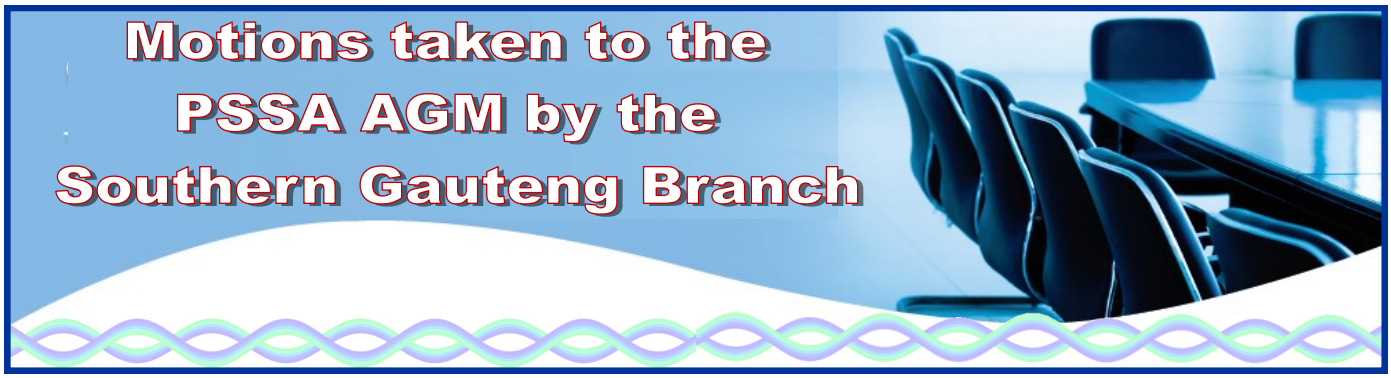
The Golden Mortar

News from the Southern Gauteng Branch of the Pharmaceutical Society of South Africa and associated pharmaceutical sectors.

Edition 4/June 2014



In the lead article of the last edition of The Golden Mortar we mentioned that we intended taking a number of Motions to the meeting for consideration.

Motion 1 had to do with our extreme concern regarding the large increases in the Pharmacy Council's registration fees. We can report that the General Council agreed with us and has instructed the PSSA National Executive Committee to demand a satisfactory explanation from the Council as to what caused these sudden large increases.

Motion 2 concerned our opinion that the PSS National Constitution needed to be brought up to date with current demands and to meet changed circumstances. We were not successful with this particular Motion for some rather technical reasons but we intend to take the whole matter to the next National Executive Committee Meeting for urgent attention.

Motion 3 had to do with the urgent need to reconsider how to make changes to the manner in which the PSSA organises its AGM and Conference in the light of all the changed circumstances that we currently are experiencing. The General Council agreed with us and this too will go forward for urgent attention by the NEC.

In addition to these three Motions our Chairman, Lynette Terblanche, moved a Late Motion from the floor asking the NEC to appoint a specific committee to provide a blueprint of a possible pharmacy value proposition to present to the DoH for consideration regarding the role that we can play in the introduction of NHI. General Council also agreed with the sentiments expressed in this Motion.

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PSSA Conference 2014 Delegate Comments and Impressions

PANEL DISCUSSION.

Bronwyn Lotz

Question 1

If a patient presented in front of you at a pharmacy with an Adverse Drug Reaction (ADR) what would you do?

The question was posed to Anri Hornsveld. She said that if it had been her, she would call the doctor and advise him of the ADR and that the medication would need to be changed and then send the patient to the doctor for an explanation. She felt this would help reduce the anxiety for the patient.

The floor was opened and the general impression was that it was the pharmacist's responsibility to advise the patient and to report the ADR. The pharmacist could also discuss the matter with the doctor to change the medication.

Question 2

If a pregnant patient presented for a repeat prescription and you noticed that the locum who dispensed the original had dispensed an incorrect item that should not be used in pregnancy, what would you do?

The question was posed to Jan Du Toit. He felt that the error should be corrected as soon as possible and an explanation given to the patient.

The general impression from the floor was that it was the pharmacist's responsibility to advise the patient and to make an apology (it was felt that not enough professionals apologise in these instances), the doctor should be notified of the error and the patient should be sent to her doctor as soon as possible to make sure that the pregnancy was not compromised in any way.

Question 3

If a patient presented at a pharmacy with a prescription for an antiretroviral, and later that same day the patient's wife presented with a prescription from the dentist for an abscess in her mouth, what would you do? Should you tell the wife of her husband's status or should you maintain a confidentiality?

The question was posed to Walter Mbatha. He felt that you should keep the patient's status confidential as this is a fundamental requirement for all medical professionals.

The floor was opened and there was much debate around the issue as you could be exposing another patient to risk by not telling her. Some suggested that you should tell the husband of the wife's condition as not to expose her. Others felt that you should counsel the patient on disclosure to their family and especially to their sexual partner and find out the background, - possibly the wife was aware. Debbie Hoffman then gave advice from the legal side, the basis of which was that you should counsel the patient on disclosure to his wife, but give him a period of time to do so. If this is not done in the agreed timeframe then it would be your duty to disclose this information to her.

Our future in the hands of the young "Impressions of a young Pharmacist"

Walter Mbatha

The creation of an interest group to be known as the Young Pharmacists Group (YPG) group in the Society was motivated by Mariet Eksteen. By Young Pharmacists is meant any registered Pharmacist including Interns who are under the age of 35 years.

The group intends to serve as a bridge between young Pharmacists and the more senior body of Pharmacists of the Society by creating a platform that will allow young Pharmacists to become involved in the PSSA and also increase membership numbers of young Pharmacists within the Society.

YPG intends to draw up an Operational Guideline for the group that would be in line with the Constitution of the PSSA and also serve the interests of young Pharmacists.

A request was made to the PSSA NEC to include a parallel session on the programmes of future conferences to accommodate YPG, to allow YPG to organise their own workshops, presentations and report back on projects undertaken by the YPG in the previous year.

Also for the YPG to arrange their own social event which could run concurrently with, for example, the Fellows Dinner, which would be entertainment for YPG members.

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PSSA Conference 2014: A student aspect
Jasmin Duxbury

I was recently honoured with the opportunity of representing the students of The University of the Witwatersrand at the 69th Annual PSSA Conference on the 8th to the 11th of May. For extending to me this opportunity, I would like to thank the PSSA Southern Gauteng Branch. The conference was a real eye-opener into the world of pharmacy beyond the lecture theatre.

What intrigued me the most was that we weren't introduced to new concepts during the conference, but the speakers rather elaboration of topics already known to me, and introduced me to new approaches to concepts I am familiar with. It is for this reason that I have realized that everything we learn at university will be relevant in our future endeavours as pharmacists, but as students we often look at certain issues with a "I wonder if this will be tested" attitude. But can you really blame us? We have so much to get through that a lot of the time trying to apply a broader understanding to everything we learn is not really possible. I've approached many pharmacists and enquired further into their individual journeys from the lecture hall to where they are now and as a general consensus it is evident that we learn most of the things we "really need to know" when we're shoved into the real world of work with a mere piece of paper suggesting we've acquired enough knowledge to move forward. I did not have to approach these pharmacists to figure this out, however, it did confirm what I inherently already knew.

At the conference there was a lot of emphasis on poly pharmacy, adverse drug reactions and drug interactions. But in the twenty first century with a heap of information available to us at the touch of a button, why should we rely solely on our personal knowledge and experience. Then I heard about a system that provides information on the dispensing screen, and I thought what a brilliant programme. This definitely should be implemented in each and every pharmacy around South Africa. And while we're at it, let's implement a universal data-base for all pharmacies, not just those with the same name. Also, TrustaTAG® - when I asked a pharmacist if they knew about this I got a shrug of the shoulders. Both brilliant systems that if implemented correctly could solve many of the problems pharmacists are faced with. Think of what a tremendous help these could be in terms of counselling. And the assistants and students can't possibly be expected to know much about any of the medicines we dish out. Let's make the drastic change that is yet to be made.

Another topic that interested me was the afternoon spent with the Young Pharmacists. Not so long ago I was asking a fellow student where to go after SAPSF, and I received my answer that day. I was particularly intrigued by what Nadine Butler had to say regarding Generation Y. We are definitely techno savvy, and yes, we might enjoy taking selfies and have limited concentration spans, but the thing that I didn't enjoy hearing was that we're perceived as having very little interest in building relationships beyond our handhelds. And maybe I didn't enjoy hearing it because there was some truth to it. As a council we struggle to get students to participate in our events and yes we do bribe them with food and free coffee. My experience was shared with the two other presidents of their pharmacy student councils from RUPSA (Rhodes University Pharmacy Students Association) and PEPSA (Port Elizabeth Pharmacy Students Association). It has always been a challenge for the student council even before my term, which brings me to the point of how the PSSA can get involved with the students. My opinion is, let the students come to the PSSA willingly. We will, as a council, get as many students registered as members. But does the PSSA really want students who can't take initiative themselves and have a proactive approach to being involved in something bigger? I think the responsibility should be left with the students. But hey, who knows, maybe it's our techno savviness that is needed to drive the profession forward. After all, we barely use pens anymore.

My experience at the conference was one that has fuelled a fire in myself to burn brighter and with even more intensity. I will attempt to ignite this fire in other students and hopefully improve memberships of the Young Pharmacists Group in the years to come.

First time attendee
Anton Heyman

As a member of the PSSA Southern Gauteng Branch and a newcomer to CPS Southern Gauteng Branch Committee, it was interesting being part of the PSSA conference, where I could see first-hand how Pharmacists (young and older) dedicate time, effort and energy into making the Pharmacy profession a better place for Pharmacy professionals and patients. For the first time I could appreciate what the PSSA and the CPS are all about, and what's involved to keep all the busy engine components working. This PSSA conference was very enjoyable, as it encompassed all the elements that the delegates needed to feel that they were benefiting, i.e. insightful talks, AGMs, break-away sessions, networking with colleagues and fellow professionals, and of course the fantastic venue with its catering and accommodation.

Fellowship acceptance

Stavros Nicolaou, FPS

At the Fellows Dinner held in Port Elizabeth at the time of the PSSA Conference Stavros Nicolaou was presented with his Fellows Certificate. He also addressed the Fellows, an abbreviated version of which is shared with our readers.

I'm extremely honoured and at the same time humbled, that the Society has decided to bestow Fellowship of the PSSA on me. I thought there were many others in the profession that were more deserving of this recognition than I am and consequently I am extremely humbled.

Through my Pharmaceutical qualification and training, I have been able to enjoy some of the most incredible experiences, which have enabled not only my own personal development, but equally in the creation of value in various businesses, the growth of our economy and most importantly in contributing directly to patients and society.

These experiences commenced 30 years ago with my involvement in local and later international Pharmaceutical students affairs, culminating in my election as the Vice-President of the International Pharmaceutical Student Federation (IPSF) which enabled me to influence international Pharmaceutical students policy direction and to give some input into the future architecture of the profession. Patient counselling was a significant area of focus for us as students 30 years ago and an area I personally championed within IPSF.

In more recent times, through my current employer Aspen, I've had the privilege of leading, in conjunction with Stephen Saad, Aspen Group CEO, Aspen's HIV strategy. This has been a roller coaster ride, a ride which has in part contributed to shaping South African society as we know (it) today and which will have direct consequence(s) on its future generations.

Back in 2001, when our country started coming to terms with the magnitude of the HIV pandemic, as an Aspen management team, we had to decide how we reacted to this. We knew a couple of things, we knew that people were perishing at the rate of knots and that the little hope of treatment through ARV's was completely inaccessible to most of the South African population, particularly the poorest of the poor who were the population grouping in our country most likely to be in need of these drugs.

The enforcement of patents and other Intellectual Property (IP) rights meant that there was little or no prospect of ARV prices coming down anytime soon. We knew that we needed to become involved, the question however was how? Did we join the campaign calling for SA Government to issue compulsory licences and jump onto that bandwagon? Or, did we go ahead and break patents? No, all these strategies carried significant risks and would not have been good for the investment climate of our country in the long term. We decided on a different approach, we thought it better to speak directly to the multinational IP holders and attempt to persuade them to give us a voluntary license to use their patents in South Africa, in order to develop less expensive generic versions of their ARV's.

Most analysts gave us no chance of succeeding with this approach and some even felt we should be admitted into an institution for even suggesting anything along these lines. The Aspen team felt we had a persuasive argument and that we could succeed. We had the courage of our convictions. We put our convictions to the test. A year earlier, the late President Nelson Mandela asked us to sponsor a clinic near his ancestral home, in Qunu in the Transkei. On completing the clinic, it was evident that most of its patients were HIV infected and they had little prospect of survival. To all intents and purposes these patients were on death row.

Back to the voluntary licenses. In 2002 we decided to test our convictions and after many months we were able to secure a meeting with Bristol Myers Squibb (BMS) in the hope of discussing a voluntary license for Stavudine, one of three ARV's used in triple combinations in those days. We went cap in right hand and a wish and a prayer and a video in the left hand. We eventually convinced BMS to allow us to show them the video. You could see the (attitude of the) meeting shift when they saw the plight and hopelessness of the HIV patients in the Mandela clinic. This proved a turning point and some weeks later we were able to secure "immunity of suite" for Stavudine and pioneer the manufacture and introduction of generic ARV's on the African continent. I believe that moment that BMS and the subsequent actions that followed, let to securing other ARV licenses and materially reduce the cost of ARV's making these drugs accessible to those who needed them most in society. The price of triple therapy ARV treatment reduced from around $30 000 per patient per annum to around $180 per patient in the public sector. I believe this bold action and having the courage of one's convictions made it possible to prevent the disaster that faced our next generation – a generation was saved and society spared of the calamitous consequences of an unchallenged HIV virus ravaging our country.

This is one of many stories I can share about my Pharmaceutical career……..

Who is to blame?

Hester Coetzee

It was Mother's Day. The previous night I was preparing snackwiches for the family and as I was about to cut the bread, I realised that I did not know any woman who would simply slap two pieces of bread together for someone to eat. I realised again that women are really wonderful creatures. We will take the time to cut the bread into attractive triangles, display them nicely on a plate and only then hand them over to be eaten. Women do nice things for their families, sometimes without the family even realising it.

I spoke to a man the other day who was heartbroken. His wife had died a while back and he missed her terribly. He missed the little things - the way she cut his bread, the way she made a salad, and the way she brought him his coffee in the morning. He told me that he was convinced that the clinic had killed his wife! She had become addicted to codeine after a car accident, a few years ago, had left her with constant back pain. She bought codeine-containing pain killers and took so many so often that she became totally dependent on them. She simply could not cope without them anymore. Being a loving and very concerned husband, he booked her into a clinic for rehabilitation. The correct thing to do – or so he thought.

She was booked into the clinic on a Sunday. The clinic kept her anti-depressants, duloxetine and blood pressure medication (furosemide) that she brought to the clinic, but sent all the other medication back home. They then phoned the psychiatrist and he prescribed his routine treatment for codeine dependence over the telephone. Mrs. Anderson died on Wednesday, the fourth day of her stay at the clinic. She was 62 years old. The autopsy report stated that she had probably died of heart arrhythmia.

To practice medicine at any level is a very huge responsibility and medicine, as a subject, is extremely complex. This is why I believe that we need modern software and computers to help us identify the problems people may experience when taking medication and perhaps ***prevent*** the problems from occurring in the first place. Or perhaps we should use the software to help identify the problems that patient's experience and ***rectify*** them before it is too late.

I immediately asked myself the question: would I have dispensed the medication on the prescription? I went and added all the drugs she took in the clinic to my drug interaction software to see if the system could point out any obvious problem. I entered duloxetine, furosemide and the drugs that the clinic started her on, namely, clonidine, quetiapine, stemetil and carvedilol. The system very clearly warned of an increased risk of QT-prolongation. A risk of sudden death. Increased anti-cholinergic effects. Blood sugar increases etc.

The system also pointed out the following: Firstly both prochlorperazine and quetiapine have the inherent characteristics to cause QT-prolongation. Secondly this risk increased because of probable low magnesium and potassium levels due to furosemide that the patient was taking. Thirdly, as we know, females and the elderly are at greater risk to experience QT-prolongation. Fourthly there was a great risk of bradycardia.

She was given carvedilol. The system clearly stated that the dose of any B-blocker should be reduced if patients experience bradycardia (heart rate less than 55 beats/minute). It also warns that concomitant administration of a B-blocker with a diuretic or another antihypertensive can be expected to produce additive effects and exaggerate hypotension. On the clinic charts you could clearly see how quickly her blood pressure had started to drop. The last heart rate noted was 58 beats per minute. Remember that bradycardia is an ongoing proarrhythmic condition. Bradycardia increases the risk of rhythm disorder. The programme also warned that duloxetine inhibits the CYP2D6-metabolism of carvedilol. I believe this was overlooked when she was booked into the clinic. This inhibition of CYP2D6-metabolism of carvedilol lead to higher than anticipated blood levels of carvedilol, thus leading to an exacerbated effect of carvedilol. Blood pressure and heart rate therefore dropped *more than expected*. Had she perhaps taken venlafaxine or fluvoxamine, the metabolism of carvedilol would not have been inhibited. Or they could have chosen a B-blocker that is not metabolised in the liver. Safer choices could have been made.

The system also indicated that there is an added risk of bradycardia when clonidine and a B-blocker are used concurrently. This combination requires the close monitoring of both blood pressure and heart rate. Clonidine is also a CYP2D6-substrate. Duloxetine (CYP2D6-inhibitor) probably also inhibited the metabolism of clonidine, also leading to higher plasma levels of clonidine! In fact: duloxetine, clonidine, carvedilol and prochlorperazine are all CYP2D6-substrates. CYP2D6-enzymes are low capacity, high affinity enzymes.

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Loop diuretics cause a rapid reduction in plasma potassium. Loop diuretics and any drug (like quetiapine) that prolongs the QT-interval should not be used concurrently due to the serious risk of QT-prolongation and should be avoided. Recommendation: it is best not to use unless it is known that potassium levels are correct. The combination of prochlorperazine and quetiapine also comes with a warning that *if* used, use with extreme caution only, monitor ECG, monitor electrolytes as there is a risk of sudden death.

How to prevent drug induced QT-prolongation? According to Aggarwal et al (December 2006) : 'In clinical practice, adverse effects of QT prolonging drugs can be prevented by not exceeding the recommended dose, avoiding their use in patients with pre-existing heart disease or risk factors, previous ventricular arrhythmias, and/or electrolyte imbalance such as hypokalaemia. Concomitant administration of drugs that inhibit the cytochrome P450 or those that can prolong the QT interval or drugs that cause electrolyte disturbance should be avoided. The serum potassium concentration should be checked regularly as a matter of routine care when the patient is on potassium wasting diuretics. Furthermore, it may be sound clinical practice to perform ECG routinely before and after initiation or increment of dosage of a drug that may prolong the QT interval. If the patient develops torsades de pointes, the offending drug should be stopped and electrolyte abnormalities corrected. Replenishing the potassium concentration to 4.5-5 mmol/L, and infuse intravenous magnesium (1-2g). In resistant cases, temporary cardiac pacing may be needed to increase the heart rate and shorten the QT interval.'

So in my opinion, there were many red flags and the clinic should have paid more attention when Mrs Anderson started complaining about an extremely dry mouth, when her blood pressure and heart rate started to drop severely and she seemed to be sleeping all the time and did not even wake up for meals. Because of her age and because of the medications she was taking, they should not have started with their 'normal' treatment before monitoring her potassium and magnesium levels first and they could have chosen safer alternatives. They also should have intervened when her blood pressure and heart rate started to drop. By the fourth day it was too late.

Codeine is sold freely to people, I think, without some of us realising what the effect on people can be. This is a case where codeine addiction indirectly lead to the death of a women. Who is to blame? The husband who took her to the clinic for treatment? The doctor who made bad choices and treated her as a number rather than a patient? The clinic that did not perform its duties adequately? The pharmacist at the clinic who dispensed the medication that had a clear risk of causing sudden death? Or, was it the community pharmacist who, being responsible for keeping his Schedule 2 register up to date, should have counselled Mrs Anderson on the risks of taking codeine for longer than 3 days and who should not have supplied her with unlimited codeine-containing painkillers?

Many incorrect choices were made here, but it is now all too late. Mrs Anderson was not given a chocolate at church this morning. She was not there to see the smiles on the faces of the boys and girls that handed out the chocolates. Her husband didn't hold her hand and she could not make his day special with attractively sliced bread and a pretty salad. Even if Mr Anderson wanted to, he can't thank her for all the special little things that she used to do for him. It is simply too late and my question to you is this: who is to blame?

DISPENSING ERRORS.

What must be done in the pharmacy to avoid dispensing errors?

It would be a good policy to brainstorm this problem with all staff involved in dispensing and to write an SOP of the rules to follow in order to dispense accurately.

What type of error is likely to occur? Wrong medication, wrong dose, wrong dosage form, wrong strength, wrong directions and so on.
For each of these possible errors there should be set procedures for checking, not simply one quick look. Some will need to be checked a few times before one can be satisfied that all is correct.

Scales in Pharmacy

Ray Pogir

Scales, weights and measures in some form or other have been necessary from the time that man wanted to trade or exchange goods either by weight or by measure.

Research in the recorded history of scales dates back some 6000 years. Relics of ancient scales have been discovered which date back to 2000 B.C.

The principle always relies on a comparison of masses by balancing the force of gravity of the object to be weighed against a known mass i.e. the graduated weight.

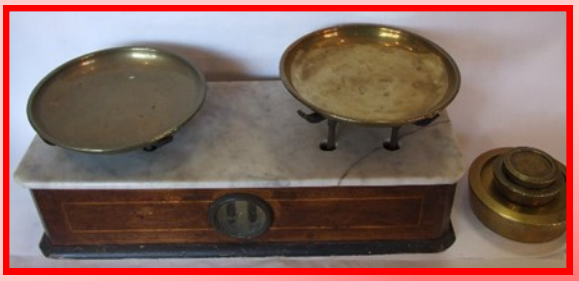
The first simple structure was based in two plates, an overhead beam and central pole. These early scales were handheld.

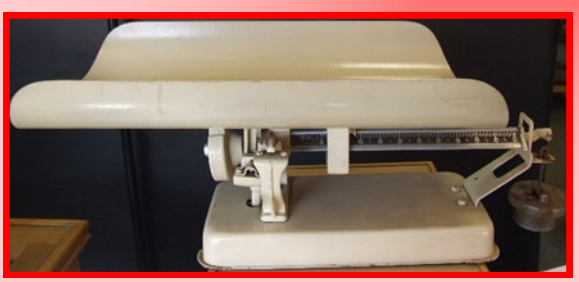
There are a number of examples of various types of scales in the Museum which come from, and have been used in pharmacies, over many years. These include counter scales, baby scales and personal platform scales.

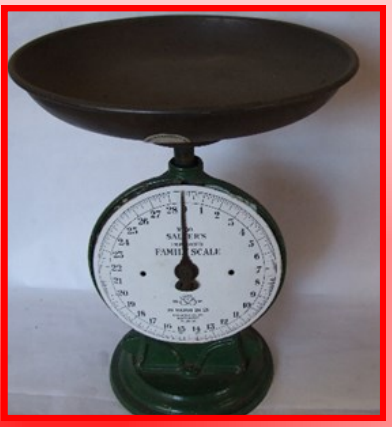
The major change in the structure of scales came with the Industrial era of the late 18th century and many innovations have taken place since then.

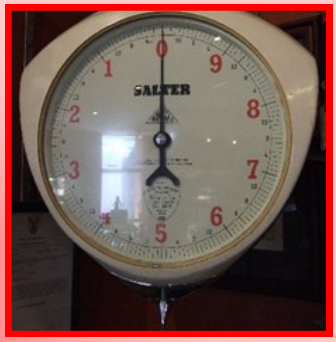
In about 1770 Richard Salter Introduced the principle of the spring balance and this formed the basis of many types of scales used in pharmacy.

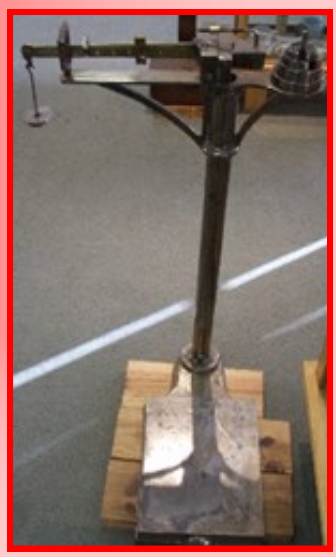
The photographs are of examples from the Museum.











Interesting facts about cold sores

J Souter—Amayeza Info Centre

Introduction
Cold sores (herpes labialis), which are also called fever blisters, are caused by the herpes simplex virus type1 (HSV-1). HSV-1 is highly contagious with between 80% and 90% of adults worldwide being seropositive for HSV-1 by the time they are 40 years old. In immune-competent individuals, the virus usually causes mild clinical disease or is asymptomatic. It is estimated that 20% to 40% of individuals develop recurrent symptoms after infection with the virus.

Transmission
Transmission of HSV-1 can occur through direct contact with the lesion, infected oral secretions or contact with contaminated objects. Asymptomatic viral shedding can also occur and pose a risk of transmission. The viral titre is 100-1000 times greater when lesions are present. Therefore, transmission is more likely to occur when the infected individual is symptomatic.

Primary infection
The initial infection usually occurs in childhood or adolescence. The HSV-1 virus gains entry into the body from the mucosal or skin sites to the epidermis, dermis and then to the sensory and autonomic nerve endings. HSV-1 can cause a primary infection anywhere on the skin, especially if there is a break in the skin. In immune-competent individuals the initial infection is usually asymptomatic. However, some individuals may develop multiple vesicular lesions and general symptoms such as fever and malaise.

Children may present with fever, an ulcerated mouth and enlarged lymph nodes. When a cold sore appears for the first time, it may be misdiagnosed as a small patch of impetigo.

Reactivation
The HSV-1 lives in a latent state in the neuronal bodies. Reactivation can occur, usually at the same site or close to the site of the primary infection. Although HSV-1 has a specific tropism for oral mucosa, the infected individual has the ability to spread the virus to other anatomical sites such as to the nose, eyes and genital area.

A number of factors can trigger reactivation of HSV-1. These include exposure to sunlight, fever, menstruation, fatigue, exposure to hot and cold temperatures, viral upper respiratory tract infections and stress. Trauma to the area of the primary infection can also trigger a reactivation. In patients with a history of cold sores, reactivation has occurred in patients undergoing trigeminal root decompression, facial dermabrasion and dental extractions.

Specific risk groups
HSV-1 infections are considered to be a health risk for athletes involved in contact sports and healthcare workers.

Prevention
Individuals should be advised to avoid touching the lesion and to wash their hands frequently to reduce the risk of spreading the virus to other anatomical sites and to other people. Women with cold sores, must be careful when applying eye make-up in order to prevent spread of the virus to the eyes. Oral sex should be avoided when there is a cold sore present, to prevent spread to the genital area. Sunscreen applied to the face and lips may prevent a recurrent attack.

Antiviral prophylaxis may be considered for patients with a history of cold sores who are undergoing trigeminal nerve root decompression or facial dermabrasion. However, the optimal regimen and duration of treatment are not known.

Treatment
The initial HSV-1 infection in immune-competent individuals is usually managed with supportive care, such as pain relief and ensuring that the individual remains well hydrated. Antiviral therapy (such as aciclovir or valaciclovir) can be considered, especially if the patient has significant pain and difficulty swallowing. For the maximum clinical benefit, antiviral therapy should

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For the treatment of recurrent HSV-1 infection in immune-competent individuals, antiviral topical therapy (aciclovir or penciclovir cream) or oral therapy (aciclovir or valaciclovir) may be considered. Treatment should be started as soon as symptoms are felt and before the lesion appears. Individuals should be advised to use treatment as soon as they feel the characteristic tingling or itching which precedes the appearance of a cold sore.

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REPORT ON COPD CPD APRIL 23, 2014

Dave Sieff

"Chronic Obstructive Pulmonary Disease (COPD) – An Update on Management" was the topic of the presentation by Professor Charles Feldman, Professor of Pulmonology at Witwatersrand University, to a large audience of pharmacists in the Glen Hove auditorium of the PSSA, Southern Gauteng Branch.

After defining the disease, also commonly known as "Emphysema," he listed the usual symptoms and risk factors. These can lead to mortality in severe cases. The term "lung attack" is being used more frequently, for simpler understanding by patients.

Management of COPD aims to reduce symptoms and risks, and mortality, employing various choices of medication combinations in their treatment, and also the prevention of exacerbating factors and the interventions used to reduce their frequency or hospitalisation of patients.

Prof. Feldman concluded his presentation with the latest developments in pneumococcal vaccination and its preventive use for different indications and ages of patients. He highlighted strategies and medications to help patients willing to quit smoking successfully. Question time raised many requests from the floor for elaboration of certain aspects COPD management. Prof. Feldman was thanked by Geraldine Bartlett for his interesting and informative presentation.

Seen at the CPD session on 23 April
From L to R: Lina Machado, Giovanna de Lorenzo, Raffaella de Pretto, Raymond Wong, Tony Glaser and Debbie Bartkunsky

The WPSC 2014

By Rookaya Moolla

The Wits Pharmacy Students Council (WPSC) is a council by students, for students. Being warmly welcomed by the remarkable WPSC 2013 team, we are determined to follow in their massive footsteps. WPSC is made up of her highness, Madam President- Jasmine Duxbury, Vice President- Divishya Reddy, Secretary- Samantha Govender, Treasurer- Lora Frank, Media and Communication Officer- Nonkululeko Madondo, Academic Officer- Christiaan Strydom, Entertainment Officer- NicaiseIneza, Pharmacy Ball Officer- Jennifer Austin and Community Outreach Officer- Rookaya Moolla.

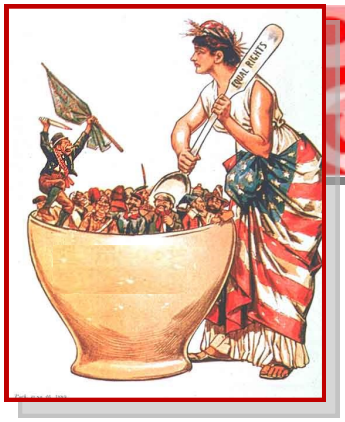
Our events for the year include fundraisers such as a Valentine's Day raffle, a condom raffle in support of National Condom Day, a bake sale, an outdoor movie night and a fun-fair inspired stall at the Faculty of Health Sciences' Sports Day. We will be utilising proceeds for WPSC events, such as the Pharmacy Ball and Pharmacy Week. Our soccer team, called 'The Whoopsie Daisies', will also be competing at sports day. We hope NOT to live up to our name this year, but to have the same amount of fun!!

Pharmacy students are always determined to be actively involved in community projects. As health sciences students, we realise that one needs to be well nourished to be alert while studying. WPSC is currently collecting non-perishable food items for the WITS food bank, an initiative by the SRC providing for students who cannot afford food. We also plan to have various charity events, including a sandwich hand-out at a hospital, painting of a ward or children's home and a visit to an orphanage during July, in light of Nelson Mandela day.

International Day for Older Persons, Nurse Appreciation Day and African Traditional Medicine Day are some of the days that we would like to draw attention to on campus. Being blessed with an expert in our midst (Mr. David Bayever), we will be hosting a Drug-Awareness Walk in August, a campaign hosted by the South African Pharmaceutical Students Federation (SAPSF).

Had the only symptom of a myocardial infarction been 'a feeling of impending doom', then we would have witnessed many of these by observing stressed out students during test week! WPSC hosts pre- and post-exam 'chill out sessions' with snacks and games to help students to unwind.

We hope to have a successful term of office this year and always keep the pharmacy flag flying high!



STIRRING THE POT

What is an equivalent?

A number of incidents have recently been reported where patients have been recommended therapeutic substitutes rather than generic substitute which have the exact same formula, strength and dosage form.

Enquiries revealed that this advice was given by pharmacist's assistants at the dispensary, mainly as a result of the current medicine shortages.

Obviously, this is a misguided attempt to keep the customer satisfied. There should be no need to emphasise the possible consequences.

The Responsible Pharmacist would most likely bear the brunt of any disciplinary inquiry that resulted from these actions, so it is vitally important that education and training take place on a regular basis with special emphasis on ethics and responsible counseling.

Marketing Code Authority

The Marketing Code Authority (MCA) is a voluntary body established to create a mechanism for the self-regulation of companies within Associations that have agreed to be signatories to the Code of Marketing Practice (Code). At the end of March there were 252 member companies and the membership is growing steadily.

The MCA's Constitution is a world-first, in that member companies originate from the innovator, generics and veterinary medicine sectors, as well as medical devices and in-vitro diagnostics. The Code governs ethical promotional practices for health products within the scope of the MCA.

To enhance Code awareness the MCA prioritises engagement with related bodies and with organs of the government to progress discussions and to ensure recognition of the Code in legislation.

With respect to internal stakeholder engagement, the MCA website (www.marketingcode.co.za) is a valuable tool for interaction with the MCA membership. Online certification resulted in almost 7000 visits to the site in March alone! The number of individuals to be certified as versant in the Code grows on a daily basis. Individuals who are active in the marketing and sales environment as well as health care professionals who have an interest in the Code are encouraged to do the training and to be certified before the 30th June 2014 – the certification deadline for members. Health care professionals other than pharmacists have the opportunity to obtain 4 CPD points on successful completion of the certification. Pharmacists can include their certification as part of their CPD activity report to Pharmacy Council. For more information regarding certification, access the MCA website.

The MCA initiated an enforcement structure on the 2nd May 2013 and 49 skilled panellists assist with adjudicating matters. The essence of this process is to enhance Code compliance and intercompany dialogue is strongly encouraged, prior to escalating the matter to the MCA. Year-to-date the MCA has facilitated 5 matters, including 2 appeals and 1 expedited matter i.e. where a party did not comply with a committee ruling. The maximum timeline for adjudication is 29 days and should a matter proceed to an appeal, 60 days. The MCA rulings are published in a summarised format on their website. These precedents can be used constructively by members to maintain high ethical standards.

The Marketing Code Authority's inaugural seminar held on the 27th March 2014 was oversubscribed. This discussion forum addressed a number of topical issues raised by members. The MCA envisages more frequent face-to-face meetings with members to facilitate training.

The TrustaTAG 2D Barcode Presentation at Conference

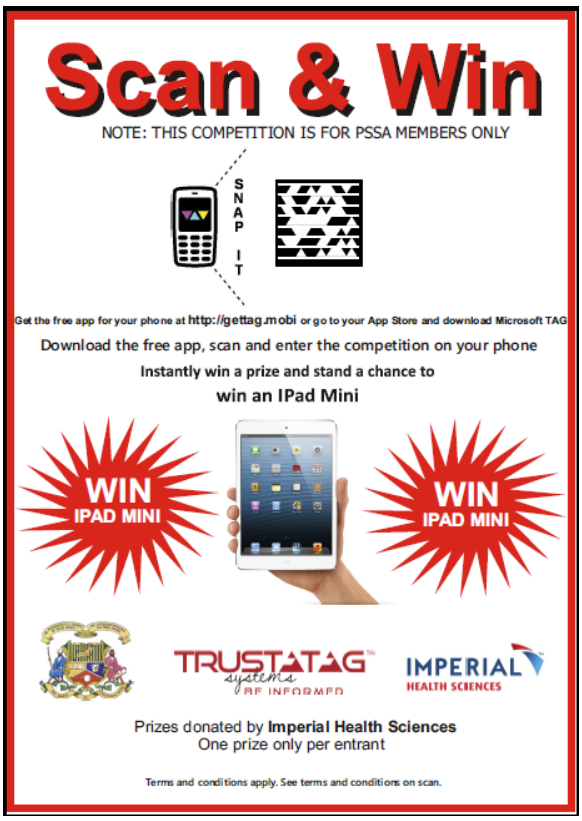
Nicola Brink

The Southern Gauteng Branch in conjunction with the Pretoria Branch of the PSSA shared an exhibition stand at the Conference where the Codeine Care project and the TrustaTAG 2D barcode or TAG offerings were the main items promoted. Many delegates visited the stand to learn more about these projects.

The TrustaTAG 2D barcode or TAG was also the subject of a presentation by Nicola Brink, Director of TrustaTAG Systems, in which she highlighted the opportunities that this technology opens up for pharmacists who are conversant with it and apply it in their pharmacies. Consumers are more and more adopting mobile phone technology in South Africa and this trend should not be ignored by the profession and in particular those pharmacists whose practices benefit from communication with their clientele / patients.

To motivate delegates to learn how to install the "app" on to their mobile phones (both feature and smart phones) various posters, (see below) and leaflets were displayed and handed out explaining the process and allowing for delegates to simply scan the TAG and enter the competition on their phone. A TAG was also used to access the conference agenda. The competition continued each day which had the effect of drawing many delegates to the stand. Nicola was in attendance at the stand to assist with loading the "app" and scanning the TAG. On a successful entering of the competition a delegate was given a USB multi-plug. At the end of the Conference a draw was made and a prize for the competition winner, in the form of an IPad Mini, was won by Gill Enslin of Technical University Tshwane. Congratulations to Gill.

Special and sincere appreciation and thanks are due to Imperial Health Sciences for sponsoring the USB multi- plugs and the IPad Mini and to Nicola Brink of TrustaTAG Systems for her professional involvement and for giving of her time at Conference.



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