

DRUG INTERACTION ALERTS

Responding to drug interaction alerts is difficult

From Dr K. E. Neil, MRPharmS

A recent Broad Spectrum article (*PJ*, 22 November, p708) draws attention to some of the problems associated with responding to drug interactions in primary care and particularly community pharmacy. This is an area in which I have been interested for some time.

The problems with drug interaction alerts highlighted by John Wilson are common to both general practice and community pharmacy. They leave health professionals feeling overwhelmed and it is therefore not surprising that many of these copious warnings are ignored.

Dr Ivan H. Stockley from the University of Nottingham is recognised as a world expert in the field of drug interactions and has produced a comprehensive reference book. This is an essential guide to the clinical relevance of drug interactions and provides concise advice regarding their management. I take my own copy to all locum placements and find that general practitioners are grateful when I relay the practical information it contains.

I find that one of the most difficult problems relates to those interactions that require close monitoring. Community pharmacists do not currently have access to biochemical data and the decision to contact the GP is a difficult one. Added to time restraints, dealing with drug interaction queries is extremely difficult and good support staff are essential. When working as a community pharmacist, I find myself selectively contacting GPs I know who welcome such intervention, or occasionally asking patients when they last had a blood test.

There is work under way to improve drug interaction software and Dr Stockley has produced a database including

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short advisory messages for GPs and pharmacists. The National Patient Safety Agency is currently involved in work to identify hazardous interactions with the aim of making warnings relating to these interactions difficult to override. In the meantime, I would encourage readers to consult 'Stockley's drug interactions'.¹ Readers may also be interested in the prescribing safety series currently running in *Prescriber* (www.escriber.com), which includes examples of detailed case studies taken from our work on the prescribing of hazardous or contraindicated drug combinations in general practice.²

*Karen Neil
Nottingham*

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Overhaul has already been done

From Dr I. H. Stockley, FRPharmS

The title of John Wilson's Broad Spectrum article ("Crying wolf! Why computerised drug interaction alerts need an overhaul" (*PJ*, 22 November, p708) neatly sums up his conclusions after tussling with some obviously irritating and unhelpful interaction alerts while doing locums. But Mr Wilson, I have already done this overhauling exercise. It is very much past history. What needs to be done now is the replacement of these alerting systems by something much better.

My overhaul almost precisely followed Mr Wilson's list of recommendations. I went through the vast list of interactions to filter off the "noise" of unimportant interactions, retaining only those where the pharmacist needs to do something in response. I wrote a series of short alerts saying what happens (and sometimes why) when particular pairs of drugs interact. Each alert was given a broad "hazard/severity" rating with an indication of incidence and magnitude wherever possible; and all of them were rounded off with a suggested course of action for the pharmacist. I also designed the alerts to be linked to a coloured traffic-light coding system.

You can see these "Stockley Drug Interaction Alerts" in action on NDC's "Pharmacy Manager" computer system in the United Kingdom. A new combined system of alerts appropriate for both doctors and pharmacists has also recently been written.

I think that these alerts are practically tailor-made for Mr Wilson's requirements. But do not just take my word for it. See for yourself.

*Ivan Stockley
Willoughby-on-the-Wolds,
Leicestershire*

Serious interactions may be overlooked

From Mr P. J. Beckley, MRPharmS

As a pharmacist working in a "prescription factory" receiving many prescriptions with more than 10 items, usually for patients over 80 years old, I would like to express my appreciation to John Wilson for drawing attention to the problem caused by computerised drug interaction alerts (*PJ*, 22 November, p708).

My system even flashes up an "interaction" between identical drugs, eg, diclofenac, and I have been concerned for some time that serious interactions may be overlooked in such a maze of misleading information.

I sincerely hope that the companies responsible for these programs will consider the issues raised in this excellent article and work with community pharmacists to resolve them.

*Peter Beckley
Crawley, West Sussex*

TELEPHONE NUMBER

It would be helpful if correspondents supply a daytime telephone number.

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EMOLLIENTS

Sample size packs would be helpful

From Ms A. K. Smith,
MRPharmS

In the paper "An audit of adverse drug reactions to aqueous cream in children with atopic eczema" (*Pf*, 29 November, p747), it is noted that "finding the most suitable emollient for an individual may be a matter of trial and error".

In the light of this would it not be a good idea if the manufacturers of emollient creams produced a small sample size to sell, so that people could try them without spending a fortune on preparations that they may react adversely to?

Annette Smith
Towcester,
Northamptonshire

TACROLIMUS

A place for both tacrolimus and pimecrolimus in eczema treatment

From Dr S. Kownacki, MRCP

Your news item (*Pf*, 1 November, p607) entitled "Advantage for tacrolimus" raised some interesting issues around the new steroid-free treatments for atopic eczema — tacrolimus (Protopic) and pimecrolimus (Elidel).

In the United Kingdom the two treatments have different roles in the management of the disease. Elidel is licensed for acute treatment of mild-to-moderate atopic eczema and can be, and is already, prescribed in the primary care setting. Protopic is licensed for moderate-to-severe atopic eczema that is unresponsive or intolerant to other therapies, and is licensed for specialist use or initiation at least — usually in a dermatology department in the hospital setting.

When interpreting the results of the study reported in your article, it is important to note that both products were in fact used outside their United Kingdom licence.

First, the dose of Protopic used was 3.3 times higher than that recommended for children and was applied for up to twice as long as is recommended, even for adults. Secondly, Elidel was used on patients with severe atopic eczema when the licence clearly states mild-to-moderate use.

As such the study is not as helpful as it appears in deciding which to use here in the UK since we as general practitioners would be using new drugs outside their licences if we were to follow the treatment schedules used in the trial.

It would be a shame if a "battle" between these two useful and, I believe, important drugs confuses rather than illuminates the best and safest way for us clinicians to use them. The disease is difficult enough for patients and there is a place for both treatments with due consideration to the indications outlined in the British National Formulary and the recommended doses.

Stephen Kownacki
Chairman,
Primary Care Dermatology Society

DISPENSING

Open dispensaries are distracting

From Ms S. Coyle, MRPharmS

I am in total agreement with Judith Rees's comments about open dispensaries and patient confidentiality (*Pf*, 22 November, p709). I work occasionally as a locum and have worked once in such a dispensary. I am in no hurry to repeat this experience. I found it extremely distracting and was concerned that customers were able to read the details on prescriptions I was checking, as well as seeing what I was putting into bags and handing to patients. A checking pharmacist (or technician) needs to concentrate on the task in hand and I do not think this is made easy by the design of some open dispensaries. I am all for pharmacists being available to customers, but they should not be able to watch other peoples' prescriptions being dispensed and checked.

Susan Coyle
Practice Pharmacist
London Road Surgery
Carlisle, Cumbria

COMMUNITY PHARMACY

Shortfall due to inadequate pay

From Mr R. B. A. Johns,
MRPharmS

In the first leading article this week (*Pf*, 29 November, p730) it is suggested that the current shortfall of full-time community pharmacists may be due to its limited appeal to those interested in clinical care. My belief is that a more probable cause is limited appeal to those interested in making a living that reflects the increasingly arduous nature of the training required to enter our profession.

R. B. A. Johns
Boston,
Lincolnshire

HOSPITAL PHARMACY

What does a microbiology pharmacist do?

From Dr A. Jepson, MRCPath,
and Dr H. J. Wickens, MRPharmS

In June 2003, the Department of Health announced specific funding for hospital pharmacists to expand their roles within anti-infective management.¹ This has highlighted the opportunity for new posts to become available. We thought a brief overview of the activities of a specialist microbiology/infectious diseases (ID) pharmacist might be of interest to those who are considering applying for such a post, or creating one.

This is a personal view. There are currently over 20 specialist pharmacist posts in the United Kingdom and, inevitably, each has a slightly different role reflecting the needs of their hospital trust. However, there are a number of activities that are likely to form the core of such a role.^{2,3} These may include, but are not limited to:

- The preparation of prescribing guidelines for antimicrobials
- Monitoring of antibiotic use and expenditure
- Teaching and training
- Attending ward rounds and acting as a point of contact between pharmacy and

microbiology/ID/infection control teams

At St Mary's Hospital in London, the post encompasses all of the above, and the post-holder acts as secretary for the antibiotic review group, a specialist sub-group of the medicines management board. The post was originally funded as a cost-saving initiative, but is now funded on a quality basis.

Given the recognised failure of traditional means of communication to restrict use and abuse of anti-infectives,^{4,5} personal contact between prescriber and the microbiology/ID teams is of vital importance. A model that we have developed at St Mary's enables anti-infective issues from across the hospital trust to be addressed within the working day. In our scheme, ward pharmacists refer all complex antibiotic-related queries to the specialist microbiology pharmacist. These may include unusual (non-policy) combinations of antibiotics, inappropriate use of restricted antibiotics or cases where there is uncertainty regarding the anti-infective treatment plan for a patient. Our aim is not to deskill ward pharmacists; rather it is to provide a focus of expertise where they may discuss these issues. Queries are resolved either by direct response from the microbiology pharmacist, or following discussion with the microbiology/ID doctors.

More complex queries are discussed at the twice weekly multidisciplinary team meetings attended by the microbiology pharmacist. These meetings are attended by consultant and registrar microbiologists and ID physicians, the consultant in public health, and often consultant staff from specialist areas such as paediatric haematology. There is a dedicated weekly microbiology/pharmacy ward round undertaken by the microbiology pharmacist and the consultant clinical microbiologist, structured around referrals taken by the microbiology pharmacist.

Recommendations are documented in the patient's notes wherever possible and fed back to the ward pharmacist via e-mail or in person. This arrangement has been well received within the trust, and a review of preliminary data has demonstrated that in almost 90 per cent of reviews, advice was followed.

In addition, the microbiology pharmacist provides inductions for all medical and

pharmacy staff, and educational sessions for other health care professionals. Regular updates on antimicrobial prescribing and resistance patterns are provided to medical and surgical teams, and the profile of microbiology and pharmacy has been raised throughout the trust.

In summary, we believe the pharmacist to be an invaluable addition to the microbiology/ID team, and welcome the decision by the Department of Health to allocate resources in this important area of collaboration.

Annette Jepson
Consultant Clinical Microbiologist

Hayley Wickens
Microbiology Pharmacist
St Mary's Hospital,
London

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PACKAGING

Designers should bear shelf space in mind

From Mr M. C. Shab, MRPPharmS

Some pharmaceutical companies have changed their packaging by making it bigger or wider. Do these companies think

we have acres of space in our dispensaries to accommodate these pack changes, especially with the increase in generic products as a result of patent losses?

Let us hope the package designers will keep our shelf space in mind before they change the packaging in future.

Manish Shab
Ilford,
Essex

MODERNISATION

I do not know enough about the new Charter

From Mrs M. D. Benfield, MRPPharmS

There must be many members of the Royal Pharmaceutical Society who, like me, did not reply to the consultation document on the draft new Charter, and who would find it difficult to reply “yes” or “no” to a referendum. This is not because I am not interested, but

because I do not know enough to join in the discussion or make a good decision.

Circumstances mean that it is difficult for me to get to branch meetings, where I might have had a chance to join in discussions, possibly with an informed Council member. But this does not mean that I am not interested in the future of the Society and the Charter — and the people we need to be most concerned about are the younger and yet-to-be pharmacists. (It is unlikely to affect me, as my working days are long over.)

To me, as far as I can judge, the idea of two bodies (the “Council” and “Senate”, or something similar) appears the best future form.

Margaret Benfield
Hemel Hempstead,
Hertfordshire

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PHARMACY CONTRACT

Compliance aids should not be an essential service

From Mrs E. A. Haines-Nutt,
MRPharmS

I voted "yes" to the new contract referendum but, like many, have strong reservations about the Government delivering fair funding. What particularly concerns me is the inclusion in "essential services" of the phrase "providing compliance aids needed by disabled patients (in line with the Disability Discrimination Act (DDA) 1995)".

At my local contract roadshow I was told that it would only be for "registered disabled". I decided I needed to find out what this means. The National Pharmaceutical Association had no idea and suggested I try social services. They told me that:

- If someone has a disabled sticker for their car from the DVLA they are automatically "registered"

- If a person receives DLA (disability living allowance) they are automatically "registered"
- Otherwise they can be assessed locally

I was told that "to be honest the only benefit is VAT exemption for buying disability aids".

Therefore the term "registered disabled" is meaningless in relation to medicines and concordance with a medicine regimen. Anyone who takes medicines could be called disabled and I think social services would be inclined to "register" almost anyone if it meant that they could have a compliance aid filled free from their local pharmacy.

I realise that "compliance aid" encompasses more than monitored dosage systems but, in reality, the vast majority of compliance aids are MDS.

With the National Institute for Clinical Excellence producing protocols that involve multiple drug therapy, what used to be decried as "polypharmacy" is on the increase. Many patients find this confusing and would, I am sure, be happy to be called "disabled" if it meant that all their

tablets were dispensed in an MDS.

Under the DDA, discrimination occurs where a disabled person is treated less favourably than someone else for a reason relating to the person's disability, and this is unjustified. I do not provide MDS to non-disabled customers so how would I be discriminating against disabled ones?

Under the Act a service provider can refuse to serve a disabled customer as long as they can justify such action. Without wishing to be too dramatic, would avoiding bankruptcy be justification? The cost of materials and time could severely strain the payment for essential services.

I have been told that legal opinion suggests that not providing compliance aids would be in breach of the DDA and render the service provider liable to prosecution.

It follows that as the community pharmacy is providing a service on behalf of the National Health Service, it is only right that the NHS should fund the provision of such aids. As an essential, basically paid, service I can see no way that the Pharmaceutical Services Negotiating Committee can

ensure that the explosion of demand for compliance aids would be adequately funded.

The PSNC says that since all pharmacies must provide the service it must be "essential". I do not see that this part of the funding will be visible and adjustable to demand.

Anne Haines-Nutt
Torquay, Devon

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