**Oral methotrexate and risk of medication errors.** The Health Products Regulatory Authority (HPRA) recently issued a reminder to healthcare professionals (HCPs) regarding the risk of medication errors associated with use of oral methotrexate (HPRA Drug Safety Newsletter December 2015 71st Edition). Oral methotrexate is indicated for a number of conditions including rheumatoid arthritis, adult psoriasis and oncological indications; there are different dosing regimens for the various indications. For rheumatology and dermatology indications, oral methotrexate should be administered **once weekly** only. Medication errors resulting in overdose due to daily intake of methotrexate rather than a once weekly dose have been reported in Ireland and elsewhere. Some of these medication errors have resulted in cases of serious adverse reactions including fatal outcomes due to the haematological and pulmonary toxicity of methotrexate. The medication errors have occurred at prescribing or at administration stages (mainly for hospitalised patients) but errors in self-administration (by patients at home, either inadvertently, or by misunderstanding the medication schedule) have also occurred. HCPs are reminded that they should (1) ensure that the patient understands the prescribed therapy, including the dose and frequency, (2) that any treatment changes are highlighted and (3) that patients should be encouraged to read the Package Leaflet provided with methotrexate. In particular, patients and/or carers should be aware of the importance of adhering to once weekly dosing of methotrexate, of the risks associated with an overdose and of the signs and symptoms associated with toxicity. Patients should be advised to contact a HCP if they consider that an error in dosing has occurred. It is suggested that when methotrexate is prescribed for rheumatological and dermatological indications that the day of intake should be specified on the prescription and dispensing label. HCPs are reminded that adverse reactions resulting from a medication error associated with use of methotrexate should be reported to the HPRA. [Editors’ note: further information is available on the HPRA website www.hpra.ie]

**Resource for prescribing opioids for pain.** There has been a marked and progressive rise in the prescribing of opioid drugs, predominantly for the treatment of non-cancer pain in the UK over the past 10 years. The Royal College of Anaesthetists have recently produced an online resource for patients and healthcare professionals to support the prescribing of opioids for pain (http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware). The resource which was developed by UK healthcare professionals and policy makers provides specific information relating to the clinical use of opioids for pain and aims to support prescribers and patients in making an informed decision on whether or not to use opioids. The resource includes a review of the different types of pain experienced by patients (acute, chronic, neuropathic and cancer pain). It highlights the challenges of managing long term pain, identifies the factors which need to be considered when assessing long term pain, outlines the role of medicines in the management of pain and provides a stepped approach to prescribing for pain for the individual patient. There is a review of the place of opioids in acute and chronic pain management, and the management of pain in palliative care. Other issues covered include a checklist for prescribers when initiating opioid treatment, factors to consider when switching opioids and considerations when prescribing for patients with a history of substance misuse. There is also a section targeted specifically to patients which may be useful. [Editors’ note: The National Clinical Effectiveness Committee also recently produced a National Clinical Guideline on the pharmacological management of cancer pain in adults which readers might find useful. It is available on http://health.gov.ie/wp-content/uploads/2015/11/Pharma-Mgmt-Cancer-Pain_web.pdf]
Hormonal contraceptive use in Ireland: trends and co-prescribing practices. Oral contraceptives (OCP) have been available for use for over 50 years. In 1995, a warning about a potential 2-fold increased risk of venous thromboembolism (VTE) with use of the third-generation versus second-generation combined oral contraceptives (COCs) resulted in altered prescribing practices of OCPs throughout Europe, including Ireland. Following this warning third-generation COC prescriptions fell from 50 to 30% while second-generation COCs rose from 31 to 43% (from 1995 to 1996). In 2012, another safety review of third and fourth generation COCs took place at EU level, but little is known about current usage of COCs in Ireland. A recent Irish study evaluated trends in OCP usage from 2008-13, according to age and co-prescribed potentially interacting medicines. It also identified the level of contraceptive use in patients co-prescribed anti-epileptic drugs (AEDs) in 2013 (BJCP 2015; 80: 1315-1323). The HSE-PCRS pharmacy claims database was used to identify women 16-44 years of age, who were prescribed any OCP, contraceptive patch, implant formulation or intra-uterine device (IUD). OCPs were further divided according to oestrogen content (>50ug; <50 ug). Results showed that on average, 17% of GMS eligible women aged 16-44 years were prescribed any contraceptive; this figure remained fairly constant during the study period. OCPs represented 74% of total contraceptive usage: COCs were most frequently prescribed, followed by progestin-only pills (POP), patches, IUDs and implants. Fourth generation (drospirenone-containing), followed by second generation COCs were most popular for those <35 years, while POPs were most often prescribed for those >35 years. A significant reduction in third generation COCs was noted during the study period and across all age groups, while the number of second generation COC prescriptions rose. Low uptake of long-acting reversible contraceptive (LARC) methods was seen among all age groups and over time. Overall, low co-prescribing rates with interacting medicines (2.4% in 2013) were observed. Of patients who were prescribed an AED, 31% were co-prescribed any contraceptive (22% = enzyme inducing AED monotherapy; 34% = non-enzyme inducing AED monotherapy; 19.2% = both AED types). It was found that 94% of the contraceptive methods used with enzyme-inducing AEDs contained <50ug oestrogen, which the authors state may be suggestive of ineffective contraception. However this figure must be viewed with caution as it included patients who may have been on a COC containing <50 ug during the year who were subsequently switched to an alternative more effective method such as the levonorgestrel IUS. Of note, the levonorgestrel IUS (LNG-IUS) was used in 17% of patients on an enzyme-inducing AED compared to 6% of the general population. The LNG-IUD is one of the recommended forms of contraception for this group. The authors state that the results highlight the need to address the barriers to the low uptake of LARC (which is consistent with other countries) and the need to optimise co-prescribing practices involving hormonal contraceptives and AEDs. [Editors’ note: readers are reminded that current recommendations advise that women on enzyme-inducing AEDs should be on reliable contraception not affected by enzyme-inducing drugs. The Faculty of Sexual Health and Reproductive Healthcare has a useful guidance document on drug interactions with contraceptives that is available to download from www.fsrh.org]

Guidance on diagnosis and management of the menopause
The UK National Institute for Health and Care Excellence (NICE) has produced a guideline on the diagnosis and management of the menopause (http://www.nice.org.uk/guidance/ng23). The guideline includes information on the management of women in the peri-menopause and post-menopause, the needs of women with premature ovarian insufficiency and women with hormone-sensitive cancer (e.g. breast cancer). It concentrates on the clinical management of menopause-related symptoms and reviews the pharmacological and non-pharmacological management of the menopause. It also reviews the benefits and adverse effects associated with hormone replacement therapy (HRT).