Pharmacists’ skills ‘may not be understood’ by medical profession

By Pat Kelly

The International Pharmaceutical Federation (FIP) General Secretary and Chief Executive Officer Mr Luc Besançon has told Irish Pharmacist that much of the tension between pharmacists’ and doctors’ organisations may be down to the fact that the skills of pharmacists are not fully understood by the medical profession.

In a wide-ranging interview, Mr Besançon explained that the current tensions regarding expanding pharmacists’ roles is not unique to Ireland. “There is tension [between pharmacists’ and doctors’ bodies] in many countries,” he explains.

“That was clear when Australia started to roll-out its vaccination pilot project in two states, where doctors strongly opposed it. So I don’t think Ireland really lags behind other developed countries in evolution.

“In Ireland, you have developed an interesting number of new pharmacy services. These tensions are sometimes based on whether pharmacists can deliver those services or not. In other countries, it’s more to do with, ‘do pharmacists have the right to prescribe’ or ‘do pharmacists have the right to be involved in [certain] services’.”

“Thank goodness we will have, this year, your name on a website and what you receive and who gave it to you. I think that will make very instructive reading — I look forward to reading it.”

Meanwhile, Prof Barry revealed that the majority of the 17 products that underwent full NCPE health technology assessments (HTAs) last year were not reimbursed.

“We recommended reimbursements in three and we recommended not to reimburse in 14. So our pass rate is about 20 per cent. The three we recommended were for hepatitis C. In those that were not recommended, half of those were for cancer drugs. We were not convinced that the benefit we were getting was commensurate with the price that was asked.”

The NCPE ‘rapidly reviewed’ 43 products in 2015 and decided that a HTA was not required in 17. “So 40 per cent of products were given the green light. That’s good for industry; you get your product onto market very quickly. On the other hand, we said that a full HTA was required in 60 per cent of cases, because we were not sure if that was value for money or not.”

“I have a real problem with key opinion leaders from the medical world. I like to term it, ‘key, paid opinion leaders’. The pharmaceutical industry is very adept at this. I don’t mind someone taking money for a lecture, I do mind taking money for a lecture and you try and influence the prescribing of other people; it is inherently biased. Transparency is the key.”

Under new rules this year, the details of payments and financial support made by pharmaceutical companies to named doctors and other healthcare professionals in Ireland will be publicly disclosed, which Prof Barry welcomed.

“The holistic health approach

Pictured was Ms Patricia Lohan from Dublin exhibiting at Ireland’s biggest wellbeing event, the Mind, Body, Spirit and Yoga Festival, which runs in the RDS from Friday 18 March to Sunday 20. The festival features over 75 talks and workshops from positive psychology and personal development experts.

NCPE Director criticises ‘paid opinion leaders’ in pharmaceutical industry

By David Lynch

The Director of the National Centre for Pharmacoeconomics (NCPE) has called for greater transparency in the relationship between pharmaceutical companies and healthcare professionals, strongly criticising what he called ‘paid opinion leaders’.

Prof Michael Barry said he would like to see “more transparency in relation to vested interests” in the medical arena, during a questions and answers session at the National Health Summit recently.

“I have a real problem with key opinion leaders from the medical world. I like to term it, ‘key, paid opinion leaders’. The pharmaceutical industry is very adept at this. I don’t mind someone taking money for a lecture, I do mind taking money for a lecture and you try and influence the prescribing of other people; it is inherently biased. Transparency is the key.”

Under new rules this year, the details of payments and financial support made by pharmaceutical companies to named doctors and other healthcare professionals in Ireland will be publicly disclosed, which Prof Barry welcomed.

“Thank goodness we will have, this year, your name on a website and what you receive and who gave it to you. I think that will make very instructive reading — I look forward to reading it.”

Meanwhile, Prof Barry revealed that the majority of the 17 products that underwent full NCPE health technology assessments (HTAs) last year were not reimbursed.

“We recommended reimbursements in three and we recommended not to reimburse in 14. So our pass rate is about 20 per cent. The three we recommended were for hepatitis C. In those that were not recommended, half of those were for cancer drugs. We were not convinced that the benefit we were getting was commensurate with the price that was asked.”

The NCPE ‘rapidly reviewed’ 43 products in 2015 and decided that a HTA was not required in 17. “So 40 per cent of products were given the green light. That’s good for industry; you get your product onto market very quickly. On the other hand, we said that a full HTA was required in 60 per cent of cases, because we were not sure if that was value for money or not.”

“Thank goodness we will have, this year, your name on a website and what you receive and who gave it to you. I think that will make very instructive reading — I look forward to reading it.”

Meanwhile, Prof Barry revealed that the majority of the 17 products that underwent full NCPE health technology assessments (HTAs) last year were not reimbursed.

“We recommended reimbursements in three and we recommended not to reimburse in 14. So our pass rate is about 20 per cent. The three we recommended were for hepatitis C. In those that were not recommended, half of those were for cancer drugs. We were not convinced that the benefit we were getting was commensurate with the price that was asked.”

The NCPE ‘rapidly reviewed’ 43 products in 2015 and decided that a HTA was not required in 17. “So 40 per cent of products were given the green light. That’s good for industry; you get your product onto market very quickly. On the other hand, we said that a full HTA was required in 60 per cent of cases, because we were not sure if that was value for money or not.”

Under new rules this year, the details of payments and financial support made by pharmaceutical companies to named doctors and other healthcare professionals in Ireland will be publicly disclosed, which Prof Barry welcomed.

“The holistic health approach

Pictured was Ms Patricia Lohan from Dublin exhibiting at Ireland’s biggest wellbeing event, the Mind, Body, Spirit and Yoga Festival, which runs in the RDS from Friday 18 March to Sunday 20. The festival features over 75 talks and workshops from positive psychology and personal development experts.

INSIDE: News p4, 6, 8 | FIP p10, 14 | Euronews p16 | Pharmacy jobs in jeopardy p18 | Infant dermatology p25, 26

NEW Pain and fever relief for babies & children

EASOFEN

for Children Strawberry

100 mg/5 ml Oral Suspension
Six Plus 200 mg/5 ml Oral Suspension
IBUPROFEN

Easofen for Children Strawberry 100 mg/5 ml Oral Suspension and Easofen for Children Six Plus 200 mg/5 ml Oral Suspension. Always read the label. Do not exceed the stated dose. Consult your doctor if there is no improvement. Available in Pharmacy only. Contains maltitol, liquid & sodium, sugar-free and colour free.

ClenMedica (Ireland) Ltd., Waterford Road, Clonmel, Co. Tipperary. Data prepared: September 2016. 2014/ADV/BRU/167
Solpadeine Soluble Tablets (P) contain Paracetamol, Codeine Phosphate Hemihydrate and Caffeine. For the treatment of acute moderate pain not relieved by other analgesics such as paracetamol or ibuprofen alone; for symptoms of headache, including migraine, toothache, backache, common cold, influenza, menstrual pain, musculoskeletal pain. Adults and children 12 years and over: 2 tablets in water three to four times in 24 hours as required; not more frequently than once every four hours. Maximum 8 tablets in 24 hours. Children under 12 years: Not recommended. Do not take for more than 3 days without consulting a doctor. Do not take any other paracetamol or codeine containing products concurrently. Avoid excessive caffeine intake. Can cause addiction. Use for 3 days only. In case of overdose, seek immediate medical advice, even if the patient feels well.

Contraindications:
- Lactation, acute asthma, known hypersensitivity to ingredients, known CYP2D6 ultra-rapid metabolisers, patients under 18 years who undergo tonsillectomy or adenoidectomy for obstructive sleep apnoea syndrome, rare hereditary fructose intolerance.

Precautions:

Always read the label. Can cause addiction. For three days use only. **IMS MAT Value Sales Aug 2015.
contents

news

4, 6, 8 News
10, 14 The world view
   International Pharmaceutical Federation General Secretary and Chief Executive Officer Mr Luc Besançon talks to IP about the parallels and differences between pharmacy in Ireland and worldwide

16 Euronews

comment & analysis

19 Letters and Editorial
20 Dr Des Corrigan
22 Terry Maguire
24 David Jordan
36 The Outside Edge with Fintan Moore

life

28 Gallery
30, 31 Products
32 Science news blog
34 Gadgets
35 Crossword

professional development

Dr Des Corrigan 20
Infant dermatology 25, 26
CPD pull-out: Depression

Need a Locum?
- Regular Locums
- Holiday periods
- One-off placements
- Short notice & emergency cover
- Nationwide service

Full-time recruitment
- Pharmacist-led recruitment
- Industry-leading flat fee
- All levels: Supervising to OTC
- Permanent, contract, maternity, etc.
- No recruit – no fee

1,000s of pharmacy professionals choose Clarity. Operating nationwide, we offer a fast, efficient and highly responsive service.

Talk to us today.

Call us: 01 532 5441
Book online: www.claritylocums.ie
Drop into our offices: 93 Lower Baggot Street, Dublin 2

* Terms and conditions:
- Zero fee offer applies to new clients only
- 30% discount for all existing clients
- Standard rate booking fees only (emergency and short notice excluded from offer)
- Must be redeemed before 31st March, 2016
Study sheds new light on perceptions of ‘adherence’

A new study has challenged how medication adherence is measured and claims to show that patients automatically defined as ‘adherent’ may not actually be any more compliant with their treatment plan than those classified as ‘non-adherent’.

The study was conducted by Pharmacy Lecturers at Universidad Miguel Hernández (UMH) in Elche, Spain. Surveying 602 patients, Elsa López Pintor and Blanca Lumbreras Lacarra found that those who unerringly collected their medicines from pharmacies were not necessarily any better at actually taking their medications. The patients were being treated for hypertension and were an average age of 68.8 years and the research was conducted across 40 pharmacies throughout Alicante.

The authors noted that the current system of measuring adherence is flawed and over-complicated and automatically categorises patients as adherent if they collect their prescriptions from pharmacies, with insufficient focus on whether they follow-through and actually take their medications when they are supposed to and in the correct doses.

Based on this evaluation, their main finding was that non-adherence was as high as 32 per cent — based on questionnaires and in-pharmacy physiologists — among those who collected their medicines on time and were previously considered to be adherent, based on existing criteria.

Worthy of particular note was the fact that if either the packaging or the appearance of medications changed in any way, patients were far less likely to take them. This was most pronounced when changes were made to the colour, shape or size of the pills.

“We know this because patients who were given the new-look medication presented higher hypertension and systolic blood pressure than either of their peers whose medication was unchanged or simply wrapped in a different packaging,” the authors wrote.

In their conclusion, they stated that pharmacists need to have a greater role in patient care and draw patients into their medicines are provided in primary care and not just in another. It points out that the most recent official OECD report for Ireland relates to 2012 and since then, expenditure on medicines in the HSE Community Drugs Schemes has been flat, “while volumes have increased; the average price per item in the Community Drugs Schemes has fallen, as it has every year since 2009; under IPHA’s Agreement with the State 2013-2015, €400 million has been saved; Irish medicines prices are not the highest in Europe; the price of patented medicines is close to the average of nine EU countries; and proven new medicines have been made available for a wide range of treatments.”

IPHA refutes OECD statistic on Irish pharmaceutical expenditure

The Irish Pharmaceutical Health-care Association (IPHA) has refuted the claim by the Organisation for Economic Cooperation and Development (OECD) that Irish pharmaceutical expenditure is now the highest in Europe.

The claim came to prominence after it was reported in the Sunday Business Post and repeated on the Morning Ireland radio show.

The OECD claims the “conclusion [was] based on the report of a ‘preliminary’, unpublished and unverified statistic of the OECD relating to Ireland, takes no account of differences across countries in pharmaceutical expenditure, which the OECD itself notes in its official publications”.

IPHA says, for example, that expenditure on pharmaceuticals is excluded. “This results in Denmark, where an estimated half of medicines spend is through hospitals, having an understated pharmaceutical spend per capita on the OECD measure,” says the Association.

It contends that statistics on pharmaceutical expenditure within country, and especially for cross-country comparisons, “need detailed examination of the elements of cost and the specific dynamic for each element in order for robust conclusions informing policy to be drawn.”

It points out that the most recent official OECD report for Ireland relates to 2012 and since then, expenditure on medicines in the HSE Community Drugs Schemes has been flat, “while volumes have increased; the average price per item in the Community Drugs Schemes has fallen, as it has every year since 2009; under IPHA’s Agreement with the State 2013-2015, €400 million has been saved; Irish medicines prices are not the highest in Europe; the price of patented medicines is close to the average of nine EU countries; and proven new medicines have been made available for a wide range of treatments.”

CarePlus Pharmacy donates €5,000 to pharmacists’ Frontline Cycle for mental health

CarePlus Pharmacy — a network of independent pharmacies across Ireland — has donated €5,000 from the Frontline Cycle and First Fortnight, a mental health arts charity, in a bid to challenge mental health stigma.

The donation was made in recognition of the achievement last July by more than 50 pharmacists who successfully cycled from Dublin to Galway as part of the annual Frontline Cycle.

Pictured are Mr John Carroll, Managing Director of CarePlus, who presented Mr Robert Keane, organiser of the Frontline Cycle, and Mr Steve Cummins of First Fortnight, with the cheque for €5,000 at Keane’s CarePlus Pharmacy on the Green Road in Mullingar.
Our innovative pack replacement model, offers you the best margins & value across our portfolio.

FOR MORE INFORMATION CONTACT YOUR LOCAL KEY ACCOUNT EXECUTIVE

John MacHale
M: 086 884 1114
E: John.MacHale@actavis.com
Cork, Kerry, Limerick, Waterford, Kilkenny

Richard Doherty
M: 087 667 1725
E: Richard.Doherty@actavis.com
Clare, Donegal, Galway, Tipperary, Mayo, Offaly, Sligo

Paul Kenny
M: 087 361 6027
E: Paul.kenny2@actavis.com
North Co. Dublin, Cavan, Longford, Leitrim, Louth, Meath, Monaghan, Roscommon, Westmeath

Louise Mooney
M: 086 044 3956
E: Louise.Mooney@actavis.com
South Co. Dublin, Carlow, Kildare, Laois Wexford, Wicklow

Our innovative pack replacement model, offers you the best margins & value across our portfolio.
Two elected pharmacists pledge to represent profession

The two pharmacists recently elected have told Irish Pharmacist (IP) that they intend to represent the interests of pharmacists as well as their constituents.

Ms Kate O’Connell (FG), who was elected for the Dublin Bay South area, and Mr John Brassil (FF), of the Kerry constituency, said their political platforms will allow them to represent the interests of pharmacists, whether their parties are in power or not.

“It was a very tight vote and it’s never easy when you are also running your own business — I am on my way to the pharmacy now for the evening,” said Ms O’Connell, who owns two pharmacies with her husband Morgan. “The first question is whether we will be in government, because at this point we don’t know that for certain. If we are, one of the first thing we will look at, from a pharmacists’ point of view, is the meningitis vaccine for children. I would love to see that rolled out.

“There is also the VAT on injections, which I think is crazy,” she told IP. “It is costing about €1,000 per child, which is prohibitively expensive. I would also like to see the appointment of a Chief Pharmacist. These are things I will be advocating, whether we are in government or in opposition.”

She explained that even if FG is not in government, she will be raising these matters in health committees. “I do intend to be on my shop floor at weekends; it’s the ideal clinic in which to meet people. I think one of the reasons I was elected is that as a pharmacist, you couldn’t be more in touch with the real world.

“I thought that in the national FG campaign, there was a lack of humanity and I think being a pharmacist served me well in keeping in touch with how people are actually suffering. I don’t want to be sucked into a political bubble where you can become detached from what’s happening on the ground.”

Mr Brassil told IP: “Having pharmacists elected is something that I hope will be good for the profession. I know and recognise the contributions that pharmacists make, both in the community and in hospitals, and I don’t think pharmacists are properly recognised for the work they do. I will be advocating that pharmacists be treated with the same regard as any other healthcare professional.

“I would also like to see our contribution to society compensated and rewarded properly,” he added. “Even with the expansion of our services, I think there is a lot more work that we could do to take the workload off the local GP and I would hope that pharmacists and local GPs could work hand-in-glove.

“I was elected by the people of Kerry but I’m a healthcare professional and I hope that the pharmacy sector would see me as someone who will be there to represent their cause in Dáil Éireann — I’m always mindful of the fact that I’m there to represent the people but I see no conflict in being able to represent the people of Kerry but also being an advocate for the pharmacy profession.”

One-in-eight Europeans have vitamin D deficiency

A recent report by University College Cork (UCC) researchers has shown that one out of every eight Europeans are vitamin D-deficient and up to 40 per cent have vitamin D levels that are not sufficient to support good bone health.

The report, by Professors Kevin Cashman and Mairead Kiely of UCC’s Centre for Vitamin D and Nutrition Research, was published recently in the American Journal of Clinical Nutrition.

The research, which was funded by the European Commission, involved an analysis of 18 regionally or nationally representative studies involving age groups including the elderly, adults, teenagers and children to assess their vitamin D status.

The ODIN study is the first Europe-wide information on vitamin D intake and status and covered areas from Crete to Norway and collectively included 55,844 individuals.

It showed that among white Europeans, 12-to-15 per cent, 12 per cent and 20 per cent of the German, Irish and UK populations, respectively, have vitamin D deficiency.

This equates to 11 million, 500,000 and 13 million people in these populations, respectively.

It also showed that 18-to-65 per cent of dark-skinned people in the UK, Norway and Finland are also vitamin D deficient, a much higher rate than the white populations in these countries.

Asthma is costing sufferers ‘11 times more than Irish Water’

The Asthma Society of Ireland recently launched its ‘Who will Speak Up for Asthma?’ campaign in the run-up to the election. In an effort to draw attention to the huge financial strain placed on those who suffer with asthma. The Society called on election candidates to place asthma high on their list of priorities and based their figures on its survey from June 2015, but points out that the figures only address medication and GP visit costs.

The estimation of the financial burden on populations, respectively, have vitamin D deficiency. Many of our members are paying up to €144 a month on their asthma medication, before you factor in an additional minimum cost of €150 per year on GP visits. This brings the combined total to in excess of €1,800 per annum.

“The comparison of the cost between the cost per household for Irish Water and the cost of asthma for a person or a family is not a fair comparison. The cost of asthma is much more than the cost of Irish Water.”

New advice for pharmacists on financial planning and retirement

A new book has been released, which aims to help pharmacists to plan for their financial future and retirement.

The book — Pharmacy Capital Management — was produced through voluntary work by pharmacist Mr Michael Tierney and Mr Richard Collins of Walfrid Private.

The book encourages pharmacists to be proactive in planning their financial future and offers practical advice on optimum money management and urges pharmacists to plan for a secure financial status in their retirement.

According to the book’s summary: “This is a must-read for every pharmacist/business owner. Never was more common sense condensed into such a small package. Running a business or managing a professional practice can be challenging. Add the extra complications of minimising tax, investing wisely, getting the best value from insurance, protecting the family and business from loss, planning for retirement — the list is endless. It’s hard enough to be an expert in your own business without having to deal with these complex issues, none of which were taught at college or university.”

The Irish Pharmacy Union has bought a large number of copies and will be distributing the book free of charge to all of its members, with all proceeds going to the Jack Kavanagh Trust.
**NEW ONCE-DAILY LIXIANA**
(Edoxaban).

**ANOTHER STEP AHEAD.**

Only LIXIANA® combines:
- Proven efficacy comparable to well-controlled warfarin\(^1\)\(^2\)
- Superior reduction in clinically relevant bleeding vs. well-controlled warfarin\(^1\)\(^2\)
- Once-daily dosing across both NVAF and VTE indications\(^3\)

---

**Indicated for:**

- Prevention of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥75 years, diabetes mellitus, prior stroke or transient ischemic attack (TIA), and treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults.
- Prevention of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥75 years, diabetes mellitus, prior stroke or transient ischemic attack (TIA) and treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults.

**Presentation:** 60 mg (yellow)/30 mg (pink)/15 mg (orange) edoxaban film coated tablets (as tosilate).

**Posology and method of administration:**

**NVAF:**
- The recommended dose is 60 mg edoxaban once daily following initial use of parenteral anticoagulant for at least 5 days with or without food. Duration of therapy (at least 3 months) should be based on risk profile of the patient. For NVAF and VTE the recommended dose is 30 mg edoxaban once daily in patients with one or more of the following clinical factors: moderate or severe renal impairment (creatinine clearance (CrCl) 15–50 ml/min), low body weight (<50 kg) and/or concomitant use of the following P-glycoprotein (P-gp) inhibitors: ciclosporin, dexamethasone, etravirine, or ritonavir. The 15 mg dose of edoxaban is not indicated as monotherapy, and should only be used during a switch from edoxaban to VKA (see SmPC for full details). If a dose of edoxaban is missed, the dose should be taken immediately and then continued once daily on the following day.

**Contraindications:** Hypersensitivity to the active substance or to any of the excipients; clinically significant active bleeding; Hepatic disease associated with coagulopathy and clinically relevant bleeding risk; Lesion or condition, if considered to be a significant risk for major bleeding. This may include current or recent gastrointestinal GI ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected osseous fragility, artefactual malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities. Uncontrolled severe hypertension. Concomitant treatment with any other anticoagulants e.g. UFH, low molecular weight heparins, heparin derivatives (t fondaparinux, etc.), VKA or NOACs except under specific circumstances of switching oral anticoagulant therapy or when UFH is given at doses necessary to maintain an open central venous or arterial catheter. Pregnancy and breastfeeding. Special warnings and precautions for use: Haemorrhagic risk: Use with caution in patients with increased risk of bleeding such as elderly on ASA and should be discontinued if severe haemorrhage occurs. The anticoagulant effect of edoxaban cannot be reliably monitored with standard laboratory testing. A specific anticoagulant reversal agent for edoxaban is not available. Haemorrhagic risk does not significantly clear edoxaban. Renal impairment: Renal function should be assessed prior to initiation of edoxaban and every 1–2 months when clinically indicated. Not recommended in patients with end-stage renal disease or on dialysis. Renal function and NVAF. A trend towards decreasing efficacy with increasing creatinine clearance was observed for edoxaban compared to well-managed warfarin. Edoxaban should only be used in patients with NVAF and high creatinine clearance after a careful benefit-risk evaluation. Hepatic impairment: Not recommended in patients with severe hepatic impairment and should be used with caution in patients with mild or moderate hepatic impairment. Edoxaban should be used with caution in patients with elevated liver enzymes (ALT > 2 x ULN) or total bilirubin > 1.5 x ULN. Surgery or other interventions: discontinue edoxaban at least 24 hours before the procedure. If the procedure cannot be delayed, the increased risk of bleeding should be weighed against the urgency of the procedure. Edoxaban should be restarted as soon as haemostasis is achieved. Prothrombin heart valves and moderate to severe mitral stenosis: Not recommended. Haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy: Not recommended. Patients with active cancer: Not recommended. Drug interactions: The P-gp inhibitors ciclosporin, dexamethasone, etravirine, or ritonavir result in increased concentration of edoxaban and a dose reduction of 30 mg is required. Edoxaban should be used with caution with concomitant P-gp inducers (e.g. phenytoin, carbamazepine, phenobarbital or St John’s Wort). Concomitant high dose ASA (>105 mg or chronic NSAIDs is not recommended. There is very limited experience with dual antiplatelet therapy or fibrinolytic agents. Pregnancy: Not recommended. Breastfeeding: Discontinue breastfeeding or edoxaban therapy.

**Undesirable effects:**

**References:**

Almost 75% of smokers have never consulted their pharmacist or doctor about lung health

A recent survey commissioned by the Irish Cancer Society (ICS) has shown that nearly three-quarters of smokers have never spoken to either their pharmacist or doctor about lung health issues. Releasing the figures, the Society has also called for better support for those who want to kick the habit, including easier access to smoking cessation services.

The survey, which was carried out in December 2015, included 1,000 adults and showed that only 4 per cent of people had spoken to their pharmacist about lung health, while 15 per cent had spoken with their doctor and only 3 per cent had spoken with both their doctor and pharmacist for advice.

Among active smokers aged 65 years and older, some 41 per cent said they had never spoken to their pharmacist or doctor about lung health.

"Right now, one-in-two smokers trying to quit in Ireland are not using any of the supports available and are using willpower alone," said Mr Kevin O’Hagan, Cancer Prevention Manager at the ICS.

"The result of this survey shows that all of those involved in talking to smokers — doctors, pharmacists, hospital consultants and NGOs — have a part to play in ensuring we reach the Department of Health’s ambitious target of 5 per cent by 2025. “This can be done but it will require innovative, courageous thinking across all quit services.”

Mr O’Hagan also commented: “We have made enormous strides in Ireland in preventing young people from taking up the habit and that shows in the drop in smoking among 10-17 year olds from 21.2 per cent in 1999 to 8 per cent in 2015. “The challenge now is to have enough resources in place to help make quitting easier for smokers. This news that almost three-quarters of smokers have never spoken to a health professional about their lung health shows there is much work to be done.

"We want the HSE and the Department of Health to develop their thinking beyond the existing quit supports. The recent Healthy Ireland report shows that 45 per cent of all smokers in Ireland have tried to quit in the past year without success. “As well as committing a proportion of the tax taken from tobacco sales to increase quit supports, we also want nicotine replacement therapies to be free for those smokers who sign up to a support programmes such as the Irish Cancer Society’s ‘We Can Quit’."

The Irish Pharmaceutical Healthcare Association (IPHA), in collaboration with the Medical Representatives Institute of Ireland (MRII), has launched an eLearning version of the IPHA Code of Practice for the Pharmaceutical Industry.

The Code is updated regularly and is adhered to by member companies, their employees and third parties employed by those companies.

IPHA and the MRII partnered to deliver training and education in the code in a format that uses modern technology via a responsive website that can be accessed on any device. Each IPHA member company can securely track and monitor each employee for compliance, with continuing education on the Code through a dedicated portal.

The eLearning portal was developed by CPD Sessions Ltd. MRII President Mr John Elliot said at the launch: “Our Institute is delighted to have played such a central role in the development of this course. It is of marvellous educational value to our members in helping them to understand their obligations under the IPHA Code of Practice.”

IPHA President Dr Leisha Daly added: “The IPHA Code of Practice sets the gold standard for our companies and any initiative which will help to ensure that it is better understood and valued by those working in the industry is to be very welcomed.”

Pharmacists being invited to hold in-store asthma education events

The Asthma Society of Ireland is inviting pharmacies to join its ‘Asthma in the Pharmacy’ programme, an initiative designed to offer specialist advice to patients.

The Society will provide an asthma nurse specialist to offer information, advice and support to people with the condition, as well as their carers and parents of young people with asthma. The Society says the nurse will see up to 11 patients over a six-hour period.

The nurse will advise patients on a range of topics, including: asthma in children; allergies; asthma management and control; inhaler technique; peak flow monitoring; and smoking cessation.

They will also conduct an asthma control test to help patients gain control of their symptoms and discuss ways to improve the score, and advise patients on medication usage.

In addition, the nurse will urge patients to draw-up an asthma ‘action plan’ and encourage them to develop this in conjunction with their GP.

When poor asthma control is identified, patients will be advised to attend their GP or specialist.

The Society delivered more than 90 such events around Ireland last year. The cost of hosting the event is €90, while overall support for the programme and accompanying asthma booklets is provided by GlaxoSmithKline.

Pharmacists who wish to participate can contact orla.th behan@asthma.ie or contact Tel: 01 554 9209.

Pharmacy group to create 20 new jobs

The chain store Meagher’s Pharmacy is set to add two new pharmacies to its operation in 2016, creating 20 jobs in the process.

The business began as a single pharmacy outlet in 2001 in Baggot St, Dublin, and currently employs 65 people, including 14 pharmacists. The company has stated that it intends to double the number of stores in its chain by 2020. It plans to incorporate dedicated hospital pharmacies and larger retail store formats.

In addition, the company has qualified to represent Ireland in the public voting round of the 2016 European Business Awards. Entrants to this award are independently adjudicated in the first round of the competition, based on video and written entries, with finalists then entering a second round of online public voting.
Did you know that 40% of the population have difficulty swallowing tablets?¹

Can Help!

What is Gloup®?

Gloup® is a clear, cherry flavoured gel that facilitates the intake of medication in solid form, including tablets and capsules. It works by moistening the mucous membranes in the mouth and throat cavity and allowing the tablets to pass smoothly via the oesophagus to the stomach.

Who can use Gloup®?

Gloup® can be used by / given to anyone who can swallow autonomously, over the age of 2.

Ask your pharmacist for advice.
For further information go to www.gloup.eu
Always read the label. Clonmel Healthcare Ltd., Waterford Road, Clonmel, Co. Tipperary.
Date prepared: October 2015. 2015/AVH/GL098
Ref 1. Schwartz: 40% of American adults reporting swallowing difficulties

The gel that aids the swallowing of solid medication.
The worldwide view

In an exclusive interview, International Pharmaceutical Federation General Secretary and Chief Executive Officer Mr Luc Besançon speaks with Pat Kelly about the present and future, as pharmacists move into a new area of involvement in healthcare provision.

As the worldwide body for pharmacists, the International Pharmaceutical Federation (FIP) has a broad and challenging remit. As well as advocating for pharmacists on a global level, the FIP must not lose sight of the practical, everyday issues affecting pharmacists, regardless of the country in which they operate or their specialty.

But the FIP must also have the ability to react to any given situation. One example of this is the recent migrant crisis in Europe, as reported in the February issue of Irish Pharmacist (IP). For example, the Federation has developed tools for pharmacists, such as its health advisory document, Providing pharmaceutical care to migrant populations, information and guidelines for pharmacists and the pharmacy workforce, as well as a multilingual framework and pictograms to assist communication with patients.

FIP General Secretary Mr Luc Besançon explained to IP that the organisation is keen to play the most active role possible to improve outcomes for this very unusual patient population. “We have a Military and Emergency Pharmacy Section within FIP which has been involved in humanitarian support for many years,” he explains. “It’s important to note that there were already significant numbers of migrants and refugees in neighbouring countries in Europe.”

FIP provides tools to facilitate intake of medical history and facilitate medication use instructions, with the view to ultimately improving the quality of pharmaceutical care to migrants (www.fip.org/emergencies). “Of course, this is difficult if you don’t share a common language,” he states. “So we developed the advisory document, which has now been distributed to various countries.

“The other aspect of the care we are providing is a set of pictograms, which can be used either when the pharmacist doesn’t share the same language as the patient, or if the patient has difficulty reading. There are around 14 different languages currently available through our software, which can be downloaded free of charge from the FIP website [www.fip.org/pictograms].”

Mr Besançon tells IP that he is aware of the recent tensions between pharmacists’ and doctors’ representative bodies in Ireland, but does this situation exist in other countries, and specifically where FIP members are treating the migrant populations?

“There are two basic elements,” he explains. “Firstly, you need to differentiate the countries where the migrants are transiting, where pharmacists provide basic care on issues that relate to the journey, for example with foot problems, so this can often be fragmented, short-term treatment. Then, on the other hand, there are countries like Austria or Germany, where the migrant population aims to settle. In these countries, migrants will have to receive more comprehensive care as part of long-term treatment.

“in Germany, organisations such as the Red Cross provide complete health services to this population, so there is usually a very good collaboration between pharmacists and doctors within such organisations. But care is provided by individual healthcare professions, and there are a number of challenges impeding collaborative practice, including the lack of a sound legal or compensation framework to support working together. This translates into challenges around issues like shared information, shared identification of patients, and so on,” he said.

Tension

But does Mr Besançon feel that Ireland lags behind other jurisdictions in terms of the powers and responsibility given to pharmacists in the overall delivery of healthcare?

“We see there is tension [between pharmacists’ and doctors’ bodies] in many countries,” he explains. “That was clear when Australia started to roll-out its vaccination pilot project in two states, where doctors strongly opposed it. So I don’t think Ireland really lags behind other developed countries in evolution. In Ireland, you have developed an interesting number of new pharmacy services.

“These tensions are sometimes based on a lack of understanding of the skills that pharmacists bring and some concerns for the financial consequences on medical doctors. There are several ways to mitigate such tensions, for example through regulations and financial contracting with different healthcare professionals we are collaborating with.”

He continues: “In 2013, the World Medical Association and FIP, as well as other organisations, said that we need to have collaborative practice. We have made a statement on this matter, which is published on the World Health Professions Alliance (WHPA) website.”

The statement to which Mr Besançon refers reads: “The WHPA calls on governments to fund structures which support interprofessional collaborative practice (ICP). The structures of health systems around the world should enable ICP, educational systems should promote shared learning, and health professionals need to respect each others’ expertise.”

The FIP remains highly collaborative with other healthcare organisations such as the World Health Organisation, UNESCO and the WHPA, among others. Mr Besançon acknowledges the importance of such partnerships in order to make other healthcare professionals aware of the importance of having pharmacists deeply involved in healthcare delivery and policy planning.

“FIP published a report on interprofessional..."
Acroxia Advert A4 IMD Full Page.indd   1

**For the symptomatic relief of**

- **Osteoarthritis**
  - 30-60 mg once daily
- **Rheumatoid Arthritis**
  - 90 mg once daily
- **Ankylosing Spondylitis**
  - 30 mg once daily

**For the short-term treatment of**

- **Postoperative Moderate Dental Surgery Pain**
  - 90 mg once daily, maximum 3 days
- **Acute Gouty Arthritis**
  - 120 mg once daily, maximum 8 days

**Cyclosporin and tacrolimus**: Co-administration of cyclosporin or tacrolimus with any NSAID may increase neurotoxic effects. Monitor renal and hepatic function. If concomitantly used, Class of drugs may be associated with an increased risk of pharmacological interaction. Children: P450 enzymes.

Other important undesirable effects:

- **GI**: Diarrhoea, dyspepsia/epigastric discomfort, nausea, vomiting, oesophagitis, oral ulcer, ALT increase.
- **Cardiovascular events**: Hypertension, hyperlipidaemia, diabetes mellitus, smoking.
- **Non-cardiovascular events**: Upper respiratory infection, leukopenia, hypersensitivity, atrial fibrillation, tachycardia, congestive heart failure, angina pectoris, myocardial infarction, cerebrovascular accident, transient ischaemic attack, hypertensive crisis, vasculitis, gastrointestinal ulcer, pustular ulcers including gastrointestinal perforation and bleeding, pancreatitis, hepatitis, hepatic failure, Stevens-Johnson syndrome, toxic epidermal necrolysis, angiodysplasia, angiolytic reactions including shock. Additional information available on request. **Overdose**: Remove unabsorbed material from GI tract, clinical monitoring, institute supportive therapies if required. Not dialyzable by haemodialysis, not known whether dialysable by peritoneal dialysis. **Merck Sharp & Dohme Ireland** Co-administration of drugs with other drugs in concomitant use resulting in fatal outcome have occurred with etoricoxib. Caution in patients at risk of developing GI complications with NSAIDs, elderly, using other NSAIDs or acetylsalicylic acid concomitantly or patients with history of GI disease. Increased risk of GI adverse effects when taken concomitantly with acetylsalicylic acid. Cardiovascular effects: Class of drugs may be associated with risk of thrombotic events. Careful consideration in patients with significant risk factors for cardiovascular events (hypertension, hyperlipidaemia, diabetes mellitus, smoking). Discontinue anti-platelet therapies. **Cardiovascular events**: Hypertension, hyperlipidaemia, diabetes mellitus, smoking.

**Acrobis**

For the short-term treatment of

Postoperative Moderate Dental Surgery Pain

Acute Gouty Arthritis

**Postoperative Moderate Dental Surgery Pain**

**Acute Gouty Arthritis**

**For the symptomatic relief of**

- Osteoarthritis
  - 30-60 mg once daily
- Rheumatoid Arthritis
  - 90 mg once daily
- Ankylosing Spondylitis
  - 30 mg once daily

**References:**

1. Arcoxa SmPC, www.medicines.ie. A dose greater than those recommended for each indication have either not demonstrated additional efficacy or have not been studied. Due to cardiovascular risk, the shortest duration possible and the lowest effective dose of ARCOXIA should be used. A. The recommended dose for osteoarthritis is 30 mg once daily. An increased dose of 60 mg once daily may increase efficacy. The dose for osteoarthritis should not exceed 60 mg daily. 

**Date of preparation:** January 2015

IRE/A14/1003

Grunenthal Pharma Ltd., Dublin, Ireland, www.grunenthalie
Tension headache — exploring the most common myths

Introduction
Tension-type headache (TTH) is the most prevalent headache disorder throughout the world, and places a significant burden on both individuals and society. The World Health Organisation — from its Atlas of Headache Disorders and Resources in the World 2011 — highlighted a need for increased education and patient support in the area of headache management. Research gathered for the WHO Atlas showed that lack of education around headache disorders among healthcare professionals was a key factor in preventing good management of headache.

Furthermore, research published in 2013 states that pharmacists are vital in helping customers with headache to choose an appropriate treatment; however, guidance provided by pharmacists surveyed in the study was often insufficient to adequately manage headache in patients.

For this reason, the Tension-Type Headache Management Network recently formed in Ireland, to outline the importance of using evidence-based guidance when helping customers with their headache and ensure the burden of this disorder is decreased.

The Network is supported by RB, makers of Nurofen Express, and is comprised of Dr Eddie O’Sullivan, Director, Migraine Clinic, Cork University Hospital; Cork; Ms Julie Sugrue, Physiotherapist, Headache Clinic, Beaumont Hospital, Dublin; Mr Pat Little, CEO, Migraine Association of Ireland; and Ms Maureen Reidy, Mr Eoghan Ryan and Ms Grace O’Connor, all pharmacists.

This article, under the guidance of the Network, aims to outline and elucidate some common myths about TTH, as well as briefly outlining an update on treatment.

About TTH
TTH (also known as ‘common headache’) is the most common type of primary headache, with a lifetime prevalence of up to 78 per cent. Sufferers may describe the disorder as a constant ache that affects both sides of the head, with tight neck muscles and a feeling of pressure behind the eyes. A tension headache normally lasts for 30 minutes to several hours, although it can also last for several days.

According to the International Headache Society, frequent episodic TTH is defined as the following:
1. At least 10 episodes occurring on ≥1 but <15 days per month for at least three months (≥12 and <180 days per year);
2. Headache lasting from 30 minutes to seven days.
3. Headache has at least two of the following characteristics:
   - Bilateral location.
   - Pressing/tightening (non-pulsating) quality
   - Mild or moderate intensity.
   - Not aggravated by routine physical activity, such as walking or climbing stairs.
4. Both of the following:
   - No nausea or vomiting (anorexia may occur).
   - No more than one of photophobia or phonophobia.
5. Not attributed to another disorder.

Around half of TTH sufferers manage without consulting a healthcare professional and the pharmacy is often the first point of information for patients.

Evidence-based treatment for TTH
Specialists agree that TTH can be effectively and safely treated with over-the-counter (OTC) pain relievers in most cases. This highlights the importance of ensuring customers who present with this common headache choose the right OTC analgesic for their needs.

According to the European Headache Federation and the European Federation of Neurological Societies, paracetamol may be less effective than non-steroidal anti-inflammatory drugs (NSAIDs) in treating TTH. When considering NSAIDs, the European Federation of Neurological Societies recommends ibuprofen 400mg as the first-choice NSAID for treating common headache due to its favourable gastrointestinal (GI) safety profile compared with other NSAIDs.

Furthermore, data show that the 400mg dose of standard ibuprofen tablets can start relieving common headache within 15 minutes.

Myth 1: TTH does not need any intervention
The WHO Atlas found that headache disorders are under-diagnosed, under-treated and under-recognised, and that TTH is one of three headache disorders that cause the most ill health amongst the population. The common idea (as seen throughout this article) that TTH does not need any intervention — when in fact a simple visit to the pharmacy for guidance can help sufferers — simply adds to this burden of ill-health.

As outlined above, many patients with TTH do not attend a healthcare professional for treatment, believing the headache will resolve on its own. However, TTH can put a heavy burden on sufferers, impacting quality of life and leading to depression and anxiety. Furthermore, suffering from TTH at work has been shown to cut productivity by as much as 25 per cent.

Education is therefore important in helping TTH sufferers manage their headaches better and all health professionals play a vital role in providing this support, according to the World Health Organisation.

Pharmacy staff are welcome sources of information for patients and customers with TTH. In a recent survey, 55 per cent of pharmacy customers said they welcome an approach from the pharmacy team offering headache advice, and 85 per cent said that this advice may change their decision on which treatment to buy. Nearly 75 per cent also said that they would treat a headache sooner if they knew it would reduce the severity.

It should be noted that customers who regularly suffer from TTH should be warned about the dangers of taking pain relievers too frequently, as this could make their headache worse and lead to medication-overuse headache.

Myth 2: Tension-type headache starts in the brain
Increasingly, research is leading to the knowledge that tension-type headaches are caused by muscle strain.

When a tension-type headache begins, the pericranial myofascial tissues in the head and neck become increasingly painful and tender to the touch. Tension muscle knots can develop hyperirritable areas called myofascial trigger points. Research shows that people with TTH have a greater tenderness in the muscles of the head and neck and an increased number of myofascial trigger points.

When activated, myofascial trigger points release inflammatory mediators, such as prostaglandins, that make the nerves more sensitive to painful stimuli. This referred muscle pain from the head or neck manifests as episodic TTH. These myofascial trigger points often develop as a result of stress-related activities, such as jaw-clenching or sitting hunched over a computer, for example.

Myth 3: Ibuprofen and paracetamol are equally as effective in treating TTH
Ibuprofen has demonstrated superior efficacy to paracetamol in relieving the pain of common headache.

In a double-blind, randomised trial that...
The most common headache disorder is TTH. Pharmacists should consider all the above when aiming to treat their customers presenting with TTH.

**Conclusion**
- TTH is the most common headache disorder and can be managed efficiently in pharmacy, where patients welcome assistance in choosing an analgesic.
- Common myths about TTH include that it will go away easily without help; that it begins in the brain; and that it can be treated with paracetamol and ibuprofen equally effectively.
- Pharmacists should consider all the above evidence when aiming to treat their customers presenting with TTH.

**References**
What is also interesting is that over the past 10 years, pharmacists have been able to provide more evidence of the added value we can provide. That not only helps in the country in which they operate, but helps other countries in their advocacy for similar services. The most obvious example is administration of vaccines; in Ireland, as in other European countries, there are challenges in terms of having pharmacists vaccinate against flu or even to extend the scope of immunisations.

He explains that in the US, for the past 20 years it has been shown that pharmacists can contribute significantly to effective vaccination coverage in the safest way, providing huge benefit to patients most at risk or those who would not otherwise have been vaccinated by other healthcare professionals.

“We are here to complement what other healthcare professionals are offering, so that care for our communities is improved.”

‘Prescribing’

However, when asked about the potential for pharmacists to take on prescribing powers, Mr Besançon takes a singular view on the definition of the term. “I will pick up on the concept of prescribing,” he tells IP.

“When people go to the pharmacy and the pharmacist recommends a medicine, this is in fact already ‘prescribing’. Basically, a prescription is a formalisation of the selection of a medicine, an authorisation to dispense this particular product.”

He continues: “In Brazil, the pharmacy regulator, which is their equivalent to the PSI, has stated that when pharmacists make the decision to recommend an OTC medicine, they need to formalise it as a ‘pharmaceutical prescription’. Different countries have different approaches and the term ‘prescription’ can be weighed-down with different connotations and can seem a little scary for doctors. However, there are similar approaches to prescribing, leading to the same result: the capability of pharmacists to dispense a medicine that is on a different schedule, sometimes based on collaborative practice associated with protocol of care — there is really a lot of evolution going on.”

He explains that in Switzerland, pharmacists cannot prescribe per se, but they do have access to prescription-only medicines, for example. “We need to put the patient at the core of everything we do, to be sure we serve them in the best way and respond to their needs. In several Canadian provinces there are collaborative agreements, and often the drivers behind that are specialist doctors who approach pharmacists and say, ‘we have a problem and we believe you can help us solve it.’”

He cited Quebec, where there is a shortage of obstetricians in specific regions, and those specialists approach pharmacists for help and delegate certain prescription rights to pharmacists. This leads to better treatment for patients, but also, when pharmacists refer patients to an obstetrician, obstetricians know that these patients have presented with ‘red flag’ issues identified by pharmacists.

“So whether you call it a ‘prescription’ or use another term — I’m not so much interested in terminology — it boils down to a pharmacist being able to offer good solutions based on their competencies and these solutions should be integrated within the healthcare system.”

Burden of disease

Mr Besançon touched on the FIP Congress, which continues to go from strength to strength and this year will be held in Argentina.

“One focus of the Congress will be the fact that the burden of disease is increasingly becoming a global issue. If we look at the sustainable development goals (SDGs) adopted by the United Nations in 2015, this is a quite ambitious agenda for the next 15 years,” he tells IP. “FIP has identified a number of SDGs where pharmacists are very well positioned, not only as a gateway to the healthcare system, but we believe that beyond health promotion, we also have the ability to optimise health outcomes for patients taking medicines currently funded by governments.”

He describes pharmacists as the “insurance” of the government to ensure that expenditure on medicines truly results in better health outcomes.

“At a time of greater expectations towards government spending accountability, the investments made in pharmacists and their services is a guarantee of the impact of their investment in medicines reimbursement.”

“At the coming FIP Congress this year, we have tried to reflect these global discussions in the programme through four pillars: One is around social determinants of health, and that is a very important topic.

“Indeed, apart from the actions of individuals to improve their health, we also need to explain why poor populations (or with lower education) may have more health issues, and that’s about empowering people and changing determinants of health.”

“The second pillar is innovations in treatment. By ‘innovations’, we mean not just around medicines, but also around the delivery of healthcare and whether that will be through technology; there will be a number of sessions dedicated to that.”

“The third element, he continues, “is around adherence. In 2012, there was a report which showed that half a trillion US dollars could be saved if medicines were used responsibly and half of this was linked to adherence. There is growing interest in this area and we will focus on that issue.”

The fourth area of focus, says Mr Besançon, is around sustainability and affordability of global healthcare. “We operate in systems where there are increasing concerns around healthcare costs and we want to make sure that systems are sustainable, but are also sustainable for healthcare professions offering services, which obviously includes pharmacists. Sustainability also refers to more personalised pharmaceutical care. There will also be topics geared towards more disparate, but specific, groups with an interest in this area.”

For the first time, the 2016 Congress will include satellite sessions on immunisation training. “We have seen different countries push more and more for vaccination by pharmacists so we will offer delivery of the training carried out in the US. There will also be sessions on first aid and CPR refresher courses in collaboration with the Red Cross in Argentina.”

The Congress will feature 60-to-65 sessions and Mr Besançon concludes: “I’m rather happy when people say, ‘it was difficult to choose which sessions to attend’, as it demonstrates the relevance of the topics covered. But every individual members and congress participants can also have access to the presentations and some videos on the FIP website — some of them are also available to any pharmacist free of charge.”
BLOATING?  
CONSTIPATION?  
STOMACH CRAMPS?  
DIARRHOEA?

Symprove is a unique, liquid formulation containing four strains of live and active bacteria.

It is clinically proven with independent, medical trials* to work on mild and severe digestive problems.

A non-dairy, liquid formulation that does not trigger digestion so it can bypass the stomach and get directly into the intestines quickly and alive, where it gets to work.

For more information:  
www.symprove.com

JOIN THE SYMPROVE™ 12 WEEK PROGRAMME

The European Directive on Falsified Medicines has finally been signed into EU law after years of debate and multiple delays. The law paves the way for the introduction of a new ‘unique identifier’ — a 2D barcode — and anti-tamper devices to be fixed to every prescription medicines pack dispensed in the EU. The system will alert pharmacists and wholesalers to counterfeit medicines in the supply chain before they can be sold to patients. For retail pharmacists, this is likely to mean a de facto obligation to purchase scanning machines for every sales point where prescription medicines are dispensed. Previous estimates put the likely cost of this hardware at around €250 per scanner.

Software and robust broadband connections will be required to link pharmacists with a Europe-wide database, which will verify the authenticity of the pack before it is sold. Hospital pharmacists will also be required to comply with the new rules but there is some flexibility regarding when products are scanned for verification. The system will make it more difficult for counterfeit products to enter the system and is expected to facilitate product recalls.

The long-awaited rules were first proposed as part of the Pharmaceutical Package put forward by the European Commission in 2008. The path to approval has been long and winding, besieged by technical challenges and intense competition among stakeholders to design and host the verification system.

It now seems certain that a new European Medicines Verification System will be operated by a consortium including the Pharmaceutical Group of the European Union (PGEU), which represents community pharmacists. After years of discussion between the Commission, national governments and Members of the European Parliament (MEPs), the new rules were approved by the European Parliament ‘delegated regulation’ in February. The final text was then published in the Official Journal of the European Union. However, pharmacists and wholesalers still have a grace period before the law comes into effect. While the directive is now a formal part of European law, national authorities have until 9 February 2019 to implement it in full.

European Association of Hospital Pharmacists joins mHealth group

The European Association of Hospital Pharmacists (EAHP) has been accepted as a member of a European Commission working group developing assessment guidelines for mobile health (mHealth) applications in the European Union.

The challenge arising from mHealth has proven a thorny one for regulators around the world, given the proliferation of health apps, of which thousands come to market every year. Many are essentially lifestyle apps that help track exercise or diet but a minority offer medical advice, including suggestions about drugs, vitamin supplements and alternative medicines.

Some commentators have suggested that apps should be subject to existing legislation covering medical devices, while others say new legislation is needed. Health apps are seen as a fast-moving target, evolving at a faster pace than regulation. In the US, regulators have suggested that the task of vetting every new health app could prove prohibitively labour-intensive.

EAHP Board Member Robert Moss will lead the Association’s representatives within the group. The hospital pharmacists’ group says it sees opportunities arising from mobile devices but is also conscious of potential threats to patient safety, represented by the uptake of mHealth applications in the sphere of medicines use.

The group is calling for appropriate regulation for apps that involve medicines use, and for the advice of hospital pharmacists to be taken into account within regulatory processes.

“Hospital pharmacists are the secondary care sector’s experts in medicines and medicines use, and is a profession that takes patient safety as fundamental to its mission,” said Moss. “Our insight on medicines risk can help protect the welfare of patients from sources of potential harm that may otherwise remain unseen.”

The European Commission has now set up a working group to develop guidelines for assessing the validity and reliability of the data that health apps collect and process. Based on their expertise, 20 members representing civil society, research and industry organisations were selected to participate in the working group. The guidelines are expected to be published by the end of 2016.

Plans for European Paediatric Formulary

The European Directorate for the Quality of Medicines and Healthcare (EDQM) has announced details of its project to create a European Paediatric Formulary. The future online publication will give hospital and retail pharmacies across Europe easy access to a formulary for the preparation of unlicensed formulations of paediatric medicines. Although there have been significant efforts to increase the number of available licensed medicines for children, there is still a shortfall — especially of those containing well-known active substances.

At present, national or regional formularies on pharmacy preparations for the treatment of children still play an important role in pediatrics. Although some individual countries have good approaches, these are not shared across all countries.

The Formulary is under development by The European Committee on Pharmaceuticals and Pharmaceutical Care (CD-P-PH) and the European Pharmacopoeia Commission, with the secretariat provided by EDQM.

A working party under the auspices of the European Pharmacopoeia Commission began work earlier this year to evaluate existing formularies and to develop the European Paediatric Formulary. Draft monographs will in future be published for public consultation in EDQM’s online forum Phareuropa before final adoption by the two committees.
Introducing the latest in the professional range from LISTERINE® – a twice-daily mouthwash clinically proven to treat gum disease as an adjunct to mechanical cleaning.

Advanced Defence Gum Treatment is an alternative to chlorhexidine-based remedies. It’s formulated with unique LAE (Ethyl Lauroyl Arginate) technology that forms a physical coating on the pellicle to prevent bacteria attaching, and so interrupts biofilm formation.

When used after brushing it treats gum disease by reducing bleeding; 50.9% (p<0.001) in only 4 weeks.¹

In addition, Advanced Defence Gum Treatment is designed to not cause staining.²

References:
1. Bleeding Index Reduction DOF 1 – 2013 (LAEBBA0001), 50.9% reduction in whole-mouth mean Bleeding Index at 4 weeks.
2. DOF 2 – 2013 (UNKPLT0006).
IRE/LI/15-1184
An appeal to pharmacy colleagues for support to help save our jobs

Dear Editor,

I am a pharmaceutical assistant. I am 57 years old. This year marks 40 years for me working in community pharmacy. I am appealing to my colleagues in pharmacy to support us, as we try to save our jobs. The PSI has issued draft rules, in an attempt to define ‘Temporary Absence’, for public consultation.

If this succeeds, it will mean that we, as Qualified Assistants, may only work for 12 hours per week in ‘Temporary Absence’. This draft publication is open to the public until Monday, 7 March. The PSI welcome comments via email at consultation@psi.ie with the subject ‘Temporary Absence Consultation’ or via post to Pharmaceutical Society of Ireland, PSI House, Fenian Street, Dublin 2.

It is incredible, in the true sense of the word, that the PSI insists on pursuing this matter, given as Mr Richard Collis (PSI Executive Council member) said that it is the Supervising/Supersident pharmacist who is responsible for the pharmacy at all times. This will cause more redundancies, as employers would not want to pay for a downgraded ‘skilled assistant’, rather than the autonomous and qualified professional, as the law has viewed us for the last 126 years. It is important to state that we can work independently, as distinct from technicians, whose work must be supervised by a pharmacist at all times.

Mission statement

The mission statement on the PSI Website is that it wishes to “provide a fair and workable model of temporary absence and also provide public assurance of safe pharmacy practice and public safety”.

This suggests that there are public safety issues but the PSI have not presented any research that shows that the current or indeed historic practice of pharmaceutical assistants has led to unsafe practice or patient safety issues. Pharmaceutical Assistants do not fall under Fitness to Practice regulations under the 2007 Act, whereas pharmacists do. If this is the yardstick to measure competence, then Pharmaceutical Assistants have always maintained that this should be introduced for all. It would seem a more professional approach on the regulator’s part to work to introduce Fitness to Practice and CPD rules, rather than to limit the hours of practice. How can it be justified that a person is fit to practice for a specified number of hours and if they work one minute above that specification, they would be committing an offence? If a person is trained and qualified, they are competent and the number of hours is not relevant.

Experience

There are approximately 400 assistants left on the register. All are over 50 years old, each one with over 30 years’ pharmacy experience. Over 99.5 per cent are women and the majority have been working part-time in same pharmacy for many years.

Many are close to retirement, with little or no pension provisions.

So what does the PSI Executive have to say? Here are some comments made by the Executive at the PSI Council Meeting (March 2015).

Dr Paul Gorecki suggested the assistants should work alongside the pharmacist for as long as the supervising pharmacist felt was appropriate for them to provide cover... He felt that the PSI should not get into detailed regulation on this issue.”

Mr Collis said Dr Gorecki’s suggestion should be looked at, as it was the pharmacist who was responsible if anything went wrong in his pharmacy. He pointed out that they were talking, by and large, about a diminishing band of people with a lot of experience who had given great service over the years.

Dr Jean Holohan remarked that this was a group of very professional healthcare professionals who had worked alongside pharmacists for a long time and she agreed with the need for a more high-level view.

Prof Kieran Murphy agreed that one solution could be a high-level rule with detailed guidelines that could be changed.

1994 Draft Code of practice

It is only now that the PSI has decided to act on Section 30(2) of the 2007 Pharmacy Act. This allows the council to determine, with the consent of the Minister, what we may do in temporary absence and what constitutes the temporary absence of a pharmacist.

A previous attempt to define temporary absence was resolved in the High Court (1983), in a case heard by Judge Costello. The outcome led to the old PSI having to withdraw guidelines that had interpreted temporary absence to mean four hours per week.

The judgement reiterated that temporary absence was a matter for interpretation by a competent court to decide, in a particular case, having regard for all the surrounding circumstances. This position was confirmed once again by the then Minister for Health, Barry Desmond, in 1986, when he stated in a written answer to the Dáil: “It will be appreciated that interpretation of statutes is a matter for the courts alone to decide.”

The old PSI attempted to define Temporary Absence again in 1994, with a view to including these terms in the 2007 Act. Despite this, the implementation of the 1994 Draft Code has already caused untold damage to qualified Pharmaceutical Assistants, many of whom are now unemployed. With regard to the 94 Draft Code, under Freedom of Information, the PSI has recently acknowledged that there is no signed copy of the 1994 Code of Practice.

Having achieved a qualification under the old PSI that set out the parameters and expectations for a career pathway and associated earnings, Pharmaceutical Assistants have a legitimate expectation that the parameters will not be altered in a way that is unreasonable and adversely affects them.

Kind regards,
Vyra Hardy,
Qualified Pharmaceutical Assistant.

Per aspera ad astra — ‘to the stars through difficulties’
Seats at the top table

As the dust settles on the election — and while we might have one eye on the possibility of another one soon — there were a couple of interesting results. Naturally, the ones that jump off the page are the election of two pharmacists.

I am open to correction, but to my knowledge, the last pharmacist to grace Dáil Éireann was Progressive Democrats TD Tim O’Malley, who was elected in 2002. To have two pharmacists elected in 2016 is therefore remarkable.

Kate O’Connell in Dublin and John Brassil in Kerry got over their respective lines, and congratulations to them. Now, when issues arise that pertain to this is a case of ‘the more the merrier’.

One issue they could choose to take up, sooner rather than later, is the plight of Pharmacy Assistants (PAs). The letter in this month’s issue articulates how PAs feel on this issue better than I could, but apart from the obvious threat to these health professionals’ careers, there should be a more broad, societal concern over the massive amount of experience that could be lost.

Of course, the IPU represents the interests of the sector and is not shy about making its views known to the political powers that be, but when it comes to having representation at policy-making level, they will be there, in the corridors and at the committee meetings, representing the views of pharmacists, and that is to be welcomed.

One issue they could choose to take up, sooner rather than later, is the plight of Pharmacy Assistants (PAs).

The letter in this month’s issue articulates how PAs feel on this issue better than I could, but apart from the obvious threat to these health professionals’ careers, there should be a more broad, societal concern over the massive amount of experience that could be lost.

At time of writing, an online petition (http://bit.ly/T0DFwuz) had garnered over 300 votes in a matter of four days, so the strength of feeling on this matter is evident.
In the UK, prescribing of pregabalin increased by 350 per cent in five years and gabapentin by 150 per cent at the same time. These drugs are collectively called the gabapentinoids. Pregabalin, which is structurally similar to GABA, is indicated in Europe as a treatment for epilepsy, peripheral and central neuropathic pain, fibromyalgia and for general anxiety disorder (GAD). Gabapentin is used either as mono-therapy or as an adjunct in the treatment of partial seizures and for peripheral neuropathic pain associated with diabetic neuropathy or post-herpetic neuralgia. Pregabalin is known to be more potent than gabapentin, is more rapidly absorbed and has a greater bioavailability, leading to suggestions that it has a higher abuse potential. The literature suggests that pregabalin is often prescribed 'off-label' for other conditions including bipolar disorder, ADHD, restless legs syndrome, trigeminal neuralgia, non-neuropathic pain and, ironically in view of what has happened here, in Britain and in Europe, in alcohol and opioid withdrawal syndromes.

In the UK, prescribing of pregabalin increased by 350 per cent in five years and gabapentin by 150 per cent at the same time. Anecdotally, there appears to be a growing black market in the UK, which is allegedly being fuelled by non-prescription availability through online pharmacies. The data from Trinity Court suggest that something similar may be happening here. Of 440 patients tested, 39 tested positive for pregabalin (9.2 per cent). The researchers contacted the relevant clinicians and established that only 10 patients had been prescribed pregabalin. Therefore, 7 per cent of the sample were using non-prescribed drug on top of their methadone or in one case buprenorphine/naloxone. They estimated that up to 675 patients nationally might be similarly misusing pregabalin by extrapolating from the 9,640 patients known to be receiving opioid substitution therapy in 2013.

At one stage, these two drugs were seen as having a low potential for misuse, even though they were believed to have alcohol/hydroxybutyrate (GHB) and benzodiazepine-like effects linked to euphoria in up to 12 per cent of patients in some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.

Addiction liability seems to be low at therapeutic doses but misusers seem to be individuals with a history of recreational polydrug use who consume doses three-to-twenty times the normal medicinal dose. Many appear to see pregabalin as a substitute for many common illicit drugs. In Belfast, recreational users admitted to A&E with seizures after so-called ‘Lyrica Nights’ stated that the drug induced a drunk-state, hence the street name ‘Budweisers’. Cases of pregabalin abuse or dependence were first reported to the German medicines regulator in 2008, which noted that the mean daily dose in such individuals was 1,424mg compared to a 600mg maximum daily dose, as set out in the SPC. In some clinical populations. A 2012 Canadian Agency for Drugs and Technology in Health review of pregabalin noted clinical studies in 5,500 patients, which showed that 4 per cent reported euphoric effects compared to 1 per cent in placebo groups. An abuse liability study suggested that the drug had a potential for euphoric effects in susceptible patients.
Teva Respiratory

DuoResp® Spiromax® (budesonide/formoterol fumarate dihydrate) 320 mcg/9 mcg inhalation powder

**Intuitive to handle**

- Intuitive to handle
- Ready in one flip of the cover
- For asthma and COPD

**Intuitive by design**

DuoResp® Spiromax® (budesonide/formoterol fumarate dihydrate) 320 mcg/9 mcg inhalation powder

*Instructions for use should be followed as per the patient information leaflet.*

**DuoResp Spiromax® is licensed for use in adults 18 years of age and older.**
Comment & Analysis

view from above

Terry Maguire

Terry Maguire owns two pharmacies in Belfast. He is an honorary senior lecturer at the School of Pharmacy, the Queen’s University of Belfast. His research interests include the contribution of community pharmacy to improving public health.

Long-suffering wives

Terry Maguire on the issue of female desire-enhancing drugs

Frank (not his real name) was very angry on the telephone. It was the same thing every month, he complained, and we needed to get our act together or he would take his business elsewhere. Just like last month, we forgot his Viagra. Everything else was in the bag not the Viagra. I apologised and told him I would get to the bottom of it. He was a good customer, his family were good, loyal customers too, so I undertook an investigation. Staff involved were adamant his eight Viagra 100 tablets were in the medicines bag. One counter assistant suggested I study the CCTV for the time the medicines were collected. Our street-facing camera showed Frank’s wife leaving the pharmacy, opening the medicine bag, walking over to the street wastepaper bin and dumping something. “There”, said my counter-assistant with veracity, “is your missing Viagra.” It proved a difficult conversation with Frank. I merely confirmed that we had dispensed the Viagra. Have a look in the house, I suggested, but the Viagra left the pharmacy.

I’m not sure how common this phenomenon might be. I’m not sure how the average long-suffering partner of a 60-year-old, overweight male with minimal personal hygiene and bearing a strong resemblance to a church gargoyle, might respond to a guarantee ‘night of prolonged passion’. I suggested, but the Viagra left the pharmacy.

I’m not sure how common this phenomenon might be. I’m not sure how the average long-suffering partner of a 60-year-old, overweight male with minimal personal hygiene and bearing a strong resemblance to a church gargoyle, might respond to a guarantee ‘night of prolonged passion’. I suggested, but the Viagra left the pharmacy.

Irwin was initially taken aback by my cynicism of the drug but he rose to the challenge in his attempt to convince. As we talked, I saw the real Irwin and understood why he had so irritated me in our earlier meeting. He instinctively knows what most people want and he uses his considerable interpersonal skills and influence to push people in his direction, knowing the unbelievers will eventually be forced to follow.

For me, the flibanserin story is one of the darkest of modern drug regulation and I still feel the FDA should be ashamed they allowed it to market. People-power and a perverted view of equality forced the FDA, a respected drug regulator, to concede to a public relations and in doing so, diminished its objectivity and reputation.

Flibanserin was developed as an antidepressant but performed poorly in early trials. Its main action is on serotonin receptors in the brain’s pre-frontal cortex and it is thought it increases dopamine and noradrenaline levels, while suppressing serotonin. This profile suggests it might make humans happier while less inhibited, but the evidence is poor. As dopamine is the desire chemical, it was postulated flibanserin might improve sexual desire and since most men don’t seem to have much of a problem desiring sex, the focus for flibanserin was on women who apparently do. Studies in 11,000 women, claimed eminent sex doctors including Irwin, showed it was a major breakthrough. Others such as the FDA and Pharmed Out — a group committed to exposing overhype by Big Pharma — said the opposite.

In a simple model; there is a disease and there is a drug, with few side-effects, that treats the disease. Where this is tested and shown to be the case, the drug gets a license. It might be sexist to say but in this case the condition — the disease — comes from the controversial Diagnostic and Statistical Manual of Mental Disorders (DSMIV) which, to be fair, has been accused of inventing diseases on more than a few occasions. The disease in question, “hyposexual sexual desire disorder” (HSDD), is questionable but since the DSMIV says it’s a disease, this provides justification for a drug cure. First, we need some means to measure the condition and for HSDD, the measure is the ‘satisfying sexual event’ score. The score, for women with HSDD, is 2.75 events per month (pretty bad apparently). In the study, women keep a diary record while they take flibanserin or a placebo. Results showed that those taking the drug improved their score from 2.75 to 4.5, while those taking a sugar pill went up from 2.75 to 3.7. There were of course some side-effects in the flibanserin group, including an impressive fall in blood pressure if alcohol was also taken.

Boehringer, who developed the drug, gave up the fight for a license in 2010 and sold it on to Sprout Pharmaceuticals. Their forceful CEO Cindy Whitehead went all-out. Rather than plan new studies to improve the data, she went the PR route. ‘Even the Score’ was her lobby group and was made up of national women’s organisations, with the support of the Journal of Sexual Medicine, of which Irwin is the Editor-in-Chief. Women’s sexual needs were being ignored; men have Viagra etc, therefore FDA had a gender bias in drug regulation and so flibanserin was to ‘Even the Score’. JAMA was not impressed seeing drug licensing hijacked by consumer advocacy groups. Pharmed Out called it “the worst kind of precedent”.

On getting a license, Sprout sold immediately to Valeant Pharmaceuticals for $100 million. Charlie Munger of Hathaway called Valeant’s business model “deeply immoral”, in that they buy rights to old but essential medicines and pump up the price. Flibanserin, since it entered the Valeant stable, has not been very successful. In the month following launch in 2015, only 227 prescriptions had been issued. Addy is costly, at $780 a month, alcohol must be stopped and doctors wishing to prescribe must do online training. Irwin claims he has 50 people on the drug.

Still, having considered the weak evidence and Irvin’s passionate advocacy for female desire problems, he failed to convince me that Frank’s wife was suffering from any form of clinical syndrome.
As the Leading Generic supplier in Ireland, we are proud to offer the medical community throughout the country the choice to prescribe and dispense quality generic treatments. In doing so, we are working with you to help your patients benefit from quality and cost-effective medications.

With over 30 years manufacturing healthcare products in Ireland, Pinewood Healthcare is one of the largest generic suppliers with a workforce of over 340 people. We are always committed to providing the Irish market with quality brands at inexpensive prices.
Are you doing your bit?

We can all play our part to try to influence the PSI, writes David Jordan

There is no doubt that you are all well used to me giving out yards about each and every of the PSI’s endeavours. But did you ever sit down and think to yourself, how did it ever come to this? How did we ever reach such a level where is PSI is so detached from the reality on the ground for most pharmacists?

The problems only arose at the formation of the new PSI. Its predecessor was a benign body for the most part. There was a heavy involvement of pharmacists who were very much down-to-earth characters. Certainly, the old PSI had less powers than the current body, but it was more judicious in how it exercised them. I think that there may have been a bit of an assumption when the new PSI came in, that things would be much as before. It also came at a bad time for most pharmacists, as it coincided with the whammy that is the recession. Understandably, many of us had a lot on our plates at the time.

Most of us would rather keep our contact with the PSI to the minimum. If we want to effect change, then this will not work.

Now, getting back to the title of this article — have you done your bit? So what can you do? I think that the time has come to be a bit more proactive in our dealings with the PSI. I have taken them to task previously for having too many consultations. The effect of some of these consultations would make the civil service look like Speedy Gonzales. (For those below a certain age, you are now allowed to break off and search YouTube for ‘Speedy Gonzales’). I myself have doubts about the usefulness of submissions in relation to the various consultation. All of the submissions and the PSI’s response are available for public consumption and what I have read to date didn’t encourage me to make any more. But for all that, they still remain one of the best ways to try and influence the non-pharmacist members of Council. However, as these are all political appointees, to my mind they all come with their own preconceived notions and winning hearts and minds is going to be a long slog.

Another way that you can have your input is to get involved with the various pilot programs and sub-committees run by the PSI. But if you look at the PSI’s website, there is nothing there about how to do this. There are practising community pharmacists involved but there needs to be more.

The rude awakening came with the first bill for registration from the new body. The only reason that they would give at the time, and then only as a result of a Dáil question, was that they wanted/needed to build up a reserve to cover the possibility of a legal challenge. Well, two things have happened since. Firstly, they have built up their reserve fund, approximately €12 million, and secondly, it is now all the more likely that there will be a legal challenge to them at some point in the near future.

The one on vaccinations will be closed before you read this. Let’s just hope that they don’t make it another bureaucratic nightmare that meant for most of us that it was uneconomic to provide the service. If your time off is covered by a Qualified Assistants (QAs), then you might want to put in something about the proposed draft rules. In the past, I have accused the PSI of bullying and nowhere is this exemplified more than by their approach to the QAs. Some of the actions of the PSI towards pharmacists who employ QAs and the QAs themselves has been little short of disgraceful. This leaves aside the illogicality of some of their arguments.

How a QA can be competent to cover a pharmacy for 12 hours per week but be incompetent for 12 hours and five minutes is beyond me. How can a QA be competent on a regular basis but not in an emergency if she (and it is usually a she) has already passed their 12-hour allocation? All of these leaves aside the fact that QAs have benefited from a definition of ‘Temporary Absence’, which pre-dates the Pharmacy Act of 1875.

Rather than engaging with the QAs and their representatives on the matter, the PSI will just consider their submission to the consultation process. I wish the QAs well in their endeavours, they are a tough bunch and it will take a lot to beat them.

Another way that you can have your input is to get involved with the various pilot programs and sub-committees run by the PSI. But if you look at the PSI’s website, there is nothing there about how to do this. There are practising community pharmacists involved but there needs to be more.

The rude awakening came with the first bill for registration from the new body. The only reason that they would give at the time, and then only as a result of a Dáil question, was that they wanted/needed to build up a reserve to cover the possibility of a legal challenge. Well, two things have happened since. Firstly, they have built up their reserve fund, approximately €12 million, and secondly, it is now all the more likely that there will be a legal challenge to them at some point in the near future.

The one on vaccinations will be closed before you read this. Let’s just hope that they don’t make it another bureaucratic nightmare that meant for most of us that it was uneconomic to provide the service. If your time off is covered by a Qualified Assistants (QAs), then you might want to put in something about the proposed draft rules. In the past, I have accused the PSI of bullying and nowhere is this exemplified more than by their approach to the QAs. Some of the actions of the PSI towards pharmacists who employ QAs and the QAs themselves has been little short of disgraceful. This leaves aside the illogicality of some of their arguments.

How a QA can be competent to cover a pharmacy for 12 hours per week but be incompetent for 12 hours and five minutes is beyond me. How can a QA be competent on a regular basis but not in an emergency if she (and it is usually a she) has already passed their 12-hour allocation? All of these leaves aside the fact that QAs have benefited from a definition of ‘Temporary Absence’, which pre-dates the Pharmacy Act of 1875.

Rather than engaging with the QAs and their representatives on the matter, the PSI will just consider their submission to the consultation process. I wish the QAs well in their endeavours, they are a tough bunch and it will take a lot to beat them.

Doing your bit doesn’t just extend to the PSI. The IIPD needs our input as well. Though I fear in the case of the IIPD that it has become a puppet of the PSI and any input that practising community pharmacists have there will just be a case of bolting the stable door.

And what is the IPU doing in all this? Well, the IPU, like any other union, can only do what its members tells it that they want doing. Unlike the PSI, the IPU wants our input. Input on a formal level is subject to the same provisos as above but the IPU is open to all sorts of input via all sorts of channels.

Like the general election, if you don’t vote, then you can’t complain. Sometimes I wonder if voting in elections is about as useful as sending input into the PSI.

But don’t get me started on real politicians!
The first line of defence

Mary Corcoran reports on the most common forms of dermatological issues among the very young

Regarded as one of the most important defences against illness and infection, the skin is one of our most remarkable organs. It serves a host of functions, including protecting the body from bacteria and viruses, as well as the elements.

However, in the first year of life this fascinating organ is at its weakest and it is vital that it is protected during this period. Recent research has shown that infant skin appears to have a thinner epidermis and stratum corneum, as well as smaller corneocytes, at least until the second year of life. Furthermore, research also shows the water-handling properties of the skin are not fully developed before the end of the first year of life and infant SC stratum corneum contains more water and less amounts of natural moisturising factors. Infant skin is also considered more prone to injury and more sensitive than adult skin.

Back to basics

From birth to toddlerhood

When it comes to caring for the delicate skin of a newborn, latest research suggests that less really is more, particularly in the early stages of life.

Good skincare practices should begin just after birth and healthcare professionals are increasingly recommending that parents delay bathing their infant for the first time, allowing the vernix caseosa — the white, waxy substance which covers a newborn’s skin when they are born — to be absorbed. The World Health Organisation has even issued guidelines recommending delaying the first bath until at least six hours of age and says that vernix should not be wiped away, if present. The reason for these new guidelines is that vernix caseosa is known to have a number of health benefits, including temperature regulation in the first week of life (if left intact), wound healing, moisturising and antioxidant properties.

Once the parent or carer is ready to bathe their baby, a mild cleanser is all that is needed for that first bath. In fact, some healthcare professionals recommending using only warm water to cleanse newborn skin. Water should be kept to around 36 degrees.

Once the neonate stage has passed, parents or carers may choose to add a mild cleanser and moisturiser to their baby’s bath routine. At this point, they will often ask the pharmacist for advice and recommendations about specific products, which are best suited to their infant. There are a plethora of old and new products in this area, many of which are very effective in keeping skin well-hydrated and...
helping to prevent dry skin conditions which can be recommended. Specialist products are also readily available for children with atopic tendencies or sensitivities. Pharmacists should advise parents and carers that there is no need to bathe infants every day (two or three baths a week will suffice).

There are certain essentials, which every household will need for caring for their infants skin including a cleanser, shampoo, moisturiser, barrier cream and sunscreen.

The key to protecting and caring for an infant’s skin is to keep their skincare routine as simple as possible, avoiding harsh products aimed at adults and traditional natural remedies, which may not be as effective as it was once thought.

Common conditions

Dry skin

Traditionally, many healthcare professionals would have recommended that parents could use sunflower or olive oil to help treat dry skin in infants, however new research suggests that using these natural products could be causing more harm than good. The study, undertaken by the University of Manchester, said using olive oil on newborn babies’ skin damages the barrier, which usually prevents water loss and blocks allergens and infections. The research even suggested the use of topical oils on baby skin may contribute to the development of childhood atopic eczema. Instead, pharmacists can advise that they keep skin well moisturised with an emollient — creams or lotions are suitable for mild dry skin, whereas an ointment is more suitable for treating very dry skin.

Eczema

It’s estimated that one-in-five children has eczema and in most cases, children will develop the condition before their first birthday. The severity of the condition varies from infant to infant, with some parents reporting mild, dry skin, while other parents will say their baby is being kept awake at night by scratching and has areas of cracked, sore and bleeding skin.

The key to managing eczema is in keeping the skin well hydrated. Mild cases of eczema can be treated with emollients and mild cleansers. Bubble baths, fragranced products and soaps should be avoided. As environmental factors such as house dust mites, pet dander and pollen can also aggravate eczema, parents should be advised to avoid these allergens by regularly dusting their home with a damp cloth and vacuuming. Detergents can also often trigger a skin reaction and carers should be advised that if they think their child may have a sensitivity to their washing detergent, they should try changing detergent to a non-biological product or to a different brand.

Atopic eczema can also be caused by food allergies and can present during weaning to foods like cows’ milk, eggs, nuts, soya and wheat. If a parent suspects their infant may have a food allergy which has triggered the eczema, they should contact their GP and arrange for allergy testing. If a breastfed baby is showing a sensitivity to an allergen like dairy, the mother should be advised to consider temporarily removing the food from her diet and continuing to breastfeed.

More severe cases of eczema warrant a trip to the doctor, particularly if there are concerns the skin could be infected. In such instances, the GP may prescribe a topical or oral antibiotic or corticosteroid to help control the flare up.

Nappy rash

Nappy rash affects up to a third of all babies at some stage, and depending on its severity, can be quite distressing for the infant. In mild cases, a small part of the nappy area may be pink or red and the baby will experience a stinging sensation when passing urine or faeces. In more severe cases, the skin may crack or may appear to have small ulcers or blisters — in these cases, it may spread down the legs or up to the abdomen. If the infant has a temperature with nappy rash, the skin looks swollen or the infant is particularly upset, the parent should contact the GP to rule out an infection, which may need to be treated with antibiotics.

Mild nappy rash can often be treated at home without any specialist products. Parents should be advised to allow the infant to have nappy-free time, cleanse their baby’s bottom with just warm water until the rash improves and apply a barrier cream every time they change the infant’s nappy. If the rash persists, parents can be advised to consider changing the type of nappy they are using.

Some parents report that applying breast milk to the rash can help it to improve, however new research found barrier cream delivers more effective results than treatment with human breast milk, particularly in the treatment of newborns with moderate-to-severe nappy dermatitis.

In more severe cases, topical corticosteroids or topical antifungals may be needed to treat the rash and reduce inflammation in the area.

Baby acne

Commonly presenting on the cheeks, forehead and chin, this harmless condition is often one that has many a worried parent presenting to the pharmacy. The condition involves the appearance of whiteheads and pimples at around the three-to-four week mark and often persists until the baby is aged around three months. In almost every case, this condition will resolve on its own and parents can be advised to just keep the area clean and to wash the face two or three times a day with warm water.

Cradle cap

While very common and harmless, cradle cap is a condition, which most parents are keen to eliminate. Usually appearing at around three months, cradle cap sees the development of thick, yellow scales and crust appearing on the scalp of the infant. While the condition usually clears up after a few months, it can persist until the child’s second birthday, or in rare cases into childhood. Washing the scalp and hair with a mild shampoo regularly may help to prevent a build up of scales on the scalp. The crust can be loosened by applying a natural oil to the scalp at night-time, and using a soft baby brush to remove the scales in the morning before washing the hair. A number of specialist cradle cap shampoos are now also available on the market, which can be very effective in treating the condition. In severe cases, or if an infection is suspected, the parent may need to take the infant to the GP, who may prescribe a course of antibiotics or an antifungal cream or shampoo, such as ketoconazole.

Conclusion

The key to protecting and caring for an infant’s skin is to keep their skincare routine as simple as possible, avoiding harsh products aimed at adults and traditional natural remedies, which may not be as effective as it was once thought.
Latest module

Angina – causes, risk factors and treatment

This module, by Margaret McCahill, examines the causes of and risk factors for angina. Precipitants of attacks are included, along with interventions to reduce the frequency of attacks. Drug treatment is discussed with reference to treatment of other concomitant cardiac disorders.

Regular drug therapy is indicated if a patient uses GTN spray more than twice daily. True or false?

Check your answer against the latest module on pharmacistcpd.ie.
Launch of We Love Quitters campaign

Ms Laura Payne, Marketing Manager Clonmel Healthcare

Prof Luke Clancy, Director General, Tobacco Free Research Institute Ireland, and Ms Laura Payne, Marketing Manager Clonmel Healthcare

Mr Martin Gallagher, Director of Marketing and Business, Clonmel Healthcare

Prof Luke Clancy, Director General, Tobacco Free Research Institute Ireland

Mr Martin Gallagher, Director of Marketing and Business Development and Mr Barry Fitzpatrick, Director of Sales for Clonmel Healthcare, pictured with Prof Luke Clancy, Director General, Tobacco Free Research Institute Ireland, and Mr Tom Farrell, Sales Manager, Clonmel Healthcare

Ms Laura Payne, Marketing Manager Clonmel Healthcare

Pictures: Andres Poveda
Latest module

Atrial Fibrillation
– rate and rhythm control (part 1)

Written by Margaret McCahill, Senior Pharmacist, Bon Secours Hospital, Glasnevin, this module examines the causes of, and morbidity and mortality associated with atrial fibrillation (AF). It discusses methods of cardioversion and the treatment options for AF, namely rate control and rhythm control.

In atrial fibrillation, pharmacological cardioversion is more successful than direct current cardioversion (DCC). True or false?

Check your answer against the latest module on pharmacistcpd.ie
Nicochew launch ‘We Love Quitters’ quit Smoking Challenge on National No Smoking Day

Patients can save €4,650 per year by becoming a quitter

If you are one of the many who have already broken your New Year’s Resolution to Quit Smoking? You can pick it up again with the We Love Quitters Challenge — helping smokers that want to quit the habit this National No Smoking Day by offering them support with hints, tips and motivation when they sign up for the challenge at facebook.com/welovequittersonireland.

We Love Quitters Quit Smoking Challenge, which started on National No Smoking Day on 10 February and will last for the 47 days of Lent to 27 March, is proudly sponsored by Nicochew, a Clonmel Healthcare over-the-counter brand. For smokers, this is an amazing opportunity and fantastic motivation to help them to quit. Every day without a cigarette is good news for their health, family and friends and their pockets, with savings of €4,650 per year if they currently smoke 20 cigarettes a day.

Prof Luke Clancy, Director General, Tobacco Free Research Institute Ireland, said of smokers quitting: “Tobacco use is the most preventable cause of death, chronic disability and a major cause of health inequality in Ireland today — 70 per cent of smokers want to quit and many make several attempts without success. Effective treatments exist and every smoker should be offered help to quit. Although smoking is decreasing, it still remains high at some 20 per cent and if we want to achieve the government’s goal of becoming smoke-free by 2025, it is imperative that we improve the treatment of tobacco dependence for smokers and offer them the support they need to help them quit.”

Mr Martin Gallagher, Director of Marketing and Business Development, Clonmel Healthcare, said of the campaign: “National No Smoking Day is the ideal opportunity to become a quitter. Clonmel Healthcare and Nicochew are delighted to be launching this initiative for the second year. Last year’s campaign was a great success and we would like to see the We Love Quitters Quit Smoking Challenge growing year-on-year, ensuring a healthier life for all and perhaps seeing Ireland becoming a leader, not only with the success of the smoking ban, but on decreasing numbers of smokers.”

Every cigarette smoked reduces a smoker’s life by five-and-a-half minutes. Every 6.5 seconds, someone in the world dies from tobacco use. This adds up to a shocking 1.5 million people dying needlessly each year, so now is the time to become a Quitter.

The Office of Tobacco Free Research Institute Ireland recently stated that the overall prevalence of cigarette smoking in 2014 was 19.5 per cent. This compares to 21.5 per cent for 2013. This equates to over 70,000 fewer smokers in 2014, compared to 2013.

Smoking rates were highest among young adults (18-to-34 years), reaching 27.3 per cent in the 25-to-34 year-old age group. Prevalence was lowest among the 15-to-17 age group, at 7.9 per cent.

The Office of Tobacco Free Research Institute Ireland recently stated that the overall prevalence of cigarette smoking in 2014 was 19.5 per cent. This compares to 21.5 per cent for 2013. This equates to over 70,000 fewer smokers in 2014, compared to 2013.

We Love Quitters will be online to help smokers who want to break their unhealthy habit forever by providing motivation, moral support, guidance and helpful advice to ease them on their journey towards a smoke-free future.

Once smokers sign up to become a Quitter through the innovative social media campaign, supported by Nicochew, the ‘welovequitters’ pages on twitter (@welovequitters) and facebook (facebook.com/welovequittersireland) promises to support quitters every day on their journey to becoming cigarette-free with daily quit smoking tips and motivation to help them stay on track. There will be ongoing helpful hints and tips.

We all know that by becoming a Quitter it will not only benefit health, but a simple calculation will show that if you smoke 20 cigarettes a day you can save €4,650 a year just by becoming a Quitter.

The We Love Quitters Quit Smoking Challenge runs from National No Smoking Day, 10 February, until Easter Sunday, but smokers can join in at any time and start their challenge on any date and become a Quitter.

Gloup — helping the medicine go down

Clonmel Healthcare adds Gloup to its ever-growing portfolio of OTC products to the Irish market

Gloup is a clear, cherry-flavoured gel that facilitates the intake of medication in solid form, including tablets and capsules. It works by moistening the mucous membranes in the mouth and throat cavity and allowing the tablets to pass smoothly via the oesophagus to the stomach. Gloup can be used by given to anyone who can swallow autonomously, over the age of 2.

Gloup is available as an OTC product as a single pack in two size options; 75ml tube RRP €5.47 and 150ml tube RRP €7.49 and is available in all good pharmacies nationwide.

For further information, please contact Ann-Marie Sheehan, Aspire PR & Marketing, Tel: 087 298 5569 or email: annmarie@aspire-pr.com.
Clonmel Healthcare Ltd, a pharmaceutical marketing and distribution company founded in 1970 which is currently owned by the German Healthcare Group Stada. Clonmel Healthcare has two locations in Clonmel, Co. Tipperary and its Sales and Marketing office in Dublin.

Clonmel Healthcare currently has a large portfolio of products covering three business units: Prescription medicines; specialty or high-tech medicines; and the Consumer Division. The Consumer Division product range focuses on the three main areas: women and babies’ health, skincare and pain management.

Myles Murray, CEO, PMD Solutions, wins innovation prize at dotMED Conference with Medtech product RespiraSense, saving lives in the acute medical setting

PMD Solutions, an SME based in Cork, is committed to ‘make every breath count’ while reducing the cost of Irish healthcare.

Mr Myles Murray, CEO, PMD Solutions, engaged the audience of the dotMED conference recently with his vision of how new technologies like ‘RespiraSense’ (from PMD Solutions) will positively impact the future of Irish Healthcare.

RespiraSense is the world’s first continuous and accurate discrete sensor that measures the ‘mechanics of respiration’. This gives medical staff the earliest signs of possible patient deterioration from conditions such as respiratory compromise, increasing severity of sepsis, worsening pneumonia, and oncoming heart attacks. The device, a discrete wireless sensor, is ideally designed for general ward patients who are at risk of adverse events until discharge.

Mr Murray stated: “PMD is excited to ‘make every breath count’ for Irish patients, while providing clinicians the earliest signs of possible patient deterioration so changes in this vital sign can provide indications of respiratory compromise. "This technology supports the HSE’s EWS (Early Warning Score) initiatives, while also providing a boost towards the implementation of digital (and paperless) healthcare. “RespiraSense is designed to continuously measure this vital sign, which if detected to be abnormal, can help medical staff prevent these from happening with patients on the general ward.

“This can result in better patient outcomes and overall reduce length of stay for patients in hospitals and to free up beds — a current need for ICU and Emergency Departments nationwide.”

PMD Solutions is currently collaborating with three of the largest research hospitals across Ireland to demonstrate the positive outcomes from continuous monitoring of respiration rate.

Over 100 pharmacies and beauty outlets are seeking the public’s vote to help them win the Go Green with the Green Angel Skincare Challenge — a nationwide search to find Ireland’s most creative shop window

The Guaranteed Irish-backed competition challenges Green Angel stockists to produce the country’s best St Patrick’s Day-themed window featuring the successful Irish skincare brand

The competition was launched by former Miss Ireland Aoife Walsh and Gerhard Scully, who was the iconic window dresser at Clery’s department store for 25 years.

“There are two key components to a good window — individuality and creativity,” said Gerhard.

“People need to bring their own things into a window display, and make it in their own image almost. “It should be something that they have designed themselves, put together themselves and shown that bit of love to.”

All of the entrants’ pictures will be posted on the Green Angel Skincare Facebook page, where the public can vote for their favourite store and staff to win valuable prizes plus a €1,000 contribution to a charity of their choice, sponsored by Guaranteed Irish.

And one lucky voter in each county will win a luxury hamper of Green Angel products.

Green Angel stockists can still register for the competition, which closes on March 14, by emailing customerservice@greenangel.ie or phoning 01 412 4900.

“With over 500 stockists nationwide, Green Angel Skincare has been one of the great growth stories in the Irish beauty industry over the past few years,” said Elizabeth Hunt of Guaranteed Irish, who are sponsoring the first prize for the winning outlet.

“We would urge all of our stockists to dress their windows imaginatively, help get their towns buzzing, and let the public vote for their favourite window,” said Mary Mitchell, Creative Director with Green Angel Skincare.

Easofen – Feeling Better Already

Clonmel Healthcare, a leading supplier of over-the-counter medicines in Ireland, has announced the launch of the Easofen Range 30-second TV commercial.

The concept behind the commercial is to position Easofen as the go-to brand that ‘takes care of all the family’. Easofen is the all-family brand. It comprises a range of products that give pain relief to any member of the family, whenever required. The hero of the Easofen commercial is a typical nine-year-old girl, kept home from school under the care of her mother because she’s feeling poorly.

Situated in the family kitchen, the story unfolds via a charming old-school pop-up/pull-tab book (My Family Story), which the little girl is leafing through and pondering upon. The interaction of the pull-tabs depicts various and everyday pain symptoms each member of the family may encounter. The narrative and accompanying visuals reflect that when any one member of the family is touched by pain symptoms, the whole family is affected. Pain curtails normal family life.

The solution to pain is to be found in one of the relevant products from the Easofen Range. The commercial is underpinned by the new Easofen tagline — ‘Feeling Better Already’.

The commercial also clearly communicates that the Easofen range is to be found only at pharmacies.

The new TV campaign is part of the ongoing investment in the Easofen range. This latest commercial from Clonmel Healthcare was developed by Shape Branding and directed by Cathal Watters. Easofen 200mg Film-coated and 400mg Max Strength Film-coated Tablets. Easofen for Children Strawberry 100mg/Sml and Easofen for Children Strawberry Six Plus 200mg/Sml Oral Suspension. Contains ibuprofen. Medicinal product not subject to prescription. Additional information or a copy of the SmPC available upon request. PA Holder: Clonmel Healthcare Ltd., Waterford Road, Clonmel, Co. Tipperary.
**Faster MS diagnosis**

A new technique to use MRI scanners to search for evidence of multiple sclerosis (MS) in the brain has been successfully tested by researchers in the UK. The team utilised a standard clinical MRI scanner to carry out a T2-weighted imaging process in order to be able to reveal lesions in the brain's white matter that are centred on a vein, which is known as a known indicator of MS.

MS can be difficult to diagnose because of its many symptoms and not all sufferers experience all of the symptoms, as well as the fact that the disease can progress at different rates.

Forty patients were enlisted from the Neurology Outpatients' Department of Nottingham University Hospitals NHS Trust in the UK.

In the test cohort, all patients with MS had central veins in more than 45 per cent of brain lesions, while the rest had central veins visible in less than 45 per cent of lesions. The team, which is based at the University of Nottingham and Nottingham University Hospitals NHS Trust, then applied the same diagnostic rules to the second cohort and all the remaining patients were correctly categorised into MS or non-MS by the blind observer. The process took less than two minutes per scan and the results may have diagnostic implications, as among patients with suspected MS referred to treatment clinics in the UK, fewer than 50 per cent are found to have the condition.

“We already knew that large research MRI scanners could detect the proportion of lesions with a vein in the brain’s white matter, but these scanners are not clinically available,” said lead author Dr Nikos Evangelou.

“So we wanted to find out whether a single brain scan in an NHS hospital scanner could also be effective in distinguishing between patients known to have MS and patients known to have non-MS brain lesions.

“We are excited to reveal that our results show that clinical application of this technique could supplement existing diagnostic methods for MS.”

The results were reported in the *Multiple Sclerosis Journal*.

**Inflammation and autism**

New research from the US has elaborated on previous findings that women who suffered severe infection during pregnancy were exponentially more likely to have a child with autism.

In 2010, a large Danish study made this finding and established that infections severe enough to require hospitalisation were implicated in autism in all children born in Denmark between 1980 and 2005. The infections the mothers suffered included urinary tract infections, viral gastroenteritis and influenza, with infections in the second trimester associated with a 1.5-fold risk, and when the mothers were infected during the first trimester, this translated to a three-fold risk.

Now a US follow-up study — involving researchers from MIT, the University of Colorado, New York University Langone Medical Centre and the University of Massachusetts Medical School — have found a potential mechanism for how this process occurs.

The teams discovered that immune cells activated in the mother during such infections produce IL-17, an immune effector molecule, which appears to affect brain development.

Using mice, they discovered behavioural anomalies in offspring including abnormal communication, repetitive behaviours and negatively-affected social ability. However, when they disabled the Th-17 cells in mothers before they were infected, the young mice showed none of these behavioural abnormalities.

**Inflammation and autism**

The teams discovered that immune cells activated in the mother during such infections produce IL-17, an immune effector molecule, which appears to affect brain development.

Using mice, they discovered behavioural anomalies in offspring including abnormal communication, repetitive behaviours and negatively-affected social ability. However, when they disabled the Th-17 cells in mothers before they were infected, the young mice showed none of these behavioural abnormalities.

**Inflammation and autism**

The teams discovered that immune cells activated in the mother during such infections produce IL-17, an immune effector molecule, which appears to affect brain development.

Using mice, they discovered behavioural anomalies in offspring including abnormal communication, repetitive behaviours and negatively-affected social ability. However, when they disabled the Th-17 cells in mothers before they were infected, the young mice showed none of these behavioural abnormalities.

**Inflammation and autism**

The teams discovered that immune cells activated in the mother during such infections produce IL-17, an immune effector molecule, which appears to affect brain development.

Using mice, they discovered behavioural anomalies in offspring including abnormal communication, repetitive behaviours and negatively-affected social ability. However, when they disabled the Th-17 cells in mothers before they were infected, the young mice showed none of these behavioural abnormalities.
Register once for all the news and education you need

859* Number of nurses who have registered with nurse cpd
1277* Number of doctors who have registered with medilearning
1742* Number of pharmacists who have registered with pharmacist cpd
2588* Number of doctors who have registered with the medical independent

6466* Number of healthcare professionals receiving ecopy

THE ONLY MEDICAL E-NEWSPAPER CIRCULATED TO NURSES, DOCTORS AND PHARMACISTS

THE FIGURES DON’T LIE
REGISTER NOW
Dealing with the threat of ‘malware’ — what is it and how to get rid of it

Malware (short for malicious software) refers to software used to gain access to computer systems, thereby disrupting operations, gathering sensitive information or displaying unwanted advertising.

It is defined by its malicious intent, acting against the requirements of the computer user, and does not include software that causes unintentional harm due to some deficiency.

Malware may be stealthy, with the intention of stealing information, spying on computer users, and may be designed to cause harm through sabotage or to extort payment.

Malware is an umbrella term used to refer to a variety of forms of hostile or intrusive software, including computer viruses, worms, Trojan horses, ransomware, spyware, adware and scareware.

As of 2011, the majority of active malware threats were worms or Trojans rather than viruses.

How to check if it is on your system
Malware exploits security defects (security bugs or vulnerabilities) in the design of the operating system, in applications such as older versions of Microsoft Internet Explorer supported by Windows XP, or in vulnerable versions of browser plug-ins such as Adobe Flash Player, Adobe Acrobat or Reader, or Java.

Sometimes even installing new versions of such plug-ins does not automatically uninstall old versions. Security advisories from plug-in providers announce security-related updates. Common vulnerabilities are assigned Common Vulnerabilities and Exposures (CVE) IDs and listed in the US National Vulnerability Database.

Malware authors target bugs, or loopholes, to exploit.

How did I get it?
Most computers boot from built-in hard drives, but it is possible to boot from another device, such as a CD-ROM, DVD-ROM, USB flash drive or network.

Sometimes the user would intentionally insert, for example, a CD into the optical drive to boot the computer in some special way (e.g., to install an operating system). Even without booting, computers can be configured to execute software on some media as soon as they become available, for example, to autorun a CD or USB device when inserted.

Malicious software distributors would trick the user into booting or running from an infected device or medium; for example, a virus could make an infected computer add autorunnable code to any USB stick plugged into it; anyone who then attached the stick to another computer set to autorun from USB would, in turn, become infected, and also pass on the infection in the same way. More generally, any device that plugs into a USB port — including gadgets like lights, fans, speakers, toys, or even a digital microscope — can be used to spread malware. Devices can be infected during manufacturing or supply if quality control is inadequate.

This form of infection can largely be avoided by setting up computers by default to boot from the internal hard drive, if available, and not to autorun from devices. Intentional booting from another device is always possible by pressing certain keys during boot.

Older email software would automatically open HTML emails containing potentially malicious JavaScript code; users may also execute disguised malicious email attachments and infected executable files supplied in other ways.

How do I get rid of it?
As malware attacks become more frequent, attention has shifted from viruses and spyware protection to malware protection.

A specific component of antivirus and anti-malware software, commonly referred to as an on-access or real-time scanner, hooks deep into the operating system’s core and functions in a manner similar to how certain malware itself would attempt to operate. Any time the operating system accesses a file, the on-access scanner checks if the file is legitimate. If the file is identified as malware, the access operation will be stopped, the file will be dealt with by the scanner and the user will be notified. The goal is to stop any operations the malware may attempt on the system before they occur.

Anti-malware programmes can combat malware in two ways:
1. Anti-malware software programmes can be used solely for detection and removal of malware software that has already been installed onto a computer. This type of anti-malware software scans the contents of the Windows registry, operating system files and installed programmes on a computer. It will provide a list of any threats found, allowing the user to choose which files to delete or keep, or to compare this to a list of known malware components, removing files that match.
2. Real-time protection from malware works identically to real-time antivirus protection: the software scans disk files at download time and blocks the activity of components known to represent malware. In some cases, it may also intercept attempts to install start-up items or to modify browser settings. Because many malware components are installed as a result of browser exploits or user error, using security software (some of which are anti-malware, though many are not) to ‘sandbox’ browsers (essentially isolate the browser from the computer and hence any malware-induced change) can also be effective in helping to restrict any damage done.

Malwarebytes Anti-Malware has a free trial version.

Dublin GP practice becomes first GP practice to offer online consultations to its patients with VideoDoc

A GP practice in Tallaght in Dublin has become one of the first GP practices in Ireland to offer online video consultations to its patients using VideoDoc. The installation of the VideoDoc technology in the Jobstown Family Practice means that patients there will now be able to see their local GP from their own homes or workplaces.

Founded in 2014, VideoDoc’s technology is being supplied directly to GPs to allow them to offer it to their own patients based on their clinical need. Through the use of telemedicine and mobile technology, VideoDoc has the potential to improve access for patients, while at the same time maintaining continuity of patient care.

The technology is currently in use in four sites in the US and is in the pilot launch phase with GPs in Ireland. It is planned to make the technology available to patients throughout Ireland through their GPs in the spring.

Commenting on the pilot launch phase, Dr Robert Kelly, Consultant Cardiologist, Beacon Hospital, Dublin, and Medical Director at VideoDoc, said: “The launch of VideoDoc’s online consultations with GPs is a unique ground-breaking development in the modern-day treatment of patients in primary care in Ireland.

“Healthcare is all about trust and patients need to build a level of trust in their GPs offline in order to feel comfortable with an online consultation. This is how VideoDoc is different. It allows patients to see their own GPs with whom they have built a trusting relationship already from their own homes or workplaces.”

Commenting on the benefits to patients and GPs, Jobstown Family Practice GP, Dr Darach Ó Ciardha (pictured) said: ‘I am excited to offer this technology to our patients in Tallaght and am looking forward to seeing how it works. The technology offers patients the opportunity to see their own GPs, rather than a GP whom they have never met before. It allows us as GPs to ensure the continuity of care of our patients, as we know them and have access to their records and medical history during the online consultation. Through VideoDoc, we can offer access to patients who might not be in a position to travel to the surgery due to work or family commitments, illness, immobility or isolation.”

GPs who are interested in getting involved in the pilot phase are invited to register their interest by visiting www.videodoc.ie.

Dublin GP practice becomes first GP practice to offer online consultations to its patients with VideoDoc

A
The IPU recognises that all pharmacy technicians (CPD) for Qualified Pharmacy Technicians
Spring 2016 Continuing Professional Development
Tea and coffee will be available at the venue from 19:00
Please complete a post-course learning assessment and evaluation.
Participants will be required to complete pre-course learning, attend the evening classroom event and complete a post-course learning assessment and evaluation.
Tea and coffee will be available at the venue from 19:00 and the session will commence promptly at 19:30.
See www.iip.ie.

Spring 2016 Continuing Professional Development (CPD) for Qualified Pharmacy Technicians
The IPU recognises that all pharmacy technicians should be afforded continuing professional development (CPD). The Spring Programme below will equip pharmacy technicians with practical advice which will be easy to implement and will further enhance their role on the pharmacy dispensary team.

The Spring CPD Training for Pharmacy Technicians is:
Topic 1: An Overview of Skin Care
Topic 2: Mental Health Part 1 — Depression
Topic 3: Asthma Treatment
It will be held over three consecutive weeks at the following venues:
See www.ipu.ie for registration details.

Congratulations to the winner of last month’s crossword: Edwina McGuire of Bettystown, Co Meath.

For a chance to win €50, please send completed entries by 25 March to: The Editor, Irish Pharmacist, GreenCross Publishing Ltd, 7 Upper Leeson Street, Dublin 4. Fax: 01 547 2388. Please note the winner’s cheque will be issued 45 days after publication.

Diary entries
March
March 9
IIOP Pharmacy Addiction Services Workshop, Dublin
Location: Houston Lecture Theatre, RCSI, 123 St Stephens Green, Dublin 2, Ireland
Cost: Free
This blended learning programme is provided by the HSE and includes an evening course in Dublin on 9 March (further locations to be confirmed, subject to demand) accompanied by pre- and post-course online learning.
Participants will be required to complete pre-course learning, attend the evening classroom event and complete a post-course learning assessment and evaluation.
Tea and coffee will be available at the venue from 19:00 and the session will commence promptly at 19:30.
See www.iip.ie.

Spring 2016 Continuing Professional Development (CPD) for Qualified Pharmacy Technicians
The IPU recognises that all pharmacy technicians should be afforded continuing professional development (CPD). The Spring Programme below will equip pharmacy technicians with practical advice which will be easy to implement and will further enhance their role on the pharmacy dispensary team.

The Spring CPD Training for Pharmacy Technicians is:
Topic 1: An Overview of Skin Care
Topic 2: Mental Health Part 1 — Depression
Topic 3: Asthma Treatment
It will be held over three consecutive weeks at the following venues:
See www.ipu.ie for registration details.

ANSWERS TO LAST MONTH’S CROSSWORD

Across
8 - Applicable in all cases (9)
9 - Before the present (3)
10 - In the area (5)
11 - Concern; implicate (7)
12 - Latter part of the day (7)
13 - At what time (4)
14 - Learned person (7)
22 - Science of matter and energy (7)
24 - Type of bus (5)
25 - Eg English Breakfast (3)
26 - State of possessing a thing (9)

Down
1 - Remorse (5)
2 - Find (8)
3 - Part of a room opposite the floor (7)
4 - Allocate (6)
5 - Continuing in existence (5)
6 - Entrance corridor (4)
7 - An unknown person (7)
8 - Applicable in all cases (9)
9 - Worrying problem (8)
10 - Musical performance (7)
11 - Vie; contend (7)
12 - Latter part of the day (7)
13 - At what time (4)
14 - Learned person (7)
22 - Science of matter and energy (7)
24 - Type of bus (5)
25 - Eg English Breakfast (3)
26 - State of possessing a thing (9)

16 March-18 March
Hospital pharmacists taking the lead — partnerships and technologies.
Vienna, Austria.
The EAHP is pleased to invite you to the 21st Congress of the EAHP, 16-18 March 2016, with the theme of ‘Hospital pharmacists taking the lead — partnerships and technologies’. The scientific program is well advanced and is relevant for you as a hospital pharmacist dealing with the challenge of rapid technological change in healthcare. The role of the hospital pharmacist is not only to use these new technologies in their own practice but also to influence decision-makers, multidisciplinary team members and patients about the appropriate use of these technologies in the medication process. EAHP’s annual congress is the largest congress for hospital pharmacy in Europe and is attended by pharmacists from all over the world. This Congress continues to provide you with an exceptional opportunity to meet, network and share expertise and best practice with colleagues while keeping up to date with the latest developments in hospital pharmacy.

Contact: Address: Rue Abbé Cuypers, 3-8
Tel: 0032 (0) 2/741.24.36
E-mail: congress@eahp.eu.
Long-term gain and loss

I was talking to a pharmacist recently who has a patient who suffered a serious spinal injury. The patient is not in a wheelchair, but is suffering from chronic pain and other complications. There are an estimated 12,000 people in the country who have this level of spinal injury. There is a support group that is hoping to have spinal injury added to the list of conditions covered by the Long-Term Illness (LTI) scheme. My initial thought on hearing this suggestion was that it would make sense to give this cohort of patients a ‘green book’ to enable them to get painkillers and other medication free of charge, given that by any yardstick, their injuries are definitely a ‘long-term illness’. However, on thinking about it for bit longer, I can see why the HSE is certain to never grant this request.

Can any of you picture Leo Varadkar (still the Minister for Health at time of writing) standing up in the Dáil to announce the extension of the LTI scheme to any one specific medical condition? Imagine the reaction from every other patient support group advocating on behalf of people with various illnesses that are, lower case, ‘long-term’ but not officially ‘Long Term’. The most obvious condition with a strong claim for inclusion is asthma, but if this particular Pandora’s box ever gets opened, everything from high blood pressure to a low thyroid could be in the mix to be covered.

Safety first?

A perennial bugbear of community pharmacy is the money lost due to controlled drugs (CDs) going out of date. It is impossible to avoid this problem because so many palliative care patients end up on high doses of painkillers such as oxycontin, usually for relatively short periods of time. As patients deteriorate, the palliative care teams often need to change the doses and the medication, so we inevitably end up with split packs of medication that we have no hope of getting rid of. All we can do is tuck the packs out of the way in the corner of the CD cabinet and wait for them to pass their expiry date, at which point we can destroy them, or rather we can destroy them under the supervision of a Garda or a PSI inspector. This requirement for supervised destruction probably seemed like a good idea when it was first suggested, but it paradoxically creates a greater danger than the one it prevents.

Having a Garda or PSI inspector present possibly deters any hypothetical rogue pharmacist from quietly taking the expired controlled drugs out of the pharmacy to use at home or sell on the street, but the reality is that rogue pharmacists desperate or depraved enough to do this are a rarity. They also have a variety of other ways to beat the system if they wanted to, rather than dipping into the out-of-date stock. For the vastly overwhelming majority of pharmacists who simply want to get rid of the expired CDs, the requirement to have a Garda present means that these drugs hang around in the safe for much longer than one would want. Human nature dictates that nobody wants to trouble a Garda to come in specially to watch the destruction of just a single lot of tablets, so the tendency is to wait until there are a few items to make it worth their while calling in. Unfortunately, if the pharmacy is raided before the few items have been destroyed, and the contents of the CD safe are stolen, the raiders end up with a lot more booty than they would if the expired stock could be simply destroyed as it expires. And somehow, I don’t think Whacker and Anto will be too worried if the ‘Oxys’ they just scored are out of date.

‘Everything’, but…

There are some words in the life of a pharmacist that instantly signify trouble, such as ‘audit’ or ‘inspection’ or ‘system upgrade’ or ‘down on the floor, now!’ There are other superficially harmless words that also come as harbingers of doom. One of these words is ‘everything’, when used by a patient who is in for ‘my prescription’ or even worse, for ‘the wife’s prescription’, and they have been asked, ‘what do you need this month?’ In a perfect universe, being told ‘everything’ would simply mean dispensing all the items on the prescription, but you know damn well that if you do that and bring the bag to the counter, the patient will fish through it and hand you back the inhaler they ‘don’t need’, and the calcium tablets they ‘have enough of’, and the cream that the GP ‘keeps putting on the prescription’. You also know that if you try to guess what part of ‘everything’ they don’t need, you will leave out something they do actually want.