The Golden Mortar

Newsletter of the Southern Gauteng Branch of the Pharmaceutical Society of South Africa and associated Sectors.

Edition 4/June 2016

71st Annual General Meeting Pharmaceutical Society of SA

The 71st Annual General Meeting of the PSSA was held at Birchwood Conference Centre in Boksburg on Friday the 13th May 2016.

This was not one of those traditional three day affairs combined with a conference that we are accustomed to, and in fact lasted just over two hours. However, the business of the meeting was conducted adequately in that time thanks to the efficient chairmanship of our President, Professor Sarel Malan.

The meeting began with the singing of the National Anthem and moved on to the various reports that make up most of the agenda of any institution's annual general meeting. After all it is the opportune time on which to report on the general state of health, growth and financial well-being of an organisation and this one was no different.

Ivan Kotze, the Executive Director, reported on the growth in membership of the Society to a record high of just on eight thousand members representing a growth of 73% when compared with the figure for 2010 which is most pleasing. This growth, understandably, has come mainly from our younger pharmacists (under the age of forty years) who now represent 57% of our membership. Further analysis indicates that nearly 63% of our members are female – so much for it being a man's world!

Another important matter that Ivan reported on was the construction of the Society's own offices in Lynwood, Pretoria which will be ready for occupation in November this year. If possible to do so it is always far better to own one's own property rather than paying off the landlord's bond.

Treasurer, Michele Coleman, presented a very acceptable set of audited financial for the 2015/2016 financial year and was thanked for taking on this responsibility and her control over the Society's finances.

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Elections for Office Bearers took place that returned Professor Sarel Malan as President, Mr. Stéphan Möller as Vice President and Ms. Michele Coleman as Treasurer for a further term.

The other members making up the National Executive Committee will be appointed by their respective Branches and Sectors in due course in time for the next scheduled meeting.

Four Motions were presented and discussed by the General Council, the first two being Motions to amend the Constitution - just to tidy it up and make certain intentions a little clearer and the other two Motions dealt with awards.

Motion 3 was to confer Fellowship of the Society on Professor Douglas Oliver and Motion 4 was to confer the William Paterson award on Mr. Raymond Pogir.

Both of these Motions received the unanimous support of General Council and both were thoroughly deserved by outstanding and worthy members who in different ways have contributed so much to our Society and our profession over many years.

Other matters of importance and interest that were presented and discussed included;

- Changes in PPS contact details after the retirement of Mr. Charles Skinner who many members had got to know over the years.
- Expanded services available from PPS such as Free Legal Assistance Hotline, Health and Safety Hotline, Business Identity Theft Cover.
- Free membership of Commonwealth Pharmacists Association (CPA) for PSSA members.
- The Dispensing Fee – letter to the Minister requesting a meeting to discuss the fee.
- National health Insurance – PSSA comment on the White Paper
- PSSA submission to the Private Healthcare Market Inquiry
- Young Pharmacist's Group.

Among the documentation made available to all Councillors were individual Branch Reports indicating the activities of the various Branches throughout the year as well as Sector reports from the four Sectors.

All in all it was an interesting and efficiently run meeting and attendees were pleased to hear the announcement that in 2017 the AGM of the Society will revert to a three day combined AGM and Conference that will take place at the Indaba Hotel from the 6th to the 9th July 2017.

Raymond Pogir receives the William Paterson award

L to R: Ray Pogir receiving the William Paterson medal and citation from PSSA President Prof Sarel Malan

Few people in this country can lay claim to having had a passion for the profession of pharmacy lasting over sixty years, but our friend and colleague Raymond Pogir is just such a person.

At the AGM of the PSSA held in May this year the General Council agreed to confer on him the Society's highest honour, namely The William Paterson Award, which was presented to him at a combined PSSA /SAACP gala dinner after the recent SAACP Symposium held on the East Rand.

The award is made to those rare and exceptional members of the Society who have demonstrated outstanding focus on the attainment of the objectives of the PSSA through consistent involvement in associated professional, business and educational organisations and have contributed significantly to both the Society and the profession's development over many years to the benefit of its members as well as to the benefit of consumers of health care services.

It would be difficult to think of anyone more deserving of this high accolade than Raymond Pogir.

Ray was born in Johannesburg on the 8th March 1931 and matriculated at Krugersdorp High School 1948 where he was house captain, played 1st team rugby and was awarded colours for rugby in 1948.

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He played a number of different sports and had a number of athletic records to his name.

Ray qualified as a Pharmacist. Dip. Pharm. in 1955 at the Johannesburg Technical College and in 1961 he completed the Diploma in Clinical Chemistry.

From 1956 to 1979 he was the owner of a number of Retail Pharmacies in Durban and in 1980 he relocated to Johannesburg and had a career change to wholesale pharmacy with SAPDC.

Ray held the position Deputy Managing Director of TPS Mutual Trust, which later became Medikredit, until the business was sold in 1998.

In 2009 he was appointed as the Curator of the S. A. National Pharmacy Museum, at 52 Glenhove Rd., Melrose Estate, Johannesburg.

Ray became involved in the Society while he was a member of the Natal Coastal Branch of the Pharmaceutical Society of South Africa (PSSA) and served on the committee from 1962 to 1979. He was Chairman of the Branch in 1965 and is an Honorary Life Member of the Branch.

When Ray moved to Johannesburg he joined the S. Gauteng Branch of the PSSA and has served on local committee since 1980 to the present. He has also been awarded Honorary Life Membership of the Branch Committee He served as Branch Chairman from 1981 to 1984 and is also an Honorary Life Member of this Branch. In addition Ray has been Chairman of Pharmaceutical Management Services (Pty) Ltd. since 1996 to the present time.

Raymond served on the National Executive Committee of the PSSA for 17 years – from 1967 to 1984 and was the Chairman of PSSA Contracts (Pty) Ltd. the company responsible for concluding contracts between Medical Schemes, the PSSA and community pharmacies for prescription processing and payment.
Ray headed the PSSA campaign against Drug Abuse and was an appointed member of the SA Government Committee of Inquiry into Drug Abuse in SA by the Minister of Social Services.

In 1973-1974 Ray served as the National President of the PSSA. He was appointed as the Chairman of the negotiating committee of the PSSA for the Pharmacy Act 1973-1974, - the first separate Act for Pharmacy in South Africa.

Raymond's service to our Society has been recognised by the Society and he is both an Honorary Life Member and a Fellow of the PSSA.

Ray has also served as a member of the South African Pharmacy Council from1988-2002 where he held positions such as Treasurer and Vice-President and was Chairman of the Committee of Preliminary Enquiry for ten years. He was also the Chairman of the Committee of Informal Inquiry for five years as well as a member of the Practice Committee.

Ray is currently the Curator of the S. A. National Pharmacy Museum and in recent years has published some 35 research articles on the artifacts in the Museum in The Golden Mortar.

Raymond Pogir has dedicated a lifetime to the profession of Pharmacy as well as to the Pharmaceutical Society of South Africa and has been responsible for some truly major changes and contributions along the way.
He is certainly a worthy recipient of our Society's highest accolade, namely the William Paterson Award and this Branch is extremely proud to have had him as a member for over 36 years.
The Branch salutes you Raymond and thanks you very much indeed for the massive contributions that you have made to the Branch, to the Society and the profession over many, many years.

Go well.

Professional Indemnity Insurance

You should be aware that pharmacists in all spheres of practice require Personal Professional Indemnity Insurance.

Not to have it is simply not an option—it is a requirement of the SA Pharmacy Council

You should also be aware that the PSSA offers its members access to this essential cover at very competitive rates through the Professional Provident Society.

For further details please contact; Tersea at the PSSA Head Office on 012 470 9558

How easy is that? The PSSA – pharmacy in action!

Fellowship of the PSSA bestowed on Prof. Douglas Oliver

"Fellowship is the formal recognition by one's peers of significant contribution over a period of time. It results in an invitation to join a group or guild of similarly recognised members of the Society".

Prof Sarel Malan, President of the PSSA welcoming Prof Oliver as a Fellow.

Any member of the Pharmaceutical Society of SA, who has significantly furthered the aims of Pharmacy in any sphere of the Profession, may be invited to be elected a Fellow.

Since the early 1970's about 170 Fellows have been recognised and have been honoured with Fellowship of our Society.

Professor Douglas William Oliver is someone who is deemed to be worthy of this honour and in his career he has held high level pharmacy leadership positions, has contributed enormously to the development of the pharmaceutical sciences, to the furthering of the profession and to the development of pharmacy professionals.

- **In his working career**
  - ◊ *He has served in more than 50 pharmacies in South Africa and Namibia.*
- **Has held senior academic posts including:**
  - ◊ *Professor and Head of Medicinal Chemistry at University of Pretoria,*
  - ◊ *Head of Pharmacology at North-West University,*
  - ◊ *Research Director of Drug Research and Development and Director of Pharmacy at North-West University.*
- **His Academic Achievements are of the highest order.**
  - ◊ *He has two doctoral degrees,*
    - one in Pharmacology in the field of *in vivo* cerebral perfusion pharmacology, and
    - one in Pharmaceutical and Medicinal Chemistry in drug discovery,
  - ◊ *He has trained more than 30 doctoral and master degree students, and*
  - ◊ *is author of some 120 publications*
  - ◊ *He holds local and international patents and,*
  - ◊ *has presented more than 250 national and international presentations in 25 countries.*
  - ◊ *He is a certified API auditor of the European Council.*
- **He is generous in the time he contributes to professional community commitments and has been contributed and been recognised as a leader in multiple circles including:**
  - ◊ *An executive committee member of the Union of Basic and Clinical Pharmacology 2014 (IUPHAR),*
  - ◊ *Chair: Pharmacology for Africa Initiative,*
  - ◊ *President: South African Society for Basic and Clinical Pharmacology, 2001-2007,*
  - ◊ *President: World Congress of Pharmacology 2014 (WCP2014),*
  - ◊ *Chair and vice-chair: Academy of Pharmaceutical Sciences in South Africa,*
  - ◊ *EXCO member of SAAPI.*
  - ◊ *He serves on several international scientific advisory boards.*
  - ◊ *He has served as a member of both the Medicine Control Council and the SA Pharmacy Council.*
- **And has been Awarded:**
  - ◊ *The South African Academy for Science and Arts: FARMOVS prize for Pharmacology and Drug Development: For outstanding contributions and achievements in the field of Pharmacology and Drug Development.*

His leisure time has been spent:

- ◊ *As a marathon and Comrades runner,*
- ◊ *A sky diver, and*
- ◊ *Bungee jumper.*

He is currently an advanced scuba diver and a keen underwater photographer.

We must surely add courage and determination to his many attributes. Professor Oliver was nominated by the SA Association of Pharmacists in Industry.

The Society recognises Prof Oliver's many magnificent achievements, his personal contribution to the profession of Pharmacy and to the pharmaceutical sciences.

66th AGM - S A Association of Community Pharmacists
1st National Symposium
13 and 14 May 2016

Christine Venter presenting the JB Israelsohn Award to Gary Köhn

The Annual General Meeting was held at the Birchwood Hotel and Conference Centre in Boksburg on the morning of Friday 13 May. The office bearers elected for the ensuing period were Mrs Christine Venter, President; Mr T Rabali as Vice – President; Mr HG Manolas as Honorary Secretary and Mr J Ravele as Honorary Treasurer.

Various resolutions and recommendations were adopted and the way forward will be discussed at the SAACP NEC meeting scheduled for 13 and 14 August next.

The 1st National Symposium for Community Pharmacists was well attended, the feedback from delegates was positive and the need for a separate annual symposium was supported by many of the delegates.

To round off the Symposium a glittering Gala Dinner was held at the venue at which Mr Ravele acted as Master of Ceremonies. Awards were presented at the function and special mention must be made of the presentation of the J B Israelsohn Award to Mr Gary Köhn for his dedicated, unstinting and exemplary service to the pharmacy profession, in particular the South African Association of Community Pharmacists (SAACP).

Re-launch of Trinity Health Services Clinic

Deanne Johnston, B Pharm
Lecturer, Faculty of Health Sciences, Wits University
Responsible Pharmacist, Trinity Health Services

Deanne Johnston

What is Trinity Health Services (THS)?

Trinity Health Services is a non-profit clinic that serves a homeless community from the premises of the Holy Trinity Catholic Church (Braamfontein). The clinic is run by students registered in the Health Sciences Faculty at the University of the Witwatersrand and assisted by university staff.

The members of the homeless community represent a vulnerable group within society and as a result they often present with a poor health and nutritional status. Many of these patients are foreigners without South African identification documents and are scared to seek help from State hospitals and clinics.

How did THS start?

The clinic stemmed from a soup kitchen that is run by the St Vincent de Paul Society which serves meals to the local homeless community every Monday night. In 2004 a few medical students saw the need to provide healthcare services for the homeless people living in the inner city. They approached the Holy Trinity Catholic Church for assistance and THS was formed. The clinic operated until 2011, when it was closed temporarily until a pharmacy licence could be acquired so that medication could be issued to these patients. The service we provide is an opportunity for these patients to come forward for free health care as well as holistic well-being through the church.

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THS Re-launch

After the acquisition of the pharmacy licence in 2015 it took a few months to raise sufficient funds to reopen the facility. THS was back in action on the 1st February 2016, following its closure in 2011 and since February the clinic has operated every second Monday night.

The official prelaunch of the clinic took place on the 24th May, which was a celebration where sponsors, supervising staff and students could be thanked and recognised for their involvement.

What is a student-run clinic?

Medical and pharmacy students have taken joint responsibility for assisting and managing the clinic. Some of the tasks that they are responsible for include:

- Establishing a multi-disciplinary healthcare team,
- Inviting fellow students to volunteer and ensuring there is sufficient help,
- Assigning students tasks,
- Organising medical doctors to supervise,
- Fundraising,
- Ensuring that the facilities are kept clean and tidy as well as that the equipment is in working order,
- Determining the social and healthcare needs of the community and working with the church to help address these issues.

Students are given support and encouragement from staff members within the facility. Due to the legislative requirements associated with a pharmacy, tasks pertaining to a pharmacy are strictly regulated by the Responsible Pharmacist.

Our facilities

THS consists of four consultation rooms where medical students, under the direct supervision of a doctor, consult with patients and prescribe medication according to a restricted formulary. Patients then take the prescription to the pharmacy where the medication is dispensed by pharmacy students (registered as Pharmacist's Assistants) under the direct supervision of a registered pharmacist.

The pharmacy is registered and is owned by the University of the Witwatersrand.

How is the clinic funded?

The clinic provides a free service to the homeless community of Braamfontein and its surrounds and runs on donations. The staff and volunteer doctors and pharmacists supervising the students donate many hours of their time to ensure that a quality service is provided to this underprivileged community.

Thus far we have been very fortunate to have had material and/or financial assistance from the Southern Gauteng Branch of the Pharmaceutical Society of SA, the DisChem Foundation, the SA Association of Pharmacists in Industry, CKS Computer Kit Systems and 3Js.

What Impact has THS had on the students?

Sonal Parekh (B Pharm IV) comments: "Working at the Trinity Clinic has been a 'one-of-a-kind' experience. Aside from it being fulfilling experience to work and give back to the community, it also gives a sense of purpose as a Wits Student. With each time volunteering at the clinic, students are able to see exactly how and where their training at Wits comes into play in the real world. Every concept we are taught at Wits has been exemplified through each of the various patients and problems we encounter. Furthermore, Trinity Clinic has proved to not only illustrate what we have already learned, but also to provide us with new, more integrated challenges in terms of a patients's diagnosis. Working at the clinic has taught me, personally, way more than I could ever learned working in a regular pharmacy in Sandton."

Zanel Olivier (B Pharm II) comments: "The Trinity Clinic means a great deal to us as Pharmacy students as we get to experience raw and extremely eye-opening cases among the patients who visit the clinic. This is extremely valuable to us as students as well as to the patients that we are able to help. These patients change the way we see the Pharmacy profession for the better, and I hope that we help them to restore their faith in the Health System of South Africa".

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Comments from Alexandria Green – Thompson (GEMP II). "I have a particular experience that is memorable for me. It was my second or third time volunteering when I took over some consultations. I went in feeling as though I knew nothing and could not possibly help our patients. Coming out of the consultations, I still felt like I had a lot to learn, but my confidence in my clinical skills had definitely grown. My experience at the clinic has made my times at the hospital during learning hours much more meaningful and gave my learning direction and focus. More than that, the clinic has taught me an awareness and respect for patients that I feel you cannot be taught through exams. It has really been a valuable learning experience."

What help does THS need?
It is our intention that the clinic will operate weekly as soon as we have sufficient staff to supervise the students. If you are a passionate pharmacist or doctor who is willing to donate about 4 hours of your time every two months, please let us know. (Deanne.Johnston@wits.ac.za)

In Addition … The clinic needs to provide a sustainable quality healthcare service to the community. We therefore require assistance in donations to purchase medicines and medical supplies as well as much needed medical equipment. In assessing the needs of the homeless community and donations of food, toiletries, clothing and shoes would also be much appreciated. For further information please contact Mrs Deanne Johnston (Deanne.Johnston@wits.ac.za)

Editor's Note: The Southern Gauteng Branch is proud to be associated with this important social responsibility initiative and wishes THS every success in its future endeavours.

Common Sports Injuries
Report of a Clinical CPD presentation

Dr Jon Patricios

At the Clinical CPD session held on the evening of 19 May, Dr Patricios, a Sports Physician, opened his presentation by saying that the major contributor to one's health status is one's health behaviour (50%). The remaining contributors are genetics (20%), environment (20%) and access to medical care (10%).
He emphasised the importance of exercise and its positive contribution to one's health. However, effective adaptation to exercise is an essential part of avoiding injury and requires to be managed. Overload, overuse, intrinsic and extrinsic, eg bad training, overtraining are contributors to injury. When undertaking training it should be remembered that skeletal adaptation is slower than cardiac and respiratory changes (adaptation).

Dr Patricios also emphasised that a correct diagnosis of a sports injury is an important starting point if the correct treatment is to be applied and a positive outcome is to be achieved. He commented on the frequent incidence of quinolone antibiotic treatment resulting in damage to tendons.

During his presentation he also addressed the subject of sports supplements. He indicated that the claims made by some sports supplements have not been substantiated and some do not reflect on their labels some inclusions which have been identified after analysis as harmful and therefore one has to be mindful of possible adverse effects resulting from their consumption.

Dr Patricios informed the audience that an APP listing IOC banned substances could be useful to pharmacists dispensing medicines for known sports participants including athletes. The link to access the list or APP is http://list.wada-ama.org/ . He also addressed concussion during his presentation.

In closing the session the MC, Geraldine Bartlett thanked Dr Patricios for his informative presentation. MSD were also thanked for their part-sponsorship of the CPD session.

A Heads Up on Head Injuries

By Lynda Steyn, B Pharm - Amayeza Information Centre

All is not as it seems

It is sometimes difficult, upon immediate witness of a head injury, to ascertain how serious it is. Since the blood vessels in the scalp are profuse, a minor injury to the head may produce substantial bleeding. Conversely, a severe head injury may have no bleeding or visible outward signs. Bleeding or swelling could be taking place within the skull.[2] Injury to the brain can also occur without any direct impact to the head, e.g. head injuries due to shaking.[1, 3]

How does one recognize a serious head injury?

The patient may become lethargic, lose balance, lose consciousness (even briefly), have unequal pupil sizes, a stiff neck, severe headache, be unable to move an arm or leg and may also start behaving abnormally.[2] There may also be drainage of a clear fluid from the nose or ear.[2] These are some of the symptoms of a severe head injury and urgent medical help would be needed. *A patient with a serious head injury should not be moved, in case the neck is injured or broken.*[1]

When a head injury causes a change in brain function, it is known as a traumatic brain injury (TBI).[3] A mild TBI where there is a temporary change in the brain function, but no damage to the brain structure, is known as a concussion.[1]

Symptoms of a concussion may include: [3, 5, 6]

- Confusion
- Memory loss (unable to recall events surrounding the time of injury)
- Headache
- Dizziness
- Vomiting
- Loss of consciousness (uncommon)
- Lethargy

Patients who have suffered a mild TBI should be referred to a doctor for evaluation.[4] Usually a complete recovery can be expected after a mild traumatic injury. However, if the patient has suffered a loss of consciousness, or experiences persistent symptoms as described above, a prompt referral to the emergency department would be required.[1,4]

Mostly, the symptoms of a mild concussion take a week to ten days to resolve.[7] Some symptoms, however, such as headache, changes in sleep patterns, increased light and noise sensitivity, problems with day-to-day functioning and mood changes may persist for a while after the concussion. This is known as "post-concussion syndrome."[1, 4]

Unless otherwise prescribed, the preferred treatment for a headache after mild head injury should be **paracetamol**.[6] Nonsteroidal anti-inflammatories, such as ibuprofen or aspirin should be **avoided**, due to a possible increased risk of intracranial bleeding.[7] Codeine should also be avoided after an acute head injury, due to the risk of increased intracranial pressure and the possibility of respiratory depression. It may also affect a neurologic examination by interfering with pupillary response, as well as consciousness.[8] A study has shown that overuse of analgesics after a head injury may make the headache worse and may even cause the headaches to become chronic.[9]

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The signs and symptoms of a serious head injury are not always immediately noticeable. Sometimes it may take a few hours or days to present.[2] For this reason, monitoring of symptoms after a head injury, even after a mild head injury, should continue for a few days afterwards.[3] If a patient has had a head injury, it is prudent to be aware of these symptoms and also to recognise the danger signs upon which a patient would need to be immediately referred.

When to refer a patient who has had a concussion- the danger signs: [1,4, 5,6]

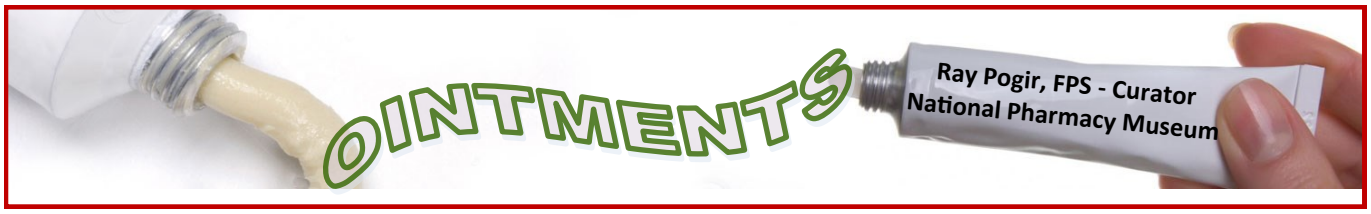
- Headache that is progressively worse and won't abate
- Decrease in coordination
- Numbness or weakness
- Slurring of speech
- Vomiting, fever, or stiff neck
- Increase in drowsiness, difficult to waken
- Seizures
- Cannot stop crying (children)
- One pupil wider than the other

Every effort should be made not to have another head injury soon after the first injury. The consequences may be serious or fatal and is known as "second impact syndrome."[6]

Athletes who have sustained a concussion should under no circumstances return to play on the same day of their injury. A thorough evaluation by a physician who is experienced in the management of concussion should be undertaken before returning to play.[7]

References:

1. MSD Manual. Wilberger J, Dupre DA. Overview of Head Injuries.[homepage on the Internet.] c2016. [cited 11 Apr 2016]. Available from: https://www.msdmanuals.com/home/injuries-and-poisoning/head-injuries/overview-of-head-injuries#v739962
2. National Institutes of Health. U.S. national Library of Medicine. Head injury-first aid.[homepage on the internet]. [updated 5 Apr 2016; cited 11 Apr 2016]. Available from: https://www.nlm.nih.gov/medlineplus/ency/article/000028.htm
3. Reed-Guy L. Head Injury. [home page on the internet]. [reviewed 3 Dec 2015; cited 11 Apr 2016]. Available from: http://www.healthline.com/health/head-injury#Overview1
4. Evans RW. Concussion and mild traumatic brain injury. [cited 14 Apr 2016]. In: UpToDate, Waltham, MA, 2016.
5. Centers for Disease Control and Prevention (CDC). Traumatic Brain Injury and Concussion.[home page on the internet]. [updated 22 Jan 2016; cited 11 Apr 2016]. Available from: http://www.cdc.gov/traumaticbraininjury/symptoms.html
6. Schutzman S. Patient information: Head injury in children and adolescents (Beyond the Basics). [cited 15 Apr 2016]. In: UpToDate, Waltham, MA, 2016. Available from: http://www.uptodate.com/contents/head-injury-in-children-and-adolescents-beyond-the-basics
7. Halstead ME, Walter KD. Sport-related Concussion in Children and Adolescents. Pediatrics. Sept 2010: 126(3). Available from: http://pediatrics.aappublications.org/content/126/3/597
8. Drugs.Com. Codeine. [home page on the internet].c2016 [cited 17 Apr 2016]. Available from: http://www.drugs.com/ppa/codeine.html
9. Medscape. Bernhardt DT. Concussion Medication. [home page on the internet]. [updated 21 Sept 2015; cited 17 Apr 2016]. Available from: http://emedicine.medscape.com/article/92095-medication



Throughout the ages man has sought the illusive ingredients which could alleviate or heal a host of skin conditions, from boils to wounds, burns to piles and even for the skin eruptions caused by syphilis. Looking back in history one finds a wide range of "medicaments" and formularies which have long been forgotten or no longer approved.

As an example, Mercury was used in a variety of formulations. The BPC of 1923 has a formula for Mercury Ointment which contains 30% mercury. It states that "the mercury prevents the movement of the white blood corpuscles in the skin vessels over which it is rubbed, and so inhibits inflammation" The same BPC also has a formula for an ointment containing mercury, lead and zinc oxide.

Many pharmacists in the late 1800's till well into the mid 1900's had a range of private formularies which included ointments and creams. Some gained a reputation for their products such as "nappy rash" and" dry skin" in winter and attracted quite a following for their products.

The preparation of an elegant and acceptable ointment or cream in the dispensary required some considerable amount of skill and the use of "secundum artem", an unwritten art, which was acquired over the ages and passed on from "master" to apprentice. The bible in Ezekiel chapter 30 describes a "holy ointment" to be compounded after the art of the Apothecary.

The photographs accompanying this article are some examples of the range of ointment storage jars which pharmacists kept in order to fill the prescriptions from the doctors.

A reminder that the second National Pharmacy Conference will take place at the International Conference Centre (ICC) in Durban between 21 and 24 October 2016.

Go to http://www.sapcconference.za.org/ where you will be able to access the provisional programme and to register and take advantage of the early bird offer.

There are many sessions to choose from. The conference is sure to attract many delegates and to provide many opportunities to network, to meet colleagues and to make new acquaintances...

Law and Ethics

Contributed by Val Beaumont, M Pharm (Industrial Pharmacy), FPS

National Health Insurance (NHI) and the contracting of pharmacist's services.

The PSSA has made a submission in response to the NHI white paper. Key principles were highlighted in the document, amongst other important issues, that are important to pharmacy – they are reproduced below. The challenge for the Society now is for us to defend these principles and open up the frameworks, and for individual pharmacists and pharmacies to explore innovative ways of delivering services and being ready to contract services to the NHI fund.

Specific issues around contracting providers are dealt with in an NHI work stream known as Work Stream 3. Work Stream 3 had a consultative meeting with pharmacists recently and has indicated the intention to engage with the profession to develop models for service delivery and reimbursement.

Principles highlighted by the PSSA.

The PSSA submission on the NHI white paper includes the following principles which the PSSA believes describe the key opportunities for pharmacists and pharmacy to deliver healthcare in an NHI environment

1. *It is in the interest of patients, individuals and communities that the pharmacist, where possible, is accountable for the provision of pharmaceutical services including all services in terms of the Pharmacy Act which fall within the scope of a pharmacist.*
2. *Pharmaceutical service provision in an NHI will be determined on need and informed by burden of disease and community demographics and in this respect flexibility needs to be provided in the frameworks within which a pharmacist can work.*
3. *Provision of pharmaceutical services by an individual in an independently owned facility or a state facility as well is the provision of pharmaceutical services in a pharmacy as a primary health care facility, as is the case with community pharmacist, should all be options in contracting pharmaceutical services. Pharmacy Council frameworks will need to be reassessed and aligned to meet these needs.*
4. *Multidisciplinary healthcare practices need to be facilitated taking account of professional skills and capabilities, risk-taking and fair remuneration and new models will be explored. Roles and responsibilities need to be clearly defined to ensure that adequate services can be provided through the formation of appropriate teams.*
5. *Practice standards determined and enforced by the Pharmacy Council will guide the provision of pharmaceutical services in conjunction with the Office of Health Standards Compliance.*
6. *The nature of pharmaceutical services that can be contracted, (as in the scope of practice for pharmacists), must be fairly remunerated and will be guided by the current Pharmacy Council guidelines.*
7. *Patient care should not be compromised as a result of lack of willingness by the NHI fund to provide the type of pharmaceutical care envisaged by the Pharmacy Act.*
8. *Where appropriate, patients and other healthcare providers should have access to pharmaceutical services at a specialist level including PCDT pharmacists, authorised prescriber pharmacists, clinical pharmacists, pharmacokineticists and industrial pharmacist's and possible other specialist pharmacists as needed.*
9. *All the re-engineering of the primary health care system focuses on nurse – driven services. The PSSA would like to express concern because revelations at the Private Healthcare Market Enquiry showed that there are no registers of the various categories of nurses showing who they are, where they practice and what their authorised scope of practice is. This needs urgent correction.*
10. *The white paper raises concerns over perverse incentives in connection with the procurement of medicines. The PSSA urges finalisation of the draft documents intended to deal with this issue and at which the PSSA has made extensive comment.*
11. *The PSSA opposes centralised buying of pharmacy services where it leads to the marginalisation of independent and smaller players.*

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12. *The PSSA has also requested involvement in Work Stream 2: design and implementation of NHI health care service benefits. This is very relevant to the pharmacist scope of practice.*
13. *Of more specific concern to the PSSA is the suggestion that the distribution of medicines is through a community-based distribution system. We urge, in the interests of the public, that the distribution of medicines to patients remains as far as possible under the control of a pharmacist. (Section 180)*

Control of Complementary Medicines

The Heath Products Association (HPA) and the Self Medications Association of SA (SMASA) recently held a one day workshop to discuss the new legislative frameworks for complementary medicines.

Complementary medicines fall within the definition of **medicines** in the Medicines and Related Substances Control Act and as such the need to register them has always been the subject of legislation. What is new however is that regulations and guidelines for the registration of these products are falling into place and implementation is becoming a reality.

Some learnings from the workshop:

- Guidelines provide different approaches to the evaluation of safety and efficacy for discipline specific complementary medicines, e.g. homeopathic medicines and health supplements.

- Quality standards for the registration of complementary medicines are the same as for allopathic medicines.

- Registration requirements will in principle not differ from current medicines registration practices and the first complementary medicines were called up in 2013. (Some 120 000 complementary medicines are on record at the MCC but large numbers of dossiers are still to be submitted.)

- Scheduling of complementary medicines will follow new frameworks and will be informed mainly by the potential "risk" attributed to a product. They will typically be S0.

- Foodstuffs and cosmetics are separately controlled via the Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972. The challenge for an organisation wishing to market a product which does not fall clearly into the definition of either a medicine or a foodstuff, or a cosmetic as the case may be, is to understand which legislation and regulatory pathway is applicable to that product. If the clarity is not to be found in the definitions then the intended or promoted use of the product will be used to classify that product. Therefore if a product which could be either a cosmetic or a medicine is promoted to have therapeutic properties, it needs to be registered as a medicine and similarly in the case of foodstuffs.

<u>References pertinent to complementary medicines</u>

- Current MCC documentation relating to the registration of complimentary medicines:
- Roadmap for complimentary medicines, December 2013.
- Complementary Medicines submitted for registration - right to sale, April 2016
- Complimentary medicines - discipline specific safety and efficacy, June 2016
- Complimentary medicines – helps supplements safety and efficacy, June 2016.
- Complementary Medicines - Use of the ZA-CTD format in the Preparation of a Registration Application
- Complementary Medicines Registration Application ZA-CTD – Quality, June 2016.
- Call up of vitamins and minerals for registration as category a medicines, October 2014
- Regulations in terms of the Medicines and Related Substances Act 101 of 1965. Includes the definition of complementary medicines

IMPORTANT NOTICE

INTERNSHIP AND COMMUNITY SERVICE PROGRAMME (ICSP)

The Pharmaceutical Society received a notice from the Department of Health requesting the PSSA to distribute the following to Pharmacy Interns.

The Online Application System can be accessed with effect from mid-day 6th June 2016.

To access the system the link is http://health.icsponline.dhmis.org . All users of the online application system will be expected to create an account and register on the said link.

Applicants may also make use of our National Department Call Centre by e-mailing icsp@dhis.org or call us on 012 395 8678/8916/9678.

What can you, as a pharmacist do about malaria prevention?

Lee Baker, FPS
Amayeza Info Centre

A lot more than you could a few months ago! After a number of meetings with the scheduling committee of the Medicines Control Council and applications being submitted, the South African Malaria Elimination Committee and the manufacturers have been successful in getting doxycycline down-scheduled to S2 when used for malaria prophylaxis. On the 15th March this year, it was gazetted as follows: - *S2 Doxycycline - when intended and labelled for the chemoprophylaxis of malaria in those aged 8 years and older, for periods not exceeding 4 months of continuous use; (S4) …….* .

South Africa is aiming to eliminate malaria by 2018. This means that there should be no locally acquired cases. Significant progress has been made in the malaria risk areas, thanks to a number of control measures including spraying of dwellings, active surveillance and good case management. In addition, the devastating drought that we are experiencing in South Africa has one positive aspect – the number of malaria cases this year is down by 100% in some areas!

A substantial number of malaria cases currently reported, however, are imported cases; that is, although the person presents with malaria infection in South Africa, the infection was contracted elsewhere, frequently in the countries bordering South Africa, such as Mozambique. In all the provinces, the number of cases spike in January, due to people returning to South Africa after the December holidays, from malaria areas, most notably from Mozambique.

This highlights the need to offer advice and chemoprophylaxis to all those travelling to these areas, and how important it is to make malaria prophylaxis readily accessible to all those travelling to these areas. Many years ago, prophylaxis was easy to obtain as the products were available from pharmacies without a prescription. Due to the development of resistance, these products are no longer recommended and up until now, all recommended products were only available on prescription, limiting the assistance that can be offered by the pharmacist to counselling and offering mosquito prevention products. This minimised accessibility of antimalarials for the majority of the population, resulting in most travellers to malaria risk areas taking no chemoprophylaxis, thus increasing their risk of contracting malaria and thwarting efforts to eliminate malaria in South Africa.

One of the major concerns regarding malaria prevention, is lack of awareness – as one saying goes – *After mosquitoes, the next biggest cause of malaria, is ignorance!* Pharmacists, being so easily accessible by the public, are in the ideal position to inform the travelling public of their potential risks and how to minimise them. In order to do this, you need to familiarise yourself with regards to the malaria risk areas, methods to reduce mosquito bites, symptoms of malaria, the medications recommended for chemoprophylaxis and their precautions and side effects.

The current map on malaria areas in South Africa can guide you on when to recommend prophylaxis and it is also important to know that most of the countries in Southern Africa are also malaria areas – some more so than others.

Preventing mosquito bites, is the most important aspect of preventing malaria – so accurate advice on what to do is essential. Products containing between 20% and 50% DEET (Diethyl toluamide) are the only recommended insect repellents in South Africa. Natural products, wrist bands and electronic buzzers have not been shown to be effective at all!

The travellers need to understand how and when they are likely to be infected with malaria – it takes >7 days, usually 10-14 days after being bitten by a malaria infected mosquito, before any symptoms will appear. Until then, there is no indication that they are incubating malaria and there is no test that can be done to inform them.

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The most common symptoms of malaria are flu-like symptoms, but young children may not present the same way, so one has to be very vigilant when it comes to signs and symptoms in children.

The three recommended medications for malaria prophyalxis are:

- → Mefloquine
- → Atovaquone-proguanil
- → Doxycycline

They are all equally effective in Africa if taken correctly, but each one has different pros and cons. This article will look specifically at doxycycline as you, as pharmacists, can now prescribe it for travellers, if appropriate.

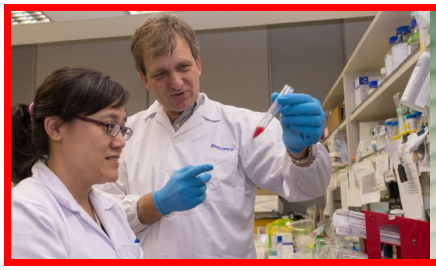
- → Doxycycline can be started the day before entering a malaria area, making it ideal for those 'last minute travellers'
- → It is the best option for travellers who are HIV+ve and on antiretrovirals, as there are no known drug reactions with ARVs.
- → It is also the best option for travellers on rifampicin.
- → There is no documented resistance.
- → It can be used for two or more years.
- → The adult dose is 100mg daily.
- → The paediatric dose for those over 8 years of age, is 2mg/kg daily.
- → **It is contraindicated in pregnant women and in children eight years of age or younger .**
- → **Use doxycycline with caution in travellers who have myasthenia gravis.**
- → **Take note of drug interactions with doxycycline.**

To ensure that the traveller uses doxycycline safely and effectively, patient counselling is most important – you can have the most effective product in the world, but if its not taken correctly, it wont work!

- → Doxycycline should be taken after a meal, with a full glass of water and the traveller should not lie down for an hour after a dose, in order to minimise the risk of oesophageal irritation.
- → The course of doxycycline should be started the day before entering a malaria area, taken daily while in the area and for four weeks after leaving the malaria area. The daily dose is due to the short half-life of doxycycline and the length of the course is because doxycycline is a suppressive prophylactic – that is, it only works on the parasites once they invade the red blood cells.
- → No doses should be missed – doxycycline is unforgiving, miss a dose, and prophylactic failure may occur.
- → Photosensitivity is one of the adverse effects, so advise travellers taking doxycycline to use an effective sunscreen and wear a hat when going into the sun.

It is beyond the scope of this article to give all the details regarding possible adverse effects, precautions and contraindications, so read the package inserts carefully before recommending doxycycline as an antimalarial. Remember to report any adverse effects that may be experienced.

Many people will have heard the myth regarding prophylaxis masking the symptoms, and use it as a reason not to take anything. This is incredibly dangerous and pharmacists can do much to overturn this myth. Symptoms arise from the multiplication of the parasite in the red blood cells – an appropriate antimalarial will kill these parasites and thereby prevent the symptoms AND THE INFECTION!! Too many people have learned this the hard way.



The realities and risks of counterfeit medicines

Sumari Davis
Medicine Information Pharmacist - Amayeza Info Centre

Introduction

Circulation of counterfeit medicines was first identified in the 1980s and has since grown into a lucrative business for criminals. Counterfeit medicines reflect a high profit margin and penalties are often less severe than for other types of crime. The main sources of counterfeit medicines are India, China and Russia, but no country is spared in terms of the distribution of counterfeit medicines. Counterfeit medicines are clearly lucrative for traders and are often seen as a solution for desperate patients such as cancer patients, who cannot afford the high-cost treatments they so desperately need.

What are counterfeit medicines?

Counterfeit medicines are products fraudulently and deliberately manufactured to be mistaken for legitimate medicines. These include medicines containing little or no active ingredients, extremely high quantities of active ingredients, incorrect active ingredients and even dangerous impurities. Some of the harmful ingredients that have been found in counterfeit medicines include:

Caffeine	Nickel
Starch	Heavy metals
Chalk	Leaded highway paint
Gypsum	Floor polish
Flour	Brick dust
Sugar	Arsenic
Boric acid	Rat poison

An example of the conditions under which counterfeit medicines are produced.

Criminals often repack expired medication with fake labeling to indicate that it can still be used. Counterfeiters have also emptied medicine containers and filled them with other less expensive medicines.

Why is this a problem – for the patient?

The first and most obvious problem would be lack of therapeutic effect, ranging from failure to treat minor symptoms, to lack of efficacy in critical illnesses such as cancer and HIV/AIDS, to ill health or death from overdose or other harmful substances. Sub-therapeutic doses of antibiotics and antimalarial can lead to drug resistance, therefore also affecting the rest of the population and efficacy of approved medicines. Various statistics indicate that between 100 000 and as many as 1 million people die annually from counterfeit medication. This is especially tragic when considering that patients pay to improve their health and instead suffer terrible consequences.

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Why is this a problem – for the profession?

In addition to the obvious loss of income to the legitimate pharmaceutical industry, counterfeit medicines also result in a loss of reputation, loss of valuable research and development opportunities and loss of intellectual property. The presence of counterfeit medicines reduces the confidence of the public in medication, the health systems and the regulatory bodies designed to provide oversight and control.

Which products are targeted?

The counterfeit problem was initially identified in the mid-1980s and mostly targeted the soft "lifestyle" products to combat obesity and hair loss. Today, no product is exempt from fraudulent replication and counterfeit products include both branded and generic medicines, injectables and medical devices. Criminals target high-value, high-turnover and high-demand medicines or products. Counterfeit medicines for erectile dysfunction are offered to patients on-line without prescription, sparing the patient the embarrassment of a face-to-face consultation.

Counterfeit cancer treatment is another lucrative target. The high cost of cancer treatment and the desperation of patients seeking affordable treatment often result in patients purchasing treatment with no therapeutic effects. These products are often marketed as cancer treatment that will not cause nausea; treatment that will cure cancer without surgery, chemotherapy or radiation therapy; and products that can treat any form of cancer.

How do we overcome the problem?

As pharmacists, we need to inform and educate the public of the dangers of counterfeit products. Almost 90% of Microsoft-sponsored internet pharmacy search results were reported to be fake or illegal pharmacies that target patients directly. Patients should also investigate any changes in the form, colour, taste or the way in which their products dissolve to exclude counterfeit products. Patients are often reluctant to report these concerns as they are scared of the consequences. It is important to emphasize to patients that they can play an important role in eliminating the sources of counterfeit products.

Pharmacists need to order pharmaceuticals from well-known reputable distributors. However, illegitimate products have, on occasion, still managed to infiltrate legitimate supply systems. Therefore, it is also important to report any lack of efficacy to companies for further investigation. Although companies are investigating security features such as hologram labels, 2 dimensional barcodes and radio frequency identification (RIDF) tags, these technologies have also fallen prey to counterfeiting and therefore act only to deter and do not altogether prevent counterfeiting. Finally, the price of a product may also be an indication of its legitimacy, and pharmacists should be suspicious if prices seem too low.

Conclusion:

Counterfeit medicines are a lucrative opportunity for criminals but have devastating effects on patient health and the economy. Pharmacists need to inform and educate their patients and monitor product changes and lack of efficacy with high suspicion. Reporting is essential in the combat against counterfeit medicines.

References:

1. National Crime Prevention Council. Intellectual property theft: Get real. Counterfeit drugs. Fake drugs are bad medicine. Available from: https://www.ncpc.org/topics/intellectual-property-theft/counterfeit-drugs-1
2. Pfizer. A serious threat to patient safety. Counterfeit Pharmaceuticals. 2007. Available from: http://www.pfizer.com/files/products/CounterfeitBrochure.pdf
3. World Courier. Securing the global pharmaceutical supply chain against the threat of counterfeit drugs. June 2014. Available from: https://www.worldcourier.com/insights-events/market-insights/detail/securing-global-pharmaceutical-supply-chain
4. PhRMA Importation. The dangers of imported medicines. Available from: http://www.phrma.org/safety/importation

A global movement to defeat urban diabetes – Major cities collaborate

Dave Sieff, FPS

As the largest city in South Africa, Johannesburg is feeling the burden of type-2 diabetes, but according to Dr Debashis Basu, Wits University School of Public Health, there is light at the end of the tunnel. The answer lies in multi-sectoral collaboration. The wish for prosperity and a better life continues to attract new arrivals to the city, and while city life offers social and economic possibilities that rural areas cannot, it has its downsides - one being the increased risk and occurrence of type-2 diabetes - a silent and costly epidemic. There is an urgent need for a co-ordinated approach to managing the growing problem.

Studies show that 3.9 billion people globally today live in cities, as do two thirds of diabetics. Projections indicate that by 2040, 10.4% - i.e. 642 million - of the global population will have diabetes, while 66% will live in cities by 2050, and it has been described as an emergency in slow motion. Urban diabetes is not inevitable if businesses, city leaders and planners, healthcare professionals, academics and community leaders work together to create cities which help us to live more healthy lives, i.e. "This confluence of ever-growing cities and the rise in diabetes must be taken seriously as a force determining the health outcomes of increasing numbers of people across the globe. The problem is undeniably complex and will require both local and global cooperation." - as quoted from an article by Professor David Napier, University College, London, and this forms the basis for the CITIES CHANGING DIABETES initiative - a response which is a first-of-its-kind partnership platform for cross-disciplinary and cross-sector collaboration.

A multidisciplinary meeting to launch this project for Johannesburg was held on 8th April at the Metropolitan Centre, Braamfontein, thus joining five large cities globally already implementing the programme. Attending dignitaries included representatives from the City Council, Wits University, the Novo Nordisk pharmaceutical company, the Joburg Junior City Council.

A Memorandum Of Understanding (MOU) was signed by the representatives of the CoJ, Novo Nordisk, Wits University, Junior Mayor and Deputy.

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