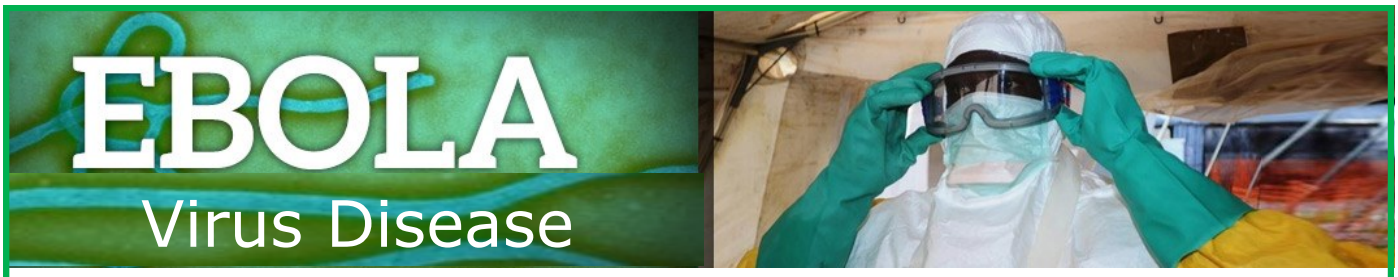
The Golden Mortar

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

Edition 6/August 2014



Stephani Schmidt - Amayeza Info Centre

Ebola virus disease, previously known as Ebola haemorrhagic fever, is a serious infectious disease caused by a virus (filovirus). It first appeared in 1976 and since then, sporadic outbreaks have occurred in the Democratic Republic of Congo, Uganda, South Sudan, Congo and Gabon (West Africa). The disease can spread quickly during outbreaks, and is often fatal when contracted by humans and primates (such as monkeys, chimpanzees and gorillas).

Transmission

The natural host of the Ebola virus is not known. However, it is thought to be animal-borne with fruit bats being the most likely reservoirs. It is thought that the first patient became infected after contact with an infected animal.

The Ebola virus is usually transmitted from person to person through contact with blood or other bodily fluids and secretions from an infected person (dead or alive).

However, infection can also occur from direct contact (through broken skin, or mucous membranes – including the nose, eyes and mouth) with objects (e.g. needles; syringes, other instruments, soiled clothing and bed linen) that have been contaminated with infected secretions. Therefore, proper cleaning, sterilising and/or disposal of instruments are of utmost importance when treating infected patients. Healthcare workers need to wear appropriate protective equipment, such as masks, gowns, and gloves when caring for patients infected with the Ebola virus. In order to prevent further spread of the disease, strict isolation precautions need to be implemented.

.../continued on page 2

INDEX

The Ebola virus does not spread through the air, cannot be transmitted by mosquitoes and there is no risk of transmission during the incubation phase and a low risk in the early phase of the disease. It is easily killed by soap and/or bleach, and only survives a short time on surfaces that have dried or that are in the sun.

Prevention

Currently, there is no vaccine available for clinical use and preventing initial cases is challenging. Once an initial case occurs in the community, preventing the spread to other people is of critical importance. One measure is to educate hunters, the public and community members (e.g. family members or friends in close contact and mourners) about the disease and how to prevent it from spreading further.

Symptoms

During the incubation period the person is well and shows no signs of being infected. It normally takes 2 to 21 days (average of 8-10 days) after exposure to the Ebola virus for the symptoms to start. Symptoms include fever, diarrhoea, vomiting, stomach pain, lack of appetite, weakness, headache, joint and muscle aches. Some patients may also experience a rash, sore throat, chest pains, red eyes, hiccups, difficulty in breathing and swallowing, impaired kidney and liver function as well as bleeding inside and outside of the body. The infection is often fatal, but some are able to recover and the reason behind this is not fully understood.

Treatment

Early treatment is important, but due to the lack of specific symptoms it is often misdiagnosed in the early stages of the disease. There is no specific treatment for Ebola virus disease and treatment is still limited to general supportive treatment and includes balancing the patient's fluids and electrolytes as well as maintaining their oxygen status and blood pressure. Any other complicating infections also need to be treated.

Information for travellers

Under normal circumstances the risk for travellers being infected with the Ebola virus is extremely low and the disease is not spread via casual contact in public places with people who do not appear to be sick. Travellers to endemic areas should be advised to:

- Avoid direct contact with blood or bodily secretions of an infected person (dead or alive)
- Avoid contact with wild animals (dead or alive) - do not eat "bush meats"
- Adhere to safe water and food practices
- Avoid having unprotected sexual intercourse with patients for up to seven weeks after they have recovered from the disease
- Avoid contact with objects that might be contaminated
- Regularly wash hands with clean water and soap
- Seek medical attention if any related symptoms appear and to mention their travel history to the doctor before the consultation

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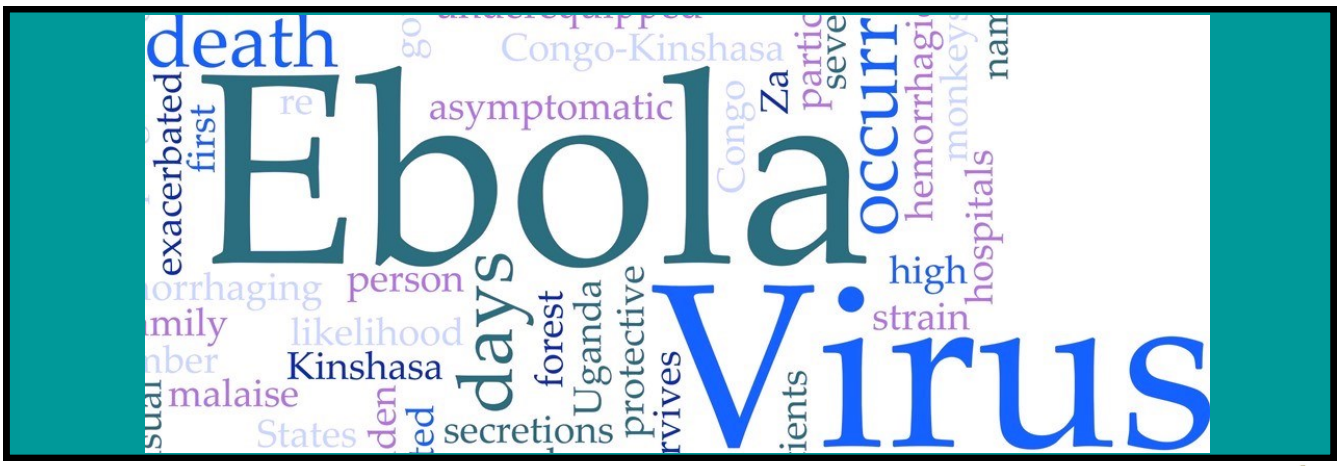

NOMINATION AND ELECTION PROCESS 2014

As members will be aware for the last two years we have successfully run an electronic (SMS) system of calling for nominations and voting for the nominees to serve on the Southern Gauteng Branch Committee.

Our members readily accepted this innovative and efficient method and consequently we received a greater number of nominations and more member participation in the voting process than we had in the past.

Consequently we will conduct the process of nomination and election in the same manner this year and members are asked to take note of these important dates in the process;

1. Call for nominations for members to serve on Branch Committee - 14th to 21st November 2014.
2. Voting for six of these nominees to serve on Branch Committee - 28th November to 5th December 2014.
3. Branch Annual General Meeting – Monday the 26th January 2015.

We will make available to members a short CV of each candidate to provide more information about those for whom you may wish to vote.

It is important for members to be assured that complete confidentiality is maintained throughout the entire procedure and that only cell phone numbers registered in the PSSA membership database are accepted during the process.

In addition, each registered cell phone number can only be used once for voting purposes and a comprehensive, auditable reporting system is in place to ensure that these controls are strictly adhered to.

In order for you to participate in this important process please ensure that you have informed us of any changes that may have occurred in regard to your contact details, particularly your current cellphone number.

THE EFFECT OF OMEGA-3 FATTY ACIDS IN DRY EYE SYNDROME

Stephani Schmidt - Amayeza Info Centre

Overview

Dry eye syndrome is a multifactorial disease of the tears and ocular surface and one of the main reasons patients visit eye care clinics. It's of clinical significance because of the impact it has on visual acuity, social and physical functioning, daily activities and workplace productivity. The exact prevalence is unknown due to the difficulty in defining the disease and the lack of a single diagnostic test to identify or classify the severity of dry eye. Common symptoms of dry eye include itching or burning, sandy or gritty sensation, redness, blurring of vision, ocular fatigue, excessive blinking and visual disturbances, including reduction in vision.

Tear film contains aqueous, mucus and lipid components, and a healthy tear film relies on the synergistic interaction of the lacrimal glands, ocular surface and eyelids. Dry eye is either caused by a decrease in tear production (lacrimal gland destruction or dysfunction) or an increase in tear film evaporation.

…/continued on page 4

A decrease in tear production can be sub-classified into Sjögren or non-Sjögren syndrome. Sjögren syndrome is a systemic autoimmune disease characterised by excessive dryness of the eyes, mouth and other mucous membranes whereas non-Sjögren syndrome involves lacrimal dysfunction without associated systemic findings (e.g. age-related dry eye, contact lens use and diabetes mellitus).

An increase in tear film evaporation is most commonly caused by meibomian gland (responsible for the lipid component of the tear film) dysfunction, also known as posterior blepharitis. Abnormalities of eyelid position or decreased blink function as well as ocular surface irritation due to chronic contact lens wear, ocular allergy syndromes and topical medicated or preserved eye drop use are associated with a higher rate of tear film evaporation.

A reduction in tear film results in an increase in tear film omolarity (hyperosmolarity) and subsequent ocular surface inflammation that leads to the variety of symptoms and signs associated with dry eye.

Evidence for the use of omega-3

Artificial tear supplementation is the most common therapy for dry eye. However it provides only temporary and incomplete symptomatic relief.

Recent advances in understanding the pathophysiology of dry eye syndrome has led to the development of newer modalities of treatment. Inflammation plays a significant role in dry eye syndrome and omega-3 fatty acid (eicosapentaenoid acid (EPA), docosahexaenoic acid (DHA)), modulate prostaglandin metabolism towards anti-inflammatory prostaglandin synthesis. Omega-3 cannot be synthesized by the body and has to be taken in via the diet or supplemented.

The effect of omega-3 supplementation on dry eye was measured in a randomised controlled trial. The control group received placebo (corn oil) and the treated group received omega-3. It was found that 65% of patients in the omega-3 group and 33% of patients in the placebo group had significant improvement in symptoms after 3 months. The study indicated that omega-3 supplementation induced changes in the ocular surface, improved the inherent stability of tear film and reduced aqueous tear evaporation rate. These benefits seemed to be more marked in conditions such as blepharitis and meibomian gland disease.
Another study done to determine the effect of short-term consumption of omega-3 on dry eye syndrome, demonstrated a decrease in the rate of tear evaporation, an increase in tear secretion and an improvement of dry eye symptoms after 30 days.

Another small study found that 70% of the patients became asymptomatic after receiving treatment, for three months with various doses of fish oil and flaxseed, compared to 37% of patients in the placebo group.

Conclusion

The diagnosis, prevention and definitive treatment of dry eye remains unclear. Patients with evaporative dry eye seem to yield the most consistent benefit from omega-3 supplementation. Evidence accumulated over the last decade has shown a potential benefit of omega-3 use in dry eye and in macular disease. However, more studies are needed to determine the role of omega-3 on tear production and secretion and to establish an appropriate therapeutic dosage.

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Pessary mould

Suppositories, Pessaries and Bougies

Ray Pogir, FPS

The use of suppositories, pessaries and bougies to deliver medication to various orifices of the body dates back many centuries. There are records of formularies dating back to about 450BC and some historians record their use at the time of Galen in the sixteenth century. Their use waned for quite a long period after that but revived again with the development and use of Cocoa Butter and Glycero-Gelatin as a base for the delivery of the medication.

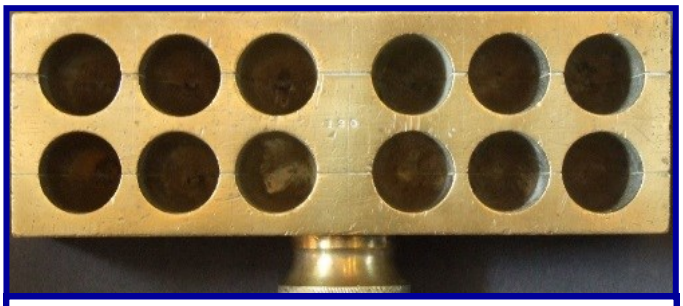
Pharmacists had to be skilled in the production of suppositories, pessaries, and bougies in the pharmacy. A good set had to perfectly formed, all of uniform size and the medication had to be evenly distributed throughout the dosage unit. In addition they had to melt at body temperature whilst remaining solid at room temperature.

The use of Cocoa Butter involved a critical skill. The melting point of between 30°C and 36°C had to be carefully monitored and maintained. The medication required rapid incorporation into the mixture before pouring it into a suitable mould. This required great attention to detail. Final year pharmacy students in South Africa could always expect that a set of suppositories would have to be made under the watchful eye of the examiner during the practical dispensing examination.

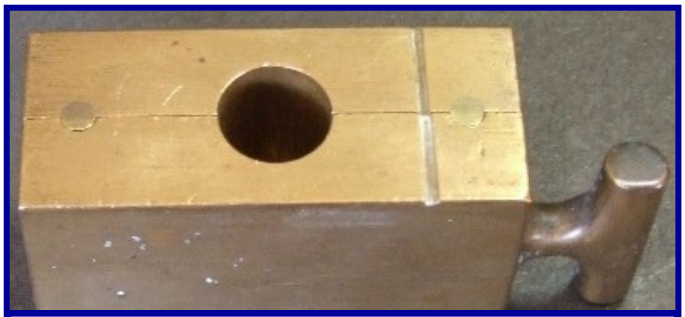
Bunson Burner, Steam bath, Crucible, Stirring rod and cocoa

Glycerin Suppositories were used when the medication was water soluble. They consisted of Gelatin, Glycerin and water and were used less often than Cocoa Butter suppositories.

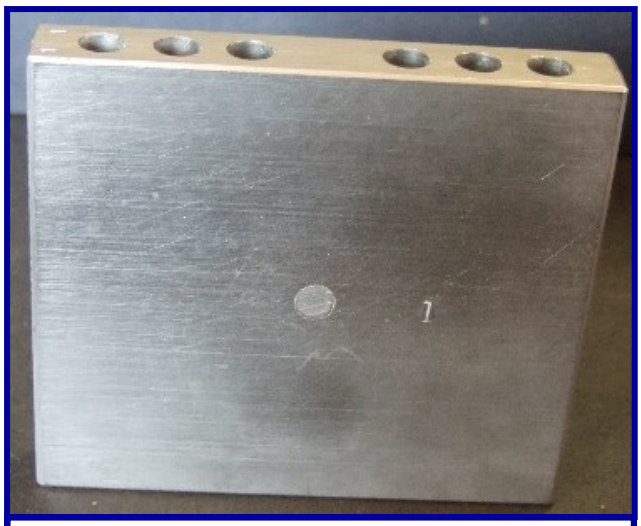
The photographs are examples of some of the moulds on display in the museum and examples of the apparatus used to obtain the correct temperature of the base to be used to incorporate the medication.



Suppository Mould



Suppository Mould



Bougie mould

World Pharmacology Congress

The first time in Africa

Prof Doug Oliver

The World Congress, was held under the auspices of the International Union of Basic and Clinical Pharmacology (IUPHAR, the umbrella world body of Pharmacology) and hosted by the South Africa Society.

The conference was held at the Cape Town International Conference Centre and was attended by delegates from more than 80 different countries. An excellent scientific programme was organised with 100 sessions and over 1000 poster sessions. The Executive Director of SAAPI, Miranda Viljoen, was afforded the opportunity to represent SAAPI at this congress and found it a most rewarding experience.

The World Congress scientific programme was designed to present cutting-edge basic and clinical discoveries addressing healthcare needs and challenges. This mission was accomplished with great success.

Following an extensive bidding process in 2005/6, the South African Society for Basic and Clinical Pharmacology (SASBCP) was selected as host of the 17th World Congress of Basic and Clinical Pharmacology (WCP2014), a quadrennial meeting of the International Union of Basic and Clinical Pharmacology (IUPHAR) held from 13-18 July 2014. As this was the first time ever that this meeting was to be held on the African continent, it provided South Africa and the rest of the continent an opportunity to showcase their achievements in science and health care. Indeed, the recognition of the medical and

pharmaceutical expertise and capability of South Africa followed the successful FIFA World Cup hosted in South Africa in 2010.

The Conference was opened by the Deputy Minister of Health, Joe Phaahla and the opening keynote address was given by Dr Robert Lefkowitz, Nobel Laureate for Chemistry, on G Protein Coupled Receptors. The Minister of Science and Technology, Naledi Pandor, presided at the Gala Dinner as guest speaker.

Arthur Christopoulos (Australia) delivered the IUPHAR prestigious lecture, and Alexander Dodoo (Ghana) presented the first ever "Pharmacology for Africa" prestigious lecture. They were accompanied by more than 300 invited speakers as well as 20 plenary speakers, presenting in more than 100 scientific sessions, and with more than 1500 delegates from six continents across the globe. In addition, more than 12 satellite meetings directly before, during and after the World Congress have addressed various areas of medicines research and training.

A variety of talks from International Council for Science, WHO, MCC and representatives from various countries gave a series of stimulating presentations on a diverse range of topics from Antimicrobial Pharmacogenetics, Pharmaco-epidemiology, Biosimilars, Regulatory Issues , Oncology, Immunology, HIV/AIDS and other infectious diseases, Diseases of life style (diabetes, cholesterol, cardiovascular), Pharmacology of the brain, Fundamental pharmacology and much more. Nearly 40 exhibition stands showcased academia and pharmaceutical industry and other related industries in South Africa.

"Pharmacology for Africa", a South African initiative founded in 2006 during the Beijing World Congress, has been a key partner to the World Congress focussing on the development and participation of delegates from the African continent and featured prominently at the Congress. Several training and capacity building sessions were presented. The Congress Organizers also identified Next Generation Scientist development is a critical component of the World Congress activities.

.../continued on page 7

It was very encouraging to see the emphasis on young pharmacologists, particularly through the Young Pharmacologists Committee of the British Pharmacological Society, who raised £17,000.00 towards student bursaries for attendance at the conference, by selling tee-shirts in the UK. In addition there were several Young Scientists Sessions and competitions

The Congress was very beneficial for all the delegates and sponsors, not only because of the excellent scientific knowledge gained but also because of the many networking opportunities, through the social program and the memorable gala dinner.

The Congress fittingly closed on Friday 18th of July 2014, with World Congress delegates participating in social responsibility activities organised for the Nelson Mandela International Day.

L to R Prof Doug Oliver, Dr Robert Lefkowitz, Dr Joe Phaahla

Minister of Science and Technology Naledi Pandor and Prof Doug Oliver.

SAAPI

NOTICE IS HEREBY GIVEN OF THE 20th ANNUAL GENERAL MEETING OF SAAPI TO BE HELD ON 16 SEPTEMBER 2014

Venue of Meeting:

52 Glenhove Rd
Melrose Estate
Johannesburg

Time : 8:30 AM

Light finger breakfast will be served from 8:00 am

We are very privileged to have Ms Mandisa Hela give us a presentation on her "Reflections and Visions" at the AGM.

RSVP: saapi@pssasg.co.za

Healthy Eating Plans

Ray Pogir, FPS

CPD presented by Sue Scharf on Thursday 24th July.

Sue dealt with the different perceptions of what constitutes a Healthy Eating Plan. She demonstrated the effects of a wide range of fad diets such as High Protein - High Carb - Hi Fat and even those such as The Cabbage Soup Diet and The Chocolate Diet.

Whilst some consumers of one or other of these diets may have shown early weight loss, this was not sustainable and some even resulted in extra weight gain after a few months. Body Mass Index (BMI) is used as a measure of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. The BMI is calculated by multiplying the weight in KGs by height in M squared.

She stressed that the best healthy eating plans are to provide the body with the correct balance of protein, carbohydrate and fats in moderation. Different life styles ranging from strenuous exercise or sport to sedentary work will require a different balance of the food groups.

Sue explained in some detail, how the various foods in each group affect weight and performance.

Essentially we require to understand the range of the desirable foods and to plan the balance accordingly. This should consist of roughly 25% carbohydrate, 25% protein and the remaining 50% of fruit and vegetables. The intake of salt needs to be limited. Also important is lots of water since about 60% of our bodies consist of water and dehydration affects performance greatly.

We were treated to a wide ranging and scientific explanation of the latest research on this subject from Sue and this was greatly appreciated by the audience.

Where is Community Pharmacy Twenty Years after 1994?

Gary Kohn, FPS

In 1995 the Government Medicine Policy Document introduced various changes in the health delivery system making changes to the pharmacy and medicine legislation. Many of these and subsequent changes are chronicled below. The question can be asked "Have these changes resulted in a better pharmaceutical service to the people of our country?"

Ownership: Open pharmacy ownership was introduced, whereas up to then only pharmacists could own pharmacies. This new development provided an opportunity for lay ownership of pharmacies to be legal. This led to the licensing of pharmacy premises as well as dispensing licenses.

Prescribers and dispensers of medicine: The legislation made provision for prescribers of medicine excluding the pharmacist as a prescriber. In addition dispensers of medicines, other than pharmacists, were required to undergo short training courses to obtain dispensing licences to legally undertake this function.

Pricing of medicines: A transparent pricing system for all medicines and scheduled substances sold in the Republic was introduced and a dispensing fee to be charged by a pharmacist was legislated.

…/continued on page 9

The transparent pricing system introduced the concept of a single exit price (SEP). No pharmacist or person licensed to do so would be legally able to sell a medicine at a price greater than the price contemplated in this system. The SEP and the professional dispensing fee were introduced replacing the previous cost plus mark-up plus dispensing fee and discount system.

All purchases would be at SEP only with no applicable rebates or incentives. In addition the supply of any medicine according to a bonus system, rebate system or any other incentive scheme was no longer allowed and the distribution of medicine samples was also denied.

The principle of National Health Insurance is being introduced in an attempt to provide medicine to all the people of South Africa.

Generic substitution: The concept of the patient being responsible for their own health was favoured and legislation was introduced to allow the patient to determine whether to select a generic version of a medicine, as long as the generic medicine was less expensive than the original prescribed product.

What has transpired after twenty years of policy implementation

The original intention was that the National Drug Policy would be updated five years after first publication. This has never taken place.

The most significant changes can be seen in the proliferation and expansion of the chain pharmacies, building them into a large national network of stores. Their trading areas are in the previously defined urban business areas and have not yet penetrated the rural areas as was originally hoped.

Privately owned pharmacies still make up a large proportion of community pharmacies, country wide.

The mail order dispensaries are still with us, with some medical schemes using them, almost exclusively, to supply the chronic medicine needs to their patients.

As a direct consequence the number of privately owned community pharmacies has dwindled over this period.

The implementation of the SEP system has taken place.

The full implementation of the new dispensing fees (26th of September 2013 government Gazette R.714) has not been that successful in the market place in that the gazetted fees have been reduced by medical scheme tariffs and competition among pharmacies for this business.

Medical scheme payments indicate that in 2013 Community Pharmacies still received the larger share of the SEP payment (44%) and their share of the dispensing fee amounts to 59%.

Although the legislation has endeavoured to remove all bonusing and discounting, there is still reimbursement of marketing fees making the transparency of the fees legislation, unachievable.

The utilisation of generics has increased to 49.1% by volume and 33.3% by value, in the private medicine market mainly due to medicine price lists and reimbursement caps being applied. The international substitution rate of generics is estimated to be at about 80% by comparison.

For pharmacies to remain on medical scheme networks the substitution of medicines to lower priced generics is now being required and enforced by some medical schemes.

The dispensing doctor problem for pharmacy during the nineties seems to be of less concern now, due to reduced numbers of dispensing doctors brought about, in part, by the medical schemes rules, dispensing fees, removal of bonuses and discounts.

Without doubt, the pharmacist, generally not being a legal prescriber, is being under-utilized in this country. The pharmacist can play a greater role in primary health delivery, assisting with responsible self-medication clinic services. The licensing of a greater numbers of PCDT pharmacists would assist in expanding these extended services available from pharmacies.

Further benefits can also be derived by expanding “group practice” arrangements between nurses and pharmacists, to address the primary healthcare needs of the country.

Conclusion:

As can be seen, the last twenty years have brought about major changes to pharmacy, some of which have not achieved the desired effects envisioned by the Department of Health, but there are indications that the next twenty years will bring even more changes.

It is clear that the profession must stand together and consistently address issues so that the changes that take place, where appropriate, are mutually beneficial to the profession and the people of South Africa.

Where are we?

Are we proactive? ***Are we reactive?***

At first glance these two questions may sound rather simple. In fact they encompass the whole philosophy of our planning and strategy.

When we are proactive we plan to create situations or events which would be to our benefit and then proceed to implement actions designed to achieve our goals. *We set the agenda.*

When we are reactive we are forced to respond to situations which are imposed by others. The strategy then changes and the initiative is no longer in our hands. *The agenda is set by someone else.*

Much has been written in books on strategy and planning to achieve a favorable outcome.
The short summary of where we should be is as follows:

PROACTIVE	**REACTIVE**
Look ahead.	There is nothing I can do.
Plan to create and control the outcome.	I will handle the situation when it comes.
Choose the method to proceed.	I will proceed when I see their agenda.

The future of our profession in the present conditions of a wide ranging change in the healthcare scene lies in which of these alternatives our leaders choose to follow.

This thinking was stimulated by a recent discussion amongst some colleagues on the role that pharmacists could play in a National Health system.

This led to a consideration of the value that pharmacists could add and the fact that many pharmacies are actively involved in a wide range of Primary Care activities. The question asked was “Are we being PROACTIVE in offering the value of what we can do?”, or “are we waiting to be REACTIVE when we find that the nurses, doctors and the other proposed new classes of Medical Assistants have been designated to provide a range of services which we as pharmacists are already doing and could easily expand?”

We hear of new clinics being planned and pilot sites being established.

What is the cost compared to using and expanding the facilities of an established pharmacy with an existing clinic and one or two primary care nurses?

HAVE WE BEEN PROACTIVE?

If we have, where are our proposals? Have we had a reaction from the powers involved?

Should you wish to comment on this article please do by emailing your thoughts to pssa@pssasg.co.za

Desmond Brothers

New NAPM Executive Committee

At its recent Annual General Meeting Mr Desmond Brothers of Ranbaxy was appointed Chairman, taking over from Mr Paul Anley of PharmaDynamics.

The Committee comprises Mr Desmond Brothers, Mr Paul Anley, Mr Shaun Martin, Ms Anita Smal, Mr Muhammad Bodhania, Mr Herman Grobler, Mr Gaurav Jain, Mr Suhail Gani, Mr Nihar Patnaik and Mr Kingsley Tloubatla. Mr Vivian Frittelli is the CEO of the NAPM.

Following his election, Mr Brothers explained that a key function of the new EXCO will be to look at how the Committee can best utilise the expertise and strengths of its members, to ensure that when NAPM engages with government and other role players, that NAPM will make a meaningfully impact on the sector, in a constructive manner that enhances access to medicines for all our citizens.

He also added that currently the NAPM's Pricing Committee is working on submissions to assist Government with realistic pricing policies that will keep the industry sustainable and ensure that access to generic medicines remains affordable. Through NAPM's representation on and secretaryship of the Industry Technical Group they will continue to engage with the Secretariat of the Medicines Control Council, to improve the input and output of the regulatory processes.

Brothers concluded by indicating that he was excited to take on the role of Chairmanship of NAPW and was confident that the diverse expertise of the newly appointed EXCO members would be invaluable as they focused on developing strategies that supported quality and standardization of the generics sector, to ensure that their members were able to operate in a fair and equitable environment.

Reminders

Proposed regulations relating to Bonusing and Sampling

Government Gazette No 37936, published on 22 August, 2014 announced that the Minister of Health in consultation with the Pricing Committee in terms of Section 35(1) of the Medicines and Related Substances Act, 1965 intends to make regulations relating to Bonusing and Sampling.

Interested persons are invited to make comment on the proposed regulations within 3 months of the date of publication to the Director-General of the Department of Health.

FPE Post Graduate Bursaries

The Foundation for pharmaceutical Education, administered by the national office of the PSSA advises that they make bursaries available for postgraduate study in pharmacy related subjects. Application forms may be downloaded from the PSSA website (www.pssa.org.za) from October each year. The closing date for submission of these applications is 15th February, 2015. The criteria relevant to the bursaries is available on the PSSA website.

Complienz
for optimal drug usage

The National Pharmacy Museum

The curator, Ray Pogir has recently received artefacts donated to the museum, which adds to the fine collection that has built up over many years. He, on behalf of the National Museum, expressed his appreciation to the many donors for their foresight in making these donations.

These donations of artefacts have made it possible to retain the many important examples of pharmacy practice of yesteryear. With the rapid changes and technological developments that have taken place in pharmacy in recent years, the ability to demonstrate the heritage of the profession to students, young pharmacists and other interested persons, is invaluable.

In an article which appeared in the SA Pharmaceutical Journal in November 1956 pictures were shown of the beginnings of the National Pharmacy Museum. In that edition of the SAPJ an appeal was made "to every chemist and druggist to help preserve objects that may be in danger of vanishing for ever from the realms of pharmacy". That appeal continues today.

Over the years the curators of the museum have been Prof CH Price of Rhodes University, Mr A H Bridge, Head of the Department of Pharmacy at Witwatersrand Technical College, Mr Julius Israelsohn, previously of Sunray Pharmacy. Ray Pogir has held this position since the retirement of the late Julius Israelsohn.

The museum has also accumulated a valuable collection of reference and other books which also form part of the "artefacts" which are representative of the development of pharmacy over more than a century.

"Help preserve objects that may be in danger of vanishing for ever from the realms of pharmacy." Please bear the National Pharmacy Museum in mind when considering the disposal of items from your collection.

The Chairman of the Editorial Board is David Sieff and the members are Doug Gordon, Neville Lyne, Ray Pogir, Miranda Viljoen, Jan du Toit and Gary Kohn.
All articles and information contained in The Golden Mortar of whatsoever nature do not necessarily reflect the views or imply endorsement of the Editorial Board, the Branch Committee, the PSSA, its Branches or Sectors. The Editorial Board and the afore-said cannot therefore be held liable. Every effort is made to ensure accurate reproduction and The Golden Mortar is not responsible for any errors, omissions or inaccuracies which may occur in the production process.
We welcome all contributions and as space permits, these will be published, abridged and edited if necessary.

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Industrial Pharmacy:	Yolanda Peens & Walter Mbatha
Academy	Paul Danckwerts & Deanne Johnston

Contact them through the Branch Office: Tel: 011 442 3615

The Editorial Board acknowledges, with thanks, the contributions made by the CPS Southern Gauteng Branch to the production of this newsletter.

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