

SUTURES

Cedars-Sinai Medical Center
Department of Surgery
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In This Issue:

- IMPORTANT REMINDER TO PHYSICIANS TO NOTE BOTH DATE AND TIME ON PHYSICIAN ORDERS
- NEWS FROM THE OR
 - UPDATE ON THE PACS
 - ALREADY USING PACS?
 - UPGRADING THE ENDOSCOPIC IMAGING SYSTEMS IN THE OR
- PHARMACY UPDATES
 - METHADONE RISK ASSESSMENT: QTC PROLONGATION AND POTENTIALLY PROARRHYTHMIC
 - PROTON PUMP INHIBITORS (PPIS) IN THE NEWS
- CLINICAL TRIALS ANNOUNCEMENT
- CITIZENSHIP AND BEYOND



IMPORTANT REMINDER TO PHYSICIANS TO NOTE BOTH DATE AND TIME ON PHYSICIAN ORDERS

While Cedars-Sinai medical staff continues to improve its compliance with federal regulations regarding dating and timing of physician orders, it is important to remember that all entries must be signed, **dated AND timed**.

A recent sample of records at the medical center demonstrate that while nearly 100% of the entries reviewed were properly signed, 93% were dated and only 85% of them were timed.

Physicians are reminded that we must submit our compliance results to The Joint Commission in early July. We must meet at least 90% compliance to continue to be a fully accredited hospital. We are hoping to significantly improve our compliance percentage over the next two weeks so we can meet our required compliance level with room to spare. Thank you for doing your part to make this happen.

(approved by Linda Burnes Bolton)



NEWS FROM THE OR

Update on PACS in the OR

Beginning Monday, August 3rd, the 7th floor surgical suites 1, 2, 3 and 4 will be filmless, with PACS images available via Web/Vs. For Orthopedic Surgeons, film will continue to be provided for templating. Back-up CDs will be available for all others. Laminated instruction cards will be positioned on the wall next to the workstation.

For advance viewing of outside CDs, as well as viewing PACS images, a portable OR-compatible workstation is positioned in the 7th floor doctor's lounge.

If you have any questions/comments, please contact George Depaolis, Manager of Imaging Information and Logistics at 423-2709 or depaolis@cshs.org.

Already Using PACS To View Images In The OR?

As the fiscal year comes to an end, we would like to get some feedback on the functionality and ease-of-use for getting radiology images via the PACS system. Thank you for taking the time to complete this short zoomerang survey - your feedback is important to us.

<http://www.zoomerang.com/Survey/?p=WEB229BHHQAPCC>

Upgrading the Endoscopic Imaging Systems in the OR:

We will be upgrading the Endoscopic Imaging Systems as part of our ongoing improvements in the Operating Room. Starting in July the OR will be replacing the Storz Endoscopic Tri-Cam Video Towers (analog technology) with Storz High Definition Endoscopic Video Towers in 6 OR, 7 OR and 8 OR. The 3rd floor OR will have the Olympus High Definition Video Towers installed. These systems, with larger viewing displays and the highest possible resolution, will provide improved image quality for your laparoscopic procedures.

We still will have several Storz OR - 1 Digital Video Towers in use to cover the increased demand for Endoscopic Imaging. These systems will be primarily used in 7OR Cysto and they will also be available in other areas of the OR.

5th floor OR will have a combination of both Storz High Definition and Digital OR -1 Systems.

The current digital Arthroscopy Video Towers in 7 OR and 310 Bldg. will be evaluated as part of our continuing OR improvement project.

If you have any questions, please feel free to contact Gary Nobiensky, OR Clinical Equipment Coordinator (Gary.Nobiensky@cshs.org)



PHARMACY UPDATES:

Methadone Risk Assessment: Qtc Prolongation And Potentially Proarrhythmic

Methadone currently carries a boxed warning regarding QTc prolongation and its potential to be proarrhythmic:

A government-sponsored expert panel (sponsored by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services) recently published recommendations regarding monitoring QTc in patients receiving methadone.

The recommendations include:

- Physician should inform patients of the risk of arrhythmia when prescribing methadone

- Physicians should obtain the patient's history to discern predisposing risk factors
- Obtaining pre-(methadone) treatment QTc and follow-up ECG within 30 days and annually; additional ECG monitoring if dose >100 mg/day or symptoms present
- Risk vs benefit analysis, more frequent monitoring if QTc > 450 msec < 500 msec; considering discontinuing (or decreasing) methadone if QTc >500 msec
- Screening for drug-drug interactions

<http://www.annals.org/cgi/reprint/0000605-200903170-00103v1.pdf>

To assure proper risk assessment and follow-up for patients receiving methadone, the following is being implemented in the Medical Center:

- Inpatients: ECG monitoring for QTc evaluation protocol (if not ordered by MD, Pharmacist will order under CSMC P&T approved protocol). Baseline/pre-(methadone) treatment and follow-up ECG in patients prescribed > 100 mg/day methadone as follows:
 - Weekly during hospitalization
 - Additional ECG following dosage increases or
 - A 'Dear Doctor' letter will be placed in the patient's chart
- Outpatients: Order will not be dispensed unless:
 - EKG is checked once during the 1st 30 days of therapy and annually while patient remains on methadone
 - Additional ECG following dose increases above 100 mg/day
- Physicians must obtain patient history to discern predisposing risk factors
- Physicians to consider checking ECG if patient develops cardiac symptoms
- Physician to evaluate risk vs benefit analysis and consider more frequent monitoring if QTc > 450 msec < 500 msec; considering d/c (or decreasing) methadone if QTc >500 msec
- Physician to screen for drug-drug interactions

Proton Pump Inhibitors (PPIs) in the News

1. PPI-clopidogrel (Plavix®) interaction An early communication from the FDA in 1/09 warned of potential decreased clopidogrel effectiveness when administered with PPIs. This month, the Society for Cardiovascular Angiography and Interventions (SCAI) issued a statement (http://www.scai.org/drlt1.aspx?PAGE_ID=5870) based on the results of the Clopidogrel Medco Outcomes Study, which showed a 50% increased combined risk of hospitalization for heart attack, stroke, unstable angina, or repeat revascularization when patients were on clopidogrel and a PPI concurrently. The recommendation included consideration to use an H2 blocker or antacid instead of a PPI when appropriate in patients receiving clopidogrel. Further, a review article (attached) will be published in the Annals of Pharmacotherapy July/August 2009 issue which reinforces the theory that a clinically significant drug-drug interaction occurs between clopidogrel and the PPIs (possibly some more than others)

2. Two articles last month (May 2009) highlighted more potential adverse outcomes associated with over-utilization of PPIs:

- An American Journal of Gastroenterology article (**attached**) concluded that PPI use was associated with higher risk of development of subacute bacterial peritonitis in patients with advanced cirrhosis
- A JAMA article (**attached**) found a 30% increased risk of developing hospital-acquired pneumonia in patients receiving PPIs (but not H2 blocker therapy) as inpatients

At CSMC, a Dear Doctor letter will be placed in the charts of patients who are receiving clopidogrel concurrently with esomeprazole (the CSMC formulary PPI). The letter will inform the MD of the potential consequences of the drug-drug interaction and recommend consideration of switch from PPI

to an H2-receptor antagonist, unless patient has an acute GI bleed or GERD or has a platelet count <50,000/ μ L. The following substitutions are recommended:

Patient not tolerating enterals: esomeprazole 40 mg IV to ranitidine 50 mg IV Q8H

If Clcr < 50 ml/min: ranitidine 50 mg IV Q24H

Patient tolerating enterals: esomeprazole 40 mg IV/enteral to ranitidine 150 mg PO/NGT/G-tube BID

If Clcr < 50 ml/min: ranitidine 150 mg PO/NGT/G-tube BID



CLINICAL TRIALS ANNOUNCEMENT

Please note that the following 2 new clinical trials are currently active and enrolling surgical patients:

1. A prospective, multicenter, double-blind, randomized, comparative study to estimate the safety, tolerability and efficacy of NXL104/ceftazidime plus metronidazole vs. meropenem in the treatment of complicated intra-abdominal infections (cIAI) in hospitalized adults

PI: Shirin Towfigh, MD

IRB# **Pro00017778**

We will be screening for adult patients with GI tract perforations (of appendix, intestine, ulcer, gallbladder) or post-operative intra-abdominal abscesses who will require at least 5 days of intravenous antibiotics.

2. A randomized, open-label, efficacy and safety study of Octaplex and FFP in patients under vitamin K antagonist therapy with the need for urgent surgery or invasive procedures.

PI: Shirin Towfigh, MD

IRB# **Pro00017884**

We will be screening for adult patients on warfarin therapy with INR>2.0 who will be undergoing surgery or an invasive procedure (e.g., central line placement) and will require reversal of the warfarin with FFP.

If you would like to submit your patient for enrollment, please call Dr. Towfigh (310-709-9343) or Study Coordinatory Laura Sarmiento (310-849-4356).

For more information, please contact Dr. Towfigh (shirin.towfigh@cshs.org)



CITIZENSHIP AND BEYOND

Presentations

An oral presentation was given at the APSA 40th Annual Meeting in Puerto Rico by Philip K. Frykman titled "A Mouse Model of Post-Pullthrough Hirschsprung Associated Enterocolitis". The authors on the presentation were: Philip K. Frykman, Zhi Cheng, Lifu Zhao, Deepti Dhall.



Items for submission to Sutures may be sent to Meg Jenkins at jenkinsml@cshs.org

The next SUTURES will be Tuesday, June 23, 2009.