The Prudent Prescriber

Phil Mohler, M.D. • phil.mohler@rmhp.org
2775 Crossroads Blvd • P.O. Box 10600 • Grand Junction, CO 81502-5600

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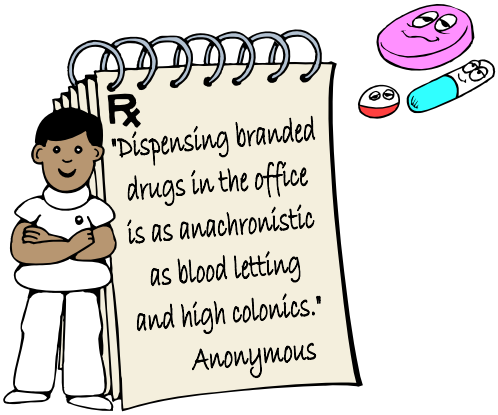
Pharm Reps ≠ Rational Prescribing (PR) (RP)



5 Pharma Tips to Use in the Exam Room Today

1) The **EpiPen's** tangled web continues, but there is hope with the pharmaco-economics. The new "authorized generic" from Mylan joined their branded EpiPen. The generic Adrenaclick, (*2 injectors for $110), involves two safety caps before injection while Epipen (*2 injectors for $148) and Auvi-Q (*2 injectors for $4,599) (Yes it talks you through the injection process) require removal of only one safety cap. In addition, the generic Adrenaclick is supposed to be held to the thigh for 10 seconds, compared to five seconds with Auvi-Q or three seconds with Epi-pen.

Take home: Find out where the best deal is in your town and be sure patients understand how to use the auto-injector you prescribe. No good prices locally? Consider Canadian drugs at Pharmacy Checker.com.

- Best price in Grand Junction on March 21, 2017 from GoodRx app.

CHF?

Think:
Ace
Aldactone
B-blocker
Dig
Diuretic

Avoid these expensive "me-too" drugs:

Intermezzo
Vimovo
Livalo
Pristiq
Viibyrd
Edarbi
Daliresp

Antibiotics do NOT help acute bronchitis

ß-blockers in post-MI save lives

Pill splitters save BIG

2) My PharmD colleague, Steve Nolan, put together a useful review of the **"less is more" concept in in terms of the lengths of antibiotic courses for various common infections**. Shorter courses of therapy are associated with lessening risk of resistance, reduced adverse effects, reduced cost and increased adherence.
    - Uncomplicated cystitis in women: SMX/TMP-3 days, Nitrofurantoin-5 days [Cochrane Database Syst Rev 2005;(2):CD004682]
    - Pediatric UTI– 7 to 14 days; older age school children without fever, consider 2 to 4 days; avoid single-dose therapy.[Paediatr Child Health 2014; 19:315-25]
    - Acute bacterial sinusitis – *if antibiotics are necessary,* Adults, uncomplicated – 5-7 days (5 days is as effective as 10 days for most adults); 10 to 14 days may be necessary for complicated infections or infections in children. [Clin Infect Dis 2012 Apr; 54(8)]
    - Acute exacerbation of chronic bronchitis– *Likely no antibiotic needed*. If suspected pneumonia: 5 days or less, if mild to moderate. [Thorax 2008 May; 63(5):415-22]
    - Community acquired pneumonia–5 days of therapy is equally effective compared to longer durations, even hospitalized CAP patients, with pneumonia severity index scores ranging from I to IV. Longer courses may be necessary in some patients with previous antibiotic treatment, immunosuppression, chest tubes, mechanical ventilation, or severe sepsis.
    - Cellulitis – 5 days is as effective as 10 days for uncomplicated cellulitis, if improvement is seen by 5 days. [Arch Intern Med 2004 Aug 9-23; 164(15): 1669-74]
    - Acute Otitis media–*if antibiotics are deemed necessary*: AAP recommends 5 to 10 days; [Evidence level A, high quality meta-analysis]
      > children less than two years old, 10 days,
      > older than two years, 5 to 7 days,
      > consider 3 days with uncomplicated infection.

3) I get blank stares when I'm precepting at our family practice residency and suggest that **muscle relaxants** do not have a role in the treatment of back pain. The February 2017 edition of the Prescriber's Letter supports my view, in part. They point out that about 1 in 3 patients with low back pain is on a muscle relaxant and that the benefit is not primarily in relaxing muscles, but in putting patients to sleep. If you absolutely, positively need to write for a muscle relaxant, the Prescriber's Letter recommends cyclobenzaprine. It is the most studied muscle relaxant and should be used only on a PRN basis for acute back pain and for not more than one week. Both the 5mg and 10mg size tablets are available for a dime a piece. (GoodRx, GJ, March 21, 2017). Recall that cyclobenzaprine may be associated with the serotonin syndrome when used with SSRIs, SNRIs and tricyclic antidepressants.

4) The FDA has **removed** the **Black Box warnings** for psychiatric events associated with **Chantix** (varenicline) and bupropion. A large (8144 participants) randomized, controlled study [Lancet 18 June 2016] found no differences in adverse neuropsychiatric events comparing both bupropion and Chantix with nicotine patches or placebo in patients with or without a coexisting psychiatric disorder. This change increases the opportunities for prescribing smoking cessation medications in patients with stable psychiatric conditions. This study, paid for by Pfizer and GlaxoSmithKline, also showed that varencline was more effective than placebo, nicotine patch and bupropion in helping smokers achieve abstinence, whereas bupropion and nicotine patch were more effective than placebo.

5) **An NSAID a day keeps your colon cancer from coming back.** This is the message of a meta-analysis of 14 randomized trials (BMJ 2016 Dec 5; 355:i6188) that involved 12,000 adults with previous colorectal neoplasia (either polyps or cancer with resection). The researchers compared the effectiveness and safety of various agents in preventing recurrent colorectal neoplasia. Celecoxib, sulindac, low dose aspirin, calcium, vitamin D and folic acid were compared head-to-head with each other and with placebo.

Celecoxib and sulindac were superior to placebo and all other agents. For preventing recurrent neoplasia, low dose (< 160mg per day) aspirin ranked second in efficacy. Compared with controls, the two NSAIDs reduced the risk for recurrent neoplasia from 7.4% to 3.9% in lower risk patients. In high-risk patients (those with more advanced previous cancers), celecoxib and sulindac created greater risk reduction – from 16.3% to 6.7% compared with placebo. Risk reduction with low-dose aspirin was about half that of the NSAIDs. Serious adverse events occurred in 22% of the sulindac and celecoxib recipients, 19% of the placebo recipients and 15% of the low-dose aspirin recipients.

My Take: the risk benefit ratio for sulindac and celecoxib may not be favorable for low risk patients (NNT = 30). On the other hand, the NNT for high-risk patients is only 10 and maybe warrant the associated risks.

You may access previous issues at https://www.rmhp.org/i-am-a-provider/provider-resources/publications-for-providers

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