NORTH AND EAST DEVON HEALTHCARE COMMUNITY SHARED CARE PRESCRIBING GUIDELINE

Sulfasalazine Enteric Coated

Treatment of rheumatological conditions

Specialist: Please complete letter on page 6 before sending guideline to GP

GP: Please indicate whether you wish to share patient's care by completing letter on page 6 and return to specialist

Aim of treatment

Sulfasalazine is a long term treatment. The earliest initial response is at 6-12 weeks.
Indication: Treatment of adults with inflammatory joint disease

A summary of prescribing information is provided on page 4

Specialist responsibilities

- Initiate sulfasalazine, supply 28 days' medication.
- Discuss benefits and side effects of treatment with patient or patient's carers including where appropriate the risks associated with pregnancy and need for a reliable method of contraception.
- Refer patient to specialist nurse service where appropriate (eg. new patient) for advice on taking the drug, its cautions, side effects associated with treatment, monitoring requirements and the timing of re-assessment and by whom.
- Ascertain immune status by enquiring about history of chickenpox. Measurement of antibodies to varicella-zoster is not recommended.
- Issue a booklet for recording test results to patient
- Conduct baseline tests – as specified below. Copy test results to GP.
- Specify review dates.
- Prompt verbal communication followed up in writing to GP of changes in treatment or monitoring requirements, results of monitoring, assessment of adverse events or when to stop treatment. Urgent changes to treatment should be communicated by telephone to GP.
- Reporting adverse events to MHRA.

General practitioner responsibilities

If GP has agreed to share care:

- Continue to prescribe oral sulfasalazine in accordance with these guidelines.
- Undertake monitoring as specified below. Review results and undertake any necessary action. Routine monitoring is not required beyond 12 months for stable patients.
- Take appropriate action if patient reports sign(s) or symptom(s) specified under Monitoring.
- Be aware of criteria for referral to rheumatology team.
- Respond to advice from secondary care on dose changes and frequency of monitoring.
- Report to and seek advice from specialist on any aspect of patient care of concern to GP which may affect treatment. Prompt referral to specialist if there is a change in patient's health status.
- Report adverse events to specialist.
- Stop treatment in case of a severe adverse event or as per shared care guideline.

Monitoring

1. Monitoring prior to starting therapy: rheumatology team

- Measure baseline height & weight, blood pressure, full blood count, LFTs (ALT and/or AST, and albumin), U&Es, creatinine, folate and vitamin B12.
- Consider patient risk factors for viral infections and screen for occult viral infections (hepatitis B and C and HIV) where appropriate

2. Monitoring during treatment: general practice

Laboratory tests – for 12 months then no routine monitoring for stable patients

<table>
<tr><th>Tests</th><th>Frequency of monitoring</th><th>Guidance</th><th>Action to be taken by GP</th></tr>
<tr><td>FBC</td><td rowspan="3">Every two weeks until on stable dose for 6 weeks, then every month for 3 months, then at least every 12 weeks. Routine monitoring is not required beyond 12 months for stable patients.
Following dose increases, monitor every 2 weeks until on a stable dose for 6 weeks, then as above.
Patient factors where continued monthly monitoring is recommended (unless otherwise specified):
• Previous toxicity or deranged FBC or LFTs while on DMARDs
• Chronic kidney disease (CKD 3 or worse)
• Pre-existing liver disease

Additional urgent monitoring tests should be carried out within 24 hours for any patient with acute kidney injury</td><td>WCC < 3.5 x 10^9/L
Neutrophils < 1.6 x 10^9/L
Eosinophils >0.5 x 10^9/L
Platelets < 140 x 10^9/L
MCV > 108fl</td><td rowspan="3">If results meet specified criteria, stop treatment and refer to specialist.
If isolated MCV rise, check for other causes (B12, folate, thyroid function and alcohol consumption). If results are normal, refer to specialist.
If concerned about sequential drops in FBC indices (possibly still within normal range), consider an early re-test/seek specialist advice.
If deterioration in renal function, dose adjustment may be necessary; if toxicity suspected or dosing advice required refer to specialist team.</td></tr>
<tr><td>Creatinine / eGFR</td><td>Creatinine increase >30% over 12 months and/or eGFR <60ml/min/1.73m^2</td></tr>
<tr><td>ALT and/or AST and albumin</td><td>ALT and/or AST >100 U/L

Albumin unexplained reduction to <30g/L</td></tr>
<tr><td colspan="4">Other factors that may increase risk of toxicity include moderate renal impairment, extremes of body weight, polypharmacy (especially other haematotoxic/ hepatotoxic/ nephrotoxic drugs), comorbidities, age > 80 years. Where more frequent ongoing monitoring is required due to a combination of patient factors this will be advised by the specialist prescriber.</td></tr>
</table>

Signs and symptoms

Patients MUST report mouth ulcers, sore throat, fever, epistaxis, unexpected bruising or bleeding and any unexplained illness/infection.

Action to be taken by GP:

- **Review patient with any of the signs or symptoms listed above within 24 hours** for clinical assessment, full blood count and liver function tests. Signpost patient to alternative provider if this is not possible e.g. weekend/bank holiday
- **Stop treatment and refer if:**
    - Rash – in cases of unexplained acute widespread rash, stop treatment and seek urgent advice (preferably from dermatology team)

- Abnormal bruising
- Severe sore throat
- Severe oral ulceration
- Unexplained illness including severe nausea, vomiting or diarrhoea

During a **serious** infection STOP sulfasalazine. During minor infections (e.g. uncomplicated UTI treated with a short antibiotic course) treatment can be continued.

Do not stop treatment prior to surgery unless significant risk of infection.

Contact Microbiology if a patient, not known to be immune to chickenpox comes into contact with shingles or chickenpox, for advice on whether zoster immune globulin or other treatment is indicated.

Patient/carer responsibilities

Patients (and/or their carers):

- MUST report mouth ulcers, sore throat, fever, epistaxis, rash, unexpected bruising or bleeding, and any unexplained illness/infection to their GP and/or specialist (or out of hours service e.g. NHS 111 if their GP practice is closed for weekend/bank holiday)
- Report any other adverse effect to their GP and/or specialist whilst being treated with sulfasalazine.
- Ensure that they have a clear understanding of their treatment.
- Ensure they attend for monitoring requirements.
- Be aware that treatment will be stopped if patient does not attend for monitoring.

Back-up advice and support

Contact details	Telephone No	E-mail address
Dr R Haigh	(01392) 403705	richardhaigh@nhs.net
Dr S Earl	(01392) 406351	Susannah.earl@nhs.net
Dr M Brown	(01392) 403567	mary.brown11@rnhs.net
Dr R Mascarenhas	(01392) 406355	r.mascarenhas@nhs.net
Dr M Abusalameh	(01392) 403772	m.abusalameh@nhs.net
Dr M Cates	(01392) 403707	matthewcates1@nhs.net
Dr S Kyle	(01271) 311571	stuartkyle@nhs.net
Dr R Manhas	(01271) 311571	roopemanhas@nhs.net
Dr V Arya	(01271) 311571	vivek.arya2@nhs.net
RD&E rheumatology dept		rde-tr.rheumatology@nhs.net
NDHT rheumatology dept		ndht.rheumatology@nhs.net

Please do not use rheumatology department emails for enquiries relating to patients receiving DMARDs under the care of other specialties e.g. dermatology, gastroenterology etc.

Supporting Information

This guideline highlights significant prescribing issues, not all prescribing information and potential adverse effects are listed. Please refer to SPC/data sheet for full prescribing data.

Dose

Dose:

(Prescribed as **enteric coated** tablets):

Week 1: 500mg each evening
Week 2: 500mg twice daily
Week 3: 500mg in the morning and 1 gram in the evening
Week 4: 1 gram twice daily
The dose may be increased to 3 grams if no response (after 3 months). Tablets should not be crushed or broken. It is recommended that tablets should be taken with water.

Special patient groups: Use doses at the lower end of the range for patients with hepatic or renal impairment.

Contraindications

- Hypersensitivity to sulfasalazine, sulfonamides or salicylates
- Porphyria

Precautions

- Hepatic or renal impairment.
- Adequate fluid intake is required as sulfasalazine causes crystalluria and kidney stone formation
- Limit alcohol intake to within national recommendations
- Patients with blood dyscrasias
- Patients with severe allergy or bronchial asthma.
- Patients with G-6-PD deficiency: caution as sulfasalazine may cause haemolytic anaemia
- Pregnancy: When planning a pregnancy, women of child bearing potential are advised to use a reliable method of contraception until discussion with the rheumatology team about pregnancy planning. There is no evidence that sulfasalazine is teratogenic, but the possible risks and benefits to the mother and child should be discussed. Also, sulfasalazine may cause reversible oligospermia and infertility in men.
- Lactation: see SPC for further information.

Side effects

Common/uncommon:

- Leukopenia, thrombocytopenia
- Insomnia, depression, dizziness, headache, taste disorders, convulsions, tinnitus, vertigo
- Vasculitis, cough, dyspnoea, arthralgia
- Gastric distress, nausea, abdominal pain, diarrhoea, vomiting, stomatitis
- Elevation of liver enzymes, proteinuria
- Pruritus, alopecia, urticaria, fever, facial oedema
- (Epidermal necrolysis, Stevens-Johnson Syndrome and drug rash with eosinophilia and symptoms (DRESS) have been reported but less frequently)

Interactions

- Azathioprine and mercaptopurine: sulfasalazine inhibits TPMT enzyme. Risk of bone marrow suppression and leucopenia with concurrent use of azathioprine or mercaptopurine.
- Digoxin: concomitant use results in reduced absorption of digoxin
- Folates: sulfasalazine possibly reduces absorption of folic acid
- Hypoglycaemic agents: Hypoglycaemia has occurred in patients receiving sulfonamides. Patients receiving hypoglycaemic agents and sulfasalazine should be closely monitored.
- Methotrexate: increased incidence of gastrointestinal adverse events with concurrent use of sulfasalazine. Pharmacokinetics of either drug not affected by concurrent use.

Pregnancy and lactation

See SPC for further information.

Date ratified by Effective Practice Committee: April 2011
Partially updated: October 2019, March 2021

Shared Care Agreement Letter - Consultant Request

To: Dr……

Practice Address: ……

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Patient Name:	
Hospital number:	
Date of birth:	
Address:	

DIAGNOSED CONDITION: **…….**

I recommend treatment with the following drug: **……**

I request your agreement to sharing the care of this patient according to the North and East Devon Health Community Shared Care Prescribing Guidelines for this drug.

Principles of shared care:
GPs are invited to participate. If GP is not confident to undertake these roles, then 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 practical. Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient and accepted by them.

The doctor who prescribes the medication has the clinical and legal responsibility for the drug and the consequences of its use.

Signed:		**Date:**	
Consultant name:			
Consultant email:			
Department email:			
Contact telephone:			

GP RESPONSE
I agree/ do not agree* to share the care of this patient in accordance with the Shared Care Guideline.

Signed: …… Date: ……..

GP name: …… ***Delete as appropriate**