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To: Lynn Mynott, Thyroid UK

Thank you for your feedback to bulletin 121 Liothyronine in primary hypothyroidism

Also as a point of clarification the acronym DROP stands for Drugs to Review for Optimised Prescribing - it does not mean that all treatments should be stopped and it is not a suggested ban on all products within the list. Our subscribers understand that this is not a list of products to ban from the NHS and we are not saying these resources can no longer be prescribed. Within every bulletin we state that individual circumstances should be borne in mind when reviewing treatment. In relation to bulletin 121, the title of the bulletin clearly states it is for primary hypothyroidism only and it does not cover other conditions where liothyroinine may be used.

We note that you have linked to the BTA statement in your response (http://www.btf-thyroid.org/images/documents/FAQ_for_BTA_Hypothyroidism_Statement.pdf) with a statement underneath it saying unfortunately the judgement of local doctors and endocrinologists does not seem to enter into the picture. We do not understand this concern as we have also highlighted this document in the bulletin and also stated the BTA advice that some patients may benefit from a trial of T3/T4 therapy and that these patients should be managed by an accredited endocrinologist.

The PrescQIPP recommendations do not state switch all patients that are on T3 to T4 and the bulletin clearly states switch all suitable patients and that any switch should be tailored to the individual patient. We are not sure how you have come to the conclusion that this will be ignored by GPs- they are ultimately responsible for making the clinical decision. The BTA statement also says that many clinicians may not agree that atrial of L-T4/L-T3 combination may be warranted in these circumstances and their clinical judgement must be recognised as being valid, given the current understanding of the science and evidence of treatments.

PrescQIPP try and produce supporting resources with all our bulletins and with this particular bulletin we have produced a patient information letter discussing the fact that their treatment is being reviewed and inviting them in for a discussion. This supports our position around bearing individual circumstances in mind and hope assures you that the intention of the bulletin is not to have a blanket switch without patient involvement. We have attached a copy of this patient letter for your information.

Regarding your point about proving a patient is genuinely hypothyroid before prescribing treatment- this recommendation is based on feedback from GPs that have tested patients and found they are not hypothyroid. If a GP does not have information from the initial prescribing doctor about why the patient is taking T3 then they have a responsibility to establish a diagnosis before continuing to prescribe.

The recommendation around liaising with secondary care is to ensure that the communication channels are open and that GPs and secondary care are not bouncing individual patients backwards and forwards. It allows the GP and consultant to discuss individual patients as well as ensure consistency in prescribing across the interface. We always encourage communication across the interface in our bulletins as this leads to better patient care. Also the BTA statement recommends that patients being prescribed T3 and T4 combination therapy should be managed by an accredited endocrinologist so the few patients who would potentially remain on the combination would need to be managed by the specialist and this service will need to be commissioned at a local level with communication between the GP and specialist being essential.

The statement in the European Thyroid association's guidelines on the use of L-T3 and L-T4 combination therapy supports this position: http://www.karger.com/Article/FullText/339444

"There is insufficient evidence that L-T4 + L-T3 combination therapy is better than L-T4 monotherapy, and it is recommended that L-T4 monotherapy remains the standard treatment of hypothyroidism. L-T4 + L-T3 combination therapy might be considered as an experimental approach in compliant L-T4-treated hypothyroid patients who have persistent complaints despite serum TSH values within the reference range, provided they have previously received support to deal with the chronic nature of their disease, and associated autoimmune diseases have been excluded. Treatment should only be instituted by accredited internists/endocrinologists, and discontinued if no improvement is experienced after 3 months".

Natural desiccated thyroid is a natural product and not a licenced medicine in the UK and therefore not regulated. The amount of thyroid hormone in the thyroid gland can vary from animal to animal and between batches of product so a consistent effect cannot be guaranteed with desiccated thyroid extract products.

Regarding the supply and cost of the product, PrescQIPP is unable to set prices for drugs or change the cost of treatment. The treatment costs are set by the Department of Health and we have no influence over how these are set. Also the fact that there are products available in Europe which are easily accessible and at a lower cost will not have an impact on the spend. Unless a medicine is licenced in the UK, it will be imported as a special product with no list price in the National Drug Tariff and therefore costs could be high.

A copy of the updated bulletin is attached for your information.

Finally, we would like to thank you for taking the time to engage with us and hope that you are reassured that we are not seeking a ban on the prescribing of liothyronine on the NHS or to switch all patients to thyroxine.

Yours sincerely

Sajida Khatri
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PrescQIPP CIC