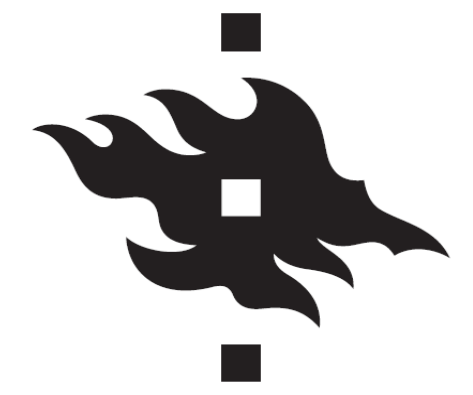


MEDICATION RECONCILIATION AND MEDICATION REVIEW IN THE UROLOGIC ONCOLOGY OUTPATIENT CLINIC

Abstract number NP-002

Kähkönen Asta¹ (M.Sc.Pharm.), Schepel Lotta¹ (Ph.D.), Tolonen Hanna¹ (M.Sc.Pharm.), Utraiainen Meri² (MD), Utraiainen Tapio² (MD), Airaksinen Marja³ (Prof., Ph.D.)

1. HUS Pharmacy; 2. HUS Comprehensive Cancer Center; 3. University of Helsinki, Faculty of Pharmacy



HELSINGIN YLIOPISTO
HELSINGFORS UNIVERSITET
UNIVERSITY OF HELSINKI
FARMASIAN TIEDEKUNTA
FARMACEUTISKA FAKULTETEN
FACULTY OF PHARMACY

Background

Internationally, clinical pharmacy services in oncology are usually patient oriented and often include medication reconciliations and reviews¹. There was a need to find out if clinical pharmacist can improve medication safety in the division of the solid tumors of Helsinki University Hospital Comprehensive Cancer Center, which was earlier identified in the emergency department of the Helsinki University Hospital².

The aim of this study was to find out the accuracy of the medication charts and identify drug related problems (DRPs) among over 65-year-old patients using 6 or more medicines in the urologic oncology outpatient clinic.

Materials and methods

When patient was arrived to the urologic oncology outpatient clinic, accuracy of the medication charts was assessed by pharmacist-led medication reconciliation including patient interview². Information concerning patient's medication was also searched from the national electronic prescription centre and from the records of previous hospital visits. DRPs, such as drug-drug interactions, adverse drug reactions and overlapping medications, were identified with the pharmacist-led medication review². Pharmacist discussed about clinical relevance of DRPs with the oncology specialist.

Results

Altogether 100 patients with urologic cancer were included in this study. On average, they were 73 years old and used 12 medications (Fig.1). Only two patients had a correct medication chart. On average, there were 6 discrepancies per patient in the hospital medication chart. In the medication review process, 139 DRPs were identified with 70 patients (2 per patient, Fig.2). Of these DRPs, 70% were regarded clinically relevant and lead to actions by the oncology specialist. Reconsidering the need or efficacy of the medication (39%) or medication adjustment due to renal insufficiency (17%) were most commonly identified with medication reviews. DRPs were usually related to non-oncology medications such as pantoprazole (n=19), the combination of calcium and vitamin-D (n=9) and codeine (n=7).

Conclusions

Medication reconciliation process needs improvement in the urologic oncology outpatient clinic. Interprofessional medication review can be used to detect and resolve DRPs of older patients with urologic cancer. The results of this study can be exploited when clinical pharmacy services will be created and developed in Helsinki University Hospital Comprehensive Cancer Center.

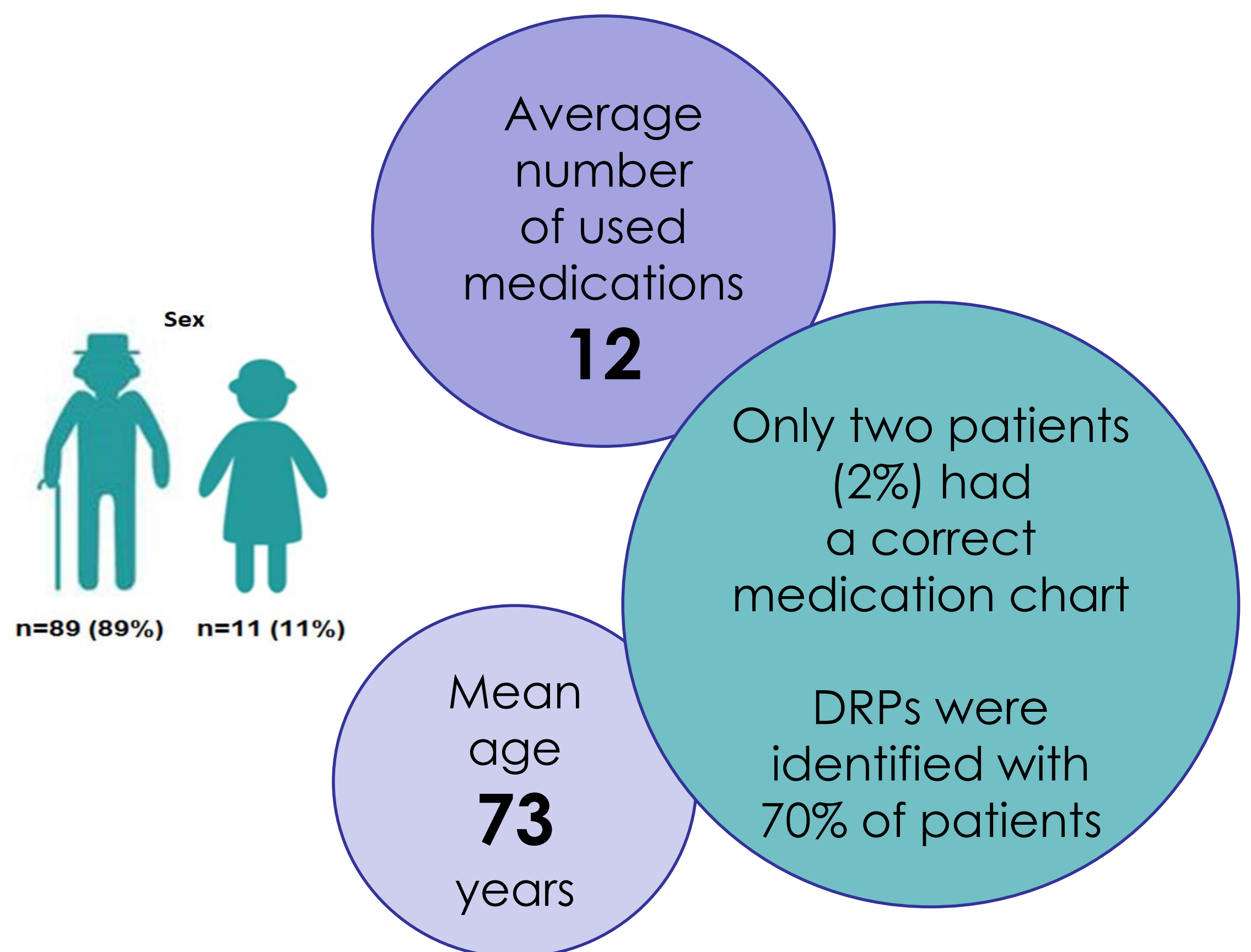


Fig.1 Patient characteristics (n=100) and main results of the study.

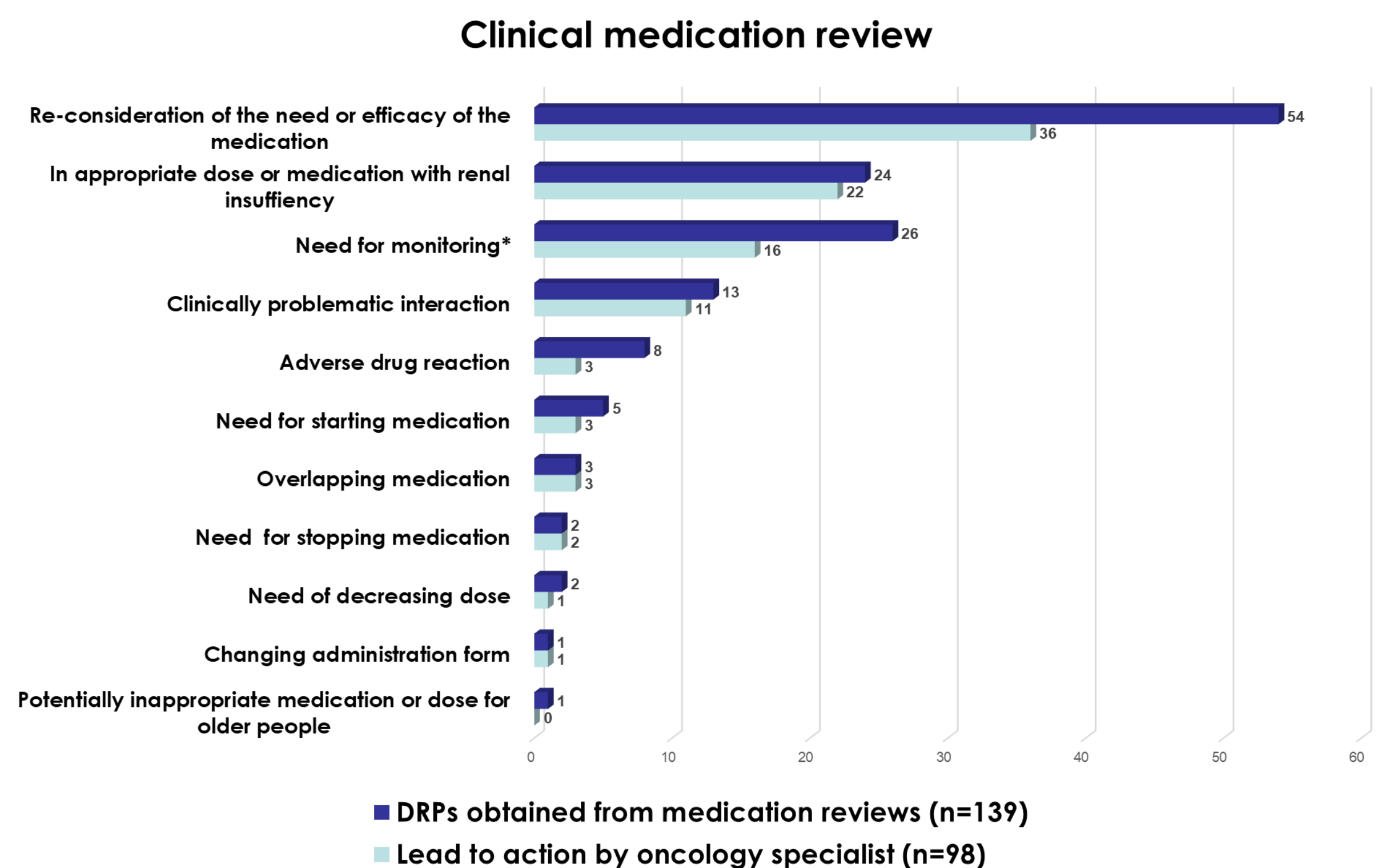


Fig.2 Drug related problems (DRPs) (n=139) obtained from medication reviews (n=100) in urologic oncology outpatient clinic and DRPs (n=98) that lead to action by oncology specialist. *Monitoring: checking laboratory results (n=18), therapeutic drug monitoring (n=7) and orthostatic measurement (n=1).



References

1. Leveque D, Delpeuch A, Gourieux B. New Anticancer Agents: Role of Clinical Pharmacy Services. *Anticancer Research* 34: 1573-1578, 2014
2. Schepel L, Lehtonen L, Airaksinen M, Ojala R, Ahonen J, Lapatto-Reiniluoto O. Medication reconciliation and review for older emergency patients requires improvement in Finland. *International Journal of Risk & Safety in Medicine* 30:1 19-31, 2019