

# The GeriJournal



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## **Epival Out; Valproic In**

Epival® (divalproex sodium) tablets and all generic versions of this product have been on backorder for an extended time. This is a critical medication, used in the treatment of seizures, bipolar disorder and behavioural problems and should not be discontinued abruptly.

The best available option to use in the place of this medication is Depakene® (valproic acid) capsules. Since Epival® is converted to valproic acid when it is absorbed into the body, the therapeutic action of the drug matches that of the currently backordered product.

Valproic acid can have more GI adverse effects than Epival®, however, as it lacks an enteric coating. Epival's enteric coating also delays absorption by about one hour, so valproic acid will enter the bloodstream a bit faster. Finally, valproic acid is not available in the 125 mg strength, so liquid valproic acid must be used for residents taking that dose.

We recently sent a listing of all residents currently taking Epival® to our facilities. Physicians have written matching orders for valproic acid (e.g. Epival® 250mg TID changes to valproic acid 250mg TID) in most cases, and should complete this action as soon as possible. When Epival® becomes available again we will reverse the process so the residents can resume their prior treatment.

Please monitor closely for signs of GI upset and increased dizziness or sedation. Dosage adjustments may be necessary in the small number of residents who may experience these adverse events.

## **Steroids for Acute Gout**

Back in the day, indomethacin was commonly used to contain the painful, inflammatory flares associated with gouty attacks. Colchicine is still used with some regularity to treat the same condition.

Each of these agents, and other nonsteroidal anti-inflammatory substitutes, are high risk drugs for many of our residents. Even short term treatment can predispose the elderly to significant GI, cardiac and renal events. Colchicine also has GI issues, plus potentially serious interactions with many commonly used drugs, such as statins, diltiazem and tamoxifen.

A recently published trial in the *Annals of Internal Medicine* evaluated a different strategy. The study compared the effectiveness of indomethacin 50mg TID to prednisolone (equipotent with prednisone) 30mg daily. Treatment was initiated in the hospital ER and continued for five days. The study was double-blinded and had a total of 376 subjects enrolled.

All measures of pain and inflammation were similar between the two groups over the entire 14 day study period. The steroid approach would be much safer for the majority of our residents, except perhaps those with poorly controlled diabetes, open wounds or serious infections.

## **Olanzapine the Analgesic**

Antipsychotic drugs have occasionally been used to treat pain. A review of studies examining this approach show olanzapine (Zyprexa®) to be the most effective option.

Olanzapine may be active at opioid receptors, because its action is reversed by naloxone. Those with psychopathology are responsive, but patients with neither depression nor psychosis benefit as well. For refractory pain not resolved by traditional analgesics, consider a trial of supplemental olanzapine. The reason for use should be clearly documented in the chart.

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