

From the Deputy Chief Medical Officer
Dr Paddy Woods

Chief Pharmaceutical Officer
Dr Mark Timoney



Patient Safety Alert

Subject:

Risk of patient harm from an interaction between miconazole and coumarin anticoagulants

Chief Executives, HSC Trusts for cascade to:

Medical Directors

Directors of Acute Hospital Services

Directors of Nursing

Chief Executive, NIMDTA

Chief Executive, RQIA

Chief Executive, HSCB

For Information to:

Chief Executive, NIAS

Chief Executive, Public Health Agency

Director of Public Health/Medical Director, PHA

Director of Nursing, PHA

Dir of Performance Management & Service Improvement, HSCB

Safety & Quality Alerts Team, HSC Board

Prof. Sam Porter, Head of Nursing & Midwifery, QUB

Prof. Pascal McKeown, Head of Medical School, QUB

Prof. Donald Burden, Head of School of Dentistry, QUB

Professor Carmel Hughes, Head of School of Pharmacy QUB

Dr Owen Barr, Head of School of Nursing, UU

Prof. Paul McCarron, Head of Pharmacy School, UU

Post Graduate Dean, NIMDTA

Post Graduate Dental Dean, NIMDTA

Staff Tutor of Nursing, Open University

Director, Safety Forum

Lead, NI Medicines Governance Team

NI Medicines Information Service

NI Centre for Pharmacy Learning and Development

Clinical Education Centre

NI Royal College of Nursing

Circular Reference: HSC (SQSD) 38/16

Date of Issue: 17 June 2016

Related documents

Patient Safety Notice PSN 032 May 2016 available at:

<http://www.patientsafety.wales.nhs.uk/news/41541>

Summary of Contents:

The purpose of this circular is to highlight the risk of patient harm from an interaction between miconazole and coumarin anticoagulants

Superseded documents

N/A

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Chief Pharmaceutical Officer

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Implementation

Immediate

Dear Colleagues.

Risk of patient harm from an interaction between miconazole and coumarin anticoagulants

Coroner's Report

A Regulation 28 Report was issued by HM Coroner to Welsh Government on 7 March 2016 regarding the death of a patient from intracerebral haemorrhage (stroke). In this particular incident, the patient was regularly prescribed warfarin for treatment of atrial fibrillation and was concomitantly prescribed miconazole oral gel for the treatment of oral thrush by a dentist. On admission to hospital the patient was found to have a significantly raised International Normalised Ratio (INR) and subsequently died from an intracerebral haemorrhage. The coroner considered that the combined use of warfarin and miconazole may have been a contributory factor in the death of this patient.

The coroner is concerned that:

- There appears to be a lack of knowledge of the interaction of warfarin and miconazole amongst health professionals; and/or
- It is not clear which sources of information health professionals should use to check possible interactions.

A Patient Safety Notice (PSN) has been issued by the Welsh Government to ensure that health professionals who prescribe and supply medicines in Wales are aware of the potential for interactions to occur between miconazole, including topical preparations, and coumarin anticoagulants (warfarin, acenocoumarol, phenindione); and to highlight readily accessible sources of information regarding drug-drug interactions. A copy of the PSN is available from:

<http://www.patientsafety.wales.nhs.uk/news/41541>

Yours sincerely



Dr Paddy Woods
Deputy Chief Medical Officer



Dr Mark Timoney
Chief Pharmaceutical Officer

Action Required

Chief Executives of HSC Trusts should:

- Circulate this notice to all medical, dental, nursing, pharmacy and non-medical prescribing staff.
- Identify if the co-prescribing of miconazole containing products and coumarin anticoagulants has or could occur in your organisation.
- Consider if immediate action needs to be taken locally and ensure that an action plan is put in place, if required, to minimise the risks of these incidents occurring.
- Before prescribing any miconazole containing products, ensure that prescribers check the patient's medical and drug history (using electronic records and/or questioning the patient/relatives), in particular the current use of coumarin anticoagulants.
- Before dispensing miconazole containing products, pharmacy staff must check the patient's medical and drug history (using electronic records and/or questioning the patient/relatives), in particular the current use of coumarin anticoagulants.
- Ensure that healthcare professionals prescribing, supplying and administering miconazole containing products must check for drug interactions using an appropriate resource (e.g. British National Formulary, electronic Medicines Compendium) and take appropriate action to ensure patient safety.

Chief Executive, RQIA should:

- Disseminate this alert to all relevant independent sector providers.

Chief Executive, HSCB should:

- Disseminate this alert to community pharmacies, General Medical Practitioners, General Dental Practitioners and community nurses.
- Share any learning from local investigations or locally developed good practice resources via the medicines governance network.

Chief Executive, NIMDTA should:

- Disseminate this alert to doctors and dentists in training in all relevant specialities.