See How Far We've Come in 40 Years

We're celebrating 40 years of our sister product, *Pharmacist's Letter*, this month!

Help us commemorate with a throwback to a couple of the topics we covered in June 1985...our very first issue.

HIV. We've come a LONG way with HIV over the past 40 years...from considering it an incurable infection to one we can now prevent.

What we said in 1985: There is no cure for AIDS on the immediate horizon despite all the news coverage.

What we say now: Emphasize HIV prevention.

Keep pre-exposure prophylaxis (PrEP) top of mind in discussions with ALL sexually active patients...to help raise awareness and limit stigma.

Explain that daily oral PrEP prevents HIV infection in about 1 in 50 adults at higher risk...such as a person whose partner is living with HIV.

Prescribe generic emtricitabine/tenofovir DISOPROXIL fumarate (Truvada) daily for most patients...it costs less than other options.

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But keep long-acting IM cabotegravir in mind if adherence is a concern or less frequent dosing is preferred.

Also know when to prescribe POST-exposure prophylaxis (PEP)...after possible HIV exposure during sex, sharing needles, etc. Ensure patients start PEP ASAP within 72 hr of exposure...and continue meds for 28 days.

Be aware, preferred PEP regimens recently changed.

For most adults and teens, lean toward bictegravir/emtricitabine/ tenofovir ALAFENAMIDE (Biktarvy)...it's a single tablet taken once daily.

Use our checklists, HIV PrEP and HIV PEP, for screening and monitoring, alternative meds, how to help patients afford meds, and more.

Ischemic stroke. We've known for decades that antiplatelets reduce the risk of recurrent stroke. But we're still studying the best approach.

What we said in 1985: Persantine (dipyridamole) with aspirin is no better than aspirin alone in the prevention of strokes.

What we say now: Generally give aspirin OR clopidogrel alone.

Dipyridamole ER/aspirin seems a bit more effective than aspirin. But it's bid...headache is common...and it still costs about $60/month.

But don't be surprised to see patients discharged on a short course of dual antiplatelet therapy (DAPT) with aspirin plus clopidogrel after a high-risk TIA ($ABCD^2$ score 4 or above) or milder stroke (NIH Stroke Scale score 5 or less).

In these cases, recent data suggest DAPT for 21 days prevents 1 recurrent stroke for every 53 patients treated compared to aspirin alone.

But there's no proof that the benefit of DAPT outweighs the risk of bleeding in patients with more severe strokes...or who got a thrombolytic or take an anticoagulant.

Dive into our chart, Antiplatelets for Recurrent Ischemic Stroke, for more on the preferred options, dosing, and estimated cost.

Key References:

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