MEDICAL ARTS PHARMACY

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Health Matters

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Pearls for COPD | Pain Diabetes | New Anticoagulants

From the LTC Conference, Ottawa, Sept.12, 2014

Did you know that by 2030,

COPD is expected to be the No. 1 cause of death in Canada?

This was reported by Ottawa respirologist, Steven Bencze during his presentation titled: *Breathing New Life into Multi-disciplinary COPD Management*, which also shed light on the following:

- COPD is presently the No. 1 cause of admission and re-admission to hospital.
- Age of onset (>40 years) and smoking history are the most important factors related to COPD (vs. asthma).
- Smoking cessation and oxygen are the most effective interventions, however exercise and medication use are also important.

About inhaled corticosteroids

Inhaled corticosteroids may be helpful in severe COPD. But chronic high doses of Advair have been reported to increase the risk of pneumonia in COPD patients. For this reason it is recommended to reduce Advair from 500 mcg to 250 mcg, and eventually to 100 mcg. (Note: The corticosteroid dose reduction can be safely done every 6 weeks according to a study published in the NEJM September 2014.)

Tudorza and Seebri – two new molecules – are now available to treat COPD. The Seebri device is similar to Spiriva, whereas Tudorza employs a powder device which is reportedly easier to use and also permits healthcare workers to know if the patient is able to inhale the powder.

Another new device called Respimat will soon be available improve “ease of use” for Spiriva and Combivent.

The second topic covered at the conference was:

The clinical management of older patients with persistent pain

A few facts:

- Pain affects 33% to 40% of patients living in nursing homes.
- Exercise helps decrease pain.
- If a patient becomes inactive, pain will get worse earlier because joints do not get blood supply unless they are kept moving. In other words, staying physically active is a very important component in prevention and treatment of pain.

In assessing pain

The real question for healthcare workers who wish to assess pain is:

What did you stop doing because of your pain?

Other facts:

- Pain should be considered as an independent source of agitation.
- The maximum chronic dose of Tylenol is 2600 mg in the elderly.
- Patients taking Aspirin for cardio prophylaxis should not take Ibuprofen.

  Ibuprofen can reduce the antiplatelet effects of Aspirin.
- Codeine is a pro-drug and should be avoided in the elderly because of higher risk of drug-drug interaction and higher risk of constipation.
- A medication for pain is considered effective if it reduces pain by approximately 30%. A decrease of pain by 30% shows a good result for a single medication.

Diabetes Now:

Practical Management of Diabetes in the Elderly

was a third conference topic with many "pearls"

- For the frail elderly, new guidelines shift from reducing chronic complications to managing acute complications such as severe and recurrent or prolonged hypoglycemia, and acute side effects of treatment regimens.

- Glycemic goals for frail, elderly patients should be individualized, and in many cases, be higher than in younger populations. For example, in frail elderly patients an A1C between 7.1 and 8.5 is acceptable whereas in younger patients an A1C of less than 7.1 would be desirable.

- In renal failure (Creatinin clearance < 30 ml/min), use linagliptin (Trajenta) or Repaglinide (Gluconorm), and avoid Metformin, Glyburide and Gliclazide.

- Repaglinide (Gluconorm) could be covered with a Section 8 or Exceptional Access Drug (EAP) for patients with renal failure.

- Basal insulin (Lantus or Levemir) with antihyperglycemic agent may control sugar in approximately 70% of elderly patients.

- The objective of treatment is to avoid hypoglycemia, defined as blood sugar (BS) lower than 5 for elderly versus blood sugar (BS) lower than 4 for younger patients.

- When adjusting the dose of insulin, the first goal is to prevent hypoglycemia. Next, we treat pre-prandial hyperglycemia and finally we treat post-prandial hyperglycemia. Always start by controlling morning, pre-prandial blood sugar.

- Avoid sliding scale insulin because of increased risk of hypoglycemia especially if short acting insulin is given at bedtime.

- Finally, there is usually no need to split the dose of basal insulin in the elderly type 2 Diabetes clients.

Finally, the fourth presentation was on:

Bleeding management with the use of novel oral anticoagulants (NOAC) to treat atrial fibrillation

Because the peak effect is 1 – 2 hours after the first dose, NOACs (Pradaxa, Eliquis and Xarelto) are effective 1 – 2 hours after the administration of the first dose, while Warfarin could take up to five days, or more, to be therapeutic. These agents can be used if creatinine clearance is higher than 30 ml/min.

Eliquis is less likely to cause gastrointestinal bleeding and is a good option if patient cannot tolerate Pradaxa or Xarelto.

According to expert opinion, there is no need to stop anticoagulation therapy with Warfarin or any of the NOACs (Pradaxa, Eliquis or Xarelto) in patients undergoing minor procedures such as cataract surgery, skin biopsy or dental extractions or other dental procedures.

Concomitant antiplatelet and anticoagulant therapy might be appropriate for selected patients with coronary artery disease (CAD), especially prior coronary artery bypass graft (CABG) or stent.

➡ **Because of their short half-life, compliance to the NOAC is very important.**

- Pradaxa 110mg or 150mg is given twice a day with breakfast and supper to decrease stomach upset and the capsule should not be opened because it would increase bioavailability and increase the risk of bleeding.
- Eliquis 2.5 or 5 mg is administered twice a day every 12 hours with or without food. (Eliquis can be crushed.)
- Xarelto 15 mg or 20 mg is usually given daily with food, ideally with the biggest meal of the day to decrease stomach upset. (Xarelto can be crushed.)