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PMHC Pharmacy

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The Aspirin/Plavix Combo

There have been recent concerns about the aspirin/Plavix combination.

We know that Plavix plus aspirin is beneficial for patients with acute coronary syndrome or after a stent. In these patients, the combo can reduce the risk of heart attack, death, and restenosis.

But the combo doesn't fare as well in a much broader group…patients with established cardiovascular disease OR multiple risk factors. In these patients, the combo does NOT work better than aspirin alone to reduce the risk of heart attack, stroke, or death. Plus, the combo increases the risk of bleeding.

Reassure your patients the combination is appropriate in certain situations. Here is the bottom line to help keep it straight:

Cardiovascular risk factors only –	Aspirin/Plavix combo NOT beneficial
Established cardiovascular disease –	Aspirin/Plavix combo NOT beneficial
Acute coronary syndrome	Aspirin/Plavix combo beneficial
After a stent	Aspirin/Plavis combo beneficial

From the Stone Tablets of JCAHO

"After July 1, 2006 access to any part of the pharmacy by non-pharmacist personnel after hours is not allowed, even if permitted by law and regulation. All after-hours medications must be stored outside of the pharmacy (e.g., in a night cabinet, automated dispensing cabinet). If a needed drug is not available in that supply, an on-call pharmacist must come in to retrieve it or the medication must be obtained from an outside pharmacy that is open…with current technology, planning, and cooperation from medical and nursing staff, night access to the pharmacy can be eliminated, even in rural hospitals."

When Bill Redinger, PMHC Quality Coordinator, questioned the JCAHO on this, he got this response:

"The intent of the July 1 revision is to prohibit access to the pharmacy to anyone other than pharmacy staff. Therefore, your organization needs to evaluate its processes carefully to limit access to the pharmacy when it is closed."

While we are waiting for further clarification, there are some things we can do to limit access:

1. We can stock the night cupboard with a larger selection of medications
2. No routine stocking of auxiliary drug inventories after hours
3. Only retrieving medications that have to be given immediately that can't wait until pharmacy personnel are present
4. By using a therapeutic substitution in the interim until the pharmacy is open.

These are ideas that have been proposed. This will be discussed further at the next Pharmacy & Therapeutics Committee.

The High Cost of Doing Business, The Night Cupboard

And speaking of the night cupboard, (page 1) we currently have a less than ideal situation. Our night cupboard is unsightly, has no stops on the drawers, no outside listing of the meds contained within and the inventory needs to be expanded.

We are shopping for a night cupboard which would house an expanded inventory, would be secure, and would give us an audit trail of who entered the night cupboard, when it was entered and what was taken.

We visited with one vendor who had a night cupboard with "guiding light" technology. When the drug was selected on a "touch" screen, a series of lights would guide us to the correct drawer and then to the correct bin. This can be ours if we simply write a check for around $75,000. (About what a new well-appointed E-Class Mercedes would cost) We can, however, lease the night cupboard for around $2,000/month or $24,000 annually. (Equivalent to purchasing a new Toyota Camry…every year)

Needless to say, we are looking into other options.

Drug Studies, according to USA Today…

Psychiatric drugs fare favorably when companies pay for studies. Drug companies fund a growing number of the studies in leading psychiatric journals, and drugs fare much better in these company-funded studies than in trials done independently or by competitors, researchers reported Wednesday.

About 57% of published studies were paid for by drug companies in 2002, compared to 25% in 1992, says psychiatrist Igor Galynker of Beth Israel Medical Center, New York City.

His team looked at clinical research in four influential journals: *American Journal of Psychiatry, Archives of General Psychiatry, Journal of Clinical Psychiatry and Journal of Clinical Psychopharmacology*.

In the report, released at the American Psychiatric Ass'n meeting in Toronto, reviewers did not know who paid for the studies they evaluated, Galynker says. There were favorable outcomes for a medication in about:

* Eight out of 10 studies paid for by the company that makes the drug.
* Five out of 10 studies done with no industry support.
* Three out of 10 studies done by competitors of the firm making the drug.

The findings don't prove the companies are knowingly biasing studies, says co-author Robert Kelly Jr., of Beth Israel. The report didn't look at the evidence for bias in design of the studies.

As drug companies increasingly fund research that yields favorable outcomes for their drugs, there may be a built-in bias as journals are reluctant to publish studies with negative or inconclusive findings, Galynker says.

To improve transparency, in October 2004, the pharmaceutical industry set up a database (www.clinicalstudyresults.org) to allow publication of all studies, positive and negative.

Because drug studies are expensive, pharmaceutical companies may fund those most likely to have a positive outcome. The firms weed out drugs that don't work and consult with the FDA to design trials that will pass their approval.

Posting a negative study on the database is voluntary. "Common sense dictates the worse the drug does, the less likely you are to volunteer to beat yourself up publicly by sharing that," says Sidney Wolfe of Public Citizen, a Washington-based consumer advocacy group.

"We're seeing a huge tilting in the education of psychiatrists toward the industry point of view on psychiatric drugs," Wolfe says. "Which is: 'Prescribe my drug, it's better."

The government should be funding more of this research because public programs, such as Medicare, pay so much for psychiatric drugs, Wolfe says.