Tablet Press

The prescribing newsletter for GPs, nurses and pharmacists in Northamptonshire Primary Care Trust

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- **Yellow card reports for HPV vaccine**

The national HPV vaccination program commences this month. All healthcare professionals are reminded that any adverse effects should be reported via the MHRA's "Yellow card" scheme. Yellow cards are available at the back of the BNF.

- **Diltiazem prescribing**

A recent incident reported to the PCT involved a once-daily formulation of diltiazem that was prescribed twice-daily. Prescribers and pharmacists are reminded to check that appropriate dose timings are given for the once- and twice-daily formulations, both at the point of prescribing and dispensing.

- **Methotrexate tablet strength**

Following another incident report, in line with the Northamptonshire Shared Care Protocols, prescribers are requested to ensure that all new initiations of methotrexate tablets should be for multiples of the 2.5mg tablet strength. However, to avoid any confusion, patients currently taking 10mg tablets should not be changed to 2.5mg tablets, unless this is done in secondary care in consultation with the rheumatology nurses.

- **Aspirin plus dipyridamole similar to clopidogrel for recurrent stroke prevention**

According to the results of a large controlled trial (PRoFESS, New Engl J Med, published early online 27 Aug 2008), early initiation of treatment after stroke with clopidogrel or low-dose plus aspirin plus dipyridamole both give similar rates of recurrent stroke and other major cardiovascular outcomes.
Aspirin (low-dose), clopidogrel, and aspirin plus dipyridamole have all been shown to reduce the risk of recurrent stroke. Aspirin plus dipyridamole, and clopidogrel have both been shown to be superior to aspirin alone (by around 20-23% and 8% respectively), however there has been no direct comparison between them. This study aimed to compare the relative efficacy of the two approaches.
Participants were aged 55 and over, had had a stroke within 90 days of randomisation, and were stable. They were randomised to treatment with the fixed combination of low-dose aspirin (25 mg) and extended-release dipyridamole (200 mg) given twice daily as compared with clopidogrel (75 mg) given once daily. The primary outcome was recurrent stroke and the secondary outcome was a composite of stroke, myocardial infarction, or death from vascular causes.
A total of 20,332 patients was randomised, of whom 10,181 received aspirin plus dipyridamole and 10,151 clopidogrel. Median interval from occurrence of stroke to treatment initiation was 15 days, and mean duration of follow-up was 2.5 years. Over this time, 1,814 patients had confirmed recurrent stroke, 916 (9.0%) in the aspirin plus dipyridamole group and 898 (8.8%) in the clopidogrel group (hazard ratio, 1.01; 95% CI, 0.92 to 1.11). The composite secondary outcome occurred in 1,333 patients in each group (13.1% each, HR for aspirin/dipyridamole, 0.99; 95% CI, 0.92 to 1.07). There were numerically more major bleeding events in the aspirin / dipyridamole group, although this was of borderline statistical significance (4.1% vs. 3.6%; HR, 1.15; 95% CI, 1.00 to 1.32). Net risk of recurrent stroke or major bleeding was similar for the two groups (11.7% vs. 11.4%; HR, 1.03; 95% CI, 0.95 to 1.11).
The authors conclude that their results show neither treatment to be superior for prevention of recurrent stroke. There was also no clinically significant difference between the two treatments for the composite secondary outcome, and both primary and secondary outcomes were consistent across subgroups with different baseline risk factors. While there were numerically more major bleeding events in the combination group, the net risk of recurrent stroke or bleeding was similar in the two groups.

This edition is also available on HNN (Health Network Northants)
http://nww.northants.nhs.uk/Display/Dynamic.jsp?topid=14070&lhsid=514&oid=2854&currentid=2854

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