quality safe use of medicines

Medication Alert

Colchicine

Alert 8 June 2009

For the attention of: All prescribers and pharmacists
For action by: Primary Care Facilitators, PHO Clinical Leaders—for dissemination to all GPs in your PHO, DHB Medicines Advisory Committees
For information to: College of GPs, Pharmacy Council, College of Nurses, Schools of Medicine, Pharmacy and Nursing

Purpose of this alert

To highlight the dangers associated with using colchicine in the treatment of acute gout and to change prescribing from the traditional dose of 1-2 tablets every 4-6 hours (potentially 12 tablets in 24 hours) to the lower dose now recommended that allows a **maximum of 5 tablets in 24 hours**

Recommended Action

- **Remove colchicine from your favourites list in your Practice Management System or change the dose instructions to the recommendations below**
- **Colchicine should no longer be considered first line management of acute gout**
- **Treatment for acute gout should be with either NSAIDs or oral steroids depending on co-morbidities and the age of the patient unless there are contraindications to both**
- **Colchicine prescribing guidelines:-**
  - **Initial dosage 2 tablets (2 x 500mcg) followed every six hours by 1 tablet (500mcg) until relief is obtained, up to a maximum of 5 tablets (2.5mg) in the first 24 hours**
  - **In elderly patients, patients with renal or hepatic impairment, or patients weighing less than 50kg, if it is necessary to use colchicine the initial dosage should not exceed 2 tablets in the first 24 hours**
  - **A cumulative oral dose of 12 tablets (6mg) over 4 days should not be exceeded (Additional colchicine should not be administered for at least 3 days after a course of oral treatment)**
- **Consider limiting prescriptions to a maximum of 12 tablets at any one time when prescribing for acute gout**
- **Patients should be told to discontinue colchicine immediately if they develop abdominal pain, diarrhoea, nausea or vomiting even if symptoms of acute attack have not been relieved**
- **Ensure patients understand the potential side effects and dosage limitation, with particular support for patients where English is not their first language**
- **Colchicine can be fatal for children in very small doses, warn patients to store their tablets out of reach of children**

Background to this Safe Use of Medicines Alert

A recent fatal case (due to colchicine poisoning) in a young family man for whom English was a second language, has highlighted the dangers of using colchicine in the treatment of acute gout without careful explanation of the dosage restrictions. This man woke in pain at night and took 30 colchicine tablets—unfortunately colchicine poisoning is almost invariably fatal and there is no antidote.

For further action by Safe and Quality Use of Medicines Group

- SQM Group will advocate that the data sheet and funding for colchicine are reviewed to limit the number of colchicine tablets prescribed for **acute gout**
- The impact of this alert will be audited 3 –6 months following distribution

For an electronic version of this alert download from the website, www.safeuseofmedicines.co.nz or contact Beth Loe, Beth.Loe@waitematadhb.govt.nz

If you require any further information or wish to provide feedback on this alert, please go to www.safeuseofmedicines.co.nz