This guideline is currently under review. In the interim, the guideline remains valid; if GPs have any specific concerns or questions, they should seek advice from the specialist with whom they have agreed to share care.

North and East Devon Healthcare Community Shared Care Guidelines

Azathioprine and Mercaptopurine for Inflammatory Bowel Disease

Key changes to updated guideline (ratified 2011)

1. Background to revisions

This guideline has been updated as part of the new process for shared care guidelines. The sections on specialist, GP and patient responsibilities and monitoring requirements are broadly consistent with the updated shared care guideline for azathioprine for rheumatological conditions with the exception that the first prescription for azathioprine or mercaptopurine is issued by the gastroenterology team.

2. Specialist responsibilities

New statements:

- Ascertain patient's immune status by enquiring about history of chickenpox.
- Copy baseline test results to GP.

3. GP responsibilities

Statement added to alert GP to interaction between azathioprine and allopurinol and mercaptopurine and allopurinol.

4. Monitoring

4.1 Baseline monitoring

Conducted by gastroenterology team

- Baseline tests added: creatinine and U&Es,vitamin B12, folate and TSH.

4.2 Monitoring during treatment

Conducted by primary care

- Statement added advising GP that frequency of monitoring is dependent on condition being treated and patient characteristics.

4.2.1 New tests

U&Es and creatinine added to monitoring at same frequency as FBCs and LFTs.

4.2.2 Change to frequency of monitoring

- FBC and LFTs were measured fortnightly for first three months then monthly. This has changed to every week for six weeks and then every two weeks until dose stable for six weeks, then monthly.
- New advice on frequency of monitoring after dose increases.

4.2.3 Action to be taken by GP including changes to criteria for stopping treatment and referral to specialist

- Neutrophil count added to FBC tests to check.
- New advice for FBC tests in response to GP questions. If concerned, about sequential drops in FBC indices (possibly still within normal range) consider early retest.
- New advice to refer if rise in MCV and no cause identified.
- LFTs: threshold for action changed. Early next test if >2 x ULN, stop treatment and refer if > 3 x ULN.

- Creatinine level added to criteria for stopping treatment and referral.
- Clarification of advice: patients reporting specific signs or symptoms should be seen within 24 hours for FBC and LFTs.
- Following symptoms added to criteria for stopping treatment and referral: abnormal bruising, severe sore throat, severe oral ulceration, rash and unexplained illness including severe nausea, vomiting or diarrhoea.

4.3 Other statements

- New advice on what to do if patient requires surgery
- New advice on action to be taken if patient, who is not immune to chickenpox, comes into contact with chickenpox or shingles

Clinical Effectiveness Team, Public Health, NHS Devon
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