June / July 2012

ICP ConsultantConnection

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James H. Vogel Scholarship Award

Each year since 2006 ICP through EFOHCA presents the James H. Vogel Scholarship Award to a young person looking to further their education in health care.

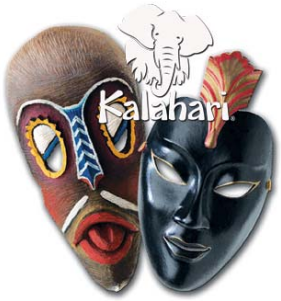
This year it was ICP's privilege to present the award to Allison Walsh, daughter of David Walsh, Chief Executive Officer of Heritage Health Care Services, Inc.

Pictured: Allison Walsh, Scholarship Award Recipient and Richard Sandilands, Executive Vice President ICP, Inc.

Allison graduated from Madeira High School where she participated on the schools soccer team as well as carried an academic AP honors curriculum. After high school, she enrolled at the University of Cincinnati and earned her undergraduate degree in speech-language pathology, graduating Magna Cum Laude. This fall she is off to the University of Toledo to begin her masters' degree in her chosen field of speech-language pathology. Upon graduating, she will be able to evaluate, diagnosis and treat speech, language, cognitive-communication and swallowing disorders.

Congratulations Allison and good luck in your studies at UT.

Mark your calendar!
ICP's Great Adventure
October 5-6, 2012
at Great Wolf Lodge, Mason, Ohio
and
October 12-13, 2012
at Kalahari, Sandusky, Ohio
to receive a registration for this year's program
email: gscherger@icppharm.com



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Mission Statement:
ICP is committed to exceeding our customers' and employees' expectations through quality health-care service, continuous education, and effective communication.

Mom Hopes Son's Overdose Spurs Prevention Efforts

A grieving mother recently contacted the Institute for Safe Medication Practices (ISMP) about the death of her 2-year-old son, Blake (see photo), from an accidental drug overdose. Her son was not ill, he was not taking any medicine, and he was not hospitalized. Instead, the tragic event began, of all places, at a longterm care facility.

Last November, the family was visiting the boy's great-grandmother at the long-term care facility. Two days after the visit, Blake was found unconscious and in respiratory arrest, and emergency medical personnel were unable to revive him. A medical examiner later found a small, white, 1 x 1.5 inch piece of what appeared to be tape in the boy's throat. Later, after a toxicology report indicated that a lethal dose of fentaNYL was in Blake's system, the "tape" was sent to a lab to be analyzed. The tape turned out to be a fentaNYL patch.

An investigation led to the long-term care facility where the boy had visited days earlier. Authorities found that medication patches were not being discarded properly. A used fentanyl patch was found on a bedside table. Authorities also found used medication patches in other resident's rooms on the floor, stuck to bed railings, and in other unsecured patient areas. Blake's mother also stated that patches had been discarded in the trash bin in the great-grandmother's room.

One theory is that Blake may have run over a used fentaNYL patch on the floor of his great-grandmother's room while playing with his toy truck. The patch probably stuck to the wheels of the toy. Later, he may have peeled off the patch and put it in his mouth. From there, the fentaNYL began absorbing into his body. The patch then became stuck in his throat. A used fentanyl patch can still contain a large amount of unabsorbed medication. So, both new and used patches can be dangerous to children (and pets).

This theory about the child's death is quite feasible given that there have been reports of other children who have been exposed to patches in a similar manner. In fact, we have received a number of reports over the years about children being accidentally exposed to used fentaNYL transdermal patches. A 4-year-old boy died after placing a fentaNYL patch on his body. His mother had been using these patches for pain from Crohn's disease. After she found her son dead, she also found a torn fentaNYL patch wrapper in an overturned bedroom trash can. Children have also been exposed to danger from medication patches that have fallen off a family member. In one case, the child sat on the fallen patch and it stuck to her upper thigh. Another child removed a patch while his grandmother was sleeping and applied it to himself. In these cases, the patches were noticed right away and the children were not injured.

In April 2012, the US Food and Drug Administration (FDA) alerted the public to this risk (www.fda.gov/Drugs/DrugSafety/ucm300747.htm). FDA reported that 26 children have been accidentally exposed to fentaNYL patches during the past 15 years. Ten children have died, and 12 were hospitalized. Sixteen cases involved children 2 years old or younger Blake's mother asked us to share information about how to properly use, store, and dispose of fentanyl patches, which can be found to the right. She also asked us to emphasize that parents need to be aware of possible hazards when they visit a healthcare facility with their child. She warns, "You can't count on people not making mistakes like dropping pills or forgetting them on a bed rail. Parents should keep a close eye on their kids when visiting someone where any medicine is used." Regulatory agencies should also require safe patch disposal in all healthcare facilities.

Follow these suggestions for safe medication patch use, storage, and disposal.

- Keep track of patches on the body. While medication patches have adhesive backings, they do not always stay on the skin. Patients and their caregivers should be taught to regularly check to make sure the patch is still where it belongs, particularly soon after awakening, after a shower, and anytime clothes or bed sheets are changed. The healthcare professional or caregiver who applies the patch should document its placement and check its location during routine assessments. Always ensure it is removed before applying a new patch.

- Dispose of patches safely. As a precaution, the FDA instructs patients to fold the adhesive side of a used fentaNYL patch together and flush it down the toilet. Only after a used fentaNYL patch has been disposed of properly should a new patch be placed on the patient. The used patch should never be placed temporarily on a bedside table or stuck to a bed rail while applying a new patch.

- Keep out of reach. Patients who will be using medication patches at home should be educated to keep new patches far away from the reach or discovery of children, and to not let children see them apply patches or call them stickers, tattoos, or special Band-Aids. This could attract children and encourage them to mimic their actions.

Combating Constipation in the Elderly

Constipation can best be defined as unsatisfactory defecation characterized by infrequent stool, difficult stool passage or both. Difficult stool passage may include straining, hard stools, a feeling of incomplete evacuation or the need to use manual maneuvers to assist with defecation. Constipation is one of the most common gastrointestinal complaints and accounts for more than 2.5 million physician visits a year, and ranks among the most frequent reasons for self-medication, particularly in the elderly. Constipation is a troubling condition for older adults, often resulting in anxiety and diminished quality of life.

The prevalence of chronic constipation averages between 12-15% of the population in the United States depending on how constipation is defined. However, this number is believed to be higher due to under-reporting symptoms to their doctors for a variety of reasons, including the relative low cost of over-the-counter therapies, a misunderstanding of their symptoms as "normal" and not indicative of an underlying problem, or simple embarrassment. The rise in prevalence of chronic constipation is particularly dramatic after the age of 65. Constipation is nearly three times more common among females than males and is more prevalent among nonwhites than whites. Although constipation is more common among those over age 65, it is probably not a consequence of normal aging. Rather there are a number of comorbidities among patients in this age group which likely contribute to their increased risk of developing chronic constipation. These potential risk factors include: immobility, concomitant chronic illness, polypharmacy, and underlying neurologic disease, the most important being dementia although cerebrovascular disease, Parkinson's disease and Multiple Sclerosis also represent significant risk factors.

The onset of constipation is generally unrelated to any known event. Early in the course of constipation, infrequent or difficult evacuation may represent the only symptom. As constipation progresses in severity, patients typically develop bloating and mild cramping type abdominal pain that is frequently worse after meals. Patients who have suffered from constipation for many years may additionally note fatigue, malaise and anorexia.

Constipation appears to be a slowly progressive disorder that rarely resolves. Long-standing constipation has been associated with several potentially serious complications. The most common of these is fecal impaction, which is a particular risk among the elderly and even more so among the institutionalized elderly. Indeed, it is of such concern that a fecal impaction is now a reportable quality event in nursing homes. If severe and prolonged, fecal impaction can lead to colonic perforation. Chronic constipation sufferers also are at risk of developing a sigmoid volvulus, or "twist" of the colon. A volvulus typically results from elongation and redundancy of the sigmoid colon. Once the sigmoid has sufficiently elongated, it twists around itself leading to obstruction and subsequent ischemia of the colon at the level of the volvulus. If not resolved, the ischemia also may lead to colonic perforation. A third potential complication of chronic constipation is the formation of a stercoral ulcer. A stercoral ulcer is a pressure ulcer of the sigmoid or rectum which results from stool remaining in the colon for long periods of time, applying pressure to the colon wall. If this condition is prolonged, again, colonic perforation may occur.

Given the potential for serious complications among elderly patients with constipation, particularly those who are institutionalized, it is important to provide effective therapy with consistent follow-up to ensure that these patients first and foremost are comfortable, but also to optimize their quality of life and to ensure that these potentially serious complications of constipation are avoided.

Once a diagnoses of constipation has been established there are basic laboratory tests for these individuals including a complete blood count, serum blood urea nitrogen, serum creatinine, serum sodium, serum calcium, serum magnesium, a thyroid-stimulating hormone level, and stool for occult blood. Sigmoidoscopy or colonoscopy should be considered for any person with prolonged chronic constipation. An abdominal x-ray is also important to exclude fecal impaction. Additional tests that may be helpful include colon transit measurements, colonic manometry, anorectal manometry, balloon expulsion testing, and defecography.

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Consultant Pharmacist, ICP, Inc.

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Medications To Avoid In Heart Failure

Heart failure is a significant disease state in the elderly population. The main goal in this patient population is to prevent acute exacerbations. These patients are more sensitive to changes in fluid status and sodium retention than other patients. Therefore, as caregivers, it is important for these to be monitored and possibly restricted in our patients as well as avoiding treatments that further hinder the ability of the heart to pump blood effectively. An important way to prevent an exacerbation of heart failure is to avoid medications that can have these types of effects in our patients. The following medications are of concern in heart failure patients for a variety of reasons.

Nonsteroidal anti-inflammatory drugs (NSAIDs) as a class have been shown to increase the likelihood of a patient to be readmitted to the hospital due to an exacerbation of heart failure. The main way that NSAIDs worsen this condition is by causing vasoconstriction. This increases the afterload, meaning the heart has to work harder to push the blood throughout the body. Increasing the stress on the heart further damages its ability to perfuse the body. In addition, the vasoconstriction counteracts the positive benefits of angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs). ACEs and ARBs have been shown to decrease morbidity and mortality in heart failure patients.

Actos (pioglitazone) is part of the class of medication called thiazolidinediones. This class of medication has effects on the kidney that cause an increase in sodium reabsorption in the kidney which leads to sodium retention. The increase in sodium levels causes the body to hold on to fluids, resulting in edema. This can lead to an exacerbation of heart failure since the heart cannot handle the extra fluid. There has been shown to be an increased risk of hospitalization and death in heart failure patients when this drug is added. Actos should be avoided in most heart failure patients especially the more severe cases.

These two calcium channel blockers, diltiazem and verapamil, have the ability to decrease the contracting force of the heart, which sounds like it would be beneficial in heart failure patients. However, in typical heart failure patients that have decreased ejection fraction, these drugs can actually activate damaging systems in the body. Due to the increased damage done to the heart, studies have shown that these two medications can increase risk for deterioration in the patient's status. Hence, they are not recommended for use in most heart failure patients.

Pletal (cilostazol) is used to treat intermittent claudication. Due to the way this drug works, it increases the patient's heart rate and can affect the heart rhythm. Other drugs in this same class have been shown to increase mortality due to these effects. Therefore, cilostazol is contraindicated for use in patients with heart failure.

Megace (megestrol) is often used to help increase weight in our patient population. This medication has the potential to cause increase in fluid retention, which could lead to an exacerbation of heart failure in our patients. This is something to watch out for if this medication was recently added. Daily weights and evaluation of edema can help to catch an acute situation earlier.

As shown above, medications have the potential to worsen heart failure through various mechanisms, and this is just a sample of the large list of concerning medications. It is important that we are vigilant with this patient population to prevent increased morbidity and mortality.

Elise Weyrauch, PharmD Candidate

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