Interface Pharmacist Network
Specialist Medicines

Changes in the recent Northern Ireland shared care guidelines for monitoring of DMARD type amber drugs.

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Key points:

- The reviewed shared care guidelines aim to provide a standard monitoring template for most patients. (However, in some patients such as those with co-morbidity, or those with a history of drug-related toxicity, more frequent monitoring may be appropriate).
- The reviewed guidance now follows recent British Society of Rheumatology (BSR) guidance which aims to provide a standard monitoring template for most drugs. Previous guidelines have recommended different monitoring schedules for each drug. This will streamline recommendations, reducing confusion and lead to more consistent monitoring.
- These guidelines recommend a reduced frequency of monitoring compared to previous guidelines. This will not only be of value to patients but also have beneficial implications for service providers. This follows the guidance of the BSR.
- The monitoring guidance is set out in tabular form consistently across all the guidelines. This will help to improve readability for users.
- Users should familiarise themselves with the updated shared care guidance especially the monitoring recommendations, and frequency of monitoring.
- For those patients who are established in a shared care arrangement, their monitoring should generally now be superseded by this updated guidance. If in doubt GPs should check with the secondary care clinic/consultant.
- Links to the shared care guidelines can be found at http://www.ipnsm.hscni.net/shared-care-guidelines/

Background.

In June 2017 the Regional Group on Specialist Medicines approved updated shared care guidelines for a number of DMARD type amber drugs. The recommendations in the guidelines are in line with the new 2016 BSR guidance.

The monitoring recommendations outlined in these new shared care guidelines represent a minimal monitoring schedule. More frequent monitoring is appropriate in patients at higher risk of toxicity. Recognition of patients at increased risk of complications remains a clinician judgement that will depend upon a multitude of factors, including a patient's prior history of adverse drug events, their medical co-morbidities and also the co-prescription of medications that may interact with a DMARD.

What are the main changes in monitoring?

For secondary care:
The guidelines make two specific recommendations that will increase monitoring in secondary care. These are:

1. The recommendation for routine documentation of height and weight prior to DMARD initiation.
2. The recommendation to include objective retinal screening for patients receiving hydroxychloroquine.

For primary care:
Previous guidelines have recommended different monitoring schedules for each drug. In line with BSR, the development group have recommended a standard monitoring template for **most** drugs.

Standard monitoring*: Check FBC, renal function, and liver function every 2 weeks until on stable dose for 6 weeks; then once on stable dose, check monthly for 3 months; thereafter, check at least every 12 weeks. More frequent monitoring is appropriate in patients at higher risk of toxicity.

At dosage increases the initial starting schedules should be reinstated.

Table 1 below sets out a comparison with the previous shared care guideline version, other exceptions, additions or significant changes to the monitoring schedule for specific drugs.

Table 1

Drug	**Laboratory monitoring**	**Other monitoring**
Cyclophosphamide	No change: as previous guideline	
Hydroxycarbamide	No change: as previous guideline	
Penicillamine	No change: as previous guideline	
Hydroxychloroquine	No routine laboratory monitoring	Annual eye assessment (ideally including OCT) if continued for >5 years
Azathioprine	Standard monitoring schedule*	
Sodium aurothiomalate	Standard monitoring schedule*	Urinalysis for blood and protein prior to each dose
Leflunomide	Standard monitoring schedule*	BP and weight at each monitoring visit
Methotrexate	Standard monitoring schedule*	
Mycophenolate mofetil	Standard monitoring schedule*	
Sulfasalazine	Standard monitoring schedule for 12 months then no routine monitoring needed	
Ciclosporin	Extend monthly monitoring longer-term**	BP and glucose at each monitoring visit
Tacrolimus	Extend monthly monitoring longer-term**	BP and glucose at each assessment

*Standard monitoring schedule: Check FBC, renal function, and liver function every 2 weeks until on stable dose for 6 weeks; then once on stable dose, check monthly for 3 months; thereafter, check at least every 12 weeks. More frequent monitoring is appropriate in patients at higher risk of toxicity

**Patients who have been stable for 12 months can be considered for reduced frequency monitoring on an individual patient basis.

References.

The above article and table has been produced from information documented within "BSR/BHPR Non-Biologic DMARD Guidelines" (2017)