The Pharmacist Activist

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Editorial

HAPPY NEW YEAR!

Resolutions for Our Profession

With the arrival of a new year many of us make personal resolutions. In this commentary I am suggesting some resolutions for our profession. However, many pharmacists will have to be personally involved if these resolutions are to be accomplished.

1. We must provide, to a much greater extent, the services, counseling, and monitoring with respect to drug therapy that we claim to be capable of providing. There are some excellent examples of pharmacists providing medication therapy management and other professional services. However, these initiatives are far too few in number and invisible to much of the public.

2. We must make a stronger commitment to increase our professional skills and expertise. We claim to be drug experts. Many practicing pharmacists are not! We have an obligation to our patients, our profession, and ourselves to be competent and skilled in the practice responsibilities we are licensed to provide.

3. We must take ownership of the responsibility for assuring optimum drug therapy. This will require collaboration with prescribers and other health professionals. If we have the drug therapy expertise we claim to have, why have we had to observe physician assistants and nurse practitioners pass us as they assume authority with respect to drug therapy (e.g., prescribing) that we do not have? We must be the advocates for and guardians of effective and safe drug therapy for our patients.

4. We must no longer tolerate short-staffing situations and stressful working conditions that increase the risk of errors. Employers who persist with policies and expectations that place patient safety in jeopardy must be challenged. If they refuse to make appropriate changes, you should not let them continue placing your license at risk. Changing positions may not be easy but there is a shortage of pharmacists and better opportunities are available.

5. We must have more extensive and effective communication among pharmacists. Many local pharmacy associations no longer exist and some state associations are weak to the point of having limited effectiveness and value. Even in an era of rapid dissemination and retrieval of information, many pharmacists are not familiar with, or are ignoring, important issues and challenges facing our profession. If pharmacists do not have an awareness and understanding of these issues to an extent that facilitates effective communication with other pharmacists, how can we expect to be effective in communicating our concerns to legislators and the public whose support we hope to secure? We must strengthen our local and state associations!

6. The leaders of our national associations of pharmacists must address the question, "What organizational structure will best serve the profession in responding to the problems, challenges, and opportunities that we face now and can anticipate in the future?" They must then act to promptly and effectively establish this structure. The title for my editorial in the

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Postscript to the December Editorial

In my December editorial I observed that all of us know individuals who would appreciate and benefit from a message of encouragement. I mentioned that one of my former students, at a young age, was battling cancer and that I needed to call her and tell her that she was in my thoughts and prayers. I was not able to reach her by phone so I called another former student who knew her well to obtain a better phone number. He informed me that she had died a month ago. I waited too long to try to reach her and can't help but think of the many unimportant things that I did find time for.

Daniel A. Hussar

The Pharmacist Activist Editor's Note

Although the content outline for these commentaries on new drugs is generally the same as in previous issues, beginning with this January issue the sequence in which the information is presented is revised to identify the Comparable drugs, Advantages, and Disadvantages at an earlier point in the commentary.

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New Drug Review

Nebivolol hydrochloride
(Bystolic – Forest)

Antihypertensive Agent

New Drug Comparison Rating (NDCR) = 3

(no or minor advantages/ disadvantages)

in a scale of 1 to 5, with 5 being the highest rating

Indication:

Treatment of hypertension; may be used alone or in combination with other antihypertensive agents.

Comparable drug:

Carvedilol (Coreg).

Advantages:

- Less risk in patients with asthma or related bronchospastic conditions (carvedilol is contraindicated);
- May increase nitric oxide-mediated vasodilatation.

Disadvantages:

- Indications are limited (carvedilol is also indicated in patients with heart failure and in patients with left ventricular dysfunction following myocardial infarction);
- Dosage should be reduced in patients with severe renal impairment or moderate hepatic impairment.

Most important risks/adverse events:

Contraindicated in patients with severe bradycardia, heart block greater than first degree, cardiogenic shock, decompensated heart failure, sick sinus syndrome (unless a permanent pacemaker is in place), or severe hepatic impairment; should generally be avoided in patients with bronchospastic diseases, although risk is lower than with the nonselective beta-blockers); may mask some of the manifestations of hypoglycemia, particularly tachycardia; may mask clinical signs of hyperthyroidism (e.g., tachycardia); may precipitate or aggravate symptoms in patients with peripheral vascular disease; patients with a history of severe anaphylactic reactions may be more reactive to subsequent exposure to the allergen and less responsive to usual doses of epinephrine used to treat allergic reaction; is a substrate of CYP2D6 and action may be increased by the concurrent use of a CYP2D6 inhibitor (e.g., fluoxetine [e.g., Prozac]); increased risk of cardiovascular adverse events when used concurrently with digoxin, diltiazem (e.g., Cardizem), or verapamil (e.g., Covera-HS).

Most common adverse events (incidences reported with a dosage of 10 mg daily):

Headache (6%), dizziness (3%), nausea (3%), diarrhea (2%), fatigue (2%).

Usual dosage:

5 mg once a day initially, as monotherapy or in combination with other antihypertensive agents; if needed, dosage may be increased at two-week intervals up to 40 mg once a day; in patients with severe renal impairment or moderate hepatic impairment, the recommended initial dosage is 2.5 mg once a day; if a dose is missed, patient should take the next dose at the scheduled time; if treatment is to be discontinued, should taper over one to two weeks.

Products:

Tablets – 2.5 mg, 5 mg, 10 mg.

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January 2007 issue of *The Pharmacist Activist* was, "A New Year, an Old Theme." My opinion that there is an urgent need for a more effective national organizational structure was the focus of this editorial, and I have also addressed this issue in editorials in other publications in recent years. Soon after the publication of the January 2007 editorial, I was informed by leaders of several of the national associations that the Joint Commission of Pharmacy Practitioners was addressing this issue and that I could look forward to some positive action. Another year has gone by and I have heard nothing further. If progress has been made, it is being kept a secret. I will wait another year and address this topic again in my January 2009 editorial. If substantive action in addressing this matter has not been taken by that time, I will propose a national organizational structure for the profession that I anticipate will capture the imagination and support of many within our profession. Some will say that one year is not a long period of time and that I am too impatient. I will respond that I have been too patient and have waited 40 years to see progress made in this area. The major changes that have been made over that period of time are that we now have more national pharmacy associations rather than an organizational structure that best serves the needs of the profession, and not just the individual constituencies of the profession.

7. We must have much more extensive and effective communication with our legislators. The geographical distribution and accessibility of pharmacists provide an opportunity for legislative influence that is second to no other profession or vocation. However, we are not even close to reaching our potential in this regard.

8. We must accomplish the changes in legislation that will permit pharmacists and our organizations to collectively negotiate for equitable compensation for the services we provide. As noted earlier, we must provide the scope and quality of services that will be recognized and valued if we are to be successful in obtaining equitable compensation.

9. The sale of tobacco products must be discontinued in pharmacies and other facilities (e.g., supermarkets, mass merchandisers) that include pharmacies. The sale of these products that have been the cause of illness and death of millions of people is a contradiction to the responsibilities, services, and message that pharmacists provide in the promotion of better health care. Most independent pharmacies, Target stores, and, most recently, Wegmans, a chain of 71 supermarkets in the mid-Atlantic area, do not sell tobacco products. We must urge those pharmacies that continue to do so to stop selling these products. Let's set a goal of November 20, 2008 (the Great American Smokeout) as the date after which tobacco products will no longer be sold in any pharmacies or any facilities that include pharmacies.

10. We must make a stronger personal commitment to protect and advance the profession of pharmacy. This is the profession that provides us with fulfilling responsibilities and a good livelihood regardless of the type and place of our practice and what degree we hold. We must be members of our professional associations and participants in their activities. We need thousands of pharmacists who will take the next step in becoming leaders and pharmacist activists. This activism is needed in addressing professional and political issues, as well as in support of personal values and beliefs that we consider important.

There will be many who respond to this resolution by saying they do not have enough time to be involved, and I understand that there are periods of time in our careers in which we have little or no discretionary time to devote to activities of our profession. I respect and am an advocate for the establishment of personal priorities and attaining the best balance of commitments with respect to our faith, family, friends, employment responsibilities, and profession. However, too often, a "lack of time" becomes a convenient excuse for a lack of will and commitment. If you are not in a position to be a participant, leader, and/or activist now, look ahead and anticipate/plan when you will be.

Daniel A. Hussar

New Drug Review (cont.)

Comments:

Nebivolol is a preferentially $beta_1$-selective (cardioselective) beta-adrenergic blocking agent (beta-blocker) when used in doses of 10 mg or less in patients who are extensive metabolizers of the drug (most of the population). However, it inhibits both $beta_1$ and $beta_2$ receptors at higher doses and in patients who are poor metabolizers. It has been suggested to reduce vascular resistance by increasing nitric oxide-mediated vasodilatation although specific clinical and safety benefits attributable to this action have not been conclusively demonstrated. Unlike carvedilol, it does not inhibit $alpha_1$-adrenergic receptors and it does not have labeled indications for the treatment of patients with heart failure or patients with left ventricular dysfunction following myocardial infarction.

Nebivolol is a racemic mixture that is composed of d- and l-isomers. Although the exposure to l-nebivolol is higher than for d-nebivolol, the l-isomer contributes little to the drug's activity as the beta receptor affinity of the active d-isomer is more than 1000-fold higher than that for the l-isomer. The new drug is primarily metabolized via direct glucuronidation and to a lesser extent via N-dealkylation and oxidation via CYP2D6. Its concentration and activity may be increased by the concurrent use of a CYP2D6 inhibitor (e.g., fluoxetine).

Daniel A. Hussar