The Pharmacist Activist

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Editorial

JANUARY 1, 2010

Make This Date the Goal to GET CIGARETTES OUT of All Pharmacies!

If 440,000 Americans were to die this year from a cause or catastrophe that was *preventable*, we would be outraged! We would demand accountability and action from our government and any others who were in a position to prevent such a terrible situation. However, when the cause of all these deaths is identified as tobacco, the response, or more accurately the lack thereof, is very different. Many are somehow able to rationalize that this situation is acceptable because a decision to smoke is personal and voluntary, and the consequences of illness and death are self-inflicted. Some are able to rationalize even further by considering it acceptable to profit from the sale of a product that has a high probability of causing harm to the purchaser. However, although some individuals wish to continue to smoke, most smokers want to stop but have been unsuccessful in doing so. They need assistance and support in liberating themselves from their addiction to nicotine. As individuals and as a society, we have a responsibility to help.

Tobacco use is the leading preventable cause of disease and premature death in the United States. More than 440,000 Americans die each year from cancers and other smoking-related illnesses. I was interested in another perspective on the toll that smoking takes that was published in the *Philadelphia Inquirer* on November 12, 2001. Soon after the tragedies of September 11, 2001, there was additional concern because of four deaths attributed to exposure to anthrax that had been sent through the mails. The newspaper commentary provided a comparison of the number of deaths from various causes during the previous five weeks and some of these are noted below:

Cause of death	Number of deaths
Anthrax	4
Airplane crashes	9
Medication errors	673
AIDS	1,412
Murders	1,618
Alcohol-induced	1,835
Auto accidents	4,080
Smoking-related	38,462

Why does our society that is so often preoccupied with the problems of health care, its cost, and insurance coverage tolerate this situation? As members of a health care profession and as individual pharmacists, what responsibilities do we have in addressing this issue?

The good news

There is some good news with respect to pharmacists and our profession assuming expanded responsibilities in addressing smoking-related issues, as well as the sale of cigarettes in pharmacies, and examples are noted below:

- A large number of pharmacists have developed, or are otherwise participating in, smoking cessation programs that have helped many individuals stop smoking;
- A large majority of independent community pharmacies do not sell cigarettes;

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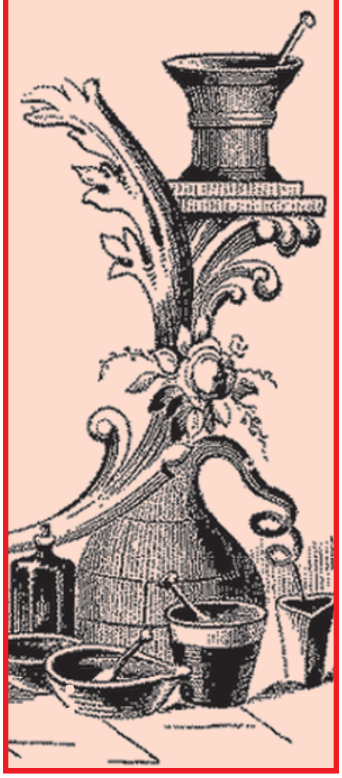

- Target stores do not sell cigarettes;
- Wegmans, a chain of 71 grocery stores with pharmacies in the mid-Atlantic area, discontinued the sale of cigarettes earlier this year;
- The city of San Francisco banned the sale of cigarettes in pharmacies, effective October 1, 2008, although pharmacies located inside of "big box" (e.g., Wal-Mart) or grocery stores are exempt. The mayor of San Francisco is on record as saying, "Pharmacies should be places where people go to get better, not where people go to get cancer." It is noteworthy that the mayor and board of supervisors of San Francisco have a more positive image of pharmacies than the cigarette-selling pharmacies apparently have of themselves. I consider it very unfortunate that the pharmacies selling cigarettes would not make their own decisions to discontinue their sale, rather than having a ban on their sale promulgated by the city. In response to the ban on cigarette sales in pharmacies, Walgreens and Philip Morris each sought a preliminary injunction/restraining order to block its implementation. Judges denied both of these requests but Walgreens has announced it will appeal the judge's decision. Regardless of the outcome of the appeal, San Francisco's action is the "tipping point" that will increase the commitment and momentum to get cigarettes out of all pharmacies;
- The city of Boston is also considering a ban on cigarette sales in pharmacies (without exemptions for pharmacies in grocery stores, etc.). The executive director of the Boston Public Health Commission is on record as saying, "Why, in a place where people go to get healthy and get information about staying healthy, would you want to sell something that has absolutely no redeeming value and ends up killing a lot of people?"

The bad news

- Even more risks of smoking continue to be identified. The latest is an increased risk of abdominal aortic aneurysm in smokers. The results of a recent study indicate that women who smoke have heart attacks nearly 14 years earlier than women who don't smoke;
- Some tobacco companies have been quietly increasing the nicotine content of cigarettes, thereby increasing the likelihood of addiction and the difficulty of quitting;
- Most chain pharmacies continue to sell cigarettes;
- Some chain pharmacies are not only selling cigarettes, but are also promoting their sale.

A course of action

I have heard all the reasons that some have used in an attempt to defend the continued sale of cigarettes in their pharmacies. At best, these reasons have serious flaws and, at worst, they are poor excuses to disguise an obsession to make more money. The sale of cigarettes in pharmacies is a contradiction to the responsibilities, services, and message that pharmacists provide in the promotion of better health care. A course of action is needed and the following components are among those that should be included:

1. A date should be established as a goal by which cigarettes will no longer be sold in any pharmacies or any facility that includes a pharmacy (e.g., grocery stores, mass merchandisers, "big-box" stores). Let's establish January 1, 2010 as the goal.
2. Many more pharmacists are needed to be active in this effort at both the local and national level. At this time, only a small number of pharmacists have been active in these efforts beyond the local level including Karen Hudmon of Purdue University, Robin Corelli, Lisa Kroon, and Mary Anne Koda-Kimble of the University of California at San Francisco, and Fred Mayer of the Pharmacy Council on Tobacco Dependence. We need hundreds more! We will hold a planning/strategy meeting at the annual meeting of the American Pharmacists Association in San Antonio in April. Please let me know if you wish to participate.
3. We need to meet with the highest-level executives of the chain pharmacies that sell cigarettes. In the many discussions I have had with pharmacists who work in these pharmacies, I often receive the response that they agree with me but only the CEO of the company has the authority to make the decision to discontinue the sale of cigarettes. Over the last several months I have tried to schedule meetings with the CEOs of CVS, Rite-Aid, Walgreens, and Wal-Mart for the purpose of discussing reasons for which I think it is in their company's best interest to stop selling cigarettes. So far, I have met with the chief operating officer and vice-president of one of these companies and a vice-president and regional manager of another company, but not yet with any of the CEOs. However, I am determined to do so and will provide a report on my communications and meetings with individuals in these companies in a future issue of *The Pharmacist Activist*.
4. Pharmacists and pharmacy students who work in pharmacies that sell cigarettes should urge the owner/manager/executive to discontinue their sale.
5. Colleges of pharmacy should not use pharmacies that sell tobacco products as experience sites to send students.
6. Colleges of pharmacy and pharmacy organizations should encourage pharmacy students and pharmacists who are seeking employment in a community pharmacy to first consider pharmacies that do not sell tobacco products.
7. Pharmacists should actively support initiatives such as the ones in San Francisco and Boston that would ban the sale of cigarettes in pharmacies. However, pharmacies should make these decisions voluntarily so that such bans would not be necessary.

It is my belief that January 1, 2010 is an attainable goal for getting cigarettes out of all pharmacies, and that we can avoid the need to consider additional strategies.

Daniel A. Hussar

WARNING: The content of this editorial may disturb the conscience of the owners of pharmacies that sell cigarettes.

New Drug Review

Difluprednate
(Durezol – Sirion)
Ophthalmic Corticosteroid

New Drug Comparison Rating (NDCR) = 4
(significant advantages) in a scale of 1 to 5, with 5 being the highest rating

Indication:

For ophthalmic use for the treatment of inflammation and pain associated with ocular surgery.

Comparable drugs:

Ophthalmic corticosteroids used in conjunction with ocular surgery; loteprednol etabonate (Lotemax), rimexolone (Vexol).

Advantages:

- First ophthalmic corticosteroid to be demonstrated to be effective in the treatment of pain associated with ocular surgery (other agents are indicated only for the treatment of inflammation);
- Emulsion formulation may provide more uniform drug delivery and enhance intraocular penetration (loteprednol and rimexolone are supplied in ophthalmic suspension formulations).

Disadvantages:

- Has not been directly compared in clinical studies with other ophthalmic corticosteroids in patients having ocular surgery;
- Labeled indications are more limited (loteprednol and rimexolone are also indicated for ophthalmic inflammatory conditions not associated with surgery, and loteprednol is also indicated [in a lower-potency formulation (Alrex)] for seasonal allergic conjunctivitis).

Most important risks/adverse events:

Contraindicated in patients with viral diseases of the cornea and conjunctiva such as epithelial herpes simplex keratitis, vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures [fungal invasion should be considered in patients who experience persistent corneal ulceration]); increased risk of secondary ocular infections; increased intraocular pressure (IOP) that could result in glaucoma with damage to the optic nerve, and defects in visual acuity and fields of vision (IOP should be monitored if used for 10 days or longer); posterior subcapsular cataract formation; may delay healing.

Most common adverse events *(each at an incidence of 5%-15%)*:

Corneal edema, ciliary and conjunctival hyperemia, eye pain, photophobia, posterior capsule opacification, anterior chamber cells, anterior chamber flare, conjunctival edema, blepharitis.

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Great American Smokeout

is on

Thursday, November 20, 2008

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New Drug Review (cont.)

Usual dosage:

One drop into the conjunctival sac of the affected eye(s) four times daily beginning 24 hours after surgery and continuing throughout the first two weeks of the postoperative period, followed by two times daily for a week and then a taper based on the response.

Product:

Ophthalmic emulsion - 0.05%.

Comments:

Ophthalmic surgeries (e.g., cataract surgery) frequently result in postoperative inflammation which, if left untreated, may interfere with a patient's visual rehabilitation and result in complications. Ophthalmic formulations of corticosteroids and nonsteroidal anti-inflammatory drugs (NSAIDs; e.g., nepafenac [Nevanac]) are frequently used in the treatment of inflammation following eye surgery. Difluprednate is the ninth corticosteroid on the market in ophthalmic formulations for the treatment of ocular inflammatory conditions. Loteprednol and rimexolone are the only other corticosteroids indicated for use in conjunction with ocular surgery; these agents are indicated for inflammation associated with ocular surgery whereas difluprednate is the first ophthalmic corticosteroid to also be demonstrated to be effective for the treatment of postoperative pain. The effectiveness of difluprednate has been demonstrated in two placebo (vehicle)-controlled studies in which relief of pain was reported 15 days following surgery in 63% of patients treated with the new drug, compared with 35% of those receiving placebo.

The emulsion formulation of difluprednate was developed to provide uniform drug delivery and enhance intraocular penetration compared to an ophthalmic suspension of the drug. However, the new drug has not been directly compared with the suspension formulations of loteprednol and rimexolone. The emulsion does not have to be shaken prior to administration. It may be stored at room temperature but should be protected from light. When not in use, the bottle should be kept in the protective carton.

Daniel A. Hussar