Ward MEDICATION MANAGEMENT

E- News

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From the Clinical Director

Very often we can tend to take things for granted when all is working well and things are doing things as they should. So it is with our bones – out of sight, the skeletal structure of the body is something we don't necessarily have at the front of mind until something goes wrong – for example, when a broken bone occurs. Apart from the obvious pain and disability associated with fractures, a broken bone can be a particularly serious overall health issue for an elderly person. A further complicating factor is that older people are particularly prone clinically significant falls, creating a doubled potential for harm.

One common fracture seen amongst older people is the fractured Neck of Femur (commonly referred to by the abbreviated form, the NOF). A fractured NOF almost always results in a hospital stay and major orthopaedic procedure for an older person, and the rate of serious complications accompanying these circumstances is striking. For example, the six-month mortality for an elderly person who has sustained a fractured NOF is in the order of 25% - quite considerably worse than some forms of malignancy and other major medical syndromes. Overall, it has been estimated that 6% of all falls amongst older people result in a fracture – as well as fractured NOFs, other examples include fractured collar bones and the Colles fracture, a fracture of the radius in the wrist, with a resultant backward displacement of the hand.

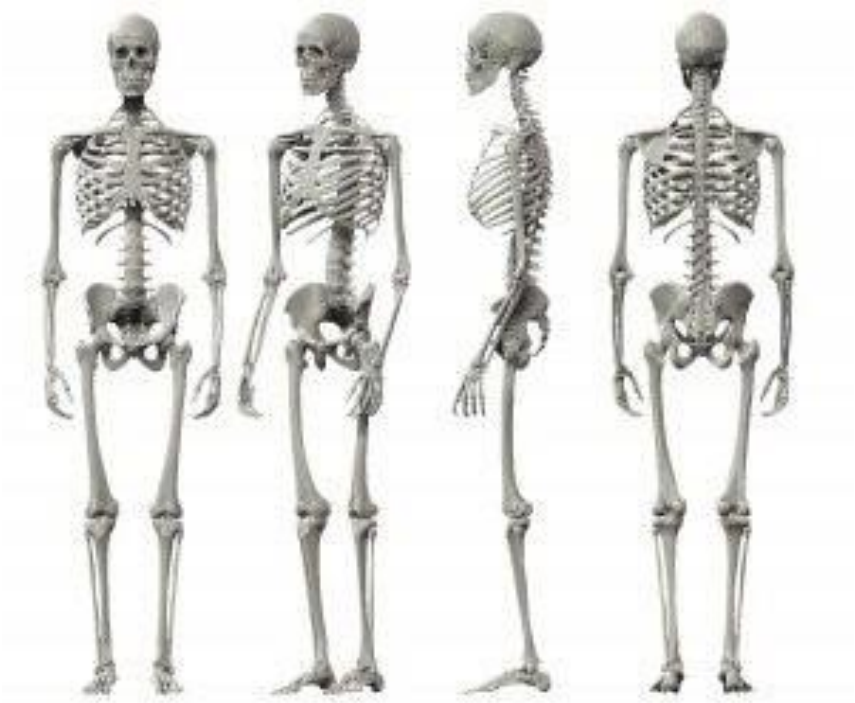
Even though the ramifications of fractures amongst the elderly are potentially dire, there are positive steps that can be taken to lessen the likelihood of these and to improve outcomes if they do happen. Regular weight-bearing exercise is a key contributor to improved bone health, and smoking cessation is also known to reduce the propensity for fractures.

There is now much more awareness of the importance of maintaining adequate calcium intake and supplements to ensure healthy serum concentrations of vitamin D. It is also understood that some medications are known to reduce bone mineral density (BMD), especially if used over the long term. An example of medicines that can compromise BMD are the corticosteroids.

Much more so than in the past, we appreciate the need to minimise exposure to drugs like prednisolone, using the lowest possible dose for the shortest possible time, or using alternative routes of delivery (e.g. inhaled steroids) to minimise systemic exposure where possible. There are so many ways in which medications can influence bone health and the likelihood of fractures amongst older people. Your Ward MM clinical pharmacist can arrange for a Residential Medication Management Review (RMMR) to identify optimisations to the medications of an older person – please feel free to contact them to arrange this whenever necessary.

Thank you to everyone who attended our second Aged Care Medication Masterclass. It appears to have been a great success with almost 100 attendees packed in to the booked out venue. The day started off with a reminder about the issue of mental health in the elderly and an overview on prescribing practices. We were then enlightened about depression and how that can affect the older population. Next myths were dispelled around the use of psychotropic agents. In the afternoon we had two guest speakers - Associate Professor Simon Bell from Monash University who discussed Drugs, Dilemmas, Delirium and Disasters, and Professor Jeff Hughes who entertained us with a talk around identifying pain in those with mental illness. The final session was a lively panel case discussion where we were joined by Dr Nigel Berry, Leah Bisani and Annette Chan.

Dr Chris Alderman, Director of Clinical Excellence, Ward MM.



Feature Article:

Bone health –

critical for everyone, especially older people.

Osteoporosis is a serious disease that is quite common in Australia. By definition, osteoporosis occurs when bone mineral density is low and the microscopic structures of bone tissue are disturbed, causing fragility and an increased risk of fractures.

The diagnosis of osteoporosis is often associated with a fragility fracture (which has been defined as a fracture resulting from the equivalent of a fall from standing height or less, or a fracture that would not be expected to have occurred in a healthy young person).

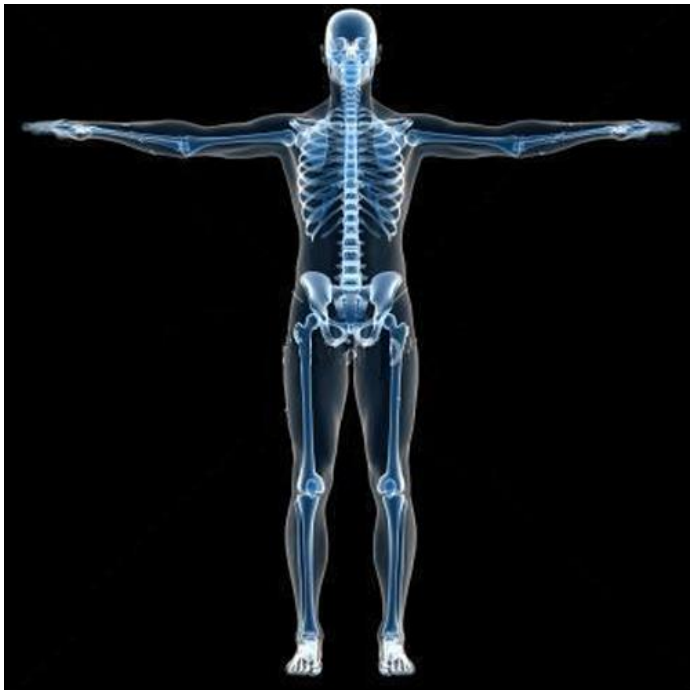
Osteoporosis is diagnosed when the BMD is more than 2.5 standard deviations below the mean for young normal subjects, but diagnosis and treatment of osteoporosis should rely on assessment of fracture risk factors rather than solely being based upon BMD scores.

Thus, management of lifestyle risk factors, and the effects of some medications and disease states need to be taken into account reduce overall fracture risk. This style of approach is likely to improve the overall health of the resident as well as addressing bone health.

The risk of fractures for people with osteoporosis can be derived from a composite consideration of a range of risk factors: older age is an important predisposing factor, as is smoking, alcohol abuse, low vitamin D status, low Body Mass Index (BMI <20), falls, and physical inactivity.

Added to this, medical conditions such as thyroid disease, rheumatoid arthritis, and chronic kidney and liver disease also increase risk. As will be discussed in more detail below, the long-term use of some medications can also compromise bone health.

Adequate vitamin D serum concentrations are vital to good bone health. Exposure to appropriate sunlight is a good start, but particularly for elderly people living in a residential care setting, oral supplementation may be needed. Oral calcium supplementation may also be appropriate for people at high risk.



Some medications can actually reverse bone mineral density loss – examples include bisphosphonates such as alendronate risedronate (which can be administered orally on a daily or weekly basis, or periodic IV infusions in the case of zoledronic acid). Denosumab is another option that can be administered as a 60 mg subcutaneous injection once every six months. Treatment choices are complex and dependent upon various patient specific factors. An RMMR can help to provide clarity around these issues.

The Ward MM freecall number 1800 WARDMM (1800 927 366) can be used at any time to seek advice about the issues raised here, or indeed any medication-related matters.

Getting ready for the **Aged Care Medication Masterclass – Mental Health in the Older Person.**

Photo courtesy of Caroline Holdstock

Quick Tip

Ward Alerts™

From time to time critical information comes to attention that will impact upon the safety and efficacy of medication use in the residential aged care sector.

Examples include product recalls, safety notices, discontinued lines etc.

Ward MM considers the timely conveyance of this information to our clients to be of high importance and for this reason we have created Ward Alerts™ - electronic communication of information by email to all Ward MM clients and related entities.

This material will be distributed on an opt-out basis – should recipients wish to stop receiving this information all that is necessary is to send a brief email in return to this effect.

We trust that this service will assist facilities and staff in the care provided for residents.

Quick Tip

Ward Clinical Pearls™

Ward MM have commenced weekly distribution of a brief digest of information that addresses topics of contemporary interest in relation to medication use and therapeutics.

This service will be offered on an opt-in basis – to receive these weekly email update simply contact the Ward MM head office at info@wardmm.com.au or your local Ward MM pharmacist.

Anyone can opt to receive Ward Clinical Pearls, not just Ward MM clients.

Your Questions Answered

Notes from facilities serviced by Ward MM

It is quite common for us to receive similar enquiries from more than one facility in our network. In this section we summarise questions with a common basis – as a part of our "connect – network – share" ethos, we share the information with all of our facilities.

Q. "What is Shingles and how is it treated?"

A. Varicella-zoster virus (VZV) causes two distinct but related conditions: varicella (chickenpox) and herpes zoster (shingles). Chickenpox usually occurs in childhood and causes a vesicular rash. VZV infects the dorsal root ganglia during chickenpox, and remains latent until reactivated. Reactivation of latent VZV usually occurs in adulthood, resulting in shingles.

The disease is characterised by a unilateral dermatomal vesicular rash, and is usually associated with severe pain.

Shingles occurs most commonly in people over 50 years of age, but can occur at any age. The onset of shingles is often heralded by pain within a dermatome, which may precede vesicular lesions by 48 to 72 hours. The total duration of disease is generally between 7 and 10 days, but it may take up to 4 weeks for the skin to return to normal. Lesions may appear on the face, tongue, or in the mouth or eye if the trigeminal nerve is involved.

The most debilitating complication of shingles is the pain associated with acute neuritis and post-herpetic neuralgia (pain after the acute rash has subsided). Shingles may also involve the central nervous system, and symptomatic meningoencephalitis is characterised by headache, fever, photophobia, and vomiting.

Treatment of shingles in the non-immunocompromised patient involves oral acyclovir, famciclovir, or valaciclovir. These accelerate the healing of lesions and resolution of acute neuralgia. However, post-herpetic pain may still occur despite treatment with these agents. Treatment should be commenced as soon as possible because the best response occurs when treatment is started within 24 hours of the onset of the rash. Little benefit is gained if treatment is delayed beyond 72 hours. The dose of all three agents may need to be reduced for patients with renal impairment.

Management of acute and/or post-herpetic neuralgia can be difficult. Analgesics (narcotics and non-narcotics), carbamazepine, gabapentin and amitriptyline have been reported to be beneficial for pain relief. For more information contact your Ward MM pharmacist or call 1800 WardMM.

Meet your Ward MM Team Member

James Shankie-Williams is one of Ward MM's youngest recruits (known in-house as the "Owlets" – young wise owls!). You'll find James in NSW working with the team to find innovative ways to deliver quality care to residents.

Most meaningful moment… is a difficult one and to be honest, it's a dead heat between two – my visit to the Grand Canyon and sunrise at Angkor Watt – two truly magical and spectacular places.

My biggest challenge… at this point in my life I've been fortunate to not have to encounter anything too huge. My biggest challenge so far has probably been my second year Chemistry exam –so much theoretical chemistry and wave function equations! Somehow I managed to pull through though and even managed a credit.

I'd be lost without… as with all stereotypical Gen Y's - my smartphone – it's my portal to the world, I can do everything on it. I actually almost get anxious without it!