Shared Care Guideline for Methotrexate

Name of patient treated under this guideline:

This shared care guideline has been produced to support the seamless transfer of patient treatment from secondary to primary care, and provides an information resource to support clinicians providing care to the patient. It does not replace discussion about transfer of care on an individual patient basis.

This guideline was prepared using information available at the time of preparation, but users should refer to the manufacturer’s current edition of the Summary of Product Characteristics (“data sheet”) for more details.

1. Indication and Licensed Status
   - Patients with active rheumatoid arthritis or other inflammatory arthritis conditions.
   - Psoriasis where treatment with a disease-modifying agent is indicated.
   - Methotrexate is also sometimes used off-license in Crohn’s disease.

   NB The 'Metoject' methotrexate pre-filled syringes (50mg/ml) are indicated for the treatment of active rheumatoid arthritis in adults, polyarthritic forms of severe active juvenile idiopathic arthritis, severe psoriatic arthritis in adults and severe recalcitrant, disabling psoriasis. The District Prescribing Committee has approved the use of Metoject off licence for Crohn’s disease.

2. Initial Referral Criteria
   Consultants will consider methotrexate as a therapy for any patient attending their clinics with the indications described in section 1.

3. Pre-treatment Assessment
   Monitoring before starting methotrexate or if reinstating methotrexate after a rest period:
   - Full blood count including differential blood count and platelets.
   - Liver function tests including serum albumin
   - Renal function tests.
   - Exclude hepatitis B and C if clinically indicated.
   - Exclude TB if clinically indicated
   - Chest X-ray
   - Patient to be given relevant information, leaflets and advice

4. Safety Issues - For full details consult the summary of product characteristics
   4.1. Contra-indications
   - Hypersensitivity to methotrexate or any of the excipients
   - Severe liver insufficiency
   - Chronic renal impairment where the creatinine clearance is less than 20ml/min.
   - Acute or acute on chronic renal impairment (methotrexate should be withheld and the FBC checked).
   - Pre-existing blood dyscrasias such as bone marrow hypoplasia, leucopenia, thrombocytopenia or significant anaemia.
   - Serious, acute or chronic infections such as TB, HIV or other immunodeficiency syndromes.
   - Patients (especially the elderly) with an acute illness eg a severe infection
   - Ulcers of the oral cavity and known active gastrointestinal ulcer disease.
   - Alcohol abuse. The consumption of alcohol should be avoided or minimised.
• Concurrent vaccination with live vaccines
• Methotrexate must not be given to pregnant or breast feeding women.
• Patients of a sexually mature age (women and men) must use effective contraception during treatment with methotrexate and for at least 6 months thereafter. Patients and their partners should be advised.
• The Consultant must be notified of a suspected pregnancy immediately.

4.2. Cautions
• Methotrexate should be used with caution in patients with chronic renal impairment.
  o Creatinine clearance 20-50 ml/minute: 50% dose
  o Creatinine clearance < 20 ml/minute: do not use methotrexate.
• Methotrexate should be used with caution in patients with acute renal impairment. The methotrexate should be withheld and the FBC checked.
• Methotrexate should be used with caution, if at all, in patients with significant current or previous liver disease, especially if due to alcohol. If the bilirubin is > 85.5micromol/L then methotrexate is contraindicated.
• Patients (especially the elderly) with an acute illness.
• Systemic toxicity of methotrexate may be enhanced in patients with ascites or other effusions due to prolongation of the serum half life. Pleural effusions and ascites should be drained prior to initiation of methotrexate therapy.
• Caution in presence of inactive, chronic infections (herpes zoster, TB, hepatitis B or C) due to possible activation.
• Methotrexate may, due to its effects on the immune system, impair response to vaccination.

4.3. Side effects
For more information see the relevant summary of product characteristics.

| Liver | Rise in serum transaminases, cirrhosis, fibrosis & fatty degeneration of liver |
| Kidney | Renal failure (rare), inflammation & ulceration of urinary bladder |
| Haematological | Leucopenia, infection, septicaemia, chills & fever |
| | Thrombocytopenia |
| | Anaemia |
| Cardiovascular | Pericarditis |
| Respiratory | Pneumonia, interstitial alveolitis / pneumonitis often associated with eosinophilia. Pulmonary fibrosis. Symptoms indicating potentially severe lung injury are dyspnoea, dry non-productive cough and fever. |
| Nervous system | Headache, tiredness, drowsiness |
| Musculoskeletal | Vasculitis |
| | Myalgia |
| | Arthralgia |
| Skin | Erythema, pruritus, urticaria |
| | Herpetiform eruptions of skin, herpes zoster |
| | vasculitis, photosensitisation |
| | Exanthema |
| | Rheumatoid nodulosis |
| | Stevens-Johnson syndrome |
| | Epidermal necrolysis |
| Eye | Visual disturbances |
| Gastrointestinal | Nausea & vomiting, dyspepsia |
| | Diarrhoea |
| | Mucosal ulceration of intestinal & oral epithelium, stomatitis |
| Fertility | Defective oogenesis & spermatogenesis |
| | Impaired fertility, menstrual dysfunction |
| | Teratogenic |
4.4. Interactions

See also Appendix 1 of the most recent edition of the BNF.

- **Acitretin - Avoid.** May increase serum concentration of methotrexate & increase risk of hepatotoxicity
- **Alcohol.** Advise patients to stay within 4-6 units per week.
- **Aspirin, NSAIDs.** Reduced methotrexate excretion. Clinically significant interaction with NSAIDs is rare, continue standard doses advised by specialist, but patients should be advised to avoid self-medication with over the counter aspirin or ibuprofen. Low dose aspirin can be continued.
- **Ciclosporin.** Monitor closely. Risk of toxicity
- **Ciprofloxacin.** Monitor closely. Reduced methotrexate clearance may increase toxicity
- **Clozapine-Avoid.** Increased risk agranulocytosis
- **Cotrimoxazole- Avoid.** Increased antifolate effect of methotrexate which increases risk of marrow aplasia
- **Digoxin- Caution.** Methotrexate possibly reduces adsorption
- **Fluorouracil topical - Avoid.** Risk of toxic skin reaction
- **Leflunomide- Monitor closely.** Increased risk of liver/haematotoxicity
- **Vaccines-Avoid live vaccines.** Pneumococcal & flu vaccines can be given but pneumococcal revaccination is not recommended. Passive immunisation may be given with VZIg in non-immune patients exposed to chicken pox or shingles. Contact specialist for advice
- **Penicillins- Monitor closely.** Some penicillins can reduce methotrexate clearance, but methotrexate toxicity has only rarely been reported
- **Phenytoin- Caution.** Increases antifolate effect of methotrexate
- **Probenecid- Avoid.** Reduces methotrexate excretion & increases toxicity
- **Proton pump inhibitors- Monitor closely.** Possibly reduce methotrexate excretion
- **Tetracyclines/Doxycycline- Monitor carefully.** Increased risk methotrexate toxicity
- **Tolbutamide- Monitor closely.** Increases serum concentration of methotrexate
- **Trimethoprim- Avoid.** Increased antifolate effect of methotrexate which increases risk of marrow aplasia
- **Warfarin- Monitor INR closely**

4.5. Routine Safety Monitoring

**NB.** These are guidelines only, which may be overridden at the discretion of the consultant. Results outside recommendations should be discussed with the consultant along with trends raising concerns.

When a dose increase has occurred close monitoring should be reinstated for 6 weeks.

Patients taking other hepatotoxic or haematotoxic drugs concomitantly should be monitored more frequently (e.g. leflunomide).

Where renal function is compromised monitoring should take place more frequently and when medicinal products are administered concomitantly which affect the elimination of methotrexate or cause kidney damage, monitoring should occur more frequently.

Patients who develop severe dehydration, acute renal failure or acute on chronic renal failure must have their FBC checked immediately and the methotrexate therapy temporarily withheld.

Patients (especially the elderly) with an acute illness e.g. with a severe infection, should have their methotrexate withheld and FBC checked.
### Monitoring Frequency

<table>
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<tr>
<th>Parameter</th>
<th>Rheumatology Patients</th>
<th>Dermatology Patients</th>
<th>Gastroenterology Patients</th>
<th>Results that require discussion with the consultant/treatment withheld</th>
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</table>
| Full Blood Count, including differential blood count and platelets       | Every 2 weeks for 6 weeks after the last dose change, then monthly until the patient is stabilised. Once patient is established on treatment and dose and response trends are stable, monitoring may be reduced to every 2-3 months after discussion with specialist | Initially once a week under supervision of specialist. Gradually increase interval between tests until therapy stabilised. GPs to take on monitoring only when therapy is stabilised sufficiently to allow monitoring every 2 weeks for 6 weeks after the last dose change, then monthly until the patient is stabilised. Once patient is established on treatment and dose and response trends are stable, monitoring may be reduced to every 2-3 months after discussion with specialist | Every 2 weeks for 6 weeks after the last dose change, then monthly until the patient is stabilised. Once patient is established on treatment and dose and response trends are stable, monitoring may be reduced to every 2-3 months after discussion with specialist | • Total WBC <3.5x10^9/L  
• Neutrophils <2.0x10^9/L  
• Platelets <150x10^9/L  
• Mean Corpuscular Volume (MCV) > 105fl (check vitamin B12 and folate levels) |
| Renal function tests: Urea & Electrolytes                                 | As for Full Blood Count | As for Full Blood Count | As for Full Blood Count | • Acute renal failure or decline from normal renal function. |
| Liver Function Tests including serum albumin and bilirubin.              | As for Full Blood Count | As for Full Blood Count | As for Full Blood Count | • AST or ALT greater than twice the upper limit of reference range  
• Unexplained fall in serum albumin (in absence of active disease) |

The following symptoms also require treatment to be withheld and FBC and other appropriate investigations to be arranged:

- Rash
- Oral ulceration
- Abnormal bruising or severe sore throat
- Dry, unproductive cough, shortness of breath and fever may indicate potentially severe lung disease – arrange for a chest X-ray
- An unexplained fall in albumin
- Patients should be advised to report all signs and symptoms suggestive of infection.

### Efficacy & Less Routine Monitoring

- For Rheumatology patients: ESR / CRP
- For Dermatology patients: PIIINP assay should be performed every 3 months and in cases where the consultant deems it appropriate further investigation (eg liver biopsy) may be undertaken.
5. Dosage
The dose is variable with the usual range being between 5mg and 25mg once a week. The dose is taken on the same day once weekly. Treatment is generally started at a dose of 10-15mg and gradually increased by 2.5mg per week or as determined by the Consultant Rheumatologist, Gastroenterologist or Dermatologist. A weekly dose of 25mg should in general not be exceeded. Dose reduction should be considered in elderly patients due to reduced liver and kidney function as well as lower folate reserves which occur with increased age.

5.1. Route of administration
2.5mg tablets orally, or sub-cutaneous injection by patient. Oral methotrexate should be used first line. The patient should be explicitly informed about the once weekly administration. It is advisable to determine a fixed day of administration.

5.2. Supporting Therapies
A single dose of oral folic acid 5mg may be prescribed to be taken once a week on a different day to the methotrexate (not routinely prescribed in dermatology patients). The frequency may be increased if there are troublesome gastrointestinal side effects or nausea.

5.3. Prescribing Guidance (Oral)
The directions should state the number of tablets as well as the dose in mg to be taken. Additionally the directions should state a specific day of the week for them to be taken on or “to be taken once weekly as a single dose”. Do not prescribe "As Directed".

5.4. Prescribing Guidance (Subcutaneous)
When the SC route is used the prescription for the pre-filled syringes should include the brand name ‘Metoject’. The prescription should state directions for use and a specific day for the syringe to be injected on or the directions “to be injected once weekly as a single dose” not “As Directed”.

Metoject pre-filled methotrexate syringes are available as the following strengths:

- 1 pre-filled syringe of 0.15ml contains 7.5mg methotrexate
- 1 pre-filled syringe of 0.20ml contains 10mg methotrexate
- 1 pre-filled syringe of 0.25ml contains 12.5mg methotrexate
- 1 pre-filled syringe of 0.30ml contains 15mg methotrexate
- 1 pre-filled syringe of 0.35ml contains 17.5mg methotrexate
- 1 pre-filled syringe of 0.40ml contains 20mg methotrexate
- 1 pre-filled syringe of 0.45ml contains 22.5mg methotrexate
- 1 pre-filled syringe of 0.50ml contains 25mg methotrexate
- 1 pre-filled syringe of 0.55ml contains 27.5mg methotrexate
- 1 pre-filled syringe of 0.60ml contains 30mg methotrexate

Each time methotrexate is due to be prescribed it is the prescriber’s responsibility to ensure that the necessary safety investigations (e.g. LFTs), required for patients receiving methotrexate, have been undertaken. The prescriber must ensure that these results have been checked and (if necessary, acted upon) before prescribing/administration of methotrexate, as directed above (see section 4).

It is the prescriber’s responsibility to record the test results in the patient held monitoring booklet and to communicate any necessary dose changes to the patient.
The SC route (not usually prescribed by dermatologists) is indicated where the oral route cannot be tolerated and the benefits of methotrexate therapy have been demonstrated. Subcutaneous methotrexate can be administered by practice or district nurses when it is physically impossible for patients or their carers to self-administer subcutaneously.

6. Parenteral Treatment

Subcutaneous (SC) Methotrexate Administration

The Consultant Rheumatologist will decide which patients are suitable to receive SC methotrexate. Patients will be assessed by the clinic nurses taking into account:

- The patient is compliant
- The patient has hand function adequate for self administration
- The patient has a good understanding of:
  - The medication (methotrexate)
  - Side effects
  - Importance of follow up appointments in outpatients
  - Importance of regular blood monitoring
  - Information on injection technique – self administration
  - Awareness of contact numbers
  - Awareness of the storage requirements
  - Understanding of disposal requirements

The final decision will be made by the hospital staff in conjunction with the patient.

Patients will be trained by the clinic nurses who will document that training has occurred and sign the check-list and certificate. The training will start by the nurse demonstrating how to give the injection, and then the patient self administering while supervised by the nurse. When the patient feels confident, and the nurse is convinced that the patient ‘passes’ the Check-list, they can start to self administer at home. The clinic will provide the patient with details of who to contact in case of difficulties. Where the patient cannot self-administer consideration will be given to training a carer.

Secondary care will normally supply the first four syringes when patients are initiated on Metoject®. Thereafter it will be the responsibility of the GP to write the prescriptions and the patient will need to obtain supplies from a community pharmacy.

The hospital will supply:

- Record cards
- The first four Metoject syringes
- The first cytotoxic sharps bin
- Appropriate personal protective equipment (e.g. gloves) if the patient is not self-administering

The GP will need to supply:

- Further prescriptions for Metoject pre-filled methotrexate syringes
- Mediswabs/gauze – for bleeding after injection
- Further cytotoxic sharps bins.

Contact of methotrexate with the skin and mucosa should be avoided. In case of contamination, the affected parts should be rinsed immediately with plenty of water.
7 Role of Professionals and Patient

It is the prescriber’s responsibility to ensure that the required monitoring is carried out for all those patients on methotrexate.

7.1. Role of Consultant

- To assess the suitability of the patient for methotrexate
- To explain the possible side effects of the medication to the patient and emphasise the importance of regular monitoring
- To advise the patient to report all signs and symptoms of infection.
- Emphasise to patients taking oral methotrexate that the tablet(s) are to be taken once a week and not daily
- To give the patient the methotrexate pre-prescribing information sheet
- Determine the route of administration
- To carry out initial investigations and initial safety monitoring (i.e. while the consultant is prescribing the methotrexate) and record this in the monitoring book
- To write to the patient’s GP recommending that a shared care agreement is initiated
- To initiate therapy unless, by exception, the GP indicates a preference to initiate therapy on the consultant’s recommendation.
- If it is necessary for the consultant to write a prescription this should be written in accordance with the prescribing guidelines above (5.3 & 5.4)
- To give the patient a patient held monitoring booklet containing the appropriate details
- To remind patients to bring their monitoring booklet with them each time they see a healthcare professional (so results can be recorded appropriately)
- To monitor the patient’s response to methotrexate therapy (eg ESR / CRP)
- To communicate any necessary dose changes in terms of number of 2.5mg tablets (or strength of pre-filled syringe) to the patient and their GP – and request that the GP issue a new prescription for the new dose
- To advise the GP on the appropriate action with respect to any of the safety monitoring results.
- To monitor all other safety monitoring while he or she is issuing prescriptions.
- Decide when to stop therapy

The prescriber should carry out the safety monitoring unless otherwise agreed in writing with the other parties.

Criteria for Transfer of Prescribing to GP

All patients should have their methotrexate routinely prescribed and monitored in primary care. In accepting prescribing responsibility the GP also accepts responsibility for undertaking the activities outlined in this shared care guideline in 7.2 below, which will include monitoring.

7.2. Role of GP

- To reply to the consultant if not willing to accept shared care
- To ensure that all relevant staff within the practice are aware of the shared care guideline
- To carry out the ongoing safety monitoring (i.e. while the GP is prescribing the methotrexate) and any other tests as per the shared care guideline and ensure that the results are recorded in the monitoring booklet when they see the patient. Often the results may actually be recorded by the patient themselves.
- To remind patients to bring their monitoring booklet with them each time they see a healthcare professional (so that results can be recorded appropriately)
- The GP must ensure under all circumstances that they receive copies of the safety monitoring before writing a prescription
To consider any side effects reported by the patient, and discuss with the consultant if action is uncertain.

To write the prescription in accordance with the prescribing guidelines above (5.3 & 5.4)

To increase the dose if necessary, but only on the advice of the consultant.

To communicate any necessary dose changes in terms of number of 2.5mg tablets (or strength of pre-filled syringes) to the patient.

To avoid or appropriately manage the drug interactions indicated in Section 4 & current BNF.

Emphasise to patients taking oral methotrexate that the tablet(s) are to be taken once a week and not daily.

To refer back to the Consultant if the methotrexate therapy becomes less effective.

To refer to secondary care any problems with self-administration of subcutaneous methotrexate.

7.3. Role of Patient

To report any side effects to the GP or consultant.

To report any symptoms e.g. mouth ulceration, easy bruising, bleeding, signs of infection especially sore throats.

To report breathlessness or coughs.

To have blood tests carried out at agreed intervals. The patient must fully understand the need for safety monitoring whilst on methotrexate.

To carry the patient held monitoring booklet (it must be brought to each appointment with a doctor so that results can be recorded appropriately).

To avoid an excessive alcohol intake.

To report suspected pregnancy of the patient or their partner.

To dispose of full cytotoxic sharps bins in the correct way – The patient should be directed to their local authority.

7.4. Role of Specialist Nurse

(At UHS the dermatology nurses are not involved with methotrexate patients and do not perform the roles outlined below. The dermatology consultants at UHS carry out all of the roles listed under ‘nurse’ roles with the exception of training the patients to self-administer methotrexate subcutaneously and supplying the patients with the cytotoxic sharps bin. These two roles are performed by Sr Yvonne Owen, the specialist rheumatology nurse, UHS).

To make sure all patients have the appropriate monitoring booklet and patient information.

To remind patients to bring their monitoring booklet with them each time they see a healthcare professional (so results can be recorded appropriately).

To train the patients to self-administer methotrexate subcutaneously and ensure that they are capable of doing so safely.

To reinforce as necessary with the patient the importance of once weekly dosing.

To make sure, at hospital appointments, that patient held monitoring cards are up to date.

To chase up any patients who have missed hospital appointments.

To supply the patient with their first cytotoxic sharps bin. Further supplies are available from the GP via FP10.
8. Further information

<table>
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9. Authorisation

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<tr>
<th>Produced by:</th>
<th>Caron Underhill, Pharmacist, UHS</th>
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<tbody>
<tr>
<td></td>
<td>Malcolm Irons, Chief Pharmacist, WEHT</td>
</tr>
<tr>
<td>Updated by:</td>
<td>Edward Horne, Pharmacist, UHS September 2008</td>
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<td>Updated by:</td>
<td>Caron Underhill, Pharmacist, UHS Sept 2011 &amp; Dec 2012</td>
</tr>
<tr>
<td>Updated by:</td>
<td>Julia Wright, Pharmacist West Hants CCG June 2013. Revision to remove pneumococcal vaccine October 2013</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Basingstoke, Winchester and Southampton District Prescribing Committee (Martin Stephens, Chairman), plus local specialist departments.</td>
</tr>
<tr>
<td>Date approved by DPC:</td>
<td>June 2013</td>
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<td>Date for review:</td>
<td>June 2015</td>
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Appendix A - Guidance on Medicines and Health & Safety Assessment

Introduction
As employers Practices and PCTs and employees have responsibilities for health & safety at work. This document is intended to supplement general guidance on these issues relating to Medicine usage

Health & Safety Risk Assessment
Prior to introducing a new medicine into a working environment a Health & Safety Assessment should be carried out.

Control of Substances Hazards to Health (COSHH) Assessment
Medicines by their very nature should be considered substances hazardous to health, therefore where staff are handling medicines, (eg nurse administration, extemporaneous dispensing in dispensing practices), a COSHH assessment should be carried out. Information of the risks associated from medicines can be found in their Summary of Product Characteristics or Hazard data sheets (where available) and should be available on site for reference.

Generally these can be grouped by the nature of the risk eg:
- General medicines
- Cytotoxic medicines
- Drugs prone to allergy eg penicillins
- Flammable products
- Chiropody and dermatological products are often corrosive and / or irritant.

Cryogenic Liquid Regulations
These regulations apply to Liquid Nitrogen and other very cold products

Occupational Health for staff handling the medicines
Where a COSHH assessment identifies a medicine could be a hazard to staff, discussions should be held with occupational health to decide if health monitoring is required and the nature of any monitoring

Storage
Consideration should be given to
- Limiting the stock holding
- Where and how stock is held
- Highlighting what stock is held where
- Written procedures on ordering & storage

Handling
Consideration should be given to:
- Staff involved
- Education & training
- Written procedures

Waste disposal
Waste associated with medicine generally falls into three groups:
- Packaging (outer boxes) – Normal Waste
- Discharged vials / syringes (empty / used) – Clinical Waste
- Containers not fully discharged of medicines (vials / syringes) – Special Clinical Waste – Cytotoxic containing waste will need to be identified and may need to be segregated from other Special Clinical Waste – Your waste contractor will need to be contacted to identify the local situation.
Appendix B - Occupational Health Monitoring

Cytotoxic Medicines (methotrexate)
The occupational health risk associated with parenteral methotrexate is with the reconstitution of the product rather than the administration.

Where staff reconstitute / prepare a cytotoxic agent they should be covered by six monthly health surveillance including questionnaire, lung function testing and periodic blood screens.

Simple administration of reconstituted drugs in their final container (syringe / infusion device) should not pose an appreciable risk. Unexpected exposures (spillage etc) should be dealt with on a case by case basis.

Concerning pregnancy:
Staff need to be informed of the need to avoid potential exposure in the early stages of pregnancy, which effectively means when pregnancy is planned or may be expected Where staff reconstitute / prepare cytotoxics they should inform their manager and be removed from these duties before becoming pregnant
This does not mean that unplanned or accidental pregnancy while undertaking such duties automatically carries a high risk, just that risk assessment shows that avoidance of such agents is advisable

Immunocompromised staff:
These should be treated in a similar manner to those who are pregnant

References
1. Dr P Johnson, Employee Safety & Occupational Health Dept., Winchester & Eastleigh NHS Trust, Personal Communication, 16-Aug-02

2. Mary Simpson, Occupational Health Dep., New Forest PCT, Personal Communication, 14-Aug-02
Appendix C- Personal Protective Equipment for the IM or SC Administration of Methotrexate

Health risks
- Limited evidence of a carcinogenic effect
- Possible risk of impaired fertility
- Possible risk of harm to the unborn child
- Irritating to eyes
- Irritating to skin
- Refer to Management of Health & Safety at Work Regulations 1999 (Reg 16-18)
  - do not breathe dust
  - when using do not eat, drink or smoke
  - avoid contact with skin and eyes

A Health & Safety risk assessment should be carried out before each administration

Personal Protective Equipment to be used by practitioners administering SC methotrexate in PRE-PREPARED syringes
- Gloves - PVC, Nitrile or high-quality (surgeon's) latex gloves. The key factor is the thickness of the gloves, standard latex or plastic gloves do not offer adequate protection.
- Apron - plastic apron
- Goggles - need only be worn if there is a risk of contamination eg. due to sudden patient movement. If worn they should meet the British Standard EN 166
- Administration should take place in a well-ventilated room.

RECONSTITUTING methotrexate for injection
- This is a high risk situation and must only take place in a Laminar Flow Cabinet by someone trained and experienced in this skill. (see Appendix A & B)
- Pre-filled syringes of methotrexate are produced commercially by a number of firms both licensed and specials depending on the strength(see Appendix D)

References

Mike Knill, Health & Safety Advisor
Kate Panico, Professional Development Nurse, District Nursing