

review of circulars and OFFICIAL PUBLICATIONS

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Recent NICE guidance, notification of product discontinuations and prevention of intrathecal medical errors are the subjects of our review this month

A number of publications issued recently by the National Institute for Clinical Excellence (NICE) will be of interest to hospital pharmacists.

"**Compilation volume 2**", issued in April, 2001, provides a useful summary of guidance issued to date, and includes the 24 technology appraisals and two guidelines to the NHS in England and Wales. These are listed sequentially in appendices and have been classified under 14 section headings which are broadly equivalent to British National Formulary (BNF) chapters although "Nutrition and blood" and "Anaesthesia" are not included. A new classification of "Oral and maxillofacial" is introduced. It is noted that no guidance has yet been issued for the sections on "Eye", "Immunological products and vaccines" or "Obstetrics, gynaecology and urinary tract" (NICE have since issued guidance on the induction of labour, on June 15).

The "Compilation" sets out the forward work plan for NICE, lists the membership of the Appraisals Committee and Guidelines Advisory Committee, and outlines the process used for technology appraisals and clinical guidelines. An appendix details progress in piloting a referral practice document which gives guidance on appropriate referrals from general to specialist services. The "Compilation" can be accessed via www.nice.org.uk.

Technology Appraisal Guidance has been issued recently for the following:

- Guidance on the use of temozolomide for the treatment of recurrent malignant glioma (brain cancer) was issued as **Technology Appraisal Guidance** number 23, in April, 2001). The use of the drug is suggested for patients with brain cancer who have failed first-line

chemotherapy treatment with other agents.

- Guidance on the use of debriding agents and specialist wound care clinics for difficult to heal surgical wounds (**Technology Appraisal Guidance** number 24, April, 2001). This notes that there is no randomised control trial evidence to support any particular method of debridement but less robust studies suggest that modern dressings and bio-surgical techniques may reduce pain and be more acceptable to patients.
- Prophylaxis for patients who have experienced a myocardial infarction (**Clinical guideline A**, April, 2001). Information is provided on drug treatment, cardiac rehabilitation and dietary manipulation.
- Guidance on the use of gemcitabine for the treatment of pancreatic cancer (**Technology Appraisal Guidance** number 25, May, 2001). The drug should be considered as a treatment option for defined patients where first line chemotherapy is to be used.

"**Ensuring Best Practice in the Notification of Product Discontinuations: Best Practice Guidelines**" was issued in May, 2001, as a joint publication by the Department of Health and the Association of the British Pharmaceutical Industry. It is recognised that every product has a limited medical or economic lifespan and decisions to delete can be made for a variety of reasons. The guidance aims to ensure that, where this occurs, unnecessary problems for patients and prescribers are not caused and that sufficient notice is given so that alternative sources of supply can be located or patients switched to alternative therapies. The guidance suggests that discussions take place with the Department of Health at least 12 months before deletion from the market place with formal notification being given three to six months before deletion. Notification to professional bodies and organisations should be given two months

prior to deletion with wholesalers being informed one month in advance. Hospital pharmacists will generally welcome the guidance if its application ensures that they have prior notice to manage the deletion appropriately in the best interests of patients. The guidance will form a useful basis on which to assess performance of suppliers in such circumstances.

"**The Prevention of Intrathecal Medication Errors: A Report to the Chief Medical Officer**" was issued in April, 2001. It can be accessed on www.doh.gov.uk/imeprevent. The report notes that five incidents have occurred in NHS hospitals in the last decade in which vinca alkaloids have been administered by the spinal route, rather than intravenously. This invariably causes death or severe neurological damage. The report identifies factors which have contributed to such errors and explores possible safety measures to reduce risk. It is recommended that there should be an urgent assessment of the feasibility and safety of dispensing vinca drugs either in an infusion bag or in a non-Luer syringe allowing intravenous administration only. The report notes that drug prescribing and administration errors occur with unacceptable frequency, particularly among recently qualified doctors, and it is recommended that steps are taken to ensure that therapeutics and risk management are thoroughly covered in core curricula in medical schools. The subsequent views of the Chief Medical Officer will be of much interest to hospital pharmacists but the report might form a useful basis to commence a review of existing practices in the meantime.

A separate, detailed report on an external inquiry into an incident which occurred at Queen's Medical Centre, Nottingham, on January 4, which involved the intrathecal administration of vincristine will also be of interest in this respect (details of the report can be found on two websites: <http://www.doh.gov.uk/qmcinquiry/> and <http://www.doh.gov.uk/imeprevent/>).

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