Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Prescribing Framework for Injectable Gold (Sodium Aurothiomalate) in Rheumatic Diseases

Patient's Name:…… Unit Number: ……

Patient's Address:……(Use addressograph sticker)

GP's Name:……..

Communication

We agree to treat this patient within this Prescribing Framework. Consultant's Signature:…….. GP's Signature:…….

If the General Practitioner is unable to accept prescribing responsibility for the above patient the consultant should be informed within one week of receipt of this framework and consultant's / nurse specialist's letter. In such cases the GP are requested to update the consultant, by letter, of any relevant changes in the patient's medication / medical condition.

APPROVAL PROCESS

Written by:	**Dr Tim Gillott, Consultant Rheumatologist**
Monitoring Guidance:	**Yorkshire Monitoring Guidelines 2014**
Approved by:	**Northern Lincolnshire and Goole Medicines and Therapeutic Committee**
Ratified by:	**Northern Lincolnshire Area Prescribing Committee**
Review date:	**May 2021**

Background

DMARDs are fundamental to arresting the disease process in Rheumatoid Arthritis and other inflammatory arthritides. While early initiation of therapy is essential to arrest the disease process, sustained use is vital if disease suppression is to be maintained. Prolonged therapy requires long-term monitoring for toxicity and safety profile

Intra muscular gold is a DMARD that may be used for rheumatoid arthritis (NICE Clinical Guideline 79, www.nice.org.uk/cg79).

These guidelines aim to provide a framework for the prescribing of I.M.Gold by GPs and to set out the associated responsibilities of GPs and hospital specialists who enter into the shared care arrangements.

INJECTABLE GOLD (SODIUM AUROTHIOMALATE)	
Dose:	RA - An initial 10mg intra-muscular test dose should be given in the first week followed by a maintenance dose of 50mg by intra-muscular injection the following week and then weekly. Patients should be monitored for 30 minutes following each dose. FBC and urine should be checked before each injection. Frequency of injections can be reduced according to response to once every 4 - 8 weeks.
Baseline Tests:	• FBC • U&E • LFT • Urinalysis • Baseline chest X-ray Inform patient to report – pruritis, metallic taste in the mouth, sore throat or tongue, buccal ulceration, easy bruising, purpura, epistaxis, bleeding gums, inappropriate menstrual bleeding or diarrhoea.
Routine Monitoring:	• FBC, U&E, LFT and Urinalysis at the time of each injection (Provided blood results are stable. The results of the FBC need not be available before the injection is given but must be available before the next injection (i.e. it is permissible to work one FBC in arrears). Blood test frequency may be reduced to 3 monthly in long term stable users. Patients could be guided to have a blood test (e.g. for CRP) just prior to their secondary care appointment. • Urinalysis must be done before each injection.
Indications for Stopping Therapy:	**Note:** Anaphylactic reaction may occur at any stage of treatment and usually occurs within the first 10 minutes of administering the injection. If the patient develops sore throat, glossitis, buccal ulceration, easy bruising, a rash or bleeding perform an immediate blood test. If any of the following occur, **stop treatment** and contact the hospital specialist: WCC <3.5 $10^{9/}$L or below local normal range Neutrophils < 2.0 $10^{9/}$L or below local normal range Platelets <150 $10^{9/}$L or below local normal range Proteinuria/Blood >1+ (Where protein is detected do MSU and if negative perform a urine PCI / PCR (or 24 hour urine collection for protein and creatinine clearance). If blood tests are normal despite the above symptoms, stop treatment for 1-2 weeks (until symptoms

	disappear) and consider re-challenge with test dose (consult hospital specialist).
Assessment of Response:	If after reaching a total dose of 1g (excluding test dose), no major improvement has occurred the Specialist will usually discontinue therapy.
Additional information:	Contra-indicated - Gross renal or hepatic disease, history of blood dyscrasias, exfoliative dermatitis and systemic lupus erythematosus (SLE). Important drug reactions: • Penicillamine (increased risk of rashes and bone marrow depression) • Aspirin (increased risk of aspirin-induced hepatic dysfunction) • ACE inhibitors (increased risk of severe anaphylactoid reactions) • Phenylbutazone or oxyphenbutazone (use with caution)
Pregnancy & Breastfeeding:	Avoid in pregnancy and breastfeeding as safety has not been established.
Please refer to licensed datasheet for more comprehensive prescribing information: http://www.medicines.org.uk/EMC/medicine/18613/SPC/Myocrisin+100mg+ml+Solution+for+Injection/	

Responsibilities of clinicians involved

Stage of Treatment	Hospital Specialist	General Practitioner
Initiation	Assess the patient following referral by GP Recommend appropriate treatment to the GP Carry out baseline full blood count, differential WCC, platelets, U&Es and LFTs Give patient a DMARD alert card which records the name of the medicines started and dose. Administer test dose and prescribe first month of treatment	
Maintenance	Assess clinical response to treatment Provide adequate advice and support for the GP. Provide information to GP on frequency of monitoring if doses are changed Update DMARD alert card where relevant	Prescribe on FP10 Monitor for adverse effects, refer to consultant where necessary. Blood & Urine tests for monitoring as above Patients should be asked about the presence of rash or oral ulceration at each visit.

Contact Details:

Rheumatology Specialist Nurses: 03033 304849