anecdotal
Aprepitant is predicted to moderately increase the exposure to dutasteride. [Mild] Study
Efavirenz is predicted to decrease the exposure to aprepitant. [Moderate] Study
Aprepitant is predicted to increase the exposure to eletriptan. [Moderate] Study
Aprepitant is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. [Severe] Study
Aprepitant is predicted to moderately increase the exposure to enocafenib. [Moderate] Study
Enzalutamide is predicted to markedly decrease the exposure to apremitap. Avoid. [Moderate] Study
Aprepitant (continued)
▶ Aprepitant is predicted to increase the risk of ergotism when given with ergometrine. [Severe] Theoretical
▶ Aprepitant is predicted to increase the risk of ergotism when given with ergotamine. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to erlotinib. [Moderate] Theoretical
▶ Aprepitant is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 316. [Severe] Theoretical
▶ Aprepitant is predicted to increase the concentration of everolimus. Avoid or adjust dose. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to fosoterodine. Adjust fosoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild]
▶ Aprepitant is predicted to increase the exposure to gefitinib. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the concentration of guanfacine. Adjust guanfacine dose, p. 223. [Moderate] Theoretical
▶ HIV-protease inhibitors are predicted to markedly increase the exposure to aprepitant. [Moderate] Study
▶ Aprepitant is predicted to decrease the effects of hormone replacement therapy. [Moderate] Aneocolal
▶ Aprepitant is predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose with moderate inhibitors of CYP3A4. [Severe] Study
▶ Idelalisib is predicted to markedly increase the exposure to aprepitant. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to imatinib. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to intravenous irinotecan. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to lapatinib. [Moderate] Study
▶ Aprepitant is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to lomitapide. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to luraside. Adjust luraside dose. [Moderate] Study
▶ Macrolides (clarithromycin) are predicted to markedly increase the exposure to aprepitant. [Moderate] Study
▶ Macrolides (erythromycin) are predicted to increase the exposure to aprepitant. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to maraviroc. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to midostaurin. [Moderate] Theoretical
▶ Mitotane is predicted to markedly decrease the exposure to aprepitant. Avoid. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
▶ Nevirapine is predicted to decrease the exposure to aprepitant. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to nilotinib. [Moderate] Theoretical
▶ Aprepitant is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Aneocolal
▶ Aprepitant is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to opioids (methadone, sufentanil). [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to oxazepam. [Mild] Theoretical
▶ Aprepitant is predicted to increase the exposure to pazopanib. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Adjust dose. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to quetiapine. Avoid. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to ranolazine. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to ribociclib. [Moderate] Study
▶ Rifampicin is predicted to markedly decrease the exposure to aprepitant. Avoid. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to ruxolitinib. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to saxagliptin. [Mild] Study
▶ Aprepitant increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to SSRI. (dapoxetine). Adjust dapoxetine dose with moderate inhibitors of CYP3A4. [Moderate] Theoretical
▶ St John’s Wort is predicted to decrease the exposure to aprepitant. Avoid. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to sunitinib. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the concentration of tacrolimus. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to taxanes (cabazitaxel). [Moderate] Theoretical
▶ Aprepitant is predicted to increase the concentration of temsirolimus. [Moderate] Theoretical
▶ Aprepitant is predicted to increase the exposure to tezacafor. Adjust tezacafor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
▶ Aprepitant given with a potent CYP3A19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to tolcavast. [Mild] Theoretical
▶ Aprepitant is predicted to increase the exposure to tollvapant. Manufacturer advises caution or adjust tollvapant dose with moderate inhibitors of CYP3A4. [Moderate] Study
▶ Aprepitant is predicted to increase the exposure to trazodone. [Moderate] Theoretical
▶ Aprepitant decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Aneocolal
▶ Aprepitant is predicted to increase the exposure to venooclax. Avoid or adjust dose—consult product literature. [Severe] Study
▶ Aprepitant is predicted to increase the exposure to vinca alkaloids. [Severe] Theoretical
▶ Aprepitant is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study

Argatroban ▶ see TABLE 3 p. 874 (anticoagulant effects)
Ranibizumab is predicted to increase the risk of bleeding events when given with argatroban. [Severe] Theoretical

Aripiprazole ▶ see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

Antidepressants (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study ▶ Also see TABLE 11 p. 876

Antifungals (itraconazole, ketoconazole, voriconazole) are predicted to slightly increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Bupropion is predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Cinacalcet is predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Aripiprazole is predicted to decrease the effects of dopamine receptor agonists. [Moderate] Theoretical ▶ Also see TABLE 8 p. 875

Enzalutamide is predicted to moderately decrease the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

HIV-protease inhibitors are predicted to slightly increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Ivermectin is predicted to slightly increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Aripiprazole is predicted to decrease the effects of levodopa. [Severe] Theoretical ▶ Also see TABLE 8 p. 875

Macrolides (clarithromycin) are predicted to slightly increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Mitotane is predicted to moderately decrease the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Rifampicin is predicted to moderately decrease the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

SSRIs (fluoxetine, paroxetine) are predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

Terbinafine is predicted to moderately increase the exposure to aripiprazole dose, p. 255. [Moderate] Study

Arsenic trioxide ▶ see TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)

Artemether ▶ see antimalarials

Articaine ▶ see TABLE 11 p. 876 (CNS depressant effects)

Ascorbic acid ▶

Ascorbic acid is predicted to increase the risk of cardiovascular side-effects when given with deferiprone. [Severe] Theoretical

Ascorbic acid is predicted to increase the risk of cardiovascular side-effects when given with iron chelators (desferrioxamine). [Severe] Theoretical

Asenapine ▶ see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

Asenapine is predicted to decrease the effects of dopamine receptor agonists. Adjust dose. [Moderate] Theoretical ▶ Also see TABLE 8 p. 875

Asenapine is predicted to decrease the effects of levodopa. Adjust dose. [Severe] Theoretical ▶ Also see TABLE 8 p. 875

SSRIs (fluvoxamine) increase the exposure to asenapine. [Moderate] Study

SSRIs (paroxetine) moderately increase the exposure to asenapine. [Moderate] Study

Aspirin ▶ see TABLE 1 p. 874 (hepatoxicity), TABLE 15 p. 877 (myelosuppression)

Aspirin is predicted to increase the risk of hepatotoxicity when given with imatinib. [Severe] Theoretical ▶ Also see TABLE 15 p. 877

Aspirin affects the efficacy of methotrexate. [Severe] Amodiated ▶ Also see TABLE 1 p. 874 ▶ Also see TABLE 15 p. 877

Aspirin potentially increases the risk of neurotoxicity when given with vinca alkaloids (vincristine). Vincristine should be taken 3 to 24 hours before aspirin. [Severe] Amodiated ▶ Also see TABLE 1 p. 874 ▶ Also see TABLE 15 p. 877

Amodiated ▶ see TABLE 4 p. 874 (antiplatelet effects)

Acetazolamide increases the risk of severe toxic reaction when given with aspirin (high-dose). [Severe] Study

Antacids decrease the absorption of aspirin (high-dose). [Moderate] Study

Amodiated ▶ also see TABLE 1 p. 874

Amodiated ▶ also see TABLE 1 p. 874

Amodiated ▶ also see TABLE 1 p. 874

Amodiated ▶ also see TABLE 1 p. 874

Amodiated ▶ also see TABLE 1 p. 874

Amodiated ▶ also see TABLE 1 p. 874
Axitinib → see TABLE 15 p. 877 (myelosuppression)
Antiarrhythmics (dronedarone) are predicted to increase the exposure to axitinib. [Moderate] Theoretical
Anti-epileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to axitinib. Avoid or adjust dose. [Moderate] Study
Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to axitinib. [Moderate] Theoretical
Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to axitinib. Avoid or adjust dose. [Moderate] Study
Aprepitant is predicted to increase the exposure to axitinib. [Moderate] Theoretical
Bosentan is predicted to decrease the exposure to axitinib. [Moderate] Theoretical
Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to axitinib. [Moderate] Theoretical
Cobicistat is predicted to increase the exposure to axitinib. [Moderate] Theoretical
Axitinib is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
Crizotinib is predicted to increase the exposure to axitinib. [Moderate] Theoretical
Efravirenz is predicted to decrease the exposure to axitinib. [Moderate] Theoretical → also see TABLE 15 p. 877
Enalapril is predicted to decrease the exposure to axitinib. Avoid or adjust dose. [Moderate] Study
Idelalisib is predicted to increase the exposure to axitinib. Avoid or adjust dose. [Moderate] Study → also see TABLE 15 p. 877
Imatinib is predicted to increase the exposure to axitinib. [Moderate] Theoretical → also see TABLE 15 p. 877
Macrolides (clarithromycin) are predicted to increase the exposure to axitinib. Avoid or adjust dose. [Moderate] Study
Macrolides (erythromycin) are predicted to increase the exposure to axitinib. Avoid or adjust dose. [Moderate] Study
Netupitant is predicted to increase the exposure to axitinib. [Moderate] Theoretical
Neuraminine is predicted to decrease the exposure to axitinib. [Moderate] Theoretical
Nilotinib is predicted to increase the exposure to axitinib. [Moderate] Theoretical → also see TABLE 15 p. 877
Axitinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
Rifampicin is predicted to decrease the exposure to axitinib. Avoid or adjust dose. [Moderate] Study
St John’s Wort is predicted to decrease the exposure to axitinib. [Moderate] Theoretical
Azathioprine → see TABLE 15 p. 877 (myelosuppression)
ACE inhibitors are predicted to increase the risk of anaemia and/or leucopenia when given with azathioprine. [Severe] Anecdotal
Allopurinol potentially increases the risk of haematological toxicity when given with azathioprine. Adjust azathioprine dose, p. 536. [Severe] Study
Azaithioprine decreases the anticogulant effect of coumarins. [Moderate] Study
Fexofenadine is predicted to increase the exposure to azathioprine. Avoid. [Severe] Theoretical
Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with azathioprine (high-dose). Public Health England advises avoid (refer to Green Book). [Severe] Study
Azelastine → see antihistamines, non-sedating
Amitizaltel → see angiotensin II receptor antagonists
Azithromycin → see macrolides
Bacillus Calmette-Guérin vaccine → see live vaccines
Bacitracin → see TABLE 2 p. 874 (nephrotoxicity)
Baclofen → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects), TABLE 10 p. 876 (antimuscarinics)
Baclofen is predicted to increase the risk of side-effects when given with levodopa. [Severe] Anecdotal → also see TABLE 8 p. 875
Balsalazide → see TABLE 15 p. 877 (myelosuppression)
Balsalazide is predicted to decrease the concentration of digoxin. [Moderate] Theoretical
Bambuterol → see beta agonists
Baricitinib
Leflunomide potentially increases the exposure to baricitinib. [Moderate] Theoretical
Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with baricitinib. Avoid. [Severe] Theoretical
Teriflunomide potentially increases the exposure to baricitinib. [Moderate] Theoretical
Basiliximab → see monoclonal antibodies
Bazedoxifene
Anti-epileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to bazedoxifene. [Moderate] Theoretical
Rifampicin is predicted to decrease the exposure to bazedoxifene. [Moderate] Theoretical
Beclometasone → see corticosteroids
Bedaquiline → see TABLE 1 p. 874 (hepatotoxicity), TABLE 9 p. 879 (QT-interval prolongation)
Antiarrhythmics (dronedarone) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical → also see TABLE 9 p. 876
Anti-epileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical → also see TABLE 1 p. 874 → also see TABLE 9 p. 876
Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study → also see TABLE 1 p. 874 → also see TABLE 9 p. 876
Aprepitant is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical
Bosentan is predicted to decrease the exposure to bedaquiline. Avoid. [Severe] Study
Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study → also see TABLE 1 p. 874 → also see TABLE 9 p. 876
Idelalisib is predicted to increase the exposure to bedaquiline. Avoid. [Severe] Study
Imatinib is predicted to decrease the exposure to bedaquiline. Avoid prolonged use. [Mild] Study
Crizotinib is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study → also see TABLE 9 p. 876
Efavirenz is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study → also see TABLE 9 p. 876
Amitizaltel decreases the exposure to bedaquiline. Avoid. [Severe] Study
Etravirine is predicted to decrease the exposure to bedaquiline. Avoid. [Severe] Theoretical
HIV-protase inhibitors are predicted to decrease the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical → also see TABLE 1 p. 874
Clofazimine potentially increases the risk of QT-prolongation when given with bedaquiline. [Severe] Study
Cobicistat is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study
Rifampicin is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study → also see TABLE 9 p. 876
Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study → also see TABLE 9 p. 876
St John’s Wort is predicted to increase the exposure to bedaquiline. Avoid. [Severe] Study
Macrolides (clarithromycin) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical → also see TABLE 9 p. 876
Amitizaltel decreases the exposure to bedaquiline. Avoid. [Severe] Study
Azithioprine decreases the exposure to bedaquiline. Avoid. [Severe] Study
Belatacept

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with belatacept. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Bellimump > see monoclonal antibodies

Bendroflumethiazide > see thiazide diuretics

Benperidol > see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

- Benperidol is predicted to decrease the effects of dopamine receptor agonists. Avoid. [Moderate] Theoretical > Also see TABLE 8 p. 875

- Benperidol is predicted to decrease the effects of guanethidine. [Moderate] Theoretical > Also see TABLE 8 p. 875

- Benperidol is predicted to decrease the effects of levodopa. [Severe] Study > Also see TABLE 8 p. 875

Benzymadine > see NSAIDs

Benzylenepicillin > see penicillins

Beta blockers, non-selective > see TABLE 8 p. 875 (bradycardia), TABLE 8 p. 875 (hypotension), TABLE 9 p. 876 (QT-interval prolongation)

- carvedilol, labetalol, levo-bunolol, nadolol, pindolol, propranolol, sotalol, timolol

ROUTE-SPECIFIC INFORMATION Since systemic absorption can follow topical application of levo-bunolol and timolol the possibility of interactions should be borne in mind.

- Beta blockers, non-selective are predicted to increase the risk of bronchospasm when given with aminophylline. Avoid. [Severe] Theoretical

  - Antiarrhythmics (amiodarone, disopyramide, dronedarone, flecaainide, lidocaine) are predicted to increase the risk of cardiovascular side-effects when given with beta blockers, non-selective. Use with caution or avoid. [Severe] Study > Also see TABLE 6 p. 875 (see amlodipine, benzydamine, benzylenepicillin, beta blockers, non-selective, calcium channel blockers, diuretics, flunarizine, fludrocortisone, guanethidine, lidocaine, metoprolol, midodrine, propranolol, timolol, verapamil, xenamem)

  - Antiarrhythmics (propafenone) are predicted to increase the risk of cardiovascular side-effects when given with propranolol. Use with caution or avoid. [Severe] Study

  - Antiarrhythmics (propafenone) are predicted to increase the exposure to timolol and timolol is predicted to increase the risk of cardiodepression when given with antiarrhythmics (propafenone). [Severe] Anecdotal

  - Antiarrhythmics (propafenone) are predicted to increase the risk of cardiovascular side-effects when given with beta blockers, non-selective. [Moderate] Anecdotal > Also see TABLE 6 p. 875

  - Antiarrhythmics (propafenone) are predicted to increase the risk of cardiodepression when given with antiarrhythmics (propafenone). [Severe] Anecdotal

  - Antiarrhythmics (propafenone) are predicted to increase the risk of cardiovasular side-effects when given with beta blockers, non-selective (labetalol, levo-bunolol, nadolol, pindolol, sotalol). Use with caution or avoid. [Severe] Study

- Anticholinesterases, centrally acting are predicted to increase the risk of bradycardia when given with beta blockers, non-selective. [Moderate] Anecdotal > Also see TABLE 6 p. 875

- Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to propranolol. [Moderate] Study

- Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to beta blockers, non-selective (carvedilol, labetalol). [Moderate] Theoretical

- Antifungals, azoles (itraconazole, ketoconazole) are predicted to increase the exposure to nadolol. [Moderate] Study

- Antimalarias (mefloquine) are predicted to increase the risk of bradycardia when given with beta blockers, non-selective. [Severe] Theoretical
Beta blockers, selective (continued)

- **Antiarrhythmics** *(propranolol)* are predicted to increase the exposure to metoprolol. **(Moderate Study)**
- **Antiarrhythmics** *(propranolol)* are predicted to increase the exposure to nebivolol and nebivolol is predicted to increase the risk of cardiodepression when given with antiarrhythmics *(propranolol).* **Avoid. (Severe) Theoretical**
- **Antiarrhythmics** *(propranolol)* are predicted to increase the risk of cardiovascular side-effects when given with beta blockers, selective *(acebutolol, atenolol, betaxolol, bisoprolol, celiprolol, esmolol).* Use with caution or avoid. **(Severe) Study**
- **Anticholinesterases, centrally acting** *(duloxetine)* are predicted to increase the risk of hypotension when given with beta blockers, selective. **(Severe) Study**
- **Calcium channel blockers** *(diltiazem)* are predicted to increase the risk of cardiodepression when given with beta blockers, selective. **(Severe) Study**
- **Bisoprolol, metoprolol, nebivolol)* reduce the exposure to cisapride when given with beta blockers, selective. **(Severe) Study**
- **Cisapride** is predicted to decrease the exposure to metoprolol. **(Severe) Study**
- **Cimetidine** is predicted to increase the exposure to metoprolol, nebivolol. **(Severe) Study**
- **Cimetidine** is predicted to increase the exposure to metoprolol, nebivolol. **(Severe) Study**
- **Duloxetine** is predicted to increase the exposure to metoprolol. **(Moderate Study)**
- **Eliglustat** is predicted to increase the exposure to metoprolol. **(Moderate Study)**
- **Beta blockers, selective** are predicted to increase the risk of peripheral vasoconstriction when given with ergotamine. **(Severe) Study**
- **Beta blockers, selective** are predicted to increase the risk of peripheral vasoconstriction when given with ergotamine. **(Severe) Study**
- **Grapefruit juice** greatly decreases the exposure to cefipime. **(Severe) Study**
- **HIV-1 protease inhibitors** *(ritonavir)* are predicted to increase the exposure to metoprolol. **(Severe) Study**
- **Beta blockers, selective** are predicted to increase the risk of cardiodepression when given with lanreotide. **(Moderate Theoretical)**
- **Mexiletine** potentially increases the risk of cardiovascular side-effects when given with beta blockers, selective. **Avoid or monitor. (Severe) Study**
- **Mirabegron** is predicted to increase the exposure to metoprolol. **(Moderate Study)**
- **Panobinostat** is predicted to increase the exposure to metoprolol, metoprolol. Monitor and adjust dose. **(Moderate Theoretical)**
- **Panobinostat** is predicted to increase the exposure to nebivolol. Monitor and adjust dose. **(High) Theoretical**
- **Rifampicin** slightly decreases the exposure to beta blockers, selective *(bisoprolol, metoprolol).* **(High) Study**
- **Rifampicin** moderately decreases the exposure to celiprolol. **(Moderate Study)**
- **Rolapitant** is predicted to moderately increase the exposure to metoprolol. **(Severe) Study**
- **SSRI (fluoxetine, paroxetine)** are predicted to increase the exposure to beta blockers, selective *(metoprolol, nebivolol).* **(Moderate Study)**
- **Beta blockers, selective** increase the risk of hypertension and bradycardia when given with sympathomimetics, inotropic *(dobutamine).* **(Moderate Theoretical)**
- **Beta blockers, selective** are predicted to increase the risk of hypertension and bradycardia when given with sympathomimetics, vasoconstrictor *(adrenaline/epinephrine, noradrenaline/norepinephrine).* **(Severe) Study**
- **Terbinafine** is predicted to increase the exposure to beta blockers, selective *(metoprolol, nebivolol).* **(Moderate Study)**
- **Beta blockers, selective** are predicted to increase the risk of bronchospasm when given with theophylline. **Avoid. (Severe) Theoretical**
- **Beta, agonists** → see **TABLE 17. p. 878** *(reduced serum potassium)*
- **Bicalutamide** is predicted to increase the exposure to salmeterol. **Avoid. (Severe) Study**
- **Aplatunderol, formoterol - indacaterol - olodaterol - salbutamol - salmeterol - terbutaline - vilanterol** are predicted to increase the exposure to salmeterol. **Avoid. (Severe) Study**
- **Antiarrhythmics, Selective** *(flupirtine, mexiletine)* are predicted to increase the risk of glaucoma when given with **(High) Theoretical**
- **Beta, agonists** are predicted to increase the risk of severe hypertension when given with beta, agonists. **Avoid. (Severe) Study**
- **Idelalisib** is predicted to increase the exposure to salmeterol. **Avoid. (Severe) Study**
- **Cobicistat** is predicted to increase the exposure to salmeterol. **Avoid. (Severe) Study**
- **HIV-1 protease inhibitors** are predicted to increase the exposure to salmeterol. **Avoid. (Severe) Study**
- **Beta, agonists** are predicted to increase the risk of severe hypertension when given with beta, agonists. **(High-dose). (Moderate) Study**
- **Beta, agonists** are predicted to increase the risk of severe hypertension when given with beta, agonists. **(Severe) Theoretical**
- **Netupitant** is predicted to increase the exposure to salmeterol. **(Moderate Study)**
- **Beta, agonists** are predicted to increase the risk of glaucoma when given with **(High) Theoretical**
- **Beta, agonists** are predicted to increase the risk of severe hypertension when given with beta, agonists. **(High) Theoretical**
- **Bicalutamide** is predicted to increase the exposure to salmeterol. **(Moderate Study)**
- **Beta, agonists** are predicted to increase the risk of severe hypertension when given with beta, agonists. **(High-dose). (Moderate) Study**
- **Beta, agonists** are predicted to increase the risk of severe hypertension when given with beta, agonists. **(Severe) Theoretical**
- **Netupitant** is predicted to increase the exposure to salmeterol. **(Moderate Study)**
- **Betalastine** are predicted to decrease the effects of betahistine. **(Moderate) Theoretical**
- **Antihistamines, non-sedating** are predicted to decrease the effects of betahistine. **(Moderate) Theoretical**
- **Antihistamines, sedating** are predicted to decrease the effects of betahistine. **(Moderate) Theoretical**
- **Betamethasone** → see corticosteroids
- **Betaxolol** → see beta blockers, selective
- **Bevacizumab** → see monoclonal antibodies
- **Bexarotene** → see retinoids
- **Bicalutamide** → see fibers
- **Bicalutamide** is predicted to increase the exposure to **lomiptamide.** Separate administration by 12 hours. **(Moderate) Theoretical**
- **Bicalutamide** is predicted to increase the exposure to **lomiptamide.** Separate administration by at least 2 hours. **(Moderate) Study**
- **Antacids** decrease the exposure to **bicalutamide.** Separate administration by at least 2 hours. **(Moderate) Study**
- **Beta blockers, selective** are predicted to increase the exposure to **bicalutamide.** Use with caution or avoid. **(Moderate) Theoretical**
- **Antiepileptics** *(carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)* are predicted to decrease the exposure to **bicalutamide.** Avoid. **(Moderate) Study**
- **Antiepileptics** *(oscarbazepine)* are predicted to decrease the exposure to **bicalutamide.** Avoid. **(Moderate) Theoretical**
- **Antifungals, azoles** *(itraconazole, ketoconazole, voriconazole)* are predicted to decrease the exposure to **bicalutamide.** Avoid. **(Moderate) Study**
• Calcium channel blockers (verapamil) are predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Cyclosporin is predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Ezetimibe is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Study

• HIV-protease inhibitors (atazanavir) moderately increase the exposure to bictegravir. Avoid. (Severe) Study

• HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Iron (oral) decrease the exposure to bictegravir. Bictegravir should be taken 2 hours before iron (oral). (Moderate) Study

• Lapatinib is predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Macrolides are predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Bictegravir slightly increases the exposure to metformin. (Moderate) Study

• Mitotane is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Study

• Bictegravir is predicted to increase the exposure to opioids (methadone). (Moderate) Theoretical

• Randazone is predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Rifabutin slightly decreases the exposure to bictegravir. Avoid. (Moderate) Study

• Rifampicin is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Study

• St John’s Wort is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Theoretical

• Sucralfate is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Theoretical

• Venlafaxine is predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

• Bilastine → see antihistamines, non-sedating

• Bisoprolol → see beta blockers, selective

• Bisphosphonates → see TABLE 2 p. 874 (nephrotoxicity)

• Aminoglycosides increase the risk of hypocalcaemia when given with bisphosphonates. (Moderate) Anecdotal → also see TABLE 2 p. 874

• Antacids decrease the absorption of alendronic acid. Alendronic acid should be taken at least 30 minutes before antacids. (Moderate) Study

• Antacids are predicted to decrease the absorption of ibandronic acid. Avoid antacids for at least 4 hours before or 1 hour after ibandronic acid. (Moderate) Theoretical

• Antacids decrease the absorption of risedronate. Separate administration by at least 2 hours. (Moderate) Study

• Antacids decrease the absorption of sodium clodronate. Avoid antacids for 2 hours before or 1 hour after sodium clodronate. (Moderate) Study

• Aspirin (high-dose) is predicted to increase the risk of gastrointestinal irritation when given with bisphosphonates (alendronic acid, ibandronic acid). (Moderate) Study

• Aspirin (high-dose) is predicted to increase the risk of renal impairment when given with sodium clodronate. (Severe) Theoretical

• Oral calcium salts decrease the absorption of alendronic acid. Alendronic acid should be taken at least 30 minutes before calcium salts. (Moderate) Study

• Oral calcium salts are predicted to decrease the absorption of oral ibandronic acid. Avoid calcium salts for at least 6 hours before or 1 hour after ibandronic acid. (Moderate) Theoretical

• Oral calcium salts decrease the absorption of risedronate. Separate administration by at least 2 hours. (Moderate) Study

• Oral calcium salts decrease the absorption of sodium clodronate. Avoid calcium salts for 2 hours before or 1 hour after sodium clodronate. (Moderate) Study

• Iron (oral) is predicted to decrease the absorption of oral ibandronic acid. Avoid iron (oral) for at least 6 hours before or 1 hour after ibandronic acid. (Moderate) Theoretical

• Iron (oral) decreases the absorption of risedronate. Separate administration by at least 2 hours. (Moderate) Study

• Iron (oral) decreases the absorption of sodium clodronate. Avoid iron (oral) for 2 hours before or 1 hour after sodium clodronate. (Moderate) Study

• Bisphosphonates are predicted to increase the risk of gastrointestinal bleeding when given with iron chelators (deferasirox). (Severe) Theoretical

• Oral magnesium decreases the absorption of alendronic acid. Alendronic acid should be taken at least 30 minutes before magnesium. (Moderate) Study

• Oral magnesium is predicted to decrease the absorption of oral ibandronic acid. Avoid magnesium for at least 6 hours before or 1 hour after ibandronic acid. (Moderate) Theoretical

• Oral magnesium decreases the absorption of risedronate. Separate administration by at least 2 hours. (Moderate) Study

• Oral magnesium decreases the absorption of sodium clodronate. Avoid magnesium for at least 6 hours before or 1 hour after sodium clodronate. (Moderate) Study

• NSAIDs are predicted to increase the risk of gastrointestinal irritation when given with bisphosphonates (alendronic acid, ibandronic acid). (Moderate) Study

• NSAIDs are predicted to increase the risk of renal impairment when given with sodium clodronate. (Severe) Theoretical

• Bisphosphonates are predicted to decrease the effects of parathyroid hormone. Avoid. (Moderate) Study

• Oral zinc decreases the absorption of oral alendronic acid. Zinc should be taken at least 50 minutes before alendronic acid. (Moderate) Study

• Oral zinc is predicted to decrease the absorption of oral ibandronic acid. Avoid zinc for at least 6 hours before or 1 hour after ibandronic acid. (Moderate) Theoretical

• Oral zinc decreases the absorption of oral risedronate. Separate administration by at least 2 hours. (Moderate) Study

• Oral zinc decreases the absorption of oral sodium clodronate. Avoid zinc for 2 hours before or 1 hour after sodium clodronate. (Moderate) Study

• Bivalirudin → see TABLE 3 p. 874 (anticoagulant effects)

• Ranibizumab is predicted to increase the risk of bleeding events when given with bivalirudin. (Moderate) Theoretical

• Bleomycin → see TABLE 15 p. 875 (myelosuppression), TABLE 5 p. 874 (thromboembolism)

• Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with bleomycin. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

• Monoclonal antibodies (brentuximab vedotin) increase the risk of pulmonary toxicity when given with bleomycin. Avoid. (Severe) Study → also see TABLE 15 p. 877

• Platinum compounds (cisplatin) increase the risk of pulmonary toxicity when given with bleomycin. (Severe) Study → also see TABLE 15 p. 877

• Blinatumomab → see monoclonal antibodies

• Bortezomib → see TABLE 8 p. 875 (hypotension), TABLE 15 p. 877 (myelosuppression), TABLE 12 p. 877 (peripheral neuropathy)

• Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) slightly decrease the exposure to bortezomib. Avoid. (Severe) Study → also see TABLE 12 p. 877

• Antifungals (itraconazole, ketoconazole, voriconazole) slightly increase the exposure to bortezomib. (Moderate) Study

• Cobicistat slightly increases the exposure to bortezomib. (Moderate) Study

• Enalapril slightly decreases the exposure to bortezomib. Avoid. (Severe) Study

• HIV-protease inhibitors slightly increase the exposure to bortezomib. (Moderate) Study

• Idelalisib slightly increases the exposure to bortezomib. (Moderate) Study → also see TABLE 15 p. 877

• Macrolides (clarithromycin) slightly increase the exposure to bortezomib. (Moderate) Study

• Mitotane slightly decreases the exposure to bortezomib. Avoid. (Severe) Study → also see TABLE 15 p. 877

• Rifampicin slightly decreases the exposure to bortezomib. Avoid. (Severe) Study
Bosentan

- **Bosentan** is predicted to decrease the exposure to antiarrhythmics (dronedarone). **(Severe) Theoretical**
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) affect the exposure to **bosentan**. Avoid. **(Severe) Study**
- Antifungals, azoles (fluconazole) are predicted to increase the exposure to **bosentan**. Avoid. **(Severe) Study**
- Antifungals, azoles (itraconazole) are predicted to increase the exposure to **bosentan**. **(Moderate) Theoretical**
- Antifungals, azoles (ketoconazole) moderately increase the exposure to **bosentan**. **(Moderate) Study**
- Antifungals, azoles (voriconazole) are predicted to increase the exposure to **bosentan**. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to aprepitant. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to axitinib. Avoid. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to bedaquiline. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to bosutinib. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to cabozantinib. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nifedipine, nimodipine). Monitor and adjust dose. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to calcium channel blockers (diltiazem, verapamil). **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to cariprazine. Avoid. **(Severe) Theoretical**
- **Bosentan** moderately decreases the exposure to ciclosporin and ciclosporin moderately increases the exposure to **bosentan**. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to ciclosporin. Avoid. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to cisplatin. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to cisplatin. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to desogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. **(Severe) Study**
- **Bosentan** decreases the anticoagulant effect of coumarins. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to crizotinib. Avoid. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to crizotinib. **(Severe) Study**
- **Bosentan** is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. **(Severe) Study**
- **Bosentan** decreases the anticoagulant effect of coumarins. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to crizotinib. **(Severe) Theoretical**
- **Bosentan** decreases the exposure to dolutegravir. Adjust dose. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. **(Severe) Theoretical**
- **Bosentan** is predicted to moderately decrease the exposure to elbasvir. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to eliglustat. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the concentration of elvitegravir. Avoid. **(Severe) Theoretical**
- Enzalutamide affects the exposure to **bosentan**. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the effects of ergotamine. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to erlotinib. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to eritravine. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the concentration of everolimus. Avoid or adjust dose. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to fosaprepitant. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to gefitinib. Avoid. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to glecaprevir. Avoid. **(Severe) Study**
- **Bosentan** is predicted to markedly decrease the exposure to grazoprevir. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the concentration of guanfacine. Adjust dose. **(Moderate) Theoretical**
- HIV-protease inhibitors are predicted to increase the exposure to **bosentan**. **(Severe) Study**
- **Bosentan** is predicted to decrease the effects of hormone replacement therapy. **(Moderate) Anecdotial**
- **Bosentan** is predicted to decrease the exposure to idelalisib. Avoid. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to imatinib. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to ivacaftor. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to lapatinib. Avoid. **(Severe) Study**
- Leflunomide is predicted to increase the exposure to **bosentan**. Avoid. **(Moderate) Study**
- Letemovir is predicted to increase the concentration of bosentan. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the exposure to lurasidone. Monitor and adjust dose. **(Moderate) Theoretical**
- Macrolides (clarithromycin) are predicted to increase the exposure to **bosentan**. **(Moderate) Theoretical**
- **Bosentan** is predicted to increase the exposure to maraviroc. Avoid. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the concentration of midazolam. Monitor and adjust dose. **(Moderate) Theoretical**
- Mitotane affects the exposure to **bosentan**. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to nilotinib. Avoid. **(Severe) Theoretical**
- **Bosentan** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. **(Severe) Anecdotial**
- **Bosentan** is predicted to decrease the exposure to olaparib. Avoid. **(Moderate) Theoretical**
- **Bosentan** decreases the exposure to opioids (methadone). Monitor and adjust dose. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to osimertinib. **(Moderate) Theoretical**
- **Bosentan** is predicted to decrease the exposure to ospemifene. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to paritaprevir (with ritonavir and ombravirus). Avoid. **(Severe) Study**
- **Bosentan** decreases the exposure to phosphodiesterase type-5 inhibitors. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to pibrentasvir. Avoid. **(Severe) Study**
- **Bosentan** is predicted to decrease the exposure to quetiapine. **(Moderate) Study**
- **Bosentan** is predicted to decrease the exposure to ribociclib. **(Moderate) Study**
- Rifampicin affects the exposure to **bosentan**. Avoid. **(Severe) Study**
**Bosentan** is predicted to decrease the exposure to rilpivirine. Avoid. (Severe) Theoretical

**Bosentan** is predicted to decrease the exposure to rolipitant. Avoid. (Severe) Study

**Bosentan** is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Theoretical

**Bosentan** is predicted to decrease the concentration of sirolimus and sirolimus potentially increases the concentration of bosentan. Avoid. (Severe) Theoretical

**St John’s Wort** is predicted to decrease the exposure to bosentan. Avoid. (Moderate) Theoretical

**Bosentan** slightly decreases the exposure to statins (atorvastatin). (Minimal) Study

**Bosentan** moderately decreases the exposure to statins (simvastatin). (Moderate) Study

**Bosentan** increases the risk of hepatotoxicity when given with sulfonyleures (glibenclamide). Avoid. (Severe) Study

**Bosentan** is predicted to decrease the concentration of tacrolimus and tacrolimus potentially increases the concentration of bosentan. Avoid. (Severe) Theoretical

**Bosentan** is predicted to decrease the exposure to taxanes (cabazitaxel). Avoid. (Severe) Study

**Bosentan** is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Theoretical

**Teriflunomide** is predicted to increase the exposure to bosentan. (Moderate) Study

**Bosentan** is predicted to decrease the exposure to ticagrelor. (Moderate) Theoretical

**Bosentan** is predicted to decrease the exposure to tofacitinib. (Moderate) Study

**Bosentan** decreases the efficacy of ulipristal. For FSHR guidance, see Contraceptives, interactions p. 516. Severe Anecdotal

**Bosentan** is predicted to decrease the exposure to venetoclax. Avoid. (Severe) Study

**Venetoclax** is predicted to increase the exposure to bosentan. (Moderate) Theoretical

**Bosentan** is predicted to increase the concentration of vinblastine. Avoid. (Severe) Theoretical

**Bosutinib** → see TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)

**Antacids** are predicted to decrease the absorption of bosutinib. (Moderate) Theoretical

**Bosutinib** should be taken at least 12 hours before antacids. Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876

**Antihydmics (dronedarone)** are predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 9 p. 876

**Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to markedly decrease the exposure to bosutinib. Avoid. (Severe) Study

**Antifungals, azoles (itraconazole, isavuconazole, posaconazole)** are predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 9 p. 876

**Antiepileptics (carbamazepine, febrerophenytin, phenobarbital, phentoin, primidone)** are predicted to very markedly decrease the exposure to bosutinib. Avoid. (Severe) Study

**Efavirenz** is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876

**Enzalutamide** is predicted to very markedly decrease the exposure to bosutinib. Avoid. (Severe) Study

**Etiravirine** is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical

**Fosaprepitant** is predicted to increase the exposure to bosutinib. (Severe) Theoretical

**Grapefruit juice** is predicted to increase the exposure to bosutinib. Avoid. (Moderate) Theoretical

**H₂ receptor antagonists** are predicted to decrease the absorption of bosutinib. (Moderate) Theoretical

**HIV-protease inhibitors** are predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Study → Also see TABLE 9 p. 876

**Idelalisib** is predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Study → Also see TABLE 15 p. 877

**Imatinib** is predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 15 p. 877

**Macrolides (clarithromycin)** are predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 9 p. 876

**Macrolides (erythromycin)** are predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical

**Modafinil** is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical

**Netupitant** is predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical

**Nevirapine** is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical

**Nilutamide** is predicted to increase the exposure to bosutinib. Avoid. (Severe) Theoretical

**Proton pump inhibitors** are predicted to decrease the absorption of bosutinib. (Moderate) Study

**Rilpivirine** is predicted to very markedly decrease the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 15 p. 877

**St John’s Wort** is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical

**Brigatinib** is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Study

**Bowel cleansing preparations**

**Separation of administration** Other oral drugs should not be taken 1 hour before, or after, administration of bowel cleansing preparations because absorption may be impaired. Consider withholding ACE inhibitors, angiotensin-II receptor antagonists, and NSAIDs on the day that bowel cleansing preparations are given and for up to 72 hours after the procedure. Also consider withholding diuretics on the day that bowel cleansing preparations are given.

**Brentuximab vedotin** → see monoclonal antibodies

**Brigatinib**

**Antiepileptics (carbamazepine, fosphenytin, phenobarbital, phentoin, primidone)** are predicted to decrease the exposure to brigatinib. Avoid. (Severe) Study

**Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to increase the exposure to brigatinib. Adjust brigatinib dose. (Severe) Study

**Bosentan** is predicted to decrease the exposure to brigatinib. Avoid. (Severe) Study

**Cobicistat** is predicted to increase the exposure to brigatinib. Adjust brigatinib dose. (Severe) Study

**Brigatinib** decreases the exposure to combined hormonal contraceptives. Use additional contraceptive precautions. (Severe) Theoretical
Brigatinib (continued)

- Brigatinib potentially increases the concentration of dabigatran. [Moderate] Theoretical
- Brigatinib potentially increases the concentration of digoxin. [Moderate] Theoretical
- Efavirenz is predicted to decrease the exposure to brigatinib. Avoid. [Severe] Study
- Enalapril is predicted to decrease the exposure to brigatinib. Avoid. [Severe] Study
- Ertapenem is predicted to decrease the exposure to brigatinib. Avoid. [Moderate] Theoretical
- Grapefruit juice is predicted to increase the concentration of brigatinib. Avoid. [Severe] Study
- HIV-protease inhibitors are predicted to increase the exposure to brigatinib. Adjust brigatinib dose. [Severe] Study
- Iloperidone is predicted to increase the exposure to brigatinib. Adjust brigatinib dose. [Severe] Study
- Macrolides (clarithromycin) are predicted to increase the exposure to brigatinib. Adjust brigatinib dose. [Severe] Study
- Mitotane is predicted to decrease the exposure to brigatinib. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to brigatinib. Avoid. [Severe] Study
- Brigatinib potentially decreases the concentration of opioids (alfentanil, fentanyl). Avoid. [Moderate] Theoretical
- Rifabutin is predicted to decrease the exposure to brigatinib. Avoid. [Moderate] Theoretical
- Rifampicin is predicted to decrease the exposure to brigatinib. Avoid. [Moderate] Theoretical
- St John's Wort is predicted to decrease the exposure to brigatinib. Avoid. [Severe] Study
- Brigatinib potentially decreases the concentration of sirolimus. Avoid. [Moderate] Theoretical
- Tigecycline is predicted to decrease the exposure to brigatinib. Avoid. [Severe] Study
- Brigatinib potentially decreases the concentration of tacrolimus. Avoid. [Moderate] Theoretical

**BRIMONIDINE**

- See also TABLE 6 p. 875 (bradycardia), TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

**ROUTE-SPECIFIC INFORMATION**

- Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

**BRIVARACETAM**

- See also antiepileptics

**BRODULAMAB**

- See monoclonal antibodies

**BROMFENAC**

- See NSAIDs

**BROMOCRIPTINE**

- See dopamine receptor agonists

**BUCLIZINE**

- See antihistamines, sedating

**BUDESONIDE**

- See corticosteroids

**BUMETANIDE**

- See loop diuretics

**BUPIVACAINE**

- See anaesthetics, local

**BUPRENORPHINE**

- See opioids

**BUPROPION**

- See TABLE 13 p. 877 (serotonin syndrome)

- Bupropion is predicted to increase the exposure to anticholinesterases, centrally acting (galantamine). Monitor and adjust dose. [Moderate] Study

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to bupropion. [Severe] Study

- Antiepileptics (valproate) increase the exposure to bupropion. [Severe] Study

- Antifungals, azoles (isavuconazole) slightly increase the exposure to bupropion. Adjust dose. [Moderate] Study

- Bupropion is predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

- Bupropion is predicted to markedly increase the exposure to atomoxetine. Adjust dose. [Severe] Study

- Bupropion is predicted to markedly increase the exposure to atomoxetine. Adjust dose. [Severe] Study

- Bupropion is predicted to slightly increase the exposure to darifenacil. [HiID] Study

- Bupropion increases the risk of side-effects when given with dopamine receptor agonists (amantadine). [Moderate] Study

- Efavirenz is predicted to decrease the exposure to bupropion. [Moderate] Study

- Bupropion is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. [Severe] Study

- HIV-protease inhibitors (ritonavir) are predicted to decrease the exposure to bupropion. [Moderate] Study

- Bupropion increases the risk of side-effects when given with levodopa. [Moderate] Study

- Bupropion is predicted to increase the risk of intraoperative hypertension when given with linezolid. [Severe] Anecdotal → Also see TABLE 13 p. 877

- Methylenidium chloride is predicted to increase the risk of severe hypertension when given with bupropion. Avoid. [Severe] Theoretical → Also see TABLE 13 p. 877

- Bupropion is predicted to increase the exposure to mexiteline. [Moderate] Study

- Moclobemide is predicted to increase the risk of severe hypertension when given with bupropion. Avoid. [Severe] Theoretical → Also see TABLE 13 p. 877

- Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the risk of severe hypertension when given with bupropion. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical → Also see TABLE 13 p. 877

- Monoamine-oxidase B inhibitors are predicted to increase the risk of severe hypertension when given with bupropion. Avoid. [Moderate] Theoretical → Also see TABLE 13 p. 877

- Bupropion is predicted to decrease the efficacy of opioids (codeine). [Moderate] Theoretical

- Bupropion is predicted to decrease the efficacy of opioids (tramadol). [Severe] Study → Also see TABLE 13 p. 877

- Bupropion is predicted to moderately increase the exposure to pilocarpine. Use with caution and adjust dose. [Moderate] Study

- Rifampicin is predicted to decrease the exposure to bupropion. [Moderate] Study

- Bupropion is predicted to increase the exposure to risperidone. Adjust dose. [Moderate] Study

- Bupropion is predicted to increase the exposure to SSRIs (dapoxetine). [Moderate] Theoretical → Also see TABLE 13 p. 877

- Bupropion is predicted to decrease the efficacy of tamoxifen. Avoid. [Severe] Study

- Bupropion is predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. [Severe] Study → Also see TABLE 13 p. 877

- Bupropion is predicted to increase the exposure to vortioxetine. Monitor and adjust dose. [Moderate] Study → Also see TABLE 13 p. 877

**BUSPIRONE**

- See TABLE 13 p. 877 (serotonin syndrome)

- Antiarrhythmics (dronedarone) are predicted to increase the exposure to buspirone. Use with caution and adjust dose. [Moderate] Study

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to buspirone. Use with caution and adjust dose. [Severe] Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to buspirone. Use with caution and adjust dose. [Moderate] Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to buspirone. Adjust buspirone dose. [Severe] Study

- Antifungals, azoles (miconazole) are predicted to increase the concentration of buspirone. Use with caution and adjust dose. [Moderate] Theoretical

- Aplutamide is predicted to decrease the exposure to buspirone. Avoid or monitor. [Moderate] Study

- Aprepitant is predicted to increase the exposure to buspirone. Use with caution and adjust dose. [Moderate] Study

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to buspirone. Use with caution and adjust dose. [Moderate] Study

- Cobimetinib is predicted to increase the exposure to buspirone. Adjust buspirone dose. [Severe] Study

- Crizotinib is predicted to increase the exposure to buspirone. Use with caution and adjust dose. [Moderate] Study

- Enzalutamide is predicted to decrease the exposure to buspirone. Use with caution and adjust dose. [Severe] Study

- Grapefruit juice increases the exposure to buspirone. Avoid. [Severe] Study
> **HIV-protease inhibitors** are predicted to increase the exposure to buspirone. Adjust buspirone dose. **(Severe) Study**
> **Idelalisib** is predicted to increase the exposure to buspirone. Adjust buspirone dose. **(Severe) Study**
> **Imatinib** is predicted to increase the exposure to buspirone. Use with caution and adjust dose. **(Moderate) Study**
> **Buspirone** is predicted to increase the risk of elevated blood pressure when given with **linezolid**. Avoid. **(Severe) Theoretical → Also see TABLE 13 p. 877**
> **Macrolides (clarithromycin)** are predicted to increase the exposure to buspirone. Adjust buspirone dose. **(Severe) Study**
> **Macrolides (erythromycin)** are predicted to increase the exposure to buspirone. Use with caution and adjust dose. **(Moderate) Study**
> **Mitotane** is predicted to decrease the exposure to buspirone. Use with caution and adjust dose. **(Moderate) Study**
> **Buspirone** is predicted to increase the risk of elevated blood pressure when given with **linezolid**. Avoid. **(Severe) Theoretical → Also see TABLE 13 p. 877**
> **Macrolides (clarithromycin)** are predicted to increase the exposure to buspirone. Adjust buspirone dose. **(Severe) Study**
> **Macrolides (erythromycin)** are predicted to increase the exposure to buspirone. Use with caution and adjust dose. **(Moderate) Study**
> **Nilotinib** is predicted to increase the exposure to buspirone. Use with caution and adjust dose. **(Moderate) Study**
> **Rifampicin** is predicted to decrease the exposure to buspirone. Use with caution and adjust dose. **(Severe) Study**
> **Buspirone** is predicted to increase the risk of elevated blood pressure when given with **linezolid**. Avoid. **(Severe) Theoretical → Also see TABLE 13 p. 877**
> **Macrolides (clarithromycin)** are predicted to increase the exposure to buspirone. Adjust buspirone dose. **(Severe) Study**
> **Macrolides (erythromycin)** are predicted to increase the exposure to buspirone. Use with caution and adjust dose. **(Moderate) Study**
> **Mitotane** is predicted to decrease the exposure to buspirone. Use with caution and adjust dose. **(Severe) Study**

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**Caffeine citrate**

> **Caffeine citrate** decreases the efficacy of **antiarrhythmics** (adenosine). Separate administration by 24 hours. **(Moderate) Study**
> **Antiepileptics (fosphenytoin, phenytoin)** are predicted to moderately increase the clearance of **caffeine citrate**. Monitor and adjust dose. **(Moderate) Study**
> **HIV-protease inhibitors (ritonavir)** are predicted to moderately increase the clearance of **caffeine citrate**. Monitor and adjust dose. **(Moderate) Study**
> **SSRIs (flusoxamine)** markedly decrease the clearance of **caffeine citrate**. Monitor and adjust dose. **(Severe) Study**
> **Teriflunomide** is predicted to moderately increase the clearance of **caffeine citrate**. Monitor and adjust dose. **(Moderate) Study**
> **Buspirone** decreases the clearance of **theophylline**. **(Moderate) Study**

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**Calcipotriol**

> **Calcipotriol** is predicted to see vitamin D substances
> **Calcitonin (salmon)** decreases the concentration of **lithium**. Monitor concentration and adjust dose. **(Moderate) Study**

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**Calcium channel blockers**

> **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to **abemaciclib**. **(Moderate) Study**
> **Verapamil** is predicted to increase the exposure to **afatinib**. Separate administration by 12 hours. **(Moderate) Study**
> **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to **aldosterone antagonists** (eplerenone). Adjust eplerenone dose. **(Severe) Study → Also see TABLE 8 p. 875**
> **Verapamil** moderately increases the exposure to **alisikiren**. **(Moderate) Study → Also see TABLE 8 p. 875**
> **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to **alpha blockers** (tamsulosin). **(Moderate) Theoretical → Also see TABLE 8 p. 875**
> **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to **alprazolam**. **(Severe) Study**
> **Verapamil** moderately increases the exposure to **anthracyclines** (doxorubicin). **(Moderate) Study**
> **Antiarrhythmics (disopyramide)** are predicted to increase the risk of cardiodepression when given with **verapamil**. **(Severe) Theoretical**
> **Antiarrhythmics (dronedarone)** are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine, verapamil). Monitor and adjust dose. **(Moderate) Study**
> **Antiarhythmics (amiodarone)** are predicted to increase the risk of cardiodepression when given with calcium channel blockers (diltiazem, verapamil). Avoid. **(Severe) Theoretical → Also see TABLE 6 p. 875**
> **Calcium channel blockers** (diltiazem, verapamil) increase the exposure to antiarrhythmics (dronedarone) and antiarrhythmics (amiodarone) increases the exposure to calcium channel blockers (diltiazem, verapamil). **(Moderate) Study**

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**Antiepileptics**

> **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) moderately decrease the exposure to cabozantinib. **(Moderate) Study → Also see TABLE 9 p. 876**
> **Antifungals, azoles** (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical → Also see TABLE 9 p. 876**
> **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** moderately decrease the exposure to cabozantinib. **(Moderate) Study**
> **Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) slightly increase the exposure to cabozantinib. **(Moderate) Study → Also see TABLE 9 p. 876**
> **Aprepitant** is predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical**
> **Bosentan** is predicted to decrease the exposure to cabozantinib. **(Moderate) Theoretical**
> **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical**
> **Cobicistat** is predicted to slightly increase the exposure to cabozantinib. **(Moderate) Study**
> **Cabozantinib** is predicted to increase the risk of bleeding events when given with **coumarins**. **(Severe) Theoretical**
> **Crizotinib** is predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876**
> **Efavirenz** is predicted to decrease the exposure to cabozantinib. **(Moderate) Theoretical → Also see TABLE 9 p. 876**
> **Enzalutamide** moderately decreases the exposure to cabozantinib. **Avoid. (Moderate) Study**
> **Grapefruit juice** is predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical**
> **HIV-protease inhibitors** slightly increase the exposure to cabozantinib. **(Moderate) Study → Also see TABLE 9 p. 876**
> **Idelalisib** slightly increases the exposure to cabozantinib. **(Moderate) Study → Also see TABLE 15 p. 877**
> **Imatinib** is predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical → Also see TABLE 15 p. 877**
> **Macrolides (clarithromycin)** slightly increase the exposure to cabozantinib. **(Moderate) Study → Also see TABLE 9 p. 876**
> **Macrolides (erythromycin)** are predicted to increase the exposure to cabozantinib. **(Moderate) Theoretical → Also see TABLE 9 p. 876**
> **Mitotane** moderately decreases the exposure to cabozantinib. **Avoid. (Moderate) Study → Also see TABLE 15 p. 877**
Calcium channel blockers (continued)

- **Verapamil** increases the risk of cardiodepression when given with antiarrhythmics (flecainide). **Moderate** Anecdotal → Also see TABLE 6 p. 875
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to antiarrhythmics (propafenone). Monitor and adjust dose. **Moderate** Study
- **Calcium channel blockers** (diltiazem, verapamil) increase the risk of bradycardia when given with anticholinesterases, centrally acting (such as donepezil). **Anecdotal** → Also see TABLE 6 p. 875
- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. **Moderate** Study
- **Diltiazem** increases the concentration of antiepileptics (carbamazepine) and antiepileptics (carbamazepine) are predicted to decrease the exposure to diltiazem. **Severe** Anecdotal
- **Verapamil** increases the concentration of antiepileptics (carbamazepine) and antiepileptics (carbamazepine) are predicted to decrease the exposure to verapamil. **Severe** Anecdotal
- **Antiepileptics** (phenobarbital, primidone) are predicted to decrease the exposure to calcium channel blockers (diltiazem, verapamil, verapamil). **Severe** Study
- **Calcium channel blockers** (diltiazem, verapamil) potentially increase the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the exposure to calcium channel blockers (diltiazem, verapamil). **Severe** Study
- **Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to lercanidipine. Avoid. **Severe** Study
- **Antifungals, azoles** (miconazole) are predicted to increase the exposure to calcium channel blockers (amlodipine, clevidipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine, verapamil). Use with caution and adjust dose. **Moderate** Theoretical
- **Antifungals, azoles** (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine, verapamil). Monitor and adjust dose. **Moderate** Study
- **Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. **Moderate** Study
- **Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). **Moderate** Theoretical
- **Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). **Severe** Study
- **Antifungals, azoles** (posaconazole) are predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). **Moderate** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to antihistamines, non-sedating (mizolastine). **Severe** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to antihistamines, non-sedating (rapatadine). Avoid. **Moderate** Study
- **Antimalarials** (mefloquine) are predicted to increase the risk of bradycardia when given with calcium channel blockers. **Severe** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the concentration of antimalarials (piperazine). **Severe** Theoretical
- **Apalutamide** is predicted to decrease the exposure to calcium channel blockers (felodipine, lercanidipine). Avoid or monitor. **Moderate** Study
- **Verapamil** is predicted to increase the exposure to apixaban. **Moderate** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to aprepitant and aprepitant is predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). **Moderate** Study
- **Aprepitant** is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. **Moderate** Study
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to axitinib. **Moderate** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to bedaquiline. Avoid prolonged use. **Pregnancy** Theoretical
- **Diltiazem** is predicted to increase the risk of cardiodepression when given with beta blockers, non-selective. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Intravenous verapamil** increases the risk of cardiovascular side-effects when given with beta blockers, non-selective. Avoid. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Diltiazem** is predicted to increase the risk of cardiodepression when given with beta blockers, selective. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Intravenous verapamil** increases the risk of cardiovascular side-effects when given with beta blockers, selective. Avoid. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Oral verapamil** increases the risk of cardiovascular side-effects when given with beta blockers, non-selective. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the risk of cardiodepression when given with beta blockers, selective. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the risk of cardiovascular side-effects when given with beta blockers, selective. **Severe** Study → Also see TABLE 6 p. 875 → Also see TABLE 8 p. 875
- **Verapamil** is predicted to increase the exposure to bictegravir. Use with caution or avoid. **Moderate** Theoretical
- **Boventan** is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. **Moderate** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to buspirone. Use with caution and adjust dose. **Moderate** Study
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to cannabis. **Moderate** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to bosutinib. Avoid or adjust dose. **Moderate** Study
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to buspirone. **Moderate** Study → Also see TABLE 8 p. 875
- **Calcium channel blockers** (verapamil) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. **Moderate** Study → Also see TABLE 8 p. 875
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to apixaban. **Moderate** Theoretical
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the concentration of ciclosporin. **Severe** Study
- **Ciclosporin** moderately increases the exposure to lercanidipine. Use with caution or avoid. **Severe** Study
- **Nicardipine** increases the concentration of ciclosporin. **Severe** Study
- **Cobicistat** is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine), **Moderate** Study
Calcium channel blockers

- **Enzalutamide** is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate Study]
- **Cobicistat** is predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). [Severe Study]
- **Cobicistat** is predicted to markedly increase the exposure to lercanidipine. Avoid. [Severely]
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to cobimetinib. [Severe] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor and adjust dose. [Moderate] Study
- **Crixivane** is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- **Verapamil** increases the exposure to dabigatran. Adjust dabigatran dose. [Severe Study]
- Intravenous dantrolene potentially increases the risk of acute hyperkalaemia and cardiovascular collapse when given with calcium channel blockers (diltiazem, verapamil). Avoid. [Severe] Anecdotal
- Calcium channel blockers (diltiazem, verapamil) are predicted to slightly increase the exposure to darifenacin. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to dasatinib. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) increase the concentration of digoxin. Monitor and adjust dose. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) increase the risk of QT-prolongation when given with domperidone. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to dopamine receptor agonists (bromocriptine). [Severe] Theoretical → Also see Table 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of dopamine receptor agonists (cabergoline). [Moderate] Anecdotal
- Calcium channel blockers (diltiazem, verapamil) are predicted to moderately increase the exposure to dutasteride. [Mild] Study
- **Verapamil** is predicted to slightly increase the exposure to edoxaban. [Severe] Theoretical
- Efavirenz is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Theoretical
- Efavirenz is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine) with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- **Verapamil** is predicted to increase the exposure to fexofenadine. Avoid. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to fingolimod. Avoid. [Moderate] Theoretical → Also see Table 6 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to gefitinib. [Moderate] Theoretical
- Grapefruit juice very slightly increases the exposure to amiodipine. Avoid. [Mild] Study
- **Grapefruit juice** increases the exposure to calcium channel blockers (nifedipine, verapamil). Avoid. [Mild] Study
- **Grapefruit juice** increases the exposure to felodipine. Avoid. [Mild] Study
- **Grapefruit juice** is predicted to increase the exposure to lercanidipine. Avoid. [Moderate] Theoretical
- **Grapefruit juice** increases the exposure to nicardipine. [Mild] Study
- **Grazoprevir** is predicted to increase the concentration of calcium channel blockers. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of guanfacine. Adjust guanfacine dose. p. 237 [Moderate] Theoretical → Also see Table 8 p. 875
- **H₂ receptor antagonists (cimetidine)** (high-dose) are predicted to increase the exposure to lercanidipine. [Moderate] Theoretical
- **H₂ receptor antagonists (cimetidine)** moderately increase the exposure to nifedipine. Monitor and adjust dose. [Severe] Study
- **H₂ receptor antagonists (cimetidine)** increase the exposure to verapamil. [Moderate] Study
- **H₂ receptor antagonists (cimetidine)** slightly increase the exposure to calcium channel blockers (diltiazem, nimodipine). Monitor and adjust dose. [Moderate] Study
- HIV-protease inhibitors are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- **HIV-protease inhibitors** are predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). [Severe] Study
- **HIV-protease inhibitors** are predicted to markedly increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Severe] Study
- **Ibrutinib** is predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- **Ibrutinib** is predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- **Ibrutinib** is predicted to markedly increase the exposure to lercanidipine. Avoid. [Severe] Study
- **Ibrutinib** is predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- **Ibrutinib** is predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lercanidipine. Avoid. [Severe] Study
Calcium channel blockers (continued)

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose. [Moderate] Study → Also see TABLE 8 p. 875
- Macrolides (clarithromycin) are predicted to markedly increase the exposure to lercanidipine. Avoid. [Severe] Study
- Macrolides (erythromycin) are predicted to increase the exposure to diltiazem. [Severe] Theoretical
- Macrolides (erythromycin) are predicted to increase the exposure to verapamil. [Severe] Study
- Macrolides (erythromycin) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- Macrolides (clarithromycin) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- Macrolides (clarithromycin) are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- Intravenous magnesium potentially increases the risk of hypotension when given with calcium channel blockers (amlodipine, clevidipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine, verapamil) (in pregnant woman). [Severe] Anecdotal
- Mexiletine increases the risk of cardiovascular side-effects when given with diltiazem. Avoid or monitor. [Severe] Theoretical
- Mexiletine potentially increases the risk of cardiovascular side-effects when given with verapamil. Avoid or monitor. [Severe] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to midostaurin. [Moderate] Theoretical
- Mitotane is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine). Monitor and adjust dose. [Moderate] Study
- Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to calcium channel blockers. Monitor and adjust dose. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to nilotinib. Adjust naxoselogol dose and monitor side effects. [Moderate] Study
- Nevirapine is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- Nevirapine is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
- Verapamil is predicted to increase the exposure to nitrendipin. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. [Moderate]
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to opioids (methadone, sufentanil). [Moderate] Theoretical → Also see TABLE 6 p. 875

Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to oxybutynin. [Moderate] Theoretical
- Verapamil is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to pazopanib. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. [Moderate] Theoretical → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4. [Moderate] Study → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). [Severe] Theoretical → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to pimecrolimus. Avoid. [Severe] Theoretical → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to pimecrolimus. [Moderate] Study → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ranolazine. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ribociclib. [Moderate] Study
- Rivampicin is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine). Monitor and adjust dose. [Moderate] Study
- Rivampicin greatly decreases the exposure to calcium channel blockers (diltiazem, verapamil). [Severe] Study
- Rivampicin moderately decreases the exposure to nifedipine. Avoid. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ruxolitinib. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to saxagliptin. [Mild] Study
- Calcium channel blockers (diltiazem, verapamil) increase the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to SSRIs (dapoxetine). Adjust dapoxetine dose with moderate inhibitors of CYP3A4. [Moderate] Theoretical
- St John’s Wort is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Theoretical
- St John’s Wort is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Theoretical
- Amlodipine slightly increases the exposure to statins (simvastatin). Adjust simvastatin dose, p. 136. [Mild] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose. p. 136. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to sunitinib. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of tacrolimus. [Severe] Study
- Niacardipine potentially increases the concentration of tacrolimus. Monitor concentration and adjust dose. [Severe]
- Amlodipine slightly increases the exposure to statins (simvastatin). Adjust simvastatin dose, p. 136. [Mild] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose. p. 136. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to sunitinib. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of tacrolimus. [Severe] Study
- Niacardipine potentially increases the concentration of tacrolimus. Monitor concentration and adjust dose. [Severe]
Calcium channel blockers — Capecitabine 923

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to taxanes (cabazitaxel). [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of temsiroliimus. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to tezacafor. Adjust tezacafor with ivacafor. p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) given with a potent CYP3A4/5 inhibitor are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to tolterodine. [High] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. [Moderate] Study
- Verapamil is predicted to increase the exposure to topotecan. [Severe] Study
- Verapamil is predicted to increase the concentration of trametinib. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to trazodone. [Moderate] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to venetoclax. Avoid or adjust dose consult product literature. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to vinca alkaloids. [Severe] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study

Calcium chloride → see calcium salts
Calcium gluconate → see calcium salts
Calcium lactate → see calcium salts
Calcium phosphate → see calcium salts

Calcium salts

Calcium acetate - calcium carbonate - calcium chloride - calcium gluconate - calcium lactate - calcium phosphate

**SEPARATION OF ADMINISTRATION**

Calcium carbonate-containing antacids should preferably not be taken at the same time as other drugs since they might impair absorption. Antacids might damage enteric coatings designed to prevent dissolution in the stomach.

- Oral calcium salts decrease the absorption of alkylating agents (estramustine). [Severe] Study
- Calcium carbonate decreases the absorption of antimalarials (chloroquine). Separate administration by at least 4 hours. [Moderate] Study
- Calcium carbonate is predicted to decrease the absorption of antimalarials (propaunil). Separate administration by at least 2 hours. [Moderate] Study
- Oral calcium salts are predicted to decrease the absorption of antimalarials (chloroquine). Separate administration by at least 4 hours. [Moderate] Study
- Oral calcium salts are predicted to decrease the absorption of oral bisphosphonates (ibandronic acid). Avoid calcium salts for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical
- Oral calcium salts are predicted to decrease the absorption of bisphosphonates (ralendronate). Separate administration by at least 2 hours. [Moderate] Study
- Oral calcium salts are predicted to decrease the absorption of bisphosphonates (sodium clodronate). Avoid calcium salts for 2 hours before or 1 hour after sodium clodronate. [Moderate] Study
- Cefephalosporins (ceftriaxone) increase the risk of cardio-respiratory arrest when given with calcium chloride. Avoid. [Severe] Anecdotal
- Cefephalosporins (ceftriaxone) increase the risk of cardio-respiratory arrest when given with intravenous calcium gluconate. Avoid. [Severe] Anecdotal
- Intravenous calcium salts increase the concentration of digoxin. Avoid. [Moderate] Anecdotal
- Oral calcium salts decrease the absorption of dolutegravir. Dolutegravir should be taken 2 hours before or 6 hours after calcium salts. [Moderate] Study
- Oral calcium salts decrease the absorption of etrombopag. Etrombopag should be taken 2 hours before or 4 hours after calcium salts. [Severe] Study
- Calcium carbonate decreases the absorption of hydroxychloroquine. Separate administration by at least 4 hours. [Moderate] Study
- Calcium carbonate decreases the absorption of iron (oral). Calcium carbonate should be taken 1 hour before or 2 hours after iron (oral). [Moderate] Study
- Calcium carbonate is predicted to decrease the exposure to ledipasvir. Separate administration by 4 hours. [Moderate] Theoretical
- Calcium carbonate decreases the absorption of quinolones (ciprofloxacin). Separate administration by 2 hours. [Moderate] Study
- Calcium carbonate greatly decreases the exposure to raltegravir (high-dose). Avoid. [Severe] Study
- Calcium carbonate is predicted to slightly decrease the exposure to rifapirvine. Calcium carbonate should be taken 2 hours before or 4 hours after rifapirvine. [Severe] Theoretical
- Calcium carbonate is predicted to decrease the absorption of tetracyclines. Separate administration by at least 2 to 3 hours. [Moderate] Theoretical
- Thiazide diuretics increase the risk of hypercalcaemia when given with calcium salts. (Severe) Anecdotal
- Oral calcium salts are predicted to decrease the absorption of thyroid hormones (levothyroxine). Separate administration by at least 4 hours. [Moderate] Anecdotal
- Calcium carbonate is predicted to decrease the concentration of velpatasvir. Separate administration by 4 hours. [Moderate] Anecdotal
- Oral calcium salts decrease the absorption of zinc. [Moderate] Study

Canagliflozin → see TABLE 14 p. 877 (antidiabetic drugs), TABLE 8 p. 875 (Hypertension)

Rifampicin moderately decreases the exposure to canagliflozin. Adjust canagliflozin dose. [Moderate] Study

Canakinumab → see monoclonal antibodies
Canedesartan → see angiotensin-II receptor antagonists
Cangrelor → see TABLE 4 p. 874 (antiplatelet effects)
Cannabis extract → see TABLE 11 p. 876 (NS depressant effects)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cannabis extract. Avoid. [Severe] Theoretical → Also see TABLE 11 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical
- Cobicistat is predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical
- Enalaprilamid is predicted to decrease the exposure to cannabis extract. Avoid. [Severe] Theoretical
- HIV- protease inhibitors are predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical
- Idealalisib is predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical
- Macrolides (clarithromycin) are predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical
- Mitotane is predicted to decrease the exposure to cannabis extract. Avoid. [Severe] Theoretical
- Rifampicin is predicted to decrease the exposure to cannabis extract. Avoid. [Severe] Theoretical
- Capecitabine → see TABLE 15 p. 877 (myelosuppression)
- Allopurinol is predicted to decrease the effects of Capecitabine. Avoid. [Severe] Study
- Capecitabine increases the concentration of antiepileptics (fosphenytoin, phenytoin). [Severe] Anecdotal
Capcetabine

- **Capcetabine** increases the effects of **coumarins**, Monitor INR and adjust dose. **(Moderate) Anecdotal**

- **Folates** are predicted to increase the risk of toxicity when given with **capcetabine**. **(Severe) Anecdotal**

- H₂-receptor antagonists (cimetidine) are predicted to slightly increase the exposure to **capcetabine**. **(Severe) Theoretical**

- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with **capcetabine**. Public Health England advises avoid (refer to Green Book). **(Severe) Theoretical**

- **Metronidazole** is predicted to increase the risk of capcetabine toxicity when given with **capcetabine**. **(Severe) Theoretical**

- **Capreomycin** → **Table 2 p. 874** (nephrotoxicity), **Table 19 p. 878** (ototoxicity)

Captorpli → see ACE inhibitors

Carbamazepine → see antiepileptics

**Carbapenems**

- *ertapenem,* *imipenem,* *meropenem*

- **Carbenems** decrease the concentration of antiepileptics (valproate). **(Severe) Anecdotal**

- **Ganciclovir** is predicted to increase the risk of seizures when given with **imipenem**. Avoid. **(Severe) Anecdotal**

- **Valganciclovir** is predicted to increase the risk of seizures when given with **imipenem**. Avoid. **(Severe) Anecdotal**

Carbidoa

- **Iron (oral)** is predicted to decrease the exposure to **carbidoa**. **(Moderate) Theoretical**

Carbimazole → see **Table 15 p. 877** (myelosuppression)

- **Carbamazepine** affects the concentration of **digoxin**. Monitor and adjust dose. **(Moderate) Theoretical**

- **Carbamazepine** decreases the effect of **metyrapone**. Avoid. **(Moderate) Theoretical**

- **Carboplatin** → see platinum compounds

Carfilzomib → see **Table 15 p. 877** (myelosuppression)

Cariprazine → see **Table 8 p. 875** (hypotension), **Table 11 p. 876** (CNS depressant effects)

- **Antiarrhythmics (dronedarone)** are predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical** → Also see **Table 11 p. 876**

- **Antifungals, azoles (fluconazole, isavuconazole, posaconazole)** are predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to moderately increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Aprepitant** is predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Boseant** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study** → Also see **Table 8 p. 875**

- **Cobicistat** is predicted to moderately increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Crizotinib** is predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Efavirenz** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

- **Enalaprilat** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

- **HIV-protease inhibitors** are predicted to moderately increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Iralisib** is predicted to moderately increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Imatinib** is predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Macrolides (erythromycin)** are predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Mitotane** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

- **Netupitant** is predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Nevirapine** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

- **Nilotinib** is predicted to increase the exposure to **cariprazine**. Avoid. **(Severe) Study**

- **Rifampicin** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

- **St John’s Wort** is predicted to decrease the exposure to **cariprazine**. Avoid. **(Severe) Theoretical**

Carmustine → see alkylating agents

Carvedilol → see beta blockers, non-selective

- **Caspofungin** is predicted to decrease the concentration of **caspofungin**. Adjust caspofungin dose, p. 386. **(Moderate) Theoretical**

- **Ciclosporin** slightly increases the exposure to **caspofungin**. **(Severe) Study**

- **Corticosteroids (dexamethasone)** are predicted to decrease the concentration of **caspofungin**. Adjust caspofungin dose, p. 386. **(Moderate) Theoretical**

- **Efavirenz** is predicted to decrease the concentration of **caspofungin**. Adjust dose. **(Moderate) Study**

- **Nevirapine** is predicted to decrease the concentration of **caspofungin**. Adjust dose. **(Moderate) Theoretical**

- **Rifampicin** decreases the concentration of **caspofungin**. Adjust caspofungin dose, p. 386. **(Moderate) Study**

Cefadroxil → see cephalosporins

Cefalexin → see cephalosporins

Cefazolin → see cephalosporins

Cefazidime → see cephalosporins

Ceftabiprole → see cephalosporins

Cefotaxime → see cephalosporins

Ceftriaxone → see cephalosporins

Ceftaroline → see cephalosporins

Ceftazidime → see cephalosporins

- **Ceftobiprole** → see cephalosporins

Ceftriaxone → see cephalosporins

Ceftobiprole → see cephalosporins

Cefuroxime → see cephalosporins

Celecoxib → see NSAIDS

Celirol → see beta blockers, selective

Cephalosporins → see **Table 2 p. 874** (nephrotoxicity)

- **Ceftobiprole** is predicted to increase the exposure to **bosentan**. **(Moderate) Theoretical**

- **Ceftriaxone** increases the risk of cardio-respiratory arrest when given with **calcium salts (calcium chloride)**. Avoid. **(Severe) Anecdotal**

- **Ceftriaxone** increases the risk of cardio-respiratory arrest when given with intravenous **calcium salts (calcium gluconate)**. Avoid. **(Severe) Anecdotal**

- **Ceftriaxone** potentially increases the risk of bleeding events when given with **counmarins**. **(Severe) Anecdotal**

- **Leflunomide** is predicted to increase the exposure to **cefaclor**. **(Moderate) Theoretical**

- **Ceftriaxone** potentially increases the risk of bleeding events when given with **phenindione**. **(Severe) Anecdotal**

- **Ceftobiprole** is predicted to increase the concentration of **statins**. **(Moderate) Theoretical**

- **Ceftobiprole** is predicted to increase the concentration of **sulfonilureas (glibenclamide)**. **(Moderate) Theoretical**

- **Teriflunomide** is predicted to increase the exposure to **cefaclor**. **(Moderate) Study**

Ceritinib → see **Table 15 p. 877** (myelosuppression), **Table 9 p. 876** (QT-interval prolongation)

- **Ceritinib** is predicted to increase the exposure to **aliskiren**. **(Moderate) Theoretical**
Ceritinib is predicted to increase the exposure to opioids (alfentanil, fentanyl). Avoid. [Severe] Theoretical

Ceritinib is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical

Proton pump inhibitors are predicted to decrease the absorption of ceritinib. [Moderate] Theoretical

Ranolazine is predicted to increase the exposure to ceritinib. [Moderate] Theoretical

Rifampicin is predicted to decrease the exposure to ceritinib. [Severe] Study

Ceritinib is predicted to increase the exposure to sirolimus. Avoid. [Severe] Theoretical

St John's Wort is predicted to decrease the exposure to ceritinib. Avoid. [Severe] Theoretical

Ceritinib is predicted to increase the exposure to sulfonyleurals (glibipide). Adjust dose. [Moderate] Theoretical

Ceritinib is predicted to increase the exposure to tacrolimus. Avoid. [Severe] Theoretical

Ceritinib is predicted to increase the exposure to taxanes (paclitaxel). [Moderate] Theoretical

Ceritinib is predicted to increase the exposure to topotecan. [Moderate] Theoretical

CertoZumab pegol → see monoclonal antibodies

Cetirizine → see antihistamines, non-sedating

Cetuximab → see monoclonal antibodies

Chenodeoxycholic acid

Oral antacids (aluminium hydroxide) decrease the absorption of chenodeoxycholic acid. [Moderate] Study

Antiepileptics (phenobarbital, primidone) are predicted to affect the efficacy of chenodeoxycholic acid. Monitor and adjust dose. [Moderate] Theoretical

Ciclosporin is predicted to affect the efficacy of chenodeoxycholic acid. Monitor and adjust dose. [Moderate] Theoretical

Oral combined hormonal contraceptives potentially decrease the efficacy of chenodeoxycholic acid. Avoid. [Moderate] Theoretical

Sirolimus is predicted to affect the efficacy of chenodeoxycholic acid. Monitor and adjust dose. [Moderate] Theoretical

Chloral hydrate → see TABLE 11 p. 876 (CNS depressant effects)

Intravenous loop diuretics (furosemide) potentially increase the risk of sweating, variable blood pressure, and tachycardia when given after chloral hydrate. [Moderate] Aneecdotal

Chlorambucil → see alkylating agents

Chlorpromazine

ROUTE-SPECIFIC INFORMATION Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Antiepileptics (phenobarbital, primidone) decrease the concentration of chlorpromazine. [Moderate] Study

Intravenous chlorpromazine increases the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) affect the concentration of intravenous chlorpromazine. Monitor concentration and adjust dose. [Severe] Study

Chlorpromazine potentially increases the anticoagulant effect of coumarins. [Moderate] Aneecdotal

Chlorpromazine is predicted to increase the exposure to guanfacine. Adjust guanfacine dose, p. 227. [Moderate] Theoretical

Chlorpromazine decreases the efficacy of intravenous iron (injectable). [Moderate] Aneecdotal

Chlorpromazine decreases the efficacy of oral iron (oral). [Moderate] Theoretical

Chlorpromazine increases the concentration of chloramphenicol. [Moderate] Study

Chlorpromazine is predicted to increase the exposure to sirolimus. [Moderate] Study

Chlorpromazine increases the concentration of tacrolimus. [Severe] Study

Chloral hydrate 

Chlorpromazine is predicted to increase the exposure to sulfonyleurals. [Severe] Study

Chlorpromazine increases the concentration of tacrolimus. [Severe] Study

Chlorpromazine 

Chloral hydrate → see TABLE 11 p. 876 (CNS depressant effects)

Chloral hydrate affects the concentration of antiepileptics (fosphenytoin, phenytoin). [Severe] Study

Rifampicin is predicted to decrease the exposure to chloralhydrate. [Moderate] Theoretical

Chloroquine → see antimalarials
Ciclosporin is predicted to affect the efficacy of <em>chendoxycholic acid</em>. Monitor and adjust dose. [Moderate] Theoretical

Ciclosporin affects the concentration of <em>cholic acid</em>. Avoid. [Moderate] Study

Ciclosporin increases the exposure to <em>colchicine</em>. Avoid or adjust <em>colchicine</em> dose. [Severe] Study

Ciclosporin is predicted to increase the concentration of <em>ciclesonide</em>. Avoid. [Severe] Study

Ciclosporin increases the concentration of <em>ciclesonide</em>. Avoid. [Severe] Study

Ciclosporin is predicted to increase the risk of rhabdomyolysis when given with <em>daptomycin</em>. [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>darifenacine</em>. Monitor and adjust dose. [Severe] Theoretical

Ciclosporin increases the concentration of <em>digoxin</em>. Monitor and adjust dose. [Severe] Study

Ciclosporin slightly increases the exposure to <em>edoxaban</em>. Adjust edoxaban dose. [Severe] Study

Efavirenz decreases the concentration of ciclosporin. Monitor concentration and adjust dose. [Moderate] Study

Ciclosporin decreases the exposure to <em>elotrombopag</em>. Monitor and adjust dose. [Moderate] Study

Enalapril decreases the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the exposure to <em>erlotinib</em>. [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>etoposide</em>. Monitor and adjust dose. [Severe] Theoretical

Ciclosporin moderately increases the exposure to <em>everolimus</em>. Avoid or adjust dose. [Severe] Study

Ciclosporin moderately increases the exposure to <em>ezetimibe</em> and <em>ezetimibe</em> slightly increases the exposure to ciclosporin. [Moderate] Study

Fibrates (bezafibrate) are predicted to increase the risk of nephrotoxicity when given with ciclosporin. [Severe] Theoretical

Fibrates (fenofibrate) increase the risk of nephrotoxicity when given with ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the exposure to <em>fidaxomicin</em>. Monitor and adjust dose. [Moderate] Study

Ciclosporin is predicted to increase the exposure to <em>glecaprevir</em>. Avoid or monitor. [Severe] Study

Grapefruit juice increases the concentration of ciclosporin. Avoid. [Severe] Study

Ciclosporin greatly increases the exposure to <em>grazoprevir</em>. Avoid. [Severe] Study

<em>H</em>2 receptor antagonists (cimetidine) increase the concentration of ciclosporin. [Mild] Study

HIV-protease inhibitors increase the concentration of ciclosporin. [Severe] Study

Idelalisib increases the concentration of ciclosporin. [Severe] Study

Imatinib is predicted to increase the concentration of ciclosporin. [Severe] Study

Lanreotide is predicted to decrease the absorption of oral ciclosporin. Adjust dose. [Severe] Theoretical

Letermovir increases the exposure to ciclosporin and ciclosporin increases the exposure to <em>letemovir</em>. Monitor and adjust <em>letemovir</em> dose. [Severe] Study

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with ciclosporin. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>lomitapide</em>. Separate administration by 12 hours. [Moderate] Theoretical

Lumacaftor is predicted to decrease the exposure to ciclosporin. Avoid. [Severe] Theoretical

Macrolides (clarithromycin) increase the concentration of ciclosporin. [Severe] Study

Macrolides (erythromycin) are predicted to increase the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to affect the efficacy of <em>chendoxycholic acid</em>. Monitor and adjust dose. [Moderate] Theoretical

Ciclosporin affects the concentration of <em>cholic acid</em>. Avoid. [Moderate] Study

Colchicstat increases the concentration of ciclosporin. Avoid. [Moderate] Study

Ciclosporin is predicted to increase the exposure to dabigatran. Avoid. [Severe] Theoretical

Danazol increases the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the risk of rhabdomyolysis when given with <em>daptomycin</em>. [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>darifenacine</em>. Avoid. [Moderate] Theoretical

Ciclosporin increases the concentration of <em>digoxin</em>. Monitor and adjust dose. [Severe] Theoretical

Ciclosporin increases the concentration of <em>edoxaban</em>. Adjust edoxaban dose. [Severe] Study

Efavirenz decreases the concentration of ciclosporin. Monitor concentration and adjust dose. [Moderate] Study

Ciclosporin decreases the exposure to <em>elotrombopag</em>. Monitor and adjust dose. [Moderate] Study

Enalapril decreases the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the exposure to <em>erlotinib</em>. [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>etoposide</em>. Monitor and adjust dose. [Severe] Theoretical

Ciclosporin moderately increases the exposure to <em>everolimus</em>. Avoid or adjust dose. [Severe] Study

Ciclosporin moderately increases the exposure to <em>ezetimibe</em> and <em>ezetimibe</em> slightly increases the exposure to ciclosporin. [Moderate] Study

Fibrates (bezafibrate) are predicted to increase the risk of nephrotoxicity when given with ciclosporin. [Severe] Theoretical

Fibrates (fenofibrate) increase the risk of nephrotoxicity when given with ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the exposure to <em>fidaxomicin</em>. Avoid or adjust dose. [Moderate] Study

Ciclosporin is predicted to increase the exposure to <em>glecaprevir</em>. Avoid or monitor. [Severe] Study

Grapefruit juice increases the concentration of ciclosporin. Avoid. [Severe] Study

Ciclosporin greatly increases the exposure to <em>grazoprevir</em>. Avoid. [Severe] Study

<em>H</em>2 receptor antagonists (cimetidine) increase the concentration of ciclosporin. [Mild] Study

HIV-protease inhibitors increase the concentration of ciclosporin. [Severe] Study

Idelalisib increases the concentration of ciclosporin. [Severe] Study

Imatinib is predicted to increase the concentration of ciclosporin. [Severe] Study

Lanreotide is predicted to decrease the absorption of oral ciclosporin. Adjust dose. [Severe] Theoretical

Letermovir increases the exposure to ciclosporin and ciclosporin increases the exposure to <em>letemovir</em>. Monitor and adjust <em>letemovir</em> dose. [Severe] Study

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with ciclosporin. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>lomitapide</em>. Separate administration by 12 hours. [Moderate] Theoretical

Lumacaftor is predicted to decrease the exposure to ciclosporin. Avoid. [Severe] Theoretical

Macrolides (clarithromycin) increase the concentration of ciclosporin. [Severe] Study

Macrolides (erythromycin) are predicted to increase the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to affect the efficacy of <em>chendoxycholic acid</em>. Monitor and adjust dose. [Moderate] Theoretical

Ciclosporin affects the concentration of <em>cholic acid</em>. Avoid. [Moderate] Study

Colchicstat increases the concentration of ciclosporin. Avoid. [Moderate] Study

Ciclosporin is predicted to increase the exposure to dabigatran. Avoid. [Severe] Theoretical

Danazol increases the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the risk of rhabdomyolysis when given with <em>daptomycin</em>. [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>darifenacine</em>. Avoid. [Moderate] Theoretical

Ciclosporin increases the concentration of <em>digoxin</em>. Monitor and adjust dose. [Severe] Theoretical

Ciclosporin slightly increases the exposure to <em>edoxaban</em>. Adjust edoxaban dose. [Severe] Study

Efavirenz decreases the concentration of ciclosporin. Monitor concentration and adjust dose. [Moderate] Study

Ciclosporin decreases the exposure to <em>elotrombopag</em>. Monitor and adjust dose. [Moderate] Study

Enalapril decreases the concentration of ciclosporin. [Severe] Study

Ciclosporin is predicted to increase the exposure to <em>erlotinib</em>. [Severe] Theoretical

Ciclosporin is predicted to increase the exposure to <em>etoposide</em>. Monitor and adjust dose. [Severe] Theoretical

Ciclosporin increases the concentration of <em>edoxaban</em>. Adjust edoxaban dose. [Severe] Study

Efavirenz decreases the concentration of ciclosporin. Monitor concentration and adjust dose. [Moderate] Study
Ciclosporin is predicted to decrease the efficacy of mifepristone. Avoid. (Severe) Theoretical

Mitotane decreases the concentration of ciclosporin. (Severe) Study

Monoclonal antibodies (binatumomab) are predicted to transiently increase the exposure to ciclosporin. Monitor and adjust dose. (Moderate) Theoretical

Monoclonal antibodies (sarilumab) potentially affect the exposure to ciclosporin. Monitor and adjust dose. (Moderate) Theoretical

Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to ciclosporin. Monitor and adjust dose. (Moderate) Theoretical

Netupitant is predicted to increase the concentration of ciclosporin. (Severe) Study

Nevirapine is predicted to decrease the concentration of ciclosporin. (Moderate) Study

Nilotinib is predicted to increase the concentration of ciclosporin. (Severe) Study

Ciclosporin is predicted to increase the exposure to nintedanib. (Moderate) Study

Ciclosporin increases the concentration of NSAIDs (diclofenac). See also TABLE 2 p. 874 Also see TABLE 16 p. 878

Octreotide decreases the absorption of oral ciclosporin. Adjust ciclosporin dose, p. 537. (Severe) Anecdotal

Palbociclib is predicted to increase the exposure to ciclosporin. Adjust dose. (Severe) Theoretical

Pitolisant is predicted to decrease the exposure to ciclosporin. Avoid. (Severe) Theoretical

Ciclosporin is predicted to increase the concentration of ranolazine and ranolazine is predicted to increase the exposure to ciclosporin. (Moderate) Theoretical

Ciclosporin moderates the increase in the exposure to repaglinide. (Moderate) Study

Ribociclib is predicted to increase the exposure to ciclosporin. Use with caution and adjust dose. (Moderate) Theoretical

Rifampicin decreases the concentration of ciclosporin. (Severe) Study

Ciclosporin very markedly increases the exposure to rifaximin. (Severe) Study

Ciclosporin is predicted to increase the exposure to riociguat. (Moderate) Theoretical

Rucaparib is predicted to increase the exposure to ciclosporin. Monitor and adjust dose. (Moderate) Study

Ciclosporin moderately increases the exposure to sirolimus. Separate administration by 6 hours. (Severe) Study

St John’s Wort decreases the concentration of ciclosporin. Avoid. (Moderate) Study

Ciclosporin very markedly increases the exposure to statins (atorvastatin). Avoid or adjust atorvastatin dose, p. 134. (Severe) Study

Ciclosporin moderately increases the exposure to statins (fluvastatin). Avoid or adjust fluvastatin dose, p. 134. (Severe) Study

Ciclosporin markedly increases the exposure to statins (pravastatin). Adjust dose. (Severe) Study

Ciclosporin markedly increases the exposure to statins (rosuvastatin, simvastatin). Avoid. (Severe) study

Ciclosporin increases the concentration of tacrolimus. Avoid. (Severe) Study Also see TABLE 2 p. 874 Also see TABLE 16 p. 878

Ciclosporin is predicted to increase the exposure to tenofovir alafenamide. (Moderate) Theoretical

Ciclosporin is predicted to increase the exposure to tenofovir disoproxil. (Moderate) Theoretical Also see TABLE 2 p. 874

Ciclosporin is predicted to increase the exposure to ticagrelor. Use with caution or avoid. (Severe) Study

Ciclosporin increases the exposure to tofacitinib. Avoid. (Severe) Study

Ciclosporin is predicted to increase the exposure to toptotecan. (Severe) Study

Ciclosporin is predicted to increase the concentration of trametinib. (Moderate) Theoretical

Ursodeoxycholic acid affects the concentration of ciclosporin. Use with caution and adjust dose. (Severe) Anecdotal

Ciclosporin is predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. (Severe) Theoretical

Vitamin E substances affect the exposure to ciclosporin. (Moderate) Study

Ciclosporin increases the concentration of voxpilapriv. Avoid. (Severe) Study

Cidofovir → see TABLE 2 p. 874 (nephrotoxicity)

Cilostazol → see TABLE 4 p. 874 (antiplatelet effects)

GENERAL INFORMATION

Concurrent use with 2 or more antiplatelets or anticoagulants is contra-indicated.

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to alter the effects of cilostazol. (Moderate) Theoretical

Antifungals, azoles (fluconazole) are predicted to increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Antifungals, azoles (miconazole) are predicted to increase the exposure to cilostazol. Use with caution and adjust dose. (Moderate) Theoretical

Cobicistat is predicted to moderately increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Enzalutamide is predicted to alter the effects of cilostazol. (Moderate) Theoretical

HIV protease inhibitors are predicted to moderately increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Idelalisib is predicted to moderately increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Cilostazol is predicted to increase the exposure to lipitapide. Separate administration by 12 hours. (Moderate) Theoretical

Macrolides (clarithromycin) are predicted to moderately increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Macrolides (erythromycin) slightly increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Mitotane is predicted to alter the effects of cilostazol. (Moderate) Theoretical

Moclobemide is predicted to increase the exposure to cilostazol. (Moderate) Theoretical

Proton pump inhibitors (omeprazole) are predicted to increase the exposure to cilostazol. (Moderate) Theoretical

Proton pump inhibitors (omeprazole) are predicted to increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Rifampicin is predicted to alter the effects of cilostazol. (Moderate) Theoretical

SSRIs (fluoxetine, fluvoxamine) are predicted to increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Theoretical Also see TABLE 4 p. 874

St John’s Wort is predicted to alter the effects of cilostazol. (Moderate) Theoretical

Cimetidine → see H2 receptor antagonists

Cinacalcet

FOOD AND LIFESTYLE: Dose adjustment might be necessary if smoking started or stopped during treatment.

Cinacalcet is predicted to increase the exposure to anticholinesterases, centrally acting (galantamine). Monitor and adjust dose. (Moderate) Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cinacalcet. Monitor and adjust dose. (Moderate) Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to cinacalcet. Adjust dose. (Moderate) Study

Cinacalcet is predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. (Moderate) Study

Cinacalcet is predicted to markedly increase the exposure to atomoxetine. Adjust dose. (Severe) Study
Cinacalcet — Clonipogrel

Cinacalcet (continued)

- Clonipogrel is predicted to increase the exposure to beta blockers, selective (metoprolol, nebivolol). (Moderate) Study
- Cobicistat is predicted to moderately increase the exposure to cinacalcet. Adjust dose. (Moderate) Study
- Cinacalcet is predicted to slightly increase the exposure to darifenacin. (Mild) Study
- Clonipogrel is predicted to increase the exposure to eliglustrast. Avoid or adjust dose—consult product literature. (Severe) Study
- Clobazam is predicted to decrease the exposure to cinacalcet. Monitor and adjust dose. (Moderate) Study
- Clonipogrel increases the risk of hypocalcaemia when given with etelcalcetide. Avoid. (Severe) Theoretical
- HIV-protease inhibitors are predicted to moderately increase the exposure to cinacalcet. Adjust dose. (Moderate) Study
- Idealisib is predicted to moderately increase the exposure to cinacalcet. Adjust dose. (Moderate) Study
- Macrolides (clarithromycin) are predicted to moderately increase the exposure to cinacalcet. Adjust dose. (Moderate) Study
- Cinacalcet is predicted to increase the exposure to mexiletine. (Moderate) Study
- Mitotane is predicted to decrease the exposure to cinacalcet. Monitor and adjust dose. (Moderate) Study
- Clonipogrel is predicted to moderately increase the exposure to opioids (tramadol). (Severe) Study
- Cinacalcet is predicted to moderately increase the exposure to piritolidine. Use with caution and adjust dose. (Moderate) Study
- Rifampcin is predicted to decrease the exposure to cinacalcet. Monitor and adjust dose. (Moderate) Study
- Clonipogrel is predicted to increase the exposure to risperidone. Adjust dose. (Moderate) Study
- SSRIs (fluvoxamine) are predicted to increase the exposure to cinacalcet. Adjust dose. (Moderate) Theoretical
- Cinacalcet is predicted to increase the exposure to SSRIs (dapoxetine). (Moderate) Theoretical
- Cinacalcet is predicted to decrease the efficacy of tamoxifen. Avoid. (Severe) Study
- Clonipogrel is predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. (Severe) Study
- Cinacalcet is predicted to increase the exposure to vortioxetine. Monitor and adjust dose. (Moderate) Study
- Cinnarizine → see antihistamines, sedating
- Ciprofloxacin → see quinolones
- Cladribacurium → see neumoscular blocking drugs, non-depolarising
- Clonipogrel increases the exposure to platinum compounds
- Citalopram → see SSRIs
- Cladribine ← see TABLE 15 p. 877 (myelosuppression)

Separation of administration

Oral cladribine might affect the absorption of concurrently administered drugs—consider separating administration by at least 3 hours.

- Antiepileptics (carbamazepine) are predicted to increase the risk of haematological toxicity when given with oral cladribine. (Moderate) Theoretical
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with cladribine. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Clarihromycin → see macrolides
- Clavulanic acid → see TABLE 1 p. 874 (hepatotoxicity)
- Clemastine → see antihistamines, sedating
- Clevipidine → see calcium channel blockers
- Clindamycin

Route-specific information

Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- Clindamycin increases the effects of neumoscular blocking drugs, non-depolarising. (Severe) Anecdotal
- Clindamycin increases the effects of suxamethonium. (Severe) Anecdotal
- Clindamycin → see TABLE 11 p. 876 (CNS depressant effects)
- Antiepileptics (stiripentol) increase the concentration of clobazam. (Severe) Study
- Clobazam potentially affects the concentration of antiepileptics (fosphenytoin, phenytoin). (Severe) Anecdotal
- Antifungals, azoles (fluconazole, voriconazole) potentially increase the exposure to clobazam. Adjust dose. (Moderate) Theoretical
- Moclobemide potentially increases the exposure to clobazam. Adjust dose. (Moderate) Theoretical
- Proton pump inhibitors (esomeprazole, omeprazole) potentially increase the exposure to clobazam. Adjust dose. (Moderate) Theoretical
- SSRIs (fluoxetine, fluvoxamine) potentially increase the exposure to clobazam. Adjust dose. (Moderate) Theoretical
- Clorofarabine ← see TABLE 15 p. 877 (myelosuppression)
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with clorafabine. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Clorofazime

- Clorofazime potentially increases the risk of QT-prolongation when given with bedaquiline. (Severe) Study
- Clofethiazole ← see TABLE 11 p. 876 (CNS depressant effects)
- Alcohol (beverage) causes serious, potentially fatal, CNS depression when given with clomethiazole. Avoid. (Severe) Study
- Clomipramine ← see tricyclic antidepressants
- Clonazepam ← see TABLE 11 p. 876 (CNS depressant effects)
- Clonazepam potentially affects the concentration of antiepileptics (fosphenytoin, phenytoin). (Severe) Anecdotal
- Clonidine ← see TABLE 6 p. 875 (bradycardia), TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
- Tricyclic antidepressants decrease the antihypertensive effects of clonidine. Monitor and adjust dose. (Moderate) Anecdotal
- Clonipogrel ← see TABLE 8 p. 875
- Clobazam is predicted to increase the exposure to apalutamide. (Mild) Study
- Cloripogrel is predicted to increase the exposure to dabrafenib. (Moderate) Theoretical
- Cloripogrel is predicted to very markedly increase the exposure to dasabuvir. Avoid. (Severe) Study
- Cloripogrel moderately increases the exposure to enzalutamide. Avoid or adjust enzalutamide dose. (Severe) Study
- Grapefruit juice markedly decreases the exposure to clobazam. (Severe) Study
- Cloripogrel is predicted to moderately increase the exposure to montelukast. (Moderate) Study
- Cloripogrel increases the exposure to pioglitazone. Monitor blood glucose and adjust dose. (Severe) Study
- Cloripogrel is predicted to moderately increase the exposure to pioglitazone. Monitor blood glucose and adjust dose. (Severe) Study
- Cloripogrel is predicted to increase the exposure to repaglinide. Avoid. (Severe) Study
- Cloripogrel is predicted to increase the exposure to retinoids (allretinoin). Adjust altretinoin dose. (Moderate) Theoretical
Clarithromycin → see antibiotics, azoles

Clomipramine see TABLE 8 p. 875 (hypotension), TABLE 15 p. 877 (myelosuppression), TABLE 11 p. 876 (CNS depressant effects), TABLE 10 p. 876 (antimuscarinics)

Dose adjustment might be necessary if smoking started or stopped during treatment.

Avoid concomitant use of clozapine with drugs that have a substantial potential for causing agranulocytosis.

Antiepileptics (carbamazepine) are predicted to increase the risk of myelosuppression when given with clozapine. Avoid. (Severe) Anecdotal

Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to clozapine. (Moderate) Anecdotal → Also see TABLE 11 p. 876

Combined hormonal contraceptives are predicted to increase the risk of myelosuppression when given with clozapine. Monitor side effects and adjust dose. (Severe) Study

Clonazepam is predicted to decrease the effects of dopamine receptor agonists. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 10 p. 876

Enalapril is predicted to decrease the exposure to clozapine. (Moderate) Theoretical

HIV- protease inhibitors (ritonavir) are predicted to affect the exposure to clozapine. Avoid. (Severe) Theoretical

Iron chelators (deferasirox) are predicted to increase the exposure to clozapine. Avoid. (Moderate) Theoretical

Leflunomide is predicted to decrease the exposure to clozapine. (Moderate) Theoretical → Also see TABLE 15 p. 877

Clonazepam is predicted to decrease the effects of levodopa. (Severe) Theoretical → Also see TABLE 8 p. 875

Macrolides (erythromycin) potentially increase the risk of toxicity when given with clonazepam. (Severe) Anecdotal

Mexitelone increases the concentration of clonazepam. Monitor side effects and adjust dose. (Severe) Study

Quinolones (ciprofloxacin) increase the concentration of clonazepam. Monitor side effects and adjust dose. (Severe) Study

Rifampin decreases the exposure to clonazepam. (Severe) Anecdotal

SSRIs (fluvoxamine) increase the concentration of clonazepam. Monitor side effects and adjust dose. (Severe) Study

Teriflunomide is predicted to decrease the exposure to clonazepam. (Moderate) Theoretical

Cobicistat

Cobicistat is predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. (Severe) Study

Cobicistat is predicted to markedly increase the exposure to aldosterone antagonists (eplerenone). Avoid. (Severe) Study

Cobicistat increases the exposure to almogitran. (Mild) Study

Cobicistat is predicted to moderately increase the exposure to alpha blockers (alfuzosin, tamsulosin). Use with caution or avoid. (Moderate) Study

Cobicistat is predicted to increase the exposure to alpha blockers (doxazosin). (Moderate) Study

Cobicistat moderately increases the exposure to alprazolam. Avoid. (Moderate) Study

Cobicistat potentially increases the concentration of antiarrhythmics (amiodarone, disopyramide, flecainide, lidocaine). (Severe) Theoretical

Cobicistat very markedly increases the exposure to antiarrhythmics (dronedarone). Avoid. (Severe) Study

Cobicistat is predicted to increase the exposure to antiarrhythmics (propafenone). Monitor and adjust dose. (Severe) Study

Cobicistat is predicted to increase the exposure to anticholinesterases, centrally acting (galantamine). Monitor and adjust dose. (Moderate) Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cobicistat. Avoid. (Severe) Theoretical

Antiepileptics (oxcarbazepine) are predicted to decrease the concentration of cobicistat. (Severe) Theoretical

Cobicistat is predicted to very slightly increase the exposure to antiepileptics (perampanel). (Mild) Study

Cobicistat is predicted to increase the exposure to antifungals, azoles (fluconazole, posaconazole). (Moderate) Theoretical

Cobicistat is predicted to increase the exposure to antifungals, azoles (itraconazole, ketoconazole). Avoid or monitor side effects. (Severe) Study

Cobicistat is predicted to increase the exposure to antifungals, azoles (itraconazole, ketoconazole). Adjust dose. (Moderate) Theoretical

Cobicistat is predicted to affect the exposure to antihistamines, non-sedating (mizolastine). Avoid. (Severe) Study

Cobicistat is predicted to increase the exposure to antihistamines, non-sedating (rupatadine). Avoid. (Moderate) Study

Cobicistat is predicted to increase the concentration of antimalarials (piperazine). (Severe) Theoretical

Cobicistat is predicted to increase the exposure to beta blockers (atenolol, metoprolol). Avoid. (Severe) Theoretical

Cobicistat slightly increases the exposure to bortezomib. (Moderate) Study

Bosentan is predicted to decrease the exposure to cobicistat. Avoid. (Severe) Theoretical

Cobicistat is predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Study

Cobicistat is predicted to increase the exposure to brigatinib. Adjust brigatinib dose. (Severe) Study

Cobicistat is predicted to increase the exposure to buspirone. Adjust buspirone dose. (Severe) Study

Cobicistat slightly increases the exposure to cabozantinib. (Moderate) Study

Cobicistat is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. (Moderate) Study

Cobicistat is predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). (Severe) Study

Cobicistat is predicted to markedly increase the exposure to calcium channel blockers (laropiprant). Avoid. (Severe) Study

Cobicistat is predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. (Moderate) Theoretical

Cobicistat is predicted to moderately increase the exposure to cariprazine. Avoid. (Severe) Study

Cobicistat is predicted to increase the exposure to ceritinib. Avoid or adjust ceritinib dose. (Severe) Study

Cobicistat increases the concentration of ciclosporin. (Severe) Study

Cobicistat is predicted to increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Study

Cobicistat is predicted to moderately increase the exposure to cinacalcet. Adjust dose. (Moderate) Study

Cobicistat is predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. (Severe) Study

Cobicistat is predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. (Severe) Study
**Cobicistat – Cobicistat**

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Impact</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cobicistat is predicted to decrease the efficacy of <strong>combined hormonal contraceptives</strong>.</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to corticosteroids (beclomethasone) (risk with beclomethasone is likely to be lower than with other corticosteroids).</td>
<td>Moderate</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone).</td>
<td>Monitor side effects.</td>
<td></td>
</tr>
<tr>
<td>Cobicistat is predicted to moderately increase the exposure to <strong>enzalutamide</strong>.</td>
<td>Avoid or adjust dose—consult product literature.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>dabigatran</strong>.</td>
<td>Avoid.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>dabrafenib</strong>.</td>
<td>Use with caution or avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly to very markedly increase the exposure to <strong>darifenacin</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly increase the exposure to <strong>dasatinib</strong>.</td>
<td>Avoid or adjust dose.</td>
<td>Moderate Theoretical</td>
</tr>
<tr>
<td>Cobicistat is very slightly increases the exposure to <strong>delamanid</strong>.</td>
<td></td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat increases the risk of QT-prolongation when given with <strong>domperidone</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat increases the exposure to dopamine receptor agonists (bromocriptine),</td>
<td>Moderate</td>
<td>Anecdotal Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the concentration of dopamine receptor agonists (cabergoline).</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>doravirine</strong>.</td>
<td></td>
<td>Mild Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>dutasteride</strong>.</td>
<td>Monitor side effects and adjust dose.</td>
<td>Moderate Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>edoxaban</strong>.</td>
<td>Avoid.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to decrease the exposure to <strong>elafirenz</strong>.</td>
<td>Increase dose.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly increase the exposure to <strong>elotrisib</strong>.</td>
<td>Avoid or adjust dose—consult product literature.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>encorafenib</strong>.</td>
<td>Avoid or monitor.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to decrease the exposure to <strong>enalapril</strong>.</td>
<td>Avoid.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly increase the risk of ergotism when given with <strong>ergotamine</strong>.</td>
<td>Avoid.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the risk of ergotism when given with <strong>ergotamine</strong>.</td>
<td>Avoid.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to slightly increase the exposure to <strong>erlotinib</strong>.</td>
<td>Use with caution and adjust dose.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>esketamine</strong>.</td>
<td>Adjust dose.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the concentration of <strong>everolimus</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to moderately increase the exposure to <strong>fesoterodine</strong>.</td>
<td>Adjust dose.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to moderate to markedly increase the exposure to <strong>fesoterodine</strong>.</td>
<td>Adjust dose.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to decrease the exposure to <strong>fosaprepitant</strong>.</td>
<td>Moderate</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>gefitinib</strong>.</td>
<td></td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat potentially increases the exposure to <strong>glecaprevir</strong>.</td>
<td></td>
<td>Moderate Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to moderately to markedly increase the exposure to <strong>grazoprevir</strong>.</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>guanfacine</strong>.</td>
<td>Adjust guanfacine dose, p. 237.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to very markedly increase the exposure to <strong>ibritinib</strong>.</td>
<td>Avoid potent inhibitors of CYP3A4 or adjust ibritinib dose.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>imatibib</strong>.</td>
<td></td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the risk of toxicity when given with <strong>irinotecan</strong>.</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>ivabradine</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>ivacaftor</strong>.</td>
<td></td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>lapatinib</strong>.</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly increase the exposure to <strong>lomitapide</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>lurasidone</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>macitentan</strong>.</td>
<td></td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly increase the exposure to <strong>maraviroc</strong>. Refer to specialist literature.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>mexiletine</strong>.</td>
<td>Avoid or monitor side effects.</td>
<td>Moderate Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly to very markedly increase the exposure to <strong>midazolam</strong>.</td>
<td>Avoid or adjust dose.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to very markedly increase the exposure to <strong>midostaurin</strong>.</td>
<td>Avoid or monitor for toxicity.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>mirabegron</strong>.</td>
<td>Adjust mirabegron dose in hepatic and renal impairment.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>mitazapine</strong>.</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>modafinil</strong>.</td>
<td>Avoid.</td>
<td>Mild Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to monoclonal antibodies (trastuzumab emtansine).</td>
<td>Avoid.</td>
<td>Severe Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to markedly increase the exposure to <strong>naloxegol</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>netupitant</strong>.</td>
<td>Avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>nelotinib</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>nitisineone</strong>.</td>
<td>Adjust dose.</td>
<td>Moderate Theoretical</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>olaparib</strong>.</td>
<td>Avoid potent inhibitor of CYP3A4 or adjust olaparib dose.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil).</td>
<td>Monitor and adjust dose.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>osmipentane</strong>.</td>
<td>Avoid in poor CYP2C9 metabolisers.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>oxybutynin</strong>.</td>
<td>Avoid.</td>
<td>Mild Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>palbociclib</strong>.</td>
<td>Avoid or adjust palbociclib dose.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>panobinostat</strong>.</td>
<td>Adjust panobinostat dose; in hepatic impairment avoid.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>paritaprevir</strong>.</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>paazopanib</strong>.</td>
<td>Avoid or adjust pazopanib dose.</td>
<td>Moderate Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>phosphodiesterase type-5 inhibitors</strong> (avanafil, vardenafil).</td>
<td>Avoid.</td>
<td>Severe Study</td>
</tr>
<tr>
<td>Cobicistat is predicted to increase the exposure to <strong>phosphodiesterase type-5 inhibitors</strong> (sildenafil).</td>
<td>Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122.</td>
<td>Severe Study</td>
</tr>
</tbody>
</table>
> Cobicistat is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Use with caution or avoid. [Severe] Study

> Cobicistat is predicted to increase the exposure to pimozide. Avoid. [Severe] Study

> Cobicistat is predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

> Cobicistat is predicted to moderately increase the exposure to praziquantel. [Mild] Study

> Cobicistat is predicted to increase the exposure to quetiapine. Avoid. [Severe] Study

> Cobicistat is predicted to increase the exposure to ranolazine. Avoid. [Severe] Study

> Cobicistat is predicted to increase the exposure to reboxetine. Avoid. [Moderate] Study

> Cobicistat is predicted to increase the exposure to regorafenib. Avoid. [Moderate] Study

> Cobicistat is predicted to increase the exposure to repaglinide. [Moderate] Study

> Cobicistat is predicted to increase the exposure to retinoids (alitretinoin). Adjust alitretinoin dose. [Moderate] Theoretical

> Cobicistat is predicted to increase the exposure to riticlib. Avoid or adjust riticlib dose. [Moderate] Study

> Rifabutin decreases the concentration of cobicistat and cobicistat increases the exposure to rifabutin. Avoid or adjust dose. [Severe] Study

> Rifampicin is predicted to decrease the exposure to cobicistat. Avoid. [Severe] Theoretical

> Cobicistat is predicted to increase the exposure to risperidone. Adjust dose. [Moderate] Study

> Cobicistat is predicted to increase the exposure to rivaroxaban. Avoid. [Severe] Theoretical

> Cobicistat is predicted to increase the exposure to roxulitixtin. Adjust dose and monitor side effects. [Moderate] Study

> Cobicistat is predicted to increase the exposure to saxagliptin. [Moderate] Study

> Cobicistat is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

> Cobicistat is predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. [Severe] Study

> Cobicistat is predicted to moderately increase the exposure to SSRIs (dapoxetine). Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. [Severe] Study

> Sultana’s Wort is predicted to decrease the exposure to cobicistat. Avoid. [Severe] Theoretical

> Cobicistat is predicted to increase the exposure to statins (atorvastatin). Avoid or adjust dose and monitor rhabdomyolysis. [Severe] Study

> Cobicistat is predicted to increase the exposure to statins (simvastatin). Avoid. [Severe] Study

> Cobicistat is predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study

> Cobicistat is predicted to increase the concentration of tacrolimus. Monitor and adjust dose. [Severe] Study

> Cobicistat is predicted to increase the exposure to taxanes (cabazitaxel). Avoid. [Severe] Study

> Cobicistat is predicted to moderately increase the exposure to taxanes (docetaxel). Avoid or adjust dose. [Severe] Study

> Cobicistat is predicted to increase the exposure to taxanes (paclitaxel). [Severe] Theoretical

> Cobicistat is predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical

> Cobicistat is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor. p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study

> Cobicistat is predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study

> Cobicistat is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study

> Cobicistat is predicted to increase the exposure to tolterodine. Avoid. [Severe] Study

> Cobicistat is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. [Severe] Study

> Cobicistat is predicted to increase the exposure to toremifene. [Moderate] Theoretical

> Cobicistat is predicted to increase the exposure to trabectedin. Avoid or adjust dose. [Severe] Theoretical

> Cobicistat is predicted to moderately increase the exposure to trazodone. Avoid or adjust dose. [Moderate] Study

> Cobicistat is predicted to slightly increase the exposure to tricyclic antidepressants. [Mild] Study

> Cobicistat is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Severe] Study

> Cobicistat is predicted to increase the exposure to vemurafenib. [Severe] Theoretical

> Cobicistat is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. [Severe] Study

> Cobicistat is predicted to increase the exposure to vinca alkaloids. [Severe] Theoretical

> Cobicistat is predicted to increase the exposure to vitamin D substances (paricalcitol). [Moderate] Study

> Cobicistat is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Theoretical

**Cobimetinib**

> Antiarrhythmics (dronedarone) are predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

> Antifungals, azoles (fluconazole, isavuconazole, miconazole, posaconazole) are predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. [Severe] Study

> Aripiprazole is predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Bosantan is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

> Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Cobimetinib is predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. [Severe] Study

> Crizotinib is predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Efavirenz is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

> Enzalutamide is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

> Grapefruit juice is predicted to increase the exposure to cobimetinib. Avoid. [Severe] Theoretical

> HIV protease inhibitors are predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. [Severe] Study

> Idelalisib is predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. [Severe] Study

> Imatinib is predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Macrolides (clarithromycin) are predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. [Severe] Study

> Mitotane is predicted to markedly increase the exposure to cobimetinib. Avoid. [Severe] Theoretical

> Netupitant is predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Nevirapine is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

>Nilotinib is predicted to increase the exposure to cobimetinib. [Severe] Theoretical

> Rifaximin is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

> St John’s Wort is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

**Codeine** → see opioids
Colchicine

- Antiarrhythmics (dronedarone) are predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Antifungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Apalutamide is predicted to decrease the exposure to colchicine. [Mild] Study
- Aprepitant is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Certitinib is predicted to increase the exposure to colchicine. [Moderate] Theoretical
- Ciclosporin increases the exposure to colchicine. Avoid or adjust colchicine dose. [Severe] Study
- Ciclosporin is predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Crizotinib is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Eltrombopag is predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Colchicine increases the risk of rhabdomyolysis when given with fibrates. [Severe] Aneotal
- HIV-protease inhibitors are predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Idelalisib is predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Imatinib is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Lapatinib is predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. [Moderate] Theoretical
- Macrolides (azithromycin) are predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. [Severe] Theoretical
- Macrolides (clarithromycin) are predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study
- Macrolides (erythromycin) are predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Mirabegron is predicted to increase the exposure to colchicine. [Mild] Theoretical
- Nitazoxanide is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. [Severe] Study
- Pemetrexed (with gemcapped) is predicted to increase the exposure to colchicine. [Moderate] Study
- Prednisone is predicted to decrease the exposure to colchicine. [Mild] Theoretical
- Ranolazine is predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. [Severe] Theoretical
- Rolapitant is predicted to increase the exposure to colchicine. [Moderate] Study
- Colchicine increases the risk of rhabdomyolysis when given with statins. [Severe] Aneotal
- Velpatasvir is predicted to increase the exposure to colchicine. [Severe] Theoretical
- Venlafaxine is predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. [Severe] Theoretical

Colecalciferol \(\rightarrow\) see vitamin D substances

Colestyramine

- Combined hormonal contraceptives are predicted to increase the exposure to agomelatine. [Moderate] Study
- Combined hormonal contraceptives are predicted to increase the exposure to aminophylline. Adjust dose. [Moderate] Theoretical
- Combined hormonal contraceptives are predicted to increase the exposure to anagrelide. [Moderate] Theoretical
- Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- Combined hormonal contraceptives alter the exposure to antiepileptics (lamotrigine). Adjust dose. [Moderate] Study
- Aprepitant is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- Bosentan is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- Brigatinib decreases the exposure to combined hormonal contraceptives. Use additional contraceptive precautions. [Severe] Theoretical
- Oral combined hormonal contraceptives potentially decrease the efficacy of chenodeoxycholic acid. Avoid. [Moderate] Theoretical
- Combined hormonal contraceptives increase the concentration of clozapine. Monitor side effects and adjust dose. [Severe] Study
- Macrolides (azithromycin) are predicted to decrease the efficacy of combined hormonal contraceptives. Avoid. [Severe] Study
- Combined hormonal contraceptives (containing ethinylestradiol) increase the risk of increased ALT concentrations when given with dasabuvir. Avoid. [Severe] Study
- Combined hormonal contraceptives are predicted to increase the exposure to dopamine receptor agonists (ropinirole). Adjust dose. [Moderate] Study
- Efavirenz is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- Encorafenib is predicted to affect the exposure to combined hormonal contraceptives. [Severe] Theoretical
- Combined hormonal contraceptives slightly increase the exposure to erlotinib. Monitor side effects and adjust dose. [Moderate] Study
- Fosaprepitant is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with gliclazepir. Avoid. [Severe] Study
- Griseofulvin potentially decreases the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- HIV-protease inhibitors (atazanavir) are predicted to decrease the efficacy of combined hormonal contraceptives. Adjust dose. [Severe] Study
Combined hormonal contraceptives increase the exposure to tizanidine. Avoid. [Moderate] Study

Ulipristal is predicted to decrease the efficacy of combined hormonal contraceptives. Avoid. [Severe] Theoretical

Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with voxilaprevir (with sofosbuvir and velpatasvir). Avoid. [Severe] Study

Combined hormonal contraceptives are predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical

Corticosteroids → see Table 17 p. 878 (reduced serum potassium)

beclometasone · betamethasone · budesonide · ciclesonide · deflazacort · dexamethasone · fluocortisone · fluticasone · hydrocortisone · methylprednisolone · mometasone · prednisolone · triamcinolone

Interactions do not generally apply to corticosteroids used for topical action (including inhalation) unless specified.

With intravitreal use of dexamethasone in adults: caution with concurrent administration of anticoagulant or antiplatelet drugs—increased risk of haemorrhagic events.

Antacids are predicted to decrease the absorption of deflazacort. Separate administration by 2 hours. [Moderate] Theoretical

Antacids decrease the absorption of dexamethasone. [Moderate] Study

Antihistamines (dronedarone) are predicted to increase the exposure to methylprednisolone. Monitor and adjust dose. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to fluticasone. [UnKnown] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to corticosteroids (budesonide, deflazacort, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone, triamcinolone). Monitor and adjust dose.

Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to methylprednisolone. Monitor and adjust dose. [Moderate] Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to beclometasone (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

Antifungals, azoles (miconazole) are predicted to increase the concentration of methylprednisolone. Monitor and adjust dose. [Moderate] Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

Apalutamide is predicted to decrease the exposure to corticosteroids (budesonide, fluticasone). Avoid or monitor. [Moderate] Study

Apreamiptant is predicted to increase the exposure to oral budesonide. [Moderate] Study

Apreamiptant moderately increases the exposure to dexamethasone. Monitor and adjust dose. [Moderate] Study

Apreamiptant is predicted to increase the exposure to fluticasone. [Moderate] Study

Apreamiptant is predicted to increase the exposure to methylprednisolone. Monitor and adjust dose. [Moderate] Study

Corticosteroids are predicted to decrease the concentration of aspirin (high-dose) and aspirin (high-dose) increases the risk of gastrointestinal bleeding when given with corticosteroids. [Moderate] Study

Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to methylprednisolone. Monitor and adjust dose. [Moderate] Study

HIV-protease inhibitors (ritonavir) are predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study

Combined hormonal contraceptives are predicted to increase the risk of venous thromboembolism when given with lenalidomide. Avoid. [Severe] Theoretical

Oral combined hormonal contraceptives slightly increase the exposure to loxapine. Avoid. [Unknown] Theoretical

Lumacaftor is predicted to decrease the efficacy of combined hormonal contraceptives. Use additional contraceptive precautions. [Severe] Theoretical

Combined hormonal contraceptives are predicted to increase the exposure to melatonin. [Moderate] Theoretical

Combined hormonal contraceptives decrease the effects of metyrapone. Avoid. [Moderate] Theoretical

Modafinil is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Study]

Combined hormonal contraceptives slightly increase the exposure to monoamine-oxidase B inhibitors (rasagiline). [Moderate] Study

Combined hormonal contraceptives increase the exposure to monoamine-oxidase B inhibitor (selegiline). Avoid. [Severe] Study

Monoclonal antibodies (sarilumab) potentially decrease the exposure to combined hormonal contraceptives. [Severe] Theoretical

Neuvirine is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study

NSAIDs (etoricoxib) slightly increase the exposure to combined hormonal contraceptives. [Moderate] Study

Combined hormonal contraceptives potentially oppose the effects of ospemifene. Avoid. [Severe] Theoretical

Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe] Study

Combined hormonal contraceptives are predicted to increase the exposure to pirfenidone. Use with caution and adjust dose. [Moderate] Study

Pitolisant is predicted to decrease the efficacy of combined hormonal contraceptives. Avoid. [Severe] Theoretical

Combined hormonal contraceptives are predicted to increase the risk of venous thromboembolism when given with pomalidomide. Avoid. [Severe] Theoretical

Combined hormonal contraceptives potentially oppose the effects of rolflumilast. Avoid. [Severe] Theoretical

St John’s Wort decreases the efficacy of combined hormonal contraceptives. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Sugammadex is predicted to decrease the exposure to oral combined hormonal contraceptives. Refer to patient information leaflet for missed pill advice. [Severe] Theoretical

Combined hormonal contraceptives are predicted to increase the risk of venous thromboembolism when given with thalidomide. Avoid. [Severe] Study

Combined hormonal contraceptives are predicted to increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical

Modafinil is predicted to decrease the exposure to tolmetin. Avoid. [Moderate] Study

Pomalidomide (with ritonavir and ombitasvir). Avoid. [Severe] Study

Sulindac is predicted to decrease the concentration of deflazacort. Avoid. [Moderate] Study

Budesonide is predicted to decrease the concentration of deflazacort. Avoid. [Moderate] Study

Combined hormonal contraceptives are predicted to increase the exposure to zopiclone. [Severe] Study

Lumiraftor is predicted to decrease the efficacy of combined hormonal contraceptives. Avoid. [Severe] Theoretical

Combined hormonal contraceptives increase the exposure to tizanidine. Avoid. [Moderate] Study

Ulipristal is predicted to decrease the efficacy of combined hormonal contraceptives. Avoid. [Severe] Theoretical

Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with voxilaprevir (with sofosbuvir and velpatasvir). Avoid. [Severe] Study

Combined hormonal contraceptives are predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical
Corticosteroids (continued)

- **Dexamethasone** is predicted to decrease the concentration of *caspofungin*. Adjust *caspofungin* dose; p. 386. [Moderate] Theoretical

- **Corticosteroids** are predicted to decrease the concentration of *choline salicylate*. [Moderate] Study

- **Cobicistat** is predicted to increase the exposure to *beclometasone* (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

- **Cobicistat** is predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

- **Corticosteroids** are predicted to increase the effects of *coumarins*. [Moderate] Study

- **Crizotinib** is predicted to increase the exposure to *methylprednisolone*. Monitor and adjust dose. [Moderate] Study

- **Enalapril** is predicted to decrease the exposure to *flucanazole*. [Unknown] Theoretical

- **Corticosteroids** increase the risk of gastrointestinal perforation when given with *erlotinib*. [Severe] Theoretical

- **Corticosteroids** potentially oppose the effects of *glycerol phenylbutyrate*. [Moderate] Theoretical

- **Grapefruit juice** moderately increases the exposure to oral *budesonide*. Avoid. [Moderate] Study

- **HIV-protease inhibitors** are predicted to increase the exposure to *beclometasone* (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

- **HIV-protease inhibitors** are predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

- **Idelalisib** is predicted to increase the exposure to *beclometasone* (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

- **Idelalisib** is predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

- **Imatinib** is predicted to increase the exposure to *methylprednisolone*. Monitor and adjust dose. [Moderate] Study

- **Corticosteroids** are predicted to increase the risk of gastrointestinal bleeding when given with *iron chelators* (deferasirox). [Severe] Theoretical

- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with corticosteroids (high-dose). Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

- **Lumacaftor** is predicted to increase the exposure to *methylprednisolone*. Adjust dose. [Severe] Theoretical

- **Macrolides (clarithromycin)** are predicted to increase the exposure to *beclometasone* (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

- **Macrolides (erythromycin)** are predicted to increase the exposure to *methylprednisolone*. Monitor and adjust dose. [Moderate] Study

- **Macrolides (clarithromycin)** are predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

- **Corticosteroids** are predicted to decrease the efficacy of *mifamurtide*. Avoid. [Severe] Theoretical

- **Mifepristone** is predicted to decrease the efficacy of corticosteroids. Use with caution and adjust dose. [Moderate] Theoretical

- **Mitotane** is predicted to decrease the exposure to corticosteroids (budesonide, deflazacort, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone, triamcinolone). Monitor and adjust dose. [Moderate] Study

- **Mitotane** is predicted to decrease the exposure to *fluticasone*. [Unknown] Theoretical

- **Corticosteroids** (betamethasone, deflazacort, dexamethasone, hydrocortisone, methylprednisolone, prednisolone) are predicted to decrease the efficacy of monoclonal antibodies (atezolizumab, ipilimumab, nivolumab, pembrolizumab). Use with caution or avoid. [Severe] Theoretical

- **Monoclonal antibodies (tocilizumab)** are predicted to decrease the exposure to corticosteroids (dexamethasone, methylprednisolone). Monitor and adjust dose. [Moderate] Theoretical

- **Corticosteroids** are predicted to increase the risk of immunosuppression when given with monoclonal antibodies (dinituximab). Avoid except in life-threatening situations. [Severe] Theoretical

- **Netupitant** is predicted to increase the exposure to oral *budesonide*. [Moderate] Study

- **Netupitant** is predicted to increase the exposure to *dexamethasone*. Adjust dose. [Moderate] Study

- **Netupitant** is predicted to increase the exposure to *fluticasone*. [Unknown] Theoretical

- **Corticosteroids** increase the risk of gastrointestinal perforation when given with *nicorandil*. [Severe] Anecdotal

- **Nilotinib** is predicted to increase the exposure to *methylprednisolone*. Monitor and adjust dose. [Moderate] Study

- **NSAIDs** increase the risk of gastrointestinal bleeding when given with corticosteroids. [Severe] Study

- **Corticosteroids** are predicted to increase the effects of *neuromuscular blocking drugs, non-depolarising*. [Severe] Anecdotal

- **Corticosteroids** increase the risk of gastrointestinal perforation when given with *nicorandil*. [Severe] Anecdotal

- **Nilotinib** is predicted to increase the exposure to *methylprednisolone*. Monitor and adjust dose. [Moderate] Study

- **Corticosteroids** are predicted to increase the effects of *phenindione*. [Moderate] Anecdotal

- **Dexamethasone** decreases the exposure to *praziquantel*. [Moderate] Study

- **Rifampicin** is predicted to decrease the exposure to corticosteroids (budesonide, deflazacort, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone, triamcinolone). Monitor and adjust dose. [Moderate] Study

- **Rifampicin** is predicted to decrease the exposure to *fluticasone*. [Unknown] Theoretical

- **Dexamethasone** is predicted to decrease the concentration of *rilpivirine*. Avoid multiple-dose dexamethasone. [Severe] Theoretical

- **Corticosteroids** potentially decrease the effects of *sodium phenylbutyrate*. [Moderate] Anecdotal

- **Corticosteroids** are predicted to decrease the effects of *somatropin*. [Moderate] Theoretical

- **Corticosteroids** are predicted to decrease the effects of *suxamethonium*. [Severe] Anecdotal

### Coumarins

- **COUMARINS**

  -  → **TABLE 3** p. 874 (anticoagulant effects)

<table>
<thead>
<tr>
<th>Acenocoumarol</th>
<th>Warfarin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food and Lifestyle</strong></td>
<td>The effects of coumarins can be reduced or abolished by vitamin K, including that found in healthy foods, food supplements, enteral feeds, or large amounts of some green vegetables or green tea. Major changes in diet (especially involving salads and vegetables) and in alcohol consumption can affect anticoagulant control. Pomegranate juice is predicted to increase the INR in response to acenocoumarol and warfarin.</td>
</tr>
</tbody>
</table>
• Antirrhythmic (amiodarone) increase the anticoagulant effect of coumarins. (Severe) Study
• Antirrhythmic (propafenone) increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Moderate) Study
• Antiepileptics (carbamazepine) decrease the effects of coumarins. Monitor and adjust dose. (Severe) Study
• Antiepileptics (fosphenytoin, phenytoin) are predicted to alter the anticoagulant effect of coumarins. (Moderate) Theoretical
• Antiepileptics (phenobarbital, primidone) decrease the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Moderate) Study
• Antifungals, azoles (fluconazole) increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. Monitor INR and adjust dose. (Moderate) Study
• Apalutamide increases the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Moderate) Study
• Axitinib is predicted to increase the risk of bleeding events when given with coumarins. Avoid or monitor. (Severe) Study
• Aprepitant decreases the anticoagulant effect of coumarins. (Moderate) Study
• Azathioprine decreases the anticoagulant effect of coumarins. (Moderate) Study
• Bosutinib decreases the anticoagulant effect of coumarins. (Moderate) Study
• Bosutinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Cabozantinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Certitinib is predicted to increase the exposure to warfarin. Avoid. (Severe) Theoretical
• Chloramphenicol potentially increases the anticoagulant effect of coumarins. (Moderate) Anecdotal
• Corticosteroids are predicted to increase the effects of coumarins. (Moderate) Study
• Cranberry juice potentially increases the anticoagulant effect of warfarin. Avoid. (Severe) Anecdotal
• Crizotinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Dabrafenib is predicted to decrease the anticoagulant effect of coumarins. (Severe) Theoretical
• Danazol potentially increases the anticoagulant effect of coumarins. (Severe) Anecdotal
• Dasatinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Disulfiram increases the anticoagulant effect of coumarins. Monitor and adjust dose. (Severe) Study
• Efavirenz is predicted to affect the concentration of coumarins. Adjust dose. (Moderate) Theoretical
• Eltsegravir is predicted to decrease the anticoagulant effect of coumarins. (Moderate) Theoretical
• Enteral feeds (vitamin-K containing) potentially decrease the anticoagulant effect of coumarins. (Severe) Anecdotal
• Enzalutamide potentially decreases the exposure to coumarins. Avoid or adjust dose and monitor INR. (Severe) Study
• Erlotinib increases the anticoagulant effect of coumarins. (Severe) Anecdotal
•埃特拉韦林 increases the anticoagulant effect of coumarins. (Moderate) Theoretical
• Fibrates are predicted to increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Severe) Study
• Fluorouracil increases the anticoagulant effect of coumarins. (Severe) Anecdotal
• Fosaprepitant is predicted to decrease the anticoagulant effect of coumarins. (Moderate) Theoretical
• Gefitinib is predicted to increase the anticoagulant effect of coumarins. (Severe) Anecdotal
• Glucagon increases the anticoagulant effect of warfarin. (Severe) Study
• Glucosamine potentially decreases the anticoagulant effect of acenocoumarol. (Moderate) Anecdotal
• Glucosamine potentially decreases the anticoagulant effect of warfarin. Avoid. (Moderate) Anecdotal
• Griseofulvin potentially decreases the anticoagulant effect of coumarins. (Moderate) Anecdotal
• H2 receptor antagonists (cimetidine) increase the anticoagulant effect of coumarins. (Severe) Study
• Imafitinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Ivenafarin is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Ivermectin potentially increases the anticoagulant effect of warfarin. (Severe) Theoretical
• Leflunomide increases the anticoagulant effect of coumarins. (Moderate) Anecdotal
• Letermovir is predicted to decrease the concentration of warfarin. Monitor and adjust dose. (Moderate) Theoretical
• Lomitapide increases the exposure to warfarin. Monitor INR and adjust dose. (Severe) Study
• Macrolides (clarithromycin, erythromycin) increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Severe) Anecdotal
• Mercaptopurine decreases the anticoagulant effect of coumarins. (Moderate) Anecdotal
• Metronidazole increases the anticoagulant effect of coumarins. (Severe) Anecdotal
• Mexiletine increases the anticoagulant effect of warfarin. (Severe) Study
• Methylene potentially affects the exposure to warfarin. Avoid. (Unknown) Theoretical
• Monoclonal antibodies (blinatumomab) are predicted to transiently increase the exposure to warfarin. Monitor and adjust dose. (Moderate) Theoretical
• Monoclonal antibodies (sarilumab) potentially affect the exposure to warfarin. Monitor and adjust dose. (Severe) Theoretical
• Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to warfarin. Monitor and adjust dose. (Moderate) Theoretical
• Nandrolone is predicted to increase the anticoagulant effect of coumarins. Monitor and adjust dose. (Severe) Theoretical
• Nevirapine potentially alters the anticoagulant effect of coumarins. (Severe) Anecdotal
• Nilotinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Obeticholic acid decreases the anticoagulant effect of warfarin. (Severe) Study
• Oxymetholone increases the anticoagulant effect of coumarins. (Severe) Anecdotal
• Paracetamol increases the anticoagulant effect of coumarins. (Severe) Anecdotal
• Partaprevir (in fixed-dose combination with dasabuvir) decreases the anticoagulant effect of acenocoumarol. Monitor INR and adjust dose. (Severe) Anecdotal
• Partaprevir (in fixed-dose combination) decreases the anticoagulant effect of warfarin. Monitor INR and adjust dose. (Severe) Anecdotal
• Pazopanib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
• Penicillins potentially alter the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Severe) Anecdotal

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Appendix 1
Coumarins (continued)

- **Pitolisant** is predicted to decrease the exposure to warfarin. [Mild] Theoretical
- **Ponatinib** is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
- **Quinolones** increase the anticoagulant effect of coumarins. [Severe] Anecdotal
- **Ranibizumab** increases the risk of bleeding events when given with coumarins. [Severe] Theoretical
- **Rifampicin** decreases the anticoagulant effect of coumarins. [Severe] Study
- **Rucaparib** slightly increases the exposure to warfarin. Monitor and adjust dose. [Severe] Study
- **Ruxolitinib** is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
- **Sorafenib** increases the anticoagulant effect of coumarins. [Severe] Anecdotal
- **St John's Wort** decreases the anticoagulant effect of coumarins. Avoid. [Severe] Anecdotal
- **Statins (fluvastatin, rosuvastatin)** increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Severe] Study
- **Sucralfate** potentially decreases the effects of warfarin. Separate administration by 2 hours. [Moderate] Anecdotal
- **Sulfonamides (sulfadiazine)** are predicted to increase the anticoagulant effect of coumarins. [Severe] Theoretical
- **Sulfonamides (sulfamethoxazole)** increase the anticoagulant effect of coumarins. [Severe] Study
- **Sunitinib** is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
- **Tamoxifen** increases the anticoagulant effect of coumarins. [Severe] Study
- **Tegafur** increases the anticoagulant effect of coumarins. [Theoretical]
- **Teriflunomide** affects the anticoagulant effect of coumarins. [Severe] Study
- **Tetracyclines** increase the risk of bleeding events when given with coumarins. [Moderate] Anecdotal
- **Tindazole** is predicted to increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Severe] Theoretical
- **Toremifene** is predicted to increase the anticoagulant effect of coumarins. [Severe] Theoretical
- **Trimethoprim** is predicted to increase the anticoagulant effect of coumarins. [Severe] Study
- **Vandetanib** is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
- **Venetoclax** slightly increases the exposure to warfarin. [Moderate] Study
- **Cranberry juice** potentially increases the anticoagulant effect of coumarins (warfarin). [Avoid. Severe] Anecdotal
- **Crisantaspase** → see Table 1 p. 874 (hepatotoxicity), Table 15 p. 877 (myelosuppression)
  - Crisataspase is predicted to increase the risk of hepatotoxicity when given with imatinib. [Severe] Theoretical → Also see Table 15 p. 877
  - Crisantaspase affects the efficacy of methotrexate. [Severe] Anecdotal → Also see Table 1 p. 874 → Also see Table 15 p. 877
  - Crisantaspase potentially increases the risk of neurotoxicity when given with vinca alkaloids (vincristine). Vincristine should be taken 3 to 24 hours before crisantaspase, p. 571. [Severe] Anecdotal → Also see Table 1 p. 874 → Also see Table 15 p. 877
- **Crizotinib** see Table 6 p. 875 (bradycardia), Table 15 p. 877 (myelosuppression), Table 9 p. 876 (QT-interval prolongation)
  - General information: Caution with concurrent use of drugs that cause gastrointestinal perforation—discontinue treatment if gastrointestinal perforation occurs.
  - **Crizotinib** is predicted to increase the exposure to abemaciclib. [Moderate] Study
  - **Crizotinib** is predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. [Severe] Study
  - **Crizotinib** is predicted to increase the exposure to alpha blockers (tamsulosin). [Moderate] Theoretical
  - **Crizotinib** is predicted to increase the exposure to alprazolam. [Severe] Study
  - **Crizotinib** is predicted to increase the exposure to antiarrhythmics (propranolone). Monitor and adjust dose. [Moderate] Study
  - **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to markedly decrease the exposure to crizotinib. Avoid. [Severe] Study
  - **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to moderately increase the exposure to crizotinib. Avoid. [Moderate] Study → Also see Table 9 p. 876
  - **Crizotinib** is predicted to increase the exposure to antihistamines, non-sedating (mizolastine). [Severe] Theoretical
  - **Crizotinib** is predicted to increase the exposure to antihistamines, non-sedating (rupatadine). Avoid. [Moderate] Study
  - **Crizotinib** is predicted to increase the concentration of antimalarials (piperazine). [Severe] Theoretical
  - **Crizotinib** is predicted to increase the exposure to axitinib. [Moderate] Theoretical → Also see Table 15 p. 877
  - **Crizotinib** is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Theoretical → Also see Table 9 p. 876
  - **Bosentan** is predicted to decrease the exposure to crizotinib. Avoid. [Severe] Theoretical
  - **Crizotinib** is predicted to increase the exposure to bosutinib. Avoid or adjust dose. [Severe] Theoretical → Also see Table 15 p. 877 → Also see Table 9 p. 876
  - **Crizotinib** is predicted to increase the exposure to capecitabine. Use with caution and adjust dose. [Moderate] Study
  - **Crizotinib** is predicted to increase the exposure to cabozantinib. [Moderate] Theoretical → Also see Table 15 p. 877 → Also see Table 9 p. 876
  - **Crizotinib** is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study
  - **Crizotinib** is predicted to increase the exposure to cariprazine. Avoid. [Severe] Study
  - **Crizotinib** is predicted to increase the exposure to ceritinib. [Moderate] Theoretical → Also see Table 15 p. 877 → Also see Table 9 p. 876
  - **Crizotinib** is predicted to increase the concentration of ciclesonide. [Severe] Study
  - **Cobicistat** is predicted to moderately increase the exposure to crizotinib. Avoid. [Moderate] Study
  - **Cemiplimab** is predicted to increase the exposure to cemiplimab. Avoid. Study
  - **Cranberry juice** is predicted to increase the concentration of corticosteroids (methylprednisolone). Monitor and adjust dose. [Moderate] Study
  - **Crizotinib** is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
  - **Crizotinib** is predicted to slightly increase the exposure to darifenacin. [Moderate] Study
  - **Crizotinib** is predicted to increase the exposure to dasatinib. [Severe] Study → Also see Table 15 p. 877 → Also see Table 9 p. 876
  - **Crizotinib** increases the risk of QT-prolongation when given with dorperidone. Avoid. [Severe] Study
  - **Crizotinib** is predicted to increase the exposure to dopamine receptor agonists (bromocriptine). [Severe] Theoretical
  - **Crizotinib** is predicted to increase the concentration of dopamine receptor agonists (cabergoline). [Moderate] Anecdotal
  - **Crizotinib** is predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - **Efavirenz** is predicted to decrease the exposure to crizotinib. Avoid. [Severe] Theoretical → Also see Table 9 p. 876
  - **Crizotinib** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. [Severe] Study
  - **Crizotinib** is predicted to moderately increase the exposure to encorafenib. [Moderate] Study → Also see Table 9 p. 876
  - **Enzalutamide** is predicted to markedly decrease the exposure to crizotinib. Avoid. [Severe] Study
Crizotinib is predicted to increase the risk of ergotism when given with ergonovine. (Severe) Theoretical

Crizotinib is predicted to increase the risk of ergotism when given with ergotamine. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to erlotinib. (Moderate) Theoretical

Crizotinib is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the exposure to fosfoterodine. Adjust fosfoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. (Mild) Study

Crizotinib is predicted to increase the exposure to gefitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877

Crizotinib potentially decreases the exposure to glecaprevir. Avoid. (Severe) Theoretical

Grapefruit juice is predicted to increase the exposure to crizotinib. Avoid. (Moderate) Theoretical

Grapefruit juice is predicted to decrease the exposure to guanfacine. Adjust guanfacine dose, p. 237. (Moderate) Theoretical

HIV-protease inhibitors are predicted to moderately increase the exposure to crizotinib. Avoid. (Moderate) Study → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to ibritinib. Adjust ibritinib dose with moderate inhibitors of CYP3A4. (Severe) Study → Also see TABLE 9 p. 876

Idelalisib is predicted to moderately increase the exposure to crizotinib. Avoid. (Moderate) Study → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. (Severe) Theoretical → Also see TABLE 6 p. 875

Crizotinib is predicted to increase the exposure to ivacaftor. Adjust ivacaftor dose. (Severe) Study. Avoid or adjust dose. (Moderate) Study → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the exposure to lapatinib. (Moderate) Study → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to lomipidine. Avoid. (Moderate) Theoretical

Crizotinib is predicted to increase the exposure to lurasidone. Adjust lurasidone dose. (Moderate) Study

Macrolides (clarithromycin) are predicted to moderately increase the exposure to crizotinib. Avoid. (Moderate) Study → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to midozolam. Monitor side effects and adjust dose. (Severe) study

Crizotinib is predicted to increase the exposure to midostaurin. (Moderate) Theoretical

Mitotane is predicted to markedly decrease the exposure to crizotinib. Avoid. (Severe) Study → Also see TABLE 9 p. 877

Crizotinib is predicted to increase the exposure to naltrexone. Adjust naltrexone dose and monitor side effects. (Moderate) Study

Nevirapine is predicted to decrease the exposure to crizotinib. Avoid. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study → Also see TABLE 6 p. 875

Crizotinib is predicted to increase the exposure to oxycodone. (Mild) Theoretical → Also see TABLE 6 p. 875 → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to oxycodone. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to pazopanib. (Moderate) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanaflil). Adjust avanaflil dose. (Moderate) Theoretical

Crizotinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 120. (Moderate) Study → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). (Severe) Theoretical

Crizotinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Adjust dose. (Severe) Theoretical → Also see TABLE 9 p. 876

Crizotinib potentially decreases the exposure to pibrentasvir. Avoid. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to pimozide. Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876

Pitolisant is predicted to decrease the exposure to crizotinib. Avoid. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study

Crizotinib is predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to ribociclib. (Moderate) Study → Also see TABLE 9 p. 876

Rifampicin is predicted to markedly decrease the exposure to crizotinib. Avoid. (Severe) Study

Crizotinib is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the exposure to saxagliptin. (Mild) Study

Crizotinib increases the concentration of sirolimus. Monitor and adjust dose. (Moderate) Study

Crizotinib is predicted to increase the exposure to SSRIs (doxepin). Adjust doxepin dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical

St John’s Wort is predicted to decrease the exposure to crizotinib. Avoid. (Severe) Theoretical

Crizotinib is predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. (Severe) Study

Crizotinib is predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose, p. 136. (Severe) Study

Crizotinib is predicted to increase the exposure to sunitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the concentration of tacrolimus. (Severe) Study

Crizotinib is predicted to increase the exposure to taxanes (cabazitaxel). (Moderate) Theoretical → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the concentration of temsirolimus. (Moderate) Theoretical → Also see TABLE 15 p. 877

Crizotinib is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study

Crizotinib given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study

Crizotinib is predicted to increase the exposure to tolterodine. (Mild) Theoretical → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

Crizotinib is predicted to increase the exposure to trazodone. (Moderate) Theoretical

Crizotinib is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study

Crizotinib is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. (Severe) Study

Crizotinib is predicted to increase the exposure to vinca alkaloids. (Severe) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876

Crizotinib is predicted to increase the exposure to zopiclone. Adjust dose. (Moderate) Study

Cyclizine → see antihistamines, sedating
Cyclophosphamide → see CYCLOPHOSPHAMIDE p. 174 (antimuscarnics)
Cyclophosphamide → see alkylating agents

Cycloserine

Cycloserine increases the risk of CNS toxicity when given with isoniazid. Monitor and adjust dose. (Moderate) Study

Cyproheptadine → see antihistamines, sedating
Cytarabine \(\rightarrow\) see TABLE 15 p. 877 (myelosuppression)

- Cytarabine decreases the concentration of flucytosine. Avoid. [Severe] Study
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with cytarabine. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

**Dabigatran** \(\rightarrow\) see TABLE 3 p. 874 (anticoagulant effects)

- Antiarrhythmics (amiodarone) increase the exposure to dabigatran. Adjust dabigatran dose. [Moderate] Study
- Antiarrhythmics (dronedarone) slightly increase the exposure to dabigatran. Avoid. [Severe] Study
- Antiepileptics (carbamazepine) are predicted to decrease the exposure to dabigatran. Avoid. [Severe] Study
- Antiepileptics (phenytoin) are predicted to decrease the exposure to dabigatran. Avoid. [Severe] Theoretical
- Antiepileptics (azoles [itraconazole, ketoconazole, voriconazole]) are predicted to increase the exposure to dabigatran. Use with caution or avoid. [Moderate] Study
- Clopidogrel is predicted to increase the exposure to dabigatran. [Moderate] Theoretical
- Ciclosporin is predicted to increase the exposure to dabigatran. Use with caution or avoid. [Moderate] Study
- Danaparoid is predicted to increase the exposure to dabigatran. Avoid. [Severe] Study
- Dapoxetine is predicted to increase the exposure to dabigatran. Avoid or adjust dose. [Severe] Study
- Dapagliflozin \(\rightarrow\) see TABLE 14 p. 877 (antidiabetic drugs), TABLE 8 p. 875 (hypotension)
- Dapoxetine \(\rightarrow\) see SSRIs

**Dabrafenib** \(\rightarrow\) see TABLE 15 p. 877 (myelosuppression)

- Antiangiopetics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to dabrafenib. Avoid. [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to dabrafenib. Use with caution or avoid. [Moderate] Study
- CYP3A4 inhibitors (ritonavir and ombitasvir) are predicted to increase the exposure to dabrafenib. [Moderate] Theoretical
- Delavirdine is predicted to increase the exposure to dabrafenib. Use with caution or avoid. [Moderate] Study
- Dabrafenib is predicted to decrease the anticoagulant effect of coumarins. [Severe] Theoretical
- Dabrafenib is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to dabrafenib. Avoid. [Moderate] Theoretical
- Fibrates (gemfibrozil) are predicted to increase the exposure to dabrafenib. [Moderate] Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to dabrafenib. Use with caution or avoid. [Moderate] Study
- Dabrafenib and tramadol are predicted to increase the risk of generalised infection (possibly life-threatening) when given with dabrafenib. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

**Dacarbazine** \(\rightarrow\) see alkylating agents

**Dactinomycin** \(\rightarrow\) see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression)

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with dactinomycin. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

**Dairy products**

- Dairy products are predicted to decrease the absorption of eltorbopag. Etorbopag should be taken 2 hours before or 4 hours after dairy products. [Severe] Theoretical
- Dairy products decrease the exposure to tetracyclines (demeclocycline, oxytetracycline, tetracycline). Avoid. [Moderate] Study

**Dalteparin** \(\rightarrow\) see low molecular-weight heparins

**Danaparoid** \(\rightarrow\) see TABLE 3 p. 874 (anticoagulant effects)

- Ranibizumab is predicted to increase the risk of bleeding events when given with danaparoid. [Severe] Theoretical

**Danzol**

- Danazol moderately increases the concentration of antiepileptics (carbamazepine). Monitor and adjust dose. [Severe] Study
- Danazol increases the concentration of ciclosporin. [Severe] Study
- Danazol potentially increases the anticoagulant effect of coumarins. [Severe] Anecdotal
- Danazol is predicted to increase the risk of rhabdomyolysis when given with statins (atorvastatin). [Severe] Theoretical
- Danazol increases the risk of rhabdomyolysis when given with statins (simvastatin). Avoid. [Severe] Anecdotal
- Danazol potentially increases the concentration of tacrolimus. [Severe] Anecdotal

**Dantrolene** \(\rightarrow\) see TABLE 1 p. 874 (hepatotoxicity)

- Intravenous dantrolene potentially increases the risk of acute hyperkalaemia and cardiovascular collapse when given with calcium channel blockers (diltiazem, verapamil). Avoid. [Severe] Anecdotal

**Dapagliflozin** \(\rightarrow\) see TABLE 14 p. 877 (antidiabetic drugs), TABLE 8 p. 875 (hypotension)

**Dapoxetine** \(\rightarrow\) see SSRIs
Dapsone

- **Aminosalicylic acid** is predicted to increase the risk of methaemoglobinemia when given with dapsone. **Severe**
- **Theoretical**
- **Dapsone** is predicted to increase the risk of methaemoglobinemia when given with topical anaesthetics, local (prilocaine). Use with caution or avoid. **Severe**
- **Theoretical**
- **Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to increase the risk of methaemoglobinemia when given with dapsone. **Severe**
- **Theoretical**
- **Antimalariais (chloroquine, primaquine)** are predicted to increase the risk of methaemoglobinemia when given with dapsone. **Severe**
- **Theoretical**
- **Nitrate**s are predicted to increase the risk of methaemoglobinemia when given with dapsone. **Severe**
- **Theoretical**
- **Nitrofurantoin** is predicted to increase the risk of methaemoglobinemia when given with dapsone. **Severe**
- **Theoretical**
- **Paracetamol** is predicted to increase the risk of methaemoglobinemia when given with dapsone. **Severe**
- **Theoretical**
- **Darifenacin** is predicted to increase the exposure to trimethoprim and decreases the exposure to dapsone. **Severe**
- **Study**

Daptomycin

- **Aspirin (high-dose)** increases the risk of renal impairment when given with daptomycin. **Moderate**
- **Theoretical**
- **Ciclosporin** is predicted to increase the risk of rhabdomyolysis when given with daptomycin. **Severe**
- **Theoretical**
- **Fibrates** are predicted to increase the risk of rhabdomyolysis when given with daptomycin. **Severe**
- **Theoretical**
- **NSAIDs** increase the risk of renal impairment when given with daptomycin. **Moderate**
- **Theoretical**
- **Statins** are predicted to increase the risk of rhabdomyolysis when given with daptomycin. **Severe**
- **Theoretical**
- **Dapsone** increases the exposure to trimethoprim and terbinafine and decreases the exposure to daptomycin. **Severe**
- **Study**

Darifenacin

- **See** Table 10 p. 876 (thromboembolism), Table 16 p. 876 (increased serum potassium)
- **Table 15** p. 877 (antimuscarinics)
- **Antiarhythmics (dronedaron)** are predicted to slightly increase the exposure to darifenacin. **Moderate**
- **Theoretical**
- **Antifungals, azoles (fluconazole, itraconazole, posaconazole)** are predicted to slightly increase the exposure to darifenacin. **Moderate**
- **Study**
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to markedly increase the exposure to darifenacin. **Avoid.**
- **Severe**
- **Study**
- **Apalutamide** is predicted to decrease the exposure to darifenacin. **Avoid or monitor.**
- **Moderate**
- **Study**
- **Aprepitant** is predicted to slightly increase the exposure to darifenacin. **Moderate**
- **Study**
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to slightly increase the exposure to darifenacin. **Moderate**
- **Study**
- **Ciclosporin** is predicted to increase the exposure to darifenacin. **Avoid.**
- **Moderate**
- **Theoretical**
- **Cinacalcet** is predicted to slightly increase the exposure to darifenacin. **Moderate**
- **Study**
- **Cobicistat** is predicted to markedly to very markedly increase the exposure to darifenacin. **Avoid.**
- **Severe**
- **Study**
- **Crizotinib** is predicted to slightly increase the exposure to darifenacin. **Moderate**
- **Study**
- **Enzalutamide** is predicted to decrease the exposure to darifenacin. **Moderate**
- **Theoretical**
- **Table 13** p. 877 (QT-interval prolongation), Table 4 p. 874 (antiplatelet effects)
- **Anticols** decrease the absorption of dapsinib. Separate administration by at least 2 hours. **Moderate**
- **Study**
- **Antiarhythmics (dronedaron)** are predicted to increase the exposure to darifenacin. **Severe**
- **Study**
- **Also see Table 9 p. 876

Dasabuvir

- **See** Table 10 p. 876 (antimuscarinics)
- **Antitarhythmics (dronedaron)** are predicted to slightly increase the exposure to dasabuvir. **Severe**
- **Study**
- **Clopiprodil** is predicted to very markedly increase the exposure to dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Combined hormonal contraceptives** (containing ethinylestradiol) increase the risk of increased ALT concentrations when given with dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Efavirenz** increases the concentration of loop diuretics (furosemide). **Adjust dose.** **Moderate**
- **Study**
- **Enzalutamide** is predicted to decrease the exposure to dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Etravirine** is predicted to decrease the exposure to dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Darunavir** is predicted to very markedly increase the exposure to dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Dasabuvir** (with ombitasvir, paritaprevir, and ritonavir) decreases the concentration of HIV-protective inhibitors (darunavir). **Avoid or adjust dose.** **Moderate**
- **Study**
- **Dasabuvir** (with ombitasvir, paritaprevir, and ritonavir) increases the concentration of loop diuretics (furosemide). **Adjust dose.** **Moderate**
- **Study**
- **Mitosone** is predicted to decrease the exposure to dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Netralavir** is predicted to decrease the exposure to dasabuvir. **Avoid.**
- **Severe**
- **Study**
- **Darifenacin** is predicted to increase the exposure to tricyclic antidepressants. **Moderate**
- **Theoretical**
- **Also see Table 10 p. 876

Dasetinib

- **See** Table 4 p. 876 (thromboembolism), Table 9 p. 876 (QT-interval prolongation), Table 15 p. 877 (myelosuppression), Table 10 p. 876
### Interactions

**Dasatinib** (continued)

- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to dasatinib. Avoid. (Severe) Study
- Delfungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to dasatinib. (Severe) Study, See also Table 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study, See also Table 9 p. 876
- Aprepitant is predicted to decrease the exposure to dasatinib. Avoid or monitor. (Moderate) Study, See also Table 9 p. 876
- Bosantan is predicted to decrease the exposure to dasatinib. (Severe) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to dasatinib. (Severe) Study
- Cobastic is predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study
- Dasatinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
- Cimetidine is predicted to increase the exposure to dasatinib. (Severe) Study, See also Table 15 p. 877, See also Table 9 p. 876
- Efavirenz is predicted to decrease the exposure to dasatinib. (Severe) Study, See also Table 9 p. 876
- Enzalutamide is predicted to markedly decrease the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study
- HIV-protease inhibitors are predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study
- Idelalisib is predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study, See also Table 9 p. 876
- Imatinib is predicted to increase the exposure to dasatinib. (Severe) Study, See also Table 9 p. 876
- Macrolides (clarithromycin) are predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study, See also Table 9 p. 876
- Macrolides (erythromycin) are predicted to increase the exposure to dasatinib. (Severe) Study, See also Table 9 p. 876
- Mitotane is predicted to markedly decrease the exposure to dasatinib. Avoid. (Severe) Study, See also Table 15 p. 877
- Netupitant is predicted to increase the exposure to dasatinib. (Severe) Study
- Nevirapine is predicted to decrease the exposure to dasatinib. (Severe) Study
- Nitrofurantoin is predicted to increase the exposure to dasatinib. (Severe) Study, See also Table 15 p. 877, See also Table 9 p. 876
- Dasatinib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical
- Pitolisan is predicted to decrease the exposure to dasatinib. Avoid. (Severe) Study
- Proton pump inhibitors are predicted to slightly to moderately decrease the exposure to dasatinib. Avoid. (Severe) Study
- Rifampicin is predicted to markedly decrease the exposure to dasatinib. Avoid. (Severe) Study
- St. John’s Wort is predicted to decrease the exposure to dasatinib. Avoid. (Severe) Study
- Dasatinib is predicted to increase the exposure to statins (simvastatin). (Moderate) Theoretical
- Daunorubicin—see anthracyclines
- Decitabine—see Table 15 p. 877 (myelosuppression)
- Deferasirox—see iron chelators
- deferoxprone—see Table 15 p. 877 (myelosuppression)
- Antacids (aluminium hydroxide) are predicted to decrease the absorption of deferiprone. Avoid. (Moderate) Theoretical
- Ascorbic acid is predicted to increase the risk of cardiovascular side-effects when given with deferiprone. (Severe) Theoretical
- Delflazocort—see corticosteroids
- Delamanid—see Table 9 p. 876 (Q-T interval prolongation)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to slightly decrease the exposure to delamanid. Avoid. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) very slightly increase the exposure to delamanid. (Severe) Study, See also Table 9 p. 876
- Cobastic is very slightly increases the exposure to delamanid. (Severe) Study
- Enzalutamide is predicted to slightly decrease the exposure to delamanid. Avoid. (Moderate) Study
- HIV-protease inhibitors very slightly increase the exposure to delamanid. (Severe) Study, See also Table 9 p. 876
- Idelalisib very slightly increases the exposure to delamanid. (Severe) Study
- Macrolides (clarithromycin) very slightly increase the exposure to delamanid. (Severe) Study
- Nevirapine is predicted to increase the risk of bleeding events when given with delamanid. Avoid. (Severe) Study, See also Table 15 p. 877
- Mitotane is predicted to markedly decrease the exposure to delamanid. Avoid. (Moderate) Study
- Rifampicin is predicted to slightly decrease the exposure to delamanid. Avoid. (Moderate) Study
- Demeclocycline—see tetracyclines
- Desferrioxamine—see iron chelators
- Desflurane—see volatile halogenated anaesthetics
- Desloratadine—see antihistamines, non-sedating
- Desmopressin—see Table 18 p. 878 (hypoprolactinaemias). (Severe) Theoretical
- Antiepileptics (lamotrigine) are predicted to increase the risk of hypoprolactinaemia when given with desmopressin. (Severe) Theoretical
- Loperamide greatly increases the absorption of oral desmopressin (and possibly sublingual). (Moderate) Study
- Phenothiazines (chlorpromazine) are predicted to increase the risk of hypoprolactinaemia when given with desmopressin. (Severe) Theoretical
- Desogestrel
- Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) are predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Desogestrel is predicted to increase the exposure to antiepileptics (lamotrigine). (Moderate) Study
- Aprepitant is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Moderate) Theoretical
- Efavirenz is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Bosantan is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Griseofulvin potentially decreases the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- HIV-protease inhibitors (ritonavir) are predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Modafinil is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Nevirapine is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Rifabutin is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
- Rifampicin is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. S16. (Severe) Theoretical
**St John’s Wort** is predicted to decrease the efficacy of desogestrel. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

**Sugammadex** is predicted to decrease the exposure to desogestrel. Refer to patient information leaflet for missed pill advice. [Severe] Theoretical

**Ulipristal** is predicted to decrease the efficacy of desogestrel. Avoid. [Severe] Theoretical

**Dexamethasone** → see corticosteroids

**Dexamfetamine** → see amphetamines

**Dexibuprofen** → see NSAIDs

**Dexketoprofen** → see NSAIDs

**Dexmedetomidine** → see TABLE 11 p. 876 (CNS depressant effects)

**Dexrazoxane** → see iron chelators

**Diazepam** → see opioids

**Diazepam** → see TABLE 11 p. 876 (CNS depressant effects)

**Diazepam potentially affects the concentration of antiepileptics (fosphenytoin, phenytoin) Monitor concentration and adjust dose. [Severe] Study**

**Antifungals, azoles (fluconazole, voriconazole) moderately increase the exposure to diazepam. Monitor and adjust dose. [Moderate] Study**

**Apalutamide** is predicted to decrease the exposure to diazepam. Avoid. [Moderate] Study

**SSRIs (fluvoxamine) moderately increase the exposure to diazepam. [Moderate] Study**

**Diazoxide** → see TABLE B p. 875 (hypotension)

**Diazoxide decreases the concentration of antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the effects of diazoxide. Monitor concentration and adjust dose. [Moderate] Anaesthetic**

**Diazoxide increases the risk of severe hypotension when given with hydralazine. [Severe] Study → Also see TABLE B p. 875**

**Diclofenac** → see NSAIDs

**Dicycloverine** → see TABLE 10 p. 876 (antimuscarinics)

**Didanosine** → see TABLE 1 p. 874 (hepatotoxicity), TABLE 12 p. 877 (peripheral neuropathy)

**ROUTE-SPECIFIC INFORMATION** Antacids in tablet formulation might affect absorption of other drugs—give at least 2 hours apart.

**Allopurinol** moderately increases the exposure to didanosine. Avoid. [Severe] Study

**Didanosine (buffered) decreases the exposure to antifungals, azoles (itraconazole, ketoconazole). Separate administration by 2 hours. [Moderate] Study**

**Fexofenadine** is predicted to increase the exposure to didanosine. [Severe] Theoretical

**Ganciclovir** is predicted to increase the exposure to didanosine. [Moderate] Study

**HIV-protease inhibitors (tipranavir) decrease the exposure to didanosine. Separate administration by 2 hours. [Moderate] Study**

**Didanosine (buffered) decreases the exposure to HIV-protease inhibitors (atazanavir). Didanosine should be taken 2 hours after atazanavir. [Severe] Study**

**Didanosine (buffered) is predicted to decrease the exposure to HIV-protease inhibitors (darunavir boosted with ritonavir). Didanosine should be taken 1 hour before or 2 hours after darunavir. [Moderate] Theoretical**

**Hydroxyurea** increases the risk of toxicity when given with didanosine. Avoid. [Severe] Study

**Isoniazid** is predicted to increase the risk of peripheral neuropathy when given with didanosine. [Severe] Theoretical → Also see TABLE 1 p. 874 → Also see TABLE 12 p. 877

**Didanosine is predicted to increase the risk of pancreatitis when given with pentamidine. Avoid. [Severe] Study**

**Didanosine (buffered) is predicted to greatly decrease the exposure to oral quinolones. Didanosine should be taken 2 hours after quinolones. [Moderate] Study**

**Ribavirin** is predicted to increase the exposure to didanosine. Avoid. [Severe] Study

**Didanosine increases the risk of toxicity when given with stavudine. Avoid. [Severe] Study → Also see TABLE 12 p. 877**

**Tenofivir disoproxil increases the risk of toxicity when given with didanosine. [Moderate] Study**

**Valganciclovir** is predicted to increase the exposure to didanosine. [Moderate] Study

**Digoxin** → see TABLE 6 p. 875 (bradycardia)

**Acarbose** decreases the concentration of digoxin. [Moderate] Study

**Aldosterone antagonists (epelone) very slightly increase the exposure to digoxin. [Mid] Study**

**Aldosterone antagonists (spironolactone) increase the concentration of digoxin. Monitor and adjust dose. [Moderate] Study**

**Aminoglycosides** potentially increase the concentration of digoxin. Monitor and adjust dose. [Mid] Study

**Antacids** decrease the absorption of digoxin. Separate administration by 2 hours. [Moderate] Study

**Antiarrhythmics (amiodarone, dronedarone) are predicted to moderately increase the exposure to digoxin. Monitor and adjust dose. p. 82. [Severe] Study → Also see TABLE 6 p. 875**

**Antiarrhythmics (propafenone) increase the concentration of digoxin. Monitor and adjust dose. [Severe] Study**

**Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the concentration of digoxin. [Moderate] Anaesthetic**

**Antifungals, azoles (isavuconazole) slightly increase the exposure to digoxin. Monitor and adjust dose. [Moderate] Study**

**Antifungals, azoles (posaconazole) are predicted to markedly increase the concentration of digoxin. Monitor and adjust dose. [Severe] Study**

**Antimalarials (mefloquine) are predicted to increase the risk of bradycardia when given with digoxin. [Severe] Theoretical**

**Antimalarials (quinine) increase the concentration of digoxin. Monitor and adjust digoxin dose. p. 82. [Severe] Anaesthetic**

**Apalutamide** is predicted to decrease the exposure to digoxin. [Mid] Study

**Balsalazide** is predicted to decrease the concentration of digoxin. [Moderate] Theoretical

**Brigatinib potentially increases the concentration of digoxin. [Moderate] Theoretical**

**Calcium channel blockers (diltiazem, verapamil) increase the concentration of digoxin. Monitor and adjust dose. [Severe] Study → Also see TABLE 6 p. 875**

**Intravenous calcium salts increase the concentration of digoxin. Avoid. [Moderate] Anaesthetic**

**Carbamazepine affects the concentration of digoxin. Monitor and adjust dose. [Moderate] Theoretical**

**Cetirizine is predicted to increase the risk of bradycardia when given with digoxin. Avoid. [Severe] Theoretical**

**Ciclosporin increases the concentration of digoxin. Monitor and adjust dose. [Severe] Theoretical**

**Eliglustat increases the exposure to digoxin. Adjust dose. [Moderate] Study**

**Glucarpidase (with pirbuterol) increases the exposure to digoxin. [Moderate] Study**

**Ivacaftor slightly increases the exposure to digoxin. [Moderate] Study**

**Lapatinib is predicted to increase the exposure to digoxin. [Moderate] Theoretical**

**Ledipasvir is predicted to increase the exposure to digoxin. Monitor and adjust dose. [Moderate] Theoretical**

**Macrolides increase the concentration of digoxin. [Severe] Anaesthetic**

**GENERAL INFORMATION** Drugs that reduce serum potassium are predicted to increase the risk of digoxin toxicity, see TABLE 17 p. 878.
Digoxin — Domperidone

Diluhydrine → see opioids
Diluhydrin → see vitamin D substances
Diltiazem + see calcium channel blockers
Dimenhydrinate → see Table 10 p. 876 (antimuscarinics)

Dimethyl fumarate
- Alcohol (beverage) (excessive consumption) potentially increases the risk of gastrointestinal side-effects when given with dimethyl fumarate. Avoid. [Moderate] Theoretical
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with dimethyl fumarate. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical
- Dexamethasone + see monoclonal antibodies
- Diphenoxylate → see opioids
- Dipropionate → see opioids
- Dipyrnidamoto → see Table 8 p. 875 (hypotension), Table 4 p. 874 (antiplatelet effects)
- Antacids are predicted to decrease the absorption of dipyrnidamoto (immediate release tablets). [Moderate] Theoretical
- Dipyrnidamoto increases the exposure to antiarrhythmics (adenosine). Avoid or adjust dose. [Severe] Study

H₂-receptor antagonists are predicted to decrease the absorption of dipyrnidamoto (immediate release tablets). [Moderate] Theoretical
- Proton pump inhibitors are predicted to decrease the absorption of dipyrnidamoto (immediate release tablets). [Moderate] Theoretical
- Disopyramide → see antiarrhythmics
- Disulfiram → see Table 12 p. 877 (peripheral neuropathy)
- Alcohol (beverage) causes an extremely unpleasant systemic reaction when given with disulfiram. Avoid for at least 24 hours before and up to 14 days after stopping treatment. [Severe] Study
- Disulfiram increases the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. [Severe] Study
- Disulfiram increases the anticoagulant effect of coumarins. Monitor and adjust dose. [Severe] Study
- Disulfiram increases the risk of acute psychoses when given with metronidazole. [Severe] Study → Also see Table 12 p. 877
- Pitolisant is predicted to increase the anticoagulant effect of phenindione. [Severe] Theoretical
- Dobutamine → see sympathomimetics, inotropic
- Docetaxel → see taxanes
- Docusate sodium

ROUTE-SPECIFIC INFORMATION
Interactions do not generally apply to topical use of docusate unless specified.

Dolutegravir
- Antacids moderately decrease the exposure to dolutegravir. Dolutegravir should be taken 2 hours before or 6 hours after antacids, p. 427. [Moderate] Study
- Dolutegravir interaction with phenytoin, primidone) is predicted to decrease the exposure to dolutegravir. Adjust dose. [Moderate] Study
- Dolutegravir increases the risk of peripheral neuropathy. Avoid unless given with atazanavir, darunavir, or lopinavir (all boosted with ritonavir). [Severe] Study
- Dolutegravir increases the risk of generalised rash when given with dolutegravir. Avoid unless given with atazanavir, darunavir, or lopinavir (all boosted with ritonavir). [Severe] Study
- Dolutegravir increases the anticoagulant effect of coumarins. Monitor and adjust dose. [Severe] Study
- Dolutegravir decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- Oral calcium salts decrease the absorption of dolutegravir. Dolutegravir should be taken 2 hours before or 6 hours after calcium salts. [Moderate] Study
- Dolutegravir is predicted to increase the exposure to dopamine receptor agonists (pramipexole). Adjust dose. [Moderate] Study
- Mocazenren decreases the exposure to dolutegravir. Adjust dose. [Moderate] Study
- Dolutegravir decreases the exposure to dolutegravir. Refer to specialist literature. [Severe] Study
- Enulatamim decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- EFavirenz decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- Encorafenib is predicted to increase the exposure to dolutegravir. [Moderate] Theoretical

Etravirine moderately decreases the exposure to dolutegravir. Avoid unless given with atazanavir, darunavir, or lopinavir (all boosted with ritonavir). [Severe] Study
- HIV-protease inhibitors (fosamprenavir boosted with ritonavir) moderately decrease the exposure to dolutegravir. Avoid if resistant to HIV-integrase inhibitors. [Severe] Study
- HIV-protease inhibitors (tipranavir) moderately decrease the exposure to dolutegravir. Refer to specialist literature. [Severe] Study

Iron (oral) decreases the absorption of dolutegravir. Dolutegravir should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study
- Dolutegravir increases the exposure to metformin. Use with caution and adjust dose. [Severe] Study
- Mitotene decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- Nevirapine decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- Rifampicin decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- St John’s Wort decreases the exposure to dolutegravir. Adjust dose. [Severe] Study
- Sucralfate decreases the absorption of dolutegravir. [Moderate] Study
- Domperidone → see Table 9 p. 876 (QT-interval prolongation)
**Domperidone — Dopamine receptor agonists**

- Antiarhythmics (dronedarone) increase the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Antifungals, azoles (fluconazole, itraconazole, ketoconazole, posaconazole, voriconazole) increase the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Aprepitant increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Calcium channel blockers (diltiazem, verapamil) increase the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Cobicistat increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Crizotinib increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Domperidone is predicted to decrease the prolactin-lowering effect of dopamine receptor agonists (bromocriptine, cabergoline). (Moderate) Theoretical
- Idelalisib increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Imatinib increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Netupitant increases the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- Dopamine receptor agonists are predicted to increase the risk of QT-prolongation. (Hyponatremia, Table 9, p. 876) (OR-interval prolongation, Table 10, p. 876) (antimuscarinics)

**FOOD AND LIFESTYLE** Dose adjustment might be necessary if smoking started or stopped during treatment with ropinirole.

- Amisulpride is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see Table 9, p. 876
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Antiarrhythmics (dronedarone) are predicted to increase the concentration of cabergoline. (Severe) Anecdotal
- Antifungals, azoles (fluconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Antifungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) increase the exposure to bromocriptine. (Severe) Study
- Aprepitant is predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Aprepitant is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Ariziprazole is predicted to decrease the effects of dopamine receptor agonists. (Moderate) Theoretical → Also see Table 8, p. 875
- Asenapine is predicted to decrease the effects of dopamine receptor agonists. Adjust dose. (Moderate) Theoretical → Also see Table 8, p. 875
- Benperidol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see Table 8, p. 875
- Bupropion increases the risk of side-effects when given with amantadine. (Moderate) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to bromocriptine. (Severe) Theoretical → Also see Table 8, p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of cabergoline. (Moderate) Anecdotal → Also see Table 8, p. 875
- Clozapine is predicted to decrease the effects of dopamine receptor agonists. (Moderate) Theoretical → Also see Table 8, p. 875 → Also see Table 10, p. 876
- Cobicistat increases the exposure to bromocriptine. (Severe) Study
- Cobicistat is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Combined hormonal contraceptives are predicted to increase the exposure to ropinirole. Adjust dose. (Moderate) Study
- Crizotinib is predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Domperidone is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Duloxetine is predicted to increase the exposure to pramipexole. Adjust dose. (Moderate) Study
- Domperidone is predicted to increase the exposure to pramipexole. Adjust dose. (Moderate) Study
- Dopamine receptor agonists (bromocriptine, cabergoline) are predicted to increase the risk of ergotism when given with dopamine receptor agonists (bromocriptine). Avoid. (Moderate) Theoretical → Also see Table 8, p. 875
- Dopamine receptor agonists (bromocriptine, cabergoline) are predicted to increase the risk of ergotism when given with dopamine receptor agonists (pergolide). Avoid. (Moderate) Theoretical → Also see Table 8, p. 875
- Dopamine receptor agonists (amantadine) are predicted to increase the exposure to dopamine receptor agonists (pramipexole). Adjust dose. (Moderate) Theoretical → Also see Table 8, p. 875
- Droperidol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see Table 8, p. 875 → Also see Table 9, p. 876
- Ergometrine is predicted to increase the risk of ergotism when given with dopamine receptor agonists (cabergoline, pergolide). Avoid. (Moderate) Theoretical
- Ergotamine is predicted to increase the risk of ergotism when given with dopamine receptor agonists (bromocriptine, cabergoline). Avoid. (Moderate) Theoretical
- Ergotamine is predicted to increase the risk of ergotism when given with pergolide. (Moderate) Theoretical
- Flupenthixol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see Table 8, p. 875
- Apomorphine is predicted to increase the risk of severe hypotension when given with gramineuron. (Severe) Theoretical
- H₂ receptor antagonists (cimetidine) are predicted to increase the exposure to pramipexole. Adjust dose. (Moderate) Study
- Haloperidol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see Table 8, p. 875 → Also see Table 9, p. 876 → Also see Table 10, p. 876
- HIV-protease inhibitors increase the exposure to bromocriptine. (Severe) Study
- HIV-protease inhibitors are predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Hormone replacement therapy decreases the clearance of ropinirole. Monitor and adjust dose. (Moderate) Study
- Idelalisib increases the exposure to bromocriptine. (Severe) Study
- Idelalisib is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Imatinib is predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Imatinib is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Loxapine is predicted to decrease the effects of dopamine receptor agonists. (Moderate) Theoretical → Also see Table 8, p. 875 → Also see Table 10, p. 876
- Macrolides (clarithromycin) increase the exposure to bromocriptine. (Severe) Study
- Theoretical
- Study

**TABLE 8**

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**TABLE 9**

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<tbody>
<tr>
<td>Study</td>
<td>Theoretical</td>
</tr>
</tbody>
</table>

**A1**

Interactions | Appendix 1
Dopamine receptor agonists

- Macrolides (clarithromycin, erythromycin) are predicted to increase the concentration of cabergoline. Avoid. (Severe) Study
- Macrolides (erythromycin) are predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Amantadine increases the risk of CNS toxicity when given with memantine. Use with caution or avoid. (Severe) Theoretical
- Memantine is predicted to increase the effects of dopamine receptor agonists (apomorphine, bromocriptine, cabergoline, pergolide, pramipexole, quinagolide, ropinirole, rotigotine). Avoid. (Moderate) Theoretical
- Metoclopramide is predicted to decrease the effects of dopamine receptor agonists (apomorphine, bromocriptine, cabergoline, pergolide, pramipexole, quinagolide, ropinirole, rotigotine). Avoid. (Moderate) Theoretical
- Apomorphine is predicted to increase the exposure to ropinirole. Adjust dose. (Moderate) Study
- Netupitant is predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Netupitant is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Nilotinib is predicted to increase the exposure to bromocriptine. (Severe) Theoretical
- Nilotinib is predicted to increase the concentration of cabergoline. (Moderate) Anecdotal
- Olanzapine is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875
- Apomorphine increases the risk of severe hypotension when given with ondansetron. Avoid. (Severe) Study → Also see TABLE 9 p. 876
- Paliperidone is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876 → Also see TABLE 10 p. 876
- Pimozide is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876 → Also see TABLE 10 p. 876
- Quetiapine is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875
- Quinolones (ciprofloxacin) are predicted to increase the exposure to ropinirole. Adjust dose. (Moderate) Study
- Ranolazine is predicted to increase the exposure to pramipexole. Adjust dose. (Moderate) Study
- Risperidone is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876
- SSRIs (fluvoxamine) are predicted to increase the exposure to ropinirole. Adjust dose. (Moderate) Study
- Sultopride is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876
- Sympathomimetics, vasoconstrictor (isomethaneptene) potentially increase the risk of side-effects when given with bromocriptine. Avoid. (Severe) Anecdotal
- Trimethoprim is predicted to increase the exposure to pramipexole. Adjust dose. (Moderate) Study
- Vandetanib is predicted to increase the exposure to pramipexole. Adjust dose. (Moderate) Study
- Zuclopenthixol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876

Doravirine

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to increase the exposure to doravirine. Avoid. (Severe) Study
- Antiepileptics (oxcarbazepine) are predicted to decrease the exposure to doravirine. Avoid. (Severe) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to doravirine. (Moderate) Study
- Bosentan is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. (Severe) Theoretical
- Cobimetinib is predicted to increase the exposure to doravirine. (Moderate) Study
- Dabrafenib is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. (Severe) Theoretical
- Efavirenz is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. (Severe) Theoretical
- Enzalutamide is predicted to decrease the exposure to doravirine. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to doravirine. (Moderate) Study
- Idealisib is predicted to increase the exposure to doravirine. (Moderate) Study
- Lumacaftor is predicted to decrease the exposure to doravirine. Avoid. (Severe) Study
- Modafinil is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. (Severe) Theoretical
- Nevirapine is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. (Severe) Theoretical
- Rifabutin moderately decreases the exposure to doravirine. Adjust doravirine dose. (Severe) Study
- Rilpamycin is predicted to decrease the exposure to doravirine. Avoid. (Severe) Study
- Doravirine is predicted to decrease the exposure to sirolimus. Monitor sirolimus concentration and adjust dose, p. 539. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to doravirine. Avoid. (Severe) Study
- Doravirine is predicted to decrease the exposure to tacrolimus. Monitor tacrolimus concentration and adjust dose, p. 540. (Moderate) Theoretical
- Telotristat ethyl is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. (Severe) Theoretical

Dorzolamide

ROUTE-SPECIFIC INFORMATION
Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Dosulepin → see tricyclic antidepressants
Doxapram
- Aminophylline increases the risk of agitation when given with doxapram. (Moderate) Study
- Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the effects of doxapram. (Moderate) Theoretical
- Theophylline increases the risk of agitation when given with doxapram. (Moderate) Study
- Doxazosin → see alpha blockers
- Doxepin → see tricyclic antidepressants
- Doxorubicin → see anthracyclines
- Doxycycline → see tetracyclines
- Doxytamine → see antibacterials, sedating
- Drocnodare → see antihistimics
- Droperidol → see TABLE 8 p. 875 (hypotension), TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects)
- Droperidol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876
- Droperidol is predicted to decrease the effects of guanethidine. Monitor and adjust dose. (Moderate) Theoretical → Also see TABLE 8 p. 875
- Droperidol decreases the effects of levodopa. Avoid. (Severe) Study → Also see TABLE 8 p. 875
- Drosperenone → see TABLE 16 p. 878 (increased serum potassium)
- Antifungals, azoles (ketoconazole) moderately increase the exposure to drosperenone. (Severe) Study
- Dulaglutide → see TABLE 14 p. 877 (antidiabetic drugs)
- Duloxetine → see TABLE 18 p. 878 (hyponatremia), TABLE 13 p. 877 (serotonin syndrome), TABLE 4 p. 874 (antiplatelet effects)
Duloxetine – Efavirenz 945

- Antiepileptics (phenytoin) are predicted to decrease the exposure to duloxetine. [Moderate] Theoretical
- Duloxetine is predicted to increase the exposure to beta blockers, selective (metoprolol). [Moderate] Study
- Duloxetine is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. [Severe] Study
- HIV-protease inhibitors (ritonavir) are predicted to decrease the exposure to duloxetine. [Moderate] Theoretical
- Leflunomide is predicted to decrease the exposure to duloxetine. [Moderate] Theoretical
- Duloxetine is predicted to increase the exposure to pitolisant.
  Use with caution and adjust dose. [Moderate] Study
- Quinolones (ciprofloxacin) are predicted to increase the exposure to duloxetine. Avoid. [Moderate] Theoretical
- Rifampicin is predicted to decrease the exposure to duloxetine. [Moderate] Theoretical
- SSRI (fluvoxamine) markedly increased the exposure to duloxetine. Avoid. [Severe] Study → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877 → Also see TABLE 4 p. 874
- Teriflunomide is predicted to decrease the exposure to duloxetine. [Moderate] Theoretical
- Dupilumab → see monoclonal antibodies
- Dutasteride
  - Antiarhythmics (dronedarone) are predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical
  - Aprepitant is predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to dutasteride. [Mild] Study
  - Cobimetinib is predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical
  - Crizotinib is predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - HIV-protease inhibitors are predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical
  - Idealisib is predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical
  - Imatinib is predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - Macrolides (clarithromycin) are predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical
  - Macrolides (erythromycin) are predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - Nilotinib is predicted to moderately increase the exposure to dutasteride. [Mild] Study
  - Eculizumab → see monoclonal antibodies

Edoxaban → see TABLE 3 p. 874 (anticoagulant effects)
- Antiarhythmics (amiodarone) slightly increase the exposure to edoxaban. Adjust edoxaban dose. [Severe] Study
- Antiarhythmics (dronedarone) slightly increase the exposure to edoxaban. Adjust edoxaban dose. [Severe] Study
- Antiepileptics (carbamazepine) are predicted to decrease the exposure to edoxaban. [Moderate] Study
- Antiepileptics (phenytoin) are predicted to decrease the exposure to edoxaban. [Moderate] Theoretical
- Antifungals, azoles (itraconazole) are predicted to slightly increase the exposure to edoxaban. [Severe] Theoretical
- Antifungals, azoles (ketoconazole) slightly increase the exposure to edoxaban. Adjust edoxaban dose. [Severe] Study
- Calcium channel blockers (verapamil) are predicted to slightly increase the exposure to edoxaban. [Severe] Theoretical
- Ceritinib is predicted to increase the exposure to edoxaban. [Moderate] Theoretical
- Ciclosporin slightly increases the exposure to edoxaban. Adjust edoxaban dose. [Severe] Study
- Cobimetinib is predicted to increase the exposure to edoxaban. Avoid. [Severe] Theoretical
- Eliglustat is predicted to increase the exposure to edoxaban. Adjust dose. [Moderate] Study
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to slightly increase the exposure to edoxaban. [Severe] Theoretical
- Lapatinib is predicted to slightly increase the exposure to edoxaban. [Severe] Theoretical
- Macrolides (azithromycin, clarithromycin) are predicted to slightly increase the exposure to edoxaban. [Severe] Theoretical
- Macrolides (erythromycin) slightly increase the exposure to edoxaban. Adjust edoxaban dose. [Severe] Study
- Mirabegron is predicted to increase the exposure to edoxaban. [Mild] Theoretical
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to edoxaban. [Severe] Study
- Pipobendavir (with glecaprevir) is predicted to increase the exposure to edoxaban. [Moderate] Study
- Edoxaban and dabigatran is predicted to increase the exposure to edoxaban. [Severe] Study
- Edoxaban and warfarin is predicted to increase the exposure to edoxaban. Avoid. [Severe] Theoretical
- Efavirenz → see TABLE 9 p. 876 (QT-interval prolongation)
- Efavirenz is predicted to decrease the exposure to antiarhythmics (dronedarone). [Severe] Theoretical → Also see TABLE 9 p. 876
- Antiepileptics (carbamazepine) slightly decrease the exposure to efavirenz and efavirenz slightly decreases the exposure to antiepileptics (carbamazepine). [Severe] Study
- Antiepileptics (fosphenytoin, phenytoin) slightly decrease the exposure to efavirenz and efavirenz slightly decreases the exposure to antiepileptics (fosphenytoin, phenytoin). [Severe] Theoretical
- Antiepileptics (phenobarbital) are predicted to decrease the exposure to efavirenz and efavirenz affects the concentration of antiepileptics (phenobarbital). [Severe] Theoretical
- Efavirenz is predicted to slightly increase the efficacy of antiepileptics (primidone) and antiepileptics (primidone) are predicted to slightly decrease the exposure to efavirenz. [Severe] Theoretical
- Efavirenz is predicted to decrease the exposure to antifungals, azoles (isavuconazole). Avoid. [Severe] Theoretical
- Efavirenz slightly decreases the exposure to antifungals, azoles (itraconazole), Avoid and for 14 days after stopping efavirenz. [Moderate] Study
- Efavirenz moderately decreases the exposure to antifungals, azoles (ketoconazole). [Severe] Study
- Efavirenz slightly decreases the exposure to antifungals, azoles (posaconazole). Avoid. [Moderate] Study
- Efavirenz moderately decreases the exposure to antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole) slightly increase the exposure to efavirenz. Adjust dose. [Severe] Study → Also see TABLE 9 p. 876
- Efavirenz decreases the concentration of antimalarials (artemether). [Severe] Study → Also see TABLE 9 p. 876
- Efavirenz moderately decreases the exposure to antimalarials (atovaquone). Avoid. [Moderate] Study
- Efavirenz affects the concentration of antimalarials (proguanil). Avoid. [Moderate] Study
- Efavirenz is predicted to decrease the exposure to aprepitant. [Moderate] Study
- Efavirenz is predicted to decrease the exposure to xitinib. [Moderate] Theoretical

Study

Theoretical
Efavirenz (continued)

- **Efavirenz** is predicted to decrease the exposure to **bedaquiline**. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to **bosutinib**. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to **briganitinib**. Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **bupropion**. [Moderate] Study
- **Efavirenz** is predicted to decrease the exposure to **cabozaantinib**. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to calcium channel blockers (amiodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **cariprazine**. Avoid. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- **Efavirenz** is predicted to decrease the concentration of **ciclosporin**. Adjust dose. [Moderate] Study
- **Efavirenz** is predicted to decrease the concentration of **cilostazol**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **clobetasol (bbam) replacement therapy**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **cobicistat**. Avoid. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **cyclobenzaprine**. Avoid. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **dabrafenib**. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to **dalsatrinib**. [Severe] Study → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to increase the concentration of **deltanabin**. Increase dose. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **doravirine**. Avoid or adjust doravirine dose. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **elbasvir**. Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **elgicultinib**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the concentration of **elvitegravir**. Avoid. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the effects of **ergotamine**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **erlotinib**. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the efficacy of **etanercept**. For FSRH guidance, see Contra-ceptives, interactions p. 516. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **etatravirine**. Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the concentration of **everolimus**. Avoid or adjust dose. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **fasaprepitant**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to glecaprevir. Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the concentration of guanfacine. Adjust dose. [Moderate] Theoretical
- **Efavirenz** decreases the exposure to **HIV-protease inhibitors**. Refer to specialist literature. [Severe] Study → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the effects of hormone replacement therapy. [Moderate] Anecdotal
- **Efavirenz** is predicted to decrease the exposure to **idelalisib**. Avoid. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **imatinib**. [Moderate] Study
- **Efavirenz** is predicted to decrease the exposure to **invacafor**. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **lapatinib**. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the concentration of **intermover**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the efficacy of **levonorgestrel**. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **lurasidone**. Monitor and adjust dose. [Moderate] Theoretical
- **Efavirenz** decreases the exposure to macrolides (clarithromycin). [Moderate] Study → Also see TABLE 9 p. 876
- **Efavirenz** decreases the exposure to **maraviroc**. Refer to specialist literature. [Severe] Theoretical
- **Efavirenz** is predicted to alter the effects of **midazolam**. Avoid. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **netupitan**. [Moderate] Theoretical
- **Nevirapine** decreases the concentration of efavirenz. Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **nilotinib**. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the efficacy of **noretinesterone**. For FSRH guidance, see Contra-ceptives, interactions p. 516. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **olapitinib**. Avoid. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **ombitasvir**. Avoid. [Severe] Theoretical
- **Efavirenz** decreases the exposure to **opioids (methadone)**. Monitor and adjust dose. [Severe] Study → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to **osimertinib**. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to **osmidine**. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **paritaprevir** (with ritonavir and ombravistat). Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **phosphodiesterase type-5 inhibitors**. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Efavirenz** is predicted to decrease the exposure to **pibrentavir**. Avoid. [Severe] Study
- **Pitolisant** is predicted to decrease the exposure to efavirenz. [Mild] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **quetiapine**. [Moderate] Study
- **Efavirenz** is predicted to decrease the exposure to **ribociclib**. [Moderate] Study → Also see TABLE 9 p. 876
- **Efavirenz** slightly decreases the exposure to **rifabutin**. Adjust dose. [Severe] Study
- **Rifampicin** slightly decreases the exposure to efavirenz. Adjust dose. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **rilpivirine**. Avoid. [Severe] Theoretical
- **Efavirenz** is predicted to decrease the exposure to **rolipamatin**. Avoid. [Severe] Study
- **Efavirenz** is predicted to decrease the exposure to **ruoxolitinib**. Monitor and adjust dose. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the concentration of **sirolimus**. Monitor and adjust dose. [Moderate] Theoretical
- **St John’s Wort** is predicted to decrease the concentration of efavirenz. Avoid. [Severe] Theoretical
- **Efavirenz** slightly decreases the exposure to **statins (atorvastatin)**. [Mild] Study
- **Efavirenz** moderately decreases the exposure to **statins (simvastatin)**. [Moderate] Study
- **Efavirenz** is predicted to decrease the concentration of **tacrolimus**. Monitor and adjust dose. [Moderate] Theoretical
Efavirenz is predicted to decrease the exposure to taxanes (cabazitaxel). Avoid. (Severe) Study
Efavirenz is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Theoretical
Efavirenz is predicted to decrease the exposure to ticagrelor. (Moderate) Theoretical
Efavirenz is predicted to decrease the exposure to tofacitinib. (Moderate) Study
Efavirenz decreases the efficacy of elipristal. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal
Efavirenz is predicted to decrease the exposure to velpatasvir. Avoid. (Moderate) Theoretical
Efavirenz is predicted to decrease the exposure to venetoclax. Avoid. (Severe) Study
Efavirenz is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
Elbasvir
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, Primidone) are predicted to decrease the exposure to elbasvir. Avoid. (Severe) Study
- Bosentan is predicted to moderately decrease the exposure to elbasvir. Avoid. (Severe) Study
- Elbasvir is predicted to decrease the concentration of dabigatran. (Moderate) Theoretical
- Elbasvir is predicted to decrease the exposure to eliglustat. Avoid. (Severe) Study
- Enalapril is predicted to decrease the exposure to elbasvir. Avoid. (Severe) Study
- Erlotinib is predicted to decrease the concentration of erlotinib. (Unknown) Theoretical
- Mitotane is predicted to decrease the exposure to elbasvir. Avoid. (Severe) Study
- Modafinil is predicted to decrease the exposure to elbasvir. Avoid. (Severe) Study
- Nevirapine is predicted to moderately decrease the exposure to elbasvir. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to elbasvir. Avoid. (Severe) Study
- St John's Wort is predicted to moderately decrease the exposure to elbasvir. Avoid. (Severe) Study
- Elbasvir increases the exposure to statins (atorvastatin). Adjust atorvastatin dose, p. 124. (Moderate) Study
- Elbasvir is predicted to increase the exposure to statins (fluvastatin). Adjust fluvastatin dose, p. 124. (Unknown) Theoretical
- Elbasvir increases the exposure to statins (rosuvastatin). Adjust rosuvastatin dose, p. 135. (Moderate) Study
- Elbasvir is predicted to increase the exposure to statins (simvastatin). Adjust simvastatin dose, p. 136. (Unknown) Theoretical
- Elbasvir is predicted to increase the concentration of sunitinib. Use with caution and adjust dose. (Moderate) Theoretical
Eliletriptan  see TABLE 13 p. 877 (serotonin syndrome)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to eliletriptan. Avoid. (Severe) Study
- Aprepitant is predicted to increase the exposure to eliletriptan. (Moderate) Study
- Cobicistat is predicted to markedly increase the exposure to eliletriptan. Avoid. (Severe) Study
- Eliletriptan increases the risk of vasoconstriction when given with ergotamine. Separate administration by 24 hours. (Severe) Study
- HIV-protease inhibitors are predicted to markedly increase the exposure to eliletriptan. Avoid. (Severe) Study
- Idealisib is predicted to markedly increase the exposure to eliletriptan. Avoid. (Severe) Study
- Eliletriptan increases the risk of vasoconstriction when given with ergotamine. Separate administration by 24 hours. (Severe) Study
- HIV-protease inhibitors are predicted to markedly increase the exposure to eliletriptan. Avoid. (Severe) Study
- Macrolides (clarithromycin) are predicted to markedly increase the exposure to eliletriptan. Avoid. (Severe) Study
- Macrolides (erythromycin) moderately increase the exposure to eliletriptan. Avoid. (Moderate) Study
- Netupitant is predicted to increase the exposure to eliletriptan. (Moderate) Study
- Abiraterone is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Eliglustat is predicted to increase the exposure to aliskiren. Adjust dose. (Moderate) Study
- Antiarhythmics (dronedarone, propafenone) are predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to eliglustat. Avoid. (Severe) Study
- Antifungals (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Eliglustat is predicted to increase the exposure to antihistamines, non-sedating (fexofenadine). Adjust dose. (Moderate) Study
- Aprepitant is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Eliglustat is predicted to increase the exposure to atorvastatin. Adjust dose. (Moderate) Theoretical
- Eliglustat is predicted to increase the exposure to beta blockers, non-selective (propranolol). Adjust dose. (Moderate) Study
- Eliglustat is predicted to increase the exposure to beta blockers, selective (metoprolol). Adjust dose. (Moderate) Study
- Bosentan is predicted to decrease the exposure to eliglustat. (Moderate) Theoretical
- Bupropion is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Cinacalcet is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Cobicistat is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Eliglustat is predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. (Severe) Theoretical
- Crizotinib is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Eliglustat is predicted to increase the exposure to dabigatran. Adjust dose. (Moderate) Study
- Eliglustat increases the exposure to digoxin. Adjust dose. (Moderate) Study
- Duloxetine is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Eliglustat is predicted to increase the exposure to edoxaban. Adjust dose. (Moderate) Study
- Efavirenz is predicted to decrease the exposure to eliglustat. (Severe) Study
- Enzalutamide is predicted to decrease the exposure to eliglustat. Avoid. (Severe) Study
- Eliglustat is predicted to increase the exposure to everolimus. Adjust dose. (Moderate) Study
- Grapefruit juice is predicted to increase the exposure to eliglustat. Avoid. (Severe) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Idealisib is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Imitinib is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Bivalirudin is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Mirabegron is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Mitotane is predicted to decrease the exposure to eliglustat. Avoid. (Severe) Study
Eliglustat (continued)

- **Moclobemide** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Theoretical
- **Netupitant** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- **Nevirapine** is predicted to decrease the exposure to eliglustat. (Moderate) Theoretical
- **Nilotinib** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- **Quinolones** are predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- **Rifampicin** is predicted to decrease the exposure to eliglustat. Avoid. (Severe) Study
- **Eliglustat** is predicted to increase the exposure to sirolimus. Adjust dose. (Moderate) Study
- **SSRIs (fluoxetine, paroxetine)** are predicted to decrease the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- **St John’s Wort** is predicted to increase the exposure to eliglustat. Avoid. (Severe) Study
- **Eliglustat** is predicted to increase the exposure to taxanes (paclitaxel). Avoid. (Severe) Study
- **Terbinafine** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study
- **Eliglustat** is predicted to increase the exposure to tolterodine. Adjust dose. (Moderate) Theoretical
- **Eliglustat** is predicted to increase the exposure to topotecan. Adjust dose. (Moderate) Study
- **Eliglustat** is predicted to increase the exposure to tricyclic antidepressants (nortriptyline). Adjust dose. (Moderate) Theoretical
- **Elotuzumab** → see monoclonal antibodies

**Eltrombopag**

- **Antacids** decrease the absorption of eltrombopag. Eltrombopag should be taken 2 hours before or 4 hours after antacids. (Severe) Study
- **Oral calcium salts** decrease the absorption of eltrombopag. Eltrombopag should be taken 2 hours before or 4 hours after calcium salts. (Severe) Study
- **Dairy products** are predicted to decrease the absorption of eltrombopag. Eltrombopag should be taken 2 hours before or 4 hours after dairy products. (Severe) Theoretical
- **Iron (oral)** is predicted to decrease the absorption of eltrombopag. Eltrombopag should be taken 2 hours before or 4 hours after iron (oral). (Severe) Theoretical
- **Eltrombopag** is predicted to increase the concentration of itos闪ezuvir. (Moderate) Study
- **Eltrombopag** is predicted to increase the concentration of methotrexate. (Moderate) Theoretical
- **Rifampicin** is predicted to decrease the exposure to eltrombopag and eltrombopag is predicted to increase the concentration of rifampicin. (Moderate) Theoretical
- **Oral selenium** is predicted to decrease the absorption of eltrombopag. Eltrombopag should be taken 2 hours before or 4 hours after selenium. (Severe) Theoretical
- **SSRIs (fluvoxamine)** are predicted to increase the exposure to eltrombopag. (Moderate) Theoretical
- **Eltrombopag** is predicted to increase the exposure to statins. Monitor and adjust dose. (Moderate) Study
- **Eltrombopag** is predicted to increase the exposure to tenofovir alafenamide. (Moderate) Theoretical
- **Eltrombopag** is predicted to increase the exposure to tenofovir disoproxil. (Moderate) Theoretical
- **Eltrombopag** is predicted to increase the exposure to tenofovir. Eltrombopag should be taken 2 hours before or 4 hours after zinc. (Severe) Theoretical

**Elvitegravir**

- **Antacids** moderately decrease the exposure to elvitegravir. Separate administration by at least 4 hours. (Moderate) Study
- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Bosentan** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Elvitegravir** is predicted to decrease the anticoagulant effect of coumarins. (Moderate) Theoretical
- **Efavirenz** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Enalapril** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Elvitegravir** markedly increases the exposure to grazoprevir. Avoid. (Severe) Study
- **HIV-protease inhibitors** (atazanavir, lopinavir) (boosted with ritonavir) increase the concentration of elvitegravir. Refer to specialist literature. (Moderate) Study
- **Mitotane** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Nevirapine** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Rifampicin** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **St John’s Wort** is predicted to decrease the concentration of elvitegravir. Avoid. (Severe) Theoretical
- **Empagliflozin** → see TABLE 14 p. 877 (antidiabetic drugs), TABLE 8 p. 875 (hypotension)

**Emtricitabine** → see AC inhibitors

**Encorafenib** → see TABLE 9 p. 876 (QT-interval prolongation)
- **Antiarrhythmics (dronedarone)** are predicted to moderately increase the exposure to encorafenib. (Moderate) Study → Also see TABLE 9 p. 876
- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to encorafenib. (Severe) Theoretical
- **Antifungals, azoles** (fluconazole, isavuconazole, posaconazole) are predicted to moderately increase the exposure to encorafenib. (Moderate) Study → Also see TABLE 9 p. 876
- **Antifungals, azoles** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to encorafenib. Avoid or monitor. (Severe) Study → Also see TABLE 9 p. 876
- **Aprepitant** is predicted to moderately increase the exposure to encorafenib. (Moderate) Study
- **Calcium channel blockers** (diltiazem, verapamil) are predicted to moderately increase the exposure to encorafenib. (Moderate) Study
- **Cobicistat** is predicted to increase the exposure to encorafenib. Avoid or monitor. (Severe) Study
- **Encorafenib** is predicted to affect the exposure to combined hormonal contraceptives. (Severe) Theoretical
- **Crizotinib** is predicted to moderately increase the exposure to encorafenib. (Moderate) Study → Also see TABLE 9 p. 876
- **Encorafenib** is predicted to increase the exposure to dolutegravir. (Moderate) Theoretical
- **Enzalutamide** is predicted to decrease the exposure to encorafenib. (Severe) Theoretical
- **Grapefruit juice** is predicted to increase the exposure to encorafenib. Avoid. (Moderate) Study
- **HIV-protease inhibitors** are predicted to increase the exposure to encorafenib. Avoid or monitor. (Severe) Study → Also see TABLE 9 p. 876
- **Idelalisib** is predicted to increase the exposure to encorafenib. Avoid or monitor. (Severe) Study → Also see TABLE 9 p. 876
- **Macrolides** (clarithromycin) are predicted to increase the exposure to encorafenib. Avoid or monitor. (Severe) Study → Also see TABLE 9 p. 876
- **Macrolides (erythromycin)** are predicted to moderately increase the exposure to encorafenib. (Moderate) Study → Also see TABLE 9 p. 876
- **Mitotane** is predicted to decrease the exposure to encorafenib. (Severe) Theoretical
- **Netupitant** is predicted to moderately increase the exposure to encorafenib. (Moderate) Study
- **Nilotinib** is predicted to moderately increase the exposure to encorafenib. (Moderate) Study → Also see TABLE 9 p. 876
- **Encorafenib** is predicted to increase the exposure to raltegravir. (Moderate) Theoretical
Enzalutamide is predicted to markedly decrease the exposure to aprepitant. Avoid. (Moderate) Study

Enzalutamide is predicted to moderately decrease the exposure to apiprazole. Adjust apiprazole dose, p. 255. (Moderate) Study

Enzalutamide is predicted to decrease the exposure to axitinib. Avoid or adjust dose. (Moderate) Study

Enzalutamide decreases the exposure to bedaquiline. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Study

Enzalutamide slightly decreases the exposure to bortezomib. Avoid. (Severe) Study

Enzalutamide is predicted to very markedly decrease the exposure to bosutinib. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to brigatinib. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to cabozantinib. Avoid. (Moderate) Study

Enzalutamide is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. (Moderate) Study

Enzalutamide decreases the exposure to calcium channel blockers (diltiazem, verapamil). (Severe) Study

Enzalutamide is predicted to decrease the exposure to cannabis extract. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to cariprazine. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to ceritinib. Avoid. (Severe) Study

Enzalutamide decreases the concentration of ciclosporin. (Severe) Study

Enzalutamide is predicted to alter the effects of cilostazol. (Moderate) Study

Enzalutamide is predicted to decrease the exposure to ciclosporin. Monitor and adjust dose. (Moderate) Study

Enzalutamide decreases the exposure to clomethiazole. Monitor and adjust dose. (Moderate) Study

Clopidogrel moderately increases the exposure to enzalutamide. Avoid or adjust enzalutamide dose. (Severe) Study

Enzalutamide is predicted to decrease the exposure to clozapine. (Moderate) Study

Enzalutamide is predicted to decrease the exposure to cobimetinib. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to corticosteroids (budesonide, deflazacort, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone, triamcinolone). Monitor and adjust dose. (Moderate) Study

Enzalutamide is predicted to decrease the exposure to corticosteroids (fluticasone). (Unknown) Study

Enzalutamide potentially decreases the exposure to coumarins. Avoid or adjust dose and monitor INR. (Severe) Study

Enzalutamide is predicted to markedly decrease the exposure to crizotinib. Avoid. (Severe) Study

Enzalutamide is predicted to decrease the exposure to dabrafenib. Avoid. (Moderate) Study

Enzalutamide is predicted to decrease the exposure to dasatinib. Avoid. (Severe) Study

Enzalutamide is predicted to markedly decrease the exposure to dasabuvir. Avoid. (Severe) Study

Enzalutamide is predicted to markedly decrease the exposure to dasabuvir. Avoid. (Severe) Study

Enzalutamide is predicted to slightly decrease the exposure to delamanid. Avoid. (Moderate) Study

Enzalutamide decreases the exposure to dolutegravir. Adjust dose. (Severe) Study
Enzalutamide (continued)

- Enzalutamide is predicted to decrease the exposure to doravirine. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to elbasvir. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to elvitegravir. Avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the concentration of encorafenib. Avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the effects of ergotamine. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to etravirine. Avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the concentration of everolimus. Avoid or adjust dose. [Severe] Study
- Enzalutamide moderately decreases the exposure to exemestane. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to fexofenadine. Avoid. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to fingolimod. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study
- Enzalutamide is predicted to greatly decrease the concentration of gliclazide. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the concentration of guanfacine. Adjust guanfacine dose, p. 237. [Moderate] Study
- Enzalutamide decreases the concentration of haloperidol. Adjust dose. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to ibritinib. Avoid or adjust ibritinib dose. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to imatinib. Avoid. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study
- Enzalutamide is predicted to greatly decrease the exposure to ivabradine. Adjust dose. [Moderate] Theoretical
- Enzalutamide is predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to lapiatinib. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to linagliptin. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to lomitapide. Monitor and adjust dose. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to luradoline. Avoid. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to midazolam. Monitor and adjust dose. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to midostaurin. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to mirtazapine. Adjust dose. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to montelukast. [Mild] Study
- Enzalutamide is predicted to markedly decrease the exposure to naloxegol. Avoid. [Moderate] Study
- Enzalutamide is predicted to slightly decrease the exposure to nateglinide. [Mild] Study
- Enzalutamide is predicted to decrease the exposure to netupitant. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to nevirapine. [Severe] Theoretical
- Enzalutamide is predicted to moderately decrease the exposure to nilotinib. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to nitrofurantoin. Adjust dose. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to ondansetron. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to opioids (alfentanil, fentanyl). [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to opioids (buprenorphine). Monitor and adjust dose. [Moderate] Theoretical
- Enzalutamide decreases the exposure to opioids (methadone). Monitor and adjust dose. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to oseltamivir. Avoid or adjust dose. [Moderate] Study
- Enzalutamide is predicted to moderately decrease the exposure to paroxetine. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to pazopanib. Avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to phosphodiesterase-type-5 inhibitors (avanafil, tadalfil). Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to phosphodiesterase-type-5 inhibitors (sildenafil, vardenafil). [Moderate] Theoretical
- Enzalutamide is predicted to moderately to markedly decrease the exposure to pimecrolimus. Avoid. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to pimobendan. Avoid. [Severe] Study
- Enzalutamide is predicted to increase the exposure to propranolol. Adjust dose. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to quetiapine. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to ranolazine. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to reboxetine. [Moderate] Anecdotal
- Enzalutamide is predicted to decrease the exposure to regorafenib. Avoid. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to repaglinide. Monitor blood glucose and adjust dose. [Moderate] Study
- Enzalutamide is predicted to markedly decrease the exposure to rivaroxaban. Avoid unless patient can be monitored for signs of thrombosis. [Severe] Study
Enzalutamide – Ergotamine

- Enzalutamide is predicted to decrease the exposure to roluminast. Avoid. [Moderate] Study
- Enzalutamide is predicted to markedly decrease the exposure to rolipitant. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. [Moderate] Study
- Enzalutamide is predicted to moderately decrease the exposure to saxagliptin. [Moderate] Study
- Enzalutamide is predicted to decrease the concentration of sirolimus. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to solifenacin. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to sorafenib. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to statins (simvastatin). [Severe] Study
- Enzalutamide is predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study
- Enzalutamide decreases the concentration of tacrolimus. Monitor and adjust dose. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to taxanes (docetaxel). [Severe] Theoretical
- Enzalutamide is predicted to decrease the concentration of temsirolimus. Avoid. [Severe] Study
- Enzalutamide is predicted to markedly decrease the exposure to ticagrelor. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to tivozanib. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to tofacitinib. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to tolvaptan. Use with caution or avoid depending on indication. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to toremifene. Adjust dose. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to trabectedin. Avoid. [Severe] Theoretical
- Enzalutamide is predicted to markedly decrease the exposure to ulipristal. Avoid and for 4 weeks after stopping ulipristal. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to vandetanib. Avoid. [Moderate] Study
- Enzalutamide is predicted to moderately decrease the exposure to velpatasvir. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to vemurafenib. Avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to venooclax. Avoid. [Severe] Study
- Enzalutamide is predicted to increase the exposure to vinca alkaloids (vinblastine, vincristine, vindesine). [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to vinca alkaloids (vinflunine). Avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to vinca alkaloids (vinorelide). Use with caution or avoid. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to vismodegib. Avoid. [Moderate] Theoretical
- Enzalutamide is predicted to decrease the exposure to vortioxetine. Monitor and adjust dose. [Moderate] Study
- Enzalutamide is predicted to decrease the concentration of voxtiaprevir. Avoid. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to zopiclone. Adjust dose. [Moderate] Study

Ephedrine – see sympathomimetics, vasoconstrictor
Ephedrine → see sympathomimetics, vasoconstrictor
Ephedrinerone → see aldosterone antagonists
Epoetin alfa → see TABLE 5 p. 874 (thromboembolism), TABLE 16 p. 878 (increased serum potassium)
Ergotamine – Erlotinib

**Ergotamine (continued)**

- Antiarhythmics (dronedarone) are predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the risk of ergotism when given with ergotamine. Avoid. **Severe** Theoretical
- Beta blockers, non-selective are predicted to increase the risk of peripheral vasoconstriction when given with ergotamine. **Severe** Study
- Beta blockers, selective are predicted to increase the risk of peripheral vasoconstriction when given with ergotamine. **Severe** Study
- Bosantan is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Ceritinib is predicted to increase the exposure to ergotamine. Avoid. **Severe** Theoretical
- Cobimetinib is predicted to increase the risk of ergotism when given with ergotamine. Avoid. **Severe** Theoretical
- Crizotinib is predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Ergotamine is predicted to increase the risk of ergotism when given with dopamine receptor agonists (bromocriptine, cabergoline). Avoid. **Moderate** Theoretical
- Ergotamine is predicted to increase the risk of ergotism when given with dopamine receptor agonists (pergolide). **Moderate** Theoretical
- Elafin is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Erlotinib increases the risk of vasoconstriction when given with ergotamine. Separate administration by 24 hours. **Severe** Study
- Enalaprilamide is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Grapefruit juice is predicted to increase the exposure to ergotamine. **Severe** Theoretical
- HIV-protease inhibitors are predicted to increase the risk of ergotism when given with ergotamine. Avoid. **Severe** Theoretical
- Idelalisib is predicted to increase the risk of ergotism when given with ergotamine. Avoid. **Severe** Theoretical
- Imatinib is predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Letermovir is predicted to increase the concentration of ergotamine. Avoid. **Severe** Theoretical
- Macrolides (clarithromycin) are predicted to increase the risk of ergotism when given with ergotamine. Avoid. **Severe** Theoretical
- Macrolides (erythromycin) are predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Mitotane is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Naratriptan is predicted to increase the risk of vasoconstriction when given with ergotamine. Separate administration by 24 hours. **Severe** Theoretical
- Nevirapine is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Nilotinib is predicted to increase the risk of ergotism when given with ergotamine. **Severe** Theoretical
- Palbociclib is predicted to increase the exposure to ergotamine. Adjust dose. **Moderate** Theoretical
- Ribociclib (high-dose) is predicted to increase the exposure to ergotamine. Avoid. **Moderate** Theoretical
- Rifampicin is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Rizatriptan is predicted to increase the risk of vasoconstriction when given with ergotamine. Ergotamine should be taken at least 24 hours before or 6 hours after rizatriptan. **Severe** Theoretical
- Rucaparib is predicted to increase the exposure to ergotamine. Monitor and adjust dose. **Moderate** Study
- St John’s Wort is predicted to decrease the effects of ergotamine. **Moderate** Theoretical
- Sumatriptan increases the risk of vasoconstriction when given with ergotamine. Ergotamine should be taken at least 24 hours before or 6 hours after sumatriptan. **Severe** Study
- Ticagrelor is predicted to increase the exposure to ergotamine. Avoid. **Severe** Theoretical

**Erlotinib**

- See TABLE 15, p. 877 (myelosuppression), TABLE 12 p. 877 (peripheral neuropathy), TABLE 9 p. 876 (QT-interval prolongation)

**Erlotinib**

**FOOD AND LIFESTYLE** Dose adjustment may be necessary if smoking started or stopped during treatment.

- Antacids are predicted to decrease the absorption of erlotinib. Avoid. Be taken 4 hours before or 2 hours after erlotinib. **Moderate** Theoretical
- Antiarhythmics (amiodarone, dronedarone) are predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to erlotinib. Avoid or adjust erlotinib dose. **Severe** Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. **Moderate** Study
- Aprepitant is predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Erlotinib is predicted to increase the risk of gastrointestinal perforation when given with aspirin (high-dose). **Severe** Theoretical
- Bosantan is predicted to decrease the exposure to erlotinib. **Severe** Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Ciclosporin is predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Cobimetinib is predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. **Moderate** Study
- Combined hormonal contraceptives slightly increase the exposure to erlotinib. Monitor side effects and adjust dose. **Moderate** Study
- Corticosteroids increase the risk of gastrointestinal perforation when given with erlotinib. **Severe** Theoretical
- Erlotinib increases the anticoagulant effect of warfarin. **Severe** Anecdotal
- Erlotinib is predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Erlotinib is predicted to decrease the exposure to erlotinib. **Severe** Theoretical
- Enalapril is predicted to decrease the exposure to erlotinib. **Severe** Study
- Grapefruit juice is predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- H1 receptor antagonists are predicted to decrease the exposure to erlotinib. Erlotinib should be taken 2 hours before or 10 hours after H1 receptor antagonists. **Moderate** Study
- HIV-protease inhibitors are predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. **Moderate** Study
- Idelalisib is predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. **Moderate** Study
- Imatinib is predicted to increase the exposure to erlotinib. **Moderate** Theoretical
- Lapatinib is predicted to increase the exposure to erlotinib. **Moderate** Theoretical
Estramustine → Esomeprazole → Eslicarbazepine

Esketamine

Rifampicin → HIV-protease inhibitors → Cobicistat

Antifungals, azoles → Esketamine → Ertugliflozin

Ertapenem → Rifaximin

Erlotinib → Nilotinib

Nevirapine → Netupitant

Mitotane → Modafinil

Macrolides (azithromycin, erythromycin) are predicted to increase the exposure to etoricoxib. (Moderate) Theoretical

Macrolides (clarithromycin) are predicted to slightly increase the exposure to etoricoxib. Use with caution and adjust dose. (Moderate) Study

Mexitelone slightly increases the exposure to etoricoxib. Monitor side effects and adjust dose. (Moderate) Study

Mitotane is predicted to decrease the exposure to etoricoxib. Avoid or adjust etoricoxib dose. (Severe) Study

Netupitant is predicted to increase the exposure to etoricoxib. (Moderate) Theoretical

Nevirapine is predicted to decrease the exposure to etoricoxib. (Severe) Theoretical

Nilotinib is predicted to increase the exposure to etoricoxib. (Moderate) Theoretical

Erlotinib is predicted to increase the risk of gastrointestinal perforation when given with NSAIps. (Severe) Theoretical

Erlotinib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical

Proton pump inhibitors are predicted to slightly decrease the exposure to etoricoxib. Avoid or adjust etoricoxib dose. (Moderate) Study

Quinolones (ciprofloxacin) slightly increase the exposure to etoricoxib. Monitor side effects and adjust dose. (Moderate) Study

Ranolazine is predicted to increase the exposure to etoricoxib. (Moderate) Theoretical

St John’s Wort is predicted to decrease the exposure to etoricoxib. (Severe) Theoretical

Vemurafenib is predicted to increase the exposure to etoricoxib. (Moderate) Theoretical

Erlapenem → see carbapenems

Ertugliflozin → see TABLE 14 p. 877 (antidiabetic drugs), TABLE 8 p. 875 (hypotension)

Erythromycin → see macrolides

Escitalopram → see SSRIs

Esketamine → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

Esketamine is predicted to increase the risk of seizures when given with aminophylline. Avoid. (Severe) Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone, rifampin, topiramate) are predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Aprepitant is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Bosantan is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Efavirenz is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Fosaprepitant is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Griseofulvin decreases the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

HIV-protease inhibitors (ritonavir) are predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Nevirapine is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Etanercept

Anakinra is predicted to increase the risk of generalised infection (possibly life-threatening) when given with etanercept. Avoid. (Severe) Theoretical

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with etanercept. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

Etelecalcetide

Cinacalcet increases the risk of hypocalcaemia when given with etelcalcetide. Avoid. (Severe) Theoretical

Ethambutol

Isoniazid increases the risk of optic neuropathy when given with ethambutol. (Severe) Anecdotal

Ethosuximide → see antiepileptics

Etodolac → see NSAIDs

Etomideate → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

Etonogestrel

Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rifampin, topiramate) are predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Aprepitant is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Bosantan is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Efavirenz is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Fosaprepitant is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Griseofulvin decreases the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

HIV-protease inhibitors (ritonavir) are predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Nevirapine is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, Interactions p. 516. (Severe) Theoretical

Etanercept

Anakinra is predicted to increase the risk of generalised infection (possibly life-threatening) when given with etanercept. Avoid. (Severe) Theoretical

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with etanercept. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

Etelecalcetide

Cinacalcet increases the risk of hypocalcaemia when given with etelcalcetide. Avoid. (Severe) Theoretical

Ethambutol

Isoniazid increases the risk of optic neuropathy when given with ethambutol. (Severe) Anecdotal

Ethosuximide → see antiepileptics

Etodolac → see NSAIDs

Etomideate → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
Etravirine

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to etravirine. Avoid. (Severe) Theoretical
- Etravirine decreases the exposure to antimalarials (artemether). (Moderate) Study
- Etravirine is predicted to decrease the exposure to bedaquiline. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to etravirine. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to etravirine. Avoid. (Mild) Theoretical
- Etravirine increases the anticoagulant effect of coumarins. (Mild) Theoretical
- Etravirine is predicted to decrease the exposure to dasabuvir. Avoid. (Severe) Theoretical
- Etravirine moderately decreases the exposure to dolutegravir. Avoid unless given with atazanavir, darunavir, or lopinavir (all boosted with ritonavir). (Severe) Study
- Efavirenz is predicted to decrease the exposure to etravirine. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to elbasvir. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to efavirenz. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to grazoprevir. Avoid. (Mild) Theoretical
- HIV- protease inhibitors (tipranavir) decrease the exposure to etravirine. Avoid. (Severe) Study
- Etravirine increases the exposure to HIV- protease inhibitors (fosamprenavir boosted with ritonavir). Refer to specialist literature. (Moderate) Study
- Etravirine is predicted to decrease the exposure to etermovir. (Moderate) Theoretical
- Etravirine decreases the exposure to macrolides (clarithromycin) and macrolides (clarithromycin) slightly increase the exposure to etravirine. (Severe) Study
- Etravirine (with a boosted protease inhibitor) increases the exposure to maraviroc. Avoid or adjust dose. (Moderate) Study
- Mitotane is predicted to decrease the exposure to etravirine. Avoid. (Severe) Theoretical
- Nevirapine is predicted to decrease the exposure to etravirine. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to paritaprevir. Avoid. (Severe) Theoretical
- Etravirine moderately decreases the exposure to phosphodiesterase type-5 inhibitors. Adjust dose. (Moderate) Study
- Rifabutin decreases the exposure to etravirine. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to etravirine. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to rilpivirine. Avoid. (Severe) Theoretical
- St John's Wort is predicted to decrease the exposure to etravirine. Avoid. (Severe) Study
- Everolimus is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Everolimus potentially increases the risk of angioedema when given with ACE inhibitors. (Severe) Anecdotal
- Antiarrhythmics (dronedaron) are predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to decrease the concentration of everolimus. Avoid. (Severe) Study
- Apalutamide is predicted to decrease the exposure to everolimus. Avoid or monitor. (Moderate) Study
- Aprepitant is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Bosentan is predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Ceritinib is predicted to increase the exposure to everolimus. (Moderate) Theoretical. Also see TABLE 15 and p. 877
- Ciclosporin moderately increases the exposure to everolimus. Avoid or adjust dose. (Severe) Study
- Ciclosporin is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Cobicistat is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Grapefruit juice is predicted to increase the exposure to everolimus. Avoid. (Severe) Study
- HIV- protease inhibitors are predicted to increase the concentration of everolimus. Avoid. (Severe) Study
- Ibalipivir is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Imatinib is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Lipitor is predicted to increase the exposure to everolimus. Adjust dose. (Moderate) Study
- Enalapril is predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Everolimus is predicted to increase the exposure to loratadine. Separate administration by 12 hours. (Moderate) Theoretical
- Lumacaftor is predicted to decrease the exposure to everolimus. Avoid. (Severe) Theoretical
- Macrolides (clarithromycin) are predicted to increase the concentration of everolimus. Avoid. (Severe) Study
- Macrolides (erythromycin) are predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Miraclon is predicted to increase the exposure to everolimus. (Mild) Theoretical
- Mitotane is predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Mitotane is predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Netupitant is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- Nevirapine is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Nilotinib is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Severe) Study
- Everolimus is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study
- St John's Wort is predicted to decrease the concentration of everolimus. Avoid or adjust dose. (Severe) Study
Everolimus – Fibrates

Interactions | Appendix 1

- Velpatasvir is predicted to increase the exposure to everolimus. [Severe] Theoretical
- Venetoclax is predicted to increase the exposure to everolimus. Avoid or adjust dose. [Severe] Study
- Exemestane
  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) moderately decrease the exposure to exemestane. [Moderate] Study
  - Enzalutamide moderately decreases the exposure to exemestane. [Moderate] Study
  - Mitotane moderately decreases the exposure to exemestane. [Moderate] Study
  - Rifampicin moderately decreases the exposure to exemestane. [Moderate] Theoretical
- St John’s Wort is predicted to decrease the exposure to exemestane. [Moderate] Theoretical

Exenatide → see Table 14 p. 877 (antidiabetic drugs)

Ferrous fumarate
- Ferric maltol
- Ferric carboxymaltose
- Fentanyl
- Fenofibrate

Fenofibrate → see fibrates
- Fesoterodine is predicted to decrease the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- Enzalutamide is predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study
- HIV- protease inhibitors are predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. [Severe] Study

Idelalisib is predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. [Severe] Study
- Imatinib is predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study

- Macrolides (erythromycin) are predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4 in hepatic and renal impairment. [Severe] Study
- Mitotane is predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study
- Netupitant is predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study

- Nilotinib is predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- Rifampicin is predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study
- St John’s Wort is predicted to decrease the exposure to fesoterodine. Avoid. [Severe] Theoretical
- Exemestane
- Velpatasvir

- Ezetimibe
  - Ciclosporin moderately increases the exposure to ezetimibe and ezetimibe slightly increases the exposure to ciclosporin. [Moderate] Study
  - Fibrates are predicted to increase the risk of gallstones when given with ezetimibe. [Severe] Theoretical
  - Ezetimibe potentially increases the risk of rhabdomyolysis when given with statins. [Severe] Anecdotal

- Famotidine → see H₂ receptor antagonists
- Fampidine
  - H₂ receptor antagonists (cimetidine) increase the concentration of fampridine. Avoid. [Severe] Theoretical
- Fexofenadine → see antihistamines, non-sedating
- Felbinac → see NSAIDs
- Felodipine → see calcium channel blockers
- Fenofibrate → see fibrates
- Fentanyl → see opioids
- Ferric carboxymaltose → see iron (injectable)
- Ferric maltol → see iron (oral)
- Ferrous fumarate → see iron (oral)
- Ferrous gluconate → see iron (oral)
- Ferrous sulfate → see iron (oral)
- Fosoterodine → see Table 10 p. 876 (antimuscarinics)

- Antiarrhythmics (dronedarone) are predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study
- Antifungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. [Severe] Study
- Aprepitant is predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study
- Cobicistat is predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. [Severe] Study

- H₂ receptor antagonists (cimetidine) increase the concentration of fampridine. Avoid. [Severe] Theoretical
- Nitric oxide (nitroglycerin) are predicted to decrease the exposure to fesoterodine. Adjust fesoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. [Mild] Study

- Antacids slightly to moderately decrease the exposure to gemfibrozil. [Moderate] Study
- Gemfibrozil is predicted to increase the exposure to apalutamide. [Mild] Study
- Bezlazebacil is predicted to increase the risk of nephrotoxicity when given with ciclosporin. [Severe] Theoretical
- Fenofibrate increases the risk of nephrotoxicity when given with ciclosporin. [Severe] Study
- Colchicine increases the risk of rhabdomyolysis when given with fibrates. [Severe] Anecdotal
- Fibrates are predicted to increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Severe] Study
- Gemfibrozil is predicted to increase the exposure to dabrafenib. [Moderate] Theoretical
- Fibrates are predicted to increase the risk of rhabdomyolysis when given with daptomycin. [Severe] Theoretical
- Gemfibrozil is predicted to very markedly increase the exposure to dasabuvir. Avoid. [Severe] Study
- Gemfibrozil moderately increases the exposure to enzalutamide. Avoid or adjust enzalutamide dose. [Severe] Study
- Fibrates are predicted to increase the risk of gallstones when given with ezetimibe. [Severe] Theoretical
- Fibrates are predicted to increase the risk of hypoglycaemia when given with insulins. [Moderate] Theoretical
- Gemfibrozil is predicted to increase the exposure to irinotecan. Avoid. [Moderate] Theoretical
- Gemfibrozil is predicted to increase the concentration of letermovir. [Moderate] Study
- Gemfibrozil is predicted to moderately increase the exposure to montelukast. [Moderate] Study
- Fibrates are predicted to increase the anticoagulant effect of phenindione. Monitor INR and adjust dose. [Severe] Study
Fibrates (continued)

- Gemfibrozil increases the exposure to pioglitazone. Monitor blood glucose and adjust dose. (Severe) Study
- Gemfibrozil increases the exposure to repaglinide. Avoid. (Severe) Study
- Gemfibrozil is predicted to increase the exposure to retinoids (allitretinoin). Adjust allitretinoin dose. (Moderate) Theoretical
- Gemfibrozil increases the concentration of retinoids (bexarotene). Avoid. (Severe) Study
- Gemfibrozil increases the exposure to selexipag. Avoid. (Severe) Study
- Ciprofibrate increases the risk of rhabdomyolysis when given with statins (atorvastatin). Avoid or adjust dose. (Severe) Study
- Bezafibrate increases the risk of rhabdomyolysis when given with statins (atorvastatin, fluvastatin). (Severe) Study
- Fenofibrate increases the risk of rhabdomyolysis when given with statins (atorvastatin, simvastatin). Adjust fenofibrate dose, p. 133. (Severe) Anecdotal
- Ciprofibrate increases the risk of rhabdomyolysis when given with statins (fluvastatin). Adjust fenofibrate dose, p. 133. (Severe) Theoretical
- Fenofibrate is predicted to increase the risk of rhabdomyolysis when given with statins (fluvastatin). Adjust fenofibrate dose, p. 133. (Severe) Theoretical
- Fenofibrate is predicted to increase the risk of rhabdomyolysis when given with statins (pravastatin). Avoid. (Severe) Study
- Fibrates (bezafibrate, ciprofibrate) increase the risk of rhabdomyolysis when given with statins (rosuvastatin). Adjust rosuvastatin dose, p. 135. (Severe) Study
- Fibrates (bezafibrate, ciprofibrate) increase the risk of rhabdomyolysis when given with statins (simvastatin). Adjust simvastatin dose, p. 136. (Severe) Study
- Gemfibrozil increases the risk of rhabdomyolysis when given with statins. Avoid. (Severe) Anecdotal
- Fibrates are predicted to increase the risk of hypoglycaemia when given with sulfonlureas. (Moderate) Theoretical
- Gemfibrozil is predicted to increase the concentration of taxanes (paclitaxel). (Severe) Anecdotal
- Fibrates are predicted to decrease the efficacy of ursoodeoxycholic acid. Avoid. (Severe) Theoretical

Fidaxomicin

- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Antifungals, azoles (itraconazole, ketoconazole) are predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Calcium channel blockers (verapamil) are predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Ciclosporin is predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Lapatinib is predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Macrolides are predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Ranolazine is predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study
- Venmurasfemib is predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study

Fingolimod

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to fingolimod. (Moderate) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to fingolimod. Avoid. (Moderate) Theoretical
- Also see TABLE 6 p. 875
- Fingolimod increases the risk of QT-prolongation when given with drugs that prolong the QT interval. Avoid. (Severe) Theoretical
- Enzalutamide is predicted to decrease the exposure to fingolimod. (Moderate) Study
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with fingolimod. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Mitotane is predicted to decrease the exposure to fingolimod. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to fingolimod. (Moderate) Study
- St John’s Wort is predicted to decrease the exposure to fingolimod. Avoid. (Moderate) Theoretical

Flavoxate → see TABLE 10 p. 876 (antimuscarinics)
Flecainide → see antiarrhythmics
Fluoxacinil → see penicillins
Flucloxacillin → see antifungals, azoles
Flucytosine
- Amphotericin increases the risk of toxicity when given with flucytosine. (Severe) Study
- Cytarabine decreases the concentration of flucytosine. Avoid. (Severe) Study
- Zidovudine increases the risk of haematological toxicity when given with flucytosine. Monitor and adjust dose. (Severe) Theoretical

Fludarabine

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with fludarabine. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
- Fludarabine increases the risk of pulmonary toxicity when given with pentostatin. Avoid. (Severe) Study → Also see TABLE 15 p. 877

Fludrocortisone → see corticosteroids

Fluvastatin

- Fluphenazine increases the anticoagulant effect of warfarin (coumarins). Monitor concentration and adjust dose. (Severe) Theoretical
- Fluphenazine is predicted to decrease the exposure to fingolimod. (Severe) Study
- Fluphenazine increases the risk of severe skin reaction when given with topical fludarabine. Avoid. (Severe) Study
- Fluphenazine increases the risk of pulmonary toxicity when given with fludrocortisone. Avoid. (Severe) Study
- Fluphenazine increases the risk of QT-prolongation when given with drugs that prolong the QT interval. Avoid. (Severe) Theoretical
- Fluphenazine is predicted to decrease the exposure to fingolimod. (Moderate) Study
- Fluvoxamine increases the risk of toxicity when given with fluvoxamine. (Severe) Study
- Foscarnet decreases the effects of levodopa. Avoid or monitor worsening parkinsonian symptoms. (Severe) Theoretical → Also see TABLE 8 p. 875

Fulturne → see SSRIs
Flumazenil → see SEDS
Flupentixol → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
Flupentixol is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875
Flupentinol decreases the effects of levodopa. Avoid or monitor worsening parkinsonian symptoms. (Severe) Theoretical → Also see TABLE 8 p. 875

Fulturne → see phenothiazines
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▶

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▶

Theoretical

folic acid . folinic acid . levofolinic acid .

▶

Folates are predicted to decrease the concentration of
antiepileptics (fosphenytoin, phenobarbital, phenytoin,
primidone). Monitor concentration and adjust dose. r

▶

▶
▶

Folates are predicted to increase the risk of toxicity when
given with capecitabine. r Anecdotal
Folic acid is predicted to increase the risk of toxicity when
given with fluorouracil. Avoid. r Theoretical
Folinic acid is predicted to increase the risk of toxicity when
given with fluorouracil. Monitor and adjust dose. r

▶
▶

▶

Theoretical
▶

Folates are predicted to alter the effects of raltitrexed. Avoid.
o Study

▶

Sulfasalazine is predicted to decrease the absorption of folates.
o Study

▶

Folates are predicted to increase the risk of toxicity when
given with tegafur. r Theoretical
Folic acid → see folates
Folinic acid → see folates
Fondaparinux → see TABLE 3 p. 874 (anticoagulant effects)
Formoterol → see beta2 agonists
Fosamprenavir → see HIV-protease inhibitors
Fosaprepitant
▶ Fosaprepitant is predicted to increase the exposure to
alkylating agents (ifosfamide). r Theoretical
▶ Fosaprepitant is predicted to increase the exposure to
alprazolam. o Study
▶ Antiepileptics (carbamazepine, fosphenytoin, phenobarbital,
phenytoin, primidone) are predicted to decrease the exposure
to fosaprepitant. Avoid. o Theoretical
▶ Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are
predicted to increase the exposure to fosaprepitant. o
Theoretical
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Antifungals, azoles (posaconazole) are predicted to increase the
exposure to fosaprepitant. o Study
Bosentan is predicted to decrease the exposure to
fosaprepitant. o Theoretical
Fosaprepitant is predicted to increase the exposure to
bosutinib. r Theoretical
Cobicistat is predicted to increase the exposure to
fosaprepitant. o Theoretical
Fosaprepitant is predicted to decrease the efﬁcacy of combined
hormonal contraceptives. For FSRH guidance, see
Contraceptives, interactions p. 516. r Study
Fosaprepitant is predicted to decrease the anticoagulant effect
of coumarins. o Theoretical
Fosaprepitant is predicted to decrease the efﬁcacy of
desogestrel. For FSRH guidance, see Contraceptives,
interactions p. 516. r Theoretical
Efavirenz is predicted to decrease the exposure to
fosaprepitant. o Theoretical
Enzalutamide is predicted to decrease the exposure to
fosaprepitant. Avoid. o Theoretical
Fosaprepitant is predicted to decrease the efﬁcacy of
etonogestrel. For FSRH guidance, see Contraceptives,
interactions p. 516. r Theoretical
Fosaprepitant is predicted to increase the concentration of
guanfacine. o Theoretical
HIV-protease inhibitors are predicted to increase the exposure
to fosaprepitant. o Theoretical
Fosaprepitant is predicted to decrease the effects of hormone
replacement therapy. o Anecdotal
Fosaprepitant is predicted to slightly increase the exposure to
ibrutinib. o Theoretical
Idelalisib is predicted to increase the exposure to
fosaprepitant. o Theoretical

Macrolides (clarithromycin) are predicted to increase the
exposure to fosaprepitant. o Theoretical
Fosaprepitant slightly increases the exposure to midazolam.
o Study

▶

Study
▶

Fosaprepitant is predicted to increase the exposure to
intravenous irinotecan. r Theoretical
Fosaprepitant is predicted to decrease the efﬁcacy of
levonorgestrel. For FSRH guidance, see Contraceptives,
interactions p. 516. r Theoretical
Fosaprepitant is predicted to increase the exposure to
lomitapide. Separate administration by 12 hours. o

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Mitotane is predicted to decrease the exposure to
fosaprepitant. Avoid. o Theoretical
Nevirapine is predicted to decrease the exposure to
fosaprepitant. o Theoretical
Fosaprepitant is predicted to decrease the efﬁcacy of
norethisterone. For FSRH guidance, see Contraceptives,
interactions p. 516. r Anecdotal
Fosaprepitant is predicted to increase the exposure to
pimozide. Avoid. r Theoretical
Rifampicin is predicted to decrease the exposure to
fosaprepitant. Avoid. o Theoretical
St John’s Wort is predicted to decrease the exposure to
fosaprepitant. Avoid. o Theoretical
Fosaprepitant decreases the efﬁcacy of ulipristal. For FSRH
guidance, see Contraceptives, interactions p. 516. r
Anecdotal

▶

Fosaprepitant is predicted to increase the exposure to vinca
alkaloids. r Theoretical
Foscarnet → see TABLE 2 p. 874 (nephrotoxicity)
▶ Foscarnet increases the risk of hypocalcaemia when given with
pentamidine. r Anecdotal → Also see TABLE 2 p. 874
Fosinopril → see ACE inhibitors
Fosphenytoin → see antiepileptics
Frovatriptan → see TABLE 13 p. 877 (serotonin syndrome)
▶ SSRIs (fluvoxamine) increase the concentration of frovatriptan.
r Study → Also see TABLE 13 p. 877
Fulvestrant → see TABLE 5 p. 874 (thromboembolism)
Furosemide → see loop diuretics
Fusidic acid
ROUTE-SPECIFIC INFORMATION Interactions do not generally
apply to topical use unless speciﬁed.
▶

Fusidic acid increases the risk of rhabdomyolysis when given
with statins. Avoid. r Anecdotal
Gabapentin → see antiepileptics
Galantamine → see anticholinesterases, centrally acting
Ganciclovir → see TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874
(nephrotoxicity)
ROUTE-SPECIFIC INFORMATION Since systemic absorption can

follow topical application, the possibility of interactions
should be borne in mind.
▶

Ganciclovir is predicted to increase the risk of seizures when
given with carbapenems (imipenem). Avoid. r Anecdotal
▶ Ganciclovir is predicted to increase the exposure to didanosine.
o Study
▶

Leflunomide is predicted to increase the exposure to
ganciclovir. o Theoretical → Also see TABLE 15 p. 877
▶ Mycophenolate is predicted to increase the risk of
haematological toxicity when given with ganciclovir. o
Theoretical → Also see TABLE 15 p. 877
▶ Teriflunomide is predicted to increase the exposure to
ganciclovir. o Study
Gefitinib → see TABLE 15 p. 877 (myelosuppression)
▶ Antacids are predicted to slightly decrease the exposure to
gefitinib. o Theoretical
▶ Antiarrhythmics (dronedarone) are predicted to increase the
exposure to gefitinib. o Theoretical
▶ Antiepileptics (carbamazepine, fosphenytoin, phenobarbital,
phenytoin, primidone) are predicted to decrease the exposure
to gefitinib. Avoid. r Study
▶ Antifungals, azoles (fluconazole, isavuconazole, posaconazole)
are predicted to increase the exposure to gefitinib. o
Theoretical

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Interactions | Appendix 1

Flurazepam → see TABLE 11 p. 876 (CNS depressant effects)
▶ HIV-protease inhibitors (ritonavir) are predicted to increase the
exposure to flurazepam. Avoid. o Theoretical
Flurbiprofen → see NSAIDs
Fluticasone → see corticosteroids
Fluvastatin → see statins
Fluvoxamine → see SSRIs
Folates


Gefitinib—Grapefruit juice

Gefitinib (contd.)

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to gefitinib. [Moderate] Study
- Aprepitant is predicted to increase the exposure to gefitinib. [Moderate] Theoretical
- Bosentan is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to gefitinib. [Moderate] Theoretical
- Cobicistat is predicted to increase the exposure to gefitinib. [Moderate] Study
- Gefitinib is predicted to increase the anticoagulant effect of coumarins. [Severe] Anecdotal
- Crizotinib is predicted to increase the exposure to gefitinib. [Moderate] Theoretical
- Efavirenz is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Theoretical
- Enalapril is predicted to decrease the exposure to gefitinib. [Moderate] Study
- Gefitinib is predicted to increase the exposure to gemcitabine. [Moderate] Theoretical
- Idelalisib is predicted to increase the exposure to gefitinib. [Moderate] Study
- Imatinib is predicted to increase the exposure to gefitinib. [Moderate] Study
- Macrolides (clarithromycin) are predicted to increase the exposure to gefitinib. [Moderate] Study
- Macrolides (erythromycin) are predicted to increase the exposure to gefitinib. [Moderate] Theoretical
- Mitotane is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Theoretical
- Nilotinib is predicted to increase the exposure to gefitinib. [Moderate] Theoretical
- Gefitinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
- Proton pump inhibitors are predicted to decrease the exposure to gefitinib. [Severe] Theoretical
- Rifampicin is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study
- St John’s Wort is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Theoretical
- Gemcitabine is predicted to decrease the exposure to gefitinib. [Moderate] Theoretical
- Live vaccines are predicted to increase the risk of generalised infarction (possibly life-threatening) when given with gemcitabine. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical
- Gemfibrozil is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Theoretical
- Gentamicin is predicted to decrease the exposure to gefitinib. [Severe] Theoretical
- Glucarpidase is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study
- Aminophospholipids (dronedarone) potentially increase the exposure to glecaprevir. [Moderate] Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to glecaprevir. Avoid. [Severe] Study
- Antiepileptics (eslicarbazepine, oxcarbazepine) potentially decrease the exposure to glecaprevir. Avoid. [Severe] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole) potentially increase the exposure to glecaprevir. [Moderate] Theoretical
- Bosentan is predicted to decrease the exposure to glecaprevir. Avoid. [Severe] Study
- Ciclosporin increases the exposure to glecaprevir. Avoid or monitor. [Severe] Study
- Cobicistat potentially increases the exposure to glecaprevir. [Moderate] Theoretical
- Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with glecaprevir. Avoid. [Severe] Study
- Crizotinib potentially decreases the exposure to glecaprevir. Avoid. [Severe] Theoretical
- Glecaprevir with pibrentasvir increases the exposure to dabigatran. Avoid. [Moderate] Study
- Glecaprevir with pibrentasvir is predicted to increase the exposure to digoxin. [Moderate] Study
- Efavirenz is predicted to decrease the exposure to glecaprevir. Avoid. [Severe] Study
- Enalapril is predicted to greatly decrease the concentration of glecaprevir. Avoid. [Severe] Study
- HIV-protease inhibitors (atazanavir, darunavir, lopinavir) increase the exposure to glecaprevir. Avoid. [Severe] Theoretical
- HIV-protease inhibitors (ritonavir) increase the exposure to glecaprevir. Avoid. [Severe] Study
- Lumacatmorf potentially decreases the exposure to glecaprevir. Avoid. [Severe] Theoretical
- Mitotane is predicted to greatly decrease the concentration of glecaprevir. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to glecaprevir. Avoid. [Severe] Study
- Rifampicin markedly affects the exposure to glecaprevir. Avoid. [Severe] Study
- St John’s Wort is predicted to decrease the exposure to glecaprevir. Avoid. [Severe] Study
- Glecaprevir with pibrentasvir markedly increases the exposure to statins (atorvastatin). Avoid. [Severe] Study
- Glecaprevir with pibrentasvir is predicted to increase the exposure to statins (fluvastatin). [Moderate] Theoretical
- Glecaprevir with pibrentasvir is predicted to increase the exposure to statins (pravastatin). Use with caution and adjust pravastatin dose. [Moderate] Study
- Glecaprevir with pibrentasvir increases the exposure to statins (rosuvastatin). Use with caution and adjust rosuvastatin dose. p. 125. [Moderate] Theoretical
- Glecaprevir with pibrentasvir increases the exposure to statins (simvastatin). Avoid. [Moderate] Study
- Glecaprevir with pibrentasvir increases the exposure to statins. Monitor and adjust dose. [Mil] Study
- Gilbencamide is predicted to decrease the exposure to tacrolimus. [Mild] Study
- Glipizide is predicted to slightly increase the exposure to sulfonylureas. See sulfonylureas
- Glycylcholine is predicted to decrease the exposure to sulfonylureas. See sulfonylureas
- Glucagon increases the anticoagulant effect of coumarins (warfarin). [Severe] Study
- Glucopyramine increases the anticoagulant effect of coumarins (acenocoumarol). [Moderate] Anecdotal
- Glucosamine potentially decreases the anticoagulant effect of coumarins (acenocoumarol). [Moderate] Anecdotal
- Glycerol phenylbutyrate
- Antiepileptics (valproate) potentially oppose the effects of glycerol phenylbutyrate. [Moderate] Theoretical
- Corticosteroids potentially oppose the effects of glycerol phenylbutyrate. [Moderate] Theoretical
- Haloperidol potentially opposes the effects of glycerol phenylbutyrate. [Moderate] Theoretical
- Glyceryl trinitrate is predicted to decrease the effects of nitrites. See nitrites
- Glycycopyronium is predicted to increase the effects of antimuscarinics. See antimuscarinics

ROUTE-SPECIFIC INFORMATION: Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- Golimumab is predicted to increase the effects of monoclonal antibodies. See monoclonal antibodies
- Granisetron is predicted to increase the effects of antimuscarinics. See antimuscarinics
- Dopamine receptor agonists (apomorphine) are predicted to increase the risk of severe hypotension when given with granisetron. [Severe] Theoretical
- Grapefruit juice increases the anticoagulant effect of coumarins (warfarin). [Severe] Study
- Grapefruit juice is predicted to increase the exposure to abacavir. Avoid. [Moderate] Theoretical
- Grapefruit juice moderately decreases the exposure to aliskiren. Avoid. [Severe] Study

Grapefruit juice

Grapefruit juice is predicted to increase the exposure to abacavir. Avoid. [Moderate] Theoretical
- Grapefruit juice moderately decreases the exposure to aliskiren. Avoid. [Severe] Study
Grapefruit juice increases the exposure to antiarrhythmics (amiodarone). Avoid. (Moderate) Study
Grapefruit juice moderately increases the exposure to antiarrhythmics (dronedarone). Avoid. (Severe) Study
Grapefruit juice increases the exposure to antiarrhythmics (propafenone). Monitor and adjust dose. (Moderate) Study
Grapefruit juice slightly increases the exposure to antiepileptics (carbamazepine). Monitor and adjust dose. (Moderate) Study
Grapefruit juice slightly decreases the exposure to antiarrhythmics, non-sedating (bilastine). Bilastine should be taken 1 hour before or 2 hours after grapefruit juice. (Moderate) Study
Grapefruit juice increases the exposure to antihistamines, non-sedating (rufapadine). Avoid. (Moderate) Study
Grapefruit juice increases the exposure to antimalarials (artemether). (Unkown) Study
Grapefruit juice is predicted to increase the concentration of antimalarials (piperaquine). Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to azithromycin. Avoid. (Moderate) Theoretical
Grapefruit juice greatly decreases the exposure to beta blockers, selective (celiprolol). (Moderate) Study
Grapefruit juice is predicted to increase the exposure to bosutinib. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the concentration of brigatinnib. Avoid. (Severe) Study
Grapefruit juice increases the exposure to buspirone. Avoid. (Mild) Study
Grapefruit juice is predicted to increase the exposure to calcium channel blockers (amlodipine). Avoid. (Mild) Study
Grapefruit juice increases the exposure to calcium channel blockers (felodipine). Avoid. (Moderate) Study
Grapefruit juice very slightly increases the exposure to calcium channel blockers (lercanidipine). Avoid. (Moderate) Theoretical
Grapefruit juice increases the exposure to calcium channel blockers (nicardipine). (Mild) Study
Grapefruit juice increases the exposure to calcium channel blockers (nifedipine, verapamil). Avoid. (Mild) Study
Grapefruit juice is predicted to increase the exposure to cariprazine. Avoid. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to ceftriaxone. (Severe) Theoretical
Grapefruit juice increases the concentration of ciclosporin. Avoid. (Severe) Study
Grapefruit juice markedly decreases the exposure to clopidogrel. (Severe) Study
Grapefruit juice is predicted to increase the exposure to cobicistat. Avoid. (Severe) Theoretical
Grapefruit juice moderately increases the exposure to oral corticosteroids (budesonide). Avoid. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to crizotinib. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to darifenacin. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to dasatinib. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to eliglustat. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to encorafenib. Avoid. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to ergometrine. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to ergotamine. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to erlotinib. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to everolimus. Avoid. (Severe) Study
Grapefruit juice is predicted to increase the exposure to guanfacine. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to ibritinib. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to imatinib. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to ivabradine. Avoid. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to ivacaftor. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to lapatinib. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to lurasidone. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to naldemedion. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to nilotinib. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to olaparib. Avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to palbociclib. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to pazopanib. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to phosphodiesterase type 5 inhibitors. Use with caution or avoid. (Moderate) Study
Grapefruit juice increases the exposure to pimozide. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to ponatinib. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to praziquantel. Avoid. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to quetiapine. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the concentration of raloxifene. Avoid. (Severe) Study
Grapefruit juice is predicted to increase the exposure to ruxolitinib. Avoid. (Severe) Theoretical
Grapefruit juice is predicted to increase the exposure to saxagliptin. (Mild) Theoretical
Grapefruit juice increases the concentration of sirolimus. Avoid. (Mild) Study
Grapefruit juice moderately increases the exposure to SSRIs (sertraline). Avoid. (Moderate) Study
Grapefruit juice increases the exposure to statins (atorvastatin). (Mild) Study
Grapefruit juice increases the exposure to statins (simvastatin). Avoid. (Severe) Study
Grapefruit juice is predicted to increase the exposure to suntinib. Avoid. (Moderate) Theoretical
Grapefruit juice greatly increases the concentration of tacrolimus. Avoid. (Severe) Study
Grapefruit juice is predicted to increase the concentration of temsirolimus. Use with caution or avoid. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to tezacaftor. Avoid. (Severe) Study
Grapefruit juice moderately increases the exposure to ticagrelor. (Moderate) Study
Grapefruit juice increases the exposure to tolvaptan. Avoid. (Moderate) Study
Grapefruit juice is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to venetoclax. Avoid. (Severe) Theoretical

Grass pollen extract

GENERAL INFORMATION Desensitising vaccines should be avoided in patients taking beta-blockers (adrenaline might be ineffective in case of a hypersensitivity reaction) or ACE inhibitors (risk of severe anaphylactoid reactions).
Grazoprevir

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to grazoprevir. [Severe] Study
- Aripiprazole, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately to markedly increase the exposure to grazoprevir. [Avoid] [Severe] Study
- Bosentan is predicted to markedly decrease the exposure to grazoprevir. [Avoid] [Severe] Study
- Grazoprevir is predicted to increase the concentration of calcium channel blockers. [Moderate] [Theoretical]
- Ciclosporin greatly increases the exposure to grazoprevir. [Avoid] [Severe] Study
- Elvitegravir markedly increases the exposure to grazoprevir. [Avoid] [Severe] Study
- Etravirine is predicted to decrease the exposure to grazoprevir. [Avoid] [Mild] [Theoretical]
- HIV- protease inhibitors are predicted to moderately to markedly increase the exposure to grazoprevir. Avoid. [Severe] Study
- Idelalisib is predicted to moderately markedly increase the exposure to grazoprevir. Avoid. [Severe] Study
- Macrolides (clarithromycin) are predicted to moderately markedly increase the exposure to grazoprevir. Avoid. [Severe] Study
- Mitotane is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study
- Modafinil is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study
- Nevirapine is predicted to markedly decrease the exposure to grazoprevir. Avoid. [Severe] Study
- Rifampicin is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study
- St John’s Wort is predicted to markedly decrease the exposure to grazoprevir. Avoid. [Severe] Study
- Grazoprevir increases the exposure to statins (atorvastatin). Adjust atorvastatin dose, p. 134. [Moderate] [Study]
- Grazoprevir is predicted to increase the exposure to statins (fluvastatin). Avoid fluvastatin dose, p. 134. [Unknown] [Theoretical]
- Grazoprevir increases the exposure to statins (rosuvastatin). Avoid rosuvastatin dose, p. 135. [Moderate] [Study]
- Grazoprevir is predicted to increase the exposure to statins (simvastatin). Adjust simvastatin dose, p. 136. [Unknown] [Theoretical]
- Grazoprevir is predicted to increase the concentration of sunitinib. Use with caution and adjust dose. [Moderate] [Theoretical]
- Grazoprevir increases the exposure to tacrolimus. [Moderate] Study

Griseofulvin

ROUTE-SPECIFIC INFORMATION

- Alcohol (beverage) potentially causes a disulfiram-like reaction when given with griseofulvin. [Moderate] [Anecdotal]
- Antiepileptics (phenobarbital, primidone) decrease the effects of griseofulvin. [Moderate] Study
- Griseofulvin potentially decreases the efficacy of combined hormonal contraceptives. ForFSRH guidance, see Contraceptives, interactions p. 516. [Severe] [Anecdotal]
- Griseofulvin potentially decreases the anticoagulant effect of coumarins. [Moderate] [Anecdotal]
- Griseofulvin potentially decreases the efficacy of desogestrel. For FSRR guidance, see Contraceptives, interactions p. 516. [Severe] [Anecdotal]
- Griseofulvin decreases the efficacy of etonogestrel. ForFSRH guidance, see Contraceptives, interactions p. 516. [Severe] [Anecdotal]
- Griseofulvin potentially decreases the efficacy of oral levonorgestrel. ForFSRH guidance, see Contraceptives, interactions p. 516. [Severe] [Anecdotal]
- Griseofulvin potentially decreases the efficacy of norethisterone. ForFSRH guidance, see Contraceptives, interactions p. 516. [Severe] [Anecdotal]
- Griseofulvin potentially decreases the efficacy of ulipristal. ForFSRH guidance, see Contraceptives, interactions p. 516. [Severe] [Anecdotal]
- Guanethidine decreases the effectiveness of griseofulvin. [Severe] Study
- Benperidol is predicted to decrease the effects of guanethidine. [Moderate] [Theoretical] Also see TABLE 8, p. 875
- Droperidol is predicted to decrease the effects of guanethidine. Monitor and adjust dose. [Moderate] [Theoretical] Also see TABLE 8, p. 875
- Haloperidol is predicted to decrease the antihypertensive effects of guanethidine. Monitor and adjust dose. [Moderate] [Theoretical]
- Monoamine-oxidase A and B inhibitors, irreversible are predicted to decrease the antihypertensive effects of guanethidine. Avoid and for 14 days after stopping the MAOI. [Severe] [Theoretical] Also see TABLE 8, p. 875
- Phenothiazines are predicted to decrease the antihypertensive effects of guanethidine. [Moderate] [Theoretical] Also see TABLE 8, p. 875
- Guanethidine is predicted to increase the effects of sympathomimetics, inotropic (dopamine). [Severe] [Theoretical]
- Guanethidine is predicted to increase the effects of sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). [Moderate] [Study]
- Guanethidine increases the effects of sympathomimetics, vasoconstrictor (metaraminol). [Severe] [Anecdotal]
- Guanethidine increases the effects of sympathomimetics, vasoconstrictor (phenylephrine). [Severe] [Study]
- Tricyclic antidepressants are predicted to decrease the antihypertensive effects of guanethidine. [Moderate] [Study] Also see TABLE 8, p. 875

Guanethidine

- Guanethidine decreases the effectiveness of griseofulvin. [Severe] Study
- Antiarhythmics (dronedarone) are predicted to increase the concentration of guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Antitussives (codeine) increases the effects of sympathomimetics (vasoconstrictor). [Unknown] [Theoretical]
- Anecdotal
- Guanethidine increases the concentration of antiepileptics (valproate). Monitor and adjust dose. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to decrease the concentration of guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Bosantan is predicted to decrease the concentration of guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Chloramphenicol is predicted to increase the exposure to guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Cobicistat is predicted to increase the exposure to guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Crizotinib is predicted to increase the concentration of guanethidine. Adjust guanethidine dose, p. 237. [Moderate] [Theoretical]
- Efavirenz is predicted to decrease the concentration of guanethidine. Adjust dose. [Moderate] [Theoretical]
Cimetidine is predicted to decrease the concentration of guanfacine. Adjust guanfacine dose, p. 237. Moderate Study

Fosaprepitant is predicted to increase the concentration of guanfacine. Moderate Theoretical

Grapefruit juice is predicted to increase the exposure to guanfacine. Avoid. Moderate Theoretical

HIV-protease inhibitors are predicted to increase the exposure to guanfacine. Adjust guanfacine dose, p. 237. Moderate Study

Idealisib is predicted to increase the exposure to guanfacine. Adjust guanfacine dose, p. 237. Moderate Study

Imatinib is predicted to increase the concentration of guanfacine. Adjust guanfacine dose, p. 237. Moderate Theoretical

Macrolides (clarithromycin) are predicted to increase the concentration of guanfacine. Adjust guanfacine dose, p. 237. Moderate Theoretical

Guselkumab ➝ see monoclonal antibodies

H₂ receptor antagonists

cimetidine • famotidine • nizatidine • ranitidine

Cimetidine decreases the clearance of albendazole. Moderate Study

Cimetidine increases the concentration of aminophylline. Adjust dose. Severe Study

Cimetidine slightly increases the exposure to anthracyclines (epirubicin). Avoid. Moderate Study

Cimetidine increases the exposure to antiarrhythmics (amiodarone). Moderate Study

Cimetidine slightly increases the exposure to antiarrhythmics (flecainide). Monitor and adjust dose. Mild Study

Cimetidine increases the exposure to antiarrhythmics (lidocaine). Monitor and adjust dose. Moderate Study

Cimetidine is predicted to increase the exposure to antiarrhythmics (propanofol). Monitor and adjust dose. Moderate Theoretical

Cimetidine transiently increases the concentration of antiepileptics (carbamazepine). Monitor concentration and adjust dose. Moderate Study

H₂ receptor antagonists are predicted to decrease the absorption of antifungals, azoles (itraconazole). Administer itraconazole capsules with an acidic beverage. Moderate Study

H₂ receptor antagonists are predicted to decrease the absorption of antifungals, azoles (ketoconazole). Administer ketoconazole with an acidic beverage. Moderate Study

H₂ receptor antagonists are predicted to decrease the exposure to antifungals, azoles (posaconazole). Avoid use of posaconazole oral suspension. Moderate Study

Cimetidine decreases the clearance of antimalarials (chloroquine). Moderate Study

Cimetidine slightly increases the exposure to antimalarials (quinine). Moderate Study

H₂ receptor antagonists are predicted to decrease the absorption of bosutinib. Moderate Theoretical

Cimetidine slightly increases the exposure to calcium channel blockers (diltiazem, nimodipine). Monitor and adjust dose. Moderate Study

Cimetidine (high-dose) is predicted to increase the exposure to calcium channel blockers (lercanidipine). Moderate Theoretical

Cimetidine moderately increases the exposure to calcium channel blockers (nifedipine). Monitor and adjust dose. Severe Study

Cimetidine increases the exposure to calcium channel blockers (verapamil). Moderate Study

Cimetidine is predicted to slightly increase the exposure to capcetabine. Severe Theoretical

H₂ receptor antagonists are predicted to decrease the decrease of cerititinib. Moderate Theoretical

Cimetidine increases the concentration of ciclosporin. Mild Study

Cimetidine increases the antiangiogenic effect of coumarins. Severe Study

H₂ receptor antagonists are predicted to decrease the exposure to dasatinib. Avoid. Moderate Study

H₂ receptor antagonists are predicted to decrease the absorption of dipyriramole (immediate release tablets). Moderate Theoretical

Cimetidine is predicted to increase the exposure to dopamine receptor agonist (pramipexole). Adjust dose. Moderate Study

H₂ receptor antagonists are predicted to decrease the exposure to erlotinib. Erlotinib should be taken 2 hours before or 10 hours after H₂ receptor antagonists. Moderate Study

Cimetidine increases the concentration of fampridine. Avoid. Severe Theoretical

Cimetidine slightly increases the exposure to fluorouracil. Severe Study

H₂ receptor antagonists are predicted to slightly to moderately decrease the exposure to gefitinib. Moderate Study

H₂ receptor antagonists decrease the exposure to HIV-protease inhibitors (atazanavir). Monitor and adjust dose. Moderate Study

Cimetidine is predicted to decrease the clearance of hydrochlorothiazide. Monitor and adjust dose. Moderate Theoretical

H₂ receptor antagonists are predicted to decrease the absorption of laptatinib. Avoid. Moderate Theoretical

H₂ receptor antagonists are predicted to decrease the exposure to ledipasvir. Adjust dose, see ledipasvir with sofosbuvir p. 416. Moderate Study

Leflunomide is predicted to increase the exposure to H₂ receptor antagonists (cimetidine, famotidine). Moderate Theoretical

Cimetidine increases the concentration of mebendazole. Moderate Study

Cimetidine increases the exposure to metformin. Monitor and adjust dose. Moderate Study

Cimetidine slightly increases the exposure to mirtazapine. Use with caution and adjust dose. Moderate Theoretical

Cimetidine increases the exposure to moclobemide. Adjust moclobemide dose. Mild Study

H₂ receptor antagonists are predicted to decrease the absorption of nilotinib. H₂ receptor antagonists should be taken 10 hours before or 2 hours after nilotinib. Mild Theoretical

Cimetidine increases the clearance of opioids (alfentanil). Use with caution and adjust dose. Severe Study

Cimetidine increases the exposure to opioids (fentanyl). Moderate Study

H₂ receptor antagonists are predicted to decrease the exposure to pazopanib. H₂ receptor antagonists should be taken 10 hours before or 2 hours after pazopanib. Moderate Theoretical

Cimetidine increases the exposure to phenindione. Severe Anecdotal

Cimetidine moderately increases the exposure to praziquantel. Moderate Study

H₂ receptor antagonists are predicted to decrease the exposure to ripovirine. H₂ receptor antagonists should be taken 12 hours before or 4 hours after ripovirine. Severe Study

Cimetidine slightly increases the exposure to roflumilast. Moderate Study
H₂ receptor antagonists (continued)

- H₂ receptor antagonists potentially decrease the exposure to sofosbuvir. Adjust dose, see ledipasvir with sofosbuvir p. 416, sofosbuvir with velpatasvir, and sofosbuvir with velpatasvir and voxilaprevir. [Moderate] Study
- Cimétidine slightly increases the exposure to SSRIs (citalopram, escitalopram). Adjust dose. [Moderate] Study
- Cimétidine slightly increases the exposure to SSRIs (paroxetine, sertraline). [Moderate] Study
- Cimétidine is predicted to increase the risk of toxicity when given with tegafur. [Severe] Theoretical
- Teriflunomide is predicted to increase the exposure to H₂ receptor antagonists (cimetidine, famotidine). [Moderate] Study
- Cimétidine increases the concentration of theophylline. Adjust dose. [Severe] Study
- Cimétidine increases the exposure to tricyclic antidepressants. [Moderate] Study
- H₂ receptor antagonists are predicted to decrease the concentration of velpatasvir. Adjust dose, see sofosbuvir with velpatasvir. [Moderate] Study
- Cimétidine slightly increases the exposure to venlafaxine. [Mild] Study
- Cimétidine slightly increases the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 306. [Mild] Study

Haloperidol → see TABLE 8 p. 875 (hypotension), TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects), TABLE 10 p. 876 (antimuscarinics)  

**FOOD AND LIFESTYLE** Dose adjustment might be necessary if smoking started or stopped during treatment.

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the concentration of haloperidol. Adjust dose. [Moderate] Study → Also see TABLE 11 p. 876
- Haloperidol potentially increases the risk of overheating and dehydration when given with antiepileptics (zonisamide). Avoid in children. [Severe] Theoretical
- Antifungals, azoles (itraconazole) increase the concentration of haloperidol. [Moderate] Study
- Haloperidol is predicted to decrease the effects of dopamine receptor agonists. Avoid. [Moderate] Study → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876 → Also see TABLE 10 p. 876
- Enzalutamide decreases the concentration of haloperidol. [Theoretical]
- Haloperidol potentially opposes the effects of glycerol phenylbutyrate. [Moderate] Theoretical
- Haloperidol is predicted to decrease the antihypertensive effects of guanethidine. Monitor and adjust dose. [Moderate] Theoretical → Also see TABLE 8 p. 875
- HIV-protease inhibitors (ritonavir) are predicted to increase the exposure to haloperidol. [Severe] Theoretical
- Haloperidol decreases the effects of levodopa. [Severe] Study → Also see TABLE 8 p. 875
- Mitotane decreases the concentration of haloperidol. Adjust dose. [Moderate] Study
- Rifampicin decreases the concentration of haloperidol. Adjust dose. [Moderate] Study
- Haloperidol potentially decreases the effects of sodium phenylbutyrate. [Moderate] Anecdotal
- SSRIs (fluoxetine) increase the concentration of haloperidol. Adjust dose. [Moderate] Study
- SSRIs (fluvoxamine) increase the concentration of haloperidol. Adjust dose. [Moderate] Study
- Venlafaxine slightly increases the exposure to haloperidol. [Severe] Study → Also see TABLE 9 p. 876 → Also see TABLE 11 p. 876
- Heparin (unfractionated) → see TABLE 16 p. 878 (increased serum potassium), TABLE 3 p. 874 (anticoagulant effects)
- Ranibizumab increases the risk of bleeding events when given with heparin (unfractionated). [Severe] Theoretical

**Hepatitis B immunoglobulin** → see immunoglobulins

**HIV-protease inhibitors** → see TABLE 9 p. 876 (QT-interval prolongation)

- Caution on concurrent use of atazanavir, lopinavir with ritonavir, and ritonavir with drugs that prolong the PR interval.
- Concurrent use of saquinavir with drugs that prolong the PR interval is contra-indicated.
- Caution with concurrent use of tipranavir with drugs that increase risk of bleeding.
- Tipranavir slightly decreases the exposure to acaivir. Avoid. [Severe] Study
- HIV-protease inhibitors are predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. [Severe] Study
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to alfatinib. Separate administration by 12 hours. [Moderate] Study
- Ritonavir is predicted to decrease the exposure to agomelatine. [Moderate] Theoretical
- Ritonavir decreases the exposure to albendazole. [Moderate] Study
- HIV-protease inhibitors are predicted to markedly increase the exposure to aldosterone antagonists (spironolactone). Avoid. [Severe] Study
- HIV-protease inhibitors (lopinavir, saquinavir) are predicted to increase the exposure to aliskiren. [Moderate] Theoretical
- Ritonavir decreases the exposure to amiflamine. Adjust dose. [Moderate] Study
- Ritonavir is predicted to decrease the exposure to anaesthetics, local (ropivacaine). [Moderate] Theoretical
- Antacids are predicted to decrease the absorption of atazanavir. Atazanavir should be taken 2 hours before or 1 hour after antacids. [Severe] Theoretical
- Antacids are predicted to decrease the absorption of ritonavir. Separate administration by 2 hours. [Moderate] Study
- HIV-protease inhibitors are predicted to increase the exposure to antiarrhythmics (amiodarone). Avoid. [Severe] Study
- HIV-protease inhibitors are predicted to decrease the exposure to antiarrhythmics (disopyramide). [Severe] Theoretical → Also see TABLE 9 p. 876
- HIV-protease inhibitors very markedly increase the exposure to antiarrhythmics (dronedarone). Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Ritonavir is predicted to increase the exposure to antiarrhythmics (flexinidine). Avoid or monitor side effects. [Severe] Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to antiarrhythmics (lidocaine). Avoid. [Severe] Study
- HIV-protease inhibitors are predicted to increase the exposure to antiarrhythmics (propafenone). Monitor and adjust dose. [Severe] Study
- HIV-protease inhibitors are predicted to increase the exposure to antiepileptics (carbamazepine) and antiepileptics (carbamazepine) are predicted to decrease the exposure to HIV-protease inhibitors. [Severe] Theoretical
- HIV-protease inhibitors are predicted to affect the exposure to antiepileptics (fosphenytoin, phenytoin) and antiepileptics (fosphenytoin, phenytoin) decrease the concentration of HIV-protease inhibitors. [Severe] Theoretical
- Ritonavir slightly decreases the exposure to antiepileptics (lamotrigine). [Severe] Study
HIV-protease inhibitors are predicted to very slightly increase the exposure to antiepileptics (perampanel). [Mild] Study

HIV-protease inhibitors are predicted to slightly increase the concentration of antiepileptics (phenobarbital, primidone) and antiepileptics (phenobarbital, primidone) are predicted to decrease the concentration of HIV-protease inhibitors. [Severe] Theoretical

Ritonavir is predicted to decrease the concentration of antiepileptics (valproate). [Severe] Antiepileptic

Antifungals, azoles (fluconazole) slightly increase the exposure to tipranavir. Avoid or adjust dose. [Moderate] Study

Antifungals, azoles (miconazole) are predicted to increase the concentration of HIV-protease inhibitors. Use with caution and adjust dose. [Moderate] Theoretical

Antifungals, azoles (posaconazole) are predicted to increase the exposure to antifungals, azoles (isavuconazole). Avoid or monitor side effects. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to antifungals, azoles (itraconazole). Use with caution and adjust dose. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to antifungals, azoles (ketoconazole). Use with caution and adjust dose. [Moderate] Study

HIV-protease inhibitors are predicted to affect the exposure to antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole) potentially affect the exposure to HIV-protease inhibitors. [Severe] Study → Also see TABLE 9 p. 876

HIV-protease inhibitors are predicted to increase the exposure to antifungals, azoles (itraconazole) and antifungals, azoles (itraconazole) are predicted to affect the concentration of antimalarials (atovaquone). Avoid if boosted with ritonavir. [Moderate] Study

HIV-protease inhibitors are predicted to increase the concentration of antimalarials (piperaquaine). [Severe] Theoretical

HIV-protease inhibitors are predicted to decrease the exposure to antimalarials (proguanil). Avoid. [Moderate] Study

HIV-protease inhibitors are predicted to affect the exposure to antimalarials (quinine). [Severe] Study → Also see TABLE 9 p. 876

HIV-protease inhibitors are predicted to increase the exposure to apalutamide. [Mild] Study → Also see TABLE 9 p. 876

Ritonavir is predicted to increase the exposure to apixaban. Avoid. [Severe] Theoretical

HIV-protease inhibitors are predicted to markedly increase the exposure to aprepitant. [Moderate] Study

HIV-protease inhibitors are predicted to slightly increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to axitinib. Avoid or adjust dose. [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to bedaquiline. Avoid prolong use. [Mild] Study → Also see TABLE 9 p. 876

HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to beta blockers, non-selective (nadolol). [Moderate] Study

Ritonavir is predicted to increase the exposure to beta blockers, selective (metoprolol). [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to beta, agonists (salmeterol). Avoid. [Severe] Study

Atazanavir moderately increases the exposure to bictegravir. Avoid. [Severe] Study

HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to bictegravir. Use with caution or avoid. [Moderate] Theoretical

HIV-protease inhibitors slightly increase the exposure to bortezomib. [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to bosentan. [Severe] Study

HIV-protease inhibitors are predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. [Severe] Study → Also see TABLE 9 p. 876

HIV-protease inhibitors are predicted to increase the exposure to brigitinib. Adjust brigitinib dose. [Severe] Study

Ritonavir is predicted to decrease the exposure to bupropion. [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to bupropine. Adjust bupropine dose. [Severe] Study

HIV-protease inhibitors slightly increase the exposure to cabazantinib. [Moderate] Study → Also see TABLE 9 p. 876

Ritonavir is predicted to moderately increase the clearance of caffeine citrate. Monitor and adjust dose. [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study

HIV-protease inhibitors are predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). [Severe] Study

HIV-protease inhibitors are predicted to markedly increase the exposure to calcium channel blockers (lercanidipine). Avoid. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical

HIV-protease inhibitors are predicted to moderately increase the exposure to cariprazine. Avoid. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to ceritinib. Avoid or adjust ceritinib dose. [Severe] Study → Also see TABLE 9 p. 876

HIV-protease inhibitors increase the concentration of ciclosporin. [Severe] Study

HIV-protease inhibitors are predicted to moderately increase the exposure to ciclosporin. Adjust ciclosporin dose. Adjust ciclosporin dose. [Moderate] Study

HIV-protease inhibitors are predicted to moderately increase the exposure to cladribine. Avoid. [Severe] Study

HIV-protease inhibitors are predicted to increase the concentration of cladribine. Avoid or monitor for toxicity. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study

Atazanavir (unboosted) increases the exposure to combined hormonal contraceptives. Adjust dose. [Severe] Study

Ritonavir is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRM guidance, see Contraceptives, interactions p. 516. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to corticosteroids (beclometasone) (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

HIV-protease inhibitors are predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

HIV-protease inhibitors are predicted to affect the anticoagulant effect of coumarins. [Moderate] Study

HIV-protease inhibitors are predicted to moderately increase the exposure to crizotinib. Avoid. [Moderate] Study

Ritonavir is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRM guidance, see Contraceptives, interactions p. 516. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to dabigatran. Avoid. [Severe] Study

HIV-protease inhibitors are predicted to increase the exposure to dabrafenib. Use with caution or avoid. [Moderate] Study

HIV-protease inhibitors are predicted to markedly increase the exposure to darifenacin. Avoid. [Severe] Study

Dasabuvir (with ombitasvir, paritaprevir, and ritonavir) decreases the concentration of darunavir. Avoid or adjust dose. [Moderate] Study
HIV-protease inhibitors (continued)

- HIV-protease inhibitors are predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study  Also see TABLE 9 p. 876
- HIV-protease inhibitors very slightly increase the exposure to delamin. (Severe) Study  Also see TABLE 9 p. 876
- Ritonavir is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- Ritonavir is predicted to increase the exposure to diazepam. Avoid. (Moderate) Theoretical
- Didanosine (buffered) decreases the exposure to atazanavir. Didanosine should be taken 2 hours after atazanavir. (Severe) Study
- Didanosine (buffered) is predicted to decrease the exposure to darunavir (boosted with ritonavir). Didanosine should be taken 1 hour before or 2 hours after darunavir. (Moderate) Theoretical
- Tipranavir decreases the exposure to didanosine. Separate administration by 2 hours. (Moderate) Study
- Ritonavir increases the concentration of digoxin. Adjust dose and monitor concentration. (Severe) Study
- Fosamprenavir (boosted with ritonavir) slightly decreases the exposure to dolutegravir. Avoid if resistant to HIV-integrase inhibitors. (Severe) Study
- Tipranavir moderately decreases the exposure to dolutegravir. Refer to specialist literature. (Severe) Study
- HIV-protease inhibitors increase the risk of QT-prolongation when given with domperidone. Avoid. (Severe) Study
- HIV-protease inhibitors increase the exposure to dopamine receptor agonists (bromocriptine). (Severe) Study
- HIV-protease inhibitors are predicted to increase the concentration of dopamine receptor agonists (cabergoline). (Moderate) Anecdotal
- HIV-protease inhibitors are predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. (Moderate) Theoretical
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to slightly increase the exposure to edoxaban. (Severe) Theoretical
- Efavirenz decreases the exposure to HIV-protease inhibitors. Refer to specialist literature. (Severe) Study  Also see TABLE 9 p. 876
- HIV-protease inhibitors are predicted to markedly increase the exposure to elagritrptan. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to elagritrptan. Avoid or adjust dose—consult product literature. (Severe) Study
- HIV-protease inhibitors (atazanavir, lopinavir) (boosted with ritonavir) increase the concentration of elavatrigitrptan. Refer to specialist literature. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to encaferelin. Avoid or monitor. (Severe) Study  Also see TABLE 9 p. 876
- HIV-protease inhibitors are predicted to increase the risk of ergotism when given with ergometrine. Avoid. (Severe) Theoretical
- HIV-protease inhibitors are predicted to increase the risk of ergotism when given with ergotamine. Avoid. (Severe) Theoretical
- HIV-protease inhibitors are predicted to slightly increase the exposure to elotristib. Use with caution and adjust dose. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to esketamine. Adjust dose. (Moderate) Study
- Ritonavir is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- Etravirine increases the exposure to fosamprenavir (boosted with ritonavir). Refer to specialist literature. (Moderate) Study
- Tipranavir decreases the exposure to etravirine. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the concentration of everolimus. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. (Severe) Study
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to fidaxomycin. Avoid. (Moderate) Study
- Ritonavir is predicted to increase the exposure to fluazepton. Avoid. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to fosaprepitant. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to gefitinib. (Moderate) Study
- HIV-protease inhibitors (atazanavir, darunavir, lopinavir) (boosted with ritonavir) increase the exposure to glecaptreon. Avoid. (Severe) Study
- Ritonavir increases the exposure to glecaptreon. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to moderately to markedly increase the exposure to grazopretron. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to guanafacine. Adjust guanafacine dose. p. 237. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to imatinib. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the risk of toxicity when given with irinoctcan. Avoid. (Moderate) Study
- Ritonavir is predicted to decrease the exposure to iron chelators (deferasirox). Monitor serum ferritin and adjust dose. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to ivabradine. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to ivacafactor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to lapatinib. Avoid. (Moderate) Study  Also see TABLE 9 p. 876
- Tipranavir (boosted with ritonavir) is predicted to decrease the exposure to leupasb. Avoid. (Severe) Theoretical
- HIV-protease inhibitors (atazanavir, lopinavir) (boosted with ritonavir) are predicted to increase the concentration of letomervar. (Moderate) Study
- Ritonavir is predicted to decrease the concentration of letomervar. (Moderate) Theoretical
- Ritonavir is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- HIV-protease inhibitors are predicted to markedly increase the exposure to lomitapide. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to lurasidone. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to macitentan. (Moderate) Study
- HIV-protease inhibitors (clarithromycin) increase the exposure to saquinavir and saquinavir increases the exposure to macitentan (clarithromycin). Avoid. (Severe) Study  Also see TABLE 9 p. 876
- HIV-protease inhibitors (erythromycin) are predicted to increase the exposure to saquinavir. Avoid. (Severe) Theoretical  Also see TABLE 9 p. 876
- Atazanavir is predicted to increase the exposure to macitentan (clarithromycin). Adjust dose in renal impairment. (Severe) Study
- Ritonavir increases the exposure to macitentan (clarithromycin). Adjust dose in renal impairment. (Severe) Study.
HIV-protease inhibitors – HIV-protease inhibitors

- Tipranavir (boosted with ritonavir) increases the exposure to macrolides (clarithromycin) and macrolides (clarithromycin) increase the exposure to tipranavir (boosted with ritonavir). Monitor; adjust dose in renal impairment. (Severe) Study
- HIV-protease inhibitors (darunavir, fosamprenavir, lopinavir) (boosted with ritonavir) are predicted to increase the exposure to macrolides (clarithromycin). Adjust dose in renal impairment. (Severe) Study
- HIV-protease inhibitors (atazanavir, darunavir, fosamprenavir, lopinavir, ritonavir, tipranavir) are predicted to increase the exposure to macrolides (erythromycin). (Severe) Theoretical
- Darunavir (boosted with ritonavir) markedly increases the exposure to maraviroc. Refer to specialist literature. (Severe) Study
- Maraviroc potentially decreases the exposure to fosamprenavir and fosamprenavir potentially decreases the exposure to maraviroc. Avoid. (Severe) Study
- HIV-protease inhibitors (atazanavir, saquinavir) moderately to markedly increase the exposure to maraviroc. Refer to specialist literature. (Severe) Study
- Lopinavir (boosted with ritonavir) moderately increases the exposure to maraviroc. Refer to specialist literature. (Severe) Study
- Ritonavir markedly increases the exposure to maraviroc. Refer to specialist literature. (Severe) Study
- Ritonavir is predicted to decrease the exposure to melatonin. (Moderate) Theoretical
- Ritonavir is predicted to increase the clearance of mexiletine. Monitor and adjust dose. (Moderate) Study
- HIV-protease inhibitors are predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. (Severe) Study
- HIV-protease inhibitors are predicted to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to mirtazapine. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to modafinil. (Mild) Theoretical
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the risk of neutropenia when given with monoclonal antibodies (brentuximab vedotin). Monitor and adjust dose. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to monoclonal antibodies (trastuzumab emtansine). Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to markedly increase the exposure to naloxegol. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to netupitant. (Moderate) Study
- Nevirapine decreases the exposure to HIV-protease inhibitors. Refer to specialist literature. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to nitazoxanide. Adjust dose. (Moderate) Study
- HIV-protease inhibitors are predicted to moderately increase the exposure to nilotinib. Avoid. (Severe) Study → Also see TABLE 9 p. 876
- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to nintedanib. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to nitisinone. Adjust dose. (Moderate) Theoretical
- Ritonavir is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Aneclotal
- Ritonavir is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Ombitasvir (in fixed-dose combination with dasabuvir) decreases the concentration of darunavir. Avoid or adjust dose. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. (Severe) Study
- HIV-protease inhibitors (boosted with ritonavir) are predicted to decrease the exposure to opioids (methadone). (Moderate) Study → Also see TABLE 9 p. 876
- Ritonavir is predicted to decrease the concentration of opioids (morphine). (Moderate) Theoretical
- Ritonavir increases the risk of CNS toxicity when given with opioids (pethidine). Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to ospemifene. Avoid in poor CYP2C9 metabolisers. (Moderate) Study
- HIV-protease inhibitors are predicted to increase the exposure to oxybutynin. (Mild) Study
- HIV-protease inhibitors are predicted to increase the exposure to palbociclib. Avoid or adjust palbociclib dose. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. (Moderate) Study → Also see TABLE 9 p. 876
- Atazanavir (boosted with ritonavir) markedly increases the exposure to paritaprevir. Avoid or give unboosted. (Moderate) Study
- Darunavir (boosted with ritonavir) slightly decreases the exposure to paritaprevir. Avoid or give unboosted. (Moderate) Study
- HIV-protease inhibitors (fosamprenavir, tipranavir) (boosted with ritonavir) are predicted to increase the exposure to paritaprevir. Avoid. (Severe) Study
- Lopinavir (boosted with ritonavir) moderately increases the exposure to paritaprevir. Avoid or give unboosted. (Severe) Study
- Saquinavir is predicted to increase the exposure to paritaprevir (in fixed-dose combination). Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. (Moderate) Study → Also see TABLE 9 p. 876
- HIV-protease inhibitors are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. (Severe) Study → Also see TABLE 9 p. 876
- HIV-protease inhibitors are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil, tadalafil). Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. (Severe) Study → Also see TABLE 9 p. 876
- HIV-protease inhibitors are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Use with caution or avoid. (Severe) Study
- HIV-protease inhibitors (atazanavir, lopinavir) (boosted with ritonavir) increase the exposure to pibrentasvir. Avoid. (Severe) Study
- Ritonavir potentially increases the exposure to pibrentasvir. (Severe) Theoretical
- Saquinavir is predicted to increase the exposure to pibrentasvir. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to pimozide. Avoid. (Severe) Study → Also see TABLE 9 p. 876
- Ritonavir is predicted to decrease the exposure to pirenidone. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. (Moderate) Study
- HIV-protease inhibitors are predicted to moderately increase the exposure to praziquantel. (Mild) Study
- Proton pump inhibitors decrease the exposure to atazanavir. Avoid or adjust dose. (Severe) Study
- Proton pump inhibitors increase the exposure to saquinavir. Avoid. (Severe) Study
- Tipranavir decreases the exposure to proton pump inhibitors. Avoid. (Severe) Study
- HIV-protease inhibitors are predicted to increase the exposure to quetiapine. Avoid. (Severe) Study
- Atazanavir increases the exposure to raltegravir (high-dose). Avoid. (Moderate) Study
- Darunavir increases the risk of rash when given with raltegravir. (Moderate) Study
HIV-protease inhibitors (continued)

▶ Fosamprenavir (boosted with ritonavir) decreases the exposure to raltegravir and raltegravir decreases the exposure to fosamprenavir (boosted with ritonavir). Avoid. [Severe] Study
▶ Tipranavir (boosted with ritonavir) is predicted to decrease the exposure to raltegravir (high-dose). Avoid. [Moderate] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to ranolazine. Avoid. [Severe] Study  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to rifabutin. Avoid. [Severe] Study  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to ripafibutin. Avoid. [Severe] Study
▶ Tipranavir markedly increases the exposure to rifabutin. Avoid or adjust dose. [Severe] Study
▶ Rifampicin is predicted to moderately to markedly decrease the exposure to HIV-protease inhibitors (atazanavir, darunavir, fosamprenavir, fosamprenavir, lopinavir, saquinavir, tipranavir) (boosted with ritonavir) increase the exposure to rifabutin. Monitor and adjust dose. [Severe] Study
▶ Ritonavir markedly increases the exposure to rifabutin. Avoid or adjust dose. [Severe] Study
▶ Rifampicin is predicted to markedly decrease the exposure to rifapentine. Adjust dose. [Moderate] Study  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to rifapentine. Adjust dose and monitor side effects. [Moderate] Study
▶ HIV-protease inhibitors are predicted to increase the concentration of sirolimus. Avoid. [Severe] Study
▶ Tipranavir is predicted to decrease the exposure to sofosbuvir. Avoid. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to sofosbuvir. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the concentration of sirolimus. Avoid. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to SSRIs (dapoxetine). Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. [Severe] Study
▶ St John's Wort is predicted to decrease the exposure to HIV-protease inhibitors. Avoid. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to statins (atrovasstatin). Avoid or adjust dose and monitor cholesterolyis. [Severe] Study
▶ HIV-protease inhibitors slightly to moderately increase the exposure to statins (rosuvastatin). Avoid or adjust dose. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to statins (simvastatin). Avoid or adjust dose. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to simvastatin. Avoid or adjust simvastatin dose. [Moderate] Study  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the concentration of tacrolimus. Monitor and adjust dose. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to taxanes (cabazitaxel). Avoid. [Severe] Study
▶ HIV-protease inhibitors are predicted to moderately increase the exposure to taxanes (docetaxel). Avoid or adjust dose. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to taxanes (paclitaxel). [Severe] Theoretical
▶ HIV-protease inhibitors are predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical
▶ HIV-protease inhibitors (atazanavir, darunavir, lopinavir) increase the exposure to tenofovir alafenamide. Avoid or adjust dose. [Moderate] Study
▶ HIV-protease inhibitors are predicted to decrease the exposure to tenofovir alafenamide. Avoid. [Moderate] Theoretical
▶ HIV-protease inhibitors (atazanavir, darunavir, lopinavir) are predicted to increase the risk of renal impairment when given with tenofovir disoproxil. [Severe] Anecdotal
▶ HIV-protease inhibitors are predicted to increase the exposure to tezacafar. Adjust tezacafar with ivacafar to 190 mg with potent inhibitors of CYP3A4. [Severe] Study
▶ Ritonavir is predicted to decrease the exposure to theophylline. Adjust dose. [Moderate] Study
▶ Ritonavir decreases the concentration of thyroid hormones (levothyroxine). MHR advises monitor TSH for at least one month after starting or stopping ritonavir. [Moderate] Anecdotal
▶ HIV-protease inhibitors are predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study
▶ Ritonavir moderately decreases the exposure to tizanidine. [Mild] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to tolterodine. Avoid. [Severe] Study  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. [Severe] Study
▶ HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to totopecan. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to toremifene. [Moderate] Theoretical  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to trabectedin. Avoid or adjust dose. [Severe] Theoretical
▶ HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the concentration of trametinib. [Moderate] Theoretical
▶ HIV-protease inhibitors are predicted to moderately increase the exposure to trazodone. Avoid or adjust dose. [Moderate] Study
▶ HIV-protease inhibitors (ritonavir, tipranavir) are predicted to increase the exposure to tricyclic antidepressants. [Moderate] Theoretical
▶ HIV-protease inhibitors (atazanavir, darunavir, fosamprenavir, lopinavir, saquinavir, tipranavir) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Severe] Study
▶ Ritonavir decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
▶ Tipranavir is predicted to increase the exposure to velpatasvir. [Severe] Theoretical
▶ HIV-protease inhibitors are predicted to increase the exposure to vemurafenib. [Severe] Theoretical  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. [Severe] Study
▶ HIV-protease inhibitors are predicted to increase the exposure to vinflazane. [Moderate] Study  Also see TABLE 9 p. 876
▶ HIV-protease inhibitors are predicted to increase the exposure to vitamin D substances (paricalcitol). [Moderate] Study
▶ Atazanavir (boosted with ritonavir) increases the concentration of voxilaprevir. Avoid. [Severe] Study
▶ Lopinavir (boosted with ritonavir) is predicted to increase the concentration of voxilaprevir. Avoid. [Severe] Theoretical
▶ Tipranavir (boosted with ritonavir) is predicted to increase the concentration of voxilaprevir. [Severe] Theoretical
Hydroxychloroquine is predicted to decrease the effects of vitamin K antagonists (warfarin, acenocoumarol, phenprocoumon), but not vitamin K antagonists (nimodipine, diltiazem). Avoid. Study

Hydroxychloroquine is predicted to decrease the risk of haematological toxicity when given with penicillamine. Avoid. Theoretical

Hydroxychloroquine is predicted to increase the risk of heart failure when given with amiodarone. Avoid. Theoretical

Hydroxychloroquine is predicted to increase the risk of thrombocytopenia when given with ciprofloxacin, clindamycin (oral), clindamycin (IV), levofloxacin, moxifloxacin, norfloxacin, ofloxacin, piperacillin/tazobactam, quinupristin/dalfopristin, rifampicin, trimethoprim, vancomycin. Avoid. Theoretical

Hydroxychloroquine is predicted to increase the risk of ototoxicity when given with aminoglycosides (amikacin, gentamicin, tobramycin, neomycin, streptomycin). Avoid. Theoretical

Hydroxychloroquine is predicted to increase the risk of dermatomyositis when given with cobicistat. Avoid. Theoretical

Hydroxychloroquine, antimalarials, chloroquine, primaquine, hydroxychloroquine, quinine are predicted to increase the risk of bone fracture when given with bisphosphonates. Avoid. Theoretical

Hydroxychloroquine is predicted to increase the risk of cardiovascular events when given with verapamil. Avoid. Study

Hydroxychloroquine is predicted to increase the risk of retinopathy when given with vitamin A. Avoid. Study

Hydroxychloroquine is predicted to increase the risk of phototoxicity when given with isoniazid. Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with hydroxyurea. Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with hydroxyurea, chlorambucil, 6-mercaptopurine, mercaptopurine, methotrexate. Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with cyclosporine. Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with cyclophosphamide, azathioprine, 6-mercaptopurine, mercaptopurine. Avoid. Theoretical

Hydroxychloroquine increases the risk of toxicity when given with retinoic acid. Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with retinoids. Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with immunomodulators (cyclosporine, tacrolimus, mycophenolate mofetil, sirolimus, thalidomide). Avoid. Study

Hydroxychloroquine increases the risk of toxicity when given with extracorporeal membrane oxygenation (ECMO). Avoid. Study
Ibrutinib (continued)

- Macrolides (erythromycin) are predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose with moderate inhibitors of CYP3A4. [Severe] Study

- Mitotane is predicted to decrease the exposure to ibrutinib. Avoid or adjust ibrutinib dose. [Severe] Study Also see TABLE 15 p. 877

- Netupitant is predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose with moderate inhibitors of CYP3A4. [Severe] Study

- Nilotinib is predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose with moderate inhibitors of CYP3A4. [Severe] Study Also see TABLE 15 p. 877

- Quinolones (ciprofloxacin) are predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose. [Severe] Study

- Rifampicin is predicted to decrease the exposure to ibrutinib. Avoid or adjust ibrutinib dose. [Severe] Study

- St John’s Wort is predicted to decrease the exposure to ibrutinib. Avoid. [Severe] Theoretical

- Ibuprofen is predicted to decrease the efficacy of ibatibant and icatibant is predicted to decrease the efficacy of ACE inhibitors. Avoid. [Moderate] Theoretical

- Ibrutinib is predicted to decrease the efficacy of icatibant and icatibant is predicted to decrease the efficacy of ACE inhibitors. Avoid. [Moderate] Theoretical

- Ibrutinib is predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose. [Severe] Study

- Ibrutinib is predicted to markedly increase the exposure to aldosterone antagonists (eplerenone). Avoid. [Severe] Study

- Ibrutinib increases the exposure to alprazolam. Use with caution or avoid. [Moderate] Study

- Ibrutinib is predicted to increase the exposure to alpha blockers (alfuzosin, tamsulosin). Use with caution or avoid. [Moderate] Study

- Ibrutinib is predicted to increase the exposure to alpha blockers (doxazosin). [Moderate] Study

- Ibrutinib moderately increases the exposure to alprazolam. Avoid. [Moderate] Study

- Ibrutinib is predicted to increase the exposure to antihistamines (amiodarone). Avoid. [Moderate] Theoretical

- Ibrutinib is predicted to increase the exposure to antihistamines (dronedarone). Avoid. [Severe] Study

- Ibrutinib is predicted to increase the exposure to antihistamines (propafenone). Monitor and adjust dose. [Severe] Study

- Ibrutinib is predicted to increase the exposure to anticholinesterases, centrally acting (galantamine). Monitor and adjust dose. [Moderate] Study

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to idelalisib. Avoid. [Severe] Study

- Ibrutinib is predicted to very slightly increase the exposure to antiepileptics (perampanel). [Mild] Study

- Ibrutinib is predicted to increase the exposure to antifungals, azoles (itraconazole). Avoid or monitor side effects. [Severe] Study

- Ibrutinib is predicted to increase the exposure to antihistamines, non-sedating (mizolastine). Avoid. [Severe] Study

- Ibrutinib is predicted to increase the exposure to antihistamines, non-sedating (rupatadine). Avoid. [Moderate] Study

- Ibrutinib is predicted to increase the concentration of antimalarials (piperazine). [Severe] Theoretical

- Ibrutinib is predicted to increase the exposure to apalutamide. [Mild] Study

- Ibrutinib is predicted to markedly increase the exposure to aripiprazole. Adjust aripiprazole dose, p 255. [Moderate] Study

- Ibrutinib is predicted to increase the exposure to aripiprazole. Adjust dose. [Moderate] Study Also see TABLE 15 p. 877

- Ibrutinib is predicted to increase the exposure to bedaquiline. Avoid prolonged use. [Mild] Study

- Ibrutinib is predicted to increase the exposure to beta, agonists (salmeterol). Avoid. [Severe] Study

- Ibrutinib slightly increases the exposure to bortezomib. [Moderate] Study Also see TABLE 15 p. 877

- Bosantan is predicted to decrease the exposure to idelalisib. Avoid. [Moderate] Theoretical

- Ibrutinib is predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. [Severe] Study Also see TABLE 15 p. 877

- Ibrutinib is predicted to increase the exposure to brigatinib. Adjust brigatinib dose. [Severe] Study

- Ibrutinib is predicted to increase the exposure to buspirone. Adjust buspirone dose. [Severe] Study

- Ibrutinib slightly increases the exposure to cabozantinib. [Moderate] Study Also see TABLE 15 p. 877

- Ibrutinib is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Study

- Ibrutinib is predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). [Severe] Study

- Ibrutinib is predicted to markedly increase the exposure to calcium channel blockers (lercanidipine). Avoid. [Severe] Study

- Ibrutinib is predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. [Moderate] Theoretical

- Ibrutinib is predicted to moderately increase the exposure to cariprazine. Avoid. [Severe] Study

- Ibrutinib is predicted to increase the exposure to ceritinib. Avoid or adjust ceritinib dose. [Severe] Study Also see TABLE 15 p. 877

- Ibrutinib increases the concentration of ciclosporin. [Severe] Study

- Ibrutinib is predicted to moderately increase the exposure to cilostazol. Adjust cilostazol dose. [Moderate] Study

- Ibrutinib is predicted to moderately increase the exposure to cinacalcet. Adjust dose. [Moderate] Study

- Ibrutinib is predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. [Severe] Study

- Ibrutinib is predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. [Severe] Study

- Ibrutinib is predicted to increase the exposure to corticosteroids (beclometasonide) (risk with beclometasone is likely to be lower than with other corticosteroids). [Moderate] Theoretical

- Ibrutinib is predicted to increase the exposure to corticosteroids (betamethasone, budesonide, budesonide, ciclesonide, deflazacort, dexamethasone, fludrocortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. [Severe] Study

- Ibrutinib is predicted to moderately increase the exposure to crizotinib. Avoid. [Moderate] Study Also see TABLE 15 p. 877

- Ibrutinib is predicted to increase the exposure to dabrafenib. Use with caution or avoid. [Moderate] Study Also see TABLE 15 p. 877

- Ibrutinib is predicted to markedly to very markedly increase the exposure to darifenacin. Avoid. [Severe] Study

- Ibrutinib is predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. [Severe] Study Also see TABLE 15 p. 877

- Ibrutinib very slightly increases the exposure to delamanid. [Severe] Study

- Ibrutinib increases the risk of QT-prolongation when given with domperidone. Avoid. [Severe] Study

- Ibrutinib increases the exposure to dopamine receptor agonists (bromocriptine). [Severe] Study

- Ibrutinib is predicted to increase the concentration of dopamine receptor agonists (cabergoline). [Mild] Aneocolial

- Ibrutinib is predicted to increase the exposure to doravirine. [Mild] Study

- Ibrutinib is predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. [Moderate] Theoretical

- Efavirenz is predicted to decrease the exposure to idelalisib. Avoid. [Moderate] Theoretical

- Ibrutinib is predicted to markedly increase the exposure to eletriptan. Avoid. [Severe] Study
Idelalisib is predicted to increase the exposure to elisibastat. Avoid or adjust dose—consult product literature. [Severe] Study

Idelalisib is predicted to increase the exposure to encorafenib. Avoid or monitor. [Severe] Study

Enzalutamide is predicted to decrease the exposure to idelalisib. Avoid. [Severe] Study

Idelalisib is predicted to increase the risk of ergotism when given with ergometrine. Avoid. [Severe] Theoretical

Idelalisib is predicted to increase the risk of ergotism when given with ergotamine. Avoid. [Severe] Theoretical

Idelalisib is predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. [Moderate] Study

Idelalisib is predicted to increase the exposure to esketamine. Adjust dose. [Moderate] Study

Idelalisib is predicted to increase the concentration of everolimus. Avoid. [Severe] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to moderately increase the exposure to fesoterodine. Adjust fesoterodine dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. [Severe] Study

Idelalisib is predicted to increase the exposure to fosaprepitant. [Moderate] Theoretical

Idelalisib is predicted to increase the exposure to gefitinib. [Moderate] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to moderately to markedly increase the exposure to gefitinib. Avoid potent inhibitors of CYP3A4 or adjust gefitinib dose. [Severe] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to guanfacine. Adjust guanfacine dose, p. 237. [Moderate] Study

Idelalisib is predicted to very markedly increase the exposure to irinotecan. Avoid. [Severe] Study

Idelalisib is predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to ivabradine. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study

Idelalisib is predicted to increase the exposure to lapatinib. Avoid. [Moderate] Study

Idelalisib is predicted to markedly increase the exposure to lomitapide. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to lurasidone. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to macitentan. [Moderate] Study

Idelalisib markedly increases the exposure to maraviroc. Adjust dose. [Severe] Theoretical

Idelalisib is predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. [Severe] Study

Idelalisib is predicted to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. [Severe] Study

Idelalisib is predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. [Moderate] Study

Idelalisib is predicted to increase the exposure to mirtazapine. [Moderate] Study

Mitotane is predicted to decrease the exposure to idelalisib. Avoid. [Severe] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to mofafenil. [Mild] Theoretical

Idelalisib is predicted to increase the exposure to monoclonal antibodies (trastuzumab emtansine). Avoid. [Severe] TheoreticalAlso see TABLE 15 p. 877

Idelalisib is predicted to markedly increase the exposure to naloxone. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to netupitant. [Moderate] Study

Nevirapine is predicted to decrease the exposure to idelalisib. Avoid. [Moderate] Theoretical

Idelalisib is predicted to moderately increase the exposure to nilotinib. Avoid. [Severe] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to nitidine. Adjust dose. [Moderate] Theoretical

Idelalisib is predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. [Moderate] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. [Severe] Study

Idelalisib is predicted to increase the exposure to opioids (methadone). [Severe] Theoretical

Idelalisib is predicted to increase the exposure to ospemifene. Avoid in poor CYP2C9 metabolisers. [Moderate] Study

Idelalisib is predicted to increase the exposure to oxybutynin. [Mild] Study

Idelalisib is predicted to increase the exposure to palbociclib. Avoid or adjust palbociclib dose. [Severe] Study

Idelalisib is predicted to increase the exposure to panobinostat. Adjust panobinostat dose, in hepatic impairment avoid. [Moderate] Study. Also see TABLE 15 p. 877

Paritaprevir is predicted to increase the exposure to idelalisib. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. [Severe] Study

Idelalisib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Use with caution or avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to pimozide. Avoid. [Severe] Study

Idelalisib is predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

Idelalisib is predicted to moderately increase the exposure to paziquantel. [Mild] Study

Idelalisib is predicted to increase the exposure to quetiapine. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to ranolazine. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to reboxetine. Avoid. [Moderate] Study

Idelalisib is predicted to increase the exposure to regorafenib. Avoid. [Moderate] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to reglaxidine. [Moderate] Study

Idelalisib is predicted to increase the exposure to retinoids (all-transretinoin). Adjust all-transretinoin dose. [Moderate] Theoretical

Idelalisib is predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to idelalisib. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to risperidone. Adjust dose. [Moderate] Study

Idelalisib is predicted to increase the exposure to ruxolitinib. Adjust dose and monitor side effects. [Moderate] Study. Also see TABLE 15 p. 877

Idelalisib is predicted to increase the exposure to saxagliptin. [Mild] Study

Idelalisib is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

Idelalisib is predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. [Severe] Study

Idelalisib is predicted to moderately increase the exposure to SSRIs. [Moderate] Study. Also see dapoxetine dos. [Severe] Study

St John’s Wort is predicted to decrease the exposure to idelalisib. Avoid. [Moderate] Theoretical
Idelalisib (continued)

- **Idelalisib** is predicted to increase the exposure to statins (atorvastatin). Avoid or adjust dose and monitor rhabdomyolysis. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to statins (simvastatin). Avoid. (Severe) Study
- **Idelalisib** is predicted to slightly increase the exposure to **sunitinib**. Avoid or adjust **sunitinib** dose. (Moderate) Study → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to increase the concentration of **tocrolimus**. Monitor and adjust dose. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to taxanes (cabazitaxel). Avoid. (Severe) Study → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to moderately increase the exposure to taxanes (docetaxel). Avoid or adjust dose. (Severe) Study → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to increase the exposure to taxanes (paclitaxel). (Severe) Theoretical → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to increase the concentration of temsirolimus. Avoid. (Severe) Theoretical → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to increase the exposure to tezacafor. Adjust tezacafor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
- **Idelalisib** is predicted to markedly increase the exposure to ticagrelor. Avoid. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study
- **Idelalisib** is predicted to increase the exposure to tolterodine. Avoid. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to toremifene. (Moderate) Theoretical
- **Idelalisib** is predicted to increase the exposure to trabectedin. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to moderately increase the exposure to trazodone. Avoid or adjust dose. (Moderate) Study
- **Idelalisib** is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to vemurafenib. (Severe) Theoretical
- **Idelalisib** is predicted to increase the exposure to venlafaxine. (Moderate) Study
- **Idelalisib** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to vinca alkaloids. (Severe) Theoretical → Also see TABLE 15 p. 877
- **Idelalisib** is predicted to increase the exposure to vitamin D receptor agonists (tamsulosin). (Moderate) Theoretical
- **Idelalisib** is predicted to increase the exposure to zopiclone. Adjust dose. (Moderate) Theoretical
- **Ilosframide** → see alkylating agents
- **Iloprost** → see TABLE 4 p. 874 (antiplatlet effects)
- **Imatinib** is predicted to increase the exposure to abemaciclib. (Moderate) Study
- **Imatinib** is predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. (Severe) Study
- **Imatinib** is predicted to increase the exposure to alpha blockers (tamsulosin). (Moderate) Theoretical
- **Imatinib** is predicted to increase the exposure to alprazolam. (Severe) Study
- **Imatinib** is predicted to increase the exposure to antihypertensives (dronedarone). (Severe) Theoretical
- **Imatinib** is predicted to increase the exposure to antihypertensives (propafenone). Monitor and adjust dose. (Moderate) Study
- **Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to imatinib. Avoid. (Moderate) Study
- **Antiepileptics** (oxcarbazepine) decrease the exposure to imatinib. Avoid. (Moderate) Study
- **Antifungals**, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to imatinib. (Moderate) Theoretical
Imatinib

- Imatinib is predicted to increase the risk of ergotism when given with ergotamine. (Severe) Theoretical
- Imatinib is predicted to increase the exposure to erlotinib. (Moderate) Theoretical
- Imatinib is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to fosoterodine. Adjust fosoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. (Severe) Study
- Imatinib is predicted to increase the exposure to gefitinib. (Moderate) Theoretical
- Grapefruit juice is predicted to increase the exposure to imatinib. (Moderate) Theoretical
- Imatinib is predicted to increase the concentration of guanafacine. Adjust guanafacine dose, p. 237. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to imatinib. (Moderate) Study
- Imatinib is predicted to increase the exposure to irinotecan. Avoid. (Moderate) Theoretical
- Imatinib is predicted to increase the exposure to lenalidomide. Avoid. (Moderate) Theoretical
- Idelalisib is predicted to increase the exposure to imatinib. (Moderate) Study
- Imatinib is predicted to increase the exposure to lomitapide. Avoid. (Moderate) Theoretical
- Imatinib is predicted to increase the exposure to lurasonone. Adjust lurasonone dose. (Moderate) Study
- Macrolides (erythromycin) are predicted to increase the exposure to imatinib. (Moderate) Study
- Mitotane is predicted to decrease the exposure to imatinib. Avoid. (Moderate) Study → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to naltrexone. Adjust naltrexone dose and monitor side effects. (Moderate) Study
- Netupitant is predicted to increase the exposure to imatinib. (Moderate) Theoretical
- Nevirapine is predicted to decrease the exposure to imatinib. (Moderate) Study
- Imatinib is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study
- Imatinib is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical
- Imatinib is predicted to increase the exposure to oxystigmat. Avoid. (Moderate) Study
- Imatinib increases the risk of hepatotoxicity when given with paracetamol. (Severe) Anecdotal
- Imatinib is predicted to increase the exposure to pazopanib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Pegasparaginase is predicted to increase the risk of hepatotoxicity when given with imatinib. (Severe) Theoretical → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical
- Imatinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Adjust sildenafil dose. (Moderate) Theoretical
- Imatinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 120. (Moderate) Study
- Imatinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). (Severe) Theoretical
- Imatinib is predicted to increase the exposure to phosphodiesterase type-5 inhibitors ( vardenafl). Adjust dose. (Severe) Theoretical
- Imatinib is predicted to increase the exposure to pimozide. Avoid. (Severe) Theoretical
- Imatinib is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study
- Imatinib is predicted to increase the exposure to ranolazine. (Severe) Study
- Imatinib is predicted to increase the exposure to ribociclib. (Moderate) Study
- Rifampcin is predicted to decrease the exposure to imatinib. Avoid. (Moderate) Study
- Imatinib is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to saxagliptin. (Mild) Study
- St John’s Wort is predicted to decrease the exposure to imatinib. (Moderate) Study
- Imatinib is predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. (Severe) Study
- Imatinib is predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose, p. 136. (Severe) Study
- Imatinib is predicted to increase the concentration of tacrolimus. (Severe) Study
- Imatinib is predicted to increase the exposure to taxanes (cabazitaxel). (Moderate) Theoretical → Also see TABLE 15 p. 877
- Vedolizol is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study
- Imatinib is predicted to increase the concentration of temsirolimus. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
- Imatinib is predicted to increase the exposure to tepotinib. Adjust tepotinib dose. (Moderate) Study
- Imatinib is predicted to increase the exposure to tolgodirone. (Mild) Theoretical
- Imatinib is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study
- Imatinib is predicted to increase the exposure to trazodone. (Moderate) Theoretical
- Imatinib is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study
- Imatinib is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. (Severe) Study
- Imatinib is predicted to increase the exposure to vinca alkaloids. (Severe) Theoretical → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to zopiclone. Adjust dose. (Moderate) Study
- Indacaterol see ACE inhibitors
- Imipenem see carbapenems
- Impiramine see tricyclic antidepressants

Immunoglobulins

- Anti-D (Rh), immunoglobulin - antithymocyte immunoglobulin (rabbit) - hepatitis B immunoglobulin - normal immunoglobulin - rabies immunoglobulin - tetanus immunoglobulin - varicella-zoster immunoglobulin

- Immunoglobulins are predicted to alter the effects of monoclonal antibodies (dinutuzumab). Avoid. (Severe) Theoretical

Indacaterol see beta, agonists

Imatinib — Indacaterol 971
Interactions
Appendix 1

Irinotecan
▶ Rifampicin are predicted to increase the risk of hypoglycaemia when given with insulin. [Moderate] Theoretical

Insulins → Deferasirox are predicted to decrease the exposure to oral iron chelators. Monitor serum ferritin and adjust dose. [Moderate] Theoretical

Iron (oral) decreases the absorption of oral iron (oral). Dolutegravir should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Iron (oral) decreases the absorption of oral bisphosphonates (ibandronic acid). Avoid iron (oral) for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical

Iron (oral) decreases the absorption of bisphosphonates (risendronate). Separate administration by at least 2 hours. [Moderate] Study

Iron (oral) decreases the absorption of bisphosphonates (sodium clodronate). Avoid iron (oral) for 2 hours before or 1 hour after sodium clodronate. [Moderate] Study

Calcium salts (calcium carbonate) decrease the absorption of iron (oral). Calcium carbonate should be taken 1 hour before or 2 hours after iron (oral). [Moderate] Study

Iron (oral) is predicted to decrease the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Efalizumab is predicted to decrease the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Infliximab is predicted to increase the exposure to irinotecan. [Severe] Study

Insulins are predicted to increase the risk of hypoglycaemia when given with irinotecan. Avoid. [Severe] Study

Iron (oral) decreases the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Efalizumab is predicted to decrease the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Iron (oral) decreases the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Efalizumab decreases the efficacy of intravenous iron (injectable). [Moderate] Anecdotal

Iron (injectable)
ferric carboxymaltose - iron dextran - iron isomaltoside 1000 - iron sucrose

Chloramphenicol decreases the efficacy of intravenous iron (injectable). [Moderate] Anecdotal

Iron (oral)
ferric maltol - ferrous fumarate - ferrous gluconate - ferrous sulfate - sodium ferederate

Antacids decrease the absorption of iron (oral). Iron (oral) should be taken 1 hour before or 2 hours after antacids. [Moderate] Study

Iron (oral) decreases the exposure to bictegravir. Bictegravir should be taken 2 hours before iron (oral). [Moderate] Study

Iron (oral) is predicted to decrease the absorption of oral bisphosphonates (ibandronic acid). Avoid iron (oral) for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical

Iron (oral) decreases the absorption of bisphosphonates (risendronate). Separate administration by at least 2 hours. [Moderate] Study

Iron (oral) decreases the absorption of bisphosphonates (sodium clodronate). Avoid iron (oral) for 2 hours before or 1 hour after sodium clodronate. [Moderate] Study

Calcium salts (calcium carbonate) decrease the absorption of iron (oral). Calcium carbonate should be taken 1 hour before or 2 hours after iron (oral). [Moderate] Study

Iron (oral) is predicted to decrease the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Efalizumab is predicted to decrease the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Efalizumab decreases the efficacy of iron (oral). [Moderate] Theoretical

Iron (oral) decreases the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Iron (oral) decreases the absorption of oral efalizumab. Efalizumab should be taken 2 hours before or 6 hours after iron (oral). [Moderate] Study

Efalizumab decreases the efficacy of iron (oral). [Moderate] Theoretical

Iron (oral) decreases the absorption of levodopa. [Moderate] Study

Iron (oral) decreases the effects of methyldopa. [Moderate] Study

Iron (oral) is predicted to decrease the absorption of penicillamine. Separate administration by at least 2 hours. [Hrud] Study

Iron (oral) decreases the exposure to quinolones. Separate administration by at least 2 hours. [Moderate] Study

Iron (oral) decreases the absorption of tetracyclines. Tetracyclines should be taken 2 to 3 hours after iron (oral). [Moderate] Study

Iron (oral) decreases the absorption of thyroid hormones (levothyroxine). Separate administration by at least 4 hours. [Moderate] Study

Iron (oral) potentially decreases the absorption of iron (oral). [Moderate] Theoretical

Zinc is predicted to decrease the efficacy of iron (oral) and iron (oral) is predicted to decrease the efficacy of zinc. [Moderate] Study

Iron chelators
deferasirox - desferrioxamine - dextrazene

Deferasirox is predicted to increase the exposure to aminophylline. Avoid. [Moderate] Theoretical

Antacids (aluminium hydroxide) are predicted to decrease the exposure to deferasirox. Avoid. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to deferasirox. Monitor serum ferritin and adjust dose. [Moderate] Theoretical

Ascorbic acid is predicted to increase the risk of cardiovascular side-effects when given with desferrioxamine. [Severe] Theoretical

Indapamide
▶ see thiazide diuretics

Indometacin → see NSAIDs

Indoramin → see alpha blockers

Infliximab → see mononuclear antibodies

Influenza vaccine (live) → see live vaccines

Inotuzumab ozogamicin → see mononuclear antibodies

Insulins → see TABLE 14 p. 877 (antiplatlet effects)
▶ Fibrates are predicted to increase the risk of hypoglycaemia when given with insulin. [Moderate] Theoretical

Interferon alfa → see interferons

Interferons → see TABLE 15 p. 877 (myelosuppression)

Interferons - interferon beta - peginterferon alfa

Interferons are predicted to slightly increase the exposure to aminophylline. Adjust dose. [Moderate] Theoretical

Interferon alfa is predicted to increase the risk of peripheral neuropathy when given with telbivudine. Avoid. [Severe] Study

Interferons are predicted to slightly increase the exposure to theophylline. Adjust dose. [Moderate] Study

Peginterferon alfa increases the risk of peripheral neuropathy when given with telbivudine. Avoid. [Severe] Study

Interferons are predicted to slightly increase the exposure to theophylline. Adjust dose. [Moderate] Study

Ipratropium → see TABLE 10 p. 876 (antimuscarinics)

Beta2 agonists are predicted to increase the risk of glaucoma when given with ipratropium. [Moderate] Anecdotal

Irbesartan → see angiotensin-receptor antagonists

Irinotecan → see TABLE 15 p. 877 (myelosuppression)

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study

Aprepitant is predicted to increase the exposure to intravenous irinotecan. [Severe] Theoretical

Cobicistat is predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study

Enalaprilat is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study

Fibrates (gemfibrozil) are predicted to increase the exposure to irinotecan. Avoid. [Moderate] Theoretical

Fosaprepitant is predicted to increase the exposure to intravenous irinotecan. [Severe] Theoretical

HIV-protease inhibitors are predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study

Idelalisib is predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study → Also see TABLE 15 p. 877

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with irinotecan. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Macrolides (clarithromycin) are predicted to increase the risk of toxicity when given with irinotecan. Avoid. [Moderate] Study

Mitotane is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study → Also see TABLE 15 p. 877

Netupitant is predicted to increase the exposure to irinotecan. [Moderate] Study

Irinotecan is predicted to decrease the effects of neuromuscular blocking drugs, non-depolarising. [Moderate] Theoretical

Pitolisant is predicted to decrease the exposure to irinotecan. [Hrud] Theoretical

Rifampicin is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study

Rolapitant is predicted to increase the exposure to irinotecan. Avoid or monitor. [Moderate] Study

St John’s Wort slightly decreases the exposure to irinotecan. Avoid. [Severe] Study

Irinotecan is predicted to increase the risk of prolonged neuromuscular blockade when given with suxamethonium. [Moderate] Theoretical
Isoniazid potentially increases the risk of nephrotoxicity when given with volatile halogenated anaesthetics (methoxyflurane). Avoid. (Severe) Theoretical

Isosorbide dinitrate → see nitrates
Isosorbide mononitrate → see nitrates
Isoretinoin → see retinoids
Itraconazole → see antifungals, azoles
Ivabradine → see TABLE 6 p. 875 (bradycardia), TABLE 9 p. 876 (QT-interval prolongation)
Antiarhythms (dronedarone) are predicted to increase the exposure to ivabradine. Adjust ivabradine dose. (Severe) Theoretical
Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ivabradine. Adjust dose. (Moderate) Theoretical
Antifungals, azoles (itraconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ivabradine. Adjust ivabradine dose. (Severe) Theoretical
Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ivabradine. Avoid. (Severe) Study
Aprepitant is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. (Severe) Theoretical
Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ivabradine. Avoid. (Moderate) Study Also see TABLE 6 p. 875
Cobicistat is predicted to increase the exposure to ivabradine. (Severe) Study
Crizotinib is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. (Severe) Theoretical Also see TABLE 6 p. 875
Ivabradine is predicted to increase the risk of torsade de pointes when given with drugs that prolong the QT interval. Avoid. (Severe) Theoretical
Enzalutamide is predicted to decrease the exposure to ivabradine. Adjust dose. (Moderate) Theoretical
Grapefruit juice is predicted to increase the exposure to ivabradine. Avoid. (Moderate) Study
HIV-protease inhibitors are predicted to increase the exposure to ivabradine. Avoid. (Severe) Study
Ivatropine is predicted to decrease the exposure to ivabradine. Adjust dose. (Moderate) Theoretical
St John's Wort decreases the exposure to ivabradine. Avoid. (Moderate) Study

Ivacaftor

FOOD AND LIFESTYLE Avoid bitter (Seville) oranges as they are predicted to increase the exposure to ivacaftor.

Antiarhythms (dronedarone) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. (Severe) Study
Antifungals, azoles (itraconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor
Ivacaftor (continued)

with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study

▶ Apalutamide is predicted to decrease the exposure to ivacaftor. Avoid or monitor. (Moderate) Study
▶ Aprepitant is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Bosantan is predicted to decrease the exposure to ivacaftor. (Severe) Theoretical
▶ Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Cobicistat is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
▶ Crizotinib is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Idelalisib is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
▶ Imatinib is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Ivacaftor is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical
▶ Miconazole (clarithromycin) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
▶ Macrolides (erythromycin) are predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or lumacaftor with ivacaftor p. 190 or tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
▶ Memantine is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Mitotane is predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. (Severe) Study
▶ Netupitant is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Nevirapine is predicted to decrease the exposure to ivacaftor. (Severe) Theoretical
▶ Nilotinib is predicted to increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
▶ Rifampicin is predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. (Severe) Study
▶ St John’s Wort is predicted to decrease the exposure to ivacaftor. (Severe) Theoretical

Ivermectin

ROUTE-SPECIFIC INFORMATION Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

▶ Ivermectin potentially increases the anticoagulant effect of coumarins. (Severe) Anecdotal
▶ Levamisole increases the exposure to ivermectin. (Moderate) Study

Ivacaftor

▶ Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ivacaftor. Avoid. (Severe) Study
▶ Enzalutamide is predicted to decrease the exposure to ivacaftor. Avoid. (Severe) Study
▶ Mitotane is predicted to decrease the exposure to ivacaftor. Avoid. (Severe) Study
▶ Rifampicin is predicted to decrease the exposure to ivacaftor. Avoid. (Severe) Study
▶ St John’s Wort is predicted to decrease the exposure to ivacaftor. Avoid. (Severe) Theoretical

Ivacaftor with moderate inhibitors of CYP3A4.

Avoid or monitor.

Ivacaftor with moderate inhibitors of CYP3A4.

Adjust ivacaftor.

Ivacaftor with moderate inhibitors of CYP3A4.

Avoid or monitor.
Interactions

Lapatinib is predicted to increase the exposure to 
panobinostat. Adjust dose. (Moderate) Theoretical → Also see TABLE 9 p. 876

Lapatinib is predicted to increase the risk of bleeding events when given with 
phenindione. (Severe) Theoretical

Lapatinib is predicted to increase the exposure to 
piobrentasvir. (Moderate) Theoretical

Pitolisant is predicted to decrease the exposure to lapatinib. Avoid. (Severe) Theoretical

Rifampicin is predicted to decrease the exposure to lapatinib. Avoid. (Severe) Study

Lapatinib is predicted to increase the exposure to 
sirolimus. (Moderate) Theoretical

St John’s Wort is predicted to decrease the exposure to 
lapatinib. Avoid. (Moderate) Theoretical

Lapatinib is predicted to increase the concentration of 
trametinib. (Moderate) Theoretical

Lapatinib is predicted to increase the exposure to 
venetoclax. Avoid or monitor for toxicity. (Severe) Theoretical

Laronidase

Antimalarials (chloroquine) are predicted to decrease the 
exposure to laronidase. Avoid simultaneous administration. (Severe) Theoretical

Hydroxychloroquine is predicted to decrease the exposure to 
laronidase. Avoid simultaneous administration. (Severe) Theoretical

Ledipasvir

Antacids are predicted to decrease the exposure to 
ledipasvir. Separate administration by 4 hours. (Moderate) Theoretical

Ledipasvir increases the risk of severe bradycardia or heart 
block when given with antiarrhythmics (amiodarone). Refer to 
specialist literature. (Severe) Anecdotal

Antiepileptics (carbamazepine) are predicted to decrease the 
exposure to ledipasvir. Avoid. (Severe) Study

Antiepileptics (fosphenytoin, oxcarbazepine, phenobarbital, 
phenytoin, primidone) are predicted to decrease the exposure to 
ledipasvir. Avoid. (Severe) Theoretical

Calcium salts (calcium carbonate) are predicted to decrease the 
exposure to ledipasvir. Separate administration by 4 hours. (Moderate) Theoretical

Leflunomide

→ see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression)
Leflunomide – Letermovir

**PHARMACOLOGY** Leflunomide has a long half-life; washout procedure recommended before switching to other DMARDs (consult product literature).

- **Leflunomide** is predicted to increase the exposure to *adefovir*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to decrease the exposure to *agonolatine*.  
  - **[Moderate] Theoretical**
- **Leflunomide** decreases the exposure to *aminophylline*. Adjust dose.  
  - **[Moderate] Study**
- **Leflunomide** is predicted to decrease the exposure to *anaesthetics, local* (*ropivacaine*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *antracyclines* (*daunorubicin, doxorubicin, mitoxantrone*).  
  - **[Moderate] Theoretical → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *antihistamines, non-sedating* (*fexofenadine*).  
  - **[Moderate] Study**
- **Leflunomide** potentially increases the exposure to *barticinib*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *bosentan*.  
  - **[Moderate] Study**
- **Leflunomide** is predicted to moderately increase the clearance of *caffeine citrate*. Monitor and adjust dose.  
  - **[Moderate] Study**
- **Leflunomide** is predicted to increase the exposure to *cephalosporins* (*cefaclor*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to decrease the exposure to *clozapine*.  
  - **[Moderate] Theoretical → Also see TABLE 15 p. 877**
- **Leflunomide** increases the anticoagulant effect of *coumarins*.  
  - **[Severe] Anecdotal**
- **Leflunomide** is predicted to decrease the exposure to *duloxetine*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *ganciclovir*.  
  - **[Moderate] Theoretical → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *H₂ receptor antagonists* (*cimetidine, famotidine*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the concentration of *letermovir*.  
  - **[Moderate] Study**
- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with leflunomide. Public Health England advises avoid (refer to Green Book).  
  - **[Severe] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *loop diuretics* (*furosemide*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to decrease the exposure to *melatonin*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *methotrexate*.  
  - **[Moderate] Theoretical → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the clearance of *mexiteline*. Monitor and adjust dose.  
  - **[Moderate] Study**
- **Leflunomide** is predicted to increase the exposure to *nateglinide*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *NSAIDs* (*indometacin, ketoprofen*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to decrease the exposure to *olanzapine*. Monitor and adjust dose.  
  - **[Moderate] Study → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *oseltamivir*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *penicillins* (*benzylicillin*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *pioglitazone*.  
  - **[Moderate] Study**
- **Leflunomide** is predicted to decrease the exposure to *pifithrin*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *quinolones* (*ciprofloxacin*).  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *repaglinide*.  
  - **[Moderate] Study**
- **Leflunomide** is predicted to increase the exposure to *rifampicin*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *selexipag*. Adjust dose.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *statins* (*atorvastatin, fluvastatin, pravastatin, simvastatin*).  
  - **[Moderate] Study → Also see TABLE 1 p. 874**
- **Leflunomide** is predicted to increase the exposure to *statins* (*rosuvastatin*). Adjust dose.  
  - **[Moderate] Study → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *sulfsalazine*.  
  - **[Moderate] Study → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *sulfonylureas* (*glibenclamide*).  
  - **[Moderate] Study**
- **Leflunomide** is predicted to increase the concentration of *taxanes* (*paclitaxel*).  
  - **[Severe] Anecdotal → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *tenofovir alafenamid*.  
  - **[Moderate] Theoretical**
- **Leflunomide** is predicted to increase the exposure to *tenofovir disoproxil*.  
  - **[Theoretical] Theoretical**
- **Leflunomide** is predicted to decrease the exposure to *theophylline*. Adjust dose.  
  - **[Moderate] Study**
- **Leflunomide** moderately decreases the exposure to *tizianidine*.  
  - **[Anecdotal] Study**
- **Leflunomide** is predicted to increase the exposure to *topotecan*.  
  - **[Moderate] Study → Also see TABLE 15 p. 877**
- **Leflunomide** is predicted to increase the exposure to *zidovudine*.  
  - **[Moderate] Theoretical → Also see TABLE 15 p. 877**
- **Lenalidomide** → see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression), TABLE 5 p. 874 (thromboembolism)
- **Combined hormonal contraceptives** are predicted to increase the risk of venous thromboembolism when given with lenalidomide. Avoid.  
  - **[Severe] Theoretical**
- **Hormone replacement therapy** is predicted to increase the risk of venous thromboembolism when given with lenalidomide.  
  - **[Severe] Theoretical**
- **Lenvatinib** → see TABLE 9 p. 876 (QT-interval prolongation)
- **Lercanidipine** → see calcium channel blockers

**Letermovir**

- **Letermovir** is predicted to increase the concentration of *antiarrhythmics* (*amiodarone*).  
  - **[Moderate] Theoretical**
- **Antiepileptics* (*carbamazepine, phenobarbital, primidone*) are predicted to decrease the concentration of *letermovir*.  
  - **[Moderate] Theoretical**
- **Letermovir** is predicted to decrease the concentration of *antiepileptics* (*fosphenytoin, phenytoin*) and antiepileptics (*fosphenytoin, phenytoin*) are predicted to decrease the concentration of *letermovir*.  
  - **[Moderate] Theoretical**
- **Letermovir** slightly decreases the exposure to *antifungals*, *azoles* (*voriconazole*).  
  - **[Moderate] Study**
- **Letermovir** is predicted to increase the concentration of *antihistamines, non-sedating* (*fexofenadine*).  
  - **[Moderate] Theoretical**
- **Letermovir** is predicted to increase the concentration of *boventan*.  
  - **[Moderate] Theoretical**
- **Letermovir** increases the exposure to *ciclosporin* and *ciclosporin* increases the exposure to *letermovir*. Monitor and adjust *letermovir* dose.  
  - **[Severe] Study**
- **Letermovir** is predicted to decrease the concentration of *coumarins* (*warfarin*). Monitor and adjust dose.  
  - **[Moderate] Theoretical**
- **Letermovir** is predicted to decrease the concentration of *dabigatran*. Avoid.  
  - **[Severe] Theoretical**
- **Efavirenz** is predicted to decrease the concentration of *letermovir*.  
  - **[Moderate] Theoretical**
- **Eltrombopag** is predicted to increase the concentration of *letermovir*.  
  - **[Moderate] Study**
- **Letermovir** is predicted to increase the concentration of *ergometrine*.  
  - **[Severe] Theoretical**
- **Letermovir** is predicted to increase the concentration of *ergotamine*.  
  - **[Severe] Theoretical**
- **Etravirine** is predicted to decrease the exposure to *letermovir*.  
  - **[Moderate] Theoretical**
- **Letermovir** is predicted to increase the concentration of *everolimus*. Monitor and adjust dose.  
  - **[Severe] Study**
- **Fibrates* (*gemfibrozil*) are predicted to increase the concentration of *letermovir*.  
  - **[Moderate] Study**
- HIV-protease inhibitors (atazanavir, lopinavir) (boosted with ritonavir) are predicted to increase the concentration of letermovir. [Moderate] Study
- HIV-protease inhibitors (ritonavir) are predicted to decrease the concentration of letermovir. [Moderate] Theoretical
- Leflunomide is predicted to increase the concentration of letermovir. [Moderate] Study
- Macrolides (clarithromycin, erythromycin) are predicted to increase the concentration of letermovir. [Moderate] Study
- Levetiracetam is predicted to decrease the effects of letermovir. [Moderate] Study
- Levofolinic acid increases the risk of side-effects when given with levetiracetam. Monitor and adjust dose. [Moderate] Study
- Modafinil is predicted to decrease the concentration of letermovir. [Moderate] Theoretical
- Letrozole is predicted to increase the exposure to opioids (alfentanil, fentanyl). Avoid. [Moderate] Theoretical
- Letrozole is predicted to increase the exposure to midazolam. Monitor and adjust dose. [Moderate] Study
- Modafinil is predicted to decrease the concentration of letermovir. [Moderate] Theoretical
- Letrozole is predicted to increase the exposure to opioids (alfentanil, fentanyl). Monitor and adjust dose. [Moderate] Study
- Letrozole is predicted to increase the concentration of pimozide. Avoid. [Moderate] Theoretical
- Letrozole is predicted to increase the concentration of repaglinide. Avoid. [Moderate] Theoretical
- Rifabutin is predicted to decrease the concentration of letermovir. [Moderate] Theoretical
- Rifampicin is predicted to affect the concentration of letermovir. [Severe] Theoretical
- Letrozole moderately increases the exposure to sirolimus. Monitor and adjust dose. [Severe] Study
- St John’s Wort is predicted to decrease the concentration of letermovir. [Moderate] Theoretical
- Letrozole moderately increases the exposure to statins (atorvastatin). Avoid or adjust atorvastatin dose, p. 134. [Severe] Study
- Letrozole is predicted to increase the exposure to statins (fluvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Letrozole is predicted to increase the exposure to statins (pravastatin). Avoid or adjust dose. [Moderate] Theoretical
- Letrozole is predicted to increase the exposure to statins (rosuvastatin, simvastatin). Avoid. [Severe] Study
- Letrozole is predicted to increase the concentration of sulfonylureas (glibenclamide). [Moderate] Theoretical
- Letrozole moderately increases the exposure to tacrolimus. Monitor and adjust dose. [Severe] Study
- Teriflunomide is predicted to decrease the concentration of letermovir. [Moderate] Study

### Levamisole
- Albendazole slightly decreases the exposure to levamisole and levamisole moderately decreases the exposure to albendazole. [Moderate] Study
- Alcohol (beverage) potentially causes a disulfiram-like reaction when given with levamisole. [Moderate] Study
- Levamisole increases the exposure to ivermectin. [Moderate] Study
- Levetiracetam is predicted to decrease the effects of levetirapine. See antiepileptics
- Levobunolol is predicted to decrease the effects of levetirapine. See beta blockers, non-selective
- Levobupivacaine is predicted to decrease the effects of levetirapine. See anaesthetics, local
- Levocetirizine is predicted to decrease the effects of levetirapine. See antihistamines, non-sedating
- Levodopa is predicted to increase the concentration of levetirapine. See general information.
- Levofolinic acid is predicted to decrease the effects of levetirapine. See folates
- Levomethadone is predicted to decrease the effects of levetirapine. See general information.
- Levonorgestrel is predicted to decrease the effects of levetirapine. See general information.
- Levonorgestrel is predicted to decrease the effects of levetirapine. See general information.
- Levonorgestrel is predicted to decrease the effects of levetirapine. See general information.
Levonorgestrel (continued)

- **Fosaprepitant** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **Lactose** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **HIV-protease inhibitors (ritonavir)** are predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **Lumacaftor** is predicted to decrease the efficacy of levonorgestrel. Use additional contraceptive precautions. (Severe) Theoretical
- **Modafinil** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **Nevirapine** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **Rifabutin** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **Rifampicin** is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **St John’s Wort** is predicted to decrease the efficacy of levonorgestrel. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- **Sugammadex** is predicted to decrease the efficacy of levonorgestrel. Use additional contraceptive precautions. (Severe) Theoretical
- **Ulipristal** is predicted to decrease the efficacy of levonorgestrel. Avoid. (Severe) Theoretical

Levothyroxine → see thyroid hormones
Linagliptin → see antihyperglycemics
Linagliptin → see antihyperglycemics
Linagliptin → see antihyperglycemics

**Antiepileptics** (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to linagliptin. (Moderate) Study

**Enalaprilamide** is predicted to decrease the exposure to linagliptin. (Moderate) Study

**Linagliptin** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

**Mitotane** is predicted to decrease the exposure to linagliptin. (Moderate) Study

**Rifampicin** is predicted to decrease the exposure to linagliptin. (Moderate) Study

**Linezolid** → see Table 15 p. 877 (serotonin syndrome), Table 9 p. 876 (QT-interval prolongation)

**ACE inhibitors** are predicted to increase the concentration of lithium. Monitor and adjust dose. (Severe) Anecdotal

**Acetazolamide** alters the concentration of lithium. (Severe) Anecdotal

**Aldosterone antagonists** (eplerenone) potentially increase the concentration of lithium. Avoid. (Moderate) Theoretical

**Aldosterone antagonists** (spironolactone) potentially increase the concentration of lithium. Avoid. (Moderate) Study

**Aminophylline** is predicted to decrease the concentration of lithium. (Moderate) Theoretical

**Angiotensin-II receptor antagonists** potentially increase the concentration of lithium. Monitor concentration and adjust dose. (Severe) Anecdotal

**Antiepileptics** (carbamazepine, oxcarbazepine) are predicted to increase the risk of neurotoxicity when given with lithium. (Severe) Anecdotal

**Calcitonin (salmon)** decreases the concentration of lithium. Monitor concentration and adjust dose. (Moderate) Study

**Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the risk of neurotoxicity when given with lithium. (Severe) Anecdotal

**Loop diuretics** increase the concentration of lithium. Monitor and adjust dose. (Severe) Study

**Methyl dopa** increases the risk of neurotoxicity when given with lithium. (Severe) Anecdotal

**Mexiletine** potentially affects the exposure to lithium. Avoid. (Unknown) Theoretical

**NSAIDs** increase the concentration of lithium. Monitor and adjust dose. (Severe) Study

**Phenothiazines** potentially increase the risk of neurotoxicity when given with lithium. (Severe) Anecdotal → Also see Table 9 p. 876

**Potassium-sparking diuretics** (triamterene) potentially increase the clearance of lithium. (Moderate) Study

**Quetiapine** potentially increases the risk of neurotoxicity when given with lithium. (Severe) Anecdotal

**Risperidone** potentially increases the risk of neurotoxicity when given with lithium. (Severe) Anecdotal → Also see Table 9 p. 876

**Sodium bicarbonate** decreases the concentration of lithium. (Severe) Anecdotal

**Monoamine-oxidase A and B inhibitors, irreversible** are predicted to increase the risk of side-effects when given with linezolid. Avoid and for 14 days after stopping the MAOI. Avoid. (Severe) Theoretical → Also see Table 13 p. 877

**Monoamine-oxidase B inhibitors** (rasagiline, selegiline) are predicted to increase the risk of side-effects when given with linezolid. Avoid and for 14 days after stopping the MAOI. Avoid. (Severe) Theoretical → Also see Table 13 p. 877

**Rifaximin** is predicted to increase the risk of a hypertensive crisis when given with linezolid. Avoid. (Severe) Theoretical

**Rifampicin** slightly decreases the exposure to linezolid. (Moderate) Study

**Sympathomimetics, inotropic** are predicted to increase the risk of elevated blood pressure when given with linezolid. Avoid. (Severe) Theoretical

**Sympathomimetics, vasoconstrictor** (adrenaline/epinephrine, ephedrine, isometheptene, noradrenaline/norepinephrine, phenylephrine) are predicted to increase the risk of elevated blood pressure when given with linezolid. Avoid. (Severe) Theoretical

**Sympathomimetics, vasoconstrictor (pseudoephedrine)** increase the risk of elevated blood pressure when given with linezolid. Avoid. (Severe) Study

**Lothyrone** → see thyroid hormones

**Liraglutide** → see Table 14 p. 877 (antidiabetic drugs)

**Lisdexamfetamine** → see amphetamines

**Lisinopril** → see ACE inhibitors

**Lithium** → see Table 13 p. 877 (serotonin syndrome), Table 9 p. 876 (QT-interval prolongation)

**FOOD AND LIFESTYLE** Patients taking linezolid should avoid consuming large amounts of tyramine-rich foods (such as mature cheese, salami, pickled herring. Bovril®, Oxo®, Marmitex® or any similar meat or yeast extract or fermented soybean extract, and some beers, lagers or wines).
Live vaccines

Bacillus Calmette-Guérin vaccine - influenza vaccine (live) - measles, mumps and rubella vaccine, live - rotavirus vaccine - typhoid vaccine, oral - varicella-zoster vaccine - yellow fever vaccine, live

GENERAL INFORMATION Oral typhoid vaccine is inactivated by concurrent administration of antibacterials or antimalarials; antibacterials should be avoided for 5 days before and after oral typhoid vaccination; melamine should be avoided for at least 12 hours before or after oral typhoid vaccination; for other antimalarials oral typhoid vaccine vaccination should be completed at least 3 days before and after oral typhoid vaccination; for other antimalarial oral typhoid vaccine vaccination should be completed at least 5 days before the first dose of the antimalarial (except proguanil hydrochloride with atovaquone, which can be given concurrently).

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with abatacept. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with alkylation agents. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with alkylating agents. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with amsacrine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with anakinra. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with baricitinib. Avoid. (Severe theoretical).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with belatacept. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with bleomycin. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with capcitabine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with cisplatin. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with cladribine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with clofarabine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with corticosteroids (high-dose). Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with cytarabine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with dactinomycin. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with etanercept. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with fludarabine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with fluorouracil. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with gemcitabine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with hydroxyurea. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with irinotecan. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with iron chelators (dextrazoxane). Avoid. (Severe theoretical).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with leflunomide. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with mercaptopurine. Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with methotrexate (high-dose). Public Health England advises avoid (refer to Green Book).
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with mitomycin. Public Health England advises avoid (refer to Green Book).
Live vaccines (continued)

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with monoclonal antibodies. Public Health England advises avoid (refer to Green Book).** Moderated Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with mycophenolate. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with pemtrexed. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with teriflunomide. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with platinum compounds. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with ralitrexed. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with streptozocin. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with sirolimus. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with lomitapide. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with tegafur. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with temsirolimus. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with teriflunomide. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with topotecan. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with trabectedin. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with venca alkaloids. Public Health England advises avoid (refer to Green Book).** Severe Theoretical**

**Table 14:** This table contains the separation of administration of diabetics.

- **Lixisenatide** → see **Table 14** p. 877 (antidiabetic drugs)
- **Separation of Administration** Some orally administered drugs should be taken at least 1 hour before, or 4 hours after, lixisenatide injection.
- **Lofepramine** → see tricyclic antidepressants
- **Lofezinidex** → see **Table 8** p. 875 (hypotension), **Table 9** p. 876 (QT-interval prolongation), **Table 11** p. 876 (CNP depressant effects)

**Lomitapide** → see **Table 1** p. 874 (hepatotoxicity)

**FOOD AND LIFESTYLE** Bitter (Seville) orange is predicted to increase the exposure to lomitapide; separate administration by 12 hours.

- **Alprazolam** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Antiarrhythmics (amiodarone)** are predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Antiarrhythmics (dronedarone)** are predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Antituberculosis (rifampicin and isoniazid)** are predicted to increase the exposure to lomitapide. Avoid.** Moderate Theoretical**
- **Antituberculosis (rifampicin and isoniazid)** are predicted to increase the exposure to lomitapide. Avoid.** Moderate Theoretical**
- **Antivirals (NRTIs)** are predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Bicarbonate** is predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Bicarbonate** is predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Bicarbonate** is predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

**Table 1:** This table contains the combined hormonal contraceptives.

- **Combined Hormonal Contraceptives** are predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Combined Hormonal Contraceptives** are predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

**Table 9:** This table contains the study information.

- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to decrease the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

**Table 11:** This table contains the separation of administration.

- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

**Table 12:** This table contains the study information.

- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

**Table 13:** This table contains the study information.

- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

**Table 14:** This table contains the separation of administration.

- **Study** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**

- **H₂ receptor antagonists (cimetidine, ranitidine)** are predicted to increase the exposure to lomitapide. Separate administration by 12 hours.** Moderate Theoretical**
- **HIV- protease inhibitors** are predicted to markedly increase the exposure to lomitapide. Avoid.** Severe Study**
- **Idelalisib** is predicted to markedly increase the exposure to lomitapide. Avoid.** Severe Study**
Imatinib is predicted to increase the exposure to lomitapide. Avoid. (Moderate) Theoretical

Isoniazid is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Unknown) Theoretical → Also see Table 11 p. 874

Ivacafant is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Lapatinib is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Linaclotide is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Macrolides (azithromycin) are predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Macrolides (clarithromycin) are predicted to markedly increase the exposure to lomitapide. Avoid. (Severe) Study

Macrolides (erythromycin) are predicted to increase the exposure to lomitapide. Avoid. (Moderate) Theoretical

Mitozolate is predicted to decrease the exposure to lomitapide. Monitor and adjust dose. (Moderate) Theoretical

Netrapinid is predicted to increase the exposure to lomitapide. Avoid. (Moderate) Theoretical

Nilotinib is predicted to increase the exposure to lomitapide. Avoid. (Moderate) Theoretical

Pazopanib is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Peppermint oil is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Propiverine is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Ranolazine is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Rifampin is predicted to decrease the exposure to lomitapide. Monitor and adjust dose. (Moderate) Theoretical

SSRIs (fluoxetine) are predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Unknown) Theoretical

SSRIs (fluvoxamine) are predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Unknown) Theoretical

Lomitapide increases the exposure to statins (atorvastatin). Adjust lomitapide dose or separate administration by 12 hours. (Severe) Study → Also see Table 1 p. 874

Lomitapide increases the exposure to statins (simvastatin). Monitor and adjust simvastatin dose, p. 136. (Moderate) Study → Also see Table 1 p. 874

Tacrolimus is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Tigecycline is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Tolvaptan is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Loop diuretics are predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

Loop diuretics increase the concentration of lithium. Monitor and adjust dose. (Severe) Study

Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to furosemide. Adjust dose. (Moderate) Theoretical

Reboxetine is predicted to increase the risk of hypokalaemia when given with loop diuretics. (Moderate) Theoretical

Teriflunomide is predicted to increase the exposure to furosemide. (Moderate) Study

Loperamide

Antiarrhythmics (dronedarone) are predicted to increase the exposure to loperamide. (Severe) Theoretical

Ceritinib is predicted to increase the exposure to loperamide. (Severe) Theoretical

Eperisone greatly increases the absorption of oral desmopressin (and possibly sublingual). (Moderate) Study

Eliglustat is predicted to increase the exposure to loperamide. Adjust dose. (Moderate) Study

Lapatinib is predicted to increase the exposure to loperamide. (Moderate) Theoretical

Mirabegron is predicted to increase the exposure to loperamide. (Mild) Theoretical

Opicapone is predicted to increase the exposure to loperamide. Avoid. (Moderate) Study

Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to loperamide. (Moderate) Study

Pivalentevir (with geracaparin) is predicted to increase the exposure to loperamide. (Moderate) Study

Pitolisant is predicted to decrease the exposure to loperamide. (Mild) Theoretical

Velpatasvir is predicted to increase the exposure to loperamide. (Severe) Theoretical

Lopinavir → see HIV-protective inhibitors

Loprazolam → see Table 11 p. 876 (CNS depressant effects)

Loratadine → see antihistamines, non-sedating

Lorazepam → see Table 11 p. 876 (CNS depressant effects)

Rifampicin increases the clearance of lorazepam. (Moderate) Study

Lormetazepam → see Table 11 p. 876 (CNS depressant effects)

Losartan → see angiotensin receptor antagonists

Low molecular-weight heparins → see Table 16 p. 878 (increased serum potassium), Table 3 p. 874 (anticoagulant effects)

Dalteparin - enoxaparin - tinzaparin

Ranibizumab increases the risk of bleeding events when given with low molecular-weight heparins. (Severe) Theoretical

Loxapine → see Table 8 p. 875 (hypotension), Table 111 p. 876 (CNS depressant effects), Table 10 p. 876 (antimuscarinics)

Combined hormonal contraceptives are predicted to increase the exposure to lopinavir. Avoid. (Unknown) Theoretical

Lopinavir is predicted to decrease the effects of dopamine receptor agonists. (Moderate) Theoretical → Also see Table 8 p. 875

Lopinavir is predicted to decrease the effects of levodopa. (Severe) Theoretical → Also see Table 8 p. 875

Mexitilene is predicted to increase the exposure to lorzapame. Avoid. (Unknown) Theoretical

Quinolones (ciprofloxacin) are predicted to increase the exposure to lopinavir. Avoid. (Unknown) Theoretical

SSRIs (fluvoxamine) are predicted to increase the exposure to lorzapame. Avoid. (Unknown) Theoretical

Lumacaftor

Lumacaftor is predicted to decrease the exposure to antifeptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone). Avoid. (Severe) Theoretical

Lumacaftor is predicted to decrease the exposure to antifyngals, azoles (fluconazole). Adjust dose. (Mild) Theoretical

Lumacaftor is predicted to decrease the exposure to antifyngals, azoles (itraconazole, ketoconazole, posaconazole, voriconazole). Avoid or monitor efficacy. (Moderate) Theoretical

Lumacaftor is predicted to decrease the exposure to ciclosporin. Avoid. (Severe) Theoretical

Lumacaftor is predicted to decrease the efficacy of combined hormonal contraceptives. Use additional contraceptive precautions. (Severe) Theoretical
Lumacaftor (continued)

▶ Lumacaftor is predicted to decrease the exposure to corticosteroids (methylprednisolone). Adjust dose.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to doravirine. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to everolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor potentially decreases the exposure to glecaprevir. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the efficacy of levonorgestrel. Use additional contraceptive precautions.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to macrolides (clarithromycin, erythromycin).  [Moderate] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to midazolam. Avoid.  [Severe] Theoretical

▶ Lumacaftor potentially decreases the exposure to pibrentasvir. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to rifabutin. Adjust dose.  [Moderate] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to temsirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sitatunga. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Lumacaftor is predicted to decrease the exposure to sirolimus. Avoid.  [Severe] Theoretical

▶ Antiarhythmic (dronedarone) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Antiproliferative (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to lurasidone. Avoid.  [Moderate] Study

▶ Antifungal, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Antifungal, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Antifungal, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Antiinflammatory  see antimalarials

Lurasidone  see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

▶ Antiarhythmics (dronedarone) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Antiproliferative (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to lurasidone. Avoid.  [Moderate] Study  Also see TABLE 11 p. 876

▶ Antifungal, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Antifungal, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Apalutamide is predicted to decrease the exposure to lurasidone. Avoid or monitor.  [Moderate] Study

▶ Aprepitant is predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Bosentan is predicted to decrease the exposure to lurasidone. Monitor and adjust dose.  [Moderate] Theoretical

▶ Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study  Also see TABLE 8 p. 875

▶ Cobimetpat is predicted to increase the exposure to lurasidone. Avoid.  [Severe] Study

▶ Crizotinib is predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Efavirenz is predicted to decrease the exposure to lurasidone. Monitor and adjust dose.  [Moderate] Theoretical

▶ Enzalutamide is predicted to decrease the exposure to lurasidone. Avoid.  [Moderate] Study

▶ Grapefruit juice is predicted to increase the exposure to lurasidone. Avoid.  [Severe] Theoretical

▶ HIV-protease inhibitors are predicted to increase the exposure to lurasidone. Avoid.  [Severe] Study

▶ Idealalisib is predicted to increase the exposure to lurasidone. Avoid.  [Severe] Study

▶ Imatinib is predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Lurasidone is predicted to decrease the effects of levodopa.  [Severe] Theoretical  Also see TABLE 8 p. 875

▶ Macrolides (clarithromycin) are predicted to increase the exposure to lurasidone. Avoid.  [Severe] Study

▶ Macrolides (erythromycin) are predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Mitotane is predicted to decrease the exposure to lurasidone. Avoid.  [Moderate] Study

▶ Nevirapine is predicted to decrease the exposure to lurasidone. Monitor and adjust dose.  [Moderate] Theoretical

▶ Nilotinib is predicted to increase the exposure to lurasidone. Adjust lurasidone dose.  [Moderate] Study

▶ Rifampicin is predicted to decrease the exposure to lurasidone. Avoid.  [Moderate] Study

▶ St John’s Wort is predicted to decrease the exposure to lurasidone. Monitor and adjust dose.  [Moderate] Theoretical

Lymecycline  see tetracyclines

Macitentan

▶ Antiinflammatory (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to macitentan. Avoid.  [Severe] Study

▶ Antifungal, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to macitentan.  [Moderate] Study

▶ Cobimetpat is predicted to increase the exposure to macitentan.  [Moderate] Study

▶ Enalapril is predicted to decrease the exposure to macitentan. Avoid.  [Severe] Study

▶ HIV-protease inhibitors are predicted to increase the exposure to macitentan.  [Moderate] Study

▶ Idealalisib is predicted to increase the exposure to macitentan.  [Moderate] Study

▶ Macrolides (clarithromycin) are predicted to increase the exposure to macitentan.  [Moderate] Study

▶ Mitotane is predicted to decrease the exposure to macitentan. Avoid.  [Severe] Study

▶ Rifampicin is predicted to decrease the exposure to macitentan. Avoid.  [Severe] Study

▶ St John’s Wort is predicted to decrease the exposure to macitentan. Avoid.  [Severe] Theoretical

Macrolides  see TABLE 8 p. 876 (QT-interval prolongation)

azithromycin - clarithromycin - erythromycin

▶ Interactions do not generally apply to topical use of azithromycin unless specified.

Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

▶ Clarithromycin is predicted to increase the exposure to abemaciclib. Avoid or adjust abemaciclib dose.  [Severe] Study

▶ Erythromycin is predicted to increase the exposure to abemaciclib.  [Moderate] Study

▶ Macrolides (clarithromycin, erythromycin) are predicted to increase the exposure to aliskiren.  [Moderate] Theoretical

▶ Clarithromycin increases the exposure to almotriptan.  [MID] Study

▶ Clarithromycin is predicted to moderately increase the exposure to alpha blockers (alfuzosin, tamsulosin). Use with caution or avoid.  [Moderate] Study

▶ Clarithromycin is predicted to increase the exposure to alpha blockers (doxazosin).  [Moderate] Study

▶ Erythromycin is predicted to increase the exposure to alpha blockers (tamsulosin).  [Moderate] Theoretical

▶ Clarithromycin moderately increases the exposure to alprazolam. Avoid.  [Moderate] Study

▶ Erythromycin is predicted to increase the exposure to alprazolam.  [Severe] Study

▶ Azithromycin is predicted to increase the exposure to aminophylline.  [Moderate] Theoretical
Clarithromycin is predicted to increase the exposure to aminophylline. Adjust dose. (Moderate) Theoretical

Aminophylline is predicted to decrease the exposure to erythromycin. Adjust dose. (Severe) Study

Clarithromycin very markedly increases the exposure to antirhythmic drugs (dronedarone). Avoid. (Severe) Study  Also see TABLE 9 p. 876

Erythromycin is predicted to moderately increase the exposure to antirhythmic drugs (dronedarone). Avoid. (Severe) Theoretical  Also see TABLE 9 p. 876

Macrolides (clarithromycin, erythromycin) are predicted to increase the exposure to antirhythmic drugs (lidocaine). (Moderate) Theoretical

Clarithromycin is predicted to increase the exposure to antirhythmic drugs (propafenone). Monitor and adjust dose. (Severe) Study

Erythromycin is predicted to increase the exposure to antirhythmic drugs (propafenone). Monitor and adjust dose. (Moderate) Study

Clarithromycin slightly increases the concentration of antiepileptics (carbamazepine). Monitor concentration and adjust dose. (Severe) Study

Erythromycin markedly increases the concentration of antiepileptics (carbamazepine). Monitor concentration and adjust dose. (Severe) Study

Clarithromycin is predicted to very slightly increase the exposure to antiepileptics (perampanel). (Mild) Study

Clarithromycin is predicted to increase the exposure to antifungals, azoles (isavuconazole). Avoid or monitor side effects. (Severe) Study

Erythromycin is predicted to increase the exposure to antifungals, azoles (isavuconazole). (Moderate) Theoretical

Clarithromycin is predicted to increase the exposure to antihistamines, non-sedating (mizolastine). Avoid. (Severe) Study

Erythromycin is predicted to increase the exposure to antihistamines, non-sedating (mizolastine). (Severe) Theoretical

Clarithromycin is predicted to increase the exposure to antimalarials. Avoid. (Severe) Study  Also see TABLE 9 p. 876

Erythromycin is predicted to increase the exposure to antimalarials. (Severe) Theoretical

Macrolides (clarithromycin, erythromycin) are predicted to increase the concentration of antimalarials (piperquina). (Severe) Theoretical

Clarithromycin is predicted to increase the exposure to apalutamide. (Mild) Study  Also see TABLE 9 p. 876

Erythromycin is predicted to increase the exposure to apalutamide. (Moderate) Theoretical

Clarithromycin is predicted to markedly increase the exposure to apreplint. (Moderate) Study

Erythromycin is predicted to increase the exposure to apreplint. (Moderate) Study

Clarithromycin is predicted to slightly increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. (Moderate) Study

Clarithromycin is predicted to increase the exposure to axtinib. Avoid or adjust dose. (Moderate) Study

Erythromycin is predicted to increase the exposure to axtinib. (Moderate) Theoretical

Clarithromycin is predicted to increase the exposure to bedaquiline. Avoid prolonged use. (Mild) Study  Also see TABLE 9 p. 876

Erythromycin is predicted to increase the exposure to bedaquiline. Avoid prolonged use. (Mild) Theoretical  Also see TABLE 9 p. 876

Macrolides are predicted to increase the exposure to beta blockers, non-selective (nadolol). (Moderate) Study

Clarithromycin is predicted to increase the exposure to beta2 agonists (salmeterol). Avoid. (Severe) Study

Macrolides are predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

Clarithromycin slightly increases the exposure to bortezomib. (Moderate) Study

Clarithromycin is predicted to increase the exposure to bosantan. (Moderate) Theoretical

Clarithromycin is predicted to markedly increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Study  Also see TABLE 9 p. 876

Erythromycin is predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical  Also see TABLE 9 p. 876

Clarithromycin is predicted to increase the exposure to brigitanib. Adjust brigitanib dose. (Severe) Study

Clarithromycin is predicted to increase the exposure to buspirone. Adjust buspirone dose. (Severe) Study

Erythromycin is predicted to increase the exposure to buspirone. Use with caution and adjust dose. (Moderate) Study

Clarithromycin slightly increases the exposure to cabozantinib. (Moderate) Study  Also see TABLE 9 p. 876

Erythromycin is predicted to increase the exposure to cabozantinib. (Moderate) Theoretical  Also see TABLE 9 p. 876

Erythromycin is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. (Moderate) Study

Clarithromycin is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. (Moderate) Study

Erythromycin is predicted to increase the exposure to calcium channel blockers (diltiazem). (Severe) Theoretical

Clarithromycin is predicted to increase the exposure to calcium channel blockers (diltiazem, verapamil). (Severe) Study

Clarithromycin is predicted to markedly increase the exposure to calcium channel blockers (lercanidipine). Avoid. (Severe) Study

Erythromycin is predicted to increase the exposure to calcium channel blockers (verapamil). (Severe) Study

Clarithromycin is predicted to increase the exposure to cannabis extract. Use with caution and adjust dose. (Moderate) Theoretical

Clarithromycin is predicted to moderately increase the exposure to cariprazine. Avoid. (Severe) Study

Erythromycin is predicted to increase the exposure to cariprazine. Avoid. (Severe) Study

Clarithromycin is predicted to increase the exposure to ceritinib. Avoid or adjust ceritinib dose. (Severe) Study  Also see TABLE 9 p. 876

Macrolides (azithromycin, erythromycin) are predicted to increase the exposure to ceritinib. (Moderate) Theoretical  Also see TABLE 9 p. 876

Clarithromycin increases the concentration of ciclosporin. (Severe) Study

Erythromycin is predicted to increase the concentration of ciclosporin. (Severe) Study

Clarithromycin is predicted to moderately increase the exposure to colchicine. Adjust colchicine dose. (Moderate) Study

Erythromycin potentially increases the risk of toxicity when given with colchicine. (Severe) Anecdotal

Clarithromycin is predicted to markedly increase the exposure to cobimetinib. Avoid or monitor for toxicity. (Severe) Study

Clarithromycin is predicted to increase the exposure to cobimetinib. (Severe) Theoretical

Azithromycin is predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. (Severe) Theoretical

Clarithromycin is predicted to increase the exposure to colchicine. Avoid potent inhibitors of CYP3A4 or adjust colchicine dose. (Severe) Study

Clarithromycin is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. (Severe) Study

Clarithromycin is predicted to increase the exposure to corticosteroids (beclometasone) (risk with beclometasone is likely to be lower than with other corticosteroids). (Moderate) Theoretical

Clarithromycin is predicted to increase the exposure to corticosteroids (betamethasone, budesonide, ciclesonide, ...
Macrolides (continued)

deflazacort, dexamethasone, fluordcortisone, fluticasone, hydrocortisone, methylprednisolone, mometasone, prednisolone, triamcinolone). Avoid or monitor side effects. (Severe) Study

- Erythromycin is predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor INR and adjust dose. (Moderate) Study

- Macrolides (clarithromycin, erythromycin) increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. (Severe) Anecdotal

- Clarithromycin is predicted to moderately increase the exposure to crizotinib. Avoid. (Moderate) Study → Also see TABLE 9 p. 876

- Macrolides are predicted to increase the exposure to dabrafenib. Use with caution or avoid. (Moderate) Study

- Clarithromycin is predicted to markedly increase the exposure to dabrafenib. Avoid. (Severe) Study

- Erythromycin is predicted to slightly increase the exposure to dabrafenib. Avoid. (Severe) Study

- Clarithromycin is predicted to markedly increase the exposure to dasatinib. Avoid or adjust dose—consult product literature. (Severe) Study → Also see TABLE 9 p. 876

- Erythromycin is predicted to slightly increase the exposure to dasatinib. (Severe) Study → Also see TABLE 9 p. 876

- Clarithromycin very slightly increases the exposure to delamanid. (Severe) Study → Also see TABLE 9 p. 876

- Macrolides increase the concentration of digoxin. (Severe) Anecdotal

- Clarithromycin increases the exposure to dopamine receptor agonists (bromocriptine). (Severe) Study

- Erythromycin is predicted to increase the exposure to dopamine receptor agonists (bromocriptine). (Severe) Theoretical

- Macrolides (clarithromycin, erythromycin) are predicted to increase the concentration of dopamine receptor agonists (caberetine). Avoid. (Severe) Study

- Clarithromycin is predicted to increase the exposure to doravirine. (Severe) Study

- Clarithromycin is predicted to increase the exposure to dutasteride. Monitor side effects and adjust dose. (Moderate) Theoretical

- Erythromycin is predicted to moderately increase the exposure to dutasteride. (Severe) Study

- Erythromycin slightly increases the exposure to edoxaban. Adjust dose. (Severe) Study

- Macrolides (azithromycin, clarithromycin) are predicted to slightly increase the exposure to edoxaban. (Severe) Theoretical

- Efavirenz decreases the exposure to clarithromycin. (Moderate) Study → Also see TABLE 9 p. 876

- Clarithromycin is predicted to markedly increase the exposure to eletriptan. Avoid. (Severe) Study

- Erythromycin moderately increases the exposure to eletriptan. Avoid or adjust dose—consult product literature. (Severe) Study

- Clarithromycin is predicted to increase the exposure to encofarenib. Avoid or monitor. (Severe) Study → Also see TABLE 9 p. 876

- Erythromycin is predicted to moderately increase the exposure to encofarenib. (Moderate) Study → Also see TABLE 9 p. 876

- Clarithromycin is predicted to increase the risk of ergotism when given with ergometrine. Avoid. (Severe) Theoretical

- Erythromycin is predicted to increase the risk of ergotism when given with ergometrine. (Severe) Theoretical

- Clarithromycin is predicted to increase the risk of ergotism when given with ergotamine. (Severe) Theoretical

- Erythromycin is predicted to increase the risk of ergotism when given with ergotamine. (Severe) Theoretical

- Clarithromycin is predicted to slightly increase the exposure to erlotinib. Use with caution and adjust dose. (Moderate) Study

- Macrolides (azithromycin, erythromycin) are predicted to increase the exposure to erlotinib. (Moderate) Theoretical

- Clarithromycin is predicted to increase the exposure to esetamitine. Adjust dose. (Moderate) Study

- Etravirine decreases the exposure to clarithromycin and clarithromycin slightly increases the exposure to etravirine. (Severe) Study

- Clarithromycin is predicted to increase the concentration of everolimus. Avoid. (Severe) Study

- Erythromycin is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study

- Clarithromycin is predicted to moderately increase the exposure to fosiderotinone. Adjust fosiderotinone dose with potent inhibitors of CYP3A4; avoid in hepatic and renal impairment. (Severe) Study

- Erythromycin is predicted to increase the exposure to fosiderotinone. Adjust fosiderotinone dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. (Mild) Study

- Macrolides are predicted to increase the exposure to fidaxomycin. Avoid. (Moderate) Study

- Clarithromycin is predicted to increase the exposure to fosaprinotinone. (Moderate) Theoretical

- Clarithromycin is predicted to increase the exposure to gefitinib. (Moderate) Study

- Erythromycin is predicted to increase the exposure to gefitinib. (Moderate) Theoretical

- Clarithromycin is predicted to moderately to markedly increase the exposure to grazoprevir. Avoid. (Severe) Study

- Clarithromycin is predicted to increase the exposure to guanfacine. Adjust guanfacine dose, p. 237. (Moderate) Study

- Erythromycin is predicted to increase the concentration of guanfacine. Adjust guanfacine dose. p. 237. (Moderate) Theoretical

- H₂ receptor antagonists (cinetidine) slightly increase the exposure to erythromycin. (Moderate) Study

- HIV- protease inhibitors (atazanavir) are predicted to increase the exposure to clarithromycin. Adjust dose in renal impairment. (Severe) Study

- HIV- protease inhibitors (atazanavir, darunavir, fosamprenavir, lopinavir, ritonavir, tipranavir) are predicted to increase the exposure to erythromycin. (Severe) Theoretical

- HIV- protease inhibitors (darunavir, fosamprenavir, lopinavir) (boosted with ritonavir) are predicted to increase the Theophyl to clarithromycin. Adjust dose in renal impairment. (Severe) Study

- HIV- protease inhibitors (ritonavir) increase the exposure to clarithromycin. Adjust dose in renal impairment. (Severe) Study

- HIV- protease inhibitors (ritonavir) increase the exposure to clarithromycin. Adjust dose in renal impairment. (Severe) Study

- HIV- protease inhibitors (ritonavir) increase the exposure to clarithromycin. Adjust dose in renal impairment. (Severe) Study

- HIV- protease inhibitors (ritonavir) increase the exposure to clarithromycin. Adjust dose in renal impairment. (Severe) Study

- Clarithromycin increases the exposure to HIV- protease inhibitors (saquinavir) and HIV- protease inhibitors (saquinavir) increase the exposure to clarithromycin. Avoid. (Severe) Study → Also see TABLE 9 p. 876

- Erythromycin is predicted to increase the exposure to HIV- protease inhibitors (saquinavir). Avoid. (Severe) Theoretical → Also see TABLE 9 p. 876

- Clarithromycin is predicted to very markedly increase the exposure to ibrutinib. Avoid potent inhibitors of CYP3A4 or adjust ibrutinib dose. (Severe) Study

- Erythromycin is predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose with moderate inhibitors of CYP3A4. (Severe) Study

- Clarithromycin is predicted to increase the exposure to imatinib. (Moderate) Study

- Erythromycin is predicted to increase the exposure to imatinib. (Moderate) Theoretical

- Clarithromycin is predicted to increase the exposure to irinotecan. Avoid. (Moderate) Study

- Clarithromycin is predicted to increase the exposure to ivabradine. Avoid. (Severe) Study
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- Clarithromycin is predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Erythromycin is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. (Severe) Study
- Clarithromycin is predicted to increase the exposure to ospemifene. Avoid in poor P2C9 metabolisers. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to ozanimod. (High) Study
- Clarithromycin is predicted to increase the exposure to olsuranib. Avoid or adjust olsuranib dose. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. (Moderate) Study
- Erythromycin is predicted to increase the exposure to pazopanib. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Avoid. (Severe) Study
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. (Severe) Study
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Use with caution or avoid. (Severe) Study
- Clarithromycin is predicted to increase the exposure to pimozide. Avoid. (Severe) Study
- Clarithromycin is predicted to increase the exposure to pimozone. Avoid. (Severe) Study
- Clarithromycin is predicted to increase the exposure to ponatinib. Adjust dose. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to praziquantel. (High) Study
- Clarithromycin is predicted to increase the exposure to quetiapine. Avoid. (Severe) Study

Clarithromycin is predicted to increase the exposure to ivabradine. Avoid. (Severe) Theoretical
- Clarithromycin is predicted to increase the exposure to ivacofor. Adjust ivacofor p. 199 or lumacosin with ivacofor p. 199 or tezacosin with ivacofor, p. 190 dose with potent inhibitors of CYP3A4. (Severe) Study
- Erythromycin is predicted to increase the exposure to ivacofor. Adjust ivacofor p. 199 or tezacosin with ivacofor, p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
- Clarithromycin is predicted to increase the exposure to lapatinib, Avoid. (Moderate) Study 
  → Also see TABLE 9 p. 876
- Erythromycin is predicted to increase the exposure to lapatinib, (Moderate) Study 
  → Also see TABLE 9 p. 876
- Macrolides (clarithromycin, erythromycin) are predicted to increase the concentration of letemovir. (Moderate) Study
- Clarithromycin increases the exposure to linezolid. (Moderate) Theoretical
- Azithromycin is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Study
- Clarithromycin is predicted to markedly increase the exposure to lomitapide. Avoid. (Severe) Study
- Erythromycin is predicted to increase the exposure to lomitapide. Avoid. (Moderate) Theoretical
- Lumacosin is predicted to decrease the exposure to macrolides (clarithromycin, erythromycin). (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to luradoline. Avoid. (Severe) Study
- Erythromycin is predicted to increase the exposure to luradoline. Adjust luradoline dose. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to macrifen, (High) Theoretical
- Clarithromycin is predicted to markedly increase the exposure to maraviroc. Adjust dose. (Severe) Study
- Clarithromycin is predicted to markedly increase the exposure to mildazolam. Avoid or adjust dose. (Severe) Study
- Erythromycin is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. (Severe) Study
- Clarithromycin is predicted to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. (Severe) Study
- Erythromycin is predicted to increase the exposure to midostaurin. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to mirabegron, Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to mirtazapine. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to modafinil. (High) Theoretical
- Clarithromycin increases the risk of neutropenia when given with monoclonal antibodies (brentuximab vedotin). Monitor and adjust dose. (Severe) Theoretical
- Clarithromycin is predicted to increase the exposure to monoclonal antibodies (trastuzumab emtansine). Avoid. (Severe) Theoretical
- Clarithromycin is predicted to markedly increase the exposure to naloxegol. Avoid. (Severe) Study
- Erythromycin is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to netupitant. (Moderate) Study
- Nevirapine decreases the exposure to clarithromycin. (Moderate) Study
- Clarithromycin is predicted to moderately increase the exposure to nitotinib. Avoid. (Severe) Study 
  → Also see TABLE 9 p. 876
- Erythromycin is predicted to increase the exposure to nitotinib, (Moderate) Theoretical 
  → Also see TABLE 9 p. 876
- Macrolides are predicted to increase the exposure to nintedanib. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to nitinol. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to nitinol. (Moderate) Theoretical 
  → Also see TABLE 9 p. 876
- Macrolides are predicted to increase the exposure to nitisinone. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to nitisinone. Adjust dose. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Erythromycin is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Erythromycin is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. (Severe) Study
- Clarithromycin is predicted to increase the exposure to opioids (methadone). (Severe) Theoretical 
  → Also see TABLE 9 p. 876
- Erythromycin is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical 
  → Also see TABLE 9 p. 876
- Clarithromycin is predicted to increase the exposure to ospemifene. Avoid in poor P2C9 metabolisers. (Moderate) Study
- Clarithromycin is predicted to increase the exposure to oxybutynin. (High) Study
- Erythromycin is predicted to increase the exposure to oxybutynin. (High) Theoretical
- Clarithromycin is predicted to increase the exposure to palbociclib. Avoid or adjust palbociclib dose. (Severe) Study
- Clarithromycin is predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. (Moderate) Study 
  → Also see TABLE 9 p. 876
- Macrolides (azithromycin, erythromycin) are predicted to increase the exposure to panobinostat. Adjust dose. (Moderate) Theoretical 
  → Also see TABLE 9 p. 876
- Clarithromycin is predicted to increase the exposure to paritaprevir. Avoid. (Severe) Study
- Erythromycin is predicted to increase the exposure to paritaprevir. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. (Moderate) Study 
  → Also see TABLE 9 p. 876
- Erythromycin is predicted to increase the exposure to pazopanib. (Moderate) Theoretical 
  → Also see TABLE 9 p. 876
- Erythromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. (Moderate) Theoretical
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. (Severe) Study 
  → Also see TABLE 9 p. 876
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. (Severe) Study 
  → Also see TABLE 9 p. 876
- Erythromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. (Moderate) Study 
  → Also see TABLE 9 p. 876
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Use with caution or avoid. (Severe) Study
- Erythromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Avoid. (Severe) Study
- Clarithromycin is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). Adjust dose. (Moderate) Theoretical
Macrolides (continued)

- Erythromycin is predicted to increase the exposure to quetiapine. Avoid. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to tadalafil. Avoid. [Severe] Study  Also see TABLE 9 p. 876

- Erythromycin is predicted to increase the exposure to ranolazine. Avoid. [Severe] Study  Also see TABLE 9 p. 876

- Clarithromycin is predicted to increase the exposure to reboxetine. Avoid. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to regorafenib. Avoid. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to repaglinide. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to retinoids (alitretinoin). Adjust alitretinoin dose. [Moderate] Theoretical

- Clarithromycin is predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study  Also see TABLE 9 p. 876

- Erythromycin is predicted to increase the exposure to ribociclib. [Moderate] Study  Also see TABLE 9 p. 876

- Clarithromycin increases the risk of neutropenia when given with rifabutin. [Severe] Study

- Erythromycin increases the risk of neutropenia when given with rifabutin. Adjust dose. [Severe] Study

- Azithromycin increases the risk of neutropenia when given with rifabutin. Study  Also see p. 876

- Rifampicin decreases the concentration of clarithromycin. [Severe] Study

- Clarithromycin is predicted to increase the exposure to risperidone. Adjust dose. [Moderate] Study  Also see TABLE 9 p. 876

- Erythromycin is predicted to increase the exposure to risperidone. Study

- Erythromycin is predicted to increase the exposure to saxagliptin. [Moderate] Study

- Erythromycin is predicted to increase the exposure to saxagliptin. [Severe] Study

- Clarithromycin is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

- Erythromycin increases the concentration of sirolimus. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to solifenacin. Adjust solifenacin or tamulosin with solifenacin dose; avoid in hepatic and renal impairment. [Severe] Study

- Clarithromycin is predicted to moderately increase the exposure to SSRIs. (dapoxetine). Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. [Severe] Study

- Erythromycin is predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. [Moderate] Theoretical

- Clarithromycin is predicted to increase the exposure to statins (atorvastatin). Avoid or adjust dose and monitor rhabdomyolysis. [Severe] Study

- Erythromycin is predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. [Severe] Study

- Clarithromycin moderately increases the exposure to statins (pravastatin). [Severe] Study

- Erythromycin is predicted to increase the exposure to statins (pravastatin). [Severe] Study

- Clarithromycin is predicted to increase the exposure to statins (simvastatin). Avoid. [Severe] Study

- Erythromycin is predicted to increase the exposure to statins (simvastatin). With use with caution and adjust simvastatin dose, p. 136. [Severe] Study

- Clarithromycin is predicted to slightly increase the exposure to sulfonylureas. [Moderate] Theoretical

- Clarithromycin is predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study  Also see TABLE 9 p. 876

- Erythromycin is predicted to increase the exposure to sunitinib. [Moderate] Theoretical  Also see TABLE 9 p. 876

- Clarithromycin is predicted to increase the concentration of tacrolimus. Monitor and adjust dose. [Severe] Study

- Erythromycin is predicted to increase the concentration of tacrolimus. [Severe] Study

- Clarithromycin is predicted to increase the exposure to taxanes (cabazitaxel). Avoid. [Severe] Study

- Erythromycin is predicted to increase the exposure to taxanes (cabazitaxel). [Moderate] Theoretical

- Clarithromycin is predicted to moderately increase the exposure to taxanes (docetaxel). Avoid or adjust dose. [Severe] Study

- Clarithromycin is predicted to increase the exposure to taxanes (paclitaxel). [Severe] Theoretical

- Clarithromycin is predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical

- Erythromycin is predicted to increase the concentration of temsirolimus. [Moderate] Theoretical

- Clarithromycin is predicted to increase the exposure to tezacafor. Adjust tezacafor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study

- Erythromycin is predicted to increase the exposure to tezacafor. Adjust tezacafor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study

- Erythromycin decreases the clearance of theophylline and theophylline potentially decreases the clearance of erythromycin. Adjust dose. [Severe] Study

- Macrolides (azithromycin, clarithromycin) are predicted to increase the exposure to theophylline. Adjust dose. [Moderate] Anecdotal

- Azithromycin is predicted to increase the exposure to ticagrelor. Use with caution or avoid. [Severe] Study

- Clarithromycin is predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study

- Clarithromycin is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study

- Erythromycin given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to tolterodine. Avoid. [Severe] Study  Also see TABLE 9 p. 876

- Erythromycin is predicted to increase the exposure to tolterodine. [Moderate] Theoretical  Also see TABLE 9 p. 876

- Clarithromycin is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. [Severe] Study

- Erythromycin is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. [Moderate] Study

- Macrolides are predicted to increase the exposure to topotecan. [Severe] Study

- Clarithromycin is predicted to increase the exposure to toremifene. [Moderate] Theoretical  Also see TABLE 9 p. 876

- Clarithromycin is predicted to increase the exposure to trabectedin. Avoid or adjust dose. [Severe] Theoretical

- Macrolides are predicted to increase the concentration of trametinib. [Moderate] Theoretical

- Clarithromycin is predicted to moderately increase the exposure to trazodone. Avoid. [Severe] Study

- Clarithromycin is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Severe] Study

- Erythromycin is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

- Clarithromycin is predicted to increase the exposure to vemurafenib. [Severe] Theoretical  Also see TABLE 9 p. 876

- Macrolides (clarithromycin, erythromycin) are predicted to increase the exposure to venlafaxine. [Moderate] Study  Also see TABLE 9 p. 876

- Macrolides (clarithromycin, erythromycin) are predicted to increase the exposure to vinca alkaloids. [Severe] Theoretical  Also see TABLE 9 p. 876
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- Clarithromycin is predicted to increase the exposure to vitamin D substances (paricalcitol). [Moderate] Study
- Clarithromycin decreases the absorption of zidovudine. Separate administration by at least 2 hours. [Moderate] Study
- Clarithromycin is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Theoretical
- Erythromycin is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study

**Magnesium**

- Oral magnesium decreases the absorption of bisphosphonates (alendronic acid). Alendronic acid should be taken at least 30 minutes before magnesium. [Moderate] Study
- Oral magnesium is predicted to decrease the absorption of oral bisphosphonates (ibandronic acid). Avoid magnesium for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical
- Oral magnesium decreases the absorption of bisphosphonates (risedronate). Separate administration by at least 2 hours. [Moderate] Study
- Intravenous magnesium potentially increases the risk of hypotension when given with calcium channel blockers (amlodipine, clevidipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine, verapamil) (in pregnant women). [Severe] Anecdotal
- Intravenous magnesium increases the effects of neuromuscular blocking drugs, non-depolarising. [Moderate] Study
- Intravenous magnesium is predicted to increase the effects of suxamethonium. [Moderate] Study

**Maraviroc**

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to maraviroc. Adjust dose. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to maraviroc. Adjust dose. [Severe] Study
- Aprepitant is predicted to increase the exposure to maraviroc. Avoid or monitor. [Moderate] Study
- Bosentan is predicted to decrease the exposure to maraviroc. Avoid. [Moderate] Theoretical
- Cobicistat markedly increases the exposure to maraviroc. Refer to specialist literature. [Severe] Study
- Efavirenz decreases the exposure to maraviroc. Refer to specialist literature. [Severe] Study
- Enzalutamide is predicted to decrease the exposure to maraviroc. Adjust dose. [Severe] Study
- Etravirine (with a boosted protease inhibitor) increases the exposure to maraviroc. Avoid or adjust dose. [Moderate] Study
- HIV-protease inhibitors (atazanavir, saquinavir) moderately to markedly increase the exposure to maraviroc. Refer to specialist literature. [Severe] Study
- HIV-protease inhibitors (darunavir boosted with ritonavir) markedly increase the exposure to maraviroc. Refer to specialist literature. [Severe] Study
- HIV-protease inhibitors (lopinavir boosted with ritonavir) moderately increase the exposure to maraviroc. Refer to specialist literature. [Severe] Study
- HIV-protease inhibitors (ritonavir) markedly increase the exposure to maraviroc. Refer to specialist literature. [Severe] Study
- Maraviroc potentially decreases the exposure to HIV-protease inhibitors (fosamprenavir) and HIV-protease inhibitors (fosamprenavir) potentially decrease the exposure to maraviroc. Avoid. [Severe] Study
- Idealalis markedly increases the exposure to maraviroc. Adjust dose. [Severe] Theoretical
- Macrolides (clarithromycin) are predicted to markedly increase the exposure to maraviroc. Adjust dose. [Severe] Study
- Mitotane is predicted to decrease the exposure to maraviroc. Adjust dose. [Severe] Study
- Netupitant is predicted to increase the exposure to maraviroc. [Moderate] Study
- Rifampicin is predicted to decrease the exposure to maraviroc. Adjust dose. [Severe] Study
- St John’s Wort is predicted to decrease the exposure to maraviroc. Avoid. [Severe] Theoretical

**Mebendazole**

- H₂ receptor antagonists (cimetidine) increase the concentration of mebendazole. [Moderate] Study

**Medroxyprogesterone**

- Sugammadex is predicted to decrease the exposure to medroxyprogesterone. Use additional contraceptive precautions. [Severe] Theoretical

**Mefloquine**

- See antimalarials

**Melatonin**

- See antipsychotics, mood stabilisers

**Mefloquine**

- See NSAIDs

**Melfalan**

- See alkylating agents

**Mendapine**

- Dopamine receptor agonists (amantadine) increase the risk of CNS toxicity when given with mendapine. Use with caution or avoid. [Severe] Theoretical
- Memantine is predicted to increase the effects of dopamine receptor agonists (apomorphine, bromocriptine, cabergoline, pergolide, pramipexole, quinagolide, ropinirole, rotigotine). [Moderate] Theoretical
- Memantine is predicted to increase the risk of CNS side-effects when given with ketamine. Avoid. [Severe] Theoretical
- Memantine is predicted to increase the effects of levodopa. [Moderate] Theoretical

**Mepacrine**

- Mepacrine is predicted to increase the concentration of antimalarials (primquine). Avoid. [Moderate] Theoretical

**Mepivacaine**

- See anaesthetics, local

**Meprobamate**

- See TABLE 11 p. 876 (CNS depressant effects)

**Meptazinol**

- See opioids

**Mercaptothione**

- See TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression)
- Allopurinol potentially increases the risk of haematological toxicity when given with mercaptothione. Adjust mercaptothione dose. p. 562. [Severe] Study
- Mercaptothione decreases the anticoagulant effect of coumarins. [Moderate] Anecdotal
- Febuxostat is predicted to increase the exposure to mercaptothione. Avoid. [Severe] Theoretical
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with mercaptothione (high–dose). Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

**Mepronem**

- See carbapenems

**Mesalazine**

- See TABLE 15

**ROUTE-SPECIFIC INFORMATION** The manufacturers of some mesalazine gastro-resistant and modified-release medicines (Asacol MR tablets, Ipocol, Salofalk granules) suggest that
Mesalazine (continued)

preparations that lower stool pH (e.g. lactulose) might prevent the release of mesalazine.

> **Preparations**

Metaraminol → see sympathomimetics, vasoconstrictor

Metformin → see TABLE 14 p. 877 (antidiabetic drugs)

▶ Alcohol (beverage) (excessive consumption) potentially increases the risk of lactic acidosis when given with metformin. Avoid excessive alcohol consumption. 

Moderate Theoretical

▶ Bictegravir slightly increases the exposure to metformin.

Moderate Study

▶ Dolutegravir increases the exposure to metformin. Use with caution and adjust dose. 

Severe Study

▶ Guanfacine is predicted to increase the concentration of metformin. 

Moderate Theoretical

▶ H₂ receptor antagonists (cimetidine) increase the exposure to metformin. Monitor and adjust dose. 

Moderate Study

▶ Methylphenidate is predicted to affect the exposure to metformin. 

Unknown Theoretical

▶ Pitolisant is predicted to increase the exposure to metformin. 

High Theoretical

▶ Ribocil is predicted to increase the exposure to methotrexate. 

Moderate Theoretical

▶ Vandetanib increases the exposure to metformin. Monitor and adjust dose. 

Moderate Study

Methadone → see opioids

Methenamine

▶ Acetazolamide is predicted to decrease the efficacy of methenamine. Avoid. 

Moderate Theoretical

▶ Potassium citrate is predicted to decrease the efficacy of methenamine. Avoid. 

Moderate Theoretical

▶ Sodium bicarbonate is predicted to decrease the efficacy of methenamine. Avoid. 

Moderate Theoretical

▶ Sodium citrate is predicted to decrease the efficacy of methenamine. Avoid. 

Moderate Theoretical

Methocarbamol → see TABLE 11 p. 876 (CNS depressant effects)

Methotrexate → see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874 (nephrotoxicity), TABLE 5 p. 874 (thromboembolism)

▶ Acetazolamide increases the urinary excretion of methotrexate. 

Moderate Study

▶ Methotrexate is predicted to decrease the clearance of aminophylline. 

Moderate Theoretical

▶ Antiepileptics (levetiracetam) decrease the clearance of methotrexate. 

Severe Anecdotal

▶ Antimalarials (pyrimethamine) are predicted to increase the risk of side-effects when given with methotrexate. 

Severe Theoretical

▶ Apalutamide is predicted to decrease the exposure to methotrexate. 

Mild Study

▶ Asparaginase affects the efficacy of methotrexate. 

Severe Anecdotal → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877

▶ Aspirin (high-dose) is predicted to increase the risk of toxicity when given with methotrexate. 

Severe Study

▶ Brigitinib potentially increases the concentration of methotrexate. 

Moderate Theoretical

▶ Crisantaspase affects the efficacy of methotrexate. 

Severe Anecdotal → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877

▶ Etofiban is predicted to increase the concentration of methotrexate. 

Moderate Theoretical

▶ Methotrexate potentially increases the risk of severe skin reaction when given with topical fluorouracil. 

Severe Anecdotal → Also see TABLE 15 p. 877 → Also see TABLE 5 p. 874

▶ Leflunomide is predicted to increase the exposure to methotrexate. 

Moderate Theoretical → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877

▶ Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with methotrexate (high-dose). Public Health England advises avoid (refer to Green Book). 

Severe Theoretical

▶ Nitrous oxide potentially increases the risk of methotrexate toxicity when given with methotrexate. Avoid. 

Severe Study → Also see TABLE 2 p. 874

▶ Pegaspargase affects the efficacy of methotrexate. 

Severe Anecdotal → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877

▶ Penicillins are predicted to increase the risk of toxicity when given with methotrexate. 

Severe Anecdotal → Also see TABLE 1 p. 874

▶ Potassium aminobenzoate increases the concentration of methotrexate. 

Moderate Theoretical

▶ Proton pump inhibitors decrease the clearance of methotrexate (high-dose). Use with caution or avoid. 

Severe Study

▶ Quinolones (ciprofloxacin) potentially increase the risk of toxicity when given with methotrexate. 

Severe Anecdotal

▶ Regorafenib is predicted to increase the exposure to methotrexate. 

Moderate Theoretical → Also see TABLE 15 p. 877

▶ Retinoids (acetretin) are predicted to increase the concentration of methotrexate. Avoid. 

Moderate Anecdotal

▶ Rolapitant is predicted to increase the exposure to methotrexate. Avoid or monitor. 

Moderate Study

▶ Methotrexate is predicted to decrease the efficacy of saporin. 

Moderate Theoretical

▶ Sulfonamides are predicted to increase the exposure to methotrexate. Use with caution or avoid. 

Severe Theoretical → Also see TABLE 15 p. 877

▶ Tegafur is predicted to increase the exposure to methotrexate. 

Moderate Anecdotal

▶ Methotrexate decreases the clearance of theophylline. 

Moderate Study

▶ Trimethoprim is predicted to increase the risk of side-effects when given with methotrexate. Avoid. 

Severe Theoretical → Also see TABLE 2 p. 874

Methoxyflurane → see volatile halogenated anaesthetics

Methyldopa → see TABLE 8 p. 875 (hypotension)

▶ Entacapone is predicted to increase the exposure to methyldopa. 

Moderate Theoretical

▶ Iron (oral) decreases the effects of methyldopa. 

Moderate Study

▶ Methyldopa increases the risk of neurotoxicity when given with lithium. 

Severe Anecdotal

▶ Monoamine-oxidase A and B inhibitors, irreversible are predicted to alter the antihypertensive effects of methyldopa. 

Avoid. 

Severe Theoretical → Also see TABLE 8 p. 875

Methylphenidate

▶ Methylphenidate is predicted to decrease the effects of aparcadine. Avoid. 

Severe Theoretical

▶ Methylphenidate is predicted to increase the risk of elevated blood pressure when given with linezolid. 

Avoid. 

Severe Theoretical

▶ Methylphenidate is predicted to increase the risk of a hypertensive crisis when given with moclobemide. 

Severe Theoretical

▶ Methylphenidate is predicted to increase the risk of a hypertensive crisis when given with monoamine-oxidase A and B inhibitors, irreversible. 

Avoid and for 14 days after stopping the MAOI. 

Severe Theoretical

▶ Monoamine-oxidase B inhibitors (rasagline, selegiline) are predicted to increase the risk of a hypertensive crisis when given with methylphenidate. 

Avoid. 

Severe Theoretical

▶ Methylphenidate increases the risk of dyskinesias when given with paliperidone. 

Severe Theoretical

▶ Risperidone increases the risk of dyskinesias when given with methylphenidate. 

Severe Anecdotal

Methylprednisolone → see corticosteroids

Methylylthioninium chloride → see TABLE 13 p. 877 (serotonin syndrome)

Methylthioninium chloride is predicted to increase the risk of severe hypertension when given with bupropion. 

Avoid. 

Severe Theoretical → Also see TABLE 13 p. 877

Metoclopramide

Metoclopramide is predicted to increase the risk of methaemoglobinemia when given with topical anaesthetic, local (prilocaine). Avoid. 

Severe Theoretical
Metoclopramide potentially decreases the absorption of antifungals, azoles (posaconazole) (oral suspension). [Moderate] Study

Metoclopramide decreases the concentration of antimalarials (atovaquone). Avoid. [Moderate] Study

Metoclopramide is predicted to decrease the effects of dopamine receptor agonists (apomorphine, bromocriptine, cabergoline, pergolide, pramipexole, quinagolide, ropinirole, rotigotine). Avoid. [Moderate] Study

Metoclopramide decreases the effects of levodopa. Avoid. [Moderate] Study

Metoclopramide is predicted to increase the effects of neuromuscular blocking drugs, non-depolarising. [Moderate] Study

Antiepileptics

Metoclopramide increases the effects of suxamethonium. [Moderate] Study

Metolazone → see thiazide diuretics

Metoprolol → see beta blockers, selective

Metronidazole → see TABLE 12 p. 877 (peripheral neuropathy)

ROUTE-SPECIFIC INFORMATION Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Alcohol (beverage) potentially causes a disulfiram-like reaction when given with metronidazole. Avoid for at least 48 hours stopping treatment. [Moderate] Study

Metronidazole increases the risk of toxicity when given with alkylating agents (busulfan). [Severe] Study

Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to metronidazole. [Moderate] Study

Metronidazole is predicted to increase the risk of capcetabine toxicity when given with capcetabine. [Severe] Theoretical

Metronidazole increases the anticoagulant effect of warfarin. Use with caution and adjust dose. [Severe] Study

Disulfiram increases the risk of acute psychoses when given with metronidazole. [Severe] Study → Also see TABLE 12 p. 877

Metronidazole increases the risk of toxicity when given with fluorouracil. [Severe] Study

Metyrapone

Antiepileptics (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the effects of metyrapone. Avoid. [Moderate] Study

Antihistamines, sedating (cyproheptadine) decrease the effects of metyrapone. Avoid. [Moderate] Study

Carbamazepine decreases the effects of metyrapone. Avoid. [Moderate] Theoretical

Combined hormonal contraceptives decreases the effects of metyrapone. Avoid. [Moderate] Theoretical

Phenothiazines (chlorpromazine) decrease the effects of metyrapone. Avoid. [Moderate] Theoretical

Propylthiouracil is predicted to decrease the effects of metyrapone. Avoid. [Moderate] Theoretical

Tricyclic antidepressants (amitriptyline) decrease the effects of metyrapone. Avoid. [Moderate] Theoretical

Mexiletine

FOOD AND LIFESTYLE Dose adjustment might be necessary if smoking started or stopped during treatment.

Mexiletine is predicted to increase the exposure to agomelatine. [Moderate] Study

Mexiletine is predicted to increase the exposure to aminophylline. Adjust dose. [Moderate] Theoretical

Mexiletine is predicted to increase the exposure to anagrelide. [Moderate] Theoretical

Mexiletine increases the risk of torsade de pointes when given with antiarrhythmics. Avoid. [Severe] Theoretical

Antiepileptics (phenytoin) are predicted to increase the clearance of mexiletine. Monitor and adjust dose. [Moderate] Study

Mexiletine potentially increases the risk of cardiovascular side-effects when given with beta blockers, non-selective. Avoid or monitor. [Severe] Theoretical

Mexiletine potentially increases the risk of cardiovascular side-effects when given with beta blockers, selective. Avoid or monitor. [Severe] Theoretical

Bupropion is predicted to increase the exposure to mexiletine. [Moderate] Study

Mexiletine increases the risk of cardiovascular side-effects when given with calcium channel blockers (diltiazem). Avoid or monitor. [Severe] Theoretical

Mexiletine potentially increases the risk of cardiovascular side-effects when given with calcium channel blockers (verapamil). Avoid or monitor. [Severe] Theoretical

Cinacalcet is predicted to increase the exposure to mexiletine. [Moderate] Study

Mexiletine increases the concentration of clozapine. Monitor side effects and adjust dose. [Severe] Study

Cobicistat potentially increases the exposure to mexiletine. [Severe] Theoretical

Mexiletine potentially affects the exposure to coumarins (warfarin). Avoid. [Unknown] Theoretical

Mexiletine is predicted to increase the exposure to dopamine receptor agonists (ropinirole). Adjust dose. [Moderate] Study

Mexiletine slightly increases the exposure to erlotinib. Monitor side effects and adjust dose. [Moderate] Study

HIV protease inhibitors (ritonavir) are predicted to increase the clearance of mexiletine. Monitor and adjust dose. [Moderate] Study

Leflunomide is predicted to increase the clearance of mexiletine. Monitor and adjust dose. [Moderate] Study

Mexiletine potentially affects the exposure to lithium. Avoid. [Unknown] Theoretical

Mexiletine is predicted to increase the exposure to loxapine. Avoid. [Unknown] Theoretical

Mexiletine is predicted to increase the exposure to melatonin. [Moderate] Theoretical

Mexiletine is predicted to affect the exposure to metformin. [Unknown] Theoretical

Mexiletine slightly increases the exposure to monoamine-oxidase B inhibitors (rasagline). [Moderate] Study

Mexiletine is predicted to increase the exposure to olanzapine. Adjust dose. [Moderate] Aneotaulc

Opioids potentially decrease the absorption of oral mexiletine. [Moderate] Study

Mexiletine is predicted to increase the exposure to pirenidone. Use with caution and adjust dose. [Moderate] Study

Rifampicin is predicted to increase the clearance of mexiletine. Monitor and adjust dose. [Moderate] Study

Mexiletine is predicted to increase the exposure to rifuzole. [Moderate] Theoretical

Mexiletine is predicted to increase the exposure to roflumilast. [Moderate] Theoretical

SSRI (fluoxetine, fluvoxamine, paroxetine) are predicted to increase the exposure to mexiletine. [Moderate] Study

Tertibafine is predicted to increase the exposure to mexiletine. [Moderate] Study

Mexiletine is predicted to increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical

Mexiletine increases the exposure to tizanidine. Avoid. [Moderate] Study

Mexiletine is predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical

Mianserin → see TABLE 13 p. 877 (serotonin syndrome), TABLE 11 p. 876 (CNS depressant effects)

Antiepileptics (carbamazepine) markedly decrease the exposure to mianserin. Adjust dose. [Moderate] Study

Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to mianserin. [Moderate] Study → Also see TABLE 11 p. 876

Mianserin is predicted to increase the risk of toxicity when given with moclobemide. Avoid and for 1 week after stopping mianserin. [Severe] Theoretical → Also see TABLE 13 p. 877

Mianserin is predicted to increase the risk of toxicity when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical → Also see TABLE 13 p. 877
Mianserin (continued)

- **Mianserin** is predicted to decrease the efficacy of **pitolisant**.
  - **Moderate** Theoretical
- Mianserin decreases the effects of **sympathomimetics, vasoconstrictor** (ephedrine).
  - **Severe** Anecdotal

*Micafungin* → see TABLE 1 p. 876 (Hepatotoxicity)

- *Micafungin* slightly increases the exposure to **amphotericin**.
  - Avoid or monitor toxicity. **Moderate** Study
- *Miconazole* → see antifungals, azoles
- *Midazolam* → see TABLE 1 p. 876 (CNS depressant effects)
  - Antiarhythmic drugs (dronedarone) are predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to midazolam. Monitor and adjust dose. **Moderate** Study  
  - Also see TABLE 1 p. 876
  - Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. **Severe** Study
  - Antifungals, azoles (miconazole) are predicted to increase the exposure to intravenous midazolam. Use with caution and adjust dose. **Moderate** Theoretical
  - Antifungals, azoles (miconazole) are predicted to increase the exposure to oral midazolam. Avoid. **Moderate** Theoretical
  - *Apalutamide* markedly decreases the exposure to midazolam. 
  - Avoid or monitor. **Severe** Study
  - *Aprepitant* is predicted to decrease the concentration of midazolam. Monitor and adjust dose. **Moderate** Theoretical
  - *Bosantan* is predicted to decrease the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - *Efavirenz* is predicted to alter the effects of midazolam. Avoid. **Moderate** Theoretical
  - *Enzalutamide* is predicted to decrease the exposure to midazolam. Monitor and adjust dose. **Moderate** Study
  - *Fosaprepitant* slightly increases the exposure to midazolam. **Moderate** Study
  - HIV-protease inhibitors are predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. **Severe** Study
  - *Idelalisib* is predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. **Severe** Study
  - *Letrozomib* is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - *Letemovir* slightly to moderately increases the exposure to midazolam. Monitor and adjust dose. **Moderate** Study
  - *Lumacaftor* is predicted to decrease the exposure to midazolam. Avoid. **Severe** Theoretical
  - Macrolides (clarithromycin) are predicted to markedly to very markedly increase the exposure to midazolam. Avoid or adjust dose. **Severe** Study
  - Macrolides (erythromycin) are predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - *Mitotane* is predicted to decrease the exposure to midazolam. Monitor and adjust dose. **Moderate** Theoretical
  - Monoclonal antibodies (tocilizumab) are predicted to decrease the exposure to midazolam. Monitor and adjust dose. **Moderate** Theoretical
  - *Netupitant* is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - *Nevirapine* decreases the concentration of midazolam. Monitor and adjust dose. **Moderate** Study
  - *Nilotinib* is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. **Severe** Study
  - *Pabliciclib* increases the exposure to midazolam. **Moderate** Study
  - *Pabliciclib* moderately increases the exposure to midazolam. Avoid. **Moderate** Study
  - *Rifampicin* is predicted to decrease the exposure to midazolam. Monitor and adjust dose. **Moderate** Study
  - *Rucaparib* slightly increases the exposure to midazolam. Monitor and adjust dose. **Severe** Study
  - *St John’s Wort* decreases the exposure to midazolam. **Moderate** Study
  - *Telotristat ethyl* decreases the exposure to midazolam. **Moderate** Study

*Midostaurin*

- Antiarhythmic drugs (dronedarone) are predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to midostaurin. Avoid. **Severe** Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- *Aprepitant* is predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- *Cobicistat* is predicted to markedly to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. **Severe** Study
- *Crizotinib* is predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- *Enzalutamide* is predicted to decrease the exposure to midostaurin. Avoid. **Severe** Study
- HIV-protease inhibitors are predicted to markedly to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. **Severe** Study
- *Idelalisib* is predicted to markedly to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. **Severe** Study
- *Imatinib* is predicted to markedly to very markedly increase the exposure to midostaurin. Avoid or monitor for toxicity. **Severe** Study
- *Mitotane* is predicted to decrease the exposure to midostaurin. Avoid. **Severe** Study
- *Netupitant* is predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- *Nilotinib* is predicted to increase the exposure to midostaurin. **Moderate** Theoretical
- *Rifampicin* is predicted to decrease the exposure to midostaurin. Avoid. **Severe** Study
- *St John’s Wort* is predicted to decrease the exposure to midostaurin. Avoid. **Severe** Theoretical
- *Tacrolimus* is predicted to affect the efficacy of mifamurtide. Avoid. **Severe** Theoretical
- Clopofibrate decreases the efficacy of mifamurtide. **Moderate** Theoretical
- Corticosteroids are predicted to decrease the efficacy of mifamurtide. Avoid. **Severe** Theoretical
- NSAAH (high-dose) are predicted to decrease the efficacy of mifamurtide. Avoid. **Severe** Theoretical
- Pimecrolimus is predicted to decrease the efficacy of mifamurtide. Avoid. **Severe** Theoretical
- Sirolimus is predicted to decrease the efficacy of mifamurtide. Avoid. **Severe** Theoretical
- Telotristat ethyl decreases the exposure to midazolam. **Moderate** Study
- Midodrine is predicted to decrease the exposure to midostaurin. **Moderate** Theoretical
- *Rifampicin* is predicted to decrease the exposure to midostaurin. Avoid. **Severe** Study
- *St John’s Wort* decreases the exposure to midostaurin. **Moderate** Study
- *Telotristat ethyl* decreases the exposure to midazolam. **Moderate** Study
Mifepristone
- Mifepristone is predicted to decrease the efficacy of corticosteroids. Use with caution and adjust dose. (Moderate)
- Theoretical

Minocycline → see tetracyclines

Minoxidil → see TABLE 8 p. 875 (Hypotension)

ROUTE-SPECIFIC INFORMATION: Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Mirabegron
- Mirabegron is predicted to increase the exposure to alisikiren. (Mild) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- Mirabegron is predicted to increase the exposure to anthistamines, non-sedating (fexofenadine). (Mild) Theoretical
- Mirabegron is predicted to increase the exposure to beta blockers, selective (metoprolol). (Moderate) Study
- Cobicistat is predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- Mirabegron is predicted to increase the exposure to colchicine. (Mild) Theoretical
- Mirabegron is predicted to increase the exposure to dabigatran. (Severe) Theoretical
- Mirabegron slightly increases the exposure to digoxin. Monitor concentration and adjust dose. (Severe) Study
- Mirabegron is predicted to increase the exposure to edoxaban. (Mild) Theoretical
- Mirabegron is predicted to increase the exposure to elaglutstat. Avoid or adjust dose—consult product literature. (Severe) Study
- Mirabegron is predicted to increase the exposure to everolimus. (Mild) Theoretical
- HIV- protease inhibitors are predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- Idelalisib is predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- Mirabegron is predicted to increase the exposure to loperamide. (Mild) Theoretical
- Macrolides (clarithromycin) are predicted to increase the exposure to mirabegron. Adjust mirabegron dose in hepatic and renal impairment. (Moderate) Study
- Mirabegron is predicted to increase the exposure to sirolimus. (Mild) Theoretical
- Mirabegron is predicted to increase the exposure to taxanes (paclitaxel). (Mild) Theoretical
- Mirabegron is predicted to increase the exposure to topotecan. (Mild) Theoretical

Mirtazapine → see TABLE 13 p. 877 (Serotonin Syndrome), TABLE 11 p. 876 (CNS depressant effects)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to mirtazapine. Adjust dose. (Moderate) Study → Also see TABLE 11 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to mirtazapine. (Moderate) Study
- Cobicistat is predicted to increase the exposure to mirtazapine. (Moderate) Study
- Enzalutamide is predicted to decrease the exposure to mirtazapine. Adjust dose. (Moderate) Study
- H₂ receptor antagonists (cimetidine) slightly increase the exposure to mirtazapine. Use with caution and adjust dose. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to mirtazapine. (Moderate) Study
- Idelalisib is predicted to increase the exposure to mirtazapine. (Moderate) Study
- Macrolides (clarithromycin) are predicted to increase the exposure to mirtazapine. (Moderate) Study
- Mifepristone is predicted to decrease the exposure to mirtazapine. Adjust dose. (Moderate) Study
- Mirtazapine is predicted to decrease the efficacy of pitolisant. (Moderate) Theoretical
- Rifampicin is predicted to decrease the exposure to mirtazapine. Adjust dose. (Moderate) Study
- Mitomycin → see TABLE 15 p. 877 (Myelosuppression), TABLE 5 p. 874 (Thromboembolism)

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with mitomycin. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

Mitotane → see TABLE 15 p. 877 (Myelosuppression)
- Mitotane is predicted to markedly decrease the exposure to abemaciclib. Avoid. (Severe) Study
- Mitotane is predicted to decrease the exposure to abiraterone. Avoid. (Severe) Study
- Aldosterone antagonists (spironolactone) are predicted to decrease the effects of mitotane. Avoid. (Severe) Anecdotal
- Mitotane is predicted to decrease the exposure to aldosterone antagonists (eplerenone). Avoid. (Moderate) Theoretical
- Mitotane is predicted to decrease the exposure to alprazolam. Adjust dose. (Moderate) Theoretical
- Mitotane is predicted to decrease the exposure to antiaarrhythmics (disopyramide, dronedarone). Avoid. (Severe) Study
- Mitotane is predicted to decrease the exposure to antiepileptics (propafenone). Avoid. (Moderate) Study
- Mitotane is predicted to decrease the exposure to antihistamines, non-sedating (fexofenadine). Avoid or adjust dose—consult product literature. (Severe) Study
- Mitotane is predicted to decrease the exposure to antituberculosis, centrally acting (donepezil). Avoid. (Mild) Study
- Mitotane is predicted to decrease the exposure to antituberculosis agents (perampanel). Monitor and adjust dose. (Moderate) Study
- Mitotane is predicted to decrease the exposure to antifungals, azoles (isavuconazole). Avoid. (Severe) Study
- Mitotane is predicted to decrease the exposure to antimalarials (artemether) (with lumarfantrine). Avoid. (Severe) Study
- Mitotane is predicted to decrease the concentration of antimalarials (piperaquine). Avoid. (Moderate) Theoretical
- Mitotane is predicted to moderately decrease the exposure to apixaban. Use with caution or avoid. (Severe) Study
- Mitotane is predicted to moderately decrease the exposure to apremilast. Avoid. (Severe) Study
- Mitotane is predicted to markedly decrease the exposure to aripiprazole. Avoid. (Moderate) Study
- Mitotane is predicted to decrease the exposure to artemether (with lumarfantrine). Avoid. (Severe) Study
- Mitotane decreases the exposure to bedaquiline. Avoid. (Severe) Study
- Mitotane is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Study
- Mitotane decreases the exposure to bosentan. Avoid. (Severe) Study → Also see TABLE 15 p. 877
- Mitotane affects the exposure to bosentan. Avoid. (Severe) Study
- Mitotane is predicted to very markedly decrease the exposure to bosutinib. Avoid. (Severe) Study → Also see TABLE 15 p. 877
- Mitotane is predicted to decrease the exposure to brigatinib. Avoid. (Severe) Study
- Mitotane is predicted to decrease the exposure to buspirone. Use with caution and adjust dose. (Severe) Study
- Mitotane moderately decreases the exposure to cabozantinib. Avoid. (Moderate) Study → Also see TABLE 15 p. 877
- Mitotane is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nimodipine). Monitor and adjust dose. (Moderate) Study
- Mitotane is predicted to decrease the exposure to cannabis extract. Avoid. (Severe) Theoretical
- Mitotane is predicted to decrease the exposure to cariprazine. Avoid. (Severe) Theoretical
- Mitotane is predicted to decrease the exposure to ceritinib. Avoid. (Severe) Study → Also see TABLE 15 p. 877
- Mitotane decreases the concentration of ciclosporin. (Severe) Study
Mitotane is predicted to decrease the effects of cilostazol. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to cinacalcet. Monitor and adjust dose. [Moderate] Study

Mitotane decreases the exposure to clofibrate. Monitor and adjust dose. [Moderate] Study

Mitotane is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

Mitotane is predicted to decrease the exposure to corticosteroids (budesonide, deflazacort, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone, triamcinolone). Monitor and adjust dose. [Moderate] Study

Mitotane is predicted to decrease the exposure to corticosteroids (fluticasone). Unknown Theoretical

Mitotane is predicted to markedly decrease the exposure to dabrafenib. Avoid. [Moderate] Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to darifenacin. Avoid. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to dasabuvir. Avoid. [Severe] Study → Also see TABLE 15 p. 877

Mitotane is predicted to slightly decrease the exposure to delamanid. Avoid. [Moderate] Study

Mitotane decreases the exposure to dolasetro. Adjust dose. [Severe] Study

Mitotane is predicted to decrease the exposure to doravirine. Avoid. [Severe] Study

Mitotane is predicted to decrease the concentration of eltelatro. Avoid. [Severe] Theoretical

Mitotane is predicted to decrease the exposure to enzalutamid. [Severe] Theoretical

Mitotane is predicted to decrease the effects of ergotamine. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to erlotinib. Avoid or adjust erlotinib dose. [Severe] Study

Mitotane is predicted to decrease the exposure to esteridom. Adjust dose. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to etravirine. Avoid. [Severe] Theoretical

Mitotane is predicted to decrease the concentration of everolimus. Avoid or adjust dose. [Severe] Study → Also see TABLE 15 p. 877

Mitotane moderately decreases the exposure to exemestane. [Moderate] Study

Mitotane is predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study

Mitotane is predicted to decrease the exposure to fosphatid. Avoid. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study → Also see TABLE 15 p. 877

Mitotane is predicted to greatly decrease the concentration of glecaprevir. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study

Mitotane is predicted to decrease the concentration of guanafacine. Adjust guanafacine dose, p. 227. [Moderate] Study

Mitotane decreases the concentration of haloperidol. Adjust dose. [Moderate] Study

Mitotane is predicted to decrease the exposure to ibritinib. Avoid or adjust ibritinib dose. [Severe] Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to idelalisib. Avoid. [Severe] Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to imatinib. Avoid. [Moderate] Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to ivabradine. Adjust dose. [Moderate] Theoretical

Mitotane is predicted to moderately markedly decrease the exposure to ivacaftor. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to ivazobin. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to lapatinib. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to lapatinib. Avoid. [Severe] Study

Mitotane is predicted to increase the exposure to lomitapide. Monitor and adjust dose. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to lurasidone. Avoid. [Moderate] Study

Mitotane is predicted to decrease the exposure to macitentan. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to maraviroc. Adjust dose. [Severe] Study

Mitotane is predicted to decrease the exposure to midazolam. Monitor and adjust dose. [Moderate] Study

Mitotane is predicted to decrease the exposure to midostaurin. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to mirtazapine. Adjust dose. [Moderate] Study

Mitotane is predicted to decrease the exposure to montelukast. [Mild] Study

Mitotane is predicted to markedly decrease the exposure to naloxegol. Avoid. [Moderate] Study

Mitotane is predicted to slightly decrease the exposure to nategliide. [Mild] Study

Mitotane is predicted to decrease the exposure to netupitant. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to nevirapine. [Severe] Theoretical

Mitotane is predicted to moderately decrease the exposure to nilotinib. Avoid. [Severe] Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to nitrosine. Adjust dose. [Moderate] Theoretical

Mitotane is predicted to decrease the exposure to olaparib. Avoid. [Moderate] Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to ombitasvir. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to ondasertron. [Moderate] Study

Mitotane is predicted to decrease the exposure to opioids (alfentanil, fentanyl). [Moderate] Study

Mitotane is predicted to decrease the exposure to opioids (buprenorphine). Monitor and adjust dose. [Moderate] Theoretical

Mitotane decreases the exposure to opioids (methadone). Monitor and adjust dose. [Severe] Study

Mitotane is predicted to moderately decrease the exposure to osimertinib. Avoid. [Moderate] Study

Mitotane is predicted to moderately decrease the exposure to osmepinef. [Moderate] Study

Mitotane is predicted to decrease the exposure to palbociclib. Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to paliperidone. Monitor and adjust dose. [Severe] Study

Mitotane is predicted to decrease the exposure to panobinostat. Avoid. [Moderate] Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe] Study

Mitotane is predicted to decrease the exposure to pazopanib. Avoid. [Severe] Theoretical → Also see TABLE 15 p. 877
Mitotane is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, tadalafil). Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (sildenafil, vardenafil). (Moderate) Theoretical

Mitotane is predicted to moderately to markedly decrease the exposure to pibrentasvir. Avoid. (Severe) Study

Mitotane is predicted to moderately decrease the exposure to pitolisant. (Moderate) Study

Mitotane is predicted to decrease the exposure to ponatinib. Avoid. (Moderate) Theoretical

Mitotane is predicted to markedly decrease the exposure to praziquantel. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to quetiapine. (Moderate) Study

Mitotane is predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to reboxetine. (Moderate) Aacdotal

Mitotane is predicted to decrease the exposure to regorafenib. Avoid. (Moderate) Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to repaglinide. Monitor blood glucose and adjust dose. (Moderate) Study

Mitotane is predicted to markedly decrease the exposure to rivaroxaban. Avoid unless patient can be monitored for signs of thrombosis. (Severe) Study

Mitotane is predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Mitotane is predicted to markedly decrease the exposure to rolipram. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to risperidone. Adjust dose. (Moderate) Study

Mitotane is predicted to moderately decrease the exposure to rivaroxaban. Avoid unless patient can be monitored for signs of thrombosis. (Severe) Study

Mitotane is predicted to decrease the exposure to saxagliptin. (Moderate) Study

Mitotane is predicted to decrease the concentration of sirolimus. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to solifenacin. (Moderate) Theoretical

Mitotane is predicted to decrease the exposure to sorafenib. (Moderate) Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to statins (simvastatin). (Severe) Study

Mitotane is predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. (Moderate) Study → Also see TABLE 15 p. 877

Mitotane decreases the concentration of tacrolimus. Monitor and adjust dose. (Severe) Study

Mitotane is predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. (Severe) Study → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to taxanes (docetaxel). (Severe) Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Study → Also see TABLE 15 p. 877

Mitotane decreases the exposure to tetracyclines (doxycycline). Monitor and adjust dose. (Moderate) Study

Mitotane is predicted to decrease the exposure to tezacaftor. Avoid. (Severe) Theoretical

Mitotane is predicted to markedly decrease the exposure to tigecycline. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to tofacitinib. Use with caution or avoid depending on indication. (Severe) Study

Mitotane is predicted to decrease the exposure to toremifene. Adjust dose. (Moderate) Study

Mitotane is predicted to decrease the exposure to trabectedin. Avoid. (Severe) Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to vandetanib. Avoid. (Moderate) Study

Mitotane is predicted to moderately to markedly decrease the exposure to velpatasvir. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to vemurafenib. Avoid. (Severe) Theoretical

Mitotane is predicted to decrease the exposure to venetoclax. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to vinca alkaloids (vinblastine, vincristine, vinorelbine). (Severe) Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to vinca alkaloids (vinflunine). Avoid. (Severe) Theoretical → Also see TABLE 15 p. 877

Mitotane is predicted to decrease the exposure to vismodegib. Monitor and adjust dose. (Moderate) Study

Mitotane is predicted to decrease the exposure to voriconazole. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to zopiclone. Adjust dose. (Moderate) Study

Mitocromone → see anticoagulants

Mivacurium → see neuromuscular blocking drugs, non-depolarising

Mizolastine → see antihistamines, non-sedating

Moclobemide → see TABLE 13 p. 877 (serotonin syndrome)

**FOOD AND LIFESTYLE** Moclobemide is claimed to cause less potentiation of the pressor effect of tyramine than the traditional (irreversible) MAOIs, but patients should avoid consuming large amounts of tyramine-rich foods (such as mature cheese, salami, pickled herring, Bovril®, Oxo®, Marmite® or any similar meat or yeast extract or fermented soya bean extract, and some beers, lagers or wines).

Moclobemide is predicted to increase the risk of a hypertensive crisis when given with amfetamines. Avoid. (Severe) Theoretical → Also see TABLE 13 p. 877

Apalutamide is predicted to decrease the exposure to moclobemide. Avoid or monitor. (Mild) Study

Moclobemide is predicted to increase the risk of severe hypertension when given with bupropion. Avoid. (Severe) Theoretical → Also see TABLE 13 p. 877

Moclobemide is predicted to increase the exposure to cilostazol. (Moderate) Theoretical

Moclobemide potentially increases the exposure to clobazam. Adjust dose. (Moderate) Theoretical

Moclobemide is predicted to decrease the efficacy of clopidogrel. Avoid. (Moderate) Study

Moclobemide is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Theoretical

H₂ receptor antagonists (cimetidine) increase the exposure to moclobemide. Adjust moclobemide dose. (Mild) Study

Levodopa increases the risk of side-effects when given with moclobemide. (Moderate) Study

Moclobemide is predicted to increase the risk of side-effects when given with linezolid. Avoid and for 14 days after stopping moclobemide. (Severe) Theoretical → Also see TABLE 13 p. 877

Methylphenidate is predicted to increase the risk of a hypertensive crisis when given with moclobemide. (Severe) Theoretical

Mianserin is predicted to increase the risk of toxicity when given with moclobemide. Avoid and for 1 week after stopping mianserin. (Severe) Theoretical → Also see TABLE 13 p. 877

Moclobemide is predicted to increase the effects of monoamine-oxidase B inhibitors (rasagiline, selegiline). Avoid. (Severe) Theoretical → Also see TABLE 13 p. 877
Moclobemide – Monoamine-oxidase A and B inhibitors, irreversible

Moclobemide (continued)

- Moclobemide is predicted to increase the risk of side-effects when given with monoamine-oxidase B inhibitors (safinamide). Avoid and for 1 week after stopping safinamide. [Severe] Study

  Also see TABLE 13 p. 877

- Opiocapone is predicted to increase the risk of elevated blood pressure when given with moclobemide. Avoid. [Severe] Study

- Moclobemide increases the risk of side-effects when given with phenothiazines (leomepromazine). [Moderate] Study

- Reboxetine is predicted to increase the risk of a hypertensive crisis when given with moclobemide. Avoid. [Severe] Theoretical

- Moclobemide moderately increases the exposure to rizatRIPTAN. Avoid. [Moderate] Study  Also see TABLE 13 p. 877

- Moclobemide slightly increases the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Study  Also see TABLE 13 p. 877

Modafinil

- Antiepileptics (carbamazepine, phenobarbital, primidone) are predicted to decrease the exposure to modafinil. [Mild] Theoretical

- Antiepileptics (fosphenytoin, phenytoin) are predicted to decrease the exposure to modafinil and modafinil is predicted to increase the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. [Moderate] Theoretical

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to modafinil. [Mild] Theoretical

- Modafinil is predicted to decrease the exposure to bosutinib. Avoid. [Severe] Theoretical

- Cobicistat is predicted to increase the exposure to modafinil. [Mild] Theoretical

- Modafinil is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study

- Modafinil is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

- Modafinil is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. [Severe] Theoretical

- Modafinil is predicted to decrease the exposure to elbasvir. Avoid. [Unknown] Theoretical

- Modafinil is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

- Modafinil is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Theoretical

- HIV-protease inhibitors are predicted to increase the exposure to modafinil. [Mild] Theoretical

- Modafinil is predicted to decrease the effects of hormone replacement therapy. [Moderate] Anecdotal

- idelalisib is predicted to increase the exposure to modafinil. [Mild] Theoretical

- Modafinil is predicted to decrease the concentration of intermenvir. [Moderate] Theoretical

- Modafinil is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

- Macrolides (clarithromycin) are predicted to increase the exposure to modafinil. [Mild] Theoretical

- Modafinil is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

- Rifampicin is predicted to decrease the exposure to modafinil. [Moderate] Theoretical

- Modafinil is predicted to decrease the exposure to sofosbuvir. Avoid. [Severe] Theoretical

- Modafinil decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

- Modafinil is predicted to decrease the exposure to velpatasvir. Avoid. [Severe] Theoretical

- Modafinil is predicted to decrease the concentration of voxilaprevir. Avoid. [Severe] Theoretical

Mometasone → see corticosteroids

TABLE 13 p. 877

FOOD AND LIFESTYLE

Potential life-threatening hypertensive crisis can develop in those taking MAOIs who eat tyramine-rich food (such as mature cheese, salami, pickled herring, Bovril®, Oxo®, Marmite® or any similar meat or yeast extract or fermented soya bean extract, and some beers, lagers or wines) or foods containing dopa (such as broad bean pods). Avoid tyramine-rich or dopa-rich food or drinks with, or for 2 to 3 weeks after stopping, the MAOI.

- Moclobemide and B inhibitors, irreversible are predicted to increase the effects of alpha blockers (indoramin). Avoid. [Severe] Theoretical  Also see TABLE 8 p. 875

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of a hypertensive crisis when given with amfetamines. Avoid and for 14 days after stopping the MAOI. [Severe] Anecdotal  Also see TABLE 13 p. 877

- Antiepileptics (carbamazepine) are predicted to increase the risk of severe toxic reaction when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical

- Antiepileptics (phenobarbital, primidone) are predicted to increase the effects of monoamine-oxidase A and B inhibitors, irreversible. [Severe] Theoretical

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of antimuscarinic side-effects when given with antihistamines, non-sedating. Avoid. [Severe] Theoretical

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of antimuscarinic side-effects when given with antihistamines, sedating. Avoid. [Severe] Theoretical

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of side-effects when given with atomoxetine. Avoid and for 2 weeks after stopping the MAOI. [Severe] Theoretical

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of cardiovascular side-effects when given with beta agonists. [Moderate] Anecdotal

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of severe hypertension when given with bupropion. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical  Also see TABLE 13 p. 877

- Buspirone is predicted to increase the risk of elevated blood pressure when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid. [Severe] Anecdotal  Also see TABLE 13 p. 877

- Moclobemide and B inhibitors, irreversible are predicted to increase the effects of doxapram. [Moderate] Theoretical

- Entacapone is predicted to increase the risk of elevated blood pressure when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid. [Severe] Theoretical

- Moclobemide and B inhibitors, irreversible are predicted to increase the antihypertensive effects of guanethidine. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical  Also see TABLE 8 p. 875

- Levodopa increases the risk of a hypertensive crisis when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Study  Also see TABLE 8 p. 875

- Moclobemide and B inhibitors, irreversible are predicted to increase the risk of side-effects when given with...
Monoamine-oxidase A and B inhibitors – Monoamine-oxidase B inhibitors

**Monoamine-oxidase A and B inhibitors, irreversible** are predicted to increase the exposure to **zolmitriptan**. (Severe)

Monoamine-oxidase B inhibitors — Monoamine-oxidase B inhibitors

- **Tricyclic antidepressants** are predicted to increase the risk of severe toxic reaction when given with monoamine-oxidase A and B inhibitors, irreversible. (Severe)
- **Tryptophan** increases the risk of side-effects when given with monoamine-oxidase A and B inhibitors, irreversible. (Severe)
- **Mianserin** is predicted to increase the risk of CNS toxicity when given with monoamine-oxidase A and B inhibitors, irreversible. (Severe)
- **Tolcapone** increases the risk of side-effects when given with monoamine-oxidase A and B inhibitors, irreversible. (Severe)
- **Tetrabenazine** is predicted to increase the risk of a hypertensive crisis when given with monoamine-oxidase A and B inhibitors, irreversible. (Severe)
- **Monoamine-oxidase B inhibitors** are predicted to increase the risk of severe hypertension when given with **rasagiline**, **selegiline**. (Severe)
- **Moclobemide** is predicted to increase the effects of monoamine-oxidase B inhibitors (rasagiline, selegiline). (Severe)
- **Mexiletine** slightly increases the exposure to rasagiline. (Moderate)
- **Safinamide** is predicted to increase the risk of severe hypertension when given with **beta, agonists**. (Severe)
- **Monoamine-oxidase B inhibitors** are predicted to increase the risk of severe hypertension when given with **bupropion**. Avoid. (Moderate)
- **Combined hormonal contraceptives** slightly increase the exposure to rasagiline. (Moderate)
- **Monoamine-oxidase B inhibitors** are predicted to increase the effects of **levodopa**. Adjust dose. (Hild)
- **Hormone replacement therapy** is predicted to increase the exposure to selegiline. (Moderate)
- **Moclobemide** is predicted to increase the risks of monoamine-oxidase B inhibitors (rasagiline, selegiline). Avoid. (Severe)
- **Safinamide** is predicted to increase the risk of severe side-effects when given with **linezolid**. Avoid and for 14 days after stopping the MAOI. (Severe)
- **Monoamine-oxidase B inhibitors** (rasagiline, selegiline) are predicted to increase the risk of side-effects when given with **linezolid**. Avoid and for 14 days after stopping the MAOI. (Severe)
- **Monoamine-oxidase B inhibitors** (rasagiline, selegiline) are predicted to increase the risk of side-effects when given with **linezolid**. Avoid and for 14 days after stopping the MAOI. (Severe)
Monoamine-oxidase B inhibitors (continued)

- **Reboxetine** is predicted to increase the risk of a hypertensive crisis when given with monoamine-oxidase B inhibitors (rasagline, selegiline). Avoid.  
- **Monoamine-oxidase B inhibitors** are predicted to increase the risk of a hypertensive crisis when given with sympathomimetics, inotropic. Avoid.  
- **Monoamine-oxidase B inhibitors** are predicted to increase the risk of a hypertensive crisis when given with sympathomimetics, vasocostric tors. Avoid.  
- **Blinatumomab** is predicted to transiently increase the exposure to **antifungals, azoles**. Monitor and adjust dose.  
- **Tocilizumab** is predicted to decrease the exposure to **antiepileptics**. Monitor and adjust dose.  
- **Antifungals, azoles** are predicted to increase the exposure to **anthracyclines**. Monitor and adjust dose.  
- **Anakinra** is predicted to transiently increase the exposure to **antiarrhythmics**. Monitor and adjust dose.  
- **Antiarrhythmics** (dronedarone) increase the risk of neutropenia when given with **brentuximab vedotin**. Monitor and adjust dose.  
- **Anthracyclines** are predicted to increase the risk of cardiotoxicity when given with monoclonal antibodies (trastuzumab, trastuzumab emtansine). Avoid.  
- **Antiepileptics** (carbamazepine) are predicted to decrease the exposure to **brentuximab vedotin**. Avoid.  
- **Blinatumomab** is predicted to decrease the exposure to **brentuximab vedotin**. Avoid.  
- **Tocilizumab** is predicted to decrease the exposure to **brentuximab vedotin**. Avoid.  
- **Blinatumomab** potentially affects the exposure to **brentuximab vedotin**. Avoid.  
- **Brentuximab vedotin** is predicted to increase the risk of generalised infection (possibly life-threatening) when given with **brentuximab vedotin**. Avoid.  
- **Antiepileptics** (lorazepam, valproate) are predicted to increase the exposure to **brentuximab vedotin**. Avoid.  
- **Antiepileptics** (midazolam) are predicted to increase the exposure to **brentuximab vedotin**. Avoid.  
- **Monoamine-oxidase B inhibitors** are predicted to increase the exposure to **brentuximab vedotin**. Avoid.  
- **Antiepileptics** (phenytoin) are predicted to increase the exposure to **brentuximab vedotin**. Avoid.  
- **Antiepileptics** (phenobarbital) are predicted to increase the exposure to **brentuximab vedotin**. Avoid.  
- **Antiepileptics** (phenytoin, phenobarbital) are predicted to increase the exposure to **brentuximab vedotin**. Avoid.  
- **Brentuximab vedotin** increases the risk of pulmonary toxicity when given with **brentuximab vedotin**. Monitor and adjust dose.  
- **Brentuximab vedotin** is predicted to decrease the exposure to **calcium channel blockers**. Monitor and adjust dose.  
- **Blinatumomab** is predicted to transiently increase the exposure to **cisplatin**. Monitor and adjust dose.  
- **Sarilumab** potentially affects the exposure to **cisplatin**. Monitor and adjust dose.  
- **Cisplatin** is predicted to decrease the exposure to **cisplatin**. Monitor and adjust dose.  
- **Cobimetinib** is predicted to transiently increase the exposure to **cisplatin**. Monitor and adjust dose.  
- **Sarilumab** potentially decreases the exposure to **combined hormonal contraceptives**. Avoid.  
- **Corticosteroids** are predicted to decrease the exposure to **cisplatin**. Monitor and adjust dose.  
- **Corticosteroids** (betamethasone, deflazacort, dexamethasone, hydrocortisone, methylprednisolone, prednisolone) are predicted to decrease the efficacy of monoclonal antibodies (atezolizumab, ipilimumab, nivolumab, pembrolizumab). Use with caution or avoid.  
- **Tocilizumab** is predicted to decrease the exposure to **coumarins** (dexamethasone, methylprednisolone). Monitor and adjust dose.  
- **Blinatumomab** is predicted to transiently increase the exposure to **coumarins** (warfarin). Monitor and adjust dose.  
- **Tocilizumab** is predicted to decrease the exposure to **coumarins** (warfarin). Monitor and adjust dose.  
- **HIV-protease inhibitors** (lopinavir, ritonavir, saquinavir) are predicted to increase the risk of neutropenia when given with **brentuximab vedotin**. Monitor and adjust dose.  
- **HIV-protease inhibitors** are predicted to increase the exposure to **trastuzumab emtansine**. Avoid.  
- **Immunoglobulins** are predicted to alter the effects of **dinutuximab**. Avoid.  
- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with **macrolides** (clarithromycin, azithromycin). Public Health England advises avoid (refer to Green Book).  
- **Macrolides** (clarithromycin) increase the risk of neutropenia when given with **brentuximab vedotin**. Monitor and adjust dose.  
- **Macrolides** (clarithromycin) are predicted to increase the exposure to **trastuzumab emtansine**. Avoid.  
- **Tocilizumab** is predicted to decrease the exposure to **midazolam**. Monitor and adjust dose.  
- **Ribavirin** decreases the effects of **brentuximab vedotin**. Avoid.  
- **Sarilumab** potentially affects the exposure to **sirolimus**. Monitor and adjust dose.  
- **Sarilumab** is predicted to increase the exposure to **statins** (atorvastatin, simvastatin). Monitor and adjust dose.  
- **Tocilizumab** is predicted to decrease the exposure to **statins** (atorvastatin, simvastatin). Monitor and adjust dose.  
- **Sarilumab** potentially affects the exposure to **tacrolimus**. Monitor and adjust dose.  
- **Blinatumomab** is predicted to transiently increase the exposure to **theophylline**. Monitor and adjust dose.  
- **Tocilizumab** is predicted to decrease the exposure to **theophylline**. Monitor and adjust dose.  
- **Sarilumab** potentially affects the exposure to **theophylline**. Monitor and adjust dose.  
- **Tocilizumab** is predicted to decrease the exposure to **theophylline**. Monitor and adjust dose.  
- **Montelukast** is predicted to decrease the exposure to **theophylline**. Monitor and adjust dose.  
- **Antiepileptics** (carbamazepine, phenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to **montelukast**.  
- **Clopidogrel** is predicted to moderately increase the exposure to **montelukast**.  
- **Enalapril** is predicted to increase the exposure to **montelukast**.  
- **Fibrates (gemfibrozil)** are predicted to moderately increase the exposure to **montelukast**.  
- **Mitotane** is predicted to decrease the exposure to **montelukast**.  
- **Opicapone** is predicted to increase the exposure to **montelukast**. Avoid.
Crizotinib is predicted to decrease the exposure to montelukast. [Mild] Study
Teriflunomide is predicted to increase the exposure to montelukast. [Moderate] Theoretical
Morphine → see opioids
Moxifloxacin → see quinolones
Moxisylyte → see TABLE 8 p. 875 (hypotension)
Moxonidine → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
Tricyclic antidepressants are predicted to decrease the effects of moxonidine. Avoid. [Moderate] Theoretical → Also see TABLE 8 p. 875
Mycofenolate → see TABLE 15 p. 877 (myelosuppression)
Mycofenolate is predicted to increase the risk of haematological toxicity when given with aciclovir. [Moderate] Theoretical
Antacids decrease the exposure to mycofenolate. [Moderate] Study
Antifungals, azoles (itraconazole, ketoconazole, voriconazole) increase the exposure to mycofenolate. [Moderate] Study
Mycofenolate is predicted to increase the risk of haematological toxicity when given with ganciclovir. [Moderate] Theoretical → Also see TABLE 8 p. 877
Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with mycofenolate. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical
Rifampicin decreases the concentration of mycofenolate. Monitor and adjust dose. [Severe] Study
Mycofenolate is predicted to increase the risk of haematological toxicity when given with valganciclovir. [Moderate] Theoretical
Mycofenolate is predicted to increase the risk of haematological toxicity when given with ganciclovir. [Moderate] Theoretical → Also see TABLE 8 p. 877
Nabilone → see TABLE 11 p. 876 (CNS depressant effects)
Nabilone is predicted to increase the risk of cardiovascular side-effects when given with amfetamines. [Severe] Theoretical
Nadolol → see NSAIDs
Nadolol is predicted to decrease the effects of amfetamines. [Severe] Study
Naloxegol is predicted to markedly decrease the exposure to naloxegol. Avoid. [Severe] Study
Idelalisib is predicted to markedly increase the exposure to naloxegol. Avoid. [Severe] Study
Imatinib is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
Macrolides (clarithromycin) are predicted to markedly increase the exposure to naloxegol. Avoid. [Severe] Study
Macrolides (erythromycin) are predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
Mitotane is predicted to markedly decrease the exposure to naloxegol. Avoid. [Moderate] Study
Netupitant is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
Nilotinib is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. [Moderate] Study
Rifampicin is predicted to markedly decrease the exposure to naloxegol. Avoid. [Moderate] Study
Naltrexone
GENERAL INFORMATION Avoid concurrent use of opioids.
Nandrolone
Nandrolone is predicted to increase the anticoagulant effect of coumarins. Monitor and adjust dose. [Severe] Theoretical
Nandrolone is predicted to increase the anticoagulant effect of phenindione. Monitor and adjust dose. [Severe] Study
Naproxen → see NSAIDs
Naratipran → see TABLE 13 p. 877 (serotonin syndrome)
Naratipran is predicted to increase the risk of vasoconstriction when given with ergotamine. Separate administration by 24 hours. [Severe] Theoretical
Natalizumab → see monoclonal antibodies
Nateglinide → see TABLE 14 p. 877 (antidiabetic drugs)
Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to nateglinide. [Mild] Study
Enalaprilat is predicted to slightly decrease the exposure to nateglinide. [Mild] Study
Enalaprilat is predicted to decrease the exposure to nateglinide. [Mild] Study
Enalaprilat is predicted to slightly decrease the exposure to nateglinide. [Mild] Study
Teriflunomide is predicted to increase the exposure to nateglinide. [Moderate] Theoretical
Mitotane is predicted to slightly decrease the exposure to nateglinide. [Mild] Study
Rifampicin is predicted to slightly decrease the exposure to nateglinide. [Mild] Study
Nebivolol → see beta blockers, selective
Necitumumab → see monoclonal antibodies
Nefopam → see TABLE 10 p. 876 (antimuscarinics)
Nefopam is predicted to increase the risk of serious elevations in blood pressure when given with monoamine oxidase A and B inhibitors, irreversible. Avoid. [Severe] Theoretical
Nelarabine → see TABLE 15 p. 877 (myelosuppression)
Neomycin → see TABLE 2 p. 874 (nephrotoxicity), TABLE 19 p. 878 (otoxicity), TABLE 20 p. 878 (neuromuscular blocking effects)
Neomycin decreases the absorption of digoxin. [Moderate] Study
Neomycin moderately decreases the exposure to sorafenib. [Moderate] Study
Neostigmine → see TABLE 6 p. 875 (bradycardia)
Aminoglycosides are predicted to decrease the effects of neostigmine. [Moderate] Theoretical
Nepafenac → see NSAIDs
Netupitant
Netupitant is predicted to increase the exposure to abemaciclib. [Moderate] Study
Netupitant is predicted to increase the exposure to aldosterone antagonists (eplerenone). Adjust eplerenone dose. [Severe] Study
Netupitant very slightly increases the exposure to alkylating agents (cyclophosphamide). [Moderate] Study
Nefopam
Netupitant (continued)

- **Netupitant** is predicted to increase the exposure to alkylating agents (ifosfamide). ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to alpha blockers (tamsulosin). ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to alprazolam. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to antarrhythmic (propafenone). Monitor and adjust dose. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to netupitant. Avoid. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to netupitant. ([Moderate] Study)
- **Netupitant** is predicted to decrease the exposure to antifungals, azoles (isavuconazole). ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to antihistamines, non-sedating (miolastine). ([Severe] Theoretical)
- **Netupitant** is predicted to increase the exposure to antimalarias (piriperaquine). ([Severe] Theoretical)
- **Netupitant** is predicted to increase the exposure to bedaquiline. Avoid prolonged use. ([Matt] Theoretical)
- **Netupitant** is predicted to increase the exposure to beta agonists (salmeterol). ([Moderate] Study)
- **Netupitant** is predicted to decrease the exposure to netupitant. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to bosutinib. Avoid or adjust dose. ([Severe] Theoretical)
- **Netupitant** is predicted to increase the exposure to bupirone. Use with caution and adjust dose. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to cabozantinib. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to cariprazine. Avoid. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to ceritinib. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the concentration of ciclosporin. ([Severe] Study)
- **Cobicistat** is predicted to increase the exposure to netupitant. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to cabomininib. ([Severe] Theoretical)
- **Netupitant** is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to oral corticosteroids (budesonide). ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to corticosteroids (dexamethasone). Adjust dose. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to corticosteroids (fluticasone). ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor and adjust dose. ([Moderate] Study)
- **Netupitant** is predicted to slightly increase the exposure to dasatinib. ([Moderate] Study)
- **Netupitant** increases the risk of QT-prolongation when given with domperidone. Avoid. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to dopamine receptor agonists (bromocriptine). ([Severe] Theoretical)
- **Netupitant** is predicted to increase the concentration of dopamine receptor agonists (cabergoline). ([Moderate] Anecdotal

- **Netupitant** is predicted to moderately increase the exposure to dutasteride. ([Mild] Study)
- **Efavirenz** is predicted to decrease the exposure to netupitant. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to eletriptan. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. ([Severe] Study)
- **Netupitant** is predicted to moderately increase the exposure to encorafenib. ([Moderate] Study)
- **Enzalutamide** is predicted to decrease the exposure to netupitant. Avoid. ([Severe] Study)
- **Netupitant** is predicted to increase the risk of ergotism when given with ergotamine. ([Severe] Theoretical)
- **Netupitant** is predicted to increase the risk of ergotism when given with ergotone. ([Severe] Theoretical)
- **Netupitant** is predicted to increase the exposure to erlotinib. ([Moderate] Theoretical)
- **Netupitant** slightly increases the exposure to etoposide. ([Moderate] Study)
- **Netupitant** is predicted to increase the concentration of everolimus. Avoid or adjust dose. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to gefitinib. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the concentration of guanfacine. Adjust guanfacine dose, p. 237. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to HIV-protease inhibitors are predicted to increase the exposure to netupitant. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to ibritinib. Adjust ibritinib dose with moderate inhibitors of CYP3A4. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to Idelalisib is predicted to increase the exposure to netupitant. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to imatinib. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to irinotecan. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. ([Severe] Theoretical)
- **Netupitant** is predicted to increase the exposure to ivacaftor. Adjust ivacaftor dose. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to lapatinib. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to lomiptapide. Avoid. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to lurasidone. Adjust lurasidone dose. ([Moderate] Study)
- **Macrolides (clarithromycin) are predicted to increase the exposure to netupitant. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to maraviroc. ([Moderate] Study)
- **Netupitant** is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to midostaurin. ([Moderate] Theoretical)
- **Mitotane** is predicted to decrease the exposure to netupitant. Avoid. ([Severe] Study)
- **Netupitant** is predicted to increase the exposure to naloxegol. Adjust naloxegol dose and monitor side effects. ([Moderate] Study)
- **Nevirapine** is predicted to decrease the exposure to netupitant. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to nilotinib. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. ([Moderate] Theoretical)
- **Netupitant** is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. ([Moderate] Study)
Netupitant is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical

Netupitant is predicted to increase the exposure to oxycodone. (High) Theoretical

Netupitant is predicted to increase the exposure to pazopanib. (Moderate) Theoretical

Netupitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil). Adjust avanafil dose. (Moderate) Theoretical

Netupitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4. (Moderate) Study

Netupitant is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Adjust dose. (Severe) Theoretical

Netupitant is predicted to increase the exposure to pimozide. Avoid. (Severe) Theoretical

Netupitant is predicted to increase the exposure to ranolazine. (Moderate) Study

Netupitant is predicted to increase the exposure to ribociclib. (Moderate) Study

Rifampin is predicted to decrease the exposure to netupitant. Avoid. (Severe) Study

Netupitant is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical

Netupitant is predicted to increase the exposure to saxagliptin. (High) Theoretical

Netupitant increases the concentration of sirolimus. Monitor and adjust dose. (Moderate) Study

Netupitant is predicted to increase the exposure to simvastatin (dапoxetine). Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical

Netupitant is predicted to increase the exposure to sunitinib. (Moderate) Theoretical

Netupitant is predicted to increase the concentration of tacrolimus. (Severe) Study

Netupitant is predicted to increase the exposure to taxanes (cabazitaxel). (Moderate) Theoretical

Netupitant slightly increases the exposure to taxanes (docetaxel). (Moderate) Study

Netupitant is predicted to increase the exposure to taxanes (paclitaxel). (Moderate) Study

Netupitant is predicted to increase the concentration of temsirolimus. (Moderate) Theoretical

Netupitant is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study

Netupitant is predicted to increase the exposure to tefacitinib. Adjust tefacitinib dose. (Moderate) Study

Netupitant is predicted to increase the exposure to tolerodine. (High) Theoretical

Netupitant is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

Netupitant is predicted to increase the exposure to trazodone. (Moderate) Theoretical

Netupitant is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study

Netupitant is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. (Severe) Study

Netupitant is predicted to increase the exposure to vinca alkaloids. (Severe) Theoretical

Netupitant is predicted to increase the exposure to zopiclone. Adjust dose. (Moderate) Study

Neuromuscular blocking drugs, non-depolarising. See also TABLE 6 p. 875 (bradycardia), TABLE 20 p. 878 (neuromuscular blocking effects)

- atracurium - cisatracurium - mivacurium - pancuronium - rocuronium

Anticholinesterases, centrally acting are predicted to decrease the effects of neuromuscular blocking drugs, non-depolarising. (Moderate) Theoretical

Antiepileptics (carbamazepine) are predicted to decrease the effects of (but acute use increases the effects of) neuromuscular blocking drugs, non-depolarising (atracurium, cisatracurium, pancuronium, rocuronium). Monitor and adjust dose. (Moderate) Study

Antiepileptics (fosphenytoin, phenytoin) decrease the effects of (but acute use increases the effects of) neuromuscular blocking drugs, non-depolarising (atracurium, cisatracurium, pancuronium, rocuronium). (Moderate) Study

Corticosteroids are predicted to decrease the effects of neuromuscular blocking drugs, non-depolarising. (Severe) Anecdotal

Pancuronium is predicted to increase the risk of cardiovascular side-effects when given with digoxin. (Severe) Anecdotal

Trinitro is predicted to decrease the effects of neuromuscular blocking drugs, non-depolarising. (Severe) Theoretical

Intravenous magnesium increases the effects of neuromuscular blocking drugs, non-depolarising. (Moderate) Study

Metoclopramide is predicted to increase the effects of neuromuscular blocking drugs, non-depolarising. (Moderate) Theoretical

Neuromuscular blocking drugs, non-depolarising. (Severe) Anecdotal

Potentially increase the risk of prolonged neuromuscular blockade when given with mivacurium. (Unknown) Theoretical

Nevirapine

Nevirapine is predicted to decrease the exposure to antiarrhythmics (dronedarone). (Severe) Theoretical

Nevirapine is predicted to decrease the concentration of antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) and antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of nevirapine. (Severe) Study

Antifungals, azoles (fluconazole) slightly to moderately increase the exposure to nevirapine. (Moderate) Study

Nevirapine is predicted to decrease the exposure to antifungals, azoles (isavuconazole). Avoid. (Severe) Theoretical

Nevirapine moderately decreases the exposure to antifungals, azoles (itraconazole). Avoid and for 14 days after stopping nevirapine. (Moderate) Study

Nevirapine moderately decreases the exposure to antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole) increase the exposure to nevirapine. Monitor and adjust dose. (Moderate) Study

Nevirapine is predicted to decrease the exposure to antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole). Avoid. (Severe) Study

Nevirapine is predicted to decrease the exposure to antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole). Avoid. (Severe) Study

Nevirapine is predicted to decrease the exposure to aprepitant. (Moderate) Study

Nevirapine is predicted to decrease the exposure to axitinib. (Moderate) Theoretical

Nevirapine is predicted to decrease the exposure to bedaquiline. Avoid. (Severe) Study

Boverant is predicted to decrease the exposure to nevirapine. (Severe) Theoretical

Nevirapine is predicted to decrease the exposure to bosutinib. Avoid. (Severe) Theoretical

Nevirapine is predicted to decrease the exposure to brigatinib. Avoid. (Severe) Study

Nevirapine is predicted to decrease the exposure to cabozantinib. (Moderate) Theoretical
Nevirapine (continued)

- Nevirapine is predicted to decrease the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to calcium channel blockers (diltiazem, verapamil). [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to cariprazine. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the concentration of caspofungin. Adjust dose. [Moderate] Theoretical
- Nevirapine is predicted to decrease the concentration of ciclosporin. [Moderate] Study
- Nevirapine is predicted to decrease the exposure to cobicistat. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to cobiimetinib. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study
- Nevirapine potentially alters the anticoagulant effect of coumarins. [Severe] Anecdotal
- Nevirapine is predicted to decrease the exposure to crizotinib. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to dasabuvir. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to dasatinib. [Severe] Study
- Nevirapine is predicted to decrease the exposure to dolutegravir. Adjust dose. [Severe] Study
- Nevirapine is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. [Severe] Theoretical
- Nevirapine decreases the concentration of efavirenz. Avoid. [Severe] Study
- Nevirapine is predicted to moderately decrease the exposure to elbasvir. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to eliglustat. [Moderate] Theoretical
- Nevirapine is predicted to decrease the concentration of elvitegravir. [Severe] Theoretical
- Enzalutamide is predicted to decrease the exposure to nevirapine. [Severe] Theoretical
- Nevirapine is predicted to decrease the effects of ergotamine. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to erlotinib. [Severe] Theoretical
- Nevirapine is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to etravirine. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the concentration of everolimus. Avoid or adjust dose. [Severe] Study
- Nevirapine is predicted to decrease the exposure to fosaprepitant. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to glecaprevir. Avoid. [Severe] Study
- Nevirapine is predicted to markedly decrease the exposure to grazoprevir. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the concentration of guanfacine. Adjust dose. [Moderate] Theoretical
- Nevirapine decreases the exposure to HIV-2 protease inhibitors. Refer to specialist literature. [Moderate] Study
- Nevirapine is predicted to decrease the effects of hormone replacement therapy. [Moderate] Anecdotal
- Nevirapine is predicted to decrease the exposure to idelalisib. Avoid. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to imatinib. [Moderate] Study
- Nevirapine is predicted to decrease the exposure to ivacaftor. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to lapatinib. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to lurasidone. Monitor and adjust dose. [Moderate] Theoretical
- Nevirapine decreases the exposure to macrolides (clarithromycin). [Moderate] Study
- Nevirapine decreases the concentration of midazolam. Monitor and adjust dose. [Moderate] Study
- Mitotane is predicted to decrease the exposure to nevirapine. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to netupitant. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to nilotinib. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- Nevirapine is predicted to decrease the exposure to olaparib. Avoid. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to omacetaxine. Avoid. [Severe] Theoretical
- Nevirapine decreases the exposure to opioids (methadone). Monitor and adjust dose. [Severe] Study
- Nevirapine is predicted to decrease the exposure to ospemifene. [Moderate] Study
- Nevirapine is predicted to decrease the exposure to paritaprevir (with ritonavir and omacetaxine). Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to piracetam. [Severe] Study
- Nevirapine is predicted to decrease the exposure to quetiapine. [Moderate] Study
- Nevirapine is predicted to decrease the exposure to ribociclib. [Moderate] Study
- Rifampicin decreases the concentration of nevirapine. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to rilpivirine. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to rolapitant. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. [Moderate] Theoretical
- St John’s Wort is predicted to decrease the concentration of nevirapine. Avoid. [Severe] Theoretical
- Nevirapine slightly decreases the exposure to statins (atorvastatin). [Mild] Study
- Nevirapine moderately decreases the exposure to statins (simvastatin). [Moderate] Study
- Nevirapine decreases the concentration of tacrolimus. Monitor and adjust dose. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to taxanes (cabazitaxel). Avoid. [Severe] Study
- Nevirapine is predicted to decrease the concentration of temsirolimus. Avoid. [Severe] Theoretical
- Nevirapine is predicted to decrease the exposure to ticagrelor. [Moderate] Theoretical
- Nevirapine is predicted to decrease the exposure to tofacitinib. [Moderate] Study
- Nevirapine decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- Nevirapine is predicted to decrease the exposure to velpatavir. Avoid. [Moderate] Theoretical
Nevirapine – Nilotinib 1001

- Nevirapine is predicted to decrease the exposure to venetoclax. Avoid. (Severe) Study
- Nevirapine is predicted to decrease the concentration of voxtaprevir. Avoid. (Severe) Theoretical
- Nevirapine is predicted to decrease the concentration of zidovudine. Refer to specialist literature. (Severe) Theoretical
- Nicardipine → see calcium channel blockers
- Nisoldipine → see calcium channel blockers
- Nicorandil → see TABLE 8 p. 875 (hypotension)
- Aspirin is predicted to increase the risk of gastrointestinal perforation when given with nicardipine. (Severe) Theoretical
- Corticosteroids increase the risk of gastrointestinal perforation when given with nicardipine. (Severe) Aneodal
- Nicorandil is predicted to increase the risk of gastrointestinal perforation when given with NSAIIS. (Severe) Theoretical
- Nisoldipine is predicted to increase the risk of hypotension when given with phosphodiesterase type-5 inhibitors. Avoid. (Severe) Theoretical → Also see TABLE 8 p. 875
- Nicotinic acid → see TABLE 3 p. 874 (anticoagulant effects)
- Nicotinic acid is predicted to increase the risk of rhabdomyolysis when given with statins. (Severe) Theoretical
- Nifedipine → see calcium channel blockers
- Nilotinib → see TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)
- Nilotinib is predicted to increase the exposure to abemaciclib. (Moderate) Study
- Nilotinib is predicted to increase the exposure to alpha blockers (tamsulosin). (Moderate) Theoretical
- Nilotinib is predicted to increase the exposure to alprostadil. (Moderate) Study
- Antacids are predicted to decrease the absorption of nilotinib. Separate administration by at least 2 hours. (Moderate) Theoretical
- Nilotinib is predicted to increase the exposure to antarrhythmys (propafenone). Monitor and adjust dose. (Moderate) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to nilotinib. Avoid. (Severe) Study
- Antifungals, azoles (fluconazole, posaconazole) are predicted to increase the exposure to nilotinib. (Moderate) Theoretical → Also see TABLE 9 p. 876
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to nilotinib. Avoid. (Severe) Study → Also see TABLE 9 p. 876
- Nilotinib is predicted to increase the exposure to antihistamines, non-sedating (mizolastine). (Severe) Theoretical
- Nilotinib is predicted to increase the exposure to antihistamines, non-sedating (tripatadine). Avoid. (Moderate) Study
- Nilotinib is predicted to increase the concentration of antimalarias (piperaquine). (Severe) Theoretical
- Aprepitant is predicted to increase the exposure to nilotinib. (Moderate) Theoretical
- Nilotinib is predicted to increase the exposure to axitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Nilotinib is predicted to increase the exposure to bedaquiline. Avoid prolonged use. (Moderate) Theoretical → Also see TABLE 9 p. 876
- Bosentan is predicted to decrease the exposure to nilotinib. Avoid. (Severe) Theoretical
- Nilotinib is predicted to increase the exposure to bosutinib. Avoid or adjust dose. (Severe) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- Nilotinib is predicted to increase the exposure to buspirone. Use with caution and adjust dose. (Moderate) Study
- Nilotinib is predicted to increase the exposure to cabozantinib. (Moderate) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to nilotinib. (Moderate) Theoretical
- Nilotinib is predicted to increase the exposure to calcium channel blockers (amlodipine, felodipine, lacidipine, lercanidipine, nicardipine, nifedipine, nimodipine). Monitor and adjust dose. (Moderate) Study
- Nilotinib is predicted to increase the exposure to cariprazine. Avoid. (Severe) Study
- Nilotinib is predicted to increase the exposure to ceritinib. (Moderate) Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- Nilotinib is predicted to increase the concentration of ciclosporin. (Severe) Study
- Cobastic is predicted to moderately increase the exposure to nilotinib. Avoid. (Severe) Study
- Nilotinib is predicted to increase the exposure to cobimetinib. (Severe) Theoretical
- Nilotinib is predicted to increase the exposure to colchicine. Adjust colchicine dose with moderate inhibitors of CYP3A4. (Severe) Study
- Nilotinib is predicted to increase the exposure to corticosteroids (methylprednisolone). Monitor and adjust dose. (Moderate) Study
- Nilotinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
- Nilotinib is predicted to slightly increase the exposure to darifenacin. (Moderate) Study
- Nilotinib is predicted to increase the exposure to dasatinib. (Severe) Study → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- Nilotinib increases the risk of QT-prolongation when given with domerparedone. Avoid. (Severe) Study
- Nilotinib is predicted to increase the exposure to dopamine receptor agonists (bromocriptine). (Severe) Theoretical
- Nilotinib is predicted to moderately increase the concentration of dopamine receptor agonists (cabergoline). (Moderate) Aneodal
- Nilotinib is predicted to moderately increase the exposure to dutasteride. (Moderate) Study
- Everolimus is predicted to decrease the exposure to nilotinib. Avoid. (Severe) Theoretical
- Nilotinib is predicted to increase the risk of ergotism when given with ergotamine. (Severe) Theoretical
- Nilotinib is predicted to increase the risk of ergotism when given with ergotamine. (Severe) Theoretical
- Nilotinib is predicted to increase the exposure to erlotinib. (Moderate) Theoretical
- Nilotinib is predicted to increase the concentration of everolimus. Avoid or adjust dose. (Moderate) Study → Also see TABLE 15 p. 877
- Nilotinib is predicted to increase the exposure to fosoterodine. Adjust fosoterodine dose with moderate inhibitors of CYP3A4 in hepatic and renal impairment. (Moderate) Study
- Nilotinib is predicted to increase the exposure to gefitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Grapefruit juice is predicted to increase the exposure to nilotinib. Avoid. (Severe) Theoretical
- Nilotinib is predicted to increase the concentration of guanosine. Adjust guanosine dose, p. 237. (Moderate) Theoretical
- H\textsubscript{2} receptor antagonists are predicted to decrease the absorption of nilotinib. H\textsubscript{2} receptor antagonists should be taken 10 hours before or 2 hours after nilotinib. (Moderate) Theoretical
- HIV- protease inhibitors are predicted to moderately increase the exposure to nilotinib. Avoid. (Severe) Study → Also see TABLE 9 p. 876
- Nilotinib is predicted to increase the exposure to ibritinib. Adjust ibritinib dose with moderate inhibitors of CYP3A4. (Severe) Study → Also see TABLE 15 p. 877
- Idelalisib is predicted to moderately increase the exposure to nilotinib. Avoid. (Severe) Study → Also see TABLE 15 p. 877
- Nilotinib is predicted to increase the exposure to ivabradine. Adjust ivabradine dose. (Severe) Theoretical
- Nilotinib is predicted to increase the exposure to irinotecan. Adjust irinotecan dose with moderate inhibitors of CYP3A4. (Severe) Study
- Idelalisib is predicted to moderately increase the exposure to ivacaftor. Adjust ivacaftor p. 189 or tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. (Severe) Study
- Nilotinib is predicted to increase the exposure to lapatinib. (Moderate) Study → Also see TABLE 9 p. 876
Nilotinib (continued)

- **Nilotinib** is predicted to increase the exposure to lomitapide. Avoid. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to lurasidone. Adjust lurasidone dose. [Moderate] Theoretical
- Macrolides (clarithromycin) are predicted to moderately increase the exposure to nilotinib. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Macrolides (erythromycin) are predicted to increase the exposure to nilotinib. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to midazolam. Monitor side effects and adjust dose. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to midostaurin. [Moderate] Theoretical
- Nitotane is predicted to moderately decrease the exposure to nilotinib. Avoid. [Severe] Study → Also see TABLE 15 p. 877
- **Nilotinib** is predicted to increase the exposure to naxogeol. Adjust naxogeol dose and monitor side effects. [Moderate] Study
- Neurotamine is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to opioids (methadone, sufentanil). [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to oxabutrol. Avoid. [Severe] Theoretical
- **Nilotinib** is predicted to increase the exposure to oxabutrol (avanafil). Adjust avanafil dose. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (sildenafil). Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (tadalafil). [Severe] Theoretical
- **Nilotinib** is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (vardenafil). Adjust dose. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to pimozone. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Pitolisant** is predicted to decrease the exposure to nilotinib. Avoid. [Severe] Theoretical
- **Pitolisant** is predicted to increase the exposure to quetiapine. Avoid. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to ranolazine. [Severe] Study → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to ribociclib. [Moderate] Study → Also see TABLE 9 p. 876
- **Rifampicin** is predicted to moderately decrease the exposure to nilotinib. Avoid. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to ruxolitinib. [Moderate] Theoretical → Also see TABLE 15 p. 877
- **Nilotinib** is predicted to increase the exposure to saxagliptin. [Mild] Study
- **Nilotinib** increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to SSRIs (dapoxetine). Adjust dapoxetine dose with moderate inhibitors of CYP3A4. [Moderate] Theoretical
- **St. John’s Wort** is predicted to decrease the exposure to nilotinib. Avoid. [Severe] Theoretical

**Nilotinib** is predicted to increase the exposure to statins (atorvastatin). Monitor and adjust dose. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to statins (simvastatin). Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to sunitinib. [Moderate] Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the concentration of tacrolimus. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to taxanes (cabazitaxel). [Moderate] Theoretical → Also see TABLE 15 p. 877
- **Nilotinib** is predicted to increase the concentration of temsirolimus. [Moderate] Theoretical → Also see TABLE 15 p. 877
- **Nilotinib** is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 196 dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Nilotinib** given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to tolterodine. [Mild] Theoretical → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to trazodone. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to urapidil. Avoid if used for uterine fibroids. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to vinca alkaloids. [Severe] Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- **Nilotinib** is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- **Nimodipine** → see calcium channel blockers

**Nintedanib**
- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to nintedanib. [Moderate] Study
- Antiepileptics (carbamazepine) are predicted to decrease the exposure to nintedanib. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole) are predicted to increase the exposure to nintedanib. [Moderate] Study
- Calcium channel blockers are predicted to increase the exposure to nintedanib. [Moderate] Study
- Ciclosporin is predicted to increase the exposure to nintedanib. [Moderate] Study
- HIV- protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to nintedanib. [Moderate] Study
- **Lapatinib** is predicted to increase the exposure to nintedanib. [Moderate] Study
- **Macrolides** are predicted to increase the exposure to nintedanib. [Moderate] Study
- **Ranolazine** is predicted to increase the exposure to nintedanib. [Moderate] Study
- **Rifampicin** is predicted to decrease the exposure to nintedanib. [Moderate] Study
- **St. John’s Wort** is predicted to decrease the exposure to nintedanib. [Moderate] Study
- **Vemurafenib** is predicted to increase the exposure to nintedanib. [Moderate] Study

**Nitisinone**
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to nitisinone. Adjust dose. [Moderate] Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to nitisinone. Adjust dose. [Moderate] Theoretical
- **Cobicistat** is predicted to increase the exposure to nitisinone. Adjust dose. [Moderate] Theoretical
- **Enzalutamide** is predicted to decrease the exposure to nitisinone. Adjust dose. [Moderate] Theoretical

**Table 9**

| BNFC 2019–2020 | 1002 | Nilotinib – Nitisinone | A1 | Interactions Appendix 1 |
Nitrisone – NSAIDs 1003

- **HIV-protease inhibitors** are predicted to increase the exposure to nitrisone. Adjust dose. [Moderate] Theoretical
- **Idelalisib** is predicted to increase the exposure to nitrisone. Adjust dose. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to increase the exposure to nitrisone. Adjust dose. [Moderate] Theoretical
- **Mitotane** is predicted to decrease the exposure to nitrisone. Adjust dose. [Moderate] Theoretical
- **Rifampin** is predicted to decrease the exposure to nitrisone. Adjust dose. [Moderate] Theoretical

**Nitrates → see TABLE 7 p. 875 (first-dose hypotension), TABLE 8 p. 875** (hypotension)

**glyceryl trinitrate** - isosorbide dinitrate - isosorbide mononitrate

**PHARMACOLOGY** Drugs with antimucociliar effects can cause dry mouth, which can reduce the effectiveness of sublingual glyceryl trinitrate tablets.

- **Nitrates** are predicted to increase the risk of methaemoglobinaemia when given with topical anaesthetics, local (pilocaine). Avoid. [Severe] Theoretical
- **Nitrates are predicted to increase the risk of methaemoglobinaemia when given with dapsone.** [Severe] Theoretical
- **Nitrates potentially increase the risk of hypotension when given with phosphodiesterase type 5 inhibitors.** Avoid. [Severe] Study → Also see TABLE 8 p. 875

**Nitrazepam → see TABLE 11 p. 876 (CNS depressant effects)**

**rifampin** increases the clearance of nitrazepam. [Moderate] Study

**Nitrofurantoin → see TABLE 12 p. 877 (peripheral neuropathy)**

**Nitrofurantoin** is predicted to increase the risk of methaemoglobinaemia when given with topical anaesthetics, local (pilocaine). Use with caution or avoid. [Severe] Theoretical

Antacids (magnesium trisilicate) decrease the absorption of nitrofurantoin. [Moderate] Study

**Nitrofurantoin** is predicted to increase the risk of methaemoglobinaemia when given with dapsone. [Severe] Theoretical

- **Nitrous oxide** → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
- **Nitrous oxide potentially increases the risk of methotrexate toxicity when given with methotrexate.** Avoid. [Severe] Study

**Nivolumab → see monoclonal antibodies**

**Nizatidine** → see H₂ receptor antagonists

**Noradrenaline/norepinephrine** → see sympathomimetics, vasoconstrictor

**Norwegian**

**Noroxistine**

- **Antiepilepsics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate)** are predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Aprepitant** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Bosantan** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Efavirenz** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Fosaprepitant** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Glide steps to decrease the efficacy of norethisterone.** For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Nevirapine** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Rifabutin** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Rifampin** is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **St John’s Wort** is predicted to decrease the efficacy of norethisterone. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal
- **Sugammadex** is predicted to decrease the exposure to norethisterone. Use additional contraceptive precautions. [Severe] Theoretical
- **Ulipristal** is predicted to decrease the efficacy of norethisterone. Avoid. [Severe] Theoretical

**Normal immunoglobulin** → see immunoglobulins

**Nortriptyline** → see tricyclic antidepressants

**NSAIDs → see TABLE 18 p. 878 (hypnotolamia), TABLE 2 p. 874 (nephrotoxicity), TABLE 16 p. 878 (increased serum potassium), TABLE 4 p. 874 (antiplatelet effects)**


Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- **Celecoxib** is predicted to increase the exposure to antiarrhythmics (flecainide, propafenone). Monitor and adjust dose. [Moderate] Theoretical
- **Antifungals, azoles (fluconazole)** moderately increase the exposure to celecoxib. Adjust celecoxib dose. [Moderate] Study
- **Antifungals, azoles (fluconazole)** increase the exposure to parecoxib. Monitor and adjust dose. [Moderate] Study
- **Antifungals, azoles (voriconazole)** slightly increase the exposure to diclofenac. Monitor and adjust dose. [Moderate] Study
- **Antifungals, azoles (voriconazole)** moderately increase the exposure to ibuprofen. Adjust dose. [Moderate] Study
- **NSAIDs are predicted to increase the risk of gastrointestinal irritation when given with bisphosphonates (alendronic acid, ibandronic acid).** [Moderate] Study
- **NSAIDs are predicted to increase the risk of renal impairment when given with bisphosphonates (sodium clodronate).** [Severe] Theoretical
- **Ceritinib** is predicted to increase the exposure to NSAI(Ds (celecoxib, diclofenac). Adjust dose. [Moderate] Theoretical
- **Ciclosporin** increases the concentration of diclofenac. [Severe] Study → Also see TABLE 2 p. 874 → Also see TABLE 16 p. 878
- **Etoricoxib** slightly increases the exposure to combined hormonal contraceptives. [Moderate] Study
- **NSAIDs increase the risk of gastrointestinal bleeding when given with corticosteroids.** [Severe] Study
- **NSAIDs increase the risk of renal impairment when given with daptomycin.** [Moderate] Theoretical
- **Indometacin increases the concentration of digoxin.** [Severe] Study
- **Erlotinib** is predicted to increase the risk of gastrointestinal perforation when given with NSAIDs. [Severe] Theoretical
- **Etoricoxib** slightly increases the exposure to hormone replacement therapy. [Moderate] Study
- **NSAIDs are predicted to increase the risk of gastrointestinal bleeding when given with iron chelators (deferasirox).** [Severe] Theoretical
- **Leflunomide** is predicted to increase the exposure to NSAI(Ds (indometacin, ketoprofen). [Moderate] Theoretical
- **NSAIDs increase the concentration of lithium.** Monitor and adjust dose. [Severe] Study
- **NSAIDs are predicted to increase the risk of toxicity when given with methotrexate.** [Severe] Study → Also see TABLE 2 p. 874
NSAIDs (continued)

- NSAIDs (high-dose) are predicted to decrease the efficacy of mifamurtide. Avoid. (Severe) Theoretical
- Nicorandil is predicted to increase the risk of gastrointestinal perforation when given with NSAIDs. (Severe) Theoretical
- NSAIDs are predicted to increase the exposure to penretrexed. Use with caution or avoid. (Severe) Theoretical → Also see TABLE 2 p. 874
- NSAIDs potentially increase the risk of seizures when given with quinolones. (Severe) Theoretical
- Regorafenib is predicted to increase the exposure to mefenamic acid. Avoid. (Moderate) Theoretical → Also see TABLE 4 p. 874
- Rifampicin moderately decreases the exposure to NSAIDs (celecoxib, diclofenac, etoricoxib). (Moderate) Study
- Teriflunomide is predicted to increase the exposure to NSAIDs (indometacin, ketoprofen). (Moderate) Theoretical
- NSAIDs increase the risk of acute renal failure when given with thiazide diuretics. (Severe) Theoretical → Also see TABLE 1B p. 878
- Exposure increases the risk of haematological toxicity when given with NSAIDs. (Severe) Study → Also see TABLE 2 p. 874

Obeticholic acid
- Obeticholic acid decreases the anticoagulant effect of coumarins (warfarin). (Severe) Study
- Obeticholic acid is predicted to increase the exposure to theophylline. (Severe) Theoretical
- Obeticholic acid is predicted to increase the exposure to tizanidine. (Severe) Theoretical

Olanzapine → see monocolonic antibodies
Ocrelizumab → see monocolonic antibodies
Octreotide
- Octreotide decreases the absorption of oral ciclosporin. Adjust ciclosporin dose, p. 537. (Severe) Anecdotal
- Octreotide (short-acting) decreases the exposure to telotristat ethyl. Telotristat ethyl should be taken at least 30 minutes before octreotide. (Moderate) Study

Olfaxcin → see quinolones
Olanzapine → see TABLE 8 p. 875 (hypotension), TABLE 15 p. 877 (myelosuppression), TABLE 11 p. 876 (CNS depressant effects)

FOOD AND LIFESTYLE  Dose adjustment might be necessary if smoking started or stopped during treatment.

- Antiepileptics (carbamazepine) potentially decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- Antiepileptics (phenytoin) are predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- Olanzapine is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical → Also see TABLE 8 p. 875
- HIV-protease inhibitors (ritonavir) are predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- Leflunomide is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study → Also see TABLE 15 p. 877
- Olanzapine decreases the effects of levodopa. Avoid or monitor worsening parkinsonian symptoms. (Severe) Anecdotal → Also see TABLE 8 p. 875
- Mexiletine is predicted to increase the exposure to olanzapine. Adjust dose. (Moderate) Anecdotal
- Quinolones (ciprofloxacin) are predicted to increase the exposure to olanzapine. Adjust dose. (Moderate) Anecdotal
- Rifampicin is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study
- SSRIs (fluvoxamine) moderately increase the exposure to olanzapine. Adjust dose. (Severe) Anecdotal
- Teriflunomide is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. (Moderate) Study

Olaparib → see TABLE 15 p. 877 (myelosuppression)

FOOD AND LIFESTYLE  Bitter (Seville) orange is predicted to increase the exposure to olaparib.

- Antiarrhythmics (dronedarone) are predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to olaparib. Avoid. (Moderate) Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Aprepitant is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Bosentan is predicted to decrease the exposure to olaparib. Avoid. (Moderate) Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Cobicistat is predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Crizotinib is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Efavirenz is predicted to decrease the exposure to olaparib. Avoid. (Moderate) Theoretical
- Enzalutamide is predicted to decrease the exposure to olaparib. Avoid. (Moderate) Theoretical
- Grapefruit juice is predicted to increase the exposure to olaparib. Avoid. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Idelalisib is predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study → Also see TABLE 15 p. 877
- Macrolides (clarithromycin) are predicted to increase the exposure to olaparib. Avoid potent inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Study
- Macrolides (erythromycin) are predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Mitotane is predicted to decrease the exposure to olaparib. Avoid. (Moderate) Theoretical
- Nitoufin is predicted to increase the exposure to olaparib. Avoid moderate inhibitors of CYP3A4 or adjust olaparib dose. (Moderate) Theoretical
- Ombitasvir
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin) are predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical
- Efavirenz is predicted to increase the exposure to ombitasvir. Avoid. (Severe) Theoretical
- Enzalutamide is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical

Ombitasvir
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin) are predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical
- Efavirenz is predicted to increase the exposure to ombitasvir. Avoid. (Severe) Theoretical
- Enzalutamide is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical
Etravirine is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical

Ombitasvir (in fixed-dose combination with dasabuvir) decreases the concentration of HIV-protease inhibitors (darunavir). Avoid or adjust dose. (Moderate) Study

Mitotane is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical

Nevirapine is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical

Rifampicin is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical

St John’s Wort is predicted to decrease the exposure to ombitasvir. Avoid. (Severe) Theoretical

Omega-3 acid ethyl esters → see TABLE 3 p. 874 (anticoagulant effects)

Omeprazole → see proton pump inhibitors

Ondansetron → see TABLE 3 p. 877 (serotonin syndrome), TABLE 9 p. 876 (QT-interval prolongation)

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ombitasvir. (Moderate) Study

Dopamine receptor agonists (apomorphine) increase the risk of severe hypotension when given with ondansetron. Avoid. (Severe) Study → Also see TABLE 9 p. 876

Enzalutamide is predicted to decrease the exposure to ombitasvir. (Moderate) Study

Mitotane is predicted to decrease the exposure to ondansetron. (Moderate) Study

Opicapone

Opicapone increases the exposure to levodopa. Adjust dose. (Moderate) Study

Opicapone is predicted to increase the exposure to loperamide. Avoid. (Moderate) Study

Opicapone is predicted to increase the risk of elevated blood pressure when given with moclobemide. Avoid. (Severe) Theoretical

Opicapone is predicted to increase the risk of elevated blood pressure when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid. (Severe) Theoretical

Opicapone is predicted to increase the exposure to montelukast. Avoid. (Moderate) Study

Opicapone is predicted to increase the exposure to pioglitazone. Avoid. (Moderate) Study

Opicapone is predicted to increase the exposure to repaglinide. Avoid. (Moderate) Study

Opicapone is predicted to increase the risk of cardiovascular side-effects when given with sympathomimetics, inotropic. (Severe) Theoretical

Opicapone is predicted to increase the risk of cardiovascular side-effects when given with sympathomimetics, vasconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). (Severe) Theoretical

Opioids → see TABLE 6 p. 875 (bradycardia), TABLE 13 p. 877 (serotonin syndrome), TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects)


Alcohol (beverage) causes rapid release of opioids (hydromorphone, morphine) (from extended-release preparations). Avoid. (Severe) Study → Also see TABLE 11 p. 876

Antiarrhythmics (amiodarone) are predicted to increase the concentration of fentanyl. (Moderate) Theoretical → Also see TABLE 6 p. 875

Antiarrhythmics (dronedarone) are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study

Antiarrhythmics (dronedarone) are predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical → Also see TABLE 9 p. 876

Antiepileptics (carbamazepine) decrease the concentration of tramadol. Adjust dose. (Severe) Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to buprenorphine. Monitor and adjust dose. (Moderate) Theoretical → Also see TABLE 11 p. 876

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to methadone. Monitor and adjust dose. (Severe) Study → Also see TABLE 11 p. 876

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to oxycodone. Monitor and adjust dose. (Moderate) Study → Also see TABLE 11 p. 876

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to opioids (alfentanil, fentanyl). (Moderate) Study → Also see TABLE 11 p. 876

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). (Moderate) Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to methadone. Adjust dose. (Severe) Theoretical → Also see TABLE 9 p. 876

Antifungals, azoles (miconazole) are predicted to increase the exposure to alfentanil. Use with caution and adjust dose. (Moderate) Study

Antifungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. (Moderate) Study

Aprepitant is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study

Aprepitant is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical

Bictegravir is predicted to increase the exposure to methadone. (Moderate) Theoretical

Bosentan decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study

Brigatinib potentially decreases the concentration of opioids (alfentanil, fentanyl). Avoid. (Moderate) Theoretical

Buproprion is predicted to decrease the efficacy of codeine. (Moderate) Theoretical

Buproprion is predicted to decrease the efficacy of tramadol. (Severe) Study → Also see TABLE 13 p. 877

Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone). Monitor and adjust dose. (Moderate) Study → Also see TABLE 6 p. 875

Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical

Certinib is predicted to increase the exposure to fentanyl. Avoid. (Severe) Theoretical

Cinacalcet is predicted to decrease the efficacy of codeine. (Moderate) Theoretical

Cinacalcet is predicted to decrease the efficacy of tramadol. (Severe) Study

Cobicistat is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. (Severe) Study

Crizotinib is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodone, sufentanil). Monitor and adjust dose. (Moderate) Study → Also see TABLE 6 p. 875

Crizotinib is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical → Also see TABLE 6 p. 875

Efavirenz decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study → Also see TABLE 9 p. 876
Opioids (continued)

- **Enalaprilat** is predicted to decrease the exposure to buprenorphine. Monitor and adjust dose. (Moderate) Theoretical
- **Enalaprilat** decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study
- **Enalaprilat** is predicted to decrease the exposure to opioids (alfentanil, fentanyl). (Moderate) Study
- **Enalaprilat** is predicted to decrease the exposure to oxycodeone. Monitor and adjust dose. (Severe) Study
- **H₂ receptor antagonists** (cimetidine) increase the concentration of alfentanil. Use with caution and adjust dose. (Severe) Study
- **H₂ receptor antagonists** (cimetidine) increase the exposure to fentanyl. (Moderate) Study
- **HIV-protease inhibitors** (boosted with ritonavir) are predicted to decrease the exposure to methadone. (Moderate) Study
  - Also see TABLE 9 p. 876
- **HIV-protease inhibitors** (ritonavir) are predicted to decrease the concentration of morphine. (Moderate) Theoretical
- **HIV-protease inhibitors** (ritonavir) increase the risk of CNS toxicity when given with pethidine. Avoid. (Severe) Study
- **HIV-protease inhibitors** are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone, sufentanil). Monitor and adjust dose. (Severe) Study
- **Idelalisib** is predicted to increase the exposure to methadone. Also see TABLE 9 p. 876
- **Idelalisib** is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone, sufentanil). Monitor and adjust dose. (Severe) Study
- **Imatinib** is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone, sufentanil). Monitor and adjust dose. (Severe) Study
- **Imatinib** is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical
- **Letermovir** is predicted to increase the exposure to opioids (alfentanil, fentanyl). Monitor and adjust dose. (Moderate) Study
- **Macrolides (clarithromycin)** are predicted to increase the concentration of methadone. (Severe) Theoretical Also see TABLE 9 p. 876
- **Macrolides (erythromycin)** are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone). Monitor and adjust dose. (Moderate) Study
- **Macrolides (clarithromycin)** are predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone, sufentanil). Monitor and adjust dose. (Severe) Study
- **Macrolides (erythromycin)** are predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical
- **Opioids potentially decrease the absorption of oral mexiletine. (Moderate) Study
- **Mitotane** is predicted to decrease the exposure to buprenorphine. Monitor and adjust dose. (Moderate) Theoretical
- **Mitotane** decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study
- **Mitotane** is predicted to decrease the exposure to opioids (alfentanil, fentanyl). (Moderate) Study
- **Mitotane** is predicted to decrease the exposure to oxycodeone. Monitor and adjust dose. (Moderate) Study
- **Opioids** are predicted to increase the risk of CNS excitation or depression when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid. (Severe) Study Also see TABLE 13 p. 877
- **Monoamine-oxidase B inhibitors (rasagiline)** are predicted to increase the risk of side-effects when given with pethidine. Avoid and for 14 days after stopping rasagiline. (Severe) Theoretical Also see TABLE 13 p. 877
- **Monoamine-oxidase B inhibitors (selegiline)** are predicted to increase the risk of side-effects when given with pethidine. Avoid and for 1 week after stopping selegiline. (Severe) Theoretical Also see TABLE 13 p. 877
- **Nalmefene** is predicted to decrease the efficacy of opioids. Avoid. (Severe) Theoretical
- **Netupitant** is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone). Monitor and adjust dose. (Moderate) Study
- **Netupitant** is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical
- **Neurontin** decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study
- **Nilotinib** is predicted to increase the exposure to opioids (alfentanil, buprenorphine, fentanyl, oxycodeone). Monitor and adjust dose. (Moderate) Study
- **Nilotinib** is predicted to increase the exposure to opioids (methadone, sufentanil). (Moderate) Theoretical Also see TABLE 9 p. 876
- **Opioids (buprenorphine)** are predicted to increase the risk of opiate withdrawal when given with opioids (alfentanil). (Severe) Theoretical Also see TABLE 11 p. 876
- **Opioids (buprenorphine)** are predicted to increase the risk of opiate withdrawal when given with opioids (codeine, diamorphine, dihydrocodeine, dipipanone, fentanyl, hydromorphone, meptazinol, methadone, morphine, oxycodone, papaveretum). (Severe) Theoretical Also see TABLE 11 p. 876
- **Opioids (buprenorphine)** are predicted to increase the risk of opiate withdrawal when given with opioids (codeine, diamorphine, dihydrocodeine, dipipanone, fentanyl, hydromorphone, meptazinol, methadone, morphine, oxycodone, papaveretum, pentazocine, pethidine, remifentanil, sufentanil, tapentadol, tramadol). (Severe) Theoretical Also see TABLE 11 p. 876
- **Opioids (pentazocine)** are predicted to increase the risk of opiate withdrawal when given with opioids (sufentanil). (Severe) Also see TABLE 11 p. 876
- **Palbociclib** is predicted to increase the exposure to opioids (alfentanil, fentanyl). Adjust dose. (Moderate) Theoretical
- **Pitolisant** is predicted to decrease the exposure to morphine. (similar to pemoline) (Moderate) Theoretical
- **Ribocebin** is predicted to increase the exposure to opioids (alfentanil, fentanyl). Use with caution and adjust dose. (Moderate) Study
- **Rifampicin** is predicted to decrease the exposure to buprenorphine. (similar to rifampicin) (Moderate) Theoretical
- **Rifampicin** is predicted to decrease the exposure to buprenorphine. Monitor and adjust dose. (Moderate) Theoretical
- **Rifampicin** decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study
- **Rifampicin** is predicted to decrease the exposure to opioids (alfentanil, fentanyl). (Moderate) Study
- **Rifampicin** decreases the exposure to methadone. (Moderate) Study
- **Rifampicin** is predicted to decrease the exposure to oxycodone. Monitor and adjust dose. (Moderate) Study
- **Rucaparib** is predicted to increase the exposure to opioids (alfentanil, fentanyl). Monitor and adjust dose. (Moderate) Study
- **SSRI Is (fluoxetine, paroxetine) are predicted to decrease the efficacy of codeine. (Moderate) Theoretical
- **SSRI Is (fluoxetine, paroxetine) are predicted to decrease the efficacy of tramadol. (Severe) Study Also see TABLE 13 p. 877
- **St John’s Wort** decreases the exposure to methadone. Monitor and adjust dose. (Severe) Study Also see TABLE 13 p. 877
- **St John’s Wort** moderately decreases the exposure to oxycodone. Adjust dose. (Moderate) Study
- **Terbinafine** is predicted to decrease the efficacy of codeine. (Moderate) Theoretical
- **Terbinafine** is predicted to decrease the efficacy of tramadol. (Severe) Study

Orlistat

**SEPARATION OF ADMINISTRATION** Orlistat might affect the absorption of concurrently administered drugs—consider separating administration. Particular care should be taken with antiepileptics, antiretrovirals, and drugs that have a narrow therapeutic index.

**Orphenadrine** → see TABLE 10 p. 876 (antimuscarinic)
Paliperidone — Paritaprevir

Paliperidone — see TABLE 8 p. 875 (hypotension), TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects)

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to paliperidone. Monitor and adjust dose. [Severe] Study Also see TABLE 9 p. 876

Antiepileptics (valproate) slightly increase the exposure to paliperidone. Adjust dose. [Moderate] Study

Paliperidone is predicted to decrease the effects of dopamine receptor agonists. Avoid. [Moderate] Theoretical Also see TABLE 8 p. 875 Also see TABLE 9 p. 876

Enzalutamide is predicted to decrease the exposure to paliperidone. Monitor and adjust dose. [Severe] Study

Paliperidone is predicted to decrease the effects of levodopa. [Severe] Theoretical Also see TABLE 8 p. 875

Methylphenidate increases the risk of dyskinasias when given with paliperidone. [Severe] Theoretical

Mitotane is predicted to decrease the exposure to paliperidone. Monitor and adjust dose. [Severe] Study

St John's Wort is predicted to decrease the exposure to paliperidone. [Severe] Theoretical

Palonosetron — see TABLE 9 p. 876 (QT-interval prolongation), TABLE 13 p. 877 (serotonin syndrome)

Dopamine receptor agonists (apomorphine) are predicted to increase the risk of severe hypotension when given with palonosetron. [Severe] Theoretical

Pamidronate — see bisphosphonates

Pancreatin

Pancreatin is predicted to decrease the effects of acarbose. Avoid. [Moderate] Theoretical

Pancuronium — see neuromuscular blocking drugs, non-depolarising

Panumumab — see monoclonal antibodies

Panobinostat — see TABLE 15 p. 876 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)

FOOD AND LIFESTYLE

Avoid pomegranate, pomegranate juice, and star fruit as they are predicted to increase panobinostat exposure.

Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical Also see TABLE 9 p. 876

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to panobinostat. Avoid. [Moderate] Theoretical

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. [Moderate] Study Also see TABLE 9 p. 876

Antifungals, azoles (posaconazole) are predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical

Panobinostat is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical Also see TABLE 9 p. 876

Panobinostat is predicted to decrease the exposure to beta blockers, selective (metoprolol). Monitor and adjust dose. [Moderate] Theoretical

Panobinostat is predicted to increase the exposure to beta blockers, selective (nebivolol). Monitor and adjust dose. [High] Theoretical

Calcium channel blockers (verapamil) are predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical

Ciclosporin is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical

Cobicistat is predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. [Moderate] Study

Enzalutamide is predicted to decrease the exposure to panobinostat. Avoid. [Moderate] Theoretical

HIV-protease inhibitors are predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. [Moderate] Study Also see TABLE 15 p. 876

Idelalisib is predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. [Moderate] Study Also see TABLE 15 p. 876

Lapatinib is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical Also see TABLE 9 p. 876

Macrolides (azithromycin, erythromycin) are predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical Also see TABLE 9 p. 876

Macrolides (clarithromycin) are predicted to increase the exposure to panobinostat. Adjust panobinostat dose; in hepatic impairment avoid. [Moderate] Study Also see TABLE 9 p. 876

Mitotane is predicted to decrease the exposure to panobinostat. Avoid. [Moderate] Theoretical Also see TABLE 15 p. 877

Panobinostat is predicted to increase the exposure to pimozone. Avoid. [Severe] Theoretical Also see TABLE 9 p. 876

Ranolazine is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical Also see TABLE 9 p. 876

Rifampicin is predicted to decrease the exposure to panobinostat. Avoid. [Moderate] Theoretical

Vemurafenib is predicted to increase the exposure to panobinostat. Adjust dose. [Moderate] Theoretical Also see TABLE 9 p. 876

Pantoprazole — see proton pump inhibitors

Parpaveretum — see opioids

Paracetamol — see TABLE 1 p. 874 (hepatotoxicity)

Alcohol (beverages) (in those who drink heavily) causes severe liver damage when given with paracetamol. [Severe] Study Also see TABLE 1 p. 874

Paracetamol is predicted to decrease the clearance of alkylation agents (busulfan). [Moderate] Theoretical

Paracetamol is predicted to increase the risk of methaemoglobinemia when given with topical anaesthetics, local (prilocaine). Use with caution or avoid. [Severe] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to paracetamol. [Moderate] Study Also see TABLE 1 p. 874

Paracetamol increases the anticoagulant effect of coumarins. [Moderate] Study

Paracetamol is predicted to increase the risk of methaemoglobinemia when given with dapsone. [Severe] Theoretical

Imatinib increases the risk of hepatotoxicity when given with paracetamol. [Severe] Anecdotal

Paracetamol potentially increases the risk of high anion gap metabolic acidosis when given with penicillins (fluocoxacillin). [Severe] Theoretical Also see TABLE 1 p. 874

Paracetamol is predicted to increase the anticoagulant effect of phenindione. [Severe] Theoretical

Pitolisant is predicted to decrease the exposure to paracetamol. [High] Theoretical

Pitolisant decreases the exposure to paracetamol. [Moderate] Study

Paraldehyde — see antiepileptics

Parathyroid hormone

Bisphosphonates are predicted to decrease the effects of parathyroid hormone. Avoid. [Moderate] Study

Paroxetine — see NSAIDs

Paricalcitol — see vitamin D substances

Paritaprevir

Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to aliskiren. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe] Study

Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to paritaprevir (with ritonavir and ombitasvir) and paritaprevir (with ritonavir and ombitasvir) is predicted to
increase the exposure to antifungals, azoles (posaconazole). Avoid. [Moderate Study]

- Bosentan is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe Study]
- Cobicistat is predicted to increase the exposure to paritaprevir. Avoid. [Severe Study]
- Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe Study]
- Paritaprevir (in fixed-dose combination with daalabuvir) decreases the anticoagulant effect of coumarins (acenocoumarol). Monitor INR and adjust dose. [Severe Anecdotal]
- Paritaprevir (in fixed-dose combination) decreases the anticoagulant effect of coumarins (warfarin). Monitor INR and adjust dose. [Severe Anecdotal]
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to dabigatran. [Severe Study]
- Paritaprevir (with ritonavir and ombitasvir) increases the exposure to digoxin. Monitor and adjust digoxin dose, p. 82. [Moderate Study]
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to edoxaban. Avoid. [Severe Study]
- Efalizumab is predicted to decrease the exposure to paritaprevir. Avoid. [Severe Study]
- HIV-protease inhibitors (atazanavir) boosted with ritonavir markedly increase the exposure to paritaprevir. Avoid or give unboosted. [Moderate Study]
- HIV-protease inhibitors (darunavir boosted with ritonavir) slightly decrease the exposure to paritaprevir. Avoid or give unboosted. [Moderate Study]
- HIV-protease inhibitors ( fosamprenavir, tipranavir) boosted with ritonavir are predicted to increase the exposure to paritaprevir. Avoid. [Severe Study]
- HIV-protease inhibitors (saquinavir) are predicted to increase the exposure to paritaprevir (in fixed-dose combination). Avoid. [Severe Study]
- Paritaprevir is predicted to increase the exposure to idelalisib. Avoid. [Severe Study]
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to loperamide. [Moderate Study]
- Macrolides (clarithromycin) are predicted to increase the exposure to paritaprevir. Avoid. [Severe Study]
- Mitotane is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe Study]
- Neoral is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe Study]
- Rifampicin is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe Study]
- St John’s Wort is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe Study]
- Paritaprevir (in fixed-dose combination) is predicted to increase the risk of rhabdomyolysis when given with statins (atorvastatin). Avoid. [Severe Theoretical]
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to statins (fluvastatin). Avoid. [Moderate Theoretical]
- Paritaprevir (with ritonavir and ombitasvir) increases the exposure to taxanes (paclitaxel). [Moderate Study]
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to thyroid hormones (levothyroxine). Monitor and adjust dose. [Moderate Theoretical]
- Paritaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to topectan. [Moderate Study]
- Paroxetine is predicted to increase the exposure to paritaprevir. Avoid. [Severe Theoretical]
- Pasireotide is predicted to decrease the absorption of oral ciclosporin. Adjust dose. [Severe Theoretical]

Paritaprevir is predicted to decrease the absorption of ciclosporin. Adjust dose. [Severe Theoretical]

### Patiromer

#### SEPARATION OF ADMINISTRATION

Manufacturer advises take 3 hours before, or after, other drugs.

### Pazopanib

- see TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)
- Antacids are predicted to decrease the absorption of pazopanib. Pazopanib should be taken 1 hour before or 2 hours after antacids. [Moderate Theoretical]
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to pazopanib. [Moderate Theoretical] → Also see TABLE 9 p. 876
- Antidepressants (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to pazopanib. Avoid. [Severe Theoretical]
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to pazopanib. [Moderate Theoretical]
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate Study] → Also see TABLE 9 p. 876
- Aprepitant is predicted to increase the exposure to pazopanib. [Moderate Theoretical]
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to pazopanib. [Moderate Theoretical]
- Cobasistat is predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate Study]
- Pazopanib is predicted to increase the risk of bleeding events when given with coumarins. [Severe Theoretical]
- Crizotinib is predicted to increase the exposure to pazopanib. [Moderate Theoretical] → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- Enalapril is predicted to decrease the exposure to pazopanib. Avoid. [Severe Theoretical]
- Grapefruit juice is predicted to increase the exposure to pazopanib. Avoid. [Severe Theoretical]
- H1 Receptor antagonists are predicted to decrease the exposure to pazopanib. H1 receptor antagonists should be taken 10 hours before or 2 hours after pazopanib. [Moderate Theoretical]
- HIV-protease inhibitors are predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate Study] → Also see TABLE 9 p. 876
- Idealalisib is predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate Study] → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to pazopanib. [Moderate Theoretical] → Also see TABLE 15 p. 877
- Pazopanib is predicted to increase the exposure to sorafenib. [Moderate Theoretical] Separate administration by 12 hours. [Moderate Theoretical]
- Macrolides (clarithromycin) are predicted to increase the exposure to pazopanib. Avoid or adjust pazopanib dose. [Moderate Study] → Also see TABLE 9 p. 876
- Macrolides (erythromycin) are predicted to increase the exposure to pazopanib. [Moderate Theoretical] → Also see TABLE 9 p. 876
Pazopanib – Phenindione

**Pazopanib (continued)**

- **Mitotane** is predicted to decrease the exposure to pazopanib. Avoid. **Severe** Theoretical → Also see TABLE 15 p. 877
- **Netupitant** is predicted to increase the exposure to pazopanib. **Moderate** Theoretical
- **Nilotinib** is predicted to increase the exposure to pazopanib. **Moderate** Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- **Pazopanib** is predicted to increase the risk of bleeding events when given with phenindione. **Severe** Theoretical
- **Proton pump inhibitors** are predicted to decrease the exposure to pazopanib. Avoid or administer concurrently without food. **Moderate** Study
- **Rifampicin** is predicted to decrease the exposure to pazopanib. Avoid. **Severe** Theoretical
- **Pazopanib** is predicted to affect the exposure to statins (atorvastatin). **Moderate** Anecdotal
- **Pazopanib** is predicted to affect the exposure to statins (pravastatin, rosuvastatin, simvastatin). **Moderate** Theoretical
- **Pegasparagase** → see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression)
- **Pegasparagase** is predicted to increase the risk of hepatotoxicity when given with imatinib. **Severe** Theoretical → Also see TABLE 15 p. 877
- **Pegasparagase** affects the efficacy of methotrexate. **Severe** Anecdotal → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877
- **Pegasparagase** potentially increases the risk of neurotoxicity when given with vinca alkaloids (vincristine). Vincristine should be taken 3 to 24 hours before pegasparagase. **Severe** Anecdotal → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877
- **Peginterferon alfa** → see interferons
- **Peginterferon beta-1a** → see TABLE 15 p. 877 (myelosuppression)
- **Pembrolizumab** → see monoclonal antibodies
- **Pemetrexed** → see TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874 (nephrotoxicity)
- **Antimalarials** (pyrimethamine) are predicted to increase the risk of side-effects when given with pemetrexed. **Severe** Theoretical → Also see TABLE 15 p. 877
- **Aspirin** (high-dose) potentially increases the exposure to pemetrexed. Use with caution or avoid. **Severe** Theoretical
- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with pemetrexed. Public Health England advises avoid (refer to Green Book). **Severe** Theoretical
- **NSAID**s are predicted to increase the exposure to pemetrexed. Use with caution or avoid. **Severe** Theoretical → Also see TABLE 2 p. 874
- **Penicillamine** → see TABLE 2 p. 874 (nephrotoxicity)
- **Antacids** decrease the absorption of penicillamine. Separate administration by 2 hours. **High** Study
- **Antimalarials** (chloroquine) are predicted to increase the risk of haematological toxicity when given with penicillamine. Avoid. **Severe** Theoretical
- **Iron** (oral) is predicted to decrease the absorption of penicillamine. Separate administration by at least 2 hours. **High** Study
- **Sodium aurothiomalate** potentially increases the risk of side-effects when given with penicillamine (in those who have had previous adverse reactions to gold). Avoid. **Severe** Study
- **Zinc** is predicted to decrease the absorption of penicillamine. **High** Theoretical
- **Penicillins** → see TABLE 1 p. 874 (hepatotoxicity)
- **amoxicillin** - **ampicillin** - **benzypenicillin** - **flucloxacinil** - **phenoxymethylpenicillin** - **piperacillin** - **pivmecillinam** - **temocillin** - **ticarcillin**
- **Alliopirinol** increases the risk of skin rash when given with penicillins (amoxicillin, ampicillin). **Moderate** Study
- **Antiepileptics** (valproate) increase the risk of side-effects when given with pivmecillinam. Avoid. **Severe** Anecdotal
- **Penicillins** potentially alter the anticoagulant effect of **coumarins**. Monitor INR and adjust dose. **Severe** Anecdotal
- **Leflunomide** is predicted to increase the exposure to benzypenicillin. **Moderate** Theoretical
- **Penicillins** are predicted to increase the risk of toxicity when given with methotrexate. **Severe** Anecdotal → Also see TABLE 1 p. 874
- **Piperacillin** increases the effects of **neuromuscular blocking drugs**, **non-depolarising**. **Moderate** Study
- **Paracetamol** potentially increases the risk of high anion gap metabolic acidosis when given with fluocoxidin. **Severe** Theoretical → Also see TABLE 1 p. 874
- **Penicillins** are predicted to increase the risk of bleeding events when given with **phenindione**. **Severe** Theoretical
- **Piperacillin** increases the effects of **suxamethonium**. **Moderate** Study
- **Teriflunomide** is predicted to increase the exposure to benzypenicillin. **Moderate** Study
- **Pentamidine** → see TABLE 9 p. 876 (CFI-interval prolongation), TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874 (nephrotoxicity)
- **Didanosine** is predicted to increase the risk of pancreatitis when given with pentamidine. Avoid. **Severe** Study
- **Foscarnet** increases the risk of hypocalcaemia when given with pentamidine. **Severe** Anecdotal → Also see TABLE 2 p. 874
- **Pentazocine** → see opioids
- **Pentostatin** → see TABLE 15 p. 877 (myelosuppression), TABLE 5 p. 874 (thromboembolism)
- **Alkylating agents** (cyclophosphamide) (high-dose) increase the risk of toxicity when given with pentostatin. Avoid. **Severe** Anecdotal → Also see TABLE 15 p. 877 → Also see TABLE 5 p. 874
- **Fludarabine** increases the risk of pulmonary toxicity when given with pentostatin. Avoid. **Severe** Study → Also see TABLE 15 p. 877
- **Pentoxifylline**
- **Pentoxifylline** is predicted to increase the concentration of **aminophylline**. Use with caution or avoid. **Severe** Theoretical
- **Quinolones** (ciprofloxacin) very slightly increase the exposure to pentoxifylline. **Moderate** Study
- **SSRIs** (fluvoxamine) are predicted to increase the exposure to pentoxifylline. **Moderate** Theoretical
- **Pentoxifylline** increases the concentration of **theophylline**. Monitor and adjust dose. **Severe** Study
- **Peppermint oil**
- **Peppermint oil** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. **Moderate** Theoretical
- **Perampanel** → see antiepileptics
- **Pergolide** → see dopamine receptor agonists
- **Pericyazine** → see phenothiazines
- **Perindopril** → see ACE inhibitors
- **Pertuzumab** → see monoclonal antibodies
- **Pethidine** → see opioids
- **Phenelzine** → see monoamine-oxidase A and B inhibitors, irreversible
- **Phenindione** → see TABLE 3 p. 874 (anticoagulant effects)

**FOOD AND LIFESTYLE** The effects of phenindione can be reduced or abolished by vitamin K, including that found in health foods, food supplements, enteral feeds, or large amounts of some green vegetables or green tea. Major changes in diet (especially involving salads and vegetables) and in alcohol consumption can affect anticoagulant control.

- **Antirhythmic**s (propafenone) are predicted to increase the anticoagulant effect of phenindione. Monitor and adjust dose. **Moderate** Theoretical
- **Antifungals**, azoles (miconazole) greatly increase the anticoagulant effect of phenindione. **Severe** Theoretical
- **Axitinib** is predicted to increase the risk of bleeding events when given with phenindione. **Severe** Theoretical
- **Bosutinib** is predicted to increase the risk of bleeding events when given with phenindione. **Severe** Theoretical
- **Cabozzatinib** is predicted to increase the risk of bleeding events when given with phenindione. **Severe** Theoretical
- **Cephalosporins** (ceftriaxone) potentially increase the risk of bleeding events when given with phenindione. **Severe** Anecdotal
- **Corticosteroids** are predicted to increase the effects of phenindione. **Moderate** Anecdotal
> Crizotinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Dasetubin is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Disulfiram is predicted to increase the anticoagulant effect of phenindione. [Severe] Theoretical
> Enteral feeds (vitamin-K containing) potentially decrease the effects of phenindione. [Severe] Theoretical
> Erlotinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Fibrates are predicted to increase the anticoagulant effect of phenindione. Monitor INR and adjust dose. [Severe] Study
> Gefitinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> H₂ receptor antagonists (cimetidine) increase the exposure to phenindione. [Severe] Theoretical
> Imatinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Lapatinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Nandrolone is predicted to increase the anticoagulant effect of phenindione. Monitor and adjust dose. [Severe] Theoretical
> Nitrofurantoin is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Oxymetholone increases the anticoagulant effect of phenindione. [Severe] Theoretical
> Paracetamol is predicted to increase the anticoagulant effect of phenindione. [Severe] Theoretical
> Pazopanib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Penicillins are predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Ponatinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Ranibizumab is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Regorafenib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Ruxolitinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Sotalol is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Statins (rosuvastatin) are predicted to increase the anticoagulant effect of phenindione. Monitor INR and adjust dose. [Severe] Theoretical
> Sunisib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Vandetanib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
> Phosphodiesterase type-5 inhibitors → see antiepileptics

**Phenothiazines** → see antiepileptics

**Phenothiazines are predicted to decrease the antihypertensive effects of guanethidine. [Moderate] Theoretical** → Also see TABLE 8 p. 875
> Phenothiazines decrease the effects of levodopa. Avoid or monitor worsening parkinsonian symptoms. [Severe] Study → Also see TABLE 8 p. 875
> Phenothiazines potentially increase the risk of neurotoxicity when given with lithium. [Severe] Anecdotal → Also see TABLE 9 p. 876
> Chlorpromazine decreases the effects of metyrapone. Avoid. [Moderate] Theoretical
> Moclobemide increases the risk of side-effects when given with levomepromazine. [Moderate] Study
> Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the risk of neuroleptic malignant syndrome when given with phenothiazines. [Severe] Theoretical → Also see TABLE 8 p. 875

**Phenoxymethylpenicillin → see penicillins**
> Phenytoin → see antiepileptics
> Pholcodine is predicted to increase the risk of CNS excitation or depression when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical

**Phosphodiesterase type-5 inhibitors** → see TABLE 8 p. 875 (hypotension). TABLE 9 p. 876 (QT-interval prolongation)avanafil - sildenafil - tadalafil - vardenafil

**Alpha blockers cause significant hypotensive effects when given with phosphodiesterase type-5 inhibitors. Patient should be stabilised on first drug then second drug should be added at the lowest recommended dose. [Severe] Study** → Also see TABLE 8 p. 875
> Antiarhythmics (dronedarone) are predicted to increase the exposure to avanafil. Adjust avanafil dose. [Moderate] Theoretical
> Antiarhythmics (dronedarone) are predicted to increase the exposure to sildenafil. Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study → Also see TABLE 9 p. 876
> Antiarhythmics (dronedarone) are predicted to increase the exposure to tadalafil. [Severe] Theoretical
> Antiarhythmics (dronedarone) are predicted to increase the exposure to vardenafil. Adjust dose. [Severe] Theoretical → Also see TABLE 9 p. 876
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, tadalafil, vardenafil). Avoid. [Severe] Study
> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (sildenafil, vardenafil). [Moderate] Theoretical
> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to avanafil. Adjust avanafil dose. [Moderate] Theoretical
> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to sildenafil. Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study → Also see TABLE 9 p. 876
> Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to vardenafil. Adjust dose. [Severe] Theoretical → Also see TABLE 9 p. 876
> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to sildenafil. Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. [Severe] Study → Also see TABLE 9 p. 876
> Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tadalafil. Use with caution or avoid. [Severe] Study
> Antifungals, azoles (miconazole) are predicted to increase the exposure to sildenafil. Use with caution and adjust dose. [Severe] Theoretical
Phosphodiesterase type-5 inhibitors (continued)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. [Severe] Study → Also see TABLE 8 p. 876
- Apalutamide is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, sildenafil, vardenafil). Avoid or monitor. [Moderate] Study → Also see TABLE 9 p. 876
- Aprepitant is predicted to increase the exposure to avanafil. Adjust avanafil dose. [Moderate] Theoretical
- Aprepitant is predicted to increase the exposure to sildenafil. Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4. [Moderate] Study
- Aprepitant is predicted to increase the exposure to tadalafil. [Severe] Theoretical
- Aprepitant is predicted to increase the exposure to vardenafil. Adjust dose. [Severe] Theoretical
- Bosentan decreases the exposure to phosphodiesterase type-5 inhibitors. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to avanafil. Adjust avanafil dose. [Moderate] Theoretical → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to sildenafil. Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4. [Moderate] Study → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to tadalafil. [Severe] Theoretical → Also see TABLE 8 p. 875
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to vardenafil. Adjust dose. [Severe] Theoretical → Also see TABLE 8 p. 875
- Cobicistat is predicted to increase the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. [Severe] Study
- Cobicistat is predicted to increase the exposure to sildenafil. Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. [Severe] Study → Also see TABLE 9 p. 876
- Cobicistat is predicted to increase the exposure to tadalafil. Use with caution or avoid. [Severe] Study
- Cobicistat is predicted to increase the exposure to vardenafil. Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study → Also see TABLE 9 p. 876
- Macrolides (clarithromycin) are predicted to increase the exposure to sildenafil. Avoid potent inhibitors of CYP3A4 or adjust sildenafil dose, p. 122. [Severe] Study → Also see TABLE 9 p. 876
- Macrolides (erythromycin) are predicted to increase the exposure to sildenafil. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Mitotane is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. [Severe] Study
- Mitotane is predicted to decrease the exposure to sildenafil. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Mitotane is predicted to decrease the exposure to vardenafil. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors. [Moderate] Theoretical
- Nicorandil is predicted to increase the risk of hypotension when given with phosphodiesterase type-5 inhibitors. Avoid. [Severe] Theoretical → Also see TABLE 8 p. 875
- Nitroglycerin is predicted to increase the exposure to sildenafil. Monitor or adjust sildenafil dose with moderate inhibitors of CYP3A4, p. 122. [Moderate] Study → Also see TABLE 9 p. 876
- Nilotinib is predicted to increase the exposure to vardenafil. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Nitrates potentially increase the risk of hypotension when given with phosphodiesterase type-5 inhibitors. Avoid. [Severe] Study → Also see TABLE 8 p. 875
- Rifampicin is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, vardenafil). Avoid. [Severe] Study
Pibrentasvir
- Rifampicin (with glecaprevir) is predicted to decrease the exposure to pibrentasvir. (Moderate) Study
- St John's Wort is predicted to decrease the exposure to pibrentasvir. Avoid. (Severe) Study

Phosphodiesterase type-5 inhibitors
- Tadalafil (with glecaprevir) is predicted to increase the exposure to pibrentasvir. Avoid. (Moderate) Study
- Pibrentasvir (with glecaprevir) is predicted to increase the exposure to tadalafil. (Moderate) Study

Calcium channel blockers
- Diltiazem (with glecaprevir) is predicted to increase the exposure to pibrentasvir. Avoid. (Severe) Study

Antiepileptics
- Phenytoin (with glecaprevir) is predicted to increase the exposure to pibrentasvir. Avoid. (Severe) Study
- Pibrentasvir (with glecaprevir) is predicted to increase the exposure to carbamazepine, oxcarbazepine, phenobarbital, phenytoin, primidone. Avoid. (Severe) Study

Pilocarpine
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to pibrentasvir. (Moderate) Study

A1
Pimozide (continued)

- Pimozide decreases the effects of levodopa. [Severe] Theoretical → Also see TABLE 8 p. 875
- Macrolides (clarithromycin) are predicted to increase the exposure to pimozide. Avoid. [Severe] Study → Also see TABLE 9 p. 876
- Macrolides (erythromycin) are predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- Netupitant is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical
- Nitelidipine is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- Palbociclib is predicted to increase the exposure to pimozide. Adjust dose. [Moderate] Theoretical
- Panobinostat is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- Pitolisant is predicted to decrease the exposure to pimozide. Avoid. [Severe] Theoretical
- Rifabutin is predicted to decrease the exposure to pimozide. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- Rolapitant is predicted to decrease the exposure to pimozide. Avoid. [Severe] Theoretical
- St John’s Wort is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical
- Voriconazole is predicted to increase the exposure to pimozide. Avoid. [Severe] Theoretical

Food and Lifestyle

- Smoking increases pirenidone clearance; patients should be encouraged to stop smoking before and during treatment with pirenidone.
- Antiepileptics ( fosphenytoin, phenytoin) are predicted to decrease the exposure to pirenidone. [Moderate] Theoretical
- Combined hormonal contraceptives are predicted to increase the exposure to pirenidone. Use with caution and adjust dose. [Moderate] Study
- HIV-protease inhibitors (ritonavir) are predicted to decrease the exposure to pirenidone. [Moderate] Theoretical
- Jeflumidine is predicted to decrease the exposure to pirenidone. [Moderate] Theoretical
- Mexiletine is predicted to increase the exposure to pirenidone. Use with caution and adjust dose. [Moderate] Study
- Quinolones (ciprofloxacin) are predicted to increase the exposure to pirenidone. Use with caution and adjust dose. [Moderate] Study
- Rifampicin is predicted to decrease the exposure to pirenidone. Avoid. [Moderate] Theoretical
- SSRIs ( fluvoxamine) are predicted to moderately increase the exposure to pirenidone. Avoid. [Moderate] Theoretical
- Teriflunomide is predicted to decrease the exposure to pirenidone. [Moderate] Theoretical

Piroxicam → see NSAIDs

Pitolisant

- Pitolisant is predicted to decrease the exposure to aliskiren. [Moderate] Theoretical
- Antiepileptics ( carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to pitolisant. [Moderate] Study
- Pitolisant is predicted to decrease the exposure to antihistamines, non-sedating ( fexofenadine). [Mild] Theoretical
- Antihistamines, sedating are predicted to decrease the efficacy of pitolisant. [Moderate] Theoretical
- Pitolisant is predicted to decrease the exposure to bosutinib. Avoid. [Severe] Theoretical
- Bupropion is predicted to moderately increase the exposure to pitolisant. Use with caution and adjust dose. [Moderate] Study
- Pitolisant is predicted to decrease the exposure to ciclosporin. Avoid. [Severe] Theoretical
- Cinacalcet is predicted to moderately increase the exposure to pitolisant. Use with caution and adjust dose. [Moderate] Study
- Pitolisant is predicted to decrease the exposure to colchicine. [Mild] Theoretical
- Pitolisant is predicted to decrease the efficacy of combined hormonal contraceptives. Avoid. [Severe] Theoretical
- Pitolisant is predicted to decrease the exposure to corticosteroids (dexamethasone). [Mild] Theoretical
- Pitolisant is predicted to decrease the exposure to efavirenz. [Mild] Theoretical
- Enzalutamide is predicted to moderately decrease the exposure to pitolisant. [Moderate] Study
- Pitolisant is predicted to decrease the exposure to everolimus. Avoid. [Severe] Theoretical
- Pitolisant is predicted to decrease the exposure to irinotecan. [Mild] Theoretical
- Pitolisant is predicted to decrease the exposure to lapatinib. Avoid. [Severe] Theoretical
- Pitolisant is predicted to decrease the exposure to loperamide. [Mild] Theoretical
- Pitolisant is predicted to increase the exposure to metformin. [Mild] Theoretical
- Mianserin is predicted to decrease the efficacy of pitolisant. [Moderate] Theoretical
- Mirtazapine is predicted to decrease the efficacy of pitolisant. [Moderate] Theoretical
- Mitotane is predicted to moderately decrease the exposure to pitolisant. [Moderate] Study
- Pitolisant is predicted to decrease the exposure to nilotinib. Avoid. [Severe] Theoretical
- Pitolisant is predicted to decrease the exposure to opioids (morphine). [Mild] Theoretical
- Pitolisant is predicted to decrease the exposure to paracetamol. [Mild] Theoretical
- Pitolisant is predicted to decrease the exposure to pimozide. Avoid. [Severe] Theoretical
- Pitolisant is predicted to decrease the exposure to repaglinide. [Mild] Theoretical
- Rifampicin is predicted to moderately decrease the exposure to pitolisant. [Moderate] Study
- Pitolisant is predicted to decrease the exposure to sirolimus. Avoid. [Severe] Theoretical
- SSRIs (fluoxetine, paroxetine) are predicted to moderately increase the exposure to pitolisant. Use with caution and adjust dose. [Moderate] Study
- St John’s Wort is predicted to decrease the exposure to pitolisant. Monitor and adjust dose. [Moderate] Theoretical
- Pitolisant is predicted to decrease the exposure to tacrolimus. Avoid. [Severe] Theoretical
Pitolisant is predicted to slightly increase the exposure to taxanes (docetaxel). Avoid. [Severe] Theoretical

Pitolisant is predicted to decrease the exposure to taxanes (paclitaxel). [Mild] Theoretical

Pitolisant is predicted to decrease the exposure to temsirolimus. Avoid. [Severe] Theoretical

Terbinafine is predicted to moderately increase the exposure to pitolisant. Use with caution and adjust dose. [Moderate] Study

Pitolisant is predicted to decrease the exposure to topotecan. [Mild] Theoretical

Tricyclic antidepressants are predicted to decrease the efficacy of pitolisant. [Severe] Theoretical

Venlafaxine is predicted to increase the exposure to pitolisant. Use with caution and adjust dose. [Mild] Theoretical

Pimecrolimus → see pencillins

Pizotifen → see antihistamines, sedating

Platinum compounds → see TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874 (nephrotoxicity), TABLE 19 p. 878 (ototoxicity), TABLE 12 p. 877 (peripheral neuropathy)

carbo platinum - cisplatin - oxaliplatin

• Cisplatin increases the risk of pulmonary toxicity when given with bleomycin. [Severe] Study → Also see TABLE 15 p. 877

• Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with platinum compounds. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Polymyxins → see TABLE 2 p. 874 (nephrotoxicity), TABLE 20 p. 878 (neuromuscular blocking effects)

ROUTE-SPECIFIC INFORMATION Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Polystyrene sulfonate

SEPARATION OF ADMINISTRATION Manufacturers advise take other drugs at least 3 hours before or after calcium– or sodium-polystyrene sulfonate; a 6-hour separation should be considered in gastroparesis.

• Antacids increase the risk of metabolic alkalosis when given with polystyrene sulfonate. [Severe] Anecdotal

Pomalidomide → see TABLE 15 p. 877 (myelosuppression), TABLE 5 p. 874 (thromboembolism)

• Combined hormonal contraceptives are predicted to increase the risk of venous thromboembolism when given with pomalidomide. Avoid. [Severe] Theoretical

• Hormone replacement therapy is predicted to increase the risk of venous thromboembolism when given with pomalidomide. [Severe] Theoretical

• Quinolones (ciprofloxacin) are predicted to increase the exposure to pomalidomide. Adjust pomalidomide dose. [Moderate] Theoretical

• SSRI (fluvoxamine) moderately increase the exposure to pomalidomide. Adjust pomalidomide dose. [Moderate] Study

Ponatinib

• Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to decrease the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Cobicistat is predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Ponatinib is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical

• Enzalutamide is predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

• Grapefruit juice is predicted to increase the exposure to ponatinib. [Moderate] Theoretical

• HIV-protease inhibitors are predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Idelalisib is predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Macrolides (clarithromycin) are predicted to slightly increase the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Mitotane is predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

• Ponatinib is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical

• Rifampicin is predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

• St John’s Wort is predicted to decrease the exposure to ponatinib. Avoid. [Severe] Theoretical

Ponatinib

• Active metabolites (pomalidomide, piperacillin, topotecan) are predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

• Combined hormonal contraceptives are predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

• Statins (lovastatin, simvastatin) are predicted to decrease the exposure to ponatinib. Monitor and adjust ponatinib dose. [Moderate] Study

• Temsirolimus is predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

• Carboplatin is predicted to increase the risk of pulmonary toxicity when given with bleomycin. [Severe] Study

• Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with platinum compounds. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Potassium aminobenzoate → see TABLE 16 p. 878 (increased serum potassium)

• Potassium aminobenzoate increases the concentration of methotrexate. [Moderate] Theoretical

• Potassium aminobenzoate is predicted to affect the efficacy of sulfonamides. Avoid. [Severe] Theoretical

Potassium canrenoate → see TABLE 16 p. 878 (increased serum potassium)

• Potassium chloride → see TABLE 16 p. 878 (increased serum potassium)

Potassium citrate

• Potassium citrate is predicted to decrease the efficacy of methotrexate. Avoid. [Moderate] Theoretical

• Potassium citrate increases the risk of side-effects when given with sulphradine. Avoid. [Moderate] Theoretical

Potassium-sparring diuretics → see TABLE 18 p. 878 (hypopotassemia), TABLE 16 p. 878 (increased serum potassium)

• Amlodipine - triamterene

• Triamterene potentially increases the clearance of lithium. [Moderate] Study

Pramipexole → see dopamine receptor agonist antipsychotics

Prasugrel → see TABLE 4 p. 874 (antiplatelet effects)

Pravastatin → see statins

Praziquantel

• Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to praziquantel. Avoid. [Moderate] Study

• Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to praziquantel. [Mild] Study

• Antimalarials (chloroquine) moderately decrease the exposure to praziquantel. Use with caution and adjust dose. [Moderate] Study

• Corticosteroids (dexamethasone) decrease the exposure to praziquantel. [Moderate] Study

• Enzalutamide is predicted to markedly decrease the exposure to praziquantel. Avoid. [Moderate] Study

• Grapefruit juice is predicted to increase the exposure to praziquantel. [Moderate] Study

• H₂ receptor antagonists (cimetidine) moderately increase the exposure to praziquantel. [Moderate] Study

• HIV-protease inhibitors are predicted to markedly increase the exposure to praziquantel. [Mild] Study

• Idelalisib is predicted to markedly increase the exposure to praziquantel. [Mild] Study

• Macrolides (clarithromycin) are predicted to moderately increase the exposure to praziquantel. [Mild] Study

• Mitotane is predicted to markedly decrease the exposure to praziquantel. Avoid. [Moderate] Study

• Rifampicin is predicted to markedly decrease the exposure to praziquantel. Avoid. [Moderate] Study

• Prazosin → see alpha blockers

Prednisolone → see corticosteroids

Pregabalin → see antiepileptics

Pramipexole → see dopamine receptor agonist antipsychotics

Primane → see antimalarials

Primidone → see antiepileptics

Procarnosoline → see TABLE 15 p. 877 (myelosuppression), TABLE 13 p. 877 (serotonin syndrome)
Propanolol → see beta blockers, non-selective
Antiepileptics (carbamazepine, phenobarbital, phenytoin, primidone) are predicted to increase the risk of hypersensitivity reactions when given with procarbazine. (Severe) Anecdotal
Antiepileptics (fosphenytoin) are predicted to increase the risk of hypersensitivity when given with procarbazine. (Severe) Anecdotal
Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with procarbazine. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical
Prochlorperazine → see phenothiazines
Propofol → see TABLE 10 p. 876 (antimuscarinics)
Propylthiouracil → see antithyroidism, iodides
Propafenone → see antiarrhythmics
Promazine → see antipsychotics
Promethazine → see antiarrhythmics
Promazine → see antipsychotics
Procyclidine is predicted to decrease the effects of metyrapone. Avoid. (Moderate) Theoretical
Proxymetacaine → see anaesthetics, local
Pyrazinamide → see antimycobacterial agents
Pyridostigmine → see anticholinesterase agents
Pyrimethamine → see antifalciparum (Ehrlichia species) agents
Pyridostigmine → see anticholinesterase agents
Pyrimethamine → see antifalciparum (Ehrlichia species) agents
Pyrimethamine → see antifalciparum (Ehrlichia species) agents
Pyrimethamine → see antifalciparum (Ehrlichia species) agents
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Pyrimethamine → see antifalciparum (Ehrlichia species) agents
Pyrimethamine → see antifalciparum (Ehrlichia species) agents
Pyrimethamine → see antifalciparum (Ehrlichia species) agents
Quetiapine → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
Quetiapine is predicted to decrease to moderately increase the exposure to velpatasvir. Avoid adjust dose, see sofosbuvir with velpatasvir and voxilaprevir. (Moderate) Study
Quetiapine is predicted to decrease to moderately increase the exposure to velpatasvir. Avoid adjust dose, see sofosbuvir with velpatasvir and voxilaprevir. (Moderate) Study
Quetiapine is predicted to decrease to moderately increase the exposure to velpatasvir. Avoid adjust dose, see sofosbuvir with velpatasvir and voxilaprevir. (Moderate) Study
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Quetiapine is predicted to decrease to moderately increase the exposure to velpatasvir. Avoid adjust dose, see sofosbuvir with velpatasvir and voxilaprevi...
Cobicistat is predicted to increase the exposure to quetiapine. Avoid. (Severe) Study

Crizotinib is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study

Quetiapine is predicted to decrease the effects of dopamine receptor agonists. Avoid. (Moderate) Theoretical Also see TABLE 8 p. 875

Efavirenz is predicted to decrease the exposure to quetiapine. (Moderate) Study

Enalaprilat is predicted to decrease the exposure to quetiapine. (Moderate) Study

Grapefruit juice is predicted to increase the exposure to quetiapine. Avoid. (Severe) Theoretical

HIV- protease inhibitors are predicted to increase the exposure to quetiapine. Avoid. (Severe) Study

Idelalisib is predicted to increase the exposure to quetiapine. Avoid. (Severe) Study

Imatinib is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study

Quetiapine decreases the effects of levodopa. (Severe) Anecdotal Also see TABLE 8 p. 875

Quetiapine potentially increases the risk of neurotoxicity when given with lithium. (Severe) Anecdotal

Macrolides (clarithromycin) are predicted to increase the exposure to quetiapine. Avoid. (Severe) Study

Mitotane is predicted to decrease the exposure to quetiapine. (Moderate) Study

Netupitant is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study

Nevirapine is predicted to decrease the exposure to quetiapine. (Moderate) Study

Nilotinib is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Study

Rilrobicitil (high-dose) is predicted to increase the exposure to quetiapine. Avoid. (Moderate) Theoretical

Rifampicin is predicted to decrease the exposure to quetiapine. (Moderate) Study

St John’s Wort is predicted to decrease the exposure to quetiapine. (Moderate) Study

Quinagolide see dopamine receptor agonists

Quinapril see ACE inhibitors

Quinine see antimalarials

Quinolones see TABLE 9 p. 876 (QT-interval prolongation)

ciprofloxacin - levofloxacin - moxifloxacin - ofloxacin

Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

Interactions do not generally apply to topical use of moxifloxacin unless specified.

Ciprofloxacin is predicted to increase the exposure to quetiapine. (Severe) Study

Ciprofloxacin is predicted to increase the exposure to aminophylline. Adjust dose. (Moderate) Theoretical

Ciprofloxacin is predicted to increase the exposure to anagrelide. (Moderate) Theoretical

Antacids decrease the absorption of quinolones. Quinolones should be taken 2 hours before or 4 hours after antacids. (Moderate) Study

Ciprofloxacin slightly increases the exposure to antithrythmics (lidocaine). (High) Study

Ciprofloxacin affects the concentration of antiepileptics (fosphenytoin, phenytoin) to predict increase the concentration and adjust dose. (Severe) Study

Calcium salts (calcium carbonate) decrease the absorption of ciprofloxacin. Separate administration by 2 hours. (Moderate) Study

Ciprofloxacin increases the concentration of clozapine. Monitor side effects and adjust dose. (Severe) Study

Quinolones increase the anticoagulant effect of coumarins. (Severe) Anecdotal

Didanosine (buffered) is predicted to greatly decrease the exposure to oral quinolones. Didanosine should be taken 2 hours after quinolones. (Moderate) Study

Ciprofloxacin is predicted to increase the exposure to dopamine receptor agonists (ropinirole). Adjust dose. (Moderate) Study

Ciprofloxacin is predicted to increase the exposure to duloxetine. Avoid. (Moderate) Theoretical

Ciprofloxacin is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Theoretical

Enteral feeds decrease the exposure to ciprofloxacin. (Moderate) Study

Ciprofloxacin slightly increases the exposure to erlotinib. Monitor side effects and adjust dose. (Moderate) Study

Ciprofloxacin is predicted to increase the exposure to ibrutinib. Adjust ibrutinib dose. (Severe) Theoretical

Iron (oral) decreases the exposure to quinolones. Separate administration by at least 2 hours. (Moderate) Study

Lanthanum moderately decreases the exposure to quinolones. Quinolones should be taken 2 hours before or 4 hours after lanthanum. (Moderate) Study

Lenalidomide is predicted to increase the exposure to ciprofloxacin. (Moderate) Theoretical

Ciprofloxacin is predicted to increase the exposure to lodoxapine. Avoid. (Unknown) Theoretical

Ciprofloxacin is predicted to increase the exposure to melatonin. (Moderate) Theoretical

Ciprofloxacin potentially increases the risk of toxicity when given with methotrexate. (Severe) Anecdotal

Ciprofloxacin slightly increases the exposure to monoamine-oxidase B inhibitors (rasagiline). (Moderate) Study

NSAIDs potentially increase the risk of seizures when given with quinolones. (Severe) Theoretical

Ciprofloxacin is predicted to increase the exposure to olanzapine. Adjust dose. (Moderate) Anecdotal

Ciprofloxacin very slightly increases the exposure to pentoxyfylline. (Moderate) Study

Ciprofloxacin is predicted to increase the exposure to pirofendone. Use with caution and adjust dose. (Moderate) Study

Ciprofloxacin is predicted to increase the exposure to pomalidomide. Adjust pomalidomide dose. (Moderate) Theoretical

Ciprofloxacin is predicted to increase the exposure to riluzole. (Moderate) Theoretical

Ciprofloxacin is predicted to increase the exposure to roflumilast. (Moderate) Theoretical

Sucralfate decreases the exposure to quinolones. Separate administration by 2 hours. (Moderate) Study

Teriflunomide is predicted to increase the exposure to ciprofloxacin. (Moderate) Theoretical

Ciprofloxacin is predicted to increase the exposure to theophylline. Monitor and adjust dose. (Moderate) Theoretical

Ciprofloxacin increases the exposure to tizanidine. Avoid. (Moderate) Study

Ciprofloxacin is predicted to increase the exposure to tolvaptan. Use with caution and adjust tolvaptan dose. (Moderate) Theoretical

Zinc is predicted to decrease the exposure to quinolones. Separate administration by 2 hours. (Moderate) Study

Ciprofloxacin is predicted to decrease the exposure to zolmitriptan. Adjust zolmitriptan dose. p. 300. (Moderate) Theoretical

Rabeprazole see proton pump inhibitors

Rabies immunoglobulin see immunoglobulins

Rabies vaccine

Antimalarials (chloroquine) decrease the efficacy of rabies vaccine. Avoid. (Moderate) Study

Hydroxychloroquine is predicted to decrease efficacy of rabies vaccine. (Moderate) Theoretical

Ralofoxifene see TABLE 5 p. 874 (thromboembolism)

Combined hormonal contraceptives potentially oppose the effects of ralofoxifene. Avoid. (Severe) Theoretical

Hormone replacement therapy potentially opposes the effects of ralofoxifene. Avoid. (Severe) Theoretical

Raltegravir

Antacids slightly decrease the exposure to raltegravir. Avoid. (Moderate) Study

Antiepileptics (carbamazepine) are predicted to affect the exposure to raltegravir. (Moderate) Theoretical
Raltegravir (continued)

- **Antiepileptics** (fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to affect the exposure to raltegravir. Use with caution or avoid. (Moderate) Theoretical
  - Phenobarbital (calcium carbonate) greatly decrease the exposure to raltegravir. (high-dose). Avoid. (Severe) Study
  - *Enoralfen* is predicted to increase the exposure to raltegravir. (Moderate) Theoretical
  - HIV-protease inhibitors (atazanavir) increase the exposure to raltegravir. (high-dose). Avoid. (Moderate) Study
  - HIV-protease inhibitors (darunavir) increase the risk of rash when given with raltegravir. (Moderate) Study

- **Ranolazine** (boosted with ritonavir) decrease the exposure to raltegravir and raltegravir decreases the exposure to HIV-protease inhibitors (fosamprenavir) (boosted with ritonavir). Avoid. (Severe) Study

- **Ranolazine** (tipranavir) boosted with ritonavir are predicted to decrease the exposure to raltegravir (high-dose). Avoid. (Moderate) Study

- **Rifampin** slightly decreases the exposure to raltegravir. Avoid or adjust dose—consult product literature. (Moderate) Study

**Raltrexed** → see TABLE 15 p. 877 (myelosuppression)

- **Folates** are predicted to alter the effects of raltrexed. Avoid. (Moderate) Study

- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with raltrexed. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

- **Ramipril** → see ACE inhibitors

- **Ramucirumab** → see monoclonal antibodies

- **Ranibumab**
  - Ranibumab is predicted to increase the risk of bleeding events when given with argatroban. (Severe) Theoretical
  - Ranibumab is predicted to increase the risk of bleeding events when given with bivalirudin. (Moderate) Theoretical
  - **Ranibumab** increases the risk of bleeding events when given with coumarins. (Severe) Theoretical
  - **Ranibumab** is predicted to increase the risk of bleeding events when given with heparin (unfractionated). (Severe) Theoretical
  - **Ranibumab** increases the risk of bleeding events when given with low molecular-weight heparins. (Severe) Theoretical
  - **Ranibumab** is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical

- **Ranitidine** → see H$_2$ receptor antagonists

- **Ranolazine** → see TABLE 9 p. 876 (QT-interval prolongation)
  - **Ranolazine** is predicted to increase the exposure to afatinib. Separate administration by 12 hours. (Moderate) Study
  - **Ranolazine** is predicted to increase the exposure to aliskiren. (Moderate) Theoretical
  - **Antiarrhythmics** (dronedarone) are predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876
  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study

- **Antifungals** (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ranolazine. Avoid. (Severe) Study → Also see TABLE 9 p. 876

- **Antifungals** (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to ranolazine. Avoid. (Severe) Study → Also see TABLE 9 p. 876

- **Aprepitant** is predicted to increase the exposure to ranolazine. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to beta blockers, non-selective (nadolol). (Moderate) Study

- **Ranolazine** is predicted to increase the exposure to bictegravir. Use with caution or avoid. (Moderate) Theoretical

- **Calcium channel blockers** (diltiazem, verapamil) are predicted to increase the exposure to ranolazine. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to ceritinib. (Moderate) Theoretical → Also see TABLE 9 p. 876

- **Ciclosporin** is predicted to increase the concentration of ranolazine and ranolazine is predicted to increase the concentration of ciclosporin. (Moderate) Theoretical

- **Cobicistat** is predicted to increase the exposure to ranolazine. Avoid. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to colchicine. Avoid or adjust colchicine dose. (Severe) Theoretical

- **Crizotinib** is predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876

- **Ranolazine** is predicted to increase the exposure to dabigatran. (Severe) Theoretical

- **Ranolazine** increases the concentration of digoxin. (Moderate) Study

- **Ranolazine** is predicted to increase the exposure to dopamine receptor agonists (pramipexole). Adjust dose. (Moderate) Study

- **Ranolazine** is predicted to slightly increase the exposure to edoxaban. (Severe) Theoretical

- **Enalapril** is predicted to decrease the exposure to ranolazine. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to erlotinib. (Moderate) Theoretical

- **Ranolazine** is predicted to increase the exposure to fidaxomicin. Avoid. (Moderate) Study

- **Grapefruit juice** is predicted to increase the concentration of ranolazine. Avoid. (Severe) Theoretical

- **HIV-protease inhibitors** are predicted to increase the exposure to ranolazine. Avoid. (Severe) Study → Also see TABLE 9 p. 876

- **Idelalisib** is predicted to increase the exposure to ranolazine. Avoid. (Severe) Study

- **Imatinib** is predicted to increase the exposure to ranolazine. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Moderate) Theoretical

- **Macrolides** (clarithromycin) are predicted to increase the exposure to ranolazine. Avoid. (Severe) Study → Also see TABLE 9 p. 876

- **Macrolides** (erythromycin) are predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876

- **Mitotane** is predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study

- **Netupitant** is predicted to increase the exposure to ranolazine. (Severe) Study

- **Nilotinib** is predicted to increase the exposure to ranolazine. (Severe) Study → Also see TABLE 9 p. 876

- **Ranolazine** is predicted to increase the exposure to nintedanib. (Moderate) Study

- **Ranolazine** is predicted to increase the exposure to panobinostat. Adjust dose. (Moderate) Theoretical → Also see TABLE 9 p. 876

- **Ranolazine** is predicted to increase the exposure to pibrantavir. (Moderate) Theoretical

- **Rifampicin** is predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study

- **St John’s Wort** is predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to statins (atorvastatin). (Moderate) Theoretical

- **Ranolazine** slightly increases the exposure to statins (simvastatin). Adjust simvastatin dose. p.13e (Moderate) Study

- **Ranolazine** increases the concentration of tacrolimus. Adjust dose. (Severe) Anecdotal

- **Ranolazine** is predicted to increase the exposure to ticagrelor. Use with caution or avoid. (Severe) Study

- **Ranolazine** is predicted to increase the exposure to topotecan. (Severe) Study

- **Ranolazine** is predicted to increase the concentration of trame tinib. (Moderate) Theoretical

- **Ranolazine** is predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. (Severe) Theoretical

- **Rasagiline** → see monoamine-oxidase B inhibitors

- **Reboxetine**
  - Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to reboxetine. (Moderate) Anecdotal
### Interactions

| Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to repaglinide. Avoid.  
| (Moderate) Study |
| Antifungals, azoles (miconazole) are predicted to increase the concentration of repaglinide. Use with caution and adjust dose.  
| (Moderate) Theoretical |
| Cobicistat is predicted to increase the exposure to repaglinide.  
| Avoid.  
| (Moderate) Study |
| Enzalutamide is predicted to decrease the exposure to repaglinide.  
| (Moderate) Anecdotal |
| HIV-protease inhibitors are predicted to increase the exposure to repaglinide. Avoid.  
| (Moderate) Study |
| Idealalisib is predicted to increase the exposure to repaglinide.  
| Avoid.  
| (Moderate) Study |
| Repaglinide is predicted to increase the risk of a hypertensive crisis when given with linezolid. Avoid.  
| (Severe) Theoretical |
| Repaglinide is predicted to increase the risk of hypokalaemia when given with loop diuretics.  
| (Moderate) Theoretical |
| Macrolides (clarithromycin) are predicted to increase the exposure to repaglinide. Avoid.  
| (Moderate) Study |
| Mitotane is predicted to decrease the exposure to repaglinide.  
| (Moderate) Anecdotal |
| Repaglinide is predicted to increase the risk of a hypertensive crisis when given with moclобемид. Avoid.  
| (Severe) Theoretical |
| Repaglinide is predicted to increase the risk of a hypertensive crisis when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid.  
| (Severe) Theoretical |
| Repaglinide is predicted to increase the risk of a hypertensive crisis when given with monoamine-oxidase B inhibitors (rasagiline, selegiline). Avoid.  
| (Severe) Theoretical |
| Repaglinide is predicted to decrease the exposure to repaglinide.  
| (Moderate) Anecdotal |
| Repaglinide is predicted to increase the risk of hypokalaemia when given with thiazide diuretics.  
| (Moderate) Anecdotal |
| Regorafenib → see TABLE 15 p. 877 (myelosuppression), TABLE 4 p. 874 (antidiabetic drugs) |
| Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to repaglinide. Monitor blood glucose and adjust dose.  
| (Moderate) Study |
| Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to repaglinide.  
| (Moderate) Study |
| Ciclosporin moderately increases the exposure to repaglinide.  
| (Moderate) Study |
| Clopidogrel increases the exposure to repaglinide. Avoid.  
| (Severe) Study |
| Cobicistat is predicted to increase the exposure to repaglinide.  
| (Moderate) Study |
| Enzalutamide is predicted to decrease the exposure to repaglinide. Monitor blood glucose and adjust dose.  
| (Moderate) Study |
| HIV-protease inhibitors are predicted to increase the exposure to repaglinide.  
| (Moderate) Study |
| Iron chelators (deferasirox) moderately increase the exposure to repaglinide. Avoid.  
| (Moderate) Study |
| Leflunomide is predicted to increase the exposure to repaglinide.  
| (Moderate) Study |
| Letemovir is predicted to increase the concentration of repaglinide. Avoid.  
| (Moderate) Theoretical |
| Macrolides (clarithromycin) are predicted to increase the exposure to repaglinide.  
| (Moderate) Study |
| Mitotane is predicted to decrease the exposure to repaglinide. Monitor blood glucose and adjust dose.  
| (Moderate) Study |
| Opicapone is predicted to increase the exposure to repaglinide. Avoid.  
| (Moderate) Study |
| Pitavastatin is predicted to decrease the exposure to repaglinide.  
| (Moderate) Study |
| Verapamil is predicted to increase the exposure to repaglinide.  
| (Moderate) Study |
| Trimethoprim slightly increases the exposure to repaglinide. Avoid or monitor blood glucose.  
| (Moderate) Study |
| Venetoclax is predicted to increase the exposure to repaglinide.  
| (Moderate) Theoretical |
| Retigabine → see antiepileptics |

### Retinoids

- Acitretin - adapalene - alitretinoin - bexarotene - isotretinoin - tazarotene - tretinoin

- Acitretin and isotretinoin. Since systemic absorption can follow topical application of isotretinoin and tretinoin, the possibility of interactions should be borne in mind.

- Avoid concomitant use of keratolytics in patients taking acitretin and isotretinoin.

### Alcohol (beverage)

- Alcohol (beverage) potentially increases the concentration of acitretin. Avoid and for 2 months after stopping acitretin. Avoid.  
| (Moderate) Study |

- Antiarrhythmics (amiodarone) are predicted to increase the exposure to alitretinoin. Adjust alitretinoin dose.  
| (Moderate) Theoretical |

- Antifungals, azoles (fluconazole, itraconazole, ketoconazole, miconazole, voriconazole) are predicted to increase the exposure to alitretinoin. Adjust alitretinoin dose.  
| (Moderate) Theoretical |

- Ciclosporin moderately increases the exposure to alitretinoin. Adjust alitretinoin dose.  
| (Moderate) Theoretical |

- Clopidogrel is predicted to increase the exposure to alitretinoin. Adjust alitretinoin dose.  
| (Moderate) Theoretical |

- Fibrates (gemfibrozil) are predicted to increase the exposure to alitretinoin. Adjust alitretinoin dose.  
| (Moderate) Theoretical |

- Studies indicate that alitretinoin is well absorbed following oral administration. It is relatively extensively metabolized by the liver and extensively secreted into human milk. Dosage adjustments are not necessary for patients with reduced renal function.
Retinoids (continued)

- **Fibrates (gemfibrozil)** increase the concentration of bexarotene. Avoid. [Severe] Study
- **HIV-protease inhibitors** are predicted to increase the exposure to altretinoin. Adjust altretinoin dose. [Moderate] Theoretical
- **Idelalisib** is predicted to increase the exposure to altretinoin. Adjust altretinoin dose. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to increase the exposure to altretinoin. Adjust altretinoin dose. [Moderate] Theoretical
- **Aprepitant** is predicted to increase the concentration of methotrexate. Avoid. [Moderate] Anecdotal
- **Ribociclib (acitretin, altretinoin, isoretinoin, tretonin)** increase the risk of benign intracranial hypertension when given with macrolines. Avoid. [Severe] Anecdotal
- **Bexarotene** is predicted to increase the risk of toxicity when given with vitamin A. Adjust dose. [Moderate] Theoretical
- **Retinoids (acitretin, altretinoin, isoretinoin, tretonin)** are predicted to increase the risk of vitamin A toxicity when given with vitamin A. Avoid. [Severe] Study
- **Tretinoin** is predicted to increase the risk of vitamin A toxicity when given with vitamin A. Avoid. [Severe] Study

**Ribavirin**

- **Ribavirin** is predicted to increase the exposure to didanosine. Avoid. [Severe] Study
- **Ribavirin** increases the risk of toxicity when given with stavudine. Avoid. [Severe] Study
- **Ribavirin** increases the risk of anaemia and/or leucopenia when given with zidovudine. Avoid. [Severe] Study

**Ribociclib** → See Table 9 p. 876 (Q7-interval prolongation)

**FOOD AND LIFESTYLE**

- Avoid concomitant use of pomegranate or pomegranate juice as it is predicted to increase ribociclib exposure.
- **Ribociclib** (high-dose) is predicted to increase the exposure to alpha blockers (alfuzosin). Avoid. [Moderate] Theoretical
- **Antiarhythmics (dronedarone)** are predicted to increase the exposure to ribociclib. [Moderate] Study → Also see Table 9 p. 876
- **Ribociclib** (high-dose) is predicted to increase the exposure to antiarhythmics (amiodarone). Avoid. [Moderate] Theoretical → Also see Table 9 p. 876
- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to markedly decrease the exposure to ribociclib. Avoid. [Severe] Study
- **Antifungals, azoles (fluconazole, isavuconazole, posaconazole)** are predicted to increase the exposure to ribociclib. [Moderate] Study → Also see Table 9 p. 876
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study → Also see Table 9 p. 876
- **Aprepitant** is predicted to increase the exposure to ribociclib. [Moderate] Study
- **Bosantan** is predicted to decrease the exposure to ribociclib. [Moderate] Study
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to ribociclib. [Moderate] Study
- **Ribociclib** is predicted to increase the exposure to ciclosporin. Use with caution and adjust dose. [Moderate] Theoretical
- **Cobicistat** is predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study
- **Crizotinib** is predicted to increase the exposure to ribociclib. [Moderate] Study → Also see Table 9 p. 876
- **Ribociclib** is predicted to increase the exposure to digoxin. [Moderate] Theoretical
- **Efavirenz** is predicted to decrease the exposure to ribociclib. [Moderate] Study → Also see Table 9 p. 876
- **Enzalutamide** is predicted to markedly decrease the exposure to ribociclib. Avoid. [Severe] Study
- **Ribociclib** (high-dose) is predicted to increase the exposure to ergotamine. Avoid. [Moderate] Theoretical
- **Ribociclib** is predicted to increase the exposure to everolimus. Use with caution and adjust dose. [Moderate] Theoretical
- **Grapefruit juice** is predicted to increase the exposure to ribociclib. Avoid. [Moderate] Theoretical

**HIV-protease inhibitors** are predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study → Also see Table 9 p. 876

- **Idelalisib** is predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study
- **Imatinib** is predicted to increase the exposure to ribociclib. [Moderate] Study
- **Macrolides (clarithromycin)** are predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study → Also see Table 9 p. 876
- **Macrolides (erythromycin)** are predicted to increase the exposure to ribociclib. Avoid or adjust ribociclib dose. [Moderate] Study

**Ribociclib** is predicted to increase the exposure to **metformin**. [Moderate] Theoretical

- **Ribociclib** moderately increases the exposure to **midazolam**. Avoid. [Moderate] Study
- **Mirtazapine** is predicted to markedly decrease the exposure to ribociclib. Avoid. [Severe] Study
- **Netupitant** is predicted to increase the exposure to ribociclib. [Moderate] Study
- **Nevirapine** is predicted to decrease the exposure to ribociclib. [Moderate] Study
- **Nilotinib** is predicted to increase the exposure to ribociclib. [Moderate] Study → Also see Table 9 p. 876
- **Ribociclib** is predicted to increase the exposure to opioids (alfentanil, fentanyl). Use with caution and adjust dose. [Moderate] Theoretical
- **Ribociclib** is predicted to increase the exposure to phosphodiesterase type 5 inhibitors (sildenafil). Avoid. [Moderate] Theoretical → Also see Table 9 p. 876
- **Ribociclib** (high-dose) is predicted to increase the exposure to pimozide. Avoid. [Moderate] Theoretical → Also see Table 9 p. 876
- **Ribociclib** (high-dose) is predicted to increase the exposure to quetiapine. Avoid. [Moderate] Theoretical
- **Rifampicin** is predicted to markedly decrease the exposure to ribociclib. Avoid. [Severe] Study
- **Ribociclib** is predicted to increase the exposure to sirolimus. Use with caution and adjust dose. [Moderate] Theoretical
- **St John’s Wort** is predicted to decrease the exposure to ribociclib. Avoid. [Severe] Study
- **Ribociclib** is predicted to increase the exposure to statins (pravastatin, rosuvastatin). [Moderate] Theoretical
- **Ribociclib** (high-dose) is predicted to increase the exposure to statins (simvastatin). Avoid. [Moderate] Theoretical
- **Ribociclib** is predicted to increase the exposure to tacrolimus. Use with caution and adjust dose. [Moderate] Theoretical

**Rifabutin**

**GENERAL INFORMATION** Although some manufacturers class rifabutin as a potent inducer of CYP3A4, clinical data suggests it is potentially a weak inducer, and therefore the BNF does not extrapolate the interactions of potent CYP3A4 inducers to rifabutin. For those who wish to err on the side of caution, see the interactions of rifampicin but bear in mind other mechanisms might be involved.

- **Antifungals, azoles (fluconazole)** increase the risk of uveitis when given with rifabutin. Adjust dose. [Severe] Study
- **Antifungals, azoles (itraconazole, posaconazole)** increase the concentration of rifabutin and rifabutin decreases the concentration of antifungals, azoles (itraconazole, posaconazole). Avoid. [Severe] Study
- **Antifungals, azoles (ketoconazole)** are predicted to increase the concentration of rifabutin and rifabutin decreases the concentration of antifungals, azoles (ketoconazole). Avoid. [Severe] Theoretical
- **Antifungals, azoles (miconazole)** are predicted to increase the concentration of rifabutin. Use with caution and adjust dose. [Moderate] Theoretical
- **Rifabutin** is predicted to decrease the exposure to antifungals, azoles (isavuconazole). Avoid. [Severe] Theoretical
- **Rifabutin** decreases the concentration of antifungals, azoles (voriconazole) and antifungals, azoles (voriconazole) increase the concentration of rifabutin. Avoid or adjust voriconazole dose, p. 392. [Severe] Study
- **Rifabutin** slightly decreases the exposure to antimalarials (atovaquone). Avoid. [Moderate] Study
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- Rifabutin slightly decreases the exposure to bicitravir. Avoid. (Moderate) Study
- Rifabutin is predicted to decrease the exposure to brigitamine. Avoid. (Moderate) Theoretical
- Rifabutin decreases the concentration of cobicitstat and cobicitstat increases the exposure to rifabutin. Avoid or adjust dose. (Severe) Study
- Rifabutin is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Study
- Rifabutin decreases the exposure to dapsone. (Moderate) Study
- Rifabutin is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Study
- Rifabutin moderately decreases the exposure to doravirine. Adjust doravirine dose. (Severe) Study
- Efavirenz slightly decreases the exposure to rifabutin. Adjust dose. (Severe) Study
- Rifabutin is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- Rifabutin decreases the exposure to etravirine. (Moderate) Study
- HIV-protease inhibitors (atazanavir, darunavir, fosamprenavir, lopinavir, saquinavir, tipranavir) (boosted with ritonavir) increase the exposure to rifabutin. Monitor and adjust dose. (Severe) Study
- HIV-protease inhibitors (ritonavir) markedly increase the exposure to rifabutin. Avoid or adjust dose. (Severe) Study
- Rifabutin is predicted to decrease the effects of hormone replacement therapy. (Moderate) Anecdotal
- Rifabutin is predicted to decrease the exposure to ledipasvir. Avoid. (Severe) Theoretical
- Rifabutin is predicted to decrease the concentration of lettermenor. (Moderate) Theoretical
- Rifabutin is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- Lumacaftor is predicted to decrease the exposure to rifabutin. Adjust dose. (Moderate) Theoretical
- Macrolides (azithromycin) increase the risk of neutropenia when given with rifabutin. Avoid. (Severe) Study
- Macrolides (clarithromycin) increase the risk of uveitis when given with rifabutin. Adjust dose. (Severe) Study
- Macrolides (erythromycin) are predicted to increase the risk of uveitis when given with rifabutin. Adjust dose. (Severe) Theoretical
- Rifabutin is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal
- Rifabutin slightly decreases the exposure to ripivirine. Adjust dose. (Severe) Study
- Rifabutin is predicted to decrease the exposure to rolapitant. Avoid. (Moderate) Theoretical
- Rifabutin is predicted to decrease the exposure to sofosbuvir. Avoid. (Severe) Theoretical
- Rifabutin is predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical
- Rifabutin is predicted to decrease the exposure to tezacafator. Avoid. (Severe) Theoretical
- Rifabutin decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal
- Rifabutin is predicted to decrease the concentration of vonlapirovir. Avoid. (Severe) Theoretical

Rifampicin

- Rifampicin is predicted to markedly decrease the exposure to abemacilch. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to abiraterone. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to afatinib. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to agomelatine. (Moderate) Theoretical
- Rifampicin is predicted to decrease the exposure to aldosterone antagonists (eplerenone). Avoid. (Moderate) Theoretical
- Rifampicin decreases the exposure to aliskiren. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to alprazolam. Adjust dose. (Moderate) Theoretical
- Rifampicin transiently increases the exposure to ambrisentan. (Moderate) Study
- Rifampicin decreases the exposure to aminophylline. Adjust dose. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to anaesthetics, local (ropivacaine). (Moderate) Theoretical
- Antacids decrease the absorption of rifampicin. Rifampicin should be taken 1 hour before antacids. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to antiarhythymics (disopyramide, dronedarone). Avoid. (Severe) Study
- Rifampicin is predicted to decrease the efficacy of antiarhythymics (propafenone). (Moderate) Study
- Rifampicin is predicted to decrease the exposure to anticholinesterases, centrally acting (donepezil). (Severe) Study
- Antiepileptics (phenobarbital, primidone) are predicted to decrease the exposure to rifampicin and rifampicin is predicted to decrease the exposure to antiepileptics (phenobarbital, primidone). Use with caution and adjust dose. (Moderate) Study
- Rifampicin slightly decreases the exposure to antiepileptics (brivaracetam). Adjust dose. (Moderate) Study
- Rifampicin decreases the concentration of antiepileptics (topiramate, phenytoin, phenytoin). Use with caution and adjust dose. (Moderate) Study
- Rifampicin markedly increases the clearance of antiepileptics (lamotrigine). Adjust lamotrigine dose, p. 207. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to antiepileptics (perampanel). Monitor and adjust dose. (Moderate) Study
- Rifampicin slightly decreases the exposure to antifungals, azoles (fluconazole). Adjust dose. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to antifungals, azoles (itraconazole). Avoid. (Severe) Study
- Rifampicin markedly decreases the exposure to antifungals, azoles (itraconazole). Avoid and for 14 days after stopping rifampicin. (Moderate) Study
- Rifampicin markedly decreases the exposure to antifungals, azoles (ketoconazole). Avoid. (Moderate) Study
- Rifampicin markedly decreases the exposure to antifungals, azoles (ketoconazole) and antifungals, azoles (ketoconazole) potentially decrease the exposure to rifampicin. Avoid. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to antifungals, azoles (miconazole). Avoid. (Moderate) Anecdotal
- Rifampicin very markedly decreases the exposure to antifungals, azoles (voriconazole). Avoid. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to antihistamines, non-sedating (bilastine). (Moderate) Theoretical
- Rifampicin increases the clearance of antihistamines, non-sedating (fexofenadine). (Moderate) Study
- Rifampicin is predicted to decrease the exposure to antimalarias (artemether) (with lumefantrine). Avoid. (Severe) Study
- Rifampicin moderately decreases the exposure to antimalarias (atovaquone) and antimalarias (atovaquone) slightly increase the exposure to rifampicin. Avoid. (Moderate) Study
- Rifampicin moderately decreases the exposure to antimalarias (mefloquine). (Severe) Study
- Rifampicin is predicted to decrease the concentration of antimalarias (piperaquine). Avoid. (Moderate) Theoretical
- Rifampicin decreases the exposure to antimalarias (quinine). (Severe) Study
- Rifampicin is predicted to moderately decrease the exposure to aripiprazole. Use with caution or avoid. (Severe) Study
- Rifampicin moderately decreases the exposure to aripiprazole. Avoid. (Severe) Study
- Rifampicin is predicted to markedly decrease the exposure to aprepitant. Avoid. (Moderate) Study
- Rifampicin is predicted to moderately decrease the exposure to aprepitant. Adjust aripiprazole dose, p. 255. (Moderate) Study
- Rifampicin decreases the exposure to ataluren. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to axitinib. Avoid or adjust dose. (Moderate) Study
Rifampicin (continued)

- Rifampicin is predicted to decrease the exposure to bazedoxifene. [Moderate] Theoretical
- Rifampicin decreases the exposure to bedaquiline. Avoid. [Severe] Study

Rifampicin moderately decreases the exposure to beta blockers, non-selective (carvedilol). [Moderate] Study

Rifampicin decreases the exposure to beta blockers, non-selective (propranolol). Monitor and adjust dose. [Moderate] Study

Rifampicin slightly decreases the exposure to beta blockers, selective (bisoprolol, metoprolol). [BL] Study

Rifampicin moderately decreases the exposure to beta blockers, selective (celiprolol). [Moderate] Study

Rifampicin is predicted to decrease the exposure to bictegravir. Avoid. [Moderate] Study

- Rifampicin affects the exposure to bosentan. Avoid. [Severe] Study

Rifampicin is predicted to very markedly decrease the exposure to bosutinib. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to bupropion. [Moderate] Study

Rifampicin is predicted to decrease the exposure to buspirone. Use with caution and adjust dose. [Severe] Study

Rifampicin moderately decreases the exposure to cabazitaxel. [Moderate] Study

Rifampicin moderately decreases the exposure to canagliflozin. Adjust canagliflozin dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to cannabis extract. Avoid. [Severe] Theoretical

Rifampicin is predicted to decrease the exposure to cariprazine. Avoid. [Severe] Study

Rifampicin decreases the concentration of caspofungin. Adjust caspofungin dose, p. 386. [Moderate] Study

Rifampicin is predicted to decrease the exposure to certitibib. Avoid. [Severe] Study

- Rifampicin decreases the concentration of chloramphenicol. [Moderate] Study

- Rifampicin is predicted to decrease the exposure to chlor Diazepoxide. [Moderate] Theoretical

Rifampicin decreases the concentration of ciclesonide. [Severe] Study

- Rifampicin is predicted to alter the effects of ciclosporin. [Severe] Study

Rifampicin is predicted to increase the exposure to ciclosporin. [Moderate] Theoretical

- Rifampicin is predicted to decrease the exposure to cinacalcet. Monitor and adjust dose. [Moderate] Study

Rifampicin decreases the exposure to clomethiazole. Monitor and adjust dose. [Moderate] Study

- Rifampicin decreases the exposure to clozapine. [Severe] Anecdotal

- Rifampicin is predicted to decrease the exposure to cobicistat. Avoid. [Severe] Theoretical

- Rifampicin is predicted to decrease the exposure to cobimetinib. Avoid. [Severe] Theoretical

Rifampicin is predicted to decrease the efficacy of combined hormonal contraceptives. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Study

Rifampicin is predicted to decrease the exposure to corticosteroids (budesonide, deflazacort, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone, triamcinolone). Monitor and adjust dose. [Moderate] Study

- Rifampicin is predicted to decrease the exposure to corticosteroids (fluticasone). [Unknown] Theoretical

- Rifampicin decreases the anticoagulant effect of coumarins. [Severe] Study

Rifampicin is predicted to markedly decrease the exposure to crizotinib. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to dabigatran. Avoid. [Severe] Study

- Rifampicin is predicted to decrease the exposure to dabrafenib. Avoid. [Moderate] Theoretical

- Rifampicin decreases the exposure to dapsone. [Moderate] Study

- Rifampicin is predicted to decrease the exposure to darifenacin. [Moderate] Theoretical

- Rifampicin is predicted to decrease the exposure to dasabuvir. Avoid. [Severe] Theoretical

- Rifampicin is predicted to markedly decrease the exposure to dasatinib. Avoid. [Severe] Study

- Rifampicin is predicted to slightly decrease the exposure to deathmanid. Avoid. [Moderate] Study

- Rifampicin is predicted to decrease the efficacy of desogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

- Rifampicin moderately decreases the exposure to diazepam. Avoid. [Moderate] Study

- Rifampicin decreases the concentration of digoxin. [Moderate] Study

Rifampicin decreases the exposure to dolutegravir. Adjust dose. [Severe] Study

Rifampicin is predicted to decrease the exposure to doravirine. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to dolutegravir. [Moderate] Theoretical

- Rifampicin is predicted to decrease the exposure to edoxaban. [Moderate] Study

Rifampicin slightly decreases the exposure to efavirenz. Adjust dose. [Severe] Study

Rifampicin is predicted to decrease the exposure to elbasvir. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to eliglustat. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to eltorbogap and eltorbogap is predicted to increase the concentration of rifampicin. [Moderate] Theoretical

Rifampicin is predicted to decrease the concentration of elvitegravir. Avoid. [Severe] Theoretical

Rifampicin is predicted to decrease the exposure to encorafenib. [Severe] Theoretical

Rifampicin is predicted to decrease the effects of ergotamine. [Moderate] Theoretical

Rifampicin is predicted to decrease the exposure to erlotinib. Avoid or adjust erlotinib dose. [Severe] Study

Rifampicin is predicted to decrease the exposure to esomeprazole. Adjust dose. [Moderate] Theoretical

Rifampicin is predicted to decrease the efficacy of etonogestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

Rifampicin is predicted to decrease the exposure to etravirine. Avoid. [Severe] Theoretical

Rifampicin is predicted to decrease the concentration of everolimus. Avoid or adjust dose. [Severe] Study

Rifampicin moderately decreases the exposure to exemestane. [Moderate] Study

Rifampicin is predicted to decrease the exposure to fesoterodine. Avoid. [Moderate] Study

Rifampicin is predicted to decrease the exposure to fingolimod. [Moderate] Study

Rifampicin is predicted to decrease the exposure to fosaprepitant. [Moderate] Theoretical

Rifampicin is predicted to decrease the exposure to gefitinib. Avoid. [Severe] Study

Rifampicin markedly affects the exposure to glecaprevir. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to grazoprevir. Avoid. [Severe] Study
Rifampicin is predicted to decrease the concentration of guanfacine. Adjust guanfacine dose. [Moderate] Study

Rifampicin decreases the concentration of haloperidol. Adjust dose. [Moderate] Study

Rifampicin is predicted to moderately to markedly decrease the exposure to HIV-1 protease inhibitors (atazanavir, darunavir, fosamprenavir, lopinavir, saquinavir). Avoid. [Severe] Study

Rifampicin slightly decreases the exposure to HIV-1 protease inhibitors (ritonavir). [Severe] Study

Rifampicin is predicted to decrease the exposure to HIV-1 protease inhibitors (tipranavir). Avoid. [Severe] Study

Rifampicin is predicted to decrease the effects of hormone replacement therapy. [Moderate] Anecdotal

Rifampicin is predicted to decrease the exposure to ilbutramine. Avoid. [Moderate] Study

Rifampicin is predicted to decrease the exposure to imatinib. Avoid. [Moderate] Study

Leflunomide is predicted to decrease the exposure to iron chelators (deferasirox). Monitor serum ferritin and adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to ivabradine. Adjust dose. [Moderate] Theoretical

Rifampicin is predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to irinotecan. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to iron chelators (deferasirox). Monitor serum ferritin and adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to ivabradine. Adjust dose. [Moderate] Theoretical

Rifampicin is predicted to moderately to markedly decrease the exposure to ivacaftor. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to ketoconazole. Avoid. [Severe] Study

Rifampicin is predicted to increase the clearance of lapatinib. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to lepadipasir. Avoid. [Severe] Study

Leflunomide is predicted to increase the exposure to rifampicin. [Moderate] Theoretical

Rifampicin is predicted to affect the concentration of letermovir. [Severe] Theoretical

Rifampicin is predicted to decrease the efficacy of levonorgestrel. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Theoretical

Rifampicin is predicted to decrease the exposure to linagliptin. [Moderate] Study

Rifampicin slightly decreases the exposure to lincosamide. Monitor and adjust dose. [Moderate] Theoretical

Rifampicin increases the clearance of lorazepam. [Moderate] Study

Rifampicin is predicted to decrease the exposure to lurasidone. Avoid. [Moderate] Study

Rifampicin is predicted to decrease the exposure to macitentan. Avoid. [Severe] Study

Rifampicin decreases the concentration of macrolides (clarithromycin). [Severe] Study

Rifampicin is predicted to decrease the exposure to maraviroc. Adjust dose. [Severe] Study

Rifampicin is predicted to decrease the exposure to melatoninin. [Moderate] Theoretical

Rifampicin is predicted to increase the clearance of mexiteline. Monitor and adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to midazolam. Monitor and adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to midostaurin. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to mirtazapine. Adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to modafinil. [Moderate] Theoretical

Rifampicin decreases the effects of monoclonal antibodies (brentuximab vedotin). [Severe] Study

Rifampicin is predicted to decrease the exposure to montelukast. [Mild] Study

Rifampicin decreases the concentration of mycophenolate. Monitor and adjust dose. [Severe] Study

Rifampicin is predicted to markedly decrease the exposure to naloxegol. Avoid. [Moderate] Study

Rifampicin is predicted to slightly decrease the exposure to nateglinide. [Mild] Study

Rifampicin is predicted to decrease the exposure to netupitant. Avoid. [Severe] Study

Rifampicin decreases the concentration of nevirapine. Avoid. [Severe] Study

Rifampicin is predicted to moderately decrease the exposure to nilotinib. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to nintedanib. [Moderate] Study

Rifampicin is predicted to decrease the exposure to nitisine. Avoid. [Moderate] Theoretical

Rifampicin increases the clearance of nitrazepam. [Moderate] Study

Rifampicin is predicted to decrease the efficacy of norethisterone. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Rifampicin decreases the exposure to NSAI: Ds (celecoxib, diclofenac, etoricoxib). [Moderate] Study

Rifampicin is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to olaparib. Avoid. [Moderate] Theoretical

Rifampicin is predicted to decrease the exposure to ondansetron. [Moderate] Study

Rifampicin is predicted to decrease the exposure to opioids (alfentanil, fentanyl). [Moderate] Study

Rifampicin is predicted to decrease the exposure to opioids (buprenorphine). Monitor and adjust dose. [Moderate] Theoretical

Rifampicin decreases the exposure to opioids (codeine, morphine). [Moderate] Study

Rifampicin decreases the exposure to opioids (methadone). Monitor and adjust dose. [Severe] Study

Rifampicin is predicted to decrease the exposure to oxycodone. Monitor and adjust dose. [Moderate] Study

Rifampicin is predicted to moderately decrease the exposure to osimertinib. Avoid. [Moderate] Study

Rifampicin is predicted to moderately decrease the exposure to ospemifene. [Moderate] Study

Rifampicin is predicted to decrease the exposure to paclitaxel. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to palbociclib. [Severe] Study

Rifampicin is predicted to decrease the exposure to paliperidone. Monitor and adjust dose. [Severe] Study

Rifampicin is predicted to decrease the exposure to panobinostat. Avoid. [Moderate] Theoretical

Rifampicin decreases the exposure to paracetamol. [Moderate] Study

Rifampicin is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to pazopanib. Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (avanafil, tadalafil). Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors (sildenafil, vardenafil). Avoid. [Severe] Study

Rifampicin is predicted to decrease the exposure to pioglitazone. Monitor and adjust dose. [Moderate] Study

Rifampicin is predicted to decrease the exposure to pirenzepine. Avoid. [Moderate] Theoretical

Rifampicin is predicted to moderately to markedly decrease the exposure to piritondasvir. Avoid. [Severe] Study

Rifampicin is predicted to moderately decrease the exposure to piritonab. Avoid. [Moderate] Theoretical

Rifampicin is predicted to decrease the exposure to ponatinib. Avoid. [Moderate] Theoretical

Rifampicin is predicted to markedly decrease the exposure to praziquantel. Avoid. [Moderate] Study
Rifampicin — Rilpivirine

Rifampicin (continued)
- Rifampicin is predicted to decrease the exposure to quetiapine. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to rilpivirine.
- Rifampicin slightly decreases the exposure to raltegravir.
  Avoid or adjust dose—consult product literature. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to reboxetine. (Anecdotal) Study
- Rifampicin is predicted to decrease the exposure to regorafenib. Avoid. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to repaglinide. Monitor blood glucose and adjust dose. (Moderate) Study
- Rifampicin is predicted to markedly decrease the exposure to ribociclib. Avoid. (Severe) Study
- Rifampicin markedly decreases the exposure to rilpivirine. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to risperidone. Adjust dose. (Moderate) Study
- Rifampicin is predicted to moderately decrease the exposure to rivaroxaban. Avoid unless patient can be monitored for signs of thrombosis. (Severe) Study
- Rifampicin is predicted to decrease the exposure to roflumilast. (Anecdotal) Study
- Rifampicin is predicted to markedly decrease the exposure to rolapitant. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to ruoxolitinib. Monitor and adjust dose. (Moderate) Study
- Rifampicin is predicted to moderately decrease the exposure to saxagliptin. (Moderate) Study
- Rifampicin moderately decreases the exposure to the active metabolite of selexipag. Adjust dose. (Moderate) Study
- Rifampicin is predicted to decrease the concentration of sirolimus. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to sofosbuvir. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to solifenacin. (Moderate) Theoretical
- Rifampicin is predicted to decrease the exposure to sorafenib. (Moderate) Theoretical
- Rifampicin markedly decreases the exposure to statins (atorvastatin). Atorvastatin should be taken at the same time as rifampicin. (Moderate) Study
- Rifampicin moderately decreases the exposure to statins (fluvasatin). Monitor and adjust dose. (Moderate) Study
- Rifampicin very markedly decreases the exposure to statins (simvastatin). (Moderate) Study
- Rifampicin is predicted to decrease the exposure to sulfonylurea. Monitor and adjust dose. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. (Moderate) Study
- Rifampicin decreases the concentration of tacrolimus. Monitor and adjust dose. (Severe) Study
- Rifampicin markedly decreases the exposure to tamoxifen. (Unknown) Study
- Rifampicin is predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to taxanes (docetaxel). Avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical
- Rifampicin decreases the exposure to terbinafine. Adjust dose. (Moderate) Study
- Teriflunomide is predicted to increase the exposure to rifampicin. (Moderate) Theoretical
- Rifampicin decreases the exposure to tetracyclines (doxycycline). Monitor and adjust dose. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to tezacaftor. Avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the exposure to theophylline. Adjust dose. (Moderate) Study
- Rifampicin is predicted to markedly decrease the exposure to ticagrelor. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to tivozanib. (Severe) Study
- Rifampicin moderately decreases the exposure to tizanidine. (Anecdotal) Study
- Rifampicin is predicted to decrease the exposure to tofacitinib. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to tolvaptan. Use with caution or avoid depending on indication. (Severe) Study
- Rifampicin is predicted to decrease the exposure to toremifene. Adjust dose. (Moderate) Study
- Rifampicin decreases the exposure to trimethoprim. (Anecdotal) Study
- Rifampicin decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 56. (Severe) Theoretical
- Rifampicin is predicted to decrease the exposure to vandetanib. Avoid. (Moderate) Study
- Rifampicin is predicted to markedly decrease the exposure to velpatasvir. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to vemurafenib. Avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the exposure to venetoclax. Avoid. (Severe) Study
- Rifampicin is predicted to decrease the exposure to vinca alkaloids (vinblastine, vincristine, vindesine). Avoid. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to vinca alkaloids (vinflunine). Avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the exposure to vinorelbine. Use with caution or avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the exposure to vismodegib. Avoid. (Moderate) Theoretical
- Rifampicin potentially increases the risk of nephrotoxicity when given with volatile halogenated anaesthetics (methoxyflurane). Avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the exposure to vortioxetine. Monitor and adjust dose. (Moderate) Study
- Rifampicin is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Study
- Rifampicin moderately decreases the exposure to zolpidem. (Moderate) Study
- Rifampicin is predicted to decrease the exposure to zopiclone. Adjust dose. (Moderate) Study

Rilpivirine
- Ciclosporin very markedly increases the exposure to rilpivirine. (Severe) Study

Antacids are predicted to decrease the exposure to rilpivirine. Antacids should be taken 2 hours before or 4 hours after rilpivirine. (Severe) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) markedly decrease the exposure to rilpivirine. Avoid. (Severe) Theoretical
- Bosentan is predicted to decrease the exposure to rilpivirine. Avoid. (Severe) Theoretical
- Calcium salts (calcium carbonate) are predicted to slightly decrease the exposure to rilpivirine. Calcium carbonate should be taken 2 hours before or 4 hours after rilpivirine. (Severe) Theoretical
- Corticosteroids (dexamethasone) are predicted to decrease the concentration of rilpivirine. Avoid multiple-dose dexamethasone. (Severe) Theoretical
- Efavirenz is predicted to decrease the exposure to rilpivirine. Avoid. (Severe) Theoretical
- Enzalutamide markedly decreases the exposure to rilpivirine. Avoid. (Severe) Theoretical
- Etravirine is predicted to decrease the exposure to rilpivirine. Avoid. (Severe) Theoretical
Risperidone is predicted to decrease the exposure to risperidone. Adjust dose. (Moderate Study)

Rifampicin is predicted to decrease the exposure to risperidone. Adjust dose. (Moderate Study)

SSRIs (fluoxetine, paroxetine) are predicted to increase the exposure to risperidone. Adjust dose. (Moderate Study)

Terbinafine is predicted to increase the exposure to risperidone. Adjust dose. (Moderate Study)

Ritonavir → see HIV-protease inhibitors

Rifaximin → see monocolonal antibodies

Rivaroxaban → see TABLE 3 p. 874 (anticoagulant effects)

Antiarrhythmics (dronedarone) are predicted to increase the exposure to rivaroxaban. Avoid. (Moderate) Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to rivaroxaban. Avoid unless patient can be monitored for signs of thrombosis. (Severe) Study

Antifungals, azoles (itraconazole, ketoconazole) are predicted to moderately increase the exposure to rivaroxaban. Avoid. (Severe) Study

Ciclosporin is predicted to decrease the exposure to rivaroxaban. Avoid. (Moderate) Study

Cobicistat is predicted to increase the exposure to rivaroxaban. Avoid. (Severe) Theoretical

Moclobemide moderately increases the exposure to rivaroxaban. Avoid. (Moderate) Study

RizatRIPTAN → see TABLE 13 p. 877 (serotonin syndrome)

Beta blockers, non-selective (propranolol) slightly to moderately increase the exposure to rizatRIPTAN. Adjust rizatRIPTAN dose and separate administration by at least 2 hours. (Moderate) Study

RizatRIPTAN is predicted to increase the risk of vasoconstriction when given with ergotamine. Ergotamine should be taken at least 24 hours before or 6 hours after rizatRIPTAN. (Severe) Theoretical

Rivastigmine → see anticholinesterases, centrally acting

 ASA and clopidogrel are predicted to increase the exposure to roflumilast. Adjust roflumilast dose and separate administration by at least 24 hours. Avoid. (Severe) Study

Combination of ASA and roflumilast increases the risk of bleeding. (Severe) Study

Clobenpropit is predicted to increase the exposure to roflumilast. Adjust dose. (Moderate) Study

Aminophylline is predicted to slightly increase the exposure to roflumilast. Avoid. (Moderate) Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Combined hormonal contraceptives are predicted to increase the exposure to roflumilast. (Moderate) Study

Mexiteline is predicted to increase the exposure to roflumilast. (Moderate) Theoretical

Mitotane is predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to roflumilast. Adjust dose. (Moderate) Study

Rivacoxiban is predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Mexiteline is predicted to increase the exposure to roflumilast. (Moderate) Theoretical

Rifampicin is predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Rifampicin is predicted to decrease the exposure to roflumilast. Avoid. (Moderate) Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to roflumilast. Adjust dose. (Moderate) Study

Theophylline is predicted to slightly increase the exposure to roflumilast. Avoid. (Moderate) Theoretical
Rolapitant
- Rolapitant is predicted to increase the exposure to alkylating agents (bendamustine). Avoid or monitor. (Moderate) Study
- Rolapitant is predicted to increase the exposure to antineoplastics (doxorubicin, mitoxantrone). Avoid or monitor. (Moderate) Study
- Rolapitant is predicted to increase the exposure to antituberculous (rifampicin). Monitor and adjust dose. (Moderate) Study
- Rolapitant is predicted to increase the exposure to antiarrhythmics (propafenone). (Severe) Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to rolapitant. Avoid. (Severe) Study
- Rolapitant is predicted to moderately increase the exposure to beta blockers, selective (metoprolol). (Severe) Study
- Bosantan is predicted to decrease the exposure to colchicine. (Moderate) Study
- Rolapitant is predicted to increase the exposure to colchicine. (Moderate) Study
- Rolapitant is predicted to increase the exposure to dabigatran. (Moderate) Study
- Rolapitant is predicted to increase the exposure to efavirenz. Avoid. (Severe) Study
- Enzalutamide is predicted to markedly decrease the exposure to efavirenz. Avoid. (Severe) Study
- Rolapitant is predicted to increase the exposure to methotrexate. Avoid or monitor. (Moderate) Study
- Rolapitant is predicted to increase the exposure to mitotane. Avoid. (Severe) Study
- Nevirapine is predicted to decrease the exposure to rolapitant. Avoid. (Severe) Study
- Rolapitant is predicted to increase the exposure to pimozide. (Severe) Study
- Rifabutin is predicted to decrease the exposure to rolapitant. (Moderate) Study
- Riftimpicin is predicted to markedly decrease the exposure to rolapitant. Avoid. (Severe) Study
- St John's Wort is predicted to decrease the exposure to rolapitant. Avoid. (Severe) Study
- Rolapitant is predicted to increase the exposure to statins (rosuvastatin). Monitor and adjust dose. (Severe) Study
- Rolapitant increases the exposure to sulfasalazine. (Severe) Study
- Rolapitant is predicted to increase the exposure to tamoxifen. (Severe) Study
- Rolapitant is predicted to increase the exposure to topotecan. Avoid or monitor. (Moderate) Study
- Ropinirole → see dopamine receptor agonists
- ropivacaine → see anaesthetics, local
- Rosuvastatin → see statins
- Rotavirus vaccine → see live vaccines
- Ropivacaine → see anaesthetics, local
- Ruxolitinib is predicted to increase the exposure to theophylline. Monitor and adjust dose. (Moderate) Study
- Rucaparib is predicted to increase the exposure to tizzandine. Monitor and adjust dose. (Moderate) Study
- Rifinamide → see antiepileptics
- Rupatadine → see antihistamines, non-sedating
- Ruxolitinib → see TABLE 15 p. 877 (myelosuppression)
- Antiarhythmics (dronedaron) are predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Study
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ruxolitinib. Adjust dose and monitor side effects. (Moderate) Study
- Aprepitant is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical
- Bosantan is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Theoretical
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical
- Cobicistat is predicted to increase the exposure to ruxolitinib. Adjust dose and monitor side effects. (Moderate) Study
- Ruxolitinib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical
- Crizotinib is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Efavirenz is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Theoretical
- Enzalutamide is predicted to decrease the exposure to ruxolitinib. (Moderate) Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to ruxolitinib. Adjust dose and monitor side effects. (Moderate) Study
- Idelalisib is predicted to increase the exposure to ruxolitinib. Adjust dose and monitor side effects. (Moderate) Study → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Macrolides (clarithromycin) are predicted to increase the exposure to ruxolitinib. Adjust dose and monitor side effects. (Moderate) Study
- Macrolides (erythromycin) are predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical
- Mitotane is predicted to decrease the exposure to ruxolitinib. (Moderate) Theoretical
- Nitazoxanide is predicted to increase the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Study → Also see TABLE 15 p. 877
- Netupitant is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical
- Nevirapine is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Theoretical
- Nilotinib is predicted to increase the exposure to ruxolitinib. (Moderate) Theoretical → Also see TABLE 15 p. 877
- Ruxolitinib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical
- Rifampicin is predicted to increase the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Study
- St John's Wort is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Study
- Sacubitril → see TABLE 8 p. 875 (hypotension)
- Salsalate is predicted to increase the exposure to statins. (Severe) Study
- Sapropterin → see TABLE 8 p. 875 (hypotension)
- Methotrexate is predicted to decrease the efficacy of sapropterin. (Moderate) Theoretical
Phosphodiesterase type-5 inhibitors are predicted to increase the risk of hypotension when given with sapropterin. [Moderate]

Trimethoprim is predicted to decrease the efficacy of sapropterin. [Moderate] Theoretical → Also see Table 8 on p. 875

Saquinavir is predicted to increase the exposure to saxagliptin. [High] Study

Sarilumab → see monoclonal antibodies

Saxagliptin → see Table 14 on p. 877 (antidiabetic drugs)

Antiarrhythmics (dronedaron) are predicted to increase the concentration of saxagliptin. [Moderate] Theoretical

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to saxagliptin. [Moderate] Study

Antifungals, azoles (fluconazole, itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to saxagliptin. [High] Study

Aprepitant is predicted to increase the exposure to saxagliptin. [High] Study

Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to saxagliptin. [High] Study

Cobicistat is predicted to increase the exposure to saxagliptin. [Moderate] Study

Crizotinib is predicted to increase the exposure to saxagliptin. [High] Study

Enalaprilat is predicted to moderately decreases the exposure to saxagliptin. [Moderate] Study

Grapefruit juice is predicted to increase the exposure to saxagliptin. [High] Theoretical

HIV-protease inhibitors are predicted to increase the exposure to saxagliptin. [High] Study

Idelalisib is predicted to increase the exposure to saxagliptin. [Moderate] Study

Imatinib is predicted to increase the exposure to saxagliptin. [High] Study

Macrolides (clarithromycin) are predicted to increase the exposure to saxagliptin. [Moderate] Study

Macrolides (erythromycin) are predicted to increase the exposure to saxagliptin. [High] Study

Mitotane is predicted to moderately decrease the exposure to saxagliptin. [Moderate] Study

Netupitant is predicted to increase the exposure to saxagliptin. [High] Study

Nilotinib is predicted to increase the exposure to saxagliptin. [High] Study

Rifampicin is predicted to moderately decrease the exposure to saxagliptin. [Moderate] Study

Secukinumab → see monoclonal antibodies

Selegiline → see monoamine-oxidase B inhibitors

Selenium

ROUTE-SPECIFIC INFORMATION Interactions do not generally apply to topical use unless specified.

Oral selenium is predicted to decrease the absorption of etorfrabopag. Etorfrabopag should be taken 2 hours before or 4 hours after selenium. [Severe] Theoretical

Selexipag

Antiepileptics (carbamazepine, fosphenytoin, phenytoin) are predicted to decrease the exposure to the active metabolite of selexipag. Adjust dose. [Moderate] Study

Antiepileptics (valproate) are predicted to increase the exposure to selexipag. [Unknown] Theoretical

Antifungals, azoles (fluconazole) are predicted to increase the exposure to selexipag. [Unknown] Theoretical

Clopidogrel is predicted to increase the exposure to selexipag. Adjust dose. [Moderate] Study

Fibrates (gemfibrozil) increase the exposure to selexipag. Avoid. [Severe] Study

Iron chelators (deferasirox) are predicted to increase the exposure to selexipag. Adjust dose. [Moderate] Study

Leflunomide is predicted to increase the exposure to selexipag. Adjust dose. [Moderate] Theoretical

Rifampicin moderately decreases the exposure to the active metabolite of selexipag. Adjust dose. [Moderate] Study

Teriflunomide is predicted to increase the exposure to selexipag. Adjust dose. [Moderate] Theoretical

Semaclutide → see Table 14 p. 877 (antidiabetic drugs)

Sertraline → see SSRIs

Sevoflurane → see volatile halogenated anaesthetics

Sildenafil → see phosphodiesterase type-5 inhibitors

Siltuximab → see monoclonal antibodies

Silver sulfadiazine

PHARMACOLOGY Silver might inactivate enzymatic debridging agents—concurrent use might not be appropriate.

Simvastatin → see statins

Sirolius

Antiarrhythmics (amiodarone) are predicted to increase the concentration of sirolimus. [Severe] Anecdotal

Antiarrhythmics (dronedaron) increase the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of sirolimus. Avoid. [Severe] Study

Antifungals, azoles (fluconazole, itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Aprepitant increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Bosentan is predicted to decrease the concentration of sirolimus and sirolimus potentially increases the concentration of bosentan. Avoid. [Severe] Theoretical

Brigatinib potentially decreases the concentration of sirolimus. Avoid. [Moderate] Theoretical

Ciclosporin is predicted to affect the efficacy of chenodeoxycholic acid. Monitor and adjust dose. [Moderate] Theoretical

Ciclosporin moderately increases the exposure to sirolimus. Separate administration by 4 hours. [Severe] Study

Cobicistat is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

Crizotinib increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Doravirine is predicted to decrease the exposure to sirolimus. Monitor sirolimus concentration and adjust dose, p. 529. [Moderate] Theoretical

Efavirenz is predicted to decrease the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Eliglustat is predicted to increase the exposure to sirolimus. Adjust dose. [Moderate] Study

Flavopiridol increases the concentration of sirolimus. Avoid. [Severe] Study

Grapefruit juice increases the concentration of sirolimus. Avoid. [Moderate] Study

HIV-protease inhibitors are predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

Idelalisib is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

Imatinib increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Lapatinib is predicted to increase the exposure to sirolimus. [Moderate] Theoretical

Letemovir moderately increases the exposure to sirolimus. Monitor and adjust dose. [Severe] Study

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with sirolimus. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Silver sulfadiazine

PHARMACOLOGY Silver might inactivate enzymatic debridging agents—concurrent use might not be appropriate.

Simvastatin → see statins

Sirolius

Antiarrhythmics (amiodarone) are predicted to increase the concentration of sirolimus. [Severe] Anecdotal

Antiarrhythmics (dronedaron) increase the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of sirolimus. Avoid. [Severe] Study

Antifungals, azoles (fluconazole, itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Aprepitant increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Bosentan is predicted to decrease the concentration of sirolimus and sirolimus potentially increases the concentration of bosentan. Avoid. [Severe] Theoretical

Brigatinib potentially decreases the concentration of sirolimus. Avoid. [Moderate] Theoretical

Ciclosporin is predicted to affect the efficacy of chenodeoxycholic acid. Monitor and adjust dose. [Moderate] Theoretical

Ciclosporin moderately increases the exposure to sirolimus. Separate administration by 4 hours. [Severe] Study

Cobicistat is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

Crizotinib increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Doravirine is predicted to decrease the exposure to sirolimus. Monitor sirolimus concentration and adjust dose, p. 529. [Moderate] Theoretical

Efavirenz is predicted to decrease the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Eliglustat is predicted to increase the exposure to sirolimus. Adjust dose. [Moderate] Study

Flavopiridol increases the concentration of sirolimus. Avoid. [Severe] Study

Grapefruit juice increases the concentration of sirolimus. Avoid. [Moderate] Study

HIV-protease inhibitors are predicted to increase the concentration of sirolimus. Avoid. [Moderate] Study

Idelalisib is predicted to increase the concentration of sirolimus. Avoid. [Severe] Study

Imatinib increases the concentration of sirolimus. Monitor and adjust dose. [Moderate] Study

Lapatinib is predicted to increase the exposure to sirolimus. [Moderate] Theoretical

Letemovir moderately increases the exposure to sirolimus. Monitor and adjust dose. [Severe] Study

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with sirolimus. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical
**Sirolimus** (continued)

- **Lumacafor** is predicted to decrease the exposure to sirolimus. **Avoid.** **Severe** Theoretical
- **Macrolides (clarithromycin)** are predicted to increase the concentration of sirolimus. **Avert.** **Severe** Study
- **Macrolides (erythromycin)** increase the concentration of sirolimus. Monitor and adjust dose. **Moderate** Study
- **Sirolimus** is predicted to decrease the efficacy of **mifamurtide**. **Avert.** **Severe** Theoretical
- **Mirabegron** is predicted to increase the exposure to sirolimus. **Avert.** **Severe** Theoretical
- **Mitotane** is predicted to decrease the concentration of sirolimus. **Avert.** **Severe** Study
- **Monoclonal antibodies (sarilumab)** potentially affect the exposure to sirolimus. **Monitor and adjust dose.** **Moderate** Theoretical
- **Neticatant** increases the concentration of sirolimus. **Monitor and adjust dose.** **Moderate** Study
- **Nevirapine** is predicted to decrease the concentration of sirolimus. **Monitor and adjust dose.** **Moderate** Theoretical
- **Nilotinib** increases the concentration of sirolimus. **Monitor and adjust dose.** **Moderate** Study
- **Palbociclib** is predicted to increase the exposure to sirolimus. **Adjust dose.** **Moderate** Theoretical
- **Pibrentasvir** (with glecaprevir) is predicted to increase the exposure to sirolimus. **Avert.** **Severe** Theoretical
- **Pitolisant** is predicted to decrease the exposure to sirolimus. **Avert.** **Severe** Theoretical
- **Ribociclib** is predicted to increase the exposure to sirolimus. **Use with caution and adjust dose.** **Moderate** Theoretical
- **Rifampicin** is predicted to decrease the concentration of sirolimus. **Avert.** **Severe** Study
- **Rucaparib** is predicted to increase the exposure to sirolimus. **Monitor and adjust dose.** **Moderate** Study
- **St John’s Wort** is predicted to decrease the concentration of sirolimus. **Monitor and adjust dose.** **Severe** Theoretical
- **Sirolimus** is predicted to decrease the concentration of **tacrolimus** and **tacrolimus** increases the exposure to sirolimus. **Severe** Study
- **Velpatasvir** is predicted to increase the exposure to sirolimus. **Severe** Study
- **Venetoclax** is predicted to increase the exposure to sirolimus. **Avoid or adjust dose.** **Severe** Study

**Sodium aurothiomalate**

- **ACE inhibitors** are predicted to increase the risk of hypersensitivity when given with **sodium aurothiomalate**. **Severe** Anecdotal
- **Sodium aurothiomalate** potentially increases the risk of side-effects when given with **penicillins** (in those who have had previous adverse reactions to gold). **Avoid.** **Severe** Study

**Sodium bicarbonate**

**Route-specific information** Interactions do not generally apply to topical use unless specified.

- **Oral sodium bicarbonate** decreases the absorption of **antifungals, azoles (ketoconazole)**. **Moderate** Study
- **Sodium bicarbonate** decreases the concentration of **lithium**. **Severe** Anecdotal
- **Sodium bicarbonate** is predicted to decrease the efficacy of **methenamine**. **Avert.** **Moderate** Theoretical

**Sodium citrate**

- **Sodium citrate** is predicted to decrease the efficacy of **methenamine**. **Avert.** **Moderate** Theoretical
- **Sodium citrate** is predicted to increase the risk of side-effects when given with **sucralfate**. **Avoid.** **Moderate** Theoretical

**Sodium clofibrate** → see bisphosphonates

**Sodium feredolate** → see iron (oral)

**Sodium nitroprusside** → see TABLE 8 p. 875 (hypotension)

- **Sodium nitroprusside** is predicted to increase the risk of methaemoglobinaemia when given with topical **anaesthetics, local (prilocaine)**. **Use with caution or avoid.** **Severe** Theoretical
- **Sodium nitroprusside** is predicted to increase the risk of methaemoglobinaemia when given with **dapsone**. **Severe** Theoretical

**Sodium oxybate** → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)

- **Antiepileptics (valproate)** increase the exposure to **sodium oxybate**. **Adjust sodium oxybate dose.** **Moderate** Study
- **Antiepileptics (valproate)** potentially decrease the effects of **sodium phenylbutyrate**. **Moderate** Anecdotal
- **Corticosteroids** potentially decrease the effects of **sodium phenylbutyrate**. **Moderate** Anecdotal
- **Haloperidol potentially decreases the effects of sodium phenylbutyrate.** **Moderate** Anecdotal

**Sodium picosulfate** → see TABLE 18 p. 878 (hypotension)

**Sodium stibogluconate**

- **Sodium stibogluconate** increases the risk of cardiovascular side-effects when given with **amphotericin**. Separate administration by 14 days. **Severe** Study

**Sofosbuvir**

- **Sofosbuvir** is predicted to increase the risk of severe bradycardia or heart block when given with **antiarrhythmics** (amiodarone). Refer to specialist literature. **Severe** Anecdotal
- **Antiepileptics (carbamazepine)** are predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Study
- **Antiepileptics (fosphenytoin, oxcarbazepine, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Study
- **H₂ receptor antagonists potentially decrease the exposure to sofosbuvir.** **Adjust dose, see lepidapsir with sofosbuvir p. 416, sofosbuvir with velpatasvir, and sofosbuvir with velpatasvir and voxilaprevir.** **Moderate** Study
- **HIV-rotease inhibitors (tipranavir)** are predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Theoretical
- **Modafinil** is predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Theoretical
- **Proton pump inhibitors** potentially decrease the exposure to sofosbuvir. **Avert.** **Severe** Theoretical
- **Rifampicin** is predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Study
- **Rifabutin** is predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Study
- **St John’s Wort** is predicted to decrease the exposure to sofosbuvir. **Avert.** **Severe** Study

**Solifenacin** → see TABLE 10 p. 876 (antimuscarinic)

- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to solifenacin. **Moderate** Theoretical
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. **Severe** Study
- **Cobicistat** is predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. **Severe** Study
- **Enalapril** is predicted to decrease the exposure to solifenacin. **Moderate** Theoretical
- **HIV-rotease inhibitors** are predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. **Severe** Study
- **Macrolides (clarithromycin)** are predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. **Severe** Study
- **Macrolides (erythromycin)** are predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. **Severe** Study
- **Mirabegron** is predicted to increase the exposure to solifenacin. Adjust solifenacin or tamsulosin with solifenacin dose; avoid in hepatic and renal impairment. **Severe** Study
- **Mitotane** is predicted to decrease the exposure to solifenacin. **Moderate** Theoretical
- **Rifampicin** is predicted to decrease the exposure to solifenacin. **Moderate** Theoretical

**Somatropin**

- **Corticosteroids** are predicted to decrease the effects of somatropin. **Moderate** Theoretical
Sorafenib → see TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to sorafenib. (Moderate) Theoretical
- Sorafenib increases the anticoagulant effect of coumarins. (Severe) Anecdotal
- Enalaprilat is predicted to decrease the exposure to sorafenib. (Moderate) Theoretical
- Fluvoxamine is predicted to decrease the exposure to sorafenib. (Moderate) Theoretical
- Neomycin moderately decreases the exposure to sorafenib. (Moderate) Study
- Sorafenib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical
- Fluoxetine is predicted to decrease the exposure to sorafenib. (Severe) Theoretical
- Sotalol → see beta blockers, non-selective
- Spironolactone → see aldosterone antagonists

SSRIs → see TABLE 18 p. 878 (hyponatraemia), TABLE 13 p. 877 (serotonin syndrome), TABLE 9 p. 876 (QT-interval prolongation), TABLE 4 p. 874 (antiplatelet effects)

- Citalopram, dapoxetine, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline

  ▶ Fluvoxamine very markedly increases the exposure to agomelatine. Avoid. (Severe) Study
  ▶ Fluvoxamine moderately increases the exposure to alprazolam. Adjust dose. (Moderate) Study
  ▶ SSRIs (fluoxetine, paroxetine) are predicted to increase the exposure to amfetamines. (Severe) Theoretical → Also see TABLE 13 p. 877
  ▶ Fluvoxamine moderately to markedly increases the exposure to aminophylline. Avoid. (Severe) Study
  ▶ Fluvoxamine decreases the clearance of anaesthetics, local (ropivacaine). Avoid prolonged use. (Moderate) Study
  ▶ Fluvoxamine is predicted to increase the exposure to anagrelide. (Moderate) Theoretical → Also see TABLE 4 p. 874
  ▶ Antiarrhythmics (dronedarone) are predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical
  ▶ Antiarrhythmics (dronedarone) are predicted to increase the exposure to SSRIs (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline). (Severe) Theoretical → Also see TABLE 9 p. 876
  ▶ Fluvoxamine is predicted to increase the exposure to antiarrhythmics (propafenone). Monitor and adjust dose. (Moderate) Study
  ▶ SSRIs (fluoxetine, paroxetine) are predicted to increase the exposure to anticholinesterases, centrally acting (galantamine). Monitor and adjust dose. (Moderate) Study
  ▶ Antiepileptics (fosphenytoin, phenytoin) decrease the concentration of paroxetine. (Moderate) Study
  ▶ Sertraline potentially increases the risk of toxicity when given with antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. (Severe) Anecdotal
  ▶ SSRIs (fluoxetine, fluvoxamine) are predicted to increase the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor and adjust dose. (Severe) Anecdotal
  ▶ Antiepileptics (azoles) are predicted to moderately increase the exposure to paroxetine. Avoid potential inhibitors of CYP3A4 or adjust dapoxetine dose. (Severe) Study
  ▶ Antiepileptics, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to dapoxetine. Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. (Severe) Study
  ▶ Antihistamines, sedating (cyproheptadine) potentially decrease the effects of SSRIs. (Moderate) Anecdotal
  ▶ Aplaviroc is predicted to decrease the exposure to citalopram. Avoid or monitor. (R1D) Study → Also see TABLE 9 p. 876

Aprepitant is predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical
- SSRIs (fluoxetine, paroxetine) are predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose, p. 255. (Moderate) Study
- Fluvoxamine increases the exposure to asenapine. (Moderate) Study
- Paroxetine moderately increases the exposure to asenapine. (Moderate) Study
- SSRIs (fluoxetine, paroxetine) are predicted to markedly increase the exposure to atomoxetine. Adjust dose. (Severe) Study
- Fluvoxamine moderately increases the concentration of beta blockers, non-selective (propranolol). (Moderate) Study
- SSRIs (fluoxetine, fluvoxamine) are predicted to increase the exposure to beta blockers, selective (metoprolol, nebivolol). (Moderate) Study
- Bupropion is predicted to increase the exposure to dapoxetine. (Moderate) Theoretical → Also see TABLE 13 p. 877
- Fluvoxamine markedly decreases the clearance of caffeine citrate. Monitor and adjust dose. (Severe) Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical
- SSRIs (fluoxetine, fluvoxamine) are predicted to increase the exposure to cilostazol. Adjust cilostazol dose. (Moderate) Theoretical → Also see TABLE 4 p. 874
- Cinacalcet is predicted to increase the exposure to dapoxetine. (Moderate) Theoretical
- Fluvoxamine is predicted to increase the exposure to cinacalcet. Adjust dose. (Moderate) Theoretical
- SSRIs (fluoxetine, fluvoxamine) potentially increase the exposure to clozapam. Adjust dose. (Moderate) Theoretical
- SSRIs (fluoxetine, fluvoxamine) are predicted to decrease the efficacy of clopidogrel. Avoid. (Severe) Theoretical → Also see TABLE 4 p. 874
- Fluvoxamine increases the concentration of clozapine. Monitor side effects and adjust dose. (Severe) Study
- Cobicistat is predicted to moderately increase the exposure to dapoxetine. Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. (Severe) Study
- Crizotinib is predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical
- SSRIs (fluoxetine, paroxetine) are predicted to slightly increase the exposure to darifenacin. (R1D) Study
- Fluvoxamine moderately increases the exposure to diazepam. (Moderate) Study
- Fluvoxamine is predicted to increase the exposure to dopamine receptor agonists (ropinirole). Adjust dose. (Moderate) Study
- Fluvoxamine markedly increases the exposure to duloxetine. Avoid. (Severe) Study → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877 → Also see TABLE 4 p. 874
- SSRIs (fluoxetine, paroxetine) are predicted to increase the exposure to elgilustat. Avoid or adjust dose—consult product literature. (Severe) Study
- Fluvoxamine is predicted to increase the exposure to etoromopogat. (Moderate) Theoretical
- Fluvoxamine is predicted to increase the exposure to erlotinib. Monitor side effects and adjust dose. (Moderate) Theoretical
- Fluvoxamine increases the concentration of frovatriptan. (Severe) Study → Also see TABLE 13 p. 877
- Grapefruit juice moderately increases the exposure to sertraline. Avoid. (Moderate) Study
- H3 receptor antagonists (cimetidine) potentially increase the exposure to SSRIs (citalopram, escitalopram). Adjust dose. (Moderate) Study
- H3 receptor antagonists (cimetidine) slightly increase the exposure to SSRIs (paroxetine, sertraline). (Moderate) Study
- Fluvoxamine increases the concentration of haloperidol. Adjust dose. (Moderate) Study
- Fluvoxamine increases the concentration of haloperidol. Adjust dose. (Moderate) Study

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SSRIs (continued)

- **HIV-protease inhibitors** are predicted to moderately increase the exposure to dapoxetine. Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. (Severe) Study

- **Itraconazole** is predicted to moderately increase the exposure to dapoxetine. Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. (Severe) Study

- **Imatinib** is predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical

- **Fluvoxamine** is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. (Unknown) Theoretical

- **Fluvoxamine** is predicted to increase the exposure to loxapine. Avoid. (Unknown) Theoretical

- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to dapoxetine. Avoid potent inhibitors of CYP3A4 or adjust dapoxetine dose. (Severe) Study

- **Macrolides (erythromycin)** are predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical

- **Fluvoxamine** very markedly increases the exposure to melatonin. Avoid. (Severe) Study

- **SSRIs (fluoxetine, paroxetine, paxil)** are predicted to increase the exposure to mexitelinate. (Moderate) Study

- **Netupitant** is predicted to increase the exposure to mexitelinate. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical

- **SSRIs potentially increase the risk of prolonged neuromuscular blockade when given with neuromuscular blocking drugs, non-depolarising (miavacurium).** (Unknown) Theoretical

- **Nilotinib** is predicted to increase the exposure to dapoxetine. Adjust dapoxetine dose with moderate inhibitors of CYP3A4. (Moderate) Theoretical

- **Fluvoxamine** moderately increases the exposure to olanzapine. Adjust dose. (Severe) Aneotal

- **SSRIs (fluoxetine, paroxetine)** are predicted to decrease the efficacy of opioids (codeine). (Moderate) Theoretical

- **SSRIs (fluoxetine, paroxetine)** are predicted to decrease the efficacy of opioids (tramadol). (Severe) Study → Also see TABLE 13 p. 877

- **Citalopram** is predicted to increase the exposure to pentoxifylline. (Moderate) Theoretical

- **Fluvoxamine** is predicted to moderately increase the exposure to pirenidone. Avoid. (Moderate) Study

- **SSRIs (fluoxetine, paroxetine)** are predicted to moderately increase the exposure to piriton. Use with caution and adjust dose. (Moderate) Study

- **Fluvoxamine** moderately increases the exposure to pomalidomide. Adjust pomalidomide dose. (Moderate) Study

- **Paroxetine** slightly increases the exposure to procyclidine. Monitor and adjust dose. (Moderate) Study

- **SSRIs (fluoxetine, paroxetine)** are predicted to slightly to moderately increase the exposure to riluzole. Adjust dose. (Moderate) Study

- **Fluvoxamine** is predicted to increase the exposure to rifampicin. (Moderate) Theoretical

- **SSRIs (fluoxetine, paroxetine)** are predicted to increase the exposure to risperidone. Adjust dose. (Moderate) Study

- **Fluvoxamine** is predicted to increase the exposure to roflumilast. (Moderate) Study

- **SSRIs (fluoxetine, paroxetine)** are predicted to increase the exposure to SSRIs (dapoxetine). (Moderate) Theoretical → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877 → Also see TABLE 4 p. 874

- **SSRIs potentially increase the risk of prolonged neuromuscular blockade when given with suxamethonium.** (Unknown) Theoretical

- **SSRIs (fluoxetine, paroxetine)** are predicted to decrease the efficacy of tamoxifen. Avoid. (Severe) Study

- **Terbinafine** is predicted to increase the exposure to fluoxetine. Adjust dose. (Moderate) Theoretical

- **Terbinafine** moderately increases the exposure to paroxetine. (Moderate) Study

- **Terbinafine** is predicted to increase the exposure to SSRIs (citalopram, dapoxetine, escitalopram, fluvoxamine, sertraline). (Moderate) Theoretical

- **Fluvoxamine** moderately to markedly increases the exposure to theophylline. Avoid. (Severe) Study

- **Fluvoxamine** very markedly increases the exposure to tizanidine. Avoid. (Severe) Study

- **SSRIs (fluoxetine, fluvoxamine)** given with a moderate CYP3A4 inhibitor are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. (Moderate) Study

- **SSRIs (fluoxetine, paroxetine)** are predicted to increase the exposure to tricyclic antidepressants. Adjust dose. (Severe) Study → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877

- **Fluvoxamine** markedly increases the exposure to tricyclic antidepressants (clopimarin). Adjust dose. (Severe) Study → Also see TABLE 13 p. 877 → Also see TABLE 4 p. 874

- **Fluvoxamine** is predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose. p. 300. (Severe) Theoretical → Also see TABLE 13 p. 877

| **St John’s Wort** | see also | TABLE 13 p. 877 (serotonin syndrome) |

| **St John’s Wort** | predicted to decrease the exposure to abemacilb. | Avoid. | (Severe) Study |

| **St John’s Wort** | is predicted to decrease the exposure to atafinib. | (Moderate) Study |

| **St John’s Wort** | is predicted to slightly decrease the exposure to aldostrone antagonists (epilunenone). Avoid. | (Moderate) Study |

| **St John’s Wort** | decreases the exposure to atalclinen. | (Moderate) Study |

| **St John’s Wort** | moderately decreases the exposure to alprazolam. | (Moderate) Study |

| **St John’s Wort** | is predicted to decrease the concentration of aminophylline. | (Severe) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to antiarrhythmics (dronedaron). Avoid. | (Severe) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to antipileptics (brivracetam). | (Moderate) Theoretical |

| **St John’s Wort** | is predicted to decrease the concentration of antipileptics (carbamazepine). Monitor and adjust dose. | (Moderate) Theoretical |

| **St John’s Wort** | is predicted to decrease the concentration of antipileptics (fosphenytoin, phenobarbital, phenytoin, primidone). Avoid. | (Severe) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to antipileptics (perampanel). Monitor and adjust dose. | (Moderate) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to antipileptics (tiagabine). Avoid. | (Mild) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to antifungals, azoles (isavuconazole). Avoid. | (Severe) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to aliskiren. | (Moderate) Study |

| **St John’s Wort** | is predicted to decrease the exposure to apixablan. Use with caution or avoid. | (Moderate) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to apremilast. Avoid. | (Severe) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to aprepitant. Avoid. | (Moderate) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to azithinib. | (Moderate) Theoretical |

| **St John’s Wort** | is predicted to decrease the exposure to bedaquiline. Avoid. | (Severe) Study |
- St John’s Wort is predicted to decrease the exposure to **bitergravir**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **bocsantrinib**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **bosutinib**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **brigitinib**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **caripazine**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **cobicistat**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **cimetobinib**. Avoid. (Severe) Theoretical
- St John’s Wort decreases the efficacy of **combined hormonal contraceptives**. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal
- St John’s Wort decreases the concentration of **clofazimine**. Avoid. (Severe) Study
- St John’s Wort is predicted to alter the effects of **clofazimine**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **dabigatran**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **darifenacin**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **dasabuvir**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **dasatinib**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **dansazolin**. Avoid. (Severe) Study
- St John’s Wort decreases the concentration of **doxycycline**. Avoid. (Severe) Study
- St John’s Wort increases the exposure to **dolutegravir**. Adjust dose. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **edoxaban**. (Moderate) Study
- St John’s Wort is predicted to decrease the concentration of **efavirenz**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to moderately decrease the exposure to **elbasvir**. Avoid. (Severe) Study
- St John’s Wort is predicted to increase the exposure to **elagabalol**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **elvitegravir**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **enocafenib**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the effects of **ergotamine**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **erlotinib**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the efficacy of **etanercept**. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **etravirine**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **everolimus**. Avoid or adjust dose. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **exemestane**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **fesoterodine**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **fingolimod**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **fosaprepitant**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **gatifloxacin**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **glecaprevir**. Avoid. (Severe) Study
- St John’s Wort is predicted to markedly decrease the exposure to **grazoprevir**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **guanfacine**. Adjust dose. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **HIV-protease inhibitors**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the efficacy of **hormone replacement therapy**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **ibrutinib**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **idelalisib**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **imidapsinib**. Avoid. (Moderate) Study
- St John’s Wort slightly decreases the exposure to **irmotecan**. Avoid. (Severe) Study
- St John’s Wort decreases the exposure to **ivarabradine**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **ixazomib**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **lapatinib**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **ledipasvir**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **lertumimib**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the efficacy of **levnorgestrel**. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal
- St John’s Wort is predicted to decrease the exposure to **libraxone**. Avoid. (Severe) Study
- St John’s Wort moderately decreases the exposure to **midazolam**. Monitor and adjust dose. (Moderate) Study
- St John’s Wort is predicted to decrease the exposure to **midostaurin**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **maraviroc**. Avoid. (Severe) Theoretical
- St John’s Wort moderately decreases the exposure to **minagelvin**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **mirvatinib**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **nivipavride**. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to **nitinetinib**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to **nobiletine**. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of **noretetronone**. MHRA advises avoid. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal
- St John’s Wort is predicted to decrease the exposure to **olaparib**. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to **omipavrinib**. Avoid. (Severe) Theoretical
- St John’s Wort decreases the exposure to **opioids (methadone)**. Monitor and adjust dose. (Severe) Study Also see TABLE 13 p. 877
- St John’s Wort moderately decreases the exposure to **opioids (oxycodeone)**. Adjust dose. (Moderate) Study
St John’s Wort (continued)

- St John’s Wort is predicted to decrease the exposure to osimertinib. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to temel Essence. (Moderate) Study
- St John’s Wort is predicted to decrease the exposure to palbociclib. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to paliperidone. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to panobinostat. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to paritaprevir (with ritonavir and ombitasvir). Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to phosphodiesterase type-5 inhibitors. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to pibrentasvir. Avoid. (Severe) Study
- St John’s Wort slightly decreases the exposure to pioiltizone. (MILD) Study
- St John’s Wort is predicted to decrease the exposure to pitolisant. Monitor and adjust dose. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to ponatinib. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to pot. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to ranolazine. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to ripilivirine. Avoid. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to roliprant. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to ruxolitinib. Monitor and adjust dose. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the concentration of sirolimus. Monitor and adjust dose. (Severe) Theoretical
- St John’s Wort is predicted to decrease the exposure to simvastatin. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of tacrolimus. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to tensofur falaenamide. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to tezalcator. Avoid. (Severe) Theoretical
- St John’s Wort potentially decreases the exposure to thapsiglylone. (Severe) Aneotodal
- St John’s Wort is predicted to decrease the exposure to ticagrelor. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to tofacitinib. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to tolvaptan. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to ospemifene. (Severe) Theoretical
- St John’s Wort decreases the efficacy of ulipristal. For FSHR guidance, see Contraceptives, interactions p. 51A. (Severe) Aneotodal
- St John’s Wort is predicted to decrease the exposure to velpatasvir. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to venoclay. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the exposure to vismodegib. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical

**Statin** → see TABLE 1 p. 874 (hepatotoxicity)

- atorvastatin - fluvastatin - pravastatin - rosuvastatin - simvastatin
- Atorvastatin slightly to moderately increases the exposure to aliskiren. (Moderate) Study
- Antacids moderately decrease the absorption of rosuvastatin. Separate administration by 2 hours. (Moderate) Study
- Antiarrhythmics (amiodarone) are predicted to increase the risk of rhabdomyolysis when given with atorvastatin. Monitor and adjust dose. (Moderate) Theoretical
- Antiarhythmics (amiodarone) are predicted to increase the exposure to fluvasatin. (Severe) Theoretical
- Antiarrhythmics (amiodarone) increase the risk of rhabdomyolysis when given with simvastatin. Adjust simvastatin dose, p. 136. (Severe) Study
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to atorvastatin. Monitor and adjust dose. (MILD) Study
- Antiarrhythmics (dronedarone) slightly increase the exposure to rosuvastatin. Adjust dose. (Severe) Study
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. (Severe) Study
- Antiepileptics (carbamazepine) moderately decrease the exposure to simvastatin. Monitor and adjust dose. (Severe) Study → Also see TABLE 1 p. 874
- Antiepileptics (carbamazepine, eslicarbazepine) are predicted to decrease the exposure to atorvastatin. Monitor and adjust dose. (Moderate) Theoretical → Also see TABLE 1 p. 874
- Antiepileptics (eslicarbazepine) moderately decrease the exposure to simvastatin. Monitor and adjust dose. (Moderate) Study
- Antiepileptics (fosphenytin, phenytoin) potentially decrease the exposure to statins (atorvastatin, simvastatin). (Moderate) Aneotodal
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to atorvastatin. Monitor and adjust dose. Also see TABLE 1 p. 874
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. (Severe) Study → Also see TABLE 1 p. 874
- Antifungals, azoles (fluconazole, miconazole) are predicted to increase the exposure to fluvastatin. (Severe) Theoretical → Also see TABLE 1 p. 874
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to atorvastatin. Avoid or adjust dose and monitor rhabdomyolysis. (Severe) Study → Also see TABLE 1 p. 874
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to simvastatin. Avoid. (Severe) Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to simvastatin. (Moderate) Theoretical
- Apalutamide slightly decreases the exposure to rosuvastatin. (MILD) Study
- Apalutamide is predicted to decrease the exposure to simvastatin. Avoid or monitor. (Moderate) Study
- Aprepitant is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. (Severe) Study
- Aprepitant is predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. (Severe) Study
- Bosentan slightly decreases the exposure to atorvastatin. (MILD) Study
- Bosentan moderately decreases the exposure to simvastatin. (Moderate) Study
- Calcium channel blockers (amlodipine) slightly increase the exposure to simvastatin. Adjust simvastatin dose, p. 136. [MID] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- Cephalosporins (ceftobiprole) are predicted to increase the concentration of statins. [Moderate] Theoretical
- Ciclosporin very markedly increases the exposure to atorvastatin. Avoid or adjust atorvastatin dose, p. 134. [Severe] Study
- Ciclosporin moderately increases the exposure to fluvastatin. [Severe] Study
- Ciclosporin markedly to very markedly increases the exposure to pravastatin. Adjust dose. [Severe] Study
- Ciclosporin markedly increases the exposure to statins (rosuvastatin, simvastatin). Avoid. [Severe] Study
- Clopidogrel increases the exposure to rosuvastatin. Adjust rosuvastatin dose, p. 135. [Moderate] Study
- Cobimetinib is predicted to increase the exposure to atorvastatin. Avoid or adjust dose and monitor rhabdomyolysis. [Severe] Study
- Cobimetinib is predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- Colchicine increases the risk of rhabdomyolysis when given with statins. [Severe] Anecdotal
- Statins (fluvastatin, rosuvastatin) increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Severe] Study
- Crizotinib is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Crizotinib is predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- Danazol is predicted to increase the risk of rhabdomyolysis when given with atorvastatin. [Severe] Theoretical
- Danazol increases the risk of rhabdomyolysis when given with simvastatin. Avoid. [Severe] Anecdotal
- Statins (fluvastatin, rosuvastatin) increase the anticoagulant effect of coumarins. Monitor INR and adjust dose. [Severe] Study
- Dasabuvir increases the exposure to rosuvastatin. Adjust rosuvastatin dose, p. 135. [Moderate] Study
- Dasatinib is predicted to increase the exposure to simvastatin. [Moderate] Theoretical
- Efavirenz slightly decreases the exposure to atorvastatin. [MID] Study
- Efavirenz moderately decreases the exposure to simvastatin. [Moderate] Study
- Elbasvir increases the exposure to atorvastatin. Adjust atorvastatin dose, p. 134. [Moderate] Study
- Elbasvir is predicted to increase the exposure to fluvastatin. Adjust fluvastatin dose, p. 134. [Unknown] Theoretical
- Elbasvir increases the exposure to rosuvastatin. Adjust rosuvastatin dose, p. 135. [Moderate] Study
- Elbasvir is predicted to increase the exposure to simvastatin. Adjust simvastatin dose, p. 136. [Unknown] Theoretical
- Eltrombopag is predicted to increase the exposure to statins. Monitor and adjust dose. [Moderate] Study
- Enzalutamide is predicted to decrease the exposure to simvastatin. [Severe] Study
- Ezetimibe potentially increases the risk of rhabdomyolysis when given with statins. [Severe] Anecdotal
- Fibrates (bezafibrate, clofibric acid) increase the risk of rhabdomyolysis when given with pravastatin. Avoid. [Severe] Study
- Fibrates (bezafibrate, clofibric acid) increase the risk of rhabdomyolysis when given with rosuvastatin. Adjust rosuvastatin dose, p. 135. [Severe] Study
- Fibrates (bezafibrate, clofibric acid) increase the risk of rhabdomyolysis when given with simvastatin. Adjust simvastatin dose, p. 136. [Severe] Study
- Fibrates (clofibrate, fenofibrate) increase the risk of rhabdomyolysis when given with atorvastatin. Avoid or adjust dose. [Severe] Study
- Fibrates (clofibrate, fenofibrate) increase the risk of rhabdomyolysis when given with fluvastatin. [Severe] Study
- Fibrates (fenofibrate) are predicted to increase the risk of rhabdomyolysis when given with fluvastatin. Adjust fenofibrate dose, p. 133. [Severe] Theoretical
- Fibrates (fenofibrate) are predicted to increase the risk of rhabdomyolysis when given with pravastatin. Avoid. [Severe] Theoretical
- Fibrates (fenofibrate) increase the risk of rhabdomyolysis when given with rosvastatin. Adjust fenofibrate and rosvastatin doses, p. 131, 135. [Severe] Anecdotal
- Fibrates (gemfibrozil) increase the risk of rhabdomyolysis when given with statins. Avoid. [Severe] Anecdotal
- Fibrates (bezafibrate) increase the risk of rhabdomyolysis when given with statins (atorvastatin, fluvastatin). [Severe] Study
- Fibrates (fenofibrate) increase the risk of rhabdomyolysis when given with statins (atorvastatin, simvastatin). Adjust fenofibrate dose, p. 133. [Severe] Anecdotal
- Fusidic acid increases the risk of rhabdomyolysis when given with statins. Avoid. [Severe] Anecdotal
- Glecaprevir (with pibrentasvir) markedly increases the exposure to atorvastatin. Avoid. [Severe] Study
- Glecaprevir (with pibrentasvir) is predicted to increase the exposure to fluvastatin. [Moderate] Theoretical
- Glecaprevir (with pibrentasvir) increases the exposure to pravastatin. Use with caution and adjust pravastatin dose, p. 135. [Moderate] Study
- Glecaprevir (with pibrentasvir) increases the exposure to rosuvastatin. Use with caution and adjust rosuvastatin dose, p. 135. [Moderate] Study
- Glecaprevir (with pibrentasvir) increases the exposure to simvastatin. Avoid. [Moderate] Study
- Grapefruit juice increases the exposure to atorvastatin. [MID] Study
- Grapefruit juice increases the exposure to simvastatin. Avoid. [Severe] Study
- Grazoprevir increases the exposure to atorvastatin. Adjust atorvastatin dose, p. 134. [Moderate] Study
- Grazoprevir is predicted to increase the exposure to fluvastatin. Adjust fluvastatin dose, p. 134. [Unknown] Theoretical
- Grazoprevir increases the exposure to rosuvastatin. Adjust rosuvastatin dose, p. 135. [Moderate] Study
- Grazoprevir is predicted to increase the exposure to simvastatin. Adjust simvastatin dose, p. 136. [Unknown] Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to atorvastatin. Avoid or adjust dose and monitor rhabdomyolysis. [Severe] Study
- HIV-protease inhibitors slightly to moderately increase the exposure to rosuvastatin. Avoid or adjust dose. [Severe] Study
- HIV-protease inhibitors are predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- Idelalisib is predicted to increase the exposure to atorvastatin. Avoid or adjust dose and monitor rhabdomyolysis. [Severe] Study
- Idelalisib is predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- Imatinib is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Imatinib is predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Avoid. [Severe] Theoretical
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Ledipasvir is predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Ledipasvir is predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Ledipasvir is predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- Ledipasvir is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). Monitor and adjust dose. [Moderate] Theoretical
- Ledipasvir is predicted to increase the exposure to rosuvastatin. Adjust dose. [Moderate] Study
- Ledipasvir is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- Ledipasvir is predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
Statins

- **Letrozomiv** moderately increases the exposure to atorvastatin. Avoid or adjust atorvastatin dose, p. 134. [Severe] Study
- **Letrozomiv** is predicted to increase the exposure to fluuvastatin. Monitor and adjust dose. [Moderate] Theoretical
- **Letrozomiv** is predicted to increase the exposure to pravastatin. Avoid or adjust dose. [Moderate] Theoretical
- **Letrozomiv** is predicted to increase the exposure to statins (rosuvastatin, simvastatin). Avoid. [Severe] Study
- **Letrozomiv** increases the exposure to atorvastatin. Adjust lomitapide dose or separate administration by 12 hours. [Mild] Study → Also see TABLE 1, p. 874
- **Lomitapide** increases the exposure to simvastatin. Monitor and adjust simvastatin dose, p. 136. [Moderate] Study → Also see TABLE 1, p. 874
- **Macrolides** (clarithromycin) are predicted to increase the exposure to atorvastatin. Avoid or adjust dose and monitor rhabdomyolysis. [Severe] Study
- **Macrolides** (clarithromycin) moderately increase the exposure to pravastatin. [Severe] Study
- **Macrolides** (clarithromycin) are predicted to increase the exposure to simvastatin. Avoid. [Severe] Study
- **Macrolides** (erythromycin) are predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- **Macrolides** (erythromycin) are predicted to increase the exposure to pravastatin. [Severe] Study
- **Macrolides** (erythromycin) are predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- **Mitotane** is predicted to decrease the exposure to simvastatin. [Severe] Study
- **Monoclonal antibodies** (sarilumab) are predicted to decrease the exposure to statins (atorvastatin, simvastatin). [Moderate] Study
- **Monoclonal antibodies** (tocilizumab) are predicted to decrease the exposure to statins (atorvastatin, simvastatin, rosuvastatin). Monitor and adjust dose. [Moderate] Study
- **Netupitant** is predicted to increase the exposure to atorvastatin. Monitor and adjust dose. [Severe] Study
- **Netupitant** is predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- **Nevirapine** slightly decreases the exposure to atorvastatin. [Mild] Study
- **Nevirapine** moderately decreases the exposure to simvastatin. [Moderate] Study
- **Nicotinic acid** is predicted to increase the risk of rhabdomyolysis when given with statins. [Severe] Theoretical
- **Nilotinib** is predicted to increase the exposure to atorvastatin. Avoid or adjust dose. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to simvastatin. Use with caution and adjust simvastatin dose, p. 136. [Severe] Study
- **Osimertinib** slightly increases the exposure to rosuvastatin. [Mild] Study
- **Paritaprevr** (in fixed-dose combination) is predicted to increase the risk of rhabdomyolysis when given with atorvastatin. Avoid. [Severe] Theoretical
- **Paritaprevr** (with ritonavir and ombitasvir) is predicted to increase the exposure to fluuvastatin. Avoid. [Moderate] Theoretical
- **Paritaprevr** (with ritonavir and ombitasvir) increases the exposure to pravastatin. Adjust pravastatin dose, p. 135. [Moderate] Study
- **Paritaprevr** (with ritonavir and ombitasvir) slightly to moderately increases the exposure to rosuvastatin. Adjust rosuvastatin dose, p. 135. [Moderate] Study
- **Paritaprevr** (in fixed-dose combination) is predicted to increase the risk of rhabdomyolysis when given with atorvastatin. [Severe] Theoretical
- **Pazopanib** is predicted to affect the exposure to atorvastatin. [Moderate] Aneodal
- **Pazopanib** is predicted to affect the exposure to statins (pravastatin, rosuvastatin, simvastatin). [Moderate] Theoretical
- **Rosuvastatin** is predicted to increase the anticoagulant effect of phenindione. Monitor INR and adjust dose. [Severe] Theoretical
- **Pibrentasvir** (with glecaprevir) markedly increases the exposure to atorvastatin. Avoid. [Severe] Study
- **Pibrentasvir** (with glecaprevir) is predicted to increase the exposure to fluuvastatin. [Moderate] Theoretical
- **Pibrentasvir** (with glecaprevir) increases the exposure to pravastatin. Use with caution and adjust pravastatin dose, p. 135. [Moderate] Study
- **Pibrentasvir** (with glecaprevir) increases the exposure to rosuvastatin. Use with caution and adjust rosuvastatin dose, p. 135. [Moderate] Study
- **Pibrentasvir** (with glecaprevir) increases the exposure to simvastatin. Avoid. [Moderate] Study
- **Ranolazine** is predicted to increase the exposure to atorvastatin. [Moderate] Theoretical
- **Ranolazine** slightly increases the exposure to simvastatin. Adjust simvastatin dose, p. 136. [Moderate] Study
- **Regorafenib** is predicted to increase the exposure to statins (atorvastatin, fluuvastatin, rosuvastatin). [Moderate] Study
- **Ribociclib** (high-dose) is predicted to increase the exposure to siavastatin. Avoid. [Moderate] Theoretical
- **Ribociclib** is predicted to increase the exposure to statins (pravastatin, rosuvastatin). [Moderate] Theoretical
- **Rifampicin** markedly decreases the exposure to atorvastatin. Monitor and adjust dose. [Moderate] Study
- **Rifampicin** very markedly decreases the exposure to simvastatin. [Moderate] Study
- **Rolapitant** is predicted to increase the exposure to rosvastatin. Monitor and adjust dose. [Severe] Study
- **St John’s Wort** slightly decreases the exposure to atorvastatin. [Mild] Study
- **St John’s Wort** moderately decreases the exposure to simvastatin. [Moderate] Study
- **Fluvastatin** slightly increases the exposure to sulfonlureas (glibenclamide). [Mild] Study
- **Tedizolid** is predicted to increase the exposure to statins (atorvastatin, fluuvastatin, rosuvastatin). Avoid. [Moderate] Study
- **Teriflunomide** moderately increases the exposure to rosuvastatin. Adjust rosuvastatin dose, p. 135. [Moderate] Study
- **Teriflunomide** is predicted to increase the exposure to statins (atorvastatin, fluuvastatin, pravastatin, simvastatin). [Moderate] Study
- **Ticagrelor** slightly increases the exposure to simvastatin. [Moderate] Study
- **Tivozanib** is predicted to decrease the exposure to rosuvastatin. [Moderate] Theoretical
- **Velpatasvir** is predicted to increase the exposure to atorvastatin. Avoid. [Severe] Study
- **Velpatasvir** increases the exposure to rosuvastatin. Monitor and adjust side effects, p. 135. [Severe] Study
- **Velpatasvir** is predicted to increase the exposure to simvastatin. Monitor side effects and adjust dose. [Severe] Theoretical
- **Venetoclax** is predicted to increase the exposure to atorvastatin. [Moderate] Study
- **Venetoclax** is predicted to increase the exposure to statins (fluvastatin, pravastatin, rosuvastatin, simvastatin). [Moderate] Theoretical
- **Voxilaprevir** is predicted to increase the exposure to atorvastatin. Avoid. [Moderate] Theoretical
- **Voxilaprevir** (with sofosbuvir and velpatasvir) moderately increases the exposure to pravastatin. Monitor and adjust pravastatin dose, p. 135. [Moderate] Study
- **Voxilaprevir** (with sofosbuvir and velpatasvir) markedly increases the exposure to rosuvastatin. Avoid. [Severe] Study
- **Voxilaprevir** (with sofosbuvir and velpatasvir) is predicted to increase the exposure to statins (fluvastatin, simvastatin). Avoid. [Moderate] Theoretical

**Stavudine** → see TABLE 12, p. 877 (peripheral neuropathy)
**Didanosine** increases the risk of toxicity when given with stavudine. Avoid. (Severe) Study → Also see TABLE 12 p. 877

**Hydroxyurea** increases the risk of toxicity when given with stavudine. Avoid. (Severe) Study

**Isoniazid** is predicted to increase the risk of peripheral neuropathy when given with stavudine. (Severe) Theoretical → Also see TABLE 12 p. 877

**Ribavirin** increases the risk of toxicity when given with stavudine. Avoid. (Severe) Study

**Zidovudine** is predicted to decrease the efficacy of stavudine. Avoid. (Severe) Theoretical

**Stiripentol** → see antiepileptics

**Streptokinase** → see TABLE 3 p. 874 (anticoagulant effects)

**Streptomyacin** → see aminoglycosides

**Streptozocin** → see TABLE 1 p. 874 (hepatotoxicity), TABLE 2 p. 874 (nephrotoxicity)

**Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with streptozocin. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

**Sucralfate**

- **Sucralfate** is predicted to decrease the exposure to bictegravir. Avoid. (Moderate) Theoretical

- **Sucralfate** potentially decreases the effects of coumarins (warfarin). Separate administration by 2 hours. (Moderate) Anecdotal

- **Sucralfate** decreases the absorption of digoxin. Separate administration by 2 hours. (Moderate) Study

- **Sucralfate** decreases the absorption of dolutegravir. (Moderate) Study

- **Sucralfate** increases the risk of blocked enteral or nasogastric tubes when given with enteral feeds. Separate administration by 1 hour. (Moderate) Study

- **Potassium citrate** increases the risk of side-effects when given with sucrafate. Avoid. (Moderate) Theoretical

- **Sucralfate** decreases the exposure to quinolones. Separate administration by 2 hours. (Moderate) Study

- **Sodium citrate** is predicted to increase the risk of side-effects when given with sucrafate. Avoid. (Moderate) Theoretical

- **Sucralfate** decreases the absorption of sulpiride. Separate administration by 2 hours. (Moderate) Study

- **Sucralfate** potentially decreases the absorption of theophylline. Separate administration by at least 2 hours. (Moderate) Study

- **Sucralfate** decreases the absorption of thyroid hormones (levothyroxine). Separate administration by at least 4 hours. (Moderate) Study

- **Sucralfate** is predicted to decrease the absorption of tricyclic antidepressants. (Moderate) Study

**Sulfentanil** → see opioids

**Sugammadex**

- **Sugammadex** is predicted to decrease the exposure to oral combined hormonal contraceptives. Refer to patient information leaflet for missed pill advice. (Severe) Theoretical

- **Sugammadex** is predicted to decrease the exposure to desogestrel. Refer to patient information leaflet for missed pill advice. (Severe) Theoretical

- **Sugammadex** is predicted to decrease the efficacy of etonogestrel. Use additional contraceptive precautions. (Severe) Theoretical

- **Sugammadex** is predicted to decrease the exposure to levonorgestrel. Use additional contraceptive precautions. (Severe) Theoretical

- **Sugammadex** is predicted to decrease the exposure to medroxyprogesterone. Use additional contraceptive precautions. (Severe) Theoretical

- **Sugammadex** is predicted to decrease the exposure to norethisterone. Use additional contraceptive precautions. (Severe) Theoretical

**Sulfadiazine** → see sulfonamides

**Sulfadoxine** → see sulfonamides

**Sulfamethoxazole** → see sulfonamides

**Sulfasalazine** → see sulfonamides

**Sulfadiazine** → see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression)

**Antifungals, azoles (isavuconazole)** are predicted to increase the exposure to sulfasalazine. (Moderate) Theoretical

**Sulfasalazine** decreases the concentration of digoxin. (Moderate) Study

**Sulfasalazine** is predicted to decrease the absorption of folates. (Moderate) Study

**Leflunomide** is predicted to increase the exposure to sulfasalazine. (Moderate) Study → Also see TABLE 1 p. 874 → Also see TABLE 15 p. 877

**Regorafenib** is predicted to increase the exposure to sulfasalazine. (Moderate) Study → Also see TABLE 15 p. 877

**Rolapitant** increases the exposure to sulfasalazine. (Severe) Study

**Tedizolid** is predicted to increase the exposure to sulfasalazine. (Moderate) Study

**Velpatasvir** is predicted to increase the exposure to sulfasalazine. (Moderate) Theoretical

**Voxilaprevir** is predicted to increase the concentration of sulfasalazine. Avoid. (Severe) Theoretical

**Sulfonamides** → see TABLE 15 p. 877 (myelosuppression)

**Sulfadiazine** - sulfadoxine - sulfamethoxazole

**Sulfonamides** potentially increase the risk of methaemoglobinemia when given with topical anaesthetics, local (prilocaine). Use with caution or avoid. (Severe) Anecdotal

**Sulfadiazine** is predicted to increase the concentration of antiepileptics (phenytoin). Monitor and adjust dose. (Moderate) Study

**Sulfadiazine** increases the concentration of antiepileptics (phenytoin). Monitor and adjust dose. (Moderate) Study

**Antimalarials (pyrimethamine) increase the risk of side-effects when given with sulfonamides. (Severe) Study → Also see TABLE 15 p. 877

**Sulfadiazine** is predicted to increase the anticoagulant effect of coumarins. (Severe) Theoretical

**Sulfamethoxazole** increases the anticoagulant effect of coumarins. (Severe) Study

**Sulfonamides** are predicted to increase the risk of methaemoglobinemia when given with dapson. (Severe) Theoretical

**Sulfonamides** are predicted to increase the exposure to methotrexate. Use with caution or avoid. (Severe) Theoretical → Also see TABLE 15 p. 877

**Potassium aminobenzoate** is predicted to affect the efficacy of sulfonamides. Avoid. (Severe) Theoretical

**Sulfonamides** are predicted to increase the exposure to sulfonylureas. (Moderate) Study

**Sulfonamides** are predicted to increase the effects of thiopental. (Moderate) Theoretical

**Sulfonylureas** → see TABLE 14 p. 877 (antidiabetic drugs)

**glibenclamide** - gliclazide - glimepiride - glipizide - tolbutamide

**Antiarrhythmics (amiodarone)** are predicted to increase the exposure to sulfonylureas. Use with caution and adjust dose. (Moderate) Study

**Antifungals, azoles (flucanazole, micronazole)** are predicted to increase the exposure to sulfonylureas. Use with caution and adjust dose. (Moderate) Study

**Antifungals, azoles (voriconazole)** are predicted to increase the concentration of sulfonylureas. Use with caution and adjust dose. (Moderate) Study

**Bosantan** increases the risk of hepatotoxicity when given with glibenclamide. Avoid. (Severe) Study

**Cephalosporins (cefotibiprole)** are predicted to increase the concentration of glibenclamide. (Moderate) Theoretical

**Certinib** is predicted to increase the exposure to glimepiride. Adjust dose. (Moderate) Theoretical

**Chloramphenicol** is predicted to increase the exposure to sulfonylureas. (Severe) Study

**Fibrates** are predicted to increase the risk of hypoglycaemia when given with sulfonylureas. (Moderate) Theoretical

**Leflunomide** is predicted to increase the exposure to glibenclamide. (Moderate) Study
Sulfonylureas (continued)

- **Letrozomir** is predicted to increase the concentration of glibenclamide. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to slightly increase the exposure to sulfonylureas. [Moderate] Theoretical
- **Rifampicin** is predicted to decrease the exposure to sulfonylureas. [Moderate] Study
- **Statins (fluvastatin)** slightly increase the exposure to glibenclamide. [Mild] Study
- **Sulfonylamides** are predicted to increase the exposure to sulfonylureas. [Moderate] Study
- **Teriflumodine** is predicted to increase the exposure to glibenclamide. [Moderate] Study
- **Venetoclax** is predicted to increase the exposure to glibenclamide. [Moderate] Theoretical

Sulindac → see NSAIDs.

Sulpiride → see TABLE 8 p. 875 (hypotension), TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects)

- **Antacids** decrease the absorption of sulpiride. Separate administration by 2 hours. [Moderate] Study
- **Sulpiride** is predicted to decrease the effects of dopamine receptor agonists. Avoid. [Moderate] Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 9 p. 876
- **Sulpiride** is predicted to decrease the effects of levodopa. Avoid. [Severe] Theoretical → Also see TABLE 8 p. 875
- **Sulpiride** potentially increases the risk of neurotoxicity when given with lithium. [Severe] Amodata → Also see TABLE 9 p. 876
- **Sucralfate** decreases the absorption of sulpiride. Separate administration by 2 hours. [Moderate] Study

Sumatriptan → see TABLE 13 p. 877 (serotonin syndrome)

- **Sumatriptan** increases the risk of vasoconstriction when given with ergotamine. Ergotamine should be taken at least 24 hours before or 6 hours after sumatriptan. [Severe] Study
- **Moclobemide** moderately increases the exposure to sumatriptan. Avoid. [Moderate] Study → Also see TABLE 13 p. 877
- **Monoamine-oxidase A and B inhibitors, irreversible** are predicted to increase the exposure to sumatriptan. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical → Also see TABLE 13 p. 877

Sunitinib → see TABLE 15 p. 877 (myelosuppression), TABLE 9 p. 876 (QT-interval prolongation)

- **Antiarrhythmics (dronedaron)** are predicted to increase the exposure to sunitinib. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study
- **Antifungals, azoles (fluconazole, itraconazole, ketoconazole) and posaconazole** are predicted to increase the exposure to sunitinib. Avoid. [Moderate] Study
- **Antiarrhythmics (dronedaron)** are predicted to increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study → Also see TABLE 9 p. 876
- **Aprepitant** is predicted to increase the exposure to sunitinib. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to sunitinib. [Moderate] Theoretical
- **Cobicistat** is predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study
- **Sunitinib** is predicted to increase the risk of bleeding events when given with coumarins. [Severe] Theoretical
- **Crisotibin** is predicted to increase the exposure to sunitinib. [Moderate] Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- **Evelauro** is predicted to increase the concentration of sunitinib. Use with caution and adjust dose. [Moderate] Theoretical
- **Enzalutamide** is predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study
- **Grapefruit juice** is predicted to increase the exposure to sunitinib. Avoid. [Moderate] Theoretical
- **Grazoprevir** is predicted to increase the concentration of sunitinib. Use with caution and adjust dose. [Moderate] Theoretical
- **HIV-protease inhibitors** are predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study → Also see TABLE 9 p. 876
- **Ildalibis** is predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study → Also see TABLE 15 p. 877
- **Imatinib** is predicted to increase the exposure to sunitinib. [Moderate] Theoretical → Also see TABLE 15 p. 877
- **Macrolides (clarithromycin)** are predicted to slightly increase the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study → Also see TABLE 9 p. 876
- **Macrolides (erythromycin)** are predicted to increase the exposure to sunitinib. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Mitotane** is predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study → Also see TABLE 15 p. 877
- **Netapitant** is predicted to increase the exposure to sunitinib. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to sunitinib. [Moderate] Theoretical → Also see TABLE 15 p. 877 → Also see TABLE 9 p. 876
- **Sunitinib** is predicted to increase the risk of bleeding events when given with phenindione. [Severe] Theoretical
- **Rifampicin** is predicted to decrease the exposure to sunitinib. Avoid or adjust sunitinib dose. [Moderate] Study
- **Suxamethonium** → see TABLE 20 p. 878 (neuromuscular blocking effects)
- **Alkalizing agents (cyclophosphamide)** increase the risk of prolonged neuromuscular blockade when given with saximumethion. [Moderate] Study
- **Antiarrhythmics (lidocaine)** are predicted to increase the effects of saximumethion. [Moderate] Study
- **Anticholinesterases, centrally acting** increase the effects of saximumethion. [Moderate] Theoretical
- **Antiepileptics (carbamazepine)** increase the risk of prolonged neuromuscular blockade when given with saximumethion. [Moderate] Study
- **Antiepileptics (fosphenytoin, phenytoin)** increase the effects of saximumethion. [Moderate] Study
- **Clindamycin** increases the effects of saximumethion. [Severe] Amodata
- **Corticosteroids** are predicted to decrease the effects of saximumethion. [Severe] Amodata
- **Saximumethion** is predicted to increase the risk of cardiovascular side-effects when given with digoxin. [Severe] Amodata
- **Irinotecan** is predicted to increase the risk of prolonged neuromuscular blockade when given with saximumethion. [Moderate] Theoretical → Also see TABLE 9 p. 876
- **Intravenous magnesium** is predicted to increase the effects of saximumethion. [Moderate] Study
- **Metoclopramide** increases the effects of saximumethion. [Moderate] Study
- **Penicillins (piperacillin)** increase the effects of saximumethion. [Moderate] Study
- **SSRIs** potentially increase the risk of prolonged neuromuscular blockade when given with saximumethion. [Unknown] Theoretical

**Symphathomimetics, inotropic**

- **Dobutamine • dopamine**
  - **Symphathomimetics, inotropic** are predicted to decrease the effects of apraclonidine. Avoid. [Severe] Theoretical
  - **Beta blockers, non-selective** increase the risk of cardiovascular side-effects when given with sympathomimetics, inotropic. [Theoretical]
  - **Ergometrine** potentially increases the risk of peripheral vasoconstriction when given with dopamine. Avoid. [Severe] Amodata
Sympathomimetics, inotropic – Tacrolimus 1037

- Guanethidine is predicted to increase the effects of dopamine.
  
  
- Sympathomimetics, inotropic are predicted to increase the risk of elevated blood pressure when given with linezolid. Avoid. Moderate Theoretical
  
- Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the risk of a hypertensive crisis when given with sympathomimetics, inotropic. Avoid. Severe Theoretical
  
- Opicapone is predicted to increase the risk of cardiovascular side-effects when given with sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Moderate Theoretical
  
- Ephedrine increases the risk of side-effects when given with linezolid.

Sympathomimetics, vasoconstrictor

<table>
<thead>
<tr>
<th>Inotropic – Tacrolimus 1037</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guanethidine</td>
</tr>
<tr>
<td>phenylephrine</td>
</tr>
</tbody>
</table>

ROUTE-SPECIFIC INFORMATION Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- Ephedrine increases the risk of side-effects when given with aminophylline. Avoid in children. Moderate Study
  
- Sympathomimetics, vasoconstrictor are predicted to decrease the effects of apraclonidine. Avoid. Severe Theoretical
  
- Atropine increases the risk of severe hypertension when given with phenylephrine. Severe Study
  
- Beta blockers, non-selective are predicted to increase the risk of hypertension and bradycardia when given with sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Severe Study
  
- Beta blockers, selective are predicted to increase the risk of hypertension and bradycardia when given with sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Moderate Study
  
- Isometheptene potentially increases the risk of side-effects when given with dopamine receptor agonists (bromocriptine). Avoid. Severe Anecdotal
  
- Entacapone is predicted to increase the risk of cardiovascular side-effects when given with sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Moderate Study
  
- Ergometrine is predicted to increase the risk of peripheral vasoconstriction when given with noradrenaline/norepinephrine. Anecdotal Study
  
- Guanethidine increases the effects of metaraminol. Anecdotal Study
  
- Guanethidine increases the effects of phenylephrine. Severe Study

† Guanethidine is predicted to increase the effects of sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Moderate Study

† Pseudoephedrine increases the risk of elevated blood pressure when given with linezolid. Avoid. Severe Study

† Sympathomimetics, vasoconstrictor (adrenaline/epinephrine, epinephrine, isometheptene, noradrenaline/norepinephrine, phenylephrine) are predicted to increase the risk of elevated blood pressure when given with linezolid. Avoid. Severe Theoretical

† Mianserin decreases the effects of ephedrine. Severe Anecdotal

† Moclobemide is predicted to increase the risk of a hypertensive crisis when given with sympathomimetics, vasoconstrictor (epinephrine, isometheptene, phenylephrine, pseudoephedrine). Avoid. Severe Study

† Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the risk of a hypertensive crisis when given with sympathomimetics, vasoconstrictor. Avoid and for 14 days after stopping the MAOI. Severe Study

† Monoamine-oxidase B inhibitors are predicted to increase the risk of a hypertensive crisis when given with sympathomimetics, vasoconstrictor. Avoid. Severe Theoretical

† Opicapone is predicted to increase the risk of cardiovascular side-effects when given with sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Moderate Theoretical

† Ephedrine increases the risk of side-effects when given with theophylline. Avoid in children. Moderate Study

† Tolcapone is predicted to increase the effects of sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). Moderate Theoretical

† Tricyclic antidepressants are predicted to decrease the effects of ephedrine. Avoid. Severe Study

† Tricyclic antidepressants increase the effects of sympathomimetics, vasoconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine, phenylephrine). Avoid. Severe Study

Tacalcitol → see vitamin B substances

Tacrolimus → see TABLE 2 p. 874 (nephrotoxicity), TABLE 16 p. 878 (increased serum potassium)

- Pomelo and pomegranate juices might greatly increase the concentration of tacrolimus.

- Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- Alcohol (beverage) increases the risk of facial flushing and skin irritation when given with topical tacrolimus. Moderate Study

- Antiarhythmics (amiodarone) are predicted to increase the concentration of tacrolimus. Severe Anecdotal

- Antiarhythmics (dronedarone) are predicted to increase the concentration of tacrolimus. Severe Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the concentration of tacrolimus. Moderate Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of tacrolimus. Monitor and adjust dose. Severe Study

- Antifungals, azoles (miconazole) are predicted to increase the concentration of tacrolimus. Monitor and adjust dose. Severe Theoretical

- Aprapant is predicted to increase the concentration of tacrolimus. Severe Study

- Bosentan is predicted to decrease the concentration of tacrolimus and tacrolimus potentially increases the concentration of bosentan. Avoid. Severe Theoretical

- Brigitinib potentially decreases the concentration of tacrolimus. Avoid. Moderate Theoretical

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of tacrolimus. Severe Study

- Calcium channel blockers (nicardipine) potentially increase the concentration of tacrolimus. Monitor concentration and adjust dose. Severe Anecdotal

- Ceritinib is predicted to increase the exposure to tacrolimus. Avoid. Severe Theoretical

- Chloramphenicol increases the concentration of tacrolimus. Severe Study

- Ciclosporin increases the concentration of tacrolimus. Avoid. Severe Study – Also see TABLE 2 p. 874 → Also see TABLE 16 p. 878

- Cobicistat is predicted to increase the concentration of tacrolimus. Monitor and adjust dose. Severe Study

- Crizotinib is predicted to increase the concentration of tacrolimus. Severe Study

- Tacrolimus is predicted to increase the exposure to dabigatran. Avoid. Severe Theoretical

- Danazol potentially increases the concentration of tacrolimus. Severe Anecdotal

- Doravirine is predicted to decrease the exposure to tacrolimus. Monitor tacrolimus concentration and adjust dose, p. 540. Moderate Theoretical

- Efavirenz is predicted to decrease the concentration of tacrolimus. Monitor and adjust dose. Moderate Theoretical
Tacroliomus (continued)
- Enalaprilamide decreases the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Glucaprevir (with ribavirin) slightly increases the exposure to tacrolimus. Monitor and adjust dose. *Moderate* Study
- Grapefruit juice greatly increases the concentration of tacrolimus. Avoid. *Severe* Study
- Grazoprevir increases the exposure to tacrolimus. *Moderate* Study
- HIV-protease inhibitors are predicted to increase the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Idealisib is predicted to increase the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Imatinib is predicted to increase the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Letermovir moderately increases the exposure to tacrolimus. Separate administration by 12 hours. *Moderate* Theoretical
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with tacrolimus. Public Health England advises avoid (refer to Green Book). *Severe* Theoretical
- Tacrolimus is predicted to increase the exposure to lonidamine. Separate administration by 12 hours. *Moderate* Theoretical
- Lumacaftor is predicted to decrease the concentration of tacrolimus. Avoid. *Severe* Theoretical
- Macrolides (clarithromycin) are predicted to increase the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Macrolides (erythromycin) are predicted to increase the concentration of tacrolimus. *Severe* Study
- Tacrolimus is predicted to affect the efficacy of mifepristone. Avoid. *Severe* Theoretical
- Mitotane decreases the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Monoclonal antibodies (sarilumab) potentially affect the exposure to tacrolimus. Monitor and adjust dose. *Moderate* Theoretical
- Netupitant is predicted to increase the concentration of tacrolimus. *Severe* Study
- Nevirapine is predicted to decrease the concentration of tacrolimus. Monitor and adjust dose. *Moderate* Theoretical
- Nilotinib is predicted to increase the concentration of tacrolimus. *Severe* Study
- Palbociclib is predicted to increase the exposure to tacrolimus. Adjust dose. *Moderate* Theoretical
- Pibrentasvir (with glucaprevir) slightly increases the exposure to tacrolimus. Monitor and adjust dose. *Mild* Study
- Piritramide is predicted to decrease the exposure to tacrolimus. Avoid. *Severe* Study
- Ranolazine increases the concentration of tacrolimus. Adjust dose. *Severe* Anecdotal
- Ribociclib is predicted to increase the exposure to tacrolimus. Use with caution and adjust dose. *Moderate* Theoretical
- Rifampicin decreases the concentration of tacrolimus. Monitor and adjust dose. *Severe* Study
- Rucaparib is predicted to increase the exposure to tacrolimus. Monitor and adjust dose. *Moderate* Study
- Sirolimus is predicted to decrease the concentration of tacrolimus and tacrolimus increases the exposure to sirolimus. *Severe* Study
- St John’s Wort decreases the concentration of tacrolimus. Avoid. *Severe* Study
- Tacrolimus increases the exposure to tofacitinib. Avoid. *Severe* Study
- Tacrolimus potentially increases the risk of serotonin syndrome when given with venlafaxine. *Severe* Anecdotal
- Tadalafil → see phosphodiesterase type-5 inhibitors
- Tamoxifen → see TABLE 5 p. 874 (thromboembolism)
- Bupropion is predicted to decrease the efficacy of tamoxifen. Avoid. *Severe* Study
- Cinacalcet is predicted to decrease the efficacy of tamoxifen. Avoid. *Severe* Study
- Tamoxifen increases the anticoagulant effect of coumarins. *Severe* Study
- Rifampicin markedly decreases the exposure to tamoxifen. Unknown Study
- Rolapitant is predicted to increase the exposure to tamoxifen. *Severe* Study
- SSRIs (fluoxetine, paroxetine) are predicted to decrease the efficacy of tamoxifen. Avoid. *Severe* Study
- Terbinafine is predicted to decrease the efficacy of tamoxifen. Avoid. *Severe* Study
- Tamulosin → see alpha blockers
- Tapentadol → see opioids
- Taxanes → see TABLE 15 p. 877 (myelosuppression), TABLE 12 p. 877 (peripheral neuropathy)
- Cabazitaxel - docetaxel - paclitaxel
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to cabazitaxel. *Moderate* Theoretical
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to paclitaxel. *Severe* Theoretical
- Anti-epileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to docetaxel. *Severe* Theoretical → Also see TABLE 12 p. 877
- Anti-epileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to increase the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. *Severe* Study → Also see TABLE 12 p. 877
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to cabazitaxel. *Moderate* Theoretical
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to cabazitaxel. Avoid. *Severe* Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to moderately increase the exposure to docetaxel. Avoid or adjust dose. *Severe* Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to paclitaxel. *Severe* Study
- Antifungals, azoles (miconazole) are predicted to increase the concentration of docetaxel. Use with caution and adjust dose. *Moderate* Theoretical
- Aprepitant is predicted to increase the exposure to cabazitaxel. *Moderate* Theoretical
- Bosentan is predicted to decrease the exposure to cabazitaxel. Avoid. *Severe* Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to cabazitaxel. *Moderate* Theoretical
- Ceritinib is predicted to increase the exposure to paclitaxel. *Moderate* Theoretical → Also see TABLE 15 p. 877
- Clopidogrel is predicted to increase the concentration of paclitaxel. *Severe* Anecdotal
- Cobimetinib is predicted to increase the exposure to cabazitaxel. Avoid. *Severe* Study
- Cobimetinib is predicted to moderately increase the exposure to docetaxel. Avoid or adjust dose. *Severe* Study
- Cobimetinib is predicted to increase the exposure to paclitaxel. *Severe* Theoretical
- Crizotinib is predicted to increase the exposure to cabazitaxel. *Moderate* Theoretical → Also see TABLE 15 p. 877
- Elaf dolphin is predicted to decrease the exposure to cabazitaxel. Avoid. *Severe* Study
- Eliglustat is predicted to increase the exposure to paclitaxel. Adjust dose. *Moderate* Study
- Enzalutamide is predicted to decrease the exposure to docetaxel. *Severe* Theoretical
- Enzalutamide is predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. *Severe* Study
- Fibrates (gemfibrozil) are predicted to increase the concentration of paclitaxel. *Severe* Anecdotal
- HIV-protease inhibitors are predicted to increase the exposure to cabazitaxel. Avoid. *Severe* Study
- HIV-protease inhibitors are predicted to moderately increase the exposure to docetaxel. Avoid or adjust dose. *Severe* Study
- HIV-protease inhibitors are predicted to increase the exposure to paclitaxel. *Severe* Theoretical
- Idelalisib is predicted to increase the exposure to cabazitaxel. Avoid. *Severe* Study → Also see TABLE 15 p. 877
Tedizolid

- Tedizolid is predicted to increase the exposure to imatinib. Avoid. [Moderate] Theoretical
- Tedizolid is predicted to increase the exposure to lopinavir. Avoid. [Moderate] Theoretical
- Tedizolid is predicted to increase the exposure to methotrexate. Avoid. [Moderate] Theoretical
- Tedizolid is predicted to increase the exposure to statins (atorvastatin, fluvastatin, rosuvastatin). Avoid. [Moderate] Study
- Tedizolid is predicted to increase the exposure to topotecan. Avoid. [Moderate] Study

Tedizolid is predicted to increase the exposure to docetaxel. Avoid or adjust dose. [Severe] Study → Also see TABLE 15 p. 877

Tedizolid is predicted to increase the exposure to paclitaxel. [Severe] Theoretical → Also see TABLE 15 p. 877

Lapatinib is predicted to increase the exposure to cabazitaxel. [Moderate] Theoretical → Also see TABLE 15 p. 877

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with taxanes (docetaxel, paclitaxel). Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Macrolides (clarithromycin) are predicted to increase the exposure to cabazitaxel. Avoid. [Severe] Study

Macrolides (clarithromycin) are predicted to increase the exposure to paclitaxel. [Severe] Theoretical

Macrolides (erythromycin) are predicted to increase the exposure to cabazitaxel. [Moderate] Theoretical

Mirabegron is predicted to increase the exposure to paclitaxel. [Mild] Theoretical

Mitotane is predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. [Severe] Study → Also see TABLE 15 p. 877

Netupitant is predicted to increase the exposure to cabazitaxel. [Moderate] Theoretical

Netupitant slightly increases the exposure to docetaxel. [Moderate] Study

Netupitant is predicted to increase the exposure to paclitaxel. [Moderate] Study

Nevirapine is predicted to decrease the exposure to cabazitaxel. Avoid. [Severe] Study

Nilotinib is predicted to increase the exposure to cabazitaxel. [Moderate] Theoretical → Also see TABLE 15 p. 877

Paritaprevir (with ritonavir andombitasvir) is predicted to increase the exposure to paclitaxel. [Moderate] Study

Pibrentasvir (with glecaprevir) is predicted to increase the exposure to paclitaxel. [Moderate] Study

Pitolisant is predicted to decrease the exposure to docetaxel. Avoid. [Severe] Theoretical

Pitolisant is predicted to decrease the exposure to paclitaxel. [Mild] Theoretical

Rifampicin is predicted to decrease the exposure to docetaxel. [Severe] Theoretical

Rifampicin is predicted to decrease the exposure to taxanes (cabazitaxel, paclitaxel). Avoid. [Severe] Study

St John’s Wort is predicted to decrease the exposure to cabazitaxel. Avoid. [Severe] Study

Teriflunomide is predicted to increase the concentration of paclitaxel. [Severe] Anecdotal

Velpatasvir is predicted to increase the exposure to paclitaxel. [Severe] Theoretical

Tazarotene → see retinoids

Tedizolid potentially increases the concentration of antiepileptics (fosphenytoin, phenytoin). Monitor concentration and adjust dose. [Severe] Anecdotal

Tedizolid increases the anticoagulant effect of coumarins. [Moderate] Theoretical

Folates are predicted to increase the risk of toxicity when given with teagafur. [Severe] Theoretical

H₂ receptor antagonists (cimetidine) are predicted to increase the risk of toxicity when given with tegafur. [Severe] Theoretical

Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with tegafur. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical

Methotrexate is predicted to increase the risk of toxicity when given with tegafur. [Severe] Theoretical

Teicoplanin

GENERAL INFORMATION If other nephrotoxic or neurotoxic drugs are given, monitor renal and auditory function on prolonged administration.

Telavancin → see TABLE 2 p. 874 (nephrotoxicity), TABLE 19 p. 878 (ototoxicity), TABLE 9 p. 876 (QT-interval prolongation)

Telbivudine

- Interferons (interferon alfa) are predicted to increase the risk of peripheral neuropathy when given with telbivudine. Avoid. [Severe] Theoretical

- Interferons (peginterferon alfa) increase the risk of peripheral neuropathy when given with telbivudine. Avoid. [Severe] Study

Telmisartan → see angiotensin-II receptor antagonists

Telotristat ethyl

- Telotristat ethyl is predicted to decrease the exposure to doravirine. Avoid or adjust doravirine dose. [Severe] Theoretical

- Telotristat ethyl decreases the exposure to midazolam. [Moderate] Study

- Octreotide (short-acting) decreases the exposure to telotristat ethyl. Telotristat ethyl should be taken at least 30 minutes before octreotide. [Moderate] Study

Temazepam → see TABLE 11 p. 876 (CNS depressant effects)

Temocilin → see penicillins

Temozolomide → see alkylating agents

Temozolomide is predicted to increase the concentration of temsirolimus. [Severe] Study

- Antiarhythmics (dronedarone) are predicted to increase the concentration of temsirolimus. [Moderate] Theoretical

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of temsirolimus. Avoid. [Severe] Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the concentration of temsirolimus. [Moderate] Theoretical

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical

- Anticoagulants (warfarin, phenprocoumon) are predicted to increase the concentration of temsirolimus. [Severe] Theoretical

- Antiarrhythmics (dronedarone) are predicted to increase the concentration of temsirolimus. [Moderate] Theoretical

- Apalutamide is predicted to decrease the exposure to temsirolimus. Avoid or monitor. [Moderate] Study

- Aprepitant is predicted to increase the concentration of temsirolimus. [Moderate] Theoretical

- Bosentan is predicted to decrease the concentration of temsirolimus. Avoid. [Severe] Theoretical

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the concentration of temsirolimus. [Moderate] Theoretical

- Cobicistat is predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical

- Crizotinib is predicted to increase the concentration of temsirolimus. [Moderate] Theoretical → Also see TABLE 15 p. 877

- Efavirenz is predicted to decrease the concentration of temsirolimus. Avoid. [Severe] Theoretical

- Enzalutamide is predicted to decrease the concentration of temsirolimus. Avoid. [Severe] Study

- Grapefruit juice is predicted to increase the concentration of temsirolimus. Use with caution or avoid. [Moderate] Theoretical

- HIV-protease inhibitors are predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical

- Idelalisib is predicted to increase the concentration of temsirolimus. Avoid. [Severe] Theoretical → Also see TABLE 15 p. 877

Netupitant is predicted to increase the exposure to taxanes (docetaxel, paclitaxel). Avoid. [Severe] Study
Temsirolimus (continued)

- **Irinotecan** is predicted to increase the concentration of temsirolimus. (Moderate) Theoretical → Also see TABLE 15 p. 877

- **Live vaccines** are predicted to increase the risk of generalised infection (possibly life-threatening) when given with temsirolimus. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

- **Lumacaftor** is predicted to decrease the exposure to temsirolimus. Avoid. (Severe) Theoretical

- Macrolides (clarithromycin) are predicted to increase the concentration of temsirolimus. Avoid. (Severe) Theoretical

- **Macrolides** (erythromycin) are predicted to increase the concentration of temsirolimus. (Moderate) Theoretical

- **Mitotane** is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Study

- **Nevirapine** is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Theoretical

- **Nilotinib** is predicted to increase the concentration of temsirolimus. (Moderate) Theoretical

- Also see TABLE 15 p. 877

- **Pitolisant** is predicted to decrease the exposure to temsirolimus. Avoid. (Severe) Theoretical

- **Rifampicin** is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Theoretical

- **St John’s Wort** is predicted to decrease the concentration of temsirolimus. Avoid. (Severe) Theoretical

**Tenofovir alafenamide**

- Antiepileptics (carbamazepine, fosphenytoin, oxcarbazepine, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical

- **Ciclosporin** is predicted to increase the exposure to tenofovir alafenamide. (Moderate) Theoretical

- **Eltorbopag** is predicted to increase the exposure to tenofovir alafenamide. (Moderate) Theoretical

- **HIV-protease inhibitors** (atazanavir, darunavir, lopinavir) increase the exposure to tenofovir alafenamide. Avoid or adjust dose. (Moderate) Study

- **HIV-protease inhibitors** (tipranavir) are predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical

- **Leflunomide** is predicted to increase the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical

- **Rifabutin** is predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical

- **Rifampicin** is predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical

- **St John’s Wort** is predicted to decrease the exposure to tenofovir alafenamide. Avoid. (Moderate) Theoretical

- **Teriflunomide** is predicted to increase the exposure to tenofovir alafenamide. Avoid or adjust dose. (Moderate) Study

**Tenofovir disoproxil**

- **Ciclosporin** is predicted to increase the exposure to tenofovir disoproxil. (Moderate) Theoretical → Also see TABLE 2 p. 874 (nephrotoxicity)

- **Eltorbopag** is predicted to increase the exposure to tenofovir disoproxil. (Moderate) Theoretical

- HIV-protease inhibitors (atazanavir, darunavir, lopinavir) are predicted to increase the risk of renal impairment when given with tenofovir disoproxil. (Severe) Anecdotal

- **Ledipasvir** (with sofosbuvir) slightly increases the exposure to tenofovir disoproxil. (Moderate) Study

- **Leflunomide** is predicted to increase the exposure to tenofovir disoproxil. (Moderate) Theoretical

- **Teriflunomide** is predicted to increase the exposure to tenofovir disoproxil. (Moderate) Theoretical

- **Velpatasvir** is predicted to increase the exposure to tenofovir disoproxil. (Severe) Study

- **Voxilaprevir** (with sofosbuvir and velpatasvir) potentially increases the concentration of tenofovir disoproxil. (Severe) Study

**Terbinafine**

**ROUTE-SPECIFIC INFORMATION** Since systemic absorption can follow topical application, the possibility of interactions should be borne in mind.

- **Terbinafine** is predicted to increase the exposure to anticholinesterases, centrally acting (gallantamine). Monitor and adjust dose. (Moderate) Study

- **Terbinafine** is predicted to moderately increase the exposure to aripiprazole. Adjust aripiprazole dose. p. 255. (Moderate) Study

- **Terbinafine** is predicted to markedly increase the exposure to atomoxetine. Adjust dose. (Severe) Study

- **Terbinafine** is predicted to increase the exposure to beta blockers, selective (metoprolol, nebivolol). (Moderate) Study

- **Terbinafine** is predicted to slightly increase the exposure to darifenacin. (Mild) Study

- **Terbinafine** is predicted to increase the exposure to eliglustat. Avoid or adjust dose—consult product literature. (Severe) Study

- **Terbinafine** is predicted to increase the exposure to mexiletine. (Moderate) Study

- **Terbinafine** is predicted to decrease the efficacy of opioids (codeine). (Moderate) Theoretical

- **Terbinafine** is predicted to decrease the efficacy of opioids (triametadol). (Severe) Study

- **Terbinafine** is predicted to moderately increase the exposure to pitolisant. Use with caution and adjust dose. (Moderate) Study

- **Rifampicin** decreases the exposure to terbinafine. Adjust dose. (Moderate) Study

- **Terbinafine** is predicted to increase the exposure to risperidone. Adjust dose. (Moderate) Study

- **Terbinafine** is predicted to increase the exposure to SSRIs (citalopram, dapoxetine, escitalopram, fluvoxamine, sertraline). (Moderate) Theoretical

- **Terbinafine** is predicted to increase the exposure to SSRIs (paroxetine). (Moderate) Study

- **Terbinafine** is predicted to decrease the efficacy of tamoxifen. Avoid. (Severe) Study

- **Terbinafine** is predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. (Severe) Study

- **Terbinafine** is predicted to increase the exposure to vortioxetine. Monitor and adjust dose. (Moderate) Study

**Terbutaline** → see beta agonists

**Teriflunomide**

- **Teriflunomide** is predicted to increase the exposure to adefovir. (Moderate) Study

- **Teriflunomide** is predicted to decrease the exposure to agomelatine. (Moderate) Theoretical

- **Teriflunomide** decreases the exposure to aminophylline. Adjust dose. (Moderate) Study

- **Teriflunomide** is predicted to decrease the exposure to anesthetics, local (ropivacaine). (Moderate) Theoretical

- **Teriflunomide** is predicted to increase the exposure to anthracyclines (daunorubicin, doxorubicin, mitoxantrone). (Moderate) Theoretical

- **Teriflunomide** is predicted to increase the exposure to baricitinib. (Moderate) Theoretical

- **Teriflunomide** is predicted to increase the exposure to bosentan. (Moderate) Study

- **Teriflunomide** is predicted to moderately increase the clearance of caffeine citrate. Monitor and adjust dose. (Moderate) Study

- **Teriflunomide** is predicted to increase the exposure to cephalosporins (cefator). (Moderate) Study

- **Teriflunomide** is predicted to decrease the exposure to clozapine. (Moderate) Theoretical

- **Teriflunomide** affects the anticoagulant effect of coumarins. (Severe) Study

- **Teriflunomide** is predicted to decrease the exposure to duloxetine. (Moderate) Theoretical

- **Teriflunomide** is predicted to increase the exposure to ganciclovir. (Moderate) Study
Teriflunomide – Tezacaftor 1041

- Teriflunomide is predicted to increase the exposure to H₂ receptor antagonists (cimetidine, famotidine). [Moderate] Study
- Teriflunomide is predicted to increase the concentration of lertemovir. [Moderate] Study
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with teriflunomide. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical
- Teriflunomide is predicted to increase the exposure to loop diuretics (furosemide). [Moderate] Study
- Teriflunomide is predicted to increase the exposure to melatonin. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to methotrexate. [Moderate] Study
- Teriflunomide is predicted to increase the clearance of mexiletine. Monitor and adjust dose. [Moderate] Study
- Teriflunomide is predicted to increase the exposure to montelukast. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to nateglinide. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to NSAIDs. (indometacin, ketoprofen). [Moderate] Theoretical
- Teriflunomide is predicted to decrease the exposure to olanzapine. Monitor and adjust dose. [Moderate] Study
- Teriflunomide is predicted to increase the exposure to oxalamivir. [Moderate] Study
- Teriflunomide is predicted to increase the exposure to penicillins (benzylpenicillin). [Moderate] Study
- Teriflunomide is predicted to increase the exposure to piperacillin. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to quinolones (ciprofloxacin). [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to repaglinide. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to rifampicin. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to selexipag. Adjust dose. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to statins (atorvastatin, fluvastatin, pravastatin, simvastatin). [Moderate] Study
- Teriflunomide moderately increases the exposure to statins (rosuvastatin). Adjust rosvastatin dose. p. 125. [Moderate] Study
- Teriflunomide is predicted to increase the exposure to suflasalazine. [Moderate] Study
- Teriflunomide is predicted to increase the exposure to sulfonylureas (glibenclamide). [Moderate] Study
- Teriflunomide is predicted to decrease the concentration of taxanes (paclitaxel). [Severe] Anecdotal
- Teriflunomide is predicted to increase the exposure to tenofovir alafenamide. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to tenofovir disoproxil. [Moderate] Theoretical
- Teriflunomide is predicted to increase the exposure to theophylline. Adjust dose. [Moderate] Study
- Teriflunomide moderately decreases the exposure to tizanidine. [High] Study
- Teriflunomide is predicted to increase the exposure to topotecan. [Moderate] Study
- Teriflunomide is predicted to increase the exposure to zidovudine. [Moderate] Theoretical

Tetanus immunoglobulin → see immunoglobulins
Tetrabenzazine → see TABLE 9 p. 876 (QT-interval prolongation)
Tetragenazine is predicted to decrease the effects of levodopa. Use with caution or avoid. [Moderate] Theoretical
Tetragenazine is predicted to increase the risk of CNS toxicity when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical
Tetracaine → see anaesthetics, local
Tetracycline → see tetracyclines
Tetracyclines → see TABLE 1 p. 874 (hepatotoxicity)

demeclocycline • doxycycline • lymecycline • minocycline • oxytetracycline • tetracycline • tigecycline

ROUTE-SPECIFIC INFORMATION Interactions do not generally apply to topical use of oxytetracycline unless specified.

- ACE inhibitors (quinapril) (tablet) decrease the absorption of oral tetracycline. Avoid. [Moderate] Study
- Antacids decrease the absorption of tetracyclines. Separate administration by 2 to 3 hours. [Moderate] Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) decrease the exposure to doxycycline. Monitor and adjust dose. [Moderate] Study Also see TABLE 1 p. 874
- Tetracycline decreases the concentration of antimarialars (atovaquone). [Moderate] Study
- Calcium salts (calcium carbonate) are predicted to decrease the absorption of tetracyclines. Separate administration by 2 to 3 hours. [Moderate] Theoretical
- Tetracyclines increase the risk of bleeding events when given with coumarins. [Moderate] Anecdotal
- Dairy products decrease the absorption to tetracyclines (demeclocycline, oxytetracycline, tetracycline). Avoid. [Moderate] Study
- Enalapril decreases the exposure to doxycycline. Monitor and adjust dose. [Moderate] Study
- Iron (oral) decreases the absorption of tetracyclines. Tetracyclines should be taken 2 to 3 hours after iron (oral). [Moderate] Study
- Ketoconazole decreases the absorption of tetracyclines. [Moderate] Theoretical
- Lansoprazole decreases the exposure to tetracyclines. Separate administration by 2 hours. [Moderate] Theoretical
- Mitotane decreases the exposure to doxycycline. Monitor and adjust dose. [Moderate] Study
- Retinoids (acitretin, altretinoin, isotretinoin, tretinoin) increase the risk of benign intracranial hypertension when given with tetracyclines. Avoid. [Severe] Anecdotal
- Rifampicin decreases the exposure to doxycycline. Monitor and adjust dose. [Moderate] Study
- Oral zinc is predicted to decrease the absorption of tetracyclines. Separate administration by 2 to 3 hours. [Moderate] Theoretical

Tezacaftor

FOOD AND LIFESTYLE Avoid bitter (Seville) oranges as they are predicted to increase the exposure to tezacaftor.

- Antiarrhythmics (dronedarone) are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tezacaftor. Avoid. [Severe] Theoretical
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- Antibacterials are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study
- Aprepitant is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- Antihypertensives (angiotensin receptor antagonists, dihydropyridine calcium channel blockers, (diltiazem, verapamil)) are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- Crizotinib is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study
- Enalapril decreases the exposure to tezacaftor. Avoid. [Severe] Theoretical
**Tezacaftor** (continued)

- **Grapefruit juice** is predicted to increase the exposure to tezacaftor. Avoid. [Severe] Study
- **HIV-protease inhibitors** are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study
- **Idelalisib** is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study
- **Irinotecan** is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Macrolides (clarithromycin)** are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with potent inhibitors of CYP3A4. [Severe] Study
- **Macrolides (erythromycin)** are predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Mitotane** is predicted to decrease the exposure to tezacaftor. Avoid. [Severe] Theoretical
- **Netupitant** is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Nilotinib** is predicted to increase the exposure to tezacaftor. Adjust tezacaftor with ivacaftor p. 190 dose with moderate inhibitors of CYP3A4. [Severe] Study
- **Rifabutin** is predicted to decrease the exposure to tezacaftor. Avoid. [Severe] Theoretical
- **Rifampin** is predicted to decrease the exposure to tezacaftor. Avoid. [Severe] Theoretical
- **St John’s Wort** is predicted to decrease the exposure to tezacaftor. Avoid. [Severe] Theoretical
- **Thalidomide** see TABLE 6 p. 875 (bradycardia), TABLE 15 p. 877 (myelosuppression), TABLE 12 p. 877 (peripheral neuropathy), TABLE 5 p. 874 (thromboembolism), TABLE 11 p. 876 (CNS depressant effects)
- **Combined hormonal contraceptives** are predicted to increase the risk of venous thromboembolism when given with thalidomide. Avoid. [Severe] Study
- **Hormone replacement therapy** is predicted to increase the risk of venous thromboembolism when given with thalidomide. Avoid. [Severe] Study
- **Theophylline** see TABLE 17 p. 878 (reduced serum potassium)

**FOOD AND LIFESTYLE** Smoking can increase theophylline clearance and increased doses of theophylline are therefore required; dose adjustments are likely to be necessary if smoking started or stopped during treatment.

- **Aciclovir** is predicted to increase the exposure to theophylline. Adjust dose with moderate and high doses. [Severe] Theoretical
- **Theophylline** decreases the efficacy of antiarrhythmics (adenosine). Separate administration by 24 hours. [Mid] Study
- **Antiepileptics (carbamazepine)** potentially increase the clearance of theophylline and theophylline decreases the exposure to antiepileptics (carbamazepine). Adjust dose. [Moderate] Anecdotal
- **Antiepileptics (fosphenytoin, phenytoin)** are predicted to decrease the exposure to theophylline. Adjust dose. [Moderate] Study
- **Antiepileptics (phenobarbital, primidone)** are predicted to increase the clearance of theophylline. Adjust dose. [Moderate] Theoretical
- **Antiepileptics (stiripentol)** are predicted to increase the exposure to theophylline. Avoid. [Moderate] Theoretical
- **Beta blockers, non-selective** are predicted to increase the risk of bronchospasm when given with theophylline. Avoid. [Severe] Theoretical
- **Beta blockers, selective** are predicted to increase the risk of bronchospasm when given with theophylline. Avoid. [Severe] Theoretical
- **Caffeine citrate** decreases the clearance of theophylline. [Moderate] Study
- **Combined hormonal contraceptives** are predicted to increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **Theophylline** increases the risk of agitation when given with doxapram. [Moderate] Study
- **Enteral feeds** decrease the exposure to theophylline. [Moderate] Study
- **Esketamine** is predicted to increase the risk of seizures when given with theophylline. Avoid. [Severe] Theoretical
- **H. receptor antagonists (cimetidine)** increase the concentration of theophylline. Adjust dose. [Severe] Study
- **HIV-protease inhibitors (ritonavir)** are predicted to decrease the exposure to theophylline. Adjust dose. [Moderate] Study
- **Interferons** slightly increase the exposure to theophylline. Adjust dose. [Moderate] Study
- **Iron chelators (deferasirox)** increase the exposure to theophylline. Avoid. [Moderate] Study
- **Isoniazid** is predicted to affect the clearance of theophylline. Avoid. [Severe] Anecdotal
- **Leflunomide** is predicted to decrease the exposure to theophylline. Adjust dose. [Moderate] Study
- **Theophylline** is predicted to decrease the concentration of lithium. Monitor concentration and adjust dose. [Moderate] Anecdotal
- **Macrolides (azithromycin, clarithromycin)** are predicted to increase the exposure to theophylline. Avoid. [Moderate] Anecdotal
- **Macrolides (erythromycin)** decrease the clearance of theophylline and theophylline potentially decreases the clearance of macrolides (erythromycin). Adjust dose. [Severe] Study
- **Methotrexate** decreases the clearance of theophylline. [Moderate] Study
- **Mesxetine** is predicted to increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **Monoclonal antibodies (bentolimumab)** are predicted to transiently increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **Monoclonal antibodies (tocilizumab)** are predicted to decrease the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **Obeticholic acid** is predicted to increase the exposure to theophylline. [Severe] Theoretical
- **Pentoxifylline** increases the concentration of theophylline. Monitor and adjust dose. [Severe] Study
- **Quinolones (ciprofloxacin)** are predicted to increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **Rifaximin** is predicted to decrease the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **Rifampin** is predicted to decrease the exposure to theophylline. Adjust dose. [Moderate] Study
- **Theophylline** is predicted to slightly increase the exposure to rifamycin. Avoid. [Moderate] Theoretical
- **Rucaparib** is predicted to increase the exposure to theophylline. Monitor and adjust dose. [Moderate] Theoretical
- **SSRIs (fluvoxamine)** moderately to markedly increase the exposure to theophylline. Avoid. [Severe] Study
- **St John’s Wort** potentially decreases the exposure to theophylline. [Severe] Anecdotal
- **Sucralfate** potentially decreases the absorption of theophylline. Separate administration by at least 2 hours. [Moderate] Study
- **Symptomptomimetics, vasconstrictor (ephedrine)** increase the risk of side-effects when given with theophylline. Avoid in children. [Moderate] Study
- **Teriflunomide** is predicted to decrease the exposure to theophylline. Adjust dose. [Moderate] Study
- **Valaciclovir** is predicted to increase the exposure to theophylline. [Severe] Theoretical

**Thiazide diuretics** see TABLE 18 p. 878 (hyponatraemia), TABLE 8 p. 875 (hypotension), TABLE 17 p. 878 (reduced serum potassium)

- **Benzoato de hidroclorotiazida - chlorothiazida - chlorotidina - hidroclorotiazida - hidroflumethiazida - indapamina - metolazona - xipamide**
- **Thiazide diuretics** are predicted to increase the risk of hypersensitivity reactions when given with allopurinol. [Severe] Theoretical
Thiazide diuretics — Tizanidine 1043

- Aspirin (high-dose) increases the risk of acute renal failure when given with thiazide diuretics. [Severe] Theoretical
- Thiazide diuretics increase the risk of hypercalcaemia when given with calcium salts. [Severe] Anecdotal
- Thiazide diuretics increase the concentration of lithium. Avoid or adjust dose and monitor concentration. [Severe] Study
- NSAIDs increase the risk of acute renal failure when given with thiazide diuretics. [Severe] Theoretical → Also see TABLE 18 p. 878
- Reboxetine is predicted to increase the risk of hypokalaemia when given with thiazide diuretics. [Moderate] Anecdotal
- Thiazide diuretics are predicted to increase the risk of hypercalcaemia when given with toremifene. [Severe] Theoretical
- Thiazide diuretics increase the risk of hypercalcaemia when given with vitamin D substances. [Moderate] Theoretical

Thiopental → see TABLE 8 p. 875 (hypotension), TABLE 11 p. 876 (CNS depressant effects)
- Sulfonamides are predicted to increase the effects of thiopental. [Moderate] Theoretical
- Tricyclic antidepressants increase the risk of cardiac arrhythmias and hypotension when given with thiopental. [Moderate] Study → Also see TABLE 8 p. 875

Thiotepa → see alkylating agents

Thyroid hormones
- Levothyroxine - liothyronine
- Antacids are predicted to decrease the absorption of levothyroxine. Separate administration by at least 4 hours. [Moderate] Anecdotal
- Antiarhythmics (amiodarone) are predicted to increase the risk of thyroid dysfunction when given with thyroid hormones. Avoid. [Moderate] Study
- Antiepileptics (carbamazepine, fosphenytoin, phenytoin) are predicted to increase the risk of hypothyroidism when given with thyroid hormones. [Moderate] Study
- Antiepileptics (phenobarbital, primidone) are predicted to decrease the effects of thyroid hormones. [Moderate] Theoretical
- Apalutamide potentially decreases the exposure to levothyroxine. [Mild] Theoretical
- Oral calcium salts are predicted to decrease the absorption of levothyroxine. Separate administration by at least 4 hours. [Moderate] Anecdotal
- Thyroid hormones are predicted to affect the concentration of digoxin. Monitor and adjust dose. [Moderate] Theoretical
- HIV-protease inhibitors (ritonavir) decrease the concentration of levothyroxine. MHRA advises monitor TSH for at least one month after starting or stopping ritonavir. [Moderate] Anecdotal
- Oral hormone replacement therapy is predicted to decrease the effects of thyroid hormones. [Moderate] Theoretical
- Iron (oral) decreases the absorption of levothyroxine. Separate administration by at least 4 hours. [Severe] Study
- Lanthanum decreases the absorption of thyroid hormones. Separate administration by 2 hours. [Moderate] Study
- Paritaprevir (with ritonavir andombitasvir) is predicted to increase the absorption of levothyroxine. Monitor and adjust dose. [Moderate] Theoretical
- Sucralfate decreases the absorption of levothyroxine. Separate administration by at least 4 hours. [Moderate] Study

Tiagabine → see antiepileptics

Tiapronenic acid → see NSAIDs

Tilolone → see TABLE 8 p. 874 (thromboembolism)

Ticagrelor → see TABLE 4 p. 874 (antiplatelet effects)
- Antiarrhythmics (amiodarone) are predicted to increase the exposure to ticagrelor. Use with caution or avoid. [Severe] Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to markedly decrease the exposure to ticagrelor. Avoid. [Severe] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study
- Bosentan is predicted to decrease the exposure to ticagrelor. [Moderate] Theoretical
- Ciclosporin is predicted to increase the exposure to ticagrelor. Use with caution or avoid. [Severe] Study
- Cobicistat is predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study
- Ticagrelor increases the concentration of digoxin. [Moderate] Study
- Eravirenz is predicted to decrease the exposure to ticagrelor. [Moderate] Theoretical
- Enalapril is predicted to markedly decrease the exposure to ticagrelor. Avoid. [Severe] Study
- Ticagrelor is predicted to increase the exposure to ergotamine. Avoid. [Severe] Anecdotal
- Grapefruit juice moderately increases the exposure to ticagrelor. [Moderate] Study
- HIV-protease inhibitors are predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study
- Idelalisib is predicted to markedly decrease the exposure to ticagrelor. Avoid. [Severe] Study
- Ticagrelor is predicted to increase the exposure to lomitapide. Separate administration by 12 hours. [Moderate] Theoretical
- Macrolides (azithromycin) are predicted to increase the exposure to ticagrelor. Use with caution or avoid. [Severe] Study
- Macrolides (clarithromycin) are predicted to markedly increase the exposure to ticagrelor. Avoid. [Severe] Study
- Mitotane is predicted to markedly decrease the exposure to ticagrelor. Avoid. [Severe] Study
- Nevirapine is predicted to decrease the exposure to ticagrelor. [Severe] Study
- Ranolazine is predicted to increase the exposure to ticagrelor. Use with caution or avoid. [Severe] Study
- Rifampicin is predicted to markedly decrease the exposure to ticagrelor. Avoid. [Severe] Study
- St John’s Wort is predicted to decrease the exposure to ticagrelor. [Severe] Theoretical
- Ticarclidin → see penicillins
- Tigecycline → see tetracyclines
- Tildrazikumab → see monoclonal antibodies
- Timolol → see beta blockers, non-selective

Tinzaparin
- Alcohol (beverage) potentially causes a disulfiram-like reaction when given with tizanidine. Avoid for 72 hours stopping treatment. [Moderate] Theoretical
- Tiazidizole is predicted to increase the antiangiostatic effect of coumarins. Monitor INR and adjust dose. [Severe] Theoretical
- Tizzanapin → see low molecular-weight heparins
- Tioguanine → see TABLE 15 p. 877 (myelosuppression)
- Tispropan is predicted to increase the risk of generalised infection (possibly life-threatening) when given with tioguanine. Public Health England advises avoid (refer to Green Book). [Severe] Theoretical
- Tiopropium → see TABLE 10 p. 876 (antimuscarinics)
- Tirofiban → see HIV-protease inhibitors
- Tivozanib
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tivozanib. [Severe] Study
- Enalapril is predicted to decrease the exposure to tivozanib. [Severe] Study
- Mitotane is predicted to decrease the exposure to tivozanib. [Severe] Study
- Tivozanib is predicted to decrease the exposure to statins (rosuvastatin). [Moderate] Theoretical

Tizanidine → see TABLE 6 p. 875 (bradycardia), TABLE 8 p. 875 (hypotension), TABLE 9 p. 876 (Q-interval prolongation), TABLE 11 p. 876 (CNS depressant effects)
- Antiepileptics (fosphenytoin, phenytoin) moderately decrease the exposure to tizanidine. [Mild] Study
Tizanidine (continued)
» Combined hormonal contraceptives increase the exposure to tizanidine. Avoid. [Moderate] Study
» HIV-protease inhibitors (ritonavir) moderately decrease the exposure to tizanidine. [Mild] Study
» Iron chelators (deferasirox) are predicted to increase the exposure to tizanidine. [Mild] Study
» Leflunomide moderately decreases the exposure to tizanidine. [Mild] Study
» Mesalazine increases the exposure to tizanidine. Avoid. [Moderate] Study
» Obeticholic acid is predicted to increase the exposure to tizanidine. [Severe] Theoretical
» Quinolones (ciprofloxacin) increase the exposure to tizanidine. Avoid. [Moderate] Study
» Rifampicin moderately decreases the exposure to tizanidine. [Mild] Study
» Rucaparib is predicted to increase the exposure to tizanidine. Monitor and adjust dose. [Moderate] Study
» SSRI (fluvoxamine) very markedly increase the exposure to tizanidine. Avoid. [Severe] Study
» Teriflunomide moderately decreases the exposure to tizanidine. [Mild] Study

Tizanidine → see aminoglycosides
Tolcizumab → see monoclonal antibodies

Tofacitinib
» Antiarrhythmics (dronedarone) given with a potent CYP2C19 inhibitor are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to tofacitinib. Avoid. [Severe] Study
» Antifungals (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Aprepitant given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Bosantan is decreased to predict the exposure to tofacitinib. [Moderate] Study
» Calcium channel blockers (diltiazem, verapamil) given with a potent CYP2C19 inhibitor are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Ciclosporin increases the exposure to tofacitinib. Avoid. [Severe] Study
» Cobicistat is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Crizotinib given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Efavirenz is predicted to decrease the exposure to tofacitinib. [Mild] Study
» Enalapril is predicted to decrease the exposure to tofacitinib. [Mild] Study
» HIV-protease inhibitors are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Idealisib is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Immunosuppressant (mycophenolate mofetil) is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Live vaccines potentially increase the risk of generalised infection (possibly life-threatening) when given with tofacitinib. Avoid. [Severe] Theoretical
» Macrolides (clarithromycin) are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Macrolides (erythromycin) given with a potent CYP2C19 inhibitor are predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Mitotane is predicted to decrease the exposure to tofacitinib. Avoid. [Severe] Study
» Netupitant given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Mild] Study
» Nevirapine is predicted to decrease the exposure to tofacitinib. [Moderate] Study
» Nilotinib given with a potent CYP2C19 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» Rifampicin is predicted to decrease the exposure to tofacitinib. Avoid. [Severe] Study
» SSRI (fluoxetine, fluvoxamine) given with a moderate CYP3A4 inhibitor is predicted to increase the exposure to tofacitinib. Adjust tofacitinib dose. [Moderate] Study
» St John’s Wort is predicted to decrease the exposure to tofacitinib. [Moderate] Study
» Tacrolimus increases the exposure to tofacitinib. Avoid. [Severe] Study

Tolbutamide → see sulphonylureas

Tolcapone
» Tolcapone increases the exposure to levodopa. Monitor and adjust dose. [Moderate] Study
» Tolcapone is predicted to increase the effects of monoamine oxidase A and B inhibitors, irreversible. Avoid. [Severe] Theoretical
» Tolcapone is predicted to increase the risk of cardiovascular side-effects when given with sympathomimetics, inotropic. [Theoretical] Theoretical
» Tolcapone is predicted to increase the effects of sympathomimetics, vasconstrictor (adrenaline/epinephrine, noradrenaline/norepinephrine). [Moderate] Theoretical

Tolfenamic acid → see NSAIDs

Tolterodine → see TABLE 9 p. 878 (OT-interval prolongation), TABLE 10 p. 876 (antimuscarinics)
» Antiarrhythmics (dronedarone) are predicted to increase the exposure to tolterodine. [Mild] Theoretical → Also see TABLE 9 p. 876
» Antifungals, azoles (fluconazole, itraconazole, posaconazole) are predicted to increase the exposure to tolterodine. [Mild] Theoretical → Also see TABLE 9 p. 876
» Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tolterodine. Avoid. [Severe] Study → Also see TABLE 9 p. 876
» Aprepitant is predicted to increase the exposure to tolterodine. [Mild] Theoretical
» Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to tolterodine. [Mild] Theoretical
» Cobicistat is predicted to increase the exposure to tolterodine. [Mild] Theoretical
» Crizotinib is predicted to increase the exposure to tolterodine. [Mild] Theoretical → Also see TABLE 9 p. 876
» Eliglustat is predicted to increase the exposure to tolterodine. Adjust dose. [Moderate] Theoretical
» HIV-protease inhibitors are predicted to increase the exposure to tolterodine. Avoid. [Severe] Study → Also see TABLE 9 p. 876
» Idealisib is predicted to increase the exposure to tolterodine. Avoid. [Severe] Study
» Immunosuppressant (mycophenolate mofetil) is predicted to increase the exposure to tolterodine. Adjust tofacitinib dose. [Moderate] Study
» Macrolides (clarithromycin) are predicted to increase the exposure to tolterodine. [Mild] Theoretical → Also see TABLE 9 p. 876
» Macrolides (erythromycin) are predicted to increase the exposure to tolterodine. [Mild] Theoretical
» Netupitant is predicted to increase the exposure to tolterodine. [Mild] Theoretical → Also see TABLE 9 p. 876

Tolvaptan → see TABLE 10 p. 878 (increased serum potassium)

GENERAL INFORMATION
Avoid concurrent use of drugs that increase serum-sodium concentrations.
» Antiarrhythmics (dronedarone) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. [Moderate] Study
» Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure
to tolvaptan. Use with caution or avoid depending on indication. (Severe) Study

- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study

- Apalutamide is predicted to decrease the exposure to tolvaptan. Avoid or monitor. (Moderate) Study

- Aprepitant is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

- Cobimetinib is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study

- Crizotinib is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study

- Tolvaptan increases the concentration of digoxin. (Mild) Study

- Enalaprilat is predicted to decrease the exposure to tolvaptan. Use with caution or avoid depending on indication. (Severe) Study

- Grapefruit juice increases the exposure to tolvaptan. Avoid. (Moderate) Study

- HIV-protease inhibitors are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study

- Imatinib is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

- Macrolides (clarithromycin) are predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with potent inhibitors of CYP3A4. (Severe) Study

- Mitotane is predicted to decrease the exposure to tolvaptan. Use with caution or avoid depending on indication. (Severe) Study

- Netupitant is predicted to increase the exposure to tolvaptan. Manufacturer advises caution or adjust tolvaptan dose with moderate inhibitors of CYP3A4. (Moderate) Study

- Topiramate is predicted to increase the exposure to tolvaptan. Use with caution and adjust tolvaptan dose. (Moderate) Theoretical

- Rifampicin is predicted to decrease the exposure to tolvaptan. Use with caution or avoid depending on indication. (Severe) Study

- St John’s Wort is predicted to decrease the exposure to tolvaptan. Avoid. (Moderate) Theoretical

- Topiramate + see antiepileptics

- Topotecan + see table 15 p. 877 (myelosuppression)

- Antiarrhythmics (amiodarone, dronedarone) are predicted to increase the exposure to topotecan. (Severe) Study

- Antiepileptics (fosphenytoin, phenytoin) increase the clearance of topotecan. (Moderate) Study

- Antifungals, azoles (isavuconazole) are predicted to increase the exposure to topotecan. (Moderate) Theoretical

- Antifungals, azoles (itraconazole, ketoconazole) are predicted to increase the exposure to topotecan. (Severe) Study

- Calcium channel blockers (verapamil) are predicted to increase the exposure to topotecan. (Severe) Study

- Ceritinib is predicted to increase the exposure to topotecan. (Moderate) Theoretical + see table 15 p. 877

- Ciclosporin is predicted to increase the exposure to topotecan. (Severe) Study

- Eliglustat is predicted to increase the exposure to topotecan. Adjust dose. (Moderate) Study

- HIV-protease inhibitors (lopinavir, ritonavir, saquinavir) are predicted to increase the exposure to topotecan. (Severe) Study

- Lapatinib is predicted to increase the exposure to topotecan. (Severe) Study

- Leflunomide is predicted to increase the exposure to topotecan. (Moderate) Study + see table 15 p. 877

- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with topotecan. Public Health England advises avoid (refer to Green Book). (Severe) Theoretical

- Macrolides are predicted to increase the exposure to tolvaptan. (Severe) Study

- Mirabegron is predicted to increase the exposure to tolvaptan. (Mild) Theoretical

- Partaprevir (with ritonavir and ombitasvir) is predicted to increase the exposure to tolvaptan. (Moderate) Study

- Pibrentasvir (with glecaprevir) is predicted to increase the exposure to topotecan. (Moderate) Study

- Pitolisant is predicted to decrease the exposure to tolvaptan. (Mild) Study

- Ranolazine is predicted to increase the exposure to topotecan. (Severe) Study

- Regorafenib is predicted to increase the exposure to topotecan. (Moderate) Study + see table 15 p. 877

- Rilpamid is predicted to increase the exposure to topotecan. Avoid or monitor. (Moderate) Study

- St John’s Wort is predicted to decrease the exposure to topotecan. (Severe) Theoretical

- Tedizolid is predicted to increase the exposure to topotecan. Avoid. (Moderate) Study

- Velpatasvir is predicted to increase the exposure to topotecan. (Severe) Theoretical

- Vemurafenib is predicted to increase the exposure to topotecan. (Severe) Study

- Venetoclax is predicted to increase the exposure to topotecan. (Mild) Theoretical

- Voxelaprevir is predicted to increase the concentration of topotecan. Avoid. (Severe) Theoretical

- Torasemide + see loop diuretics

- Toremifene + see table 5 p. 874 (thromboembolism), table 9 p. 876 (QT-interval prolongation)

- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to toremifene. Adjust dose. (Moderate) Study

- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to toremifene. (Moderate) Theoretical + see table 9 p. 876

- Cobicistat is predicted to increase the exposure to toremifene. (Moderate) Theoretical

- Toremifene is predicted to increase the anticoagulant effect of coumarins. (Severe) Theoretical

- Enalaprilat is predicted to decrease the exposure to toremifene. Adjust dose. (Moderate) Study

- HIV-protease inhibitors are predicted to increase the exposure to toremifene. (Moderate) Theoretical + see table 9 p. 876

- Idelalisib is predicted to increase the exposure to toremifene. (Moderate) Theoretical + see table 9 p. 876

- Macrolides (clarithromycin) are predicted to increase the exposure to toremifene. (Moderate) Theoretical + see table 9 p. 876

- Mitotane is predicted to decrease the exposure to toremifene. Adjust dose. (Moderate) Study
Toremifene (continued)

- **Rifampicin** is predicted to decrease the exposure to toremifene. Adjust dose. [Moderate] Study
- **Thiazide diuretics** are predicted to increase the risk of hypercalcaemia when given with toremifene. [Severe] Theoretical
- **Trabectedin** → See TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 887 (myelosuppression)
- **Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)** are predicted to decrease the exposure to toremifene. Avoid. [Severe] Theoretical → Also see TABLE 1 p. 874
- **Antifungals, azoles (itraconazole, ketoconazole, voriconazole)** are predicted to increase the exposure to trabectedin. Avoid or adjust dose. [Severe] Theoretical → Also see TABLE 1 p. 874
- **Cobicistat** is predicted to increase the exposure to trabectedin. Avoid or adjust dose. [Severe] Theoretical
- **Enalaprilamide** is predicted to decrease the exposure to trabectedin. Avoid. [Severe] Theoretical
- **HIV-protease inhibitors** are predicted to increase the exposure to trabectedin. Avoid or adjust dose. [Severe] Theoretical
- **Idelalisib** is predicted to increase the exposure to trabectedin. Avoid. [Severe] Theoretical
- **Trazodone** → See TABLE 1 p. 874
- **Trastuzumab emtansine** → See TABLE 1 p. 874
- **Tranexamic acid**
- **Trandolapril** → See TABLE 1 p. 874
- **Vemurafenib** → See TABLE 1 p. 874
- **Lapatinib** → See TABLE 1 p. 874
- **HIV-protease inhibitors** are predicted to moderately increase the exposure to trametinib. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to trameitinb. Avoid or adjust dose. [Moderate] Theoretical
- **Netupitant** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Rifampicin** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Trametinib** → See TABLE 1 p. 874
- **Trametinib** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Toremifene** (continued)
- **Antihistamines (clomipramine, imipramine)** are predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Cyproheptadine** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Tramadol** → See opioids
- **Tramadol** → See opioids
- **HIV-protease inhibitors** are predicted to moderately increase the exposure to trametinib. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to trametinb. Avoid or adjust dose. [Moderate] Theoretical
- **Netupitant** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Tobramycin** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Toremifene** (continued)
- **Antihistamines (clomipramine, imipramine)** are predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Cyproheptadine** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Tramadol** → See opioids
- **Tramadol** → See opioids
- **HIV-protease inhibitors** are predicted to moderately increase the exposure to trametinib. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to trametinb. Avoid or adjust dose. [Moderate] Theoretical
- **Netupitant** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Tobramycin** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Toremifene** (continued)
- **Antihistamines (clomipramine, imipramine)** are predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Cyproheptadine** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Tramadol** → See opioids
- **Tramadol** → See opioids
- **HIV-protease inhibitors** are predicted to moderately increase the exposure to trametinib. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to trametinb. Avoid or adjust dose. [Moderate] Theoretical
- **Netupitant** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Tobramycin** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Toremifene** (continued)
- **Antihistamines (clomipramine, imipramine)** are predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Cyproheptadine** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study
- **Tramadol** → See opioids
- **Tramadol** → See opioids
- **HIV-protease inhibitors** are predicted to moderately increase the exposure to trametinib. [Moderate] Theoretical
- **Macrolides (clarithromycin)** are predicted to moderately increase the exposure to trametinb. Avoid or adjust dose. [Moderate] Theoretical
- **Netupitant** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Nilotinib** is predicted to increase the exposure to oxapitinb. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Calcium channel blockers (diltiazem, verapamil)** are predicted to increase the exposure to trametinib. [Moderate] Theoretical
- **Tobramycin** is predicted to increase the exposure to oxapitinb. Avoid or adjust dose. [Moderate] Study

**GENERAL INFORMATION**

Desensitising vaccines should be avoided in patients taking beta-blockers (adrenaline might be ineffective in case of a hypersensitivity reaction) or ACE inhibitors (risk of severe anaphylactoid reactions).

**Tresoluran** → See alkylating agents

**Tretinoin** → See retinoids

**Triamcinolone** → See corticosteroids

**Triameterene** → See potassium-sparing diuretics

**Tricyclic antidepressants** → See TABLE 18 p. 873 (hypotension), TABLE 13 p. 877 (serotonin syndrome), TABLE 9 p. 876 (QT-interval prolongation), TABLE 10 p. 876 (antimuscarinics)

- **antidepressants** → See corticosteroids

- **Tricyclic antidepressants** (clomipramine, doxepin, imipramine, nortriptyline, trimipramine)

**ROUTE-SPECIFIC INFORMATION**

Since systemic absorption can follow topical application, the possibility of interactions of topical doxepin should be borne in mind.

**Toremifene** (continued)

- **Antiarhythmic drugs (dronedarone)** are predicted to increase the exposure to tricyclic antidepressants. Avoid. [Severe] Theoretical → Also see TABLE 9 p. 876
- **Antiarhythmic drugs (propafenone)** are predicted to increase the concentration of tricyclic antidepressants. [Moderate] Theoretical → Also see TABLE 10 p. 876
- **Antiepileptics (carbamazepine)** decrease the exposure to tricyclic antidepressants. Adjust dose. [Moderate] Study → Also see TABLE 18 p. 878
- **Antiepileptics (phenobarbital, primidone)** are predicted to decrease the exposure to tricyclic antidepressants. [Moderate] Study
- **Tricyclic antidepressants (clomipramine, imipramine)** potentially increase the risk of overheating and dehydration when given with antiepileptics (zonisamide). Avoid in children. [Severe] Theoretical
- **Bupropion** is predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. [Severe] Study → Also see TABLE 13 p. 877
- **Cinacalcet** is predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. [Severe] Study
- **Tricyclic antidepressants** decrease the antihypertensive effects of clonidine. Monitor and adjust dose. [Moderate] Anecdotal → Also see TABLE 8 p. 875
- **Darifenacin** is predicted to slightly increase the exposure to tricyclic antidepressants. [Mild] Study
- **Eliquisat** is predicted to increase the exposure to tricyclic antidepressants. [Moderate] Theoretical
- **Tricyclic antidepressants** are predicted to decrease the antihypertensive effects of guanethidine. [Moderate] Study → Also see TABLE 8 p. 875
H1 receptor antagonists (cimetidine) increase the exposure to tricyclic antidepressants. [Moderate] Study

HIV-protease inhibitors (ritonavir, tipranavir) are predicted to increase the exposure to tricyclic antidepressants. [Moderate] Theoretical

Tricyclic antidepressants potentially increase the risk of neurotoxicity when given with lithium. [Severe] Anecdotal → Also see TABLE 13 p. 877. Also see TABLE 9 p. 876

Amtripryline decreases the effects of metyrapone. Avoid. [Moderate] Theoretical

Tricyclic antidepressants are predicted to increase the risk of severe toxic reaction when given with moclobemide. Avoid. [Severe] Theoretical → Also see TABLE 13 p. 877

Tricyclic antidepressants are predicted to increase the risk of severe toxic reaction when given with monoamine-oxidase A and B inhibitors, irreversible. Avoid and for 14 days after stopping the MAOI. [Severe] Theoretical → Also see TABLE 8 p. 875 → Also see TABLE 13 p. 877

Tricyclic antidepressants are predicted to decrease the effects of moxonidine. Avoid. [Moderate] Theoretical → Also see TABLE 8 p. 875

Tricyclic antidepressants are predicted to decrease the efficacy of pitolisant. [HLD] Theoretical

SSRIs (fluoxetine, paroxetine) are predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. [Severe] Study → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877

SSRIs (fluvoxamine) markedly increase the exposure to clomipramine. Adjust dose. [Severe] Study → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877

SSRIs (fluvoxamine) increase the exposure to tricyclic antidepressants (amitriptyline, imipramine). Adjust dose. [Severe] Study → Also see TABLE 18 p. 878 → Also see TABLE 13 p. 877

Sucralfate is predicted to decrease the absorption of tricyclic antidepressants. [Moderate] Study

Tricyclic antidepressants increase the effects of sympathomimetics, vasoconstrictor (adrenaline/epinephrine, norepinephrine/norepinephrine, phenylephrine). Avoid. [Severe] Study

Tricyclic antidepressants are predicted to decrease the effects of sympathomimetics, vasoconstrictor (ephedrine). Avoid. [Severe] Study

Terbutaline is predicted to increase the exposure to tricyclic antidepressants. Monitor for toxicity and adjust dose. [Severe] Study

Tricyclic antidepressants increase the risk of cardiac arrhythmias and hypotension when given with thioridazine. [Moderate] Study → Also see TABLE 8 p. 875

Trimipramine

Trimipramine potentially decreases the absorption of iron (oral). [Moderate] Theoretical

Trimipramine potentially decreases the absorption of zinc. [Moderate] Theoretical

Trifluoperazine → see phenothiazines

Trimepr俘frolide → see TABLE 10 p. 876 (antimycosics)

Trimethoprim → see TABLE 18 p. 878 (amnucosics), TABLE 2 p. 874 (nephrotoxicity), TABLE 16 p. 878 (increased serum potassium)

Trimethoprim increases the concentration of antiepileptics (fosphenytoin, phenytoin). [Moderate] Study

Antimalarials (pyrimethamine) increase the risk of side-effects when given with trimethoprim. [Severe] Study

Trimethoprim is predicted to increase the anticoagulant effect of coumarins. [Severe] Study

Dapsone increases the exposure to trimethoprim and trimethoprim increases the exposure to dapsone. [Severe] Study

Trimethoprim increases the concentration of digoxin. [Moderate] Study

Trimethoprim is predicted to increase the exposure to dopamine receptor agonists (pramipexole). Adjust dose. [Moderate] Theoretical

Trimethoprim is predicted to increase the exposure to l-DOPA. Trimethoprim slightly increases the exposure to levodopa. Avoid. [Moderate] Theoretical → Also see TABLE 2 p. 874

Trimethoprim slightly increases the exposure to repaglinide. Avoid or monitor blood glucose. [Moderate] Study

Rifampicin decreases the exposure to trimethoprim. [Moderate] Study

Trimethoprim is predicted to decrease the efficacy of saquinavir. [Moderate] Theoretical

Trimipramine → see tricyclic antidepressants

Tropicamide → see TABLE 10 p. 876 (antimycosics)

Trospleum → see TABLE 10 p. 876 (antimycosics)

Trvophanopan → see TABLE 13 p. 877 (serotonin syndrome)

Trvophanp greatly decreases the concentration of levodopa. [Moderate] Study

Trvophan greatly increases the risk of side-effects when given with monoamine-oxidase A and B inhibitors, irreversible. [Severe] Anecdotal → Also see TABLE 13 p. 877

Trvophan, oral → see live vaccines

Ulipristal

Antiarrhythmics (dronedarone) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

Antiepileptics (carbamazepine, eslicarbazepine, fosphenytoin, oxcarbazepine, perampanel, phenobarbital, phenytoin, primidone, rufinamide, topiramate) decrease the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

Aprepitant decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Bosentan decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

Cobicistat is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Severe] Study

Ulipristal is predicted to decrease the efficacy of combined hormonal contraceptives. [Severe] Theoretical

Crisotinib is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

Ulipristal is predicted to decrease the efficacy of desogestrel. Avoid. [Severe] Theoretical

Efavirenz decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Enzalutamide is predicted to markedly decrease the exposure to ulipristal. Avoid and for 4 weeks after stopping ulipristal. [Severe] Theoretical

Ulipristal is predicted to decrease the efficacy of etonogestrel. Avoid. [Severe] Theoretical

Fosaprepitant decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Griseofulvin potentially decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

HIV-protease inhibitors (atazanavir, darunavir, fosamprenavir, lopinavir, saquinavir, tipranavir) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Severe] Study

HIV-protease inhibitors (ritonavir) decrease the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Idelalisib is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

Imatinib is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. [Moderate] Study

Interactions | Appendix 1

TABLE 13

For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

Ulipristal

TABLE 2

For FSRH guidance, see Contraceptives, interactions p. 516. [Severe] Anecdotal

TABLE 8

Ulipristal

TABLE 16

TABLE 10

TABLE 18

TABLE 2

TABLE 13

TABLE 8
Ulipristal – Velpatasvir

Ulipristal (continued)

> Ulipristal is predicted to decrease the efficacy of levonorgestrel. Avoid. (Severe) Theoretical

> Lumacaftor is predicted to decrease the efficacy of ulipristal. Use additional contraceptive precautions. (Severe) Theoretical

> Macrolides (clarithromycin) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Severe) Study

> Macrolides (erythromycin) are predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study

> Modafinil decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal

> Netupitant is predicted to increase the exposure to ulipristal. Avoid if used for uterine fibroids. (Moderate) Study

> Ulipristal is predicted to decrease the efficacy of norethisterone. Avoid. (Severe) Theoretical

> Rifabutin decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal

> Rifampicin decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal

> St John’s Wort decreases the efficacy of ulipristal. For FSRH guidance, see Contraceptives, interactions p. 516. (Severe) Anecdotal

Umeclidinium → see TABLE 10 p. 876 (antimuscarinic)

Urokinase → see TABLE 3 p. 874 (anticoagulant effects)

Ursodeoxycholic acid

> Antacids are predicted to decrease the absorption of ursodeoxycholic acid. Separate administration by 2 hours. (Moderate) Theoretical

> ursodeoxycholic acid affects the concentration of ciclosporin. Use with caution and adjust dose. (Severe) Anecdotal

> Fibrates are predicted to decrease the efficacy of ursodeoxycholic acid. Avoid. (Severe) Theoretical

Ustekinumab → see monoclonal antibodies

Valaciclovir → see TABLE 2 p. 874 (nephrotoxicity)

Valdarclovir is predicted to increase the exposure to aminophylline. (Severe) Anecdotal

> Mycophenolate is predicted to increase the risk of haematological toxicity when given with valaciclovir. (Moderate) Theoretical

> Valaciclovir is predicted to increase the exposure to theophylline. (Severe) Theoretical

Valganciclovir → see TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874 (nephrotoxicity)

> Valganciclovir is predicted to increase the risk of seizures when given with carbapenems (imipenem). Avoid. (Severe) Anecdotal

> Valganciclovir is predicted to increase the exposure to didanosine. (Moderate) Study

> Mycophenolate is predicted to increase the risk of haematological toxicity when given with valganciclovir. (Moderate) Theoretical → Also see TABLE 15 p. 877

Valproate → see antiepileptics

Valstarin → see angiotensin-II receptor antagonists

Vancomycin → see TABLE 2 p. 874 (nephrotoxicity), TABLE 19 p. 878 (ototoxicity)

Vandetanib → see TABLE 9 p. 876 (QT-interval prolongation)

> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vandetanib. Avoid. (Moderate) Study

> Vandetanib is predicted to increase the risk of bleeding events when given with coumarins. (Severe) Theoretical

> Vandetanib slightly increases the exposure to digoxin. Monitor ECG and adjust dose. (Moderate) Study

> Vandetanib is predicted to increase the exposure to dopamine receptor agonists (pramipexole). Adjust dose. (Moderate) Study

> Enzalutamide is predicted to decrease the exposure to vandetanib. Avoid. (Moderate) Study

> Vandetanib increases the exposure to metformin. Monitor and adjust dose. (Moderate) Study

> Mitotane is predicted to decrease the exposure to vandetanib. Avoid. (Moderate) Study

> Vandetanib is predicted to increase the risk of bleeding events when given with phenindione. (Severe) Theoretical

> Rifampicin is predicted to decrease the exposure to vandetanib. Avoid. (Moderate) Study

Vardenafil → see phosphodiesterase type-5 inhibitors

Varicella-zoster immunoglobulin → see immunoglobulins

Varicella-zoster vaccine → see live vaccines

Vedolizumab → see monoclonal antibodies

Velpatasvir

> Velpatasvir is predicted to increase the exposure to aliskiren. (Severe) Theoretical

> Antacids are predicted to decrease the concentration of velpatasvir. Separate administration by 4 hours. (Moderate) Theoretical

> Antiarrhythmics (amiodarone) are predicted to increase the concentration of velpatasvir. Avoid or monitor. (Moderate) Theoretical

> Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to moderately decrease the exposure to velpatasvir. Avoid. (Severe) Anecdotal

> Antiepileptics (oxcarbazepine) are predicted to decrease the exposure to velpatasvir. Avoid. (Severe) Theoretical

> Velpatasvir is predicted to increase the exposure to antihistamines, non-sedating (fexofenadine). (Severe) Theoretical

> Bosentan is predicted to decrease the exposure to velpatasvir. Avoid. (Moderate) Theoretical

> Calcium salts (calcium carbonate) are predicted to decrease the concentration of velpatasvir. Separate administration by 4 hours. (Moderate) Anecdotal

> Velpatasvir is predicted to increase the exposure to colchicine. (Severe) Theoretical

> Velpatasvir increases the exposure to dabigatran. Avoid. (Severe) Study

> Velpatasvir is predicted to increase the exposure to digoxin. (Severe) Study

> Velpatasvir is predicted to increase the exposure to edoxaban. (Severe) Theoretical

> Velpatasvir is predicted to increase the exposure to everolimus. (Severe) Theoretical

> H+, receptor antagonists are predicted to decrease the concentration of velpatasvir. Adjust dose. (Moderate) Study

> HIV-protase inhibitors (tipranavir) are predicted to increase the exposure to velpatasvir. (Severe) Theoretical

> Velpatasvir is predicted to increase the exposure to loperamide. (Severe) Theoretical

> Velpatasvir is predicted to moderately decrease the exposure to velpatasvir. Avoid. (Severe) Study

> Velpatasvir is predicted to increase the exposure to voriconazole. (Severe) Theoretical

> Velpatasvir is predicted to increase the exposure to voriconazole. (Severe) Theoretical

> Velpatasvir is predicted to increase the exposure to statins (atorvastatin). Avoid. (Severe) Study

> Velpatasvir is predicted to increase the exposure to statins (rosuvastatin). Adjust rosuvastatin dose and monitor side effects, p. 135. (Severe) Study
Velpatasvir – Venetoclax 1049

- **Velpatasvir** is predicted to increase the exposure to **statins** *(simvastatin)*. Monitor side effects and adjust dose. *Severe* Theoretical
- **Velpatasvir** is predicted to increase the exposure to **sulfasalazine**. *Moderate* Theoretical
- **Velpatasvir** is predicted to increase the exposure to **taxanes** *(paclitaxel)*. *Severe* Theoretical
- **Velpatasvir** is predicted to increase the exposure to **tenofovir disoproxil**. *Severe* Study
- **Velpatasvir** is predicted to increase the exposure to **topotecan**. *Severe* Theoretical

**Vemurafenib** → see TABLE 9 p. 876 (QT-interval prolongation)

**Vemurafenib** is predicted to increase the exposure to **afatinib**. Separate administration by 12 hours. *Moderate* Study

**Vemurafenib** is predicted to increase the exposure to **alkisiren**. Use with caution and adjust dose. *Moderate* Theoretical

**Antiepileptics** *(carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)* are predicted to decrease the exposure to **vemurafenib**. Avoid. *Severe* Theoretical

**Vemurafenib** is predicted to increase the exposure to **calcium channel blockers**, non-selective *(nadolol)*. *Moderate* Study

**Vemurafenib** is predicted to increase the exposure to **bictegravir**. *Theoretical*

**Cobicistat** is predicted to increase the exposure to **colchicine**. Avoid or adjust colchicine dose. *Severe* Theoretical

**Enzalutamide** is predicted to increase the exposure to **doxorubicin**. Use with caution and adjust dose. *Severe* Theoretical

**Mitotane** is predicted to decrease the exposure to **nintedanib**. *Moderate* Study

**Vemurafenib** is predicted to increase the exposure to **panobinostat**. Adjust dose. *Moderate* Theoretical → Also see TABLE 9 p. 876

**Idelalisib** is predicted to increase the exposure to **venuramifenib**. *Severe* Theoretical

**Macrolides** *(clarithromycin)* are predicted to increase the exposure to **venuramifenib**. *Severe* Theoretical → Also see TABLE 9 p. 876

**Mitotane** is predicted to decrease the exposure to **venuramifenib**. Avoid. *Severe* Theoretical

**Vemurafenib** is predicted to increase the exposure to **panobinostat**. Adjust dose. *Moderate* Theoretical → Also see TABLE 9 p. 876

**Vemurafenib** is predicted to increase the exposure to **piperentasim**. *Moderate* Theoretical

**Rifaximin** is predicted to decrease the exposure to **venuramifenib**. Avoid. *Severe* Theoretical

**Vemurafenib** is predicted to increase the exposure to **ticagrelor**. Use with caution or avoid. *Severe* Study

**Vemurafenib** is predicted to increase the exposure to **topotecan**. *Severe* Study

**Vemurafenib** is predicted to increase the concentration of **trametinib**. *Moderate* Theoretical

**Vemurafenib** is predicted to increase the exposure to **venuramifenib**. Avoid or monitor for toxicity. *Severe* Theoretical

**Venetoclax**

**FOOD AND LIFESTYLE** Avoid Seville (bitter orange) and star fruit as they might increase the exposure to venetoclax.

**Antiarrhythmics** *(amiodarone)* are predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. *Severe* Theoretical

**Antiarrhythmics** *(dronedarone)* are predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Antiepileptics** *(carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone)* are predicted to decrease the exposure to venetoclax. Avoid. *Severe* Study

**Antifungal, azoles** *(fluconazole, itraconazole, ketoconazole, posaconazole, voriconazole)* are predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Venetoclax** is predicted to increase the exposure to **antithiastamines**, non-sedating *(fexofenadine)*. *Moderate* Theoretical

**Aprepitant** is predicted to increase the exposure to **venetoclax**. Avoid or adjust dose—consult product literature. *Severe* Study

**Venetoclax** is predicted to increase the exposure to **bosentan**. *Moderate* Theoretical

**Calcium channel blockers** *(diltiazem, verapamil)* are predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Ciclosporin** is predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. *Severe* Theoretical

**Dobutamine** is predicted to increase the exposure to **venetoclax**. Avoid or adjust dose—consult product literature. *Severe* Study

**Enzalutamide** is predicted to decrease the exposure to **everolimus**. Avoid. *Severe* Study

**Grapefruit juice** is predicted to increase the exposure to **venetoclax**. Avoid. *Severe* Theoretical

**HIV-PROTEASE INHIBITORS** are predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Idelalisib** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Imatinib** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Lapatinib** is predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. *Severe* Theoretical

**Venetoclax** potentially decreases the efficacy of **live vaccines**. Avoid. *Severe* Theoretical

**Macrolides** *(clarithromycin, erythromycin)* are predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Mitotane** is predicted to decrease the exposure to venetoclax. Avoid. *Severe* Study

**Netupitant** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Nevirapine** is predicted to decrease the exposure to venetoclax. Avoid. *Severe* Study

**Nilotinib** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Dabigatran** is predicted to increase the exposure to venetoclax. Avoid or adjust dose—consult product literature. *Severe* Study

**Ranolazine** is predicted to increase the exposure to venetoclax. Avoid or monitor for toxicity. *Severe* Theoretical

**Venetoclax** is predicted to increase the exposure to **repaglinide**. *Moderate* Theoretical

**Rifampicin** is predicted to decrease the exposure to venetoclax. *Severe* Study

**Simvastatin** *(atorvastatin)*. *Moderate* Study

**Venetoclax** is predicted to increase the exposure to **sirolimus**. Avoid or adjust dose. *Severe* Study

**St John’s Wort** is predicted to decrease the exposure to **venetoclax**. Avoid. *Severe* Study

**Venetoclax** is predicted to increase the exposure to **statins** *(atorvastatin)*. *Moderate* Study

**Venetoclax** is predicted to increase the exposure to **statins** *(fluvastatin, pravastatin, rosuvastatin, simvastatin)*. *Moderate* Theoretical
Venotecax (Venoclat) (continued)

- Venotecax is predicted to increase the exposure to sulfasalazine. Moderate Theoretical
- Venotecax is predicted to increase the exposure to sulfisoxazole (glitazone). Moderate Theoretical
- Venotecax is predicted to increase the exposure to topotecan. Moderate Theoretical
- Vemurafenib is predicted to increase the exposure to venotecax. Avoid or monitor for toxicity. Severe Theoretical
- Venlafaxine is predicted to increase the exposure to venotecax. See TABLE 13 p. 877 (serotonin syndrome), TABLE 9 p. 876 (QT-interval prolongation), TABLE 11 p. 876 (CNS depressant effects), TABLE 4 p. 876 (antiplatelet effects)
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to venlafaxine. Moderate Study → Also see TABLE 9 p. 876
- Cobimetap is predicted to increase the exposure to venlafaxine. Moderate Study
- H2 receptor antagonists (cimetidine) slightly increase the exposure to venlafaxine. Mild Study
- Venlafaxine slightly increases the exposure to haloperidol. Severe Study → Also see TABLE 9 p. 876. Also see TABLE 11 p. 876
- H1-antihistamines are predicted to increase the exposure to venlafaxine. (Moderate) Study → Also see TABLE 9 p. 876
- Macrolides (clarithromycin) are predicted to increase the exposure to venlafaxine. Moderate Study → Also see TABLE 9 p. 876
- Venlafaxine is predicted to increase the exposure to pitolisant. Use with caution and adjust dose. Mild Theoretical
- Tacrolimus potentially increases the risk of serotonin syndrome when given with venlafaxine. Severe Anecdotal
- Verapamil → see calcium channel blockers

Verotep

GENERAL INFORMATION Caution on concurrent use with other photosensitising drugs.

Vigabatrin → see antiepileptics
- Vilanterol → see beta, agonists
Vildagliptin → see TABLE 14 p. 877 (antidiabetic drugs)
- Vinblastine → see vinca alkaloids
- Vinca alkaloids → see TABLE 1 p. 874 (hepatotoxicity), TABLE 15 p. 877 (myelosuppression), TABLE 19 p. 878 (ototoxicity), TABLE 12 p. 877 (peripheral neuropathy), TABLE 5 p. 877 (thromboembolism), TABLE 9 p. 876 (QT-interval prolongation)
- Vinblastine, vincristine, vindesine, vinflunine, vinorelbine
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 9 p. 876
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 12 p. 877
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vincristine, vindesine. Severe Theoretical → Also see TABLE 12 p. 877
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vinorelbine. Use with caution or avoid. Severe Theoretical → Also see TABLE 12 p. 877
- Antifungals, azoles (fluconazole, isavuconazole, itraconazole, ketoconazole, posaconazole, voriconazole) are predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 1 p. 874. Also see TABLE 12 p. 877
- Antifungals, azoles (miconazole) are predicted to increase the concentration of vinca alkaloids. Use with caution and adjust dose. Moderate Theoretical
- Aprepitant is predicted to increase the exposure to vinca alkaloids. Severe Theoretical
- Asparaginase potentially increases the risk of neurotoxicity when given with vincristine. Vincristine should be taken 3 to 24 hours before asparaginase. Severe Anecdotal → Also see TABLE 1 p. 874. Also see TABLE 15 p. 877
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to vinca alkaloids. Severe Theoretical
- Cobicistat is predicted to increase the exposure to vinca alkaloids. Severe Theoretical
- Crisantaspase potentially increases the risk of neurotoxicity when given with vincristine. Vincristine should be taken 3 to 24 hours before crisantaspase. Severe Anecdotal → Also see TABLE 1 p. 874. Also see TABLE 15 p. 877
- Crizotinib is predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 15 p. 877. Also see TABLE 9 p. 876
- Enzalutamide is predicted to decrease the exposure to vinca alkaloids (vinblastine, vincristine, vindesine). Severe Theoretical
- Enzalutamide is predicted to decrease the exposure to vinflunine. Avoid. Severe Theoretical
- Enzalutamide is predicted to decrease the exposure to vinorelbine. Use with caution or avoid. Severe Theoretical
- Fosaprepitant is predicted to increase the exposure to vinca alkaloids. Severe Theoretical
- HIV-protease inhibitors are predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 9 p. 876
- Idenalisib is predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 15 p. 877
- Imatinib is predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 15 p. 877
- Live vaccines are predicted to increase the risk of generalised infection (possibly life-threatening) when given with vinca alkaloids. Public Health England advises avoid (refer to Green Book). Severe Theoretical
- Macrolides (clarithromycin, erythromycin) are predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 9 p. 876
- Mitotane is predicted to decrease the exposure to vinca alkaloids (vinblastine, vincristine, vindesine). Severe Theoretical → Also see TABLE 15 p. 877
- Mitotane is predicted to decrease the exposure to vinflunine. Avoid. Severe Theoretical
- Mitotane is predicted to decrease the exposure to vinorelbine. Use with caution or avoid. Severe Theoretical → Also see TABLE 15 p. 877
- Netupitant is predicted to increase the exposure to vinca alkaloids. Severe Theoretical
- Nilotinib is predicted to increase the exposure to vinca alkaloids. Severe Theoretical → Also see TABLE 15 p. 877. Also see TABLE 9 p. 876
- Pegaspargase potentially increases the risk of neurotoxicity when given with vincristine. Vincristine should be taken 3 to 24 hours before pegaspargase. Severe Anecdotal → Also see TABLE 1 p. 874. Also see TABLE 15 p. 877
- Rifampicin is predicted to decrease the exposure to vinca alkaloids (vinblastine, vincristine, vindesine). Severe Theoretical
- Rifampicin is predicted to decrease the exposure to vinflunine. Avoid. Severe Theoretical
- Rifampicin is predicted to decrease the exposure to vinorelbine. Use with caution or avoid. Severe Theoretical

Vincristine → see vinca alkaloids
- Vinflunine → see vinca alkaloids
- Vinorelbine → see vinca alkaloids

Vismodegib → see TABLE 15 p. 877 (myelosuppression)
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to vismodegib. Avoid. (Moderate) Theoretical
- Enzalutamide is predicted to decrease the exposure to vismodegib. Avoid. (Moderate) Theoretical
- Mitotane is predicted to decrease the exposure to vismodegib. Avoid. (Moderate) Theoretical
- St John’s Wort is predicted to decrease the exposure to vismodegib. Avoid. (Moderate) Theoretical

Vitamin A
- Retinoids (acitretin, alitretinoin, isotretinoin) are predicted to increase the risk of vitamin A toxicity when given with vitamin A. Avoid. Severe Theoretical
Vitamin A - Yellow fever vaccine, live

Voxilaprevir
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Study
- Antiepileptics (oxcarbazepine) are predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Bosentan is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Ciclosporin increases the concentration of voxilaprevir. Avoid. (Severe) Study
- Combined hormonal contraceptives (containing ethinylestradiol) are predicted to increase the risk of increased ALT concentrations when given with voxilaprevir (with sofosbuvir and velpatasvir). Avoid. (Severe) Study
- Voxilaprevir (with sofosbuvir and velpatasvir) increases the concentration of dabigatran. Avoid. (Severe) Study
- Voxilaprevir (with sofosbuvir and velpatasvir) is predicted to increase the exposure to digoxin. Monitor and adjust dose. (Severe) Theoretical
- Voxilaprevir (with sofosbuvir and velpatasvir) is predicted to increase the concentration of edoxaban. Avoid. (Severe) Theoretical
- Efavirenz is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Enzalutamide is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Study
- HIV-protease inhibitors (atazanavir boosted with ritonavir) increase the concentration of voxilaprevir. Avoid. (Severe) Study
- HIV-protease inhibitors (lopinavir boosted with ritonavir) are predicted to increase the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- HIV-protease inhibitors (tipranavir boosted with ritonavir) are predicted to increase the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Mitotane is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Study
- Modafinil is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Nevirapine is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Proton pump inhibitors are predicted to decrease the exposure to voxilaprevir. Adjust dose. (Moderate) Study
- Rifabutin is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Nevirapine is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Proton pump inhibitors are predicted to decrease the exposure to voxilaprevir. Adjust dose. (Moderate) Study
- Rifabutin is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Rifampicin is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Study
- St John’s Wort is predicted to decrease the concentration of voxilaprevir. Avoid. (Severe) Theoretical
- Voxilaprevir is predicted to increase the exposure to statins (atorvastatin). Avoid. (Moderate) Theoretical
- Voxilaprevir (with sofosbuvir and velpatasvir) is predicted to increase the exposure to statins (fluvastatin, simvastatin). Avoid. (Moderate) Theoretical
- Voxilaprevir (with sofosbuvir and velpatasvir) moderately increases the exposure to statins (pravastatin). Monitor and adjust pravastatin dose. (Moderate) Study
- Voxilaprevir (with sofosbuvir and velpatasvir) markedly increases the exposure to statins (rosuvastatin). Avoid. (Severe) Study
- Voxilaprevir is predicted to increase the concentration of sulfasalazine. Avoid. (Severe) Theoretical
- Voxilaprevir (with sofosbuvir and velpatasvir) potentially increases the concentration of tenofovir disoproxil. (Severe) Study
- Voxilaprevir is predicted to increase the concentration of topotecan. Avoid. (Severe) Theoretical
- Warfarin → see coumarins

Wasp venom extract

GENERAL INFORMATION Desensitising vaccines should be avoided in patients taking beta-blockers (adrenaline might be ineffective in case of a hypersensitivity reaction) or ACE inhibitors (risk of severe anaphylactoid reactions).
Zidovudine → see TABLE 15 p. 877 (myelosuppression), TABLE 2 p. 874 (nephrotoxicity)
- Anti-epileptics (valproate) slightly increase the exposure to zidovudine. [Moderate] Study
- Antifungals, azoles (fluconazole) slightly increase the exposure to zidovudine. [Moderate] Study
- Antimalarials (pyrimethamine) are predicted to increase the risk of side-effects when given with zidovudine. [Severe] Theoretical → Also see TABLE 15 p. 877
- Zidovudine increases the risk of haematological toxicity when given with asparin (high-dose). [Severe] Study
- Zidovudine increases the risk of haematological toxicity when given with fluycostine. Monitor and adjust dose. [Severe] Theoretical

Zinc
ROUTE-SPECIFIC INFORMATION Interactions do not generally apply to topical use unless specified.
- Oral zinc decreases the absorption of oral bisphosphonates (alendronic acid). Zinc should be taken at least 50 minutes before alendronic acid. [Moderate] Study
- Oral zinc is predicted to decrease the absorption of oral bisphosphonates (ibandronic acid). Avoid zinc for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical
- Oral zinc decreases the absorption of oral bisphosphonates (risedronate). Separate administration by at least 2 hours. [Moderate] Study
- Oral zinc decreases the absorption of oral bisphosphonates (sodium clodronate). Avoid zinc for 2 hours before or 1 hour after sodium clodronate. [Moderate] Study
- Oral calcium salts decrease the absorption of zinc. [Moderate] Study
- Oral zinc is predicted to decrease the absorption of etrombopag. Etrombopag should be taken 2 hours before or 4 hours after zinc. [Severe] Theoretical
- Zinc is predicted to decrease the efficacy of iron (oral) and iron (oral) is predicted to decrease the efficacy of zinc. [Moderate] Study
- Zinc is predicted to decrease the absorption of penicillamine. [Mild] Theoretical
- Zinc is predicted to decrease the exposure to quinolones. Separate administration by 2 hours. [Moderate] Study
- Oral zinc is predicted to decrease the absorption of tetracyclines. Separate administration by 2 to 3 hours. [Moderate] Theoretical
- Trientine potentially decreases the absorption of zinc. [Moderate] Theoretical
- Zoledronic acid → see bisphosphonates
- Zolmitriptan → see TABLE 13 p. 877 (serotonin syndrome)
- Combined hormonal contraceptives are predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical
- H<sub>1</sub> receptor antagonists (cimetidine) slightly increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Mild] Study
- Mexiletine is predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical
- Moroebemide slightly increases the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Study → Also see TABLE 13 p. 877
- Monoamine-oxidase A and B inhibitors, irreversible are predicted to increase the exposure to zolmitriptan. [Severe] Theoretical → Also see TABLE 13 p. 877
- Quinolones (ciprofloxacin) are predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical
- SSRI (fluvoxamine) are predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Severe] Theoretical → Also see TABLE 13 p. 877
- Zolpidem → see TABLE 11 p. 876 (CNS depressant effects)
- Antiepileptics (carbamazepine) moderately decrease the exposure to zolpidem. [Moderate] Study
- Rifampicin moderately decreases the exposure to zolpidem. [Moderate] Study
- Zonisamide → see antiepileptics
- Zopiclone → see TABLE 11 p. 876 (CNS depressant effects)
- Antiarrhythmics (dronedarone) are predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Antiepileptics (carbamazepine, fosphenytoin, phenobarbital, phenytoin, primidone) are predicted to decrease the exposure to zopiclone. Adjust dose. [Moderate] Study → Also see TABLE 11 p. 876
- Antifungals, azoles (fluconazole, isavuconazole, posaconazole) are predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Antifungals, azoles (itraconazole, ketoconazole, voriconazole) are predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Theoretical
- Aprapentin is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Calcium channel blockers (diltiazem, verapamil) are predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Cobicistat is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Theoretical
- Crizotinib is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Enalaprilate is predicted to decrease the exposure to zopiclone. Adjust dose. [Moderate] Study
- HIV-protease inhibitors (tipranavir) are predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Idelalisib is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Theoretical
- Milotane is predicted to decrease the exposure to zopiclone. Adjust dose. [Moderate] Study
- Mexiletine is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Nilotinib is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Zuclopenthixol is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Zuclopenthixol is predicted to increase the exposure to zopiclone. Adjust dose. [Moderate] Study
- Zidovudine decreases the efficacy of stavudine. Avoid. [Severe] Theoretical
- Teriflunomide is predicted to increase the exposure to zidovudine. [Moderate] Theoretical
- Ribavirin increases the risk of anaemia and/or leucopenia when given with zidovudine. Avoid. [Severe] Study

Leflunomide is predicted to increase the exposure to stavudine. Avoid. [Severe] Theoretical
- Teriflunomide is predicted to increase the exposure to stavudine. [Moderate] Theoretical
- Macrolides (clarithromycin) decrease the absorption of zidovudine. Separate administration by at least 2 hours. [Moderate] Study
- Nevirapine is predicted to decrease the concentration of zidovudine. Refer to specialist literature. [Severe] Theoretical
- Zidovudine increases the risk of haematological toxicity when given with lamivudine. [Severe] Aneotald.
- Macrolides (clarithromycin) decrease the absorption of zidovudine. Separate administration by at least 2 hours. [Moderate] Study
- Oral zinc decreases the absorption of oral bisphosphonates (ibandronic acid). Avoid zinc for at least 6 hours before or 1 hour after ibandronic acid. [Moderate] Theoretical
- Oral zinc decreases the absorption of oral bisphosphonates (risedronate). Separate administration by at least 2 hours. [Moderate] Study
- Oral zinc decreases the absorption of oral bisphosphonates (sodium clodronate). Avoid zinc for 2 hours before or 1 hour after sodium clodronate. [Moderate] Study
- Oral calcium salts decrease the absorption of zinc. [Moderate] Study
- Oral zinc is predicted to decrease the absorption of etrombopag. Etrombopag should be taken 2 hours before or 4 hours after zinc. [Severe] Theoretical
- Zinc is predicted to decrease the efficacy of iron (oral) and iron (oral) is predicted to decrease the efficacy of zinc. [Moderate] Study
- Zinc is predicted to decrease the absorption of penicillamine. [Mild] Theoretical
- Zinc is predicted to decrease the exposure to quinolones. Separate administration by 2 hours. [Moderate] Study
- Oral zinc is predicted to decrease the absorption of tetracyclines. Separate administration by 2 to 3 hours. [Moderate] Theoretical
- Trientine potentially decreases the absorption of zinc. [Moderate] Theoretical
- Zoledronic acid → see bisphosphonates
- Zolmitriptan → see TABLE 13 p. 877 (serotonin syndrome)
- Combined hormonal contraceptives are predicted to increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Moderate] Theoretical
- H<sub>1</sub> receptor antagonists (cimetidine) slightly increase the exposure to zolmitriptan. Adjust zolmitriptan dose, p. 300. [Mild] Study

Zinc
Appendix 2
Borderline substances

CONTENTS

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</table>

In certain conditions some foods (and toilet preparations) have characteristics of drugs and the Advisory Committee on Borderline Substances (ACBS) advises as to the circumstances in which such substances may be regarded as drugs. Prescriptions issued in accordance with the Committee’s advice and endorsed ‘ACBS’ will normally not be investigated.

Information
General Practitioners are reminded that the ACBS recommends products on the basis that they may be regarded as drugs for the management of specified conditions. Doctors should satisfy themselves that the products can safely be prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available.

Foods which may be prescribed on FP10, GP10 (Scotland), or WP10 (Wales)
All the food products listed in this appendix have ACBS approval. The clinical condition for which the product has been approved is included with each entry.

Note
Foods included in this appendix may contain cariogenic sugars and patients should be advised to take appropriate oral hygiene measures.

Enteral feeds and supplements
For most enteral feeds and nutritional supplements, the main source of carbohydrate is either maltodextrin or glucose syrup; other carbohydrate sources are listed in the relevant table, below. Feeds containing residual lactose (less than 1 g lactose/100 mL formula) are described as ‘clinically lactose-free’ or ‘lactose-free’ by some manufacturers. The presence of lactose (including residual lactose) in feeds is indicated in the relevant table, below. The primary sources of protein or amino acids are included with each product entry. The fat or oil content is derived from a variety of sources such as vegetables, soya bean, corn, palm nuts, and seeds; where the fat content is derived from animal or fish sources, this information is included in the relevant table, below. The presence of medium chain triglycerides (MCT) is also noted where the quantity exceeds 30% of the fat content.

Enteral feeds and nutritional supplements can contain varying amounts of vitamins, minerals, and trace elements—the manufacturer’s product literature should be consulted for more detailed information. Feeds containing vitamin K may affect the INR in patients receiving warfarin; see Interactions: Appendix 1: enteral feeds.

The suitability of food products for patients requiring a vegan, kosher, halal, or other compliant diet should be confirmed with individual manufacturers.

Note
Feeds containing more than 5 g/100 mL protein or 2 g/100 mL fibre should be avoided in children unless recommended by an appropriate specialist or dietician.

Nutritional values
Nutritional values of products vary with flavour and pack size—consult product literature.

Paediatric ACBS indications: Disease-related malnutrition, intractable malabsorption, growth failure, pre-operative preparation of malnourished patients, dysphagia, short-bowel syndrome, bowel fistula
Standard ACBS indications: Disease-related malnutrition, intractable malabsorption, pre-operative preparation of malnourished patients, dysphagia, proven inflammatory bowel disease, following total gastrectomy, short-bowel syndrome, bowel fistula

Other conditions for which ACBS products can be prescribed
This is a list of clinical conditions for which the ACBS has approved toilet preparations.

Dermatitis, Eczema and Pruritus
Aveeno® Cream; Aveeno® Lotion; E45® Emollient Bath Oil; E45® Emollient Wash Cream

Disfiguring skin lesions (birthmarks, mutilating lesions, scars, vitiligo)
Covermark® classic foundation and finishing powder; Dermacolor® Camouflage cream and fixing powder; Keromask® finishing powder and masking cream; Veil®
Cover cream and Finishing Powder. (Cleansing Creams, Cleansing Milks, and Cleansing Lotions are excluded).

**Disinfectants (antiseptics)**

May be prescribed on an FP10 only when ordered in such quantities and with such directions as are appropriate for the treatment of patients, but not if ordered for general hygienic purposes.

**Dry mouth (xerostomia)**

For patients suffering from dry mouth as a result of having (or having undergone) radiotherapy, or sicca syndrome.

*AS Saliva Orthana®*, *Biotène Oralbalance®*, *Glandosane®*, *Saliveze®*

**Photodermatoses (skin protection in)**

*LA Roche-Posay Anthelios®* XL SPF 50+ cream; *Sunsense®* Ultra (Ego) SPF 50+; *Uvistat®* Lipscreen SPF 50, *Uvistat®* Suncream SPF 30 and 50

Prices quoted in Appendix 2 are basic NHS net prices; for further information see Prices in BNFC.
### Table 1 Enteral feeds (non-disease specific)

**Enteral feeds: 1 kcal/mL and less than 5 g protein/100 mL**

Not suitable for use in child under 1 year unless otherwise stated; not recommended for child 1-6 years

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresubin® 1500 Complete</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kcal</td>
<td>3.8 g</td>
<td>13 g (sugars 0.9 g)</td>
<td>3.4 g</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula and pre-operative preparation of malnourished patients. Not suitable for child under 2 years</td>
<td>Fresubin 1500 Complete liquid: 1.5 litre = £14.58</td>
</tr>
<tr>
<td>Fresubin® Original</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>420 kcal</td>
<td>3.8 g</td>
<td>13.8 g (sugars 3.5 g)</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Contains fish gelatin Feed in flexible pack contains fish oil and fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin Original drink: blackcurrant, chocolate, nut, peach, vanilla 200 ml = £2.36; Fresubin Original tube feed liquid: 500 ml = £4.57; 1000 ml = £9.07; 1500 ml = £13.60</td>
</tr>
<tr>
<td>Fresubin® Original Fibre</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kcal</td>
<td>3.8 g</td>
<td>13 g (sugars 0.9 g)</td>
<td>3.4 g</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula and pre-operative preparation of malnourished patients. Not suitable for child under 2 years</td>
<td>Fresubin Original Fibre liquid: 500 ml = £5.18; 1000 ml = £10.34</td>
</tr>
<tr>
<td>Jevity® (Abbott Laboratories Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>449 kcal</td>
<td>4 g caseinates</td>
<td>14.1 g (sugars 470 mg)</td>
<td>3.47 g</td>
<td>1.76 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula. Not suitable for child under 2 years</td>
<td>Jevity liquid: 500 ml = £5.83; 1000 ml = £10.99; 1500 ml = £16.45</td>
</tr>
<tr>
<td>Nutrison® (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kcal</td>
<td>4 g cows’ milk</td>
<td>12.3 g (sugars 1 g)</td>
<td>3.9 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Nutrison liquid: 500 ml = £5.39; 1000 ml = £9.47; 1500 ml = £14.20</td>
</tr>
<tr>
<td>Nutrison® Multi Fibre (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kcal</td>
<td>4 g cows’ milk</td>
<td>12.3 g (sugars 1 g)</td>
<td>3.9 g</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula</td>
<td>Nutrison Multi Fibre liquid: 500 ml = £5.47; 500 ml = £5.83; 1000 ml = £10.97; 1500 ml = £16.43</td>
</tr>
<tr>
<td>Osmolite® (Abbott Laboratories Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>424 kcal</td>
<td>4 g caseinates soy isolate</td>
<td>13.6 g (sugars 630 mg)</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Osmolite liquid: 500 ml = £5.40; 1000 ml = £9.48; 1500 ml = £14.22</td>
</tr>
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</table>
## SOYA PROTEIN FORMULA

<table>
<thead>
<tr>
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<th>Formulation</th>
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<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresubin® Soya Fibre (Fresenius Kabi Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3.8 g soya protein</td>
<td>13.3 g (sugars 4.1 g)</td>
<td>3.6 g</td>
<td>2 g</td>
<td>Gluten-free Lactose-free Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054; also cows’ milk protein intolerance, lactose intolerance</td>
<td>Fresubin Soya Fibre liquid: 500 ml = £5.35</td>
</tr>
<tr>
<td>Nutrison® Soya (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>4 g soy isolate</td>
<td>12.3 g (sugars 1 g)</td>
<td>3.9 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Milk protein-free</td>
<td>Borderline substances standard ACBS indications p. 1054; also cows’ milk protein and lactose intolerance</td>
<td>Nutrison Soya liquid: 500 ml = £5.82; 1000 ml = £11.66</td>
</tr>
<tr>
<td>Nutrison® Soya Multi Fibre (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>4 g soy isolate</td>
<td>12.3 g (sugars 700 mg)</td>
<td>3.9 g</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose Milk protein-free</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula; also cows’ milk protein and lactose intolerance</td>
<td>Nutrison Soya Multi Fibre liquid: 1.5 litre = £19.39</td>
</tr>
</tbody>
</table>

## PEPTIDE-BASED FORMULA

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrison Peptisorb® (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>425 kJ (100 kcal)</td>
<td>4 g whey protein hydrolysate</td>
<td>17.6 g (sugars 1.7 g)</td>
<td>1.7 g (MCT 47 %)</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Short bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula</td>
<td>Nutrison Peptisorb liquid: 500 ml = £7.72; 500 ml = £8.49; 1000 ml = £15.30</td>
</tr>
<tr>
<td>Peptamen® (Nestle Health Science)</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>4 g whey peptides</td>
<td>12.7 g (sugars 480 mg)</td>
<td>3.7 g (MCT 70 %)</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Short bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula</td>
<td>Peptamen liquid: vanilla 800 ml = £13.04; unflavoured 500 ml = £7.33; 1000 ml = £13.76</td>
</tr>
<tr>
<td>Survived® OPD (Fresenius Kabi Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>4.5 g whey protein hydrolysate</td>
<td>14.3 g (sugars 1.1 g)</td>
<td>2.8 g (MCT 51 %)</td>
<td>0.1 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054; also growth failure</td>
<td>Survived OPD: liquid 500 ml = £7.64; 800 ml = £13.56; 1000 ml = £15.28; NH liquid 500 ml = £7.36</td>
</tr>
</tbody>
</table>

## Enteral feeds: Less than 1 kcal/mL and less than 5 g protein/100 mL

### AMINO ACID FORMULA (ESSENTIAL AND NON-ESSENTIAL AMINO ACIDS)
Not suitable for use in child under 1 year; not recommended for child 1-6 years

<table>
<thead>
<tr>
<th>Product</th>
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<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elemental 028® Extra (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>360 kJ (86 kcal)</td>
<td>2.5 g (protein equivalent)</td>
<td>11 g (sugars 4.7 g)</td>
<td>3.5 g (MCT 35 %)</td>
<td>Nil</td>
<td></td>
<td>Short bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula</td>
<td>Elemental 028 extra liquid: grapefruit, orange &amp; pineapple, summer fruits 250 ml = £3.99</td>
</tr>
<tr>
<td>Standard dilution (20 %) of powder (sip or tube feed) per 100 mL</td>
<td>374 kJ (89 kcal)</td>
<td>2.5 g (protein equivalent)</td>
<td>11.8 g (sugars 1.8 g)</td>
<td>3.5 g (MCT 35 %)</td>
<td>Nil</td>
<td></td>
<td>Short bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula,</td>
<td>Elemental 028 Extra powder: banana, orange, plain 100 gram = £7.75</td>
<td></td>
</tr>
</tbody>
</table>

Powder provides protein equivalent 12.5 g, carbohydrate 59 g, fat 17.45 g, energy 1871 kJ (443 kcal)/100 g. To flavour unfavoured products, see Modjul® Flavour System p. 1082.

Borderline substances Appendix 2
### Enteral feeds (non-disease specific): 5 g (or more) protein/100 mL

#### Enteral feeds: 1.5 kcal/mL and 5 g (or more) protein/100 mL

Not suitable for use in child under 1 year unless otherwise stated; not recommended for child 1-6 years unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresubin® 2250 Complete</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>630 kJ</td>
<td>5.6 g</td>
<td>18.5 g</td>
<td>5.8</td>
<td>2 g</td>
<td>Gluten-free Residual lactose Contains fish oil and fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin 2250 complete liquid: 1.5 litre = £16.28</td>
</tr>
<tr>
<td>(Fresenius Kabi Ltd)</td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td>(1.5 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresubin® Energy</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>630 kJ</td>
<td>5.6 g</td>
<td>18.8 g</td>
<td>5.8</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Contains fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin Energy liquid: banana, blackcurrant, cappuccino, chocolate, lemon, strawberry, tropical fruits, unflavoured; vanilla 200 mL = £1.40; 500 mL = £5.60</td>
</tr>
<tr>
<td>(Fresenius Kabi Ltd)</td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fresubin Energy liquid: 1000 mL = £11.01; 1500 mL = £14.77</td>
</tr>
<tr>
<td></td>
<td>Liquid (tube feed) per 100 mL</td>
<td>630 kJ</td>
<td>5.6 g</td>
<td>18.8 g</td>
<td>5.8</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Contains fish oil and fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin Energy Fibre liquid: banana, caramel, cherry, chocolate, strawberry 200 mL = £2.20</td>
</tr>
<tr>
<td></td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fresubin Energy Fibre liquid unflavoured: 500 mL = £6.14; 1000 mL = £11.73; 1500 mL = £15.68</td>
</tr>
<tr>
<td>Fresubin® Energy Fibre</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>630 kJ</td>
<td>5.6 g</td>
<td>18.8 g</td>
<td>5.8</td>
<td>2 g</td>
<td>Gluten-free Residual lactose Contains fish oil and fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin Energy Fibre liquid: 500 mL = £5.71; 1000 mL = £11.42</td>
</tr>
<tr>
<td>(Fresenius Kabi Ltd)</td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquid (tube feed) per 100 mL</td>
<td>630 kJ</td>
<td>5.6 g</td>
<td>18.8 g</td>
<td>5.8</td>
<td>2 g</td>
<td>Gluten-free Residual lactose Contains fish oil and fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin HP Energy liquid: 500 mL = £3.10; 1000 mL = £5.71</td>
</tr>
<tr>
<td></td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jevity® 1.5 kcal</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>649 kJ</td>
<td>6.38 g</td>
<td>20.1 g</td>
<td>4.9</td>
<td>2.2 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Jevity 1.5 kcal liquid: 500 mL = £6.98; 1000 mL = £13.15; 1500 mL = £20.29</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>(154 kcal)</td>
<td>casenates and soy isolate</td>
<td>(sugars)</td>
<td>(1.47 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrison® Energy</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>630 kJ</td>
<td>6 g</td>
<td>18.5 g</td>
<td>5.8</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Nutrison Energy liquid: 500 mL = £5.87 (bottle); 500 mL = £6.28; 1000 mL = £11.82; 1500 mL = £17.58</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td>(1.5 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrison® Energy Multi</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>630 kJ</td>
<td>6 g</td>
<td>18.5 g</td>
<td>5.8</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Nutrison Multi Fibre liquid: 500 mL = £6.57 (bottle); 500 mL = £6.17; 1000 mL = £12.35; 1500 mL = £20.25</td>
</tr>
<tr>
<td>Fibre (Nutricia Ltd)</td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td>(1.5 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osmolite® 1.5 kcal</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>632 kJ</td>
<td>6.25 g</td>
<td>20 g</td>
<td>5</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Osmolite 1.5 kcal tube feed liquid: 500 mL = £6.28; 1000 mL = £11.84; 1500 mL = £17.71</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>(150 kcal)</td>
<td>(cows' milk) soya protein isolate</td>
<td>(sugars)</td>
<td>(4.9 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource® Energy</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>630 kJ</td>
<td>5.6 g</td>
<td>21 g</td>
<td>5</td>
<td>less than 0.5 g</td>
<td>Gluten-free Residual lactose Not suitable for use in child under 3 years</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Resource Energy liquid: apricot, banana, chocolate, coffee, strawberry &amp; raspberry, vanilla 800 mL = £8.24</td>
</tr>
<tr>
<td>(Nestle Health Science)</td>
<td>(150 kcal)</td>
<td>(cows' milk)</td>
<td>(sugars)</td>
<td>(5.2 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product</td>
<td>Formulation</td>
<td>Energy (kJ/100mL)</td>
<td>Protein</td>
<td>Carbohydrate</td>
<td>Fat</td>
<td>Fibre</td>
<td>Special Characteristics</td>
<td>ACBS Indications</td>
<td>Presentation &amp; Flavour</td>
</tr>
<tr>
<td>--------------------------</td>
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<td>------------------</td>
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<td>--------------------------</td>
<td>------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Fresubin® 1000 Complete</td>
<td>Liquid (tube feed)</td>
<td>420 (100kcal)</td>
<td>5.5g</td>
<td>12.5g (sugars 1.1g)</td>
<td>3.1</td>
<td>2</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin 1000 Complete liquid: 1 litre = £11.73</td>
</tr>
<tr>
<td>(Fresenius Kabi Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresubin® 1200 Complete</td>
<td>Liquid (tube feed)</td>
<td>500 (120kcal)</td>
<td>6g</td>
<td>15g (sugars 1.22g)</td>
<td>4.1</td>
<td>2</td>
<td>Gluten-Free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin 1200 Complete liquid: 1 litre = £14.93</td>
</tr>
<tr>
<td>(Fresenius Kabi Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresubin® 1800 Complete</td>
<td>Liquid (tube feed)</td>
<td>500 (120kcal)</td>
<td>6g</td>
<td>15g (sugars 1.22g)</td>
<td>4.1</td>
<td>2</td>
<td>Gluten-Free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Fresubin 1800 Complete liquid: 1.5 litre = £14.93</td>
</tr>
<tr>
<td>(Fresenius Kabi Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jevity® Plus</td>
<td>Liquid (tube feed)</td>
<td>514 (122kcal)</td>
<td>5.5g</td>
<td>15.1g (sugars 0.89g)</td>
<td>3.93</td>
<td>2.2</td>
<td>Gluten-Free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 Not suitable for child under 2 years; not recommended for children 2-10 years</td>
<td>Jevity Plus liquid: 500 ml = £6.99; 1000 ml = £12.73; 1500 ml = £19.03</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>caseinates soy isolates</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Jevity® Plus HP</td>
<td>Liquid (tube feed)</td>
<td>551 (131kcal)</td>
<td>8.13g</td>
<td>14.2g (sugars 0.95g)</td>
<td>4.33</td>
<td>1.5</td>
<td>Gluten-Free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis Not suitable for child under 2 years; not recommended for children 2-10 years</td>
<td>Jevity Plus HP gluten free liquid: 500 ml = £6.85</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk soy isolates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jevity® Promote</td>
<td>Liquid (tube feed)</td>
<td>434 (103kcal)</td>
<td>5.55g</td>
<td>12g (sugars 0.67g)</td>
<td>3.32</td>
<td>1.7</td>
<td>Gluten-Free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 Not suitable for child under 2 years; not recommended for children 2-10 years</td>
<td>Jevity Promote liquid: 1 litre = £12.18</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>caseinates soy isolates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrison® 800</td>
<td>Liquid (tube feed)</td>
<td>345 (83kcal)</td>
<td>5.5g</td>
<td>8.8g (sugars 0.6g)</td>
<td>2.5</td>
<td>1.5</td>
<td>Gluten-Free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula Not suitable for child under 6 years; not recommended for children 6-12 years</td>
<td>Nutrison 800 Complete Multi Fibre liquid: 1 litre = £11.47</td>
</tr>
<tr>
<td>Complete Multi Fibre</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk pea protein soya protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(Nutricia Ltd)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrison® 1000</td>
<td>Liquid (tube feed)</td>
<td>420 (100kcal)</td>
<td>5.5g</td>
<td>11.3g (sugars 0.7g)</td>
<td>3.7</td>
<td>2</td>
<td>Gluten-Free Residual lactose</td>
<td>Disease related malnutrition in patients with low energy and/or low fluid requirements</td>
<td>Nutrison 1000 Complete Multi Fibre liquid: 1 litre = £12.17</td>
</tr>
<tr>
<td>Complete Multi Fibre</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Nutrison® 1200</td>
<td>Liquid (tube feed)</td>
<td>505 (120kcal)</td>
<td>5.5g</td>
<td>15g (sugars 1.2g)</td>
<td>4.3</td>
<td>2</td>
<td>Gluten-Free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula</td>
<td>Nutrison 1200 Complete Multi Fibre liquid: 1000 ml = £12.87; 1500 ml = £19.33</td>
</tr>
<tr>
<td>Complete Multi Fibre</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrison® MCT</td>
<td>Liquid (tube feed)</td>
<td>420 (100kcal)</td>
<td>5g</td>
<td>12.6g (sugars 1g)</td>
<td>3.3</td>
<td>Nil</td>
<td>Gluten-Free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Nutrison MCT liquid: 1000 ml = £10.96</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrison® Protein Plus</td>
<td>Liquid (tube feed)</td>
<td>525 (125kcal)</td>
<td>6.3g</td>
<td>14.2g (sugars 1.1g)</td>
<td>4.9</td>
<td>Nil</td>
<td>Gluten-Free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Nutrison Protein Plus liquid: 1 litre = £11.25</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100mL</td>
<td></td>
<td>cows’ milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Borderline substances | Appendix 2
### Enteral feeds: Less than 1.5 kcal/mL and 5 g (or more) protein/100 mL (product list continued)

Not suitable for use in child under 1 year unless otherwise stated; not recommended for child 1–6 years unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrison Protein Plus Multifibre</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>535 kJ (128 kcal)</td>
<td>6.3 g cow's milk</td>
<td>14.1 g (sugars 1.0 g)</td>
<td>4.9 g</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose</td>
<td>For use as dietary management of disease related malnutrition.</td>
<td>Nutrison Protein Plus Multifibre liquid: 1 litre = £12.54</td>
</tr>
<tr>
<td>Osmolite Plus</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>508 kJ (121 kcal)</td>
<td>5.55 g caseinates</td>
<td>15.8 g (sugars 0.73 g)</td>
<td>3.93 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 Not suitable for child under 10 years</td>
<td>Osmolite Plus liquid: 500 ml = £5.87; 1000 ml = £10.67; 1500 ml = £15.97</td>
</tr>
<tr>
<td>Peptamen HN</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>556 kJ (133 kcal)</td>
<td>6.6 g whey protein hydrolysates</td>
<td>15.6 g (sugars 1.4 g)</td>
<td>4.9 g (MCT 70%)</td>
<td>Nil</td>
<td>Residual lactose Hydrolysed with pork trypsin</td>
<td>Short bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula Not suitable for child under 3 years</td>
<td>Peptamen HN liquid: 500 ml = £7.89</td>
</tr>
<tr>
<td>Perative</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>552 kJ (131 kcal)</td>
<td>6.7 g caseinate whey protein hydrolysates</td>
<td>17.7 g (sugars 0.66 g)</td>
<td>3.7 g (MCT 42%)</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 Not suitable for child under 5 years</td>
<td>Perative liquid: 500 ml = £8.30; 1000 ml = £15.32</td>
</tr>
</tbody>
</table>

### Enteral feeds: More than 1.5 kcal/mL and 5 g (or more) protein/100 mL

Not suitable for use in child under 1 year; not recommended for child 1–6 years.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure TwoCal</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>838 kJ (200 kcal)</td>
<td>8.4 g cows' milk</td>
<td>21 g (sugars 4.5 g)</td>
<td>8.9 g</td>
<td>1 g</td>
<td>Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054; also haemodialysis and CAPO</td>
<td>Ensure TwoCal liquid: banana, neutral, strawberry, vanilla 200 ml = £2.22</td>
</tr>
</tbody>
</table>

### Enteral feeds (non-disease specific): Child under 12 years

### Enteral feeds, Child: Less than 1 kcal/mL and less than 4 g protein/100 mL

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrini Low Energy Multi Fibre</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>315 kJ (75 kcal)</td>
<td>2.1 g whey protein and caseinate</td>
<td>9.3 g (sugars 0.6 g)</td>
<td>3.3 g</td>
<td>0.8 g</td>
<td>Residual lactose Contains fish oil</td>
<td>Borderline substances paediatric ACBS indications p. 1054 except bowel fistula, in child 1–6 years, body-weight 8–20 kg</td>
<td>Nutrini Low Energy Multifibre liquid: 200 ml = £2.89; 500 ml = £7.35</td>
</tr>
<tr>
<td>Nutriprem 1</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>355 kJ (80 kcal)</td>
<td>2.5 g whey protein and casein</td>
<td>7.6 g (lactose 6.3 g)</td>
<td>4.4 g</td>
<td>0.8 g</td>
<td>Contains soya, fish oil and egg lipid</td>
<td>Low birth-weight formula Nutriprem 1 liquid: 70 ml = Hospital supply only</td>
<td>Nutriprem 1 liquid: 70 ml = Hospital supply only</td>
</tr>
<tr>
<td>Nutriprem 2</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>310 kJ (75 kcal)</td>
<td>2 g whey protein and casein</td>
<td>7.4 g (lactose 5.8 g)</td>
<td>4 g</td>
<td>0.6 g</td>
<td>Contains soya, fish oil and egg lipid</td>
<td>Catch-up growth in pre-term infants (less than 35 weeks at birth) and small for gestational-age infants up to 6 months corrected age. Nutriprem 2 liquid: 200 ml = £1.74</td>
<td>Nutriprem 2 powders: 800 gram = £10.37</td>
</tr>
</tbody>
</table>

Powder provides: protein 13 g, carbohydrate 48.3 g, fat 26.7 g, fibre 5.2 g, energy 2030 kJ (485 kcal)/100 g.
### AMINO ACID FORMULA (ESSENTIAL AND NON-ESSENTIAL AMINO ACIDS)

**Product**

- **Emsogen®**
  - **(Nutricia Ltd)**
  - **Standard dilution**
    - (20%) of powder (sip or tube feed) per 100 mL
    - **Energy**: 368 kJ (88 kcal)
    - **Protein**: 2.5 g protein equivalent (essential and non-essential amino acids)
    - **Carbohydrate**: 12 g (sugars 1.6 g)
    - **Fat**: 3.3 g (MCT 83%)
    - **Fibre**: Nil
    - **Special Characteristics**: Lactose-free
    - **ACBS Indications**: Short-bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula
    - **Presentation & Flavour**: Not suitable for child under 1 year or as sole source of nutrition in child 1-5 years

**Powder provides:** protein equivalent 12.5 g, carbohydrate 60 g, fat 16.4 g, energy 1839 kJ (438 kcal)/100 g. Additional source of alpha linolenic acid needed if used as sole source of nutrition. To flavour unflavoured products, see Modjul® Flavour System p. 1082.

### Enteral feeds, Child: 1 kcal/mL and less than 4 g protein/100 mL

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
</table>
| **Fortini® 1.0 Multi Fibre**
  - **(Nutricia Ltd)**
| Liquid (sip feed) per 100 mL | 420 kJ (100 kcal) | 2.4 g cows' milk | 11.8 g (sugars 4.7 g) | 4.5 g | 1.5 g | Gluten-free Residual lactose | Disease-related malnutrition and growth failure in child 1-6 years, body-weight 8-20 kg | Fortini 1.0 Multi Fibre liquid: banana, chocolate, strawberry, vanilla 200 ml = £2.77 |
| **Fresenius Kabi Ltd**
| Liquid (tube feed) per 100 mL | 420 kJ (100 kcal) | 2.5 g cows' milk | 12.5 g (sugars 0.7 g) | 4.4 g | Nil | Gluten-free Residual lactose Contains fish oils and fish gelatin | Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-10 years, body-weight 8-30 kg | Frebin Original liquid: 500 ml = £6.76 |
| **Fresenius Kabi Ltd**
| Liquid (tube feed) per 100 mL | 420 kJ (100 kcal) | 2.5 g cows' milk | 12.5 g (sugars 0.7 g) | 4.4 g | 0.75 g | Gluten-free Residual lactose Contains fish oils and fish gelatin | Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-10 years, body-weight 8-30 kg | Frebin Original Fibre liquid: 500 ml = £7.52 |
| **Nutricia Ltd**
| Liquid (sip or tube feed) per 100 mL | 415 kJ (100 kcal) | 2.6 g cows' milk | 10.3 g (lactose 5.2 g) | 5.4 g | 0.8 g | Gluten-free Contains fish oil | Failure to thrive, disease-related malnutrition and malabsorption, in child from birth up to body-weight 8 kg | Infatrini liquid: 125 ml = £1.56; 200 ml = £2.49; 500 ml = £6.77 |
| **Nutricia Ltd**
| Liquid (tube feed) per 100 mL | 420 kJ (100 kcal) | 2.8 g cows' milk | 12.3 g (sugars 1 g) | 4.4 g | Nil | Gluten-free Residual lactose | Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-6 years, body-weight 8-20 kg | Nutrini liquid: 200 ml = £3.02; 500 ml = £7.49 |
| **Nutricia Ltd**
| Liquid (tube feed) per 100 mL | 420 kJ (100 kcal) | 2.8 g whey protein and caseinate | 12.3 g (sugars 0.8 g) | 4.4 g | 0.8 g | Gluten-free Residual lactose Contains fish oil | Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-6 years, body-weight 8-20 kg | Nutrini MultiFibre liquid: 200 ml = £3.34; 500 ml = £8.31 |
| **Abbott Laboratories Ltd**
| Liquid (sip or tube feed) per 100 mL | 422 kJ (100 kcal) | 2.8 g cows' milk | 11.2 g (sugars 3.92 g) | 4.98 g | Nil | Gluten-free Residual lactose | Borderline substances paediatric ACBS indications p. 1054 in child 1-10 years, body-weight 8-30 kg | PaediaSure fibre liquid: banana, strawberry, vanilla 200 ml = £2.71; 500 ml = £7.51. Nutritional values may vary with flavour—consult product literature |
| **Abbott Laboratories Ltd**
| Liquid (sip or tube feed) per 100 mL | 424 kJ (101 kcal) | 2.8 g caseinates and whey protein | 10.9 g (sugars 3.84 g) | 4.98 g | 0.73 g | Gluten-free Residual lactose | Borderline substances paediatric ACBS indications p. 1054 in child 1-10 years, body-weight 8-30 kg | PaediaSure fibre liquid: banana, strawberry, vanilla 200 ml = £2.86; 500 ml = £8.33. Nutritional values may vary with flavour—consult product literature |

**Borderline substances** | Appendix 2
### Enteral feeds, Child: 1 kcal/mL and less than 4 g protein/100 mL (product list continued)

Not suitable for use in child under 1 year unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediasure® Peptide (Abbott Laboratories Ltd)</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3 g whey protein and caseinate</td>
<td>13 g (sugars 2.98 g)</td>
<td>4 g (MCT 50%)</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-10 years, body-weight 8-30 kg</td>
<td>Paediasure Peptide liquid: 200 ml = £4.22; 500 ml = £11.71</td>
</tr>
<tr>
<td>Similac® High Energy (Abbott Laboratories Ltd)</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>419 kJ (100 kcal)</td>
<td>2.6 g cows’ milk and whey protein</td>
<td>10.1 g (sugars 5.6 g)</td>
<td>5.2 g</td>
<td>0.4 g</td>
<td>Gluten-free Contains lactose and soy oil</td>
<td>Increased energy requirements, faiering growth, and/or need for fluid restriction, in child body-weight up to 8 kg</td>
<td>Similac High Energy liquid: 60 ml = £0.73; 200 ml = £2.44</td>
</tr>
<tr>
<td>Tentrini® (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3.3 g whey protein and caseinate</td>
<td>12.3 g (sugars 0.8 g)</td>
<td>4.2 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 and growth failure in child 7-12 years, body-weight 21-45 kg</td>
<td>Tentrini liquid: 500 ml = £6.60</td>
</tr>
<tr>
<td>Tentrini® Multi Fibre (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3.3 g whey protein and caseinate</td>
<td>12.3 g (sugars 0.8 g)</td>
<td>4.2 g</td>
<td>1.1 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula, and growth failure in child 7-12 years body-weight 21-45 kg</td>
<td>Tentrini Multifibre liquid: 500 ml = £7.26</td>
</tr>
</tbody>
</table>

### HYDROLYSATE FORMULA

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrini® Peptisorb (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>2.8 g whey protein hydrolysate</td>
<td>13.7 g (sugars 0.8 g)</td>
<td>3.9 g (MCT 46%)</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-6 years, body-weight 8-20 kg</td>
<td>Nutrini Peptisorb liquid: 500 ml = £11.70</td>
</tr>
<tr>
<td>Peptamen® Junior (Nestle Health Science)</td>
<td>Liquid (tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3 g whey protein hydrolysate</td>
<td>13.2 g</td>
<td>4 g (MCT 60 %)</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Hydrolysed with pork trypsin</td>
<td>Short bowel syndrome, intractable malabsorption, proven inflammatory bowel disease, bowel fistula, in child 1-10 years</td>
<td>Peptamen Junior liquid: 500 ml = £7.32</td>
</tr>
<tr>
<td>Standard dilution (22%) of powder (sip or tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3 g whey protein hydrolysate</td>
<td>13.8 g</td>
<td>3.85 g (MCT 60 %)</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Hydrolysed with bacterial trypsin</td>
<td></td>
<td>Peptamen Junior powder: 400 gram = £19.21</td>
<td></td>
</tr>
</tbody>
</table>

Powder provides: protein 13.7 g, carbohydrate 62.9 g, fat 17.5 g, energy 1910 kJ (457 kcal)/100 g.

### Enteral feeds, Child: More than 1 kcal/mL and less than 4 g protein/100 mL

Not suitable for use in child under 1 year unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortini® (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>630 kJ (150 kcal)</td>
<td>3.4 g cows’ milk</td>
<td>18.8 g (sugars 7.4 g)</td>
<td>6.8 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Disease-related malnutrition and growth failure in child 1-6 years, body-weight 8-20 kg</td>
<td>Fortini liquid: strawberry, vanilla 200 ml = £3.59</td>
</tr>
<tr>
<td>Fortini® Multifibre (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>630 kJ (150 kcal)</td>
<td>3.4 g cows’ milk</td>
<td>18.8 g (sugars 7.4 g)</td>
<td>6.8 g</td>
<td>1.5 g</td>
<td>Gluten-free Residual lactose</td>
<td>Disease-related malnutrition and growth failure in child 1-6 years, body-weight 8-20 kg</td>
<td>Fortini Multi Fibre liquid: banana, chocolate, strawberry, unflavoured, vanilla 200 ml = £3.76</td>
</tr>
</tbody>
</table>
### Enteral feeds, Child: 1.5 kcal/mL and more than 4 g protein/100 mL

Not suitable for use in child under 1 year unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrini® Energy</td>
<td>Liquid (tube feed)</td>
<td>630 kJ (150 kcal)</td>
<td>4.1 g caseinate</td>
<td>18.5 g</td>
<td>6.7 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 and growth failure in child 1-6 years, body-weight 8-20 kg</td>
<td>Nutrini Energy liquid: 500 ml = £9.40; 200 ml = £3.67</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100 mL</td>
<td></td>
<td>whey protein</td>
<td>(sugars 1.1 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrini® Energy Multi Fibre</td>
<td>Liquid (tube feed)</td>
<td>630 kJ (150 kcal)</td>
<td>4.1 g caseinate</td>
<td>18.5 g</td>
<td>6.7 g</td>
<td>0.8 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances paediatric ACBS indications p. 1054 except bowel fistula; also total gastrectomy, in child 1-6 years, body-weight 8-20 kg</td>
<td>Nutrini Energy MultiFibre liquid: 200 ml = £3.88; 500 ml = £9.71</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100 mL</td>
<td></td>
<td>whey protein</td>
<td>(sugars 1.1 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediasure® Plus</td>
<td>Liquid (sip or</td>
<td>632 kJ (151 kcal)</td>
<td>4.2 g caseinates</td>
<td>16.7 g</td>
<td>7.47 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances paediatric ACBS indications p. 1054 in child 1-10 years, body-weight 8-30 kg</td>
<td>Paediasure Plus liquid: banana, strawberry, unflavoured, vanilla 200 ml = £3.50; 500 ml = £9.42; Sugar content varies with presentation</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>tube feed)</td>
<td></td>
<td>whey protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediasure® Plus Fibre</td>
<td>Liquid (sip or</td>
<td>635 kJ (152 kcal)</td>
<td>4.2 g caseinates</td>
<td>16.4 g</td>
<td>7.47 g</td>
<td>1.1 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances paediatric ACBS indications p. 1054 in child 1-10 years, body-weight 8-30 kg</td>
<td>Paediasure Plus fibre liquid: banana, strawberry, vanilla 200 ml = £3.77; 500 ml = £9.73. Nutritional values vary with flavour-consult product literature. Sugar content varies with presentation</td>
</tr>
<tr>
<td>(Abbott Laboratories Ltd)</td>
<td>tube feed)</td>
<td></td>
<td>whey protein</td>
<td>(sugars 5.3 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peptamen® Junior Advance</td>
<td>Liquid (tube feed)</td>
<td>630 kJ (150 kcal)</td>
<td>4.5 g whey protein</td>
<td>18 g</td>
<td>6.6 g</td>
<td>0.54 g</td>
<td>Gluten-free Residual lactose</td>
<td>Intractable malabsorption, short-bowel syndrome, bowel fistula, and proven inflammatory bowel disease in child 1-10 years</td>
<td>Peptamen Junior Advance liquid: 500 ml = £8.35</td>
</tr>
<tr>
<td>(Nestle Health Science)</td>
<td>per 100 mL</td>
<td></td>
<td>(sugars 2.1 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Enteral feeds, Child: 1.5 kcal/mL and more than 4 g protein/100 mL (product list continued)

Not suitable for use in child under 1 year unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation Energy Protein Carbohydrate Fat Fibre Special Characteristics ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tentri® Energy (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL 630 kJ (150 kcal) 4.9 g whey protein and caseinate 18.5 g (sugars 1.1 g) 6.3 g Nil Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances standard ACBS indications p. 1054 and growth failure, in child 7-12 years, body-weight 21-45 kg Tentrini Energy liquid: 500 ml = £8.16</td>
</tr>
<tr>
<td>Tentri® Energy Multi Fibre (Nutricia Ltd)</td>
<td>Liquid (tube feed) per 100 mL 630 kJ (150 kcal) 4.9 g whey protein and caseinate 18.5 g (sugars 1.1 g) 6.3 g 1.1 g Gluten-free Residual lactose Contains fish oil</td>
<td>Borderline substances paediatric ACBS indications p. 1054 and proven inflammatory bowel disease, in child 7-12 years, body-weight 21-45 kg Tentrini Energy Multifibre liquid: 500 ml = £8.99</td>
</tr>
</tbody>
</table>

### Table 2 Nutritional supplements (non-disease specific)

#### Less than 5 g protein/100 mL

Not suitable for use in child under 1 year unless otherwise stated; use with caution in child 1-5 years unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation Energy Protein Carbohydrate Fat Fibre Special Characteristics ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure® (Abbott Laboratories Ltd)</td>
<td>Liquid (sip or tube feed) per 100 mL 423 kJ (100 kcal) 4 g caseinates soy isolate 13.6 g (sugars 3.93 g) 3.36 g Nil Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 Ensure liquid: coffee, chocolate, vanilla 250 ml = £2.39</td>
</tr>
</tbody>
</table>

#### More than 1 kcal/mL and less than 5 g protein/100 mL

Not suitable for use in child under 1 year unless otherwise stated; use with caution in child 1-5 years unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation Energy Protein Carbohydrate Fat Fibre Special Characteristics ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure® Plus Juice (Abbott Laboratories Ltd)</td>
<td>Liquid (sip feed) per 100 mL 638 kJ (150 kcal) 4.8 g whey protein isolate 32.7 g (sugars 9.4 g) Nil Nil Gluten-free Residual lactose Non-milk taste</td>
<td>Borderline substances standard ACBS indications p. 1054 Ensure Plus Juice liquid: assorted 880 ml = no price available; apple, fruit punch, lemon &amp; lime, orange, peach, strawberry 220 ml = £1.97</td>
</tr>
<tr>
<td>Fortijuce® (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL 640 kJ (150 kcal) 4.0 g cows’ milk 33.5 g (sugars 13.1 g) Nil Nil Gluten-free Residual lactose Non-milk taste</td>
<td>Borderline substances standard ACBS indications p. 1054 Fortijuce Starter Pack liquid: assorted 800 ml = £8.08; Fortijuce liquid: apple, blackcurrant, forest fruits, lemon, orange, strawberry, tropical 200 ml = £2.02 Sugar content varies with flavour</td>
</tr>
<tr>
<td>Fresubin® Jucy Drink (Fresenius Kabi Ltd)</td>
<td>Liquid (sip feed) per 100 mL 630 kJ (150 kcal) 4 g whey protein 33.5 g (sugars 8 g) Nil Nil Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis Fresubin Jucy drink: apple, blackcurrant, cherry, orange, pineapple 800 ml = £3.04</td>
</tr>
<tr>
<td>PaediaSure® Plus Juice (Abbott Laboratories Ltd)</td>
<td>Liquid (sip feed) per 100 mL 638 kJ (150 kcal) 4.2 g cows’ milk 33.3 g (sugars 9.4 g) Nil Nil Gluten-free Residual lactose Non-milk taste</td>
<td>Nutritional supplement in child 1-10 years, body-weight 8-30 kg with disease-related malnutrition and, or growth failure PaediaSure Plus Juice liquid: apple, very berry 200 ml = £3.48</td>
</tr>
</tbody>
</table>
### Nutritional supplements: 5 g (or more) protein/100 mL

**Nutritional supplements: 1.5 kcal/mL and 5 g (or more) protein/100 mL**

Not suitable for child under 3 years unless otherwise stated; use with caution in child under 6 years unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altraplen® Protein (Nualtra Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>632 kJ (150 kcal)</td>
<td>10 g cows' milk soya protein</td>
<td>15 g (sugars 4.6 g)</td>
<td>5.6 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
<td>Altraplen Protein Starter Pack liquid: 400 ml = £3.18; Altraplen Protein liquid: strawberry, vanilla 800 ml = £6.59</td>
</tr>
</tbody>
</table>
| Ensure® Plus Commence (Abbott Laboratories Ltd) | Starter pack (5–10 days supply), contains: Ensure® Plus Commence (various flavours), 1 pack (10 × 220 ml) = £11.10

| Ensure® Plus Fibre (Abbott Laboratories Ltd) | Liquid (sip or tube feed) per 100 mL | 652 kJ (155 kcal) | 6.25 g cows' milk soya protein isolate | 20.2 g (sugars 5.5 g) | 4.92 g | 2.5 g | Gluten-free Residual lactose | Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis | Ensure Plus Fibre liquid: banana, chocolate, raspberry, strawberry, vanilla 200 ml = £2.14. Nutritional values vary with flavour-consult product literature |
| Ensure® Plus Milkshake style (Abbott Laboratories Ltd) | Liquid (sip or tube feed) per 100 mL | 632 kJ (150 kcal) | 6.25 g cows' milk soya protein isolate | 20.2 g (sugars 6.89 g) | 4.92 g | Nil | Gluten-free Residual lactose | Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis | Ensure Plus milkshake style liquid: banana, chocolate, coffee, fruits of the forest, neutral, peach, raspberry, strawberry, vanilla 200 ml = £1.11. Nutritional values vary with flavour-consult product literature |
| Ensure® Plus Savoury (Abbott Laboratories Ltd) | Liquid (sip or tube feed) per 100 mL | 632 kJ (150 kcal) | 6.25 g cows' milk soya protein isolate | 20.2 g (sugars 1.13 g) | 4.92 g | Nil | Gluten-free Residual lactose | Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis | Ensure Plus savoury liquid: chicken 200 ml = £1.11 |
| Ensure® Plus Yoghurt style (Abbott Laboratories Ltd) | Liquid (sip feed) per 100 mL | 632 kJ (150 kcal) | 6.25 g cows' milk soya protein isolate | 20.2 g (sugars 11.7 g) | 4.92 g | Nil | Gluten-free Residual lactose | Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis | Ensure Plus yoghurt style liquid: orchard peach, strawberry swirl 200 ml = £1.11 |
| Fortisip® Bottle (Nutricia Ltd) | Liquid (sip feed) per 100 mL | 630 kJ (150 kcal) | 6 g cows' milk | 18.4 g | 5.8 g | Nil | Gluten-free Residual lactose | Borderline substances standard ACBS indications p. 1054 Not suitable for child under 3 years; use with caution in child 3–5 years. | Fortisip Bottle: banana, caramel, chocolate, neutral, orange, strawberry, tropical fruit, vanilla, 200 ml = £1.12. Sugar content varies with flavour |
| Fortisip® Range (Nutricia Ltd) | Starter pack contains 4 × Fortisip® Bottle, 4 × Fortijuice®, 2 × Fortisip® Yoghurt Style, 1 pack (10 × 200 ml) = £20.20 |
| Fortisip® Yoghurt Style (Nutricia Ltd) | Liquid (sip feed) per 100 mL | 630 kJ (150 kcal) | 6 g cows' milk | 18.7 g (sugars 10.8 g) | 5.8 g | 0.2 g | Contains lactose | Borderline substances standard ACBS indications p. 1054 Not suitable for child under 3 years | Fortisip Yoghurt Style liquid: raspberry, vanilla & lemon 200 ml = £2.22 |

Borderline substances | Appendix 2
### Nutritional supplements: 1.5 kcal/mL and 5 g (or more) protein/100 mL (product list continued)
Not suitable for child under 3 years unless otherwise stated; use with caution in child under 6 years unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresubin® Protein Energy Drink</td>
<td>Liquid (sip feed)</td>
<td>630 kJ</td>
<td>10 g cows’ milk</td>
<td>12.4 g (sugars 6.4 g)</td>
<td>6.7 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Contains fish gelatin</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis.</td>
<td>Fresubin Protein Energy drink: cappuccino, chocolate, tropical fruits, vanilla, wild strawberry 200 ml = £2.15. Sugar content varies with flavour. Fibre content varies with flavour.</td>
</tr>
<tr>
<td>Fresubin® Thickened</td>
<td>Liquid (sip feed)</td>
<td>630 kJ</td>
<td>10 g cows’ milk</td>
<td>12 g (sugars 7.3 g)</td>
<td>6.7 g</td>
<td>0.83 g</td>
<td>Gluten-free Residual lactose</td>
<td>Dysphagia or disease-related malnutrition.</td>
<td>Fresubin Thickened Stage 1 syrup: vanilla, wild strawberry 800 ml = £9.40; Fresubin Thickened Stage 2 custard: vanilla, wild strawberry 800 ml = £9.40. Sugar content varies with consistency. Fibre content varies with consistency.</td>
</tr>
<tr>
<td>Fresubin® YoCrème</td>
<td>Semi-solid</td>
<td>630 kJ</td>
<td>7.5 g whey protein</td>
<td>19.5 g (sugars 16.8 g)</td>
<td>4.7 g</td>
<td>Nil</td>
<td>Gluten-free Contains lactose</td>
<td>Dysphagia, or presence or risk of malnutrition Not suitable for child under 3 years</td>
<td>Fresubin YoCreme dessert: apricot-peach, biscuit, lemon, raspberry 500 gram = £8.44</td>
</tr>
</tbody>
</table>

### Nutritional supplements: Less than 1.5 kcal/mL and 5 g (or more) protein/100 mL
Not suitable for infants below 1 year unless otherwise stated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure® Plus Crème</td>
<td>Semi-solid</td>
<td>574 kJ</td>
<td>5.68 g cow’s milk soy protein isolates</td>
<td>18.4 g (sugars 12.4 g)</td>
<td>4.47 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose Contains soya</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis. Not suitable for child under 3 years; use with caution in child 3-5 years.</td>
<td>Ensure Plus Crème: banana, chocolate, neutral, vanilla 500 gram = £8.00. Nutritional values vary with flavour-consult product literature.</td>
</tr>
<tr>
<td>Nutilis® Fruit Dessert Level 4</td>
<td>Semi-Solid</td>
<td>560 kJ</td>
<td>7 g whey isolate</td>
<td>16.7 g (sugars 11.3 g)</td>
<td>4 g</td>
<td>2.6 g</td>
<td>Gluten-free Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054 except bowel fistula; also CAPD, haemodialysis. Not suitable for child under 3 years; use with caution in child 3-5 years.</td>
<td>Nutilis Fruit Dessert Level 4: apple, strawberry 450 gram = £7.35</td>
</tr>
<tr>
<td>Oral Impact®</td>
<td>Standard dilution of powder (74 g in 250 mL water) (sip feed)</td>
<td>425 kJ</td>
<td>5.6 g cows’ milk</td>
<td>13.4 g (sugars 7.4 g)</td>
<td>2.8 g</td>
<td>1 g</td>
<td>Residual lactose Contains fish oil</td>
<td>Pre-operative nutritional supplement for malnourished patients or patients at risk of malnourishment Not suitable for child under 3 years; use with caution in child 3-5 years.</td>
<td>Oral Impact oral powder 74g sachets: citrus, tropical 5 sachet = £18.20</td>
</tr>
<tr>
<td>Renapros® Shot®</td>
<td>Liquid (sip feed)</td>
<td>583 kJ</td>
<td>33 g (fructose 2.0 g)</td>
<td>0.1 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>For the dietary management of dialysis patients with biochemically proven hypoproteinaemia on the recommendation of a specialist dietician.</td>
<td>Renapros Shot 60ml bottles: 30 bottle = £76.80</td>
<td></td>
</tr>
</tbody>
</table>
### Nutritional supplements: More than 1.5 kcal/mL and 5 g (or more) protein/100 mL

Not suitable for use in children under 3 years; use with caution in child 1-6 years.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ / kcal)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altrapan® Compact</td>
<td>Liquid (sip feed)</td>
<td>1008 kJ (240 kcal)</td>
<td>9.6 g</td>
<td>28.8 g</td>
<td>9.6 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Borderline substances standard</td>
<td>Altrapan Compact Starter Pack: 500 ml = £5.80; Altrapan Compact liquid: banana, hazel chocolate, strawberry, vanilla 500 ml = £5.32</td>
</tr>
<tr>
<td></td>
<td>per 100 mL</td>
<td>(cows' milk soya protein)</td>
<td>(sugars 11.3 g)</td>
<td></td>
<td></td>
<td>Residual lactose</td>
<td>ACBS indications p. 1054</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complan® Shake</td>
<td>Powder per 57 g</td>
<td>1065.9 kJ (253.7 kcal)</td>
<td>8.8 g</td>
<td>35.6 g</td>
<td>8.4 g</td>
<td>Trace</td>
<td>Contains lactose</td>
<td>Borderline substances standard</td>
<td>Complan Shake Starter Pack sachets: 5 sachet = £4.39; Complan Shake oral powder 57g sachets: banana, chocolate, milk, strawberry, vanilla 4 sachet = £2.80</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(cows' milk)</td>
<td>(sugars 18.8 g)</td>
<td></td>
<td></td>
<td>Gluten-free</td>
<td>ACBS indications p. 1054</td>
<td></td>
</tr>
</tbody>
</table>

Powder 57 g reconstituted with 200 mL whole milk provides: protein 15.5 g, carbohydrate 44.7 g, fat 15.5 g, energy 1595 kJ (380 kcal).

**Recommended serving** = the contents of a 57 g sachet in 200 mL full cream milk provides: protein 19 g, carbohydrate 41 g, fat 16 g, energy 161 kJ (383 kcal).

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ / kcal)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complan® Shake with Fibre</td>
<td>Powder per 100 g</td>
<td>1869 kJ (444 kcal)</td>
<td>21 g</td>
<td>56 g</td>
<td>15 g</td>
<td>Nil</td>
<td>Contains lactose</td>
<td>Borderline substances standard</td>
<td>Foodlink Complete powder: banana, chocolate, natural, strawberry, vanilla 1596g gram = £15.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(cows' milk soya protein)</td>
<td>(sugars 43 g)</td>
<td></td>
<td></td>
<td>Contains soya</td>
<td>ACBS indications p. 1054</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommended serving** = the contents of a 63 g sachet in 200 mL full cream milk provides: protein 19 g, carbohydrate 42 g, fat 16 g, fibre 4.5 g, energy 1667 kJ (397 kcal).

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ / kcal)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forticream® Complete</td>
<td>Semi-solid per 100 g</td>
<td>675 kJ (160 kcal)</td>
<td>9.5 g</td>
<td>19.2 g</td>
<td>5 g</td>
<td>0.1 g</td>
<td>Residual lactose</td>
<td>Borderline substances standard</td>
<td>Forticream Complete dessert: banana, chocolate, forest fruits, vanilla 500 gram = £7.84</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td></td>
<td>(cows' milk)</td>
<td>(sugars 10.6 g)</td>
<td></td>
<td></td>
<td></td>
<td>ACBS indications p. 1054; also CAPD, haemodialysis. Not suitable for child under 3 years; use with caution in child 3-5 years.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ / kcal)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortisip® Compact Fibre</td>
<td>Liquid (sip feed)</td>
<td>1010 kJ (240 kcal)</td>
<td>9.6 g</td>
<td>29.7 g</td>
<td>9.3 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Borderline substances standard</td>
<td>Fortisip Compact liquid: apricot, banana, chocolate, forest fruit, mocha, strawberry, vanilla 500 ml = £5.32</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100 mL</td>
<td>(cows' milk)</td>
<td>(sugars 15 g)</td>
<td></td>
<td></td>
<td></td>
<td>ACBS indications p. 1054</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy (kJ / kcal)</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortisip® Compact Fibre</td>
<td>Liquid (sip feed)</td>
<td>1000 kJ (240 kcal)</td>
<td>9.4 g</td>
<td>25.2 g</td>
<td>10.4 g</td>
<td>3.6 g</td>
<td>Residual lactose</td>
<td>Borderline substances standard</td>
<td>Fortisip Compact Fibre Starter Pack: 500 ml = £8.36; Fortisip Compact Fibre liquid: mocha, strawberry, vanilla 500 ml = £8.36</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100 mL</td>
<td>(cows' milk)</td>
<td>(sugars 13.9 g)</td>
<td></td>
<td></td>
<td></td>
<td>ACBS indications p. 1054</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Nutritional supplements: More than 1.5 kcal/mL and 5 g (or more) protein/100 mL (product list continued)

Not suitable for use in children under 3 years; use with caution in child 1-6 years.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortisip® Compact Protein (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>1010 kJ (240 kcal)</td>
<td>14.4 g cows’ milk</td>
<td>24.4 g (sugars 13.3 g)</td>
<td>9.4 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
</tr>
<tr>
<td>Fortisip® Extra (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>675 kJ (160 kcal)</td>
<td>10 g cows’ milk</td>
<td>18.1 g (sugars 9 g)</td>
<td>5.3 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Contains lactose</td>
<td>Borderline substances standard ACBS indications p. 1054</td>
</tr>
<tr>
<td>Fresubin® 2 kcal Drink (Fresenius Kabi Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>840 kJ (200 kcal)</td>
<td>10 g cows’ milk</td>
<td>22.5 g (sugars 5.8 g)</td>
<td>7.8 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis. Not suitable for use in child under 1 year; use with caution in child 1-5 years.</td>
</tr>
<tr>
<td>Fresubin® 2 kcal Fibre Drink (Fresenius Kabi Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>840 kJ (200 kcal)</td>
<td>10 g cows’ milk</td>
<td>22.5 g (sugars 5.8 g)</td>
<td>7.8 g</td>
<td>1.6 g</td>
<td>Gluten-free</td>
<td>Residual lactose</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis. Not suitable for use in child under 1 year; use with caution in child 1-5 years.</td>
</tr>
<tr>
<td>Fresubin® Powder Extra (Fresenius Kabi Ltd)</td>
<td>Powder per 100 g</td>
<td>1764 kJ (420 kcal)</td>
<td>17.5 g cows’ milk whey protein</td>
<td>63 g (sugars 24.7 g)</td>
<td>10.9 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Contains lactose</td>
<td>Borderline substances standard ACBS indications p. 1054; also CAPD, haemodialysis. Not suitable for use in child under 1 year; use with caution in child 1-5 years.</td>
</tr>
</tbody>
</table>

Powder 62 g reconstituted with 200 ml whole milk provides: protein 17.7 g, carbohydrate 48.5 g, fat 14.8 g, energy 1658 kJ (397 kcal).

| Nutilis® Complete Crème Level 3 (Nutricia Ltd) | Semi-solid per 100 g | 1030 kJ (245 kcal) | 9.6 g cows’ milk | 29.1 g (sugars 11.8 g) | 9.4 g | 3.2 g | Gluten-free | Residual lactose | Borderline substances standard ACBS indications p. 1054 | Nutilis Complete Creme Level 3 custard: chocolate, strawberry, vanilla 500 gram = £8.84 |
| Nutilis® Complete Drink Level 3 (Nutricia Ltd) | Liquid (pre-thickened) per 100 mL | 1010 kJ (240 kcal) | 9.6 g cows’ milk | 29.1 g (sugars 5.4 g) | 9.3 g | 3.2 g | Residual lactose | | Borderline substances standard ACBS indications p. 1054 | Nutilis Complete Drink Level 3 liquid: chocolate, lemon tea, mango & passionfruit, strawberry, vanilla 500 ml = £8.84; Nutritional values may vary with flavour-consult product literature |
| Nutricrem® (Nualtra Ltd) | Semi-solid per 100 g | 756 kJ (180 kcal) | 10 g cows’ milk soya protein | 18.8 g (sugars 9.7 g) | 7.2 g | Nil | Gluten-free | Residual lactose | Borderline substances standard ACBS indications p. 1054 | Nutricrem dessert: strawberry, vanilla 500 gram = £6.59 |
### Specialised formulas: Infant and child

#### Specialised formulas: Infant and child: Amino acid-based formula

**Table 3 Specialised formulas**

Specialised formulas are suitable for infants from birth unless otherwise indicated.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neocate® LCP</td>
<td>Standard dilution (13.9%) of powder per 100 mL</td>
<td>279 kJ (67 kcal)</td>
<td>1.8 g protein equivalent (essential and non-essential amino acids)</td>
<td>7.2 g (sugars 650 mg)</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Milk protein-free</td>
<td>Cows’ milk allergy, multiple food protein intolerance, and conditions requiring an elemental diet</td>
<td>Neocate LCP powder: 400 gram = £29.56</td>
</tr>
<tr>
<td>Neocate® Spoon</td>
<td>Standard dilution (38%) of powder per 97 g serving (37 g sachet diluted with 60 mL water)</td>
<td>733 kJ (175 kcal)</td>
<td>3 g protein equivalent (essential and non-essential amino acids)</td>
<td>24.9 g (sugars 4.6 g)</td>
<td>7 g</td>
<td>Nil</td>
<td>Milk protein-free</td>
<td>Cows’ milk allergy, multiple food protein intolerance, and conditions requiring an elemental diet. Not suitable for child under 6 months.</td>
<td>Neocate Spoon powder 37g sachets: 15 sachet = £42.65</td>
</tr>
<tr>
<td>Nutramigen® PurAmino</td>
<td>Standard dilution (13.6%) of powder per 100 mL</td>
<td>290 kJ (68 kcal)</td>
<td>1.89 g essential and non-essential amino acids</td>
<td>7.2 g</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>For use in the management of severe protein intolerance, multiple food intolerance and other gastro-intestinal disorders where an amino acid based diet is specifically indicated for infants and young children.</td>
<td>Nutramigen PurAmino powder: 400 gram = £23.00</td>
</tr>
<tr>
<td>SMA Alfamino®</td>
<td>Standard dilution (13.8%) of powder per 100 mL</td>
<td>291 kJ (69 kcal)</td>
<td>1.8 g protein equivalent (essential and non-essential amino acids)</td>
<td>7.9 g (sugars 2.2 g)</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Severe cows’ milk allergy and or multiple food allergies</td>
<td>SMA Alfamino powder: 400 gram = £22.98</td>
<td></td>
</tr>
</tbody>
</table>

For a full list of all the information above, please refer to the ACBS indications and presentation & flavour columns. The following formulas are also available:

- **Neocate LCP** (Nutricia Ltd) 250 mL = £9.47
- **Renilon 7.5** (Nutricia Ltd) 500 mL = £9.47
- **Resource Fibre** (Nestle Health Science) 500 mL = £2.02
- **Neocate Spoon** (Nutricia Ltd) 15 sachet = £42.65
### Specialised formulas: Infant and child: Hydrolysate formula

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aptamil Pepti-Junior</strong>&lt;sup&gt;®&lt;/sup&gt; (Nutricia Early Life Nutrition Ltd)</td>
<td>Standard dilution (12.8 %) of powder per 100 mL</td>
<td>275 kJ (66 kcal)</td>
<td>1.8 g whey hydrolysed</td>
<td>6.8 g (sugars 1.1 g)</td>
<td>3.5 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Lactose-free</td>
<td>100 g powder: £13.67</td>
</tr>
<tr>
<td><strong>Aptamil Pepti-Junior</strong>&lt;sup&gt;®&lt;/sup&gt; 1 (Milupa Ltd)</td>
<td>Standard dilution (13.6 %) of powder per 100 mL</td>
<td>280 kJ (67 kcal)</td>
<td>1.6 g whey hydrolysed</td>
<td>7.1 g (sugars 3.5 g)</td>
<td>3.5 g</td>
<td>0.6 g</td>
<td>Contains lactose and fish oil</td>
<td>For the dietary management of established cows’ milk allergy with/without proven secondary lactose intolerance</td>
<td>400 g powder: £9.87; 800 g powder: £19.73</td>
</tr>
<tr>
<td><strong>Aptamil Pepti-Junior</strong>&lt;sup&gt;®&lt;/sup&gt; 2 (Milupa Ltd)</td>
<td>Standard dilution (14.3 %) of powder per 100 mL</td>
<td>285 kJ (68 kcal)</td>
<td>1.6 g whey hydrolysed</td>
<td>8 g (sugars 3.6 g)</td>
<td>3.1 g</td>
<td>0.6 g</td>
<td>Contains lactose and fish oil</td>
<td>For the dietary management of established cows’ milk allergy in patients over 6 months of age.</td>
<td>400 g powder: £9.41; 800 g powder: £18.82</td>
</tr>
<tr>
<td><strong>Infatrini</strong>&lt;sup&gt;®&lt;/sup&gt; Peptisorb (Nutricia Ltd)</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>240 kJ (100 kcal)</td>
<td>2.6 g whey protein hydrolysate</td>
<td>10.3 g (sugars 2.7 g)</td>
<td>5.4 g (MCT 50%)</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Residual lactose</td>
<td>Lactose-free</td>
</tr>
<tr>
<td><strong>Nutramigen 1 with LGG</strong>&lt;sup&gt;®&lt;/sup&gt; (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution (13.5 %) of powder per 100 mL</td>
<td>280 kJ (68 kcal)</td>
<td>1.9 g casein hydrolysed</td>
<td>7.5 g</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>For the dietary management of cow’s milk allergy with / or without lactose intolerance.</td>
<td>400 g powder: £11.21</td>
</tr>
<tr>
<td><strong>Nutramigen 2 with LGG</strong>&lt;sup&gt;®&lt;/sup&gt; (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution (14.2 %) of powder per 100 mL</td>
<td>280 kJ (68 kcal)</td>
<td>1.7 g casein hydrolysed</td>
<td>8.8 g</td>
<td>2.8 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Residual lactose</td>
<td>For the dietary management of cow’s milk allergy with / or without lactose intolerance.</td>
</tr>
<tr>
<td><strong>Pepdite</strong>&lt;sup&gt;®&lt;/sup&gt; (Nutricia Ltd)</td>
<td>Standard dilution (15 %) of powder per 100 mL</td>
<td>297 kJ (71 kcal)</td>
<td>2.1 g protein equivalent (non-milk hydrolysate)</td>
<td>7.8 g (sugars 700 mg)</td>
<td>3.5 g</td>
<td>Nil</td>
<td>Lactose-free</td>
<td>Contains meat (pork) and soya derivatives</td>
<td>Lactose-free</td>
</tr>
</tbody>
</table>

Powder provides: protein equivalent 13.8 g, carbohydrate 52 g, energy 1977 kJ (472 kcal)/100 g.
<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pepdite</strong>&lt;sup&gt;®&lt;/sup&gt; 1&lt;sup&gt;+&lt;/sup&gt; (Nutricia Ltd)</td>
<td>Standard dilution (22.8%) of powder per 100 mL</td>
<td>423 kJ (100 kcal)</td>
<td>3.1 g protein equivalent (non-milk hydrolysate, essential amino acids)</td>
<td>13 g (sugars 1.2 g)</td>
<td>3.9 g (MCT 35%)</td>
<td>Nil</td>
<td>Lactose-free Contains meat (pork) and soya derivatives</td>
<td>Disaccharide and/or whole protein intolerance, or where amino acids or peptides are indicated in conjunction with medium chain triglycerides. Not suitable for child under 1 year.</td>
<td>Pepdite 1+ powder: 400 gram = £21.37</td>
</tr>
<tr>
<td><strong>Pregestimil</strong>&lt;sup&gt;®&lt;/sup&gt; Lipil (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution (13.5%) of powder per 100 mL</td>
<td>280 kJ (68 kcal)</td>
<td>1.89 g casein hydrolysed</td>
<td>6.9 g</td>
<td>3.8 g (MCT 54%)</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Disaccharide and/or whole protein intolerance, or where amino acids or peptides are indicated in conjunction with medium chain triglycerides.</td>
<td>Pregestimil LIPIL powder: 400 gram = £12.43</td>
</tr>
<tr>
<td><strong>Similac</strong>&lt;sup&gt;®&lt;/sup&gt; Alimentum (Abbott Laboratories Ltd)</td>
<td>Standard dilution (14%) of powder per 100 mL</td>
<td>283 kJ (67.6 kcal)</td>
<td>1.86 g casein hydrolysed</td>
<td>6.62 g (sugars 1.5 g)</td>
<td>3.75 g (MCT 33%)</td>
<td>Nil</td>
<td>Gluten-free Lactose-free Contains meat derivatives</td>
<td>Cows’ milk protein allergy and other conditions where an extensively hydrolysed formula is indicated.</td>
<td>Similac Alimentum powder: 400 gram = £9.44</td>
</tr>
<tr>
<td><strong>SMA Althera</strong>&lt;sup&gt;®&lt;/sup&gt; (Nestle Health Science)</td>
<td>Standard dilution (13.2%) of powder per 100 mL</td>
<td>280 kJ (67 kcal)</td>
<td>1.7 g whey hydrolysed</td>
<td>7.3 g (sugars 4 g)</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Contains lactose</td>
<td>Complete nutritional support from birth to 3 years or supplementary feeding from 6 months to 3 years, in cow’s milk protein allergy or multiple food protein allergies</td>
<td>SMA Althera powder: 450 gram = £11.09</td>
</tr>
</tbody>
</table>

### Specialised formulas: Infant and child: Residual lactose formula

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enfamil</strong>&lt;sup&gt;®&lt;/sup&gt; O-Lac (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution (13%) of powder per 100 mL</td>
<td>280 kJ (68 kcal)</td>
<td>1.42 g cows’ milk</td>
<td>7.2 g</td>
<td>3.7 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Proven lactose intolerance</td>
<td>Enfamil O-Lac powder: 400 gram = £5.28</td>
</tr>
<tr>
<td><strong>Galactomin</strong>&lt;sup&gt;®&lt;/sup&gt; (Nutricia Ltd)</td>
<td>Standard dilution (13.6%) of powder per 100 mL</td>
<td>295 kJ (70 kcal)</td>
<td>1.7 g protein equivalent (cows’ milk)</td>
<td>7.5 g (sugars 1.4 g)</td>
<td>3.7 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Proven lactose intolerance in pre-school children, galactosaemia, and galactokinase deficiency.</td>
<td>Galactomin 17 powder: 400 gram = £18.21</td>
</tr>
<tr>
<td><strong>SMA</strong>&lt;sup&gt;®&lt;/sup&gt; LF (SMA Nutrition)</td>
<td>Standard dilution (13 %) of powder per 100 mL</td>
<td>281 kJ (67 kcal)</td>
<td>1.5 g casein, whey</td>
<td>7.2 g (sugars 2.6 g)</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Proven lactose intolerance</td>
<td>SMA LF powder: 400 gram = £5.16</td>
</tr>
</tbody>
</table>

Powder provides: protein equivalent 12.5 g, carbohydrate 55.5 g, fat 26 g, energy 2119 kJ (506 kcal)/100 g.

**Specialised formulas** | **Infant and child: Residual lactose formula**

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enfamil</strong>&lt;sup&gt;®&lt;/sup&gt; O-Lac (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution (13%) of powder per 100 mL</td>
<td>280 kJ (68 kcal)</td>
<td>1.42 g cows’ milk</td>
<td>7.2 g</td>
<td>3.7 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Proven lactose intolerance</td>
<td>Enfamil O-Lac powder: 400 gram = £5.28</td>
</tr>
<tr>
<td><strong>Galactomin</strong>&lt;sup&gt;®&lt;/sup&gt; (Nutricia Ltd)</td>
<td>Standard dilution (13.6%) of powder per 100 mL</td>
<td>295 kJ (70 kcal)</td>
<td>1.7 g protein equivalent (cows’ milk)</td>
<td>7.5 g (sugars 1.4 g)</td>
<td>3.7 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Proven lactose intolerance in pre-school children, galactosaemia, and galactokinase deficiency.</td>
<td>Galactomin 17 powder: 400 gram = £18.21</td>
</tr>
<tr>
<td><strong>SMA</strong>&lt;sup&gt;®&lt;/sup&gt; LF (SMA Nutrition)</td>
<td>Standard dilution (13 %) of powder per 100 mL</td>
<td>281 kJ (67 kcal)</td>
<td>1.5 g casein, whey</td>
<td>7.2 g (sugars 2.6 g)</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Proven lactose intolerance</td>
<td>SMA LF powder: 400 gram = £5.16</td>
</tr>
</tbody>
</table>

Powder provides: protein 12 g, carbohydrate 55.6 g, fat 28 g, energy 2185 kJ (522 kcal)/100 g.

### Specialised formulas

**Borderline substances** | **Appendix 2**

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enfamil</strong>&lt;sup&gt;®&lt;/sup&gt; O-Lac (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution (13%) of powder per 100 mL</td>
<td>280 kJ (68 kcal)</td>
<td>1.42 g cows’ milk</td>
<td>7.2 g</td>
<td>3.7 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Proven lactose intolerance</td>
<td>Enfamil O-Lac powder: 400 gram = £5.28</td>
</tr>
<tr>
<td><strong>Galactomin</strong>&lt;sup&gt;®&lt;/sup&gt; (Nutricia Ltd)</td>
<td>Standard dilution (13.6%) of powder per 100 mL</td>
<td>295 kJ (70 kcal)</td>
<td>1.7 g protein equivalent (cows’ milk)</td>
<td>7.5 g (sugars 1.4 g)</td>
<td>3.7 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Proven lactose intolerance in pre-school children, galactosaemia, and galactokinase deficiency.</td>
<td>Galactomin 17 powder: 400 gram = £18.21</td>
</tr>
<tr>
<td><strong>SMA</strong>&lt;sup&gt;®&lt;/sup&gt; LF (SMA Nutrition)</td>
<td>Standard dilution (13 %) of powder per 100 mL</td>
<td>281 kJ (67 kcal)</td>
<td>1.5 g casein, whey</td>
<td>7.2 g (sugars 2.6 g)</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Proven lactose intolerance</td>
<td>SMA LF powder: 400 gram = £5.16</td>
</tr>
</tbody>
</table>
### Specialised formulas: Infant and child: MCT-enhanced formula

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipistart®</td>
<td>Standard dilution</td>
<td>282 kJ</td>
<td>2.1 g</td>
<td>8.3 g</td>
<td>3.1 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Dietary management of fat</td>
<td>Lipistart powder: 400 gram = £21.28</td>
</tr>
<tr>
<td></td>
<td>(15%) of powder per 100 mL</td>
<td>68 (kcal)</td>
<td>protein</td>
<td>(whey, soya)</td>
<td>(sugars 700 mg)</td>
<td>(MCT 81%)</td>
<td></td>
<td>malabsorption, long-chain fatty</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>acid oxidation disorders, and</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>other disorders requiring a high</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MCT, low LCT formula.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powder provides: protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>equivalent 13.7 g, carbohydrate 55.3 g, fat 20.6 g, energy 1883 kJ (450 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>MCT Pepdite®</td>
<td>Standard dilution</td>
<td>286 kJ</td>
<td>2 g</td>
<td>8.8 g</td>
<td>2.7 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Disorders in which a high intake</td>
<td>MCT Pepdite powder: 400 gram = £22.14</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>(15%) of powder per 100 mL</td>
<td>68 (kcal)</td>
<td>protein</td>
<td>(non-milk peptides, essential amino acids)</td>
<td>(sugars 1.2 g)</td>
<td>(MCT 75%)</td>
<td></td>
<td>of MCT is beneficial</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disorders in which a high intake</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powder provides: protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>of MCT is beneficial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equivalent 13.8 g, carbohydrate 59 g, fat 18 g, energy 1903 kJ (453 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not suitable for child under 1 year.</td>
<td></td>
</tr>
<tr>
<td>MCT Pepdite® + 1</td>
<td>Standard dilution</td>
<td>381 kJ</td>
<td>2.8 g</td>
<td>11.8 g</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Lactose-free</td>
<td>Disorders in which a high intake</td>
<td>MCT Pepdite 1+ powder: 400 gram = £22.14</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>(20%) of powder per 100 mL</td>
<td>91 (kcal)</td>
<td>protein</td>
<td>(non-milk peptides, essential amino acids)</td>
<td>(sugars 1.6 g)</td>
<td>(MCT 75%)</td>
<td></td>
<td>of MCT is beneficial</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Disorders in which a high intake</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powder provides: protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>of MCT is beneficial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equivalent 13.8 g, carbohydrate 59 g, fat 18 g, energy 1903 kJ (453 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not suitable for child under 1 year.</td>
<td></td>
</tr>
<tr>
<td>Monogen®</td>
<td>Standard dilution</td>
<td>310 kJ</td>
<td>2.2 g</td>
<td>12 g</td>
<td>1.9 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Long-chain acyl-CoA dehydrogenase</td>
<td>Monogen powder: 400 gram = £22.01</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>(17.5%) of powder per 100 mL</td>
<td>74 (kcal)</td>
<td>protein</td>
<td>(whey)</td>
<td>(sugars 1.2 g)</td>
<td>(MCT 80%)</td>
<td></td>
<td>deficiency (LCAD), carnitine</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>palmitoyl transferase deficiency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powder provides: protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(CPTD), primary and secondary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equivalent 12.5 g, carbohydrate 68 g, fat 11 g, energy 1769 kJ (420 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>lipoprotein lipase</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>deficiency, chylothorax, and</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>lymphangiectasia</td>
<td></td>
</tr>
</tbody>
</table>

### Specialised formulas: Infant and child: Soya-based formula

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wysoy®</td>
<td>Standard dilution</td>
<td>280 kJ</td>
<td>1.8 g</td>
<td>6.9 g</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Lactose-free</td>
<td>Proven lactose and associated</td>
<td>SMA Wysoy powder: 860 gram = £10.93</td>
</tr>
<tr>
<td>(SMA Nutrition)</td>
<td>(13.2%) of powder per 100 mL</td>
<td>67 (kcal)</td>
<td>soya protein isolate</td>
<td>(sugars 2.5 g)</td>
<td>(sugars 700 mg)</td>
<td>(MCT 80%)</td>
<td></td>
<td>sucrose intolerance in pre-school</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>children, galactokinase deficiency,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powder provides: protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>galactosaemia, and proven whole</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equivalent 14 g, carbohydrate 54 g, fat 27 g, energy 2155 kJ (515 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>cows’ milk sensitivity.</td>
<td></td>
</tr>
</tbody>
</table>
### Specialised formulas: Infant and child: Low calcium formula

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locasol® (Nutricia Ltd)</td>
<td>Standard dilution</td>
<td>278 kJ (66 kcal)</td>
<td>1.9 g</td>
<td>7 g</td>
<td>3.4 g</td>
<td>Nil</td>
<td>Contains lactose Calcium less than 7 mg/100 mL No added vitamin D</td>
<td>Conditions of calcium intolerance requiring restriction of calcium and vitamin D intake</td>
<td>Locasol powder: 400 gram = £25.33</td>
</tr>
<tr>
<td></td>
<td>(13.1%) of powder per 100 mL</td>
<td></td>
<td>cows' milk</td>
<td>(sugars 6.9 g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Powder provides:</td>
<td></td>
<td>14.6 g, carbohydrate 53.7 g, fat 26.1 g, energy 2125 kJ (508 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Specialised formulas: Infant and child: Fructose-based formula

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Galactomin 19® (Nutricia Ltd)</td>
<td>Standard dilution</td>
<td>288 kJ (69 kcal)</td>
<td>1.9 g</td>
<td>6.4 g (fructose 6.3 g)</td>
<td>4 g</td>
<td>Nil</td>
<td>Residual lactose, galactose and glucose</td>
<td>Conditions of glucose plus galactose intolerance</td>
<td>Galactomin 19 powder: 400 gram = £47.94</td>
</tr>
<tr>
<td></td>
<td>(12.9%) of powder per 100 mL</td>
<td></td>
<td>protein equivalent (cows' milk)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Powder provides:</td>
<td></td>
<td>14.6 g, carbohydrate 49.7 g, fat 30.8 g, energy 2233 kJ (534 kcal)/100 g.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Specialised formulas: Infant and child: Pre-thickened infant feeds

**Child under 12 years. Not to be used for a period of more than 6 months; not to be used in conjunction with any other feed thickener or antacid products.**

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enfamil® AR (Mead Johnson Nutrition (UK) Ltd)</td>
<td>Standard dilution</td>
<td>285 kJ (68 kcal)</td>
<td>1.7 g</td>
<td>7.6 g (lactose 4.6 g)</td>
<td>3.5 g</td>
<td>Nil</td>
<td>Contains lactose, pregelatinised rice starch</td>
<td>Significant gastro-oesophageal reflux</td>
<td>Enfamil AR powder: 400 gram = £3.95</td>
</tr>
<tr>
<td></td>
<td>(13.9%) of powder per 100 mL</td>
<td></td>
<td>cows' milk</td>
<td></td>
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<tr>
<td>Powder provides:</td>
<td></td>
<td>12.5 g, carbohydrate 56 g, fat 26 g, energy 2093 kJ (500 kcal)/100 g.</td>
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</tbody>
</table>

**Specialised formulas for specific clinical conditions**

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicalm® (Nutricia Ltd)</td>
<td>Standard dilution</td>
<td>567 kJ (135 kcal)</td>
<td>4.5 g</td>
<td>17.4 g (sugars 3.2 g)</td>
<td>5.3 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Crohn's disease Not suitable for child under 1 year; use as nutritional supplement only in children 1-6 years.</td>
<td>Alicalm oral powder: 400 gram = £23.29</td>
</tr>
<tr>
<td></td>
<td>(30%) of powder per 100 mL</td>
<td></td>
<td>caseinate whey</td>
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<tr>
<td>Powder provides:</td>
<td></td>
<td>15 g, carbohydrate 58 g, fat 17.5 g, energy 1889 kJ (450 kcal)/100 g.</td>
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<tr>
<td>Forticare® (Nutricia Ltd)</td>
<td>Liquid (sip feed) per 100 mL</td>
<td>875 kJ (160 kcal)</td>
<td>9 g</td>
<td>19.1 g (sugars 13.6 g)</td>
<td>5.3 g</td>
<td>2.1 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Nutritional supplement in patients with lung cancer undergoing chemotherapy, or with pancreatic cancer Not suitable in child under 3 years</td>
<td>Forticare liquid: cappuccino, orange &amp; lemon, peach &amp; ginger 500 ml = £9.76</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>cows' milk</td>
<td></td>
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</tr>
<tr>
<td>Heparon® Junior (Nutricia Ltd)</td>
<td>Standard dilution</td>
<td>363 kJ (85 kcal)</td>
<td>2 g</td>
<td>11.6 g (sugars 2.9 g)</td>
<td>3.6 g</td>
<td>Nil</td>
<td>Contains lactose Electrolytes/100 mL: Na+ 0.56 mmol K+ 1.9 mmol Ca++ 2.3 mmol P+ 1.6 mmol</td>
<td>Enteral feed or nutritional supplement for children with acute or chronic liver failure</td>
<td>Heparon Junior powder: 400 gram = £23.47</td>
</tr>
<tr>
<td></td>
<td>(18%) of powder per 100 mL</td>
<td></td>
<td>cows' milk</td>
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<tr>
<td>Powder provides:</td>
<td></td>
<td>11.1 g, carbohydrate 64.2 g, fat 19.9 g, energy 2016 kJ (480 kcal)/100 g.</td>
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</tr>
<tr>
<td>Product</td>
<td>Formulation</td>
<td>Energy</td>
<td>Protein</td>
<td>Carbohydrate</td>
<td>Fat</td>
<td>Fibre</td>
<td>Special Characteristics</td>
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<td>Presentation &amp; Flavour</td>
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</tr>
<tr>
<td>KetoCal®</td>
<td>Standard dilution (20%) of powder per 100 mL</td>
<td>602 kJ (146 kcal)</td>
<td>3.1 g cows’ milk with additional amino acids</td>
<td>0.6 g (sugars 120 mg)</td>
<td>14.6 g (LCT 100%)</td>
<td>Nil</td>
<td>Electrolytes/100 mL: Na+: 4.3 mmol K+: 4.1 mmol Ca2+: 2.15 mmol P+: 2.77 mmol</td>
<td>Enteral feed or nutritional supplement as part of ketogenic diet in management of epilepsy resistant to drug therapy, in children over 1 year, only on the advice of secondary care physician with experience of ketogenic diet.</td>
<td>KetoCal 4:1 powder: unflavoured, vanilla 300 gram = £33.04</td>
</tr>
<tr>
<td>Powder provides: protein 15.25 g, carbohydrate 3 g, fat 73 g, energy 3011 kJ (730 kcal)/100 g.</td>
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<tr>
<td>KetoCal® 3:1</td>
<td>Standard dilution (9.5%) of powder per 100 mL</td>
<td>276 kJ (66 kcal)</td>
<td>1.5 g</td>
<td>0.68 g (sugars 570 mg)</td>
<td>4 g</td>
<td>Nil</td>
<td>Electrolytes/100 mL: Na+: 1.3 mmol K+: 2.4 mmol Ca2+: 2 mmol P+: 1.7 mmol</td>
<td>Enteral feed or nutritional supplement as part of ketogenic diet in management of drug resistant epilepsy or other conditions for which a ketogenic diet is indicated in children from birth to 6 years, as a nutritional supplement in children over 6 years.</td>
<td>KetoCal 3:1 powder: 300 gram = £31.98</td>
</tr>
<tr>
<td>Powder provides: protein 15.3 g, carbohydrate 7.2 g, fat 67.7 g, energy 2927 kJ (699 kcal)/100 g.</td>
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<tr>
<td>KetoCal® 4:1 LQ</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>620 kJ (150 kcal)</td>
<td>3.09 g casein and whey with additional amino acids</td>
<td>0.61 g (sugars 230 mg)</td>
<td>14.8 g (LCT 100%)</td>
<td>1.12 g</td>
<td>Electrolytes/100 mL: Na+: 4.9 mmol K+: 4.7 mmol Ca2+: 2.4 mmol P+: 3.1 mmol</td>
<td>Enteral feed or nutritional supplement as part of ketogenic diet in management of drug resistant epilepsy or other conditions for which a ketogenic diet is indicated in children 1-10 years; as a nutritional supplement in children over 10 years.</td>
<td>KetoCal 4:1 LQ liquid: unflavoured, vanilla 200 ml = £4.71</td>
</tr>
<tr>
<td>Powder provides: protein 15.3 g, carbohydrate 7.2 g, fat 67.7 g, energy 2927 kJ (699 kcal)/100 g.</td>
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<tr>
<td>Kindergen®</td>
<td>Standard dilution (20%) of powder per 100 mL</td>
<td>421 kJ (101 kcal)</td>
<td>1.5 g whey protein</td>
<td>11.8 g (sugars 1.2 g)</td>
<td>5.3 g (LCT 93%)</td>
<td>Nil</td>
<td>Electrolytes/100 mL: Na+: 2 mmol K+: 0.6 mmol Ca2+: 2.8 mmol P+: 3 mmol Low Vitamin A</td>
<td>Enteral feed or nutritional supplement for children with chronic renal failure receiving peritoneal rapid overnight dialysis.</td>
<td>Kindergen powder: 400 gram = £31.50</td>
</tr>
<tr>
<td>Powder provides: protein 7.5 g, carbohydrate 59 g, fat 26.3 g, energy 2104 kJ (504 kcal)/100 g.</td>
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<tr>
<td>Modulen IBD®</td>
<td>Standard dilution (20%) of powder (sip or tube feed) per 100 mL</td>
<td>420 kJ (100 kcal)</td>
<td>3.6 g casein</td>
<td>11 g (sugars 3.98 g)</td>
<td>4.7 g</td>
<td>Nil</td>
<td>Gluten-free Residual lactose</td>
<td>Crohn’s disease active phase, in remission if malnourished</td>
<td>Modulen IBD powder: 400 gram = £16.19</td>
</tr>
<tr>
<td>Powder provides: protein 18 g, carbohydrate 54 g, fat 23 g, energy 2070 kJ (500 kcal)/100 g.</td>
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<tr>
<td>Nepro®</td>
<td>Liquid (sip or tube feed) per 100 mL</td>
<td>838 kJ (200 kcal)</td>
<td>7 g cows’ milk</td>
<td>20.6 g (sugars 3.26 g)</td>
<td>9.6 g</td>
<td>1.56 g</td>
<td>Gluten-free Residual lactose Electrolytes/100 mL: Na+: 3.67 mmol K+: 2.72 mmol Ca2+: 3.43 mmol P+: 2.23 mmol</td>
<td>Enteral feed or nutritional supplement in patients with chronic renal failure who are on haemodialysis or CAPD, or with cirrhosis, or other conditions requiring a high energy, low fluid, low electrolyte diet. Not suitable for child under 1 year; use with caution in child 1-5 years.</td>
<td>Nepro HP liquid: strawberry 220 ml = £3.51; vanilla 220 ml = £3.51; 500 ml = £8.03</td>
</tr>
<tr>
<td>Product</td>
<td>Type</td>
<td>Nutritional Value</td>
<td>Ingredients</td>
<td>Notes</td>
<td>Cost</td>
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<tr>
<td>ProSure® (Abbott Laboratories Ltd)</td>
<td>Liquid (sip or tube feed)</td>
<td>536 kJ (127 kcal)</td>
<td>6.65 g cows' milk, 18.3 g (sugars 2.95 g)</td>
<td>2.56 g, 2.07 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Nutritional supplement for patients with pancreatic cancer. Not suitable for child under 1 year; use with caution in child 1-4 years. ProSure liquid: 220 ml = £3.60</td>
<td></td>
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</tr>
<tr>
<td>Renamil® Powder (sip or tube feed when reconstituted)</td>
<td>2003 kJ (477 kcal)</td>
<td>4.6 g cows' milk, 70.8 g</td>
<td>19.3 g</td>
<td>Nil</td>
<td>Contains lactose Gluten-free Electrolytes/100 g: Na⁺ 1.04 mmol K⁺ 0.13 mmol Ca²⁺ 10.22 mmol P⁺ 1.06 mmol</td>
<td>Enteral feed or nutritional supplement for adults and children over 1 year with chronic renal failure. Renamil powder: 1000 gram = £25.40</td>
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</tr>
<tr>
<td>Renapro® (Stanningley Pharma Ltd)</td>
<td>Powder</td>
<td>1558 kJ (372 kcal)</td>
<td>90 g whey protein, 3.4 g</td>
<td>1 g</td>
<td>Nil</td>
<td>Gluten-free Do not use in cow’s milk allergy, or where absorption and digestive problems are present Electrolytes/100 g: Na⁺ 15.65 mmol K⁺ 4.60 mmol Ca²⁺ 4.74 mmol Mg²⁺ 0.82 mmol P⁺ 3.55 mmol</td>
<td>Nutritional supplement for biochemically proven hypoproteinaemia and patients undergoing dialysis. Not suitable for child under 1 year. Renapro powder 20g sachets: 30 sachet = £99.60</td>
<td></td>
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</tr>
<tr>
<td>Renastart® (Vitaflo International Ltd) Powder</td>
<td>Standard dilution (20%) of powder</td>
<td>414 kJ (95 kcal)</td>
<td>1.5 g cows' milk soya, 12.5 g (sugars 1.3 g)</td>
<td>4.8 g</td>
<td>Nil</td>
<td>Contains lactose Electrolytes/100 mL: Na⁺ 2.1 mmol K⁺ 0.6 mmol Ca²⁺ 0.6 mmol P⁺ 0.6 mmol</td>
<td>Dietary management of renal failure in child from birth to 10 years. Renastart powder: 400 gram = £28.96</td>
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</tr>
<tr>
<td>Supportan® (Fresenius Kabi Ltd)</td>
<td>Liquid (sip feed)</td>
<td>630 kJ (150 kcal)</td>
<td>10 g cows' milk, 12.4 g (sugars 7.5 g)</td>
<td>6.7 g, 1.5 g</td>
<td>Gluten-free Residual lactose Contains fish oil</td>
<td>Nutritional supplement in patients with pancreatic cancer or with lung cancer undergoing chemotherapy Not suitable for child under 1 year; use with caution in child 1-4 years Supportan drink: cappuccino 800 ml = £11.28; tropical fruits 200 ml = £2.82; 800 ml = £11.28</td>
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</tbody>
</table>
### Table 4 Feed supplements

#### High-energy supplements: carbohydrate

Flavoured carbohydrate supplements are not suitable for child under 1 year; liquid supplements should be diluted before use in child under 5 years.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maxijul® Super Soluble</td>
<td>Powder</td>
<td>1615 kJ</td>
<td>Nil</td>
<td>95 g Glucose polymer</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high or readily available carbohydrate supplement.</td>
<td>Maxijul Super Soluble: powder 132g sachets 4 sachet = £7.03; powder 200 gram = £2.82; 25000 gram = £168.65</td>
</tr>
<tr>
<td>(Nutricia Ltd)</td>
<td>per 100 g</td>
<td>(380 kcal)</td>
<td></td>
<td>(sugars 8.6 g)</td>
<td></td>
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</tr>
<tr>
<td>Polycal® (Nutricia Ltd)</td>
<td>Powder</td>
<td>1630 kJ</td>
<td>Nil</td>
<td>96 g Maltodextrin</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high or readily available carbohydrate supplement.</td>
<td>Polycal powder: 400 gram = £4.70</td>
</tr>
<tr>
<td></td>
<td>per 100 g</td>
<td>(384 kcal)</td>
<td></td>
<td>(sugars 6 g)</td>
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<tr>
<td></td>
<td>Liquid</td>
<td>1050 kJ</td>
<td>Nil</td>
<td>61.9 g Maltodextrin</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high or readily available carbohydrate supplement. Not suitable for child under 3 years.</td>
<td>Polycal liquid: neutral, orange 200 ml = £1.87</td>
</tr>
<tr>
<td></td>
<td>per 100 mL</td>
<td>(247 kcal)</td>
<td></td>
<td>(sugars 12.2 g)</td>
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<tr>
<td>S.O.S.® (Vitaflo International Ltd)</td>
<td>Powder</td>
<td>1590 kJ</td>
<td>Nil</td>
<td>95 g (sugars 9 g)</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
<td>For use as an emergency regimen in the dietary management of inborn errors of metabolism in adults and children from birth.</td>
<td>S.O.S.: 20 oral powder 42g sachets 30 sachet = £16.06; S.O.S. 10 oral powder 21g sachets 30 sachet = £8.03; S.O.S. 15 oral powder 31g sachets 30 sachet = £11.85; S.O.S. 25 oral powder 52g sachets 30 sachet = £19.86</td>
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<tr>
<td></td>
<td>per 100 g</td>
<td>(380 kcal)</td>
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<tr>
<td>Vitajoule® (Vitaflo International Ltd)</td>
<td>Powder</td>
<td>1590 kJ</td>
<td>Nil</td>
<td>95 g Dried glucose syrup</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high or readily available carbohydrate supplement. Flavoured carbohydrate supplements are not suitable for child under 1 year; liquid supplements should be diluted before use in child under 5 years.</td>
<td>Vitajoule powder: 500 gram = £4.80</td>
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<td></td>
<td>per 100 g</td>
<td>(380 kcal)</td>
<td></td>
<td>(sugars 9 g)</td>
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Contents of each sachet should be reconstituted with water to a total volume of 200 ml
### High-energy supplements: fat
Liquid supplements should be diluted before use in child under 5 years.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Calogen® (Nutricia Ltd)</td>
<td>Liquid (emulsion) per 100 mL</td>
<td>1850 kJ (450 kcal)</td>
<td>Nil</td>
<td>0.1 g</td>
<td>50 g</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat (or fat and carbohydrate) supplement. Liquid supplements should be diluted before use in child under 5 years. Calogen emulsion: neutral 200 ml = £4.78; 500 ml = £11.76; strawberry 200 ml = £4.78; 500 ml = £11.76 banana 500 ml = £11.76</td>
</tr>
<tr>
<td>Fresubin® 5 kcal Shot (Fresenius Kabi Ltd)</td>
<td>Liquid (emulsion) per 100 mL</td>
<td>2100 kJ (500 kcal)</td>
<td>Nil</td>
<td>4.0 g (sucrose)</td>
<td>53.8 g 0.4 g</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat (or fat and carbohydrate) supplement. Liquid supplements should be diluted before use in child under 5 years. Not suitable for child under 3 years. Fresubin 5 kcal shot drink: lemon, neutral 480 ml = £11.96</td>
</tr>
<tr>
<td>Liquigen® (Nutricia Ltd)</td>
<td>Liquid (emulsion) per 100 mL</td>
<td>1850 kJ (450 kcal)</td>
<td>Nil</td>
<td>Nil</td>
<td>50 g (MCT 97%) Fractionated coconut oil</td>
<td>Nil</td>
<td>Gluten-free Lactose-free</td>
<td>Steatorrhoea associated with cystic fibrosis of the pancreas, intestinal lymphangiectasia, intestinal surgery, chronic liver disease, liver cirrhosis, other proven malabsorption syndromes, ketogenic diet in epilepsy, and in type 1 lipoproteinaemia. Not suitable for child under 1 year. Liquigen emulsion: 250 ml = £10.04</td>
</tr>
<tr>
<td>Medium-chain Triglyceride (MCT) Oil (Nutricia Ltd)</td>
<td>Liquid per 100 mL</td>
<td>3515 kJ (855 kcal)</td>
<td>Nil</td>
<td>Nil</td>
<td>MCT 100%</td>
<td>Nil</td>
<td>Nutritional supplement for steatorrhoea associated with cystic fibrosis of the pancreas, intestinal lymphangiectasia, intestinal surgery, chronic liver disease and liver cirrhosis, other proven malabsorption syndromes, ketogenic diet in management of epilepsy, type 1 hyperlipoproteinaemia. MCT oil: 500 ml = £15.92</td>
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### FAT AND CARBOHYDRATE

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<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duocal® Super Soluble (Nutricia Ltd)</td>
<td>Powder per 100 g</td>
<td>2061 kJ (492 kcal)</td>
<td>Nil</td>
<td>72.7 g (sugars 6.5 g)</td>
<td>22.3 g (MCT 35%)</td>
<td>Nil</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat (or fat and carbohydrate) supplement. Duocal Super Soluble powder: 400 gram = £19.60</td>
<td></td>
</tr>
<tr>
<td>Energivit® (Nutricia Ltd)</td>
<td>Standard dilution (15%) of powder per 100 mL</td>
<td>309 kJ (74 kcal)</td>
<td>Nil</td>
<td>10 g (sugars 900 mg)</td>
<td>3.75 g</td>
<td>Nil</td>
<td>Lactose-free With vitamins, minerals, and trace elements</td>
<td>For children requiring additional energy, vitamins, minerals, and trace elements following a protein-restricted diet Energivit powder: 400 gram = £23.84</td>
</tr>
</tbody>
</table>

Powder provides: carbohydrate 66.7 g, fat 25 g, energy 2059 kJ (492 kcal)/100 g.
### High-energy supplements: protein

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
<th>Fibre</th>
<th>Special Characteristics</th>
<th>ACBS Indications</th>
<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>ProSource® Jelly</td>
<td>Semi-solid per 100 mL</td>
<td>315 kJ (75 kcal)</td>
<td>16.9 g collagen protein hydrolysate whey protein isolate</td>
<td>Less than 1 g</td>
<td>Nil</td>
<td>Less than 1 g</td>
<td>Gluten-free</td>
<td>Hypoproteinaemia Not recommended for child under 3 years</td>
<td>ProSource jelly: fruit punch, orange 118 ml = £1.94</td>
</tr>
<tr>
<td>Protifar®</td>
<td>Powder per 100 g</td>
<td>1580 kJ (373 kcal)</td>
<td>88.5 g cows' milk</td>
<td>less than 1.5 g</td>
<td>1.6 g</td>
<td>Nil</td>
<td>Gluten-free, Residual lactose</td>
<td>Nutritional supplement for use in biochemically proven hypoproteinaemia.</td>
<td>Protifar powder: 225 gram = £9.55</td>
</tr>
<tr>
<td>ProSource® Liquid</td>
<td>Liquid per 30 mL</td>
<td>420 kJ (100 kcal)</td>
<td>10 g collagen protein whey protein isolate</td>
<td>15 g (sugars 8 g)</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free, Lactose-free</td>
<td>Biochemically proven hypoproteinaemia Not recommended for child under 3 years</td>
<td>ProSource liquid 30ml sachets: citrus berry, lemon, neutral, orange creme 100 sachet = £104.80</td>
</tr>
<tr>
<td>ProSource® Plus</td>
<td>Liquid per 30 mL</td>
<td>420 kJ (100 kcal)</td>
<td>15 g collagen protein whey protein isolate</td>
<td>11 g (sugars 10 g)</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free, Residual lactose</td>
<td>Hypoproteinaemia</td>
<td>ProSource Plus liquid 30ml sachets: citrus berry, neutral, orange creme 100 sachet = £149.08</td>
</tr>
</tbody>
</table>

**PROTEIN AND CARBOHYDRATE**

Not recommended for child under 3 years

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
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<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialamine®</td>
<td>Standard dilution (20%) of powder per 100 mL</td>
<td>264 kJ (62 kcal)</td>
<td>4.3 g protein equivalent (essential and non-essential amino acids)</td>
<td>11.2 g (sugars 10.2 g)</td>
<td>Nil</td>
<td>Nil</td>
<td>Contains vitamin C</td>
<td>Hypoproteinaemia, chronic renal failure, wound fistula leakage with excessive protein loss, conditions requiring a controlled nitrogen intake, and haemodilatation. Not suitable for child under 6 months.</td>
<td>Dialamine powder: 400 gram = £79.64</td>
</tr>
<tr>
<td>ProSource® Liquid</td>
<td>Liquid per 30 mL</td>
<td>420 kJ (100 kcal)</td>
<td>10 g collagen protein whey protein isolate</td>
<td>15 g (sugars 8 g)</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free, Lactose-free May contain porcine derivatives</td>
<td>Biochemically proven hypoproteinaemia Not recommended for child under 3 years</td>
<td>ProSource liquid 30ml sachets: citrus berry, lemon, neutral, orange creme 100 sachet = £104.80</td>
</tr>
<tr>
<td>ProSource® Plus</td>
<td>Liquid per 30 mL</td>
<td>420 kJ (100 kcal)</td>
<td>15 g collagen protein whey protein isolate</td>
<td>11 g (sugars 10 g)</td>
<td>Nil</td>
<td>Nil</td>
<td>Gluten-free, Residual lactose Contains porcine derivatives</td>
<td>Hypoproteinaemia</td>
<td>ProSource Plus liquid 30ml sachets: citrus berry, neutral, orange creme 100 sachet = £149.08</td>
</tr>
<tr>
<td>Product</td>
<td>Formulation</td>
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</tr>
<tr>
<td>Calogen® Extra</td>
<td>Liquid per 100 mL</td>
<td>1650 kJ (400 kcal)</td>
<td>5 g cows' milk</td>
<td>4.5 g (sugars 3.5 g)</td>
<td>40.3 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Residual lactose Contains vitamins and minerals</td>
<td>Calogen Extra emulsion: neutral, strawberry 200 ml = £4.98</td>
</tr>
<tr>
<td>Calogen® Extra Shots</td>
<td>Liquid per 100 mL</td>
<td>1650 kJ (400 kcal)</td>
<td>5 g cows' milk</td>
<td>4.5 g (sugars 3.5 g)</td>
<td>40.3 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Residual lactose With vitamins and minerals</td>
<td>Calogen Extra Shots emulsion: neutral, strawberry 240 ml = £5.75</td>
</tr>
<tr>
<td>Calshake®</td>
<td>Powder per 87 g</td>
<td>2504 kJ (598.5 kcal)</td>
<td>12 g cows' milk</td>
<td>70.2 g (sugars 22.4 g)</td>
<td>29.9 g</td>
<td>Nil</td>
<td>Contains lactose</td>
<td>Gluten-free</td>
<td>Calshake powder 87g sachets: banana, neutral, strawberry, vanilla, 7 sachet = £18.41; Calshake powder 90g sachets chocolate: 7 sachet = £18.41</td>
</tr>
<tr>
<td>Enshake®</td>
<td>Powder per 100 g</td>
<td>1893 kJ (450 kcal)</td>
<td>8.4 g cows' milk, soy protein isolate</td>
<td>69 g (sugars 14.5 g)</td>
<td>15.6 g</td>
<td>Nil</td>
<td>Residual lactose</td>
<td>Contains vitamins and minerals</td>
<td>Enshake oral powder 96.5g sachets: banana, chocolate, strawberry, vanilla 6 sachet = £15.22</td>
</tr>
<tr>
<td>MCT Procal®</td>
<td>Powder per 100 g</td>
<td>2742 kJ (657 kcal)</td>
<td>12.5 g cows' milk</td>
<td>20.6 g (sugars 3.1 g)</td>
<td>63.1 g</td>
<td>Nil</td>
<td>Contains lactose</td>
<td>Dietary management of disorders of long-chain fatty acid oxidation, fat malabsorption, and other disorders requiring a low LCT, high MCT supplement. Not suitable for child under 1 year.</td>
<td>MCTprocal oral powder 16g sachets: 30 sachet = £26.09</td>
</tr>
</tbody>
</table>

Powder: one sachet reconstituted with 240 mL whole milk provides approx. 600 kcal and 12 g protein.

Powder: 96.5 g reconstituted with 240 mL whole milk provides approx. 2 kcal/mL and protein 16 g.

Powder 16 g provides: protein 2 g, carbohydrate 3.3 g, fat 10.1 g, energy 439 kJ (105 kcal).
### PROTEIN, FAT, AND CARBOHYDRATE (PRODUCT LIST CONTINUED)

**Not suitable for child under 3 years.**

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
<th>Carbohydrate</th>
<th>Fat</th>
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<th>Special Characteristics</th>
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<th>Presentation &amp; Flavour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro-Cal®®</td>
<td>Powder per 100 g</td>
<td>2787 kJ (667 kcal)</td>
<td>13.6 g cows' milk</td>
<td>28.2 g (sugars 16 g)</td>
<td>55.5 g</td>
<td>Nil</td>
<td>Contains lactose, Gluten-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat or carbohydrate (with protein) supplement. Not suitable for child under 1 year; use with caution in child 1-5 years.</td>
<td>Pro-Cal powder: 510 gram = £16.11; 1500 gram = £233.28</td>
</tr>
<tr>
<td>Pro-Cal®® shot (Vitafllo International Ltd)</td>
<td>Liquid per 100 mL</td>
<td>1385 kJ (334 kcal)</td>
<td>6.7 g cows' milk</td>
<td>13.4 g (sugars 13.3 g)</td>
<td>28.2 g</td>
<td>Nil</td>
<td>Contains lactose, Gluten-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat or carbohydrate (with protein) supplement. Not suitable for child under 3 years.</td>
<td>Pro-Cal: shot banana, shot neutral, shot starter pack, shot strawberry 720 ml = £15.26</td>
</tr>
<tr>
<td>Scandishake Mix (Nutricia Ltd)</td>
<td>Powder per 100 g</td>
<td>2099 kJ (500 kcal)</td>
<td>4.7 g cows' milk</td>
<td>65 g (sugars 14.3 g)</td>
<td>24.7 g</td>
<td>Nil</td>
<td>Gluten-free</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat or carbohydrate (with protein) supplement. Not suitable for child under 3 years.</td>
<td>Scandishake Mix oral powder 85g sachets: banana, caramel, chocolate, strawberry, unflavoured, vanilla 6 sachet = £15.54</td>
</tr>
<tr>
<td>Vitasavoury®® (Vitafllo International Ltd)</td>
<td>Powder per 100 g</td>
<td>2562 kJ (619 kcal)</td>
<td>12 g cows' milk</td>
<td>22.5 g (sugars 1.4 g Chicken/2.7 g Golden Vegetable)</td>
<td>52 g</td>
<td>6.4 g</td>
<td>Contains lactose, Contains soya (chicken flavour) Contains gluten (wheat) (chicken flavour) Contains celery (golden vegetable flavour)</td>
<td>Disease-related malnutrition, malabsorption states, or other conditions requiring fortification with a high fat or carbohydrate (with protein) supplement. Not suitable for child under 3 years.</td>
<td>Vitasavoury powder 50g sachets: chicken 10 sachet = £20.83; golden vegetable 10 sachet = £20.83</td>
</tr>
</tbody>
</table>

**Powder 15 g provides: protein 2 g, carbohydrate 4.2 g, fat 8.3 g, energy 418 kJ (100 kcal).**

**Powder: 85 g reconstituted with 240 mL whole milk provides: protein 11.7 g, carbohydrate 66.8 g, fat 30.4 g, energy 2457 kJ (588 kcal).**

**Vitamin and Mineral supplements**

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Energy</th>
<th>Protein</th>
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</tr>
</thead>
<tbody>
<tr>
<td>FruitVite®® (Vitafllo International Ltd)</td>
<td>Powder per 100 g</td>
<td>133 kJ (33 kcal)</td>
<td>Nil</td>
<td>8.3 g (sugars 400 mg)</td>
<td>0.1 g</td>
<td>3.3 g</td>
<td>Vitamin, mineral, and trace element supplement in children 3-10 years with restrictive therapeutic diets</td>
<td>Vitamin, mineral, and trace element supplement in children 3-10 years with restrictive therapeutic diets</td>
<td>FruitVite oral powder 6g sachets: 30 sachet = £70.55</td>
</tr>
<tr>
<td>Paediatric Seravit®® (Nutricia Ltd)</td>
<td>Powder per 100 g</td>
<td>1275 kJ (300 kcal)</td>
<td>Nil</td>
<td>75 g (sugars 6.75 g)</td>
<td>Nil</td>
<td>Nil</td>
<td>Pineapple flavour not suitable for child under 6 months</td>
<td>Vitamin, mineral, and trace element supplement in infants and children with restrictive therapeutic diets.</td>
<td>Seravit Paediatric powder: pineapple 200 gram = £20.69; unflavoured 200 gram = £19.41</td>
</tr>
</tbody>
</table>

To flavour unflavoured products, see Modjul®® Flavour System p. 1082.
Feed additives
Special additives for conditions of intolerance

**Colief ®**
- Transient Lactase Deficiency. For dosage and administration details, consult product literature.
- LIQUID, lactase 50 000 units/g

**Colief 50,000 units/g infant drops** (Forum Health Products Ltd)
- 7 ml (ACBS) - NHS indicative price = £6.40

**Fructose**
- (Laevulose) For proven glucose/galactose intolerance
- Transient Lactase Deficiency. For dosage and administration details, consult product literature.

**Dietade dietary foods fruit sugar** (Margetts)
- 250 gram - No NHS indicative price available

**Glucose**
- (Dextrose monohydrate) For use as an energy supplement in sucrose-isomaltase deficiency

Feed thickeners and pre-thickened drinks

**Carobel, Instant ®**
- For thickening feeds in the treatment of vomiting. POWDER, carob seed flour.
- Instant Carobel powder (Cow & Gate Ltd)
  - 135 gram (ACBS) - NHS indicative price = £2.91

**Multi-thick ®**
- For thickening of liquids and foods in dysphagia. Not suitable for children under 1 year except in cases of failure to thrive. POWDER, modified maize starch, gluten- and lactose-free.

**Nutilis® Clear**
- For thickening of liquids or foods in dysphagia. Not suitable for children under 3 years. POWDER, dried glucose syrup, xanthan gum, guar gum, gluten- and lactose-free.

**Nutilis Clear powder** (Nutricia Ltd)
- 175 gram (ACBS) - NHS indicative price = £8.46

**Nutilis® Powder**
- For thickening of food and fluid in dysphagia. Not suitable for child under 3 years. POWDER, carbohydrate 87.5 g, energy 1545 kJ (363 kcal)/100 g, contains modified starch. Gluten-free and lactose-free.

**Nutilis powder** (Nutricia Ltd)
- 300 gram (ACBS) - NHS indicative price = £5.50

**Resource Thickened Drink**
- For dysphagia. Not suitable for children under 3 years. POWDER, carob seed flour.
- Resource Thickened Drink custard apple (Nestle Health Science)
  - 114 ml (ACBS) - NHS indicative price = £0.78
- Resource Thickened Drink custard orange (Nestle Health Science)
  - 114 ml (ACBS) - NHS indicative price = £0.78
- Resource Thickened Drink syrup apple (Nestle Health Science)
  - 114 ml (ACBS) - NHS indicative price = £0.78
- Resource Thickened Drink syrup orange (Nestle Health Science)
  - 114 ml (ACBS) - NHS indicative price = £0.78

**Resource® ThickenedUp Clear**
- For thickening of liquids or foods in dysphagia. Not suitable for children under 3 years. POWDER, maltodextrin, xanthum gum, gluten- and lactose-free.
- Resource ThickenedUp Clear powder (Nestle Health Science)
  - 28.8 gram (ACBS) - NHS indicative price = £5.28 | 127 gram (ACBS) - NHS indicative price = £8.46

**Resource® ThickenedUp**
- For thickening of foods in dysphagia. Suitable for children above 3 years of age. POWDER, modified maize starch. Gluten-free.
- Resource ThickenedUp powder (Nestle Health Science)
  - 227 gram (ACBS) - NHS indicative price = £4.66

**SLO Drinks ®**
- Nutritional supplement for patient hydration in the dietary management of dysphagia. Not suitable for children under 3 years. POWDER, carbohydrate content varies with flavour and chosen consistency (3 consistencies available), see product literature.
- SLO Drink Stage 1: IDDSI 2 Mildly Thick oral powder blackcurrant (SLO Drinks Ltd)
  - 25 cup (ACBS) - NHS indicative price = £7.50
- SLO Drink Stage 1: IDDSI 2 Mildly Thick oral powder orange (SLO Drinks Ltd)
  - 25 cup (ACBS) - NHS indicative price = £7.50

**SLO Drink Stage 2: IDDSI 3 Moderately Thick oral powder blackcurrant** (SLO Drinks Ltd)
- 25 cup (ACBS) - NHS indicative price = £7.50

**SLO Drink Stage 2: IDDSI 3 Moderately Thick oral powder orange** (SLO Drinks Ltd)
- 25 cup (ACBS) - NHS indicative price = £7.50

**SLO Milkshakes®**
- Nutritional supplement in the dietary management of dysphagia. Not suitable for children under 3 years. POWDER, carbohydrate content varies with flavour and chosen consistency (2 consistencies available), see product literature.
- SLO Milkshake+ Stage 1 oral powder chocolate (SLO Drinks Ltd)
  - 7 x 50 gram (ACBS) - NHS indicative price = £5.88
- SLO Milkshake+ Stage 1 oral powder strawberry (SLO Drinks Ltd)
  - 7 x 50 gram (ACBS) - NHS indicative price = £5.05
- SLO Milkshake+ Stage 2 oral powder chocolate (SLO Drinks Ltd)
  - 7 x 50 gram (ACBS) - NHS indicative price = £5.88
- SLO Milkshake+ Stage 2 oral powder strawberry (SLO Drinks Ltd)
  - 7 x 50 gram (ACBS) - NHS indicative price = £5.88

**Thick and Easy®**
- For thickening of foods in dysphagia. Not suitable for children under 1 year except in cases of failure to thrive. POWDER/MODIFIED MAIZE STARCH
- Thick & Easy powder (Fresenius Kabi Ltd)
  - 225 gram (ACBS) - NHS indicative price = £5.41 | 4540 gram (ACBS) - NHS indicative price = £94.02
- Thick & Easy powder 9g sachets (Fresenius Kabi Ltd)
  - 100 sachet (ACBS) - NHS indicative price = £34.25

**Thicken Aid®**
- For thickening of foods in dysphagia. Not suitable for children under 1 year. POWDER, modified maize starch, maltodextrin, gluten- and lactose-free.
- Thicken Aid powder (M & A Pharmachem Ltd)
  - 35 gram (ACBS) - NHS indicative price = £3.71
- Thicken Aid powder 9g sachets (M & A Pharmachem Ltd)
  - 100 sachet (ACBS) - NHS indicative price = £22.40

**Thixo-D®**
- For thickening of foods in dysphagia. Not suitable for children under 1 year except in cases of failure to thrive. POWDER, modified maize starch, glucan-free.
- Thixo-D powder (Sutherland Health Ltd)
  - 375 gram (ACBS) - NHS indicative price = £8.10
- Thixo-D Cal-Free powder (Sutherland Health Ltd)
  - 50 gram - NHS indicative price = £3.00

Flavouring preparations

**FlavourPac®**
- For use with Vitaﬂo’s range of unflavoured protein substitutes for metabolic diseases; not suitable for child under 3 years. POWDER
- FlavourPac oral powder 4g sachets blackcurrant (Vitaﬂo International Ltd)
  - 30 sachet (ACBS) - NHS indicative price = £15.14
- FlavourPac oral powder 4g sachets lemon (Vitaﬂo International Ltd)
  - 30 sachet (ACBS) - NHS indicative price = £15.14
Foods for special diets

Gluten-free foods

ACBS indications: established gluten-sensitive enteropathies including steatorrhoea due to gluten sensitivity, coeliac disease, and dermatitis herpetiformis.

Bread

LOAVES

Barkat® Loaf

GLUTEN-FREE

Barkat gluten free brown rice bread (Gluten Free Foods Ltd) 500 gram (ACBS) - NHS indicative price = £5.84

Barkat gluten free par baked white bread sliced (Gluten Free Foods Ltd) 300 gram (ACBS) - NHS indicative price = £4.21

Barkat gluten free home fresh country loaf (Gluten Free Foods Ltd) 250 gram - NHS indicative price = £2.43

Barkat gluten free multigrain rice bread (Gluten Free Foods Ltd) 500 gram (ACBS) - NHS indicative price = £5.84

Barkat gluten free wholemeal bread sliced (Gluten Free Foods Ltd) 500 gram (ACBS) - NHS indicative price = £4.05

Barkat gluten free white rice bread (Gluten Free Foods Ltd) 500 gram (ACBS) - NHS indicative price = £5.84

Ener-G® Loaves

GLUTEN-FREE

Ener-G gluten free brown rice bread (Gluten Free Foods Ltd) 474 gram (ACBS) - NHS indicative price = £5.47

Ener-G gluten free tapioca bread (Gluten Free Foods Ltd) 480 gram (ACBS) - NHS indicative price = £5.47

Ener-G gluten free rice loaf (Gluten Free Foods Ltd) 612 gram (ACBS) - NHS indicative price = £5.47

Ener-G gluten free Seattle brown loaf (Gluten Free Foods Ltd) 454 gram (ACBS) - NHS indicative price = £6.22

Ener-G gluten free white rice bread (Gluten Free Foods Ltd) 456 gram (ACBS) - NHS indicative price = £5.47

Genius Gluten Free® Loaf

GLUTEN-FREE

Genius gluten free brown sandwich bread sliced (Genius Foods Ltd) 535 gram (ACBS) - NHS indicative price = £3.80

Genius gluten free white sandwich bread sliced (Genius Foods Ltd) 535 gram (ACBS) - NHS indicative price = £3.80

Glutafin® Loaves

GLUTEN-FREE

Glutafin gluten free white loaf sliced (Dr Schar UK Ltd) 300 gram (ACBS) - NHS indicative price = £2.89

Glutafin gluten free white loaf sliced (Dr Schar UK Ltd) 300 gram (ACBS) - NHS indicative price = £2.89

Glutafin gluten free Select white loaf sliced (Dr Schar UK Ltd) 300 gram (ACBS) - NHS indicative price = £2.89

Glutafin gluten free Select fibre loaf sliced (Dr Schar UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.43

Glutafin gluten free Select fresh brown loaf sliced (Dr Schar UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.43

Glutafin gluten free Select fresh white loaf sliced (Dr Schar UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.43

Glutafin gluten free Select seeded loaf sliced (Dr Schar UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.72

Glutafin gluten free Select white loaf sliced (Dr Schar UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.43

Juvela® Loaf

GLUTEN-FREE

Juvela gluten free fresh fibre loaf sliced (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.39

Juvela gluten free fresh white loaf sliced (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.69

Juvela gluten free fibre loaf sliced (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.54

Juvela gluten free part baked loaf (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.95

Juvela gluten free part baked fibre loaf (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.80

Juvela gluten free loaf unsliced (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.54

Juvela gluten free fibre loaf unsliced (Hero UK Ltd) 400 gram (ACBS) - NHS indicative price = £3.54

Lifestyle® Loaf

GLUTEN-FREE

Lifestyle gluten free brown bread sliced (Ultrapharm Ltd) 400 gram (ACBS) - NHS indicative price = £2.82

Lifestyle gluten free high fibre bread sliced (Ultrapharm Ltd) 400 gram - NHS indicative price = £2.82

Lifestyle gluten free white bread sliced (Ultrapharm Ltd) 400 gram - NHS indicative price = £2.82

Warburtons® Loaf

GLUTEN-FREE

Warburtons gluten free brown bread sliced (Warburtons Ltd) 400 gram (ACBS) - NHS indicative price = £3.06

Warburtons gluten free white bread sliced (Warburtons Ltd) 400 gram (ACBS) - NHS indicative price = £3.06

Wellfoods® Loaf

GLUTEN-FREE

Wellfoods gluten free loaf sliced (Wellfoods Ltd) 600 gram - NHS indicative price = £5.05

Wellfoods gluten free loaf unsliced (Wellfoods Ltd) 600 gram - NHS indicative price = £4.95

BAGUETTES, BUNS AND ROLLS

Barkat® Baguettes and rolls

GLUTEN-FREE

Barkat gluten free par baked rolls (Gluten Free Foods Ltd) 200 gram (ACBS) - NHS indicative price = £4.05

Barkat gluten free par baked baguettes (Gluten Free Foods Ltd) 200 gram (ACBS) - NHS indicative price = £4.05

Ener-G® Rolls

GLUTEN-FREE

Ener-G gluten free dinner rolls (Gluten Free Foods Ltd) 280 gram (ACBS) - NHS indicative price = £3.71

Ener-G gluten free white round rolls (Gluten Free Foods Ltd) 220 gram - NHS indicative price = £2.98

Glutafin® Baguettes and rolls

GLUTEN-FREE

Glutafin gluten free white long rolls (Gluten Free Foods Ltd) 220 gram - NHS indicative price = £2.98
### Foods for special diets

#### Glutafin gluten free baguettes
- (Dr Schar UK Ltd)
- 500 gram (ACBS) - NHS indicative price = £3.51

#### Glutafin gluten free 4 white rolls
- (Dr Schar UK Ltd)
- 200 gram (ACBS) - NHS indicative price = £3.68

#### Glutafin gluten free part baked 4 fibre rolls
- (Dr Schar UK Ltd)
- 200 gram (ACBS) - NHS indicative price = £3.68

#### Glutafin Select Rolls
- GLUTEN-FREE

#### Glutafin gluten free part baked 4 white rolls
- (Dr Schar UK Ltd)
- 150 gram (ACBS) - NHS indicative price = £2.81

#### Juvela Rolls
- GLUTEN-FREE

#### Juvela gluten free crispbread
- (Hero UK Ltd)
- 200 gram (ACBS) - NHS indicative price = £4.22

#### Juvela gluten free fresh fibre rolls
- (Hero UK Ltd)
- 200 gram (ACBS) - NHS indicative price = £4.42

#### Juvela gluten free fibre bread rolls
- (Hero UK Ltd)
- 425 gram (ACBS) - NHS indicative price = £4.77

#### Juvela gluten free bread rolls
- (Hero UK Ltd)
- 425 gram (ACBS) - NHS indicative price = £4.77

#### Juvela gluten free part baked fibre bread rolls
- (Hero UK Ltd)
- 375 gram (ACBS) - NHS indicative price = £4.94

#### Juvela gluten free part baked white bread rolls
- (Hero UK Ltd)
- 375 gram (ACBS) - NHS indicative price = £4.94

#### Lifestyle Rolls
- GLUTEN-FREE

#### Proceli Baguettes, buns and rolls
- GLUTEN-FREE

#### Wellfoods buns and rolls
- GLUTEN-FREE

#### Wellfoods gluten free burger buns
- (Wellfoods Ltd)
- 500 gram - NHS indicative price = £4.03

#### Wellfoods gluten free rolls
- (Wellfoods Ltd)
- 360 gram - NHS indicative price = £3.73

#### Cereals

#### Juvela Fibre flakes and oats
- GLUTEN-FREE

#### Juvela gluten free fibre flakes
- (Hero UK Ltd)
- 500 gram - NHS indicative price = £2.78

#### Juvela gluten free flakes
- (Hero UK Ltd)
- 500 gram - NHS indicative price = £2.78

#### Juvela gluten free pure oats
- (Hero UK Ltd)
- 500 gram - NHS indicative price = £2.78

#### Nairns Porridge
- GLUTEN-FREE

#### Nairn's gluten free oat porridge
- (Nairn's Oatcakes Ltd)
- 500 gram - NHS indicative price = £3.05

#### Cookies and biscuits

#### Barkat Biscuits
- GLUTEN-FREE

#### Barkat gluten free digestive biscuits
- (Gluten Free Foods Ltd)
- 175 gram - NHS indicative price = £2.66

#### Ener-G Cookies
- GLUTEN-FREE

#### Ener-G gluten free vanilla cookies
- (Gluten Free Foods Ltd)
- 435 gram - NHS indicative price = £6.23

#### Glutafin Cookies and biscuits
- GLUTEN-FREE

#### Glutafin gluten free tea biscuits
- (Dr Schar UK Ltd)
- 150 gram - NHS indicative price = £2.09

#### Glutafin gluten free digestive biscuits
- (Dr Schar UK Ltd)
- 150 gram - NHS indicative price = £2.13

#### Glutafin gluten free shortbread biscuits
- (Dr Schar UK Ltd)
- 100 gram - NHS indicative price = £1.73

#### Juvela Biscuits
- GLUTEN-FREE

#### Juvela gluten free digestive biscuits
- (Hero UK Ltd)
- 150 gram - NHS indicative price = £3.05

#### Juvela gluten free savoury biscuits
- (Hero UK Ltd)
- 150 gram - NHS indicative price = £3.82

#### Juvela gluten free sweet biscuits
- (Hero UK Ltd)
- 150 gram - NHS indicative price = £2.88

#### Juvela gluten free tea biscuits
- (Hero UK Ltd)
- 150 gram - NHS indicative price = £3.05

#### Crackers, crispbreads, and breadsticks

#### Barkat Crackers
- GLUTEN-FREE

#### Barkat gluten free matzo crackers
- (Gluten Free Foods Ltd)
- 200 gram - NHS indicative price = £3.59

#### Glutafin Crackers
- GLUTEN-FREE

#### Glutafin gluten free crackers
- (Dr Schar UK Ltd)
- 200 gram - NHS indicative price = £3.46

#### Glutafin gluten free mini crackers
- (Dr Schar UK Ltd)
- 175 gram - NHS indicative price = £2.96

#### Juvela Crispbread
- GLUTEN-FREE

#### Juvela gluten free crispbread
- (Hero UK Ltd)
- 200 gram - NHS indicative price = £4.64

#### Flour mixes and xanthan gum

#### FLOUR MIXES

#### Barkat Flour mix
- GLUTEN-FREE

#### Barkat gluten free high fibre bread mix
- (Gluten Free Foods Ltd)
- 500 gram (ACBS) - NHS indicative price = £9.13

#### Barkat gluten free all purpose flour mix
- (Gluten Free Foods Ltd)
- 500 gram (ACBS) - NHS indicative price = £4.74

#### Finax Flour mix
- GLUTEN-FREE

#### Finax gluten free coarse flour mix
- (Drossa Ltd)
- 900 gram (ACBS) - NHS indicative price = £8.85

#### Finax gluten free flour mix
- (Drossa Ltd)
- 1000 gram (ACBS) - NHS indicative price = £10.14

#### Finax gluten free flour mix
- (Drossa Ltd)
- 900 gram (ACBS) - NHS indicative price = £8.85

#### Glutafin Select Flour mix
- GLUTEN-FREE

#### Glutafin gluten free Select bread mix
- (Dr Schar UK Ltd)
- 500 gram (ACBS) - NHS indicative price = £6.66

#### Glutafin gluten free Select fibre bread mix
- (Dr Schar UK Ltd)
- 500 gram (ACBS) - NHS indicative price = £6.66
Glutafin gluten free Select multipurpose fibre mix (Dr Schar UK Ltd)
500 gram (ACBS) - NHS indicative price = £6.66

Glutafin gluten free Select multipurpose white mix (Dr Schar UK Ltd)
500 gram (ACBS) - NHS indicative price = £6.66

Gluten-free flour mix (Gluten Free Foods Ltd)

Glutafin gluten free multipurpose white mix (Dr Schar UK Ltd)
500 gram (ACBS) - NHS indicative price = £6.66

Juvéla® flour mix
GLUTEN-FREE

Juvéla gluten free fibre mix (Hero UK Ltd)
500 gram (ACBS) - NHS indicative price = £7.35

Juvéla gluten free harvest mix (Hero UK Ltd)
500 gram (ACBS) - NHS indicative price = £7.35

Juvéla gluten free mix (Hero UK Ltd)
500 gram (ACBS) - NHS indicative price = £7.35

Mrs Crimbles® flour mixes
GLUTEN-FREE

Mrs Crimbles’s gluten free bread mix (Stiletto Foods (UK) Ltd)
275 gram - NHS indicative price = £1.09

Mrs Crimbles gluten free pastry mix (Stiletto Foods (UK) Ltd)
200 gram - NHS indicative price = £1.09

Orgran® flour mix
GLUTEN-FREE

Orgran gluten free self-raising flour (Naturally Good Food Ltd)
500 gram - NHS indicative price = £3.10

Orgran gluten free all purpose plain flour (Naturally Good Food Ltd)
500 gram - NHS indicative price = £3.10

Proceli® flour mix
GLUTEN-FREE

Proceli gluten free basic mix (Ambe Ltd)
1000 gram (ACBS) - NHS indicative price = £9.95

Pure® flour mix
GLUTEN-FREE

Innovative Solutions Pure gluten free blended flour (Innovative Solutions (UK) Ltd)
1000 gram (ACBS) - NHS indicative price = £4.52

Innovative Solutions Pure gluten free brown rice flour (Innovative Solutions (UK) Ltd)
500 gram (ACBS) - NHS indicative price = £1.69

Innovative Solutions Pure gluten free white rice flour (Innovative Solutions (UK) Ltd)
500 gram (ACBS) - NHS indicative price = £1.80

Innovative Solutions Pure gluten free potato flour (Innovative Solutions (UK) Ltd)
500 gram (ACBS) - NHS indicative price = £1.80

Innovative Solutions Pure gluten free tapioca flour (Innovative Solutions (UK) Ltd)
500 gram (ACBS) - NHS indicative price = £2.42

Innovative Solutions Pure gluten free brown teff flour (Innovative Solutions (UK) Ltd)
1000 gram (ACBS) - NHS indicative price = £5.10

Innovative Solutions Pure gluten free white teff flour (Innovative Solutions (UK) Ltd)
1000 gram (ACBS) - NHS indicative price = £5.10

Tobia® flour mix
GLUTEN-FREE

Tobia Teff gluten free brown bread mix (Tobia Teff UK Ltd)
1000 gram (ACBS) - NHS indicative price = £3.60

Tobia Teff gluten free white bread mix (Tobia Teff UK Ltd)
1000 gram (ACBS) - NHS indicative price = £3.60

Tritamyl® flour mix
GLUTEN-FREE

Tritamyl gluten free brown bread mix (Gluten Free Foods Ltd)
1000 gram (ACBS) - NHS indicative price = £7.24

Tritamyl gluten free white bread mix (Gluten Free Foods Ltd)
2000 gram (ACBS) - NHS indicative price = £14.54

Tritamyl gluten free white bread mix (Gluten Free Foods Ltd)
2000 gram (ACBS) - NHS indicative price = £14.54

Wellfoods® flour mix
GLUTEN-FREE

Wellfoods gluten free flour alternative (Wellfoods Ltd)
1000 gram - NHS indicative price = £7.80

Xanthan gum

Ener-G® xanthan gum
GLUTEN-FREE

Ener-G xanthan gum (Gluten Free Foods Ltd)
170 gram (ACBS) - NHS indicative price = £6.63

Pure® xanthan gum
GLUTEN-FREE

Innovative Solutions Pure xanthan gum (Innovative Solutions (UK) Ltd)
100 gram - NHS indicative price = £7.12

Pasta

Barkat® pasta
GLUTEN-FREE

Barkat gluten free pasta animal shapes (Gluten Free Foods Ltd)
500 gram - NHS indicative price = £5.99

Barkat gluten free pasta macaroni (Gluten Free Foods Ltd)
500 gram - NHS indicative price = £5.99

Barkat gluten free pasta spaghetti (Gluten Free Foods Ltd)
500 gram - NHS indicative price = £5.99

Barkat gluten free pasta spirals (Gluten Free Foods Ltd)
500 gram - NHS indicative price = £5.99

Barkat gluten free pasta tagliatelle (Gluten Free Foods Ltd)
500 gram - NHS indicative price = £5.99

Barkat gluten free pasta buckwheat penne (Gluten Free Foods Ltd)
250 gram - NHS indicative price = £2.98

Barkat gluten free pasta buckwheat spirals (Gluten Free Foods Ltd)
250 gram - NHS indicative price = £2.98

BiAlimenta® pasta
GLUTEN-FREE

BiAlimenta gluten free pasta acini di pepe (Grossa Ltd)
500 gram - NHS indicative price = £6.11 | 1000 gram - No NHS indicative price available

BiAlimenta gluten free pasta formati misti (Grossa Ltd)
3000 gram - NHS indicative price = £36.63

BiAlimenta gluten free pasta penne (Grossa Ltd)
500 gram - NHS indicative price = £6.11 | 1000 gram - No NHS indicative price available

BiAlimenta gluten free pasta sagneette (Grossa Ltd)
500 gram - NHS indicative price = £6.11

BiAlimenta gluten free pasta spirali (Grossa Ltd)
500 gram - NHS indicative price = £6.11

BiAlimenta gluten free pasta tubetti (Grossa Ltd)
500 gram - NHS indicative price = £6.03

BiAlimenta gluten free potato pasta gnocchi (Grossa Ltd)
500 gram - NHS indicative price = £5.71

BiAlimenta gluten free potato pasta perle di gnocchi (Grossa Ltd)
500 gram - NHS indicative price = £5.72

Glutafin® pasta
GLUTEN-FREE

Glutafin gluten free pasta macaroni penne (Dr Schar UK Ltd)
500 gram - NHS indicative price = £6.73

Glutafin gluten free pasta spirals (Dr Schar UK Ltd)
500 gram - NHS indicative price = £6.73

Glutafin gluten free pasta long-cut spaghetti (Dr Schar UK Ltd)
500 gram - NHS indicative price = £6.73

Juvéla® pasta
GLUTEN-FREE

Juvéla gluten free fibre penne (Hero UK Ltd)
500 gram - NHS indicative price = £6.61

Juvéla gluten free pasta fusilli (Hero UK Ltd)
500 gram - NHS indicative price = £7.21
Juvela gluten free pasta lasagne (Hero UK Ltd)
250 gram - NHS indicative price = £3.68

Juvela gluten free pasta macaroni (Hero UK Ltd)
500 gram - NHS indicative price = £7.21

Juvela gluten free pasta spaghetti (Hero UK Ltd)
500 gram - NHS indicative price = £7.21

Juvela gluten free pasta tagliatelle (Hero UK Ltd)
250 gram - NHS indicative price = £3.47

Orgran ® Pasta
GLUTEN-FREE
Orgran gluten free pasta rice & corn lasagne (Naturally Good Food Ltd)
200 gram - NHS indicative price = £3.13

Orgran gluten free pasta rice & corn macaroni (Naturally Good Food Ltd)
250 gram - NHS indicative price = £2.42

Orgran gluten free pasta buckwheat spirals (Naturally Good Food Ltd)
250 gram - NHS indicative price = £2.42

Rizopia ® Pasta
GLUTEN-FREE
Rizopia gluten free organic brown rice pasta fusilli (PGR Health Foods Ltd)
500 gram - NHS indicative price = £2.72

Rizopia gluten free organic brown rice pasta lasagne (PGR Health Foods Ltd)
375 gram - NHS indicative price = £2.72

Rizopia gluten free organic brown rice pasta penne (PGR Health Foods Ltd)
500 gram - NHS indicative price = £2.72

Rizopia gluten free organic brown rice pasta spaghetti (PGR Health Foods Ltd)
500 gram - NHS indicative price = £2.72

Pizza bases
Barkat ®, Pizza crust
GLUTEN-FREE
Barkat gluten free brown rice pizza crust (Gluten Free Foods Ltd)
150 gram - NHS indicative price = £5.10

Barkat gluten free white rice pizza crust (Gluten Free Foods Ltd)
150 gram - NHS indicative price = £5.10

Glutafin ® Pizza base
GLUTEN-FREE
Glutafin gluten free pizza base (Dr Schar UK Ltd)
300 gram - NHS indicative price = £6.56

Juvela ® pizza base
GLUTEN-FREE
Juvela gluten free pizza base (Hero UK Ltd)
360 gram - NHS indicative price = £4.78

Proceli ® Pizza base
GLUTEN-FREE
Proceli gluten free pizza base (Ambe Ltd)
250 gram - NHS indicative price = £3.90

Wellfoods ® Pizza base
GLUTEN-FREE
Wellfoods gluten free pizza base (WellFoods Ltd)
600 gram - NHS indicative price = £9.13

Gluten- and wheat-free foods
ACBS indications: established gluten-sensitive enteropathies with coexisting established wheat sensitivity only.

Ener-G ® bread loaves, rolls and pizza bases
GLUTEN-FREE, WHEAT-FREE

Ener-G gluten free Seattle brown hamburger rolls (Gluten Free Foods Ltd)
520 gram - NHS indicative price = £4.08

Ener-G gluten free Seattle brown hot dog rolls (Gluten Free Foods Ltd)
520 gram - NHS indicative price = £4.08

Glutafin ® Flour mix, fibre and crispbread
GLUTEN-FREE, WHEAT-FREE

Glutafin gluten free crispbread (Dr Schar UK Ltd)
150 gram - NHS indicative price = £3.25

Gluten gluten free bread mix (Dr Schar UK Ltd)
500 gram (ACBS) - NHS indicative price = £6.66

Gluten gluten free fibre bread mix (Dr Schar UK Ltd)
500 gram (ACBS) - NHS indicative price = £6.66

Gluten gluten free wheat free fibre mix (Dr Schar UK Ltd)
500 gram (ACBS) - NHS indicative price = £6.66

Low-protein foods
ACBS indications: inherited metabolic disorders, renal or liver failure, requiring a low-protein diet

Bread
Ener-G ® Rice bread
LOW PROTEIN

Ener-G low protein rice bread (Gluten Free Foods Ltd)
600 gram (ACBS) - NHS indicative price = £5.60

Juvela ® Loaf and rolls
LOW PROTEIN

Juvela gluten free loaf sliced (Hero UK Ltd)
400 gram (ACBS) - NHS indicative price = £3.54

Juvela low protein bread rolls (Hero UK Ltd)
530 gram (ACBS) - NHS indicative price = £4.52

Juvela low protein loaf sliced (Hero UK Ltd)
400 gram (ACBS) - NHS indicative price = £3.64

Loprofin ® Bread
LOW PROTEIN

Loprofin low protein part baked bread rolls (Nutricia Ltd)
260 gram (ACBS) - NHS indicative price = £4.48

Loprofin low protein part baked loaf sliced (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £4.26

PK Foods ® Loaf
LOW PROTEIN

PK Foods low protein white bread sliced (Gluten Free Foods Ltd)
500 gram - NHS indicative price = £4.84

Cake, biscuits, and snacks
» Not recommended for any child under 1 year.

Juvela ® Cookies
LOW PROTEIN

Juvela low protein cinnamon cookies (Hero UK Ltd)
125 gram (ACBS) - NHS indicative price = £7.62

Juvela low protein chocolate chip cookies (Hero UK Ltd)
110 gram (ACBS) - NHS indicative price = £7.62

Juvela low protein orange cookies (Hero UK Ltd)
125 gram (ACBS) - NHS indicative price = £7.62

Loprofin ® Wafers
LOW PROTEIN

Loprofin low protein crackers (Nutricia Ltd)
150 gram (ACBS) - NHS indicative price = £3.91

Loprofin low protein herb crackers (Nutricia Ltd)
150 gram (ACBS) - NHS indicative price = £3.91

PK Foods ® Biscuits
LOW PROTEIN

PK Foods Aminex low protein rusks (Gluten Free Foods Ltd)
200 gram (ACBS) - NHS indicative price = £5.14

PK Foods low protein crispbread (Gluten Free Foods Ltd)
75 gram (ACBS) - NHS indicative price = £2.46
<table>
<thead>
<tr>
<th>Foods for special diets</th>
<th>BNFC 2019-2020</th>
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<tr>
<td><strong>Borderline substances</strong></td>
<td><strong>Appendix 2</strong></td>
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</table>

**Not recommended for any child under 1 year.**

- **Loprofin low protein breakfast cereal flakes chocolate** (Firstplay Dietary Foods Ltd)
  - N/A

- **Loprofin low protein breakfast cereal flakes strawberry** (Firstplay Dietary Foods Ltd)
  - N/A

- **Vita Bite bar**
  - Not recommended for any child under 1 year.
  - LOW PROTEIN
  - Bar, protein 30 mg (less than 2.5 mg phenylalanine), carbohydrate 15.35 g, fat 8.4 g, energy 572 kJ (137 kcal)/25 g.

- **VitaBite bar (Vitafood International Ltd)**
  - 175 g (ACBS)
  - NHS indicative price = £9.45

- **VitaBite low protein breakfast cereal loops (Vitafood International Ltd)**
  - 375 g (ACBS)
  - NHS indicative price = £8.97

- **Loprofin low protein egg white replacer**
  - 500 g (ACBS)
  - NHS indicative price = £16.81

- **Loprofin low protein pasta lasagne** (Nutricia Ltd)
  - 500 g (ACBS)
  - NHS indicative price = £9.01

- **PK Foods low protein flour mix** (Gluten Free Foods Ltd)
  - 200 g (ACBS)
  - NHS indicative price = £4.16

- **Preparation of flour and egg substitutes**
  - Not recommended for any child under 1 year.
  - **Ener-G® Egg replacer**
    - 454 g (ACBS)
    - NHS indicative price = £5.17
  - **Ener-G low protein egg replacer** (Gluten Free Foods Ltd)
    - 500 g (ACBS)
    - NHS indicative price = £5.17
  - **Fate® Flour mix**
    - 500 g (ACBS)
    - NHS indicative price = £5.17
  - **Fate low protein all purpose mix** (Fate Special Foods)
    - 500 g (ACBS)
    - NHS indicative price = £5.17
  - **Fate low protein chocolate cake mix** (Fate Special Foods)
    - 500 g (ACBS)
    - NHS indicative price = £5.17
  - **Fate low protein plain cake mix** (Fate Special Foods)
    - 500 g (ACBS)
    - NHS indicative price = £5.17
  - **Juvela® Mix**
    - 500 g (ACBS)
    - NHS indicative price = £7.79
  - **Juvela low protein mix** (Nero UK Ltd)
    - 500 g (ACBS)
    - NHS indicative price = £7.79
  - **Loprofin® Flour mixes and egg substitutes**
    - 500 g (ACBS)
    - NHS indicative price = £9.01
  - **PK Foods® Flour mix and egg substitute**
    - 500 g (ACBS)
    - NHS indicative price = £9.01

- **Preparation of pasta**
  - **Loprofin® Pasta**
    - 500 g (ACBS)
    - NHS indicative price = £9.01
  - **Loprofin low protein pasta animal shapes** (Nutricia Ltd)
    - 500 g (ACBS)
    - NHS indicative price = £9.01
  - **Loprofin low protein pasta lasagne** (Nutricia Ltd)
    - 250 g (ACBS)
    - NHS indicative price = £4.65
  - **Low protein pasta penne** (Nutricia Ltd)
    - 500 g (ACBS)
    - NHS indicative price = £9.01
  - **Loprofin low protein pasta tagliatelle** (Nutricia Ltd)
    - 250 g (ACBS)
    - NHS indicative price = £4.65

- **Preparation of desserts**
  - **PK Foods® Jelly**
    - 250 g (ACBS)
    - NHS indicative price = £4.65

- **Preparation of juices**
  - **PK Foods® Pink lemonade**
    - 250 g (ACBS)
    - NHS indicative price = £4.65

- **Preparation of other foods**
  - **PK Foods® Low protein pasta macaroni elbows** (Nutricia Ltd)
    - 250 g (ACBS)
    - NHS indicative price = £4.65

- **Preparation of snacks**
  - **PK Foods® low protein jelly mix dessert cherry** (Gluten Free Foods Ltd)
    - 320 g (ACBS)
    - NHS indicative price = £8.19
  - **PK Foods® low protein jelly mix dessert orange** (Gluten Free Foods Ltd)
    - 320 g (ACBS)
    - NHS indicative price = £8.19

- **Preparation of cereals**
  - **PK Foods® low protein cereal flakes chocolate**
    - 500 g (ACBS)
    - NHS indicative price = £9.01

- **Preparation of other foods**
  - **PK Foods® low protein cereal flakes strawberry**
    - 500 g (ACBS)
    - NHS indicative price = £9.01

- **Preparation of other foods**
  - **PK Foods® low protein cereal flakes banana**
    - 500 g (ACBS)
    - NHS indicative price = £9.01

- **Preparation of other foods**
  - **PK Foods® low protein cereal flakes apple & cinnamon**
    - 500 g (ACBS)
    - NHS indicative price = £9.01

- **Preparation of other foods**
  - **PK Foods® low protein cereal flakes apricot**
    - 500 g (ACBS)
    - NHS indicative price = £9.01
Loprofin low protein pasta long cut spaghetti (Nutricia Ltd) 500 gram (ACBS) - NHS indicative price = £9.55

Promin® Pasta
LOW-PROTEIN

Promin low protein pasta alphabets (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin Plus low protein pasta macaroni (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin Plus low protein pasta flat noodles (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin low protein pasta shells (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin low protein tricolour pasta spirals (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin low protein tricolour pasta shells (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin low protein tricolour pasta alphabets (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Pizza bases
Juvela® Pizza base

Juvela low protein pizza base (Hero UK Ltd) 560 gram (ACBS) - NHS indicative price = £8.61

Savoury meals and mixes
Promin® Savoury meals and mixes
LOW-PROTEIN

Promin low protein cous cous (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.25

Promin low protein pasta elbows (Firstplay Dietary Foods Ltd) 200 gram (ACBS) - NHS indicative price = £7.20

Promin low protein pastameal (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.25

Promin low protein pasta macaroni (Firstplay Dietary Foods Ltd) 500 gram (ACBS) - NHS indicative price = £7.20

Promin Plus low protein pasta spirals (Firstplay Dietary Foods Ltd) 200 gram (ACBS) - NHS indicative price = £7.20

Promin low protein potato pot with croutons onion (Firstplay Dietary Foods Ltd) 200 gram (ACBS) - NHS indicative price = £17.00

Promin low protein potato pot with croutons cabbages & bacon (Firstplay Dietary Foods Ltd) 200 gram (ACBS) - NHS indicative price = £17.00

Promin low protein potato pot with croutons sausage (Firstplay Dietary Foods Ltd) 200 gram (ACBS) - NHS indicative price = £17.00

Promin low protein X-Pot all day scramble (Firstplay Dietary Foods Ltd) 240 gram (ACBS) - NHS indicative price = £21.65

Promin low protein X-Pot beef & tomato (Firstplay Dietary Foods Ltd) 240 gram (ACBS) - NHS indicative price = £21.65

Promin low protein X-Pot chip shop curry (Firstplay Dietary Foods Ltd) 240 gram (ACBS) - NHS indicative price = £21.65

Promin low protein X-Pot rogan style curry (Firstplay Dietary Foods Ltd) 240 gram (ACBS) - NHS indicative price = £21.65

Spreads
Taranis® Spread
LOW-PROTEIN

Taranis low protein hazelnut spread (Lactalis Nutrition Sante) 230 gram (ACBS) - NHS indicative price = £7.95

Nutritional supplements for metabolic diseases

Glutaric aciduria (type 1)

GA1 Anamix® Infant
- Nutritional supplement for the dietary management of proven glutaric aciduria (type 1) in children from birth to 3 years. POWDER, protein equivalent (essential and non-essential amino acids except lysine, and low tryptophan) 15.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.5 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.

GA1 Anamix Infant powder (Nutricia Ltd) 400 gram (ACBS) - NHS indicative price = £42.17

GA Gel®
- Nutritional supplement for dietary management of type 1 glutaric aciduria in children 6 months–10 years. GEL, protein equivalent (essential and non-essential amino acids except lysine, and low tryptophan) 10 g, carbohydrate 10.5 g, fat, trace energy 539 kJ (81 kcal)/24 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

GA gel oral powder 24g sachets (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £233.35

XLYS, TRY Glutaridon®
- Nutritional supplement for the dietary management of type 1 glutaric aciduria in children and adults; requires additional source of vitamins, minerals, and trace elements. POWDER, protein equivalent (essential and non-essential amino acids except lysine and tryptophan) 79 g, carbohydrate 4 g, energy 1411 kJ (352 kcal)/100 g. To flavour unflavoured products, see Modjul Flavour System p. 1082.

XLYS TRY Glutaridon powder (Nutricia Ltd) 500 gram (ACBS) - NHS indicative price = £201.74

Glycogen storage disease

Corn flour and corn starch
- For glycogen storage disease

Glycosade®
- A nutritional supplement for use in the dietary management of glycogen storage disease and other metabolic conditions where a constant supply of glucose is essential. Not suitable for use in children under 2 years. POWDER, protein 200 mg, carbohydrate (maize starch) 47.6 g, fat 20.0 mg, energy 803 kJ (192 kcal)/60 g.

Glycosade oral powder 60g sachets (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £122.64

Homocystinuria or hypermethioninaemia

HCU Anamix® Infant
- Nutritional supplement for the dietary management of proven vitamin B6 non-responsive homocystinuria or hypermethioninaemia in children from birth to 3 years. POWDER, protein equivalent (essential and non-essential amino acids except methionine) 13.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.5 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides...
HCU Anaxim Infant powder (Nutricia Ltd) 400 gram (ACBS) - NHS indicative price = £42.17

HCU cooler® 15
- A methionine-free protein substitute for use as a nutritional supplement in children over 3 years with homocystinuria.
LIQUID, protein (essential and non-essential amino acids except methionine) 15 g, carbohydrate 7 g, fat 500 mg, energy 593 kJ (92 kcal)/130 mL, with vitamins, minerals, and trace elements.

HCU orange cooler 15 liquid (Vitaflo International Ltd) 150 ml (ACBS) - NHS indicative price = £12.31

HCU Express® 15
- A methionine-free protein substitute for use as a nutritional supplement in children over 8 years with homocystinuria.
POWDER, protein (essential and non-essential amino acids except methionine) 15 g, carbohydrate 5.8 g, fat 30 mg, energy 315 kJ (75.3 kcal)/25 g with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

HCU express 15 oral powder 25g sachets (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £362.37

HCU Express® 20
- A methionine-free protein substitute for use as a nutritional supplement in children over 8 years with homocystinuria.
POWDER, protein (essential and non-essential amino acids except methionine) 20 g, carbohydrate 4.7 g, fat 70 mg, energy 416 kJ (99 kcal)/54 g with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

HCU express 20 oral powder 34g sachets (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £468.17

HCU gel®
- A methionine-free protein substitute for use as a nutritional supplement for the dietary management of children 1–10 years with homocystinuria.
POWDER, protein (essential and non-essential amino acids except methionine) 10 g, carbohydrate 10.5 g, fat 20 mg, energy 339 kJ (81 kcal)/24 g with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

HCU gel oral powder 24g sachets (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £233.29

HCU Lophex® LQ 20
- Nutritional supplement for the dietary management of homocystinuria in children over 5 years.
LIQUID, protein equivalent (essential and non-essential amino acids except methionine) 20 g, carbohydrate 6.8 g, fat 440 mg, energy 509 kJ (120 kcal)/125 mL, with vitamins, minerals, and trace elements.

HCU Lophex® LQ 20 liquid (Nutricia Ltd) 125 ml (ACBS) - NHS indicative price = £17.39

HCU LV®
- Nutritional supplement for the dietary management of hypermethioninemia or vitamin B6 non-responsive homocystinuria in children over 8 years.
POWDER, protein (essential and non-essential amino acids except methionine) 20 g, carbohydrate 2.5 g, fat 190 mg, energy 390 kJ (92 kcal)/27.8 g sachet, with vitamins, minerals, and trace elements. To flavour unflavoured products, see Modjul Flavour System p. 1082.

HCU-LV oral powder 27.8g sachets tropical (Nutricia Ltd) 30 sachet (ACBS) - NHS indicative price = £534.80

HCU-LV oral powder 27.8g sachets unflavoured (Nutricia Ltd) 30 sachet (ACBS) - NHS indicative price = £534.80

XMET Homidon®
- Nutritional supplement for the dietary management of hypermethioninemia or homocystinuria in children and adults.
POWDER, protein equivalent (essential and non-essential amino acids, except methionine) 77 g, carbohydrate 4.5 g, fat nil, energy 1386 kJ (326 kcal)/100 g. To flavour unflavoured products, see Modjul Flavour System p. 1082.

Hyperlysinaemia

HYPER LYS Anamix® Infant
- Nutritional supplement for the dietary management of proven hyperlysinaemia in children from birth to 3 years.
POWDER, protein equivalent (essential and non-essential amino acids except lysine) 13.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.3 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.

HYPER LYS Anamix Infant powder (Nutricia Ltd) 400 gram (ACBS) - NHS indicative price = £42.17

Isovaleric acidemia

IVA Anamix® Infant
- Nutritional supplement for the dietary management of proven isovaleric acidemia or other proven disorders of leucine metabolism in children from birth to 5 years.
POWDER, protein equivalent (essential and non-essential amino acids except leucine) 15.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.3 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.

IVA Anamix Infant powder (Nutricia Ltd) 400 gram (ACBS) - NHS indicative price = £42.17

Maple syrup urine disease

MSUD Aid III®
- Nutritional supplement for the dietary management of maple syrup urine disease and related conditions in children and adults where it is necessary to limit the intake of branched chain amino acids.
POWDER, protein equivalent (essential and non-essential amino acids except isoleucine, leucine, and valine) 77 g, carbohydrate 4.5 g, fat nil, energy 1386 kJ (326 kcal)/100 g. To flavour unflavoured products, see Modjul Flavour System p. 1082.

MSUD Aid III powder (Nutricia Ltd) 500 gram (ACBS) - NHS indicative price = £201.74

MSUD Anamix® Infant
- Nutritional supplement for the dietary management of proven maple syrup urine disease in children from birth to 3 years.
POWDER, protein equivalent (essential and non-essential amino acids except isoleucine, leucine, and valine) 15.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.3 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.
Nutritional supplements for metabolic diseases

**MSUD Anamix Infant powder** (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £42.17

**MSUD Anamix** Junior
- Nutritional supplement for the dietary management of maple syrup urine disease in children 1–10 years.
  - POWDER, protein equivalent (essential and non-essential amino acids except isoleucine, leucine, and valine) 10 g, carbohydrate 11.5 g, fat 4.5 g, energy 566 kJ (135 kcal)/35 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see Modulj Flavour System p. 1082.

**MSUD Anamix Junior oral powder** 36g sachets (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £225.52

**MSUD Anamix** Junior LQ
- Nutritional supplement for the dietary management of maple syrup urine disease in children 1–10 years.
  - LIQUID, protein equivalent (essential and non-essential amino acids except isoleucine, leucine, and valine) 15 g, carbohydrate 8.8 g, fat 4.8 g, fibre 510 mg, energy 497 kJ (118 kcal)/125 mL, with vitamins, minerals, and trace elements. Lactose-free.

**MSUD Anamix Junior LQ liquid** (Nutricia Ltd)
125 mL (ACBS) - NHS indicative price = £9.78

**MSUD Anamix** Junior LQ 15
- Nutritional supplement for the dietary management of maple syrup urine disease in children over 3 years and adults.
  - LIQUID, protein equivalent (essential and non-essential amino acids except leucine, isoleucine, and valine) 15 g, carbohydrate 7 g, fat 500 mg, energy 395 kJ (92 kcal)/150 mL pouch, with vitamins, minerals, and trace elements.

**MSUD orange cooler** 15 liquid (Vitaflor International Ltd)
150 mL (ACBS) - NHS indicative price = £12.31

**MSUD red cooler** 15 liquid (Vitaflor International Ltd)
150 mL (ACBS) - NHS indicative price = £12.31

**MSUD express** 15
- Nutritional supplement for the dietary management of maple syrup urine disease in children over 8 years and adults.
  - POWDER, protein equivalent (essential and non-essential amino acids except leucine, isoleucine, and valine) 15 g, carbohydrate 3.8 g, fat less than 100 mg, energy 315 kJ (75 kcal)/25 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

**MSUD express 15 oral powder** 25g sachets (Vitaflor International Ltd)
30 sachet (ACBS) - NHS indicative price = £62.37

**MSUD express 20**
- Nutritional supplement for the dietary management of maple syrup urine disease in children over 8 years and adults.
  - POWDER, protein equivalent (essential and non-essential amino acids except leucine, isoleucine, and valine) 20 g, carbohydrate 4.7 g, fat less than 100 mg, energy 416 kJ (99 kcal)/54 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

**MSUD express 20 oral powder** 34g sachets (Vitaflor International Ltd)
30 sachet (ACBS) - NHS indicative price = £46.17

**MSUD Gel**
- Nutritional supplement for the dietary management of maple syrup urine disease in children 1–10 years.
  - POWDER, protein equivalent (essential and non-essential amino acids except leucine, isoleucine, and valine) 10 g, carbohydrate 10.5 g, fat less than 100 mg, energy 337 kJ (81 kcal)/24 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

**MSUD gel 24g sachets** (Vitaflor International Ltd)
30 sachet (ACBS) - NHS indicative price = £236.03

**MSUD Lophlex** LQ 20
- Nutritional supplement for the dietary management of maple syrup urine disease in children over 5 years.
  - LIQUID, protein equivalent (essential and non-essential amino acids except isoleucine, leucine, and valine) 20 g, carbohydrate 8.8 g, fat less than 500 mg, energy 509 kJ (120 kcal)/125 mL, with vitamins, minerals, and trace elements.

**MSUD Lophlex LQ 20 liquid** (Nutricia Ltd)
125 ml (ACBS) - NHS indicative price = £17.39

**MSUD Maxamum**
- Nutritional supplement for the dietary management of maple syrup urine disease.
  - POWDER, protein equivalent (essential and non-essential amino acids except isoleucine, leucine, and valine) 39 g, carbohydrate 34 g, fat less than 500 mg, energy 1260 kJ (297 kcal)/100 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see Modulj Flavour System p. 1082.

Maxamum products are generally intended for use in children over 5 years.

**MSUD Maxamum powder orange** (Nutricia Ltd)
500 gram (ACBS) - NHS indicative price = £170.70

**MSUD Maxamum powder unflavoured** (Nutricia Ltd)
500 gram (ACBS) - NHS indicative price = £170.70

**Methylmalonic or propionic acidaemia**

**MMA/PA Anamix** Infant
- Nutritional supplement for the dietary management of proven methylmalonic acidaemia or propionic acidaemia in children from birth to 5 years.
  - POWDER, protein equivalent (essential and non-essential amino acids except methionine, threonine, and valine, and low isoleucine) 15.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.3 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.

**MMA / PA Anamix infant powder** (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £42.17

**XMTVI Asadon**
- Nutritional supplement for the dietary management of methylmalonic acidaemia or propionic acidaemia in children and adults.
  - POWDER, protein equivalent (essential and non-essential amino acids except methionine, threonine, and valine, and low isoleucine) 77 g, carbohydrate 4.5 g, fat nil, energy 1586 kJ (326 kcal)/100 g. To flavour unflavoured products, see Modulj Flavour System p. 1082.

**XMTVI Asadon powder** (Nutricia Ltd)
200 gram (ACBS) - NHS indicative price = £80.69

**MMA/PA Maxamum**
- Nutritional supplement for the dietary management of methylmalonic acidaemia or propionic acidaemia.
  - POWDER, protein equivalent (essential and non-essential amino acids except methionine, threonine, and valine, and low isoleucine) 39 g, carbohydrate 34 g, fat less than 500 mg, energy 1260 kJ (297 kcal)/100 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see Modulj Flavour System p. 1082. Maxamum products are generally intended for use in children over 8 years.

**MMA / PA Maxamum powder** (Nutricia Ltd)
500 gram (ACBS) - NHS indicative price = £170.70

**Other inborn errors of metabolism**

**Cystine500**
- Nutritional supplement for the dietary management of inborn errors of amino acid metabolism in adults and children from 3 years.
  - POWDER, cystine 500 mg, carbohydrate 3.3 g, fat nil, energy 64 kJ (15 kcal)/4 g.

**Cystine500 oral powder sachets** (Vitaflor International Ltd)
30 sachet (ACBS) - NHS indicative price = £9.28

**DocOmega**
- Nutritional supplement for the dietary management of inborn errors of metabolism for adults and children from birth.
  - POWDER, protein (cows' milk, soya) 100 mg, carbohydrate 3.2 g, fat 500 mg (of which docosahexaenoic acid 200 mg), fibre nil, energy 74 kJ (18 kcal)/4 g, with minerals.
DocOmega oral powder 4g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £42.90

EAA® Supplement
- Nutritional supplement for the dietary management of disorders of protein metabolism including urea cycle disorders in children over 5 years.
  POWDER, protein equivalent (essential amino acids) 5 g, carbohydrate 4 g, fat nil, energy 151 kJ (36 kcal)/12.5 g, with vitamins, minerals, and trace elements.

EAA Supplement oral powder 12.5g sachets (Vitaflo International Ltd)
50 sachet (ACBS) - NHS indicative price = £23.68

Isoleucine50®
- Nutritional supplement for use in the dietary management of inborn errors of amino acid metabolism in adults and children from birth.
  POWDER, isoleucine 50 mg, carbohydrate 5.8 g, fat nil, energy 63 kJ (15 kcal)/4 g

Isoleucine50 oral powder 4g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £9.28

KeyOmega®
- Nutritional supplement for the dietary management of inborn errors of metabolism.
  POWDER, protein (cows’ milk, soya) 170 mg, carbohydrate 2.8 g, fat 800 mg (of which arachidonic acid 200 mg, docosahexaenoic acid 100 mg), energy 80 kcal (19 kcal)/4 g

KeyOmega oral powder 4g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £43.87

Leucine100®
- Nutritional supplement for the dietary management of inborn errors of amino acid metabolism in adults and children from birth.
  POWDER, leucine 100 mg, carbohydrate 5.7 g, fat nil, energy 63.5 kJ (15 kcal)/4 g

Leucine100 oral powder sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £9.28

Low protein drink
- Nutritional supplement for the dietary management of inborn errors of amino acid metabolism in adults and children over 1 year.
  POWDER, protein (cows’ milk) 4.5 g (phenylalanine 100 mg), carbohydrate 59.5 g, fat 29.9 g, fibre nil, energy 2194 kJ (528 kcal)/100 g, with vitamins, minerals, and trace elements. Contains lactose.
  Termed Milupa® lp-drink by manufacturer.

Milupa LP drink (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £10.00

Phenylalanine50®
- Nutritional supplement for use in the dietary management of inborn errors of metabolism in adults and children from birth.
  POWDER, phenylalanine 50 mg, carbohydrate 3.8 g, fat nil, energy 63.5 kJ (15 kcal)/4 g

Phenylalanine50 oral powder sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £57.56

ProZero®
- A protein-free nutritional supplement for the dietary management of inborn errors of metabolism in children over 6 months and adults.
  LIQUID, carbohydrate 8.1 g (of which sugars 3.5 g, fat 3.8 g, energy 278 kJ (66 kcal)/100 mL. Contains lactose.

ProZero liquid (Vitaflo International Ltd)
250 ml (ACBS) - NHS indicative price = £1.58 | 1000 ml (ACBS) - NHS indicative price = £6.31

Tyrosine100®
- Nutritional supplement for the dietary management of inborn errors of amino acid metabolism in adults and children from birth.
  POWDER, tyrosine 1 g, carbohydrate 2.9 g, fat nil, energy 63 kJ (15 kcal)/4 g sachet.

Tyrosine100 oral powder 4g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £5.42

Valine50®
- Nutritional supplement for the dietary management of inborn errors of amino acid metabolism in adults and children from birth.
  POWDER, valine 50 mg, carbohydrate 3.8 g, fat nil, energy 63 kJ (15 kcal)/4 g

Valine50 oral powder 4g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £59.28

Phenylketonuria

Easiphen®
- Nutritional supplement for the dietary management of proven phenylketonuria in children over 8 years.
  LIQUID, protein equivalent (containing essential and non-essential amino acids except phenylalanine) 6.7 g, carbohydrate 5.1 g, fat 2 g, energy 275 kJ (65 kcal)/100 mL with vitamins, minerals, and trace elements.

Easiphen liquid (Nutricia Ltd)
250 ml (ACBS) - NHS indicative price = £10.46

L-Tyrosine
- Nutritional supplement for the dietary management of phenylketonuria in pregnant women with low plasma tyrosine concentrations.
  POWDER, L-tyrosine 20 g, carbohydrate 76.8 g, fat nil, energy 1612 kJ (379 kcal)/100 g

L-Tyrosine powder (Nutricia Ltd)
100 gram (ACBS) - NHS indicative price = £23.76

Lophlex®
- Nutritional supplement for the dietary management of proven phenylketonuria in children over 8 years and adults including pregnant women.
  POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine) 20 g, carbohydrate 2.5 g, fat 60 mg, fibre 220 mg, energy 385 kJ (91 kcal)/27.8-g sachet, with vitamins, minerals, and trace elements.

Lophlex powder 27.8g sachets berry (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £314.10

Lophlex powder 27.8g sachets orange (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £314.10

Lophlex powder 27.8g sachets unflavoured (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £314.10

Loprofin® PKU Drink
- Nutritional supplement for the dietary management of phenylketonuria in children over 1 year and adults.
  LIQUID, protein (cows’ milk) 400 mg (phenylalanine 10 mg), lactose 9.4 g, fat 2 g, energy 1650 kJ (40 kcal)/100 mL

Loprofin PKU drink (Nutricia Ltd)
200 ml (ACBS) - NHS indicative price = £0.81

Loprofin® Sno-Pro
- Nutritional supplement for the dietary management of phenylketonuria, chronic renal failure and other inborn errors of amino acid metabolism.
  POWDER, protein (cows’ milk) 220 mg (phenylalanine 12.5 mg), carbohydrate 8 g, fat 3.8 g, energy 273 kJ (65 kcal)/100 mL. Contains lactose.

Loprofin Sno-PRO drink (Nutricia Ltd)
200 ml (ACBS) - NHS indicative price = £1.35

Phlexy-10® Exchange System
- Nutritional supplement for the dietary management of phenylketonuria.
  CAPSULES, protein equivalent (essential and non-essential amino acids except phenylalanine) 416.5 mg/capsule.

Phlexy-10® 500mg capsules (Nutricia Ltd)
200 capsule (ACBS) - NHS indicative price = £47.03

TABLETS, protein equivalent (essential and non-essential amino acids except phenylalanine) 833 mg tablet.

Phlexy-10 tablets (Nutricia Ltd)
75 tablet (ACBS) - NHS indicative price = £30.24
Nutritional supplement for the dietary supplement of proven phenylketonuria (PKU) in children over 3 years. LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 18 g, carbohydrate 8.2 g, energy 1307 kJ (311 kcal)/130 mL pouch, with vitamins, minerals, and trace elements.

PKU Anamix Junior QO liquid berry (Nutricia Ltd) 125 ml (ACBS) - NHS indicative price = £6.08
PKU Anamix Junior QO liquid orange (Nutricia Ltd) 125 ml (ACBS) - NHS indicative price = £6.08
PKU cooler10
- Nutritional supplement for the dietary management of phenylketonuria in children over 3 years. LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 15 g, carbohydrate 7.9 g, energy 386 kJ (92 kcal)/130 mL pouch, with vitamins, minerals, and trace elements.

PKU orange cooler 10 liquid (Vitaflo International Ltd) 87 ml (ACBS) - NHS indicative price = £5.01
PKU purple cooler 10 liquid (Vitaflo International Ltd) 87 ml (ACBS) - NHS indicative price = £5.01
PKU red cooler 10 liquid (Vitaflo International Ltd) 87 ml (ACBS) - NHS indicative price = £5.01
PKU white cooler 10 liquid (Vitaflo International Ltd) 87 ml (ACBS) - NHS indicative price = £5.01
PKU cooler15
- Nutritional supplement for the dietary management of phenylketonuria in children over 3 years. LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 15 g, carbohydrate 7 g, energy 386 kJ (92 kcal)/130 mL pouch, with vitamins, minerals, and trace elements.

PKU orange cooler 15 liquid (Vitaflo International Ltd) 130 ml (ACBS) - NHS indicative price = £7.46
PKU purple cooler 15 liquid (Vitaflo International Ltd) 130 ml (ACBS) - NHS indicative price = £7.46
PKU red cooler 15 liquid (Vitaflo International Ltd) 130 ml (ACBS) - NHS indicative price = £7.46
PKU white cooler 15 liquid (Vitaflo International Ltd) 130 ml (ACBS) - NHS indicative price = £7.46
PKU yellow cooler 15 liquid (Vitaflo International Ltd) 130 ml (ACBS) - NHS indicative price = £7.46
PKU cooler20
- Nutritional supplement for the dietary management of phenylketonuria in children over 3 years. LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 20 g, carbohydrate 9.4 g, energy 386 kJ (92 kcal)/130 mL pouch, with vitamins, minerals, and trace elements.

PKU orange cooler 20 liquid (Vitaflo International Ltd) 174 ml (ACBS) - NHS indicative price = £10.02
PKU purple cooler 20 liquid (Vitaflo International Ltd) 174 ml (ACBS) - NHS indicative price = £10.02
PKU red cooler 20 liquid (Vitaflo International Ltd) 174 ml (ACBS) - NHS indicative price = £10.02
PKU white cooler 20 liquid (Vitaflo International Ltd) 174 ml (ACBS) - NHS indicative price = £10.02
PKU yellow cooler 20 liquid (Vitaflo International Ltd) 174 ml (ACBS) - NHS indicative price = £10.02
PKU express15
- Nutritional supplement for the dietary management of phenylketonuria. Not recommended for children under 3 years. POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine) 15 g, carbohydrate 3.4 g, energy 310 kJ (74 kcal)/25 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

PKU express 15 powder 25g sachets lemon (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £219.69
PKU express 15 powder 25g sachets orange (Vitaflo International Ltd) 30 sachet (ACBS) - NHS indicative price = £219.69
PKU express 15 powder 25g sachets tropical (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £283.83

PKU express 15 powder 25g sachets unflavoured (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £283.83

PKU express 20 powder 34g sachets orange (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £283.83

PKU express 20 powder 34g sachets unflavoured (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £283.83

PKU gel ⎯
For use as part of the low-protein dietary management of phenylketonuria in children 6 months – 10 years (unflavoured), 1–10 years (flavoured).
POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine) 10 g, carbohydrate 10.3 g (unflavoured)/8.9 g (flavoured), fat less than 100 mg, energy 436 kJ (104 kcal)/322 kJ (76 kcal) (flavoured)/24 g, with vitamins, minerals, and trace elements. PKU Orange contains soya. To flavour unflavoured products, see FlavourPac p. 1081.

PKU gel powder 24g sachets unflavoured (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £151.98

PKU gel powder 24g sachets orange (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £151.98

PKU gel powder 24g sachets raspberry (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £151.98

PKU Lophlex ™ LQ 10
Nutritional supplement for the dietary management of phenylketonuria in children 4 years and adults including pregnant women.
LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 10 g, carbohydrate 4.4 g, fibre 250 mg, energy 245 kJ (58 kcal)/62.5 mL, with vitamins, minerals, and trace elements.

PKU Lophlex ™ LQ 10 liquid berry (Nutricia Ltd)
62.5 mL (ACBS) - NHS indicative price = £5.61

PKU Lophlex ™ LQ 10 liquid juicy berries (Nutricia Ltd)
62.5 mL (ACBS) - NHS indicative price = £5.61

PKU Lophlex ™ LQ 10 liquid juicy citrus (Nutricia Ltd)
62.5 mL (ACBS) - NHS indicative price = £5.61

PKU Lophlex ™ LQ 10 liquid juicy orange (Nutricia Ltd)
62.5 mL (ACBS) - NHS indicative price = £5.61

PKU Lophlex ™ LQ 10 liquid juicy tropical (Nutricia Ltd)
62.5 mL (ACBS) - NHS indicative price = £5.61

PKU Lophlex ™ LQ 20
Nutritional supplement for the dietary management of phenylketonuria in children 4 years and adults including pregnant women.
LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 20 g, carbohydrate 8.8 g, fibre 500 mg, energy 490 kJ (115 kcal)/125 mL, with vitamins, minerals, and trace elements.

PKU Lophlex ™ LQ 20 liquid berry (Nutricia Ltd)
125 mL (ACBS) - NHS indicative price = £11.19

PKU Lophlex ™ LQ 20 liquid juicy berries (Nutricia Ltd)
125 mL (ACBS) - NHS indicative price = £11.19

PKU Lophlex ™ LQ 20 liquid juicy citrus (Nutricia Ltd)
125 mL (ACBS) - NHS indicative price = £11.19

PKU Lophlex ™ LQ 20 liquid juicy orange (Nutricia Ltd)
125 mL (ACBS) - NHS indicative price = £11.19

PKU Lophlex ™ LQ 20 liquid juicy tropical (Nutricia Ltd)
125 mL (ACBS) - NHS indicative price = £11.19

PKU Lophlex ™ Sensation 20
Nutritional supplement for the dietary management of phenylketonuria in children over 4 years and adults including pregnant women.
SEMI-SOLID, protein equivalent (containing essential and non-essential amino acids except phenylalanine) 20 g, carbohydrate 20.2 g, fibre 1 g, energy 706 kJ (166 kcal)/109 g, with vitamins, minerals, and trace elements.

PKU Lophlex Sensation 20 berries (Nutricia Ltd)
327 gram (ACBS) - NHS indicative price = £35.76

PKU squeezie ™
Nutritional supplement for the dietary management of phenylketonuria in children from 6 months to 10 years.
LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine) 10 g, carbohydrate 54 g, fat less than 100 mg, energy 422 kJ (101 kcal)/34 g, with vitamins, minerals, and trace elements. PKU Orange contains soya. To flavour unflavoured products, see FlavourPac p. 1081.

PKU squeezie liquid 85g pouches (Vitaflo International Ltd)
30 pouch (ACBS) - NHS indicative price = £145.29

PKU Maxamum ™
Nutritional supplement for the dietary management of phenylketonuria in children over 8 years and adults.
POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine) 59 g, carbohydrate 34 g, fat less than 500 mg, energy 1260 kJ (297 kcal)/100 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see Modijul Flavour System p. 1082.

PKU Maxamum oral powder 50g sachets orange (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £292.20

PKU Maxamum oral powder 50g sachets unflavoured (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £292.20

PKU Maxamum powder orange (Nutricia Ltd)
500 gram (ACBS) - NHS indicative price = £97.44

PKU Maxamum powder unflavoured (Nutricia Ltd)
500 gram (ACBS) - NHS indicative price = £97.44

Tyrosinaemia
Methionine-free TYR Anamix ™ Infant
Nutritional supplement for the dietary management of proven tyrosinaemia type 1 in children from birth to 3 years.
POWDER, protein equivalent (essential and non-essential amino acids except methionine, phenylalanine, and tyrosine) 15.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.3 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.

TYR Anamix Infant methionine free powder (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £42.17

TYR Anamix ™ Infant
Nutritional supplement for the dietary management of proven tyrosinaemia where plasma-methionine concentrations are normal in children from birth to 3 years.
POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine and tyrosine) 15.1 g, carbohydrate 49.5 g, fat 23 g, fibre 5.3 g, energy 1915 kJ (457 kcal)/100 g, with vitamins, minerals, and trace elements; standard dilution (15%) provides protein equivalent 2 g, carbohydrate 7.4 g, fat 3.5 g, fibre 800 mg, energy 287 kJ (69 kcal)/100 mL.
Nutritional supplements for the dietary management of tyrosinaemia in children 1–10 years.

POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine and tyrosine) 8.4 g, carbohydrate 11 g, fat 3.9 g, energy 475 kJ (115 kcal)/29-g sachet, with vitamins, minerals, and trace elements.

TYR Anamix Junior oral powder 20 g sachets (Nutricia Ltd)
15 g, carbohydrate 4.5 g, fat nil, energy 1386 kJ (326 kcal)/100 g. To flavour unflavoured products, see FlavourPac p. 1081.

TYR Lophlex ® LQ 20
» Nutritional supplement for the dietary management of tyrosinaemia in children over 4 years and adults, including pregnant women (in conjunction with standard folic acid supplementation).
LIQUID, protein equivalent (essential and non-essential amino acids except phenylalanine and tyrosine) 20 g, carbohydrate 8.8 g, fat less than 500 mg, fibre 500 mg, energy 509 kJ (120 kcal)/125 mL, with vitamins, minerals, and trace elements.

TYR Lophlex LQ 20 liquid (Nutricia Ltd)
125 ml (ACBS) - NHS indicative price = £17.39

XPHEN TYR Tyrosidon ®
» Nutritional supplement for the management of tyrosinaemia in children and adults where plasma-methionine concentrations are normal.
POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine and tyrosine) 77 g, carbohydrate 4.5 g, fat nil, energy 1386 kJ (326 kcal)/100 g. To flavour unflavoured products, see Modjul Flavour System p. 1082.

XPHEN TYR Tyrosidon Free AA Mix powder (Nutricia Ltd)
500 gram (ACBS) - NHS indicative price = £201.74

XPTM Tyrosidon ®
» Nutritional supplement for the dietary management of tyrosinaemia type I in children and adults where plasma-methionine concentrations are above normal.
POWDER, protein equivalent (essential and non-essential amino acids except methionine, phenylalanine, and tyrosine) 77 g, carbohydrate 4.5 g, fat nil, energy 1386 kJ (326 kcal)/100 g. To flavour unflavoured products, see Modjul Flavour System p. 1082.

XPTM Tyrosidon powder (Nutricia Ltd)
500 gram - NHS indicative price = £91.31

TYR Anamix Infant methionine free powder (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £42.17

TYR Anamix Infant powder (Nutricia Ltd)
400 gram (ACBS) - NHS indicative price = £42.17

TYR Anamix ® Junior
» Nutritional supplement for the dietary management of tyrosinaemia in children 1–10 years.
POWDER, protein equivalent (essential and non-essential amino acids except phenylalanine and tyrosine) 10 g, carbohydrate 8.8 g, fat 4.8 g, fibre 510 mg, energy 500 kJ (119 kcal)/125 mL, with vitamins, minerals, and trace elements.

TYR Anamix Junior oral powder 20 g sachets (Nutricia Ltd)
30 sachet (ACBS) - NHS indicative price = £206.40

TYR Anamix ® Junior LQ
» Nutritional supplement for the dietary management of tyrosinaemia in children over 3 years and adults.
LIQUID, protein equivalent (essential and non-essential amino acids except tyrosine and phenylalanine) 15 g, carbohydrate 7 g, fat 500 mg, energy 593 kJ (92 kcal)/130 mL, with vitamins, minerals, and trace elements.

TYR Anamix Junior LQ liquid (Nutricia Ltd)
125 ml (ACBS) - NHS indicative price = £9.78

TYR cooler ® 15
» Nutritional supplement for the dietary management of tyrosinaemia in children over 8 years.
LIQUID, protein equivalent (essential and non-essential amino acids except tyrosine and phenylalanine) 15 g, carbohydrate 7 g, fat 500 mg, energy 353 kJ (86 kcal)/92 mL, with vitamins, minerals, and trace elements.

TYR orange cooler 15 liquid (Vitaflo International Ltd)
130 ml (ACBS) - NHS indicative price = £12.31

TYR red cooler 10 liquid (Vitaflo International Ltd)
87 ml (ACBS) - NHS indicative price = £7.80

TYR red cooler 15 liquid (Vitaflo International Ltd)
130 ml (ACBS) - NHS indicative price = £12.31

TYR red cooler 20 liquid (Vitaflo International Ltd)
174 ml (ACBS) - NHS indicative price = £15.89

TYR express ®
» Nutritional supplement for the dietary management of tyrosinaemia in children over 8 years and adults.
POWDER, protein equivalent (essential and non-essential amino acids except tyrosine and phenylalanine) 15 g, carbohydrate 3.4 g, fat less than 100 mg, energy 310 kJ (74 kcal)/25 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

TYR express 15 oral powder 25 g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £362.37

TYR express 20 ®
» Nutritional supplement for the dietary management of tyrosinaemia in children over 8 years.
POWDER, protein equivalent (essential and non-essential amino acids except tyrosine and phenylalanine) 20 g, carbohydrate 4.7 g, fat less than 100 mg, energy 416 kJ (99 kcal)/34 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

TYR express 20 oral powder 34 g sachets (Vitaflo International Ltd)
50 sachet (ACBS) - NHS indicative price = £468.17

TYR Gel ®
» Nutritional supplement for the dietary management of tyrosinaemia in children 1–10 years.
GEL, protein equivalent (essential and non-essential amino acids except tyrosine and phenylalanine) 10 g, carbohydrate 10.3 g, fat less than 100 mg, energy 339 kJ (81 kcal)/24 g, with vitamins, minerals, and trace elements. To flavour unflavoured products, see FlavourPac p. 1081.

TYR gel oral powder 24 g sachets (Vitaflo International Ltd)
30 sachet (ACBS) - NHS indicative price = £233.29
Appendix 3
Cautionary and advisory labels for dispensed medicines

Guidance for cautionary and advisory labels

Medicinal forms within BNF publications include code numbers of the cautionary labels that pharmacists are recommended to add when dispensing. It is also expected that pharmacists will counsel patients and carers when necessary. Counselling needs to be related to the age, experience, background, and understanding of the individual patient or carer. The pharmacist should ensure understanding of how to take or use the medicine and how to follow the correct dosage schedule. Any effects of the medicine on co-ordination, performance of skilled tasks (e.g. driving or work), any foods or medicines to be avoided, and what to do if a dose is missed should also be explained. Other matters, such as the possibility of staining of the clothes or skin, or discoloration of urine or stools by a medicine should also be mentioned.

For some medicines there is a special need for counselling, such as an unusual method or time of administration or a potential interaction with a common food or domestic remedy, and this should be mentioned where necessary.

Original packs

Most preparations are dispensed in unbroken original packs that include further advice for the patient in the form of patient information leaflets. The advice in patient information leaflets may be less appropriate when the medicine is for a child, particularly for unlicensed medicines or indications. Pharmacists should explain discrepancies to carers, if necessary. The patient information leaflet should only be withheld in exceptional circumstances because it contains other information that should be provided. Label 10 may be of value where appropriate. More general leaflets advising on the administration of preparations such as eye drops, eye ointments, inhalers, and suppositories are also available.

Scope of labels

In general no label recommendations have been made for injections on the assumption that they will be administered by a healthcare professional or a well-instructed patient. The labelling is not exhaustive and pharmacists are recommended to use their professional discretion in labelling new preparations and those for which no labels are shown. Individual labelling advice is not given on the administration of the large variety of antacids. In the absence of instructions from the prescriber, and if on enquiry the patient has had no verbal instructions, the directions given under ‘Dose’ should be used on the label.

It is recognised that there may be occasions when pharmacists will use their knowledge and professional discretion and decide to omit one or more of the recommended labels for a particular patient. In this case counselling is of the utmost importance. There may also be an occasion when a prescriber does not wish additional cautionary labels to be used, in which case the prescription should be endorsed ‘NCL’ (no cautionary labels). The exact wording that is required instead should then be specified on the prescription.

Pharmacists label medicines with various wording in addition to those directions specified on the prescription. Such labels include ‘Shake the bottle’, ‘For external use only’, and ‘Store in a cool place’, as well as ‘Discard... days after opening’ and ‘Do not use after...’, which apply particularly to antibiotic mixtures, diluted liquid and topical preparations, and to eye-drops. Although absent in the BNF for Children these labels should continue to be used when appropriate; indeed, ‘For external use only’ is a legal requirement on external liquid preparations, while ‘Keep out of the reach of children’ is a legal requirement on all dispensed medicines. Care should be taken not to obscure other relevant information with adhesive labelling.

It is the usual practice for patients to take standard tablets with water or other liquid and for this reason no separate label has been recommended.

The label wordings recommended by the BNF for Children apply to medicines dispensed against a prescription. Children and carers should be aware that a dispensed medicine should never be taken by, or shared with, anyone other than for whom the prescriber intended it. Therefore, the BNF for Children does not include warnings against the use of a dispensed medicine by persons other than for whom it was specifically prescribed.

The label or labels for each preparation are recommended after careful consideration of the information available. However, it is recognised that in some cases this information may be either incomplete or open to a different interpretation. The BNF for Children will therefore be grateful to receive any constructive comments on the labelling suggested for any preparation.

Recommended label wordings

For BNF for Children 2011–2012, a revised set of cautionary and advisory labels were introduced. All of the existing labels were user-tested, and the revised wording selected reflects terminology that is better understood by patients.

Wordings which can be given as separate warnings are labels 1–19, 29–30, and 32. Wordings which can be incorporated in an appropriate position in the directions for dosage or administration are labels 21–28. A label has been omitted for number 20; labels 31 and 35 no longer apply to any medicines in the BNF for Children and have therefore been deleted.

If separate labels are used it is recommended that the wordings be used without modification. If changes are made to suit computer requirements, care should be taken to retain the sense of the original.

Welsh labels

Comprehensive Welsh translations are available for each cautionary and advisory label.

Labels

1 Warning: This medicine may make you sleepy
Rhybudd: Gall y feddyginiaeth hon eich gwneud yn gysglyd
To be used on preparations for children containing antihistamines, or other preparations given to children where the warnings of label 2 on driving or alcohol would not be appropriate.

2 Warning: This medicine may make you sleepy, if this happens, do not drive or use tools or machines. Do not drink alcohol
Rhybudd: Gall y feddyginiaeth hon eich gwneud yn gysglyd. Peidiwch â gyrru, defnyddio offer llaw neu beiriannau os yw hyn yn digwydd. Peidiwch ag yfed alcohol
To be used on preparations for adults that can cause drowsiness, thereby affecting coordination and the ability to drive and operate hazardous machinery; label 1 is more appropriate for children. It is an offence to drive while under the influence of drink or drugs.

Some of these preparations only cause drowsiness in the first few days of treatment and some only cause drowsiness in higher doses.
In such cases the patient should be told that the advice applies until the effects have worn off. However many of these preparations can produce a slowing of reaction time and a loss of mental concentration that can have the same effects as drowsiness. Avoidance of alcoholic drink is recommended because the effects of CNS depressants are enhanced by alcohol. Strict prohibition however could lead to some patients not taking the medicine. Pharmacists should therefore explain the risk and encourage compliance, particularly in patients who may think they already tolerate the effects of alcohol (see also label 3). Queries from patients with epilepsy regarding fitness to drive should be referred back to the patient’s doctor. Side-effects unrelated to drowsiness that may affect a patient’s ability to drive or operate machinery safely include blurred vision, dizziness, or nausea. In general, no label has been recommended to cover these cases, but the patient should be suitably counselled.

3 Warning: This medicine may make you sleepy. If this happens, do not drive or use tools or machines

Rhybudd: Gall y feddygniäeth hon eich gwneud yn gysglyd. Peidiwch â gyrri; defnyddio offer iflaw neu biirianau os wy hyn yn digwedd To be used on preparations containing monoamine oxidase inhibitors; the warning to avoid alcohol and deacoholised (low alcohol) drink is covered by the patient information leaflet. Also to be used as for label 2 but where alcohol is not an issue.

4 Warning: Do not drink alcohol

Rhybudd: Peidiwch ag yfed alcohol To be used on preparations where a reaction such as flushing may occur if alcohol is taken (e.g. metronidazole). Alcohol may also enhance the hypoglycaemia produced by some oral antidiabetic drugs but routine application of a warning label is not considered necessary. Patients should be advised not to drink alcohol for as long as they are receiving/using a course of medication, and in some cases for a period of time after the course is finished.

5 Do not take indigestion remedies 2 hours before or after you take this medicine

Peidiwch â chymryd meddygniäethau camdureiàd 2 awr cyn neu ar ôl y federdygniäeth hon To be used with label 25 on preparations coated to resist gastric acid (e.g. enteric-coated tablets). This is to avoid the possibility of premature dissolution of the coating in the presence of an alkaline pH.

Label 5 also applies to drugs such as gabapentin where absorption is significantly affected by antacids. Pharmacists will be aware (from a knowledge of physiology) that the usual time during which indigestion remedies should be avoided is at least 2 hours before and after the majority of medicines have been taken; when a manufacturer advises a different time period, this can be followed, and should be explained to the patient.

6 Do not take indigestion remedies, or medicines containing iron or zinc, 2 hours before or after you take this medicine

Peidiwch â chymryd meddygniäethau camdureiàd neu federdygniäethau sy’n cynnws haearn neu sinc, 2 awr cyn neu ar ôl y federdygniäeth hon To be used on preparations containing ofloxacin and some other quinolones, doxycycline, lymecycline, minocycline, and penicillamine. These drugs chelaite calcium, iron, and zinc and are less well absorbed when taken with calcium-containing antacids or preparations containing iron or zinc. Pharmacists will be aware (from a knowledge of physiology) that these incompatible preparations should be taken at least 2 hours apart for the majority of medicines; when a manufacturer advises a different time period, this can be followed, and should be explained to the patient.

7 Do not take milk, indigestion remedies, or medicines containing iron or zinc, 2 hours before or after you take this medicine

Peidiwch â chymryd laeth, meddygniäethau camdureiàd, neu federdygniäeth sy’n cynnws haearn neu sinc, 2 awr cyn neu ar ôl cymryd y federdygniäeth hon

To be used on preparations containing ciprofloxacin, norfloxacin, or tetracyclines that chelaite calcium, iron, magnesium, and zinc, and are thus less available for absorption. Pharmacists will be aware (from a knowledge of physiology) that these incompatible preparations should be taken at least 2 hours apart for the majority of medicines; when a manufacturer advises a different time period, this can be followed, and should be explained to the patient. Doxycycline, lymecycline, and minocycline are less liable to form chelates and therefore only require label 6 (see above).

8 Warning: Do not stop this medicine unless your doctor tells you to stop

Rhybudd: Peidiwch â stopio cymryd y federdygniäeth hon, oni bai fod eich meddyg yn dweud wrthych am stopio To be used on preparations that contain a drug which is required to be taken over long periods without the patient necessarily perceiving any benefit (e.g. antituberoulous drugs). Also to be used on preparations that contain a drug whose withdrawal is likely to be a particular hazard (e.g. clonidine for hypertension). Label 10 (see below) is more appropriate for corticosteroids.

9 Space the doses evenly throughout the day. Keep taking this medicine until the course is finished, unless you are told to stop

Gadewch yr un fiant o amser rhwng pob dôs yn ystod y dydd. Parhewch i gymryd eich wythnos ar ôl yr ymweliad ychwanegol gyda’r federdygniäeth hon To be used particularly on preparations where a course of treatment should be completed to reduce the incidence of relapse or failure of treatment.

The preparations are antimicrobial drugs given by mouth. Very occasionally, some may have severe side-effects (e.g. diarrhoea in patients receiving clindamycin) and in such cases the patient may need to be advised of reasons for stopping treatment quickly and returning to the doctor.

10 Warning: Read the additional information given with this medicine

Rhybudd: Darllenwch y wybodaeth ychwanegol gyda’r federdygniäeth hon

To be used particularly on preparations containing anticoagulants, lithium, and oral corticosteroids. The appropriate treatment card should be given to the patient and any necessary explanations given.

This label may also be used on other preparations to remind the patient of the instructions that have been given.

11 Protect your skin from sunlight—even on a bright but cloudy day. Do not use sunbeds

Diogelwch eich croen rhag golau’r haul, hyd y byddai o ddiwrnod hyd yn oed ar ddiwrnod— magician. Peidiwch â defnyddio gweñlwyd os yw hi os hyd hwyl i orffen, oni bai eich bod yn cael cynnar i stopio To be used on preparations where a course of treatment should be completed to reduce the incidence of relapse or failure of treatment.

The preparations are antimicrobial drugs given by mouth. Very occasionally, some may have severe side-effects (e.g. diarrhoea in patients receiving clindamycin) and in such cases the patient may need to be advised of reasons for stopping treatment quickly and returning to the doctor.

12 Do not take anything containing aspirin while taking this medicine

Peidiwch â chymryd unrhwyth beth sy’n cynnws aspirin gyda’r federdygniäeth hon

To be used on preparations containing sulfapyrazone whose activity is reduced by aspirin.

Label 12 should not be used for anticoagulants since label 10 is more appropriate.

13 Dissolve or mix with water before taking

Gadewch i doddi mewn dwr yn ôl ei gymryd

To be used on preparations that are intended to be dissolved in water (e.g. soluble tablets) or mixed with water (e.g. powders,
granules) before use. In a few cases other liquids such as fruit juice or milk may be used.

14 This medicine may colour your urine. This is harmless
Gal y fedydgiaeth hon liwio eich dŵr. Nid yw hyn yn arwydd o ddŵr
To be used on preparations that may cause the patient’s urine to turn an unusual colour. These include triamterene (blue under some lights), levodopa (dark reddish), and rifampicin (red).

15 Caution: flammable. Keep your body away from fire or flames
Rhybudd: Fflamadwy. Ar ôl rôi'r fedydgiaeth ymlaen, cadwch yng nglir o dân neu ffîfmau
To be used on preparations containing sufficient flammable solvent to render them flammable if exposed to a naked flame.

16 Dissolve the tablet under your tongue—do not swallow. Store the tablets in this bottle with the cap tightly closed. Get a new supply 8 weeks after opening
Rhowch y dabled i dodi dan eich tafod - peidiwch â i’i lyncu. Cadwch y tablidi yng n’hotel yma gyda’r caead wedi’i gau yng dynn. Gofynnwch am dabledi newydd 8 wythnos ar ôl ei hagor
To be used on preparations containing sufficient flammable solvent to render them flammable if exposed to a naked flame.

17 Do not take more than... in 24 hours
Peidiwch â chymryd mwy na... mewn 24 awr
To be used on preparations for the treatment of acute migraine except those containing ergotamine, for which label 18 is used. The dose form should be specified, e.g. tablets or capsules.

18 Do not take more than... in 24 hours. Also, do not take more than... in any one week
Peidiwch â chymryd mwy na... mewn 24 awr. Hefyd, peidiwch â chymryd mwy na... mewn wythnos
To be used on preparations containing ergotamine. The dose form should be specified, e.g. tablets or suppositories.

19 Warning: This medicine makes you sleepy. If you still feel sleepy the next day, do not drive or use tools or machines. Do not drink alcohol
Rhybudd: Bydd y fedydgiaeth hon yn eich gwneud yn gysglyd. Os ydych yn dal i deimlo’n gysglyd dramoeth, peidiwch â gyrru, defnyddio oll llaw neu beiriannau. Peidiwch ag yfed alcohol
To be used on preparations containing hypnotics (or some other drugs with sedative effects) prescribed to be taken at night. On the rare occasions when hypnotics are prescribed for daytime administration (e.g. nitrazepam in epilepsy), this label would clearly not be appropriate. Also to be used as an alternative to the label 2 wording (the choice being at the discretion of the pharmacist) for anxiolytics prescribed to be taken at night.

It is hoped that this wording will convey adequately the problem of residual morning sedation after taking ‘sleeping tablets’.

21 Take with or just after food, or a meal
Cymerwch gyda neu ar ôl bwyd
To be used on preparations that are liable to cause gastric irritation, or those that are better absorbed with food.
Patients should be advised that a small amount of food is sufficient.

22 Take 30 to 60 minutes before food
Cymerwch 30 i 60 munud cyn bwyd
To be used on some preparations whose absorption is thereby improved.
Most oral antibacterials require label 25 instead (see below).

23 Take this medicine when your stomach is empty. This means an hour before food or 2 hours after food
Cymerwch y fedydgiaeth hon ar stumog wag. Mae hyn yn goglygu awr cyn, neu 2 awr ar ôl bwyd
To be used on oral antibacterials whose absorption may be reduced by the presence of food and acid in the stomach.

24 Suck or chew this medicine
Bydd angen cnoi neu sugno’r fedydgiaeth hon
To be used on preparations that should be sucked or chewed. The pharmacist should use discretion as to which of these words is appropriate.

25 Swallow this medicine whole. Do not chew or crush
Llynchych yn gyfan. Peidiwch â chnoi neu falfu’n fân
To be used on preparations that are enteric-coated or designed for modified-release.
Also to be used on preparations that taste very unpleasant or may damage the mouth if not swallowed whole.
Patients should be advised (where relevant) that some modified-release preparations can be broken in half, but that the halved tablet should still be swallowed whole, and not chewed or crushed.

26 Dissolve this medicine under your tongue
Gadewch i’r fedydgiaeth hon doddi o dan y tafod
To be used on preparations for the treatment of acute migraine except those containing ergotamine, for which label 18 is used. The dose form should be specified, e.g. tablets or capsules.

27 Take with a full glass of water
Cymerwch gyda llond gwydr o ddŵr
To be used on preparations that should be well diluted (e.g. chloral hydrate), where a high fluid intake is required (e.g. sulfonamides), or where water is required to aid the action (e.g. methylocellulose). The patient should be advised that ‘a full glass’ means at least 150 mL. In most cases fruit juice, tea, or coffee may be used.

28 Spread thinly on the affected skin only
Taenwch yn denau ar y croen sydd wedi’i effeithio yn unig
To be used on external preparations that should be applied sparingly (e.g. corticosteroids, dithranol).

29 Do not take more than 2 at any one time. Do not take more than 8 in 24 hours
Peidiwch â chymryd mwy na 2 ar unrhyw un adeg. Peidiwch â chymryd mwy nag 8 mewn 24 awr
To be used on containers of dispensed solid dose preparations containing paracetamol for adults when the instruction on the label indicates that the dose can be taken on an ‘as required’ basis. The dose form should be specified, e.g. tablets or capsules.

This label has been introduced because of the serious consequences of overdosage with paracetamol.

30 Contains paracetamol. Do not take anything else containing paracetamol while taking this medicine. Talk to a doctor at once if you take too much of this medicine, even if you feel well
Yn cynnwys paracetamol. Peidiwch â chymryd unrhyw arall sy’n cynnwys paracetamol tra’n chymryd y fedydgiaeth hon. Siaradwch gyda’r meddyg ar unwaith os ydych yn cymryd gormod, hyd yn oed os ydych yn teimlo’n iawn
To be used on all containers of dispensed preparations containing paracetamol.

32 Contains aspirin. Do not take anything else containing aspirin while taking this medicine
Yn cynnwys aspirin. Peidiwch â chymryd unrhyw arall sy’n cynnwys aspirin tra’n chymryd y fedydgiaeth hon
To be used on containers of dispensed preparations containing aspirin when the name on the label does not include the word ‘aspirin’.
Dental Practitioners’ Formulary

List of Dental Preparations
The following list has been approved by the appropriate Secretaries of State, and the preparations therein may be prescribed by dental practitioners on form FP10D (GP14 in Scotland, WP10D in Wales).
Licensed sugar-free versions, where available, are preferred. Licensed alcohol-free mouthwashes, where available, are preferred.
Aciclovir Oral Suspension, BP
Aciclovir Tablets, BP
Aciclovir Tablets, 200 mg
Amoxicillin Capsules, BP
Amoxicillin Oral Powder, DPF
Amoxicillin Oral Suspension, BP
Artificial Saliva Gel, DPF
Artificial Saliva Oral Spray, DPF
Artificial Saliva Pastilles, DPF
Artificial Saliva Protective Spray, DPF
Artificial Saliva Substitutes as listed below (to be prescribed only for indications approved by ACBS (patients suffering from dry mouth as a result of having or, having undergone, radiotherapy or sicca syndrome):
BioXtra® Gel Mouthspray
BioXtra® Moisturising Gel
Glandosane®
Sialoex®
Artificial Saliva Substitute Spray, DPF
Aspirin Tablets, Dispersible, BP
Azithromycin Capsules, 250 mg, DPF
Azithromycin Oral Suspension, 200 mg/5 mL, DPF
Azithromycin Tablets, 250 mg, DPF
Azithromycin Tablets, 500 mg, DPF
Beclometasone Pressurised Inhalation, BP, 50 micrograms/metered inhalation, CFC-free, as:
Clenil Modulite®
Benzydamine Mouthwash, BP 0.15%
Benzydamine Oromucosal Spray, BP 0.15%
Betamethasone Soluble Tablets, 500 micrograms, DPF
Carbamazepine Tablets, BP
Cefalexin Capsules, BP
Cefalexin Tablets, BP
Cefradine Capsules, BP
Cetirizine Tablets, BP, 5 mg/5 mL
Cetirizine Tablets, BP, 10 mg
Chlorhexidine Gluconate Gel, BP
Chlorhexidine Mouthwash, BP
Chlorhexidine Oral Spray, DPF
Chlorphenamene Oral Solution, BP
Chlorphenamine Tablets, BP
Choline Salicylate Dental Gel, BP
Clarithromycin Oral Suspension, 125 mg/5 mL, DPF
Clarithromycin Oral Suspension, 250 mg/5 mL, DPF
Clarithromycin Tablets, BP
Clindamycin Capsules, BP
Co-amoxiclav Tablets, BP, 250/125 (amoxicillin 250 mg as trihydrate, clavulanic acid 125 mg as potassium salt)
Co-amoxiclav Oral Suspension, BP, 125/31 (amoxicillin 125 mg as trihydrate, clavulanic acid 31.25 mg as potassium salt)/5 mL
Co-amoxiclav Oral Suspension, BP, 250/62 (amoxicillin 250 mg as trihydrate, clavulanic acid 62.5 mg as potassium salt)/5 mL
Diazepam Oral Solution, BP, 2 mg/5 mL
Diazepam Tablets, BP
Diclofenac Sodium Tablets, Gastro-resistant, BP
Dihydromephene Tablets, BP, 30 mg
Doxycycline Tablets, Dispersible, BP
Doxycycline Capsules, BP, 100 mg
Doxycycline Tablets, 20 mg, DPF
Ephedrine Nasal Drops, BP
Erythromycin Ethyl Succinate Oral Suspension, BP
Erythromycin Ethyl Succinate Tablets, BP
Erythromycin Stearate Tablets, BP
Erythromycin Tablets, Gastro-resistant, BP
Fluconazole Capsules, 50 mg, DPF
Fluconazole Oral Suspension, 50 mg/5 mL, DPF
Hydrocortisone Cream, BP, 1%
Hydrocortisone Oromucosal Tablets, BP
Hydrogen Peroxide Mouthwash, BP, 6%
Ibuprofen Oral Suspension, BP, sugar-free
Ibuprofen Tablets, BP
Lansoprazole Capsules, Gastro-resistant, BP
Lidocaine Ointment, BP, 5%
Lidocaine Spray 10%, DPF
Loratadine Syrup, 5 mg/5 mL, DPF
Loratadine Tablets, BP, 10 mg
Menthol and Eucalyptus Inhalation, BP 1980
Metronidazole Oral Suspension, BP
Metronidazole Tablets, BP
Miconazole Cream, BP
Miconazole Oromucosal Gel, BP
Miconazole and Hydrocortisone Cream, BP
Miconazole and Hydrocortisone Ointment, BP
Nystatin Oral Suspension, BP
Omeprazole Capsules, Gastro-resistant, BP
Oxytetracycline Tablets, BP
Paracetamol Oral Suspension, BP
Paracetamol Tablets, BP
Paracetamol Tablets, Soluble, BP
Phenoxybenzepinellenin Oral Solution, BP
Phenoxybenzepinellenin Tablets, BP
Promethazine Hydrochloride Tablets, BP
Promethazine Oral Solution, BP
Saliva Stimulating Tablets, DPF
Sodium Chloride Mouthwash, Compound, BP
Sodium Fluoride Mouthwash, BP
Sodium Fluoride Oral Drops, BP
Sodium Fluoride Tablets, BP
Sodium Fluoride Toothpaste 0.619%, DPF
Sodium Fluoride Toothpaste 1.1%, DPF
Sodium Fusidate Ointment, BP
Temazepam Oral Solution, BP
Temazepam Tablets, BP
Tetracycline Tablets, BP
Nurse Prescribers’ Formulary (NPF)

Nurse Prescribers’ Formulary for Community Practitioners

List of preparations approved by the Secretary of State which may be prescribed on form FP10P (form HS21(N) in Northern Ireland, form GP10(N) in Scotland, forms WP1UCN and WP10PN in Wales) by Nurses for National Health Service patients.

Community practitioners who have completed the necessary training may only prescribe items appearing in the nurse prescribers’ list set out below. Community Practitioner Nurse Prescribers are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name.

Medicinal Preparations

Preparations on this list which are not included in the BP or BPC are described under Details of NPF preparations.

Almond Oil Ear Drops, BP
Arachis Oil Enema, NPF
Aspirin Tablets, Dispersible, 300 mg, BP (max. 96 tablets; max. pack size 32 tablets)
Bisacodyl Suppositories, BP (includes 5-mg and 10-mg strengths)
Bisacodyl Tablets, BP
Catheter Maintenance Solution, Sodium Chloride, NPF
Catheter Maintenance Solution, ‘Solution G’, NPF
Catheter Maintenance Solution, ‘Solution R’, NPF
Chlorhexidine Gluconate Alcoholic Solutions containing at least 0.05%
Chlorhexidine Gluconate Aqueous Solutions containing at least 0.05%
Choline Salicylate Dental Gel, BP
Clotrimazol Cream 1%, BP
Co-danthramer Capsules, NPF
Co-danthramer Capsules, Strong, NPF
Co-danthramer Oral Suspension, NPF
Co-danthramer Oral Suspension, Strong, NPF
Co-danthramer Capsules, BP
Co-danthramer Oral Suspension, NPF
Crotamiton Cream, BP
Crotamiton Lotion, BP
Dimeticone barrier creams containing at least 10% Dimeticone Lotion, NPF
Docusate Capsules, BP
Docusate Enema, NPF
Docusate Oral Solution, BP
Docusate Oral Solution, Paediatric, BP
Econazole Cream 1%, BP
Emollients as listed below: Aquadrate® 10% w/w Cream
Arachis Oil, BP
Balneum® Plus Cream
Cetabren® Emollient Cream
Dermamist®
Diprobase® Cream
Diprobase® Ointment
Doublebase®
Doublebase® Dayleve Gel
E45® Cream
E45® Itch Relief Cream
Emulsifying Ointment, BP
Eucerin® Intensive 10% w/w Urea Treatment Cream
Eucerin® Intensive 10% w/w Urea Treatment Lotion
Hydromol® Cream
Hydromol® Intensive
Hydrous Ointment, BP
Lipobase®
Liquid and White Soft Paraffin Ointment, NPF
Neutrogena® Norwegian Formula Dermatological Cream
Nutraplus® Cream
Oilatum® Cream
Oilatum® junior Cream
Paraffin, White Soft, BP
Paraffin, Yellow Soft, BP
Ultrabase®
Unguentum M®
Emollient Bath and Shower Preparations as listed below: Aqueous Cream, BP
Balneum® (except pack sizes that are not to be prescribed under the NHS (see Part XVIIIA of the Drug Tariff, Part XI of the Northern Ireland Drug Tariff))
Balneum Plus® Bath Oil (except pack sizes that are not to be prescribed under the NHS (see Part XVIIIA of the Drug Tariff, Part XI of the Northern Ireland Drug Tariff))
Cetabren® Emollient Bath Additive
Dermalo® Bath Emollient
Doublebase® Emollient Bath Additive
Doublebase® Emollient Shower Gel
Doublebase® Emollient Wash Gel
Hydromol® Bath and Shower Emollient
Oilatum® Emollient
Oilatum® Gel
Oilatum® Junior Bath Additive
Zerolatum® Emollient Medicinal Bath Oil
Folic Acid Tablets 400 micrograms, BP
Glycerol Suppositories, BP
Ibuprofen Oral Suspension, BP (except for indications and doses that are prescription-only)
Ibuprofen Tablets, BP (except for indications and doses that are prescription-only)
Ispaghula Husk Granules, BP
Ispaghula Husk Granules, Effervescent, BP
Ispaghula Husk Oral Powder, BP
Lactulose Solution, BP
Lidocaïne Ointment, BP
Lidocaïne and Chlorhexidine Gel, BP
Macrograd Oral Liquid, Compound, NPF
Macrograd Oral Powder, Compound, NPF
Macrograd Oral Powder, Compound, Half-strength, NPF
Magnesium Hydroxide Mixture, BP
Magnesium Sulfate Paste, BP
Malathion aqueous lotions containing at least 0.5%
Mebendazole Oral Suspension, BP
Mebendazole Tablets, BP
Methylcellulose Tablets, BP
Miconazole Cream 2%, BP
Miconazole Oromucosal Gel, BP
Mouthwash Solution-tablets, NPF
Nicotine Inhalation Cartridge for Oromucosal Use, NPF
Nicotine Lozenge, NPF
Nicotine Medicated Chewing Gum, NPF
Nicotine Nasal Spray, NPF
Nicotine Oral Spray, NPF
Nicotine Sublingual Tablets, NPF
Nicotine Transdermal Patches, NPF
Nystatin Oral Suspension, BP
Olive Oil Ear Drops, BP
Paracetamol Oral Suspension, BP (includes 120 mg/5 mL and 250 mg/5 mL strengths—both of which are available as sugar-free formulations)
Nurse Prescribers’ Formulary (NPF) 1099

Paracetamol Tablets, BP (max. 96 tablets; max. pack size 32 tablets)
Paracetamol Tablets, Soluble, BP (includes 120-mg and 500-mg tablets; max. 96 tablets; max. pack size 32 tablets)
Permethrin Cream, NPF
Phosphates Enema, BP
Potassium–Iodine Solution, BP
Senna Oral Solution, NPF
Senna Tablets, BP
Senna and Ispaghula Granules, NPF
Sodium Chloride Solution, Sterile, BP
Sodium Citrate Compound Enema, NPF
Sodium Picosulphate Capsules, NPF
Sodium Picosulphate Elixir, NPF
Spermicidal contraceptives as listed below:
   Gygel © Contraceptive Jelly
Sterculia Granules, NPF
Sterculia and Frangula Granules, NPF
Titanium Ointment, BP
Water for Injections, BP
Zinc and Castor Oil Ointment, BP
Zinc Oxide and Dimeticone Spray, NPF
Zinc Oxide Impregnated Medicated Bandage, NPF
Zinc Oxide Impregnated Medicated Stocking, NPF
Zinc Paste Bandage, BP 1993
Zinc Paste and Ichtammol Bandage, BP 1993

Appliances and Reagents (including Wound Management Products)

Community Practitioner Nurse Prescribers in England, Wales and Northern Ireland can prescribe any appliance or reagent in the relevant Drug Tariff. In the Scottish Drug Tariff, Appliances and Reagents which may not be prescribed by Nurses are annotated Ns.

Appliances (including Contraceptive Devices) as listed in Part IXA of the Drug Tariff (Part III of the Northern Ireland Drug Tariff, Part 3 (Appliances) and Part 2 (Dressings) of the Scottish Drug Tariff). (Where it is not appropriate for nurse prescribers in family planning clinics to prescribe contraceptive devices using form FP10(P) (forms WP10CN and WP10PN in Wales), they may prescribe using the same system as doctors in the clinic.)

Incontinence Appliances as listed in Part IXB of the Drug Tariff (Part III of the Northern Ireland Drug Tariff, Part 5 of the Scottish Drug Tariff).

Stoma Appliances and Associated Products as listed in Part IXC of the Drug Tariff (Part III of the Northern Ireland Drug Tariff, Part 6 of the Scottish Drug Tariff).

Chemical Reagents as listed in Part IXR of the Drug Tariff (Part II of the Northern Ireland Drug Tariff, Part 9 of the Scottish Drug Tariff).

Details of NPF preparations

Preparations on the Nurse Prescribers’ Formulary which are not included in the BP or BPC are described as follows in the Nurse Prescribers’ Formulary. Although brand names have sometimes been included for identification purposes, it is recommended that non-proprietary names should be used for prescribing medicinal preparations in the NPF except where a non-proprietary name is not available.

Arachis Oil Enema
   arachis oil 100%

Catheter Maintenance Solution, Sodium Chloride (proprietary products: OptiFlo S; Uro–Tainer Sodium Chloride; Uniflex–S), sodium chloride 0.9%

Catheter Maintenance Solution, ’Solution G’ (proprietary products: OptiFlo G; Uro–Tainer Suby G; Uriflex G), citric acid 3.23%, magnesium oxide 0.38%, sodium bicarbonate 0.7%, disodium edetate 0.01%

Catheter Maintenance Solution, ’Solution R’ (proprietary products: OptiFlo R; Uro–Tainer Solution R; Uriflex R), citric acid 6%, gluconolactone 0.6%, magnesium carbonate 2.8%, disodium edetate 0.01%

Chlorhexidine gluconate alcoholic solutions (proprietary products: Chloraprep; Hydrex Solution; Hydrex spray), chlorhexidine gluconate in alcoholic solution

Chlorhexidine gluconate aqueous solutions (proprietary product: Unisept), chlorhexidine gluconate in aqueous solution

Co-danthramer Capsules (Pom) co-danthramer 25/200 (dantram 25 mg, poloxamer ‘188’ 200 mg)

Co-danthramer Capsules, Strong (Pom) co-danthramer 37.5/500 (dantram 37.5 mg, poloxamer ‘188’ 500 mg)

Co-danthramer Oral Suspension (Pom) (proprietary product: Codalax), co-danthramer 25/200 in 5 mL (dantram 25 mg, poloxamer ‘188’ 200 mg/5 mL)

Co-danthramer Oral Suspension, Strong (Pom) (proprietary product: Codalax Forte), co-danthramer 75/1000 in 5 mL (dantram 75 mg, poloxamer ‘188’ 1 g/5 mL)

Co-danthrusate Oral Suspension (Pom) (proprietary product: Normax), co-danthrusate 50/60 (dantram 50 mg, docusate sodium 60 mg/5 mL)

Dimeticone barrier creams (proprietary products Contonat Cream, dimeticone ‘350’ 22%; Sigel Barrier Cream, dimeticone ‘1000’ 10%), dimeticone 10–22% Dimeticone Lotion
   (proprietary product: Hedrin), dimeticone 4%

Docusate Enema
   (proprietary product: Norgalax Micro-enna), docusate sodium 120 mg in 10 g

Liquid and White Soft Paraffin Ointment
   liquid paraffin 50%, white soft paraffin 50%

Macrogol Oral Liquid, Compound
   (proprietary product: Movicol Liquid), macrogol ’3350’ (polyethylene glycol ’3350’) 13.125 g, sodium bicarbonate 178.5 mg, sodium chloride 350.7 mg, potassium chloride 46.6 mg/25 mL

Macrogol Oral Powder, Compound
   (proprietary products: Laxido Orange, Molaxole, Movicol), macrogol ’3350’ (polyethylene glycol ’3350’) 13.125 g, sodium bicarbonate 178.5 mg, sodium chloride 350.7 mg, potassium chloride 46.6 mg/sachet; (amount of potassium chloride varies according to flavour of Movicol® as follows: plain-flavour (sugar-free) = 50.2 mg/sachet; lime and lemon flavour = 46.6 mg/sachet; chocolate flavour = 31.7 mg/sachet. 1 sachet when reconstituted with 125 mL water provides K+ 5.4 mmol/litre)

Macrogol Oral Powder, Compound, Half-strength
   (proprietary product: Movicol-Half), macrogol ’3350’ (polyethylene glycol ’3350’) 6.563 g, sodium bicarbonate 89.3 g, sodium chloride 175.4 mg, potassium chloride 23.3 mg/sachet

Malathion aqueous lotions
   (proprietary products: Derbac-M Liquid), malathion 0.5% in an aqueous basis

Mebendazole Oral Suspension (Pom) (proprietary product: Vermox), mebendazole 100 mg/5 mL

Mebendazole Tablets (Pom) (proprietary products: Ovep, Vermox), mebendazole 100 mg (can be supplied for oral use in the treatment of enterobiasis in adults and children over 2 years provided its container or
package is labelled to show a max. single dose of 100 mg and it is supplied in a container or package containing not more than 800 mg)

**Mouthwash Solution-tablets**
Consist of tablets which may contain antimicrobial, colouring and flavouring agents in a suitable soluble effervescent basis to make a mouthwash.

**Nicotine Inhalation Cartridge for Oromucosal Use**
(Proprietary products: NicAssist Inhalator, Nicorette Inhalator), nicotine 15 mg (for use with inhalation mouthpiece; to be prescribed as either a starter pack (6 cartridges with inhalator device) or refill pack (42 cartridges with inhalator device))

**Nicotine Lozenges**
Nicotine (as bitartrate) 1 mg or 2 mg (Proprietary products: Nicorette Mint Lozenge, Nicotinell Mint Lozenge), or nicotine (as resinate) 1.5 mg, 2 mg, or 4 mg (Proprietary products: NiQuitin Lozenges, NiQuitin Minis, NiQuitin Pre-quit)

**Nicotine Medicated Chewing Gum**
(Proprietary products: NicAssist Gum, Nicorette Gum, Nicotinell Gum, NiQuitin Gum), nicotine 2 mg or 4 mg

**Nicotine Nasal Spray**
(Proprietary product: NicAssist Nasal Spray, Nicorette Nasal Spray), nicotine 500 micrograms/metered spray

**Nicotine Oral Spray**
(Proprietary product: Nicorette Quickmist), nicotine 1 mg/metered spray

**Nicotine Sublingual Tablets**
(Proprietary product: NicAssist Microtab, Nicorette Microtab), nicotine (as a cyclodextrin complex) 2 mg (to be prescribed as either a starter pack (2 × 15-tablet discs with dispenser) or refill pack (7 × 15-tablet discs))

**Nicotine Transdermal Patches**
Releasing in each 16 hours, nicotine approx. 5 mg, 10 mg, or 15 mg (Proprietary products: Boots NicAssist Patch, Nicorette Patch), or releasing in each 16 hours approx. 10 mg, 15 mg, or 25 mg (Proprietary products: NicAssist Translucent Patch, Nicorette Invisi Patch), or releasing in each 24 hours nicotine approx. 7 mg, 14 mg, or 21 mg (Proprietary products: Nicopatch, Nicotinell TTS, NiQuitin, NiQuitin Clear) (Prescriber should specify the brand to be dispensed)

**Permethrin Cream**
(Proprietary product: Lyclear Dermal Cream), permethrin 5%

**Senna Oral Solution**
(Proprietary product: Senokot Syrup), sennosides 7.5 mg/5 mL

**Senna and Ispaghula Granules**
(Proprietary product: Manevac Granules), senna fruit 12.4%, ispaghula 54.2%

**Sodium Citrate Compound Enema**
(Proprietary products: Micolette Micro-enema; Micralax Micro-enema; Relaxit Micro-enema), sodium citrate 450 mg with glycerol, sorbitol and an anionic surfactant

**Sodium Picosulfate Capsules**
(Proprietary products: Dulcolax Perles), sodium picosulfate 2.5 mg

**Sodium Picosulfate Elixir**
(Proprietary product: Dulcolax Liquid), sodium picosulfate 5 mg/5 mL

**Sterculia Granules**
(Proprietary product: Normacol Granules), sterculia 62%

**Sterculia and Frangula Granules**
(Proprietary product: Normacol Plus Granules), sterculia 62%, frangula (standardised) 8%

**Zinc Oxide and Dimeticone Spray**
(Proprietary product: Sprilon), dimeticone 1.04%, zinc oxide 12.5% in a pressurised aerosol unit

**Zinc Oxide Impregnated Medicated Bandage**
(Proprietary product: Steripaste), sterile cotton bandage impregnated with paste containing zinc oxide 15%

**Zinc Oxide Impregnated Medicated Stocking**
(Proprietary product: Zipzac), sterile rayon stocking impregnated with ointment containing zinc oxide 20%
Non-medical prescribing

Overview
A range of non-medical healthcare professionals can prescribe medicines for patients as either Independent or Supplementary Prescribers.

Independent prescribers are practitioners responsible and accountable for the assessment of patients with previously undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. They are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved non-proprietary name.

Supplementary prescribing is a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed Clinical Management Plan for an individual patient with that patient’s agreement.

Independent and Supplementary Prescribers are identified by an annotation next to their name in the relevant professional register.

Information and guidance on non-medical prescribing is available on the Department of Health website at www.dh.gov.uk/health/2012/04/prescribing-change.


For information on the supply and administration of medicines to groups of patients using Patient Group Directions see Guidance on prescribing p. 1.

In order to protect patient safety, the initial prescribing and supply of medicines prescribed should normally remain separate functions performed by separate healthcare professionals.

Nurses
Nurse Independent Prescribers (formerly known as Extended Formulary Nurse Prescribers) are able to prescribe any medicine for any medical condition. Unlicensed medicines are excluded from the Nurse Prescribing Formulary in Scotland.

Nurse Independent Prescribers are able to prescribe, administer, and give directions for the administration of Schedule 2, 3, 4, and 5 Controlled Drugs. This extends to dihydrocodeine tartrate p. 285, dipipanone, or cocaine for treating organic disease or injury, but not for treating addiction.

Nurse Independent Prescribers must work within their own level of professional competence and expertise.

The Nurse Prescribers’ Formulary (NPF) p. 1098 for Community Practitioners provides information on prescribing.

Physiotherapists
Physiotherapist Independent Prescribers can prescribe any medicine for any medical condition. This includes “off-label” medicines subject to accepted clinical good practice. They are also allowed to prescribe the following Controlled Drugs: oral or injectable morphine p. 299, transdermal fentanyl p. 286 and oral diazepam p. 226, dihydrocodeine tartrate p. 285, lorazepam p. 228, oxycodone hydrochloride p. 292 or temazepam p. 847.

Physiotherapist Independent Prescribers must work within their own level of professional competence and expertise.

Therapeutic radiographers
Therapeutic Radiographer Independent Prescribers can prescribe any licensed medicine for ocular conditions affecting the eye and the tissues surrounding the eye, except Controlled Drugs or medicines for parenteral administration. Therapeutic Radiographer Independent Prescribers must work within their own level of professional competence and expertise.

Optometrists
Optometrist Independent Prescribers can prescribe any licensed medicine for ocular conditions affecting the eye and the tissues surrounding the eye, except Controlled Drugs or medicines for parenteral administration. Optometrist Independent Prescribers must work within their own level of professional competence and expertise.

Podiatrists
Podiatrist Independent Prescribers can prescribe any medicine for any medical condition. This includes “off-label” medicines subject to accepted clinical good practice. They are also allowed to prescribe the following Controlled Drugs for oral administration: diazepam p. 226, dihydrocodeine tartrate p. 285, lorazepam p. 228 and temazepam p. 847.

Podiatrist Independent Prescribers must work within their own level of professional competence and expertise.

Further Information
For further details about the different types of prescribers, see Medicines, Ethics and Practice, London, Pharmaceutical Press (always consult latest edition).
## Index of manufacturers

The following is an alphabetical list of manufacturers and other companies referenced in the BNF, with their medicines information or general contact details. For information on ‘special-order’ manufacturers and specialist importing companies see ‘Special-order manufacturers’.

### 3M Health Care Ltd
Tel: 01509 611611

### A1 Pharmaceuticals
Tel: 01708 528900, enquiries@a1phc.co.uk

### Abbott Healthcare Products Ltd
Tel: 0800 1701177, ukabbottnutrition@abbott.com

### Abbvie Ltd
Tel: 01626 561092, uKmedinfo@abbvie.com

### Accord Healthcare Ltd
Tel: 01271 385257, medinfo@accord-healthcare.com

### Actavis UK Ltd
Tel: 01271 385257, medinfo@accord-healthcare.com

### Actelion Pharmaceuticals UK Ltd
Tel: 0208 9873333, medinfo.uk@gtn.jnj.com

### Advanced Medical Solutions Ltd
Tel: 01606 863500

### Advacnis Medical
Tel: 01623 751500

### Advanz Pharma
Tel: 0870 703033, medicalinformation@advanzpharma.com

### AgaMatrix Europe Ltd
Tel: 0800 0913812, info@agamatrix.co.uk

### Aguetant Ltd
Tel: 01275 463691, info@aguetant.co.uk

### Alan Pharmaceuticals
Tel: 020 72842887, info@alanpharmaceuticals.com

### Alcon Eye Care Ltd
Tel: 0345 2669363, gb.medicaldepartment@alcon.com

### Alexion Pharma UK Ltd
Tel: 0800 6891592, MedicalInformationUK@alexion.com

### Alimera Sciences Ltd
Tel: 0800 0191253, medicalinformation@alimerasciences.com

### Alissa Healthcare Research Ltd
Tel: 01489 564069, enquiries@alissahcare.com

### ALK-Abello Ltd
Tel: 0118 9037940, info@alk-abbello.com

### Allergan Ltd
Tel: 01628 494020, UK_MedInfo@allergan.com

### Allergy Therapeutics (UK) Ltd
Tel: 01264 332172, info@ccmed.co.uk

### Allergen Ltd
Tel: 01628 494020, UK_MedInfo@allergan.com

### Allergy Therapeutics
Tel: 01628 494020, UK_MedInfo@allergan.com

### Almirall Ltd
Tel: 0118 9037940, info@almirall.co.uk

### Amgen Ltd
Tel: +1 610 5303193, info@amgen.com

### Amgen Ltd
Tel: +1 610 5303193, info@amgen.com

### Amryt Pharma
Tel: 01604 549952, medinfo@amrytpharma.com

### AOP Orphan Pharmaceuticals AG
Tel: 0121 2634119, anne.worrallo-hickman@aoporpharma.com

### Aristo Pharma Ltd
Tel: 01483 920754, medinfo@aristo-pharma.co.uk

### Arjun Products Ltd
Tel: 0800 0175806, info@arjunproducts.co.uk

### Ascot Laboratories Ltd
Tel: 01923 711971, specials@ascotpharma.com

### Aspen Pharmaceuticals Ltd
Tel: 020 82500428, info@aspenpharma.co.uk

### Aspira Pharma Ltd
Tel: 01730 231148, medinfo@aspira-pharma.co.uk

### Astellas Pharma UK Ltd
Tel: 0800 7830033, medicalinformationuk@astazeneca.com

### Atlantic Pharma Ltd
Tel: 0845 5191609, enquiries@atlanticpharma.co.uk

### Awnahs Pharma UK Ltd
Tel: 01279 406759, psv@servicess@diamondpharmservicestes.co.uk

### Auden McKenzie (Pharma Division) Ltd
Tel: 01271 385257, Medinfo@accord-healthcare.com

### Alcubina Pharma Ltd
Tel: 0208 8458811, medinfo@aurubindo.com

### AYMES International Ltd
Tel: 0845 6805496, info@aymes.com

### Bard Ltd
Tel: 02039 527888, customerservices@crbarr.com

### Bausch & Lomb UK Ltd
Tel: 01748 828849, medicalinformation@bausch.com

### Baxter Healthcare Ltd
Tel: 01635 206345, medinfo.uk@baxter.com

### Bayer PTC
Tel: 0118 2063000, medicalinformation@bayer.co.uk

### BBi Healthcare Ltd
Tel: 01656 868930, info@bhibihealthcare.com

### B. Braun Medical Ltd
Tel: 0114 2259000, info@bbmuk@bbbraun.com

### B. Braun Melsungen AG
Tel: +49 5661 710, info@bbbraun.com

### Beacon Pharmaceuticals Ltd
Tel: 01233 506374, medical@altheone-laboratories.com

### Biersdorf UK Ltd
Tel: 0121 329 8800

### Bell, Sons & Co (Druggists) Ltd
Tel: 0151 4221200, Med-info@bells-healthcare.com

### Besins Healthcare (UK) Ltd
Tel: 01748 828789, BHK@professionalinformation.co.uk

### BHR Pharmaceuticals Ltd
Tel: 020 7476 37710

### BIAL Pharma UK Ltd
Tel: 01753 916010, medinfo@bbiukltd.com

### Bio Medical Sciences
Tel: +1 610 5303193, info@bilsom.com

### Bio Products Laboratory Ltd
Tel: 020 89572622, medinfo@bpl.co.uk

### Bio-Diagnostics Ltd
Tel: 01684 592626, enquiries@biodynamics.co.uk

### Biogen Idec Ltd
Tel: 0800 0087401, MedinfoUK@biogen.com

### Biolitec Pharma Ltd
Tel: +49 3641 5195330, medinfo@biolitecpharma.com

### BioMarin Europe Ltd
Tel: 0845 0177013, medinfo@bmrn.com

### Biotech Pharmacal Inc
Tel: +1 800 3451199, customerservice@bio-tech-pharm.com

### Biotest (UK) Ltd
Tel: 0121 7448444, medicinesinformation@biotest.com

### Blumont Pharma Ltd
Tel: 01476 978568

### BOC Medical
Tel: 0800 136603, healthcare-home-uk@boc.com

### Boehringer Ingelheim Ltd
Tel: 01344 742739, enquiries@boehringer-ingelheim.com

### Boston Healthcare Ltd
Tel: 01908 363499, medinfo@bostonhealthcare.co.uk

### Brancaster Pharma Ltd
Tel: 01737 243407, safety@brancasterpharma.com

### Bray Group Ltd
Tel: 01367 240736, info@bray-healthcare.com

### Bristol Laboratories Ltd
Tel: 01442 200922, info@bristol-labs.co.uk

### Bristol-Myers Squibb Pharmaceuticals Ltd
Tel: 0800 7311736, medicalinformation@bms.com

### Britannia Pharmaceuticals Ltd
Tel: 01483 920763, enquiries@medicalinformation.co.uk

### Brown & Burk UK Ltd
Tel: 0208 5778200, bbukqa@bbukltd.com

### BSN Medical Ltd
Tel: 01482 670100, orders.uk@bsnmedical.com

### BTG International Ltd
Tel: +44 877 6269989, medical.services@btgplc.com

### Cambridge Healthcare Supplies Ltd
Tel: 01908 361434, info@cambridge-healthcare.co.uk

### Cambridge Sensors Ltd
Tel: 0800 0883920, info@microdots.com

### CareFusion UK Ltd
Tel: 0800 0437546, carefusionGB@professionalinformation.co.uk

### Carinopharm GmbH
Tel: 01748 828812, carinopharm@professionalinformation.co.uk

### Casen Records Ltd
Tel: +39 91 3517964, info@casenrecords.com

### C D Medical Ltd
Tel: 01942 819333

### CD Pharma Srl
Tel: +39 02 43980539, info@cdpharmagroupone

### Celgene Ltd
Tel: 08448 010045, medinfo.uk.ie@celgene.com

### Chanelle Medical UK Ltd
Tel: 0870 1923283, chanelle@medinformation.co.uk

### Charles S. Bullen Stomacare Ltd
Tel: 0800 888501

### Chattem (U.K.) Ltd
Tel: 01942 819333

### Chemidex Pharma Ltd
Tel: 01784 477167, info@chemidex.co.uk

### Cheplapharm Arzneimittel GmbH
Tel: 0800 1450034, cheplapharm@redlinepv.co.uk

### Chiesi Ltd
Tel: 0161 4885555, medinfo.uk@chiesi.com

### Chiesi Ltd
Tel: 0161 4885555, medinfo.uk@chiesi.com
LEO Pharma, Tel: 01844 347313, medical.info.uk@leo-pharma.com
Leyden Delta B.V., Tel: +31 24 3726272, Medicalinformation@leyendelta.nl
LifeScan, Tel: +1 800 227 8862, customercare@LifeScan.co.uk
Lincoln Medical Ltd, Tel: 01722 762900, medicalinformation@lincolnmedical.co.uk
Lipomed Gmbh, Tel: +41 61 702000, lipomed@lipomed.com
Logixx Pharma Solutions Ltd, Tel: 01908 363454, mg@logixxpharma.com
Lohmann & Rauscher, Tel: +49 2634 990, info@de.LRMedmed.com
L&R Medical UK Ltd, Tel: 01283 576800, customerrelationsuk.lrm.com
Lucane Pharma Ltd, Tel: +31 3 5368750, info@lucanepharma.com
Lundbeck Ltd, Tel: 01908 638972, ukmedicalinformation@lundbeck.com
Lupin Healthcare (UK) Ltd, Tel: 01748 828380, EU-PV@lupin.com
Mallinckrodt Specialty Pharmaceuticals Ireland Ltd, Tel: 00800 5544477, mallinckrodt@professionalinformation.co.uk
Manuka Medical Ltd, Tel: +61 6567885, supportUSA@manukamed.com
Manx Healthcare Ltd, Tel: 01926 428511, info@manxhealthcare.co.uk
M & A Pharmachem Ltd, Tel: 01942 852085, safety@mapachem.co.uk
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Special-order manufacturers

Unlicensed medicines are available from ‘special-order’ manufacturers and specialist-importing companies; the MHRA maintains a register of these companies at tinyurl.com/cdsike.

Licensed hospital manufacturing units also manufacture ‘special-order’ products as unlicensed medicines, the principal NHS units are listed below. A database (Pro-File; www.pro-file.nhs.uk) provides information on medicines manufactured in the NHS; access is restricted to NHS pharmacy staff.

The Association of Pharmaceutical Specials Manufacturers may also be able to provide further information about commercial companies (www.apsm-uk.com).

The MHRA recommends that an unlicensed medicine should only be used when a patient has special requirements that cannot be met by use of a licensed medicine.

As well as being available direct from the hospital manufacturer(s) concerned, many NHS-manufactured Specials may be bought from the Oxford Pharmacy Store, owned and operated by Oxford Health NHS Foundation Trust.

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REPORT OF SUSPECTED ADVERSE DRUG REACTIONS

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**PATIENT DETAILS**
Patient Initials: ___________  Sex: M / F  Is the patient pregnant? Y / N  Ethnicity: ___________
Age (at time of reaction): ___________  Weight (kg): ___________  Identification number (e.g. Practice or Hospital Ref): ___________

**SUSPECTED DRUG(S)/VACCINE(S)**
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<th>Drug/Vaccine (Brand if known)</th>
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Date reaction(s) started: ___________  Date reaction(s) stopped: ___________

Do you consider the reactions to be serious?  Yes / No

If yes, please indicate why the reaction is considered to be serious (please tick all that apply):

- [ ] Patient died due to reaction
- [ ] Involved or prolonged inpatient hospitalisation
- [ ] Life threatening
- [ ] Involved persistent or significant disability or incapacity
- [ ] Congenital abnormality
- [ ] Medically significant; please give details: ___________

If the reactions were not serious according to the categories above, how bad was the suspected reaction?

- [ ] Mild
- [ ] Unpleasant, but did not affect everyday activities
- [ ] Bad enough to affect everyday activities
It’s easy to report online: www.mhra.gov.uk/yellowcard

OTHER DRUG(S) (including self-medication and complementary remedies)
Did the patient take any other medicines/vaccines/complementary remedies in the last 3 months prior to the reaction? Yes / No
If yes, please give the following information if known:

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Additional relevant information e.g. medical history, test results, known allergies, rechallenge (if performed). For reactions relating to use of a medicine during pregnancy please state all other drugs taken during pregnancy, the last menstrual period, information on previous pregnancies, ultrasound scans, any delivery complications, birth defects or developmental concerns.

Please list any medicines obtained from the internet:

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Information on adverse drug reactions received by the MHRA can be downloaded at www.mhra.gov.uk/daps
Stay up-to-date on the latest advice for the safe use of medicines with our monthly bulletin Drug Safety Update at: www.mhra.gov.uk/drugsafetyupdate

Please attach additional pages if necessary. Send to: FREEPOST YELLOW CARD (no other address details required)
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## PATIENT DETAILS
- Patient Initials: ___________
- Sex: M / F
- Is the patient pregnant? Y / N
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- Age (at time of reaction): ___________
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---

**Outcome**

- [ ] Recovered
- [ ] Recovering
- [ ] Continuing
- [ ] Other

---

**BNFC**

**In Confidence**

**YellowCard**

COMMISSION ON HUMAN MEDICINES (CHM)

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**MHRA**

Regulating Medicines and Medical Devices
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Additional relevant information e.g. medical history, test results, known allergies, rechallenge (if performed). For reactions relating to use of a medicine during pregnancy please state all other drugs taken during pregnancy, the last menstrual period, information on previous pregnancies, ultrasound scans, any delivery complications, birth defects or developmental concerns.

Please list any medicines obtained from the internet:

REPORTER DETAILS
Name and Professional Address:

Postcode: Tel No: Email: Speciality: Signature: Date:

CLINICIAN (if not the reporter)
Name and Professional Address:

Postcode: Tel No: Email: Speciality: Date:

Information on adverse drug reactions received by the MHRA can be downloaded at www.mhra.gov.uk/daps
Stay up-to-date on the latest advice for the safe use of medicines with our monthly bulletin Drug Safety Update at: www.mhra.gov.uk/drugsafetyupdate

Please attach additional pages if necessary. Send to: FREEPOST YELLOW CARD (no other address details required)
REPORT OF SUSPECTED ADVERSE DRUG REACTIONS

If you suspect an adverse reaction may be related to one or more drugs/vaccines/complementary remedies, please complete this Yellow Card. See ‘Adverse reactions to drugs’ section in BNFC or www.mhra.gov.uk/yellowcard for guidance. Do not be put off reporting because some details are not known.

**PATIENT DETAILS**

- Patient Initials: ____________ Sex: M / F
- Is the patient pregnant? Y / N
- Ethnicity: ________________
- Age (at time of reaction): ____________ Weight (kg): ____________ Identification number (e.g. Practice or Hospital Ref): ________________

**SUSPECTED DRUG(S)/VACCINE(S)**

<table>
<thead>
<tr>
<th>Drug/Vaccine (Brand if known)</th>
<th>Batch</th>
<th>Route</th>
<th>Dosage</th>
<th>Date started</th>
<th>Date stopped</th>
<th>Prescribed for</th>
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**SUSPECTED REACTION(S)**

Please describe the reaction(s) and any treatment given. (Please attach additional pages if necessary):

Date reaction(s) started: ________________ Date reaction(s) stopped: ________________

Do you consider the reactions to be serious? Yes / No

If yes, please indicate why the reaction is considered to be serious (please tick all that apply):

- Patient died due to reaction
- Life threatening
- Congenital abnormality

- Involved or prolonged inpatient hospitalisation
- Involved persistent or significant disability or incapacity
- Medically significant; please give details: ________________

If the reactions were not serious according to the categories above, how bad was the suspected reaction?

- Mild
- Unpleasant, but did not affect everyday activities
- Bad enough to affect everyday activities

Outcome

- Recovered
- Recovering
- Continuing
- Other
It's easy to report online: www.mhra.gov.uk/yellowcard

OTHER DRUG(S) (including self-medication and complementary remedies)
Did the patient take any other medicines/vaccines/complementary remedies in the last 3 months prior to the reaction? Yes / No
If yes, please give the following information if known:

<table>
<thead>
<tr>
<th>Drug/Vaccine (Brand if known)</th>
<th>Batch</th>
<th>Route</th>
<th>Dosage</th>
<th>Date started</th>
<th>Date stopped</th>
<th>Prescribed for</th>
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</tbody>
</table>

Additional relevant information e.g. medical history, test results, known allergies, rechallenge (if performed). For reactions relating to use of a medicine during pregnancy please state all other drugs taken during pregnancy, the last menstrual period, information on previous pregnancies, ultrasound scans, any delivery complications, birth defects or developmental concerns.

Please list any medicines obtained from the internet:

REPORTER DETAILS
Name and Professional Address:

Postcode: Tel No:
Email:
Speciality:
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Name and Professional Address:

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Stay up-to-date on the latest advice for the safe use of medicines with our monthly bulletin Drug Safety Update at: www.mhra.gov.uk/drugsafetyupdate

Please attach additional pages if necessary. Send to: FREEPOST YELLOW CARD (no other address details required)
Newborn Life Support

(Antenatal counselling)
Team briefing and equipment check

Birth

Dry the baby
Maintain normal temperature
Start the clock or note the time

Assess (tone), breathing, heart rate

If gasping or not breathing:
Open the airway
Give 5 inflation breaths
Consider SpO₂ ± ECG monitoring

Re-assess
If no increase in heart rate look for chest movement
during inflation

If chest not moving:
Re-check head position
Consider 2-person airway control and other
airway manoeuvres
Repeat inflation breaths
SpO₂ ± ECG monitoring
Look for a response

If no increase in heart rate look for chest
movement

When the chest is moving:
If heart rate is not detectable or very slow
(< 60 min⁻¹) start chest compressions:
coordinate with ventilation breaths (ratio 3:1)

Re-assess heart rate every 30 seconds
If heart rate is not detectable or very slow
(< 60 min⁻¹) consider venous access and drugs

Update parents and debrief team

Acceptable pre-ductal SpO₂
2 min 60%
3 min 70%
4 min 80%
5 min 85%
10 min 90%

Increase oxygen
guided by current if available

AT
ALL
TIMES
ASK:
DO
YOU
NEED
HELP?

Reproduced with the kind permission of the Resuscitation Council (UK) from Resuscitation Guidelines, 2015
Paediatric Basic Life Support
(Healthcare professionals with a duty to respond)

Unresponsive

Shout for help

Open airway

Not breathing normally

5 Rescue breaths

No signs of life

15 Chest compressions

2 Rescue breaths
15 Chest compressions

Call resuscitation team
(1 min CPR first, if alone)

Reproduced with the kind permission of the Resuscitation Council (UK) from Resuscitation Guidelines, 2015
Paediatric Advanced Life Support

Resuscitation Council (UK) 2015

Unresponsive
Not breathing or only occasional gasps

Call resuscitation team
(1 min CPR first, if alone)

CPR
(5 initial breaths then 15:2)
Attach defibrillator/monitor
Minimise interruptions

Assess rhythm

Return of spontaneous circulation

Immediate post cardiac arrest treatment
- Use ABCDE approach
- Controlled oxygenation and ventilation
- Investigations
- Treat precipitating cause
- Temperature control

Non-shockable (PEA/Asystole)

Immediately resume CPR for 2 min
Minimise interruptions

Shockable (VF/Pulseless VT)

1 Shock
4 J kg⁻¹

Immediately resume CPR for 2 min
Minimise interruptions

During CPR
- Ensure high-quality CPR: rate, depth, recoil
- Plan actions before interrupting CPR
- Give oxygen
- Vascular access (intravenous, intracessous)
- Give adrenaline every 3-6 min
- Consider advanced airway and capnography
- Continuous chest compressions when advanced airway in place
- Correct reversible causes
- Consider amiodarone after 3 and 5 shocks

Reversible Causes
- Hypoxia
- Hypovolaemia
- Hyper/hypokalaemia, metabolic
- Hypothermia
- Thrombosis (coronary or pulmonary)
- Tension pneumothorax
- Tamponade (cardiac)
- Toxic/therapeutic disturbances

Reproduced with the kind permission of the Resuscitation Council (UK) from Resuscitation Guidelines, 2015
# Body Surface Area in Children

## Body-weight under 40 kg

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<thead>
<tr>
<th>Body-weight (kg)</th>
<th>Surface area (m²)</th>
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Values are calculated using the Boyd equation

**Note**  Height is not required to estimate body surface using these tables

# Body Surface Area in Children

## Body-weight over 40 kg

<table>
<thead>
<tr>
<th>Body-weight (kg)</th>
<th>Surface area (m²)</th>
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<th>Body-weight (kg)</th>
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</table>

Values are calculated using the Boyd equation

**Note**: Height is not required to estimate body surface using these tables

Medical emergencies in the community

Overview
Drug treatment outlined below is intended for use by appropriately qualified healthcare professionals. Only drugs that are used for immediate relief are shown; advice on supporting care is not given. Where the child’s condition requires investigation and further treatment, the child should be transferred to hospital promptly.

Asthma: acute

ECL PLUS

OR

Either

Saltbutamol aerosol inhaler p. 158

(100 micrograms/metered inhalation)

By aerosol inhalation via large-volume spacer (and a close-fitting face mask if child under 3 years)

» Child: 2–10 puffs each inhaled separately, repeated every 10–20 minutes or as necessary

Salbutamol nebuliser solution (1 mg/ml, 2 mg/ml)

By inhalation of nebulised solution (via oxygen-driven nebuliser if available)

» Child 4 years and below: 2.5 mg every 20–30 minutes or as necessary

» Child 5–11 years: 2.5–5 mg every 20–30 minutes or as necessary

» Child 12–17 years: 5 mg every 20–30 minutes or as necessary

Or

Terbutaline sulfate nebuliser solution p. 160 (2.5 mg/ml)

By inhalation of nebulised solution (via oxygen-driven nebuliser if available)

» Child 4 years and below: 5 mg every 20–30 minutes or as necessary

» Child 5–11 years: 5–10 mg every 20–30 minutes or as necessary

» Child 12–17 years: 10 mg every 20–30 minutes or as necessary

Plus (in all cases)

Either

Prednisolone tablets p. 458 (or prednisolone soluble tablets) (5 mg)

By mouth

» Child 11 years and below: 1–2 mg/kg (max. 40 mg) once daily for up to 3 days or longer if necessary; if child has been taking an oral corticosteroid for more than a few days, give prednisolone 2 mg/kg (max. 60 mg) once daily

» Child 12–17 years: 40–50 mg once daily for at least 5 days

Or

Hydrocortisone p. 456 (preferably as sodium succinate)

By intravenous injection

» Child 17 years and below: 4 mg/kg (max. 100 mg) every 6 hours until conversion to oral prednisolone is possible; alternative dose if weight unavailable:

» Child 1 year and below: 25 mg

» Child 2–4 years: 50 mg

» Child 5–17 years: 100 mg

High-flow oxygen should be given if available (via face mask in children)

Monitor response 15 to 30 minutes after nebulisation; if any signs of acute asthma persist, arrange hospital admission. While awaiting ambulance, repeat nebulised beta2 agonist (as above) and give with

Ipratropium bromide nebuliser solution p. 155

(250 micrograms/ml)

By inhalation of nebulised solution (via oxygen-driven nebuliser if available)

» Child 11 years and below: 250 micrograms, repeated every 20–30 minutes for the first 2 hours, then every 4–6 hours as necessary

» Child 12–17 years: 500 micrograms every 4–6 hours as necessary

Or

Dexamethasone oral solution p. 455 (2 mg/5 ml)

By mouth

» Child 1 month–2 years: 150 micrograms/kg as a single dose

Anaphylaxis

Anaphylaxis

Adrenaline/epinephrine injection p. 138 (1 mg/ml (1 in 1000))

By intramuscular injection

» Child 5 years and below: 150 micrograms (0.15 ml), repeated every 5 minutes if necessary

» Child 6–11 years: 300 micrograms (0.3 ml), repeated every 5 minutes if necessary

» Child 12–17 years: 500 micrograms (0.5 ml), repeated every 5 minutes if necessary; 300 micrograms (0.3 ml) should be given if child is small or prepubertal

High-flow oxygen and intravenous fluids should be given as soon as available.

Chlorphenamine maleate injection p. 180

By intramuscular or intravenous injection

May help counter histamine-mediated vasodilation and bronchoconstriction.

Hydrocortisone (preferably as sodium succinate)

By intravenous injection

Has delayed action but should be given to severely affected patients to prevent further deterioration.

Bacterial disease

Meningococcal disease

Benzylenicillin sodium injection p. 349 (600 mg, 1.2 g)

By intravenous injection (or by intramuscular injection if venous access not available)

» Neonate: 300 mg

» Child 1 month–11 months: 300 mg

» Child 1–9 years: 600 mg

» Child 10–17 years: 1.2 g

Note A single dose should be given before urgent transfer to hospital, so long as this does not delay the transfer.

Or

If history of allergy to penicillin

Cefotaxime injection p. 330 (1 g)

By intravenous injection (or by intramuscular injection if venous access not available)

» Neonate: 50 mg/kg

» Child 1 month–11 years: 50 mg/kg (max. 1 g)

» Child 12–17 years: 1 g

Note A single dose can be given before urgent transfer to hospital, so long as this does not delay the transfer.
OR if history of immediate hypersensitivity reaction (including anaphylaxis, angioedema, urticaria, or rash immediately after administration) to penicillin or to cephalosporins

Chloramphenicol injection p. 368 (1 g)
BY INTRAVENOUS INJECTION
» Child 1 month-17 years: 12.5–25 mg/kg
NOTE A single dose can be given before urgent transfer to hospital, so long as this does not delay the transfer. See also Central nervous system infections, antibacterial therapy p. 314.

Hypoglycaemia

DIABETIC HYPOGLYCAEMIA
Glucose or sucrose
BY MOUTH
» Child over 2 years: approx. 10–20 g (110–220 mL)
  Lucozade® Energy Original or 100–200 mL
  Coca-Cola® — both non-diet versions or
  2–4 teaspoonfuls of sugar or 3–6 sugar lumps
  repeated after 10–15 minutes if necessary

OR if hypoglycaemia unresponsive or if oral route cannot be used

Glucagon injection p. 482 (1 mg/mL)
BY SUBCUTANEOUS OR INTRAMUSCULAR INJECTION
» Child body-weight up to 25 kg: 500 micrograms (0.5 mL)
» Child body-weight 25 kg and over: 1 mg (1 mL)

OR if hypoglycaemia prolonged or unresponsive to glucagon after 10 minutes

Glucose intravenous infusion p. 611 (10%)
BY INTRAVENOUS INJECTION INTO LARGE VEIN
» Child 1 month-17 years: 5 mL/kg (glucose 500 mg/kg)

Seizures

CONVULSIVE (INCLUDING FEBRILE) SEIZURES last longer than 5 minutes

EITHER Diazepam rectal solution p. 226 (2 mg/mL, 4 mg/mL)
BY RECTUM
» Neonate: 1.25–2.5 mg, repeated once after 10–15 minutes if necessary
» Child 1 month-1 year: 5 mg, repeated once after 10–15 minutes if necessary
» Child 2–11 years: 5–10 mg, repeated once after 10–15 minutes if necessary
» Child 12–17 years: 10–20 mg, repeated once after 10–15 minutes if necessary

OR Midazolam oromucosal solution p. 229
BY BUCCAL ADMINISTRATION, REPEATED ONCE AFTER 10 MINUTES IF NECESSARY
» Neonate: 300 micrograms/kg [unlicensed]
» Child 1–2 months: 300 micrograms/kg (max. 2.5 mg)
  [unlicensed]
» Child 3 months–11 months: 2.5 mg
» Child 1–4 years: 5 mg
» Child 5–9 years: 7.5 mg
» Child 10–17 years: 10 mg
### Approximate Conversions and Units

#### Conversion of pounds to kilograms

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#### Conversion of stones to kilograms

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<td>1</td>
<td>6.35</td>
</tr>
<tr>
<td>2</td>
<td>12.70</td>
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<tr>
<td>3</td>
<td>19.05</td>
</tr>
<tr>
<td>4</td>
<td>25.40</td>
</tr>
<tr>
<td>5</td>
<td>31.75</td>
</tr>
<tr>
<td>6</td>
<td>38.10</td>
</tr>
<tr>
<td>7</td>
<td>44.45</td>
</tr>
<tr>
<td>8</td>
<td>50.80</td>
</tr>
<tr>
<td>9</td>
<td>57.15</td>
</tr>
<tr>
<td>10</td>
<td>63.50</td>
</tr>
<tr>
<td>11</td>
<td>69.85</td>
</tr>
<tr>
<td>12</td>
<td>76.20</td>
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<tr>
<td>13</td>
<td>82.55</td>
</tr>
<tr>
<td>14</td>
<td>88.90</td>
</tr>
<tr>
<td>15</td>
<td>95.25</td>
</tr>
</tbody>
</table>

#### Conversion from millilitres to fluid ounces

<table>
<thead>
<tr>
<th>mL</th>
<th>fl oz</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>1.8</td>
</tr>
<tr>
<td>100</td>
<td>3.5</td>
</tr>
<tr>
<td>150</td>
<td>5.3</td>
</tr>
<tr>
<td>200</td>
<td>7.0</td>
</tr>
<tr>
<td>500</td>
<td>17.6</td>
</tr>
<tr>
<td>1000</td>
<td>35.2</td>
</tr>
</tbody>
</table>

#### Length

- 1 metre (m) = 1000 millimetres (mm)
- 1 centimetre (cm) = 10 mm
- 1 inch (in) = 25.4 mm
- 1 foot (ft) = 12 inches
- 12 inches = 304.8 mm

#### Mass

- 1 kilogram (kg) = 1000 grams (g)
- 1 gram (g) = 1000 milligrams (mg)
- 1 milligram (mg) = 1000 micrograms
- 1 microgram = 1000 nanograms
- 1 nanogram = 1000 picograms

#### Volume

- 1 litre = 1000 millilitres (mL)
- 1 millilitre (1 mL) = 1000 microlitres
- 1 pint = 568 mL

#### Other units

- 1 kilocalorie (kcal) = 4186.8 joules (J)
- 1000 kilocalories (kcal) = 1.1668 megajoules (MJ)
- 1 megajoule (MJ) = 238.8 kilocalories (kcal)
- 1 millimetre of mercury (mmHg) = 133.3 pascals (Pa)

#### Plasma-drug concentrations

Plasma-drug concentrations in BNF publications are expressed in mass units per litre (e.g. mg/litre). The approximate equivalent in terms of amount of substance units (e.g. micromol/litre) is given in brackets.

#### Prescribing for children: weight, height, and gender

The table below shows the mean values for weight, height and gender by age; these values have been derived from the UK-WHO growth charts 2009 and UK1990 standard centile charts, by extrapolating the 50th centile, and may be used to calculate doses in the absence of actual measurements. However, the child’s actual weight and height might vary considerably from the values in the table and it is important to see the child to ensure that the value chosen is appropriate. In most cases the child’s actual measurement should be obtained as soon as possible and the dose recalculated.

<table>
<thead>
<tr>
<th>Age</th>
<th>Weight (kg)</th>
<th>Height (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-term neonate</td>
<td>3.5</td>
<td>51</td>
</tr>
<tr>
<td>1 month</td>
<td>4.3</td>
<td>55</td>
</tr>
<tr>
<td>2 months</td>
<td>5.4</td>
<td>58</td>
</tr>
<tr>
<td>3 months</td>
<td>6.1</td>
<td>61</td>
</tr>
<tr>
<td>4 months</td>
<td>6.7</td>
<td>63</td>
</tr>
<tr>
<td>6 months</td>
<td>7.6</td>
<td>67</td>
</tr>
<tr>
<td>1 year</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>3 years</td>
<td>14</td>
<td>96</td>
</tr>
<tr>
<td>5 years</td>
<td>18</td>
<td>109</td>
</tr>
<tr>
<td>7 years</td>
<td>23</td>
<td>122</td>
</tr>
<tr>
<td>10 years</td>
<td>32</td>
<td>138</td>
</tr>
<tr>
<td>12 years</td>
<td>39</td>
<td>149</td>
</tr>
<tr>
<td>14 year old boy</td>
<td>49</td>
<td>163</td>
</tr>
<tr>
<td>14 year old girl</td>
<td>50</td>
<td>159</td>
</tr>
<tr>
<td>Adult male</td>
<td>68</td>
<td>176</td>
</tr>
<tr>
<td>Adult female</td>
<td>58</td>
<td>164</td>
</tr>
</tbody>
</table>
Recommended wording of cautionary and advisory labels

For details including Welsh language translation, please see Appendix 3.

1. Warning: This medicine may make you sleepy.
2. Warning: This medicine may make you sleepy. If this happens, do not drive or use tools or machines. Do not drink alcohol.
3. Warning: This medicine may make you sleepy. If this happens, do not drive or use tools or machines.
4. Warning: Do not drink alcohol.
5. Do not take indigestion remedies 2 hours before or after you take this medicine.
6. Do not take indigestion remedies, or medicines containing iron or zinc, 2 hours before or after you take this medicine.
7. Do not take milk, indigestion remedies, or medicines containing iron or zinc, 2 hours before or after you take this medicine.
8. Warning: Do not stop taking this medicine unless your doctor tells you to stop.
9. Space the doses evenly throughout the day. Keep taking this medicine until the course is finished, unless you are told to stop.
10. Warning: Read the additional information given with this medicine.
11. Protect your skin from sunlight—even on a bright but cloudy day. Do not use sunbeds.
12. Do not take anything containing aspirin while taking this medicine.
13. Dissolve or mix with water before taking.
14. This medicine may colour your urine. This is harmless.
15. Caution: flammable. Keep your body away from fire or flames after you have put on the medicine.
16. Dissolve the tablet under your tongue—do not swallow. Store the tablets in this bottle with the cap tightly closed. Get a new supply 8 weeks after opening.
17. Do not take more than... in 24 hours.
18. Do not take more than... in 24 hours. Also, do not take more than... in any one week.
19. Warning: This medicine makes you sleepy. If you still feel sleepy the next day, do not drive or use tools or machines. Do not drink alcohol.
20. Take with or just after food, or a meal.
21. Take 30 to 60 minutes before food.
22. Take this medicine when your stomach is empty. This means an hour before food or 2 hours after food.
23. Suck or chew this medicine.
24. Swallow this medicine whole. Do not chew or crush.
25. Dissolve this medicine under your tongue.
26. Take with a full glass of water.
27. Spread thinly on the affected skin only.
28. Do not take more than 2 at any one time. Do not take more than 8 in 24 hours.
29. Contains paracetamol. Do not take anything else containing paracetamol while taking this medicine. Talk to a doctor at once if you take too much of this medicine, even if you feel well.
30. Contains aspirin. Do not take anything else containing aspirin while taking this medicine.
Abbreviations and Symbols

Internationally recognised units and symbols are used in the BNF publications where possible.

ACBS Advisory Committee on Borderline Substances, see Borderline Substances
ACE Angiotensin-converting enzyme
ADHD Attention deficit hyperactivity disorder
AIDS Acquired immunodeficiency syndrome
approx. approximately
AV atrioventricular
AWMSG All Wales Medicines Strategy Group
BAN British Approved Name
BMI body mass index
BP British Pharmacopoeia 2013, unless otherwise stated
BPC British Pharmaceutical Codex 1973 and Supplement 1976, unless otherwise stated
BRCA breast cancer gene
CAPD Continuous ambulatory peritoneal dialysis
CDM preparation in Schedule 1 of the Misuse of Drugs Regulations 2001 (and subsequent amendments). For regulations see Controlled drugs and drug dependence p. 10.
CDM preparation in Schedule 2 of the Misuse of Drugs Regulations 2001 (and subsequent amendments). For regulations see Controlled drugs and drug dependence p. 10.
CDM preparation in Schedule 3 of the Misuse of Drugs Regulations 2001 (and subsequent amendments). For regulations see Controlled drugs and drug dependence p. 10.
CDM preparation in Schedule 4 (Part I) of the Misuse of Drugs Regulations 2001 (and subsequent amendments). For regulations see Controlled drugs and drug dependence p. 10.
CDM preparation in Schedule 4 (Part II) of the Misuse of Drugs Regulations 2001 (and subsequent amendments). For regulations see Controlled drugs and drug dependence p. 10.
CDM preparation in Schedule 5 of the Misuse of Drugs Regulations 2001 (and subsequent amendments). For regulations see Controlled drugs and drug dependence p. 10.
CDM, direct current
CHM Commission on Human Medicines
CHMP Committee for Medicinal Products for Human Use
c. central nervous system
c. Commission on Safety of Medicines (now subsumed under Commission on Human Medicines)
c. direct current
DMARD Disease-modifying anti-rheumatic drug
DPF Dental Practitioners’ Formulary
DT Drug Tariff price
e/c enterico-coated (terming gastro-resistant in BP)
ECG electrocardiogram
eGFR estimated glomerular filtration rate, see Prescribing in renal impairment p. 18
f/f film-coated
FSRH Faculty of Sexual and Reproductive Healthcare
G6PD glucose-6-phosphate dehydrogenase
general sale list
HDL Cholesterol high-density lipoprotein cholesterol
HIV Human immunodeficiency virus
HRT Hormone replacement therapy
i/m intramuscular
i/v intravenous
INR International normalised ratio
JCVI Joint Committee on Vaccination and Immunisation
LDL Cholesterol low-density lipoprotein cholesterol
MAOI Monoamine-oxidase inhibitor
max. maximum
m/n modified-release
NCL no cautionary labels (prescription endorsement made by prescriber when recommended cautionary labels are not required)
NHS National Health Service
NICE National Institute for Health and Care Excellence
NPI Nurse Prescribers’ Formulary
NSAID Non-steroidal anti-inflammatory drug
NSTEMI non-ST-segment elevation myocardial infarction
PARP poly (ADP-ribose) polymerase
PGD patient group direction
PHE Public Health England (formerly Health Protection Agency (HPA))
® trade mark
RNN Recommended International Non-proprietary Name
RSV respiratory syncytial virus
S/c sugar-coated
SLS Selected List Scheme
SMC Scottish Medicines Consortium
SPC Summary of Product Characteristics
SSRI Selective serotonin reuptake inhibitor
STEMI ST-segment elevation myocardial infarction
UK United Kingdom
WHO World Health Organization

limited experience of the use of this product and the MHRA requests that all suspected adverse reactions should be reported, see Adverse reactions to drugs p. 14

s/c drug monograph has a corresponding drug-class monograph; the page number of the class monograph is indicated within the tab, see How to use BNF Publications, p. xii

no price available

Latin abbreviations

Directions should be in English without abbreviation. However, Latin abbreviations have been used when prescribing.

The following is a list of appropriate abbreviations. It should be noted that the English version is not always an exact translation.

a. c. = ante cibum (before food)
b. d. = bis die (twice-daily)
o. d. = omni die (every day)
o. m. = omni mane (every morning)
o. n. = omni nocte (every night)
p. c. = post cibum (after food)
p. r. n. = pro re nata (when required)
q. d. s. = quater die sumendum (to be taken four times daily)
q. q. h. = quarta quaque hora (every four hours)
stat = immediately
i. d. = ter die sumendum (to be taken three times daily)

t.i.d. = ter in die (three daily)

E numbers

The following is a list of common E numbers and the inactive ingredients to which they correspond.

E102 Tartrazine
E104 Quinoline Yellow
E110 Sunset Yellow FCF
E123 Amaranth
E124 Ponceau 4R
E127 Erythrosine BS
E132 Indigo Carmine
E142 Green S
E171 Titanium Dioxide
E172 Iron oxides, iron hydroxides
E200 Sorbic Acid
E211 Sodium Benzoate
E223 Sodium Metabisulphite
E320 Butylated Hydroxyanisole
E321 Butylated Hydroxytoluene
E322 Lecithins
E420 Sorbitol
E421 Mannitol
E422 Glycerol
E901 Beeswax (white and yellow)
E1520 Propylene Glycol