**Methotrexate (oral)** for control of active joint inflammation

**AREAS OF RESPONSIBILITY FOR THE SHARING OF CARE**

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of Methotrexate (oral) can be shared between the specialist and general practitioner or non-medical prescriber in primary care (GP). GPs are invited to participate. If the GP is not confident to undertake these roles, then he or she is under no obligation to do so. In that case, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. **If a specialist asks the GP to prescribe drugs for this treatment, the GP should reply to this request as soon as practicable.**

Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient by the doctor initiating treatment. It is important that patients are consulted about treatment and are in agreement with it. Patients with Rheumatological inflammatory diseases are under regular specialist follow-up. This provides an opportunity to discuss and to monitor drug therapy.

The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

**RESPONSIBILITIES and ROLES**

<table>
<thead>
<tr>
<th>Specialist responsibilities</th>
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<tbody>
<tr>
<td>• Ensure FBC, liver and renal function are within normal parameters to allow Methotrexate to commence.</td>
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<tr>
<td>• Ensure baseline chest examination and Chest X-ray are acceptable to allow safe use of Methotrexate.</td>
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<td>• If abnormalities found at baseline inform GP as soon as possible.</td>
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<td>• Initiate treatment with Methotrexate (oral) or advise GP on initiating treatment.</td>
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<td>• Discuss the benefits and side effects of treatment with the patient and inform GP this has occurred.</td>
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<td>• Ask the GP whether he or she is willing to participate in shared care, and agree with the GP as to who will discuss the shared care arrangement with the patient.</td>
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<td>• Review the patient's condition and monitor response to treatment regularly where indicated.</td>
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<td>• Advise GP if monitoring is needed, and the frequency.</td>
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<tr>
<td>• Monitor any other parameters considered necessary, or advise GP on which to monitor.</td>
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<td>• Communicate promptly with the GP when treatment is changed or needs to be changed by the GP, any results of the monitoring undertaken, and assessment of adverse events.</td>
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<td>• Have a mechanism in place to receive rapid referral of a patient from the GP in the event of deteriorating clinical condition.</td>
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<td>• Advise GPs on when to stop treatment (if appropriate).</td>
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<tr>
<td>• Report adverse events to the MHRA via Yellow Card Scheme.</td>
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<td>• Ensure that clear backup arrangements exist for GPs to obtain advice and support.</td>
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General Practitioner responsibilities

- Reply to the request for shared care as soon as practicable.
- Prescribe Methotrexate (oral) at the dose recommended.
- Adjust the dose as advised by the specialist.
- Monitor any parameters considered necessary, if agreed with the specialist to do so.
- Report to and seek advice from the specialist on any aspect of patient care that is of concern and may affect treatment.
- Refer patient to specialist if his or her condition deteriorates.
- Stop treatment on the advice of the specialist or immediately if an urgent need to stop treatment arises.
- Report adverse events to the specialist and to the MHRA via the Yellow Card Scheme.

Patient’s role

1. Report to the specialist or GP if he or she does not have a clear understanding of the treatment.
3. Report any adverse effects to the specialist or GP.

BACK-UP ADVICE AND SUPPORT

<table>
<thead>
<tr>
<th>Contact details</th>
<th>Telephone No.</th>
<th>Email address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist:</td>
<td>01592 648193</td>
<td><a href="mailto:janegibson@nhs.net">janegibson@nhs.net</a></td>
</tr>
<tr>
<td>Rheumatology Dept</td>
<td>01592 265967(fax)</td>
<td><a href="mailto:helenharris@nhs.net">helenharris@nhs.net</a></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td><a href="mailto:johnmclaren@nhs.net">johnmclaren@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:sharoncullinane@nhs.net">sharoncullinane@nhs.net</a></td>
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</table>

ADTC website - FRDU adverse drug reaction document

SUPPORTING INFORMATION (taken from the SPC)

Licensed indications:

Indications – active joint inflammation, usually supported by indices of inflammation.

Dosage and Administration

Most patients commenced on 15mg orally once weekly. Usually titrated in 2.5mg – 5mg increments to 25mg once weekly (occasionally higher doses are used at the discretion of the Rheumatologist).

In renal impairment lower doses <15mg once weekly are commenced.

Please ensure that only 2.5mg tablets are prescribed.

Folic acid 5mg (orally) to be taken the day after methotrexate or every day except on the day methotrexate is taken. The dose is decided on an individual patient basis by the Rheumatologist.

May be switched to s/c administration for greater efficacy, or to minimize some side-effects.

Contraindications and precautions for use

- Cautioned in renal failure and in the elderly.
- Contra-indicated in suspected/actual local or systemic infection (temporary suspension until infection settled) and bone marrow failure.
- Contra-indicated in pregnancy and during breastfeeding.
- Effective contraception should be used by males or females during treatment and for at least 3 months after treatment discontinued.
The use of live vaccines with Methotrexate is contra-indicated.

**Side Effects (also state any specific side-effects which require the consultant to be notified)**
The incidence and severity of side effects are considered to be dose related.

- Nausea, diarrhoea, mouth ulcers, rash, haematological abnormalities (leucopenia) and raised LFTs (>2-3 times upper limit of normal ALT).
- Uraemia (though usually only at higher doses), headaches, drowsiness, blurred vision, oral ulceration, hair loss.

**Pneumonitis** is a rare, but potentially fatal side effect of methotrexate use. This may present initially as a dry, non-productive cough and/or dyspnoea. If pneumonitis is suspected, methotrexate should be discontinued and the Rheumatologist contacted urgently. Patient may require admission.

For a complete list of side effects see BNF/ Summary of product Characteristics.

**Treatment should be withheld and the Rheumatology Department contacted if:**

- Neutrophils < 1.5 x 10^9 or Platelets < 100 x 10^9
- New / increasing dyspnoea or cough
- unexplained fall in serum ALBUMIN
- MCV > 105 fl
- deterioration in renal function (reduce dose)
- rash or oral ulceration
- >2 fold increase in ALT (from upper limit of reference range)
- abnormal bruising/sore throat (urgent FBC)

**Monitoring (State specific monitoring to be undertaken by the GP / Consultant) see FRDU**

**Rheumatologist responsibilities:**
FBC, liver and renal function are within normal parameters to allow Methotrexate to commence. Baseline chest examination and Chest X-ray are acceptable to allow safe use of Methotrexate.

**General Practitioner responsibilities:**
- While taking Methotrexate patients will require FORTNIGHTLY FBC & Liver function for the first six weeks and monthly thereafter (If monitoring is normal), in the first year.
- If monitoring and methotrexate dose remains stable in the second year, FBC & Liver function can be reduced to 3 monthly.
- RENAL FUNCTION should be checked 6 - 12 monthly if no abnormality detected.
- Consider pneumonitis in any patient on methotrexate who develops new or worsening dyspnoea.

**Drug Interactions**
- Co-trimoxazole and trimethoprim should not be co-administered with methotrexate (rare reports of acute megoblastic pancytopenia).
- Folic acid or its derivatives may alter the response to methotrexate (folic acid must not be administered on the same day as methotrexate).
- New prescription of NSAIDs and aspirin can reduce the excretion of methotrexate, increasing the risk of toxicity. NSAIDs are commonly used in conjunction with methotrexate in inflammatory diseases, therefore, monitoring is essential.
- Avoid co-administration of clozapine
- Increased risk of toxicity with Ciclosporin and Leflunomide.
- Avoid concomitant use of live vaccines.

For a complete list of drug interactions please see the BNF / Summary of Product Characteristics.

**Cost (July 2012)**
28 x 2.5mg tablets = £2.31.