



# BULLETIN

of the New York City Society of  
Health System Pharmacists

SPRING 2010

## INSIDE THIS ISSUE:

President's Message	1
AIDS Walk	2
Upcoming Events	2
House of Delegates And Call for Posters	3
President's Message Cont'd	4
Diagnosis of Diabe- tes: An Update	5-6
Photo Gallery	6
Overview of Gout	7
NYCSHP Board Members	8

## PRESIDENT'S MESSAGE

-Joe Pinto M.S., R.PH

Dear Colleagues,

I recently attended the Leadership Development Conference hosted by the NYSCHP in Albany on March 1<sup>st</sup> and came away with some intriguing perspectives.

There were two presentations, one given by William Zellmer and the other by Michael Gonyeau. Mr. Zellmer spoke of Pharmacy Professionalism and the Future Model of Health-system Pharmacy. I want to focus on his point of commitment to professionalism, and the internal questions one must ask themselves; Do I practice at my full potential, What do I want as a pharmacist (not what we were trained to do) and What is the importance of individual pharmacist autonomy and self concept which he defines as professionalism.

There are different sources and influences that shape each one of us and our perception of professionalism, maybe it was your exposure to the community pharmacist, perhaps it was education or a mentor after graduation. What or who were the influences on your perception of professionalism, can you change them, do they need to change, and of equal importance to me, can you change the perception of others on how they view your professionalism. As we look at ASHP's future Pharmacy Practice Model and our evolving role within the health-system, professionalism and the perception of this profes-

sionalism will be a major factor towards the acceptance of pharmacy as an integral part of the system and team.

The title of Mr. Gonyeau's program was Work-Life Balance, the focus of his presentation was on self-assessment which tied into Mr. Zellmer's presentation and professionalism. Self-assessment is a key step in professional development, routine and meaningful self-assessment may improve effectiveness and overall job satisfaction. One must understand who they are and how they work to be most effective. It is important to do this self-assessment because most feedback we receive in our society is negative, for example performance evaluations and student classroom evaluations consistently focus on "opportunities for improvement". It is said people pay more attention to criticism than praise. A survey conducted a few years back showed that when people were asked to recall important emotional events, they remembered 4 negative events for every 1 positive event. Interestingly enough while people remember the criticism they respond to the praise. Many of the experts in the field of Time Management believe that the most effective people build their lives upon their strengths and manage their



weaknesses. Focusing on the positives can allow an individual to perform better by improving what they already do well, which can increase confidence, productivity, drive, and contribution. "Many people think that your greatest opportunity to improve your performance comes from focusing on your weaknesses. This is inaccurate. The key to achieving excellence is to develop and apply your talents and strengths. The best that anyone can become by focusing on their weaknesses is mediocre" Edward C. Anderson.

Mr. Gonyeau went on to speak about personal mission statements, what is a personal mission statement, and how should it be constructed. Personal Mission statements are meant to allow you to discover the important areas of your life and summarize those aspects that you consider significant and essential.

-Continued on page 4



## AIDS WALK

Dear Members,

Team NYCSHP (#165) will be participating in the 2010 AIDS Walk New York in Central Park on Sunday, May 16, 2010 at 9 AM. AIDS Walk New York is a 10-kilometer (6.2 mile) fundraising walkathon benefiting AIDS service organizations. This is an inspirational day filled with energy, excitement, hope, and even celebrities! Join NYC Society of Health-System Pharmacists in our FIFTH (!) consecutive year supporting the cause!

Click on the link below to JOIN or DONATE to our team! Please remember, no donation is TOO small. Plus it's tax deductible!

<http://aidswalknewyork2010.kintera.org/faf/search/searchTeamPart.asp?ievent=331281&lis=1&kntae331281=CODE055E588D4EE68D649BC5743F5576&supId=0&team=3677208&cj=Y>

Feel free to invite family and friends to join our team! We hope to see you on May 16th!

Best,  
Team NYCSHP #165



## Upcoming Events

### Save the Dates

#### Monthly Meeting

**Date: April 7, 2010**

HB Burger, NY, NY

#### Pharmacy Day

**Date: April 13, 2010**

Albany, NY

#### Stroke Awareness Non-CE Dinner

**Date: April 27, 2010**

Location: TBD

#### AIDS Walk

**Date: May 16, 2010**

Central Park

#### Monthly Meeting

**Date: May 20, 2010**

Location: TBD

#### Quad Meeting

**Date: April 13, 2010**

Hosted by the Long Island Chapter at St. Johns

#### Health System Career-Forum

**Date: April 23, 2010**

Location: TBD

#### Annual Assembly

**Date: May 6-9, 2010**

Saratoga Hilton, Saratoga, NY

#### Installation Dinner

**Date: June 24, 2010**

Manhattan Penthouse

## Annual 2010 House of Delegates

-Leila Tibi, PharmD  
Immediate Past President

### What it means to be a Delegate?

On Thursday, May 6, 2010, nine (9) elected Delegates of the NYC Society of Health-system Pharmacists (NYCSHP) will participate in the annual 2010 House of Delegates (HOD) taking place during the 49<sup>th</sup> Annual Assembly of the New York State Council of Health-system Pharmacists (NYSCHP) in Saratoga Springs. The HOD is a policy-making body which establishes policies relating to the Council and the future practice of pharmacy in hospitals and other organized health care settings. The HOD represents a democratic process in which all Council members, through election of the Chapter Delegates, have a voice in the formulation of professional policies for the NYSCHP and the future practice of pharmacy in organized health care setting. Voting delegates consist of NYSCHP Officers and Directors, Chapter Delegates, Past Presidents, if eligible for active membership in the NYSCHP, and the Chairperson of the House of Delegates. Each chapter has one (1) delegate for every 25 active members, or any portion thereof, with a minimum of two (2) delegates. This year, representing the NYC Chapter at the 2010 HOD are, **Sally Arif, Ruth Cookie Jean, Fran Jordan, Michele Kaufman, Thomas Meere, Monica Mehta, Joseph Pinto, Leila Tibi, and Karol Wollenburg.**

The HOD has the authority to make professional policy for the Council and the authority to approve, modify or disapprove recommendations, reports, action or resolutions placed before it by the Officers and the Board of Directors. If the HOD does not approve a matter of professional policy as submitted, then the reason for the disapproval will be noted in the proceedings of the HOD and the matter returned to the Board of Directors. Any matter referred to the Board must be reported back to the HOD for final action. Further authority to make proposals and recommendations to the Board of Directors is vested in the House of Delegates; such proposals and recommendations may be referred by the Board of Directors to the appropriate body of the Council for study and consideration. The status of the recommendations will be reported at the next meeting of the House of Delegates.

An open hearing Conference Call is scheduled for April 22, 2010, where the proposed resolutions composed by each Chapter of the Council will be presented and debated. If you are interested in participating in this call, you are encouraged to do so on **April 22<sup>nd</sup> at 12 NOON 1-888-721-8686; CONFERENCE ID 6203081.**

Members interested in being becoming a future delegate for the City Society, please e-mail: [nycshp@gmail.com](mailto:nycshp@gmail.com), subject: Future NYC Delegate Interest.

For more information about the House of Delegates process, please visit: <http://nyschp.org/displaycommon.cfm?an=1&subarticlenbr=6>

## CALL FOR POSTER PRESENTATION

Have you always wanted to do a poster presentation but never got a chance?

Now you can have your poster presented at our Monthly CE meeting.

Please submit your poster to [nycshp@gmail.com](mailto:nycshp@gmail.com)

*(Continued from page 1)*

A Personal Mission statement provides an “End in Mind” aspect to your life, gives a greater sense of where you are going. It will help you focus your life around the important relationships and activities that you determine to be most critical to your personal and professional success. Personal Mission statements should describe your public life, private life, and deep inner life. It should say what you want To Have, To Do, To Be.

I hope this brief synopsis of the Leadership Development Conference ignites an internal flame that will get you motivated to self-assess and improve on your weaknesses but build and further enhance your strengths. Hopefully, by developing and applying our talents and strengths we will develop and apply our Professionalism.

Thank You,  
Joe



Northeastern



BRIGHAM AND  
WOMEN'S HOSPITAL  
A Teaching Affiliate of Harvard Medical School

## Assessment Tools

Resource	Website	Specifics
Myers and Briggs Foundation MBTI® Instrument for Life	<a href="http://www.myersbriggs.org">http://www.myersbriggs.org</a>	<ol style="list-style-type: none"> <li>1. Identifies 4 sets of preferences affecting the way people use their energy, gather information, make decisions, and organize their lives</li> <li>2. Sorts preferences within those 4 areas and categorizes individuals into one of 16 personality types</li> <li>3. Provides description of each personality type along with other information such as “type dynamics,” that describes the interaction between all preferences and “type development,” that describes how your preferences may change over the course of your life</li> </ol>
Keirsey™ Temperament Sorter®	<a href="http://www.advisorsteam.org/instruments">http://www.advisorsteam.org/instruments</a>	<ol style="list-style-type: none"> <li>1. Categorizes individuals into one of 4 temperament groups</li> <li>2. 4 temperament variants or “character types” within each group</li> <li>3. Identifies one of 16 personality types with description of each type</li> </ol>
StrengthsFinder 2.0	<a href="http://www.strengthsfinder.com">http://www.strengthsfinder.com</a>	<ol style="list-style-type: none"> <li>1. Provides in-depth analysis of talents or strengths</li> <li>2. Online assessment is available in combination with a book and online resources which references 34 themes of talents</li> <li>3. After completing online assessment, user is provided with a ranking and description of their top 5 natural talents along with a “Strengths Discover and Action-Planning Guide” which provides strategies for developing and applying individual strengths in professional and personal life</li> </ol>

## ADOPT -A- HIGHWAY.....COMING SOON!

*Be on the lookout for our NYCSHP Adopt-a-Highway sign on the Henry Hudson Parkway near Kappock St. by the end of May or early June!*

## Diagnosis of Diabetes: An Update

Prepared by Christopher Ho, Pharm.D.

In the 2009 update of the Standards of Medical Care in Diabetes guideline, the use of A1C for the purpose of diagnosing diabetes was not discussed. However, A1C assays have become increasingly standardized, which led to an international expert committee recommending and the American Diabetes Association (ADA) supporting the use of an A1C  $\geq$  6.5% (Table 1) as one of the diagnostic criteria for diabetes. Generally, standardized A1C assays are certified by the National Glycohemoglobin Standardization Program and are standardized or traceable to the Diabetes Control and Complications Trial. Currently, point-of-care A1C assays are not included as one of the standardized A1C assays. The use of A1C for diagnosis has its advantages over fasting plasma glucose which includes greater stability, less day-to-day variations, and no fasting requirements. Its disadvantages are cost, availability of test depending on the practice setting, and its variable correlation with average glucose in certain patients (i.e. patients with hemoglobinopathies or anemia). For these patients, the diagnosis of diabetes must be made using blood glucose values. In addition, laboratory values used in the diagnosis of diabetes should be repeated (to rule out laboratory error) unless the patient presents with symptoms of hyperglycemia or hyperglycemic crisis.

<b>Diagnostic Criteria for Diabetes</b>
A1C $\geq$ 6.5%
Fasting plasma glucose (FPG) $\geq$ 126mg/dL
Two-hour plasma glucose $\geq$ 200mg/dL during an oral glucose tolerance test (OGTT)
Random plasma glucose $\geq$ 200mg/dL in patients with classic symptoms of hyperglycemia or hyperglycemic crisis

**Table 1:** This table lists the four diagnostic criteria used to diagnose diabetes in the general public.

### Categories of increased risk for diabetes

In addition to the impaired blood glucose levels used to define “pre-diabetes” in the last revision of the guideline, an A1C of 5.7-6.4% (Table 2) is now recommended by the ADA to define a subpopulation with an increased risk of developing diabetes as well as cardiovascular events. The lower limit of the A1C should be chosen based on encompassing the least number of false positives and false negatives. Therefore, using data from the 2005-2006 National Health and Nutrition Examination Survey, the A1C of 5.7% was selected because it was associated with the best combination of sensitivity (39%) and specificity (91%) to identify cases of impaired fasting glucose. Patients with an increased risk of developing diabetes should be counseled on ways to minimize their risk or delay of both diabetes and cardiovascular events.

<b>Categories of Increased Risk for Diabetes</b>
FPG of 100-125mg/dL
Two-hour plasma glucose of 140-199mg/dL during an OGTT
A1C of 5.7-6.4%

**Table 2:** This table lists the 3 categories of patients at increased risk for diabetes.

### Primary and Secondary Prevention of Cardiovascular Events with Aspirin

A considerable update regarding the use of aspirin for the primary prevention of cardiovascular events was made in this revision. The past recommendations for the use of aspirin in patients over 40 years old or with additional risk factors were based on a few older trials that included small samples of diabetic patients. The use of aspirin has been shown to decrease cardiovascular morbidity and mortality in patients requiring secondary prevention, however, two recent randomized controlled trials have failed to show significant reductions in cardiovascular events for primary prevention in diabetes.<sup>1-2</sup> The controversy continued as the Anti-Thrombotic Trialist' Collaboration published data from a large meta-

.-Continued on Page 6

-Continued from Page 5

analysis showing that aspirin reduced the risk of vascular events by 12% with the majority of the risk reduction in non-fatal myocardial infarctions.<sup>3</sup> No significant risk reductions were observed in coronary heart disease death or total stroke.

The U.S. Preventive Service Task Force updated its recommendations to encourage the use of aspirin in men 45-79 years of age and women 55-79 years of age. The use of aspirin in younger adults was not recommended by the Task Force. In light of the new pieces of evidence, this revision of the guideline recommends low dose aspirin for primary prevention in patients with diabetes and no history of vascular disease who have an increased 10-year cardiovascular disease (CVD) risk of >10%. This recommendation includes men >50 years of age and women >60 years of age with at least one of the following risk factors: smoking, hypertension, dyslipidemia, family history of premature CVD, and albuminuria. In this revision of the guideline, the recommendation against the use of aspirin in patients <30 years of age has been removed.

#### References

1. Ogawa H, Nakayama M, Morimoto T, Uemura S, Kanauchi M, Doi N et al. Low-dose aspirin for primary prevention of atherosclerotic events in patients with type 2 diabetes: a randomized controlled trial. *JAMA*. 2008; 300:2134-2141.
2. Belch J, MacCuish A, Campbell I, Cobbe S, Taylor R, Prescott R, et al. The prevention of progression of arterial disease and diabetes (POPADAD) trial: trial of aspirin and antioxidants in patients with diabetes and asymptomatic peripheral arterial disease. *BMJ*. 2008; 337:a1840.
3. Antithrombotic Trials' (ATT) Collaboration, Baigent C, Blackwell L, Collins R, Emberson J, Godwin J, et al. Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomized trials. *Lancet*. 2009; 373:1849-1860.

## Photo Gallery



### Holiday Celebration 2009!



## OVERVIEW AND ASSOCIATED TREATMENT OF GOUT

Kevin Sullivan, Pharm.D.

Gout describes a disease spectrum which includes hyperuricemia, recurrent attacks of acute arthritis caused by monosodium urate deposits within joints and tissues (tophi), uric acid nephrolithiasis, and interstitial renal disease. Estimates of the prevalence of gout in the United States range from 3 million to 5 million individuals, with epidemiological data showing an increase in gout among men over the age of 75. The prevalence of gout increases with the excessive intake of beer and spirits, and high consumption of meat, seafood and fructose.

The first attack of acute gouty arthritis usually occurs after years of asymptomatic hyperuricemia and typically includes severe pain, redness, and swelling of the affected joint(s). More than 80 percent of initial attacks involve a single joint, often at the base of the great toe or the knee. The earliest gout attacks usually resolve in 3-14 days, even if left untreated. Subsequent attacks often last longer, affect several joints, and spread to the arms and hands.

The identification of urate crystals in synovial fluid or tophus aspirates is necessary for a definitive diagnosis of gout. A detailed medication history should be obtained in patients who present with symptoms of gout, as many medications may raise serum uric acid concentrations; such as diuretics, tacrolimus, cyclosporine, ethambutol, pyrazinamide, low dose salicylates, levodopa, ribavirin, interferon and teriparatide.

Treatment of acute gout attacks consists of rest, application of ice to the affected joint, colchicine or non-steroidal anti-inflammatory drugs (NSAIDs) or both. Indomethacin is considered the NSAID of choice for treating acute gout attacks; however other NSAIDs such as naproxen or ibuprofen are effective in relieving the inflammation of acute gout.

Traditionally, colchicine was dosed as 1.2 mg initially, followed by 0.6 mg every 2 hours until joint symptoms subsided or abdominal discomfort or diarrhea developed. Colchicine had been used for many years without FDA approval. (In July 2009, the FDA approved Colcrys, a single ingredient colchicine product.) The FDA now recommends that 1.2 mg of colchicine followed by 0.6mg every 1 hour be used for the treatment of acute gout flares. Colchicine exerts its effect by decreasing leukocyte motility, decreasing phagocytosis in joints and lactic acid production, thereby reducing the deposition of urate crystals that perpetuate the inflammatory response. Intraarticular or oral glucocorticoids can be used in patients intolerant to NSAIDs or colchicine; however rebound attacks are relatively common when oral glucocorticoids are withdrawn.

For patients who experience recurrent gout attacks, chronic arthropathy, tophi, or gout with uric acid stones, urate-lowering therapy is indicated. Urate lowering therapy should be started 1-2 weeks after an acute attack due to the risk of precipitating another attack if started earlier. Prevention of acute flares during the initiation of urate lowering therapy may be achieved with daily low dose colchicine or NSAIDs. Treatment with urate-lowering agents should be continued indefinitely, as patients who stop treatment will experience recurrent symptoms and tophi. Allopurinol, a xanthine oxidase inhibitor, is considered first line therapy for lowering uric acid. Allopurinol, along with the newest xanthine oxidase inhibitor febuxostat, decreases urate synthesis. Febuxostat was recently approved and has similar efficacy to allopurinol; unlike allopurinol, febuxostat does not require dosage adjustment in patients with mild to moderate renal impairment. Febuxostat should be initiated at 40mg daily. Common side effects include liver function abnormalities, nausea, arthralgia and rash.

Probenecid is the only uricosuric agent available in the United States and is used as second line therapy in patients with an underexcretion of uric acid. Probenecid promotes renal clearance of uric acid by inhibiting the urate-anion exchanger in the proximal tubule.

Patient education is an important aspect of managing gout. Limiting alcohol, red meat, and seafood and achieving ideal body weight are effective ways to reduce the symptoms and severity of gout attacks. Management of other disease states such as diabetes, hypertension and hyperlipidemia may have positive outcomes on the management of gout.

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- 4.New safety information for colchicine and the approval of Colcrys. *Pharmacist's Letter/Prescriber's Letter* 2009;25(9):250902



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