Queensland Government

Metro North
Hospital and Health Service

SHARED CARE OF PATIENT on LOW DOSE METHOTREXATE FOR RHEUMATOLOGICAL DISEASE

Dear Doctor

Current pathology testing interval ……...
Private pathology ☐ (First form provided YES/NO)
Public pathology ☐ (Forms provided)

PLACE STICKER HERE

The above patient is on **once weekly methotrexate** (MTX) with folic acid for treatment of their rheumatological disease. A clinic letter containing specific dosing and titration advice will arrive within the next 14 days. If it does not, please contact the rheumatology registrar.

This patient is suitable for **shared care** methotrexate management. You may find the following information helpful with this. Sharing care can:

- Improve rheumatology access
- Enhance patient compliance and satisfaction

ACTIONS REQUIRED

Please do the following for your patient:

☐ **Review vaccination status**

Pneumococcal & yearly flu vaccinations recommended
Live vaccines (eg Zostavax) are not contraindicated with low dose MTX (<0.4mg/kg/wk). Other treatments (eg biological DMARDs) may be contraindicated

☐ **Arrange a skin check**

if not done within previous 6 months and ensure repeated annually

☐ **Discuss the critical importance of ongoing, effective contraception in women of childbearing potential**

☐ **Ensure pathology tests are done** and action results appropriately

see Box A: Blood Testing *below*

☐ **Arrange a clinical review** as appropriate

see Box B: Side Effects *and* Box C folic acid *below*

☐ **Contact the rheumatology team if you have any concerns**

For further information visit the ARA website: https://rheumatology.org.au/

Please feel free to contact the rheumatology registrar via the switchboard of the hospital where your patient is being treated if you have any concerns.

A: Blood Testing (pathology preferences at top of document)

- Regular **FBC, U/E/LFT, ESR/CRP** is required with **results to GP and rheumatologist**
- If your patient has elected to use Queensland Health pathology, they have been provided with a form
- If your patient has chosen to use a private pathology provider, they have been asked to see you for a Rule 3 Exemption form for these tests. The rheumatologist may have given them the form for their first test
- Please review the patient as per the clinical letter to assess symptoms / possible side effects and to action abnormal results. If the protocol outlined below recommends a change in treatment please forward a short note with details to the rheumatology clinic
- The clinic letter may have further details
- When the dose of MTX is stable for 3 months and there are no other relevant changes (eg development of impaired renal function) the above tests should be performed at a minimum of every 3 months
- If co-prescribed leflunomide the interval should be a minimum of 2 months

Managing abnormal tests:

- **Liver function**
  - If ALT/AST levels >2x upper limit of normal (ULN) but <3x ULN, the dose of MTX should be reduced by 50% and tests repeated in 1 month. Once normalized any MTX titration should be monitored with monthly blood tests until the dose has been stable for 3 months
  - If ALT/AST >3x ULN, withhold MTX, continue folic acid and discuss with rheumatology registrar
  - Compliance with folic acid should be confirmed
  - Lower dose MTX may be reinstituted following ALT/AST normalisation
  - Screening for other causes of LFT derangements should be considered if ALT/AST persistently >3x ULN 4 weeks after discontinuation
- **Haematology**
  - If Hb drops 20 g/l below baseline, WBC <2 x 10^9/L, neutrophils <0.5 x 10^9/L or platelets <50 x 10^9/L withhold MTX, continue folic acid and contact rheumatology registrar
  - If less severe abnormailties check compliance with folic acid treatment and consider increasing folic acid as outlined below. Reduce MTX dose by 50% and repeat tests in 2 weeks
  - Myelosuppression can occur at anytime during MTX treatment
  - While more common in the initial months it is unpredictable. Risk factors include age >70, low albumin, folate deficiency and renal impairment

B: Possible side effects

- The most common side effects are mouth ulcers, nausea, vomiting and diarrhoea. The use of folic/folinic acid and taking MTX with food or in the evening may reduce these
- Skin dryness, rashes and increased sensitivity to the sun may also occur
- Fatigue, headache, mental clouding, fever, dizziness, tinnitus, blurred vision, and alopecia are reported
- Serious side effects of myelosuppression, hepatotoxicity and pneumonitis are much less common

C: Folic acid

- Folic acid is required to minimise adverse effects and must be co-prescribed even though removed from the PBS list (unless ATSI/DVA) in May 2016
- At least 5mg once weekly should also be taken preferably not on the day of MTX due to potential competition for the same uptake transporter in the gut
- Folic acid dose can be increased to 5mg/day if needed but not the day of MTX
- Therapeutic Guidelines recommend the total weekly dose of folic acid does not exceed 3 times the total dose of weekly MTX
- Folinic Acid (Calcium Folinate/Leucovorin) may be considered if the patient is unable to tolerate MTX. It is given 7.5-15mg once a week 8-12 hours after MTX

Further Information

MTX is CONTRAINDICATED with trimethoprim (including co-trimoxazole):

- This interaction can be life threatening. Seek expert input before co-prescribing

MTX can be taken with other medications including:

- Other DMARDs including biological DMARDs
- Steroids such as prednisolone
- NSAIDs / low dose aspirin
- Simple pain medicines such as paracetamol
- PPIs

MTX and Alcohol:

- MTX usage in heavy drinkers has been associated with liver cirrhosis
- It is not known precisely what level of drinking is safe when on MTX
- Maximum intake should remain within NHMRC alcohol consumption guidelines
- Drinking >4 std drinks on one occasion, even infrequently, is strongly discouraged

Dose titration will be directed by the rheumatologist

- MTX tablets are available in 2.5mg or 10mg strengths. It is recommended to only prescribe the 10mg tablets.
- Please review the number of repeats you provide to ensure the recommended monitoring is adhered to.
- Be precise with any prescriptions e.g. “20mg once a week on Monday”
- Normal treating dose is 20-30mg/wk (can be lower in elderly / mild renal impairment)
- Dose escalations range from 5mg to 15mg every 1-4 weeks
- Response is assessed after 4-8 weeks at a specific dose
- The dose can be adjusted up to a maximum of 30mg once a week
- MTX is usually taken as a single dose on the same day each week. The dose may be divided over 24h to improve tolerance without increasing serious adverse effects
- Parenteral (SC) dosing may be considered if the patient is unable to tolerate a sufficient oral dose or has incomplete disease control. More information and a demonstration video at the ARA website**:** https://rheumatology.org.au/
- In case of accidental pregnancy: stop MTX, start folic acid 5mg daily and contact the treating rheumatologist
- The half life of MTX is 6-8 hours after ingestion; it is undetectable in serum by 24 hours; patients on low rheumatological doses given weekly are NOT “HOT” and pose no risk to others. It is not lipophilic and not absorbed through the skin; tablets and injections can be handled safely by staff and carers (https://rheumatology.org.au/downloads/ARAMethotrexateAdvice221215_000.pdf)