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**Proposal to make Aquiette 2.5mg tablets (oxybutynin hydrochloride) available from pharmacies**

**Royal Pharmaceutical Society response**

Pharmacy teams play a vital role in ensuring individuals have appropriate access to medicines. The Pharmacy (P) medicine category is important to ensure that certain medicines are available to patients in a timely manner to help manage and treat the symptoms of common conditions. P medicine supply allows a consultation to take place between the patient and pharmacist, or trained member of staff to discuss and decide on the most appropriate course of treatment for the patient. However, RPS believe that any medicines supplied should be:

1. Safe
2. Person-centred
3. Timely
4. Equitable
5. Efficient
6. Effective

Considering this, we do not believe that oxybutynin is suitable to undergo the switch from POM to P medicine and be available from pharmacies.

**Exclusion/inclusion criteria**

We note there are several exclusion criteria, however, some of these criteria also cover a large selection of patient's whose potential diagnosis could account for the very symptoms they are looking to treat. This could mean there is the potential that these symptoms are masked, and diagnosis of a more serious condition delayed, leading to the worsening of an undiagnosed condition. For example, urinary retention, this is a common side effect of oxybutynin, but the patient may wait the stipulated 6 weeks until the next consult is due or more if using online procurement. This delay has the potential to cause harm.

We are also concerned about the possibility of red flags for potentially serious conditions being missed if suitability is determined using algorithms. Alongside this is the fear of ‘ordering online’ and ‘internet prescribing’ mechanisms being used for the inappropriate self-treatment of conditions such as this.

The safe supply of Aquiette, and the reduction of risk of harm from its use, relies on the patient being aware of and reporting the presence of symptoms other than those associated with an overactive bladder. There is the possibility that the absence, or lack of awareness, of these symptoms could lead to harm if the patient accesses Aquiette.

Patients would also need to be aware of their current kidney and liver function and any problems associated with either organ. In the absence of access to blood results, pharmacists would need to rely on patients being aware and honest about these issues to ensure they were not put at increased risk and exclude them from supply.

With regards the inclusive age range, the lower limit of 18 would be young for symptoms like these to present for the first time and that in itself could be considered a red flag. The delay in diagnosis for an underlying condition could pose risks.

**Side effects**

It is true that oxybutynin is a well-established product with a known side-effect profile, however, there is mounting evidence implicating the active ingredient with brain health harm, cognitive decline, the progression of dementia and greater mortality in those taking it. (1,2,3,4,5) Evidence has specifically shown a decrease in Mini-Mental State Exam (MMSE) scores in patients who take anticholinergics which suggests a worsening of their dementia which can be attributed to the medication being taken. (5,6) This ever-increasing evidence of unintentional harm from oxybutynin clearly demonstrates that before it can be considered safe to be moved from POM to P, further investigation of these side-effects would be required.

The proposed licensing age range for Aquiette is 18-65. However, being aged below 65 does not guarantee good health, mental or physical, and Alzheimer's Scotland states: ‘There are an estimated 90,000 people with dementia in Scotland. Around 3,000 of these people will be under the age of 65 years.’ (7) This means there will be patients under 65 with, possibly undiagnosed, dementia potentially being exposed to a medication which can worsen their symptoms.

Oxybutynin has also been known to cause acute confusional states in the elderly especially those with pre-existing cognitive impairment. (6)

The extensive side effect profile of oxybutynin means that, without access to patient notes, it could be challenging to determine its suitability in patients who do not fully disclose all current and previous medical diagnosis. This raises the potential for unintended harm from using this medicine.

There is also the risk of inadvertently pushing the anticholinergic burden to dangerous levels in patients. This could happen because of other prescribed or purchased medication which a patient may access with anticholinergic activity which would have a cumulative effect of side effects, increasing the risk of physical harm. Again, while it is true pharmacists are aware of all the interactions with this medication and are well placed to advise, they can only do so when they have all the relevant information, something which cannot be guaranteed, and without which harm could be caused.

**Prescribing guidelines**

In many areas across GB prescribing of oxybutynin has been limited due to the unacceptable side effect profile of the medication and to reduce the risk of increasing the anticholinergic burden in patients. (6,8) Oxybutynin is not first or second line treatment in many places and in some areas, prescribers have been specifically asked to stop prescribing this medicine in elderly care due to the risk of falls and dementia when it is taken. (9) It is listed in some prescribing guidelines as ‘avoid if possible’ and is the focus of deprescribing in many areas. (6,10)

If available as a P medicine, we could see an increasing number of women attend the GP after 12 weeks wishing to continue a medication that prescribers are being asked to stop prescribing. This will mean they either must be switched to another medicine, following a full assessment of their condition, or allowed to continue on a medicine which is not formulary compliant or cost effective. Further down the line, this will then increase workload as these patients will need to be identified, reviewed again, and switched.

NICE guidelines for the treatment of urgency incontinence and the associated prescribing of anticholinergics state that prior to starting treatment the patient must have explained to them the likelihood of treatment success and the risks, side-effects, and long-term effects of anticholinergic drugs. (11,12) This would need to be consistently applied regardless of how the patient was accessing this medication. These are in depth, lengthy, conversations which we have concerns are not suitable or feasible to have in a community pharmacy setting. Pharmacists would also need to be provided with up-to-date data on likelihood of treatment success, which is absent from current literature relating to Aquiette, and supporting materials would need to be provided to help pharmacists provide patients with all the relevant information prior to starting treatment. It would also be necessary to record this conversation and the agreements that come out of it.

**Abuse potential**

We have concerns around the abuse potential of oxybutynin. The SPC side effects lists somnolence (among others) as very common. It also lists "dependence (in patients with history of drug or substance abuse)" with frequency not known. The possible desirable side effects of anticholinergic medication make them targets for abuse and evidence reviews found that this abuse appears to be more prevalent than first thought. (13,14)

**Patient centred**

We also must question the value, compared to the risk, in patients’ self-managing a previously undiagnosed condition, at cost, for a maximum of 12 weeks (if patient follows the advice strictly) for a condition that will likely continue after the treatment period. This intervention, which is not curative, is very unlikely to remove the need to seek advice from another healthcare professional even if the treatment controls the symptoms. It would not be expected that an overactive bladder, a long-term condition, would self-resolve even with this intervention with the BNF suggesting drug treatment may continue for several months and even years. (15) This raises concerns that the supply of this medication as a P medicine will only lead to duplication of effort for already stretched healthcare services and increased risks to patients.

The risk of patients obtaining this from multiple pharmacies must also be considered. As there is no centralised control of patients accessing P medicines, it is feasible that someone could access this medicine from one pharmacy, perhaps feel there is a benefit and return for further supplies. However, they will then be informed they must go to the GP for further supplies. Given the pressures on all services this may not be possible for the patient, and they may then make a decision to access this medication from another pharmacy, thereby delaying any more appropriate treatment or diagnosis.

**BNF/NICE recommendations**

RPS would also like to challenge why the suggested ‘inclusion criteria’ and review of treatment for Aquiette do not fall in line with the current BNF and NICE recommendations for treatment of urinary incontinence. Firstly, the BNF and NICE both recommend that prior to any drug treatment commencing, a urine screen should be taken to test for the presence of infection or blood in the urine to help identify underlying causes. (16,17) A positive test can lead to an urgent referral under certain circumstances, including in patients under 65. This is not required with Aquiette which could delay the diagnosis of more serious conditions by months. This is referenced in the consultation document itself, which acknowledges women with low grade infection or invisible traces of blood in their urine could access Aquiette but will not respond to treatment and diagnosis would be delayed. (18) However, there is no acknowledgement of the potential harm this could cause. Secondly, the requirement for Aquiette to be reviewed after 6 weeks of treatment is not in line with the current BNF and NICE recommendations which suggests a review of treatment after 4 weeks, or sooner if required. (16) We are concerned this may mean that a woman may be taking a medication which is not effective, with the potential for serious side effects, for longer than is necessary before review.

The consultation also acknowledges that ‘It is possible in certain situations that a woman may suffer a worsened outcome as a result of unsupervised use of non-prescription oxybutynin if she continues to use Aquiette in circumstances where alternative treatments might have been more suitable.’ (18) We are concerned about the outcomes a 12-week delay to a more serious diagnosis may result in for patients and feel this shows that we cannot with confidence say that Aquiette is unlikely to be a direct or indirect danger to human health when used without the supervision of a doctor, even if used correctly.

We are always supportive of wider access to medicines; however, this must be balanced against patient safety and the risk of harm. Pharmacy teams do a great deal to manage safety, identify red flags prior to supply and ensure safe and appropriate use of P medicines. However, RPS do not believe that the balance of benefit and harm make this a suitable product for P medicine status.

If there was to be any change to status of this medicine, we would be keen to be involved in any proposals to take this forward to ensure the safety of the public and to allow us to provide support for the profession to deal with this change and the challenges it will bring to the safe and effective care of affected women.

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