The GeriJournal

Volume 6, Number 12
December 2011
A publication of GeriatRx Pharmacy

Tamiflu Tweak

Last flu season the Public Health branch of MOHLTC made minor revisions to their Tamiflu® dosing guidelines. Rather than basing dosage on the serum creatinine level, it is now to be based on the calculated glomerular filtration rate (GFR). This feels like a bit of a déjà vu, as we used to use the GFR in the good old days, when amantadine was the drug of choice for the flu.

Standard dosing (Tamiflu® 75 mg bid for treatment or once daily for prophylaxis) is used when GFR is greater than 30 ml/min. More residents will receive reduced Tamiflu® doses now, as GFR < 30ml/min is more common than creatinine > 150 µmol/L, the old threshold. We may now use Tamiflu® 30 mg daily for these individuals. I prefer the 75 mg q2day option, however, as the introduction of a second strength during a hectic outbreak could cause confusion and be a potential source of error. Dosing for dialysis patients was incomplete in the previous guidelines, and is far better developed now. We have weights, creatinines and birthdates for most residents on file, so we can quickly create a custom Tamiflu® dosing list for each facility.

The agency has also produced a flow chart to guide clinicians when antiviral therapy is being started more than 48 hours after symptom onset. Tamiflu® is not effective and would normally be avoided in such cases. In the absence of a laboratory culture, however, Tamiflu® is now indicated for these residents if their condition is deteriorating. Once an outbreak has been declared, line-listed residents are rarely swabbed for a viral culture. As per the guidelines, these residents should be switched to the prophylactic Tamiflu® regimen once their treatment course is complete. If those residents' symptoms were not caused by Influenza, they would not have developed natural immunity and would need the protection of an antiviral agent. Full guidelines are available at geriatrx.com and have been attached to the e-version of this newsletter.

Sleep – Not so Much

I attended an entertaining lecture in Hamilton last month. Dr. Brian Misiaszek told us why "The Big Sleep" is highly overrated and our attempts to achieve it typically do far more harm than good.

The most interesting point came at the beginning of his talk. A 2002 study from *Arch Gen Psychiatry* showed people sleeping just six to seven hours each night had the greatest life expectancy. Sleeping meds typically reduce sleep onset by 15 minutes, but harm one of six seniors who take them. Well documented drug related problems include confusion, delirium, falls and fractures, dependence and overdose, especially when sedating meds are used in combination.

The best way to improve sleep duration and quality is to eliminate factors interfering with it. Pain, depression, Parkinson's Disease, restless legs syndrome, gastric reflux, COPD, cardiovascular disease, etc. must be treated optimally to provide an opportunity for a good night's sleep. Drugs such as Effexor, Aricept, Exelon, Reminyl and caffeine have stimulating properties and can cause insomnia.

The only treatment proven safe and effective for insomnia is cognitive behavioural therapy (CBT). This includes daytime nap restriction, relaxation, warm milk at bedtime, etc. If meds are necessary, trazodone 25 mg is preferred in dementia, while depressed residents should receive Remeron® (mirtazapine) at bedtime. Ativan®, Serax® or Imovane in low dose can be considered for 2 – 4 weeks if absolutely necessary.

GeriatRx PHARMACY

Prepared by Randy Goodman
Certified Geriatric Pharmacist