# The GeriJournal

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## Shingrix gets "Liked"

Shingrix® (SGX) has been available for several months and it is getting lots of attention. The latest recognition comes from NACI (*The National Advisory Committee on Immunization*), the preeminent body for vaccine policy-making in this country. In their newly released shingles vaccination guideline, SGX is the first line agent in multiple scenarios, with Grade A (the highest level) support.

SGX has usurped Zostavax® (ZVX) from its former position as the agent of choice. NACI testing shows the immune response to ZVX drops sharply one year after vaccination. Shingles protection with ZVX also fails to reach levels achieved by SGX, particularly in the elderly. Finally, protection with SGX does not decay over time (current studies show at least 9 years of vaccine effectiveness), while ZVX is effective for only 3 years.

The key NACI guidelines state: SGX should be offered to populations ≥50 years of age without contraindications, **and**, SGX should be offered to populations ≥50 years of age who have been previously vaccinated with ZVX. NACI recommends waiting one year after ZVX before vaccinating with SGX, though there is no compelling evidence for a shorter or longer waiting gap.

Cost of each product is notable ($300 for two SGX vs. roughly $215 for ZVX). Still, NACI states that SGX is cost effective, because shingles incidence and symptoms can be severe, and increase with age, and roughly one-third of Canadians will develop shingles in their lifetime. Based on the guideline, it would be reasonable to discuss SGX vaccination with current residents and new admissions.

## Cannabis CPSworthy

With all the chatter about cannabis these days, plus final passage of Bill C-45, it was time to make cannabis "official". The *Canadian Pharmacists Association* has now created a monograph for the CPS (attached to the digital copy of this newsletter). The monograph can also be accessed through our eCPS (RxTx) link on our website.

The monograph states that evidence for cannabis use may be insufficient or inconclusive. With these limitations in mind, it provides referenced guidance for potential clinical use.

Like other monographs, it has sections on *Warnings* (driving, smoking and pediatric use), *Effects on Body Systems* (e.g. cardiac - concerns in those with a history of MI, stroke, PVD, angina or arrhythmia), *Mechanism of Action*, and *Pharmacokinetics* (rates of absorption and elimination).

Possible *Adverse Effects* are outlined, but the monograph does not always distinguish between THC and CBD, nor does it always indicate route of administration. There is some basic *Dosing* guidance, but this section lacks the detail many prescribers would want.

In short, the monograph does not have all the answers, but it does provide useful information, while legitimizing a product that will be widely used for both medical and recreational purposes.

## ACE, ARB for Elderly

A large Swedish retrospective study evaluated ACE and ARB benefits in seniors (>80 years) with heart failure. Benefit was greater than in the under 80 crowd, with an NNT (number needed to treat) of 9 (vs 17 for <80) to prevent mortality and 12 (vs 14 for <80) to prevent hospitalization. Although our elderly are often excluded from clinical trials, they should not be denied valuable treatments which may extend or improve their lives.

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