Therapeutics Advisory Group

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Norfolk and Waveney Integrated Care System

NORFOLK AND WAVENEY STP THERAPEUTICS ADVISORY GROUP (TAG)

SHARED CARE AGREEMENT

Shared care guidelines for use of Mercaptopurine in Ulcerative Colitis & Crohn's Disease
Monitoring Amber level 2 – Prescribe drug and perform more intense level of monitoring, e.g. 3-monthly review

Generic and Proprietary/Brand Name	
Mercaptopurine (prescribe generically)	
Indications for shared care	
Ulcerative Colitis, Crohn's Disease	
Specialist Prescribing and Monitoring Responsibilities – summary. Full details in main body of document	**GP / Community Team - Primary Care Prescribing and Monitoring Responsibilities – summary. Full details in main body of document**
To initiate treatment and supply patient with information. **Initial monitoring:** • Thiopurine methyl transferase level assessed by initiating specialist, FBC, U+Es, LFTs. **Specialist monitoring:** **1.** FBCs, LFTs should be done fortnightly for the first 8 weeks of treatment after which 3 monthly blood tests are carried out by the GP (see below). Blood tests are also needed 2 weeks after each dose increase. U+Es should be checked every 6 months or more frequently if there is any reason to suspect deteriorating renal function. *It may be more convenient for the patient to have the fortnightly blood tests carried out at the GP surgery.* **2.** To send a letter to GP requesting shared care for a particular patient. The letter should contain the following information: ○ Diagnosis ○ Results of blood tests ○ Results of other appropriate investigations ○ Dose and name of treatment ○ Advice on dose alterations where appropriate **3.** To periodically review the patient	To prescribe ongoing treatment with mercaptopurine and perform 3-monthly FBC and LFTs for the duration of treatment. The table below in the main body of the document shows guidance on what to do if there are abnormalities on these tests, or if the patient reports adverse events
Patient Information	
The tablets must be swallowed whole and not chewed. The tablets should not be broken or crushed. If broken tablets are handled, wash hands immediately. See also **Consultant prescribing responsibilities** and the manufacturer's Patient Information Leaflet.	

Specialist Contact Details
JPUH: via Tel 01493 452 452 **Consultants:** Dr Anups de Silva, Dr Williams, Dr Brett, Dr Badreldin, Dr Banim, Dr Saleem **IBD Specialist Nurse:** Rowan Shaws **NNUH:** via Tel 01603 286286 **Consultants:** Dr Mark Tremelling (sec ext 4612), Dr Richard Tighe (sec ext 4230), Dr Crawford Jamieson (sec ext 4396), Dr Ian Beales (sec ext 4366), Dr Alison Prior (sec ext 5962) **IBD Specialist Nurses:** Nickie Fisher & Natasha Thomson (Bleep 0493). **QEH:** via switchboard Tel: 01553 613613. For Gastro Department Tel: 01553 214642. For Direct Dial Tel: 01553 61**** (ext number) **Consultants:** Dr Khalid Yousif (3939) Dr Shailesh Karanth (3708) Dr Abhay Bagewadi (3989) Dr Alan Wiles (3004) **IBD Specialist Nurses:** Jose Dias & Inah Cledera (4642)

GENERAL PRINCIPLES FOR SHARED CARE PRESCRIBING

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- GPs are **invited** to participate. If GPs are not confident to undertake these roles, they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist.
- **If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable if they are unwilling to do so.**
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP and when the patient's condition is stable or predictable.
- Safe prescribing must be accompanied by effective monitoring.
- **The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.**

Background to Treatment
Mercaptopurine is an immunosuppressive agent that is the active metabolite of azathioprine. It is used as a disease-modifying agent to induce and maintain remission in ulcerative colitis and Crohn's disease. Although unlicensed to treat these indications, its use is widely established in inflammatory bowel disease (see BNF)
Licensed use and agreed local off-label use
Cytotoxic agent. Mercaptopurine is indicated for the treatment of acute leukaemia. It may be utilised in remission induction and it is particularly indicated for maintenance therapy in acute lymphoblastic leukaemia and acute myelogenous leukaemia. Mercaptopurine may be used in the treatment of chronic granulocytic leukaemia.
Criteria for Patient Selection
The main role for mercaptopurine is steroid sparing. It is considered for patients who require two or more corticosteroid courses within a calendar year; those whose disease relapses as the dose of steroid is reduced below 15 mg; relapse within 6 weeks of stopping steroid steroids; or postoperative prophylaxis of complex (fistulating or extensive) CD.
Form and strength of preparation
Tablets 50mg. The tablets must be swallowed whole and not chewed. The tablets should not usually be broken or crushed. If halving a tablet is required, care should be taken not to contaminate the hands or inhale the drug. If broken tablets are handled, wash hands immediately.
Side Effects and Management
Link to BNF Link to SPC
Drug Interactions
Link to BNF Link to SPC
Cautions and Contraindications
Link to BNF Link to SPC
Initiation of therapy and ongoing dose regimen
Consultant Gastroenterologist
Administration Information
1mg to 1.5mg per kg each day orally.

Mercaptopurine may be taken with or without food but should be taken in a consistent way to minimise variability in absorption. Milk and dairy products should be avoided at the time of administration.
The tablets must be swallowed whole and not chewed. The tablets should not usually be broken or crushed. If halving of a tablet is required, care should be taken not to contaminate the hands or inhale the drug. If broken tablets are handled, wash hands immediately.

Duration of therapy / How the treatment will be reviewed and if appropriate, stopped

On going.

Due to the relatively slow onset of action, benefits may not be observed for 3 months.

Baseline assessment and ongoing monitoring – by Specialist

Initial monitoring:

- Thiopurine methyl transferase level assessed by initiating specialist, FBC, U+Es, LFTs.

Specialist monitoring:

4. FBCs, LFTs should be done fortnightly for the first 8 weeks of treatment after which 3 monthly blood tests are carried out by the GP (see below). Blood tests are also needed 2 weeks after each dose increase. U+Es should be checked every 6 months or more frequently if there is any reason to suspect deteriorating renal function. *It may be more convenient for the patient to have the fortnightly blood tests carried out at the GP surgery.*
5. To send a letter to GP requesting shared care for a particular patient. The letter should contain the following information:
    - Diagnosis
    - Results of blood tests
    - Results of other appropriate investigations
    - Dose and name of treatment
    - Advice on dose alterations where appropriate
6. To periodically review the patient

GP / Community Team or other Primary Care monitoring responsibilities

Following the initial fortnightly blood tests requested by the specialist, the patient requires 3-monthly FBC and LFTs. If there are abnormalities on these tests, or if the patient reports one of the adverse events below, these are recommendations for considering the withdrawal of mercaptopurine therapy:

Results & Actions to be taken:

Test/symptom	Result	Action
WBC	<4 x 10^9 per litre	Withhold drug & discuss with specialist
Neutrophils	<2 x 10^9 per litre	Withhold drug & discuss with specialist
Platelets	<150 x 10^9 per litre	Withhold drug & discuss with specialist
AST, ALT or Alk. Phos.	> 2-fold rise	Withhold drug & discuss with specialist
Rash or oral ulceration		Withhold drug & discuss with specialist
MCV	>105fL	Investigate and if B12 or folate low, start appropriate supplementation

Abnormal bruising, bleeding or sore throat, infection, fever, chills		Urgent FBC Withhold until FBC result available
Upper abdominal or back pain		Urgent amylase Withhold until amylase level available

Consultant / Specialist prescribing responsibilities

To initiate treatment and supply patient with information.

GP prescribing responsibilities

To prescribe ongoing treatment with mercaptopurine and perform 3-monthly FBC and LFTs for the duration of treatment.

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Document history:

Version	Date	Author / Editor	Status	Comment
1.	Sept 2007	Dr Anupama de Silva, Consultant Gastroenterology, David Todd Chief Pharmacist, JPUH / Fiona Marshall TAG Support Pharmacist	Superseded	Due for review Sept 2009
2.	Sept 2009	Dr Anupama de Silva, Consultant Gastroenterology, David Todd Chief Pharmacist, JPUH / Fiona Marshall TAG Lead Pharmacist	Superseded	GP monitoring of FBC and LFTs revised to 3-monthly and 2-weekly after each dose change
3.	Sept 2012	Dr Anupama de Silva, Consultant Gastroenterology, David Todd Chief Pharmacist, JPUH / Fiona Marshall TAG Lead Pharmacist	Superseded	Changes to JPUH / NNUH consultant contacts. Approved by the TAG on 6th September 2012.

4.	March 2013	Edited by Fiona Marshall TAG Lead Pharmacist	Superseded	QEH specialists' contacts added. Text corrected in GP monitoring section to state "mercaptopurine" instead of "azathioprine". Formatting corrected regarding hyphenation and superscripted numbers in units of measurement of blood tests. MCV units corrected to "fL". Footer updated.
5.1	July 2014	Dr Anupama de Silva, Consultant in Gastroenterology, JPUH / Fiona Marshall TAG Lead Pharmacist	Draft	For review by author and consultation with local specialists.
5.2	Aug 2014	As for 5.1 above	Draft	Amendments by Dr de Silva – update of key reference (2011) and JPUH specialist contacts. Text on the general principles of shared care prescribing added to the top of the document.
5.3	Sept 2014	As for 5.1 above	Superseded	Recommendation by the TAG to include shingles (varicella zoster vaccine) to the list of live vaccines that patients on mercaptopurine should avoid. Link to "Green Book" added.
5.4	Sept 2014	As for 5.1 above	Superseded	Incorrect names and contacts amended with details for NNUH IBD nurses, and consultants. Specialist nurse JPUH also added. Hyperlink to key reference inserted.
5.5	Sept 2014	As for 5.1 above	Superseded	Error in text under GP prescribing corrected – "azathioprine" changed to "mercaptopurine".
6.0 – 6.1	March – April 2017	As for 5.1 above	Superseded	Updated in line with current SPC – hyperlinks added to SPC and manufacturer's PIL. Advice regarding handling tablets added under dosage and administration, and Patient Information.

				Additions to Side –effects and Drug Interactions made in line with SPC. For review by author and possible consideration by the TAG in May 2017.
6.2	May 2017	As for 5.1 above	Current	Supported by the TAG
7.0	Aug 2021	Jen Carroll, TAG Lead Technician	FINAL	Discussed at August 2021 TAG meeting. Review dates extended for a year from meeting due to covid pressures
7.1	Oct 2021	Jen Carroll, TAG Lead Technician	FINAL	QEH contact details updated on page 4, as per email request 18/10/2021
8.0	Jan 2024	Jen Carroll, TAG Lead Technician	Final	Updated to new template, added info from RMOC.