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

Weekly oral and subcutaneous methotrexate for treatment of inflammatory bowel disease

Key changes to updated guideline (ratified 2011)

1. Background to revisions

This guideline has been revised as part of the process for shared care guidelines. The sections on specialist, GP and patient responsibilities and monitoring requirements are consistent with the updated shared care guideline for methotrexate for rheumatological and autoimmune diseases.

2. Specialist responsibilities

New statements:

- Exclude pregnancy in female patients of child-bearing age before initiating treatment.
- Ascertain patient's immune status by enquiring about history of chickenpox.
- Inform patient that they are responsible for recording results of monitoring in booklet. Discuss options with patient or carer for those who are not able to record results in booklet.

Clarification of responsibilities for monitoring:

- Conduct baseline tests – copy test results to GP. Review results of monitoring for sc methotrexate before issuing prescription.

3. GP responsibilities

New statements:

- Reminder to prescribe oral methotrexate in multiples of 2.5mg tablets
- Prescribe folic acid at least once weekly – dose to be taken at least 24 hours after methotrexate (advice from BSR). The dosing schedule has changed – previous advice was for folic acid to be taken on the six days of the week that methotrexate was not received.
- Add sc methotrexate to patient record on GP computer system. SC methotrexate is prescribed by hospital but should be entered on the GP computer system so that the GP is alerted to interactions. (See guideline for information on implementation).
- Statement alerting GP that there are significant interactions with methotrexate.

Change in advice:

- GP is no longer required to enter monitoring results in patient's booklet. This is now the patient's responsibility. GP must agree a system of communicating results of monitoring with patient.

4. Monitoring

4.1 Baseline monitoring

Conducted by gastroenterology team

- Tests added: folate and vitamin B12.

4.2 Monitoring during treatment

Conducted by gastroenterology team and primary care

UNDER REVIEW

4.2.1 Change to frequency of monitoring

Change to frequency of monitoring following dose increase.

4.2.2 Action to be taken by GP including change in 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.
- New advice if deterioration in renal function.
- Clarification of advice: patients reporting specific signs or symptoms should be seen within 24 hours for FBC and LFTs.
- Abnormal bruising, severe sore throat and rash added to list of symptoms requiring treatment to be stopped and referral to specialist.
- Clarification of statement: chest x-ray to exclude pneumonitis for patients with pulmonary symptoms to be arranged by GP.

4.3 Other statements

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

UNDER REVIEW

Clinical Effectiveness Team, Public Health, NHS Devon
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