INPHARMATION UPDATE

Canadian Society of Hospital Pharmacists
Alberta Branch

Société canadienne des pharmaciens d'hôpitaux

September 2022

Issue 57

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Canadian Society of Hospital Pharmacists | Société canadienne des pharmaciens d'hôpitaux

CSHP National Update

Greetings on behalf of CSHP National!

Please welcome the 2022-2023 year executives

- President Elect – Ashley Walus (Manitoba)
- President – Sean Spina (British Columbia)
- Past President - Zack Dumont (Saskatchewan)
- Treasurer – Megan Riordan (Ontario)
- CEO – Jody Ciufo

Best wishes and a HUGE thank you to Tania Mysak as she finishes her time on the CSHP Executive council!

Some brief updates include:

- The CSHP Board has resumed meeting in-person twice annually (Spring and Fall), with additional virtual meetings in between
- Membership targets were exceeded in 2021/2022, and are off to a strong start in 2022/2023
- Ongoing advocacy work and engagement with Health Canada about drug shortages and the impact to hospitals
- Governance Review Task Force has completed a review of the by-laws, with some updates – will be coming to 2022 AGM for approval

More updates will be available after the Fall Board Meetings and Annual General Meeting (AGM), occurring October 29-30 in Gatineau, Quebec. Please reach out any time with questions or comments related to CSHP National's activities.

Thank you all for your continued support of CSHP!

Mary Gunther
CSHP-AB Branch Delegate
mary.gunther@ahs.ca

Research Committee:

Real World Data & Real World Evidence

Written by: Paul Agbulu, RPh, MBA, FPCPharm, PhD

Real world data (RWD) and real world evidence (RWE) are key terms currently making waves in clinical research lexicons and being used in clinical decision making. (1) The digital world has created an enormous deluge of data produced on real world conditions in clinical, experimental, and regulatory decision making. (1) For example, the current widespread use of electronic health records in healthcare and the use of other technologies have created opportunities for the use of real-world data from real world patient experiences. (1) Another example is the use of smartphone and similar technology which measure the distance traveled by a patient to determine fitness. (1) This has also created opportunity for the use of real world data based on patients' real world experience. (1)

> *Real world data can be defined as data relating to patient health status and/or the delivery of health care routinely collected from a variety of sources. While real world evidence is the clinical evidence about the usage and potential benefits, or risks of a medical product derived from analysis of real world data.*

There is no doubt that randomized controlled trials (RCTs) are the gold standard for evidence-based medicine; however, they do not always reflect real-world patient populations and as such limits their generalizability or external validity. (2) The randomization of patients into different treatment groups and the stringent criteria eligibility setting can make the results of RCTs difficult to translate to real world situations. Furthermore, RWE can provide information on other areas, such as natural history and course of disease, effectiveness studies, outcome studies, and safety surveillance. (2)

Based on this premise many regulatory bodies including Health Canada now utilize RWE as a complement to RCTs**.** RWE studies complement clinical trials by generalizing the findings from clinical trials to the general population. (3) Health Canada in its recent report acknowledges that RWE has valuable use in areas where controlled clinical trials are challenging to conduct or when they are not feasible. This body has also stated that it will continue to explore the use of RWE to improve Canadians' access to drugs that are safe and efficacious. (4)

Currently, Health Canada uses RWE as part of its pre- and post-market evaluations for decision making in drugs and devices. RWE has also been utilized to monitor adverse drug reactions, evaluate risks of health technology and inform reimbursement criteria for drugs and technology. (5)

Sources of RWD

RWD can be generated from claims and billing activities, registries of patients treated with a specific drug or health technology, registries of patients with certain diseases, patient-generated data including in home-use settings, data gathered from other sources that can inform on health status, such as mobile devices, wearable and other biosensor devices, public or private insurers and electronic health records (EHR). (5)

Sources of RWE

RWE can be generated from RWD, through different study designs, randomized trials, pragmatic trials, observational studies (prospective and retrospective) and large simple trials. (2)

Research Committee:

Real World Data & Real World Evidence

Benefits of RWD & RWE

- RWD helps complement RCTs. Hence, there is more robust evidence from clinical trials.
- Helps inform regulatory decisions on drugs and devices RWE and studies can be used to study prevalence, incidence and natural history of diseases. RWE can also be used to support current treatment patterns, while providing better cost effective treatments.
- RWE can be used to conduct research which is not possible with RCT. For example, in studies of high-risk groups.
- Studies of rare adverse effects of drugs and devices will benefit more from RWE compared to RCTs. Since RWE covers more population with longer duration. (6)
- RWE uses digital records such as EHR to map specific patient populations. This is beneficial because it allows sponsors of clinical research to determine where the largest patient population exists within a specific therapeutic area. It can also be used to cross-reference patient data with relevant investigator sites to determine the correct physicians that specialize in the treatment and or study of interest. This will maximize study enrolment and can lead to shorter clinical trial timelines. (7)
- Its use will help accelerate development of new drugs and medical devices.
- Use of RWE is estimated to reduce trial costs anywhere between 5% to 50% to help expedite safety monitoring and simplify trial and data collection. (8)
- RWE better reflects the actual clinical setting in which therapeutic interventions are applied, including patient demographics, comorbidities, adherence, and concurrent treatments.
- Other uses and benefits include its application in health care utilization studies and analysis of effectiveness and efficiency of health services and program performance. (5)

Challenges and Limitations of the Use of RWE

Challenges and limitations of RWE can be summarized as people-based, organizational and technological. (1)

- There are challenges around standardization, measurement analysis and reporting of RWE as a tool for decision-making. (5)
- There are challenges around processes and achieving agreement on how to generate and plan RWE studies effectively among multiple stakeholders. (5)
- There is a lack of coordination between multiple stakeholders at national and international levels regarding RWD translation into evidence caused by insufficient interactions between groups. (9)
- A key threat to RWE is cybersecurity. Data breaches pose a danger to data integrity, confidentiality, and availability and, as such, are also a threat to the adoption and advancement of RWE. (10)
- Recent findings have suggested that for an effective use of RWE in drug funding decisions, there is a need for a cultural shift, improved data infrastructure, increased stakeholders collaboration, committed investment in capacity building and increased stakeholder collaboration. (11)

In conclusion, RWE is important as it complements data from RCTs as highlighted above. However, RCT and RWE have limitations in design and interpretation. (11) Patients in RCTs are highly selected (i.e., inclusion & exclusion criteria) and as such may not reflect the target population in whom the drug may be used. Based on this limitation, RWE has been considered to complement RCT in decision making. (5)

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CSHP-AB Student Column

As we approach the beginning of a new school year, it is paramount that we return to classrooms in a responsible manner. While it may seem that we are approaching the back-end of the pandemic, it remains important to engage in effective hygienic practices to ensure a safe transition back to school for everyone.

The Faculty of Pharmacy and Pharmaceutical Sciences looks to welcome the Class of 2026 to campus on August 29th and 30th. Classes will resume for all students on Thursday, September 1st. Similar to last year, lectures will be delivered in a hybrid format. Although lectures will no longer be live-streamed, the Faculty will be posting recordings within a few days of the date of delivery to provide students with some flexibility.

The CSHP-AB Vision Portfolio Presidential Officer, Catherine Biggs, and I look forward to bringing back the CSHP-AB Student Symposium. This event has historically served to provide an introduction to CSHP for first-year students. We look forward to enticing students with an informative presentation detailing the benefits of becoming a CSHP member and providing attendees a chance at winning some cool prizes!

This year we are excited to bring forward a new, exciting event to show appreciation for our CSHP student supporters. Students can join the CSHP Student Committee on campus for our Membership Appreciation Event! This will provide students with an opportunity to get to know their classmates over a fun movie and complimentary catering.

If the last two years have shown us anything, it's that circumstances can change in an instant. An abrupt transition back to online learning last January due to an uptick in COVID-19 cases challenged students to be resilient and adapt to an online delivery format midway through the school year. I would like to thank Carolina Ghio and the outgoing CSHP Student Committee members for the commitment and dedication they displayed despite the tremendous uncertainties they faced throughout the year. This team put forth their best foot towards providing students with well thought out, informative events despite the ever-changing climate of the pandemic. The CSHP Student Committee and I are excited to carry on their legacy and will continue to provide exciting events for the student body this upcoming term!

Karanvir Deol
CSHP-AB Student Representative (Incoming)

Carolina Ghio
CSHP-AB Student Representative (Outgoing)

National Awards Program 2022

CSHP national awards program is now accepting submissions through September 30. Nominate yourself or someone else for an award!

Distinguished Service Award

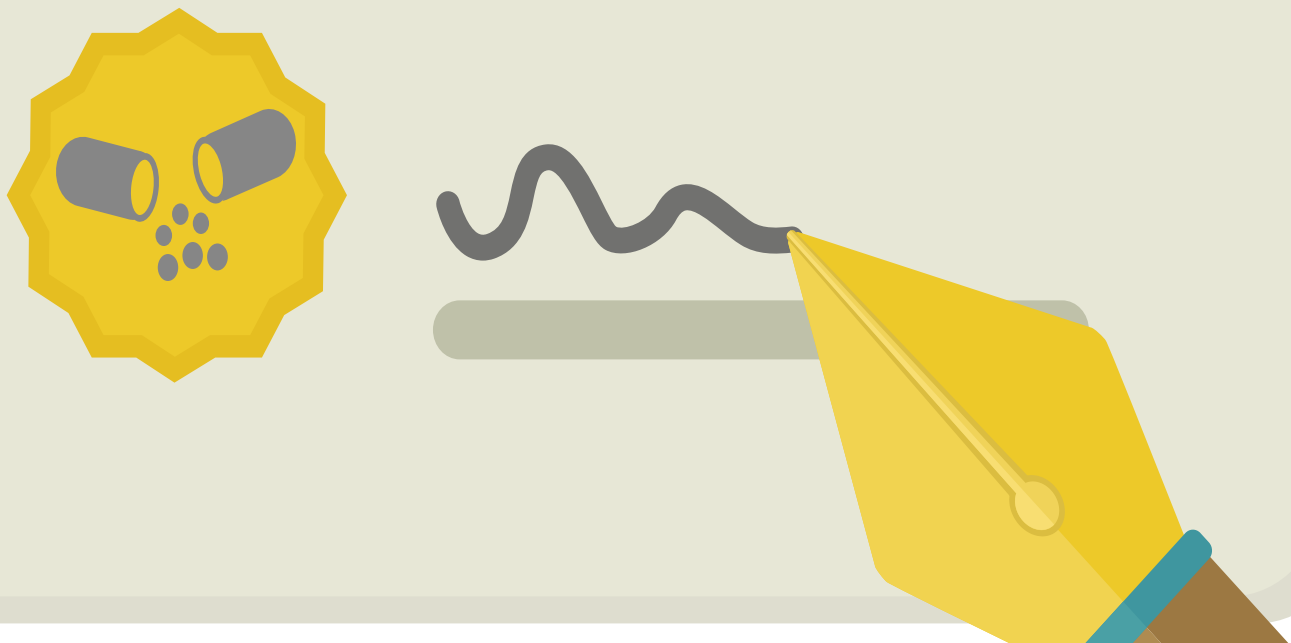
Excellence in Pharmacy Practice – Leadership

Excellence in Pharmacy Practice – Interprofessional Collaboration

Excellence in Pharmacy Practice – Patient Care

Hospital Pharmacy Student Award

More information available here.



Pharmacy Assistant Spotlight:

HILLARY PEARCE

OUTSTANDING ASSISTANT

PROFILE

POSITION
Inventory Management Assistant

LOCATION
Foothills Medical Centre
Calgary, Alberta

EXPERTISE

ATTENTION TO DETAIL	●●●●●
TEAM WORK	●●●●●
MEDICATION RECALLS	●●●●●

Amanda (interviewer): Hi Hillary. I'm excited to learn about your role today. Can you tell me what your role is?

Hillary: I manage our perpetual inventory with the assistance of BDM (Centricity). I look at drug usage and set drug quotas based on their historical use. This requires me to perform many tasks to ensure our inventory of medications is properly managed. I run drug utilisation reports to identify whether we need to adjust drug inventory quotas based on how much or how little a drug is being used.

Hillary: I will also audit these reports for accuracy. For example, yesterday I found an error on Oseltamivir 75 mg capsules. An assistant accidentally returned 110 patient-specific stock of Osteltamivir 75 mg capsules, instead of 1 capsule. These types of errors can cause significant problems for Finance by throwing off our utilisation numbers and causing financial variance. It is a bigger problem if I audit and fix an inventory error outside of the current month, because Finance has a hard time cross-referencing the new transactions required to fix the mistakes of the previous month.

I work as a team within a group of four assistants - Nicole, a safety technician; Heidi, a safety assistant; and Roberto, a split position between safety and inventory.

Hillary supports pharmacy practice by managing inventory, locating hard-to-find medications, and pulling unsafe medications off the shelves.

Amanda: How would you explain to others how you support pharmacy practice, and the hospital as a whole?

Hillary: I support pharmacy practice and the hospital by helping to locate medications. Whenever there is a medication that is on shortage, backorder, or an SAP (Special Access Programme) item, I am good at finding these drugs because I have intimate knowledge of our system. For example, if there is a medication that is out of stock, I know how to use the system and find someone who may have it.

For SAP medications, I help to collect the necessary information from the pharmacists and medical care team, and efficiently provide this information to Central Production. Once the drug arrives at our site, I verify the drug identity and quantity.

I also enjoy doing drug recalls because of the urgency of the issue. Once we had a recall of sodium chloride 4 mmol/mL (23.4%), 30mL vials, that came in at 2PM on my last day of the work week. I sprang into action. I was able to remove all affected product from the shelf before it hurt patients.

> **Take breaks**. Go for lunch! Take time away from your desk to **clear your head**.

Amanda: What do you love about your role?

Hillary: The people I work with - the assistants I work with daily, the pharmacists (who are very helpful and often can point me in the right direction), and the managers (who are supportive especially when there are SAPs involved).

Amanda: What advice would you give to your younger self?

Hillary:
I would tell that person to take breaks. Go for lunch! In my early years of doing this role, I would never take a break. I would stay late all the time. But we all need breaks because you can end up getting bitter and not enjoying your job as much. It definitely happened for me in my early years. Once I started taking breaks, and taking time away from my desk to clear my head from all the work, I really started to love my role again!

CONTACT US

Do you, or someone you know, want to be interviewed for Spotlight?
We are interviewing Pharmacists, Pharmacy Technicians, and Pharmacy Assistants who make a difference. If you would like to be interviewed or would like to nominate someone to be interviewed, please submit your request to:
babadagl@ualberta.ca and aleong@ualberta.ca

short & snappy
-A CLINICAL OVERVIEW

The blurry boundaries of outdated regimens: is once-daily ribavirin in Hepatitis C Virus reasonable?

Reem Almawed, PharmD
2021-2022 Pharmacy Resident

- Ribavirin (RBV) is a synthetic nucleoside analogue used adjunctively with direct-acting antiviral agents (DAAs) to treat chronic hepatitis C virus (HCV) in the setting of decompensated cirrhosis or past treatment failure. [1-3] It is usually dosed twice daily (Table 1).
- Hemolytic anemia is a dose-related adverse effect of RBV [1-3] – there is no consensus among clinicians on how to dose-adjust after patients experience this.
- As newer DAAs are dosed once daily, the feasibility of once daily RBV should be explored.
- RBV has a long half-life of 120 hours,[1,2] but supporting evidence is required to consider a once-daily RBV dose in HCV. [1,2] A literature search for the question "What evidence is available for the efficacy of once daily dosing of RBV in HCV treatment?" is outlined in Table 2.

Table 1: Suggested Ribavirin Dose Target Per Health Canada Monograph* [2,3]

Patient's Weight	Dose
<75 kg	1 g/day in 2 divided doses
≥75 kg	1.2 g/day in 2 divided doses

* Some clinicians may start at lower doses and titrate as tolerated by the patient

Table 2: Summary of Identified Literature

Study Summary	Findings		
Balk 2015 randomized open-label crossover study[4] 600 mg twice daily vs 1200 mg once daily – comparison of PK profiles	No significant difference in time to Cmax and AUC or steady state plasma concentrations		
Pellicelli 2017 retrospective observational study[5] DAA regimen* + RBV 800 mg once daily – comparison of safety and efficacy in elder (≥65) and younger (<65) HCV genotype 1 cirrhotic patients	**Group**	**SVR at 12 weeks**	**Grade 2 anemia (p<0.004)**
	Age <65	97.7%	19.9%
	Age ≥65	94.2%	35.3%
Poordad 2019 Phase 3 open-label study[6] DAA regimen** + RBV 600 mg once daily vs DAA regimen* + standard weight-based RBV dose in HCV genotype 1a non-cirrhotic patients	RBV 600 mg regime did not meet non-inferiority to standard weight-based dosing concerning SVR at 12 weeks. One patient (1%) experienced Grade 2 anemia.		
Pellicelli 2020 retrospective non-randomized open-label study[7]		**SVR at 12 weeks (p=0.007)**	**Grade 2 anemia (p<0.007)**
DAA regimen*** +… in HCV genotype 3 cirrhotic patients	RBV 800 mg daily vs	97.7%	19.5%
	Standard weight-based RBV dose vs	97.4%	39.5%
	No RBV	87.1%	4.8%

*sofosbuvir/simepravir (400 mg/150 mg) daily; **ombitasvir/paritaprvir/ritonavir (25 mg/150 mg/100 mg) daily + dasabuvir 250 mg BID; ***sofosbuvir/daclatasvir (400 mg/60 mg) daily; **PK** = pharmacokinetic; Cmax = maximum serum concentration; **AUC** = area under curve; **SVR** = sustained virological response; **Grade 2 anemia** = Hb of 8-10g/dL

BOTTOM LINE: There is limited evidence exploring the efficacy and safety of once-daily RBV, and no strong recommendation for the dosing strength at this frequency. Based on its long half-life and high SVR achieved in the above studies, it may be reasonable to consider the monograph-suggested strength for those who experience hemolytic anemia of 600-800 mg daily in all HCV patients taking RBV. Ultimately, this decision is one that requires professional judgment, consideration of patient-specific factors such as medication adherence, and informed decision making with the patient.

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short & snappy
-A CLINICAL OVERVIEW

Shedding Light on the Use of Doxycycline in Light Chain Amyloidosis

Lisa Zhang
2021-2022 Pharmacy Resident

Clinical Question: *In patients with light chain amyloidosis (AL), what is the evidence for the use of doxycycline with conventional chemotherapy on response and reducing patient morbidity and mortality?*

Light chain amyloidosis (AL), the deposit of misfolded protein fibril in organs, leads to widespread organ failure and dysfunction commonly cardiotoxicity and renal damage. The degree and presence of cardiac involvement determines patient outcomes, with disease staging (Mayo) determined by cardiac markers. The goal of therapy is to achieve hematological remission to suppress further formation of proteins. Conventional therapy, often CyBorD, has had suboptimal results, prompting the search for alternative therapies. Doxycycline 100mg PO BID has been shown to disrupt AL fibrils in transgenic mouse models of disease, however its place in therapy remains unknown (1). Three trials attempted to establish evidence for its inclusion into standard of care (2, 3, 4):

Study		Wechalekar, W.		D'Souza	Shen et al.	
Trial Design		Retrospective analysis, matched for cardiac disease stage, absolute NT-proBNP, age and FLC (n= 100)		Single center, single arm, Phase II clinical trial (n=25)	Multicenter RCT, 1:1 randomization (n= 140)	
Comparison/ Intervention (n)		Standard chemotherapy (70)	Standard chemotherapy + doxycycline (30)	CyBorD + doxycycline x 1 year	CyBorD alone (70)	CyBorD + doxycycline (70)
Hematologic Response	Complete Remission (CR)	35%	56%	**6 months** 38.6% p= 0.29	**6 months** 38.6%	30.0%
					p= 0.29	
	Very Good Partial Response (VGPR)	8%	10%	**6 months** 18.6%	**6 months** 18.6%	31.4%
		P= 0.32			p= 0.08	
Cardiac response (variably measured)		18%	60%	N/A	35.7%	40.0%
		p< 0.0001			p= 0.60	
Cumulative Incidence of Organ Response (soft tissue, cardiac, renal, hepatic)		**N/A**		36% 95% CI (18-57%)	**N/A**	
Overall Survival		**Median**		**12 months**	**2 year**	
		15 months	Not reached	80% 95% CI (58.4-91.1%)	64.0%	63.9%

CyBorD: cyclophosphamide, bortezomib, dexamethasone, **FLC:** free light chains, **CR:** normal FLC ratio, negative urine/serum immunofixation (IF), **VGPR:** difference in FLCs<40mg/L, M-protein detected by IF but not electrophoresis **Cardiac response:** NT-proBNP, interventricular septal thickness, improved LVEF, wall thickness

EVIDENCE REVIEW: The retrospective & single-arm study show a favourable organ & hematological response with addition of doxycycline (1, 2). However, these findings were not duplicated in the multi-center RCT, the most robust trial of the three, which demonstrated minimal improvement in these endpoints (3). Also, D'Souza's single arm study is based on cumulative organ response rather than solely cardiac response; therefore, it is difficult to establish its benefit to patient outcomes.

BOTTOM LINE: There is insufficient evidence to support the addition of doxycycline to conventional chemotherapy as evidence from clinical trials is inconclusive.

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Pharmacy Resident Research Projects

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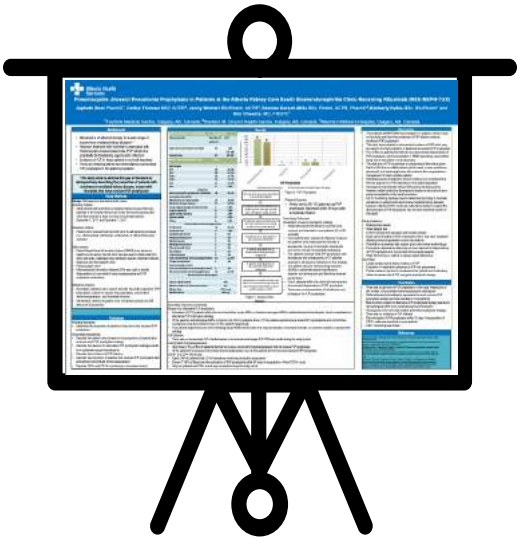
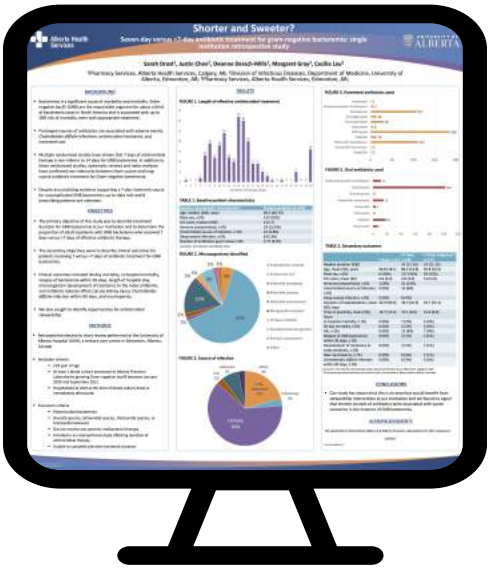
Pneumocystis Jirovecii Pneumonia Prophylaxis in Patients at the Alberta Kidney Care South Glomerulonephritis Clinic Receiving Rituximab (NEU-NEPH-TUX)

Japheth Bool
Preceptors: Carlee Thorsen, Jenny Wichart

Rituximab is an effective therapy for a number of autoimmune-mediated kidney diseases; however, it is also associated with opportunistic infections such as *Pneumocystis Jirovecii* pneumonia (PJP). Despite this, there have been limited guideline recommendations surrounding PJP prophylaxis in this population. This study aims to address this gap in literature by retrospectively describing the proportion of patients with autoimmune-mediated kidney disease, treated with rituximab, that have received PJP prophylaxis.





Proportion of patients receiving ≤7 days versus >7 days of effective antimicrobial therapy for gram-negative bacteremia at the University of Alberta Hospital

Sarah Drost
Preceptor: Cecilia Lau

We describe the real-world practice patterns and outcomes at a tertiary care hospital in Alberta in the treatment of Gram-negative bacteremia. Our study showed that, despite compelling evidence for shorter durations of therapy for bacteremia from Gram-negative bacilli, the majority of patients (93%) at our institution received greater than 7 days of therapy. This is an area that would benefit from stewardship intervention at our institution and we found no signal that shorter courses of antibiotics were associated with worse outcomes.

Pharmacy Resident Research Projects

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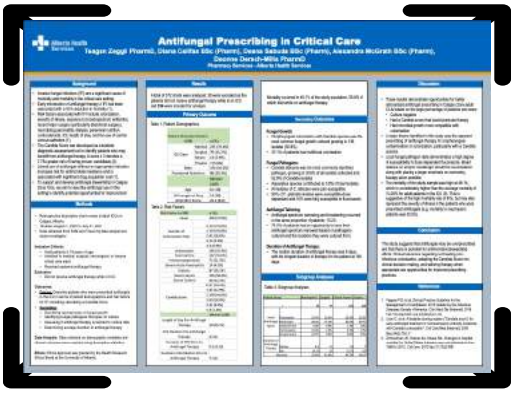
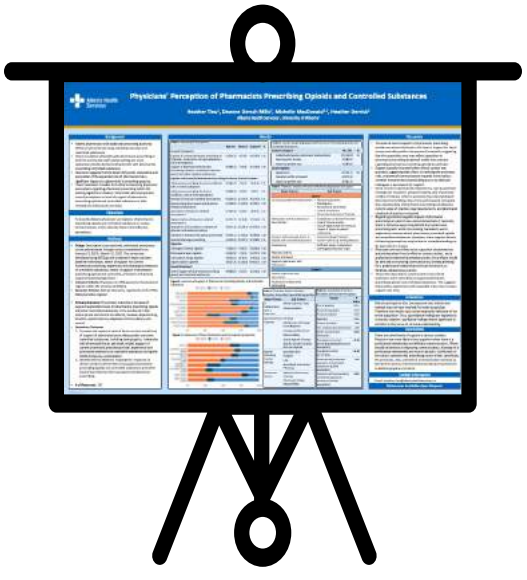
Antifungal Prescribing in the ICU

Teagan Zeggil
Preceptors: Diana Callfas, Deana Sabuda

A retrospective descriptive chart review was conducted in adult ICUs in Calgary from August 1, 2020 to July 31, 2021 to describe patients who were prescribed antifungal therapy in terms of risk factors, pathogens cultured, sites of fungal growth, duration of antifungal therapy, and to determine if antifungal therapy was tailored to culture results. A total of 334 charts were included for analysis and revealed themes including antifungal prescribing for patients who were culture negative, had a Candida Score that would preclude therapy, or had microbial growth that was more compatible with colonization. This study reveals the potential for antimicrobial stewardship efforts in the critical care setting.





Physicians' Perception of Pharmacists Prescribing Opioids and Controlled Substances

Heather Tieu
Preceptors: Heather Derrick, Michelle MacDonald

The literature suggests that the level of physician acceptance and perception of the expanded role of pharmacists has a significant impact on a pharmacist's prescribing practice. Little is known about physicians' overall perceptions of pharmacists prescribing opioids and controlled substances in both renewal and initial access contexts, and what factors influence perceptions. This gap in knowledge is what we intend to begin addressing with our study.

Pharmacy Resident Research Projects

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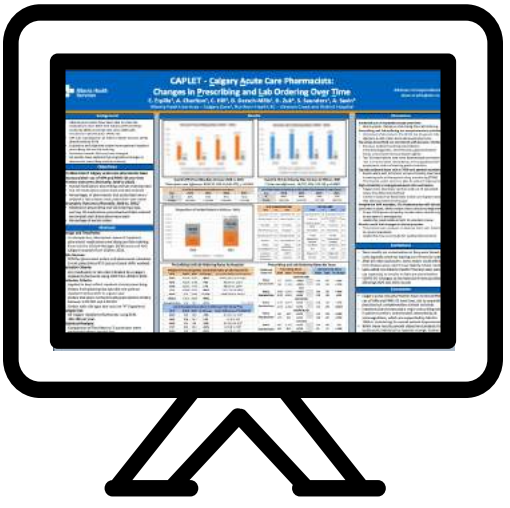
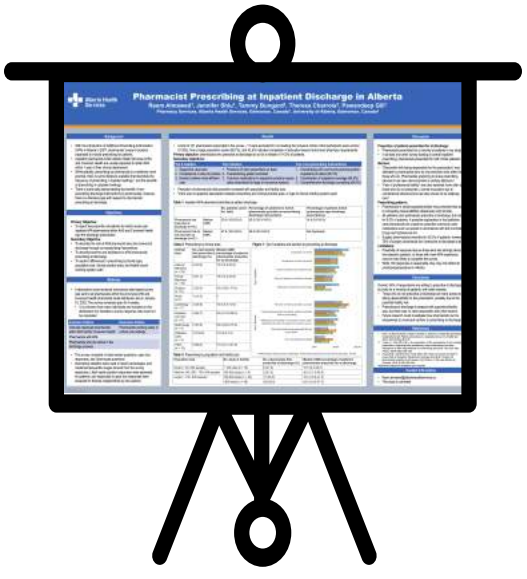
CAPLET - Calgary Acute Care Pharmacists: Changes in Prescribing and Lab Ordering Over Time

Elizer Erpilla
Preceptors: Cheryl Hill, Alexandra Charlton

CAPLET was a retrospective review of Calgary acute care pharmacists' medication and lab orders from 2018 to 2021. We wanted to see if pharmacists had used their Advanced Prescribing Authority (APA) and lab ordering privileges (PRAC-ID) more often since APA was mandated within AHS in 2018. We will share the changes in annual prescribing and lab ordering rates at the city, site, and team level, as well as the most popular medications and labs that have been ordered over time.





Pharmacist Prescribing at Inpatient Discharge in Alberta

Reem Almawed
Preceptors: Pawandeep Gill, Theresa Charrois

Inpatient clinical pharmacists across Alberta are usually expected to obtain Additional Prescribing Authorization (APA) in order to provide patient care to their fullest scope. Existing literature examines the frequency and benefits of pharmacist prescribing in hospital, but how often are pharmacists using their APA specifically to sign discharge prescriptions? In this presentation, we will present the findings of a province-wide survey exploring prescribing by inpatient pharmacists at the point of discharge.

Pharmacy Resident Research Projects

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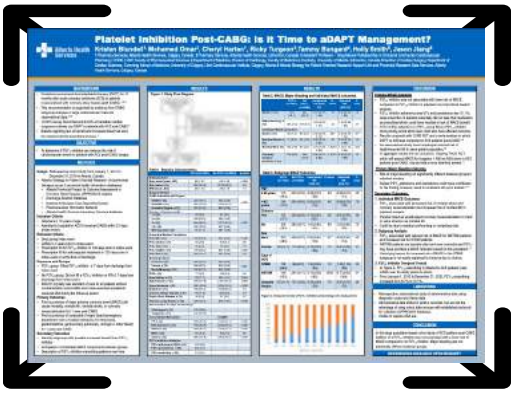
Pharmacist-Led SUpport for RurAL Acute Coronary Syndrome Program The PLURAL-ACS Pilot Program

Hazal Babadagli
Preceptors: Sheri Koshman, Glen Pearson

Alberta Health Services Cardiovascular Strategic Clinical Network (AHS CV SCN) data indicate that Northern and Central rural locations have up to double the 30-day acute coronary syndrome (ACS) readmission rates and delayed time to discharge prescription fill of up to 23 days compared to urban sites. These outcomes could be due to reduced access to medical care in rural locations, which has been demonstrated in numerous studies. While virtual and pharmacist-led programs in urban centers have separately shown improved medication management post-ACS, to our knowledge, there are currently no published programs in Canada that provide pharmacist-led virtual care for rural post-ACS patients. We present the findings of a pilot project that is aimed to examine the impact of pharmacy-led follow-up care post ACS to improve the identification and resolution of cardiac-medication-related issues in North and Central Zone Alberta patients.



Platelet inhibition post-CABG: Is it time to aDAPT management?

Kristen Blundell
Preceptors: Mohamed Omar, Cheryl Harten

Dual antiplatelet therapy (DAPT) is recommended in patients with acute coronary syndrome (ACS), including those who are revascularized with coronary artery bypass grafting (CABG). However, these recommendations are based on lower quality evidence from CABG subgroup analyses of large trials and observational studies. Thus, we sought to compare the risk of major adverse cardiovascular events (MACE) and major bleeding with P2Y12 inhibitor versus no P2Y12 inhibitor in ACS patients post-CABG.

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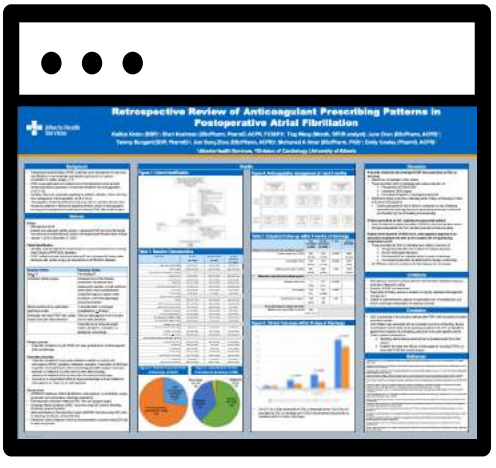
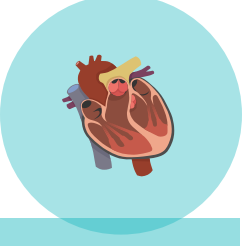
Retrospective Review of Anticoagulant Prescribing Patterns in Postoperative Atrial Fibrillation

Kaitlyn Krahn
Preceptors: Emily Cowley, Sheri Koshman

Despite post-operative atrial fibrillation (POAF) being a common complication of cardiac surgery that is associated with an increased risk of thromboembolic stroke, recommendations regarding the initiation and ongoing use of anticoagulation is unclear. We completed a retrospective cohort study to determine the proportion of patients who were prescribed an oral anticoagulant after developing new-onset POAF. Furthermore, our study aimed to describe the type of anticoagulant prescribed at discharge, outpatient management of new-onset POAF patients, and complication rates.





Direct Oral Anticoagulants in Early Post-Operative Non-Mechanical Heart Valve Surgery Patients with Atrial Fibrillation

Nils Moser
Preceptors: Cheryl Harten, Mohamed Omar

Despite increased utilization of direct oral anticoagulants (DOACs) in bioprosthetic valves, current guidelines recommend warfarin in the early postoperative period after bioprosthetic valve implantation in patients with atrial fibrillation. This retrospective cohort study describes the efficacy and safety of DOACs in the first 3 months after valve repair or bioprosthetic replacement. Our results suggest DOACs are safe and effective alternatives to warfarin in the early postoperative period after valve repair or surgical bioprosthetic valve replacement.

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DECODE IRON: DEscribing and COmparing Patient Factors Associated with Parenteral Iron Use Before and After the Implementation of an OrDEr Set for Parenteral IRON

Cameron Black
Preceptors: Thomas Brownlee, Darren Pasay

In Red Deer, Alberta, high utilization of IV iron has resulted in limited access to treatment for outpatients, significant drug costs, and health care resource utilization. This prompted the implementation of an iron sucrose order set in the Red Deer Regional Hospital Centre (RDRHC) Medical Day Room (MDR), over concerns of the increasing use of IV iron in outpatients without robust screening for relevant labs, comorbidities, or previous oral iron use. This study was designed to compare patient characteristics in those receiving iron sucrose in the RDRHC MDR prior to the implementation of an iron sucrose order set and after its implementation, in terms of pretreatment labs and previous use of oral iron.

Corticosteroid Prophylaxis in Rituximab Treated Post-Transplant Lymphoproliferative Disorder Patients

Lisa Zhang
Preceptors: Nikki Blosser, Kyla Bailey

Post-transplant lymphoproliferative disorder (PTLD) is a complication that can occur in allogeneic stem cell transplant (ASCT) patients because of EBV reactivation. Guidelines recommend reducing immunosuppression to restore EBV immune response and treatment with rituximab therapy. Clinicians have the option to omit or include the pre-infusion corticosteroid; however, whether this dose affects the grade and frequency of rituximab hypersensitivity reactions (HSRs) or EBV response is unknown.

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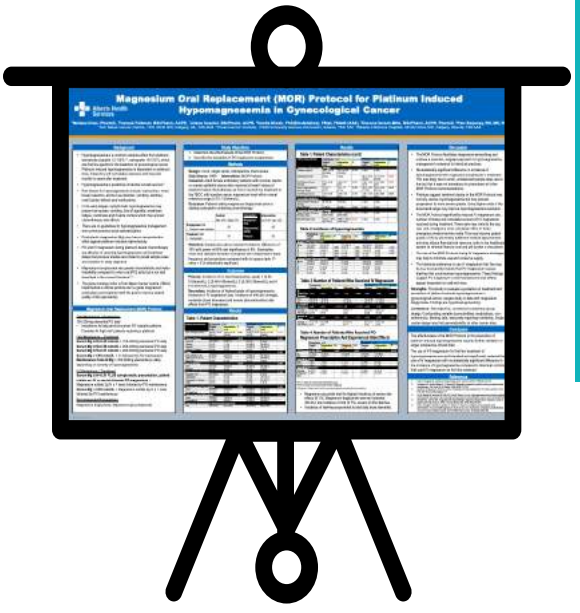
Oral Magnesium Replacement Protocol for Platinum Induced Hypomagnesemia in Gynecological Cancer

Melissa Chan
Preceptors: Frances Folkman, Jolene Guenter

Hypomagnesemia is a common adverse effect from platinum-based chemotherapy that may worsen chemotherapy side effects, and if inadequately treated, can become life threatening requiring emergency medical attention. The primary objective of this study was to assess the efficacy of an oral magnesium replacement protocol developed by a team of clinical pharmacists and nurse practitioner for the prevention and treatment of platinum-induced hypomagnesemia in gynecological cancer patients. The findings suggest that the use of PO magnesium for first line treatment of hypomagnesemia was well tolerated and significantly reduced the use of IV magnesium, with no statistically significant difference in the incidence of hypomagnesemia compared to historical controls that used IV magnesium as first line treatment.



CSHP AB Mentorship Program

CSHP Alberta Branch is launching a Research Mentorship program Fall 2022!

The research mentorship program aims to support the development of research skills of pharmacists and pharmacy technicians at any career stage, encourage and promote pharmacy-led research activities, and facilitate intra-professional and interprofessional collaborative opportunities. Our website will feature a repository of research resources and information about the mentorship program including Mentor profiles.

Who can become involved in the research mentorship program?

- All CSHP AB members are eligible to participate
- Mentors are experienced CSHP AB researchers with expertise in particular areas, and are willing to share their knowledge with Mentees.
- Mentees are CSHP AB members interested in gaining research knowledge and experience from Mentors
- Participants can be both Mentors in areas of expertise and Mentees in areas in which they want to learn more.

Become a Mentee of the CSHP Alberta Branch Research Mentorship Program - and complete the Mentee Intake Form

Why be a Mentee?

- Increased confidence & sense of professionalism
- Further developed research competencies & problem-solving skills
- Improved motivation, job satisfaction & professional growth

Have you ever wanted:

- To connect with individuals who are knowledgeable in research?
- Advice on how to get started on a research project?
- Someone experienced to provide feedback on your manuscript?

Stay tuned for more information about mentorship matching & the program launch in October/November 2022!

For more information, please contact Research Committee Chair - Bernadette Chevalier (b.chevalier@ualberta.ca)

CSHP-AB BRANCH SYMPOSIUM

PHARM FEST 2022

SATURDAY, OCTOBER 1

CSHP-AB NETWORKING EVENT
Oct 1, 2022 - 7pm

Join us for the Awards Ceremony in person at WinSport, Calgary or watch it live streamed on Zoom!

- Dress as your fave musical artist
- Music trivia
- Theme cocktails
- Contests & Games
- Festival atmosphere

Register Today!
Link

No cost for CSHP members
$60 for non-members

AM On The Virtual Stage

8:00-8:10	Welcome
8:10-9:00	Chasing Summer with the Top 5 Trials of 2021-22: The EBM Woodstock of our Generation
9:00-9:05	Word From Our Sponsors
9:05-9:55	Short & Snappies: * Keeping Current With The Scientific Literature * Suicide Awareness & Prevention - * Managing Alcohol Withdrawal Complications
9:55-10:00	Word From Our Sponsors

AM On The Virtual Stage

10:00-10:40	Reseach Poster Presentations
10:40-10:45	Word From Our Sponsors
10:45-11:45	Keynote Speaker: *Matt Day,* *Music Care Facilitator*
11:45-11:50	Word From Our Sponsors
11:50-11:55	Thank You And Door Prizes
12:00-13:00	CSHP Alberta Branch AGM

PM On The Main Stage

18:00-19:00 *Winsport Paskapoo Room*	**Paladin Labs Inc Sponsored Satellite Symposium & Dinner** **Keynote:** Rita Dhami *Targeting Treatment to the Patients: The 2022 Antimicrobial Playlist*
19:00-19:45 *Winsport Hockey House*	Virtual Awards Ceremony **Option to join by Zoom*
19:45-23:00 *Winsport Hockey House*	CSHP-AB Networking Event:

Canadian Society of Hospital Pharmacists
Alberta Branch

Société canadienne des pharmaciens d'hôpitaux

CSHP Alberta Branch Symposium 2022 Registration

Join us for the annual CSHP Alberta Branch Symposium on **Oct 1, 2022.** This event is complimentary for CSHP members and will have a fee of $60 for non-CSHP members.

Schedule of events:

- CABS Conference (virtual) 08:00 – 12:00
- AGM (virtual) 12:00 – 13:00
- Dinner Symposium (in-person in Calgary) 18:00 – 19:00
  - Presenting *"Targeting Treatment to the Patients: The 2022 Antimicrobial Playlist"* by Rita Dhami, BScPharm, PharmD, Antimicrobial Stewardship Pharmacist, London Health Sciences Center
- Networking Event and Virtual Awards Ceremony (in-person in Calgary and virtual) 19:00 – 23:00

CABS Registration: Register for the Zoom webinar here.

Dinner Symposium: Please fill out this form in order to RSVP for the Dinner Symposium sponsored by Paladin Labs Inc. at 18:00 on Saturday Oct 1st in Calgary as part of CABS 2022. Please fill out this form only if you are committed to attending the dinner symposium.

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