# The Golden Mortar

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

**Edition 5/August 2018**




## Delegate Impressions of PSSA AGM and Conference, 2018 Snippets

Conference is always a wonderful opportunity for networking.

Overwhelmed and inspired by the sense of community and family amongst delegates.

The number of young pharmacists attending and participating in proceedings of Conference was encouraging.

More common time for students and pharmacists to grow and learn from each other would be welcomed in the future.

A well-structured event, with current, stimulating and engaging presentations over the two days.

The time allowed for networking and visiting exhibitor stands was well planned.

The conference was marked by vibrancy and vigour as we had a number of pharmacy students in our midst.

Draft legislative amendments certainly set the scene and tone of many discussions.

The Conference reflected the multi-dimentionality of the profession of pharmacy in its wealth of contributions to healthcare.....

- Pharmacy integral to ensure a healthy South Africa.
- Pharmacy central to antibiotic stewardship to address the increasing challenge of AMRI.
- Pharmacists key in monitoring of patients to ensure the desired therapeutic outcomes.

Networking opportunities are key elements of successful AGMs and Conferences.

The presentations on Stewardship of Antibiotics were highlights that reinforced the notion that the pharmacist is one of the important gatekeepers of medicines.

Conference missed the opportunity to provide time for delegates to debate issues at hand within the session.

Impressed with the smooth running of conference.

Welcomed opportunity to interact with students and young pharmacists.

# WITS ACADEMY NEWS

## Wits Pharmacy Students Council for the Period 2018 /19

- Ofentse Mabokela (Chairperson)
- Nokulunga Mbatha (Vice-Chairperson)
- Anesca Singh (Secretary)
- Mosale Tlaka (Treasurer)
- Nandile Qwabe (Community Outreach Officer)
- Nothando Nyambi (Events Officer)
- Omphile Sehunoe (Media & Communications)
- Faith Masingi (Academic Officer)


**From Left to Right:** Ofentse Mabokela (Chairperson), Mosale Tlaka (Treasurer), Nandile Qwabe (Community Outreach Officer), Anesca Singh (Secretary), Omphile Sehunoe (Media and Communications), Nokulunga Mbatha (Vice-Chairperson), Nothando Nyambi (Events Officer) and Faith Masingi (Academic Officer).

The Golden Mortar wishes the Student Council a successful tenure of office.

*.../ continued on page 3*

Ms. S. De. Rapper (Left) & Dr P Kumar (Right)

Two members of the Department of Pharmacy received the prestigious Mail & Guardian Top 200 Young South Africans Award 2018. Ms. Stephanie de Rapper for Health and Dr. Pradeep Kumar for Science and Technology. It is a very rare occasion that two staff members from one Department are awarded this prize. Congratulations to Ms. Stephanie de Rapper (Pharmacy Practice Lecturer, WITS University), Dr. Pradeep Kumar (Pharmaceutics Senior Lecturer, WITS University).

SAAPI

South African Association of Pharmacists in Industry
(A sector of the Pharmaceutical Society of South Africa)

# SAAPI Conference 2018

## Right time – Right now

4-5 October 2018

Bytes Conference Centre, Midrand

**SAVE THE DATE**

The South African Association of Pharmacists in Industry (SAAPI) is hosting its Annual Conference on 4 - 5 October 2018 at the Bytes Conference Centre.

The theme of the conference is: "**Right time – Right now**"

Fees:

| | |
|---|---|
| Full Conference Fee – SAAPI Members | **R 4 000** |
| Full Conference Fee – Non Members | **R 4 700** |
| One Day Registration Fee – SAAPI Members | **R 2 860** |
| One Day Registration Fee – Non Members | **R 3 300** |

Please save the date. Registration details and the Programme to follow shortly.

# Chilblains

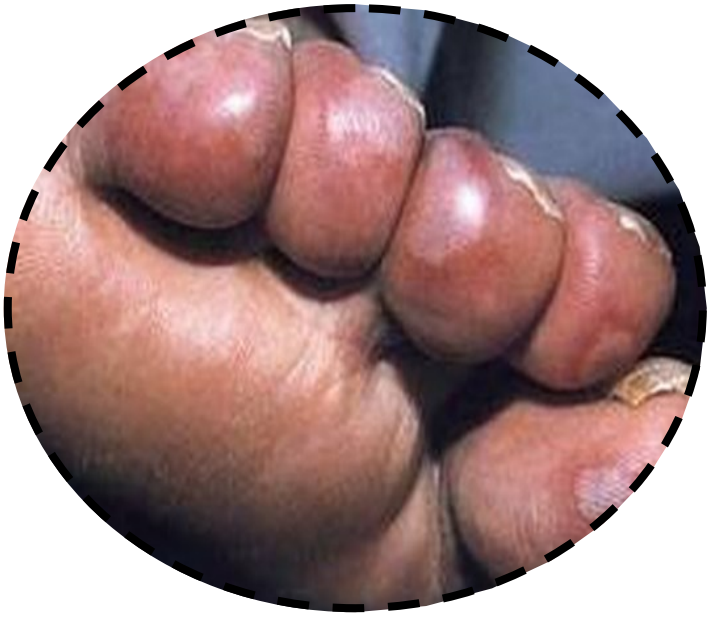
Sumari Davis, B. Pharm Amayeza Info Services

Chilblains, also known as pernio or perniosis, may have been derived from the old English words “chill” and “blegen” (sore). They occur more commonly in winter and resolve in spring as exposure to cold decreases and although they can be uncomfortable, they rarely cause any permanent damage.

## Causes and symptoms

Although the exact cause is unclear, chilblains are thought to occur due to an abnormal vascular response to cold exposure resulting in a painful inflammation of the small blood vessels in the skin. Eruptions begin within 12 – 24 hours of exposure to cold and present as red to dark blue macules, papules, plaques or nodules at the site of the exposure. The sites affected most are the fingers or toes, but the nose, ears, heels, soles of feet, calves, thighs, or buttocks can also be affected. Symptoms that occur with the skin lesion can include itching, burning and pain, and often worsen when entering a warm room. Complications that may develop include blisters, ulcers and secondary infections.

Acute episodes of chilblains usually resolve within one to three weeks, but the condition can become chronic with recurrent episodes of acute attacks that continue for longer than several weeks. Occasionally, chilblains may also continue beyond the cold season.



## Risk factors

Some patients may be at higher risk of complications and these risk factors include:

- Poor circulation
- Bunions or wearing tight-fitting shoes or clothes
- A family history of chilblains
- Regular exposure to cold, damp or draughty conditions
- Raynaud’s phenomenon
- Lupus
- A poor diet or low body weight

Nicotine can cause constriction of blood vessels, thus smokers are also at increased risk of developing chilblains. Young and middle-aged women are more likely to develop chilblains than men or children.

## Prevention

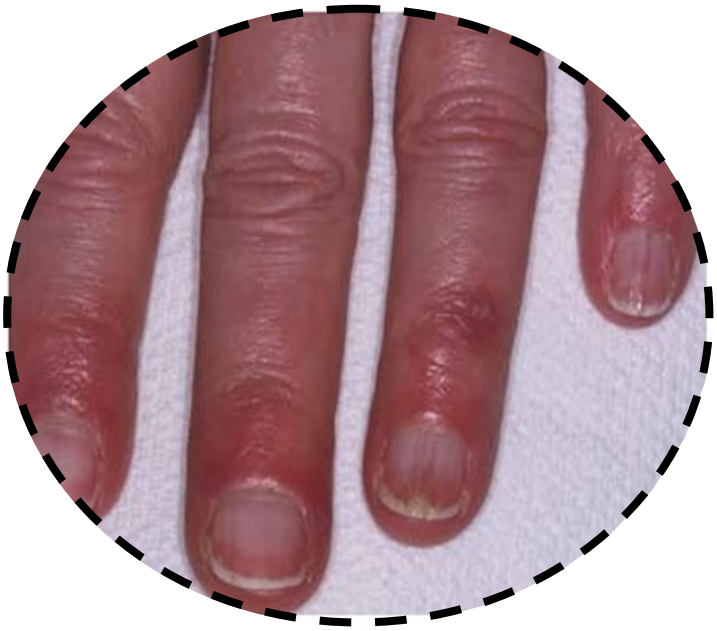
The first step in the management of chilblains is to avoid exposure to the cold. This can include wearing appropriately insulated footwear and gloves and avoidance of tight-fitting shoes and clothes that can restrict blood circulation. Hands and feet should be warmed before going out into the cold and if the hands and feet are already cold, they should not be warmed too quickly to avoid getting chilblains. Keeping active and stopping smoking can improve blood circulation and prevent chilblains. Regular use of moisturising creams will alleviate itching and prevent drying and cracking of the skin. Patients should be warned to avoid scratching so as to avoid secondary infection.

## Treatment

In patients who do not respond to preventative measures, especially those with recurrent or chronic symptoms, pharmacological treatment may be considered.

.../ *continued on page 5*

Although corticosteroid creams and ointments may have seemed helpful in some cases, there are no controlled trials to confirm their efficacy and the condition may have resolved without their use at a similar pace. In addition, one of the adverse events of topical cortisone therapy includes cutaneous atrophy. Other therapies that have been used include oral prednisone, prazosin, pentoxifyline, nicotinamide, topical minoxidil, nitro-glycerine paste and topical tacrolimus. However, further study is necessary to determine the efficacy of these therapies.



One small randomised crossover trial confirmed that the use of 20 mg nifedipine retard three times daily may be beneficial for treatment and prevention of chilblains. The side-effects of nifedipine include flushing, peripheral oedema, nausea, heartburn, and dizziness or lightheadedness, which may limit therapy in some patients. Nifedipine may be considered for patients with recurrent or chronic symptoms who do not respond to any other measures to manage chilblains.

### When to refer

Patients should be referred to a doctor if they suffer from severe or recurring chilblains or if symptoms do not disappear within a few weeks. Patients with signs of secondary infection such as swelling and pus forming at the site, swollen glands, high fever or generally feeling unwell may need an antibiotic and should also be referred to a doctor.

### In conclusion

Although chilblains can be painful and uncomfortable, they usually do not result in permanent damage. Patients should prevent chilblains by avoiding exposure to cold and wearing warm, comfortable fitting clothes, shoes and gloves. Severe or chronic symptoms may be treated with a topical corticosteroid or nifedipine after carefully considering the benefits and risks of such treatment options.

*Bibliography available on request*

Back to the Future

Save the Date

September

Twenty Second

# PSSA Super Seminar

**22 September 2018**

Glenhove Events Hub, 52 Glenhove Rd. Melrose Estate, Johannesburg

*See some Seminar topics on page7*

# Marketing Code Authority issues new code of practice for the marketing of health products

Val Beaumont- M.Pharm.,FPS. Marketing Code Authority - Executive Officer

Val Beaumont

The Marketing Code Authority has released an updated Code of Marketing Practice (v11) and Guidelines (v9). These became effective on the 22nd June 2018. The objective of the Code is to ensure the independence of healthcare practitioners in making treatment choices in the best interests of patients and consumers.

The Code is applicable to the promotion of medicines (including complementary medicines), medical devices and IVDs to all healthcare practitioners and consumers. Whilst the Medicines and Related Substances Act 101 of 1965 (the Medicines Act), regulates the advertising of these product, the legal provisions fall short of the ethical measures needed to ensure the independence of health practitioners and the provision of accurate and scientific information to consumers, patients and prescribers.
The Code provides standards and guidance on interactions with healthcare professionals, for the provision of information about products and for the thonier subjects such as attendance at conferences, sponsorships and other activities associated with product promotion.

The Marketing Code Authority (MCA) has called for regulations to be published which would render the Marketing Code enforceable across the entire industry. The MCA has also proposed prohibiting practices that directly incentivise the prescription or use of health products – a practice which is not in the interest of patients.

Code enforcement provisions, including fines and other sanctions, empower the MCA to adjudicate on complaints and implement sanctions in the event of a breach of the Code. Whilst the MCA has jurisdiction only over its members, it will accept a complaint from any person or company against a member. Should a complaint relate to a contravention of the legislation rather than a breach of the Code, the matter may be reported to the Regulator.

The importance of promoting the independence of healthcare practitioners in their prescribing or dispensing of healthcare products for patients, cannot be over-emphasised. The continuing potential for unethical marketing of healthcare products to HCPs, patients and consumers, will impact directly on the quality of care received by patients, who should be the primary focus of marketing efforts.

To download a copy of the Code: www.marketingcode.co.za

For further information contact info@marketingcode.co.za

*July 2018.*

Medicines and Related Substances Act 101 of 1965, General Regulation 42 and Regulations relating to Medical Devices and IVDs Regulation 21.

PSSA SG Super Seminar topics to be presented

- 'Apps'olutely – what's in store?
- Drugs in sport – latest on doping, taking supplements.
- Back to the future – current topics – future trends.
- Functional Medicine Pharmacy – fact or fiction?
- Being successful in a multigenerational/multicultural society.....and more

# PHARMACY COUNCIL ELECTIONS 2018

The Pharmacy Profession is about to experience a very exciting yet extremely challenging road ahead with the proposed implementation of the long awaited NHI, accompanied by proposed large scale changes to, amongst other regulations, the Pharmacy Act and the Medicines Control Act. In view of the possible far reaching implications these changes could have on our profession we, as pharmacists, need to elect well-informed and broad thinking pharmacists onto the Council that are able to successfully lead the profession into and through this next important phase. As such this election takes on an extremely important perspective and therefore should not be about what individuals or organisations can gain from serving on the Council, but rather what positive contributions they can make to the profession and more importantly the future role of pharmacy in the healthcare of South Africa.

The objectives of Pharmacy Council include assisting in maintaining the dignity of the profession through the promotion of the health of the population by upholding and safeguarding the rights of the general public to universally acceptable standards and practices in both the Public and Private sectors by providing pharmacy education and training and the requirements for registration and practice of pharmacy, including ownership of pharmacy. Therefore, serving on Council focuses your energies on all aspects of pharmacy and requires real dedication and commitment in order to progress the profession forward.

# World Pharmacists Day - Dr Mariet Eksteen explains

At the 2009 FIP Council meeting at the FIP Congress in Istanbul, Turkey, the Turkish Pharmacists Association suggested to annually celebrate a World Pharmacists Day, to be organised on 25 September (the day that FIP was founded in 1912).

This proposal was unanimously accepted by the Council and since 2010, World Pharmacists Day has been coordinated by FIP and celebrated through the involvement of its Member Organisations, either with structured, widespread campaigns or small scale projects. Each year welcomes a new theme to showcase the pharmacist in their positive affect on health.

This initiative directly supports one of FIP's key strategic objectives - to "advance pharmacy practice on a global level". By encouraging and supporting FIP member organisations to take part in World Pharmacists Day, FIP is not only raising awareness of the role of the pharmacist in healthcare but also furthering that exact role through increased community involvement on national and local levels.

This proposed project for the PSSA also directly supports one of the PSSA objects - to "promote and maintain the image of the pharmacy". By providing PSSA members the opportunity to participate in World Pharmacists Day, pharmacists will be able to celebrate their contribution and the irreplaceable role in healthcare delivery in South Africa.

### 1. Goal of this project

The goal of this proposed World Pharmacists Day project will be to firstly **showcase the role of pharmacists in healthcare delivery in South Africa to the public** and secondly **support and encourage pharmacists to fulfil their irreplaceable role in healthcare delivery in South Africa proudly**. The theme for World Pharmacists Day 2018 is "Pharmacist – your medicines expert" (theme determined by FIP).

### 2. Objectives of this project

This proposed project has the following objectives:

a. To showcase pharmacists' commitment to be a medicines expert;
b. To encourage pharmacists to think about what makes them a medicines expert;
c. To create awareness of World Pharmacists Day among all pharmacists in South Africa;
d. To brand pharmacists as medicines experts to the public of South Africa; and

*.../ continued on page 9*

e. To showcase the South African contribution to World Pharmacists Day internationally.

### 3. Research

The information that we need to achieve the above mentioned objectives, includes:

- photos with speech bubbles to indicate commitment (*this will address objective 1*),
- personal commitments on a postcard (*this will address objective 2*),
- promotional video for social media (*this will address objective 3 and 4*),
- public interviews on 25 September 2018 (*this will address objective 4*) and
- the submission of a report to FIP (*this will address objective 5*).


The following is an elaboration of the components of our (PSSA National) project this year:

a. Postcards were distributed and collected at SAAHIP Conference, SAACP Symposium, PSSA National Conference and at the PSSA SG Glenhove Events Hub. These will be posted back to delegates during August/September so that when the delegate receive the postcard in September, it will remind them of World Pharmacists Day and why they see themselves as an medicines expert.

b. Photo booth at the PSSA Conference with the speech bubble / text box. Photos were uploaded to the PSSA Facebook Page. Delegates will be able to download their photo from Facebook and are encouraged to repost it or make it their profile picture on 25 September 2018.

c. Promotion video for World Pharmacists Day highlighting the pharmacist as your medicines expert. This will be launched during Pharmacy Month and aims to create awareness between colleagues, health care professionals and international audiences on why the pharmacist is the medicines expert.

d. We would also like to secure some national interviews on 25 September 2018.

Best Wishes
Mariet Eksteen

## Always on the Go – the Curator of the National Pharmacy Museum

**Mr. Ray Pogir**

Mr. Ray Pogir, the curator of the National Pharmacy Museum, housed within the PSSA Southern Gauteng Branch and Glenhove Events Hub (Glenhove Conferencing Centre), was recently interviewed by the SABC. The interview entailed a presentation on Medicines from the Bible, where Mr. Pogir shared a journey through medicines in the Bible and their common uses today. From olive tree, to coriander, to myrrh through to grapes and garlic, and more. The interview will be flighted on a Sunday morning during August. Members will be alerted via sms once the date and time have been confirmed. We wish to congratulate Mr Pogir on this fine recognition of his knowledge and talent in this arena.

# Non-Communicable Diseases (NCDs) back to the future with a bang

The objective of this article is to:

- Introduce the global politics behind the positioning of NCDs
- Get a picture of size of the problem posed by NCDs globally and in South Africa
- Start a discussion about the role of the pharmacists in managing this new view of NCDs

Before the HIV/AIDS epidemic NCDs were simply called "chronic" diseases. In the Millennium Development Goals era (ending in 2015), the global focus was on finding solutions to the communicable disease epidemics and especially HIV/AIDS and TB. Thus dualistic classifying illnesses arose: either communicable or not. And, as a result the chronic illnesses of the past became "non" diseases called NCDs. What a way of describing conditions that affect millions of people every day in all countries!

A ray of sanity was possible when antiretroviral therapy (ART) became more widely accessible. It enables people living with HIV to thrive with life-long management and care raising life expectancy of HIV-positive. Increasingly it nears that of the general population. Today it is regarded as a chronic condition, albeit of a different genre.

That is why "back to the future" is an apt expression. "Chronic illness" is rediscovered now and because communicable diseases and survivable are being recycled today as if it is a new way of managing illness. Those with NCDs know the repackaging is just that. Back to the future.

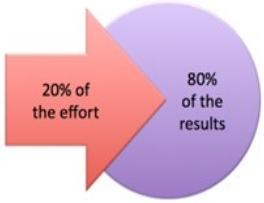
Of course, people living with HIV or TB are increasingly likely to have co-morbid NCDs like hypertension. The lesson is that any person can have NCDs. The features of NCDs are shown in Table 1.

**Table 1: Features of NCDs**

- Long-term illnesses or conditions
- Usually no cure
- The leading cause of premature death (before 70 years) 15 million people globally
  Examples: diabetes, strokes, arthritis and many, many more
- Usually you can't catch them or give them to someone else
- But some NCDs are the result of an infection
  - Rheumatic heart disease -- Strep throat infection
  - Liver cancer due -- viral hepatitis
  - Cervical cancer -- Human Papilloma Virus (HPV)
- Can occur at any age but more common from middle age onwards
- Prevention is possible by looking at risk factors
- Requires ongoing contact with pharmacists and other health care providers

A standout difference between NCDs and Communicable Diseases is the vast number of clinical conditions involved. One way to calculate this is to look at the number of ICD-10 chapters. Of the 22 chapters, only one is clearly infections "Certain infections and parasitic diseases."

Implication? It takes a lot of effort to get on top of the facts and stay on top whether you are a health professional or a person living with the illness. Support is needed.




Another implication is to simplify and focus on the smallest number of NCDs responsible for deaths and burden of disease. So, this huge list is reduced to the four main NCDs groups which account for most of the world's deaths between ages of 30-70 years (Table 2). Mental health conditions are also included - they cause huge morbidity and a great cost to the person and society. We only have to recall the Life Esidimeni mental health catastrophe (Table 3).

The situation is similar in South Africa for NCDs - mortality and morbidity (Figure 1).

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Table 2: 4 NCDs X 4 risk factors

| | | | | |
|---|---|---|---|---|
| 4 | NCDs types | Diabetes (4 types) | Cardio- and cerebro-vascular disease (Many) | Early detection – screening<br>Treatment: lifestyle and medication<br>Rehabilitation |
| | | Cancers ( >100) | Chronic respiratory disease (asthma, COPD) | |
| | Risk factors | Tobacco use | Harmful use of alcohol | Health promotion, disease prevention including taxes and healthy choices |
| | | Unhealthy diets | Physical inactivity | |

Table 3: The size of the NCDs problem

| Deaths due to NCDs | | |
|---|---|---|
| Global<br>70% = 40 million<br>  <br>38% between ages of 30-70 = premature mortality<br>NCDs cause most deaths<br>NCDs are a real threat to working age people over 30 | Where in the world? Which countries?<br>85% of premature mortality occurs in *developing* and /or *low- & middle income (LMIC)*<br>  <br>Africa<br>All Africa Countries (exception Seychelles) are LMICs<br>NB: NCDs kill more poor & working class people | South Africa[2]<br>  <br>48% = 260,000*<br>26% = risk of premature mortality 4 target NCDs<br>*Missing in death—in the 2016 death stats show 32,5% death cause unknown or unspecified |

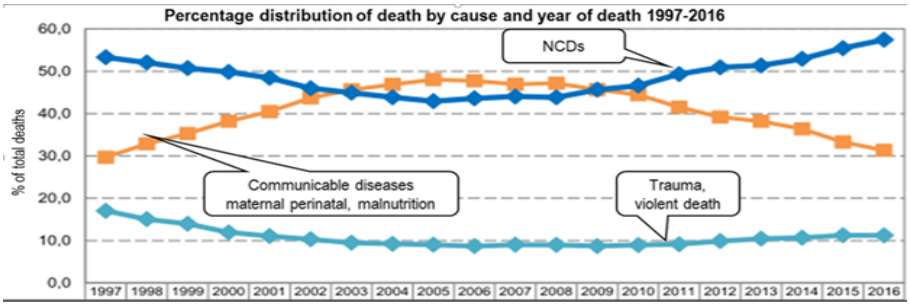


Figure 1: Percentage distribution of death by cause 1997-2016 in South Africa [3]

Table 4: Top 10 leading causes of death in South Africa 2016 [3]

| Ranking | Condition | % of total known deaths |
|---|---|---|
| 1 | TB (declining proportions down from 8,3% in 2014) | 6,5 |
| 2 | Diabetes | 5,5 |
| 3 | Other forms of heart disease | 5,1 |
| 4 | Cerebrovascular diseases | 5,1 |
| 5 | HIV disease 4,8% (static since 2014) | 4,8 |
| 6 | Hypertensive diseases | 4,4 |
| 7 | Influenza and pneumonia | 4,3 |
| 8 | Other viral diseases | 3,6 |
| 9 | Ischaemic heart disease | 2,8 |
| 10 | Lower respiratory disease | 2,8 |
| Key | NCDs % of top 10 all but tenth are cardio vascular | 25,7 |
| | Communicable diseases % of top 10 | 19,2 |

### People living with NCDs = prevalence

Let's focus on the living and not the dead. To get the best picture for our needs, let's look at the private sector information about medical scheme beneficiaries.

The 26 NCDs in the Chronic Disease List (CDL) must be treated according to The Medical Schemes Act. All are NCDs. By using this information we can get another view of the NCDs prevalence. The 2018 Council for Medical Schemes report compared the top 10 CDL conditions with HIV/AIDS prevalence.[4] It shows the considerable burden of NCDs and warranting equitable policy and resources as those for communicable diseases.

**Table 5: Top 11 - Average prevalence per 1000 beneficiaries for 26 CDL conditions & HIV/AIDS**

| Ranking | CDL & HIV/AIDS | Prevalence |
|---|---|---|
| 1 | Hypertension | 156.92 |
| 2 | Hyperlipidaemia | 75.87 |
| 3 | Diabetes Type 2 | 50.15 |
| 4 | Asthma | 49.03 |
| 5 | HIV/AIDS | 40.54 |
| 6 | Hypothyroidism | 25.84 |
| 7 | Coronary artery disease | 22.60 |
| 8 | Heart failure & cardiomyopathy[1] | 14.84 |
| 9 | Epilepsy | 13.13 |
| 10 | Diabetes Type 1 | 12.41 |
| 11 | Bipolar mood disorder [2] | 10.98 |

| Key | |
|---|---|
| | 4 major NCDs including mental health |
| | not on CDL |
| | NCDs beyond the 4 + mental health |

| Notes |
|---|
| Combined items as these overlap giving 25 CDL conditions.<br>2 Mental health issues are added. |

Prevalence is the proportion of cases in the population at a given time and it indicates how widespread a disease is. It is measured in the number with a condition per 1,000 beneficiaries

### Role of the pharmacist

There is nothing fundamentally new here rather to use these insights to gain another perspective and to look at possibilities. This is just to start the discussion or, to help you to think differently.

### People-centred care aka "batho pele" - people-first [5]

The people here are the clients and their families AND those that work in pharmacies. The skill is to make the people work together as equal partners in an ongoing relationship. The patient's goal is self-management of NCDs through learning, conversations and skills training.

In reality, it is a form of managed care with the focus on the self-management and face-to-face interactions between pharmacist and patients. It is a true interaction if you encourage and manage it. Sadly a lot of the managed care undertaken primarily by medical schemes revolve around the use of services and little or no direct interaction with beneficiaries. Again it is another back to the future scenario.

Pharmacists exceptionally position themselves in the private sector because you will encounter patients face to face more than doctors or other caregivers. It is a powerful interaction if you let it be, and, full of opportunities. It involves new ways of viewing care – shifting tasks and up-skilling. Making the customer self-sufficient is the goal. In the public sector the scarcity of pharmacists especially at the PHC level makes this very difficult.
Take a look at Table 6 and see how you might change what you do for better results for all.

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Table 6: Stages of NCDs care where pharmacist interact

| | |
|---|---|
| **1º prevention Health promotion** | Vaccinations and immunisations<br>Concentrate on healthy behaviour (nutrition, physical activity)<br>Stop risky behaviour and habits – mentioned above |
| **Disease prevention** | |
| **2º prevention Early diagnosis &** | Regular opportunities for screening and referral of common illnesses<br>Provide information for referral and information on conditions |
| **Management** | Continue with 1º prevention health promotion activities<br>Supply medicines, devices in the treatment regimen including skills and strategies |
| **The long haul** | Ensuring quick accurate uninterrupted and safe access to medications devices<br>Helping the patient to stick to the regimen month after month. That horrible word "compliance". Look at side effects and adjusting to symptoms<br>Medical waste disposal<br>Monitoring, Staying healthy, Talking. Suspecting drug interactions<br>Patients don't know everything and they need help too |
| **Acute episodes** | Readjusting to a whole new regimen and starting over |

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**About the author**

Dr Vicki Pinkney-Atkinson (BSc Nursing, MSc Medicine, PhD, RN, RM)
Person living with at least 7 NCDs, the first at 18 months of age.
Director: South African Disease Alliance www.sancda.org.za
Contact vicki@sancda.org.za +27-083-38-38-159


# REPORT ON COPD CPD 17/07/2018

**David Sieff, FPS**

Dr Grace Kaye-Eddie, a Pulmonologist and Intensive Care Specialist in private practice, and formerly Head of Pulmonology and a Consultant at the Helen Joseph Hospital, delivered a presentation titled "The latest information on the treatment of COPD of which the Pharmacist should be aware" on the 17th July, to members of the PSSA Southern Gauteng Branch. In her introduction, she stated that Chronic Obstructive Pulmonary Disease (COPD) is a major global health burden - the 4th leading cause of death worldwide, and predicted to become the 3rd by 2020.

The definition of COPD reveals some of the causes of the characteristic chronic airflow limitation, being a mixture of small airways disease (e.g. obstructive bronchiolitis) and parenchymal lung tissue destruction, commonly referred to as "emphysema."

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Risk factors include smoking of all types, indoor air pollution from heating and cooking with biomass fuels, vehicle emissions and forest fires, occupational dusts and chemicals, and severe childhood respiratory infections; pulmonary tuberculosis and HIV, as well as lower socioeconomic status and malnutrition are contributing factors.

Diagnostic symptoms are chronic cough, excess sputum production, dyspnoea, family history, and relies mainly on spirometry, which gives the best measurement of airflow limitation, after inhalation of a bronchodilator; the resultant ratio of the Forced Expiratory Volume in 1 second (FEV1) to the Forced Vital Capacity (FVC), indicates the severity of the condition. A differential diagnosis must be made between COPD and asthma, congestive heart failure, bronchiectasis, and tuberculosis.
The risk of exacerbations is measured by spirometry, and patients are at increased risk of cardiovascular disease, osteoporosis, respiratory infections, diabetes, and cancer.

Management goals are to reduce symptoms and frequency and severity of exacerbations, and to improve exercise tolerance and health status; SMOKING CESSATION is key, pharmacotherapy regular physical activity and regular Vaccination against flu and pneumonia has become very important. While patients with chronic respiratory failure must be on Oxygen Therapy for at least 15 hours per day.

Treatment of COPD to relax the airway smooth muscle is mainly with Short Acting Beta2 Agonists (SABAs) such as Salbutamol and Fenoterol, or with Long Acting LABAs, like Salmeterol and Formoterol, while the bronchoconstriction of airway smooth muscle is treated with Ipratropium bromide, Tiotropium, and Glycopyronium bromide; combinations of different pharmacological classes of bronchodilators may improve efficacy in preventing and reducing symptoms, as well as exacerbations.

The anti-inflammatory effects of inhaled corticosteroids, such as Beclamethasone, Budesonide, Fluticasone, and Mometasone have various adverse side effects, and their use is discouraged, except in selected patients, as with long-term use of oral steroids – "They are so last-season!" Oral Theophylline has a small effect in stable COPD, but is less well tolerated than inhaled bronchodilators.

Other options, such as chronic macrolide therapy for one year, mucolytics and antioxidants (e.g. carbocysteine) have been shown to reduce exacerbations and improve health status, but antitussives are not recommended.

Dr Kaye-Eddie posed the question: What is important for workers? Inhaler technique explanation and demonstration is very important for adherence.

To end her informative and interesting CPD presentation, Dr Kaye-Eddie answered questions from the floor. The session was sponsored by the PSSA Southern Gauteng Branch.

# Notification from SAACP re Permits

**Section 22A (15) permits for locum pharmacists**

The National Department of Health (NDOH) considers and issues permits in terms of section 22A (15) of the Medicines Act to pharmacists who have complied with the requirements relating to additional training. There are currently approximately 160 PCDT Pharmacists with permits recorded with the SA Pharmacy Council.

These permits are issued to pharmacists to diagnose and prescribe treatment in terms of Primary Care Drug Therapy (PCDT) and subject to conditions as may be determined by the Director General of NDOH, The NDOH is now also issuing permits to locum pharmacists, but with two additional and important conditions, namely;

- the permit may be used in a particular area only, such as Gauteng; and
- may only be used at a pharmacy premises where a permanent PCDT licence (already) exists.

**Nurses in pharmacies: Beware of the pitfalls**

Nurses are employed in community pharmacies for various reasons. Some of these nurses may also have section 22A (15) permits or dispensing licenses issued in terms of the Medicines Act. Some may even have been authorised to do physical examinations, diagnoses and prescribe medicine in accordance with an authority granted in terms of the section 56(6) of the Nursing Act.

It remains the responsibility of the Responsible Pharmacist of a community pharmacy that he/ she is fully aware of the circumstances, terms and conditions of not only the additional authority granted to professional nurses but also the scope of practice and registration status of a professional nurse employed in a pharmacy.

**Unit Dose Dispensing**

Minimum standards for Unit Dose Dispensing were presented to be finalised at the Practice Committee (6 June 2018) of the SAPC and if approved by the SAPC will be published for (wider) comment.

**Services and Support to Members**

Although SAACP is not directly involved in the drafting of Standard Operating Procedures (SOPs) acceptable to Council Inspectors, SAACP could advise on how and where pharmacy specific SOPs could be obtained at an affordable price.

**Note**: For more clarity on any of the above issues and/or to request information on any other community pharmacy related matter, please contact execdir@saacp.co.za

# Implications of Media Report on Community Pharmacy

**Gary Kohn, FPS**

Certain members of the Community Pharmacists Sector took strong exception to a recent press statement made by a medical scheme reporting on fraudulent claims submitted to them by certain pharmacies. The statement unfortunately was generalised and sensationalised in such a manner as to implicate *all* pharmacies.

From the outset it should be understood that we believe that pharmacists who act dishonestly and commit medical scheme fraud cannot be supported and this type of behaviour, as rare as it is, cannot be condoned under any circumstances.

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However, a list of service providers has been obtained, including pharmacists, whose services to medical scheme members have been suspended and claim payments stopped while investigations are still being conducted, thus effectively denying service to the patient.

We have information that some of these pharmacies have been investigated by the BHF fraud unit over a period of several months and have obtained supplier invoices to verify the medicine claims submitted for payment, checks have been conducted with medical scheme members and certain entrapment procedures conducted with the help of hidden cameras and bogus patients.

The relevant pharmacy's medical scheme claims payments have been suspended forthwith and the responsible pharmacist asked to sign an admission of guilt, admitting fraudulent activities linked to prescription claims.

The disciplinary procedure is bypassed, the *audi alteram partem* rule, in which both sides must be heard, is not used and for some reason, complaints are not submitted to the SA Pharmacy Council. This is strange as this course of action is more likely to result in the resolution of the problem after proper procedures have been followed by this authority.

Representatives of the Branch consulted a legal firm in this regard that resulted in the following information coming to the fore. The information provided to us and a suggested legal procedure that we could follow contained the following;

- Some pharmacists are at the receiving end of unscrupulous conduct by certain medical schemes and medical scheme administrators.
- Some of these pharmacists are affiliated to ICPA and/or SAACP.
- There is an urgent need to legally counter the above conduct by medical schemes and administrators.
- A number of individual pharmacies have instituted legal action against medical schemes/administrators and referred complaints to the Medical Schemes Council.
- Common problems that come to the fore are:
- Refusal to pay the pharmacy for claims submitted for services rendered.
- Schemes simply stop payment after they have received and processed claims.
- The schemes inform the pharmacist that they have stopped payments and/or suspended all payments on the strength of perceived anomalies or irregularities in such claims.
- These assertions are based on what they term Audit Reports or Investigations. In most cases the results of such investigation are not revealed to the pharmacist.
- The schemes request purchase information spanning several years making it very difficult and time consuming to collate and provide such information.
- Pharmacists are not given the opportunity to make submissions in support of why payments due to them should not be made.
- Pharmacists are sometimes intimidated and almost forced to sign an acknowledgement of debt.
- Cases of successful suspension and exposure are discussed at BHF fraud meetings which leads to other medical schemes discontinuing payment to the pharmacies concerned.
- This type of conduct by the medical schemes/administrators has caused serious damage to the business of some pharmacists leading to the closure of certain pharmacies or, at best, being placed in very difficult financial situations.

The law relating to the payment and submission and payment of claims is regulated by the Medical Schemes Act.

Section 26 (b) and section 59 (3) oblige the scheme to pay the Healthcare provider within a period of 30 days once an account has been provided in respect of services rendered.
The scheme/administrator simply disregards the statuary provision and unscrupulously provokes the provisions of section 59 (3) that entitles the scheme to deduct monies due to a healthcare provider and that such provider should not be paid on the basis that such claims were not good for payment or that false claims were submitted.

Although some of pharmacists have instituted legal action against medical schemes/administrators as reported, individual cases against such powerful schemes have not yielded any real benefits.

Our legal system however does not offer immediate redress to such problems as legal processes can be cumbersome and take a long time to provide outcomes.

It has become necessary to consider obtaining a specific legal order against schemes/administrators regarding unlawful conduct and it is suggested that a Class Action should be initiated after successfully obtaining a certification order

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on the grounds that pharmacists are faced with elements of constitutionality in that certain basic human rights are being infringed upon or likely to be infringed upon.

It should then be decided who the applicants are, - it could possibly be the SAACP or other organisations representing the rights and interests of these pharmacy owners.

The respondents, obviously, will be those medical schemes/administrators that behave unfairly.

The firm of lawyers that was consulted has a strong legal team to deal with these matters effectively but, as yet, no decision has been made by the Branch to implement the proposed Class Action.

# Does "Swine flu" live up to its name?

**Stephani Schmidt MSc (Pharm)** **Amayeza Information Services**

## Introduction

It's winter and the influenza (flu) season is here. In South Africa, the 2018 annual flu season started in the first week of May. There have been many reports in the media referring to people having "swine flu." The question is.... What is "swine flu" and is it worse than 'ordinary' flu?

This article will focus on the correct terminology i.e. when to use the term "swine flu". Information regarding the current circulating seasonal flu viruses has also been included.

## The 2009 pandemic flu strain

Flu viruses evolve constantly;[1] and in the spring of 2009, a new flu A (H1N1) virus evolved which was responsible for the first flu pandemic in more than 40 years.

This virus had a unique combination of flu virus genes and it was very different from the human influenza A (H1N1) viruses circulating at that time; it has not previously been identified in either animals or humans.
Initially, the virus was referred to as a swine-origin influenza virus, based on reports that the combination of genes in the new virus closely resembled two different swine-lineage (H1N1) influenza viruses. Consequently, during the 2009 pandemic the strain was referred to as "swine flu".

However, research later confirmed that the 2009 (H1N1) flu virus was a quadruple-reassortant virus. It contained virus genes from four different flu virus sources – two swine strains, one human strain, and one avian strain.

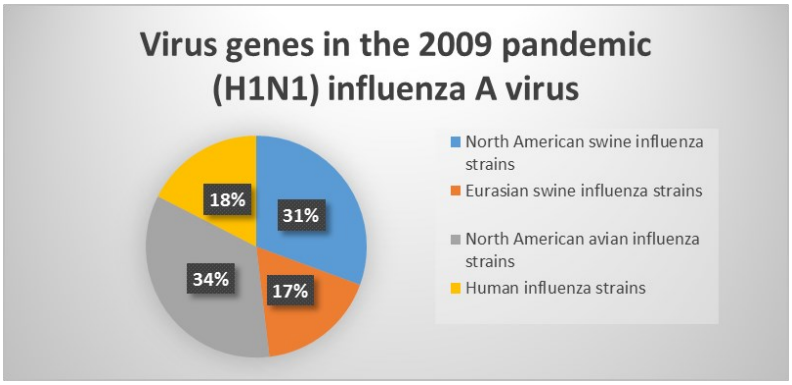


*Figure 1. Virus genes in the 2009 pandemic influenza A virus (A(H1N1)pdm09).*

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No exposure to pigs were identified during the investigation of the initial case, and it became apparent that this new virus was not circulating among U.S. pig herds - it was circulating among humans.
In August 2010, the World Health Organization (WHO) declared the end of the (H1N1) 2009 pandemic. Since then, the pandemic A(H1N1 ) 2009 virus has become a seasonal virus, circulating with other seasonal viruses.
The terminology was standardised to "A(H1N1)pdm09" in order to minimise the potential of confusion (there were many different names for the same virus) and to differentiate the virus from the old seasonal A(H1N1) viruses previously circulating in humans.

### Flu viruses: What is in the name?

Decoding the name of flu viruses - Table 1 contains information regarding the nomenclature of human flu viruses.

| Table 1. Naming of human flu viruses | |
|---|---|
| **e.g., A/Perth/16/2009 (H3N2)** | |
| **A** | The virus type |
| **Human** | The host of origin e.g. swine, equine etc. If there is no host included then it is of human-origin as in this case |
| **Perth** | Geographical site where the virus was first isolated |
| **16** | Strain number |
| **2009** | Year of isolation |
| **H3N2** | For influenza A virus the haemagglutinin and neuraminidase antigen description in parentheses e.g.(H1N1) |

### What is "swine flu" then?

Flu viruses that are routinely circulating in animals do not usually infect humans. However, sporadic human infections have occurred.

Flu viruses that infect their natural animal host are named for the animal host, for example, equine flu viruses, avian flu viruses, swine flu viruses, etc. Therefore, respiratory disease in pigs caused by flu viruses is known as swine influenza/swine flu.

"As such, the term "swine flu" refers to swine flu viruses infecting swine, and is never used when such viruses infect people."

The term "variant influenza virus" is used when a person is infected with a flu virus that normally circulates in swine (but not humans) – in this case, a "v" is then placed after the subtype of the virus e.g. (H3N2v).

### Circulating seasonal flu viruses

Flu is caused by circulating seasonal flu viruses. There are three types of flu viruses that cause illness in humans namely type A, B and C. The virus can be spread from one person to another through coughing, sneezing or by touching contaminated surfaces.

### Type A

Type A flu viruses can be divided into subtypes, based on the combination of two proteins on the surface of the virus (Fig 2). The two surface proteins are:

- Haemagglutinin (H1 through H18) and
- Neuraminidase (N1 through N11).

In South Africa, the majority (98%) of flu positive samples for the current season, to date, have been identified as influenza A(H1N1)pdm09.

Type A flu viruses currently circuating:

- Influenza A(H1N1)
- Influenza A(H3N2)

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3D Graphical representation of a flu virus

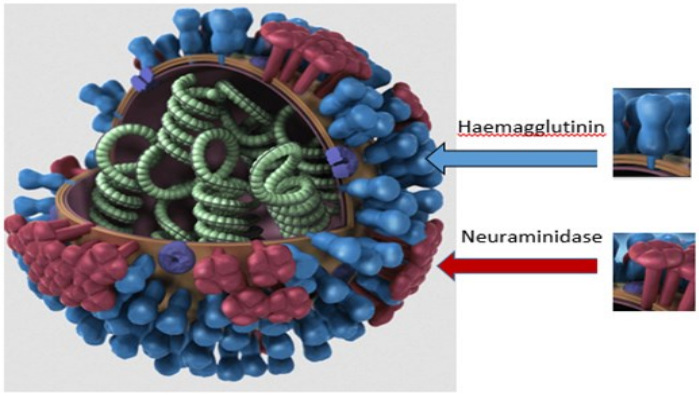


Figure 2. 3D Graphical representation of the biology and structure of a generic flu virus. Adapted from the Centers for Disease Control and Prevention (CDC).

**Type B**
Type B flu viruses can be subdivided into linages and strains and are named after the areas where they were first identified.

**Type C**
Type C flu viruses have been associated with sporadic cases and minor localised outbreaks. However, they cause milder infection and pose less of a disease burden. It is therefore not included in the seasonal flu vaccines.

**In a nutshell**

- "Swine flu" is a term used to describe pigs infected with swine flu viruses.
- The same flu virus (H1N1) that caused the 2009 flu pandemic; is now part of the seasonal circulating flu strains.
- Patients infected with the influenza A (H1N1)pdm09 strain do not require special treatment; they should be treated like any other seasonal flu case.
- Vaccination against flu is still the most effective measure to prevent illness.
- Recommended formulation for the 2018, trivalent vaccines in South Africa:
  - ⇒ A/Michigan/45/2015 (H1N1) pdm09-like virus
  - ⇒ A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus and
  - ⇒ B/Phuket/3073/2013-like virus (from the influenza B/Yamagata lineage).
- Other essential measures to prevent the spread of viruses include:
  - ⇒ Basic hand hygiene (wash hands frequently or use hand sanitiser)
  - ⇒ Cough etiquette (sneeze/cough into a tissue or your elbow)
  - ⇒ Stay at home and limit contact with others if you are sick.

*Bibliography available on request*

Type B flu viruses currently circulating:
B/Victoria lineage and
B/Yamagata lineage

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The Golden Mortar
P O Box 2467, Houghton, 2041
Tel: 011 442 3615, Fax: 011 442 3661
pssa@pssasg.co.za

**Your SG Branch Chairman:** Lynette Terblanche

*Your PSSA Southern Gauteng Branch Sector representatives are:*

Community Pharmacy: Tshifhiwa Rabali & Richard Barry
Hospital Pharmacy: Tabassum Chicktay & Rofhiwa Mulibana
Industrial: Hilton Stevens
Academy: Paul Danckwerts & Stephanie de Rapper

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

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