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Eliquis (Apixaban)

The final member of the new oral anticoagulant trio, Eliquis® (apixaban), reaches the ODB Formulary on August 29th. It joins Pradaxa® and Xarelto® as options for clot prevention in the treatment of atrial fibrillation. Like Pradaxa®, it does not carry a DVT indication.

The new anticoagulants offer tremendous convenience relative to warfarin, since routine monitoring is not required. This risk must be balanced against the lack of an antidote (vitamin K can rapidly reverse the effects of warfarin), should the newer agents trigger a bleed. The limited interaction profile of the new drugs is also a significant advantage.

The initial Eliquis® studies appeared to give it an edge over Pradaxa® and Xarelto®. The *ARISTOTLE* trial showed a mortality benefit, compared to warfarin, with a reduction in strokes and bleeds. On further analysis, the risk of ischemic stroke, the main concern with our elderly atrial fibrillation residents, may not be reduced. Hemorrhagic stroke incidence is reduced, however, and Eliquis® seems to cause fewer major bleeds than the other drugs, including warfarin.

Eliquis® and Xarelto® have one definite advantage over Pradaxa®. They are far less likely to cause GI upset. Eliquis® is also a bit less reliant on elimination by the kidneys. It can be used with creatinine clearances as low as 25 ml/ minute, compared to 30 ml/minute with the other agents.

While the usual dose of Eliquis® is 5mg twice daily, residents with two of the following characteristics: age > 80 years, body weight ≤ 60 Kg or serum creatinine ≥ 133 µmole/L, should receive 2.5 mg twice daily. The LU code is 448 and applies only to residents who are unable to use warfarin successfully.

Methotrexate Handling

I've written about reducing the hazards associated with administering methotrexate injection in the past. Precautions are listed in the High Alert section of our Policy and Procedure Manual (P & P 4.16). There are risks linked with the oral product as well; handling clothing and linens of incontinent residents present particular challenges. Some other cytotoxic and hormonal agents of note are listed in P & P 4.13.

Cytotoxic drugs have the ability to cause damage to skin, eyes, mucous membranes and the respiratory tract on contact. Crushing these products is therefore not recommended and we have alerts in place to prevent inadvertent dispensing.

Allowing the tablets to soften in applesauce with subsequent mashing may be an option. Any utensils used would have to be washed thoroughly while wearing protective gear, such as nitrile gloves, gowns and eye protection. Exclusive use of disposable products would be a better choice, with all items contacting the offending drug discarded in a hazardous waste container. Aids such as crushing syringes are sometimes used to administer these meds in the hospital environment, but they produce a cytotoxic liquid with complex handling measures and are probably not appropriate for long term care.

A greater area of concern may be the disposal of wet or soiled incontinence products, linens and clothing. Methotrexate levels in urine are high for 24 hours after administration. Staff handling disposable products should be double gloved with nitrile gloves, hazardous fluid proof gowns and goggles or a face shield if splashing is possible. The offending drugs are identified on MARs, eMARs and labels.

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