NHS
Rotherham
Clinical Commissioning Group

NSAIDs: A risk reduction strategy
Summary

By avoiding the use of NSAIDs (Non-steroidal anti-inflammatory drugs) in certain groups of patients, unless absolutely necessary, a prescriber can limit the probability of causing harm.

- **Always try non-pharmacological options & simple analgesia first**
  - Paracetamol works for some patients but may need to be as regular 2 QDS
  - Topical NSAIDs for localised pain & osteoarthritis (OA) has good evidence
    - Ibuprofen 5% or 10% gel ONLY on FP10
    - Transvasin or Algesal can be used as non-NSAID rubs on FP10
    - Other drug / brand can be bought OTC by the patient
  - Glucosamine sulphate is not recommended by NICE due to limited evidence
    - Patient can buy OTC if they find benefit
- **Avoid NSAIDs in patients with:**
  - CV (cardiovascular) disease (including hypertension & diabetes)
  - History of gastrointestinal (GI) bleed
  - Renal impairment
  - SSRIs, antiplatelets, anticoagulants & Renin-Angiotensin-System drugs

Use **ibuprofen OR naproxen** in preference to other NSAIDs
- **Ibuprofen** has lowest GI risk
- **Naproxen** has lowest CV risk

Avoid azapropazone & piroxicam

Restrict the prescribing of ketoprofen and indometacin

Coxibs (incl. meloxicam & etodolac) and **diclofenac** are not recommended because of their risk of adverse CV effects. Etoricoxib is contra-indicated in certain patients with hypertension due to its CV risk profile.
(Traditional NSAID & PPI has less GI side effects than coxibs alone)

Use the **lowest effective dose** for as **short as possible.**

If unable to avoid oral NSAIDs then GI protection is recommended (lansoprazole 15mg capsules) for the following high risk groups:

- Rheumatoid Arthritis (RA)
- over 45 years with back pain
- on aspirin/SSRI etc
- past GI bleed
- over 65 years
- OA

Enteric Coated (EC), Slow/Modified Release and suppositories DO NOT provide GI protection and possibly are a higher risk, and are more expensive.

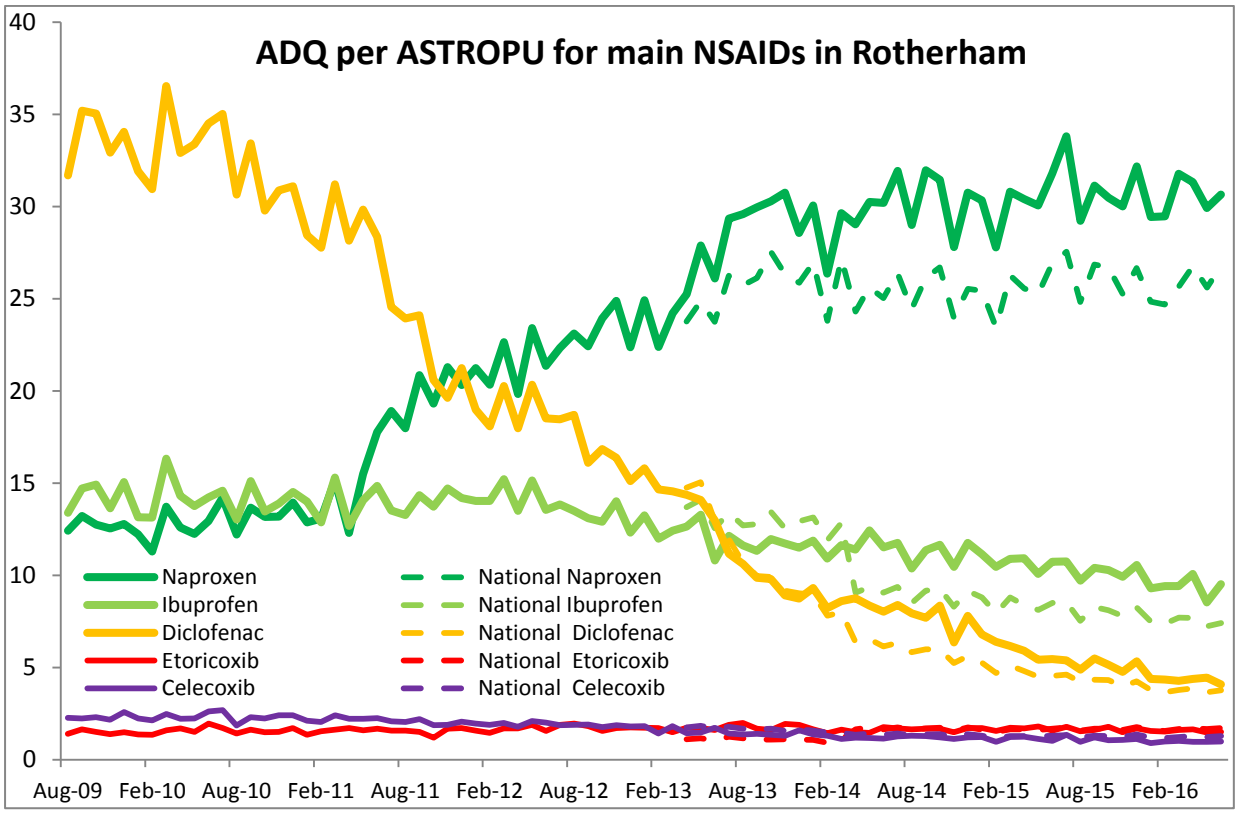
If NSAIDs are still required despite a patient having the above risks factors, ensure that such patients are informed of these risks, enabling them to make an informed decision whether to continue with their treatment. The discussion should then be recorded in the patient's notes.

For active inflammatory diseases (i.e. RA) ensure a referral to secondary care to consider DMARDs (Disease-modifying anti-rheumatic drugs) as soon as possible, ideally within 3 months of the start of persistent symptoms (> 6 weeks). Do not allow the use of NSAIDs to delay the initiation or optimization of DMARDs and biologicals.

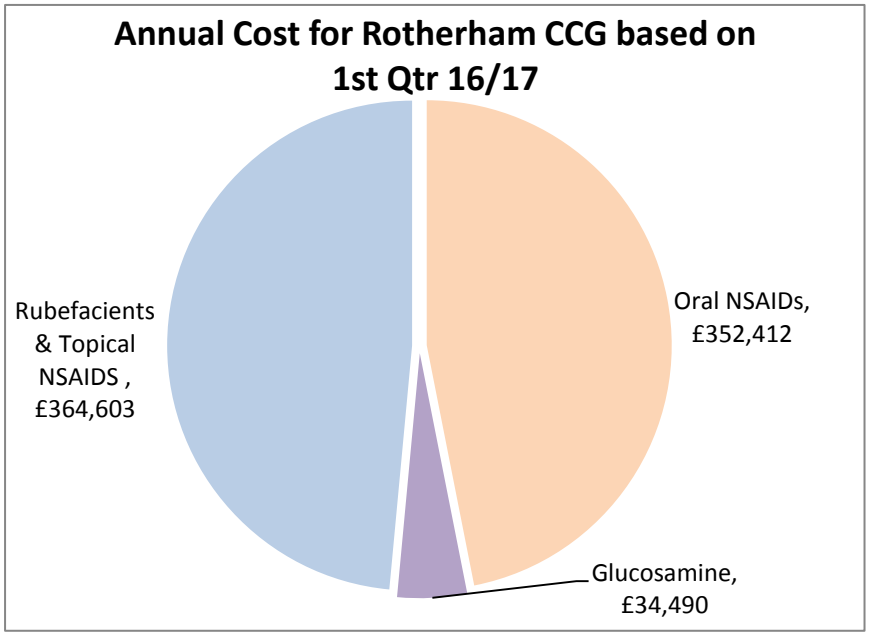
Eloise Summerfield, Medicines Management Team, Rotherham CCG
Update August 2016 Review: August 2018

NSAIDs: A risk reduction strategy
Current position August 2016

Since the launch of the original NSAID risk reduction in 2008 and LIS targets in 11/12, diclofenac use has reduced and naproxen has increased above national.



During the last year (to June 16) our volume of Oral NSAIDs has decreased by 1.4% and the cost by 25%. (Cost mainly reduced by changing EC naproxen to plain, and this will continue into the next financial year)



Currently our spend on rubefacients is more than that of Oral NSAIDs, and is where we are gaining volume at around 10% a year. (Although cost only increased by 2.2% due a QIPP and concept increasing formulary choice).

The use of glucosamine is remaining stable and could provide £34,000 /annum savings if national do not prescribe guidelines followed.

Eloise Summerfield, Medicines Management Team, Rotherham CCG
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