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ODB Update

Much has changed over the past month. Toloxin® (digoxin) has gone from unknown and uncovered, to being a famous member of the ODB Formulary. Lipitor®, the worldôs top selling prescription drug, is now generic and is the first drug in Ontario to be priced under the 25% of brand mandate.

This change will save taxpayer money. Non-seniors taking atorvastatin will realize some price savings as well, with the drug priced at 50% of the brand product in the retail setting. Apo-atorvastatin is the same colour and shape as Lipitor® and is marginally smaller. This may be of some benefit to seniors with swallowing difficulties.

A number of other technical changes are being made to the drug program, but these will not be seen by the end users. Copayments will remain at $2 or $6.11, based on patient income or type of residence.

An exciting change for pharmacists is the recognition of our clinical skills by MOHLTC. Pharmacists will now be paid for reviewing *TMRs* in LTC facilities. This will be a focus of our activity in the homes we service.

Safe Use of Warfarin

Warfarin is a pretty scary drug. Still, if I were a pensioner with atrial fibrillation, a past stroke or unprovoked deep vein thrombosis (DVT), I would insist on taking it. The truth is, if we can keep the INR in range, warfarin becomes a fairly safe medication.

There is often a reluctance to prescribe warfarin due to bleeding risk. Past bleeds, or bleeding risk factors such as frequent falls or concurrent use of NSAIDs (e.g. ASA) can make warfarin treatment seem like it is too dangerous to consider. However, this is rarely the case.

Those who have had GI bleeds in the past should take a PPI (Pantoloc®, Pariet®, etc.) to protect the stomach and duodenum, if remaining on warfarin. Aspirin should be used with extreme caution when combined with warfarin. Dual therapy for atrial fib or DVT plus stent insertion or heart valve replacement requires very close monitoring. As for a major bleed triggered by a fall, it has been estimated that a person would have to fall 300 times in a year for that risk to outweigh the benefit of warfarin.

We know that vitamin K can reverse the effects of warfarin. Changes in vitamin K intake can play havoc with INR readings. Individuals with consistently high vitamin K intake, however, experience less variability in their INRs, so consumption of green leafy vegetables is encouraged.

Warfarin dosage is relatively low in the elderly. A typical dose in adults under fifty years of age is 9 mg daily, while those over eighty require only 3 mg daily. Some individuals are deficient in the enzyme that metabolizes warfarin, cytochrome P450 2C9. They require a much lower dose than the rest of the population.

Drugs that inhibit 2C9 can cause rapid increases in INR. Examples of potent inhibitors are: Bactrim®/Septra® Flagyl® and amiodarone. When initiating amiodarone in a resident who is stable on warfarin, the warfarin dose should be dropped by 25-30%. If possible, Bactrim® or Flagyl® should be avoided, in favour of antibiotics less likely to interact, such as penicillins cephalosporins and nitrofurantoin. There are so many drugs with interaction potential that an INR should be taken 5-7 days after any new medication is started.

Warfarin is our best weapon in the stroke battle. It should be respected, but not feared.

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