Record of the Ad Hoc Critical Care Advisory Group (CCAG)

Held via Zoom videoconference on 30 April 2020

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Note that this document is not necessarily a complete record of the ad hoc CCAG meeting; rather it is a summary of the pertinent discussion at the meeting.

1. Welcome and introduction

1.1. Dr Ken Clark introduced the new advisor, Dr Andrew Brainard, to the group. Dr Clark acknowledged the valuable advice received from the group at its previous meeting, and noted that positive feedback had been received from the sector regarding the existence of this group.

2. Review of previous meeting minutes

2.1. The group noted and provided feedback on the draft record of the previous meeting, with the following comments;

2.1.1. In relation to table one: general anaesthetics, clonidine patches may also be useful in some circumstances, but are less readily titrated than injectable and oral formulations.

2.1.2. In relation to table one: general anaesthetics, from an anaesthetics perspective alternatives to propofol would include ketamine, etomidate and thiopental [thiopentone]. Thiopental is not currently subject to a supply contract with PHARMAC. PHARMAC should engage with suppliers of thiopentone to assess current Aotearoa New Zealand stock holdings.

2.1.3. In relation to table five: vasopressors/sympathomimetics, dopamine should not be included as an essential or highly desirable medicine in the context of COVID-19 critical care. Dopamine is not generally used as an inotrope, and noradrenaline or other sympathomimetics would be preferred.

3. PHARMAC communications to the sector

3.1. The group noted recent communications from PHARMAC to the sector regarding supply constraints for propofol, fentanyl 50 mcg per ml 2 ml injection, and suxamethonium.

3.2. PHARMAC staff noted that contracts with suppliers generally require a minimum of two months' stock on hand based on usual demand. PHARMAC staff noted that, early in the evolution of the COVID-19 pandemic, they had asked suppliers of critical care medicines (considered likely to be used in the management of COVID-19 patients) to increase stock holdings to 6 months of usual demand, in anticipation of an increase in use should the spread of COVID-19 not be controlled in Aotearoa New Zealand. PHARMAC staff noted that the communications above, and additional supply matters raised with the CCAG, was in response to cases where suppliers were unable to meet the request for increased stock holdings. The group considered this approach to be reasonable, and members considered that PHARMAC may wish to review its contracting approach for supply of critical medicines to ensure volumes are adequate to meet demand of future pandemics.

3.3. PHARMAC staff noted that some feedback received from the sector in response to the communications had indicated that stakeholders would appreciate more detailed information on stock levels across a range of medicines to guide the degree of response, and clear direction on clinical practice changes. PHARMAC staff noted that

while PHARMAC has tools to target usage of pharmaceuticals (such as the ability to apply Special Authority criteria), it does not have a mandate or authority to provide clinical guidance. In response, the group considered that:

3.3.1. different groups had taken different approaches to in their responses to the communications;

3.3.2. in the absence of PHARMAC being able to provide clinical guidance, PHARMAC could request DHBs and other clinical stakeholders to collaborate and respond with proposed and implemented actions; this feedback loop may help in improving the effectiveness of these communications, and suggested protocols or other clinical guidelines could be referred to on the PHARMAC website;

3.3.3. it would be useful for PHARMAC to clearly communicate early signals through use of a clear guide on the degree of severity of individual supply constraints;

3.3.4. PHARMAC should release a follow-up communication to provide further clarity on these matters, and this communication should include a call to action.

3.4. The group noted the distribution list of the previous communications, and considered that pharmacists would continue to be a critical avenue for ensuring the information was well distributed and that responses were relayed back in a timely manner.

3.5. The group considered there were important audiences outside of the public healthcare setting, including private hospitals, ambulance service providers, and other private community health providers. The relevant Colleges would, in general, be able to communicate with members working in both the private and public health sectors, and it would be important to continue to include the Colleges in further communications.

4. Specific supply considerations

Fentanyl 50 mcg per ml, 2 ml injection

4.1. Regarding supply constraints with fentanyl 50 mcg per ml, 2 ml injection, the group considered that in the majority of clinical scenarios there would be other opioid analgesics that could be considered for use, but there were some scenarios (for example for neuraxial administration) where fentanyl would be the only option. The group considered that, whilst not ideal, a product provided under Section 29 of the Medicines Act would be suitable in the short term. The group considered that in the hospital setting, the controlled drug nature of this pharmaceutical would make it simpler to record who had received a Section 29 product. The group considered it would be important to communicate that the product had been approved by a recognised regulator (for example, the TGA in Australia), and considered that in a hospital setting Section 29 supply would not generally present a significant barrier to clinical practice.

4.2. The group considered that different presentations of fentanyl were more suitable for different clinical settings. For example, the 10 ml presentation would be more suitable in the ICU setting compared with the anaesthesia setting where the 2 ml presentation may be preferred.

4.3. Regarding approaches to conserving supplies of injection in general, the group noted the recommendations of ANZCA that the contents of any one ampoule or vial should be administered only to one patient (ANZCA PS51 section 5.5.6), in the context of compliance with drug registers and of minimising the risk of cross infection between patients. The group considered this guidance was appropriate.

Propofol injection

4.4. Regarding propofol injection, the group considered that global supply issues were likely to continue for some time, and that continued careful management of stock in clinical practice would be prudent.

Suxamethonium injection

4.5. Regarding suxamethonium injection, the group considered that should an out of stock become likely then it would be important to communicate to the same stakeholder groups as for propofol and other critical care medicines. The group considered that rocuronium, vecuronium or other neuromuscular blocking agents could be used as funded alternatives, but significantly higher doses would be required to deliver the equivalent therapeutic effect.

Adrenaline 1 in 1000 injection

4.6. PHARMAC staff noted that there are no current supply concerns with this medicine specific to COVID-19, but that the supply chain for this medicine has been fragile in the past. The group considered that adrenaline is used in a wide range of clinical settings and was likely to be the only therapeutic option in where there is a risk of anaphylaxis (for example first-line use for anaphylaxis in the community or by ambulance services). The group considered that in an ICU setting noradrenaline would be the preferred sympathomimetic agent. The group considered it may be appropriate to target use of adrenaline to the anaphylaxis setting. The group considered that the 1 in 10,000 injection is not generally appropriate in settings where the 1 in 1,000 injection is used. The group considered it critical to maintain supply of this medicine.

5. Closing remarks

5.1. Dr Clark thanked the group for its contributions to date and noted that PHARMAC staff would issue additional communications to the sector on the basis of the feedback received. Dr Clark noted that PHARMAC staff and Members of the group would communicate via email in the short term as required, and PHARMAC would likely convene another meeting only in the event that a second wave of COVID-19 cases was occurring or imminent.