

## *In This Issue...*

<i>Changes to Formulary</i>	1
<i>Methadone New Pre-Printed Order</i>	1
<i>Expert Commentary on VTE Prophylaxis in Acutely-ill Medical Patients</i>	2
<i>PDTM Updates</i>	2

This and other Drug and Therapeutics Newsletters are on the Web at [www.vhpharmsci.com](http://www.vhpharmsci.com)

## *Changes to Formulary*

### **Additions**

1. **Methylnaltrexone 20 mg/mL injection (Relistor®)**
  - Selective antagonist of peripheral mu-opioid-receptors; does not cross the blood-brain barrier as is a quaternary amine compound.
  - Restricted to treatment of opioid-induced constipation where conventional laxative treatments have failed or are not appropriate.
2. **Acetazolamide injection (Diamox®)**
  - Carbonic anhydrase inhibitor diuretic for treatment of metabolic alkalosis, edema, and rapid lowering of intraocular pressure from glaucoma.
3. **Aripiprazole 2 mg, 5 mg, 10 mg, 15 mg, 30 mg tablets (Abilify®)**
  - Atypical/second-generation antipsychotic drug restricted to diagnosis of schizophrenia or other psychosis (not dementia-related) PLUS treatment failure or intolerance to another antipsychotic agent.

### **4. Ziprasidone 20 mg, 40 mg, 60 mg, 80 mg capsules (Zeldox®)**

- Atypical/second-generation antipsychotic drug restricted to diagnosis of schizophrenia or other psychosis (not dementia-related) PLUS treatment failure or intolerance to another antipsychotic agent.

## **Deletions**

### **1. Aprotinin injection (Trasylol®)**

- Only available through Bayer's Limited Access Program; contact Pharmacy to obtain aprotinin request forms.
- The manufacturer will only supply aprotinin for prophylactic use to reduce peri-operative blood loss and blood transfusions for patients undergoing isolated CABG surgery who are at risk for blood loss and blood transfusion requirement.

## *Updated Policies*

### **1. METHADONE NEW PRE-PRINTED ORDER**

To facilitate methadone ordering after hours and on weekends, a new pre-printed order (PPO) "Methadone: Temporary Exemption to Prescribe After Hours" (PPO #787) is available.

- To prescribe methadone for an in-patient, an authorized methadone prescriber must be contacted during normal working hours (i.e. Mon-Fri 0830-1630).

### **EDITORIAL STAFF:**

Karen Shalansky, Pharm.D., FCSHP  
 Tim Lau, Pharm.D., FCSHP  
 Jane Day, B.Sc.(Pharm.), ACPR  
 Nilu Partovi, Pharm.D., FCSHP

Any comments, questions, or concerns with the content of the newsletter should be directed to the editors. Write to CSU Pharmaceutical Sciences Vancouver General Hospital, 855 W12th Ave, Vancouver BC V5Z 1M9, send a FAX to 604-875-5267 or email [karen.shalansky@vch.ca](mailto:karen.shalansky@vch.ca)  
 Find us on the Web at [www.vhpharmsci.com](http://www.vhpharmsci.com)

- After 1630 or on week-ends, licensed physicians (for independent practice with no restrictions) can apply for a temporary exemption to prescribe methadone at the same dose and frequency as dispensed prior to admission. Note that only authorized prescribers can make changes to the dose and/or frequency of methadone.
- The methadone PPO details the procedures for obtaining the methadone temporary exemption. The application form for Methadone Temporary Exemption is found on page 2 of the PPO, and can also be accessed through the hyperlink embedded in the on-line PPO.
- A temporary license is valid for 60 days.

#### *Methadone Reorders:*

- The 7-day auto-stop for methadone has been removed. However, if reordering is necessary, physicians with current temporary exemption can reorder methadone if the dose and frequency remain unchanged.

#### *Methadone Post-Op Orders:*

- Continuation of a pre-operative methadone order may be authorized by any physician in the immediate post-op period as long as the dose and frequency remain unchanged.

#### *Methadone Verbal Orders:*

- Verbal orders from authorized prescribers or those with temporary methadone exemption must be countersigned within 72 hours.

## **2. EXPERT COMMENTARY: “LOW-MOLECULAR WEIGHT HEPARIN AND MORTALITY IN ACUTELY ILL MEDICAL PATIENTS” (NEJM 2011; 365:2463-72)**

Dr. Agnes Lee, Director, Thrombosis Program

The recent article by Kakkar AK *et al.*<sup>1</sup> entitled “Low-Molecular-Weight Heparin and Mortality in Acutely Ill Medical Patients” has raised questions about the usefulness of thromboprophylaxis in hospitalized medical patients. In this double-blind, randomized controlled trial of ~8000 medical in-patients, enoxaparin 40 mg subcutaneously once daily failed to show a reduction in overall mortality at 30 days compared with placebo. Although the study has solid methodological features, it also has significant design issues that limit the external validity or generalizability of the results:

- The study was designed with 90% power to detect a 25% reduction in death. This is an extremely ambitious endpoint. The majority of

medical therapies we offer to patients do not produce such a huge reduction in mortality. This was a hypothesis that was destined to fail. Furthermore, because of the lower rate of death observed in the control arm, the study only had 77% power to detect a 25% reduction.

- The goal of thromboprophylaxis is reduction in venous thromboembolism (VTE). Well-designed studies have already shown that anticoagulant prophylaxis does just that. Meta-analyses in medical patients have also shown that anticoagulant prophylaxis reduces symptomatic deep vein thrombosis (DVT), any pulmonary embolism (PE) and fatal PE.<sup>2</sup> These are clinically important endpoints to patients and physicians.
- The median duration of hospitalization for the study patients was 9 days, yet the median duration of treatment with study drug (enoxaparin or placebo) was only 6 days. Therefore, patients were under-treated according to standard practice where prophylaxis should continue for the entire hospitalization period.
- Patients included are younger (mean age 65 years) and lighter (mean BMI 23) than North Americans and are largely of Asian and Hispanic ethnicity. These characteristics and differences in medical practice question the generalizability of the results to our local practice.

Consequently, the Kakkar trial does not affect the current VCH guidelines for VTE prophylaxis in appropriate patients with an elevated risk of venous thromboembolism.

#### *Reference*

1. Kakkar AK *et al.* Low-molecular-weight heparin and mortality in acutely ill medical patients. NEJM 2011;365:2463-72.
2. Dentali F *et al.* Meta-analysis: anticoagulant prophylaxis to prevent symptomatic venous thromboembolism in hospitalized medical patients. Ann Intern Med 2007;146:278-88.

## **3. PDTM UPDATES**

- The current indications for **tranexamic acid IV** have been expanded to include treatment of **trauma-associated hemorrhage**.
- **Propofol** may be administered in the VGH **Endoscopy Clinic** for procedural sedation if using the **SEDASYs system**.