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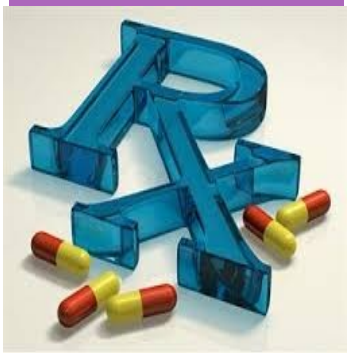

PHARMACY BULLETIN

PHARMACY DEPARTMENT, LABUAN HOSPITAL

Dispensing Separation : Are We Ready?

By Sharmila G.

Pharmacy as a profession is finally given its due recognition and respect with the birth of the idea of dispensing separation. Dispensing separation has been a controversial issue in Malaysia for quite some time now. Many are not aware that the step of moving towards dispensing separation is not in any way adapting a western culture. The practice is a norm in Asian countries like Indonesia, India, Philippines and South Korea. It will be a challenge to practice the separation not only to the medical community but also to the public.

However, it is appalling to know that petty issues have been part of the cause of delay in the enforcement of dispensing separation. Petty issues such as extra cost, hassle and that the thought of doctors being the medicine experts arise due to absence of knowledge or awareness. Pharmacist from academia, clinical and community pharmacy must see this as an opportunity to play roles in educating the public and bringing awareness on who pharmacist are, what do they do and how they affect the healthcare system.

Dispensing separation would create a vital checkpoint to avoid prescribing error as well as to educate patients on the usage, dosing, side effect, interactions and counseling points. The trust of public is to be gained by the type and quality of service provided by pharmacists. With these in mind, it is important that graduate schools not only provide pharmacists in great numbers but also with the best quality. Community pharmacist must abide to their conduct and ethics and avoid letting sales be the top priority.

Round the clock pharmacist services are also a challenge in enforcing dispensing separation. 24 hours community or hospital pharmacies must be available and this would require a huge commitment from the pharmacists. To avoid the new practice from becoming a hassle or a burden to the public, it is best to have a pharmacy in every township or a pharmacy nearby the clinics. These pharmacies can also serve the public as family pharmacies just like family doctors with the implementation of an integrated information system between the clinics and the pharmacies.

Pharmacists must move away from the stigma of just giving medications to patients as prescribed. Pharmacists must be able to assure the public that they can provide more than just basic robotic dispensing and with the gain of public support, the move towards dispensing separation can be expedited. Pharmacists must not let themselves be sidelined from being the medicine experts but at the same time recognize doctors as diagnostic specialist to be able to work as a systematic unit.

Reference;
1) How some Asian nations handled dispensing split by Rina De Silva. http://www.malaysianbar.org.my/news_features/news_focus_doctors_or_pharmacists_.html
2) http://www.freemalaysiatoday.com/category/nation/2013/01/11/healthcare-changes-will-benefit-patients/

Inside this issue:

A Publication of Drug Information Service (DIS)
Pharmacy,
Hospital Labuan

Advisor
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Any Comment, query, recommendation kindly contact DIS Pharmacy 087596888 Ext. 4185

Superbug *Acinetobacter*

by Stephanie Tiong Sze Hua

What is *Acinetobacter*?

Acinetobacterbaumannii is a pleomorphic aerobic gram negative bacillus commonly isolated from the hospital environment and hospitalized patients. This organism is often cultured from hospitalized patients' sputum or respiratory secretions, wounds and urine.[1] The organism's ability to survive under a wide range of environmental conditions and to persist for extended periods of time on surfaces make it a frequent cause of outbreaks of infection and an endemic, health care–associated pathogen.[2]

How is *Acinetobacterbaumannii* spread?

Acinetobacter can be spread from person to person by touching body fluid (blood, urine) or items that have been in contact with the patient (stethoscope, blood pressure cuff, etc.). If a patient has *Acinetobacterbaumannii* in the lungs, it can be spread by coughing, sneezing, or suctioning. *Acinetobacterbaumannii* can be removed from the hands with proper hand cleaning.[3]

What is *Acinetobacter* infection?

Acinetobacter infections are uncommon but, when they occur, usually involve organ systems that have a high fluid content (eg, respiratory tract, CSF, peritoneal fluid, urinary tract).[1] The organism causes outbreaks of infection and health care–associated infections, including bacteremia, pneumonia, meningitis, urinary tract infection, and wound infection.[2]

Risk factor of *Acinetobacter* colonization or infections

Antimicrobial therapy using agents with little or no activity against *Acinetobacter*-predisposes to *Acinetobacter* colonization. Residency in an ICU, particularly in the presence of other patients who are colonized with *Acinetobacter*, predisposes to colonization.[1] Prolonged hospitalization, intensive care unit admission, recent surgical procedures, antimicrobial agents exposure, central venous catheter use, nursing home residence, and local colonization pressure on susceptible patients.[4]

Therapeutic options for Acinetobacterbaumannii infection

Medication	Dosage	Route	Toxicity
Sulbactam (amp/sulb)	6 g per day	IV	Dermatologic, GI, nephritis
Imipenem-cilastatin	500 mg every 6 h up to 1 g every 6–8 h	IV	Phlebitis, GI, anaphylaxis, seizures,nephritis
Meropenem	500 mg to 1 g every 8 h	IV	GI, headache, dermatologic, hematologic, angioedema, seizure
Doripenem	500 mg every 8 h	IV	Dermatologic, GI, anemia, anaphylaxis, seizure
Amikacin			
Regimen 1	15 mg/kg daily	IV	Nephrotoxicity, ototoxicity, neuromuscular blockade
Regimen 2	30 mg	IVent	
Tobramycin			
Regimen 1	4–7 mg/kg daily	IV	Nephrotoxicity, ototoxicity, neuromuscular blockade
Regimen 2	300 mg (1 ampule) twice daily	IH	
Regimen 3	5– 20 mg	IT/ IVent	Not for children
Colistin (colistimethate)			
Regimen 1	5mg/kg/day, 2–4 divided doses	IV	Nephrotoxicity and neurotoxicity
Regimen 2	1–3 million IU every 8 h	IH	Must be used immediately after reconstitution to prevent accumula-tion of colistin–lung toxicity
Polymyxin B	50,000 units daily (5 mg)	IT	Meningeal irritation
Polymyxin E (colistin)	10 mg daily	IT/ IVent	Meningeal irritation
Tigecycline	100 mg once then 50 mg every12 h	IV	GI, shock, pancreatitis, anaphylaxis
Minocycline	100 mg every 12 h	IV	GI, hepatic, dermatologic

References:
1. Burke A Cunha. *Acinetobacter.* Medscape. Updated: Jul 22, 2011. http://emedicine.medscape.com/article/236891
2. Lisa L. Maragakis and Trish M. Perl. *Acinetobacterbaumannii*: Epidemiology, AntimicrobialResistance, and Treatment Options. Clinical Infetious Diseases 2008; 46:1254–63.
3.OSF Saint Francis Medical Center. Center for DiseaseControl. 2005. Patient education.
4. Joel Fishbain and Anton Y. Peleg. Treatment of *Acinetobacter* Infections. Clinical Infectious Diseases 2010; 51(1):79–84.
5. Peleg AY, Seifert H, Paterson DL. Acinetobacterbaumannii: emergenceof a successful pathogen. ClinMicrobiol Rev 2008; 21(3):538–582.

Treatment for Nausea and Vomiting in Pregnancy

by Ung Yew Jye

Commonly practised interventions for nausea and vomiting in pregnancy

- Identify and avoid known triggers
- Avoid having an empty stomach
- Eat small amounts of food often and eat at times when less nauseous
- Avoid eating spicy and fatty foods
- Taking food and fluids at separate times
- Drink small amounts of fluid often, but try to have two litres daily
- Get out of bed slowly, and avoid rushing
- Herbal teas may help (peppermint, ginger)
- Rest when possible as fatigue makes nausea worse
- Acupuncture

Drug treatments for nausea and vomiting in pregnancy according to current guidelines

Type of drug	Dose & Frequency	FDA Pregnancy Category
Pyridoxine	25–50 mg orally , up to 4 times daily (200 mg/day shown to be safe)	Fetal risk is minimal.
If symptoms persist, continue pyridoxine and add one of the following antiemetics:		
Promethazine	10–25 mg orally, 3–4 times a day	category C
Metoclopramide	10 mg orally, 3 times a day	category A
Prochlorperazine	5–10 mg orally, 3–4 times a day	category C
Patients unable to tolerate tablets, use one of the following:		
Metoclopramide	10 mg intramuscular or intravenous, every eight hours	category A
Prochlorperazine	12.5 mg intramuscular, every 8 hours	category C
Promethazine	12.5–25 mg intramuscular, every 4–6 hours	category C
If vomiting continues, consider treatment in hospital and rehydration with intravenous fluids:		
Prednisolone	50 mg orally daily for 3 days, then 25 mg daily, then reducing by 5 mg daily	category A

Excerpt from Article titled "Treatment for nausea and vomiting in pregnancy.", Australian Prescriber, Volume 37: No2: April 2014

What is the optimal dose of folic acid for patients with rheumatoid arthritis who are being treated with methotrexate?

There is no definite answer regarding the optimal dose of folic acid for patients with rheumatoid arthritis who are being treated with methotrexate. It is generally agreed that folic acid supplement reduces the toxicity of methotrexate without significantly affecting efficacy, although there seems to be consensus of opinion that folic acid supplementation should be avoided on the day of methotrexate in case it adversely affects absorption. There have not been any dose determining trials but regimens used in some of studies include:

5mg folic acid taken the day after the methotrexate dose
1mg folic acid daily except on the day of methotrexate
5mg folic acid daily except on the day of methotrexate

It is considered that the folic acid dose should be high enough to prevent folate deficiency. Many reviewers have extrapolated the data from studies and recommend using 5mg folic acid weekly, preferably the day after the methotrexate. The dose can be increased to 10mg if patient experiences any adverse effects to the methotrexate

References :
1) National Collaborating Centre for Chronic conditions. Feb 2009. Rheumatoid Arthritis: The management of rheumatoid arthritis in adult CG79. London: Narional Institute for Health and Clinical Excellence. Http;//www.nice.org.uk/nicemedia/live/12131/43327/43327.pdf .
2) Scotiish Interollegiate Guidelines Network 2000. Management of Early Rheumatoid Arthritis. Publication Number 123. NHS Quality Improvement Scotland.

Pharmacy Staff Movement

Announcements

New Staff:

En. Alvin Lim Hong Thai (Pegawai Farmasi U41)
En. Cheong Wei Kit (Pegawai Farmasi U41)
En. Melvin Francis (Pegawai Farmasi U41)
Cik Sharmila a/p Gunasekaran (Pegawai Farmasi U41)
Cik Siu Loe Ching (Pegawai Farmasi U41)
Pn. Tseu Chun Mee (Penolong Pegawai Farmasi U29)
Pn. Nurfah bt Yusof (Penolong Pegawai Farmasi U29)
En. Mahfuz bin Darwin (Pembantu Tabir N27)
Pn. Mastunah Dullah (Pembantu Tabir N22)

Transferred:

Pn Sharkirin Shaik Rahmat (Pegawai Farmasi U44)
Pn Farrahlizawaty Abdul Rahim (Penolong Pegawai Farmasi U32)
En. Wahid Musa (Pembantu Tabir N17)

To: Dear Hospital Staffs,

As the nominated representative for MIMS Gateway for Hospital Labuan i would like to inform you that a general shared account has been created for Hospital Labuan. Here are the benefits of MIMS Gateway:

1) Prescribing information
MIMS Malaysia database delivers locally accredited drug information in both concise and detailed formats for all your prescribing information needs.

2) Diagnosis
Make accurate diagnosis by reviewing signs, symptoms, differential diagnoses and pathological investigations.

3) Disease Charts
Disease management flowcharts offering an at-a-glance overview of treatment options and dosage guidelines.

4) Interaction Checker
Check drug-drug interaction on one or multiple pairs of drugs.Here are the login details for Hospital Labuan

Please visit www.mimsgateway.com.my . For Login details please contact me 087-596888 ext 4185.

From : DIC Pharmacist Hospital Labuan

MIMS GATEWAY

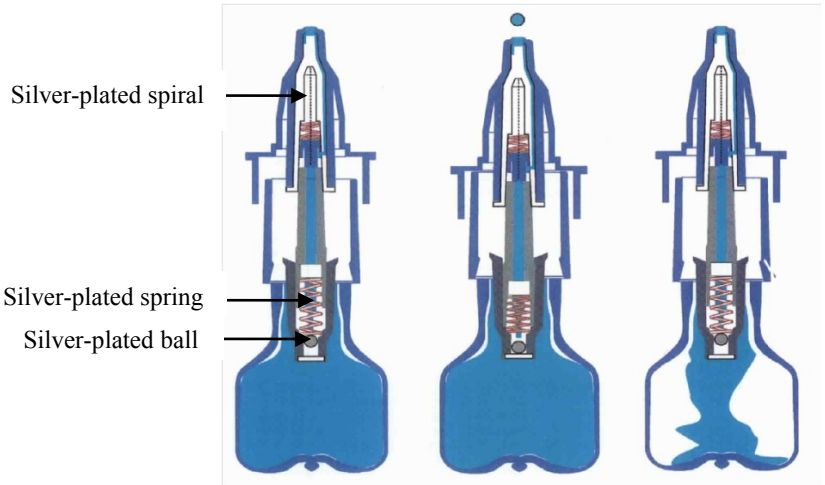
Why TIMOCOMOD® (Preservative Free Timolol Eye Drop) can still be used up to 12 weeks after opening?

For a normal preservative contained eye drop, the usage only can be up to 4 weeks after opening. However, TIMOCOMOD with it preservative free system, the usage can be up to 3 months. This is due to the design and mode of operation of the COMOD system.

- Every drop tears off in a precise manner because of the special shape of the top of the bottle.
- On the inner side of the protective cap is a small pin that fits exactly into the hole of the bottle and thus displaces remaining liquid.
- Additionally there is a small hole in the protective cap through which remaining liquid on the top of the bottle evaporates.

By these three constructive characteristics one avoids moisture remaining on the tip of the bottle enabling microbiological growth.

A silver spiral on the upper end of the capillary and the long, thin capillary itself make bacterial growth even more difficult. The capillary tube is sealed off from the contents. Silver complexes and silver ions show a high germ killing rate even in traces. Silver ions dissolve in ppb concentrations which are toxicologically safe.



Reference: Orgul/Flammer, 2000 "*The COMOD System – A Preservative Free Drug Therapy Against Glaucoma*.", Pharmacotherapy in Glaucoma, pg