BNSSG Shared Care Guidance
Please complete all sections

Section 1: Heading

Drug	Dapsone
Amber *three months*	
Indication	Adults Treatment of dermatitis herpetiformis and other dermatoses such as pemphigus/pemphigoid, vasculitis, hidradenitis suppurativa Treatment of oral ulceration secondary to immunobullous dermatoses, lichen planus and major aphthous ulceration (licensed indications under the 'dermatoses' definition within product license)

Section 2: Treatment Schedule

Usual dose and frequency of administration *(Please indicate if this is licensed or unlicensed and any relevant dosing information)*	For most dermatoses start at 25-50mg daily and increase gradually up to 300mg maximum daily if required. Once lesions have begun to subside, the dose should be reduced to a minimum as soon as possible, usually 25 to 50mg daily, which may be continued for a number of years. For dermatitis herpetiformis, maintenance dose can often be reduced in patients on a gluten free diet.
Route and formulation	Tablets for oral administration
Duration of treatment	For as long as clinically indicated. May be continued for a number of years

Section 3: Monitoring

Please give details of any tests that are required before or during treatment, including frequency, responsibilities (please state whether they will be undertaken in primary or secondary care), cause for adjustment and when it is required to refer back to the specialist.

Baseline tests - where appropriate
FBC including differential WCC, MCV, Reticulocyte count (reticulocyte testing is not reported in standard FBC results and must be specifically requested. Can be found on ICE systems by searching for 'retic' to select reticulocyte count.) U&Es LFTs G6PD enzyme levels
Subsequent tests - where appropriate *(Please indicate who takes responsibility for taking bloods and interpreting results)*

Test	Frequency	Who by	Action/management
FBC – including differential WCC, MCV, Reticulocyte count (reticulocyte testing is not reported in standard FBC results and must be specifically requested. Can be found on ICE systems by searching for 'retic' to select reticulocyte count.)	At week 2, week 4, monthly to 3 months **then 3 monthly thereafter**	Secondary care responsible for monitoring and prescribing for the first 3 months and until on a maintenance dose. Then, responsibility for monitoring is transferred to primary care.	STOP Dapsone and seek advice if: WBC < 3.5 x 10^9/L Neutrophils < 2.0 x10^9/L Platelets <150 x10^9/L Haemoglobin fall of >20g/L from baseline Reticulocyte count - If there is a steady rise in reticulocyte count (even if within normal limits) accompanied by a decrease in haemoglobin and/ or signs suggestive of anaemia - seek specialist advice MCV >105fl – Check B12, folate and TFTs (and alcohol consumption) and start supplementation if low
LFTs	At week 2 and week 4, monthly to 3 months **then 3 monthly thereafter**	Secondary care responsible for monitoring and prescribing for the first 3 months and until on a maintenance dose. Then, responsibility for monitoring is transferred to primary care.	STOP Dapsone and seek advice if: AST/ ALT > 2 times the upper limit of reference range
U+Es	At week 2, week 4, monthly to 3 months **then 3 monthly thereafter**	Secondary care responsible for monitoring and prescribing for the first 3 months and until on a maintenance dose. Then, responsibility for monitoring is transferred to primary care.	Unexpected deranged results – seek advice from dermatologist

Note:

The use of glycosolated haemoglobin (HbA1c) to monitor diabetes mellitus can be unreliable on dapsone due to the risk of haemolysis and the formation of methaemoglobin which interferes with the measurement of HbA1c. This can lead to a falsely low HbA1c.
UHBW Endocrinology team recommends:

Measure HBA1C and check for haemolysis.

If haemolysis is present:

In patients with T1DM, use estimated HBA1C that is available on all Continuous Glucose Monitoring System reports (CGM) or use Capillary Blood Glucose monitoring (CBGM) to assess blood glucose trends, if access. Contact duty biochemist via NBT/ UHBW switchboard for advice regarding any additional testing requirements. If the patient does not have access to CGM or CBGM- contact duty biochemist via NBT/ UHBW switchboard for advice regarding any additional testing requirements.

In patients with T2DM, use CBGM if has access or contact duty biochemist via NBT/ UHBW switchboard for advice regarding additional testing.

Section 4: Side Effects

Please list only the most pertinent side effects and management. Please provide guidance on when the GP should refer back to the specialist. For everything else, please see BNF or SPC.

Side effects and management	<table><tr><th>Side effect</th><th>Action/management</th></tr><tr><td>Sore throat / mouth ulcers / bleeding gums/ fever / pallor/ unexplained illness/ infection/ unexpected bruising or bleeding</td><td>Stop Dapsone until able to arrange urgent FBC, LFT. Can restart if results are normal and contact Dermatologist for advice.</td></tr><tr><td>Dapsone syndrome (rash, fever, eosinophilia) Cutaneous hypersensitivity reaction (Stevens-Johnson syndrome, toxic epidermal necrolysis etc)</td><td>Stop dapsone immediately and seek specialist advice about urgent admission - consider immediate admission if warranted.</td></tr><tr><td>Methaemolobinaemia (light-headedness, headache, fatigue, dyspnoea, chest pain, palpitations, bluish-brown lips/skin colour)</td><td>Stop dapsone immediately and seek immediate admission (Check serum methaemoglobin levels)</td></tr></table>
Referral back to specialist	As detailed above, also if drug is ineffective or side effects require discontinuation

Section 5: Other Issues

(e.g. Drug Interactions, Contra-indications, Cautions, Special Recommendations)

Please list only the most pertinent action for GP to take (For full list please see BNF or SPC)

Issues	**Cautions** Dapsone should be used with caution in patients with cardiac or pulmonary disease. It is recommended that regular blood counts be performed during treatment with dapsone. Patients deficient in glucose-6-phosphate dehydrogenase, or methaemoglobin reductase, or with haemoglobin M are more susceptible to the haemolytic effects of dapsone.

	Dapsone should be used with caution in anaemia. Severe anaemia should be treated before starting Dapsone. **Contraindications** • Hypersensitivity to dapsone, sulfonamides, sulfones, or any of the excipients • Severe anaemia • Porphyria • Severe glucose-6-phosphate dehydrogenase deficiency • Severe liver disease • Patients prescribed clozapine due to risk of blood dyscrasias **Drug interactions** Excretion of dapsone is reduced and plasma concentrations are increased by concurrent administration of probenecid. Rifampicin has been reported to increase the plasma clearance of dapsone. Increased dapsone and trimethoprim concentrations have been reported following concurrent administration in AIDs patients. Oral typhoid vaccine should not be taken until at least three days after finishing a course of dapsone, because the dapsone could make this vaccine less effective. Saquinavir should not be used in combination, as this could increase the risk of irregular heartbeat. **Pregnancy and breastfeeding** Dapsone should only be given during pregnancy when benefits outweigh any potential risks. Folic acid supplementation (5mg) advised. Dapsone diffuses into breast milk and there has been a report of haemolytic anaemia in a breast fed infant. Risk to infant is very low unless the infant is G6PD deficient **Special recommendations- HbA1C monitoring if haemolysis is present** If haemolysis is present: In patients with T1DM, use estimated HBA1C that is available on all Continuous Glucose Monitoring System reports (CGM) or use Capillary Blood Glucose monitoring (CBGM) to assess blood glucose trends, if access. Contact duty biochemist via NBT/ UHBW switchboard for advice regarding any additional testing requirements. If the patient does not have access to CGM or CBGM- contact duty biochemist via NBT/ UHBW switchboard for advice regarding any additional testing requirements. In patients with T2DM, use CBGM if has access or contact duty biochemist via NBT/ UHBW switchboard for advice regarding additional testing.
Reminder to ask patient about specific problems	Dapsone contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine

Section 6: Advice to the patient

Advice for prescribing clinician to inform patient

1. Discuss potential benefits and side-effects of treatment with the Specialist and/ or GP.
2. Share any concerns they have in relation to their treatment.
3. Patients and carers should be told how to recognise signs of blood disorders and advised to seek immediate medical attention if symptoms such as fever, sore throat, rash, mouth ulcers, purpura, bruising or bleeding develop
4. To agree to, and attend for, the monitoring of therapy (including having blood tests carried out at agreed intervals) and assessment of outcomes, to assist health professionals to provide safe, appropriate treatment.
5. To report any side-effects to the Specialist and/or GP (see individual drug fact sheet for specific information)
6. To inform GP/ specialist/ pharmacist of all medicines (including OTC preparations) that they are currently taking
7. Report any suspected pregnancy to the GP and/or Specialist and inform of any plans to conceive in a timely manner.
8. Issue a BAD Dapsone PIL
9. Warn dapsone can cause photosensitivity

Section 7: Generic principles of shared care for SECONDARY CARE

Please do not amend.

Core responsibilities

1. Initiating treatment and prescribing for the length of time specified in **section 1.**
2. Undertaking the clinical assessment and monitoring for the length of time specified in **section 1** and thereafter undertaking any ongoing monitoring as detailed in **section 3.**
3. Communicate details of the above in 1 and 2 to GP within the first month of treatment. This information should be transferred in a timely manner.
4. Refer patients to GP and provide information of further action where appropriate e.g. if blood test is due.
5. To provide advice to primary care when appropriate.
6. Review concurrent medications for potential interaction prior to initiation of drug specified in **section 1.**
7. Stopping treatment where appropriate or providing advice on when to stop.
8. Reporting adverse events to the MHRA.
9. Reminder to ask patients about particular problems see **section 5.**

Section 8: Generic principles of shared care for PRIMARY CARE

Please do not amend.

Core responsibilities

1. Responsible for taking over prescribing after the length of time specified in **section 1.**
2. Responsible for any clinical assessment and monitoring if detailed in **section 3** after the length of time specified in **section 1.**
3. Review of any new concurrent medications for potential interactions.
4. Reporting adverse events to the MHRA.
5. Refer for advice to specialist where appropriate.
6. Reminder to ask patients about particular problems see **section 5.**

Section 9: Contact Details

Name	Organisation	Telephone Number	E mail address
Sarah Hanby	UHBW NHS Foundation Trust	0117 342 2640	MedDermCNS@uhbw.nhs.uk
Debbie Shipley	UHBW NHS Foundation Trust	0117 342 9767	Click here to enter details
BRI Dermatology On Call Mon-Fri 9am–5pm	UHBW NHS Foundation Trust	No telephone number	bridermatologyoncall@uhbw.nhs.uk
BRI Medical Secretaries	UHBW NHS Foundation Trust	0117 342 9767	dermatologysecretaries@uhbw.nhs.uk

Section 10: Document Details

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Section 11: Collaboration

All shared care protocols should be BNSSG wide where possible. Specialists in any one discipline are encouraged to collaborate across the health community in preparing shared care guidance. Please give details

1. Click here to enter details

Section 12: References

Please list references

1. BNF
2. SPC
3. BAD
4. Wakelin