



Pharmacist-led cardiology clinics for diabetics: equitable patient access in primary and secondary care?

Pharmacist-led cardiology clinics are gaining momentum in both primary and secondary care. These multi-disciplinary clinics use evidence-based protocols to treat patients and their successful implementation has led the UKCPA to produce a 'Models of Care' package to assist others in implementing similar clinics. Whilst single models of best practice have taken off in some localities, discussions now centre around making such services more widely available to meet patients needs.

Which models most appropriately maximise the number of patients seen whilst ensuring equal quality of care and positive outcomes? Whilst clinics around complex medication areas may naturally be developed by secondary care pharmacists in partnership with consultant physicians, they may then provide a training base for primary care pharmacists developing clinics in the community. The challenge is how to design such services and how they would be funded. Is there a way that primary care pharmacists and general practitioners within a locality, can offer to manage all patients in that locality, regardless of which practice or pharmacy they normally attend? Would all

pharmacists and general practitioners participate? Or would it be left to those with an interest? What would be the role for locums? Many UK community pharmacies rely heavily on locum support to provide basic business functions and it is certainly an area for consideration regarding the feasibility of implementing service models.

Models developed to date are very much specialist-run. For the majority of general practitioners and community pharmacists, the continuing professional development requirements may prove to be a barrier if not considered early in the service development process.

The advent of supplementary prescribing is also key in defining the level of autonomy with which clinic staff can operate. Certainly the new GP and community pharmacy contracts will provide impetus for debate of these points.

Primary and secondary care players traditionally have different goals, visions and cultures and when they come together to discuss such service developments it may sometimes lead to loss of sight of the one thing

that they came together to discuss: best quality patient care. The issues debated for expansion of pharmacist-led cardiology clinics for diabetic patients are of equal relevance to services for other patient groups including asthma, coronary heart disease, rheumatology, mental health and epilepsy.

In an effort to answer these questions and address communication issues between primary and secondary care trusts and their equivalents in Wales and Scotland, the UKCPA has launched two new groups: cardiology and diabetes. These groups aim to network closely with all sectors to enable expansion of best practice for the benefit of patients. Membership of the groups is available to UKCPA members and the Models of Care package is available from the UKCPA office.

It is imperative for us as pharmacists in all respective fields of practice to start to share our experiences through such networks in order to provide the highest quality of patient care in an equitable and appropriate manner.

*Candy Norris, Clinical Pharmacy Manager,
Harrogate District General Hospital
General committee member UKCPA*

In this issue:

- Parenteral methotrexate services
- Patient safety
- Anticoagulation advances
- Chairman's news
- New emergency care group
- From the practice interest groups

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Vice-Chairman's news

Welcome to 'In Practice' – I hope that you find the contents interesting and thought provoking – if you don't let us know...if you do... tell your colleagues!

The UKCPA is currently reviewing its financial and budget planning; we have agreed that the main priority is the UKCPA office, without whom the organisation cannot succeed or grow. A 5 year financial plan has been proposed to outline where funding in the future may come from.

We are living in 'interesting times', with the 'NHS Knowledge and Skills Framework', Agenda for Change and the proposed Competence frameworks together with the expanding role of Supplementary prescribing, stimulating us as professionals to rise and take up the challenge. I hope that we, as an organisation,

can help the profession of pharmacy to both meet these challenges and guide its development.

I look forward to meeting members, both old and new, at the Spring Symposium.

*Helena Hodges
Vice-Chairman*

At the February 2004 business planning meeting the increase in administration costs for study days and symposia were reviewed. Additional future costs identified included website development and the professional secretary role. An increase in membership fees will be proposed at the 2004 AGM, this will go part of the way towards additional expenditure.

From the cardiology, diabetes and critical care groups

Cardiology & diabetes group news

Both groups have study days coming up in the next couple of months so look out for flyers.

The Cardiology Day will be in the North (likely to be Leeds) and the venue for the Diabetes Day has yet to be decided.

Both days are aimed at pharmacists who currently, or intend to, practice in these areas and are designed to raise an awareness of new ways to practice, with a particular emphasis on the prescribing potential.

*Candy Norris
Chair, diabetes group
Cardiology group committee*

Critical care group news

Education

The 'Starting out in Critical Care' study day was on the 11th February in London. We recognise that this day was oversubscribed and that there

were a number of interested parties who were unable to attend. If you would like to receive lecture notes from the meeting then please contact Marie Matthews at the UKCPA office. We intend to repeat this very popular day in February 2005. In addition, we are delighted to announce that another educational day in 2004 on Tuesday 14th September again in Wal-lacespace, London. This day will be aimed at those pharmacists who are already practising in critical care.

Comprehensive Critical Care

The critical care programme run by the modernisation agency (Mod. Ag.) closes in 2004, this does not mean the end of the programme, but funding has been transferred from the Mod. Ag. to strategic health authorities, who will then decide on how funding is allocated. All pharmacists with an interest in critical care should familiarise themselves with the principles of the programme and know which is their local net-

work. For further info check out:-

www.modern.nhs/criticalcare

Mark Tomlin has been nominated the AHP/pharmacist lead for the national stakeholder group
Careers in Critical Care Pharmacy

As the group representing critical care pharmacy in the UK we would like to reflect on major changes in pharmacy (Agenda for Change/ A Vision for Pharmacy) and use them to plan a career pathway in critical care. We would also like to consider whether the Critical Care Group should set up a faculty in critical care pharmacy. Do you have a view? Or would you like further information? Please contact Cathy McKenzie at:-

Catherine.mckenzie@gstt.sthames.nhs.uk

*Cathy McKenzie, Guys & St Thomas' Hospital
Critical care group committee*

Care of elderly group: Workshops, funding, discharge

Workshops planned for the Autumn symposium 2004

Three care of the elderly group workshops will be presented at this symposium:

1. Dementia

Aim: To review the therapeutic management of patients with Alzheimer's disease

At the end of this workshop participants will be able to:

- define the clinical signs and symptoms of Alzheimer's disease and other dementias
- describe mechanism of action and adverse effects of dementia therapy
- identify and discuss pharmaceutical care issues in patient's with Alzheimer's disease

2. Depression

Aim: To review the therapeutic management of patients with depression

Workshop participants will be able to:

- Outline the aetiology and classification of depression
- Describe the mechanism of action and rationale of major types of antidepressants
- Identify pharmaceutical care issues in the management of depression

3. Pharmaceutical care issues in stroke

Aim: To outline important components of a pharmaceutical care plan for stroke patients
Workshop participants will be able to:

- Discuss key changes in the latest Royal College of Physicians Stroke guidelines
- Identify areas of pharmaceutical input to

the management of stroke patients

- Prepare a pharmaceutical care plan for use in stroke patients

Members questions

If you can help these members with their queries, please send reply to me. I thank members of the newsgroup who have already replied. A copy of replies and/or local protocols can be obtained from myself.

We are putting together **funding bids for pharmacy services to a stroke unit** (set up to comply with the NSF). We are also writing bids for **pharmacist input to a discharge lounge**. Does anyone have experience of this or a job descriptions they would be willing to share?

Anne Maher

West Hertfordshire Hospitals NHS Trust

I am updating our guidelines on dealing with patients admitted to our one-stop dispensing wards, using metered dosage systems (MDS) prior to admission (inpatient and discharge supplies). We do not have facilities for preparing MDS in-house, so discharge involves organising FP10(HP)s and liaison with community pharmacy. Our main problem is having discharges sprung on us, even though we do ask doctors to give us plenty of notice. Do you have a **system for planning discharges** in place that works well?

Sara Taylor

*George Eliot Hospital NHS Trust,
Nuneaton*

Electronic newsgroup

Membership of this group, whose aim is to encourage networking amongst members, electronic distribution of group information and the dissemination of models of care, has continued to grow. If you are interested in joining this news group, please email me the following details to dataylor@tinyworld.co.uk:

1. Email address
2. Job title
3. Postal address
4. Contact telephone number

I apologise to a few members who have inadvertently been "dropped" from the newsgroup. Some emails are returned as undeliverable. Please contact me again if this has happened to you.

Derek Taylor

*Pharmacy Department, Broadgreen Hospital
Thomas Drive, Liverpool, L14 3LB
Tel: (0151) 282 6446*

Email: dataylor@tinyworld.co.uk

Care of the elderly group welcome pack

Copies are available from me. A lot more information has been added to this edition.

Derek Taylor

*Chair, care of the elderly group
Pharmacy, Broadgreen Hospital
Thomas Drive, Liverpool, L14 3LB
(0151) 282 6446, dataylor@tinyworld.co.uk*

Congratulations to Derek for his first baby!

UKCPA quality and risk management group: medication errors

Some of you may have seen the latest tome (173 pages) from the DoH – *Building a Safer NHS for patients – improving medication safety* (published 22nd January). This one comes from the Chief Pharmacist and is very focussed on causes and frequencies of medication errors. It is now recognised that medication errors cost in the order of £500m per year, or at least a quarter of all adverse events in the UK. This is an expensive problem, apart from the human dimension.

The report also notes that this is not just a UK problem. In the USA, it is estimated that 7000 deaths per year are caused by medication errors. The original *Building a Safer NHS for patients* published in 2001, and with a wider remit, set a target of reducing the number of serious errors in the use of prescribed drugs by 40%. We probably regarded this as a statistic likely to come back and haunt the Government – and, what baselines were there to relate to? Encouraging reporting, which is what the NPSA is about, may result in an apparent increase in adverse events, not less, even if the actuality is different.

However, fingers crossed, there have not been any new deaths relating to maladministration of vinca alkaloids or potassium chloride since this was published.

This report has chapters covering:

- the causes of medication errors
- the safer uses of medicines with particular regard to people with allergies, patients who are seriously ill and children
- challenges with specific drugs (drugs in anaesthetic practice, anticoagulants, cytotoxic drugs, IV infusions, methotrexate, opiate analgesics and potassium chloride),
- organisational and environmental strategies to reducing risks

Finally, the appendices include very helpful good practice recommendations for major risk areas associated with serious medication errors.

These could readily be used as a basis for local audit and risk management prioritisation.

As many of you will know there are many examples of labelling which can lead to medication errors, in the pharmacy itself

(dispensing errors) and errors in the clinical setting. The report commends the MHRA's best practice guidelines on labelling (MLX 275) and notes that all labelling of new products will be considered by the regulatory agency against this document. On this, we are pleased to see some real improvements where the simple set of principles can be applied to provide clarity to the drug name, its strength/potency and route of administration. Recently, for example, Faulding, have issued an A3 sheet showing the old and the new labelling for their range of injectables. These use colour to highlight – not colour code, with good effect.

This report is enormously important and we recommend every pharmacist and pharmacy technician to read it. It also provides an opportunity for pharmacists to take a lead with other health professionals in both primary and secondary care. Indeed it has to be a multidisciplinary approach and the final section of Annex 1 states: "NHS primary care trusts and trust boards should ensure that an overarching strategy is in place to deliver safe medication practices".

Bob Shaw

Clinical comment. Parenteral methotrexate for rheumatoid arthritis: supply and safety

Methotrexate is considered by many to be the gold standard disease modifying treatment for rheumatoid arthritis, but treatment is often withdrawn due to poor tolerance. Increasingly patients are given intra-muscular or subcutaneous methotrexate to avoid gastrointestinal side effects. This systemic route also addresses poor absorption.

Clinicians in Leeds have very recently advocated that parenteral methotrexate be used before considering biologic therapies and anecdotally, use appears to be growing in other areas of the country. This raises issues around safe administration, monitoring and safe disposal of excess or expired drug and injection paraphernalia.

Methotrexate is a cytotoxic drug thus precautions for handling and disposal are more complex than for other medicines. This may be less of an issue in secondary care where staff may be more familiar with the drug, but in primary care, there may be concerns about how to handle the drug and whether staff unfamiliar with the process should be handling methotrexate at all.

Another issue is providing parenteral supplies of the drug in a safe but convenient presentation. Some centres provide vials of

methotrexate and train patients to draw up doses. Others provide patients with syringes filled by on-site sterile production facilities, with relatively short expiry dates. This is convenient for drug administration but these short expiry dates have obvious limitations. Syringes are either self-administered by patients or given by practice nurses.



A third option is have methotrexate injections delivered to patients' home by a homecare company. However all this may change if a proprietary methotrexate injection licensed in other European countries becomes available here.

These changes offer an opportunity for community pharmacists to manage the whole process, from patient education, supply and administration to safe disposal of cytotoxics.

This would also help community pharmacists be aware which patients are receiving methotrexate and be cognisant of potential interactions and adverse effects.

With appropriate training and technology, community pharmacists could even takeover monitoring of patients' biochemical and haematological markers.

Chris Green

Assistant director of pharmacy clinical services
Royal Liverpool and Broadgreen Hospital
Chairman of UKCPA Research & Development committee

Clinical comment editorials are commissioned from UKCPA members and published in *Pharmacy Magazine* each month. Clinical comments are summarised here in *In Practice*.

UKCPA has an ongoing need for writers for clinical comment. A small fee is payable.

Topics covered to date include chronic pain, angina, CHD, COX II's, errors, combination inhalers, oxygen, methotrexate.

If you would like to submit a column contact Sonia Sanghani via the office.

Past columns are available on:
<http://www.pharmacymag.co.uk/>

New UKCPA group: emergency care

Following the success of an electronic newsgroup, UKCPA is pleased to announce the launch of the Emergency care group at the spring symposium in Birmingham, May 2004.

Emergency care encompasses many areas and settings. Pharmacists and technicians working in these fields are invited to join:

- Primary Care
- Accident and Emergency
- Medical admissions units (MAU)
- Surgical admissions units (SAU)
- Clinical decision units (CDU)
- Medicines sans frontiers/Pharmaciens sans frontiers
- Red cross
- NHS direct
- Minor injury units
- Ambulance services

- Territorial army

The group's objectives are to:

- Provide education and training events
- Share clinical experience, evidence and debate
- Encourage and support practice research
- Monitor and maintain standards of practice
- Provide clinical expertise to new and existing pharmacists and technicians working in emergency care

Members will discuss and bring together best practice in areas such as:

- Immediate assessment, stabilisation and care
- Appropriate admissions, and pharmacy's role in preventing inappropriate admissions
- Medicines management in the emergency

and urgent situation

- Working at the interface
- Rapid response teams
- Ambulatory care

If you are interested in joining the UKCPA Emergency care group, please contact the UKCPA office.

To join the Emergency care group electronic newsgroup, e-mail
UKCPA-EmergencycarePIGroup
@subscribe.yahogroups.co.uk.

We look forward to seeing you at the launch in May and at future study days and symposia workshops.

*Nicola Wake
North Tyneside General Hospital*

Surgery and theatres group: antibiotics, anticoagulation, controlled drugs

Controlled drugs seem to be the "in thing" in the newsgroup this month, probably reflecting the Shipman case and the need to tighten up procedures. There have been several discussions surrounding methods of destruction and documentation.

Jennie Simpson, surgical pharmacist, Halton Hospital has been looking into systems used for **destruction of controlled drugs (CDs)**. She asked how other hospitals managed this?

Caroline Austin, surgical directorate pharmacist, Stepping Hill Hospital, Stockport, wrote that out of date CDs on the ward are destroyed on the ward. They are signed out of the CD register by a pharmacist and double-checked by a qualified nurse who countersigns in the CD register.

CDs which the ward no longer require, but are in date, are signed out of the register on the ward and returned to pharmacy. Once they are "returned" onto both the pharmacy computer stock system and into the CD register they can be re-dispensed to any ward which requisitions them.

Patients' own CDs that are no longer required on the ward are also destroyed on the ward and signed out of the register. This method of management mirrored by Aintree hospital.

Thromboprophylaxis raised its head again. Paula Kelly asked about national use of fondaparinux for thromboprophylaxis in orthopaedic surgical and aspirin 150mg as a sole agent as indicated by the PEP study. She was particularly interested in regimens and outcomes.

Fondaparinux is not used at University Hospital Aintree for this indication but Emma Ray, surgical pharmacist, indicated trial nurses liked

using fondaparinux. It was felt to be easy to administer and the 'needle safe system' reduced risk of an injury. However problems with the trial design and management of patients meant any improved outcome was difficult to identify.

Clare Wetherell, senior clinical pharmacist clarified that University Hospital North Durham is not using fondaparinux. Aspirin 150mg daily is used for 35 days as per the PEP study for fractured neck of femur. One consultant uses aspirin for joint replacements, the others use enoxaparin for 28 days. No agreement exists for other patient groups.

Andrea White, orthopaedic directorate pharmacist wrote that in Southampton a group had decided that there was not enough evidence yet to support fondaparinux use. One of the orthopaedic consultants used aspirin as per the PEP study but all others prescribe enoxaparin and av impulse boots.

Gill Monteath, clinical pharmacy team leader, Leeds Teaching Hospitals was finalising a fondaparinux protocol for one consultant only. Within orthopaedics, aspirin 75mg daily for six weeks is indicated for patients with proximal femoral fractures over 55 years of age.

After our October study day, **prophylactic antibiotics** were also under discussion.

Jenny Stirton, lead clinical pharmacist, surgery, North Glasgow University Hospital was reviewing prophylactic antibiotic use. Their current prophylaxis protocol for appendicectomy, colorectal surgery, oesophageal surgery and hernia repair with mesh was a single dose of cefuroxime plus metronidazole. One of her surgeons suggested these be reviewed in view of changing organism sensitivities and replaced with gentamicin plus metronidazole.

Also, one site within their trust uses ceftriaxone plus metronidazole rather than cefuroxime plus metronidazole.

Keith Hinton, replied Harrogate District Hospital uses cefuroxime and metronidazole first line. Gentamicin and metronidazole were used for patients allergic to penicillin. Their microbiologist had been very helpful with the antibiotic prophylaxis policy.

This is a very interesting topic as there is little evidence for prophylactic antibiotics in surgery. **What happens in your hospital?**

Chris Jay, acting principal pharmacist clinical services, Dudley asked about **treatment of mastalgia**. One of his consultants wanted to look at topical NSAID's and extract of chaste tree (*Agnus castus*) for cyclical and non-cyclical mastalgia.

Nicola Ward, senior clinical pharmacist, surgery, Glenfield checked with her breast care nurses. They usually recommend evening primrose or starflower oil for three months initially to ascertain benefit, although little evidence exists for this. They recommend topical NSAIDs if the pain is limited to one area of the breast and find this to be very effective. A recent reference was quite positive: *J Am Coll Surg* 2003; 196: 525-30. In conjunction with these treatments they recommend a good support bra and simple analgesia. They have no experience of *Agnus Castus*.

Does anyone else use *Agnus castus*? Let the newsgroup know. Several people are interested in this alternative treatment.

*Sharron Millen
Southampton General Hospital*

Respiratory group: study day, doubling steroids, magnesium

First respiratory group study day

February 10th saw the first respiratory group (RG) study day in Leicester, where 22 members attended. First on the agenda was a brief overview of the drugs commonly used in acute respiratory failure, and was run by Joanne Arasa (respiratory pharmacist at the Northern General Hospital Sheffield) and Judith Howell (senior respiratory pharmacist/teacher practitioner at Wirral NHS Trust/Liverpool John Moores University).

The session gave an overview of the drugs commonly used in acute respiratory failure and looked at their place in therapy, doses used, administration issues and relevant monitoring. Current guidelines were also considered and compared to what happens routinely in clinical practice. This gave an opportunity for discussion of practice in base hospitals and problems encountered. The NICE guidelines for COPD would be out very soon.

Gail South, a respiratory consultant nurse based at Chesterfield Royal Hospital, conducted the second session. Gail covered a hot topic of assessing the need for nebulised drug therapy in the treatment of COPD. The main problem highlighted was the difficulty of assessing an individual patients response to treatment and posed the question is subjective improvement enough or should we insist on a measurable outcome i.e. is an increase in FEV₁? Most clinicians consider both factors and then would prescribe nebuliser therapy in patients who have demonstrated improved exercise tolerance. This can often be seen by their ability to do household chores that they were unable to do previously. In the same session the problems and pitfalls of both short term and long term oxygen therapy in the management of COPD were also considered. It was evident that oxygen is a drug and therefore should be prescribed. Some hospitals are piloting oxygen drug cards but oxygen prescribing still remains a big problem.

Jane Scullion (respiratory consultant nurse) and Anna Murphy (respiratory consultant pharmacist) both from Glenfield Hospital Leicester, ran the final session of the morning. This session looked at the medicines management issues surrounding end stage lung disease. The need for full assessment of the patient in determining the underlying reason for the breathlessness was emphasised. The agents used to alleviate these symptoms include morphine and other opiates as well as benzodiazepines. It was noted that lorazepam oral tablets could be used sub-lingually at a dose of 0.5mg PRN. The lack of robust evidence for use such agents was discussed, but it was generally accepted practice to trial the use of these agents and determine patient response.

The afternoon was devoted to bronchiectasis. Dr Simon Range (respiratory consultant physician, Glenfield General Hospital) started the session with a look at the pathogenesis and management of bronchiectasis. Lynne Brown (clinical practice pharmacist, South East Sheffield PCT) continued the afternoon with some case studies in which she highlighted the challenges of drug treatment in patients with bronchiectasis. The use of home IV antibiotics was discussed and the importance of patient education highlighted. A comparison of the available routes of administration of antibiotics was made, in severe exacerbations it was generally accepted practice to use the IV route. The various agents utilised were examined and the group discussed the various practices observed throughout the UK. In clinical practice it is often found that patients will improve on antibiotic treatments even when cultures and sensitivities show resistance in the laboratory situation. For this reason it is difficult to write guidelines on antibiotic use. Therefore when considering antibiotic treatment it is important to look at what the patient has had in the past and what they have responded to.

We are keen to make future study days as interesting and relevant as possible. Please let us know of any areas of interest that members would like covering in the future.

Other respiratory group news

Respiratory press news

Doubling steroid inhaler dose does not prevent flare – ups *Lancet 2004; 363:271-275*

The finding that doubling the dose of inhaled steroids does not prevent a flare –up of the patient's asthma was based on a study of 390 asthma patients. If peak flow testing of symptoms suggested the onset of a flare-up, patients were randomised to add a dose of trial medication (either a steroid or placebo inhaler) to their usual inhaled steroid dose for 14 days.

During the 12 month study period, 207 (53%) patients used the extra inhaler dose. Overall, 46 patients started oral steroid therapy during the study period. The findings indicated there was no evidence that a double dose of inhaled steroids prevented exacerbations, because the percentage of patients in each group that required oral steroids was almost the same – about 12%.

Moreover, the investigators pointed out that compared to placebo, doubling the inhaled steroid dose had not effect on the lowest peak flow recorded, rise in symptom scores, highest symptom score recorded, or time to recovery for peak flow and symptom scores. Although the current study suggest no benefit from dou-

bling inhaled steroid doses, larger studies are required to determine whether a larger dose increase might effectively averting flare-ups.

This study affects the information we give to patients in their self management plans. We as health care professionals need to be very clear what information we provide to patients as to not send out mixed messages.

Email questions

There have been many interesting questions and discussions via email over recent months. Topics affecting pharmacists working in all sectors of the profession have included: how to approach **osteoporosis prevention in patients on long term steroids** and **how best to assess efficacy with the new inhaled anticholinergic drug, tiotropium**. We have also received many helpful suggestions to help us all get round **supply problems with pyrazinamide**. There is no longer a UK manufacturer but supplies may be imported via IDIS. This may not always be practical hence one suggestion was to use the combined preparation of Rifater (rifampicin, isoniazid and pyrazinamide) wherever appropriate.

Other topics have included **use of tetracycline, talc and bleomycin for pleurodesis** and protocols have been shared describing preparation of some of these products. The evidence base (or lack of it!) for **using IV magnesium in acute severe asthma** was debated. It seems the jury is still out regarding its place in treatment against other agents such as IV infusions of aminophylline and salbutamol, which also lack a definitive evidence base. While the British Thoracic Society asthma guidelines do not offer specific details of how to administer IV magnesium, members of the RG described the following regimes:

- 2g Mg in 100ml 0.9% saline over 20 minutes
- 1g per hour in saline for 24 to 48 hours

Anecdotally, diarrhoea can troublesome and one hospital carried out ECG monitoring in case of arrhythmias from the magnesium. Magnesium efficacy is best described as variable! Many thanks to all who have posed and answered questions. Keep them coming.

If you are a UKPCA member and would like to join our newsgroup, visit www.ukcpa.org.uk and follow the instructions. If you have any problems please let me know.

If you are interested in joining the RG contact the UKCPA office or any committee member.

Anna Murphy

On behalf of the RG committee members

Newsgroup addresses

If you wish to join UKCPA electronic newsgroups, please email the address below, giving information on your:

- Email address
- Job title
- Postal address
- Contact telephone number

UKCPACardiologyPIG-
subscribe@yahoogroups.co.uk

UKCPA-CriticalCare-PIG-
subscribe@yahoogroups.co.uk

UKCPA-DiabetesPIG-subscribe@
yahoogroups.co.uk

UKCPA-EducationTraining-PIG-
subscribe@yahoogroups.co.uk

UKCPA-ElderlyCare-PIG-
subscribe@yahoogroups.co.uk

UKCPA-
EmergencycarePI-
Group@subscribe.yahoogroups.co.uk

Leadership and management:
lmdig-subscribe@yahoogroups.co.uk

Infection management:
barbdean@tiscali.co.uk

UKCPA-PalliativeCare-ChronicPain-
subscribe@yahoogroups.co.uk

UKCPA-PrimaryCare-PIG-
subscribe@yahoogroups.co.uk

UKCPA-QualityAssurance-PIG-
subscribe@yahoogroups.co.uk

UKCPA-RespiratoryPIG-
subscribe@yahoogroups.co.uk

UKCPA-Rheumatology-
OsteoporosisPIG-subscribe@
yahoogroups.co.uk

UKCPA-Surgery-Theatres-PIG-
subscribe@yahoogroups.co.uk

If you experience any problems trying to join a newsgroup, please email the office at admin@ukcpa.com.

Clinical comment: What future for anticoagulant services?

Ever experienced a protracted wait for a bus, only to find that a chain eventually arrive together? Those working in the field of thrombosis and haemostasis must feel the same way regarding to their pharmacological armamentarium in the battle against blood clots.

Both heparin and warfarin have proven efficacy but have significant shortcomings, yet patient management has changed little in the 50 years since their conception. This is in contrast with significant parallel scientific developments in the field. The principle inadequacies of both agents are the need for close patient monitoring and logistical issues. Control of both drugs is notoriously difficult with the consequence that for large parts of their treatment patients may be either under- or over-anticoagulated, potentially resulting in further thrombotic or haemorrhagic sequelae. Given the diversity of factors influencing efficacy (diet, health status, concurrent drugs, knowledge and skills of healthcare staff amongst others) it is surprising that until the early 1990s practice altered little.

The introduction of the low-molecular-weight heparins (LMWHs) allowed seemingly safe and effective anticoagulation without the requirement for monitoring in the majority of cases. Furthermore, dosing was simple based on a weight-based formula and were administered just once or twice daily. It permitted the management of comparatively low thrombotic risk conditions such as deep vein thrombosis (DVT) and atrial fibrillation (AF) in an out-of-hospital environment, freeing resources for more acutely ill patients.

Apart from isolated scenarios such as valve replacements or renal failure, LMWHs have successfully superseded the use of unfractionated heparin (UFH). It may be that newer agents, such as the synthetic pentasaccharides and the recombinant hirudins, may have further potential to optimise LMWH benefits. The results of some studies however suggest that there may be an optimal achievable balance between bleeding risk and anticoagulant effect that may impede any further rapid advances.

What has remained the holy grail of anticoagulation therapy, however, is development of an oral anticoagulant with sufficient simplicity as to offer the potential to replace warfarin. In much the same way that LMWHs offer advantages over UFH, patients and their carers desire a therapy that allows ease of administration, no important lifestyle interactions, and at least equivalent efficacy to warfarin, but without the requirement for regular monitoring. With a new class of oral direct thrombin inhibitor, the first of which, ximelagatran, is likely to receive a license for its first indication in 2004, it may be that a revolution is im-

minent. This in turn raises some new issues:

Firstly, the initial indication for which ximelagatran is pursuing a license is in thromboprophylaxis in elective orthopaedic surgery. It is probable that subsequent licenses for both AF and treatment of venous thromboembolic disease (VTED), such as DVT and pulmonary embolism (PE), will not follow for some months. This presents the issue of unlicensed, 'off-label' usage whereby consultants in secondary-care may wish to use the drug for patients in whom warfarin might be difficult or inappropriate.

Secondly, in the longer-term, anticoagulation services will require re-modelling. Despite the likelihood of the persisting stigma of older oral anticoagulants and the early lack of licensed indications, which may initially deter prescribers from using agents such as ximelagatran, in time their use is likely to supplant warfarin in the majority of patients. At first glance this may appear to suggest that the need for anticoagulant services will disappear. This is unlikely to be the case, as patients are still to be considered relatively high risk – for example, newer agents will not obviate the risk of intracerebral bleeds in elderly patients who fall.

Additionally, such a significant change is likely to be gradual in onset, and warfarin patients will not disappear overnight. Ximelagatran may also prove to be contra-indicated in certain patient groups, who will continue to require warfarin and therefore INR monitoring. It would perhaps be more appropriate to slowly re-model services to provide long-term support for anticoagulant patients, with the minimum of disruption to patients. With changes in the level of technical support required for such patients, it would seem appropriate for this to occur predominantly in primary care. This would free secondary care resources that might be utilised for outpatient management of venous thromboembolic disease patients via emergency departments, and general optimal inpatient anticoagulation. This appears to be supported in the new GMS contract, which offers primary care organisations the option of commissioning anticoagulant services from primary care as an enhanced service.

The financial implication of service changes to the care of anticoagulant patients is as yet unknown, with much yet to be decided. Nevertheless, it seems prudent for primary and secondary care to start collaborative work on re-structuring services sooner, rather than later.

*Robin Offord
Senior clinical pharmacist,
Critical care
Guys and St Thomas NHS Trust*

UKCPA infection management group news

Welcome to all new members that have joined the Infection Management Group (IMG). Most of the new members are new antibiotic pharmacists appointed as a result of the Department of Health funding. The IMG email network provides a helpful forum to ask questions, share ideas, update guidelines and network with other pharmacists in similar jobs.

Our section of the UKCPA website will be updated to contain a number of useful references and links. Department of Health websites relating to key documents referring to antibiotic resistance will be cited together with international action plans. There will be links to other infection related societies and to infection related journals. Key annual meetings that are held relating to anti-infectives are listed, as are publications relating to role of pharmacist in Infection Management.

The IMG has been approached by the Alliance For The Prudent Use of Antibiotics (APUA). This is a global organisation which was set up in 1981 dedicated to promoting proper antibiotic use and curbing antibiotic resistance worldwide. There are currently memberships throughout one hundred countries and international chapters, which support individual and country based activities to control and monitor antibiotic resistance.

A chapter has recently been set up in the UK and the chair, Professor Davey, has approached the UKCPA IMG network suggesting pharmacists may be interested in joining. Further information on aims and objectives is available at the UK chapter website <http://www.bsac.org.uk/default.cfm?fuseaction=resources.viewitem&itemid=229> or the parent organisation at www.apua.org. These documents will also go onto our IMG website.

The second organisation that has approached the IMG is a study group of the European Society of Clinical Microbiology and Infectious Diseases (ESCMID). The study group is known as the ESCMID study group on antibiotic policies (ESGAP).

One of the aims is to standardise antibiotic policies to establish their comparability and to facilitate the collection of data within Europe thereby promoting prudent antimicrobial use. For further information please see their website, www.escmid.org and then look for the links to Science and Education then study groups.

It is with regret that the committee announce that one of their members is stepping down - Hayley Wickens, microbiology pharmacist, St Mary's Hospital, London. Her reasons however are well founded, as she has been invited to become a member of the postgraduate education subgroup of the Special Advisory Committee on Antimicrobial Resistance (SACAR).

We wish her well and look forward to hearing about the work of the committee. Hayley is to be thanked for her work on the committee, in particular her tireless efforts in organising study day venues!

We look forward to seeing members at the Spring Symposium in Birmingham. There will be a fringe meeting for attendees interested in infection management.

*Wendy Lawson
Infectious diseases pharmacist
Hammersmith Hospital NHS Trust*

Your association needs you!

The general committee and subcommittees: public relations, education and planning, research and development, consist of voluntary (elected) members. Committee members do an excellent job including planning symposia, managing existing awards and developing new awards, adjudicating abstracts and proof-reading abstracts prior to publication, and of course producing *In Practice*.

At present there are insufficient sets of hands for other pressing tasks such as liaison with members, developing the website, writing clinical comment columns. If you feel you can help, please contact the office specifying the area in which you are interested.

Have you been the first author on a peer-reviewed research paper? Are you an experienced practitioner working in an academic setting? UKCPA committees would welcome further help with adjudication from practitioners with well-developed audit or research skills and writing skills. Contact the office or Chris Green, research and development committee.



Thank you to corporate members

UKCPA thanks corporate members and sponsors for their ongoing support:

- AstraZeneca Plc
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- Wyeth Laboratories

Letters to the editor in *In Practice*:

What do you think about the new look for *In Practice*? What articles would you like to read? Is there enough from the groups?

Do you have information that should be shared with other clinical pharmacists?

Although letters were a suggested addition for *In Practice*, we have not received any letters for this issue.

Future events

UKCPA study days

- Intensive weekend school. Developing clinical practice skills. Leeds 2-4 April 2004
- Vascular study day: keep the circulation going. Birmingham 15 April 2004
- Education and training group Interprofessional education direction and development. Leeds 23 June 2004
- Current controversies in infection management. Birmingham 14 October 2004

UKCPA symposia

Spring symposium 7-9 May 2004

Note the change of venue: Birmingham

This conference will now be held in Birmingham Hilton Metropole hotel. It will provide nine hours of continuing education. Registration closes on 23 April 2004.

Autumn symposium 19-21 November 2004

This prestigious conference will be held in Blackpool Hilton hotel.

The closing date for abstracts is 19 July 2004. Registration closes on 22 October 2004.

2004 Corporate members dinner

The corporate members' dinner is on 6 May. Corporate members, awards winners and other UKCPA members are invited to attend. Contact the UKCPA office for more details.

UKCPA Awards

- Napp Palliative Care Award
 - Merck Medicines Management Award
- Closing date for both awards is 1 June 2004.
- Pfizer Patient Safety Award
 - Unichem Community / Primary Care Award
 - Wyeth Education and Training Award
- Closing date is 10 December 2004

The deadline for contributions for the next issue is 30 May 2004

Models of care packages

UKCPA has a new resource pack for pharmacists wishing to set up cardiology clinics. It contains eight models of care covering hypertension, heart failure and cardiac medication review. This resource will help pharmacists establish models in their own area.

Packs can be obtained from the UKCPA office
Cost to UKCPA members is £10 plus £4.50 (p&p), non-members is £15 plus £4.50 (p&p)

New UKCPA groups

UKCPA aims to expand its practice group base to include more therapeutic areas. To this end, UKCPA recently launched a diabetes group and an emergency care group will be launched at the May Symposium. To join, see the addresses inside or contact the UKCPA Office.

Guidance for contributors to *In Practice*

Adherence to this guidance will make editing faster, make *In Practice* more useful to readers (and make the editor a happier person!).

General points

- Use generic drug names
- Generic names should be in lower case
- Avoid abbreviations (ab), with the exception of UKCPA and NHS. If ab are used they must be defined first. The ab MOF or VTED may seem obvious but will not be obvious to community or junior pharmacists
- Too many ab makes reading difficult
- Lower case (no initial capitalisation) for pharmacists, doctors, respiratory consultant nurses, beta agonists, district nurses, residential homes, nursing homes and criterion. However Christmas has a capital C
- No initial capitalisation for conditions in the middle of a sentence: bronchiectasis, epilepsy
- Write "and" in full. Do not use "&"
- Use patient, not pt
- A colon or a new sentence may be more appropriate than running on with a hyphen
- No space before a comma or a full-stop
- Only use one exclamation mark. Five exclamation marks is over the top!
- References should be Vancouver format (Author[s]. Title. Journal, year; volume: page-page.) Add the date of the journal issue only if you feel it facilitates locating the correct issue, e.g. recent issues
- Use words (not 1, 2, 3) in full for numbers one to ten, then use 11, 12...
- "That" is often unnecessary
- If one word will do, use only that one word

- Avoid extra-long sentences (Microsoft Word will often pick this up for you)
- Get someone else to proof-read your copy for tense consistency, verb match (was/were)
- If a word limit is suggested, stick to it
- Plain lower case is easier to read than uppercase and saves the editor time in changing it back to lower case

Summaries of study days, workshops or lectures

These should report the topic and should inform the reader for their future practice.

Writing "he was an excellent speaker with good literature review and some firm opinions about what to use in different circumstances" does not inform the reader's practice. Further, this sentence suggests that UKPCA sometimes has poor speakers with bad literature reviews and wavering opinions. Obviously we do not want to promote such an image, so either cut out this section or change it to tell readers what to do in daily practice: give a few details that will help the reader next time she goes to the wards, or omit it all together. What drugs are recommended, at what dose, in which patients? What new information or practice was reported?

If speaker covered risk factors, or drugs in acute respiratory failure, list a few that might be news to the reader (recently recognised or non-obvious risk factors), rather than just writing Dr Foster spoke on risk factors.

C. Alice Osborne
Editor, *In Practice*

Principal pharmacist, medicines use research
Guys and St Thomas Hospital

Attention clinical services managers and chief pharmacists

A leaflet is enclosed which promotes UKCPA. We would be grateful if you could disseminate copies to your staff and encourage them to join UKCPA.

Material included in *In Practice* is based on information available from resources at our disposal at the time of issue.

Opinions expressed herein do not necessarily represent those of UKCPA or individual members. The inclusion of any information does not imply any endorsement by UKCPA.

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In Practice is edited by Alice Osborne and Duncan McRobbie on behalf of the UKCPA public relations committee.

British Geriatrics Society Parkinson's disease SIG announce the 9th "from science to practice" series at the Royal College of Physicians, London 15th July 2004. For more information, contact MEP Ltd on 020 7561 5400 or email info@mepltd.co.uk.



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