Prescribing....

Gabapentin March & April 2017

- The use of anti-epileptic drugs to treat other disabling long-term conditions has increased and they have undoubtedly helped some patients.
- However increasing concerns about the misuse of pregabalin & gabapentin mean that they may be reclassified as CDs in the future.
- Both drugs have an additive effect when consumed with CNS depressants, including small quantities of alcohol, resulting in drowsiness, sedation, respiratory depression and death.
- Gabapentin is reported by misusers to cause feelings of relaxation, calmness and euphoria.

Background

The use of the anti-epileptic drugs, pregabalin and gabapentin has greatly increased in recent years. The potential benefits for patients are well known. While they do not work for everybody a proportion of patients benefit sufficiently to notice an improvement in their quality of life.

Pregabalin is not available via the States Pharmaceutical Service, but some islanders may obtain it on private prescription. Where it is used there is more concern about it than gabapentin and it is now one of the most expensive drugs prescribed in community in the UK. The change in the monthly prescribing patterns of both drugs between February 2012 and January 2017 are shown below. Despite significant increases in the use of gabapentin, costs fell in the Bailiwick due to more extensive use of generics. The spend on pregabalin in England doubled from £13.4 million per month to £26 million per month between 2012 and 2017.

Table	Drug	G & A Items	G & A Net Ingredient Cost	England Items	England Net Ingredient Cost
Feb-12	Gabapentin	452	£3,706	262,688	£2,114,888
Feb-12	Pregabalin	0	£0	198,946	£13,440,013
Jan-17	Gabapentin	746	£3,434	556,626	£2,342,173
Jan-17	Pregabalin	0	£0	481,093	£26,078,453

Ref : EPACT.net Date of search 6/4/2017

Medical harms

Pregabalin and gabapentin are very similar structurally, having been made by the same company and both are analogues of gamma-amino butyric acid. They are increasingly being recognised as possessing a potential for misuse. The key new information is that when used in combination with one or more other depressants, such as alcohol even in small amounts, antidepressants, anti-emetics, antiepileptics, antihistamines, antipsychotics, anxiolytics, barbiturates, hypnotics, opioid analgesics, skeletal muscle relaxants, they can cause drowsiness, sedation, respiratory failure and death. This central nervous system depressant effect may be addictive. There are reports of respiratory failure and coma in patients taking pregabalin and other central nervous system-depressant drugs.

Pregabalin may have a higher abuse potential than gabapentin due to its rapid absorption and faster onset of action and higher potency. Pregabalin causes a 'high' or elevated mood in users; the side effects may include

chest pain, wheezing, vision changes and less commonly, hallucinations. Gabapentin can produce feelings of relaxation, calmness and euphoria. Some users have reported that the 'high' from snorted gabapentin can be similar to taking a stimulant. Users may be consuming large quantities in single doses. There are reports of a growing black market and these drugs are often bought from online pharmacies.

Social harms

These have been identified recently by various bodies in the UK. In February 2015, HMI Prisons reported that health staff in a significant number of establishments continued to report high numbers of prisoners being prescribed pregabalin and/or gabapentin, "in a manner that does not meet best practice guidelines" and that addressing this effectively "requires significant time and resource while the correct diagnosis and appropriate pain management plan are formulated". The Drug Scope Street Drug Survey10 (2014) reported that while illegal drugs have been increasing in purity, most areas covered by the survey highlighted the significant use of the prescription drugs pregabalin and gabapentin, chiefly among Britain's opioid-using and prison populations.

The use of gabapentin and pregabalin by the opioid abusing population either together or when opioids are unavailable reinforces the behaviour patterns of this high risk population. There is a high risk of criminal behaviour stimulated by the wish to obtain gabapentin or pregabalin.

Fatalities

There has been a significant increase in deaths in the UK from 2012 onwards. In 2014, there were 38 deaths where pregabalin was mentioned on the deceased's death certificate and 26 deaths where gabapentin was mentioned on the deceased's death certificate. An iatrogenic epidemic of harm in the US results in 15,000 deaths each year from all prescribed painkillers, a figure that may be the tiny tip of an abuse iceberg.

Managing concerns, tapering off and stopping

It is appropriate, fair and reasonable to take the rights and responsibilities of all concerned i.e. the patient , the prescriber, our island community and the taxpayer, into account when making a prescribing decision. If dependence, or other misuse or diversion, is suspected or identified the patient should be reviewed and the concerns of the prescriber should be discussed and documented clearly.

If dependence is suspected or confirmed, the problem may require specialist advice on managing the dependence. Or it may simply require agreement on suitable controls on access to, and maximum daily use, of the drug being misused when it is felt that it is still needed for the management of the original indication. Reassessment of the patient may lead to a decision to offer a planned withdrawal, particularly if it does not appear any longer to be required for the main clinical indication.

If completely inappropriate use is confirmed, for example if there is unequivocal objective evidence that the drugs are simply being diverted, the drug should be stopped. However, in some cases patients may have diverted a portion of their treatment, such as to a family member where it is very difficult to prove.

The summary of product characteristics for gabapentin and pregabalin indicate that both drugs can be discontinued over one week. A more gradual dose taper may be needed in some patients, which allows observation of emergent symptoms that may have been controlled by the drug.

Gabapentin: reduce the daily dose at a maximum rate of 300mg every four days.
Pregabalin: reduce the daily dose at a maximum of 50-100mg/week.

Written by : Geraldine O'Riordan , Prescribing Advisor, Prescribing Support Unit, Edward T Wheadon House, Le Truchot, St Peter Port , Guernsey GY1 3 WH

References : 1. Health and Social Care Board of Northern Ireland "Advice for prescribers" January 2015, 2. DTB March 2017, 3. EPACT.net, 4. Advisory Council Misuse of Drugs Letter to Minister of Health January 2016