CORRESPONDENCE

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Absolute levels of risk are needed to make decisions

Renal adverse effects of proton pump inhibitors (PPIs) were described in your research briefing 'Proton pump inhibitors linked with chronic kidney disease' (*Clinical Pharmacist* 2015;7:217). Simply telling us that there was a 10% or 50% increase among trial participants gives readers no useable information. We need to know how many events we expect, say, in 1,000 patients, so that we can see the absolute risk and how it is changed by the drugs. If there were normally two events and three events in patients taking PPIs that is a 50% increase, but only one patient in 1,000 will be adversely affected. If we know that we can make an informed decision and help patients to do the same.

We need to be able to work out the absolute levels of risk in the study population, with and without the drug in question.

Brian Curwain
Christchurch, Dorset

Dosing of drugs that treat *Helicobacter pylori* infection

I read with interest comments to my learning article 'Drug therapies for *Helicobacter pylori* infections' (*Clinical Pharmacist* 2015;7:220). Regarding clarithromycin and metronidazole dosing, in other countries successful therapy has been obtained with 200mg, 250mg, 400mg and 500mg dosing of clarithromycin twice a day or 1,000mg sustained release clarithromycin once daily. Head-to-head trials are lacking. For metronidazole, 200mg, 250mg, 400mg, 500mg, and 800mg doses twice a day have been use and, again, head-to-head comparisons are lacking. However, clarithromycin resistance cannot be overcome by increasing the dose or duration, whereas metronidazole resistance can be partially overcome by giving 1,500mg or 1,600mg daily and extending the duration.

Clearly, the National Institute for Health and Care Excellence (NICE) recommendations are out of date for triple therapy with clarithromycin, metronidazole or levofloxacin, unless low cure rates are acceptable to them. Testing for cure is needed because current therapies (especially those recommended by NICE) frequently fail and testing provides doctors with knowledge of failure for that patient and the likelihood of increased resistance in their area. Poor compliance is an issue with all these therapies and generally can be reduced by patient education.

I am always amused by comments about shorter therapies and better compliance. One must do what it takes. Anti-tuberculosis therapy would be better tolerated if given for a week instead of for months but the goal is to cure the infection. Fundamentally, *Helicobacter* infection is the cause of gastric cancer.

David Graham, professor of medicine, molecular virology and microbiology, Baylor College of Medicine, Houston, Texas, United States

Reducing hospital admissions of frail elderly patients

The proactive care service in Coastal West Sussex (CWS), which was shortlisted for the HSJ Awards in 2015, provides medicines optimisation for frail elderly patients, reduces the risk of hospital admissions and made estimated savings of more than £600,000 in one year.

It is run by a team of senior clinical pharmacists who visit elderly patients with complex co-morbidities in their place of residence to do medication reviews.

The clinical pharmacists are supported by a principal clinical pharmacist and all are part of the medicines management team at Sussex Community Trust. This structure provides support, leadership and coordination across the service.

The pharmacists are embedded in 13 proactive care teams of co-located health and social care professionals working closely with GPs. This facilitates liaison with other professionals to meet patients' broader health and social care needs, for example, requesting review of a care package to prompt medicines administration.

The clinical pharmacy service was rolled out across the West Sussex region from April 2014. During the first year, the pharmacists made 1,178 medication reviews, of which 1,125 (96%) resulted in a reduced risk of harm from medications.

The overall impact of each review on the risk of harm from medicines is assessed. In this first year, 236 medication reviews had an impact score of 3 or 4 – considered to have contributed to reduced risk of hospital admission. This equates to a potential saving of £590,000. In addition, £49,560 was saved by pharmacist recommendations that led to deprescribing.

Additionally, the pharmacists contributed to individualised contingency plans that highlight predictable risks for hospital admission, advice for prevention, deterioration and response. Information added by the pharmacists may include risk factors for acute kidney injury, how to avoid dehydration, which medicines to withhold if acutely unwell, and when to seek medical advice.

Contingency plans are shared electronically with all professionals involved in patient care, including secondary care and acute services, and have resulted in a 30% reduction in conveyance to hospital in the event of an ambulance being called out.

The clinical pharmacy service is now considered a key component of the proactive care service and is commended by patients, GPs and other colleagues.

Future service developments might include incorporating pharmacy technicians into the team, developing the pharmacist role to include non-medical prescribing and further developing links with secondary care and community pharmacy. Readers who are interested in finding out more about this service can contact me at karen.varisco@nhs.net.

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