Academic Detailing by Pharmacists at GHC

- Topics for Academic detailing are chosen with the input of other departments (MD's, nursing)
- Pharmacist's/ Detailers are given a role in academic detailing
- Detailing tools enables the detailers to provide clear, concise messages on medication use.
- Expectations for Academic detailing are delineated
- Pharmacists practice the academic detailing using role playing

GHCにおける薬剤師による Academic detailing

- ❖ Academic detailingのためのテーマは他の部局(医師や看護婦)から選ばれる
- ❖ 薬剤師/説明者はacademic detailingの役割を与えられる
- ❖ 説明道具の使用によって、薬剤使用に関する明確かつ簡潔なメッセージを提供することが可能となる
- ❖ Academic detailingに期待されることが明確にされている
- ❖ 薬剤師はacademic detailingをロールプレイングによって練習する。

This past year at GHC, we implemented an Academic Detailing program by Pharmacists. Topics for Academic detailing were chosen with the input of other departments (medicine, nursing). The role of the pharmacist as detailer was identified and supported throughout the organization. Detailing tools were developed that enabled the detailers to provide the prescribing staff with clear, concise messages on medication use. Special training sessions were held for the pharmacists to impart the key messages to them and to train them how to be effective academic detailers. Clear expectations for the pharmacist were delineated. During these sessions, pharmacists practiced detailing using role playing techniques.

昨年GHCでは薬剤師によるAcademic Detailingプログラムを行いました。 Academic detailingのためのテーマは他の部局（ 医学、看護学 ）から選ばれました。説明者としての薬剤師の役割が組織の中で確立され支援されました。薬剤使用における明確で簡潔なメッセージを処方スタッフに提供できるような説明方法が開発されました。特別な講義が薬剤師のために設けられ、キーメッセージを伝え、どのようにして効果的なacademic detailersになるかといった訓練を受けました。薬剤師に期待されることが明確にされました。この講義の中で薬剤師はロールプレイングによって説明することを練習しました。

ROLE PLAYING

Role playing is an extremely important step in the training and one that should not be avoided if you implement a program similar to this. My experience is that pharmacists as a group are rather shy and do not like to get up in front of others. But the amount of benefit gained in doing this activity outweighs any complaints that you might receive!

ロールプレイング

ロールプレイングは訓練において大変重要な段階で、これに似たようなプログラムを実施するにあたって省くべきではない段階です。私の経験からすると、薬剤師はどちらかといえば内気で他の人々の前にでることを好みません。しかし、この活動を行うことで得る恩恵は、受ける苦情よりはるかに価値のあることです。

ROLE PLAYING

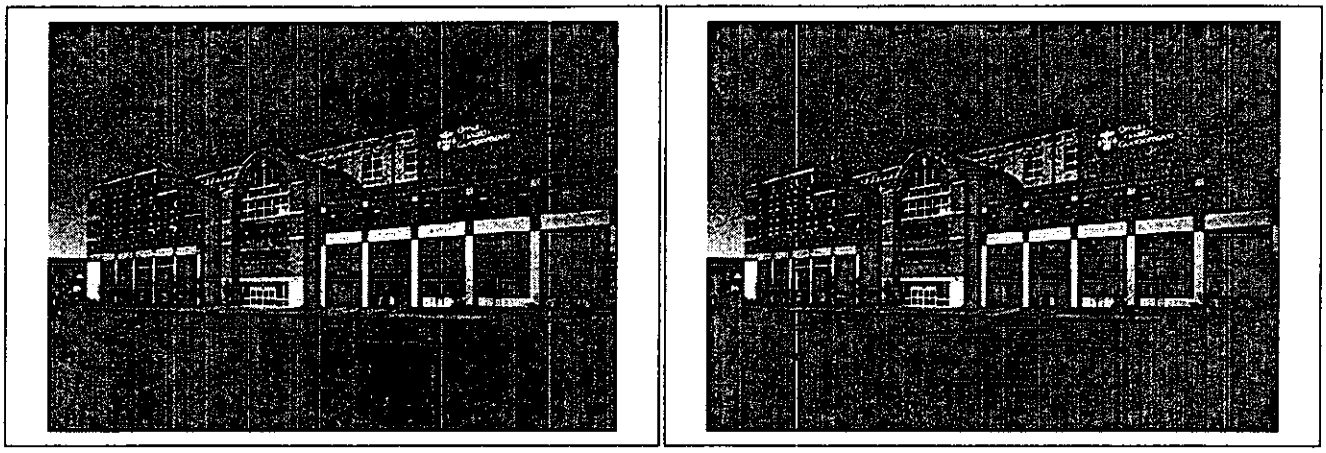
- Groups of three
- 3 role playing envelopes on your table
  - Define the areas to be addressed
  - Specific behaviors to be encouraged or discouraged
- Practice role-playing each scenario 5min max.
  - Coach
  - Detailer
  - Detailee

ロールプレイング

❖3つのグループ
❖ロールプレイングの3つの封筒がテーブルの上にある
  - 対象とする分野を限定する
  - 激励または落胆させられる特別な行動
❖最大5分のシナリオでロールプレイングを実施
  - コーチ
  - 説明者
  - 説明される人

Our role playing exercise consisted of dividing the pharmacists into groups of three. We provided them with a role playing envelope on the table in which their part and their attitude (resistant, hostile, receptive) was described. The key messages and the specific behaviors to be encouraged or discouraged were part of the educational session. Pharmacists were asked to "detail" each other. One person would serve as a observer or coach and take note if all of the key messages were provided and give feedback to the detailer at the end of the role playing exercise. Then roles would be changed until each person had had the opportunity to be the detailer, the detailee, and the coach.

私たちのロールプレイングの練習では薬剤師を3つのグループに分けます。3つに分けるためにロールプレイングの封筒をテーブルに置きます。封筒には役割と態度 (反抗者, 反意的, 理解的) が書いてあります。キーメッセージと激励または落胆させられる特別な行動は教育の一環です。 薬剤師はお互いに説明することが求められます。一人はオブザーバーまたはコーチとして全てのメッセージが伝えられるかどうかメモをとっておき、ロールプレイング練習の最後に説明者に伝えます。それから役割を変えて、どの人も説明者、説明される人、コーチを演じるようにします。



Pharmacists used academic detailing tool and training to go back to their clinics and present information to physicians and nursing staff. This is a photograph of one of the GHC Clinics located in Everett, Washington.

薬剤師はacademic detailingの手法を使って、自分の診療所に戻ってから医師や看護スタッフに情報を提供します。これはワシントン州のエヴァレットにあるGHCの診療所の写真です。

Academic Detailing Projects at GHC

- Completed 4 projects
  - Gemfibrozil for secondary prevention patients with low HDL
  - Treatment of Allergic Rhinitis
  - ACE Inhibitors for the Prevention of CVD (based upon the HOPE trial)
  - How to use our new electronic formulary system

GHCにおける Academic Detailing プロジェクト

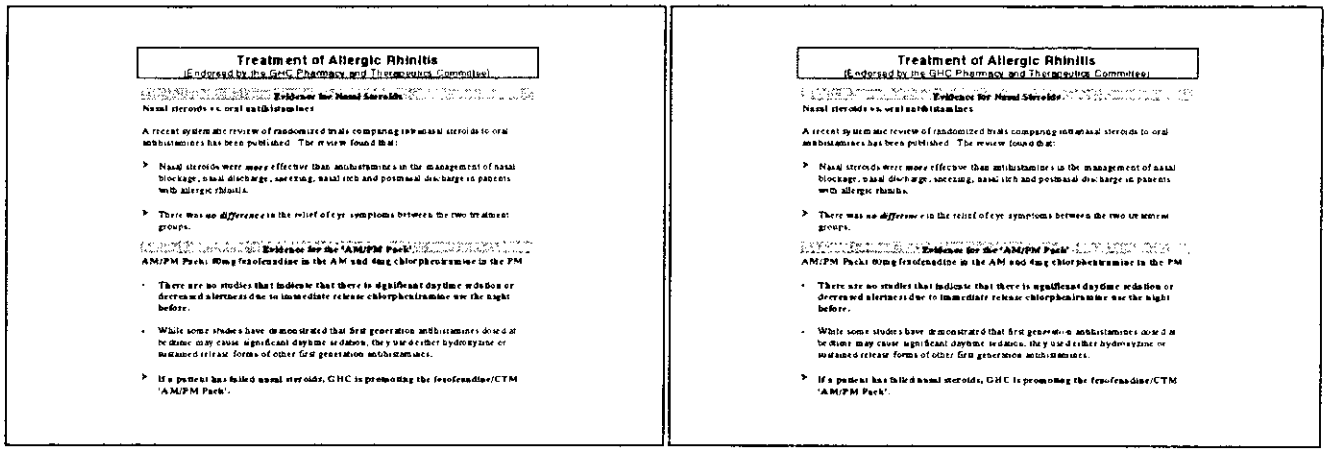
- 4つのプロジェクトを行った
  - 低HDL患者の二次予防に対するGemfibrozil
  - アレルギー性鼻炎の治療
  - CVD予防のためのACE阻害薬 (HOPE試験に基づく)
  - 新しい電子処方書システムをどのように使うか

During 2000, pharmacists at GHC participated in 4 academic detailing projects. Most of these topics were identified as problem areas by lead physicians in the GHC system. These projects included using gemfibrozil in patients with known coronary heart disease and low HDL to lower their risk of a cardiovascular event or death (based on the VA-HIT trial). The second project stemmed from the addition of a non-sedating antihistamine as a covered benefit to our formulary. Based on community use of this class of medications, GHC projected an additional $1 million dollar cost to our annual drug budget. Our goal was to encourage the use of other, less expensive, but equally effective treatments for allergic rhinitis. The next project was educate the physicians about the benefits of using an ACE inhibitor to reduce cardiovascular events in specific patient populations. In this instance, we were actually trying to encourage physicians to add a medication on to the daily regimen for a number of patients. The last project was to instruct our physicians on how to use a new electronic formulary system that was newly available on our intranet.

I will focus on the results from two of these projects: the nonsedating antihistamines and the use of ACE inhibitors.

2000年にGHCの薬剤師は 4 つのacademic detailing プロジェクトに参加しました。これらのテーマのほとんどはGHCの指導的地位にある医師によって問題分野として指摘されました。冠血管系心疾患で低HDL の患者に心臓血管系イベントや死亡の危険性を下げるためにgemfibrozilを使用することもプロジェクトの一つでした。(VA-HIT 試験に基づく)。 2つめのプロジェクトは 眠気を起こさない抗ヒスタミン剤を処方書に追加することから生じました。この種類の薬剤の地域的使用量に基づき、GHC は 100万ドルの経費を1年間の薬剤予算に追加することを計画しました。 私たちの目標はより低価格でアレルギー性鼻炎に対して同等の効果を持つ薬剤の使用を勧めることです。3つめのプロジェクトは特別な患者母集団において心臓血管系イベントを減少させるためにACE阻害薬を使うことの有用性を医師に教育することでした。この例では、私たちは実際に多くの患者の日常の処方にACE阻害薬をつけ加えるよう医師に勧めました。4つめのプロジェクトは新しくインターネットで利用できるようになった電子処方書の使い方を医師に指導することでした。

これらのプロジェクトのうち2つの結果: 眠気のない 抗ヒスタミン剤と ACE阻害薬の使用についてお話したいと思います。



In your handout should be a copy of what I have up here on the screen. This is the academic detailing tool that we developed and used to educate providers regarding alternatives to nonsedating antihistamines. I would like to point out a few of the important features:

•Only a few key messages are included to keep the message simple and concise

•Credibility is obtained by referencing support of the Pharmacy and Therapeutics Committee as well as the Chief of Allergy (at bottom of document).

•Evidence for the use of nasal steroids is summarized

•Evidence for the use of a newly developed "AM/PM" pack as an alternative for patients who have failed a nasal steroid is presented.

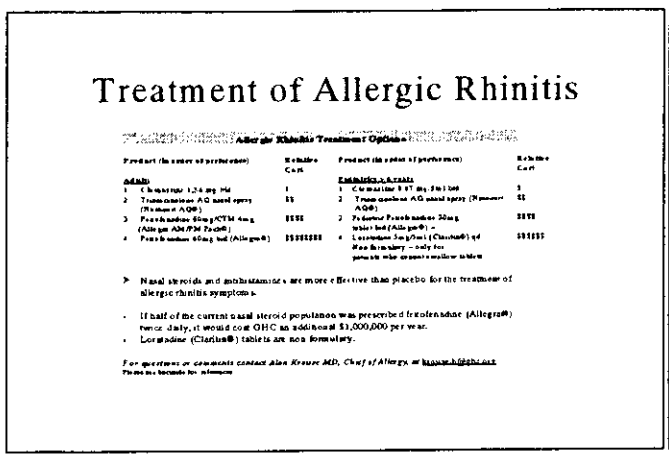
お手元の資料をスライドにしたものです。これは眠気を起こさない抗ヒスタミン剤の選択に関して教育するために、私たちが開発しまた使用してきたacademic detailing の方法です。いくつかの重要な特徴を挙げると:

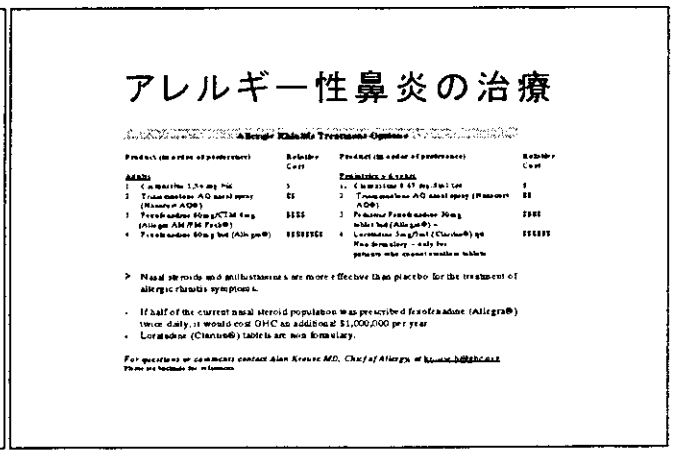
•メッセージを簡単で簡潔なものにするために2?3のキーメッセージのみとなっています。

•信頼性は薬剤・治療委員会とアレルギー部長の支持が得られていることを示すことで得ました (原稿の最後に記述) 。

•鼻用ステロイドの使用に関する根拠がまとめられています。

•鼻用ステロイドの使用に失敗した患者の選択肢として新しく開発された「AM/PMパック」の使用に関する根拠が挙げられています。





The bottom half of the detailing sheet listed our recommendations for treatment of allergic rhinitis in order of preference along with the relative cost of the intervention. For adults, a traditional antihistamine was recommended as first line therapy. Use of a nasal steroid to control symptoms was second. The AM/PM pack, a specially devised dispensing pack containing 30 fexofenadine (a 'non-sedating' antihistamine) for use during the daytime and 30 chlorpheniramine (a traditional antihistamine) for use at nighttime was listed as the preferred alternative for those patients who did not receive relief from the nasal steroid. The last choice (and most expensive) was use of twice daily fexofenadine.

資料の後半部分は、アレルギー性鼻炎治療に対する推奨を他の薬剤の相対的経費と比較して順位別に並べたものです。成人には伝統的な 抗ヒスタミン剤 がファーストラインの治療法として推奨されました。症状を緩和するための鼻用ステロイド の使用が2番目にきます。AM/PMパック、すなわち昼間用の60 mg fexofenadine (眠気のない抗ヒスタミン剤)と 夜間用の4 mg chlorpheniramine (伝統的な抗ヒスタミン剤) のパックを鼻用ステロイドでは不十分の患者の望ましい選択肢として挙げています。最後の選択肢は(一番費用がかかるのですが)はfexofenadineの一日に2度の使用です。

Results of Treatment of Allergic Rhinitis Academic Detailing

- In one month, over 300 physicians were detailed by pharmacists
- Use of NSAH's increase 336% in 2000 over that in 1999
- Total system cost for NSAH's in 2000 was $460,300 (less than 1/2 of projected cost)
- 60% of fexofenadine use was of the AM/PM pack
- If we had not used AM/PM packs, our projected cost would have been $740,000 for 2000

アレルギー性鼻炎の治療に対する Academic detailingの結果

- ❖1月で300人以上の医師が薬剤師によって説明された
- ❖NSAHの使用は2000年には1999年の336%に増加
- ❖2000年のNSAHにかかった経費は460,300ドル (計画予算の半分未満)
- ❖fexofenadineの使用のうち60%はAM/PMパック
- ❖AM/PMパックを使わなければ2000年の計画予算は740,000ドルで あった。

This slide depicts some of the results of the Academic Detailing project for the Treatment of Allergic rhinitis. In one month, over 300 physicians were detailed by pharmacists. Retrospective review of pharmacy dispensing records showed that the use of NSAH's increased 336% in 2000 over that in 1999. The total system cost for NSAH's in 2000 was $460,300 which was less than 1/2 of projected cost. In addition, 60% of fexofenadine use was for the AM/PM packs, a new product that was introduced to the physicians for the first time by the pharmacist during their detailing. If we had not used AM/PM packs, our projected cost would have been for using the nonsedating antihistamines in 2000 would have approached $750,000.

このスライドはアレルギー性鼻炎の治療におけるAcademic Detailing プロジェクトの結果を示したものです。1月で300人以上の医師が薬剤師による説明を受けました。薬剤調剤記録をレトロスペクティブに調査したところ、眠気を起こさない抗ヒスタミン剤(NSAH)の使用は2000年には1999年の336%に増加していました。2000年のNSAHにかかった経費は460,300ドル (計画予算の半分未満)でした。またfexofenadineの使用のうち60%はAM/PMパックで、薬剤師による説明によって初めて新しい薬剤が医師に紹介されたことになります。もしAM/PMパックを使わなければ、眠気のない抗ヒスタミン剤の使用に関して2000年の計画予算は740,000ドルであったと考えられます。

ACE Inhibitors for the Prevention of Cardiovascular Disease (HOPE)

- PC, DB, R, MC trial of ramipril versus placebo in 9,541 pts with hx of CAD, stroke, PVD, or diabetes plus one other risk factor (HTN, elevated CHO, low HDL, smoker, microalbuminuria)
- One event (MI, stroke, or death from CV disease) was prevented for every 27 patients treated for 5 years
- Most significant SE was cough (7.3% in trtmt group)

心臓血管系疾患の予防のための ACE阻害薬(HOPE)

- 冠血管障害，脳卒中，末梢血管障害，糖尿病に加えて別のリスクファクター(高血圧，高コレステロール，低HDL，喫煙，微量アルブミン尿)の病歴をもつ9,541人の患者に行ったRamiprilとプラセボのPC, DB, R, MC 試験
- イベント (心筋梗塞，脳卒中，または心臓血管系疾患による死亡) は5年間治療した27人のどの患者にも起こらなかった
- 最も重要な副作用は咳であった。(治療グループの7.3%)

The second project that I would like to speak briefly about is the use of ACE Inhibitors for the Prevention of Cardiovascular Disease based upon results of the Heart Outcomes Prevention Evaluation (HOPE) study published in NEJM 2000; 342:145-53. This trial was a placebo controlled, double blind, randomized, multicenter trial of ramipril versus placebo in 9,541 pts with a history of Coronary Artery Disease, stroke, Peripheral Vascular Disease, or diabetes *plus* one other risk factor (hypertension, elevated cholesterol, low High Density Lipoproteins, smoker, microalbuminuria). This study showed that one event (myocardial infarction, stroke, or death from cardiovascular disease) was prevented for every 27 patients treated for 5 years. The most significant side effect was cough (7.3% in treatment group).

手短にお話したい2つめのプロジェクトは、NEJM 2000; 342:145-53に発表されたHeart Outcomes Prevention Evaluation (HOPE) の結果に基づく心臓血管系疾患の予防のためのACE阻害薬の使用です。
この試験はramiprilと プラセボの二重盲検化、無作為化、 多施設試験で、9,541人の冠血管障害，脳卒中，末梢血管障害，糖尿病に加えてもう一つのリスクファクター(高血圧，高コレステロール,低 HDL，喫煙，微量アルブミン尿)の病歴をもつ患者に行ったものです． この研究ではイベント (心筋梗塞，脳卒中，または心臓血管系疾患による死亡) は5年間治療した27人のどの患者にも起こらなかったことを示しています。最も重要な副作用は咳でした。 (治療グループの7.3%)

Expected GHC outcomes from implementation of HOPE trial

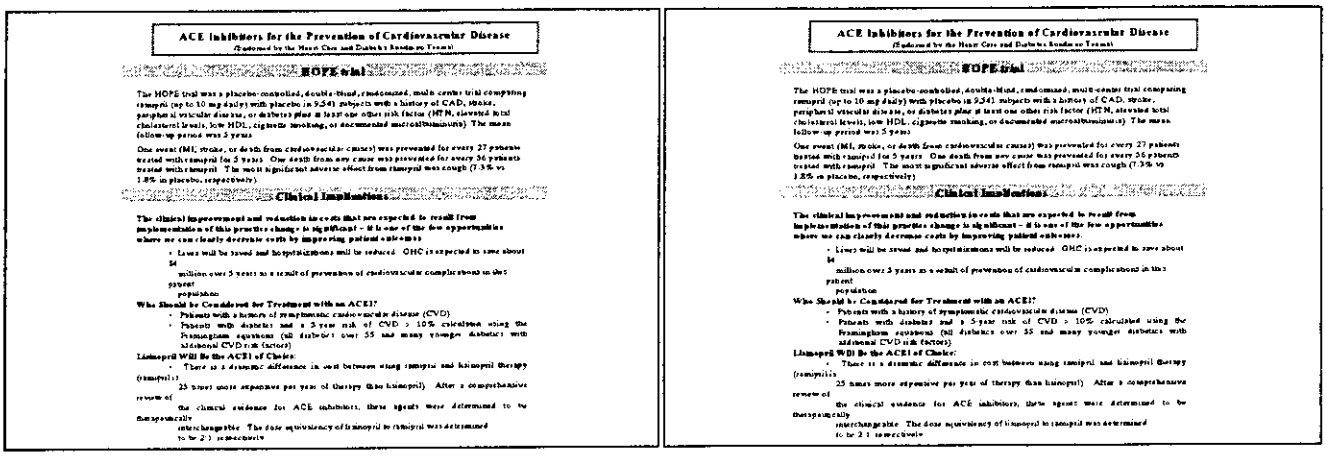
- One of the few opportunities we have were we can reduce costs and save lives
- Expect to save about $4 million over 5 years due to decreased hospitalizations and cardiovascular complications
- Used lisinopril based upon expert opinion that benefit is likely to be a class effect

HOPE 試験の実施によって期待されるGHCの成果

- ❖私たちが経費削減と人命救助できることを示す数少ない機会である
- ❖入院と心臓血管系合併症を減らすことによって、5年間で400万ドルを節約することが期待されている
- ❖効果はACE阻害薬に共通であろうという専門家の意見に基づいたlisinoprilの使用

It was felt that implementation of ACE inhibitors in these select patient populations was one of the few opportunities we have where we can reduce costs and save lives. Based upon our patient population and despite increased drug costs, we expected to save about $4 million over 5 years due to decreased hospitalizations and cardiovascular complications. We used lisinopril based upon expert opinion that benefit is likely to be a class effect.¥

これらの選ばれた患者母集団における ACE阻害薬の使用は私たちが経費削減と人命救助に貢献できることを示す数少ない機会の一つと思われます。薬物経費の増加にもかかわらず私たちの患者数の場合、入院と心臓血管系 合併症を減らして5年間で400万ドルを節約することを期待していました。また効果はACE阻害薬に共通であろうという専門家の意見に基づいてlisinoprilを使用しました。



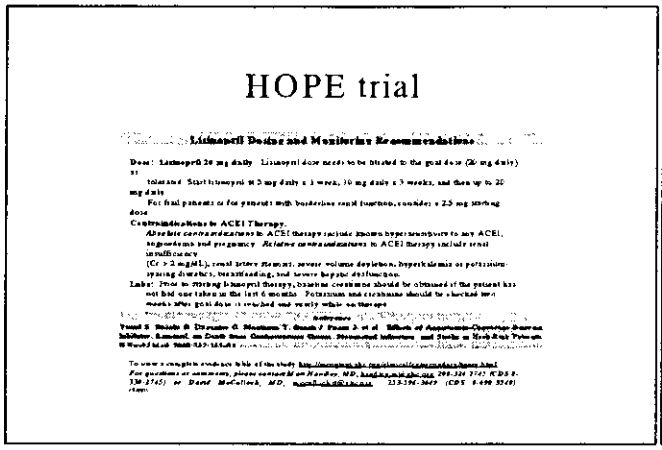
One again, we went through a similar process in developing an Academic Detailing tool, educating our pharmacists including role playing, and delineating expectations. This Academic Detailing tool is more extensive than the previous one; however, it was felt to be important to provide this information to the physicians. You have a copy in your handout of the entire document.

Once again, credibility was established by obtaining the endorsement of the Heart Care and Diabetes Roadmap teams. The HOPE trial was described and the clinical implications of its results were made a clearly as possible.

私たちはAcademic Detailing 手法の展開やロールプレイングを含む薬剤師の教育や期待されることについて先と同様のことを行いました。このAcademic Detailing 手法は前述のものより広範囲にわたるものですが、この情報を医師に提供することは重要なことと感じました。お手元の資料の中に全文書のコピーが入っています。

また、信頼性は心疾患と糖尿病の治療チームから保証を得ることで確立しました。HOPE 試験 について述べ、その結果の 臨床的な意味合いについてできるかぎり明確にしました。

HOPE trial



Lisinopril Dosing and Monitoring Recommendations

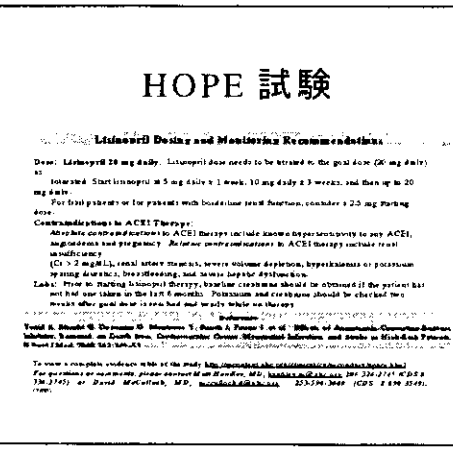
Dose: Lisinopril 20 mg daily. Lisinopril dose needs to be titrated to the goal dose (*ie* mg daily) as
tolerated. Start lisinopril at 5 mg daily x 1 week, 10 mg daily x 3 weeks, and then up to 20 mg daily.
For frail patients or for patients with borderline renal function, consider a 2.5 mg starting dose.

Contraindications to ACEI Therapy:
Absolute contraindications to ACEI therapy include known hypersensitivity to any ACEI, angioedema and pregnancy. *Relative contraindications* to ACEI therapy include renal insufficiency
(Cr > 2 mg/dL), renal artery stenosis, severe volume depletion, hyperkalemia or potassium-sparing diuretics, breastfeeding, and severe hepatic dysfunction.

Labs: Prior to starting lisinopril therapy, baseline creatinine should be obtained if the patient has not had one taken in the last 6 months. Potassium and creatinine should be checked two weeks after goal dose is reached and yearly while on therapy.

Doses for titrating the lisinopril dose are provided along with contraindications to therapy and recommended laboratory monitoring.

HOPE 試験



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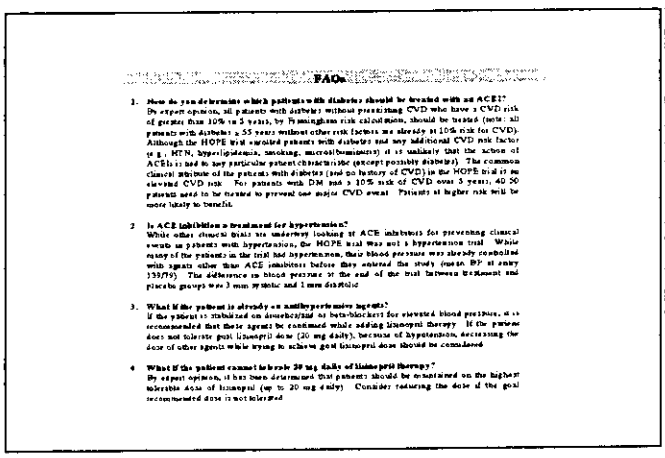
lisinoprilの投与量の記載の項には、禁忌症とともに推奨される臨床検査が示されています。



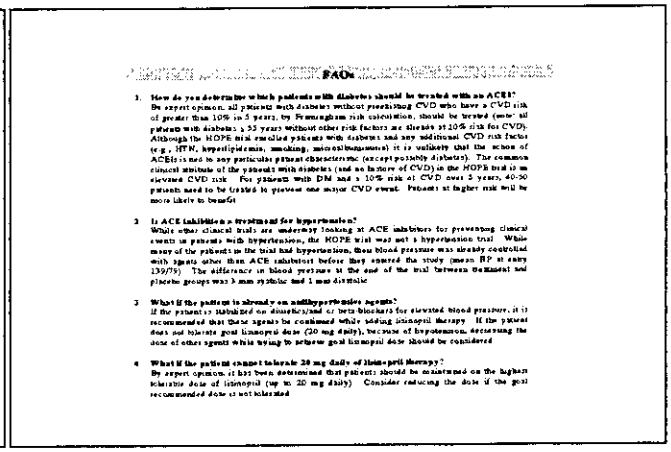
FAQs

1. How do you determine which patients with diabetes should be treated with an ACEI?
By expert opinion, all patients with diabetes without preexisting CVD who have a CVD risk of greater than 10% in 5 years, by Framingham risk calculation, should be treated (note: all patients with diabetes ≥ 55 years without other risk factors are already at 10% risk for CVD). Although the HOPE trial enrolled patients with diabetes and any additional CVD risk factor (e.g., HTN, hyperlipidemia, smoking, microalbuminuria) it is unlikely that the actions of ACEIs are tied to any particular patient characteristic (except possibly diabetes). The common clinical attribute of the patients with diabetes (and no history of CVD) in the HOPE trial is an elevated CVD risk. For patients with DM and a 10% risk of CVD over 5 years, 40-50 patients need to be treated to prevent one major CVD event. Patients at higher risk will be more likely to benefit.

2. Is ACE inhibition a treatment for hypertension?
While other clinical trials are underway looking at ACE inhibitors for preventing clinical events in patients with hypertension, the HOPE trial was not a hypertension trial. While many of the patients in the trial had hypertension, their blood pressure was already controlled with agents other than ACE inhibitors before they entered the study (mean BP at entry 139/79). The difference in blood pressure at the end of the trial between treatment and placebo groups was 3 mm systolic and 1 mm diastolic.

3. What if the patient is already on antihypertensive agents?
If the patient is stabilized on diuretic(s) and/or beta-blocker(s) for elevated blood pressure, it is recommended that these agents be continued while adding lisinopril therapy. If the patient does not tolerate goal lisinopril dose (20 mg daily), because of hypotension, decreasing the dose of other agents while trying to achieve goal lisinopril dose should be considered.

4. What if the patient cannot tolerate 20 mg daily of lisinopril therapy?
By expert opinion, it has been determined that patients should be maintained on the highest tolerable dose of lisinopril (up to 20 mg daily). Consider reducing the dose if the goal recommended dose is not tolerated.



FAQs

1. How do you determine which patients with diabetes should be treated with an ACEI?
By expert opinion, all patients with diabetes without preexisting CVD who have a CVD risk of greater than 10% in 5 years, by Framingham risk calculation, should be treated (note: all patients with diabetes ≥ 55 years without other risk factors are already at 10% risk for CVD). Although the HOPE trial enrolled patients with diabetes and any additional CVD risk factor (e.g., HTN, hyperlipidemia, smoking, microalbuminuria) it is unlikely that the actions of ACEIs are tied to any particular patient characteristic (except possibly diabetes). The common clinical attribute of the patients with diabetes (and no history of CVD) in the HOPE trial is an elevated CVD risk. For patients with DM and a 10% risk of CVD over 5 years, 40-50 patients need to be treated to prevent one major CVD event. Patients at higher risk will be more likely to benefit.

2. Is ACE inhibition a treatment for hypertension?
While other clinical trials are underway looking at ACE inhibitors for preventing clinical events in patients with hypertension, the HOPE trial was not a hypertension trial. While many of the patients in the trial had hypertension, their blood pressure was already controlled with agents other than ACE inhibitors before they entered the study (mean BP at entry 139/79). The difference in blood pressure at the end of the trial between treatment and placebo groups was 3 mm systolic and 1 mm diastolic.

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On the back side of the Academic detailing tool, we developed some Frequently Asked Questions (FAQ's) that helped answer many of the questions that physicians had regarding implementation of this recommendation.

Academic detailing手法の裏面には、この推奨の実施にあたって医師から出る質問への回答に役立つと思われる、よくある質問 (FAQ's)を載せてあります。

Results of HOPE trial Academic Detailing

- Projected that 11,000 patients at GHC met the criteria and would benefit from adding an ACE inhibitor
- Long term outcomes will need to be analyzed
- Academic detailing of physicians and nurses done by pharmacist in July, August, and September of 2000
- By December, there was a 145% increase in # patients on ACE-inhibitor;
- 34% of our projected 11,000 pts had been placed on med

HOPE試験 Academic detailing の結果

- ❖ GHCの11,000人の患者が基準を満たしており、ACE阻害薬を追加することによって利益があると予想された
- ❖ 長期的結果が分析される必要があると考えられた
- ❖ 医師および看護婦に対するAcademic detailing が 薬剤師によって2000年の7月?9月に行われた
- ❖ 12月までにはACE阻害薬を受ける患者の数は145%に増えた
- ❖ 計画した11,000 人の患者の34%が薬剤投与を受けている

Here are some of the preliminary results of HOPE trial academic detailing project. Based upon our patient population, we projected that 11,000 patients at GHC met the criteria and would benefit from adding an ACE inhibitor. As with our previous projects, pharmacists were provided the training and tools for academic detailing of physicians and nurses. Academic detailing occurred during July, August, and September of 2000. By December, there was a 145% increase in number of patients on an ACE-Inhibitor; 34% of our projected 11,000 patients had been placed on lisinopril. Long term outcomes will need to be analyzed.

これは、HOPE 試験 academic detailing プロジェクトの今現在の結果を示したものです。私たちの患者集団では、**GHCの11,000人の患者が基準を満たしており、ACE阻害薬を追加することによって効果があると予想されました。**

前のプロジェクト同様に、医師や看護婦に対してacademic detailingを行うためのトレーニングや方法が薬剤師に対して提供されました。 Academic detailingは2000年の7月?9月に行われました。12月までに ACE阻害薬を受ける患者の数は145%に増え、計画した11,000 人の患者の34%がlisinoprilの投与を受けています。長期的な結果の分析が必要と思われます。

Summary

- 2 examples presented: one where we are trying to control use of drug, other where we are trying to increase use
- Academic detailing works
- Need to use along with other means of communication
- Pharmacists have an important role to play as the recognized drug expert

まとめ

- ❖2つの例を示した：1つは薬剤の使用を制限しようとするもので、もう1つは薬剤使用を増やそうとするものである
- ❖Academic detailingが機能している
- ❖他のコミュニケーション手段とともに使用する必要がある
- ❖薬剤師は認可された薬の専門家としての重要な役割がある

I have presented two examples of academic detailing to you today: one where we were trying to control inappropriate use of a class of medications and another where we were trying to increase use of a medication to improve patient outcomes. Based upon our experience and from reports in the literature, academic detailing works to change prescribing behavior. It is important to recognize the need to use other means of communication such as patient pamphlets, internet and written communications along with academic detailing. Remember, repetition is important.

Pharmacists have an important role to play as the recognized drug expert within the health care system. I hope that I have given you some ideas today as to how you might utilize your expertise to change prescribing behavior.

今日はacademic detailing の2つの例を紹介しました。:1つは**薬剤の不適切な使用を制限しようとするもので、もう1つは患者に利益をもたらすために薬剤の使用を増やそうとするものです。**経験や論文報告に基づいて academic detailingが処方内容を変える働きをします。患者パンフレットやインターネットや記述によるコミュニケーションなど他のコミュニケーションをacademic detailing とともに用いる必要性があることを十分認識してください。また復唱も大事であることを忘れないで下さい。

薬剤師は医療システムの中で認可された薬の専門家として**行動するという重要な役割があります。あなたの専門知識を処方内容を変えるのにどのように役立てたら良いか、今日の話がいくらかヒントになれば幸いです。**

Amara (6 yo), Timothy (3 yo), Nathan 8(yo)

My children: Amara age 6, Timothy age 3, and Nathan age 8

Amara (6 yo), Timothy (3 yo), Nathan 8(yo)

私の子供達です。: Amara 6歳, Timothy 3歳, Nathan 8歳

Treatment of Allergic Rhinitis

(Endorsed by the GHC Pharmacy and Therapeutics Committee)

Evidence for Nasal Steroids

Nasal steroids vs. oral antihistamines

A recent systematic review of randomized trials comparing intranasal steroids to oral antihistamines has been published. The review found that:

- Nasal steroids were ***more*** effective than antihistamines in the management of nasal blockage, nasal discharge, sneezing, nasal itch and postnasal discharge in patients with allergic rhinitis.

- There was ***no difference*** in the relief of eye symptoms between the two treatment groups.

Evidence for the 'AM/PM Pack'

AM/PM Pack: 60mg fexofenadine in the AM and 4mg chlorpheniramine in the PM

- **There are no studies that indicate that there is significant daytime sedation or decreased alertness due to immediate release chlorpheniramine use the night before.**

- While some studies have demonstrated that first generation antihistamines dosed at bedtime may cause significant daytime sedation, they used either hydroxyzine or sustained release forms of other first generation antihistamines.

- **If a patient has failed nasal steroids, GHC is promoting the fexofenadine/CTM 'AM/PM Pack'.**

アレルギー性鼻炎の治療

（ＧＨＣ Pharmacy 及び Therapeutics Committee 是認）

和訳：中尾 誠、清水 直明、監訳：小島 康生　三重大学医学部附属病院薬剤部

点鼻ステロイド剤のエビデンス

点鼻ステロイド剤対経口抗ヒスタミン剤の比較

点鼻ステロイド剤と経口抗ヒスタミン剤の有効性を比較した無作為化試験に関する最近の総説によれば：

○点鼻ステロイド剤は抗ヒスタミン剤よりも、アレルギー性鼻炎患者の鼻づまり、鼻汁、くしゃみ、鼻掻痒感及び後鼻漏の治療において有効であった。
○
○両薬剤治療群間で、眼症状の軽減効果に差は見られなかった。

“AM/PM Pack”のエビデンス

AM/PM Pack：午前（AM）にフェキソフェナジン 60mg、午後（PM）にクロルフェニラミン 4mg

・クロルフェニラミンを夜間前に服用しても、迅速な薬剤の放出に起因する著明な鎮静又は注意力の低下が日中に起こることは、これまで報告されていない。

・第一世代抗ヒスタミン剤を就寝時に服用すると、日中に著明な鎮静が見られるという報告もあるが、それはヒドロキシジン又は他の第一世代抗ヒスタミン剤の徐放性製剤を使用したためである。

○もし、患者が点鼻ステロイド剤を使用できなければ、GHC はフェキソフェナジン／クロルフェニラミンを組み合わせた“AM/PM Pack”を推奨している。

Allergic Rhinitis Treatment Options

Product (in order of preference)	Relative Cost
Adults	
1. **Clemastine 1.34 mg bid**	$
2. Triamcinolone AQ nasal spray (Nasacort AQ®)	$$
3. Fexofenadine 60mg/CTM 4mg (Allegra AM/PM Pack®)	$$$$
4. Fexofenadine 60mg bid (Allegra®)	$$$$$$$$

Product (in order of preference)	Relative Cost
Pediatrics > 6 years	
1. **Clemastine 0.67 mg/5ml bid**	$
2. Triamcinolone AQ nasal spray (Nasacort AQ®)	$$
3. Pediatric Fexofenadine 30mg tablet bid (Allegra®) –	$$$$
4. Loratadine 5mg/5ml (Claritin®) qd Non formulary – only for patients who cannot swallow tablets	$$$$$$

- Nasal steroids and antihistamines are more effective than placebo for the treatment of allergic rhinitis symptoms.

- If half of the current nasal steroid population was prescribed fexofenadine (Allegra®) twice daily, it would cost GHC an additional $1,000,000 per year.
- Loratadine (Claritin®) tablets are non formulary.

For questions or comments contact Alan Krouse MD, Chief of Allergy, at krouse.h@ghc.org

Please see backside for references

Weiner JM, Abramson MJ, Puy RM. Intranasal corticosteroids versus oral H_1 receptor antagonists in allergic rhinitis: systematic review of randomised controlled trials. BMJ 1998;317:1624-9. www.bmj.com/cgi/reprint/317/7173/1624.pdf

Dykewicz MS, et al. Diagnosis and management of rhinitis: complete guidelines of the Joint Task Force on Practice Parameters in Allergy, Asthma and Immunology. Ann Allergy Asthma Immunol. 1998 Nov;81(5 Pt 2):478-518.

アレルギー性鼻炎治療における選択肢

薬剤（推奨される順）	相対的コスト
成人の場合	
１．クレマスチン 1.34mg １日２回	$
２．トリアムシノロンＡＱ点鼻スプレー (Nasacort AQ®)	$$
３．フェキソフェナジン 60mg／クロルフェニラミン 4mg (Allegra AM/PM Pack®)	$$$$
４．フェキソフェナジン 60mg １日２回 (Allegra®)	$$$$$$$$
小児（６歳以上）の場合	
１．クレマスチン 0.67mg/5mL １日２回	$
２．トリアムシノロンＡＱ点鼻スプレー (Nasacort AQ®)	$$
３．小児用フェキソフェナジン 30mg錠 １日２回 (Allegra®)	$$$$
４．ロラタジン 5mg/5mL (Claritin®) １日４回	$$$$$$
（この処方は一般的でなく、錠剤が服用できない患者にのみ処方する。）	

○点鼻ステロイド剤及び抗ヒスタミン剤によるアレルギー性鼻炎症状の治療効果は、プラセボよりも有効である。

・もし、現在点鼻ステロイド剤を使用している患者の半数がフェキソフェナジン (Allegra®) を１日２回処方されていたとすると、GHC のコストはさらに年間１００万ドル余分にかかっていたであろう。
・ロラタジン (Claritin®) 錠、は一般的には使用しない。

質問・コメントは Alan Krouse 医師(アレルギー部長)まで:krouse.h@ghc.org
参考文献：
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