

IRISH PHARMACIS

THE INDEPENDENT MONTHLY FOR IRISH PHARMACISTS

NEWS

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Our prescription drug problem



TERRY MAGUIRE

Getting heavy on obesity



E-PHARMACY

Sharing the good news



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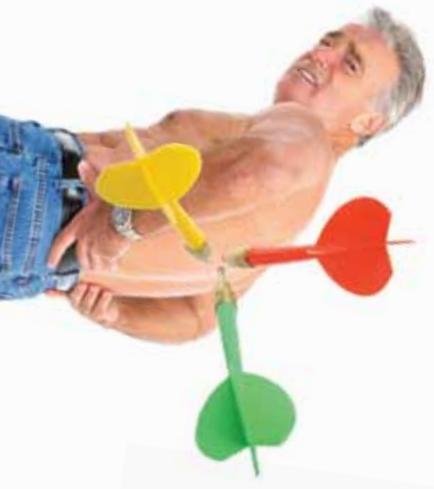
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Union eager to discuss new contracts

The President of the Irish Pharmacy Union, Mr Darragh O'Loughlin has said that the union is hoping to meet with the newly appointed Minister for Health, Dr James O'Reilly "shortly" to begin discussions about a new contract for pharmacists.

The union chief said that he understands that Dr O'Reilly had indicated that he intends to look at a new contract for pharmacists and confirmed that the IPU has formally requested a meeting with the Health Minister to begin talks on this issue.

"I understand that Dr O'Reilly intends to look at a new contract for pharmacists and we are hoping to sit down with him shortly to discuss this. A number of issues will need to be addressed in any new contract. For a start, in creating a new contract, we would like to sit down with the Minister to discuss the kind of additional services which we believe we will be able to provide and how this can fit into the Minister's agenda regarding improving care with the delivery of community care centres. For example, we are in a position



Darragh O'Loughlin

to take some capacity from GPs in terms of delivering vaccines as well as other areas," explained Mr O'Loughlin.

Pay, according to the pharmacist and IPU head, would also definitely be an issue, which needs to be discussed very seriously. "Pay is always an issue and this is something which we will also be discussing. What we have already made very clear at this stage is that there is simply, absolutely no room for adhoc unilateral cuts to pharmacists contracts," he said.

A spokesperson for the Department of Health said

that they were not aware of any official statement made by the Minister for Health, Dr James O'Reilly about any plans to look at the current contracts for pharmacists.

However, since taking office earlier this year, the Minister for Health, Dr O'Reilly has already indicated that he is very supportive of expanding the role of pharmacists.

Even in his first television interview as Health Minister on RTE News (16 March 2011), Dr O'Reilly said he believed, "pharmacists could be very much involved in vaccinations and other areas of chronic illness care" going forward.



Dr James O'Reilly, TD

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IPU to host first major national conference

More than 200 delegates from across the country are set to descend on Kilkenny this May for the Irish Pharmacy Union's (IPU) inaugural pharmacy conference.

This major, new, pharmacy event, which will be opened by the Minister for Environment, Community and Local Government, Phil Hogan TD, is set to address and examine all the major issues affecting Irish pharmacists today.

Amongst the key events set to take place over the course of the two-day conference are new business and continued education sessions, which aim to advise pharmacists on the latest news and advice with regard to running a successful business and keeping up with continued professional development.

A major panel discussion, which aims to address and discuss all the burning issues affecting pharmacists at

present, will also take place on the second day of the conference. A number of high profile names have already been added to the panel for this event including Paddy Burke, Assistant National Director Finance, PCRS, IPU President Darragh O'Loughlin, Gavin Duffy of Dragon's Den fame and Noeleen Harvey, President of the PSI as well as Ivan Yates who will chair the discussion.

Speaking ahead of the conference, Kathy Maher, Chairperson of the conference's organising committee said that the promotion for the inaugural conference has already been very well received by pharmacists and those involved behind the scenes believe that the new style of conference is set to prove very popular.

"In the past the focus of our conference has normally been the AGM, but this year,

we have introduced a number of completely new aspects including talks on continued education, business and training. We've also introduced a significant social function to the conference as we feel that it provides an important opportunity for pharmacists, many of whom often work in isolation, to meet with peers and discuss the issues impacting on them.

"We've already received a fantastic response to the conference agenda and people have been very welcoming of the style of the conference which is so new. I think part of this is because pharmacists are working in a very different climate now and are interested in looking at new ways to improve their business," she said.

Asked what the key discussions would likely be at this year's panel discussion, Ms Maher said that while at

this stage it is still difficult to grasp the big issues which will be brought up, that it was likely that this would include issues surrounding payment and the future of the sector. "Pharmacists are working in a very challenging environment and because it is still a few weeks away to the conference it is difficult to pinpoint exactly what the discussion will surround, but it is likely that amongst the issues which will top the agenda are payment to pharmacists, the stability of the sector, the future of pharmacy practice in Ireland and how pharmacists are going to adopt a more patient centered approach as well as how to provide new access to medicines," she said.

The IPU Pharmacy Conference takes place on May 7 and 8 at the Lyrath Estate Hotel in Kilkenny. For further information log on to www.pharmacyconference.ie

IN BRIEF

New medicinal garden opens at TCD

Dr Henry Oakeley, Garden Fellow, Royal College of Physicians of London visited Trinity College Dublin in April to open the university's new medicinal garden.

The new garden displays 60 plants of medicinal interest including *Humulus lupulus*, *Hypericum perforatum* and *Salvia officinalis*.

Dr Oakeley has worked with plants for nearly 60 years and is responsible for looking after the garden at the Royal College of Physicians of London which has a thousand plants used as medicines at some time in the past millennia.

Following the opening, Dr Oakeley gave a special, public lecture at the university entitled, *'Why Plants Have Been Used as Medicines for the Past 3,000 Years?'*

Only one third of patients returning unwanted meds

A new study has found that only a third of patients are returning unwanted medicines to their pharmacists.

The new research, which was conducted by second year medical students at NUI Galway, Sarah Cormican and Michelle Furey, showed that while a significant proportion of people have leftover medicines in their home, over half of these respondents reported disposing of unwanted medicines along with general household waste, by flushing down toilets and sinks, or by burning.

The study was undertaken in the context of international reports which show that many people do not know that unwanted medicines should not be by thrown into household waste or flushed down toilets or sinks because of the biological risks this poses to the environment.

New measures recommended for Pandemrix

The European Medicine Agency has recommended that the product information for Pandemrix should be amended to advise prescribers to take into account preliminary results from new studies on Pandemrix and narcolepsy, and to perform an individual benefit-risk assessment when considering the use of Pandemrix in children and adolescents.

The move is an interim measure pending the outcome of the European review, which is expected to conclude in July 2011.

Positive opinion for weekly diabetes treatment

The European Medicine's Agency has announced that it's Committee for Medicinal Products for Human Use (CHMP) has adopted a positive opinion for the marketing of a new once-weekly diabetes treatment.

The move follows on from an application by Eli Lilly and Company, together with Amylin Pharmaceuticals and Alkermes for marketing authorisation for the medicine, Exenatide. If approved, exenatide for prolonged release would be the first once-weekly type 2 diabetes treatment.

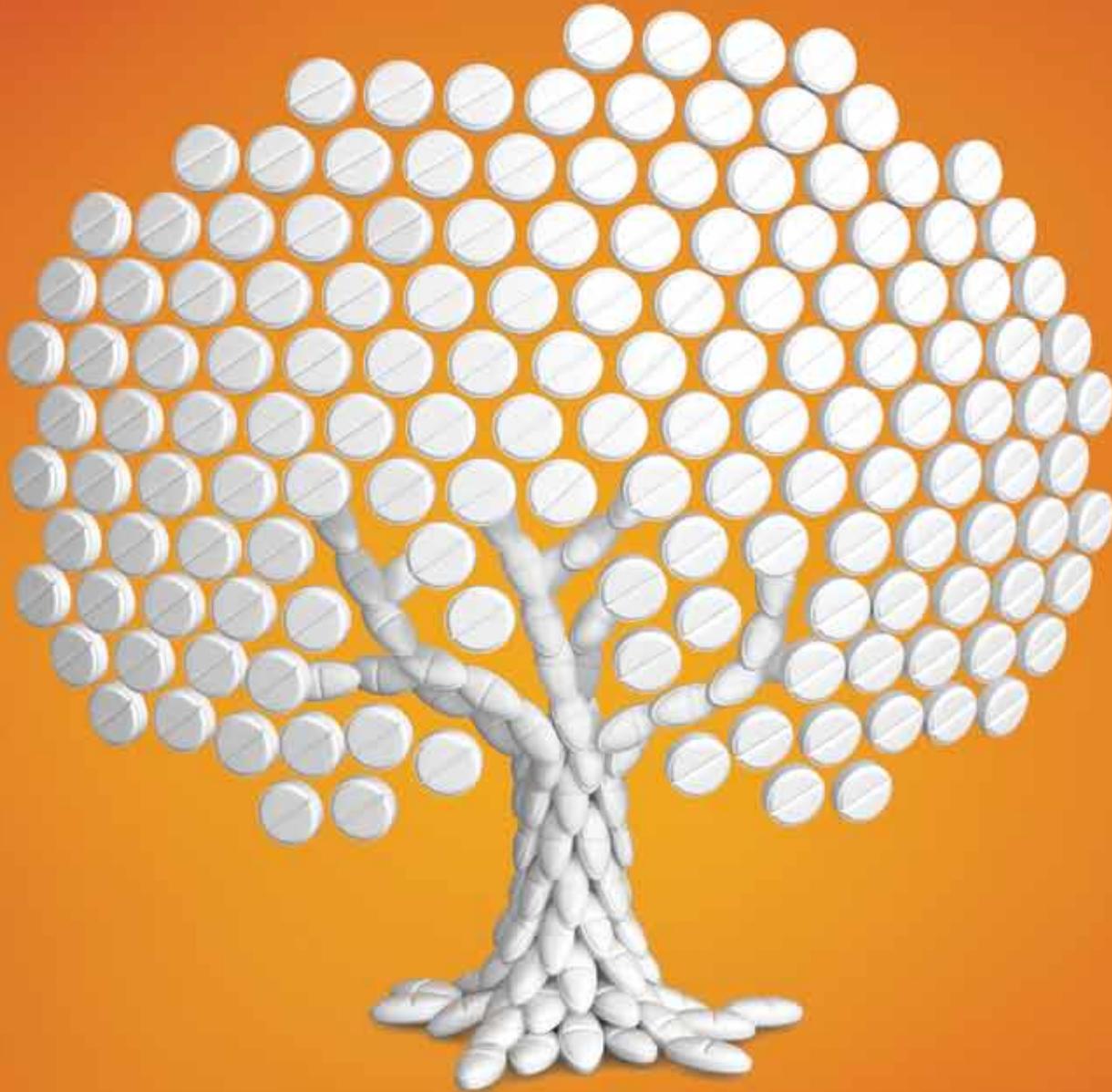
The CHMP's positive opinion is now referred for final action by the European Commission, which has the authority to approve medicines for the European Union. If approved, the treatment is planned to be marketed in the European Union under the proposed brand name Bydureon.

Pharmacy liaisons



Pictured at the Introduction course for Pharmacy Liaisons in the Clinical Care Programmes, hosted by the Royal College of Physicians of Ireland in Association with the Health Service Executive and the Pharmaceutical Society of Ireland was Dr. Barry White, National Director of CLinical Strategy and programs, HSE.

Pic. Maxwells Dublin



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70 per cent of older people taking 'inappropriate' meds

New Irish research has found that 70 per cent of older people in nursing homes in Ireland are taking at least one inappropriately prescribed medicine.

According to the study, which was funded by the Centre for Ageing Research and Development in Ireland (CARDI), 73 per cent of residents in nursing homes in the Republic of Ireland were receiving at least one potentially inappropriate medicine. In Northern Ireland, 67 per cent of those in the sample were receiving a potentially inappropriate medicine.

Overall, nearly one fifth (19 per cent) of the sample

were receiving three or more potentially inappropriate medicines.

The study, which was led by Dr Stephen Byrne, Senior Lecturer in Clinical Pharmacy at University College Cork, also found that some 630 older people in long-term care in Northern Ireland and the Cork area were receiving an average of 11 medicines each. Half of these people were prescribed 8-14 daily medicines each.

Commenting on the new research, Dr Stephen Byrne said that the global problem of inappropriate prescribing can put older people in serious danger and that a multi-disciplinary approach by pharmacists, doctors, nurses

and healthcare professionals was vital in addressing this ongoing problem. "Potentially inappropriate prescribing can lead to both minor and serious adverse drug events for older people. One of the most common instances is the risk of falls and fractures, leading to extended hospitalisation," he said.

Responding to the study, Irish Pharmacy Union President, Mr Darragh O' Loughlin described the findings as 'concerning'.

"If patients are taking inappropriate medication their health may be at risk. The Irish Pharmacy Union calls on the Minister for Health to implement proposals to introduce pharmacist led

Medicine Use Reviews for patients who are using multiple medications. The introduction of this initiative which has been advocated by the IPU in recent years will highlight problems in a patient's medication regime and, lead to safer and more cost effective medicine use, better outcomes for patients and fewer hospital admissions," he said.

The cost of the inappropriate medicines has been determined as €170 per older person in the Northern Ireland sample and €356 in the Republic of Ireland sample.

>> See page 20 and 21 for an extended feature looking at the future of pharmacist led MURs.

IN BRIEF

Novartis withdraws marketing application for Joicela

Novartis has withdrawn its marketing authorisation application to the European Medicine's Agency for the medicine Joicela (lumiracoxib).

Joicela was intended to be used for symptomatic relief in the treatment of osteoarthritis of the knee and hip in patients who are non-carriers of the DQA1*0102 allele.

The application for the marketing authorisation for Joicela was submitted to the Agency on 3 December 2009. At the time of the withdrawal it was under review by the Agency's Committee for Medicinal Products for Human Use (CHMP).

In its official letter to the EMA, Novartis said its decision to withdraw the application was based on its inability to address the CHMP's request to provide additional data within the timeframe allowed in the centralised procedure.

Major funding boost for Helix Health

Healthcare software solutions company, Helix Health, has announced it has raised €5 million of equity funding from The Ulster Bank Diageo Venture Fund, managed by NCB Ventures.

The funding will be used to strengthen Helix Health's investment in driving export sales and to facilitate further investment in R&D projects.

Commenting on the announcement Howard Beggs, CEO, Helix Health said, "This investment by The Ulster Bank Diageo Venture Fund is a very significant step in the growth story of Helix Health. It will facilitate further investment in our products to support local and international expansion."

Helix Health products are currently used by over 10,000 healthcare professionals and their systems are used in 70 per cent of pharmacies across Ireland and the United Kingdom.

Helix Health was established in 2007 as a result of the merger between Systems Solutions and Medicom, becoming Ireland's largest healthcare IT provider and an emerging player in international markets.

Education dominates agenda at HPAI conference

More than 160 delegates from across the country descended on Dublin in April for the annual Hospital Pharmacists Association of Ireland (HPAI) conference and AGM.

This year's conference featured a number of intense educational workshops, plenary sessions and presentations as well as a very well subscribed poster competition.

On the first day of the conference, delegates undertook a series of workshops on topics, which included compounding, microbiology and thromboprophylaxis.

That evening, delegates enjoyed a gala dinner at the Crowne Plaza Hotel in Santry where the newly appointed Minister for Health, Dr James Reilly, TD was the guest of honour.

On the second day of the conference, delegates attended a number of presentations including a session on continuing professional development for pharmacists which was presented by Lorraine Horgan, Head of Professional Development & Learning, Pharmaceutical Society of Ireland. This was followed by the highly regarded Servier Pharmaceutical Care Award 2010 presentation which,



Elaine Conyard, President of the HPAI speaking at the HPAI conference 2011 at the Crowne Plaza, Santry, Dublin this April.

this year, was presented on the application of electronic guidelines in Antimicrobial Stewardship.

That afternoon, the winners of this year's HPAI poster competition were also announced. This year, a total of 62 posters were entered into the competition, with some authors submitting as many as three entries.

Helen Danaher, Mater Misericordiae University

Hospital, Dublin scooped the top prize in the research category of the competition (sponsored by GlaxoSmithKline) for her poster entitled *Statin optimisation in Type 2 Diabetes Mellitus Outpatients*. Jennifer Brown, also of the Mater Misericordiae took the first place accolade in the audit category (sponsored by B Braun) for her poster, *A review of pharmacist cancelling*

dangerous prescriptions process at the MMUH and the first place in the Innovation in practice / professional Development category for her poster, *Development and implementation of a nutritional chart in the Mater Misericordiae University Hospital*. The top award in the Intern Pharmacist Project 2009-2010: Mary Harte Award was bestowed on Breda Bourke, AMNCH, Tallaght for her poster, *A baseline audit of vancomycin dosing and therapeutic drug monitoring at AMNCH* whilst the top award in the Pharmaceutical Technician competition (sponsored by Baxter Healthcare) was awarded to Martina McCabe, pharmaceutical technician, also of AMNCH, for her poster, *A re-audit of the turnaround time for urgent medication orders brought to the pharmacy reception*.

Speaking after the conference, HPAI spokesperson, Eileen Butler said that this year's conference had proved a great success. "Our remit is to further the development of hospital pharmacy and pharmacists and I think that our conference did just that. This year's event included a wide spectrum of events and educational components which were very well attended and received."

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IMPORTANT NOTICE: Breastfeeding is best for babies. Good maternal nutrition is important for the preparation and maintenance of breastfeeding. Introducing partial bottle-feeding may have a negative effect on breastfeeding and reversing a decision not to breastfeed is difficult. You should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant milks and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant milk should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.

† Alpha-lactalbumin

PFN0082/04/11

In the best of health

Well known celebrity, Calum Best visited McCabe's Pharmacy in Dundrum Town Centre this month to help launch the pharmacy's new health screening services which include a food intolerance test, a thyroid health test and a prostate health test.

The new prostate screening service is Ireland's first pharmacy-based PSA test. The test monitors the PSA levels in the blood and provides results in ten minutes.

The thyroid health test measures TSH levels and results are available in five minutes.

The food Intolerance test features screening for up to 93 food groups and is one of the most comprehensive food intolerance tests available.

Pictured here launching the new health check services are Calum Best and Olga Bennett, McCabe's Pharmacy Dundrum.



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* Source: IMS MAT 12/10

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- Patient Nominated Award
- Excellence in Hospital Pharmacy
- Practice-Based Research Award
- Young Pharmacist of the Year Award
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November 12th 2011**

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CPD comes under the spotlight at NAHPT conference

The future of continued professional development for hospital pharmacy technicians was amongst one of the key topics discussed by technicians at the recent National Association of Hospital Pharmacy Technicians annual conference.

Over the course of the one-day event, pharmacy technicians reflected on how continued professional development is changing and developing within their own sector and looked at the part they would need to play to ensure that they can continue to 'step up' and meet the growing educational demands on them.

This reflection and discussion was supported with a key presentation by Caitriona Gowing, Senior Clinical Pharmacist from AMNCH in Tallaght who discussed the topic, CPD and you.

At the meeting Julie Jordan, co-ordinator for pharmacy technician education and training, NI Pharmacy Training and Development Centre (NICPD) also presented a talk about

CPD opportunities available to pharmacy technicians in Northern Ireland including the course for 'Accredited Checking Technicians', which she offered to deliver to pharmacists in the south. Talks between the NICPD and the NAHPT are ongoing in relation to this.

Another highlight of this year's event was the annual NAHPT poster competition awards, which, was sponsored by Actavis.

Commenting on the success of this year's competition, Fran Glynn, President of the NAHPT said, "This was the first year we opened our poster competition to student pharmacy technicians. We had five poster entries and I am sure that will grow. We had a great response from hospital pharmacy technicians and there were ten poster entries all to a very high standard from these. This was our first year for

our poster competition to be sponsored by a pharmaceutical company. It was sponsored by Actavis with a brilliant prize of €500 which was won by Blathnaid McIntyre from AMNCH Tallaght."

Amongst the other key issues discussed at this year's conference were medicine management, Clozapine and the pharmacy technicians' role and finally, career motivation.



Pictured at the NAHPT conference are Jennifer O'Meara, Pharmacy Technician, AMNCH, Rebekah Corrigan, Pharmacy Technician, Connolly Hospital, Eglina Corrigan, Pharmacy Technician, Galway University Hospital, Marie McLaughlin, Pharmacy Technician, Galway University Hospital; Front: Yvonne Sheehan, Pharmacy Technician, AMNCH, Fran Glynn, President NAHPT, Laura Lyons, Pharmacy Technician, Mater Public

By Brid Ni Luasaigh

IPU say FEMPI cuts imposing 'disproportionate pain'

The Irish Pharmacy Union (IPU) has strongly criticised the latest tranche of cuts to pharmacists' payments under the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI) saying that the cuts will "impose hugely disproportionate pain on community pharmacists."

Under the latest measures announced as part of FEMPI, the HSE will be reducing a number of payments made to community pharmacy contractors under the General Medical Services (GMS) and community drugs schemes including a reduction from 50 per cent to 20 per cent in the retail mark-up payable under the Drugs Payment Scheme and the Long Term Illness Scheme in respect of non-drug items, controlled drugs and fridge items. The measures will also result in a 50 per cent reduction in the patient care fee under the high-tech medicines scheme for months when medicine is not dispensed and a reduction from 10 per cent to 8 per cent in the wholesale mark-up payable in respect of drugs dispensed under the GMS and community

drugs schemes.

Responding to the announcement, IPU president, Darragh O' Loughlin said that the wholesale margin is not being reduced as stated in the department's press release, but that what is being reduced is the very price that the HSE pays to pharmacists for dispensing medicines on the community drugs schemes.

He added, "The IPU made a detailed submission in January to the Minister entitled 'Time for a New Approach'. We clearly demonstrated that there is no scope for further unilateral and arbitrary cuts. Pharmacists have already suffered direct and indirect cuts of 32 per cent or €153m since July 2009, which is more than that suffered by any other part of the health sector. Now we are being cut by another €36m. We have clearly said that additional efficiencies and savings can be achieved by adopting a new approach. This approach would involve a substantial and direct engagement with the IPU within a defined period of time to review all existing, administrative, contractual

and payment arrangements."

Concluding, Mr O' Loughlin added that he believed that in focusing on cuts and ignoring the capacity of community pharmacy to deliver many primary care treatments more cost effectively and conveniently for patients, these cuts were undermining the capacity of the most accessible part of Ireland's primary care service.

"Community pharmacists are angry that an opportunity to deliver savings in ways that would meet patients' needs more effectively has been jettisoned. These cuts will entrench instead of challenging outdated patterns of primary care delivery. The capacity of a nationwide community pharmacy network to deliver primary care cost effectively has been ignored and undermined by these further ill-conceived cuts in payments to pharmacists. I sincerely hope that today's cuts mark the end of an ad hoc series of cuts to pharmacy payments and that the Minister will now engage with the IPU on an agenda for change," he said.

New antibiotics to tackle drug resistant TB

Two new, EU-funded research projects have found new answers in the fight against drug resistant tuberculosis.

At a time when it is estimated that drug resistant infections cause more than 25,000 deaths in the European Union alone, the first of these projects, NM4TB, has identified new substances to tackle drug resistant TB.

The study, which gathers 18 research teams from 13 countries, discovered a novel class of substances, called benzothiazinones (BTZ), that could be used in the treatment of tuberculosis and drug resistant tuberculosis.

The second project, Actinogen, involves discovering and developing new antibiotics. As part of this study, researchers from nine European countries and the Republic of Korea are currently exploiting the genetic resources of a group of bacteria called actinomycetes. It is believed that these new bacteria could play a pivotal role in the fight against antibiotic resistant bacteria.

IN BRIEF

Support urged for new pain campaign

People across Ireland are being urged to lend their support to a major new Europe-wide campaign, which aims to raise awareness of the burden of chronic pain.

Supported by Chronic Pain Ireland and Pfizer Healthcare Ireland, the *Can You Feel My Pain?* campaign aims to give a voice to 13 per cent of the Irish population (400,000) who are living with the debilitating condition.

As part of this new campaign, people across Ireland are being encouraged to help raise awareness of the difficulty of pain and show their support for the initiative by helping to develop a new Bill of Rights by signing an online petition hosted on www.chronicpain.ie

FIP Congress 2011

Details of this year's annual FIP World Congress of Pharmacy and Pharmaceutical Sciences have just been announced.

The theme of this year's congress is Compromising safety and quality: a risky path.

Amongst the issues which will be discussed over the six day event are communicating basic medicines information to patients, innovations in teaching and learning and paying pharmacists for patient outcomes.

This year's event, the 71st International Congress, will take place at Hyderabad, India from September 3 to 8.

For further details log on to www.fip.org/hyderabad2011/

Cork TD appointed as Minister for Older People

Cork Labour TD, Deputy Kathleen Lynch has been appointed as the new Minister for Older People.

Minister Lynch's priority will be to complete and implement the National Positive Ageing Strategy as outlined in the Programme for Government.

Her responsibilities also include ensuring the supply of more and better care for older people in the community and in residential settings.

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Prescription charge abolished in Scotland

Prescription charges have been abolished in Scotland as part of efforts by the Scottish Government to improve the health of the nation.

The move, which took effect in April 2011, follows a planned phasing out of prescription charges by the government, which commenced back in 2008.

This latest initiative has seen Scotland join Wales and Northern Ireland in providing

free prescriptions to patients and means that England remains the only part of the UK, which continues to have a prescription charge.

The move has been warmly welcomed by pharmacists in the UK who say that the action will help ensure patients in Scotland get the medicines, which they need. Pharmacists say however, that they are disappointed that the move has not been followed in England.

Nanette Kerr, Director of Pharmacy at the National Pharmacy Association said, "We welcome the news that from today, people in Scotland will no longer have to pay for their prescriptions. Prescription charges deter many people from getting medicines, which their doctor prescribes. Patients on low fixed incomes who do not qualify for exemption suffer the most.

"It is therefore disappoint-

ing that people in England will see prescription charges rise to £7.40 today. From a pharmacist's point of view, processing prescription levies is part of the job that adds workload but no patient benefit.

"Pharmacists, like other health care professionals, experience great pressures on their time and any release of time could be used to enhance patient care."

English pharmacists want formal role in public health

The English Pharmacy Board has called on the Department of Health in the UK to ensure that pharmacists are given a formal role in public health.

The move follows on from a three-month consultation period regarding the publication of the UK Department of Health's latest policy document *Healthy Lives, Healthy People: a strategy for public health in England*.

This document, which was published in December, sets out how the department aims to strengthen public health provision into the future via a new National Public Health Service.

Responding to the document, Chair of the English Pharmacy Board (EPB), Lindsey

Gilpin said that while the EPB supports the document, it believes that the department must ensure that this new public health services utilises the network of community pharmacies as its natural frontline.

"Community pharmacists are highly qualified health professionals who lead well trained teams already delivering public health services on a daily basis from very accessible and convenient locations.

"Informal public health provision has been central to pharmacies throughout their history and there is a growing evidence base for good outcomes from their delivery of formal public health services," she said.

Continuing, the pharmacy

body chair added, "Increasingly, public health interventions will require the use of medication. Pharmacists are the experts in medicines and have a great deal of public health expertise within primary care, especially in service design and improvement, which does not appear to be recognised in this White Paper.

"The contributions pharmacists in Great Britain already make at strategic and commissioning levels in wider public health must be recognised and supported in the new NHS structures in England. These include needs assessments, public health policy and planning, quality frameworks, evidence-based delivery and medicines management."

Top marks for independent pharmacists

Independent, community pharmacists in the US have secured top marks in a new consumer survey.

The results of the survey, which was undertaken by readers of *Consumer Reports* magazine, showed that more than 90 per cent of those surveyed were highly satisfied with their experiences at independent pharmacies in areas including personal service, knowledge and speed in filling prescriptions.

The 43,739 survey respondents also said they found

independent pharmacies offered lower prices than traditional, national pharmacy and that overall, they found independent pharmacists were competitive on pricing.

Commenting on the survey results, National Community Pharmacists Association (NCPA) Executive, Vice President and CEO Douglas Hoey said, "Independent community pharmacists are dedicated to providing patients with expert medication counseling and sterling customer service.

"It's encouraging and gratifying to see that patients notice and appreciate these efforts. We congratulate independent pharmacists throughout the country on this distinguished recognition from their patients."

The survey's findings are consistent with those of the 2010 JD Power and Associates Pharmacy Study. In that survey, patients gave among the highest satisfaction scores to independently owned, locally operated pharmacies.

IN BRIEF

New medicines quality database established

A new database, which shows the quality of medicines around the world, has just been launched.

The facility, the Medicines Quality Database (MQDB), provides information to health professionals and the public about the quality of medicines, which have been collected and analysed at a number of global locations including Ghana, Laos, Vietnam, Cambodia, the Philippines, Thailand, Peru, Guyana and Colombia.

The launch of the database comes at a time that more and more poor quality medicines, both substandard and counterfeit, are making their way into pharmacies and other outlets in developing countries.

The database, which has been launched by Promoting the Quality of Medicines (PQM), is supported by USAID and implemented by the US Pharmacopeial Convention (USP). It can be accessed at <http://www.usp.org/worldwide/medQualityDatabase/>

Marketing authorisation application for anaemia drug withdrawn

The European Medicines Agency (EMA) has announced that it has been formally notified by Reliance GeneMedix Plc. of its decision to withdraw its application for a centralised marketing authorisation for the medicine Epostim (erythropoietin).

The medicine was intended to be used for a number of indications including the treatment of anaemia, to increase the yield of autologous blood from patients in a predonation programme and to reduce exposure to allogenic blood transfusions in adult non-iron deficient patients prior to major elective orthopaedic surgery.

The application for the marketing authorisation for Epostim was submitted to the Agency on 29 October 2010. At the time of the withdrawal it was under review by the Agency's Committee for Medicinal Products for Human Use (CHMP).

In its official letter, the company stated that its decision to withdraw the application was based on its inability to address the CHMP's request to provide additional data within the time-frame allowed in the centralised procedure.

Emergency pill now free in Wales



Wales has joined ranks with Scotland and with many parts of England in introducing free emergency hormonal contraception facilities.

As part of a new policy measure by the Welsh government, women over the age of 13 can be provided with emergency contraception and sexual health advice free of charge at pharmacies in Wales.

The move forms part of an initiative to reduce the number of teenage pregnancies in Wales, which hosts the highest rate of teen pregnancies in the United Kingdom.

The service is already offered free of charge in Scotland and in many PCTs in England.

Commenting on the decision, Steve Simmonds, NPA Representation Manager in Wales said, "the decision in Wales is a clear endorsement of the expertise and unique accessibility of community pharmacy. Although this service is already offered in Scotland and in many parts of England, we'd like to see it everywhere in the UK free of charge."



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CIALIS* (TADALAFIL) REPUBLIC OF IRELAND ABBREVIATED PRESCRIBING INFORMATION

Presentation Tablets 2.5mg, 5mg, 10mg, or 20mg of tadalafil. Also contains lactose. **Uses** Treatment of erectile dysfunction in adult males. **Dosage and Administration Adult men:** The recommended dose is 10mg orally, taken at least 30 minutes prior to sexual activity. In those patients in whom tadalafil 10mg does not produce an adequate effect, 20mg might be tried. Maximum dosing frequency, once per day, 10mg or 20mg tadalafil is not recommended for continuous daily use. In patients who anticipate a frequent use of Cialis (ie, at least twice weekly), a once daily regimen with the lowest doses of Cialis might be considered. The recommended dose is 5mg taken once a day at approximately the same time of day. The dose may be decreased to 2.5mg once a day based on individual tolerability. The appropriateness of continued use of the daily regimen should be reassessed periodically. **Elderly:** Dosage adjustment not required. **Impaired renal or hepatic function:** In patients with severe renal impairment the maximum recommended dose is 10mg. Once a day dosing of Cialis is not recommended in patients with severe renal impairment. In men with hepatic impairment the recommended dose is 10mg. There are no available data about the administration of doses higher than 10mg of tadalafil to patients with hepatic impairment. There is limited clinical data on the safety of Cialis in patients with severe hepatic impairment; if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Once a day dosing has not been evaluated in patients with hepatic impairment; therefore, if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. **Diabetes:** Dosage adjustment not required. **Use in children and adolescents:** Cialis should not be used in individuals below 18 years of age. Not indicated for use by women. In clinical trials, Cialis demonstrated improvement in patients' erectile function and the ability to have successful sexual intercourse up to 36 hours following dosing. **Contra-indications** Known hypersensitivity to any ingredient. Patients using any form of organic nitrates. In men with cardiac disease for whom sexual activity is inadvisable. Physicians should consider the potential cardiac risk of sexual activity in patients with pre-existing cardiovascular disease. Patients with myocardial infarction within the last 90 days, patients with unstable angina or angina occurring during sexual intercourse, patients with New York Heart Association class 2 or greater heart failure in the last 6 months, patients with uncontrolled arrhythmias, hypotension (<90/50mmHg), or uncontrolled hypertension, patients with a stroke within the last 6 months. Cialis is contra-indicated in patients who have loss of vision in one eye because of non-arteritic anterior ischaemic optic neuropathy (NAION), regardless of whether this episode was in connection or not with previous PDE5 inhibitor exposure. **Warnings and Special Precautions** Prior to any treatment for erectile dysfunction, physicians should consider the cardiovascular status of their patients, since there is a degree of cardiac risk associated with sexual activity. Tadalafil has vasodilator properties, resulting in mild and transient decreases in blood pressure. It augments the hypotensive effect of nitrates. **Tadalafil (2.5mg and 5mg):** In patients receiving concomitant antihypertensive medicines, tadalafil may induce a blood pressure decrease. When initiating daily treatment with tadalafil, appropriate clinical considerations should be given to a possible dose adjustment of the antihypertensive therapy. Serious cardiovascular events were reported either post-marketing and/or in clinical trials. Although most of the patients in whom these events have been observed had pre-existing cardiovascular risk factors, it is not possible to determine whether these events are related directly to these risk factors, to Cialis, to sexual activity, or to a combination of these or other factors. Visual defects and cases of NAION have been reported in connection with the intake of Cialis and other PDE5 inhibitors. In case of sudden visual defect, patients should be advised to stop taking Cialis and consult a physician immediately. Due to increased tadalafil exposure (AUC), limited clinical experience, and the lack of ability to influence clearance by dialysis, once a day dosing of Cialis is not recommended in patients with severe renal impairment. There is limited clinical data on the safety of single-dose administration of tadalafil in patients with severe hepatic insufficiency (Child-Pugh class C); if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Use with caution in patients who have conditions that might predispose them to priapism, or in patients with anatomical deformation of the penis. Patients who experience erections lasting 4 hours or more should be instructed to seek medical

assistance. If priapism is not treated immediately, penile tissue damage and permanent loss of potency may result. It is not known if Cialis is effective in patients who have undergone pelvic surgery or radical non-nerve-sparing prostatectomy. Cialis should not be administered to patients with hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption. In patients who are taking alpha-blockers, concomitant administration of Cialis may lead to symptomatic hypotension in some patients. The combination of tadalafil and doxazosin is not recommended. Caution should be exercised when prescribing Cialis to patients using potent CYP3A4 inhibitors (ritonavir, saquinavir, ketoconazole, itraconazole, and erythromycin) as increased tadalafil exposure (AUC) has been observed if the drugs are combined. The safety and efficacy of combinations of tadalafil and other PDE5 inhibitors or other treatments for erectile dysfunction have not been studied. Patients should be informed not to take Cialis with such combinations. **Pregnancy and Lactation** Not indicated for use by women. There are limited data from the use of tadalafil in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition, or postnatal development. As a precautionary measure, it is preferable to avoid the use of Cialis during pregnancy. Available pharmacodynamic/toxicological data in animals have shown excretion of tadalafil in milk. A risk to the suckling child cannot be excluded. Cialis should not be used during breast-feeding. **Driving, etc** No studies on the effect on the ability to drive and use machines have been performed. Although the frequency of reports of dizziness in placebo and tadalafil arms in clinical trials was similar, patients should be aware of how they react to Cialis before driving or operating machinery. **Undesirable Effects** Very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), and not known (events not reported in registration trials cannot be estimated from post-marketing spontaneous reports). **Very common:** Headache. **Common:** Dizziness, flushing, dyspepsia, nasal congestion, back pain, myalgia, abdominal pain, gastro-oesophageal reflux, rash, hyperhidrosis (sweating), chest pain⁽¹⁾. **Rare:** Stroke⁽¹⁾ (including haemorrhagic events), syncope, transient ischaemic attacks⁽¹⁾, migraine⁽¹⁾, visual field defect, swelling of eyelids, conjunctival hyperaemia, myocardial infarction, urticaria, Stevens-Johnson syndrome⁽¹⁾, exfoliative dermatitis⁽¹⁾, prolonged erections, priapism⁽¹⁾, facial oedema⁽¹⁾, seizures, transient amnesia, NAION⁽¹⁾, retinal vascular occlusion⁽¹⁾, sudden hearing loss⁽¹⁾, unstable angina pectoris⁽¹⁾, ventricular arrhythmia⁽¹⁾, epistaxis, sudden cardiac death^(1,3). ⁽¹⁾Most of the patients in whom these events have been reported had pre-existing cardiovascular risk factors. ⁽²⁾Sudden decrease or loss of hearing has been reported in a small number of post-marketing and clinical trial cases with the use of all PDE5 inhibitors, including tadalafil. ⁽³⁾Post-marketing surveillance reported adverse reactions not observed in placebo-controlled clinical trials. Adverse reactions reported with tadalafil were transient, and generally mild or moderate. Adverse reaction data are limited in patients >75 years. A slightly higher incidence of ECG abnormalities, primarily sinus bradycardia, has been reported in patients treated with tadalafil once a day as compared with placebo. Most of these ECG abnormalities were not associated with adverse reactions. For full details of these and other side-effects, please see the Summary of Product Characteristics, which is available at <http://www.medicines.ie/>. **Legal Category** POM **Marketing Authorisation Numbers and Holder** EU/1/02/237/001 EU/1/02/237/002 EU/1/02/237/003 EU/1/02/237/004 EU/1/02/237/005 EU/1/02/237/006 EU/1/02/237/007 EU/1/02/237/008. Eli Lilly Nederland BV, Grootslag 1-5 3991, RA Houten, The Netherlands. **Date of Preparation or Last Review** March 2011. **Full Prescribing Information is Available From** Eli Lilly and Company Limited Lilly House, Priestley Road Basingstoke, Hampshire, RG24 9NL. Telephone: Basingstoke (01256) 315 000 E-mail: ukmedinfo@lilly.com or Eli Lilly and Company (Ireland) Limited Hyde House, 65 Adelaide Road, Dublin 2, Republic of Ireland. Telephone: Dublin (01) 661 4377. E-mail: ukmedinfo@lilly.com. *CIALIS (tadalafil) is a trademark of Eli Lilly and Company. **Date of Preparation:** September 2010. **Date of Revision:** March 2011. **References:** 1. Cialis Summary of Product Characteristics. 2. Dean, J. et al. Psychosocial outcomes and drug attributes affecting treatment choice in men receiving sildenafil citrate and tadalafil for the treatment of erectile dysfunction: Results of a multicenter, randomised, open label, crossover study. J Sex Med, 2006; 3:650-661. ICL500172

Lilly

The Changing Role of Pharmacy in Ireland; Emergency Contraception

Westin Hotel, Dublin on April 5, 2011

hosted by Allphar Services and HRA Pharma

Pharmacists from across the east of the country attended a special education evening in Dublin recently looking at emergency hormonal contraception.

The event was organised by HRA Pharma following from the Irish Medicines Board (IMB) decision to grant their oral emergency contraceptive pill, NorLevo (levonorgestrel 1.5mg) non-prescription status earlier this year.

Hosted in conjunction with AllPhar Services, the education meeting sought to raise awareness of how pharmacists' practices will need to evolve so that women seeking emergency contraception from their pharmacy can be offered appropriate professional support.

The meeting was opened by Tony Fraser, General Manager for HRA Pharma in Ireland and over the course of the evening pharmacists were presented with the latest information and experiences relating to emergency hormonal contraception by a panel of expert speakers which included Dr Martin Henman, Senior Lecturer at the School of Pharmacy in Trinity College, Dr Caitriona Henchion, Medical Director of the Irish Family Planning Association and John Stanley, Fellow at the School of Pharmacy, University of Hertfordshire and previous CEO Essex LPC.

Pharmacology and Practice

Dr Martin Henman, Senior Lecturer at the School of Pharmacy in Trinity College

The panel presentation was opened by Dr Martin Henman, Senior Lecturer at the School of Pharmacy in Trinity College who discussed the pharmacology of emergency hormonal contraception.

As part of this presentation, Dr Henman discussed the background of emergency hormonal contraception, the indications of Norlevo and the mechanism of such contraception both before and after ovulation.

Continuing, he discussed the various reasons for using emergency contraception which include failure of the barrier or hormonal method; being forced to have sex; sexual assault; and the risk of conception when a person has been to avoid sexual intercourse such as when taking teratogenic drugs.

Dr Henman went on to point out how the pharmacist needs to gather information and assess the appropriateness of dispensing emergency hormonal contraception before doing so. As part of this process, he said pharmacists should establish the patient's reason for seeking the contraception, establish the timing of the unprotected sex and ask if it is within 72 hours of seeking contraception, look at the



patients age and ask if it is appropriate to dispense the drug, assess if the patient is already pregnant, if they have used another emergency contraception during this cycle and if they may have any allergies to progesterone.

Dr Henman went on to point out the contraindications and cautions associated with emergency hormonal contraception and said that pharmacists need to be aware if there is hypersensitivity to any ingredient, hepatic dysfunction, salpingitis or breast cancer amongst other problems. He also said that pharmacists need to take heed that some drugs may interact with the contraception including St John's Wort and that any patients taking warfarin should have their INR measured three days after taking the pill.

He said that pharmacists must also advise nursing mothers to skip breast-feeding for a minimum of eight hours after taking the emergency contraceptive.

Concluding, Dr Henman discussed the uses of the drug and its efficacy as well as the few side effects of emergency contraception, which may include vomiting, diarrhoea and delayed menses.

Irish Family Planning Experience

Dr Caitriona Henchion, Medical Director of the Irish Family Planning Association

Following on from Dr Henman's presentation, Dr Caitriona Henchion, Medical Director of the Irish Family Planning Association (IFPA) discussed the experience of IFPA in dealing with emergency contraception.

Opening her presentation, Dr Henchion discussed how the IFPA undertake their assessments of patients before providing emergency hormonal contraception to them. She said that it is imperative that in each case the medical professional involved finds out the date of the patients last period and assesses if this

was normal, the date of the unprotected sex, any problems with emergency contraception and the patient's emergency contraception.

Dr Henchion said that it is very important that pharmacists assess the time of the unprotected sex.

Continuing, Dr Henchion said that from her experience, it is very important that pharmacists remind patients that if they do get bleeding soon after, this is just a withdrawal bleed and not a period and that they also need to make it clear that emergency hormonal contraception will not protect them from becoming pregnant for the rest of the cycle.

Dr Henchion said that pharmacists also have an opportunity during this or any subsequent consultations to be proactive in providing information about the various contraception options open to them especially to women who might have difficulty in remembering to take the pill or pre-menopausal women who suffer from vaginal dryness and find that condoms regularly rupture.

In terms of follow up, the IFPA director said that if the patient feels that everything is fine and their cycle returns to normal, that it should still be recommended to the patient that they check for sexually transmitted diseases and if their period is particularly light or heavy they should take a pregnancy test.

Continuing, Dr Henchion discussed the issue of age of consent, which she agreed was presenting a significant dilemma to doctors and pharmacists.

She cited the UK's Fraser guidelines which look specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent and said that while these guidelines had not been tested in Ireland and offer no legal protection to pharmacists, they may be of use to pharmacists.

These guidelines allow for

doctors in the UK to provide contraceptive advice and treatment to under -16s, without parental consent, if the professional is satisfied that the young person will understand their advice, cannot be persuaded to inform their parents, is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment and the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.

Dr Henchion pointed to a specific case study where they had provided emergency contraception to a 15-year-old. The next day the teen's mother contacted the office to find out why her daughter had been given the pill. The receptionist explained that she could not give out any patient information and that the woman could come in with her daughter to discuss the case. The mother came straight in with her daughter at which time it emerged that the girl was actually 14. When they came in the doctor went through her full consultation notes and discussed all the information she had gathered. In the end, Dr Henchion said the mother was actually pleased that her daughter had been given such a thorough assessment before being provided with the emergency contraception.

The International Experience EHC

John Stanley, Fellow at the School of Pharmacy, University of Hertfordshire and previous CEO Essex LPC

Following on from Dr Henman and Dr Henchion's presentations, John Stanley, Fellow at the School of Pharmacy, University of Hertfordshire and previous CEO Essex LPC took to the floor to discuss what the UK has learned from emergency hormonal contraception over the past ten years since it first became available over the counter.

Mr Stanley pointed out that the availability of emergency

contraception is very widespread not just in the UK, but across the world and that recent research has shown that 40 per cent of young people have used emergency hormonal contraception at some stage.

Mr Stanley said that the move to make emergency contraception available over the counter was in essence; giving the pharmacist "another tool in the toolkit" and he said that pharmacist should work to create awareness that they are offering this service. While he admitted that this may not be easy, he suggested perhaps that pharmacists build awareness of the service in the same way they make patients aware that they are participating in substance misuse programmes.

He said that first and foremost, the pharmacists must ensure that they begin offering a truly professional service. "Pharmacists need to put themselves in the position of the patient. What we don't want to create is a service where the patient feels judged or uncomfortable. We need to move to a more professional consultation.



Dr Martin Henman, Senior Lecturer at the School of Pharmacy in Trinity College

"The professional consultation is not something which people always expect in pharmacy. Likewise, some people expect to pull up outside on the double yellow line and want their prescription and toothpaste quickly. The patient needs to realize this is different. This is a professional service and it will take time," he said.

When considering how to develop this service as a 'professional service', Mr Stanley said that pharmacists will need to consider the time involved in the consultation, creating a confidential and personal consultation and the cost that this service will involve.

He said that it is also worthwhile that pharmacists consider if they are going to use paperwork or some form of guidance form when distributing the emergency contraception pill. He said that having used such a form in the UK for a number of years, it has been agreed that such a form can help the pharmacist

provide a better service whilst also helping them to decide if the emergency contraception should be dispensed. He said that pharmacists should also work to make more use of their consultation rooms which would also assist them in creating a more professional service overall.

Concluding, Mr Stanley discussed the various ways in which pharmacists can help to improve their services during and after the consultation by providing signposting and advice about other services. He said that this would help the profession in Ireland to move further in the direction of providing increased professional services to their patients.

Discussion

Following from the presentations by the expert panel, the floor was opened to questions from the audience. A number of key issues arose during this session which were addressed by the expert panel including what to do when supply is not appropriate, what to do if emergency contraception fail- is the pharmacist liable, what to do if a parent contacts the pharmacy looking for information about their child and the differences between the age of medical consent and sexual consent.

Follow up and further meetings

Following on from the meeting, Tony Fraser, General Manager for HRA Pharma in Ireland said that he, along with Allphar Services, was delighted to have hosted this educational evening. Mr Fraser said that he firmly believes that it is vitally important that pharmacists are armed with the most current information available when offering women the help and advice they need to manage their overall sexual and reproductive health adding, "we believe that our event went a long way to ensuring that this is the case and we hope to hold more in the future".

Pamela Logan, Director of Pharmacy Services at the Irish Pharmacy Union added, "Recent developments mean that pharmacists will now take on the new responsibility of informing and advising the women who require this form of emergency contraception. The IPU, with the support of HRA Pharma, has already sent an education pack to all pharmacies in Ireland which complements the guidelines previously produced by the Pharmaceutical Society of Ireland, the Pharmacy Regulator. The fact that the HRA Pharma event had such fantastic support is encouraging and means that attendees will now feel better prepared dealing with this health-care issue."

A number of similar educational events are set to take place around the country over the coming weeks.



TRINITY COLLEGE
The University of Dublin

Postgraduate Diploma/M.Sc. in Community Pharmacy

Applications are invited for admission to the postgraduate Diploma/M. Sc. in Community Pharmacy in Trinity College Dublin. This course has been specifically designed to meet the needs of community pharmacists practising in Ireland and also complies fully with the recommendations for specialist community pharmacy courses issued by the EU Advisory Committee on Pharmaceutical Training. Because of its distance-learning format, participants can continue in full-time employment throughout the course.

The course is intended to help community pharmacists to:

- develop their clinical, managerial and research skills;
- fulfil continuing professional development obligations under the Pharmacy Act 2007;
- meet duties imposed by the HSE contract;
- undertake the role of a supervising pharmacist or superintendent pharmacist with confidence;
- extend their professional role;
- contribute to patient care as part of the primary health care team.

Course structure

The diploma and M.Sc. have core material in common. Participants initially enter at diploma level, and on successful completion of the common material they may choose either to graduate with a Diploma in Community Pharmacy or to apply for transfer to the M.Sc. in Community Pharmacy.

Both courses are available on a part-time basis, the diploma being conducted over two years with one additional year for students who progress to the M.Sc. In both courses participants undertake a series of modules covering clinical, social and business aspects of pharmacy practice, with opportunities for specialisation in particular fields. Pharmacists who advance to M.Sc. level undertake an additional module on research methods and perform a research project relevant to community pharmacy practice.

Entry requirements

Applicants must:

- be registered (or entitled to registration) as a pharmacist with the Pharmaceutical Society of Ireland;
- work on a regular basis (full/part-time) in community pharmacy.

Additional information from:

Address Diploma/M.Sc. in Community Pharmacy, School of Pharmacy and Pharmaceutical Sciences, Trinity College, Dublin 2.

Telephone 01 896 3736 (Monday and Wednesday 9.15am-5pm, Thursday 9.15am-12 45pm)

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Patients lobby MEPs on eye drug

A leading patient organisation has written to MEPs urging them to address safety concerns arising from the use of a cancer drug in treating age-related macular degeneration (AMD).

In a letter seen by *Irish Pharmacist*, Fighting Blindness said Irish hospitals are using Avastin to treat wet AMD even though it is not licensed for this purpose. The rationale for choosing to use this drug off-label is that it is considerably cheaper than a similar medication, Lucentis, which has been

approved for AMD.

Lucentis comes in single-use sterile doses whereas Avastin normally comes in larger volumes and is designed to be given intravenously to cancer patients.

Some hospital pharmacists have been asked to prepare smaller doses of Avastin for ophthalmic use, while in other cases this is done by wholesalers who sell it on to clinics – a practice that could bring infection risks for AMD patients.

The use of medicines for purposes other than those for

which they are licensed is not uncommon and is permitted provided doctors believe there is a clinical justification for doing so.

However, former European Medicines Agency chief Thomas Lonngren sparked a fierce debate on the subject last year before leaving his position as head of the EU regulator, claiming that cost-effectiveness was the chief driver of the decision to use Avastin over Lucentis.

This is the line taken by Fighting Blindness in its letter

to Irish MEPs, claiming that hospitals were acting primarily in the interest of their balance sheets.

“We are aware of course that off-label therapies are often used in the treatment of chronic disease where there is no alternative. However, in this case a fully licensed therapy that has been through the regulatory process is not being used in favour of a therapy that has not been through this same process,” said Avril Daly, CEO of Fighting Blindness.

She said her concern is

“solely the implication of these decisions by hospital managers on patient safety and in the reporting of adverse affects”, adding that the move could undermine the established regulatory and licensing process which guarantees the safety and efficacy of medications.

To date the Irish Medicines Board has received 10 reports of suspected adverse reactions associated with the ophthalmic use of Avastin, including reports of infection and haemorrhage.

EU herbal medicines law under fire

A Europe-wide ban on unregistered herbal medicines came into force this month but campaigners are threatening to take court action to have the law overturned.

The directive on traditional herbal medicines was introduced in 2004 and required that all products obtain a formal authorisation by the end of April 2011.

Once this transitional period expired, unauthorised herbal medicines can no longer be sold online, in pharmacies or in natural health shops.

Industry campaigners are

preparing a legal challenge at the High Court in London and have threatened to take a case to the European Court of Justice in Luxembourg as part of their efforts to reverse the new rules.

Dr Robert Verkerk, executive and scientific director of the Alliance for Natural Health said the European directive is “disproportionate, non-transparent and discriminatory”, adding that the law has been interpreted differently across the 27 EU member states.

The Netherlands, for



Marian Harkin, MEP

example, classifies some herbal remedies as foodstuffs meaning they are exempt from the new regulation, while the UK and Belgian authorities have taken a harder line, which will lead to hundreds of products being withdrawn from the shelves.

Irish MEP Marian Harkin, who has campaigned on behalf of alternative remedies, said many treatments will “disappear” as a result of the directive and she questioned whether it was fair to assess traditional medicines using pharmaceutical techniques.

New EU clinical trials database goes live

Details of clinical trials taking place in the EU, Iceland, Liechtenstein and Norway will now be available online in a publicly accessible database.

The EU Clinical Trials Register also allows the public to search for information on clinical trials authorised outside the EU if these studies are part of a paediatric investigation plan.

Lise Murphy, co-chair of the EMA's Working Party with Patients' and Consumers' Organisations, said the move would increase transparency and help patients to find information on relevant clinical research.

The database gives details of the sponsor and location of clinical trials as well the opinion of the relevant ethics committee.

www.clinicaltrialsregister.eu

EMA limits ex-director

The European Medicines Agency (EMA) has published strict new rules to curb the commercial activities of its former executive director in a bid to quell a storm of criticism from MEPs and transparency groups.

Thomas Lonngren, who left the top job at Europe's regulator at the end of last year, has continued to work in the healthcare sector. The EMA

has now completed a review Mr Lonngren's activities and said it could find no conflicts of interest.

However, the London-based regulator said it would enforce new rules to ensure its former director has no professional contact with EMA staff for two years. He is also prohibited from providing product-related advice to pharmaceutical companies.

In a statement, the Agency criticised Mr Lonngren for providing it with “late notification” about his new work. He had provided a letter in the days before his departure stating that he intended to use his experience in the health and medicine sector to provide “advice and counsel to the pharmaceutical industry”.

He added that he was “very

conscious” of his obligations to the EMA and assured his former employer that his new role would not constitute a conflict of interest.

EMA chairman Pat O'Mahony had originally accepted Lonngren's assurances in writing in January, but the Agency was forced to conduct a more rigorous investigation by MEPs.



Gary Finnegan,
European Correspondent and Irish winner of 2009 and 2010 EU Health Prize for Journalists

Communication is important¹⁻³



Ebixa

Approved from the moderate stage of Alzheimer's Disease onwards⁵

Abbreviated Prescribing Information: For full prescribing information refer to the Summary of Product Characteristics. **Name:** Ebixa. **Active Substance:** Memantine Hydrochloride. **Indication:** Treatment of patients with moderate to severe Alzheimer's disease. **Dosage & Administration:** Treatment should be initiated and supervised by a physician experienced in the diagnosis and treatment of Alzheimer's dementia. Therapy should only be started if a caregiver is available who will regularly monitor the intake of the medicinal product by the patient. Treatment is orally either as tablets (10 mg) or solution (5mg/pump) taken with or without food at the same time every day. The solution should only be dosed onto a spoon or into a glass of water using the pump. Maintenance dose is 20mg/day, (two tablets or 2ml solution [4 downward pumps] once daily). Treatment starts with 5mg/day (half a tablet or 0.5 ml solution [1 downward pump] once daily) for the first week; the 2nd week 10mg/day (one tablet or 1 ml solution [2 downward pumps] once daily); the 3rd week 15mg/day (one and a half tablets or 1.5ml solution [3 downward pumps] once daily) and the 4th week 20mg/day (two tablets or 2ml solution [4 downward pumps] once daily). Moderate renal impairment 10mg/day (one tablet or 1 ml solution [2 downward pumps] once daily), if well tolerated after 7 days the dose can be titrated up to 20mg/day (two tablets or 2 ml solution [4 downward pumps] once daily). Severe renal impairment- dose is 10 mg/day (one tablet or 1 ml solution [2 downward pumps] once daily). Mild-moderate hepatic impairment- no dose adjustment. Severe hepatic impairment- no data available: Not recommended. Children & Adolescents: Not recommended. **Contraindications:** Hypersensitivity to the active substance or any of the excipients. **Pregnancy and Lactation:** Pregnancy: Memantine should not be used in pregnant women unless clearly necessary. **Lactation:** Memantine should not be used in women who are breastfeeding. **Special Warnings and Precautions for use:** Caution is recommended in patients with epilepsy. Caution is advised in patients with raised urine pH as this may elevate plasma levels. Clinical trial data are limited on patients with recent myocardial infarction, uncompensated congestive heart failure and uncontrolled hypertension and patients with these conditions should be closely supervised. Avoid concomitant use of NMDA antagonists (see also interactions). Oral solution only: Patients with rare hereditary problems of fructose intolerance should not take Ebixa 5mg/pump oral solution as it contains sorbitol. Tablets are lactose free. Patients should be warned to take special care if driving and using machines as Ebixa has minor to moderate influence on these tasks. **Interactions:** Effects

of L-Dopa, dopaminergic agonists and anticholinergics may be enhanced. Effects of barbiturates and neuroleptics may be reduced. Concomitant administration of Ebixa with antispasmodic agents e.g. dantrolene and baclofen can modify their effects, dose adjustments may be necessary. Increased plasma levels could occur with concomitant use of cimetidine, ranitidine, procainamide, quinidine, quinine and nicotine. Co-administration with hydrochlorothiazide (HCT) may lead to a reduced serum level of HCT. Concomitant use of NMDA antagonist- amantadine, ketamine, dextromethorphan or phenytoin should be avoided. Close monitoring of prothrombin time or INR is advisable for patients treated concomitantly with oral anticoagulants. **Adverse reactions:** Common ($\geq 1/100$ to $< 1/10$) headache, somnolence, hypertension, constipation, dizziness, dyspnoea and drug hypersensitivity. Uncommon reactions ($\geq 1/1,000$ to $< 1/100$): cardiac failure, fatigue, fungal infections, confusion, hallucinations (mainly in severe Alzheimer's disease), venous thrombosis/thromboembolism, vomiting, gait abnormal. Very rare ($< 1/10,000$): seizures. Not known: Isolated cases of pancreatitis and psychotic reactions have been reported post-marketing. Alzheimer's disease has been associated with depression, suicidal ideation and suicide. In post-marketing experience these events have been reported in patients treated with memantine. **Overdose:** Symptomatic treatment. **Elimination:** Mainly in unchanged form via the kidneys. **Legal Category:** POM. **Marketing Authorisation Holder:** H.Lundbeck A/S, Ottiliavej 9, DK-2500 Valby, Denmark. **Marketing Authorisation Numbers:** EU/1/02/219/005 Ebixa 5mg/pump oral solution-50ml bottle. EU/1/02/219/006 Ebixa 5mg/pump oral solution-100ml bottle. EU/1/02/219/007 Ebixa film-coated tablets 10mg, 28 pack size. EU/1/02/219/008 Ebixa film-coated tablets 10mg, 56 pack size. Further information may be obtained from: Lundbeck (Ireland) Ltd., 7 Riverwalk, Citywest Business Campus, Dublin 24.

Date of Preparation: January 2011

References: 1. Ferris et al. 2009. *Alzheimer's & Dementia* 5:369-374. 2. Emre et al. 2008. *Journal of Alzheimer's Disease* 14:193-199. 3. Hofbauer et al. 2009. Presented at the 12th Intl. Conference on *Alzheimer's Disease*. July 11-16. 4. Claxton et al. 2001. *Clinical Therapeutics*. 23:1296-1310. 5. Ebixa Summary of Product Characteristics.

Some studies include patients stable on acetylcholinesterase inhibitors.

EB2/1/11

And the nominations are open...

Pictured at the official launch of the Helix Health Irish Pharmacist Awards, in association with the Benevolent Trust Fund of the Pharmaceutical Society of Ireland, are (Right) Bonnie Conlan and Alex Nevin, (Left) Fintan Moore, Chairperson, Awards Committee and Howard Beggs, CEO, Helix Health and (Bottom) Tom McDonald, JPA Brenson Lawlor, Rebecca Garland, Activas Ireland, Jeffrey Walsh, Pinewood Healthcare, Sarah Corry, Teva Ireland, Howard Beggs, CEO Helicx Health, Donna Murphy, Pinewood Healthcare, Fintan Moore, Chairperson, Awards Committee.

This year's awards will recognise the contribution of the pharmacy profession in healthcare as well as celebrating excellence amongst pharmacists.

Nominations for this year's awards will open this May with the gala awards ceremony-taking place at the Mansion House on Saturday, November 12th 2011.

For further information on the awards please contact Fintan Moore at fm.gpp22@topmail.ie or Aisling Reast at reast@eircom.net, John Bourke at jbourke@castlemartincare.com or Cicely Roche at cicelyroche@eircom.net.

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Titration is important^{1,2}



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can modify their effects, dose adjustments may be necessary. Increased plasma levels could occur with concomitant use of cimetidine, ranitidine, procainamide, quinidine, quinine and nicotine. Co-administration with hydrochlorothiazide (HCT) may lead to a reduced serum level of HCT. Concomitant use of NMDA antagonist- amantadine, ketamine, dextromethorphan or phenytoin should be avoided. Close monitoring of prothrombin time or INR is advisable for patients treated concomitantly with oral anticoagulants. **Adverse reactions:** Common ($\geq 1/100$ to $< 1/10$) headache, somnolence, hypertension, constipation, dizziness, dyspnoea and drug hypersensitivity. Uncommon reactions ($\geq 1/1,000$ to $< 1/100$): cardiac failure, fatigue, fungal infections, confusion, hallucinations (mainly in severe Alzheimer's disease), venous thrombosis/thromboembolism, vomiting, gait abnormal. Very rare ($< 1/10,000$): seizures. Not known: Isolated cases of pancreatitis and psychotic reactions have been reported post-marketing. Alzheimer's disease has been associated with depression, suicidal ideation and suicide. In post-marketing experience these events have been reported in patients treated with memantine. **Overdose:** Symptomatic treatment. **Elimination:** Mainly in unchanged form via the kidneys. **Legal Category:** POM. **Marketing Authorisation Holder:** H.Lundbeck A/S, Ottiliavej 9, DK-2500 Valby, Denmark. **Marketing Authorisation Numbers:** EU/1/02/219/005 Ebixa 5mg/pump oral solution-50g bottle. EU/1/02/219/006 Ebixa 5mg/pump oral solution-100g bottle. EU/1/02/219/007 Ebixa film-coated tablets 10mg, 28 pack size. EU/1/02/219/008 Ebixa film-coated tablets 10mg, 56 pack size. Further information may be obtained from: Lundbeck (Ireland) Ltd., 7 Riverwalk, Citywest Business Campus, Dublin 24. **Date of Preparation: Dec 2010**

References: 1. Jones et al. 2007. *Intl J Geriatr Psychiatry* 22: 258-262. 2. Massoud et al 2010. *Current Neuropharmacology* 8:69-80. 3. Ebixa Summary of Product Characteristics. 4. Ferris et al. 2009. *Alzheimer's & Dementia* 5:369-374. 5. Emre et al. 2008. *Journal of Alzheimer's Disease* 14:193-199. 6. Doody et al. 2004. *Dement Geriatr Cogn Disord* 18:227-232. 7. Winblad et al. 2007. *Dement Geriatr Cogn Disord* 24:20-27. 8. Wilkinson et al. 2007. *Dement Geriatr Cogn Disord* 24:138-145.

Some studies include patients stable on acetylcholinesterase inhibitors.

*Approved for the moderate stage of Alzheimer's Disease onwards. Benefits of Ebixa (Memantine) include Memory, Language, Praxis, Function, Stabilisation.

MARY O'KEEFFE

MURs: where are we now?

Following on from a new report which found that seven out of ten older people in nursing homes in Ireland are receiving at least one inappropriately prescribed medicine, **Mary O'Keefe** asks if pharmacist led medicine use reviews (MURs) could help to address this serious problem and if so, how close we are to seeing MURs come to fruition.

When the Centre for Ageing Research and Development (CARDI) released a new report last month (April 2011) which highlighted a significant potential of inappropriate prescribing in nursing homes in Ireland, concerns were voiced not only about the impact that this could have on vulnerable patients, but also on the state's coffers.

The report "*An Evaluation of the inappropriate prescribing in older residents in long term care facilities in the greater Cork and Northern Ireland regions using the STOPP and Beers' criteria*" found that 73 per cent of nursing home residents in the Republic of Ireland were receiving "at least one potentially inappropriate medicine," while in Northern Ireland, 67 per cent of those in the sample were receiving a potentially inappropriate medicine.

It detailed how 630 older people in long term care in Northern Ireland and in the Republic of Ireland, who were surveyed as part of the research, were receiving an average of 11 medicines each and half of these people were prescribed eight to 14 daily medicines each.

The report also highlighted a number of areas of prescribing concern, for example, the long-term use of both benzodiazepines and hypnotics, in older residents residing in long-term care facilities.

Meanwhile, the cost of the inappropriate medicines was valued at €170 per older person in the Northern Ireland sample and €356 per person in the Republic of Ireland sample.

Can MURs solve the problem?

Following the publication of the report, a number of recommendations were made, which the report's researchers believe, could help to reduce potential inappropriate prescribing including the introduction of protocol driven medication reviews.

According to Dr Stephen Byrne, Senior Lecturer in Clinical Pharmacy at University College

Cork and lead researcher on the CARDI report, introducing such reviews would ensure that pharmacists, GPs, consultants and nurses work closely with one another and with older people and their relatives to ensure patients receive the medicines they need.

Asked how successful MURs and in particular, pharmacist led MURs might be, Dr Byrne admitted that while pharmacist led MURs have only proved successful to varying degrees in the UK and the US, where they are already in existence, and that they are somewhat time consuming, he believed these reviews could



prove to be of great importance in polypharmacy and in cases involving more vulnerable patients. "Introducing pharmacist led medicine use reviews would allow the pharmacists to see

all of the patient's medicines and see what is being used and what is not being used. Yes, it will involve the pharmacists having to remove him/herself from the dispensary for 30 minutes or so, but it will help him or her to identify compliance and non-compliance, usage issues as well as possible serious interactions. Of course there is also potential here to identify potential inappropriate medicines, particularly in patients who are vulnerable or taking a large number of medicines," he said.

Dr Byrne's beliefs are shared by Irish Pharmacy Union (IPU) President, Darragh O'Loughlin. "We're absolutely confident that MURs will have a real value for patients, not only in terms of looking at inappropriate medicines, but in making sure patients are taking the right medicines and in maybe looking at medicines that they are experiencing side effects from and substituting these drugs with new medicines instead of just treating the side effects of them," he said.

The IPU chief said the introduction of pharmacist led medicine use reviews would also help pharmacists identify where patients might not be taking medications which may be recommended for their profile. "Some patients are also not taking the medicines that they should be taking. A few years ago a decision was made that patients with diabetes should also be taking ace-inhibitors. By undertaking an MUR with a patient with diabetes, it would be very simple to see if they are taking all the medications, which have been recommended for them. The MURs will also give us the opportunity to establish where there might be other types of gaps in medication therapy. For example patients with osteoporosis are supposed to take the anti-osteoporosis drug biophosphonate, but they should also be taking calcium and vitamin D. We find in some cases these patients are taking calcium, but not taking the vitamin D needed to absorb this. An MUR would help to ensure that this does not continue to happen," he said.

Pipedream or reality?

The reality of seeing MURs developed in Ireland is one that is very real indeed.

Back in 2008, the *Pharmacy Ireland 2020 Working Group Report*, recommended that "Medicine use review (MUR) is likely to be the most appropriate method for assessing compliance and improving medicines-taking through concordance."

This report, is currently being progressed through the Pharmaceutical Society of Ireland (PSI) in a number of ways, and in particular through support of the work of the HSE Clinical Strategy and Programme's Directorate under Dr Barry White.

The PSI have reiterated that they believe "pharmacists have an essential role to play in ensuring the safe and rational use of medicines, which includes utilising their expertise in relation to therapeutic review and patient counseling".

Last year, the regulatory body issued a practice notice to pharmacists in respect of patients in nursing homes/residential care settings specifically, which some might say, signaled the beginning of MURs.

This document set out how "prior to the dispensing of each prescription, and prior to the supply of any medicinal product concerned, a registered pharmacist must review the prescription having regard to the pharmaceutical



Darragh O'Loughlin, IPU President

and therapeutic appropriateness of the medicine therapy for the patient and the use by the patient of any other medicines etc. that the pharmacist is, or ought reasonably be, aware of."

The Department of Health has also broadly, yet somewhat cautiously welcomed the introduction of pharmacist led MURs.

Asked how the Minister for Health, Dr James Reilly might welcome the introduction of such a service, a spokesperson from the Department of Health said, "The Minister is generally supportive of an expanded role for pharmacists in the delivery of services at primary care level. Any such expansion of service should be cost effective, promote best use of healthcare resources, be evidence based, be part of a structured framework of patient care and demonstrate direct benefits to patients."

The HSE pilot

Following on from the PSI recommendations, last year the Health Service Executive (HSE) undertook a pilot MUR initiative with 13 Primary Care Teams across the country.

This pilot, which involved 19 pharmacist-primary care teams, aimed at looking at improving the inter-professional relationship between Primary Care Team members and local pharmacists to achieve a "greater good".

Outlining details of the pilot study, a spokesperson for the HSE explained, "The aim of the programme is to improve the inter-professional relationship between PCT members and local pharmacists and to improve patient outcome, compliance and reduce wastage. It is envisaged that the pilot will begin to demonstrate how the skills and expertise of community pharmacists can best be utilised within the Primary Care Team setting."

As part of the initiative, pharmacists were aligned to a local PCT who undertook MURs with a number of patients. Once the patients were selected and agreed between the GP and the pharmacist (and patient consent obtained) the pharmacist arranged for the MUR to be conducted with the patient.

A feedback form was provided to the GP and indicated a list of the medication that the patient was on and any issues or problems that the GP should be aware of, which is impacting

on medication compliance. The feedback form recommended a consultation either urgently, routinely at next visit, or no action required. The pharmacist then followed up with a second MUR approximately two months later in order to allow evaluation of the initiative.

The MURs conducted under the pilot are currently being reviewed and evaluated by a Researcher in Trinity College and will be available in early Summer 2011.

The logistics involved

While the Irish Pharmacy Union in general is very supportive of the introduction of medicine use reviews and has in fact, reiterated calls on the Minister for Health to implement proposals to introduce pharmacist led medicine use reviews for patients who are using multiple medications, the Galway based union president, Mr Darragh O' Loughlin admitted that some serious thought will need to be put into the development and roll-out of this service.

When the results do come out, we will look at what is involved in the MUR and how much time it takes and we will have to make sure to get a reasonable payment for the work involved, otherwise it just won't happen.'

"When MURs are introduced, these will require a proper sit-down with the patient at a pre-dictated time. It's likely that the patient will need to make an appointment for this. I imagine that the whole process will take about 40 minutes; 20 minutes to review the patient's notes and make recommendations and 20 minutes to meet with the patient. We will need to look at how this can all best be done," he said.

Of course payment and contracts will need to be discussed prior to the development and rollout of MURs here also. "There hasn't been any discussion about payment yet. At this stage we've just done the pilot to see if it can be done and what resources it involves, but when the results do come out, we will look at what is involved in the MUR and how much time it takes and we will have to make sure to get a reasonable payment for the work involved, otherwise it just won't happen."

Look before you leap

While from the outside, some might believe a blanket introduction of MURs might seem like a good idea, the reality is that pharmacist led medicine use reviews have not been without criticism and controversy in the countries where they have been implemented.

In England, where MURs were introduced in

2005, one report undertaken for the National Institute for Health Research found that MURs were "bordering on fraudulent" with pharmacists admitting to being paid for reviews which had limited value as it was found that GPs were often ignoring the results of the reports.

That said, in the first audit of MURs in England, 80 per cent of patients who took part in the audit said that their knowledge of medicines and how to use them had improved as a result of the MUR.

In Northern Ireland and Scotland, where similar review programmes were introduced through the Medicine Management Scheme and the Chronic Medications Service respectively, the response has been equally mixed.

Northern Ireland based pharmacist, Terry Maguire says that while the schemes are ideal on an aspirational level, that practically, they are just not working.

"Under the Medicine's Management Scheme, which is a little different to England's MUR Scheme, the pharmacist meets with patients and undertakes a medicines compliance assessment as well as assessing any side-effects or issues as a result of the medicines with the patient. Following on from this review, a report is sent to the GP.

"The main problem with the scheme is the fact that it is poorly resourced and is not featured in our contracts, albeit there is payment for the service. There has been a very poor take-up of the scheme because of the fact that the documentation associated with it is turgid, GPs won't sign the report forms and many pharmacists feel out of their depth doing the assessment."

Concluding he added, "the ultimate end goal of community pharmacy is to improve patient outcomes and while we want to see pharmacy move on from a supply role to improving patient services, it is simply not easy to get to where the government wants us or indeed, where aspirationally, we want to be."

Mr Maguire said that he was hopeful that the upcoming reviews and assessments of the medicine management schemes in Northern Ireland might look at how to better ensure the development and provision of such schemes and that improvements might also be made to pharmacists' contracts to ensure the continued development of the scheme.



Terry Maguire, Northern Irish Pharmacist

Putting the spotlight on our prescription drug problem

With new research showing that more people die as a result of drugs than road traffic collisions, **Dr Des Corrigan** asks what measures need to be taken to tackle this serious problem.

Two reports from the Health Research Board (HRB); the first dealing with drug-related deaths up to the end of 2008 and the other, a trend paper dealing with benzodiazepines (BZD), have put the spotlight on problematic use of prescribed drugs.

The most disturbing feature of the report from the National Drug Related Deaths Index (NDRDI) was that 524 such deaths were recorded in 2008. This is more than the number of those killed in road accidents yet we spend far more on road safety campaigns than we spend on preventing drug deaths.

The other disturbing feature was the fact that most deaths from drug poisonings involved prescription drugs, chiefly benzodiazepines (38 per cent), methadone (29 per cent) and anti-depressant (21 per cent).

Very few of these preventable deaths involved just one substance with mixtures of narcotic analgesics (heroin and/or methadone), benzodiazepines (BZDs) and alcohol involved in most of the 2,434 poisoning deaths since 1998. Other prescription drugs were found in 22 per cent of cases. This category included non-BZD sedatives, anti-psychotics and cardiovascular medicines. Incidentally non-opiate analgesics were linked to 17 deaths in 2008.

“The most disturbing feature of the report from the National Drug Related Deaths Index (NDRDI) was that 524 such deaths were recorded in 2008. This is more than the number of those killed in road accidents yet we spend far more on road safety campaigns than we spend on preventing drug deaths.”

It is abundantly clear from the figures that the profession cannot escape playing a key role in preventing such deaths within the framework of the national overdose prevention strategy, which is at an advanced stage of development by an expert HSE group. It is also clear from the recently published Review of the Methadone Treatment Protocol that the PSI has committed itself to playing its part especially in relation to improving BZD prescribing practices. Action in relation to BZDs is long overdue on the basis of the shocking NDRDI figures and on those from the National Drug Treatment Reporting System (NDTRS). In the years 2003 to 2008, the annual number of treated cases reporting a BZD as a problem substance increased by 63 per cent from 1,054 to 1,719.

Some of the cases involve BZD as the main problem drug and this was more likely outside of Dublin. On the other hand, where BZDs were reported as an additional problem substance, this was more likely to be in Dublin and to involve those whose main problem substance was an opiate.

This ties in with the belief that there are two types of problem BZD users, namely, those who have developed dependent use as a result of long term medical use and those who are opiate-dependent and who also use huge quantities of prescribed or black market tranquillisers. It is these latter individuals, using 20 or 30 tablets a day (which is not an exaggeration) who are most at risk of death. In drawing attention to this risk I am open to an accusation of reinventing the wheel because the 2002 Benzodiazepine Report from the Dept. of Health and Children states that *patients dependent on opioids should be advised that the taking of BZDs can greatly increase the risk of overdose. This message should be conveyed as a matter of routine by all those who have contact with drug misusers.* Included in that last sentence are staff in the 522 pharmacies who dispense methadone to the 5,615 patients (out of a total of 9,428 on the Central Treatment List). That represents a lot of opportunities for individual pharmacists to intervene and save lives.

That 2002 Report also stated unambiguously that *prescribing benzodiazepines to opioid users (and other drug users) should be seen as exceptional rather than a routine decision.* For most of us involved in responding to problem drugtaking, it seems to be the other way round – that prescribing BZDs is the routine rather than the exception. Adherence to the DOHC advice would go a long way to reducing the death toll from drugs.

I have been pressing for some time for effective action in relation to the inappropriate prescribing of BZDs generally and more specifically to opiate users. It is clear from the General Population Drug Survey conducted by the NACD that there



DR DES CORRIGAN

Dr Des Corrigan is the former Director of the School of Pharmacy at TCD, and won the Lifetime Achievement Award at the 2009 Pharmacist Awards. He is the Irish representative on the Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction. He also currently chairs the National Advisory Committee on Drugs as well as the chair of the Traditional Herbal Medicinal Products Subcommittee of the Advisory Committee on Human Medicines at the Irish Medicines Board.

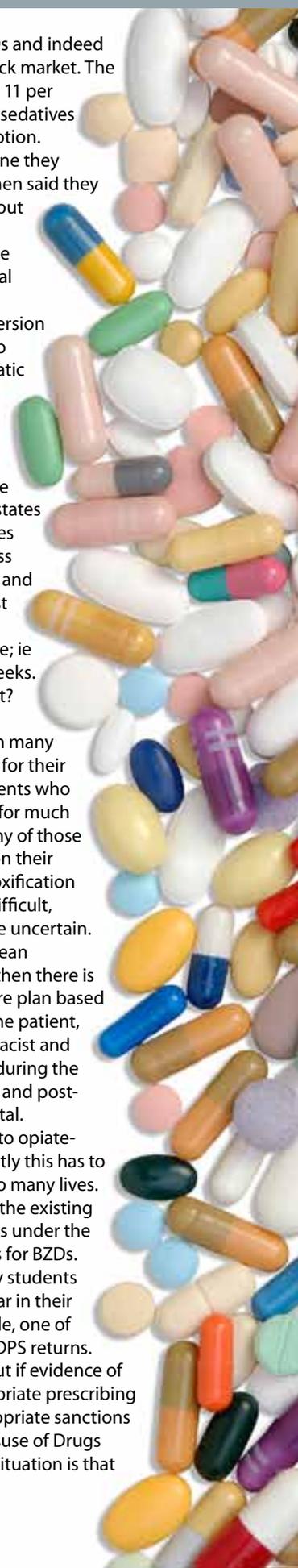
is leakage of prescribed BZDs and indeed other sedatives onto the black market. The 2006/7 Survey revealed that 11 per cent of those who had used sedatives did not get them on prescription. Many got them from someone they knew and 3 per cent of women said they got them “in a chemist without a prescription”. If that is true then it represents a complete abandonment of professional ethics by those involved.

In order to reduce the diversion onto the black market and to reduce the level of problematic BZD use, we need to start by implementing the longstanding, simple and straightforward medical guidance. Doing so will make a huge difference. The BNF states that these valuable medicines should only be used for stress or insomnia, which is severe and disabling and that the lowest possible dose be prescribed for the shortest possible time; ie no more than two to four weeks. What could be more clearcut?

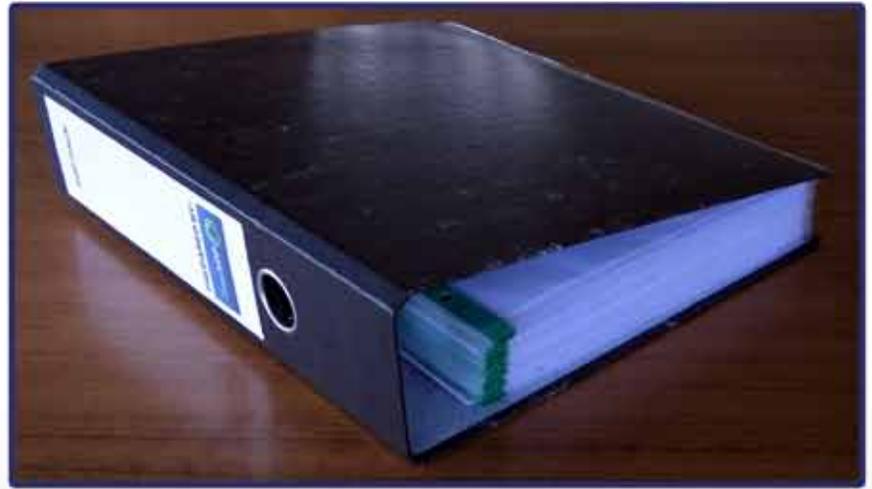
I suspect that the overwhelming reaction from many pharmacists will be concern for their many non-opiate using patients who have been prescribed BZDs for much longer than four weeks. Many of those will have to be maintained on their particular BZD because detoxification at this stage would be too difficult, unpleasant and the outcome uncertain. Where individuals wish to wean themselves off these drugs then there is the need for a structured care plan based on a partnership between the patient, their prescriber, their pharmacist and their family whose support during the lengthy tapered withdrawal and post-withdrawal phases will be vital.

In the case of prescribing to opiate-dependent individuals, bluntly this has to stop because it is costing too many lives.

There is a need to extend the existing audit of prescribing practices under the GMS to private prescriptions for BZDs. When I asked TCD pharmacy students about this at a recent seminar in their ‘Addiction Pharmacy’ module, one of the suggestions was to use DPS returns. It may involve extra work, but if evidence of persistent clinically inappropriate prescribing can be identified then appropriate sanctions as envisaged in the 1977 Misuse of Drugs Act should be applied. The situation is that serious.



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Where is the manpower?

Disillusioned and bewildered by the challenges facing pharmacy graduates, **David Jordan** asks where the manpower survey is for Irish pharmacy?

When I prepared last month's article I mentioned that to my knowledge there has never been a manpower survey undertaken for Irish pharmacy. So in the light of the undoubted tough times facing this year's crop of graduates I decided to delve a little deeper.

My initial gut feeling was that we are qualifying too many new pharmacists. We have gone from an under-supply of new pharmacists about 20-25 years ago to a massive oversupply. I think that we can all accept that the civil service, aka the hospital sector, will not be recruiting any extra staff, never mind pharmacists over the next few years. So where are the 180 or so new graduates to go? It already looks like that they will have a difficult time finding a pre-reg placement. Throw in the fact that most community pharmacies are in cutback mode rather than hiring mode at present and things are looking bleaker. And I haven't even touched on the numbers of Irish students studying pharmacy in the UK presumably with intentions of returning home and establishing themselves here.

DENMARK VERSUS IRELAND

I decided to check to see how an equivalent European country handles this. Denmark has a similar population to Ireland. They have only one school of pharmacy. It does have 230 graduates per year but they estimate that only 15 per cent of these will go into community pharmacy. Another 20 per cent will go to hospital and the remainder will work in Denmark's massive pharmaceutical manufacturing industry. That's about 35 new community pharmacists per year and a further 45 or so for hospital. It's a long way from 180. But then in Denmark, the government and the Danish equivalent of the IPU sit down every two years to agree a level of profitability for community pharmacy. That's near to Utopia compared to the current Irish situation.

So where are the pharmacy graduates of the last few years? Although the pharmacy degree leaves them amply qualified for a role in the pharmaceutical manufacturing industry it seems that few enough have sought their future there. My queries to date would seem to indicate that many of the last few years graduates now reside in the UK. And sadly it would appear that the return to emigration is the most promising option for many. The current batch of graduates were smart enough to get into pharmacy courses

in a very competitive environment. They are also smart enough to see a basic economic tenet. As supply rises price falls. The more pharmacists around, the lower salaries will be. I have already seen a full time pharmacist position offered at a salary of €25,000 per annum, i.e. €12 per hour. While this position may not be typical it does represent a huge drop in salaries from just over two years ago.

MOBILITY

This does not bode well for mobility in the pharmacy labour market. Just consider, if you are an employee pharmacist in a post where the salary was set during the boom times. How likely are you to move willingly to another post when the first thing you have to face is a significant drop in salary. From an employer point of view the surplus pharmacists has its attractions. Being able to take on new pharmacists at a lower salary definitely has some good points. But to my mind this raises questions as to the calibre of the next generation of pharmacists. Whatever about the intellectual challenge of pharmacy I cannot see the elite students seeing pharmacy as a bountiful career. However, if you are a pharmacist who has financed a second degree yourself then you are not going to hang around for this level of remuneration. Ryanair to Stansted is looking good. I cannot but wonder if this message will get through to the 500+ points cohort of students sitting for their leaving cert this year. If not I believe that this may be because all the talk about the drop in pharmacist prospects has been within the pharmacy sphere. If you are from outside of this milieu you would be forgiven for

// From an employer point of view the surplus of pharmacists has its attractions. Being able to take on new pharmacists at a lower salary definitely has some good points."



DAVID JORDAN

David Jordan has worked in community pharmacy since 1979, qualifying as a pharmacist in 1983. He was chairperson of the Community Employee Committee of the IPU from 1990 to 1998 and treasurer from 1994 to 1996. His main stress relief is riding his motorbike with his friends from www.irishbikerforum.com

thinking that all was still rosy in pharmacy land.

All this begs the question, should we as a nation be putting all the resources into training these future emigrant or unemployed pharmacists? I confess I don't know the full cost of government funding for pharmacy places in the three colleges, but if there is no need for them wouldn't the money be better spent training some other graduates? We as a nation could do with a new batch of economists and bankers. God knows the last lot haven't served us too well.

DEAFENING SILENCE

To get information for this article I emailed several bodies: the PSI, the Departments of Education and Enterprise & Employment as well as the HEA. I asked them a few things. Firstly, if they were aware of any manpower studies in relation to community pharmacy and the replacement rates necessary? I also asked the HEA and Department of Education were there any plans to change the number of places funded in pharmacy in the light of the current downturn.? And how have our overlords responded to this? The Department of Education referred me to the HEA and the Department of Employment referred me to the PSI. As for the PSI and the HEA the silence has been deafening. There are a number of issues for a regulator in this type of situation. Unemployed pharmacists are non-practising pharmacists. How might they be expected to keep their skill levels up? Similarly for pharmacists who decide to work in the manufacturing industry for a spell. How long do they have to be away from community before it may be necessary for them to undergo a period of re-acquainting themselves before being allowed to practice in community again? I am not aware of any current regulation, which would deal with this type of situation. Certainly they will need three years of community experience before they could operate as a supervising pharmacist, but nothing about operating as a regular Joe Soap pharmacist. Has Ambrose made any approaches to government to change or produce new regulations? Not that I have heard of.

As for the current batch of pharmacy students. What advice do I have for them? Seek out a career in the manufacturing sector or prepare for emigration. And as for those sitting the leaving cert this year, if you decide that you really want to be a community pharmacist then do it for the love of pharmacy.

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of levonorgestrel is enhanced by the concomitant use of liver enzyme inducers: anticonvulsants (Phenobarbital, phenytoin, carbamazepine); rifabutin; rifampicin; griseofulvin; St. John's Wort. The efficacy may be decreased in case of concomitant intake of these actives substances. **Pregnancy:** This product cannot interrupt an ongoing pregnancy. **Undesirable Effects:** Dizziness, headache, nausea, low abdominal pain, diarrhoea, breast tenderness, heavy, delayed menses, bleeding, fatigue. Consult SmPC for further information about adverse events. **Legal Category:** P **Marketing Authorisation No:** PA 1166/2/1. **Marketing Authorisation Holder:** Laboratoire HRA Pharma, 15, rue Beranger, 75003 Paris, France. **Date of Preparation:** April 2011.

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My part in the ever-growing obesity epidemic

Having been asked to share his views on the obesity epidemic on live television, **Terry Maguire** comes to realise that neither his opinion, nor those of his peers, alone can help to solve the growing problem.

I can't be sure if it was my book *"The Obesity Epidemic"*, my article *"The No Bulls**t Diet"* (which was printed in the January edition of *Irish Pharmacist*) or my negative commentary on Stephen Nolan's journalistic skills in *"Bad News"* (printed in the March edition of *Irish Pharmacist*) but, something triggered the invitation to work with the *Stephen Nolan Show* on a hard hitting TV documentary about obesity; its causes and its health impact. Stephen Nolan is Northern Ireland's answer to Gerry Ryan but twice the size.

By the way my book has now sold a total of 77 copies worldwide and I have kept the cheque for £77.00 framed on my pharmacy wall as proof – not worth cashing it as I will be forced to pay VAT at 20 per cent (I'm personally registered) and income tax at 40 per cent, which makes £36. It will serve as a reminder to me never ever again to write a book.

Anyway, I was proud, verging on conceit, to be appointed consultant (unpaid) to the programme advising Stephen and his staff on obesity management; the role of bariatric surgery, successful behavioural interventions, drugs and even bad fat diets.

The programme, broadcast at the beginning of April, was a great success, hard hitting with wide impact. Stephen attended a fat person's autopsy where he splashed around in litres of bright yellow visceral and subcutaneous fat – I suggested adipose tissue, but the producer said the viewers wouldn't understand that. Stephen had a personal assessment of his body fat and at 40 per cent of body mass or 50 litres of real volume (it should be 15 per cent) he was clearly concerned for his long-term health as were one hundred thousand obese viewers. It was sensationalist TV at its best and was widely discussed even among those who live on takeaways six days a week.

XXL GRAVES

For me, it was not the excess day-glow-yellow human tissue or Stephen's worried demure when he emerged from the body scanner, but, his concluding comment delivered in an American graveyard, where it is now common for people to be buried in double-width graves they are so obese, that hit me. It went something like this;

"Junk food is sending me to an early death. Everybody has the solution. Eat less, exercise more. I don't know, indeed no one knows, why people like me just can't do it and that's what's killing me". Cue sad reflective look into the middle distance, hold and cut!

"I don't agree," I shouted at the director when I got my DVD copy. "We know exactly why Stephen is nearly seven stone overweight and that's where we can do something". "Put it in

writing Mr Consultant," she replied and asked that I keep my comments for the big debate to be broadcast live the evening following the programme. I, as a consultant, would be on the panel, live.

So I swotted up on the questions I was sent and I ran through in my head what killer points I would make. This is how it ran:

OBESOGENIC ENVIRONMENT

Stephen; "So Terry tell me how bad obesity is in NI?"

Me, looking concerned and serious: "Well Stephen going back to 1980 only 6 per cent of the population were obese – now it's about 25 per cent. This is worse in lower social groups, among manual workers. It causes 25 per cent of CHD deaths, is the main reason for the 60,000 type 2 diabetics we have and this is going up to 80,000 diabetics by 2015 if we don't change. We are talking a reversal in the major health gains we have made over the last 20 years. And the costs are painful too. Obesity costs the UK £3.7 billion. This will be £10 billion in 2050."

Stephen looking shocked yet impressed: "And Terry tell us who's to blame?"

Me, looking even smugger, with head nodding and lip biting Bill Clinton style:

"I have a theory Stephen; the individual has 25 per cent control over their weight; a further 25 per cent the individual has a little, if any, control over. This is their desire, craving, eating compulsion, which controls them, and for many this can be impossible to override. It's about the individual's reactions to food. If you deal with stress, anger, depression or boredom by emptying out the fridge or demolishing a family sized pack of crisps then you need behaviour modification help. The remaining 50 per cent is the obesogenic environment and the individual has no control: lack of opportunity to exercise in the built environment, no regulation of calorie-dense foods (sugars and fats) which are cheap and widely available; inappropriate advertising of dangerous foods, supermarkets who refuse to implement proper labelling and, finally, fast-food outlets of which there are too many serving the wrong types of food. Stephen, If we keep doing what we are doing we keep getting what we've got".

There would then be questions from an appreciative audience and having given my insights and my answers my place in public health history would be assured.

In the end it turned out somewhat differently. Two days before the "big debate" I got e-mail indicating, subtly, that I was being dropped from the panel. I arrived on time and was seated beside a charming woman who has lost a whopping seven stone.



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.

The panel itself consisted of an overweight journalist, a painfully beautiful, lithe blonde who claimed to have lost seven stone on her own, a 30-something male who had also lost seven stone by gastric banding paid for by the health service, a highly irritating psychologist with an American accent and a specialist in childhood obesity.

The American accused, rather irresponsibly in my opinion, Stephen, our host, of being weak-willed in failing to control his weight. She persisted with this theme for much too long before accusing the gastric bypass patient of wasting £10,000 of health service money – the cost for his operation. What she knows about psychology was certainly greater than her knowledge of the cost of treating or even not treating diabetes and hypertension, of which this gastric bypass male, was now cured.

Bringing the audience into the discussions those keen to comment merely mentioned how much they had lost by attending a for-profit weight management programme. Challenged by one insightful member in the audience that advertising of fast food to children was a key problem in obesity the comment was immediately deflected by the specialist in childhood obesity into concerns on the lack of specific help for obese children. Later I was to find out he has an interest in an international hamburger company.

I did get to speak, briefly at the very end. I expressed concern that the real villains of the piece; processed food manufactures, fast food companies and supermarkets were being let off the hook, but, I was cut off before I got finished. And so it was, my deep insights ignored and, I realised, as I walked alone to my car that with this level of public engagement hopes for a resolution to our obesity epidemic does not auger well. Too many vested interests hogging too much of the obesity problem by offering their solution only while the problem gets worse. And they haven't even the decency to buy my book. And yes the painful part; I was one of them.



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Nexazole: for the treatment of erosive reflux oesophagitis

Prescribing Information for Nexazole 20 mg & 40 mg gastro – resistant capsules, hard. Qualitative and Quantitative Composition: Each capsule contains 20 mg or 40 mg of esomeprazole (as esomeprazole magnesium dihydrate). **Pharmaceutical Form:** Hard, gastro-resistant capsule. Slightly pink body and cap, containing white to almost white pellets. **Therapeutic Indications:** Treatment of erosive reflux oesophagitis. Prevention of relapse of healed oesophagitis in long-term management of patients. Symptomatic treatment of gastroesophageal reflux disease (GERD). Eradication of *H. pylori* concurrently given with appropriate antibiotic therapy for treatment of *H.pylori*-associated ulcers. Treatment of NSAID-associated gastric and duodenal ulcers in patients requiring continued NSAID-treatment. Prophylaxis of NSAID-associated gastric ulcers and duodenal ulcers in patients at risk requiring continued therapy. Prolonged treatment after i.v. induced prevention of rebleeding of peptic ulcers. Treatment of Zollinger Ellison Syndrome. **Dosage and Method of Administration:** Capsules should be swallowed whole with liquid. The capsules can be opened and the pellets mixed in half a glass of non-carbonated water or if desired this solution administered through a gastric – tube in patients with swallowing difficulties. The capsules and / or contents should not be chewed or crushed. **Treatment of erosive reflux oesophagitis:** 40 mg once daily for 4 weeks. **Long-term management of patients with healed oesophagitis to prevent relapse:** 20 mg once daily. **Symptomatic treatment of gastroesophageal reflux disease:** 20 mg once daily. **Eradication of *H. pylori* for treatment of *H.pylori*-associated ulcers:** 20 mg with 1 g amoxicillin + 500 mg clarithromycin, all twice daily for 7 days. **NSAID associated gastric & duodenal ulcers:** 20 mg once daily for 4 – 8 weeks. **Prophylaxis treatment:** 20 mg once daily. **Prolonged treatment after i.v induced prevention of rebleeding of peptic ulcers:** 40 mg once daily for 4 weeks. **Zollinger Ellison Syndrome:** Initial dose is 40 mg once daily. Dosage should be individually adjusted. Daily doses up to 160 mg have been used. If the required daily dose exceeds 80 mg, it should be divided and given twice daily. **Severe liver impairment:** Patients should not exceed a max. dose of 20 mg. **Contraindications:** Hypersensitivity to esomeprazole or to any of the excipients. Esomeprazole should not be administered with atazanavir. Pregnancy and breast-feeding due to insufficient data. Children under 12 years. **Special warnings and precautions for use:** The possibility of a malignant gastric tumour should be excluded as Nexazole may alleviate symptoms and delay diagnosis. Regularly monitor patients on long-term treatment. Patients on on-demand treatment should contact their physician if symptoms change in character. If esomeprazole is used in combination with antibiotics, then the instructions for the use of these antibiotics should also be followed. Treatment with esomeprazole may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter*. Contains sucrose – Patients with rare hereditary problems of fructose intolerance, glucose – galactose malabsorption or sucrose-isomaltase insufficiency should not take this medicine. **Drug Interactions:** Esomeprazole can affect the absorption of ketoconazole and itraconazole. Dose reduction may be required when administered with drugs metabolised by CYP2C19 as esomeprazole may increase their plasma concentration. Monitor patients when given in combination with warfarin or other coumarine derivatives. **Undesirable effects:** Common: Headache, abdominal pain, constipation, diarrhoea, flatulence, nausea/vomiting. **Shelf Life:** 2 years. **Marketing Authorisation Holder:** Pinewood Laboratories Ltd., Ballymacabry, Clonmel, Co. Tipperary. **Marketing Authorisation Holder Number(s):** PA 281/146/1-2. This medicine is a prescription only product. Further prescribing information is available on request. **Date of revision of text:** July 2010.

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Mockingbirds in Waltons



Northern Mockingbird

“When he gave us our air-rifles Atticus wouldn’t teach us how to shoot. Uncle Jack instructed us in the instruments thereof; he said Atticus wasn’t interested in guns. Atticus said to Jim one day, ‘I’d rather you shot at tins in the back yard, but I know you’ll go after birds. Shoot all the bluejays you want, if you can hit ‘em, but remember it’s a sin to kill a mockingbird.’”

Read the following, or something like it recently, ‘a friend is someone who knows your song and sings it to you when you have forgotten it. Those who love you are not fooled by mistakes you have made or about the dark images others may say of you. They remember your beauty when you feel ugly; your wholeness when you are broken; your innocence when you feel guilty; and your purpose when you feel confused.’

Everyone’s got a song as a friend, even or more especially when they’re low. You’ll sing love songs, hum chords and broken tunes and maybe, even when broken, you’ll lift a bottle to a familiar tune and try and find the dream.

A song’s like a forecast; always got the potential of something about to happen. At any time it can surge or ebb, be it in the morning or maybe just to soothe to sleep. You’ve got melodies, where notes morph, melt, glide and collide from and into teasing lips. The note will show itself off like a girl in spring and then hide and fold into itself until the summer comes inside the song.

Notes can gather speed, stretch from Ross’ point as far as Rockhall, stand and soprano to Mizen or baritone their way down to Malin. And they’ll run away from you forever, over rainbows, along side factory walls, through the rain, trains with no sunshine, into deep velvet nights where you want to sink softly forever.

I’ll betray a few years and tell you I started pharmacy in Trinity in 1985. There’s not much of that Dublin left anymore, but recently I found myself in a place that brought me back to bedsit land. A friend got me a series of singing lessons in Walton’s School of Music in George’s Street. I have to admit I was pretty reluctant to go, even the welcome and assurance from Jo,

the ever pillar of sense, when I got there didn’t help. I didn’t hear the cats, like me, only the mockingbirds and wanted to run, but the place had something going for it, like an orphan’s aura.

It’s a rabbit warren of old stairs and rooms with high bedsit ceilings and maybe it was the forgotten memory but that, for me, was the first anchor, it was like even the building itself could breathe. I’ve had the same teacher for three years now, a Polish lady called Marta. Communication can be fun there, but you don’t need words when you’ve caught a song, you don’t need words for that.

“The note will show itself off like a girl in spring and then hide and fold into itself until the summer comes inside the song.”

Marta’s all about support, connecting the body, supporting the note. She’s tiny but she knows about support; when she sings it’s like all of Warsaw is behind her. Of late it occurred to me that’s what perhaps the school and it’s old biscuit redbrick are all about. That old Georgian house can empty itself of air, breathe and then it’s burren of high ceiling rooms support volumes of happiness.

John Mardirosian and his better half set up the

present school in 1994. Today, they have some 60 teachers and approx 1400 pupils per term.

His mission is and I quote, ‘It’s about balance and choice. Music is a mysterious area for a lot of people and it can be intimidating. What is important is to demystify it up to everyone ... and you have to have breath, you can’t be narrow.’

Or for children he has; ‘Music is an outlet for children that’s every bit as valuable as sport and it’s also one that offers kids a clear indication of progress. If you practise a piece with any kind of application, then the next day you’ll be better at it.’

So, I recommend, in these somewhat dark times, to go over the rainbow, or go back to a memory and learn to sing. It’s as simple as that.

Oh, and there’s one other thing; on the way home, if she’s raining, you’ll feel the rain on the side of your cheek as opposed to getting wet. That’s what singing does.

“That was the only time I ever heard Atticus say it was a sin to do something, and I asked Miss Maudie about it.

‘Your father’s right,’ she said. ‘Mockingbirds don’t do one thing, but make music for us to enjoy. They don’t eat up people’s gardens, don’t nest in corncribs, they don’t do one thing but sing their hearts out for us. That’s why it’s a sin to kill a mockingbird.’

JULIAN JUDGE

Julian Judge qualified as a pharmacist in 1990. He has recently completed a Masters in Creative Writing at the Department of English at UCD. Contact Julian at email: julianjudge@hotmail.com

What to do with cash?

Aware that more and more people are increasingly worried about where to invest their hard earned cash, **Iain Cahill** shares his advice on how to invest wisely and safely.



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If like most people, right now, you are nervous about investing money in the current climate, then the challenge is what to do with any cash you may have in these very uncertain times. With the current upheaval in the Irish economy coupled with the continued threat of burning bondholders, IMF bailouts, the need to re-capitalise the banks and the continued government need to guarantee the banks, there is a lot of uncertainty out there.

A key challenge is that of the continued uncertainty of the risks attaching to the various banks. With the latest round of bailout announced at €37 billion, it is still uncertain if this is enough to stabilise the Irish banking system.

If we were to believe the financial journalists, the threat of a potential Eurozone break-up, would result in the dissolution of the Euro altogether or, more likely, the potential for a perceived two-tier value. In other words, that a German Euro is a far more precious currency than an Irish Euro. Before 2008, this would all have been conceived as a very unlikely occurrence. With the rising of the interest rate by the ECB and the need to bailout other European nations, unfortunately we must consider all possibilities in making informed choices.

As already mentioned, the Irish government has continued to guarantee all deposits held within Irish institutions and after this is lifted (which has been threatened twice), the amount that is guaranteed will revert to €100,000 held within an Irish bank. Note that for non-Irish banks, they are supported by the compensation rules applicable in the country of their parent bank. For example, deposits in Ulster Bank, as a subsidiary of Royal Bank of Scotland, are subject to the UK deposit combination policy. So why does this matter?

SAFEGUARDING YOUR MONEY – THE ALTERNATIVES

In 1941, Will Rogers, a famous actor, once stated that 'I am less concerned with the return on my money as the return of my money.' In the current climate, this is a good maxim to consider more most of us.

In the search for potential solutions for clients, in conjunction with several institutions, we look at how best clients can access alternative strategies to simply chasing deposit rates. Through knowledge and planning, a number of potential solutions do exist and the rest of this article is about informing you of some of the alternatives that exist for cash investors. Some of you may be familiar with the alternatives that exist to cash deposits, but maybe you haven't considered them in the context of a cash strategy. When I am working with clients, a true cash based investment strategy has as key components:

- The ability of the funds to be accessible when you need them
- Transparency in terms of charges and management fees
- Be transferable to other investment forms when required.

I mention these key aspects as you would be amazed at what exists in the market, that under scrutiny does not make sense. In one particular case I reviewed on behalf of a client, the individual had been sold a two-year fixed rate policy by his bank with a perceived three per cent interest rate. However when you looked at the small print, he was being charged a 1.25 per cent management fee to manage cash. It is very hard to make a return on this sort of basis.

A WORD OF CAUTION

It is always important to understand how returns on different strategies are taxed. It can make a difference and particularly in the current regime where taxation will become more penal as we move forward.

Secondly, it is worth your while being aware that in investment circles, many people talk about cash and cash equivalent investments. In this scenario we are therefore considering:

- Investment type potential return
- Cash deposits. 0.1%-3%
 - Money market funds. 1.2%-2%
 - Sovereign bonds 2%-9%
 - Corporate bonds 3%-15%

As you can see, there is some diversity in the potential returns that can be achieved under each of the investment headings. It is always worth remembering that the higher the return, the greater the risk or the accessibility to your funds. A classic example is what you see playing out with Irish banks. Your current account might (if you are lucky) get an interest rate of 0.1 per cent on your money whereas you can get 6 per cent over two years (or three per cent pa) providing you lock your money away for two years. As we now know, two years is a long time in the current economic climate.

REDUCING THE RISK

There is a way that if you can combine these investments, it is possible to reduce the risk on being dependent on the Irish government to secure your deposits and make returns that are as good or better than you may be used to with your deposit

returns.

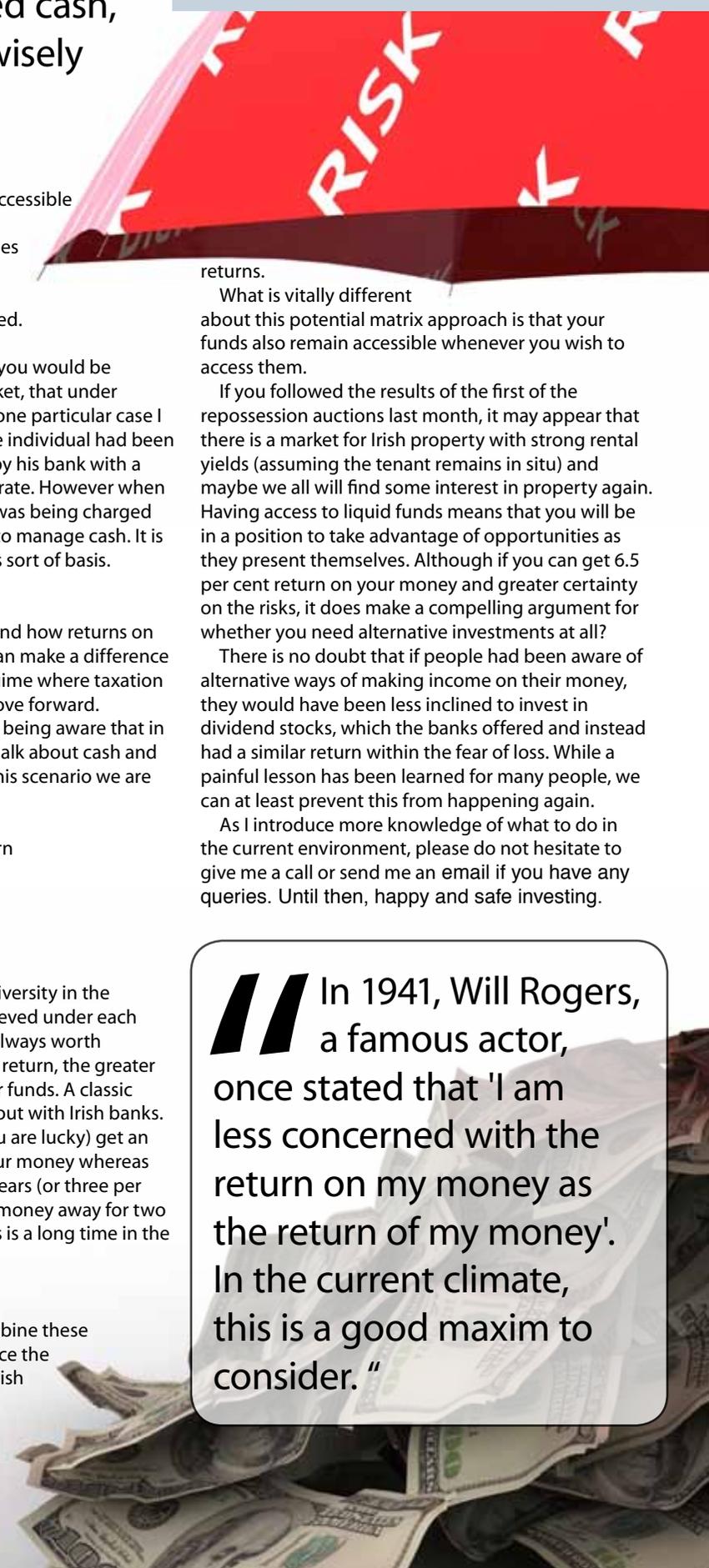
What is vitally different about this potential matrix approach is that your funds also remain accessible whenever you wish to access them.

If you followed the results of the first of the repossession auctions last month, it may appear that there is a market for Irish property with strong rental yields (assuming the tenant remains in situ) and maybe we all will find some interest in property again. Having access to liquid funds means that you will be in a position to take advantage of opportunities as they present themselves. Although if you can get 6.5 per cent return on your money and greater certainty on the risks, it does make a compelling argument for whether you need alternative investments at all?

There is no doubt that if people had been aware of alternative ways of making income on their money, they would have been less inclined to invest in dividend stocks, which the banks offered and instead had a similar return within the fear of loss. While a painful lesson has been learned for many people, we can at least prevent this from happening again.

As I introduce more knowledge of what to do in the current environment, please do not hesitate to give me a call or send me an email if you have any queries. Until then, happy and safe investing.

“ In 1941, Will Rogers, a famous actor, once stated that 'I am less concerned with the return on my money as the return of my money'. In the current climate, this is a good maxim to consider. **”**



JUNE SHANNON

From bench to bedside

At a time when tough decisions and heartbreaking tales are dominating the news agenda, *June Shannon* takes a look at the good news.

In these dark days of austerity and the seemingly unending media reports of negative equity, successive cuts to our credit rating and IMF doom and gloom, it is worth remembering that despite the recession, Ireland's long held reputation for excellence in science, technology and research is still going strong.

Nowhere is this more evident than in the numerous developments in science and biotechnology that continue to emerge from our universities.

The development of an innovative class of platinum drugs and an advanced new system for the treatment of lung cancer; these are just some of the good news stories to emerge from Irish universities in recent weeks.

A marriage of commerce and academia

In fact, addressing the Digital Enterprise Research Institute (DERI) open day which took place at NUI Galway recently, the newly elected Minister for Research and Innovation, Seán Sherlock TD said that research between commercial and academia sectors represented "a winning formula for our economic recovery."

DERI, a Centre for Science, Engineering and Technology (CSET), which is supported the Government through Science-Foundation Ireland (SFI) funding, was established in 2003, as a web science research centre. Current research projects include semantic search engines, novel collaboration and social media as well as sensor network technologies.

According to Minister Sherlock, "the clustering model of scientific research, comprising an unprecedented degree of co-operation and collaboration between commercial and academic personnel, has been "a winning formula" at DERI.

The DERI Open Day was attended by over 250 academics and industrialists who attended presentations and demonstrations on DERI's research, applied research and commercialisation activities.

According to Minister Sherlock DERI's impressive track record also provided the Government with "considerable hope and indeed



Pictured iis Declan Soden, Principal Investigating Officer, UCC, Cork Cancer Research Centre with UCC President Dr. Michael Murphy.

Michael Mac Sweeney/Provision

some expectation that science will be pivotal to our economic recovery."

Coupled with the excellent work being carried out by researchers at DERI and indeed throughout NUI Galway, a number of other Irish universities have recently published details of exciting new research projects, all of which underline the key role science, technology and research can play in assuring Ireland's economic future.

Platinum drugs

At the RCSI, for example, Dr Celine Marmion (Principal Investigator) and Dr Darren Griffith from the Department of Pharmaceutical and Medicinal Chemistry have recently discovered an innovative class of platinum drug candidates for the treatment of cancer, which has recently been licensed to a pharmaceutical company for further development.

The novel technology, developed at RCSI, has focused on the development of multi-functional platinum drug candidates, which within cancer cells would simultaneously target DNA and a class of enzymes called histone deacetylases (HDAC). These platinum drug candidates have demonstrated potent anti-cancer activity and have been shown to be selective for cancer cells over normal healthy cells.

Commenting on the RCSI project Dr Celine Marmion said, "success in drug development depends on a multi-disciplinary approach. In addition to having an excellent research group, we have been very fortunate to have strong collaborative links internally (Dr M Morgan, MCT, RCSI), nationally (Dr D Egan, IT Tallaght and Dr K Kavanagh, NUI Maynooth) and internationally (Professor V Brabec, Academy of Sciences of the Czech Republic)."

New cancer treatments

There was more good news on the development of potential new treatments for cancer from UCC last month with the news that an advanced new system for the treatment of lung cancer was one of two new technologies to be named UCC Invention of the Year.

The Invention of the Year Award recognises the world-class research being undertaken at UCC, which has developed a strong track record in commercialising and spinning-out projects in disciplines ranging from life sciences and pharmacology to ICT and engineering.

The invention by Declan Soden and John Hinchion, principal investigators at the Cork Cancer Research Centre, is a new laparoscopic device for the non-invasive treatment of lung cancer.

The Lung Laparoscopic Electroporation Electrode (LLEE) delivers, in a

targeted manner, an electrical field to tumour tissue and as a result an electrical field is generated around the tumour, which opens microscopic pores within the cancerous cells, a process known as electroporation.

With these microscopic pores opened, a cytotoxic cell-killing drug is delivered directly into the cancerous cells. The drug absorption occurs only in the area that has been electroporated (i.e., when the cell pores are opened using electrodes) and the treatment is directly targeted into the cancerous cells in the tumour, leaving surrounding healthy tissues unaffected.

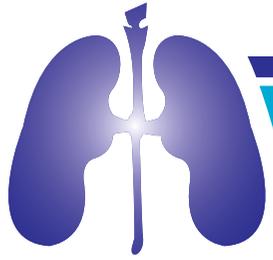
The UCC medical device will now undergo clinical trials to prove its effectiveness.

Electrochemotherapy is already an acknowledged treatment method in skin cancer and Declan Soden is also an inventor of the EndoVE, a device currently in clinical trial to treat colorectal cancer, but a similar lung treatment has not been developed until now. The system underlying the new device is currently being patented by UCC's Technology Transfer Office.

According to UCC President, Dr Michael Murphy, "The ability to commercialise Irish research projects and to bring them to a global market will be a vital contributor to the renewal and recovery of our economy. Innovative research at UCC is yielding a tangible return on investment for the State and benefits for industry, society and the economy through the licensing and spinout of patented research and new companies."

Other inventions shortlisted in the UCC competition included a new system to maximise broadband data transmission in fibre optic cables; a controlled drug delivery system for illnesses including Crohn's disease and stomach cancer; intelligent software systems for the evaluation of customer service quality in contact centres; the use of nanotechnology in the development of new drugs and a software technology that helps retailers to evaluate and extend the shelf life of fruit and vegetables.

Several other UCC research projects and inventions were also very highly commended in the evaluation process.



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* (Ref: Prevalin home use test, Belgium, Synovate Ltd. 2010 (N=80)).

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The progression of allergies

Almost one in three patients suffer from some type of allergy, it is therefore of great importance that pharmacists familiarise themselves with all aspects of allergy.

The objective of this article is to inform the reader of the natural progression of allergy from childhood to adulthood so that the 'Allergy March' can be halted at an early stage in life. Allergy is a combination of genetic and environmental factors, and therefore because we are unable to control the former, it is important to ascertain what the triggers of allergy are so we can limit this exposure. In Ireland, we must be extra cautious when discussing allergy diagnosis with patients as many of them seek the assistance and diagnosis of alternative practitioners with dubious ways of testing for allergy. The patient is not entirely at fault as the waiting lists to be seen by public immunology services range between many months up to two years sometimes. It is essential therefore that scientific and validated methods be used for allergy diagnosis.

ALLERGIES EFFECTING BABIES

There appears to be a set pathway, which allergies seem to take from childhood to

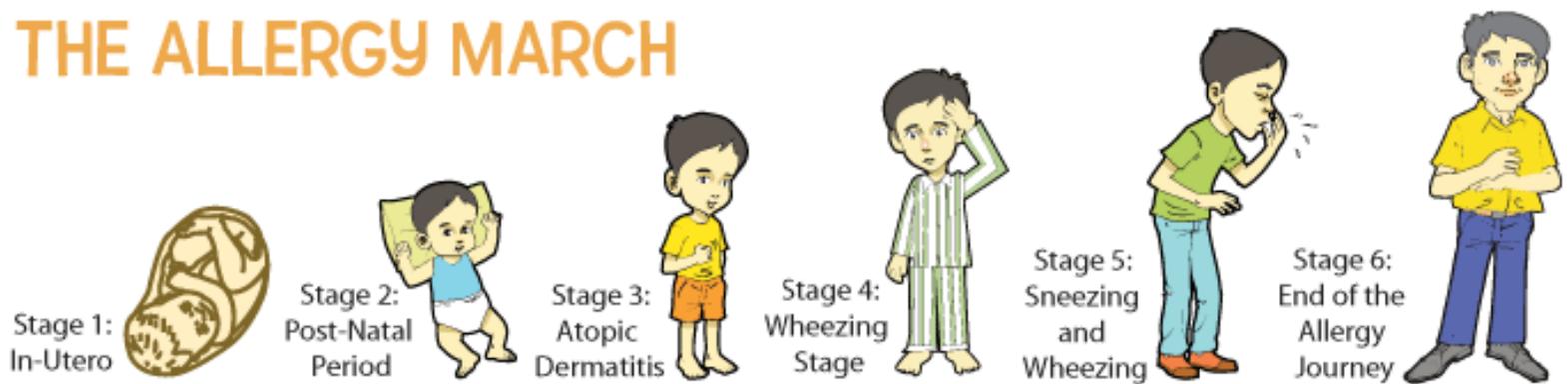
adulthood. A baby who has allergies usually presents with food allergies and typically may present with abdominal colic, although this symptom has many aetiologies. The colic may coexist with eczema and this eczema usually affects the flexural surfaces of the arms and legs in younger children. These early allergies may be caused by the proteins found in cow's milk and breast-feeding is advocated in all cases and the recommended duration remains at a minimum of six months.

One important fact to note is that parents and medical practitioners should not switch to soya protein formula without due investigation as almost half of cow's milk protein allergic children will also be allergic to soya formula – this is why some children's allergy worsens after changing to soya formula. Allergy testing will have diagnosed this at an early stage. All that is required is an allergy skin prick test or a specific IgE blood test.

Cow's milk protein allergy (CMPA) babies now have the option of hypoallergenic formulas where the cows milk protein has been partially or extensively hydrolysed, in order to reduce

// In some children allergy may not be noticed until they reach the weaning period when foods are introduced for the first time. Eight foods account for 90 per cent of all food allergic reactions.

THE ALLERGY MARCH



The Progression of Allergy from Childhood to Adulthood

Allergy March Illustration with permission from Dr Ranbir Kaulsay – theallergymarch.com / www.clontarfclinic.com

the allergenic potential of the formula. The nutritional component remains the same; it tastes slightly more bitter and these formulas are easily available either as partially hydrolysed formula for moderately allergic children or extensively hydrolysed or amino-acid formulations for more severe cow's milk protein allergic children. These formulas are more expensive than normal formulas and some may be on the medical card or drug payment scheme (DPS).

In the past it was believed that cow's milk allergy disappeared in approximately 85 per cent of the sufferers by the age of three years, but recent studies have demonstrated a more delayed time to lose this allergy. Other foods like shellfish and nuts remain a life long burden.

TODDLER ALLERGIES

In some children allergy may not be noticed until they reach the weaning period when foods are introduced for the first time. Eight foods account for 90 per cent of all food allergic reactions. They are milk, egg, peanut, tree nuts, fish, shellfish, soy, wheat and egg protein where egg white is the predominant allergy. This allergy is rather difficult to avoid because egg white or albumin is found in a great range of foods and label reading becomes important for the parent. I have heard from dietitians that deal with allergy that the duration of the average supermarket shopping trip is doubled when shopping for a child with food allergy due to the necessary label reading that has to occur.

Wheat allergy is another common allergy and this can be a major inconvenience because of the variety of commonly consumed foods that are made from or may contain wheat. The presenting complaints of this allergy can be anything from skin rashes or eczema to gastrointestinal complaints. Thankfully in modern day Ireland, there are many wheat or gluten free substitutes available. It is at this stage that I would like to introduce the concept of intolerances and how this differs from a true food allergy is that it is not mediated by the same immune mechanisms as allergy – very frequently the reactions take longer to occur and the clinical picture often presents as bloating and gastrointestinal problems and there are many unknown factors where intolerances are concerned. The tests for intolerances are many and varied and only a few have scientific merit, but a lot of research continues to occur in this field.

OLDER CHILDREN AND ADULTS

It is here that the spectrum begins to change and inhalant allergies begin to become important. Usually towards the end of the first decade of

a child's life and this age seems to be getting younger and younger the child may become allergic to environmental allergens. The most common environmental allergens are house dust mites, pollens, mould spores and pet dander. These allergens are commonly responsible for causing seasonal or intermittent allergic rhinitis (hay fever) or more persistent house dust mite induced persistent allergic rhinitis. Any one of these allergens can cause allergic asthma and may cause eye, nose and lung symptoms.

occurrence of new sensitisations. Personally, I have had very good experiences with sublingual desensitisation for pollens, dust mites and even pet dander over the last 10 years. There are very few side effects and there has yet to be a case of anaphylaxis with these treatments in clinical practice. Unfortunately, we are not able to offer such therapies for food allergens and a lot of research is on going in this field currently but no commercial preparations are available as yet.

THE END OF THE 'ALLERGY MARCH'

There are many things that we can do to decrease or even halt the 'allergy march'.

Although genetically, there is nothing that may be done to improve this situation apart from careful selection of one's partner, preferably with no family history of allergy, during pregnancy, especially in the third trimester for mothers with a strong family history of allergy, research has advocated an increased intake of omega-3 fish oils and house dust mite avoidance. These two steps are the only scientifically proven methods of reducing the incidence of allergy in a 'high risk of allergy' baby.

Once baby is born, to a family with a history of asthma, eczema, allergic rhinitis or other allergies, they have to be extra vigilant for the occurrence of eczema and should be aware of the different foods that may cause an allergy when weaning. Breast-feeding as always is recommended at least for six months and some research advocates the use of hypoallergenic formulae thereafter, but personally this should be on a case-to-case basis. If symptoms occur, early testing and therefore avoidance will be logical so that the natural progression of allergy may be halted.

The reduction of house dust mite exposure should be advocated for anyone with a family history of asthma, rhinitis or eczema because it is with a very high probability that the child may be dust mite sensitive due to the high incidence of this allergy.

Furthermore, it is relatively straight – forward to do so – no carpets in the bedroom or at least regular vacuuming with a high quality vacuum cleaner, dust mite barrier covers for the mattress, pillows and duvet, 60-90°C weekly sheet washes, de-cluttering of the room and washing of soft toys etc.

Should an allergy be detected, early avoidance is paramount and the earlier desensitisation is commenced the better especially when exposure cannot be avoided eg. pollen allergy. If the first line of medical care were on the lookout for these early symptoms, many of these babies and potentially allergic patients may be detected at a much earlier stage.

Once baby is born, to a family with a history of asthma, eczema, allergic rhinitis or other allergies, they have to be extra vigilant for the occurrence of eczema and should be aware of the different foods that may cause an allergy when weaning.

Thankfully, these allergies are easily identifiable by skin prick testing or specific IgE measurements and the practitioner is then able to offer avoidance advice, or better still, refer the patient to a medical allergist or clinical immunologist so as desensitisation may be prescribed.

The main desensitisation or immunotherapy offered recently is via the sublingual route as this is the safest, easiest and most cost effective method. In the instance of grass pollen desensitisation, this treatment can be prescribed by selected specialist throughout Ireland to be continued by their GPs and this three year protocol of sublingual tablets will then confer desensitisation to grass pollen for the next decade at least. This treatment is available on the GMS and Drug Payment Scheme. This is the main treatment being advocated by the WHO as this is the only therapy that alters the natural course of the disease and may prevent the

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with cystic fibrosis, or polyps that completely obstruct the nasal cavities. Unilateral polyps that are unusual or irregular in appearance, especially if ulcerating or bleeding, should be further evaluated. Patients who are potentially immunosuppressed should be warned of the risk of exposure to certain infections. Very rarely, nasal septum perforation or increased intraocular pressure have been reported following the use of intranasal corticosteroids. Nasonex should only be used in pregnant women, nursing mothers or women of child-bearing age if the potential benefit justifies the potential risk to the mother, foetus or infant. Growth retardation has been reported in children receiving nasal corticosteroids at licensed doses. It is recommended that the height of children receiving prolonged treatment with nasal corticosteroids is regularly monitored. If growth is slowed, therapy should be reviewed with the aim of reducing the dose of nasal corticosteroid, if possible, to the lowest dose at which effective control of symptoms is maintained. In addition, consideration should be given to referring patient to a paediatric specialist. Safety and efficacy of Nasonex Nasal Spray for the treatment of nasal polyposis in children and adolescents under 18 years of age have not been studied. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. If there is evidence for higher than recommended doses being used, then additional systemic corticosteroid cover should be considered during periods of stress or elective surgery. In a placebo-controlled clinical trial in which paediatric patients (n=49/group) were administered Nasonex 100 micrograms daily for one year, no reduction in growth velocity was observed. **INTERACTIONS:** A clinical interaction study was conducted with loratadine. No interactions were observed. **SIDE EFFECTS:** Adverse effects commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, nasal burning, nasal irritation and nasal ulceration. Other less common and rarely reported side effects are listed in the SPC. **PACKAGE QUANTITIES:** 18g per bottle, supplied with a metered-dose manual spray pump actuator which delivers 50 micrograms per actuation. **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Numbers:** 0201/0216 (UK); 277/77/1 (Ireland). **Marketing Authorisation Holder:** Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts., AL7 1TW, UK. Please refer to the full SPC text before prescribing this product. Further information is available on request. Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk (UK) and www.imb.ie (Ireland). Adverse events with this product should also be reported to Schering-Plough Drug Safety Department on +44 (0)1707 363773. Date of Revision of Text: August 2010. Date of Preparation: August 2010. Nasonex/API/08-10/7

Reference: 1. Canonica GW, Bousquet J, Mullol J, Scadding GK, Virchow JC. A survey of the burden of allergic rhinitis in Europe. *Allergy*. 2007;62(Suppl 85):17-25.



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The burning issue

As Melanoma Awareness Month draws upon us, **Mary O'Keeffe** takes a look at the incidence of skin cancer in Ireland and asks what role pharmacists can play in the battle against the disease.

92 per cent increase in cases of skin cancer

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of

www.RTE.ie, Monday, 10 May 2010

Despite the fact that skin cancer is the most common form of cancer in Ireland, the reality is that it is a subject that many people remain ill informed about.

In fact, it's likely that if you were to ask your average patient to name the different types of skin cancers and how they can protect themselves from these, some might have difficulty in differentiating between malignant and non melanoma cancers, the different ways they can protect themselves from these or perhaps, most importantly the fact that a very significant number of cancers caused by the suns rays are preventable.

Taking this gap in knowledge into consideration, Melanoma Awareness Month (which takes place this May), presents itself as a perfect opportunity for pharmacists and other health professionals to educate themselves about the incidence of skin cancer in Ireland and look at the ways they can help their patients to be more skin aware.

SKIN CANCER – THE FACTS

- Skin cancer is the most common cancer in Ireland
- Over 8,000 new cases of skin cancer were diagnosed in 2008
- Of these 721 cases related to malignant cancers; 308 cases involved men and 413 involved women. The rest of these cases relate to non-melanoma cases

WHAT IS SKIN CANCER?

There are two main types of skin cancer namely non-melanoma and malignant melanoma.

Non-melanoma skin cancer is most commonly diagnosed in people who spend a lot of time outdoors. There are two forms of non-melanoma skin cancer namely basal cell carcinoma and squamous cell carcinoma.

Basal cell carcinoma is most common in fair skinned and older people and is caused by over exposure to the sun.

Squamous cell carcinoma is a slow growing skin cancer also caused by over exposure to the sun. It usually affects older people and occurs on areas exposed to the sun such as your face, ears, neck or lim

Basal cell carcinoma and squamous cell carcinoma are often recognisable by the

BBC

Dramatic rise in malignant skin cancer in young people

www.bbc.co.uk, 25 August 2010

development of a new sore or growth that does not heal within four weeks, a spot or sore that continues to itch, hurt, crust, scab or bleed; or constant skin ulcers that are not explained by any other cause.

Malignant melanoma is the most serious form of skin cancer. It occurs in the melanocytes of the epidermis, which are the cells that give the skin colour. It is often identified by the development of a new or changing mole or freckle.

SKIN CANCER AND THE ROLE OF THE PHARMACIST

PREVENTION

Jennifer Ledwith, Cancer Information Services Nurse with the Irish Cancer Society says that pharmacists can play a major role in helping to reduce their patients risk of skin cancer and to build awareness around the disease.

"Nine out of ten skin cancers are caused by the suns rays and these can be prevented. It's so important that we look at how much time we are spending in the sun – especially with regard to children and young people as the damage done to young people by the sun shows twenty years on. The simple message, which needs to be reiterated over and over again, is to use the sun smart code and protect yourself," she said.

This code, recommends that people protect themselves from the sun by covering up, seeking shade during the hottest parts of the day, protect their eyes, use sunscreen and steering clear of sunbeds and sunlamps.

Irish city dwellers have higher skin cancer risk, study shows

Irish Times, 2 September 2010

// In addition to advising patients about how to protect themselves against the harmful rays of the sun, pharmacists are often also the first port of call for patients who have any concerns about changes to their skin and as such, can have an important role to play in advising their patients about the signs and symptoms of skin cancer."

“We always tell patients that it is just so important to protect yourself by wearing the appropriate clothing such as a wide brimmed hat and long t-shirt, by using umbrellas, wearing sunscreen and remembering the slogan ‘from one to three, sit under a tree’

“What Irish people tend to forget is that the sun is just as dangerous here as it is in other places. In fact, it can sometimes be even more dangerous, as because we only get it occasionally, we have a tendency to stay out in the sun for too long and this is very hard on the skin,” she said.

Use sunscreen and protect the eyes

Ms Ledwith said that pharmacists have an important role to play in helping ensure their patients are using the correct sunscreens for their skin.

“If people are in and are looking around and thinking of buying the sun creams, pharmacists can use this as an opportunity to raise awareness of the importance of sun screen and of the Sun Smart code.

“For a start, they can help patients to understand the labeling of the screen. All sunscreen should have an ‘A’ logo on it. Furthermore, pharmacists can advise patients about what factor they really need – as a general rule of thumb we say factor 15 or higher is perfect for the average person. When it comes to applying sunscreen, pharmacists should tell people to apply sunscreen every two hours using a teaspoon of sunscreen for each limb and a golf ball of sunscreen for the body. It’s important that parents take extra care ensuring their children are well covered up. Children can do a patch test of the sunscreen to make sure that they are not allergic to it before use. We would also advise that all babies under six months of age are not out in the sun at all,” she said.

Ms Ledwith also recommended that if patients have questions about how to protect their eyes that their pharmacist reminds them that to protect their eyes from the sun they need to wear sunglasses which either have the EN standard 1836 or the BS standard BS27241587.



Skin cancer Models Ronan Carroll and Donna Lyons not acting SunSmart

Know your skin type and your risk

Norma Cronin, Health Promotion Manager with the Irish Cancer Society says that pharmacists can also help their patients reduce their risk of skin cancer by helping them to understand their own skin type and their risk of the disease.

“It is so important to remember that anyone who spends a lot of time outdoors and not just those who sunbathe or go on sun holidays, are at risk of skin cancer such as people who work outdoors or play a lot of outdoor sports like golf. People should also take extra care if they are pale, fair or have freckled skin, if they burn easily or burn before they tan, if they have red or fair hair, green or blue eyes or have a large number of moles (more than 50),” she explained.

Ms Cronin added that it is also important that pharmacists advise people that those who use sunbeds are also at an increased risk of skin cancer. “The use of sunbeds continues to pose a problem here in Ireland and we are continuing our campaign for increased legislation surrounding the use of sunbeds both for under 18s and people in general. Sunbeds have now been classified by the world health organization as carcinogenic, but there is a lack of information out there about just how dangerous they are” she said.

SIGNS AND SYMPTOMS OF SKIN CANCER

In addition to advising patients about how to protect themselves against the harmful rays of the sun, pharmacists are often also the first port of call for patients who have concerns about changes to their skin and as such, have an important role to play in advising their patients about the signs and symptoms of skin cancer.

“The signs which we would tell pharmacists to tell people to look out for are scaling on the skin which keeps coming back (this could be squamous cell carcinoma), a new growth or a mole that changes in size, that doesn’t heal in four weeks, constant skin ulcers not related to other issues and melanoma type changes such as moles that are bleeding or that change shape, size or colour. People should also look out for burns as these can easily become infected. If people have any concerns, it is important to recommend that they seek the advice of a doctor,” concluded Jennifer Ledwith, Cancer Information Services Nurse with the Irish Cancer Society.

The Irish Cancer Society provides a number of tools aimed at helping pharmacists to ensure their patients are skin cancer aware including providing them with health promotional materials.

The society also offers special training for pharmacists on the Sun Smart Code.

For further information on these courses please contact Dominique at the Irish Cancer Society on 01 231 0541.

The Sun Smart Code

1. Seek shade

- Staying in the shade is one of the most effective ways of reducing exposure to ultraviolet radiation.
- Any shade will do. It can be from a building or a portable umbrella.
- Plan your outdoor activities to avoid exposure to ultraviolet radiation when it is at its highest, between 11am and 3pm.

2. Cover up

- Wear a wide-brimmed hat or a hat with a neck flap to cover the neck.
- Wear a t-shirt or other shirt with a close-weave material

3. Protect Your Eyes

- Wear sunglasses that give a high protection against UV rays. Look at the label and check the standard: BS Standard (BS 27 24 19 87) or European Standard (EN 1836).

4. Use sunscreen

- Use a sunscreen with an SPF of 15 higher/ Medium or higher and UVA protection
- Put sunscreen on 20 minutes before you go out into the sun.
- Put on more sunscreen every two hours.
- Put it on more often if you have been swimming or sweating

5. Avoid sunbeds and sunlamps

- Sunbeds and sunlamps increase your risk of skin cancer. If you want to protect your skin, don’t use them.



MAY: Melanoma Awareness Month 2011 – SOS Save Our Skin

– La Roche-Posay, dedicated to driving back Skin Cancer in Ireland –

As a part of **May: Melanoma Awareness Month**, developed in Ireland by La Roche-Posay in 2008 with the support of the Irish Cancer Society, La Roche-Posay launch **SOS Save Our Skin**. This public awareness campaign works to address the increasing problem of skin cancer in Ireland. This campaign is supported by the Department of Health and the Minister for Health, Dr James Reilly, will officially launch the campaign on April 28th 2011.

Did you know?*

- The **most common cancer** in Ireland is skin cancer with over **8000 new cases diagnosed in 2009**.
 - **90%** of all skin cancers are **preventable**. Virtually all the risk comes from the sun and sun beds**
 - We receive **up to 80% of our sun damage before the age of 20**, so protection in children is vital**
 - In Ireland, **1 in every 8 men** and **1 in every 10 women** will develop skin cancer by the age of 74 years**
 - **66%** of Irish people have a higher risk of developing skin cancer because of their skin type **
- *NCRI **www.cancer.ie/sunsmart



Melanoma Awareness Month is a global initiative to promote the early detection and prevention of skin cancer. In Ireland, La Roche-Posay is driving the month long awareness campaign for the fourth year running, alongside the **Irish Cancer Society**, Dr Patrick Ormond **Consultant Dermatologist¹**, as well as **Melanoma Trust²**. Also **Eccles Private Clinic³** in association with the **Mater Private Hospital³** is offering free Specialist Diagnostic & Surgical Support on May 25th³. This year, the new look campaign is called SOS Save Our Skin, to highlight the severity and urgency of the cause. It is a nationwide effort being promoted in Dermatologists rooms, Dermatology departments, GP surgeries, pharmacies and social media encouraging members of the public to get their moles/suspicious lesions checked and adopt safe behaviour in the sun.

SOS Save Our Skin is a month long drive to raise awareness and to prevent the increasing problem of skin cancer in Ireland. Research has indicated that Melanoma will continue to rapidly rise in Ireland, with an increase of 41% in incidences of skin cancer in the last 10 years from **5776 in 2000 to 8145 in 2009** and we could see a **trebling of malignant melanoma rates over the next 30 years*** with people being diagnosed at a progressively younger age. These committed parties together with the backing of the Department of Health, could help to prevent these increased figures.

www.sossaveourskin.ie

- SAVE OUR SKIN -

www.sossaveourskin.ie is a public health website dedicated to the early screening of skin cancer. It enables each individual to learn more about skin cancer, safety in the sun and to diagnose their personal risk level, self-check moles and mole map. It is a tool to support dermatologists in their effort to educate the wider public.

La Roche-Posay³ is urging the Irish public to look out for new lumps, growths or changes to existing moles, and also to be vigilant about monitoring moles in general. All details and pictures for reference are available on www.sossaveourskin.ie and any observed changes of moles should be discussed with a dermatologist or General Practitioner without delay.



These may be the early signs of skin cancer and early detection is vital for successful treatment.



Mater Private Cancer Centre

Every year, La Roche-Posay promotes SOS Save Our Skin – May Melanoma Awareness Month in Ireland. Together with the support of the **Department of Health**, the **Irish Cancer Society**, Dr Patrick Ormond **Consultant Dermatologist¹**, the **Melanoma Trust²**, and **Eccles Private Clinic³** in association with the **Mater Private Hospital³** the campaign grows each year to raise awareness and to help prevent increasing cases of skin cancer in Ireland. Also this year, La Roche-Posay is the official sun protection sponsor of **Race the Rás**, a charity cycle in stages around Ireland involving GAA legends to raise funds and awareness for the Irish Cancer Society Skin Cancer Awareness Campaign and GOAL.

1.  The Sharon Rice O'Beirne **Melanoma Trust** was set up in memory of Sharon, who on the 2nd of February 2008 lost her brave battle against Melanoma Skin Cancer. The aim of the Trust is to bring about an awareness of this potentially fatal disease and to help fund Irish research in this particular area. Sharon's great strength and positive attitude throughout her illness has encouraged her family & friends to try and promote awareness of this devastating disease to more people who are potentially at risk.

2.   **Eccles Clinic FREE Specialist Surgical Support to the SOS Save Our Skin campaign**
Eccles Clinic, founded by consultant plastic surgeon, Denis Lawlor FRCSI, in association with the Mater Private Hospital offers FREE Surgical Support to the SOS Save Our Skin campaign. On Wednesday, May 25th 2011, patients

without health insurance who have been assessed by their GP and considered appropriate for referral to Eccles Clinic will be seen by Mr Lawlor for free treatment where necessary. For consideration, the referral must reach the clinic by letter, fax (01 8303296) or email (info@ecclesclinic.ie) by the 16th May. Subject to appointment availability, this is for a limited number of patients on May 25th. If a growth is suspicious, it will be excised and the excised growth will be sent to the pathology department at the Mater Private Hospital, where it will be examined for free. Mr Lawlor is on the Plastic, Reconstructive and Aesthetic surgery section of the medical council (registration number: 06002) and also a member of the Irish Association of Plastic Surgeons.

Last year through this program, Eccles Clinic saw 64 people of which 47 were women and 15 were men. 31 required surgery, of which 25 were benign and 3 (9.6%) were a melanoma, 2 (6.5%) were squamous cell carcinoma and 1 (3%) was basal cell carcinoma. Overall, of the 31 cases, 19% were malignant. For further information on Eccles Clinic: www.ecclesclinic.ie.

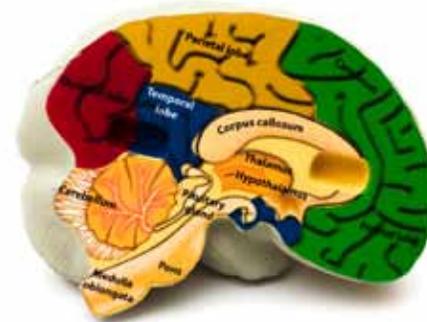
3.  **LA ROCHE-POSAY**
LABORATOIRE DERMATOLOGIQUE
La Roche-Posay's sun protection range, **Anthelios**, provides unparalleled effectiveness and dermatological tolerance to protect against cell damage caused by UV rays offering the most effective sun protection on the market. Anthelios XL filtering system has the highest level of UVA protection available of the market. It has a UVA protection level of PPD42, 12 points higher than the previous formula. La Roche-Posay, the brand of choice of 25,000 dermatologists worldwide, has demonstrated its efficacy of Anthelios XL via 21 clinical studies (4 in vitro and 17 in vivo). The in vivo clinical studies were carried out on patients suffering from sun intolerance reactions, particularly those caused by UVA rays. Anthelios filtering system ensures efficient protection against the entire spectrum of UVB-UVA rays; whatever their intensity.



La Roche-Posay further demonstrates its commitment to sun protection and sun education by donating €1 to the Irish Cancer Society for every purchase of Anthelios Fluid Extreme 50+ in 2011.

Understanding epilepsy

MARY O'KEEFFE



As preparations begin for National Epilepsy Awareness week, which takes place from May 16 to 22, **Mary O'Keeffe** takes a look at this condition and finds out what pharmacists need to know about epilepsy.

What is epilepsy?

There's no denying the fact that epilepsy is a complex and often misunderstood condition. In fact, with the wide range of forms of epilepsy, numerous treatment options and routines, not to mention the many drug interactions with epilepsy medications, it's not surprising that there are still a vast number of myths surrounding what epilepsy actually is and how it should be treated.

Brainwave, the Irish Epilepsy Association's definition of epilepsy is:

"To have epilepsy is to have a tendency to have recurring seizures. Anyone can have a seizure, if the brain is exposed to a strong enough stimulus. We know that about 1 in every 20 people will have a single seizure at some time during their lives."

Myths and misnomers

According to Geraldine Dunne, Information Officer for Brainwave, awareness of epilepsy "is an issue across the developed world", not least because of the fact that there are just so many myths surrounding the disease.

Ms Dunne says that Brainwave is constantly working to dispel these myths and increase communication and knowledge around the condition to try and quash these mistruths amongst health professionals, patients and members of the public.

"One of the myths about epilepsy which comes up again and again is that you should put something into someone's mouth when they are having an epileptic fit to stop them from biting their tongue. This is not true. For a start, you can't really prevent someone from biting their tongue and even if they do [bite it], while it might be disturbing to look at because there may be blood when they bite the surface tissue, the reality is that this tissue will heal. If you put a spoon into someone's mouth, you may actually cause him or her more serious damage as this may break all his or her teeth. Recently, we heard of a case where one person swallowed part of a denture as a result of this," she said.

Ms Dunne explained how Brainwave is also working to quash the myth that people with epilepsy cannot ever drive. She said that this is simply not the case, and that the ability to get a drivers licence in actuality depends on the type of epilepsy someone has or how long it has been since their last seizure.

"Another myth that comes up over and over is that everyone with epilepsy is affected by flashing lights. This is also not the case and many people with epilepsy are not photosensitive. We get a lot of people coming back to us because their consultant has not told them they are photosensitive and so they may have concerns about using a whiteboard or a computer, but often, it's a case that their consultant has just not specified that they are not photosensitive," she explained.

Epilepsy and the role of pharmacist

According to hospital pharmacist and board member of Brainwave, Margaret McCahill, there are a number of things which pharmacists can do to help their patients to better understand their condition and to ensure that they keep their patients safety at the top of their agenda.

This, according to Ms McCahill, begins with providing simple, easy to understand advice about epilepsy and medications to patients who are newly diagnosed with the condition. "The drug treatment of epilepsy is very complex and while the lucky ones are maintained on one drug, some will need two or three and often there are a lot of interactions with some of these drugs.

"When a newly diagnosed epilepsy patient comes to the pharmacist for the first time they

are probably still going to be in a state of shock about their diagnoses. First and foremost, it's important at this stage that the pharmacist keeps the consultation with his/her patient as simple as possible initially and reiterates that if and when the patient has any questions to come back with these. Some of the things the pharmacist can do at this stage is to explain the early side-effects of their new medications and advise them about the side effects which they need to look out for," she said.

According to Ms McCahill, some of the more common side effects of the medicines which people should be made aware of are the transitory symptoms such as stomach upset and drowsiness as well as visual disturbances. "It is important that patients are aware of these symptoms and the ones which they need to look out for as some of these can sometimes indicate toxicity for example, sometimes, as a result of a drug interaction," she said.

Ms McCahill also recommended that pharmacists advise their patients that it might be a good idea to have their bloods checked soon after starting these medicines to make sure these are working.

Other issues and contraindications

Ms McCahill stressed that pharmacists should not only advise their patients about the possible drug interactions associated with epilepsy medicines, but should also make them aware of other issues and contraindications associated with epilepsy medicines.

"Pharmacists need to explain to patients that there are a number of other factors which can affect/be affected by their epilepsy medication. Firstly, in patients who might have another condition, it is important that they realise that some medicines may lower their drug threshold. It is also really important that you tell patients to always remind their doctor and their dentist that they are epileptic and that if they come to you saying that they have found out that they are pregnant that you tell them to see their neurologist or obstetrician. It is also important to tell patients that some of the anti-epileptics can cause osteoporosis and that they may need to take calcium whilst taking their medicines just as it is important to advise women that they may need to take a higher dose of the contraceptive pill than normal to prevent pregnancy whilst taking their epilepsy medicines," she said.

National Epilepsy Week takes place from May 16 to 22, 2011

As part of the event, Brainwave will host a number of events, seminars and outreach clinics aimed at raising awareness of epilepsy, quashing the myths surrounding the condition and educating patients and health professionals about it. For further information on events taking place as part of the weeklong campaign contact Brainwave; the Irish Epilepsy Association on Phone: 01-4557500, e-mail info@epilepsy.ie or log on to www.epilepsy.ie.

// The drug treatment of epilepsy is very complex and while the lucky ones are maintained on one drug, some will need two or three and often there are a lot of interactions with some of these drugs.

Pharmacy liasons course

Pictured at the introduction course for Pharmacy Liaisons in the Clinical Care Programmes, hosted by the Royal College of Physicians of Ireland in Association with the Health Service Executive and the Pharmaceutical Society of Ireland was Dr. Helen Flint, Medication Management Programme Leader, and Dr. Ambrose McLoughlin, Registrar & CEO PSI.



Mark Ledwidge, Leonora O'Brien, and Peter Weedle.



Mr. Tim Delaney, National Programme Lead Medication Safety, Shaun Flanagan, Chief Pharmacist, Corporate Pharmaceutical Unit HSE, and Dr. Ambrose McLoughlin, Registrar & CEO PSI.

Elaine Conyard, Sinead McCool, and Kate Mulvenna.



Emergency contraception education evening

Dr Martin Henman , Senior Lecturer, School of Pharmacy at Trinity College, Brendan O'Connell, Managing Director at Allphar Services, Elaine Condon, Allphar Services, Tony Fraser, General Manager at HRA Pharma UK & Ireland and Francois Vuillet , International Operation Director, HRA Pharm at the recent emergency hormonal contraception education evening, which was held at the Westin in Dublin.

HPAI conference 2011

Katie Tutty, South Tipperary Hospital and Pat Norris, B.Braun at the HPAI conference 2011 at the Crowne Plaza, Santry, Dublin this April.

Elaine Conyard President of the HPAI and Marita Kinsella at the HPAI conference 2011 at the Crowne Plaza, Santry, Dublin this April.

NAHPT annual conference 2011



Sheila McCann, Pharmacy Technician Altnagelvin Hsop, Derry, Julie Jordan, Northern Ireland Centre for Pharmacy Learning and Development, Helen Wilson, Lecturer at South Eastern Regional College, and Caroline Hoey, Entrant into the poster competition



Tracy Kivlehan, Teva, Yvonne, Kavanagh, Teva, Ciara Devlin, Gerard Labs



Eileen Maher, Pharmacy Technician, Athlone, Diane Patterson, Lecturer in Pharmacy Practice, Athlone, Nicola Cantwell, Lecturer in Regulations and Dispensing, IT Carlow



Sarah O'Sullivan, Pharmacy Technician, St James', Eilish Nolan, Pharmacy Technician, St Michaels Hosp, Dún Laoghaire



Catherine Field, Pharmacy Technician, Mater Public, Carmel Bogue, Pharmacy Technician, CUH, Niamh McAuliffe, Pharmacy Technician, St Vincents



Ann O'Brien, Pharmacy Technician, Mater Public, Jean Baptiste Gicondo, DIT Student Pharmacy Technician



Marie McLaughlin, Pharmacy Technician, Galway University Hospital, Eglina Corrigan, Pharmacy Technician, Galway University Hospital



Jurate Godeliauskaite, Pharmacy Technician, Mullingar Hospital, Catriona Burke, Pharmacy Technician, Tullamore



Amanuel Tesfamariam, DIT Student Pharmacy Technician, Kulbeer Sindh, St James', Pharmacy Technician



Elisha Dunne, Student Pharmacy Technician, Athlone IT, Gillian Small, Student Pharmacy Technician, Athlone IT



Avril Duignan, Fresenius-Kabi, Fiona Fahy, Pharmacy Technician, Bons Secour, Galway

TCD's Class of 2011

Professor Marek Radomski, Head of the School of Pharmacy at Trinity College Dublin held a reception for his Senior Sophister Year to wish them success in their forthcoming final examinations and in their future careers. The reception was held in the school's atrium recently and attended by several of the school's academics.



AIT's Pharmacy technician conference



Representing Kelly's Pharmacy Castleisland Co. Kerry and Corrs Pharmacy Co. Louth.



Antoinette Sweeney AIT and Christina Burke, Barrister and Law Lecturer.



Dr. Pearse Murphy, Head of Dept of Nursing & Health Science AIT, Diane Patterson MPSI, AIT, President of AIT Prof Ciarán Ó Catháin and conference speakers Debbie Graham, Irish Pharmacy News, Christine Burke, Barrister and Law Lecturer AIT and Emmet Feerick MPSI Drugsaver.

Pics: Padraig Devaney.

Irish language depression support booklet launched

Popular presenters Dáithí Ó Sé and Síle Seoige recently launched an Irish language depression support booklet, 'How to Say Lean on Me'. Part of the mental health awareness campaign 'Lean on Me' aimed at encouraging friends and family to support those affected by depression, this leaflet provides information on how to begin a conversation about depression, as Gaeilge. It is estimated that 400,000 people in Ireland experience depression at any one time.

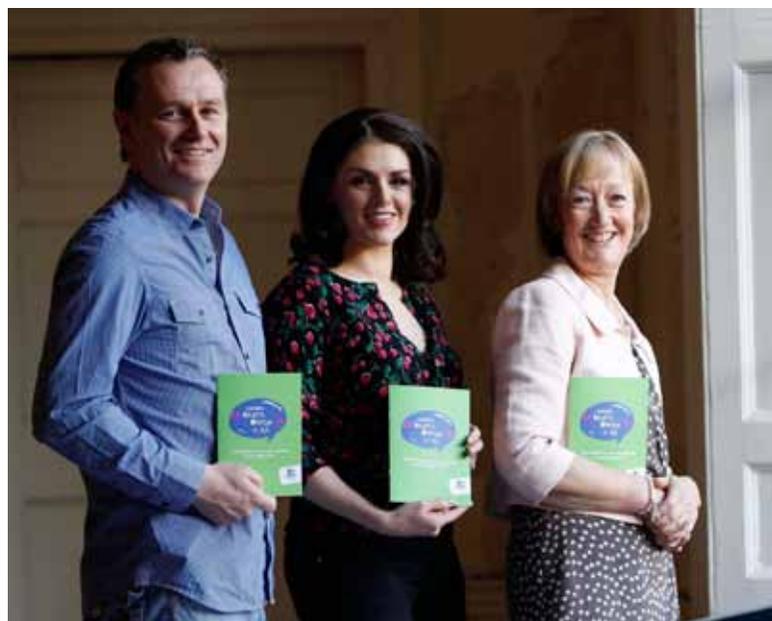
Speaking at the launch of the booklet Síle Seoige commented, "I'm delighted to support Lean on Me and am particularly pleased to see this valuable resource available in Irish. It can be difficult to know how to broach the subject of depression with a loved one but this booklet provides practical advice on how to talk, listen and above all support."

Dáithí Ó Sé explained why he supports Lean on Me: "We all know someone who has been affected by depression and support and understanding from family and friends plays a vital role in their recovery. Just being there can make a significant difference to someone with depression."

Kerry based GP Dr Conor Brosnan also welcomed the launch of the booklet: "This is a great resource for anyone who is anxious that a loved one may be experiencing depression," he said. "I encourage anyone who has concerns about family or friends to begin that conversation and encourage them to see their GP."

The Lean on Me campaign, supported by Lundbeck Ireland and Aware, was developed to dispel the myths surrounding depression. The campaign was initially developed following a survey which looked at the prevalence of depression, stigma surrounding the condition and the support experienced by those affected by depression. The survey found that almost half of respondents (48%) said that they had experienced depression at some time in their lives, with over 80% of respondents saying that they knew someone affected by depression.

The survey also found that over half (55%) of those who had experienced depression at some point in their life, did not tell their family and friends, with 75% saying that they withdrew from family and friends. There were a number of reasons for this: 57% didn't want to burden them with their problems, 29% didn't know how to tell them, 28% saying they were too scared, ashamed or overwhelmed, 18% thought they would not understand and would turn away from them.

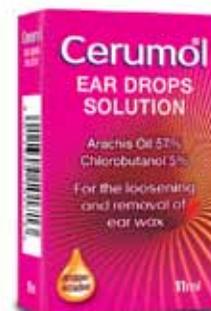


Pictured here are popular presenters Dáithí Ó Sé and Síle Seoige with Eithne Boyan, Managing Director, Lundbeck (Ireland) Ltd to launch an Irish language depression support booklet, "How to Say Lean on Me". Part of the mental health awareness campaign "Lean on Me" aimed at encouraging friends and family to support those affected by depression. This leaflet provides information on how to begin a conversation about depression, as Gaeilge.

New face for ear care leader – Cerumol

Ireland's leading ear wax removal brand, Cerumol, has a new modern face. The original formula has been marketed in Ireland for many years and now accounts for more than half of all sales in its category according to IMS data and sells more than two and half times more units than its nearest competitor. The current packaging was however very dated and, according to manufacturers Thornton & Ross Ltd, much in need of a facelift. The new packs will appear on shelves from May.

The new pack design harmonises the original ear drops with the Olive Oil Ear Drops variant that was introduced in October 2009. That newer variant provides a convenient, ready-to-use presentation of medical grade olive oil suitable for those customers who have been specifically advised "to use olive oil" prior to syringing.



For more information contact Allphar Services (01) 468 8472.

Ricola – now available exclusively from Ocean Healthcare

Founded in 1930 by Emil Richterich, Swiss confectioner Ricola has been creating its naturally refreshing sweets for more than eighty years. Ricola is now the second largest sugar confectionary brand in Europe.

Formulated with a unique blend of 13 different Swiss herbs, including cowslip, mallow and peppermint – the delicious range combines the finest natural ingredients with mouth-watering flavours for a scrumptious and naturally good treat. Ricola is sugar free.

Ricola Swiss Herb Drops gives a refreshing great taste that is sure to calm even the most stressful of days. They are the ideal sweet treat and mouth freshener, whether you're out and about, at home or in the office.

Available in convenient click-shut boxes – making them perfect for an on-the-go burst of refreshment – Ricola Swiss Herb Drops come in three mouth-watering flavours which include tempting choices such as Lemon Mint, Elderflower plus the distinctive Original Swiss Herb Drops.

Ricola is famed for its use of premium ingredients and still insists on using only the herbs grown by its independent farmers in the Swiss Alps.

The sweets contain no artificial colours or flavours, and

are suitable for vegetarians. They also carry the Toothfriendly badge and, with only 6 calories per drop, are a great guilt-free treat.

Special promotional offers are available through Ocean Healthcare including a metal display unit.

For further details and POS material contact Ocean Healthcare at 01-2968080 or info@oceanhealthcare.ie. Ricola is also available through the wholesalers.



“Wax build-up can seriously affect a person’s hearing”



“Recommend Cerumol”
the benefits are loud and clear



**NEW
distinctive
pack**

Gentle yet effective, Cerumol is
Ireland’s number 1 ear wax brand¹



With medicinal grade olive oil in a
patient-ready pack, including dropper

Ask your Allphar representative for ordering information, or call (01) 468 8472



Okuda takes the helm at Roche

Roche Products (Ireland) Limited has announced the appointment of Osamu Okuda as General Manager of the Dublin-based pharmaceutical company.

Dr Okuda joins Roche from another company within the Roche group, Chugai Pharmaceutical Co., Ltd., which is based in Tokyo, Japan.

Dr Okuda graduated from Gifu Pharmaceutical University and later received a PhD in pharmaceutical science from Osaka University in Japan. He joined Chugai in 1987 and worked in various roles in global and local clinical research, business development and lifecycle management.

Mark Rodgers will remain in Roche as Executive Chairman until his retirement at the end of June 2011. Roche wishes to thank him for his valuable contributions to Roche during his 35-year career.



Osamu Okuda appointed as General Manager of Roche Products (Ireland) Limited, succeeding Mark Rodgers who will retire from the organisation as Executive Chairman at the end of June 2011

Limited edition Marc Jacobs tote in aid of breast cancer

Brown Thomas has announced that this year it has teamed up with celebrated New York Designer Marc Jacobs to create a 'global exclusive' for the 7th annual Fashion Targets Breast Cancer Ireland Campaign.

The limited edition quirky packable tote features the designer's signature character, Miss Marc, wearing a 'Fight Like a Girl' tank and red boxing gloves. Don't let Miss Marc's big grin fool you, she is feisty and tough – and most importantly, she's a survivor. Her power: all of the proceeds from the sale of these special designer totes, which will retail for €35, will go to Action Breast Cancer (a programme of the Irish Cancer Society) and Europa Donna Ireland (raising awareness of breast cancer issues in Ireland). Now that's a cause worth fighting for! The tote will be launched exclusively at Brown Thomas and BT2 stores on Fashion Targets Friday, May 6th 2011.



Melfen 200mg/400mg tablets change in presentation

Clonmel Healthcare have announced that Melfen 200mg and 400mg tablets are being changed from a pink sugar coated tablet printed with a Clonmel logo and code 178 or 179 to a white film-coated tablet that is unprinted.

Please note that the cartons will have NEW FORMULATION printed on them also.

NEW LiftActiv Derm Source with 5% Rhamnose

Vichy Laboratoires has identified the active ingredient of plant origin capable of re-activating the Derm Source: Rhamnose 5%. The Derm Source plays the most important role in skin's youthfulness – a groundbreaking discovery that brings a step change to our understanding of skin ageing. Benefiting from this new discovery, new LiftActiv Derm Source delivers unprecedented anti-wrinkle and firmness results.



NEW LiftActiv Derm Source, available in pharmacies from 18th April, provides reinforced anti-wrinkle and firming effectiveness for a long-lasting lifting effect. The 5 commonly observed types of wrinkles on the face and neck are visibly reduced with up to 20% reduction in 2 months (clinical scoring on depth, number and length of wrinkles). Skin feels fully transformed: replenished, velvety smooth and luminous.

Located in the superficial dermis, one particular group of cells called papillary fibroblasts play a previously unsuspected but critical role in maintaining skin's youthful appearance. Vichy has named it the Derm Source. Knowledge from this discovery has led to identifying the most effective molecule to support and qualitatively regenerate these cells: Rhamnose concentrated at 5%. By reactivating the Derm Source, Rhamnose 5% acts at the very source of skin's youthfulness revealing its exceptional anti-ageing properties.

This discovery represents a new era in the understanding of how skin ages. It is the fruit of over 10 years of research by a dedicated team of L'Oreal Research scientists and has been enabled by dramatic new advances in biotechnology.

Knowing which cells are critical to skin regeneration, following experimental techniques constructing laboratory skin models, has allowed the team to screen large numbers of compounds to find and formulate the one that most effectively stimulates the activity of the cells of the *Derm Source*. From the *Derm Source*, new cells are created as well as new fibres and vital exchanges between every layer of the skin. It plays a central role in determining the quality of every skin layer, which is why it can be defined as the source of skin's youthfulness. *This aspect of the research involved 7 clinical studies and two further placebo-controlled double blind in vivo studies as well as laboratory based experiments. It has generated 7 patents.*

Vichy has transposed this scientific discovery into a daily anti-wrinkle and firming care NEW LiftActiv Derm Source. They found an ingredient which precisely activates the papillary fibroblasts located in the superficial dermis – the very source of skin youth – the '*Derm Source*'.



Rhamnose – Highly concentrated at 5%. Using techniques used in the pharmaceutical industry to review thousands of molecules, one particular ingredient seemed to have a major effect on the activity of papillary fibroblasts. After screening more than 50 anti-ageing molecules, Rhamnose in 5% concentration was identified as the most powerful ingredient capable of specifically targeting and reactivating the Derm Source.

DATES FOR YOUR DIARY

MAY

Saturday, May 7 and Sunday, May 8

IPU National Pharmacy Conference

The Irish Pharmacy Union is hosting the inaugural IPU National Pharmacy Conference on the 7th and 8th May 2011. The Conference will take place in the Lyrath Estate Hotel, Kilkenny. The two-day Conference is a new initiative by the Union and the only one of its kind in Ireland. The programme has a variety of things to satisfy your curiosity, whether it's Continuing Education sessions, Business sessions, a Panel Discussion on current pharmacy issues or the IPU AGM. A Gala Dinner will also be held on the night of 7 May.

Sunday, May 1 to Tuesday, May 31

Bealtaine

Bealtaine, the arts festival for older people in the community will take place this May. A number of events will take place across the country as part of this unique Irish festival. For further information log on to www.olderinireland.ie, e-mail info@ageandopportunity.ie or call 01-8057709.

Monday, May 2 to Monday, May 16

Sunsmart campaign

The Irish Cancer Society will run their annual Sunsmart and skin cancer awareness campaign this May. For further information log on to www.cancer.ie.

Saturday and Sunday, May 7th and 8th

IPU National Pharmacy Conference

The Irish Pharmacy Union is hosting the inaugural IPU National Pharmacy Conference on the 7th and 8th May 2011. The Conference will take place in the Lyrath Estate Hotel, Kilkenny. The two-day Conference is a new initiative by the Union and the only one of its kind in Ireland. The programme has a variety of things to satisfy your curiosity, whether it's Continuing Education sessions, Business sessions, a Panel Discussion on current pharmacy issues or the IPU AGM. A Gala Dinner will also be held on the night of 7 May.

May 16 to 22

National Epilepsy Week

Brainwave, the Irish Epilepsy Association will host a number of outreach clinics, seminars and information evenings this month to mark national epilepsy week. For a full list of events contact Brainwave on 01-4557500 e-mail info@epilepsy.ie or log on to www.epilepsy.ie

Wednesday, May 25

The origin of drugs lecture

The Royal College of Surgeons will host a public lecture this month on the origin of drugs. The lecture, which will be presented by Dr. Celine Marmion, Department of Pharmaceutical & Medicinal Chemistry, RCSI will take place on Wednesday, May 25 at 7pm at the RCSI.

SUMMER 2011

Lady Pharmacists Golf Society, Leinster

The Lady Pharmacists Golf Society will hold a number of outings this summer.

The first of these will take place on Saturday, 28th of May at Glashin Golf Club. On Saturday, 23rd of July, the society will meet at Druid's Glen Golf Club. Another outing will take place at Mount Wolsley Golf Club on Saturday, 20th of August.

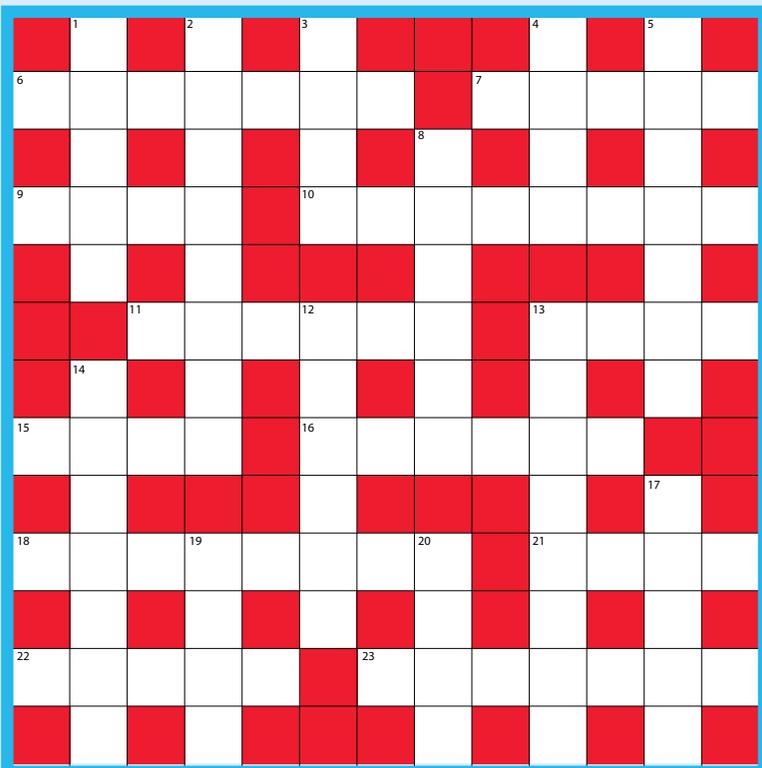
For further information contact Doreen O'Donoghue, Competition Secretary on 086 623 6896 or Ann O'Connor Hon. Sec. 087 232 6483.

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ip Crossword No.186

Paracetamol 250mg/5ml oral solution. Read instructions carefully

This crossword is sponsored by an educational grant from



Across

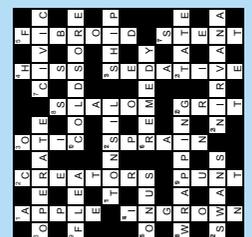
- 6 Atrial pouch sounds like oracle (7)
- 7 Plastic for old records found in V.I. nylon (5)
- 9 Skin disorder from broken cane. (4)
- 10 Cricket match and London underground form laboratory utensil! (4,4)
- 11 The sign of the heavenly twins (6)
- 13 Collapse during autumn? (4)
- 15 Confused Dane depicts Middle East port (4)
- 16 Insect sounds like old pop star! (6)
- 18 One would be spineless without one! (8)
- 21 Terribly vain Russian (4)
- 22 His name is Bond, Bond! (5)
- 23 Acute infection of small intestine from leach or ingredients (7)

Down

- 1 There's no need to qualify how this doctor practices! (5)
- 2 It needs one more for a score! (8)
- 3 Bloody idiot? (4)
- 4 How to lose weight with the turn of the tide? (4)
- 5 Sphere of vision? (7)
- 8 Have ambitions standing in O'Connell Street? (6)
- 12 Drink in denim bib eagerly (6)
- 13 Coil fell awkwardly to form a small sac (8)
- 14 Dale ran amok for a type of gland (7)
- 17 Godmother, liquid or tale (5)
- 19 Mete out a heavy shower (4)
- 20 Continuous pain during stomach examination! (4)

ANSWERS TO LAST MONTH'S CROSSWORD

- Across:** 6 Operate, 7 Civic, 9 Flea, 10 Cold sore, 11 Tonsil, 13 Ship, 15 Onus, 16 Remedy, 18 Wrapping, 21 Tate, 22 Swans, 23 Nirvana.
- Down:** 1 Apple, 2 Creators, 3 Otic, 4 Hiss, 5 Fibroid, 8 Slatom, 12 Sprain, 13 Sedative, 14 Ingrown, 17 Stent, 19 Punt, 20 Grit.



Name: _____
 Address: _____

 E-mail: _____

Congratulations to the winner of last month's crossword: Marc Veale of Superpharm Chemist, Unit 8, Main SC, Finglas Village, Dublin 11 For a chance to win €70, please send completed entries by 20 May 2011 to:

the Editor, *Irish Pharmacist*, GreenCross Publishing
 7 Adelaide Court, Adelaide Rd, Dublin 2 or
 fax to (01) 478 9449.

Please note the winner's cheque will be issued 45 days after publication.

STILL ON THE CUTTING EDGE

So FEMPI 2011 has arrived and the HSE has sliced another annual €36 million out of the pharmacy sector. This is of course on top of the €133 million per annum gone since 2009. And this is not yet the end of the line; we are still faced with the unknown losses to be caused by reference pricing. There is also the bizarre fact that the country's bailout deal from the IMF seems to hinge on Olli Rehn being happy that pharmacists no longer have a fifty per cent mark-up on dispensed medication in order to make the country competitive again. It is pretty obvious that Olli didn't come up with this gem on his own, so we are clearly still being targeted by low foes in high places. It would be interesting to know

just what these people think is an acceptable level of profit for a pharmacy so that we can see whether it's worth our while trying to stay in business or whether we should just begin an orderly wind-down of our affairs now.

Given that what mark-up we charge on our private business is of no relevance to government expenditure, then why are lots of other retailers not in the firing line? There are some very obvious areas of household expenditure that could be reduced to improve competitiveness. What's the standard ball park mark-up charged on home-heating oil, petrol, newspapers, bread, meat, milk, wine, nappies etc.? It makes as much sense to go after all of these as it does to target us, but I won't be holding my breath.



FINTAN MOORE

UNDER THE SPOTLIGHT

The other professions in the IMF spotlight are the legal and medical. Given that in any contest against the government the legal profession has written the rules, owns the pitch, selects both teams and supplies the referee we can guess who the winner will be on that one. The fate of the doctors could be more interesting. I have to admire the ability of doctors to present any cuts in HSE payments as a direct attack on patient services. The FEMPI cut earlier this year of €48 million off GP fees was even suggested by the Irish Times editor as being incompatible with the supposed desire for increased primary care services. Granted, €48 million is a big number, but there are over 2,600 GP GMS contracts in the country, so it represents an annual cut of less than ten per cent, or €20,000 per contract. This is less than each pharmacy is set to lose under FEMPI 2011, let alone what we have lost since 2009.

I have visions of a machete-hacked pharmacist staggering into a GP's surgery for treatment. The conversation goes as follows...

Pharmacist – 'Help, my arm is hanging off. I'm bleeding to death.'

GP – 'Hmmm, yes, I daresay that must sting a bit. I know just how you feel – why just this morning I was shaving and I nicked my chin. Took ages to stop the blood.'

Pharmacist – 'What can you do for me?'

GP – 'Oh these hatchet wounds just take their course. We all have to just get on with things. There's a colleague of mine was opening an envelope yesterday and the edge of the paper cut his finger quite badly. He's fine again now, but it goes to show.'

Pharmacist – 'I think I better go before I faint.'

GP – 'Faint eh? Yes, the sight of blood can do that, even for a professional like myself. I was pruning a rose bush at the weekend and pricked myself on a thorn. Right into the thumb. Excruciating. Oh, you're leaving? Have a nice day. You can pay the receptionist on the way out.'

STEALS ON WHEELS

Last June my pharmacy (in Clondalkin) was raided by a lone scumbag wearing a motorcycle helmet and a red and white jacket. The same guy raided another pharmacy in Clondalkin in March this year in exactly the same way. He has been arrested and charged with both robberies. I may be wrong, but it seems unlikely to me that he didn't commit any other robberies between June and March. If any of this sounds familiar then it might be worth a call to Clondalkin Garda station.

On the subject of raids, I recently got an access control for the door of my pharmacy. I had never been too keen on these as I didn't like the idea of a 'barrier' to entry for people. However, having had it for a few weeks now I find that it does give a lot of peace of mind, especially on dark evenings, or those occasions when a customer tells you that 'there's a couple of dodgy-lookin fellas in a car around the side of the shops.' No system is fool-proof, but if in doubt I would recommend getting it installed.

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