COVID-19 Resources
COVID-19 management continues to evolve. Ongoing studies of multiple agents are occurring internationally. Some sources for evidence based updates include:

   https://www.ashp.org/COVID-19?loginreturnUrl=SSOCheck Only

2. WHO-Clinical Management, living guidance (Download document in the upper left-hand corner of the website):
   https://www.who.int/publications/i/item/WHO-2019-nCoV-clinical-2021-l

3. NIH COVID-19 Treatment Guidelines Panel:
   https://www.covid19treatmentguidelines.nih.gov/therapeutic-management/

4. IDSA:

Selected CDC Vaccine Schedule Updates

- **COVID-19 vaccines**
  - Doses can be given up to 6 weeks apart when necessary
  - Doses should not be repeated if outside this interval
  - Patients should receive same manufacturer for both doses

- **Adult**
  - Recommendations updated to include Twinrix (HepA-HepB) accelerated schedule for travel in countries with high or intermediate endemic hepatitis A
    - 0, 7, and 21-30 days with booster at 12 months
  - 3-dose series of HPV vaccine recommended in all patients with immunocompromising conditions, including HIV, regardless of age at initial vaccination

- **Children**
  - Meningitis-addition of MenQuadfi, FDA approved April 2020
    - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
    - One dose for first-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits

- **Influenza vaccine**
  - LAIV4 should not be given if patient received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days
  - A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine

CDC released schedule changes and guidance on Feb 11, 2021

**EPIC dot phrase for new interdisciplinary clinic referrals**

Use “.IDCNEW” in patient instructions to help your patients gain an understanding of what to expect at their upcoming IDC visit.
New Guidelines: 2020 ACG Clinical Management of Irritable Bowel Syndrome

### Introduction
Irritable Bowel Syndrome (IBS) can be a chronic, debilitating disease. The prevalence of IBS in the United States is estimated to be between 10-15% of the population, although many patients remain undiagnosed. The quality of life of IBS patients can be heavily impacted by this disease. Using GRADE methodology and expert opinions, these clinical guidelines are the FIRST ever compiled for the management of IBS. Listed below is a summary of recommendations.

### Diagnosis
The Rome IV diagnostic criteria for IBS should be used for diagnosis:
- Recurrent abdominal pain on average at least 1 d/wk in the last 3 mo, associated with 2 or more of the following criteria:
  1. Related to defecation
  2. Associated with a change in the frequency of stool
  3. Associated with a change in the form (appearance) of stool
- These criteria should be fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.
- ★Perform serologic testing to rule out celiac disease in patients with IBS and diarrhea symptoms.
  - Strong recommendation; moderate quality of evidence.
- ★Check fecal calprotectin (or fecal lactoferrin) and C-reactive protein in patients without alarm features and with suspected IBS and diarrhea symptoms to rule out inflammatory bowel disease.
  - Strong recommendation; moderate quality of evidence for C-reactive protein and fecal calprotectin.
- Strong recommendation; very low quality of evidence for fecal lactoferrin.
- ★Positive diagnostic strategy as compared to a diagnostic strategy of exclusion for patients with symptoms of IBS improves time to initiate appropriate therapy.
  - Consensus recommendation.
- ★Positive diagnostic strategy as compared to a diagnostic strategy of exclusion for patients with symptoms of IBS used to improve cost-effectiveness.
  - Strong recommendation; high quality of evidence.
- ★Categorize patients based on an accurate IBS subtype improves patient therapy.
  - Consensus recommendation.

### Other Testing
- ★Recommend against routine stool testing for enteric pathogens in all patients with IBS.
  - Conditional recommendation; low quality of evidence.
- ★Recommend against routine colonoscopy in patients with IBS symptoms younger than 45 years without warning signs.
  - Conditional recommendation; low quality of evidence.
- ★Do not recommend testing for food allergies and food sensitivities in all patients with IBS unless there are reproducible symptoms concerning for a food allergy.
  - Consensus recommendation.
- ★Anorectal physiology testing should be performed in patients with IBS and symptoms suggestive of a pelvicloor disorder and/or refractory constipation not responsive to standard medical therapy.
  - Consensus recommendation.

### Treatment Don’ts
- ★Suggest against PEG products to relieve global IBS symptoms in those with IBS-C.
  - Conditional recommendation; low quality of evidence.
- ★Recommend against the use of antispasmodics for the treatment of global IBS symptoms.
  - Conditional recommendation; low quality of evidence.
- ★Do not suggest the use of bile acid sequestrants to treat global IBS-D symptoms.
  - Conditional recommendation; very low quality of evidence.
- ★Recommend against the use of fecal transplant for the treatment of global IBS symptoms.
  - Strong recommendation; very low quality of evidence.
- ★Suggest against probiotics to the treatment of global IBS symptoms.
  - Conditional recommendation; very low level of evidence.
Treatment Do’s

★ Recommend the use of **chloride channel activators** to treat global IBS symptoms.
   - Strong recommendations; moderate quality of evidence.

★ Recommend the use of **guanylate cyclase activators** to treat global IBS-C symptoms.
   - Strong recommendation; high quality of evidence.

★ The 5-HT4 agonist, tegaserod, can be used to treat IBS-C symptoms in women younger than 65 years with ≤1 cardiovascular risk factors who have not adequately responded to secretagogues.
   - Strong/conditional recommendation; low quality of evidence.

★ Recommend the use of **rifaximin** to treat global IBS-D symptoms.
   - Strong recommendation; moderate quality of evidence.

★ Recommend that **alosetron** be used to relieve global IBS-D symptoms in women with severe symptoms who have failed conventional therapy.
   - Conditional recommendation; low quality of evidence.

★ Suggest that **mixed opioid agonists/antagonists** be used to treat global IBS-D symptoms.
   - Conditional recommendation; moderate quality of evidence.

★ Recommend that **tricyclic antidepressants** be used to treat global symptoms of IBS.
   - Strong recommendation; moderate quality of evidence.

★ Suggest that **gut-directed psychotherapies** be used to treat global IBS symptoms.
   - Conditional recommendations; very low quality of evidence

★ Recommend a **limited trial of a low FODMAP diet** in patients with IBS to improve global IBS symptoms.
   - Conditional recommendation; very low quality of evidence.

★ **Soluble**, but not insoluble, **fiber** should be used to treat global IBS symptoms.
   - Strong recommendation; moderate quality of evidence.

★ Suggest the use of **peppermint** to provide relief of global IBS symptoms.
   - Conditional recommendation; low quality of evidence.

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### A Review of Potassium Supplements

**Prepared by**

Gage Fisher, PharmD Candidate 2021

There are many different potassium supplements to choose from, but most of the options are similar across the spectrum. Therapeutic range for potassium is 3.5-5 mmol/L.

**Normal daily requirement**: 40-80 mEq/day

**Hypokalemia prevention**: 20-40 mEq once or twice daily

### Treatment of hypokalemia:

- **Mild**: 40-100 mEq daily in divided doses (~25 mEq to minimize GI effects)
- **Severe**: 40mEq given 3-4 times daily (doses over 40 mEq are not recommended due to excessive nausea and GI irritation)

Titrated according to kidney function and serum potassium level. Most common side effect limiting use is GI intolerability. Extended release formulations and eating with a meal is recommended to minimize these effects.

<table>
<thead>
<tr>
<th>Formulations and Cost (per GoodRx):</th>
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<tbody>
<tr>
<td>- Potassium chloride—recommended over other potassium salts due to best absorption in the GI tract</td>
</tr>
<tr>
<td>o Klor-Con ER (price of 20mEq tablet ~$10 per 30 count)</td>
</tr>
<tr>
<td>o K-Tab (price of 20mEq tablet ~$10 per 30 count)</td>
</tr>
<tr>
<td>o Micro-K (price of 10mEq capsule ~$10 per 30 count)</td>
</tr>
<tr>
<td>- Potassium bicarbonate</td>
</tr>
<tr>
<td>o Effer-K (price of 20mEq tablet ~$20 per 30 count)</td>
</tr>
<tr>
<td>o K-Lyte (price of 25mEq tablet ~$30 per 30 count)</td>
</tr>
<tr>
<td>- Potassium gluconate</td>
</tr>
<tr>
<td>o Glu-K (Only recommended for hypokalemia prevention, not commonly used due to high cost)</td>
</tr>
</tbody>
</table>

**Key counseling points:**

- Always take with a full glass of water while eating or shortly after food
- Do not crush or chew XR and effervescent tablets.
- Klor-Con M may be broken in half and swallowed separately OR dissolved in 4 oz. water to form a slurry.

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**Glucagon Like Peptide 1 (GLP-1) Receptor Agonists (GLP-1)**

**Drug options**: Semaglutide (Ozempic), Dulaglutide (Trulicity), Liraglutide (Victoza, Saxenda), Exenatide (Byetta, Bydureon), Lixisenatide (Adlyxin)

**Ideal candidates**: overweight/obese patients who are diabetic or prediabetic patients. ADA recommends initiating therapy in diabetic patients who are at cardiovascular risk due to their added cardiovascular protective benefit regardless of A1c. Injectable therapy also preferred if A1c <9%.

**Side effects**: nausea, vomiting, diarrhea, headache, abdominal pain, injection site pain, pancreatitis (rare)

**Precautions/Contraindications**: Avoid GLP-1 agonists with gastroparesis and in patients with thyroid cancer or family history of thyroid cancer. Use precaution in patients with low GFR and vomiting due to possible acute kidney injury

**Insurance Update**: WV Medicaid and the Health Plan have removed the requirement that A1c must be <9% for GLP1 initiation, and many other payors have followed suit.

**Prepared by**

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