NHS
South West Yorkshire
Area Prescribing Committee

Prescribing Guideline on Reviewing Drug Treatment and Drug Holidays

Introduction

Whenever a prescriber is considering drug therapy with a patient and/or their carer/parent these are some of the key points to cover with them as part of shared decision making:

- effective communication of benefits and risks;
- stewardship does not just apply to antimicrobials. We need to be mindful of how medicines are prescribed, used and potentially abused;
- has the information given to them been understood?
- how long will the course of drug last, if not life-long. Are there any special instructions regarding stopping a medicine (such as reducing the dose)?
- if a drug holiday is relevant to the drug. Document the drug holiday and treatment duration in the patient's notes. Be clear if the drug holiday will be managed by primary or secondary care. Ensure patient can obtain supplies once the drug holiday is over.

Drug holidays

A drug holiday is an agreed cessation of medication for a period of time [1]. A drug holiday can be called a structured treatment interruption, tolerance break, treatment break or strategic treatment interruption. It can last from a few days to many months or even years. Reasons for drug holidays include permitting a drug to regain effectiveness after a period of continuous use or to reduce the tolerance effect that may require increased dosages.

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Additional information

Polypharmacy

NICE states in their multimorbidity and polypharmacy resource that when reviewing people on multiple medicines, a person-centred approach should be taken. The risk of harms is likely to increase as a person takes more medicines [2]. Polypharmacy is a risk factor for hospital admissions [3] and for falls in older people [4]. Harms can occur through drug interactions, side effects and non-adherence. These are magnified if the person is frail [5].

Options for management include using PINCER [6] and structured medication reviews (SMR).

Chronic pain

Pain is an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage [7]. The NICE guideline on chronic pain in over 16s defines chronic pain as pain that persists or recurs for more than three months. It includes chronic primary and chronic secondary pain, which can coexist. Chronic primary pain is **pain with no clear underlying cause or pain, or its impact, that is out of proportion to any observable disease or injury** [8]. Secondary pain is caused by an underlying condition, such as rheumatoid arthritis or ulcerative colitis [9].

Management of chronic primary pain involves exercise, acceptance and commitment therapy or cognitive behavioural therapy, acupuncture and an antidepressant. If a patient with chronic primary pain is already on an opioid, gabapentinoid, NSAIDs, paracetamol, local anaesthetics, ketamine, corticosteroid trigger point injections, benzodiazepines or antipsychotic drug review as part of shared decision making. Explain the lack of evidence for them for this condition and agree a plan if the patient has found benefit at a safe dose and with few harms or explain the harms of continuing if the patient reports little benefit or significant harm and encourage and support them to reduce and stop if possible. Discuss any problems associated with withdrawal [8].

Chronic pain affects about a third of the population of England over the age of sixteen [10]. It affects every-day life, relationships, mood, sleep, work and independence.

The International Association for the Study of Pain advocates access to opioids for severe short-term pain and end of life but continuous long-term use is associated with tolerance, dependence and neuroadaptations which compromise safety and efficacy [11].

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Primary Care Networks (PCNs) are required to undertake structured medication reviews (SMR) as part of a Directed Enhanced Service (DES) [12]. Patients on opioids or gabapentinoids are one group of patients who would benefit from SMRs. The guidance states that appropriately trained clinicians working within their competence undertake SMR [13].

A review by Public Health England found that some patients had reported harmful effects and withdrawal symptoms on stopping opioid pain medicines or gabapentinoids [14]. These effects, which could last many months, had detrimental consequences on their well-being, personal, occupational and social functioning. Higher initial opioid doses and prior mental health problems were associated with long-term use of opioids and opioid dependence, respectively. Prescribing opioid pain medicines for longer than 90 days was associated with opioid overdose and dependence. They summarised their findings on chronic, non-cancer pain by saying opioids have a role in short-term prescribing for acute pain, with non-opioid medicines and other supports. For most people with chronic non-cancer pain, opioids do not provide adequate clinical benefit when balanced against the risks of dependence and overdose poisoning, and harms to others in the community. In their conclusion they state that effective, personalised care should include shared decision making with patients and regular reviews of whether treatment is working.

The US opioid epidemic has led to similar concerns in the UK. In new users, initiation of or escalation to more potent and high dose opioids may contribute to long-term use. Additionally, physician prescribing behaviour has been described as a key driver of rising opioid prescriptions and long-term opioid use [15]. A retrospective cohort study using primary care electronic health records from the Clinical Practice Research Datalink was performed. Adult patients without cancer with a new prescription of an opioid were included; 1,968,742 new users of opioids were identified. Codeine was the most prescribed opioid. Use increased 5-fold from 2006 to 2017, reaching 2,456 prescriptions/10,000 people/year. Morphine, buprenorphine, and oxycodone prescribing rates continued to rise steadily throughout the study period. After accounting for individual patient factors, the Yorkshire and the Humber region was associated with a higher risk of long-term opioid use [15].

A study in England found that between 1998 and 2016, the total oral morphine equivalence dose increased by 127% to 431 000 mg/1000 population/year [16].

The General Medical Council advises that clinicians should comply with the recommendations made by the MHRA (in Drug Safety Update) along with other guidance, making compliance a professional duty [17].

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Using the World Health Organization (WHO) analgesic ladder in people with chronic pain, without taking into account the complexity of the person's individual needs, preferences for treatments, health priorities and lifestyle, may contribute to inappropriate prescribing. Opioids and gabapentinoids may be misused or diverted to illegal use [18].

An editorial in the British Journal of Anaesthesia states that the opioid crisis the world is seeing is due in part to long-term use in conditions for which they are ineffective, such as chronic neuropathic pain. The authors say that these medicines are being used, prescribed and misused in 'epidemic' proportions [19].

Greater Manchester Medicines Management Group (GMMMG) has an opioid prescribing for chronic pain resource pack and a gabapentinoids for pain resource pack [20,21]. These state that prescribers should consider intermittent dose reductions or drug holidays to demonstrate that on-going prescriptions are clinically appropriate and beneficial. They include a patient letter about drug holidays, a symptom diary and sections on managing patient expectations and how to identify prescription opioid dependent patients.

People with long-term conditions would benefit from care planning, including managing health and wellbeing and development and actioning of goals [22].

Decision support tools have been developed for people with musculoskeletal conditions to help people prepare for consultations and what questions to ask [23].

Medicines for sleep, agitation and depression

Public Health England has reviewed dependence and withdrawal associated with some prescribed medicines. Some patients reported harmful effects and withdrawal symptoms on stopping benzodiazepines, z-drugs and antidepressants which affected their well-being and personal, occupational and social functioning. These effects and symptoms could last many months. Effective, personalised care should include shared decision making with patients and regular reviews of whether treatment is working [14].

Patients on benzodiazepines or z-drugs are among the patient groups who could benefit from SMR as part of the DES [13].

Anticholinergic/antimuscarinic drugs

Clinical guidelines from NICE recommend that men [24] and women [25] with urinary incontinence should be offered bladder training. If this is not effective, anticholinergic medication can be offered. However, evidence is mounting that medicines with anticholinergic (antimuscarinic) effects are associated with an increased risk of cognitive impairment, falls and all-cause mortality in older people. The potential for harm increases with age and frailty. When undertaking review of treatment, stop medicines if there is no absolute need or switch to a medicine with a lower anticholinergic burden score [26].

Bisphosphonates

- During bisphosphonate treatment, patients should be advised to report any thigh, hip, or groin pain [27].
- All patients with cancer should have a dental check-up before bisphosphonate treatment. All other patients who start bisphosphonates should have a dental examination only if they have poor dental status. During bisphosphonate treatment, patients should maintain good oral hygiene, receive routine dental check-ups, and report any oral symptoms such as dental mobility, pain, or swelling [28]
- Patients should be advised to report any ear pain, discharge from the ear or an ear infection during bisphosphonate treatment [29].

There is currently no evidence on which to base recommendations on duration of treatment for men with osteoporosis [30].

ADHD

Stimulants such as methylphenidate, dexamfetamine and lisdexamfetamine have been associated with a slowing of weight gain and a reduction in attained height [31]. Growth should be monitored during treatment and patients who are not growing or gaining weight as expected may need to have their treatment interrupted.

NICE notes that it would be appropriate for healthcare professionals to discuss the option of discontinuation or dose reduction with people with ADHD [1].

A UK study looked at the reasons practitioners found it difficult to discuss a treatment break in patients with ADHD [32]. CAMHS practitioners appeared to have the capability to initiate planned drug holidays, whereas lack of knowledge and skills about ADHD in general and specifically

about drug holidays was a vital barrier for GPs. Opportunity was a main barrier for both groups. Time constraint, parental disinclination to stop medicating their children, and lack of educational or information resources about ADHD drug holidays were reported as potential barriers.

This work fits in with the Government's pledge to reduce overprescribing of medicines. A Government-commissioned review estimates that 10% of items dispensed in primary care are overprescribed with 15% of people taking 5 or more medicines a day, increasing the risk of adverse effects. In addition, about 1 in 5 hospital admissions in over-65s are caused by the adverse effects of medicines [33]. Have a look at 'Good for you, good for us, good for everybody' and plan your actions [34].

Advice on specific medicines or treatments

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
2.	Ticagrelor, prasugrel or clopidogrel	Acute coronary syndrome (ACS)	Stop ticagrelor, prasugrel or clopidogrel 12 months after the last event. Cardiology team to identify patients requiring extended duration therapy	https://www.nice.org.uk/guidance/ta420	https://www.nice.org.uk/guidance/ta420
4.	Melatonin	Sleep disorders	Schedule regular reviews in patient's clinical notes. Review patients for continued need and effectiveness after the first 3 months and stop if ineffective or no longer necessary. Review continued treatment every 6 months for up	Melatonin-commissioning-statement_final_11-10-2022.pdf (swyapc.org)	

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			to 2 years. Specialist to consider the need for a drug-free holiday lasting 2 to 4 weeks every 6 to 12 months		
4.	Dexamfetamine	Attention deficit hyperactivity disorder (ADHD)	The safety and efficacy of long-term dexamfetamine has not been systematically evaluated in controlled trials. Long-term usefulness for periods over 12 months in children and adolescents should be periodically re-evaluated for the individual patient with trial periods off medication to assess the patient's functioning without pharmacotherapy. It is recommended that specialist manages dexamfetamine de-challenge at least once yearly to assess the child's condition (preferably during school holidays, if applicable). Improvement may be sustained when the medicinal product is either temporarily or permanently discontinued. If the decision is made to continue medication, the reasons for this should be documented.	https://www.medicines.org.uk/emc/ Leeds: http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=1226 SWY: https://www.swyapc.org/wp-content/uploads/2016/04/Dexamfetamine-Lisdexamfetamine-SCG-final-Version-jan-16.pdf	https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/treatment/

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
			Further advice is available in the additional information section		
4.	Guanfacine	ADHD	The prescriber who elects to use guanfacine for over 12 months should re-evaluate the usefulness of the product every 3 months for the first year and then at least yearly based on clinical judgement. Specialist to consider trial periods off medication to assess the patient's functioning without pharmacotherapy, preferably during school holidays (if applicable). If a decision is made to continue medication, the reasons for this should be documented. Further advice is available in the additional information section	https://www.medicines.org.uk/emc/ Leeds: children: http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=6722 Leeds: adults http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=4965 SWY: https://www.swyapc.org/wp-content/uploads/2017/01/Guanfacine-SCG-final-January-2017.pdf	https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/treatment/
4.	Methylphenidate	ADHD	The safety and efficacy of long-term use of methylphenidate has not been systematically evaluated in controlled trials. Methylphenidate treatment should not and need not, be indefinite. Methylphenidate treatment is usually discontinued during or after puberty. The specialist who elects to use	https://www.medicines.org.uk/emc/ Leeds: http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=1227	https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/treatment/

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			methylphenidate for over 12 months in children and adolescents should periodically re-evaluate the long-term usefulness of the product for the individual patient with trial periods off medication to assess the patient's functioning without pharmacotherapy. It is recommended that methylphenidate is de-challenged at least once yearly to assess the child's condition (preferable during school holidays, if applicable). Improvement may be sustained when the medicinal product is either temporarily or permanently discontinued. If the decision is made to continue medication, the reasons for this should be documented. Further advice is available in the additional information section	SWY: https://www.swyapc.org/wp-content/uploads/2016/04/Methylphenidate-SCG-final-version-Jan-2016.pdf	
4.	Lisdexamfetamine	ADHD	Treatment must be stopped if the symptoms do not improve after appropriate dosage adjustment over a 1-month period. The specialist who elects	https://www.medicines.org.uk/emc/ Leeds:	https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/treatment/

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			to use lisdexamfetamine for over 12 months should re-evaluate the usefulness of this product at least yearly, and consider trial periods off medication to assess the patient's functioning without pharmacotherapy, preferably during school holidays (if applicable). If the decision is made to continue medication, the reasons for this should be documented. Further advice is available in the additional information section	http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=3634 SWY: https://www.swyapc.org/wp-content/uploads/2016/04/Dexamfetamine-Lisdexamfetamine-SCG-final-Version-jan-16.pdf	
4.	Opioid analgesics (e.g codeine, oxycodone)	Surgery	Make a plan with the patient. Everyone involved with patient has duty to ensure opioids started peri-operatively are not continued unnecessarily. Ensure deprescribing procedures are in place at hospital/primary care interface. Further advice is available in the additional information section	https://fpm.ac.uk/sites/fpm/files/documents/2021-03/surgery-and-opioids-2021_4.pdf	

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4.	Opioid analgesics, gabapentinoids, NSAIDs, paracetamol, local anaesthetics, ketamine, corticosteroid trigger point injections, benzodiazepines, antipsychotic drugs	Chronic **primary** pain in patients aged 16 and over	Non-pharmacological options are first line. Consider an antidepressant. Do not initiate any of the medicines in the first column to manage chronic primary pain in patients aged 16 and over. If a patient is already taking one of these medicines, review. Whatever medication is used it is vital that patients receive regular review and re-assessment to ensure they are still getting value from the medicine. Patients should be reviewed at least annually and more frequently if medication needs changing or co-morbidities or the pain syndrome alter. Use structured programmes which allow patients to self-manage their chronic pain.	https://www.nice.org.uk/guidance/NG193 https://www.sign.ac.uk/our-guidelines/management-of-chronic-pain/	NICE Guideline on chronic pain in over 16s https://www.nice.org.uk/guidance/NG193 Thinking about opioid treatment for pain https://www.fpm.ac.uk/opioids-aware-information-patients/thinking-about-opioid-treatment-pain Taking opioids for pain https://www.fpm.ac.uk/opioids-aware-information-patients/taking-opioids-pain Safety leaflet from MHRA: https://www.gov.uk/guidance/opioid-medicines-and-the-risk-of-addiction Leaflet for patients who have been taking gabapentin or pregabalin for more than 3 months for pain https://livewellwithpain.co.uk/wp-content/uploads/ask-yourself-leaflet.pdf Live well with pain resources https://livewellwithpain.co.uk/resources/resources-for-your-patients/

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			Further advice is available in the additional information section		The Pain Toolkit https://www.paintoolkit.org/resources/patients Managing chronic pain https://www.sign.ac.uk/patient-and-public-involvement/patient-publications/managing-chronic-pain/
4.	Clobazam	Seizures	Specialist to re-assess the patient after no more than 4 weeks and every 4 weeks thereafter to evaluate the need for continued treatment. A break in therapy may be beneficial if drug exhaustion develops, recommencing at a low dose, with specialist supervision or advice	Summaries of product characteristics available from https://www.medicines.org.uk/emc/	https://patient.info/medicine/clobazam-for-epilepsy-frisium-perizam-tapclob-zacco
4.	Dopamine agonists (e.g ropinirole, pramipexole)	Adults with idiopathic restless legs syndrome (RLS)	Short drug holiday every year to see if a remission or easing of symptoms has occurred. Be aware that these drugs are frequently associated with postural hypotension and falls	https://cks.nice.org.uk/topics/restless-legs-syndrome/	https://patient.info/bones-joints-muscles/restless-legs-syndrome-leaflet
5.	Single-dose antibiotic prophylaxis (e.g	Woman with recurrent urinary tract	Advise woman to return for review within 6 months. Assess success and discuss continuing,	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-

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	nitrofurantoin, amoxicillin)	infections (UTI) or for when exposed to an identifiable trigger	stopping or changing the medicine	infection-recurrent-antimicrobial-prescribing-pdf-66141595059397	recurrent-antimicrobial-prescribing-pdf-66141595059397
5.	Daily antibiotic prophylaxis (e.g trimethoprim, nitrofurantoin)	Woman with recurrent UTI who has failed a single dose antibiotic	Advise woman to return for review within 6 months. Assess success and discuss continuing, stopping or changing the medicine	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-recurrent-antimicrobial-prescribing-pdf-66141595059397	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-recurrent-antimicrobial-prescribing-pdf-66141595059397
5.	Daily antibiotic prophylaxis (e.g trimethoprim, nitrofurantoin)	Man, child under 16 or pregnant woman with recurrent UTI	Advise patient to return for review within 6 months. Assess success and discuss continuing, stopping or changing the medicine	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-recurrent-antimicrobial-prescribing-pdf-66141595059397	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-recurrent-antimicrobial-prescribing-pdf-66141595059397
5.	Nebulised antibiotics (e.g gentamicin, tobramycin)	Child with non-cystic fibrosis bronchiectasis	Specialist to advise on choice and regimen and if a drug holiday is necessary	https://thorax.bmj.com/content/65/Suppl_1/i1.full#	
6.	Hormone replacement therapy (HRT) (e.g estradiol, dydrogesterone)	Vasomotor menopausal symptoms	Consider appropriateness of HRT and formulation. Do physical health check. Offer HRT after discussing the short-term (up to 5 years) and longer-term benefits and risks. Review each treatment for short-term	https://www.nice.org.uk/guidance/ng23/resources/menopause-diagnosis-and-management-pdf-1837330217413 See table for risks of cancer, thromboembolism etc https://assets.publishing.service.g	HRT and risk of breast cancer https://patient.info/womens-health/menopause/hormone-replacement-therapy-hrt

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			menopausal symptoms at 3 months to assess efficacy and tolerability and annually thereafter unless treatment ineffectiveness, side effects or adverse events warrant an earlier review. The British Menopause Society states that there is no concern over the use of low dose vaginal oestrogen preparations prescribed in the UK and treatment can be continued long term	ov.uk/media/5d680409e5274a1711fbe65a/Table1.pdf And absolute and relative risks https://assets.publishing.service.gov.uk/media/5d680384ed915d53b8ebdba7/table2.pdf British Menopause Society https://thebms.org.uk/2020/01/confusion-over-vaginal-estrogen/	
6.	HRT (e.g Vagifem®, Ovestrin®)	Patient with family history of breast cancer	HRT usage should be restricted to as short a duration and as low a dose as possible. Vulvo-vaginal atrophy can be managed by vaginal moisturisers. If not effective, ultra-low dose topical oestrogen can be considered. The British Menopause Society states that there is no concern over the use of low dose vaginal	https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493 British Menopause Society https://thebms.org.uk/2020/01/confusion-over-vaginal-estrogen/	https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493

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			oestrogen preparations prescribed in the UK and treatment can be continued long term		
6.	5-alpha reductase inhibitors (e.g finasteride)	Lower urinary tract symptoms in men	Review at 3 to 6 months and then every 6 to 12 months	https://www.nice.org.uk/guidance/cg97/resources/lower-urinary-tract-symptoms-in-men-management-pdf-975754394053	https://www.nice.org.uk/guidance/cg97/resources/lower-urinary-tract-symptoms-in-men-management-pdf-975754394053
6.	Oral bisphosphonates (e.g alendronate, risedronate)	Osteoporosis in women	The optimum duration of bisphosphonate treatment for osteoporosis has not been established. Make a clear plan for continuation, stopping or swapping. The need for continued treatment should be re-evaluated periodically based on the benefits and potential risks of bisphosphonate therapy for individual patients, particularly after 5 or more years of use. Due to the increased risk of osteonecrosis and atypical femoral fractures, drug holidays are recommended, especially in people of low to moderate risk of osteoporotic fracture. Drug	https://www.sheffield.ac.uk/NOGG/NOGG%20Guideline%202017.pdf	https://www.nhs.uk/conditions/osteoporosis/treatment/

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			holidays can last six months for patients on risedronate, 12 to 24 months for alendronate and 3 years for zoledronic acid. A drug holiday in patients at high risk of osteoporotic fracture is not mandatory [18]. After drug holiday, reassess using FRAX and DXA. Restart bisphosphonate if patient reaches NOGG intervention threshold and no contraindications. Further advice is available in the additional information section		
6.	IV zoledronic acid	Osteoporosis in women	This treatment is commenced by a specialist. Specialist to advise on on-going therapy. The optimum duration of bisphosphonate treatment for osteoporosis has not been established. The need for continued treatment should be re-evaluated periodically based on the benefits and potential risks of bisphosphonate therapy	https://www.sheffield.ac.uk/NOGG/NOGG%20Guideline%202017.pdf	

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
			for individual patients, particularly after 3 years of use. Further advice is available in the additional information section		
6.	Adjuvant bisphosphonates (e.g ibandronic acid)	Early breast cancer in women	Specialist to advise patients that treatment with IV zoledronic acid and/or oral ibandronic acid is for a total of 3 years. Ensure a stop date is added to the GP system. Further advice is available in the additional information section	Leeds guidance: http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=5119	
7.	Vaginal oestrogen (e.g estriol, estradiol)	Post-menopausal woman with recurrent UTI	Review treatment at 12 months once patient established on treatment, or earlier if agreed with the woman	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-recurrent-antimicrobial-prescribing-pdf-66141595059397	https://www.nice.org.uk/guidance/ng112/resources/urinary-tract-infection-recurrent-antimicrobial-prescribing-pdf-66141595059397
7.	Alpha blockers (e.g alfuzosin, tamsulosin)	Lower urinary tract symptoms in men	Review at 4 to 6 weeks and then every 6 to 12 months. Be aware that these drugs are frequently associated with postural hypotension and falls in older men	https://www.nice.org.uk/guidance/cg97/resources/lower-urinary-tract-symptoms-in-men-management-pdf-975754394053	https://patient.info/heart-health/alpha-blockers

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7.	Anticholinergics (e.g mirabegron; tolterodine)	Lower urinary tract symptoms in men	Review every 4 to 6 weeks until symptoms are stable, and then every 6 to 12 months. Further advice is available in the additional information section	https://www.nice.org.uk/guidance/cg97/resources/lower-urinary-tract-symptoms-in-men-management-pdf-975754394053	https://www.nhs.uk/conditions/urinary-incontinence/treatment/
7.	Anticholinergics (e.g mirabegron; tolterodine)	Urinary incontinence in women	Patients to be assessed after 4 weeks, or before if adverse effects are not tolerated. Women on long-term treatment should be reviewed in primary care every 12 months, or every 6 months if they are aged over 75 and on polypharmacy. Further advice is available in the additional information section	https://www.nice.org.uk/guidance/ng123/resources/urinary-incontinence-and-pelvic-organ-prolapse-in-women-management-pdf-66141657205189 Wakefield CCG have this wording for over-active bladder (OAB) drugs: Patients taking drugs for an overactive bladder should be encouraged to have a treatment break every 6 months which should last for 4 weeks. This is because many patients will experience symptom improvement continues whilst off treatment. During this break, patients should be encouraged to fill in a bladder diary to assist them in assessing their symptoms	https://www.nhs.uk/conditions/urinary-incontinence/treatment/ Bladder training: https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Bladder%20training.pdf

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7.	Duloxetine	Stress incontinence in women	Patients to be assessed after 2 to 4 weeks to see if the medicine is beneficial or causing any side effects. Only continue medication if clear benefits	https://cks.nice.org.uk/topics/incontinence-urinary-in-women/prescribing-information/duloxetine/	https://www.nhs.uk/conditions/urinary-incontinence/treatment/
8.	Endocrine therapy (tamoxifen)	Pre-menopausal women with early and locally advanced ER-positive invasive breast cancer	Specialist to offer tamoxifen for 2 to 5 years. Specialist to consider extending the course following a discussion with the patient of the risks and benefits. If woman has become post-menopausal, consider switching to an aromatase inhibitor	https://www.nice.org.uk/guidance/ng101/resources/early-and-locally-advanced-breast-cancer-diagnosis-and-management-pdf-66141532913605	https://patient.info/cancer/breast-cancer-leaflet#nav-6
8.	Endocrine therapy (tamoxifen)	Men with early and locally advanced ER-positive invasive breast cancer	Specialist to offer tamoxifen for 5 years	https://www.nice.org.uk/guidance/ng101/resources/early-and-locally-advanced-breast-cancer-diagnosis-and-management-pdf-66141532913605	https://www.cancerresearchuk.org/about-cancer/cancer-in-general/treatment/cancer-drugs/drugs/tamoxifen
8.	Endocrine therapy (e.g anastrozole, letrozole)	Post-menopausal women with early and locally advanced ER-positive invasive breast cancer	Specialist to offer an aromatase inhibitor. If not tolerated or contraindicated offer tamoxifen. Offer extended therapy (total duration of endocrine therapy of more than 5 years) with an aromatase inhibitor for women	https://www.nice.org.uk/guidance/ng101/resources/early-and-locally-advanced-breast-cancer-diagnosis-and-management-pdf-66141532913605	https://patient.info/cancer/breast-cancer-leaflet#nav-6

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		who are at medium or high risk of disease recurrence	who have been taking tamoxifen for 2 to 5 years, or longer if warranted after a discussion of the risks and benefits		
8.	Endocrine therapy (e.g tamoxifen, anastrozole, letrozole)	Post-menopausal women with ER-positive invasive breast cancer who are at low risk of disease recurrence	Specialist to offer tamoxifen for 2 to 5 years, or longer if the benefit outweighs the risks. Consider extended therapy (total duration of endocrine therapy of more than 5 years) with an aromatase inhibitor for women who have been taking tamoxifen for 2 to 5 year following a discussion with the patient of the risks and benefits	https://www.nice.org.uk/guidance/ng101/resources/early-and-locally-advanced-breast-cancer-diagnosis-and-management-pdf-66141532913605	
8.	Chemoprotection (e.g tamoxifen, anastrozole, raloxifene)	Women at moderate risk of breast cancer	Specialist to consider tamoxifen for 5 years for pre-menopausal women. Specialist to consider anastrozole for 5 years for post-menopausal women. Alternatives are 5 years of tamoxifen or raloxifene	https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493	https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
8.	Chemoprotection (e.g tamoxifen, anastrozole, raloxifene)	Women at high risk of breast cancer	Specialist to offer tamoxifen for 5 years for pre-menopausal women. Offer anastrozole for 5 years for post-menopausal women. Alternatives are 5 years of tamoxifen or raloxifene	https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493	https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493
9.	Calcium and vitamin D	Deficiency or adjuvant to osteoporosis treatment	Compliance and persistence are poor. Check for concordance and take mitigating action	https://cks.nice.org.uk/topics/vitamin-d-deficiency-in-adults/management/management/	https://patient.info/medicine/calcium-and-ergocalciferol-tablets
10.	Quinine sulphate or quinine bisulphate	Nocturnal leg cramps	Due to safety concerns, avoid quinine if possible. If quinine is necessary, stop treatment as soon as possible. Monitor patients closely during the early stages of treatment for adverse effects. After an initial trial of 4 weeks, treatment should be stopped if there is no benefit. Treatment should be interrupted approximately every 3 months to reassess the benefit. In patients taking quinine long	https://www.gov.uk/drug-safety-update/quinine-not-to-be-used-routinely-for-nocturnal-leg-cramps	https://patient.info/medicine/quinine-for-leg-cramps

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
			term, a trial discontinuation may be considered		
13.	Topical corticosteroids (e.g hydrocortisone, betamethasone valerate)	Atopic eczema	Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed. Ensure patients know how to use it safely and effectively, including the amount to use (underuse can prolong treatment duration). Be vigilant for the signs and symptoms of topical steroid withdrawal reactions Constant use of topical corticosteroids is not recommended due to local and systemic side effects. Advise patient to apply topical corticosteroids once	https://www.gov.uk/drug-safety-update/topical-corticosteroids-information-on-the-risk-of-topical-steroid-withdrawal-reactions https://www.sign.ac.uk/media/1063/sign125.pdf	https://www.gov.uk/guidance/topical-corticosteroids-and-withdrawal-reactions https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6995

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
			daily. If there is an inadequate response to once daily application, the frequency should be increased to twice daily		
13.	Potent topical corticosteroids (e.g beclometasone diproprionate, betamethasone valerate)	Psoriasis	Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed. Ensure patients know how to use it safely and effectively, including the amount to use (underuse can prolong treatment duration). Be vigilant for the signs and symptoms of topical steroid withdrawal reactions. Continuous long-term use of potent or very potent topical corticosteroids may cause	https://www.gov.uk/drug-safety-update/topical-corticosteroids-information-on-the-risk-of-topical-steroid-withdrawal-reactions https://cks.nice.org.uk/topics/corticosteroids-topical-skin-nose-eyes/management/topical-treatment/ https://bnf.nice.org.uk/treatment-summary/psoriasis.html	https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6995 Pulsing corticosteroid treatment https://www.papaa.org/learn-about-psoriasis-and-psoriatic-arthritis/just-diagnosed/what-is-psoriasis/treatments-for-psoriasis/steroids/

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
			psoriasis to become unstable, and lead to irreversible skin atrophy and striae. Widespread use can also lead to systemic and local side-effects. Patients who have been on intermittent or short courses of potent or very potent topical corticosteroids should be offered a review of treatment at least annually. Consecutive use of potent topical corticosteroids should not be used for more than 8 weeks at any one site. Application may be restarted after a 4-week treatment break		
13.	Very potent topical corticosteroids (e.g clobetasol propionate, diflucortolone valerate)	Psoriasis	Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the	https://www.gov.uk/drug-safety-update/topical-corticosteroids-information-on-the-risk-of-topical-steroid-withdrawal-reactions https://cks.nice.org.uk/topics/corticosteroids-topical-skin-nose-	https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6995 Pulsing corticosteroid treatment https://www.papaa.org/learn-about-psoriasis-and-psoriatic-arthritis/just-diagnosed/what-is-psoriasis/treatments-for-psoriasis/steroids/

BNF chapter	Medicine/treatment	Indication	Advice	Link to guidance	Patient information
			topical corticosteroid of lowest potency needed. Ensure patients know how to use it safely and effectively, including the amount to use (underuse can prolong treatment duration). Be vigilant for the signs and symptoms of topical steroid withdrawal reactions. Continuous long-term use of potent or very potent topical corticosteroids may cause psoriasis to become unstable, and lead to irreversible skin atrophy and striae. Widespread use can also lead to systemic and local side-effects. Patients who have been on intermittent or short courses of potent or very potent topical corticosteroids should be offered a review of treatment at least annually.	eyes/management/topical-treatment/ https://bnf.nice.org.uk/treatment-summary/psoriasis.html	

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			Consecutive use of very potent topical corticosteroids should not be used for more than 4 weeks. Application may be restarted after a 4-week treatment break		
13.	Tacrolimus ointment	Atopic dermatitis/ eczema	Maintenance treatment: ointment is applied on 2 days per week to allow 2 to 3 days without tacrolimus treatment. After 12 months treatment, a review of the patient`s condition should be conducted by the physician and a decision taken whether to continue maintenance treatment in the absence of safety data for maintenance treatment beyond 12 months	https://www.medicines.org.uk/emc/	https://patient.info/medicine/tacrolimus-ointment-protopic

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