

Shared Care Fact Sheet - Leflunomide

Rheumatology Sub-Stream

This document is available under "Resources" at https://metronorth.health.qld.gov.au/specialist_service/refer-your-patient/rheumatology

Many patients with Rheumatoid Arthritis (RA) or Psoriatic Arthritis (PsA) are suitable for rheumatologist/GP **shared care** leflunomide (LEF) management. MNHHS rheumatologists are now advocating for this where appropriate (including for this patient if this document is accompanying a clinic letter). Sharing care can improve specialist access and enhance patient compliance and satisfaction.

Please complete the following for your patient:

- ☐ **Review vaccination status** – COVID, pneumococcal and yearly flu vaccinations recommended. Patients on LEF receiving a first flu vaccine should probably get 2 doses, 4 weeks apart. Biological & targeted synthetic DMARDs are a contraindication to live vaccines. [Table of Vaccinations for Rheumatology Patients](#)
- ☐ **Arrange a skin check** if not done within previous 6 months and ensure repeated annually
- ☐ Monitor BP at each visit. LEF can cause hypertension
- ☐ **Discuss the critical importance of ongoing, effective contraception for up to 2 years post cessation in women** Consider offering long-acting reversible contraception. For paternal exposure the conditional recommendation is to continue but evidence is limited - see *C:Links*.
- ☐ **Ensure pathology tests are done** and action results appropriately – see *A:Pathology testing*.
- ☐ **Arrange clinical review** as appropriate and consider software reminders for regular tasks
- ☐ **Please contact the Rheumatology team if you have any concerns (Registrar via switch)**

A: Pathology testing

- Regular **FBC, E/LFT, ESR/CRP** are required with **results to GP and rheumatologist**
- Please review the patient in the context of the clinical letter to assess symptoms, possible side effects and to action abnormal results. If the protocol outlined below recommends a change in treatment, please forward details to the rheumatology clinic
- Testing required at baseline, then 2–4 weekly for months 0-3, then 8–12 weekly for months 3-6
- When the dose of LEF is stable for 3 months and there are no other relevant changes (e.g. development of impaired renal function) the above tests should be performed at a **minimum of every 3 months**
- If **co-prescribed methotrexate (MTX)** the **minimum interval is 2 monthly** due to increased potential toxicity
- Regular cardiovascular risk review, including lipids, is advisable for all patients with autoimmune disease

If your patient has elected to use Queensland Health pathology, they have been provided with a form.
If your patient wishes to use a private pathology provider, their GP will need to issue pathology forms.
The Rheumatologist may have given them a form for their first test. Ensure your details are in the cc field.

Managing abnormal tests:

- **Liver function**
 - If ALT/AST levels >2x upper limit of normal (ULN) but <3x ULN, LEF dose should be reduced by 50% and tests repeated in 1 month. Once ALT/AST improved to <2x ULN any further LEF increase must be monitored with monthly LFT until dose stable for 3 months
 - If ALT/AST >3x ULN, withhold LEF and discuss with rheumatology registrar
 - Consider screening for other causes of LFT derangement if ALT/AST >3x ULN 4 weeks after discontinuation
- **Haematology**
 - If Hb drops 20 g/L below baseline, WBC <2 x 10⁹/L, neutrophils <0.5 x 10⁹/L or platelets <50 x 10⁹/L withhold LEF and discuss with rheumatology registrar
 - If less severe abnormalities reduce LEF dose by 50% and repeat tests in 2 weeks
 - Myelosuppression is more common in initial months but can occur any time during treatment
 - Myelosuppression is increased in older patients and when combined with MTX

B: Possible side effects

- Diarrhoea is commonest (up to 17% of patients). Taking LEF with food/in the evening may reduce this.
- Hypertension is identified up to 10% patients. LEF can aggravate existing hypertension or induce new-onset hypertension within 3 months of therapy.
- Pruritis and various other skin conditions including: non-specific rash, mucosal ulcers, Stevens-Johnson syndrome, toxic epidermal necrolysis, lichenoid reaction, cutaneous vasculitis, erythema multiforme and subacute cutaneous lupus. These usually occur at initiation but can develop later.
- Dose-dependent alopecia is a common transitory adverse effect of LEF (6–23%). Hair loss is diffuse and often mild to moderate. Aim to reassure patient of this and continue LEF at the same dose.
- Peripheral neuropathy, (distal axonal, sensory, or sensorimotor) has been reported. Patients who stop LEF within 30 days of symptom onset may be more likely to have improvement/recovery.
- Lipid dysfunction can occur
- Serious side effects of myelosuppression, hepatotoxicity and pneumonitis are much less common. LEF and MTX have synergistic toxicity so extra care is mandatory when prescribed in combination.

C: Links

The [ARA website \(rheumatology.org.au\)](http://rheumatology.org.au) has more information including COVID advice and vaccine information:

Medications: [Rheumatology Medication Information](#)

Pregnancy: [Rheumatology Medications for Autoimmune Rheumatic Diseases in Pregnancy](#)

Vaccines: [Table of Vaccinations for Rheumatology Patients](#)

HealthPathways is a valuable GP decision-support tool which includes sections on all major rheumatology conditions: [HealthPathways Brisbane North \(communityhealthpathways.org\)](http://communityhealthpathways.org) Username: [Brisbane](#) Password: [North](#)

Further Information

LEF and interactions:

- Caution is needed with drugs metabolised via cytochrome P450 2C9, such as warfarin and phenytoin
- LEF may reduce warfarin metabolism, increasing INR. Because of the active metabolite's long half-life, this effect may persist for 2–4 weeks after stopping
- No significant interactions between LEF and oral contraceptives have been found

LEF and infections:

- Patients can usually continue LEF while being treated with oral antibiotics

LEF can be taken with other medications including:

- Other DMARDs including MTX, biological and targeted synthetic DMARDs
- Steroids such as prednisolone
- NSAIDs / low dose aspirin / paracetamol

LEF and alcohol:

- LEF usage in heavy drinkers has been associated with liver cirrhosis
- It is not known precisely what level of drinking is safe when on LEF
- Maximum intake should remain within NHMRC alcohol consumption guidelines
- Drinking >4 std. drinks on one occasion, even infrequently, is strongly discouraged

Dose titration will be directed by the rheumatologist:

- LEF tablets are available in 10mg or 20mg strengths
- Standard dose is 10-20mg as a single daily dose
- Please carefully consider the number of repeats you provide to ensure recommended monitoring is adhered to
- LEF is a very slow acting DMARD; response is assessed after 4-6 months on 20mg/day
- LEF is PBS-subsidised for RA and PsA if initiated by a specialist physician.

Unplanned pregnancy / cholestyramine washout:

- In case of unplanned pregnancy: stop LEF, commence cholestyramine washout (8g tds for 11 days) and contact the treating rheumatologist promptly
- Washout may also be indicated when planning pregnancy or for other scenarios such as serious infections

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