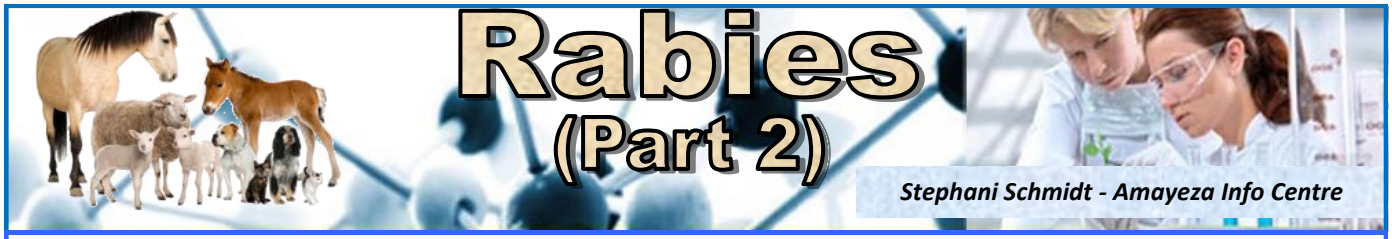
The Golden Mortar

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

Edition 6/September 2015



This is the second article of a two part series on rabies. The second article discusses post-exposure prophylaxis while the first one looked at rabies risk assessment.

What treatment is recommended for rabies post-exposure prophylaxis (PEP)?

If indicated, post-exposure prophylaxis should be initiated as soon as possible, because once the virus has invaded the nervous system, PEP will be ineffective. Nevertheless, PEP should be initiated irrespective of the time interval since exposure, provided no symptoms are present.

It is imperative to treat all bite wounds and scratches that may be contaminated with rabies virus as soon as possible. The wound should immediately be flushed and washed for a minimum of 15 minutes with soap and water, detergent, povidone-iodine or other substances that kill the rabies virus.

Depending on the category of contact (see Table 1), a course of rabies vaccines with or without rabies immunoglobulin (RIG) may be indicated, in addition to local cleaning of the wound.

Table 1. Categories of contact

Category	Type of exposure	Post-exposure prophylaxis
1	• Touching or feeding animals • Licks on intact skin	• If the case-history is reliable, then no treatment is recommended[3] • Treat as category 2 if the history is not reliable
2	• Nibbling of uncovered skin • Minor scratches or abrasions without bleeding	Previously unvaccinated individuals: • Immunocompetent • Vaccine[A] • Immunocompromised • Vaccine[A] and RIG Previously vaccinated individuals • Vaccine[A]
3	• Single or multiple bites or scratches that penetrate the skin drawing blood • Licks on broken skin • Contamination of mucous membrane with saliva from licks • Close contacts with bats	Previously unvaccinated individuals: • Immunocompetent • Vaccine[A] and RIG • Immunocompromised • Vaccine[A] and RIG Previously vaccinated individuals • Vaccine[A]

[A] Give course of rabies vaccines (see Table 2). However, if the animal is laboratory-confirmed rabies-negative or remained healthy after 10 days of observation, the vaccination series can be stopped.

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How should the vaccine be given?
The vaccine should be administered intramuscularly. The vaccine should not be administered in the gluteal area as this may result in a diminished immunologic response. The first dose should be administered as soon as possible after exposure (day 0).

Table 2. Vaccination schedules

Exposure type	Individual factors		Administer vaccine on day:
Post-exposure	Individuals previously unvaccinated	Immunocompetent	0,3,7,14
		Immunocompromised	0,3,7,14,28
	Individuals who previously received a complete rabies vaccination series (pre-or post-exposure prophylaxis)		0,3
Pre-exposure	Individuals at risk		0,7,21 or 28

What is rabies immunoglobulin (RIG)?
RIG provides rapid passive immunity. If anatomically feasible, the complete dose of RIG should be infiltrated into the depth of the wound or tissue immediately adjacent to the wound. Any remaining RIG may be administered at the same time, but at a different anatomical site, to the vaccine. RIG is then usually administered intramuscularly into the deltoid muscle.

In circumstances where the initiation of PEP is delayed, rabies immunglobulin should still be given, regardless of the interval between exposure and PEP, up to the seventh day after the first dose of vaccine was given.

Rabies exposure in an individual previously vaccinated (those who have received all the recommended doses for pre-or post-exposure prophylaxis) elicits an antibody response (anamnestic response). Such individuals should not receive RIG, as it may interfere with this response.

Who should receive pre-exposure vaccination?
Pre-exposure vaccination is usually recommended for:

- Travellers spending a lot of time outdoors, especially in rural areas, involved in activities such as bicycling, camping or hiking and those who are planning to visit remote areas where there is a risk of rabies, and medical care is difficult to obtain or may be delayed
- Individuals in certain high-risk occupations such as laboratory workers dealing with live rabies viruses and other rabies-related viruses (*lyssaviruses*)
- Individuals involved in any activities that might bring them professionally or otherwise into direct contact with animals (including veterinarians, animal health workers, conservationists, zoologists etc)

In addition, vaccinating children in high-risk areas may be considered. Children less than 15 years of age and especially children living in or visiting rabies-affected areas are at higher risk because they may lack awareness of the need to avoid animals; often play with animals and are less likely to report bites or scratches.

Pre-exposure vaccination does not eliminate the need for additional treatment after a rabies exposure. However, it does simplify the management by eliminating the need for RIG and decreasing the number of doses of vaccine needed.

Why should domestic animals be vaccinated?
In Asia and Africa, dogs are the main host and transmitter of rabies. The most cost-effective strategy for preventing rabies in people is through the elimination of rabies in dogs by vaccinating domestic dogs.

Bibliography: Available on request from pssa@pssasg.co.za

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Nominations and Elections

We are rapidly approaching that time of year again when we have to call for nominations, and then hold elections to determine who will serve on the various committees of the Branch and Society for 2016.

During the course of October we will go through the process of electing a new Fellows Committee to deal with matters pertaining Fellowship of our Society for the next three years. Although this is a national matter the Branch will undertake this process since we offered to provide the secretarial needs of the Fellows Committee when it was re-established two years ago.

In November we will conduct the nomination and election process to establish who will serve on the Branch Committee during 2016. We intend using a slightly modified but simpler to use SMS system than we have in the recent past, because it better satisfies the need for confidentiality, is capable of being audited, is efficient and cost effective and allows us to conduct the whole process in a relatively short space of time. In fact, we will be in a position to announce the names of the successful candidates before the end of November and the benefit of this is that, knowing the composition of the new committee, we can get off to an early start in the New Year.

The dates and further details of these Branch elections will be communicated to all Branch members via e-mail in the latter part of October, and we urge members to exercise their rights and participate in the process.

Common Eye Conditions Presenting in the Pharmacy

Lynda Steyn (B. Pharm) - Amayeza Info Centre

The pharmacy is frequently the first point of contact when patients are in need of advice or treatment of an eye condition. Eye Care Awareness Month spans the period from 21 September to 18 October, 2015. This provides an excellent opportunity for pharmacists to promote the importance of Eye Care to their clients. An informative article follows. In addition we have provided a TAG from which an article on Eye Care may be downloaded. Copies of the TAG may be attached to promotional material or texted to clientele. A hard copy is reproduced in this edition of The Golden Mortar for your reference. We have also included information on how to download the TAG App onto your mobile phone or iPad so that you are able to explain to clientele, who request more information.

Pharmacists are often the first to be consulted regarding an eye ailment. Many eye ailments present with similar symptoms and it can often be difficult to distinguish between them in order to offer the correct advice or treatment.

With so many conditions that can affect the eye, this article will concentrate on those conditions which are frequently seen in a pharmacy setting.

Conjunctivitis "Pink Eye" is a common eye disease affecting the conjunctiva. Two main categories of conjunctivitis: **allergic** (non-contagious), Table 1 and **infectious** (bacterial and viral), Table 2 have been compared.

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Table 1. A Comparison between Acute Allergic, Seasonal Allergic and Perennial Allergic Conjunctivitis

Condition	Causes	Symptoms
Acute Allergic Conjunctivitis (AAC)	Exposure to known allergen, e.g. cat dander	Sudden onset. Mainly bilateral, but may be unilateral. **Itchy**, red eyes. Swollen conjunctiva with burning and tearing. Eyes appear watery. Some crusting may appear in the morning. Eyelids may appear swollen. Eyes feel "scratchy" Patients may present with sneezing and a watery rhinorrhoea. Allergy disappears once allergen is removed.
Seasonal Allergic Conjunctivitis (SAC)	People usually affected during pollen season, i.e. Spring, Summer and early Autumn	Same symptoms and signs as for AAC, but with slower onset of symptoms.
Perennial Allergic Conjunctivitis (PAC)	Chronic allergy to indoor allergens, e.g. dust mites and a few outdoor allergens, e.g. air pollutants	Milder symptoms than AAC. Patients usually have a history of allergic rhinitis, asthma or eczema

Treatment:

Removal of allergen, if possible.
Cool compresses applied to eyes.
Artificial tear eye drops may soothe eye and dilute allergens.
Do not rub eyes if possible, as this can aggravate symptoms.

Topical treatment:

Antihistamines with mast cell stabilising properties, e.g. olopatadine, ketotifen, epinastine, provide rapid and sustained relief.

Antihistamines, e.g. levocabastine, emedastine provide relief of symptoms.

Mast cell stabilisers, e.g. sodium cromoglycate, nedocromil and lodoxamide will help relieve SAC. These drops have a longer onset of action, (5-14 days after initiation of therapy); therefore will not provide rapid relief of symptoms.

Antihistamine/vasoconstrictor combinations, e.g. antazoline/tetryzoline combination. Short term use only, due to possibility of conjunctivitis medicamentosa (rebound congestion)

Oral antihistamines may be helpful especially for patients presenting with rhinorrhoea, but topical treatments act quicker and are less likely to have systemic side-effects.

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Bacterial and Viral conjunctivitis are both highly contagious. Good hygiene measures to control the spread of infection should be implemented. A comparison between the causes, symptoms and treatment can be seen below in Table 2.

Table 2. A Comparison Between Bacterial and Viral Conjunctivitis

Condition	Causes	Symptoms	Treatment
Bacterial Conjunctivitis	Bacteria, mainly Staphylococcus, Streptococcus, *Haemophilus influenza and Moraxella catarrhalis*	Copious, thick, mucous discharge, which may be yellow, green or white that continues throughout the day Eye is sticky and unable to open properly in the morning. One or both eyes may be affected. Conjunctiva is pink or red, with mild to moderate pain.	Referral to doctor is necessary. Antibiotics can lessen the duration of infection and help prevent the spread of infection. Patient should contact doctor if eye does not begin to improve after 24 hours of treatment. Artificial tears and warm compresses may help give some relief.
Viral Conjunctivitis	Virus (adenovirus)	Gritty, burning eye Predominantly watery discharge Red conjunctiva May have morning crusting Usually spreads to other eye Often patient also suffering with a viral illness, e.g. cold	Infection usually takes one to three weeks to run its course Artificial tears and warm compresses may give some relief Antibiotics will not cure a viral infection

Dry Eye is caused by a decrease in tear production or an increase in tear evaporation. This may be due to menopause; medications such as antihistamines, birth control pills, isotretinoin; dry air/air-conditioning; computer use.

Symptoms include :

- Gritty, sore eyes
- Sensation of having "something in the eye"
- Excessive tear production

Artificial tears help lubricate the eyes, (preferably preservative-free formulations if irritation occurs.) In addition, Omega-3 and -6 fatty acids have been shown to improve dry eye symptoms.

Subconjunctival Haemorrhage is caused by bleeding from small blood vessels in conjunctiva. The condition is painless and idiopathic in nature. The blood in the eye appears a flat, red area and the patient may get quite a fright at its appearance. The eye usually clears within one or two weeks. Refer the patient to a doctor if the patient is on blood thinners, has a bleeding disorder, has a history of recent trauma to the eye, or if the condition reappears frequently.

Hordeolum (Stye) is an acute inflammation of the eyelid, where an eyelid follicle becomes infected. Warm compresses and washing the eyelid with very dilute baby shampoo or eyelid washes can help reduce the stye. If the stye has not reduced or healed within one or two weeks, or hardens to form a **Chalazion** ("stone-like" lesion,) the patient will need to be referred to a doctor for treatment.

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Another condition affecting the eyelid, **Blepharitis**, is a chronic inflammatory condition. The eyelid appears red, swollen and itchy. Dry scales can sometimes be seen with crusting occurring in the morning. A long-term regimen of eyelid cleaning as for styes and warm compresses may relieve symptoms. Referral to doctor may be necessary.

Conclusion

As a pharmacist, knowing when to promptly refer a patient to a doctor for treatment is essential. In general, the following symptoms should raise a red flag for referral:

Pain in the eye
Any visual loss or blurred vision
Photophobia
Severe foreign body sensation
Severe headache with nausea
Worsening symptoms
Trauma to eye
Mucopurulent discharge throughout the day
Any doubt about diagnosis

Bibliography: Available on request from pssa@pssasg.co.za

Copy as appearing in the TAG

A Healthy Eye is a Happy Eye

Lynda Steyn (BPharm) Amayeza Info Services

Healthy eyesight is so important to our well-being. Our daily lives can so easily be disrupted by an eye condition. With Eye Care Awareness month approaching, it is a good time to focus on a few conditions that affect our eyes and offer some tips on how to keep them healthy.

Why are my eyes red?

Red, **itchy** eyes with a watery discharge may be a sign of an **allergy.** This may be due to a specific cause, e.g. cat allergy or it may be when there is a lot of pollen in the air (i.e. seasonal allergies.) Some people may suffer throughout the year with red, itchy eyes. This may be due to an allergy to dust mites, animals or even pollution in the air. The itchiness usually affects both eyes, but sometimes only one eye may be affected.

- Allergic eyes may be relieved by applying cool compresses to eyes, using an artificial tear eye drop and removing the cause of the allergy (if possible.) There are a few eye drops available over-the-counter which may relieve the symptoms. Your doctor or pharmacist would be able to recommend the best choice for you.
- **Do not rub the eyes**, as this only worsens the symptoms.

Another common cause of red eyes may be due to a **bacterial** or **viral** infection. Both of these are **highly contagious**. Bacterial infections of the eye usually involve one eye only. However, both eyes can be affected. Typically, the eye has a thick, pus-like discharge throughout the day and is often glued shut in the morning upon wakening. **This can only be treated by a doctor as it requires prescription medication**. Viral infections of the eye usually have **a watery discharge**, with a bit of crusting in the morning. The eye may feel **gritty** or **irritated** and the infection often spreads to the other eye. Antibiotics do not help viral infections of the eye, and the infection usually resolves within one or two weeks.

- Applying a warm compress may help relieve the symptoms and using artificial tears may soothe the eye.
- Be sure not to touch the eye and to wash hands frequently to prevent the spread of infection. Do not share facecloths or towels.

Dry eyes are often the cause of red, scratchy eyes. The eyes may even water quite a bit. This may be due to multiple factors including staring too long at a computer screen, certain medications, air conditioning, aging and living in a dry climate. Relief may be found with various over- the-counter lubricating eye drops available.

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Determining the underlying cause of a red eye is very important. Complications may arise if there is a delay in treatment. Always seek medical attention if you experience one of the following:

- Moderate to severe pain in the eye
- Blurred vision or sensitivity to light
- Feeling as if there is "something in the eye " which prevents you from opening the eye properly
- Red eye together with nausea and vomiting, or headache
- Pus-like discharge from the eye that continues throughout the day.
- Any trauma to the eye

Contact lens wearers should remove lenses if they develop any eye symptoms and while undergoing treatment with eye products. Only a few products are suitable for use with contact lenses.

A word on over-the-counter eye drops

There are many over-the-counter eye drops on the market. Decongestant eye drops contain a substance which constricts the blood vessels in the eye and helps to whiten or clear the eye. While these eye drops may be beneficial for short-term use in certain eye conditions, prolonged use should be avoided due to a condition known as "rebound congestion," where the eye redness returns once these medications are discontinued. There are some eye conditions where certain over-the-counter eye drops are contra-indicated e.g. glaucoma. Always check with your doctor or pharmacist before using over-the-counter eye drops.

Conclusion:

Preserving our eyesight for the future depends on developing good eye-care habits.

Tips for keeping eyes healthy

- **Regular eye examinations**: Having an annual eye examination not only detects any problems with vision, but also a few common eye diseases which may have no symptoms, e.g. Glaucoma, diabetic eye disease and macular degeneration. Early detection of these diseases can prevent serious complications that can affect the eyesight.
- **Wearing sunglasses**: Protecting the eyes against the sun's damaging UV-A and UV-B rays can prevent certain conditions which may emerge in later years, such as cataracts and growths on the eye. Children should also be encouraged to wear hats and sunglasses to shield the eyes from the sun. Ensure that the sunglasses block 99-100% of the sun's UV-A and UV-B rays.
- **Maintain a healthy diet:** A diet rich in Omega 3 fatty acids, (e.g. tuna and salmon), green leafy vegetables and fruits rich in vitamin C all help to keep eyes healthy.
- **Safety eyewear:** Especially important for people who work with substances that can damage the eye, at home or at work. Welders must ensure that they always wear special safety goggles which shield the eyes and prevent a very painful condition known as "arc eyes." Eye damage from certain sports can be prevented by always wearing protective eyewear.
- **Give your eyes a break:** Staring too long at a computer screen causes eyestrain and can sometimes lead to "dry eye." Taking regular breaks from "screen time" and blinking more can help prevent the eyes from drying out and reduce eyestrain.

Bibliography: Available on request from pssa@pssasg.co.za

Using 2D barcode communication

Pharmacy Week and Health Awareness Day promotions can be very costly exercises indeed and include expensive consultants, massive printing and distribution costs that today just do not make economic sense. Consequently we have taken a completely different approach.

As you know we investigated some alternatives and decided that 2D barcoding showed a lot of promise and we introduced it to members about two years ago. However, despite all the advantages, cost savings etc. we feel that the system is not being used to its full potential by members, possibly because they do not understand its functionality.

What is 2D barcoding?
Today, more consumers have access to mobile phones than they do to radio. In addition, 98 out of every 100 cellular phones sold worldwide have digital camera capability. Another surprising statistic is that the number of SIMs in South Africa actually exceeds the population of the country. Cellular literacy in Africa is high and basic Internet data services are available wherever there is a cellular signal which now virtually covers the whole country.

We are all well acquainted with 1D bar coding - it has been on our products for years, but, 2D barcodes are relatively new. You may have noticed examples of these in magazine adverts or on packaging.

There are various codes available, such as QR Code and DataMatrix, but we elected to go with TrustaTag for a number of reasons, one of them being that it is backed by Microsoft.

These tags can be scanned by any smart phone, feature phone or i-pad - the only requirements are a camera, data access and an application to be loaded on the mobile phone or i-pad, which is essentially free of charge.
We want to encourage members once again to acquaint themselves with and actually experience the system first hand.

In order to test the system, you should download the (free) application to your particular phone or i-pad if it did not come with this software already pre-loaded, - most of the newer instruments will have the application already loaded.

Go to http://trustatag.mobi
The system will detect the type of phone and will prompt the user on how to download and install the application.

Once completed, you should scan the tag below to access the information that we have developed relating to “Eye Care Awareness”.

This will give you a good idea of how simple the system is to access and to use - and at almost no cost.
The possibilities for you to conduct your own promotions using this system are almost endless and we will continue to provide you with detailed information regarding Health Days and Pharmacy Week in future editions of this newsletter.

Eye Care Awareness TAG

54 Glenhove Road - Progress Update

54 Glenhove Road – These pictures show the preparation for the laying of the ground floor above the two levels of basement parking. With another three levels to go the contractors are still confident that the building will be completed on time for occupation at the end of April 2016.

Did you know: Aqueous cream and atopic eczema

Contributed by Liezl Fourie, SAAHIP

In March 2013 the UK Medicines and Healthcare Products Regulatory Agency conducted a review of published literature on the *benefits and risks of aqueous cream*, especially when used for children with eczema. Both the NICE paediatric guidelines and the British National Eczema Society report that aqueous cream as a leave-on emollient (but not when used as a soap substitute) may cause stinging, itching, burning or redness. This was based on an audit of 100 children attending a dermatology clinic conducted by Cork MJ et al.

Other studies have also reported thinning of the skin's outermost layer and increased water loss when aqueous cream is used as an emollient and suggested that the causative ingredient may be sodium lauryl sulphate. In clinical practice, however, aqueous cream is successfully used as an emollient and soap substitute in many patients.

Nonetheless the MHRA decided to update aqueous cream labelling and information leaflets with a warning on the potential for local skin reactions and sodium lauryl sulphate is now listed as an ingredient.

SOUTH AFRICAN ASSOCIATION OF COMMUNITY PHARMACISTS
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(Representing the Community Pharmacy Sector of the PSSA)

RESCHEDULING OF 1ST NATIONAL SYMPOSIUM FOR COMMUNITY PHARMACISTS

Please note that the EXCO of the South African Association of Community Pharmacists (SAACP) resolved at its meeting held on 15/16 August 2015, to reschedule the dates of the 1st National Symposium to **May 2016**. The rescheduling concerned will assist us to have the Symposium together with the SAACP's Annual General Meeting.

Branches are reminded of their commitment to ensure that the AGM and Symposium will be well attended. At this stage the AGM and Symposium will be held at the same venue as previously indicated, namely the Birchwood Conference Centre, Boksburg, Gauteng (to be confirmed).

More information, including a revised programme will be provided, amongst others, on or symposium website: www.saacpsymposium.co.za

Your kind support will be much appreciated.

JAN DU TOIT

EXECUTIVE DIRECTOR

ROGUE INTERNET PHARMACIES

Ray Pogir, FPS

The results of a survey into the activities of so-called “internet pharmacies” which was conducted by the National Association of Boards of Pharmacy (NABP) in the USA revealed some startling facts.

- Eleven thousand websites selling prescription medication online were reviewed. Of these, 96% did not follow pharmacy laws and public health standards.
- Hiding behind the anonymity of the internet, 85% were found to sell prescription drugs without a valid prescription, 87% were found to be affiliated to rogue drug outlets.
- Medicines on offer were found to have the incorrect strength, unauthorized excipients, mixed with substances such as rat poison and other substances which were illegal.

The NABP managed to convince the authority in the USA that registers domain names, the Internet Corporation for Assigned Names and Numbers, that only those pharmacies that are properly registered as approved internet pharmacies be permitted to register a domain name in the USA. The NABP issues an approved registration number for those pharmacies that have been approved as complying with the Law and the standards to protect the public.

They have also set up an online information site available at www.safe.pharmacy.
The reports from the NABP in the USA are certainly a pointer to the extent that rogue drug suppliers will go in order to cash in on the public ignorance.

In South Africa, pharmacies that wish to establish internet services are required by law to register such facility with the SA Pharmacy Council (SAPC) and are required as part of the registration process to provide such details as their physical address and the name of the Responsible Pharmacist amongst other important information. This requirement provides the means whereby internet pharmacies in South Africa can be held accountable. For more information contact the SA Pharmacy Council at www.pharmcouncil.co.za

However, we in South Africa are not in any way protected from the scourge of the rogue internet drug suppliers located over-border and Pharmacists should be aware of their existence. It places a heavy responsibility on us to inform the public of the dangers of this kind of internet activity.

When something goes wrong there is no recourse to a supplier who is a criminal and can disappear with a click of a button.

PRIMARY CARE DRUG THERAPY (PCDT)

Most members will be aware that for the last number of years no permits have been issued to pharmacists who had completed a course in PCDT.

The PSSA has continued to raise the matter at every opportunity because it has been our firm belief that pharmacists are in an ideal position to make a huge contribution to the provision of primary health care services that are so badly needed in the society that we serve.

At first the Section 22A (15) permits that were issued were only given to pharmacists in rural areas, but with the advent of NHI there is going to be a need for these services to be available from suitably trained healthcare professional in all areas. Progress has at last been made to the point where pharmacists with the additional educational requirements can apply to the S.A. Pharmacy Council for registration, and in fact the first of this “new wave” of PCDT permits was issued to a pharmacist who complied with the requirements quite recently.

Perhaps this is another example of “aanhouer wen”.

Pharmacists wishing to apply for or renew a PCDT permit need to register their appropriate training with the SAPC and apply to the Department of Health for the permit. Initial enquiries may be directed to the Office of the Registrar, S.A. Pharmacy Council.

What's on the Curator's Desk?

Ray Pogir, FPS
Curator, National Pharmacy Museum

The photographs with this article are obviously of instruments which were used for optical testing.
Why are they in the Museum which is of the history of pharmacy?

Some research revealed that long before "Optics" became known as a profession in its own right in South Africa hundreds of Chemists and Druggists, as the pharmacists of that time were known, were providing this important service to the public.

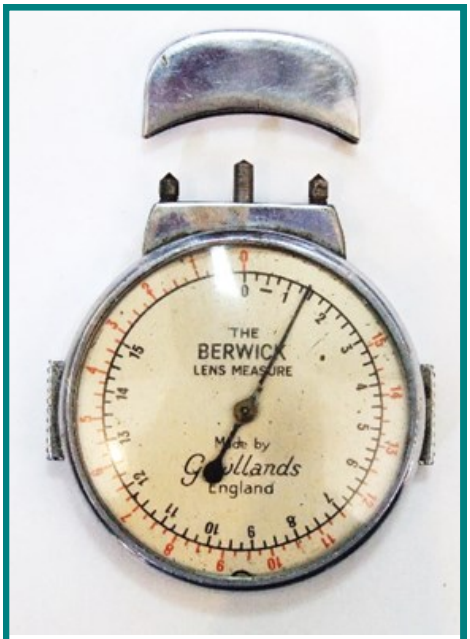
Courses of study designed for Chemists and Druggists were provided and enabled them to practice in the dual role of Chemist and Optician.

The Government Gazette number 3544 of the 14th of September 1945, in notice number 1675, published "The Rules for Registration of Optometrists".

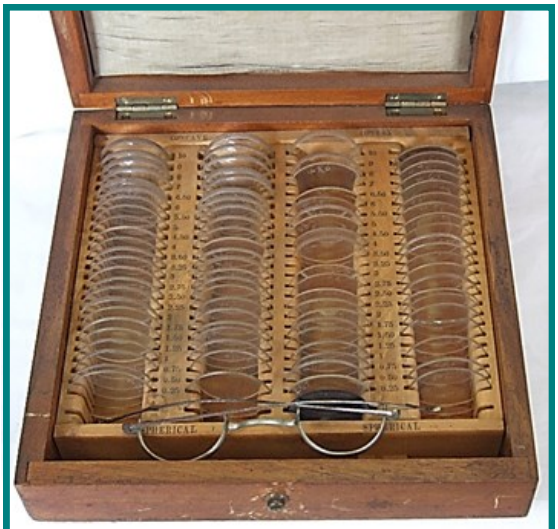
This provided for the Medical Council to be the registering body and to approve the recognized study courses. Optometrists had to practise in their own premises and pharmacists could no longer have a dual practice.

Following this announcement a number of Chemists and Druggists gave up pharmacy to follow optics as a career.

The instruments in the museum are obviously from a pharmacist who chose to remain in pharmacy.



Lens measure



Optical Sight Testing Set

Contains 50 concave lenses and 50 convex lenses each ranging from 0.25 to 10 diopters. A blank lens holder to insert the lenses, for sight testing.

Retinal Graticule Gauge (for examining the retina)

Report on CPD "ANXIETY DISORDERS", 23 JULY 2015

Dr Sandra Fernandes, Psychiatrist

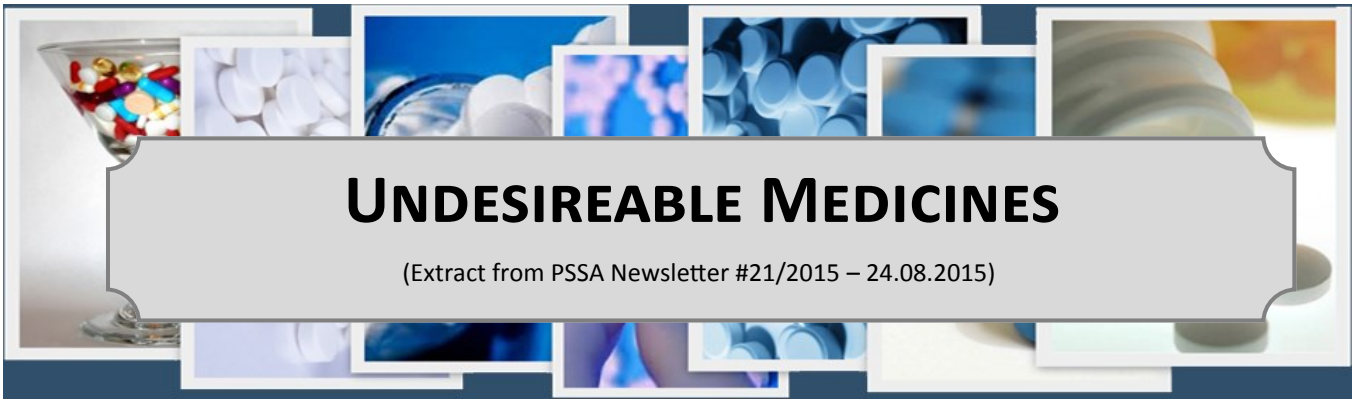
An informative and interesting presentation by Dr Sandra Fernandes, Senior Specialist Psychiatrist at Tara Hospital, on "Latest Developments in the Management of ANXIETY DISORDERS" was the subject of the Clinical CPD session held on 23 July.

After classifying the various types of anxiety disorders, and following illustrated explanations of the neuroanatomy of their different physiological origins in the brain she elaborated on risk factors for anxiety disorders, the clinical criteria, epidemiology, as well as treatment options employed.

Differential diagnosis, as either medical or psychiatric disorders were explained, while management principles were detailed for the various types of anxiety, and their course and prognosis; medication options as well as psychological approaches followed.

The importance of the role of pharmacists was emphasised by Dr Fernandes, including recognition of symptoms, comorbidity with depression and other medical disorders and conditions, external behaviour patterns and medications used – prescription and otherwise, while liaison with general practitioners regarding appropriateness of scripts, and referral to specialists were highlighted.

The presentation was concluded with a detailed summary including the symptoms, therapy options and a question and answer session. Dr Fernandes was thanked by Ray Pogir who acted as Master of Ceremonies. The session was kindly sponsored by the Southern Gauteng branch of the Pharmaceutical Society of SA.



UNDESIREABLE MEDICINES

(Extract from PSSA Newsletter #21/2015 – 24.08.2015)

The Medicines Control Council has identified a number of imported products that are not to be sold to the public, and has declared them to be undesirable medicines. In the first notice, it was stated that Betasol, Epiderm and Diprason (sic) were imported into the country by Coconut Express CC. A second notice listed the same products, as well as Lemovate, Movate, Tempovate, Dermo-Gel Plus, Top Gel and Skin Bo, but gave the names of purported manufacturers. These are Shalina Laboratories (India), Esapharma (Italy), Temp Scan Pacific Tbk (Indonesia) and Medical and Chemical Agency (Italy).

Pharmacists who have any of these products on their shelves should return them to the supplier. Lot numbers can be viewed in the Government Gazettes, which can be downloaded from the PSSA website:
http://www.pssa.org.za/E_News.asp

APSSA/SAAPI Conference 2015

"Today's Solutions for Tomorrow's Needs"

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 Cedar Woods 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.

Conference Programme – SAAPI

Thursday, 17 September 2015

08:00	***Registration & Networking***
09:00	Welcome
09:05	***APSSA/SAAPI*** Opening Address
09:30	***(Speaker TBC)*** The European Pharmacopoeia: Leadership in the Quality of Medicines
10:10	***Dr Stephen Wicks - EDQM*** A Structured Approach to the Benefit Risk Assessment of Medicines: The key to Improving Decision-Making in Drug Development and the Regulatory Review
10:50	***Prof Stuart Walker - Founder Centre for Innovation in Regulatory Science (CIRS), United Kingdom.*** 10 min Q and A
11:00	Tea (20 min)
11:20	Active Pharmaceutical Ingredients: Understanding Life Cycle Quality
11:55	***Prof Douglas Oliver*** Local Stability Testing and Requirements (Title TBC)
12:30	***Prof Anita Wessels*** Regulatory Science Institute Update
13:00	***Dr Desmond Johns*** 10 min Q and A
13:10	***Networking Lunch***
14:00	GMP Updates – From Systems Compliance to Product Quality
14:40	***Dr Chris Stubbs*** The Legal, Disciplinary and Reputational Risks of Social Media.
15:20	***Ms Emma Sadler*** 5 min Q and A
15:25	**Tea**

APSSA/SAAPI Conference 2015

"Today's Solutions for Tomorrow's Needs"

15:35	Conducting Clinical Trials in South Africa and the Role of the Clinical Research Pharmacist ***Prof Kosie van Wyk***
16:10	AGM
16:40	5 min Q and A, Prize Giving (R1000 to SAAPI workshop) and Closure
17:30	Networking and Cocktail Event (additional charge)

Friday, 18 September 2015

08:00	***Registration & Networking***
09:00	Welcome
09:05	***APSSA/SAAPI*** EDQM Certification and Inspection: Controlling the Quality of Substances and Medicines
09:45	***Dr Stephen Wicks – EDQM*** Academic Drug Discovery Centers - Cultural Bridges Over the Valley of Death?
10:25	***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 Institute, Stockholm, Sweden.*** 15 min Q and A
10:40	Tea (20 min)
11:00	The Tackling of the Backlog
11:40	***Speaker tbc*** Biosimilars - A Regulatory Update
12:20	***Prof Henry Leng*** 10 min Q and A
12:30	Lunch
13:15	Expanding the Range of Authorized Prescribers – a Very Slow Tango
13:55	***Mr Andy Gray*** Getting Ready for the eCTD
14.40	***Ms Estelle Taute*** 15 min Q and A
15.00	Conformity Assessment (Applicable ISO Standards and Guides for Supplements, CAMs and Functional Foods, Measuring the Performance of a Product and Process, Certification and Testing)
15:30	***Amit Raga – Senior Manager: Chemical Services; Food & Health Certification ,SABS*** 10 min Q and A and Closure and Tea served afterwards

For more information and to Register contact: knel@confpro.co.za

Visits to the National Pharmacy Museum and its Curator

When visiting the National Pharmacy Museum one can be sure of an enthusiastic welcome from the Curator, not because of seldom having visitors but on the contrary, the Curator has many enquiries from various institutions and organisations requesting appointments for their students (both undergraduate and post graduate) to visit the museum. These in the past year have included visits from Wits University Pharmacy students, Botswana Pharmacy Technicians, private groups of interested persons, members of Rotary clubs.

Most recently a group of students from the School of Geography, Archaeology and Environmental Studies at Wits University visited the Museum arranged by Dr Christine Sievers. The following note from her is representative of the appreciation visitors express after their visit to the museum.

"Thank you very much for hosting us at your superb museum. The students and I had an extremely stimulating excursion and are very grateful to you for hosting us and for sharing your wealth of personal knowledge of the museum and the history of pharmacognosy.

With best wishes,
Dr Christine Sievers
School of Geography, Archaeology and Environmental Studies, University of the Witwatersrand"

Dr Christine Sievers stands 2nd from left

CORRECTION

On page 9 of Edition 5 of The Golden Mortar we inadvertently referred to SAAHIP instead of SAAPI in the article regarding Pat Smith receiving his Fellowship Certificate from Tammy Chetty in recognition of his outstanding and long service. Please accept our apologies for any inconvenience that this may have caused.

The Chairman of the Editorial Board is David Sieff and the members are Doug Gordon, Neville Lyne, Ray Pogir, Miranda Viljoen, Val Beaumont, Gary Kohn & Jan du Toit. 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.
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