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# Shared Care Guideline

## Methotrexate

### Executive Summary

- Methotrexate is a disease modifying agent used within a number of specialities, including rheumatology, gastroenterology, dermatology, ophthalmology and renal.
- Methotrexate should be taken **ONCE WEEKLY** on the same day each week.
- Dose will be dependent on indication the drug is prescribed for.
- Patients should be prescribed concomitant folic acid, starting at once a week but may be increased to a maximum of six times per week (excluding day of methotrexate) if required for side effects.
- Low dose methotrexate should not normally exceed 25mg per week.
- Patients should **only** be prescribed 2.5mg tablets.
- Response can usually be seen in 4-12 weeks.
- Patients may be switched to parenteral therapy to increase tolerability.
- Due to teratogenicity in male and female patients, patients must use adequate contraception for the duration of methotrexate therapy, and for 3 months after discontinuation of therapy for female patients and until discussion with hospital specialist for male patients.
- The responsibilities of the hospital specialist, GP and patient for this Shared Care Guideline can be found within this document [here](#)

Sharing of care depends on communication between the specialist, GP and the patient or their parent/carer. The intention to share care should be explained to the patient and accepted by them. Patients are under regular follow-up and this provides an opportunity to discuss drug therapy. The doctor/healthcare professional who prescribes the medication has the clinical responsibility for the drug and the consequences of its use. Further information about the general responsibilities of the hospital specialist and GP can be found [here](#)

### 1.

#### Scope

Cross-boundary: Trust and general practice.

### 2. Aim

To provide guidance in the use of low dose methotrexate used for non-cancer indications.

### 3. Introduction

Methotrexate is a disease modifying agent that is being used to manage:

- Rheumatological conditions
- Inflammatory bowel diseases
- Skin disorders
- Eye disorders
- Vasculitis

The dermatology, rheumatology, gastroenterology, renal (vasculitis) or ophthalmology departments will supervise treatment and will ask you to manage prescribing and monitoring under shared care arrangements.

### 4. Abbreviations

- ALT alanine transaminase
- AST aspartate transaminase
- BCG bacillus Calmette-Guérin
- BNF British National Formulary
- CNS central nervous system
- CRP C-reactive protein
- CXR chest x-ray
- ESR erythrocyte sedimentation rate
- FBC full blood count
- GP) general practitioner
- LFT liver function tests
- MMR measles, mumps and rubella
- NSAIDs non-steroidal anti-inflammatory drugs
- IBD Inflammatory bowel disease
- IgG immunoglobulin G
- MMR measles, mumps and rubella
- NSAIDs non-steroidal anti-inflammatory drugs
- SPC summary of product characteristics
- VZIG varicella zoster immunoglobulin
- VZV varicella zoster virus

### 5. Dose and Administration

Methotrexate is taken or administered once a week, on the same day each week. This day should be specified and recorded in the patient's notes in the hospital computer system and the information passed to the general practitioner (GP) when the request is made for shared care.

A patient may be initiated on oral methotrexate therapy and then transferred to parenteral treatment to increase tolerability, or they may commence treatment with parenteral therapy. A reduction in the bioavailability of oral methotrexate can occur with continued use, patients may be subsequently transferred to parenteral therapy to improve bioavailability, allowing maintenance of the dose without increasing the potential for toxicity.

| Condition | Dosage |
|-----------|--------|
|-----------|--------|

|  |   |
|--|---|
| <b>Dermatological conditions (psoriasis; cutaneous sarcoid; dermatomyositis; sclerodema; eczema; autoimmune blistering conditions)</b> | Initial dose 5mg to 10mg once a week (2.5mg once a week if elderly, renal dysfunction or bone marrow dysfunction), increased in 2.5mg to 5mg increments every one to four weeks depending on clinical response. Max dose 25mg once a week.<br><br>For paediatric patients, maintenance dose is usually 0.2-0.4mg/kg once a week. Max dose 25mg once a week. |
| <b>Rheumatological conditions</b>  | Methotrexate should be started at 10mg-15mg once a week, with escalation by 2.5mg increments every one to four weeks up to a maximum dose of 25mg per week as tolerated.<br>For paediatric patients the usual dose is 10-15mg/m <sup>2</sup> once a week, increased as necessary up to 25mg/m <sup>2</sup> once a week                                      |
| <b>Vasculitis</b>  | Initial dose 10mg and increase by 2.5mg per week. The target dose is 25mg once a week (in exceptional circumstances higher doses may be used).  |
| <b>Inflammatory bowel disease (IBD)</b>  | Initial dose 15mg once a week, increasing to 20mg once a week after two weeks and up to a maximum of 25mg after a further two weeks according to response.  |
| <b>Medical ophthalmology</b>   | Initial dose 5mg-10mg once a week, increased in 2.5 to 5mg increments at four-week intervals depending on clinical response. Max dose 25mg once a week.   |
| <b>Respiratory conditions (Sarcoidosis)</b>  | Initial dose 2.5mg to 5mg once a week, increased in 2.5mg to 5mg increments every four to six weeks depending on clinical response. Max dose 25mg once a week.  |

Response may take 6-12 weeks.

Maximum dose is 25mg once a week.

There are two strengths of methotrexate tablets available (10mg and 2.5mg). **To avoid confusion and reduce the risk to patients, methotrexate must be prescribed and dispensed as 2.5 mg tablets only.**

The injection is available as Metoject® prefilled pen 50mg in 1ml of methotrexate in differing volumes to allow self-administration of the correct dose. In paediatrics in certain circumstances – patient specific - other injectable options may be available these include Nordimet prefilled pen containing 25mg in 1ml of methotrexate and Zlatal prefilled syringe containing 25mg in 1ml of methotrexate. The dose is given once weekly and should not usually exceed 25mg once a week.

All communication (letters, patient held record books etc.), discharge prescriptions and FP10s should normally carry the following details:

- **Weekly dose** (methotrexate usually taken/injected once a week on a specified day).
- **Day of the week dose taken/injected** (always same day each week).

- **Usual strength of tablets the patient takes** (e.g. if patient takes 10mg per week on Mondays as four 2.5mg tabs, this should be clearly indicated on the prescription, i.e. four x 2.5mg tablets weekly (total 10mg weekly, taken on Monday) or **usual strength of injection the patient administers**.
- To avoid confusion many prescribers prefer to specify the day to take methotrexate as "Monday".

Patients and parents/carers should be given a 'methotrexate patient held record book' detailing the dose, start date, method of administration and blood results at the initiation of treatment by the hospital team. Monitoring blood results should be entered into this record or a print out attached. Patients should be advised to bring their methotrexate book to all appointments or consultations with a health professional including the community pharmacy where their prescription is dispensed. It is the responsibility of all health care professionals to keep the booklet up to date.

All patients on methotrexate should normally be started on folic acid at a dose of at least 5mg per week (do not give on methotrexate day). For paediatric patients unable to swallow tablets, a dose of 1mg daily except on day of methotrexate is given by syrup formulation (usual strength of folic acid syrup is 1mg in 2mL).

Further information can be found in the Summary of Product Characteristics:

## 6. Adverse Effects

### Common (≥ 1 in 100 and < 1 in 10)

- Gastrointestinal disturbances:
  - Anorexia ○ Nausea ○ Vomiting
  - Diarrhoea
  - Ulcerative stomatitis (oral ulceration) ○ Rarely gastrointestinal ulceration
- Alopecia (usually minor)

### Uncommon (≥ 1 in 1000 and < 1 in 100)

- Hypersensitivity reaction ○ Fever ○ Rigors ○ Rash
- Bone marrow suppression ○ Leucopenia ○ **Thrombocytopenia** ○ Anaemia
- Central Nervous System (CNS) disturbances ○ Headache ○ Drowsiness
  - Blurred vision

### Rare (but significant) (≥ 1 in 10000 and < 1 in 1000)

- **Hepatotoxicity** (liver cirrhosis reported) – see section 7 Cautions for advice on alcohol consumption. Avoid methotrexate if pre-existing liver disease.
- **Pulmonary toxicity** (interstitial pneumonitis often associated with eosinophilia, rarely pulmonary fibrosis). This is not dose related and presents with dry cough, dyspnoea and often fever. **In adult patients this requires immediate cessation of treatment and reporting to the specialist and GP. In paediatric patients please seek advice from the specialist team before stopping treatment.**

The patient should be advised to report:

- 
- Any signs and symptoms suggestive of infection as this may be a marker of bone marrow suppression i.e.
    - Sore throat
    - Fever
    - Chills
    - Unexplained bruising or bleeding
  - Any signs of liver toxicity
    - Severe nausea and vomiting
    - Abdominal discomfort and dark urine
  - Respiratory effects (shortness of breath)

The patient should report such symptoms to the GP, who should contact the hospital specialist clinician or specialist nurse as appropriate (see actions to take in the event of abnormal test results/symptoms below)..

Further information can be found in the Summary of Product Characteristics:

## 7. Cautions

Whilst on methotrexate, patients should avoid live vaccines such as:

- Oral polio
- Oral typhoid
- Measles, mumps and rubella (MMR)
- Bacillus Calmette-Guérin (BCG)
- Yellow fever

Contact hospital specialist for advice on any vaccinations if required. See exception below for Herpes Zoster vaccine

Methotrexate is teratogenic to ova and sperm. Female patients should not become pregnant whilst on methotrexate and should be advised to take adequate contraceptive precautions during treatment and for **three months** after stopping. Men wishing to father a child whilst on methotrexate must avoid conceiving a child by taking adequate contraceptive precautions until they have taken specialist advice. The hospital specialists should be contacted in such circumstances. The risks and benefits of the duration of non-treatment with methotrexate should be assessed by the consultant and discussed with the patient.

Patients who have never had chickenpox or shingles may be at risk of severe infection whilst being treated with methotrexate. Patients should be advised to avoid close contact with people who have active chickenpox or shingles (especially if they do not have a known history of chickenpox or they know they do not have VZV IgG antibody). Patients should report any such contact (or if they develop chickenpox or shingles) to their GP or specialist for further advice (also see [responsibilities](#) below). Administration of Herpes Zoster (shingles) vaccine to appropriate individuals is considered safe. The hospital specialist will advise in each individual case.

Where time allows, children and young people who are known to be non-immune to VZV will be immunized prior to commencing methotrexate. If this is not clinically appropriate, parents/carers are given information on actions in the event of VZV exposure – namely to keep the child off school if VZV is in the class, and contact the specialist team. They may need treatment with VZIG or a prophylactic course of acyclovir (please see appendix 1).

Alcohol consumption in moderation, e.g. the occasional glass of wine, is not contraindicated. Young people must be advised not to 'binge drink'. Patients should stick to well within normal

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limits i.e. maximum of 14 units per week for men and women  
<http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx>

Patients should be given advice to avoid unpasteurised milk or soft cheese and to be aware of normal hygiene conditions in the handling of food particularly if they are also taking steroids and/or one of the biologic therapies such as adalimumab, etanercept and infliximab for example.

If stomatitis or GI toxicity occurs, then particular care and possible cessation of treatment may be indicated, due to the risk of hemorrhagic enteritis and intestinal perforation may result.

Further information can be found in the Summary of Product Characteristics:  
<https://www.medicines.org.uk/emc/>

## 8. Contraindications

- Significant liver impairment (any abnormality of LFTs before therapy or during therapy if LFTs do not normalise after two weeks of withholding methotrexate).
- Severe renal impairment.
- If on methotrexate, avoid during pregnancy (and for 3 months after stopping methotrexate) and breastfeeding.
- Active infection and immunodeficiency syndromes.
- Severe haematological impairment or profound deterioration
- If pneumonitis suspected.

Further information can be found in the Summary of Product Characteristics:  
<https://www.medicines.org.uk/emc/>

## 9. Interactions

- **Concomitant administration of a folate antagonist e.g. Septrin® (Co-trimoxazole) or trimethoprim, have been reported to cause acute megaloblastic pancytopenia. Hence concomitant use with methotrexate MUST be avoided.**
- Other antibacterials such as tetracyclines, penicillins or ciprofloxacin may increase methotrexate toxicity. It is recommended that when patients require a short course of antibiotics, methotrexate is held for the duration of the course, and restarted on the usual day. If a patient requires an antibiotic course over 2 weeks, then advice from the specialist team, or pharmacy, should be sought (For paediatric patients, the specialist team are happy for their patients to receive short courses (up to 7 days) of antibiotics without stopping the methotrexate. If in any doubt please check with the paediatric specialist team).
- Excretion of methotrexate may be reduced by non-steroidal anti-inflammatory drugs (NSAIDs), with possible increased toxicity. Patient should be advised against self-medicating with over the counter NSAIDs. However in rheumatological conditions, NSAIDs are commonly prescribed concomitantly.
- **Patients should avoid 'live' vaccines such as Oral Polio, Oral Typhoid, measles, mumps and rubella (vaccine) (MMR), bacillus Calmette-Guérin (BCG) and yellow fever, whilst on immunosuppressive therapy.**
- See [BNF](#) Appendix 1 for a full list of interactions with methotrexate.

- See the Trust's [methotrexate drug interactions of clinical significance guideline](#) for further detailed advice on the management of methotrexate interactions.
- If in doubt, contact the hospital specialist.

**Contact hospital specialist for advice on any vaccinations if required.**

- **Note:** yearly influenza vaccine is recommended in patients on methotrexate therapy.

Further information can be found in the Summary of Product Characteristics:

<https://www.medicines.org.uk/emc/>

**10. Monitoring Standards & Actions to take in the event of abnormal test results/symptoms**

**Record all blood results in the methotrexate patient held record book.**

|  |                |   |
|--|----------------|---|
| <b>Pre-treatment by the hospital team.</b>   | All conditions | FBC, creatinine, electrolytes, LFTs, CXR (adult patients only)<br><br>Varicella status: ask GP to vaccinate if not immune, record history of chickenpox or VZV IgG immunity status in patient booklet.  |
| <b>Initiation to stabilisation monitoring by the hospital team (or GP if in agreement).</b>  | All conditions | FBC and LFTs every two weeks until dose of methotrexate is stable, then monthly until disease is stable.<br>Creatinine and electrolytes six-monthly.<br>In addition for gastroenterological and rheumatological conditions: ESR and/ or CRP monthly to assess response to treatment.  |
| <b>On-going monitoring by GP once stable.</b>  | All conditions | FBC and LFTs three-monthly once stabilised. Frequency may be reduced dependant on patient-specific factors. Creatinine and electrolytes six-monthly.<br><br>In addition for gastroenterological and rheumatological conditions: ESR or CRP monthly to assess response to treatment.<br><br>In children and young people once disease is in remission, 3 monthly blood monitoring with FBC, LFT, ESR, U&E, CRP is adequate |
| Legend: CXR: chest x-ray; FBC: full blood count; LFT: liver function tests; VZV: varicella zoster virus; IgG: immunoglobulin G; ESR: erythrocyte sedimentation rate; CRP: C-reactive protein |                |   |

### Abnormal tests and side-effect management

The following tables include advice on what action to take if blood test results fall below certain limits or if the patient reports one of the adverse events below:

| Blood test results   | Action   |
|--|--|
| <input type="checkbox"/> White cell count (WCC) < 3.5 x 10 <sup>9</sup> /L   | Contact hospital specialist.   |
| <input type="checkbox"/> Neutrophils <2.0 x 10 <sup>9</sup> /L<br><input type="checkbox"/> Neutrophils <1.5 x 10 <sup>9</sup> /L                   | <b>Contact hospital specialist.<br/>Stop treatment and contact hospital specialist.</b>  |
| <input type="checkbox"/> Lymphocytes <0.5 x 10 <sup>9</sup> /L   | <b>Contact hospital specialist.</b>  |
| <input type="checkbox"/> Platelets <150 x 10 <sup>9</sup> /L but >100 x 10 <sup>9</sup> /L   | <b>Continue methotrexate and re-check in 1 week</b>  |
| <input type="checkbox"/> Platelets between 75 to 100 x 10 <sup>9</sup> /L  | <b>Stop treatment and re-check in 1 week</b>   |
| <input type="checkbox"/> Platelets <75 x 10 <sup>9</sup> /L  | <b>Stop treatment</b> and contact hospital specialists (haematologists)  |
| <input type="checkbox"/> >twofold rise in AST, ALT (from upper limit of reference range) rapidly changing AST, ALT or falling albumin.             | Refer to hospital specialist.  |
| <input type="checkbox"/> Renal function – significant deterioration  | <b>Stop treatment</b> and contact hospital specialist.   |
| Symptoms/side effects  | Action   |
| <input type="checkbox"/> Oral ulceration/ stomatitis (severe mouth ulcers)   | Check blood tests. Increase dose of folic acid and contact hospital specialist.  |
| <input type="checkbox"/> <b>New or increasing dyspnoea or persistent dry cough or fever (with no other obvious cause – suspected pneumonitis).</b> | <b>Stop treatment</b> and contact hospital specialist immediately.<br>In paediatric patients methotrexate should not be stopped for persistent Lower Respiratory Tract Infections e.g. pertussis. Please contact the paediatric specialist team for urgent review of the patient if there are clinical concerns regarding pneumonitis. |
| <input type="checkbox"/> Abnormal/ unexplained bruising or bleeding  | Take FBC, LFTs & U&Es and stop methotrexate if abnormal and contact hospital specialist immediately.   |
| <input type="checkbox"/> Persistent or severe sore throat  | Take FBC and stop if abnormal and contact hospital specialist immediately.   |

|  |   |
|--|---|
| <input type="checkbox"/> Severe or persistent infection  | Stop methotrexate and take FBC and contact hospital specialist immediately.   |
| <input type="checkbox"/> Nausea, abdominal discomfort, diarrhoea, anorexia.                        | If previously stable, check for underlying pathology. If during dose escalation:<br>Take methotrexate at night<br>Increase dose of Folic Acid<br>Prescribe PRN antiemetic for short term<br>Reduce methotrexate dose by 2.5mg<br><br>Discuss with hospital specialist. May be an indication to switch to SC methotrexate on advice from specialist. |
| <input type="checkbox"/> Whites of the eyes become yellow or patient develops severe skin itching. | Stop treatment and contact hospital specialist immediately.   |



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## 11. Shared Care Responsibilities

### a. Hospital specialist:

- Send a letter to the GP requesting shared care for the patient. Agreement to shared care will be assumed unless GP advises otherwise.
- Ensure accurate details of patient's prescription are communicated, including specified day of treatment.
- When serology shows non-immunity to chicken pox this should be reported to the GP with a request to provide varicella-zoster vaccination for the patient (if clinical urgency allows).
- Inform the GP after each clinic attendance if there is any change to treatment or monitoring.
- Inform GP of patients who do not attend clinic appointments.
- To provide any advice to the patient/carer when requested.
- Initiate treatment and prescribe the first month of treatment.
- Routine clinic follow-up on a regular basis.
- Send a letter to the GP after each clinic attendance ensuring current dose, most recent blood results and frequency of monitoring are stated.
- Evaluation of any reported adverse effects by GP or patient.
- Advise GP on review, duration or discontinuation of treatment where necessary.
- Provide methotrexate book and update after clinic appointments, if necessary.
- Ensure that backup advice is available at all times.

### b. General Practitioner:

- Agreement to shared care guideline by the GP.
- Report any adverse events to the hospital specialist, where appropriate. □ Request advice from the hospital specialist when necessary.
- Monitor patient's overall health and well-being.
- If the hospital is supplying methotrexate via Homecare (see section 12 below), the GP does not need to prescribe the drug or any other ancillaries.
- If the hospital is **not** supplying methotrexate via Homecare, the GP should prescribe the drug treatment and any ancillaries on FP10, e.g. purple cytotoxic bin.
- Monitor blood results (FBC, U+Es and LFTs, CRP, ESR) in line with recommendations from hospital specialist.
- Provide varicella-zoster vaccination where requested by the hospital specialist and record in the methotrexate monitoring booklet.
- Where a patient has not been vaccinated against or remains non-immune to chicken pox or shingles, consult the local virologist (or microbiologist) who will advise on the need for varicella zoster immunoglobulin (VZIG) or acyclovir.
- Complete blood monitoring details in the methotrexate book or provide information to be included within it and ensure that patient understands they should carry the book at all times.

### c. Patient or parent/carer:

- Report to the hospital specialist or GP if they do not have a clear understanding of their treatment.
- Patients must not exceed the recommended dose.
- Patients must attend their scheduled clinic and blood test appointments (where relevant) to assist health professionals to provide effective, safe, appropriate treatment.
- Must inform other clinical staff that they are receiving treatment.
- Report any adverse effects to the hospital specialist or GP.

- Discuss potential benefits and side effects of treatment with the specialist and GP, to identify whether they have a clear picture of these from the specialist and to raise any outstanding queries.
- Check that where possible the specialists have provided a patient-held record or information sheet for monitoring and/ or to alert other clinical staff to the treatment they are receiving.
- Share any concerns they have in relation to treatment with methotrexate.

## 12. Subcutaneous Methotrexate

Patients are assessed by the hospital team for suitability and the specialist team may decide to set up the Homecare service or request prescriptions to be continued by the GP. If through homecare, Medication is delivered directly to the patient's home address at a pre-arranged time and also included are all the disposables, sharps bins, spill kits and training. Cytotoxic waste is also removed.

Prescribing and monitoring of subcutaneous methotrexate is the same as oral, however the drug must be prescribed by brand (e.g. Metoject, Zlatal or Nordimet).

## 13. Funding for treatment with Methotrexate injections or tablets

Funding for oral and parenteral methotrexate is from the usual secondary or primary care drug budgets as this indication is 'in tariff' and is not a high cost excluded from tariff drug.

## 14. Contact numbers for advice and support

| <b>Cambridge University Hospital NHS Foundation Trust</b> |                                  |                     |
|---|----------------------------------|---------------------|
| <b>Specialist</b>   | <b>Post</b>                      | <b>Telephone</b>    |
| <b>Medicines Information Department</b>                   |                                  | <b>01223 217502</b> |
| <b>Dermatology Department</b>                             |                                  |                     |
| <b>Specialist</b>   | <b>Post</b>                      | <b>Telephone</b>    |
| Jane Day; Diane Joseph                                    | Specialist sisters - Dermatology | 01223 217391        |
| Dr Nigel Burrows  | Consultant Dermatologist         | 01223 216459        |
| Dr Shiu Kwan Chan   | Consultant Dermatologist         | 01223 216501        |
| Dr Niamh Flanagan   | Consultant Dermatologist         | 01223 586678        |
| Dr Julia Gass   | Consultant Dermatologist         | 01223 216501        |
| Dr Thomas Ha  | Consultant Dermatologist         | 01223 216459        |
| Dr Shaheen Haque  | Consultant Dermatologist         | 01223 216501        |
| Dr Paul Norris  | Consultant Dermatologist         | 01223 216459        |
| Dr Jane Sterling  | Consultant Dermatologist         | 01223 216501        |
| Dr Justyn Thomas  | Consultant Dermatologist         | 01223 216459        |
| Dr Pamela Todd  | Consultant Dermatologist         | 01223 216459        |

|  |                                       |                  |
|--|---------------------------------------|------------------|
| Dr Marc Wallace  | Consultant Dermatologist              | 01223 216459     |
| <p><b>Rheumatology Department</b><br/>Decisions to alter or discontinue treatment are usually discussed via the Rheumatology Helpline on 01223 217398. The on-call rheumatology specialist registrar (SpR) may also be contacted via the Addenbrooke's Contact Centre.</p> |                                       |                  |
| <b>Specialist</b>  | <b>Post</b>                           | <b>Telephone</b> |
| Jill Bloxham; Julie Isaacson;  | Rheumatology Practitioners            | 01223 254933     |
| Tracey Nash<br>Teresa Del Sordo  | CTD Nurse                             | 01223 274544     |
| Dr Gavin Clunie  | Consultant Rheumatologist             | 01223 216774     |
| Dr Frances Hall  | Consultant Rheumatologist             | 01223 256883     |
| Dr Deepak Jadon  | Consultant Rheumatologist             | 01223 217716     |
| Dr Natasha Jordan  | Consultant Rheumatologist             | 01223 256883     |
| Dr Mark Lillicrap  | Consultant Rheumatologist             | 01223 217716     |
| Dr Anshuman Malaviya   | Consultant Rheumatologist             | 01223 217716     |
| Dr Andra Negoescu  | Consultant Rheumatologist             | 01223 216774     |
| Dr Kenneth Poole   | Consultant Rheumatologist             | 01223 216774     |
| Dr Nick Shenker  | Consultant Rheumatologist             | 01223 256883     |
| <p><b>Paediatric Rheumatology Department</b></p>   |                                       |                  |
| Dr Kate Armon  | Consultant Paediatric Rheumatologist  | 01223 348577     |
| Dr Peter Bale  | Consultant Paediatric Rheumatologist  | 01223 348577     |
| Cathy Slynn  | Nurse Specialist                      | 01223 254988     |
| <p><b>Vasculitis/Lupus</b></p>   |                                       |                  |
| <b>Specialist</b>  | <b>Post</b>                           | <b>Telephone</b> |
| Dr D. Jayne  | Consultant in Nephrology & Vasculitis | 01223 217259     |
| Dr Frances Hall  | Consultant Rheumatologist             | 01223 256883     |
| Dr Lisa Willcocks  | Consultant in Nephrology              |                  |
| Stella Burns   | Specialist Vasculitis Sister          | 01223 586796     |
| Jane Hollis  | Lupus Nurse Specialist                | 01223 217050     |

| <b>Ophthalmology Department</b>   |  |   |
|---|--|---|
| <b>Specialist</b>   | <b>Post</b>  | <b>Telephone</b>                                    |
| Dr P Meyer  | Consultant medical ophthalmologist   | 01223 217904  |
| <b>Gastroenterology Department<br/>Inflammatory Bowel Disease Helpline 01223 257212 (voicemail)</b>   |  |   |
| <b>Specialist</b>   | <b>Post</b>  | <b>Telephone</b>                                    |
| <b>Inflammatory Bowel Disease Helpline for Patients</b>   |  | 01223 257212 (voice mail)                           |
| Dr Miles Parkes   | Consultant Gastroenterologist  | 01223 216389  |
| Dr Jeremy Woodward  | Consultant Gastroenterologist  | 01223 596231  |
| Dr Stephen Middleton  | Consultant Gastroenterologist  | 01223 216226  |
| Dr Timothy Raine  | Consultant Gastroenterologist  | 01223 348456  |
| Dr Ewen Cameron   | Consultant Gastroenterologist  | 01223 348718  |
| Dr Gareth Corbett   | Consultant Gastroenterologist  | 01223 348716  |
| Prof Arthur Kaser   | Consultant Gastroenterologist  | Ext 768308  |
| Sr Allison Nightingale  | Inflammatory Bowel Disease Nurse Specialist  | 01223 217990 <b>(for GPs to contact for advice)</b> |
| <b>Royal Papworth Hospital NHS Foundation Trust<br/>Medicines Information Department 01480 364179<br/>Respiratory Medicine ILD Department</b> |  |   |
| <b>Specialist</b>   | <b>Post</b>  | <b>Telephone</b>                                    |
| Dr Muhunthan Thillai  | Consultant Respiratory Physician (Papworth Clinical Lead for Methotrexate Shared Care) | 01480 364530  |
| Dr Helen Parfrey  | Consultant Respiratory Physician   | 01480 364521  |
| Dr Nicola Simler  | Consultant Respiratory Physician   | 01480 364530  |
| Duncan Grady  | Thoracic Directorate Pharmacist  | 01480 830541 bleep 845                              |
| Emma Harris<br>Luis Matos   | ILD Specialist Nurses  | 01480 830541 bleep 109                              |

### 15. Monitoring compliance with and the effectiveness of this document

Specialties will regularly review their incidents and feedback from GPs with regard to the use of this drug and update the guideline accordingly.

### 16. Equality and Diversity Statement

This document complies with the Cambridge University Hospital NHS Foundation Trust service Equality and Diversity statement.

### 17. Disclaimer

It is your responsibility to check that this printed out copy is the most recent issue of this document.

### 18. Document Management

| Document ratification and history |  |
|-----------------------------------|--|
| Approved by:                      | Cambridge University Hospitals NHS Foundation Trust<br>Joint Drug and Therapeutics Committee   |
| Date approved:                    | 20 February 2018   |
| Approved by:                      | Cambridgeshire and Peterborough Joint Prescribing<br>Group   |
| Date approved:                    | 18 January 2018  |
| Date placed on CPJPG website:     | 30042018   |
| Review date:                      | 20 February 2020   |
| Obsolete date:                    | 20 May 2020  |
| Supersedes which document?        | Version 2, February 2018   |
| Authors:                          | Angela Clark, Clinical Pharmacist<br>Narinder Bhalla, Consultant Pharmacist - Medication<br>Safety<br>Nigel Gooding, Consultant Pharmacist – Neonates and<br>Paediatrics |
| Owning Provider Trust:            | Cambridge University Hospitals NHS Foundation Trust  |
| File name:                        | Methotrexate SCG Version3 March 2018   |
| Version number:                   | 3  |
| CUH Document ID:                  | 2966   |

**The information contained in this guideline is issued on the understanding that it is accurate based on the resources at the time of issue. For further information please refer to the most recent Summary of Product Characteristics <http://www.medicines.org.uk/emc/medicine/2882> Appendix 1 – Information regarding chicken pox, provided by the paediatric clinical team for families of paediatric patients**

Methotrexate suppresses the immune system. Your child is not immune to chicken pox. (We can't find any evidence on blood testing that they have had chicken pox before). Thus he/she is susceptible to getting chicken pox, and because of the methotrexate, the illness may be more severe than usual. For this reason we need to take the following precautions:

In the event of exposure to chicken pox (eg a child in his/her class comes down with the infection), please phone Addenbrookes hospital (01223245151) and 'bleep' the paediatric gastroenterology/rheumatology registrar (bleep number 157767) and they will arrange for same day 'day case' admission to ward F3.

On ward F3, a blood sample will be taken to check immunity to varicella zoster again (in case immunity has developed since the last blood test was taken). If he/she is non-immune, they will need VZIG

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injection (organised via the virologist). It is important that this happens within 72 hours of the exposure to chicken pox virus.

If you discover the exposure out of hours, you can wait until the following day and follow the procedure above.

If however it is a weekend, you will need to attend A&E with this letter to show what is needed to the team at the hospital.

If your child develops clinical signs of chicken pox (fever and spots), they will need to come to the hospital to be seen on ward F3 (arranged through the paediatric gastroenterology/rheumatology registrar) and assessed. Dependent on severity, they will need acyclovir (anti-virus medication) given intravenously or by mouth and usually a hospital admission – the on call team will discuss with the paediatric rheumatology team.

If members of the immediate family have not had chicken pox, they should be vaccinated against chicken pox to protect your child.