SHARED CARE PROTOCOL AND INFORMATION FOR GPs	NHS Lothian
Sulfasalazine	
Clinical indication: For the treatment of rheumatological inflammatory diseases	
Version 2.0: September 2009	Due for review: **September 2011**

Introduction
With the exception of sulfasalazine, DMARDs are usually started after assessment by a rheumatologist.
'Rheumatological Management and Shared Care Guidelines' available on website: *www.refhelp.scot.nhs.uk*

Shared Care
A shared care protocol is used to **facilitate the sharing of care and transfer of prescribing.** This would usually take place once the patient's condition is stable; the patient is demonstrably benefiting from the treatment and is free from any significant side effects. GPs should only take on the prescribing when they are confident in the use of the drug, in the context of the protocol. Contingency plans must be in place to enable the patient to receive the recommended treatment, should the GP decline to prescribe.

Indication for Therapy
Indications – active joint inflammation usually supported by indices of inflammation.
Duration – most drugs require up to 3 to 4 months trial to assess efficacy. Therapy is continued providing the drug is working and there are no side effects.
Relapse is common after withdrawal of therapy.

Preparations Available
500mg enteric coated tablets must be used – these are licensed and have lower incidence of headache and nausea.

Recommended Dosage and Administration
500mg daily, increased by 500mg weekly to usual maintenance dose of 1000mg twice or three times daily.
Maximum dose is 40mg/kg/day.

Cost
112 x 500mg e/c tabs = £8.43..

Adverse Effects and Drug Interactions
Common: headache, GI disturbance, hypersensitivity reactions (most commonly rash), loss of appetite, raised temperature.
Rare: acute pancreatitis, hepatitis, nephritic syndrome, blood disorders.

Uptake of digoxin and folate may be reduced. Azathioprine may contribute to bone marrow toxicity.

Precautions and Contra-indications
Contra-indicated in patients hypersensitive to sulphonamides/co-trimoxazole or aspirin, and in severe renal impairment

Cautioned in glucose-6-phosphate dehydrogenase deficiency (may cause haemolysis), and in moderate renal impairment (may cause significant crystalluria).

Pregnancy and Lactation
Oligospermia – reversible on discontinuation of drug
Can be used during pregnancy and used with caution during breast feeding. If used during pregnancy then folic acid 5mg daily should be prescribed.

Shared Care Responsibilities

Aspects of Care for which the Consultant is responsible

- Assessing the need for DMARD.
- Arranging for the patient to receive counselling in verbal and written form.
- Providing relevant baseline investigations.
- Following the patient's response to treatment at the out- patient clinic.
- Communicating advice to the patient's GP re monitoring requirements.
- At any stage of treatment, advising GP of concerns re monitoring or potential adverse effects of treatment.

Aspects of Care for which the General Practitioner is responsible

- Prescribing DMARD under the guidance of the consultant.
- If the GP wishes to initiate a DMARD, the following baseline tests are recommended: FBC (incl. differential WCC), urea, creatinine, LFTs and ESR. Any abnormality in baseline tests should be discussed with a rheumatologist before treatment is commenced.
- Reporting any suspected adverse reactions to the patient's consultant and complete a Yellow Card if appropriate. Discuss any significant abnormalities with consultant.
- Liaising with the consultant regarding any complications of treatment.
- Monitoring the general health of the patient.
- Monitoring for specific side effects as detailed in "Monitoring" section.
- Provision of pneumococcal and annual influenza vaccination.

Monitoring

Test	Frequency	Abnormal result	Action if abnormal result
FBC	Monthly for first 3 months, three monthly for next 9 months. If stable, reduce to six monthly for 2nd year, if stable after 2nd year then stop. One month after any increase in dose.	WBC <3.5 x 10^9/l. neutrophils <2.0 x 10^9/l. platelets <150 x 10^9/l.	Withhold sulfasalazine and discuss with specialist team.
		MCV >105 fl.	Check B12, folate and TSH. If abnormal, treat underlying abnormality; if normal, discuss with specialist team..
LFTs		AST > twice upper limit of normal reference range. ALT > twice upper limit of normal reference range.	Withhold sulfasalazine and discuss with specialist team.

- Abnormal trends should prompt extra vigilance.
- Temporarily withdraw if the patient reports sore throat, unexplained bleeding or bruising, mouth ulcers or other signs of blood dyscrasia or evidence of infection. Perform repeat blood monitoring.
- In the event of an unexplained acute widespread rash, withhold sulfasalazine and seek urgent specialist (preferably dermatological) advice. Inform rheumatologist.
- Trends in ESR are useful in decision-making.

Contact Points

Rheumatology Clinical Nurse Specialists:
0131 537 1405
Rheumatology SpR (via switchboard):
0131 537 1000
Rheumatology Clinical Pharmacist:
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Rheumatic Diseases Unit (WGH):
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This information was prepared by the Rheumatic Diseases Unit and Pharmacy Department, Western General Hospital, NHS Lothian through liaison with the General practice Prescribing Committee and LUHD Drug and Therapeutics Committee

Approved for use by the General Practice Prescribing Committee, LPCD and the Drug & Therapeutics Committee, LUHD.