Diabetes is a progressive disorder in which the body does not properly process food, or glucose, for use as energy. In recent years, diabetes has been on the rise in the United States. This increase is due to a western style diet, where there is high consumption of saturated fat, red meat and refined grains and starches which has led to increased rates of obesity. Diabetes occurs more commonly in the elderly than any other age group with more than 25% of the U.S. population age ≥65 living with the disorder.

In diabetes, the body doesn’t make or use insulin correctly. In someone without diabetes, food is converted to glucose and sent into the blood stream. In response to high glucose levels the pancreas secretes insulin, which allows glucose to enter the cells to be used as energy. In someone with diabetes, sugar is not able to get into the cell properly, which leads to increased sugar in the body. Complications develop gradually due to persistent high blood glucose levels. Increased blood glucose can lead to cardiovascular and microvascular complications, and damage to the nerves, kidneys, feet, eyes and skin. In older adults, it is important to consider that diabetes can also increase the risk of common geriatric syndromes including falls, cognitive impairment, depression, persistent pain and urinary incontinence. Because there are so many different complications, proper treatment is important to prevent progression and improve the well-being of those affected.

Diabetes can be classified as type 1 or type 2. Type 1 diabetes only accounts for about 10% of all diabetes cases and usually occurs in young adults. In type 1 Diabetes, the pancreas does not make insulin and glucose is not able to enter the cells, which leads to high blood glucose levels. Most older adults with diabetes are classified as type 2, which is commonly caused by obesity. In type 2 diabetes, the pancreas still produces insulin, but the body becomes resistant to insulin and the cells cannot take in the glucose properly. Over time, the pancreas cannot keep up with the insulin resistance and is unable to make enough insulin to keep glucose at normal levels.

Physicians carefully evaluate patients to set individual goals based on duration of diabetes, co-existing disease states, age and health status. Co-existing disease states are serious enough that medication or lifestyle changes are needed to manage them. Examples include high blood pressure, heart failure or depression. Following is a table provided by the American Diabetes Association, which illustrates how goals can differ from person to person. These goals are a guideline that may be used by providers to help manage older adults with diabetes. Stricter goals can be set if they may be achieved without recurrent low blood glucose levels.
Lithium Use in Major Depressive Disorder

Major depressive disorder (MDD) is a serious mood disorder accompanied by persistent low mood that causes significant distress and impairment. MDD affects 30% of men and women for individuals aged 65 to 80. MDD typically co-occurs with other psychiatric disorders and medical conditions such as insomnia, dementia, bipolar, cancer, stroke, and diabetes. As the geriatric population’s health tends to decline as they age, having MDD is more detrimental to their physical and social functioning. Ineffective treatments for MDD can lead to significant disability, morbidity, and mortality. Even though many patients are on one of the first line agents, the majority still experience depressive episodes. As a result, having an effective augmentation agent is crucial in alleviating their signs and symptoms.

Patients can present with a variety of signs and symptoms. The three major categories are emotional symptoms, physical symptoms, and cognitive symptoms. Emotional symptoms comprise of persistent and diminished ability to experience pleasure, loss of interest and pleasure in usual activities, appear sad and depressed, feelings of inappropriate guilt, and anxiety. For physical symptoms, patients can have decreased ability to perform normal daily tasks, disturbances in appetite, chronic fatigue, complaints of pain, and sleep disturbances. MDD is often accompanied with cognitive impairment in the geriatric population, which may present as decreased ability to concentrate on simple tasks, poor memory of recent events, appearing confused and indecisive, and slowed thinking.

Based on the 2010 American Psychiatric Association guidelines and 2008 Texas Medication Algorithm Project, the first line treatments for MDD are selective serotonin reuptake inhibitors (SSRIs: fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram, escitalopram), serotonin-norepinephrine reuptake inhibitors (SNRIs: venlafaxine, duloxetine, desvenlafaxine), mirtazapine, or bupropion. A meta-analysis showed that, among these agents, sertraline, escitalopram, venlafaxine, and mirtazapine are more efficacious in treating patients with moderate to severe MDD. In addition, sertraline and escitalopram have better tolerability, efficacy, acceptability, and cost profiles compared to the other antidepressants. This finding qualifies sertraline or escitalopram as the agent of choice especially for therapy initiation unless contraindicated. If one of the first line agents fails to show improvement, switching to a different first line agent is recommended. In addition, combining psychotherapy with medication has shown to significantly reduce signs and symptoms, restore psychosocial and occupational functioning, and prevent relapse in patients with major depression. Antidepressants can take some time to work, so response time should be taken into consideration. Physical symptoms (e.g. sleep) typically begin to improve within one to two weeks and two to four weeks for emotional symptoms (e.g. sadness). An MDD agent should be given at least four to eight weeks to access efficacy and tolerability. Patients should be on an antidepressant for six to 12 weeks for acute phase, four to nine months for continuing phase, and 12 to 36 months for maintenance phase. For most patients with the first episode, therapy should be continued for at least 12 months. However, for patients with recurrent and/or severe MDD, indefinite treatment duration is warranted.

When the steps above have been carried out and patients still have inadequate or partial response, an augmentation agent can be incorporated into the treatment regimen. The options include augmenting with an antidepressant from a different pharmacologic class, lithium, thyroid hormone, an atypical antipsychotic (aripiprazole, quetiapine, olanzapine, brexpiprazole, risperidone, or ziprasidone), an anticonvulsant, a stimulant (modafinil or methylphenidate), omega-3, folic acid, buspi-
rone, ketamine, or a mood stabilizer. Out of all these agents, lithium is the gold standard augmentation agent since it has been shown to significantly decrease suicidal ideations and thoughts in patients with MDD.

The exact mechanism of action of lithium, an anti-manic agent, is unknown. It is hypothesized that lithium works by modulating various neurotransmitters in the brain (e.g. dopamine, glutamate, serotonin, norepinephrine) and reducing oxidative stress. As a result, lithium can have neuroprotective effects and improve emotional regulations in the brain, which assist patients in improving signs and symptoms of depression. A duration of six weeks should be given prior to assessing lithium’s response. It is typically indicated for bipolar depression, but it also has off-label uses for treatment-resistant depression and depression augmentation. The normal dose should be started at 300 mg once daily or 300 mg twice daily and increase gradually based on response and tolerability up to 900 to 1,800 mg daily in three to four divided doses. For older adults, the lowest dose range of 300 mg daily is recommended since their renal function often declines. It is excreted through the kidneys, which makes it essential to evaluate renal function periodically. The dose should be 50% to 75% of the normal dose when creatinine clearance (CrCl) is from 10 to 50 mL/minute and 25% to 50% of the normal dose when CrCl is less than 10 mL/minute. There is no hepatic adjustment required.

Lithium’s trough serum level should be drawn 8 to 12-hours post dose and the therapeutic level ranges from 0.6 to 1.2 mEq/L. It is considered toxic if the serum level is above 1.5 mEq/L. If toxicity is suspected, the patient’s airway and breathing should be assessed immediately. Some signs and symptoms of lithium toxicity are dehydration, polyuria, incontinence, tremor, ataxia, gait problems, myoclonus, hyperreflexia, dysarthria, convulsions, behavioral changes, and delirium. When that happens, the patient should be admitted to the hospital as soon as possible, then decrease or hold the dose, hydrate the patient, use saline diuresis, and/or perform dialysis. The most common adverse effects are tremor, acne, psoriasis, weight gain, hypothyroidism, polyuria, polydipsia, and gastrointestinal disturbances. As the geriatric population often have many co-morbidities such as thyroid diseases and arrhythmias, its use should be limited and reserved for treatment-resistant MDD since lithium is contraindicated in patients with severe cardiovascular or renal disease, severe debilitation, dehydration, sodium depletion, and concurrent use with diuretics. Hence, many monitoring parameters come with using lithium: complete blood count with differential at baseline and yearly thereafter; electrocardiogram at baseline and annually for everyone more than 40 years of age or with cardiac concern; thyroid panel at baseline and every six months thereafter; renal function at baseline and every six months thereafter; and weight changes, serum calcium and urine output yearly.

Furthermore, lithium is known to have many drug-drug interactions with other medications. Lithium level can increase with concurrent use of nonsteroidal anti-inflammatory drugs, angiotensin-converting-enzyme inhibitors, angiotensin II receptor blockers, and thiazide diuretics. Loop diuretics, mannitol, and methylxanthines (caffeine, theophylline) can decrease the therapeutic effect of lithium. Many elderly patients often present with and take medications for arthritis, cardiovascular disease, hypertension, psychological and/or neurological diseases, etc.; therefore, its benefits versus risks should be evaluated extensively prior to initiating this medication.

In conclusion, MDD is a serious mood disorder that should be examined periodically in the elderly population. The rationale is that the elderly often experience debilitating health conditions which could lead to depression. Escitalopram or sertraline in combination with psychotherapy has been shown to be efficacious and tolerable, which makes its use more favorable in comparison to the other agents. When patients are experiencing treatment resistant depression, lithium can be an effective augmentation agent after evaluating for potential adverse effects, drug-drug interactions, and careful monitoring.
Tardive dyskinesia (TD) is a side effect associated with the use of medications that block dopamine. Antipsychotic medications and metoclopramide (Reglan®) are the drugs that are most commonly associated with the development of TD. Rarely, other drugs can also be implicated in the development of this movement disorder. Risk factors for tardive dyskinesia during the use of dopamine blocking drug(s) include female gender and advanced age. While tardive dyskinesia can occur following the first dose of a dopamine blocking drug, the risk for tardive dyskinesia increases the longer that the drug continues to be used.

Patients with TD may experience uncontrollable facial tics, eye blinking, tongue thrusting, lip smacking, “pill rolling” tremors in the fingers, and rigidity. While tardive dyskinesia is rare, it significantly reduces patients’ quality of life when it occurs. Early identification of tardive dyskinesia is very important. Promptly reducing the dose or discontinuing the responsible drug may permit the movements to resolve. The potential for the movement disorder to become permanent increases the longer that the offending drug continues to be used. Many clinicians use either the Abnormal Involuntary Movement Scale (AIMS) or the Dyskinesia Identification System: Condensed User Scale (DISCUS) to periodically monitor for the development of tardive dyskinesia.

Until recently there were no medications approved by the FDA to treat the symptoms of tardive dyskinesia. Historically, drugs have been used without FDA approval to help control TD symptoms. These “off-label” drugs include trihexyphenidyl (Artane®), benztropine (Cogentin®), amantadine (Symmetrel®), clonazepam (Klonopin®), and others. Trihexyphenidyl and benztropine can each be challenging to use. These drugs can frequently cause constipation, dry eyes, dry mouth, or urinary retention. In addition, they may worsen dementia symptoms in some patients. While these medications can help certain types of abnormal movements acutely, data suggests that they may actually worsen tardive dyskinesia in some cases. Amantadine (Symmetrel®) is not commonly associated with these side effects, but it can theoretically reduce the efficacy of antipsychotic medications. In addition, amantadine may require a dosage adjustment in patients with impaired kidney function. Benzodiazepines such as clonazepam (Klonopin®) may be helpful in some patients, but many patients develop tolerance to the benzodiazepine benefits within a few months. In addition, benzodiazepines must be used cautiously as these drugs can cause confusion and falls in the elderly.

In April 2017 valbenazine (Ingrezza®), the first medication indicated to reduce tardive dyskinesia symptoms, was approved by the FDA. KINECT 3, the clinical trial that led to valbenazine’s approval, studied 234 patients with tardive dyskinesia. After six weeks, the patient group that received valbenazine had a statistically significant improvement in AIMS scores as compared to the group of patients that received placebo therapy. Valbenazine does not appear to worsen dementia symptoms like trihexyphenidyl or benztropine. Given the limited published data, it is unknown if patients may develop tolerance to the effects of valbenazine (Ingrezza®) over time. In the KINECT 3 clinical trial, drowsiness was observed approximately twice as often in patients receiving valbenazine as in patients receiving placebo. Valbenazine may also increase patients’ QTc interval potentially increasing the risk for clinically significant arrhythmias. This risk is increased when taking valbenazine with certain interacting drugs. Dose reduction of valbenazine may be required when using valbenaze with those interacting drugs. While valbenazine may provide benefit to patients with tardive dyskinesia, that benefit comes with a significant financial cost. Ingrezza® is expected to cost around $5000 per month of therapy.

For more information about the drugs that may cause or treat tardive dyskinesia please contact your Neil Medical Group pharmacist.

Article by Robert Smith, PharmD, BCGP, BCPS, FASCP
Director of Clinical Services, Neil Medical Group
A Look at Barrett’s Esophagus

What is Barrett’s esophagus?

Barrett’s esophagus is a condition that occurs when cells in the lining of the esophagus are damaged and replaced by abnormal, precancerous tissue. The exact cause is unknown, but the damage is usually because of chronic exposure to acid from the stomach. This can happen as a complication of longstanding gastroesophageal reflux disease (GERD). About 10% of people with chronic symptoms of GERD develop Barrett’s, which increases the risk of developing serious, potentially fatal cancer of the esophagus.

Risk factors for developing Barrett’s esophagus include:
- GERD
- H. pylori gastritis
- Obesity
- Gender (more prevalent among males)
- Ethnicity (more prevalent among Caucasians)
- Age (more common in the elderly)
- Smoking or history of smoking

Common symptoms of Barrett’s esophagus include:
- Heartburn
- Regurgitation
- Difficulty swallowing
- Longstanding dry cough
- Longstanding hoarseness

Most people with Barrett’s experience some symptoms, but some may not notice any symptoms.

Guidelines from the American Gastroenterological Association recommend screening in people who have multiple risk factors for Barrett’s esophagus. Barrett’s can only be diagnosed with an upper endoscopy to visually inspect the lining of the esophagus, and biopsy of tissue, to confirm the diagnosis. The sample will also be examined for the presence of precancerous cells or cancer. If the biopsy confirms the presence of Barrett’s esophagus, a follow-up endoscopy and biopsy to examine more tissue for early signs of developing cancer is recommended.

If you have Barrett’s esophagus but no cancer or precancerous cells are found, repeating an endoscopy periodically is still recommended as a precaution, since cancer can develop in Barrett’s tissue years after the initial diagnosis. If precancerous cells are present in the biopsy, treatment and surveillance options are available.

The primary goal of treatment is to prevent or slow the development of Barrett’s esophagus by treating and controlling acid reflux. Treatment includes lifestyle changes and medications. Lifestyle changes include:
- Making changes in your diet. Fatty foods, chocolate, caffeine, spicy foods, and peppermint can aggravate reflux.
- Avoiding alcohol, caffeinated drinks, and tobacco.
- Losing weight. Being overweight increases your risk for reflux.
- Sleeping with the head of the bed elevated. Sleeping with your head raised may help prevent the acid in your stomach from flowing up into the esophagus.
- Sitting upright for 3 hours after eating.
- Taking ALL medicines with plenty of water.

Medications may include:
- Proton pump inhibitors (PPIs) that reduce the production of stomach acid (omeprazole, esomeprazole, pantoprazole, lan-soprazole, dexlansoprazole, and rabeprazole).
- Antacids to neutralize stomach acid (Maalox, Mylanta, Gaviscon, etc.).
- H2 blockers that lessen the release of stomach acid (ranitidine, famotidine, nizatidine, cimetidine).
- A Pro-motility agent that speeds up the movement of food from the stomach to the intestines (metoclopramide (Reglan).

Dosages are typically similar to those prescribed for GERD but some patients may require higher doses and/or a combination of medications to control symptoms. PPIs are considered the treatment of choice for treating Barrett’s. Treatment is usually continued indefinitely. The evidence remains inconclusive regarding whether PPIs actually induce regression of Barrett esophagus. H2 blockers are generally not as effective as PPIs but may help alleviate symptoms in some patients.

Other treatment options include:
- Radiofrequency ablation (RFA) – the use of radio waves delivered through an endoscope inserted into the esophagus to destroy abnormal cells.
- Cryotherapy - a newer technique that applies cold nitrogen or carbon dioxide gas through the endoscope to freeze the abnormal cells.
- Photodynamic therapy (PDT) – the use of a laser through an endoscope to kill abnormal cells in the lining without damaging normal tissue. Before the procedure, the patient takes a drug known as Photofrin, which causes cells to become light-sensitive.
- Endoscopic mucosal resection (EMR) - lifts the abnormal lining and cuts it off the wall of the esophagus and removed through the endoscope. The goal is to remove any precancerous or cancer cells contained in the lining.
- Surgery to remove most of the esophagus - an option in cases where severe pre-cancer (dysplasia) or cancer has been diagnosed.

Treating and controlling acid reflux with medications and lifestyle changes may prevent or slow the development of Barrett’s esophagus. Routine examination by endoscopy will further reduce the risk of serious outcomes associated with Barrett’s by identifying precancerous and cancer cells early.
Treatment:
Diabetes may be improved by eating a balanced diet and increasing physical activity, however lifestyle changes alone are not always enough to treat diabetes. There are many different treatment options available for diabetes including, oral agents, non-insulin injections, and insulin injections. Type 1 diabetics must be treated with insulin, while Type 2 diabetics may be treated with a variety of medications chosen by their physician.

### Considerations in Treatment Goals for Glycemic Control in Older Adults

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Rationale</th>
<th>“Reasonable” A1c Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy (few chronic illnessees, intact cognitive function and functional status)</td>
<td>Longer remaining life expectancy</td>
<td>&lt; 7.5%</td>
</tr>
<tr>
<td>Multiple coexisting illnesses, mild to moderate cognitive impairment, unable to carry out activities of daily living</td>
<td>Intermediate remaining life expectancy, high treatment burden, risk of hypoglycemia and falls</td>
<td>&lt; 8.0%</td>
</tr>
<tr>
<td>Poor health (Long-term care, moderate to severe cognitive impairment)</td>
<td>Limited remaining life expectancy</td>
<td>&lt; 8.5%</td>
</tr>
</tbody>
</table>

### Insulin

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Onset (hours)</th>
<th>Duration (hours)</th>
<th>Time before food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid-Acting Insulin</td>
<td>Lispro (Humalog®)</td>
<td>0.25-0.5</td>
<td>3 - 6.5</td>
<td>0-15 minutes</td>
</tr>
<tr>
<td></td>
<td>Aspart (Novolog®)</td>
<td>0.2-0.3</td>
<td>3 - 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glulisine (Apidra®)</td>
<td>0.25-0.5</td>
<td>≤ 5</td>
<td></td>
</tr>
<tr>
<td>Short-Acting Insulin</td>
<td>Regular (humulin R®, Novolin R®)</td>
<td>0.5</td>
<td>~ 8</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td>Regular U500 (concentrated)</td>
<td>0.5</td>
<td>Up to 24 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>Intermediate-Acting Insulin</td>
<td>NPH (Humulin N®, Novolin N®)</td>
<td>1-2</td>
<td>16 - 24</td>
<td></td>
</tr>
<tr>
<td>Long-Acting Insulin</td>
<td>Glargine (Lantus®, Basaglar®)</td>
<td>1.1</td>
<td>10.8 - &gt;24</td>
<td>Not Applicable; Long Acting is usually given at bedtime</td>
</tr>
<tr>
<td></td>
<td>Glargine (Toujeo®)</td>
<td>6</td>
<td>24 - 30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detemir (Levemir®)</td>
<td>1.1-2</td>
<td>7.6 - &gt;24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Degludec (Tresiba®)</td>
<td>~1</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Class and Mechanism</td>
<td>Drug</td>
<td>Adverse Effects</td>
<td>Special Considerations</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<tr>
<td><strong>Biguanides</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Makes the tissue more sensitive to insulin, inhibits glucose absorption in the intestine | Metformin (Glucophage®) | -GI effects  
- Increased risk of lactic acidosis in those with poor renal function | -Low risk of hypoglycemia  
- First line agent  
- Cost effective  
- Take with food |
|                     | Pioglitazone (Actos®) | -Edema  
- May decrease bone density and increase risk of fracture  
** Black box warning for use in heart failure patients | Contraindicated in Heart failure NYHA class III/IV |
|                     | Rosiglitazone (Avandia®) | ** Black box warning - MI risk | |
| **Thiazolidines**   |      |                 |                        |
| Makes the tissue more sensitive to insulin | Pioglitazone | -Edema  
- May decrease bone density and increase risk of fracture  
** Black box warning for use in heart failure patients | Contraindicated in Heart failure NYHA class III/IV |
|                     | Rosiglitazone | ** Black box warning - MI risk | |
| **DPP4-Inhibitors** |      |                 |                        |
| Helps the pancreas release insulin after eating | Linagliptan (Tradjenta®) | -Headache  
- GI upset  
- Naso-pharyngitis  
- Potential for pancreatitis | Require dose adjustments for renal impairment |
|                     | Sitagliptan (Januvia®) | -Headache  
- GI upset  
- Naso-pharyngitis  
- Potential for pancreatitis | |
|                     | Saxagliptan (Onglyza®) | -Headache  
- GI upset  
- Naso-pharyngitis  
- Potential for pancreatitis | |
| **SGLT2-inhibitors** |      |                 |                        |
| Helps the body eliminate elevated glucose levels by spilling into the urine | Canagliflozin (Invokana®) | -Dehydration  
- UTI  
- Yeast infection  
- Hypotension  
- Increased potassium | -Not recommended in renal impairment.  
- Modest weight loss  
- Jardiance has additional cardiovascular benefits |
|                     | Dapagliflozin (Farxiga®) | -Dehydration  
- UTI  
- Yeast infection  
- Hypotension  
- Increased potassium | |
|                     | Empagliflozin (Jardiance®) | -Dehydration  
- UTI  
- Yeast infection  
- Hypotension  
- Increased potassium | |
| **Sulfonylureas**   |      |                 |                        |
| Helps the pancreas release insulin | Glyburide (Micronase®, Diabeta®) | - Not recommended for geriatric, renal impaired | - Increased risk of hypoglycemia  
- Modest weight gain |
|                     | Glimepiride (Amaryl®) | -Sun sensitivity  
- Take with first meal | |
|                     | Glipizide (Glucotrol®) | -Sun sensitivity  
- Take with first meal | |
| **Non-Insulin Injectables** |      |                 |                        |
| **GLP-1 Agonists**  |      |                 |                        |
| Helps the pancreas release insulin after eating, increases satiety | Exenatide (Byetta®) | - Nausea, Vomiting Diarrhea  
** Black box warning – risk of thyroid C-cell tumor and pancreatitis | - Given 60 minutes before meal  
- Twice daily  
- Not used in severe renal impairment |
|                     | Exenatide ER (Bydureon®) | - Nausea, Vomiting Diarrhea  
** Black box warning – risk of thyroid C-cell tumor and pancreatitis | - Once weekly  
- Use immediately after mixing  
- Not used in severe renal impairment |
|                     | Liraglutide (Victoza®) | - Nausea, Vomiting Diarrhea  
** Black box warning – risk of thyroid C-cell tumor and pancreatitis | - Once daily  
- Has cardiovascular benefits |
|                     | Dulaglutide (Trulicity®) | - Nausea, Vomiting Diarrhea  
** Black box warning – risk of thyroid C-cell tumor and pancreatitis | - Once weekly |

As diabetes rates continue to rise, most everyone is affected by this disease in some way. By remaining educated about diabetes and how to treat it, we can provide proper support to our patients, family members and friends.
To all the Pharm Notes Family,

My grand-daughter turned one last week.....and my daughter assigned all of those coming to her party the daunting task of writing a letter to her that she would open on her 18th Birthday. So.....in between preparing 60 cupcakes for the party, decorating two “smash cakes” (yes two because the first one had issues), and tediously decorating dozens of sugar cookies for favors......I began to long for the days of a simple Birthday Party at Chuckie Cheese. Fortunately, the extent of my contributions to the party bought me a little extra time and grace from my daughter.....so I am finally getting around to “The Letter”.

What do you say to a now baby in anticipation of her 18th Birthday? Will I still be here when she opens it? What kind of world will she be facing? What will she need to know? What is the best advice I can share with her? All these thoughts led me to something I recently read and saved...and decided to modify for her: “Ten Ways to Not Make Your Life Harder than it Has to Be” (by Tim Koch, Lawyer and Strategist).

I decided to share some excerpts here.....over the next few newsletters.....so I hope you all will bear with me and perhaps enjoy. Who knows......maybe YOU will be asked to write a similar letter, and we can all share in the experience! So....stay tuned for “The Letter”.

Till next time........

Cathy Fuquay
Pharm Notes Editor