COMMENTARY

Rural Pharmacists in Cardiac Disease Prevention

Zakwani Rajiah*

Department of Medicine, Cyril and Methodius University, Skopje, Bulgaria

Correspondence:

Zakwani Rajiah, Department of Medicine, Cyril and Methodius University, Skopje, Bulgaria, E-mail: Zakwani@st.cyril.bg

DESCRIPTION

Earlier, interactions between patients, pharmacists, and doctors were close enough that meaningful discussion might lead to effective solutions quickly. Over the last four decades, scientific progress has resulted in higher survival rates and lower morbidity rates for a variety of chronic conditions. In the 1970s, a sulfonylurea, digoxin, warfarin, and diuretics have been prescribed for the patients with diabetes, chronic systolic heart failure, and atrial fibrillation. The patient taking two or more anti-diabetic medications for diabetes, and statins, angiotensin-converting enzyme inhibitor/angiotensin receptor blocker/angiotensin receptor-neprilysin inhibitor, beta-blocker, spironolactone, diuretics, aspirin plus a new oral anticoagulant or warfarin, and possibly digoxin for the heart complications. Although studies show that polypharmacy is beneficial for high-risk patients, it also increases the risk of medication interactions, patient non-adherence, and treatment ambiguity.

During the standard treatment, the pharmacist intervention reduced cardiovascular risk score, LDL-C, HbA1c, systolic and diastolic blood pressures, and smoking. The strategy was rather straightforward: pharmacists interacted with treating physicians while advancing drugs and changing diets as needed. They did, in fact, show an improvement in these surrogate outcomes. With monthly pharmacy visits, this can be done in a relatively short amount of time.

That improved management is possible with appropriate case discovery and strict adherence to goals should serve as a remember waking call. Whether such management must be provided by physicians, pharmacists, nurses, or other facilitators which is less important than the observation that we can acquire and find patients who may benefit from additional management and that better results can be obtained quickly. The cost of medical therapy for hypertensive individuals with diabetes is significant, particularly for those with renal impairment. Removing financial incentives for adherence has not been shown to enhance outcomes for patients with a myocardial infarction.

Even among patients with heart failure who require implanted defibrillators, adherence to recommendations is inadequate. Noncompliance with guideline-directed therapy has been associated to increased morbidity and death. The R_x each study results revealed that there is opportunity for improvement in medical treatment in the trial group, which is not surprising considering how many patients do not currently meet guideline objectives for lipids, blood pressure, smoking cessation, or glycaemic control. The findings of this study should prompt more study into the potential public health advantages of long-term studies, if only for the financial benefits to the community.

Although there is no reason to expect that collaborative efforts will not last, longer studies will be necessary to define cost and risk, as well as analyse follow-up. Other limitations of this trial included no record of treatment prior to study participation, and Body Mass Index (BMI) was not tracked. Furthermore, no information about possible treatment errors is provided. To accomplish such quick glycaemic reductions, one must risk hypoglycaemia; for hypertension treatment, one must risk hypotension. Another critical problem to consider when extending this system is that there does not appear to be a uniform mechanism for feeding back information accessible to the physician to the pharmacist. The inability to determine who is accountable for spreading the information and how patient privacy will be safeguarded during such contacts may provide significant practical challenges.

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