Royal Cornwall Hospitals
NHS Trust

Midodrine in Postural Hypotension Shared Care Guideline

V5.0

December 2025

1. Aim/Purpose of this Guideline

1.1. This Shared Care Guideline has been approved whilst the system-wide approach with the Local Medical Committee to shared care is under review. Hence this guideline may be altered sooner than its review date.

1.2. This guideline applies to medical, nursing and pharmacy staff in the safe and appropriate prescription and administration of midodrine when used in postural hypotension.

1.3. Postural (orthostatic) hypotension is defined as a fall in blood pressure of over 20 mm Hg systolic, (or 10 mm Hg diastolic), on standing or during head-up tilt to at least 60°.It may be a presenting feature in certain autonomic disorders (e.g. Primary Autonomic Failure, Diabetic neuropathy), or a pointer towards an alternative diagnosis (as in multiple system atrophy presenting with parkinsonian features), and it may complicate drug therapy (as with levodopa and other dopaminergic treatments). Postural hypotension is associated with increased morbidity and also mortality, especially in elderly people due to falls resulting in injuries.

1.4. The incidence of Postural Hypotension increases with age and is more common in the over 75 age group.

1.5. Midodrine is a prodrug which is converted to desglymidodrine and stimulates α-1 adrenoreceptors. It improves orthostatic BP by increasing vasomotor and venomotor tone.

1.6. This shared care guideline sets out details for the sharing of care of adults with postural hypotension prescribed midodrine. These guidelines provide additional limited information necessary to aid in the treatment of these patients. As with all shared care guidelines they highlight relevant prescribing issues but should be used in conjunction with relevant guidance and do not replace them.

1.7. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Midodrine is recommended for the adjunctive treatment of postural hypotension in those whose postural drop is 20mm Hg or more under the following conditions:

- The hypotension is due to a neurogenic failure such as Parkinson's disease with autonomic failure and not a physical or pharmacological cause.
- Midodrine and fludrocortisone are options when conservative measures, lifestyle changes and culprit drug cessation have failed.
- See 2.2 for preparations and dosage for midodrine.
- For the mineralocorticoid fludrocortisone (off label indication) a dose of 50-300 micrograms fludrocortisone once a day is recommended. At the higher doses, hypokalaemia and excessive fluid retention may occur. Its benefits may not be realised until it is stopped.
- Midodrine may be added to ongoing fludrocortisone use. If the latter is not tolerated it would normally be withdrawn slowly. Withdrawal of corticosteroids after prolonged therapy must always be gradual to avoid acute adrenal insufficiency and should be tapered off over weeks or months according to the dose and duration of treatment.
- Careful monitoring is needed if fludrocortisone and midodrine are taken together (see drug interactions).
- If fludrocortisone is used, consider if a Steroid Emergency Card is needed.
- Midodrine treatment should be initiated by specialists but can be continued by general practitioners under a shared-care guideline.

2.2. **Preparations and Dosage**

Midodrine as a generic or as the branded Bramox- 2.5mg, 5mg, 10mg tablet. These products are licensed for severe orthostatic hypotension due to dysfunction of the autonomic nervous system when corrective factors have been ruled out.

2.2.1. Dosing is initially 2.5 mg 2-3 times daily, increased, if necessary, at weekly intervals in small increments until an optimal response is obtained. Most patients are controlled at or below 30 mg daily given in divided doses. Doses in excess of 30 mg daily are not recommended. The use of midrodine should be stopped if supine hypertension increases excessively.

2.2.2. Dosing of midodrine should occur during the daytime when the patient needs to be upright. A dosing schedule of 3-4 hour intervals is suggested. The last dose should be taken at least four hours before bedtime to reduce the risk of supine hypertension.

2.2.3. Although there is no evidence to suggest that dosage requirements are different in the elderly, it is recommended that the initial dose used be small

and that increases in dosage be titrated against the patient's clinical condition with caution.

2.3. Contraindications

Midodrine is contraindicated in severe organic heart disease (e.g. bradycardia, heart attack, congestive heart failure, cardiac conduction disturbances or aortic aneurysm), Hypertension, Serious obliterative blood vessel disease, cerebrovascular occlusions and vessel spasms, Acute kidney disease, Severe renal impairment (creatinine clearance of less than 30 ml/min), Serious prostate disorder, Urinary retention, Proliferative diabetic retinopathy, Pheochromocytoma, Hyperthyroidism, Narrow angle glaucoma, Hypersensitivity to the active substance or to any of the excipients.

2.4. Precautions

2.4.1. The patients should be cautioned to report symptoms of supine hypertension immediately such as cardiac awareness (chest pain, palpitations, shortness of breath), headache, blurred vision etc, and the patient should be advised to discontinue the medication immediately. Patients with a history of cerebrovascular accidents or with known risk factors for CVA should be monitored closely.

2.4.2. Midodrine should be prescribed with care in patients with prostate disorders as use of the drug may cause urinary retention.

2.4.3. Great caution should be exercised in patients with mild to moderate renal insufficiency (creatinine clearance >30 mL/min and <60 mL/min).

2.4.4. Slowing of the heart rate may occur after administration of midodrine, primarily due to vagal reflex, therefore great caution should be taken when using it together with other agents that directly or indirectly slow the heart rate. Patients experiencing any signs or symptoms suggestive of bradycardia (pulse slowing, increased dizziness, syncope, and cardiac awareness) should be advised to discontinue midodrine.

2.4.5. The use of midodrine in patients who have an increased risk of or suffer from glaucoma / increased intra-ocular pressure or who are treated with mineralocorticoids / fludrocortisone acetate (which may increase intra-ocular pressure) should be avoided or monitored very closely.

2.4.6. Treatment with midodrine in patients with liver impairment has not been studied. It is therefore recommended to monitor liver function before starting treatment with midodrine and on a continuous basis.

2.4.7. Bramox 5mg tablets contain the azo colouring agent Sunset Yellow FCF aluminum lake (E110), which may cause allergic reactions.

2.5. Monitoring

2.5.1. It is essential to monitor supine and sitting blood pressures during the use of the drug. The supine hypertension may often be controlled by an adjustment in the midodrine dosage. Supine hypertension may also be controlled by elevation of the head.

2.5.2. The supine and standing blood pressure should be monitored regularly during initial treatment (at least two times a week). The administration of midodrine should be stopped if the blood pressure in either position increases above 180/100 mm Hg or is considered clinically significant. Patients with persistent labile blood pressure after stabilisation on midodrine should discontinue treatment.

2.5.3. **Specialist team:**

2.5.3.1. The specialist team should review the patient to assess compliance and tolerance to the drug. A medication review will be carried out and any agents known or suspected to have contributed to postural hypotension stopped or reduced.

2.5.3.2. The aim of therapy is to provide low risk therapy, ensure appropriate mobility and function, prevent falls and associated trauma, and maintain a suitable quality of life. Reducing the postural blood pressure fall should not be the singular aim, as often there is dissociation between symptoms and the level of blood pressure. During the titration stage, the specialist will have arranged for a schedule of regular blood pressure monitoring to be undertaken by the community nurse team, for short term regular monitoring producing a data trend of the Blood Pressure readings (Lying, Standing, Standing for 2-3 minutes). Some patients may be able to monitor themselves if aware of relevant parameters.

2.5.3.3. After the first 4 weeks, regular assessments with a maximum of 6 months gap should be carried out by specialists.

2.5.3.4. The drug should normally only be continued if benefiting the patient and if this is not apparent the specialist should stop the drug at a review consultation.

2.5.4. **General Practice:**

2.5.4.1. Monitoring of postural BP post titration according to the specialists direction, usually every 3 months, or if symptoms recur. Some patients may be able to monitor themselves if aware of relevant parameters.

2.5.4.2. Renal and liver function should be monitored before starting treatment with midodrine (specialist to undertake) and every 6 months or more frequently if evidence of dysfunction (GP to undertake).

2.6. **Side Effects**

Very common > [1 in 10] > Common > [1 in 100] > Uncommon > [1 in 1000] > Rare > [1 in 10000] > Very rare [<1/10,000].

2.6.1. **Psychiatric disorders, Uncommon:** Sleep disorders, insomnia.

2.6.2. **Nervous system disorders, Common:** Paraesthesia, Headache Uncommon: restlessness, excitability, irritability.

2.6.3. **Cardiac disorders, Uncommon:** Reflex bradycardia. Rare: Tachycardia, Palpitations.

2.6.4. **Vascular disorders, Common:** Supine hypertension (Blood pressure above or equal to 180/110 mmHg) more common with daily doses above 30mg.

2.6.5. **Gastrointestinal disorders, Common:** Nausea, Dyspepsia, Stomatitis. Uncommon: abdominal pain, vomiting, diarrhoea.

2.6.6. **Hepatobiliary disorders, Rare:** Abnormal hepatic function, Raised liver enzymes

2.6.7. **Skin and subcutaneous tissue disorders, Very common:** Piloerection, Pruritus (mainly of the scalp). Common: Chills, Rash, Flushing.

2.6.8. **Renal and Urinary disorders, Very common:** Dysuria. Common: Urinary retention. Uncommon: Urinary urgency.

2.7. **Common/Significant Drug Interactions**

2.7.1. Patients taking midodrine should avoid concomitant use of other adeno-sympathomimetic drugs including over the counter remedies.

2.7.2. The concomitant use of midodrine with vasoconstrictor, sympathomimetic pressor agents e.g. decongestants, some appetite suppressants, and other drugs such as reserpine, guanethidine, methyldopa, tricyclic antidepressants, antihistamines, thyroid hormones, MAO-inhibitors **including over-the-counter remedies should be avoided.**

2.7.3. The effects of midodrine may be antagonised by α-adrenergic blocking

drugs, such as prazosin and phentolamine. The concomitant use of alpha- and beta-receptor blocking agents (which reduce the heart rate) and midodrine requires careful monitoring.

2.7.4. **Glycosides**

Great caution should be taken when administering midodrine tablets to patients experiencing bradycardia produced by digitalis (or other glycosides) or psychopharmaceutical drugs since midodrine may potentiate reflex bradycardia and other kinds of conduction disorders or arrhythmias.

2.7.5. **Atropine**

Midodrine may enhance or potentiate the blood-pressure raising effect of atropine.

2.7.6. **Corticosteroid preparations**

Patients being treated with midodrine in combination with mineralocorticoids or glucocorticoids (e.g. fludrocortisone) may be at increased risk of glaucoma/increased intraocular pressure and should be carefully monitored. Midodrine may enhance or potentiate the possible hypertensive effect of corticosteroid preparations, neuromuscular blockers, beta-blockers, digoxin and galantamine.

2.8. **References:**

Summaries of Product Characteristics (Brancaster Pharma Ltd).

NICE NG 71 (Jul'17) Parkinson's disease in adults.

Orthostatic hypotension due to autonomic dysfunction: midodrine. Evidence summary ESNM61 06 October 2015:

Areas of Responsibility for the Sharing of Care

2.8.1. These are suggested ways in which the responsibilities for the management of adult patients with postural hypotension who are prescribed **midodrine** can be shared between the specialist and the general practitioners. The expectation is that these guidelines should provide sufficient information to enable GPs to be confident to take clinical and legal responsibility for prescribing these drugs. If a specialist asks the GP to prescribe this drug the GP should reply to this request as soon as practical. Sharing of care assumes communication between the specialist, GP, and patient. The intention to share care should be explained to the patient and be accepted by them.

2.8.2. In the NHSE guidelines on responsibility for prescribing (January 2018) between hospitals and GPs, it is advised that legal responsibility for prescribing lies with the doctor who signs the prescription.

2.8.2.1. **Specialist:**

- Identify criteria to be used to assess response to treatment and make a baseline assessment - Studies ideally should utilise a tilt table, as patients with neurological disabilities or a profound fall in blood pressure can rapidly and safely be returned to the horizontal position. Additional screening tests can provide information on sympathetic vasoconstrictor and cardiac parasympathetic function. Non-neurogenic causes of postural hypotension which include intravascular volume depletion (blood or fluid loss and Addison's disease), vasodilatation (drugs such as levodopa or glyceryl trinitrate), and cardiac impairment, should be considered in diagnosis.

- Make the diagnosis of postural hypotension and assess whether the patient is suitable for treatment.

- Seek consent from the patient and his/her carer or advocate. Assess likelihood of patient/carer compliance if midodrine is prescribed as part of care and if necessary, identify a suitable person to ensure concordance with treatment (e.g. relative or other carer).

- Make the patient aware of the nature of the effect of treatment and that it could be stopped.

- Initially prescribe and titrate the dose up to a maintenance level.

- Review the patient regularly and ensure systems are in place to monitor BP at least twice weekly for about 8 weeks and assess whether the patient is tolerating the treatment and complying with therapy.

- Assess the response to treatment between 4-8 weeks. If response is satisfactory and maintenance dose is reached ask the GP whether they are willing to participate in shared care using the suggested wording template (Appendix 3).

- Liaise with carers or care agencies as appropriate.

- Assess at six monthly intervals whether the treatment should be discontinued or modified.

- Prompt communication with GP of any changes in treatment, results of monitoring undertaken and assessment of adverse events.

- Provide the GP with relevant contact information with clear arrangements for back-up advice and support should further assistance be required relating to this drug.

- Reporting adverse events to the MHRA.

2.8.2.2. **General Practitioner:**

- To respond to the shared care request from the consultant in writing without undue delay.

- Prescribing of midodrine after communication with specialists regarding the need for treatment and once the maintenance dose has been established.

- Provide any information available about the patient's progress to the consultant.

- Ensure that shared care arrangements around monitoring and follow- up by specialists are in place before continuing treatment.

- Reporting to and seeking advice from a specialist on any aspect of patient care which is of concern to the GP and may affect treatment.

- Arrange to review the patient on a regular basis to monitor their wellbeing, postural BPs (usually every 3 months, or if symptoms recur) and renal and liver function tests (every 3 months or more frequently if evidence of dysfunction).

- Avoid prescribing adeno-sympathomimetic drugs, as these may reduce the efficacy of midodrine.

- Reporting adverse events to the specialist and MHRA.

- Stopping treatment in the case of severe adverse event or as per shared care guideline.

2.8.2.3. **Patient: and parent / carer responsibilities**

- Report any adverse effects to their GP and/or specialist regarding their treatment.

- Ensure that they have a clear understanding of their treatment.

- Ensure they attend for monitoring requirements as per shared care guideline.

- Be aware that treatment will be stopped if patient does not attend for monitoring.

BACK-UP ADVICE AND SUPPORT IS AVAILABLE FROM THE RELEVANT CLINICAL TEAM.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with prescribing and administration in accordance with this guideline (or other safe practice).
Lead	Head of Prescribing Support Unit.
Tool	Audit and review tool using patient documentation.
Frequency	As required according to clinical incident reports.
Reporting arrangements	Via Cornwall Area Prescribing Committee / Medication Practice Committee.
Acting on recommendations and Lead(s)	Relevant Clinical Staff.
Change in practice and lessons to be shared	Lessons and changes in practice will be communicated through various channels to relevant staff.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Midodrine in Postural Hypotension Shared Care Guideline V5.0
This document replaces (exact title of previous version):	Midodrine in Postural Hypotension Shared Care Guideline V4.1
Date Issued/Approved:	November 2025
Date Valid From:	December 2025
Date Valid To:	December 2028
Directorate / Department responsible (author/owner):	Care of the Elderly Team / Head of Prescribing Support Unit.
Contact details:	01872 253548
Brief summary of contents:	Some clinical issues and details of prescribing responsibilities for GP and specialists.
Suggested Keywords:	Midodrine, postural hypotension.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** Yes
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Cornwall Area Prescribing Committee
General Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming approval by specialty and care group management meetings:	Kevin Wright
Links to key external standards:	None
Related Documents:	None
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pharmacy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
20 November 2013	V1.0	New version in this format.	Mike Wilcock, Head of Prescribing Support Unit
25 March 2014	V2.0	Slight correction to title in EIA page 9.	Mike Wilcock, Head of Prescribing Support Unit
September 2015	V2.1	Inclusion of branded product rather than unlicensed and slight text amendments in line with Summary of Product Characteristics.	Mike Wilcock, Head of Prescribing Support Unit
November 2018	V3.0	New format and slight text amendments to 2.3, 2.8. Also shared care agreement letter included.	Mike Wilcock, Head of Prescribing Support Unit
March 2020	V3.1	Appendix 3 added following FRG approval - CHA4215 Shared Care Agreement Letter Consultant Request.	Demi Louise Kent, Corporate records Manager
September 2021	V3.2	Replacement of Shared Care Agreement Letter with suggested wording template instead (Appendix 3).	Mike Wilcock, Head of Prescribing Support Unit
March 2022	V4.0	Minor text amendments.	Mike Wilcock, Head of Prescribing Support Unit
November 2023	V4.1	Amendment on first line choice, addition of text on need for steroid card at 2.1.	Mike Wilcock, Head of Prescribing Support Unit

Date	Version Number	Summary of Changes	Changes Made by
November 2025	V5.0	New statement at 1.1. New wording at Appendix 3. Update to references at 2.8.	Mike Wilcock, Head of Prescribing Support Unit

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Midodrine in Postural Hypotension Shared Care Guideline V5.0
Directorate and service area:	Pharmacy, Clinical Support
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Mike Wilcock, Pharmacy RCHT
Contact details:	01872 253548

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide information on prescribing of midodrine to enable General Practitioners to take over prescribing responsibility from secondary care.
2. Policy Objectives	To promote a consistent level of shared care between primary and secondary care (in relation to RCHT catchment area).
3. Policy Intended Outcomes	Confident and competent prescribers, enabling medicines to be access in a primary care setting.
4. How will you measure each outcome?	Six monthly review.
5. Who is intended to benefit from the policy?	General practitioners, hospital specialists and community pharmacists from understanding local guidance around use of these medicines. Patients/carers, from being able to access medicines from their GP.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: Yes • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Cornwall Area Prescribing Committee.
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Dan Thomas, Pharmaceutical Services Contracting Team, NHS Kernow.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Suggested wording for Specialist communication re commencement of shared care

Medication: [INSERT NAME].

Indication: [INSERT INDICATION].

Date treatment started: [DATE].

Current dose: [INSERT DOSE] mg.

Time on treatment: [INSERT NUMBER OF MONTHS] months.

Prescription provided for: [INSERT NUMBER OF WEEKS] weeks.

NB: It is expected that the specialist team will prescribe sufficient medication to provide at least 4 (four) weeks of treatment.

GP practice to monitor and prescribe from: [INSERT DATE].

Next blood monitoring due: [INSERT DATE].

Next follow up: [INSERT DATE (if known) OR TIMESCALE].

As per the agreed Cornwall Area Prescribing Committee shared care guideline, this patient is now suitable for prescribing to move to primary care.

The patient fulfils the criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

- The patient has been initiated on this therapy and on a stable dose for the following period of time stated above
- Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory.
- The condition being treated has a reasonably predictable course of progression and the patient can be suitably maintained by primary care.
- The risks and benefits of treatment have been explained to the patient.
- The roles of the specialist, specialist team, primary care prescriber, patient and pharmacist have been explained and agreed.
- The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments.
- A copy of the shared care document is either attached or can be found on the RCHT or CFT document library or via the Cornwall Joint Formulary website.

- I have provided the patient with sufficient medication to last for the period of time specified above. (NB: there is an expectation that the specialist will prescribe sufficient medication to provide at least 4 (four) weeks treatment.).

- I have arranged a follow up with this patient as specified above.

If you are in agreement, please undertake monitoring and treatment the date specified above (NB: date must be at least 1 month from initiation of treatment).