

RetroDUR

Newsletter

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Suicide Prevention during the COVID-19 Pandemic

By: Sarah Plummer, Pharm. D

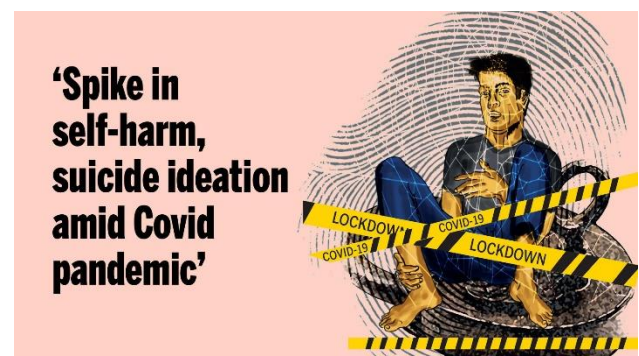
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September is National Suicide Awareness month, also commonly known as Suicide Prevention month. Suicide is a preventable public health problem first named as a concern by the surgeon general in 1999 and remains one of the leading causes of death in America. According to the Centers for Disease Control and Prevention (CDC), suicide is the 10th leading cause of death in the US. The 2nd leading cause of death for ages 10-34 and the 4th leading cause of death for ages 35-54.

In 2018, over 48,000 Americans died by suicide and an estimated 1.4 million suicide attempts. 90% of those who died by suicide had a diagnosable mental health condition at the time of their death. The rate of suicide is highest in middle-aged white men, and in 2018, men died by suicide 3.5x more often than women. On average there are 132 suicides per day. 54% of Americans have been affected by suicide.¹

Anyone could be struggling with thoughts of suicide however, there are certain populations who may be at higher risk such as youth, deaf or hard of hearing, disaster survivors, Native Americans, veterans, loss survivors, LGBTQ+, attempt survivors, and people with mental health disorders such as anxiety,



depression, bipolar disorder, and schizophrenia. The coronavirus disease 2019 (COVID-19) pandemic has also been associated with mental health challenges due to loss of jobs, housing, food insecurity, social isolation, and many more issues. According to the CDC, during the COVID-19 pandemic there has been a steady increase in




anxiety/depression symptoms, trauma/stress-related disorder symptoms, and substance use.²

The National Suicide Prevention Lifeline is a national network of local crisis centers that provide free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week.³ Additionally, there are multiple trainings available for the general public. One popular training method is “QPR” which is national suicide prevention training program developed in 1999. Like CPR (short for cardiopulmonary resuscitation, an emergency medication intervention), QPR was developed to be an emergency mental health intervention for suicidal persons. Both CPR and QPR are part of systems designed to increase the chance of survival in the event of a crisis.⁴



Q-Question
P-Persuade
R-Refer

The public health response to the COVID-19 pandemic should increase interventions and prevention efforts to address associated mental health conditions. **We can all help prevent suicide.** Health care professionals should be properly trained on screening for suicide and implement screening at each opportunity with their patients, offering treatment options for untreated mental health disorders.

 <p>Get Support by Phone The National Suicide Prevention Lifeline is free, confidential, and available 24/7. Skilled crisis workers answer incoming calls and will listen, provide support, and offer helpful resources to those in need.</p>	 <p>Get Support by Text Text the keyword 4HOPE to 741 741 to chat with a skilled crisis worker at the Crisis Text Line. You are not alone.</p>	 <p>Be Prepared with a Safety Plan If you struggle with suicidal thoughts and would like to create a safety plan for yourself that you can share with those you trust, download the free MY3 app from the National Suicide</p>
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For community members or families, the National Suicide Prevention Lifeline offers a variety of resources for both families and victims, including their 24/7 hotline. As health care providers and citizens, we have a duty to help our patients and community get treatment and access to resources to help fight this disease. Promote the lifeline, volunteer, or donate to your local suicide prevention crisis center, offer support and understanding, call is your loved ones and check on them regularly.

There is hope that the efforts of clinicians, researchers and policy makers will reduce COVID-19 suicide.

Resources for Anyone:

1. Global public speaker, bestselling author, and suicide survivor Kevin Hines
<http://www.kevinhinesstory.com/>
2. Documentary Film: “Suicide The Ripple Effect”
3. Book: “Suicide: The Forever Decision” by Dr. Paul G Quinnett

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Deprescribing – What is it and what Choices Do we Have?

By: Craig Kimble, PharmD, MBA, MS, BCACP
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All clinicians in West Virginia analyze a lot of data when making prescribing decisions. However, once we start medication, how do we make good choices about stopping them? Some medications that may have been the best choice for a patient at one time, may at some point, no longer be necessary or appropriate and may even be harmful to the patient. Taking the time to periodically “deprescribe” in a thoughtful and systematic manner is just as important as thoughtful prescribing.

Deprescribing is the process of weighing the risk-benefit of medications and stopping a medication or reducing its dose to improve a patient’s health outcomes. In some older and sometimes more frail patients, medications may cause more harm than good. Taking time to optimize a patient’s medications through targeted deprescribing is an essential part of managing a patient’s chronic diseases, avoiding adverse drug events (ADEs), and improving patient outcomes. An example would be a patient on a proton pump inhibitor (PPI) long-term. Taking a PPI long-term has been associated with an increased risk for bone fractures, pneumonia, C. difficile infections and can decrease absorption of vitamin B12, iron and magnesium. Many patients can be successfully tapered off, be treated for H. Pylori, receive intermittent dosing of H2RAs or antacids, or focus on nonpharmacologic therapy (dietary changes and weight loss).¹ It is worth your time to do this!

Often this is prompted because the patient has an issue with cost, a high pill burden, has or is currently experiencing an adverse event, or has had a change in health status (e.g. decline in patient health condition

Literature shows that as a patient’s number of medications increases, so does the corresponding risk for an ADE. Polypharmacy is associated with reduced functional capacity, increased hospitalizations, and in some cases even death. If a patient is prescribed two medications, they have an approximately 13% chance of experiencing an ADE, with four medications a 38% chance, and with seven medications an 82% chance.^{2,3}

Deprescribing has several key goals. We would like to reduce the number of medications that a patient is taking by eliminating those that a patient no longer needs, are ineffective, or are contributing to adverse effects. We would also like to increase patient adherence and persistence to medications by improving and making the patient’s medication regimen easier to follow. By doing all these things, it is our hope to improve patient outcomes.

There are several approaches to deprescribing a clinician can use. The three most common approaches are patient-based, medication-based, and protocol-based. I will briefly review each of these approaches in the following paragraphs.

Patient-based deprescribing focuses on patient specific characteristics or circumstances to prompt a medication review. In this scenario, a patient, caregiver, or other healthcare provider may ask a clinician about reducing the number of medications prescribed.

What is medication overload?

Medication overload is the use of multiple medications that pose a greater risk of harm than benefit. There is no strict cutoff for when the number of medications becomes harmful, but the more a person is taking, the greater their likelihood of experiencing harm, including serious, even life-threatening adverse drug events.



Often this is prompted because the patient has an issue with the cost, a high pill burden has or is currently experiencing an adverse event, or has had a change in health status (e.g.) decline in patient health condition that makes more sensitive to medications).

Once complaints start, noncompliance can start, and other problems can occur. While this method is effective, it is not always best to wait for a problem to address. In addition, the patient might not understand

clinical issues like having them on three medications to reach blood pressure goals and may stop taking medications on their own. Even in multiple medication hypertension treatment cases, a combination medication might be available to simplify the regimen and completing the review with the patient presents the opportunity to make the change.

Medication-based deprescribing is commonly used to target patients taking medications that are classified as “high risk” or “inappropriate”. Often this approach is the next step after a patient or other person brings up a request to possibly stop a medication or reduce the number of medications the patient is on. Some examples of this approach include the following:

1. Using Beers Criteria – TriCyclic Antidepressants (TCAs), anticholinergics, potent antihypertensives⁴
2. ISMP High Risk Medications – hypoglycemic agents (oral), opioids, insulin, warfarin
3. Short-Term Use – PPIs, antibiotics, antihistamines, steroids, NSAIDs, anxiolytics (started in hospital and continued after discharge and/or duplicate therapy purchased over the counter)
4. Others – supplements or natural remedies that patients can buy over the counter on their own.⁵

Protocol-based deprescribing combines patient and medication-based strategies in a proactive and a reactive manner. This can be done in any practice setting. These are conducted at specific intervals based on patient and medication related criteria. In this approach we do the following five steps⁵:

1. Identify patients and a complete medication list with indications – eg. 10 or more medication, over age 65, multiple disease states, short-term use medications, ISMP, “high-risk” drugs on the Beer’s list or medications with no clear indication.
2. Conduct medication review to see what exactly the patient is taking, how they are taking and any side effects the patient might be having
3. Risk-benefit analysis – review the patient’s situation and risk for drug induced harm and determine if they are an appropriate candidate to deprescribe
4. Prioritization – there may be multiple medications and stopping all of them together can have negative impacts. Choose one and approach that first (implement your plan).
5. Follow-up and monitor on any items that are deprescribed.



Barriers to deprescribing are common. A lot of patients are reluctant to change especially if they have been on a medication for a long period of time. Many prescribers are reluctant to push a patient to stop a medication as well. It is important to address barriers successfully if you want to deprescribe.

The most common barrier is a patient-related barrier. Hesitation to stop a medication is the most common reason. Patients may feel a medication is still necessary or feel that they are able to do something about their disease even if it has become harmful (feel they need

it). Fear is another factor with many patients. Patients fear negative consequences such as return or worsening of a condition. They may also feel that there is a lack of prescriber time or support to discuss stopping a medication.⁶

Prescriber related barriers are the third barrier we see. Prescribers feel there is limited time and resources to review and develop a plan and have limited time to overcome patient resistance. Also, prescribers have inertia – may feel it is not a priority if not causing immediate problems and may think they will address in the future. Also, the drug may be prescribed by another

prescriber and feel if another prescriber started, they may feel it is not their place to discontinue it. Self-efficacy is another potential barrier – prescribers may not feel confident in analyzing the risk-benefit for which medication to stop, how to handle a taper or alternative schedule for discontinuation.⁷

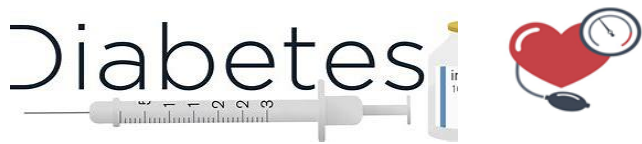
To overcome barriers in deprescribing we must use a patient centered approach. Education on goals of improved outcomes should be provided. In addition, pharmacy services may be available to assist and support the patient. Clinicians can find valuable resources at <https://deprescribing.org/resources/> which include evidence-based deprescribing guidelines, algorithms, titration protocols and links to the latest research.⁸

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Management of Hypertension of Patients with Diabetes Mellitus Revisited

By: Robert B. Stanton, M.B.A., Pharm.D., BCPS

Management of Diabetes Mellitus continues to be changing with new agents being introduced and more under clinical investigation. There have been changes in the recommendation in the management of hypertension for these patients over the past several years and it is time to provide a brief review.

The current American Diabetic Association's (ADA) guidelines state any of the first-line antihypertensive classes may be used for the treatment of hypertension of Diabetic Mellitus patients without albuminuria. First-line classes include (1) ACE Inhibitors or Angiotensin Receptor Blocker (ARBs), (2) Thiazide or Thiazide-like agents, and (3) dihydropyridine calcium channel blockers (CCBs). If albuminuria is present, then the recommended agents are ACE Inhibitors or ARBs. Since it is probable many patients with Diabetes will progress to albuminuria the question may be why not use an ACE Inhibitor or ARB as the preferred agent regardless of albuminuria? Some considerations could be women of child-bearing potential in which ACE Inhibitors and ARBs are contraindicated. Thiazides are not recommended during pregnancy as well so a CCB may be a consideration. Black adults are more likely to have hypertension and more likely to have complications relating to their hypertension compared to non-black adults. ACE Inhibitors and ARBs appear less effective in blood pressure lowering effects and the current hypertension guidelines recommend a thiazide or a thiazide-like or a CBB antihypertensive agent for this population. However, ACE Inhibitors and ARBs do have renal protection properties in black adults and should be used, perhaps in combination with other

antihypertensive agents, if albuminuria exists concurrently with hypertension.

Some other noteworthy comments from the ADA are the preferred thiazide or thiazide-like agents are "long-acting agents shown to reduce cardiovascular events" and the ADA mentions chlorthalidone and indapamide as those agents, not hydrochlorothiazide (HCTZ). Chlorthalidone was the "thiazide" used in the ALLHAT Trial, a major antihypertensive trial in the USA. Many believe the antihypertensive effect of thiazide or thiazide-like agents work via their diuretic effect, but they do not. After all these years, the exact mechanism of how these agents lower blood pressure is unknown, but we are certain the diuretic effects play no or little role.

The ADA Guidelines recommend starting two antihypertensive agents if the initial blood pressure is greater than or equal to 160 mmHg systolic or 100 mmHg diastolic. There is also a distinction of the blood pressure goals depending on the ASCVD risk. For diabetic patients who have a 10-year ASCVD risk of 15% or more the blood pressure goal is <130/80 mmHg. This is likely the majority of diabetic patients. However, if the ASCVD risk is less than 15% then the target blood pressure goal is <140/90 mmHg.

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Preparing for the 2020-2021 Influenza Season

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Introduction

- The Centers for Disease Control and Prevention (CDC) estimates between 12,000 – 61,000 deaths annually since 2010.
- With viral influenza season rapidly approaching, it is important for healthcare providers to be up to date on best practices regarding prevention and treatment.
 - The CDC regularly updates their annual recommendations for influenza prevention and treatment which can be found at www.cdc.gov/flu.
- The best way to prevent the flu is to get a vaccination annually, but medications are available for those who get sick with the flu.

Prevention

- For the 2020-2021 influenza season, the CDC recommends everyone 6 months and older to get the flu vaccine, especially those at high risk of complications from the virus (listed below). Rare exceptions do exist which includes individuals with severe, life threatening allergies to the flu vaccine or any ingredient in the vaccine.
 - For those with an egg allergy or who have ever had Guillain-Barré, it is

recommended to talk to their doctor before getting the flu shot.

High-Risk Populations

- Children aged 6 months through 4 years (59 months)
- People aged 50 years and older
- People with chronic pulmonary (including asthma) or cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)
- People who are immunosuppressed due to any cause, including immunosuppression caused by medications or by human immunodeficiency virus (HIV) infection
- Women who are or will be pregnant during the influenza season and women up to two weeks after delivery
- People who are aged 6 months through 18 years who are receiving aspirin or salicylate-containing medications and who might be at risk for experiencing Reye syndrome after influenza virus infection
- People who are residents of nursing homes and other long-term care facilities
- American Indians/Alaska Natives
- People with extreme obesity (body-mass index [BMI] is 40 or greater)
- Health care personnel
- Household contacts and caregivers of children under 5 years and adults aged 50 years and older
- Household contacts and caregivers of people with medical conditions that put them at increased risk for severe illness and complications from influenza.

ALLERGIES, COLD, FLU AND COVID-19

Most common symptoms for each

SYMPTOMS	Allergies	Cold	Flu	COVID-19
Body aches		✓		sometimes
Chills		rarely	✓	sometimes
Dry cough	✓	✓	✓	✓
Fatigue	sometimes	✓	✓	✓
Fever		rarely	✓	✓
Headache	✓	rarely	✓	sometimes
Itchy eyes	✓			
Loss of taste/smell	sometimes	rarely	sometimes	✓
Nasal congestion	✓	✓	✓	rarely
Nausea/vomiting/diarrhea		sometimes	sometimes	sometimes
Runny nose	✓	✓	✓	rarely
Sneezing	✓	✓	✓	sometimes
Sore throat	sometimes	✓	✓	sometimes
Shortness of breath	sometimes	rarely	✓	✓

Beaumont

Treatment

- Antiviral agents may be beneficial in those who are sick with the influenza virus.
- The four FDA-approved antiviral drugs recommended by the CDC to treat the flu during the 2020-2021 season includes:
 - oseltamivir phosphate (Tamiflu®): pill or liquid suspension
 - zanamivir (Relenza®): inhaler
 - peramivir (Rapivab®): intravenous injection
 - baloxavir marboxil (Xofluza®): pill

- For maximal benefit, the CDC recommends treatment with antiviral drugs within two days of becoming sick with flu symptoms but acknowledges that starting them later can still be beneficial, especially if the sick person is at high risk for serious flu complications.
- Treatment duration with oseltamivir and zanamivir is typically 5 days while peramivir and baloxavir is a one-time dose. The full 5-day course of oseltamivir and zanamivir should be completed even if the infected person is feeling better.
- Side effects vary for each medication and can be found in the manufacturer’s package inserts.

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