Shared Care Fact Sheet- Low Dose Methotrexate

Rheumatology Sub-Stream

Many rheumatology patients are suitable for rheumatologist/GP **shared care** methotrexate (MTX) management. MNHHS rheumatologists are now advocating this where appropriate (including for this patient if this document is accompanying a clinic letter). Sharing care can improve specialist access and enhance patient compliance and satisfaction.

Please do the following for your patient:

- ☐ **Review vaccination status** - Pneumococcal & yearly flu vaccinations recommended. Live vaccines (e.g. Zostavax) are not contraindicated with low dose MTX (<0.4mg/kg/wk.). Please be aware current best practice confirms biological and targeted synthetic DMARDs are a contraindication to live vaccines
- ☐ **Arrange a skin check** if not done within previous 6m 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 Tab A: below
- ☐ **Arrange a clinical review** as appropriate – see Tab B: *and* Tab C: *below*
- ☐ **Please contact the rheumatology team if you have any concerns**

A: Blood testing

- Regular **FBC, U/E/LFT, ESR/CRP** are required with **results to GP and rheumatologist**
- 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 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 (e.g. 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 every 2 months**

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 the tests. The rheumatologist may have given them the form for their first test

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 abnormalities check compliance with folic acid treatment and consider increasing folic acid as outlined in C below. Reduce MTX dose by 50% and repeat tests in 2 weeks
  - Myelosuppression is more common in the initial months but can occur any time during MTX treatment
  - Risk factors include age >70, low albumin, folate deficiency and renal impairment

B: Possible side effects

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

C: Folic acid

- Folic acid minimises adverse effects and must be co-prescribed (not funded by the PBS unless ATSI/DVA)
- At least 5mg/wk. should be taken, preferably not on the day of MTX due to potential GI absorption competition
- Folic acid dose can be increased to 5mg/day if needed but not on the day of MTX
- Therapeutic Guidelines recommend the total weekly dose of folic acid ≤3x the total weekly dose of 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) in most clinical situations:

- It may be indicated in PJP prophylaxis
- This interaction can be life threatening; seek expert input before co-prescribing

MTX and infections

- Patients can usually continue MTX while being treated with oral antibiotics (except as above)

MTX can be taken with other medications including:

- Other DMARDs including biological and targeted synthetic DMARDs
- Steroids such as prednisolone
- NSAIDs / low dose aspirin / 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”
- Standard dose is 20-30mg/wk., it may be lower in elderly / mild renal impairment
- Dose escalations range from 5mg to 15mg/week every 1-4 weeks
- Response is assessed after 4-8 weeks at a specific dose
- At doses of 20mg a week or above it is recommended to change to the parenteral (SC) route
- SC is encouraged if patient unable to tolerate a sufficient oral dose for disease control.
- Prefilled syringes are now available via PBS streamlined authority for RA (7488) and psoriasis (7581)
- MTX is usually taken as a single dose on the same day each week. The oral dose may be divided over 24h to improve tolerance without increasing serious adverse effects
- In case of accidental pregnancy: stop MTX, start folic acid 5mg daily and contact the treating rheumatologist
- MTX is undetectable in serum 24h after administration. Patients on low dose once weekly MTX are NOT “HOT” and pose no risk to others. It is not absorbed through the skin so tablets and injections can be handled safely

The ARA website has more information and a Methotrexate SC injection demonstration video: https://rheumatology.org.au/patients/medication-information.asp . For more information on MTX shared care from NPS: www.bit.ly/npsmethosharecare

Health Pathways is a valuable GP decision-support tool which includes sections on all major rheumatology conditions: https://brisbanenorth.healthpathwayscommunity.org/18668.htm Username: Brisbane Password: North

This document is available under “Resources” at: http://www.bit.ly/rheumrefer.