

PHARMACY & THERAPEUTICS COMMITTEE NEWS

FORMULARY ADDITIONS:

The Pharmacy and Therapeutics Committee approved and has recommended for approval to the Executive Committee of the Medical Board the following drugs:

<u>DRUG NAME</u>	<u>DRUG CATEGORY</u>
Reteplase (Retavase)	Thrombolytic
Dinoprostone (Cervidil)	Prostaglandin vag. insert
Thyrotropin alpha (Thyrogen)	Thyroid cancer diagnostic
Felbamate (Felbatol)	Antiepileptic
Lamotrigine (Lamictal)	Antiepileptic
Topiramate (Topamax)	Antiepileptic
Tiagabine (Gabitril)	Antiepileptic
Carbamazepine XR (Carbatrol)	Antiepileptic
Diazepam rectal gel (Diastat)	Antiepileptic
Nevirapine susp. (Virammune)	Reverse transcriptase inhibitor
Cilostazol (Pletal)	Platelet aggregation inhibitor

REMINDER:

All physicians who will be prescribing the restricted antiepilepsy drug Felbatol must remember to provide pharmacy with a copy of the signed patient informed consent form that accompanies its use.

Felbatol was approved in August 1993 for partial seizures with and without secondary generalization in adults and for Lennox-Gastaut Syndrome, a serious form of childhood epilepsy. Because of serious toxicities associated with the drug such as aplastic anemia and acute liver failure, the FDA recommended that the drug remain available only for patients with severe epilepsy for whom the benefits outweigh the risks.

Attention Oncology Nursing Staff:

When a prescription for an ambulatory oncology patient is sent to the Pharmacy, the prescription must be accompanied by a copy of the patient's OPD Admission face-sheet. This shall confirm that the patient is registered for treatment on the day of treatment.

Other News:



Good news for all physicians conducting clinical drug trials: **A RESEARCH PHARMACIST IS NOW ON STAFF.** Some of the services provided by the research pharmacist are: preparation and dispensing of the investigational drug product, drug information, maintaining the randomization schedule of the study, maintaining the inventory, ensuring proper storage of the investigational drug, and maintaining the necessary accountability logs.

You may reach the Research Pharmacist at 270-4340.

A Notice to all Physicians:

In December 1996 the Pharmacy and Therapeutics Committee approved a resolution that was sent to the Medical Board and subsequently approved by the Medical Board condemning the use of “**sublingual**” nifedipine.

In the past, short acting nifedipine had been used for rapidly reducing blood pressure in patients with hypertensive urgencies or hypertensive emergencies; however, most clinicians and the manufacturers now question the safety of short-acting nifedipine in these situations because of occasional reports of poorly tolerated severe hypotension and the potential adverse cardiovascular consequences (e.g., cerebrovascular ischemia, stroke, myocardial ischemia and infarction, death). As a result of these and other concerns and in the absence of substantial evidence clearly establishing superiority (both in terms of safety & efficacy) of nifedipine for this use, it is recommended that short-acting nifedipine no longer be used for the management of any form of hypertension, including hypertensive crisis. The only form of nifedipine approved for use in hypertension is the extended-release formulation. **Immediate-release nifedipine is indicated only for angina.** (AHFS Drug Information 1999)

The Question Corner (by Ira Dinerman- contributing editor)

Three of the basic roles of the pharmacist are to dispense, counsel and consult. In this corner of the newsletter I recount one of my recent consultations.

One of the Nephrology housestaff physicians asked: “Can Ferrlecit (sodium ferric gluconate in sucrose injection) be administered without a test dose?”

Response:

No, a test dose is still officially recommended even though Ferrlecit is better tolerated than iron dextran injection. “Before initiating therapeutic doses of Ferrlecit, administration of an intravenous test dose of 2ml Ferrlecit (25mg of elemental iron) is recommended. This test dose should be diluted in 50ml of 0.9% sodium chloride for injection and administered over 60 minutes.” Though no fatal Type-1 hypersensitivity reactions have been reported so far, still more experience is needed before skipping the test dose can be considered acceptable practice.

Summary of Adverse Drug Reactions Reported in 1999

<i>Drug</i>	<i># of Occurrences</i>	<i>Drug</i>	<i># of Occurrences</i>
<i>Amphotericin</i>	<i>1</i>	<i>Iodoform</i>	<i>1</i>
<i>Bactrim susp</i>	<i>1</i>	<i>Levaquin inj</i>	<i>2</i>
<i>Cefazolin inj</i>	<i>3</i>	<i>Mannitol inj</i>	<i>1</i>
<i>Cefotetan inj</i>	<i>1</i>	<i>MS Contin tab</i>	<i>1</i>
<i>Clindamycin inj</i>	<i>2</i>	<i>Ceftriaxone inj</i>	<i>1</i>
<i>Demerol inj</i>	<i>1</i>	<i>Ketorolac inj</i>	<i>1</i>
<i>Dexferrum inj</i>	<i>2</i>	<i>TPN</i>	<i>1</i>
<i>Diflucan</i>	<i>1</i>	<i>Trovan inj</i>	<i>1</i>
<i>Haloperidol inj</i>	<i>1</i>	<i>Ziac tab</i>	<i>1</i>
<i>HCTZ tab</i>	<i>1</i>	<i>Intralipid</i>	<i>1</i>

The Pharmacy & Therapeutics Committee is concerned that only 25 ADRs were reported in 1999. For a hospital this size at least 125-150 should have been reported



Recognizing ADRs is vitally important but highly subjective and imprecise. Defining the relationship between drug exposure and the occurrence of an event is not easy, and it is often impossible to reach a firm conclusion. Since ADRs may act through the same physiological and pathological pathways as normal disease, they are difficult and sometimes impossible to distinguish. However, the following step-wise process may be helpful in assessing for a possible drug-related adverse event:

- 1. Ensuring the drug ordered is the drug received (i.e. dispensing errors)**
- 2. Ensuring the drug was actually taken**
- 3. Verifying that the onset of the event was after the drug was taken, not before**
- 4. Determining the time interval between the beginning of drug Tx & the onset of the event**
- 5. Dechallenging - stopping the drug and monitoring the patient's status, looking for improvement**
- 6. Rechallenging - if appropriate, restarting the drug and monitoring for recurrence of any adverse events N.B. There is always the possibility that the initial exposure to the drug desensitized the patient and there will be no ADE the second time around**

**PLEASE KEEP IN MIND THAT ALL ADVERSE DRUG REACTION REPORTING IS NON-PUNITIVE!
PLEASE REPORT ALL ADVERSE DRUG EVENTS TO PHARMACY (270-2854)
OR YOU MAY CALL THE ADVERSE DRUG REACTION 24 HOUR HOTLINE (270-1890)**

Cardiac Screening Required Prior to *Propulsid* Use

Healthcare practitioners must conduct electrocardiograms on gastroesophageal reflux disease sufferers prior to prescribing **Propulsid (Cisapride)**.

“A 12-lead ECG should be performed prior to administration of **Propulsid**” to identify patients who are not appropriate candidates for cisapride therapy, Propulsid’s augmented boxed warning states.

“Treatment with Propulsid should not be initiated if the QTc value exceeds 450 milliseconds.”

In addition to requiring ECG testing, the most recent labeling revisions instruct physicians to screen serum electrolytes and creatinine levels prior to prescribing Propulsid. Serum electrolytes should also be assessed whenever conditions arise that may affect electrolyte balance or function such as patients being prescribed diuretics.

Caution must be used in elderly patients since there is a significant proportion who have conditions or use other drugs which contraindicate the use of Propulsid.

“Propulsid is contraindicated in patients taking certain macrolide antibiotics, antifungals, protease inhibitors, phenothiazines, antidepressants, Class IA and Class II antiarrhythmics, and antipsychotic medications.”



Clinical Alert:



CDC CONFIRMS FIRST U.S. DEATH FROM VANCOMYCIN-RESISTANT STAPH

The CDC reported the first confirmed death of a U.S. patient from **vancomycin-resistant *staphylococcus aureus*** bacteria and warned hospitals that staph strains are increasingly showing resistance to the antibiotic, considered a drug of last resort. The case, involving a patient who died April 1999 from a heart valve infection despite antibiotic administration, is the first to link the resistant staph bug to the fatality itself; three other cases of vancomycin-resistant bacteria have been reported since 1997 but causes of death remain unconfirmed. Staph accounts for roughly 13% of the nation’s 2 million annual nosocomial infections, and the CDC officials said the case offers “another example of why we need to use antibiotics more judiciously.” (AP / Milwaukee Journal Sentinel, 1/7)