The Golden Mortar

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

Edition 4/July 2015

Teenagers and Cannabis: Know the facts and the risks

Stephani Schmidt—Amayeza Info Services

Introduction

It has been reported that cannabis (marijuana) is the most commonly used illegal substance, with approximately four percent of the world's population using it. In South Africa, self-reported cannabis use has been shown to be 5-10% among adolescents and 2% among adults.

Marijuana is commonly smoked in the form of cigarettes (joints) made from the stems, leaves and flowering tops of the dried plant *Cannabis sativa* or *Cannabis indica*, but can also be mixed into food or brewed as a tea. The pressed resin of the plant called hashish ("hash") and the treated oily extract known as hash-oil can be used to lace cigarettes and joints, the oil can also be used to smoke using a water pipe or bong.

The pharmacology of marijuana

The active ingredient is tetrahydrocannabinol (THC) which occurs in many variations, the most powerful psychoactive substance being delta-9-THC. Cannabinoids increase the dopaminergic activity in the mesolimbic reward pathway, which could underlie the habit-forming potential of the drug. With chronic exposure, some people become dependent and exhibit characteristics of addiction.

The onset of effects of THC after smoking marijuana occurs within minutes and reaches a maximum after 1-2 hours. The half-life of THC is about four hours. The duration of subjective intoxication is typically 3-4 hours and is prolonged with oral ingestion due to slow absorption from the gut. Approximate detection time in the urine is 7-10 days for casual users and up to a month or longer for chronic users.

Consequences of cannabis use in adolescents

Recent studies indicate that cannabis is being used from a much younger age and that the crops nowadays have a higher concentration of the THC than they did in the past.

Cannabis use in adolescents is associated with a higher risk of dependence, poorer school performance, academic failure as well as a higher rate of drop-outs. Cannabis use is also often associated with crime.

Evidence also suggests that cannabis use is associated with an increased risk of mental illness (psychosis - defined as "disruptive thinking" accompanied by delusions or hallucinations), when used frequently.

Results from studies revealed that:

- There was a 40% increased risk of developing psychosis in cannabis users, compared to non-users.
- Age at initiation of cannabis use is associated with the age at onset of psychosis, an average delay of 7-8 years was observed from the first exposure to cannabis to the onset of psychotic disorders.

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- Youth who used cannabis between the ages of 15-17 experienced first episodes of psychosis an average of almost four years earlier compared to non-users. The dose or average number of marijuana cigarettes smoked per year was a predictor of age of onset of psychosis (especially in those predestined to develop the disorder).
- Cannabis usage may exert a cumulative toxic effect, particularly in patients on the pathway of developing psychosis. The risk of psychotic symptoms was increased in those who used cannabis frequently compared to non-users.
- Schizophrenia may become worse with cannabis use. Those who used cannabis by ages of 15 and 18 had more schizophrenia symptoms than nonusers and patients with schizophrenia experienced an increase in psychotic symptoms, were more likely to have relapses, had a greater likelihood of re-hospitalisation, and experienced poorer therapeutic response to antipsychotic medication compared to non-users.

The following hypotheses were given as explanation (whether alone or in combination) for the increased risk of psychosis in adolescents:

- It is a period of potentially critical brain development and the adolescent years might be particularly important and impressionable with regards to factors that trigger the onset of a psychotic disorder among those predestined to have a psychotic disorder.
- The heightened risk may be a consequence of greater cumulative cannabis use, since these individuals began using it at a younger age. This is consistent with the dose-response relationship observed.
- Genetic factors are also implicated as possible contributors in the cannabis-psychosis link.

Clinical appearance

Signs and symptoms related to the use of cannabis include:

- Depressed brain activity resulting in a dreamy state in which ideas seem disconnected and uncontrollable (a drunken appearance).
- Impaired ability to learn and concentrate.
- Poor memory.
- Mildly psychedelic, causing time, colour and spatial perception to distort and be enhanced.
- Relieved tension and a sense of well-being (the sense of exaltation, excitement and inner joyousness (a high) seems to be related to the setting in which the drug is taken – alone or in a group and the prevailing mood).
- Decreased motor abilities.
- Increased appetite and dry mouth – they appear to always be hungry and thirsty.
- Bloodshot eyes.
- Occasionally panic reactions (particularly in new users).
- An increased heart rate and blood pressure; attenuation of nausea, decreased intra-ocular pressure and relief of chronic pain.

The use of large quantities can lead to a dysphoric state, confusion, disorientation and the development of toxic psychosis (not knowing who they are, where they are or what time it is). Some people, particularly those with mental illness and first time users, are especially susceptible to these effects.

Withdrawal syndrome includes fatigue, yawning, hypersomnia, psychomotor retardation, anxiety, depression, irritability and decreased appetite.

Besides the clinical appearance of a person using cannabis, other signs of abuse include stains on the fingers and hands, the smell of cannabis and the inappropriate use of eye drops.

Conclusion

Studies indicate that cannabis usage could lead to an increased risk of developing mental illness in adolescents, especially when used frequently and in those who may have a genetic predisposition. The age of onset of psychosis is also brought forward with cannabis use and it seems to negatively alter the clinical course and overall prognosis of schizophrenia.

Other names include:
Dagga, marijuana, grass, boom, pot, reefer, weed, joint, skyf, zol, dope, Durban poison, clean green, majat, ganja, home grown, astro turf and Swazi skunk

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FELLOWSHIP OF THE PSSA

It is felt in certain quarters than insufficient understanding exists among some members of the Society regarding Fellowship and its importance in a voluntary organisation such as ours. This short history is intended to improve that understanding and appreciation.

Val Beaumont, FPS
Chairman, Fellows Committee

Fellowship has been described as a Community of interest, Companionship, a Brotherhood, a Fraternity or a Guild.

A Fellow on the other hand can be described as a comrade or colleague, elected with certain privileges, to a college or a guild.

Fellowship of the Pharmaceutical Society of S.A. started in the 1970's when it was deemed necessary and appropriate for a voluntary professional organisation such as ours to recognise certain members for exceptional and meritorious service to the Society, not only at National level, but at Branch and Sector level as well.

In other words, it was felt to be important to recognise those of our colleagues who had made a significant contribution and difference to our profession and/or the Society.

Fellowship is not an award as such and it is certainly not intended to be a long service award. Fellowship is the formal recognition by one's peers of a significant contribution made over a period of time that results in an invitation to join a group or guild of similarly recognised members of our Society.

Since the early 70's about 170 Fellows have been recognised and honoured with Fellowship of our Society. Initially the process involved nomination of a PSSA member for consideration by a Fellows Committee that was elected by the Fellows themselves. Provided that the various criteria were satisfied, the nominee was duly invited to become a Fellow of our Society and a certificate was handed to the recipient at a formal function organised and supported financially by the Fellows themselves. Traditionally this function took place at the PSSA AGM and National Conference.

This process of nomination and selection was changed when the current Constitution was rewritten to accommodate all the Sectors under one umbrella and an Awards Committee was brought into existence.

However, the change, which no longer accommodated a Fellows Committee in the PSSA Constitution consequently excluded the Committee from making nominations and from participating in the selection process; - something that was not well received by the Fellows themselves.

A survey was undertaken that established that the Fellows were overwhelmingly in favour of the re-establishment of a Fellows Committee together with its former status.

With the approval of the National Executive Committee the re-establishment of the Committee has been achieved and five members to serve on the Fellows Committee were elected by the Fellows of the PSSA.

After strong motivation by the Fellows Committee the former status of the Committee as well as its objectives and responsibilities was recently achieved when the National Executive Committee and the AGM approved the necessary changes to the Regulations to the Constitution to allow this to take place.

It is hoped that this short resume has provided some insight into the concept of Fellowship as it applies to the PSSA and its members. Branches and Sectors will be invited to consider and submit nominations for deserving members for consideration by the Fellows Committee well before 31 October deadline each year.

Nomination forms for Fellowship and Honorary Fellowship are available from;

The Chairman
Fellows Committee
P.O. Box 2467
2041 Houghton
or by sending an e-mail to pssa@pssasg.co.za

Reminder: PSSA Newsletter #16/ 2015 - Health TAGS

In the above Newsletter the PSSA reminds members how to access Health Tags, which are a means for pharmacists and their patients to gain information on topics of interest. In their Newsletter PSSA also highlights the importance of vaccinations with particular reference to Polio and to Measles.

Various Tags may be accessed on the PSSA website under the banner "For Professionals"

1st National Symposium for Community Pharmacists in South Africa

25 - 26 September 2015

Pharmacist: Your partner in health

Hosted by the South African Association of Community Pharmacists (SAACP)

25 - 26 September 2015 / Birchwood Hotel and Conference Centre / www.saacpsymposium.co.za

REGISTER NOW TO AVOID DISAPPOINTMENT: 2nd INVITE

Dear Responsible Pharmacist,

The South African Association of Community Pharmacists (previously CPS) is hosting the 1st National Symposium for Community Pharmacists in South Africa on 25 & 26 September 2015, to coincide with FIP's World Pharmacist Day.

You are cordially invited to attend this CPD Event (certificates will be issued). The intention is to create a forum where the skills, knowledge and experience of Pharmacists working in independently owned and corporate pharmacies could be brought closer together with the theme **"Pharmacist, your Partner in Health".**

Note: Limited space is available to participate in this symposium. We therefore urge you to register as soon as possible to avoid disappointment. For further information go to www.saacpsymposium.co.za

Kind regards

Jan du Toit
Executive Director
South African Association of Community Pharmacists (SAACP)

Register Decline Website

Held in conjunction with

WORLD PHARMACISTS DAY 25 September

www.saacpsymposium.co.za

FOR THE PHARMACEUTICAL INDUSTRY IN SOUTH AFRICA

Miranda Viljoen, FPS

The Department of Trade and Industry (DTI) in collaboration with the United Nations Industrial Development Organization (UNIDO) organised a 2-day dialogue event on "Bridging the Skills Gap for the Pharmaceutical Industry in South Africa", which took place on the 27th -28th of May 2015.

The organisation of the event was motivated by the fact that only 35% of the medicines that South Africans consume are manufactured in the country. This factor makes the local pharmaceutical industry a fifth leading driver of the current account deficit. In addition the low level of manufacturing activity also raises questions about the security of supply of medicines in South Africa.

While the challenges to the local production of pharmaceuticals are complex and multi-faceted, inadequate human resources have been identified as one of the key constraints along the pharmaceutical value chain (research and development, manufacturing, distribution) impacting on the industry's growth and development prospects.

It is against this background that the Department of Trade and Industry engaged with various stakeholders such as the Regulatory Authority, pharmaceutical industry, academia as well as other government departments in a practical, focused exchange.

A number of national and international experts gave presentations at the meeting and workshops took place covering subjects such as Clinical Research, Manufacturing, Regulatory and Quality systems, Production of Active Pharmaceutical Ingredients amongst others.

The meeting identified actionable priority recommendations that transpired from the insights of the participants. These recommendations will form a plan of action to solve the skills gap and in addition will be submitted to the Human Resource Development Council for consideration.

Community Service Information Session for Pharmacist Interns

James Meakings, FPS and Dave Sieff, FPS

The Southern Gauteng Branch of SAAHIP facilitated a very successful CSP evening on 2 June with more than 65 Interns in attendance.

Jacquie Fox, Branch Vice-Chairman, opened the evening by welcoming all, and introduced the representatives of Equity Pharmaceuticals, who gave an audio-visual presentation of the company and its products, and also highlighting some important aspects of Section 21 medicines' applications and the pitfalls to be avoided.

Ms Thanyusha Pillaye, former President of SAAHIP, then spoke about the SAAHIP organisation and activities, her "Passion for Pharmacy," and encouraged all to become members of PSSA and SAAHIP. Ms Amber Fourie, a recent Community Services Pharmacist (CSP), spurred the audience to use the year productively in growing their experience and careers, and gave a brief account of her Community Service year, the learning opportunities, and the responsibilities developed.

There was good interchange and questions on the process, with the Department of Health Gauteng, Pharmaceutical Services, well represented by November Nkambule, who gave an overview of the process, including selection criteria, placement allocations, conditions of service, etc.; he was ably supported by Charmaine Esterhuizen, Chief Provincial Coordinator.

In addition, Lorraine Osman, Head: Public Affairs, National PSSA Office, gave a detailed "Do's and Dont's of Community Service," with feedback on the latest developments in the registration process, allocation criteria, various deadline dates, exams which have to be passed, all documentation to be kept up to date and filed, etc.; she also spoke of the attempts by all to prevent a recurrence of the 2014 CSP placement problems.

The list of attendees will be kept informed of developments about registration, and PSSA membership information is to be sent to them.

James Meakings rounded off the event with a presentation of a video of "surf photographer" Chris Birkard's personal crusade for escape from the mundane in the harsh environments of his Arctic experience and its challenges, and his belief that some suffering adds value, leading to a sense of fulfilment, which all should take as an inspirational example.

James also encouraged all with "The 4 **P**'s" : **P**harmacy Profession – specialised training for objective counsel and service to others; **P**assion – a compelling enthusiasm; **P**urpose – the reason for which something exists or is done; and **P**ain – anything worth pursuing is worth a bit of suffering.

Thanks were expressed by Jacquie to our sponsors Equity Pharmaceuticals, who provided the refreshments for a very successful evening.

APSSA/SAAPI Conference 2015

"Today's Solutions for Tomorrow's Needs"

CedarWoods of Sandton Conference Centre, Woodmead

17th – 18th September 2015 (APSSA Conference continues to 19th September)

The Academy of Pharmaceutical Sciences of South Africa (APSSA) will be hosting a joint conference with the South African Association of Pharmacists in Industry (SAAPI) from the 17th-19th September 2015. Please note that only the APSSA Delegates will meet half day on the 19th September 2015.

The conference will be held at CedarWoods Conference Centre in Woodmead, Sandton. This is the first time the two organizations have collaborated to host a joint conference offering delegates plenary and parallel sessions. The conference will bring together academic researchers and the local industry. Postgraduate researchers from seven Schools of Pharmacy will present their research work to local and international delegates.

International Speakers:

EDQM: An Update on the CEP. (Topic to be confirmed)

Prof. Per Arvidsson - *Executive Director, Science for Life Laboratory Drug Discovery & Development Platform, & Division of Translational Medicine and Chemical Biology, Department of Medical Biochemistry and Biophysics, Karolinska Institutet, Stockholm, Sweden*: Academic Drug Discovery Centers - Cultural Bridges Over The Valley of Death?

Prof. Dhanjay Jhurry - *Head, ANDI Centre of Excellence for Biomedical and Biomaterials Research (CBBR), University of Mauritius:* Can polymeric nano-assemblies make a difference in drug delivery applications?

Prof. Stuart Walker - *Founder Centre for Innovation in Regulatory Science (CIRS) United Kingdom:* A structured approach to the Benefit Risk Assessment of Medicines: The key to improving Decision-Making in Drug Development and the Regulatory Review

National Speakers:

Dr. Helen Rees
Prof Douglas Oliver
Dr. Chris Stubbs
Prof. Kosie van Wyk
Prof. Henry Leng
Mr. Amit Raga
Mr Andy Gray

…as well as many more speakers. Conference agenda will be circulated in July.

DIPHTHERIA

Sumari Davis, MPS - Amayeza Info Centre

Introduction

Before diphtheria toxoid became readily accessible in the 1980's, diphtheria was the leading infectious cause of death worldwide, causing an estimated 1 million cases of diphtheria, including 50 000 – 60 000 deaths per year. During the period 1980 – 2000, the total number of reported diphtheria cases was reduced by more than 90%, from 98 000 cases in 1980 to 9000 cases in 2000.

Although diphtheria is an uncommon disease in South Africa, there is concern that there may be re-emergence of this disease. Recent epidemics have occurred in Afghanistan in 2003, Laos and Thailand in 1996 and in the former USSR states.

In South Africa, a total number of 13 cases of diphtheria, including 5 deaths, have been reported in KwaZulu-Natal from March up to 27 May 2015. Most of the cases occurred in patients younger than 15 years of age, although adults up to 41 years of age were also affected.

It is important that health care workers in all provinces remain vigilant; not only in identifying possible cases, but also in using any opportunity to make sure that all patients are fully vaccinated.[4]

Microbiology and Transmission

Diphtheria is caused by infection with *Corynebacterium diphtheria*, *C. ulcerans* or rarely, *C. pseudotuberculosis.*[2] Not all of the strains produce toxins and only toxigenic strains can cause severe disease. Humans are the only natural hosts for *C. diphtheria* and transmission occurs mainly through respiratory droplets (sneezing and coughing) and close physical contact.[1] Disease usually occurs during the colder months, with an increase in cases during winter and spring.[2] Respiratory disease is contagious during the symptomatic phase, but sometimes also during the asymptomatic incubation period and convalescence. The incubation period is usually 2-5 days but may be as soon as 1 day and as long as 10 days.[5] Although most infections with *C. diphtheria* are asymptomatic, or present with a relatively mild clinical course, fatality rates of 5-10% and sometimes as high as 20% have been reported.[1,6]

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Disease

Diphtheria is classified based on the anatomic site of the disease. Diphtheria usually affects the upper respiratory tract but can also affect the skin. Rare sites of involvement include the mucous membranes of the conjunctiva, vulvovaginal area as well as the external auditory canal.[5] Skin and mucosal lesions can lead to systemic disease but are also important sources of transmission of disease to others.[1]

Respiratory disease usually presents with sore throat and difficulty in swallowing. Patients with diphtheria usually do not develop fever and if they do, fever is mostly low-grade or moderate at most.[3] Diphtheria toxins cause local tissue necrosis that leads to inflammation, ulceration, and swelling. Swelling of the neck and cervical lymph nodes, cause a typical "bull neck" appearance in patients. Tissue necrosis causes formation of the classic adherent pseudomembrane that bleeds when scraped or dislodged and is present in at least a third of all patients.[2] The pseudomembrane gradually forms in the throat and may extend into the nasal cavity and the larynx. Hoarseness and a barking cough usually indicate laryngeal involvement that is associated with breathing difficulty and often needs urgent intubation and mechanical removal of the pseudomembrane.[1,2]

Complications

Toxins that are absorbed systemically, can also cause tissue damage to the heart, nervous system, and kidneys. Myocarditis is the most common complication. Cardiac toxicity can manifest acutely (during illness) as cardiac arrest and circulatory collapse or can be delayed, occurring 7-14 days after onset of disease presenting as progressive dyspnoea, weakness, cardiac dilatation and gallop rhythm.[2]

Neurological complications may include initial paralysis of the soft palate and posterior pharynx that results in regurgitation of swallowed fluids through the nose. Later on in the disease process, facial or laryngeal cranial nerves may also be affected. Delayed peripheral neuritis may occur weeks or months later, beginning in the proximal upper and lower limbs, extending distally and may range from mild weakness to total paralysis. Neurologic toxicity usually resolves completely, but recovery may be slow. Encephalitis and cerebral infarction have been described as extremely rare complications.[2]
Renal failure may occur in patients with severe disease as result of direct toxin effects.[2]

Treatment

Diphtheria antitoxin treatment (DAT) neutralises circulating unbound diphtheria toxin and prevents progression of disease. Prompt administration is the mainstay of treatment. DAT* treatment should be initiated in all probable classic respiratory diphtheria cases without waiting for laboratory results. Dosing is product specific and should be administered according to recommendations on the package insert. Antibiotic treatment does not affect healing of the local infection, but is administered to eradicate the organism from the nasopharynx and prevent further transmission of the disease. Intravenous antibiotics – benzylpenicillin or erythromycin – should be used until the patient is able to swallow. Patients may then be switched to oral treatment with a macrolide (erythromycin, azithromycin, or clarithromycin) or penicillin V. Antimicrobial treatment should be given for a total of 14 days. Elimination should be confirmed by two subsequent negative results of samples taken more than 24 hours after completion of antibiotics and at least 24 hours apart. If the toxigenic strain persists, antibiotic treatment should continue for another 10 days.

Table 1: Antibiotic treatment for diphtheria

Parenteral treatment for patients unable to swallow (switch to oral as soon as patient can swallow)				
	Penicillin G	Erythromycin		Continue treatment for a total of 14 days
Children	50 000 iu/kg/dose IV 12 hourly	15-25 mg/kg/dose IV 6 hourly (max 1g per dose)		
Adults	50 000 iu/kg/dose (max 1.2 million units per dose) IV 12 hourly	15-20 mg/kg/day (max 4 g per dose) in 4 divided doses IV 6 hourly		
Oral treatment for patients able to swallow				
	Penicillin V	Macrolides		
		Erythromycin	Azithromycin	
Children	15 mg/kg/dose (max 500 mg per dose) 6 hourly	15-25 mg/kg/dose (max 1g per dose)	10 mg/kg daily	
Adults	500 mg 6 hourly	500 mg – 1 g 6 hourly (max 4 g per day)	500 mg daily	

…./continued on page 8

Antibiotics may also be considered as post-exposure prophylaxis for close contacts:

	Benzylpenicillin IM	Erythromycin Oral	Azithromycin Oral
Children	< 6 years Single dose: 600 000 iu IM	< 2 years: 125 mg 6 hourly for 7 days	10 mg/kg per day on day one followed by 5 mg/kg per day for 4 days (total 5 days)
	> 6 years Single dose: 1.2 million iu IM	2-8 years: 250 mg 6 hourly for 7 days	
		>8 years 500 mg 6 hourly for 7 days	
Adults	Single dose: 1.2 million units IM	500 mg 6 hourly for 7 days	

Source: National Institute for Communicable Diseases available from: http://www.nicd.ac.za/

Prevention

Diphtheria disease does not always result in permanent immunity. Therefore, patients should be vaccinated as soon as possible upon recovery. Vaccination is not indicated for post-exposure prophylaxis. However, it is important to ensure full vaccination status of all patients based on age-appropriate recommendations. The South African Expanded Programme of Immunisation recommends a total of 6 doses of diphtheria vaccine by the age of 12 years. Adults should receive a booster dose every 10 years.

Note: Diphtheria is not available as a single-antigen vaccine in South Africa and is usually given as part of a combination vaccine.

Conclusion

Early detection and treatment with DAT is of utmost importance in the management of patients with severe diphtheria disease. Concurrent antibiotic treatment with macrolides or penicillin eradicates organisms from the nasopharynx and prevents further transmission of the disease. The pharmacist is often the first contact point for patients and can play an important role in referring suspect cases, advising patients on vaccination against diphtheria, counselling on good cough etiquette (cough in handkerchief or sleeve) and proper and regular washing of hands.

*DAT is not usually available in South Africa, but limited stock has been made available through generous donation by the Japanese government and is kept in Inkosi Albert Luthuli Central Hospital in KwaZulu-Natal. To obtain anti-toxin, the attending clinician needs to contact Dr M Archery on 083 446 1973.

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SAAPI Workshops

Miranda Viljoen, FPS

SAAPI held two CPD workshops during May and June.

In May a workshop on updating Package Inserts and Patient Information Leaflets for entry level regulatory pharmacists was held. The workshop was facilitated by Leneri di Toit and Esthi Beukes.

In June a Workshop on complying with current Good Manufacturing Practice was held. This was very well supported with a maximum of 135 delegates attending. Dr Andre van Zyl presented the workshop. The objective of the workshop was to provide delegates with an understanding of current GMPs recommended by the South African Medicines Control Council, World Health Organisation (WHO), Pharmaceutical Inspection Cooperation Scheme (PICS) as well as the European Union. This one day workshop facilitated discussions and sensitized delegates to the latest global changes in GMP.

The key topics of this wide subject that were covered incorporated the principles and requirements in relation to Quality Systems including Risk Management, Periodic Quality Review, Change Control, Deviations Validation, and Complaints.
The positive feedback from the delegates indicated that this subject is of utmost importance and that the workshop should be repeated annually.

Since this very successful workshop Dr van Zyl has undergone extensive coronary bypass surgery and will be out of action for several weeks.

Delegates and presenters enjoying a relaxing lunch during a SAAPI workshop.

INVALID FEEDING CUPS

Ray Pogir, FPS - Curator National Pharmacy Museum

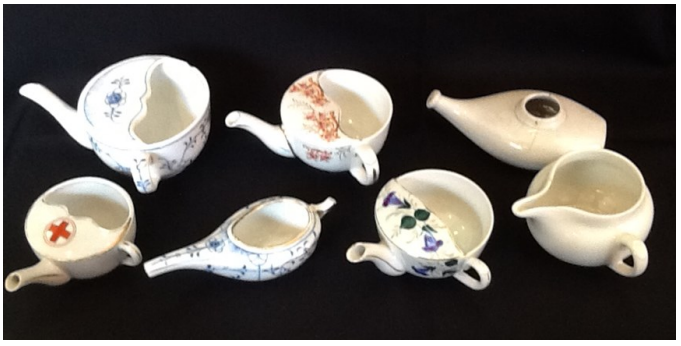
In Victorian times and well into the 20th century, patients, both adult and children, were often confined to lying flat in bed for long periods.

The problem of feeding these invalids was solved by using specially designed feeding cups as shown in the photograph.

Nurses and family members fed the bedridden invalids with liquids such as tea, milk, drinks fortified with extracts of beef, vegetables and other preparations which were specially manufactured for feeding invalids.

The feeding cups resembled a small milk jug with a spout from which the patient could drink, a round bowl to hold the liquid or semi-liquid food and a half-cover over the top to prevent wastage and spillage.

The cups were sold in pharmacies and were made in a number of shapes and sizes. Some were of plain ceramic whilst others were decorated with hand painted designs. One of the cups in the museum collection was made for the Red Cross.



Reminder: Draft Dispensing Fee – Refer to PSSA Newsletter #18/2015

On 15 June, 2015 a draft dispensing fee for pharmacists was published for comment. **The comment is due within 3 months.** It must be read in conjunction with the dispensing fee for pharmacists published on 16 March, 2015.

COMMUNITY PHARMACISTS' FIRST NATIONAL SYMPOSIUM

There are many good reasons for pharmacists to attend the 1st National Symposium for Community Pharmacists in South Africa which is to be held on the 25th and 26th September, 2015 at the Birchwood Hotel and Conference Centre, Boksburg, writes Jan du Toit, Executive Director of SAACP (CPS). The Symposium is one of numerous initiatives that SAACP are to consider in shaping the future of community pharmacists in South Africa. Some of the objectives which SAACP has identified and would possibly be addressed at the Symposium and which could form the foundation for unpacking and achieving early results:

- New models of care for pharmacists;
- Continuing Professional Development (CPD);
- Authorised Pharmacist Prescriber;
- Compliance with Good Pharmacy Practice guidelines;
- Services for which a pharmacist may levy a fee;
- Marketing the value of community pharmacists as caregivers;
- To establish a forum where all community pharmacists could come together to promote the profession of a pharmacist, irrespective of /or by whom such community pharmacist is employed (meaning independently owned or corporate pharmacy).

The Symposium is planned to be a CPD event and certificates of attendance will be issued. While the programme is still a work-in-progress, a draft may be viewed on www.saacpsymposium.co.za .

Jan du Toit appeals to colleagues to attend this 1st National Symposium for Community Pharmacists and to share their unique experiences, and thus help in shaping the future development of community pharmacists in South Africa.

The date of the Symposium coincides with World Pharmacists Day i.e. 25th September each year. This provides an opportunity for pharmacists to draw attention to the public and to other health professions the important contribution pharmacists provide towards health care,

www.fip.org/worldpharmacistsday

World Congress of Pharmacy and Pharmaceutical Sciences 2015

DÜSSELDORF
2015

fip

75th FIP World Congress of Pharmacy and Pharmaceutical Sciences 2015
Düsseldorf, Germany •
29 September – 3 October 2015

Pharmaceutical Society of South Africa

YPG Professional Innovation Project 2015

Call for applications for the PSSA Young Pharmacists' Group (YPG) **Professional Innovation Project 2015** is now open!

The Grant

A grant for Professional Innovation is offered by YPG and the PSSA to support and encourage **innovation in pharmacy**.

The Grant consists of **R15 000** for the **implementation of a project** by a young pharmacist/ pharmaceutical scientist. Projects can stem from **any field of pharmacy** (pharmacy practice, pharmaceutical science and/or pharmacy education) but should directly or indirectly benefit or **improve health of communities** and demonstrate the **value-add of pharmacy on health**.

Judging Criteria

Applications will be evaluated based on **five criteria**: Significance and relevance, Creativity and innovation, Scientific accuracy, Feasibility as well as Clarity of communication.

Grant Conditions

The Grant recipient is expected to submit a **project report** to the PSSA and to present on the winning project in 2016/2017 at a PSSA Sectoral conference. In addition, the recipient will be obliged to submit **interim reports and updates** as required by YPG or the PSSA.

Eligibility - Applicants must be PSSA-YPG members.

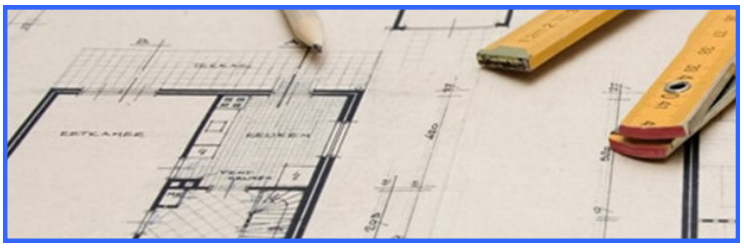
Deadline - 31st July 2015

Additional Information

PSSA YPG: Mariet Eksteen
Project Coordinator
(ypg@pharmail.co.za)

Building Progress at 54 Glenhove Road

Since the last report the building site has been a hive of activity with foundations being laid, peripheral walls erected, and scaffolding erected in anticipation of concrete being laid for the first floor parking level.



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We welcome all contributions and as space permits, these will be published, abridged and edited if necessary.

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