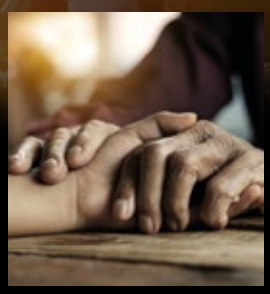
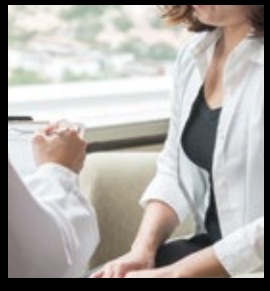
Scottish Pharmacy Review

ISSUE **123** - 2019

FEELING THE HEAT

A SUMMER OF CHALLENGES





PARKINSON'S DISEASE
Pharmacy's role in medication management

ECZEMA
How are families affected?

HIV IN SCOTLAND
The scale and drivers explored

WOMEN'S HEALTH
Cervical cancer, new research – and more

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Indications: *Adults and children over 12 years of age:* Treatment of and prophylaxis against acute or recurrent, uncomplicated lower urinary tract infections or pyelitis either spontaneous or following surgical procedures. Specifically indicated for the treatment of infections when due to susceptible strains of *Escherichia coli, Enterococci, Staphylococci, Citrobacter, Klebsiella and Enterobacter.*
Dosage and administration: For oral use. *Adults and children over 12 years of age: Acute or recurrent uncomplicated UTI and pyelitis:* 100mg twice daily for 7 days. *Surgical Prophylaxis:* 100mg twice daily on the day of the procedure and 3 days thereafter. *Elderly:* Unless significant renal impairment exists, dosage as for normal adult. *Children under 12 years:* Not recommended.
Contraindications: Hypersensitivity to nitrofurantoin, other nitrofurans or to any of the excipients. Patients suffering from renal dysfunction with an eGFR below 45 ml/minute. G6PD (glucose-6-phosphate dehydrogenase) deficiency. Acute porphyria. In infants under three months of age as well as pregnant patients at term (during labour and delivery).
Precautions and warnings: Not effective for the treatment of parenchymal infections of a unilaterally functioning kidney. Nitrofurantoin may be used with caution as short-course therapy only for the treatment of uncomplicated lower urinary tract infection in individual cases with an eGFR between 30-44 ml/min to treat resistant pathogens, when the benefits are expected to outweigh the risks. A surgical cause for infection should be excluded in recurrent or severe cases. Caution is advised in patients with pulmonary disease, hepatic dysfunction, neurological disorders, allergic diathesis, anaemia, diabetes mellitus, electrolyte imbalance, debilitating conditions, vitamin B (particularly folate) deficiency. Acute, subacute and chronic pulmonary reactions have been observed in patients treated with nitrofurantoin. Nitrofurantoin should be discontinued immediately in case of any pulmonary reactions and at any signs of haemolysis in those with suspected G6PD deficiency. Chronic pulmonary reactions (including pulmonary fibrosis and diffuse interstitial pneumonitis) can develop insidiously and may occur commonly in elderly patients. Peripheral neuropathy and susceptibility to peripheral neuropathy, which may become severe or irreversible has occurred and may be life threatening. Treatment should be stopped at the first signs of neural involvement. Close monitoring of patients receiving long-term therapy is warranted (especially in the elderly). May discolour urine and cause false positive urinary glucose test. Gastrointestinal reactions may be minimised by taking the drug with food or milk, or by adjustment of dosage. Hepatic reactions, including hepatitis, autoimmune hepatitis, cholestatic jaundice, chronic active hepatitis, and hepatic necrosis occur rarely. Fatalities have been reported. Patients should be monitored periodically for changes in biochemical tests that would indicate liver injury. The drug should be withdrawn immediately if hepatitis occurs and appropriate measures should be taken. Patient should be monitored closely for appearance of hepatic or pulmonary symptoms and other evidence of toxicity for long term treatment. Discontinue treatment if otherwise unexplained pulmonary, hepatotoxic, hematological or neurological syndromes occur.
Interactions: Food or agents delaying gastric emptying, magnesium trisilicate, probenecid, sulfinpyrazone, carbonic anhydrase inhibitors, urine alkalising agents, quinolone anti-infectives, oral typhoid vaccine, interference with some tests for glucose in urine.
Pregnancy and lactation: Should be used at the lowest dose as appropriate for a specific indication, only after careful assessment. Contraindicated in infants under three months of age and in pregnant women during labour and delivery because of the possible risk of haemolysis of the infants immature red cells. Nitrofurantoin is detected in trace amounts in breast milk**.** Breast feeding an infant known or suspected to have an erythrocyte enzyme deficiency (including G6PD deficiency), must be temporarily avoided.
Undesirable effects: *Serious:* Acute pulmonary reactions (commonly manifested by fever, chills, cough, chest pain, dyspnoea, pulmonary infiltration with consolidation or pleural effusion on chest x-ray, eosinophilia), chronic pulmonary reactions, pulmonary fibrosis; possible association with lupus-erythematous-like syndrome, collapse, cyanosis, cholestatic jaundice, chronic active hepatitis, autoimmune hepatitis, hepatic necrosis, peripheral neuropathy including optic neuritis, *exfoliative dermatitis,* erythema multiforme (including Stevens-Johnson syndrome), Lupus-like syndrome associated with pulmonary reaction, drug rash with eosinophilia and systemic symptoms (DRESS syndrome), cutaneous vasculitis, anaphylaxis, angioneurotic edema, agranulocytosis, leucopenia, granulocytopenia, haemolytic anaemia, thrombocytopenia, glucose-6-phosphate dehydrogenase deficiency, megaloblastic anaemia and eosinophilia.
(Please refer to the Summary of Product Characteristics for detailed information)
Overdose: *Symptoms:* Gastric irritation, nausea and vomiting. *Management:* Nitrofurantoin can be haemodialysed. Standard treatment is by induction of emesis or by gastric lavage in cases of recent ingestion. Monitoring of full blood count, liver function tests and pulmonary function, are recommended. A high fluid intake should be maintained to promote urinary excretion of the drug.
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Basic NHS Price: £9.50 per pack of 14 capsules.
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Marketing authorisation holder: Mercury Pharmaceuticals Ltd (a member of the Advanz Pharma group of companies), Capital House, 1st Floor, 85 King William Street, London EC4N 7BL, UK.
Date of preparation: April 2012
Date of revision: March 2019 [ADV/MAB/PI/0001]

Adverse events should be reported.
Reporting forms and information can be found at **www.mhra.gov.uk/yellowcard**.
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ADVANZ PHARMA

Date of preparation: May 2019 ADV/MAB/PM/0070

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WELCOME

Sarah Nelson Editor
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EDITOR'S LETTER

Welcome to the latest edition of Scottish Pharmacy Review!

I often find myself subscribing to a lot of everyday behaviours simply because they tie in with our society's 'customary code'.

Our over-emphasis on politeness means that I needlessly apologise to everyone – and everything – I come across. (I accidentally grovelled to my phone a couple of days ago when I dropped it.) I'm already mentally reaching for my kettle upon the very prospect of a guest arriving at my house; and grumbling about the weather and supermarket queues seems to be my go-to choice of small talk.

But there's one social convention which I've now realised lacks logic and is worth defying – that long-time inclination of retaining 'a stiff upper lip'. Where once it might have been believed that remaining silently composed in the face of struggle corelated to dignity, strength in fact comes through speaking up.

Thankfully, I'm seeing more and more that our health service shares this mindset – and those who already possess pangs of experience are taking ownership and using it to power their cause.

Take, for example, Eczema Outreach Support; a UK-wide charity that was established in Scotland by the mother of a young girl with eczema, and is helping to home in on practical and emotional support which those impacted by the condition require (page five).

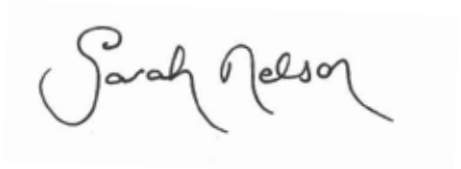
Additionally, Cancer Research UK is propelling real stories and real people to the frontlines; helping the profession to guide patients with appropriate sun safety precautions (page 32).

In this edition we also consider new approaches to help combat the dwindling uptake of cervical screening (page 30), and explore the slew of obstacles for pharmacists which the seasonal change carries (page 36).

Arm yourself with new tips and tools for helping patients take control of their Parkinson's disease (page eight), and discover just how serious allergy to cow's milk in children can be (page 21).

There's more! Remember to check in with our regular Scottish Medicines Consortium advice (page 33), while we're proud to present the second half of our Scottish Pharmacy Awards winners (beginning on page 24).

Happy reading!



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NAPP

DIABETES

A RECOMMENDED ADA/EASD GUIDELINES 2018 SGLT2i

Uncontrolled type 2 diabetes can't wait

- Invokana gets more patients to target than any other SGLT2i as an add-on to metformin.*[1-4]

  This is not a head-to-head study, figures taken from respective Summary of Product Characteristics.

- Invokana stabilises eGFR for the long term and reduces the risk of major adverse renal events.‡[5]

- Invokana has shown a **14%** relative risk reduction for major adverse cardiovascular events.

  Compared to standard of care, over 6.5 years
  HR, 0.86 (95% CI, 0.75-0.97)[6] ARR†: 4.6 per 1000 patient years

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canagliflozin tablets

After first line, take a firm line.

‡Improvements in renal outcomes with Invokana are additional benefits only and not licensed indications.

†Absolute Risk Reduction

INVOKANA® (canagliflozin) 100 mg & 300 mg film-coated tablets. PRESCRIBING INFORMATION. Please refer to Summary of Product Characteristics (SmPC) before prescribing.INDICATIONS: The treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise as monotherapy when metformin is considered inappropriate due to intolerance or contraindications, or in addition to other medicinal products for the treatment of diabetes. **DOSAGE & ADMINISTRATION:** Adults: recommended starting dose: 100 mg once daily. In patients tolerating this dose and with eGFR ≥ 60 mL/min/1.73 m2 needing tighter glycaemic control, dose can be increased to 300 mg once daily. For oral use, swallow whole. Caution increasing dose in patients ≥ 75 years old, with known cardiov ascular disease or for whom initial canagliflozin-induced diuresis is a risk. Correct volume depletion prior to initiation. When add-on, consider lower dose of insulin or insulin secretagogue to reduce risk of hypoglycaemia. **Children:** no data available. **Elderly:** consider renal function and risk of volume depletion. **Renal impairment:** not to be initiated with eGFR < 60 mL/min/1.73 m2. If eGFR falls below this value during treatment, adjust or maintain dose at 100 mg once daily. Discontinue if eGFR persistently < 45 mL/min/1.73 m2. Not for use in end stage renal disease or patients on dialysis. **Hepatic impairment:** mild or moderate; no dose adjustment. Severe; not studied, not recommended. **CONTRAINDICATIONS:** Hypersensitivity to active substance or any excipient. **SPECIAL WARNINGS & PRECAUTIONS:** Not for use in type 1 diabetes. **Renal impairment:** eGFR < 60 mL/min/1.73 m2: higher incidence of adverse reactions associated with volume depletion particularly with 300 mg dose; more events of elevated potassium; greater increases in serum creatinine and blood urea nitrogen (BUN); limit dose to 100 mg once daily and discontinue when eGFR < 45 mL/min/1.73 m2. Not studied in severe renal impairment. Monitor renal function prior to initiation and at least annually. **Volume depletion:** caution in patients for whom a canagliflozin-induced drop in blood pressure is a risk (eg, known cardiovascular disease, eGFR < 60 mL/min/1.73 m2, anti-hypertensive therapy with history of hypotension, on diuretics or elderly). Not recommended with loop diuretics or in volume depleted patients. Monitor volume status and serum electrolytes. **Elevated haematocrit:** careful monitoring if already elevated. **Genital mycotic infections:** risk in male and female patients, particularly in those with a history of GMI. **Lower limb amputation:** consider risk factors before initiating. Monitor patients with a higher risk of amputation events. counsel on routine preventative foot care and adequate hydration. Consider discontinuing ***Invokana*** when events preceding amputation occur (e.g., lower-extremity skin ulcer, infection, osteomyelitis or gangrene). Urine laboratory assessment: glucose in urine due to mechanism of action. Lactose intolerance: do not use in patients with galactose intolerance, total lactase deficiency or glucose-galactose malabsorption. Diabetic ketoacidosis (DKA): rare DKA cases reported, including life-threatening and atypical presentation cases. Where DKA is suspected or diagnosed, discontinue ***Invokana*** treatment immediately. Interrupt treatment in patients who are undergoing major surgical procedures or have acute serious medical illnesses. Consider risk factors for development of DKA before initiating Invokana treatment. **Necrotising fasciitis of the perineum (Fournier's gangrene):** post-marketing cases reported with SGLT2 inhibitors. Rare but serious, patients should seek medical attention if experiencing symptoms including pain, tenderness, erythema, genital/perineal swelling, fever, malaise. If Fournier's gangrene suspected, ***Invokana*** should be discontinued, and prompt treatment instituted. **INTERACTIONS: Diuretics:** may increase risk of dehydration and hypotension. **Insulin and insulin secretagogues:** risk of hypoglycaemia; consider lower dose of insulin or insulin secretagogue. **Effects of other medicines on *Invokana:*** enzyme inducers (e.g., St. John's wort, rifampicin, barbiturates, phenytoin, carbamazepine, ritonavir, efavirenz) may decrease exposure of canagliflozin; monitor glycaemic control. Consider dose increase to 300 mg if administered with UGT enzyme inducer. Cholestyramine may reduce canagliflozin exposure; take canagliflozin at least 1 hour before or 4-6 hours after a bile acid sequestrant. **Effects of Invokana on other medicines:** monitor patients on digoxin, other cardiac glycosides, dabigatran. Inhibition of Breast Cancer Resistance Protein cannot be excluded; possible increased exposure of drugs transported by BCRP (eg, rosuvastatin and some anti-cancer agents). **PREGNANCY:** No human data. Not recommended. **LACTATION:** Unknown if excreted in human milk. Should not be used during breast-feeding. **SIDE EFFECTS: Very common (≥1/10):** hypoglycaemia in combination with insulin or sulphonylurea, vulvovaginal candidiasis. **Common (≥1/100 to<1/10):** constipation, thirst, nausea, polyuria or pollakiuria, urinary tract infection (including pyelonephritis and urosepsis), balanitis or balanoposthitis, dyslipidemia, haematocrit increased. **Uncommon (<1/100) but potentially serious:** anaphylactic reaction, diabetic ketoacidosis, syncope, hypotension, orthostatic hypotension, urticaria, angioedema, necrotising fasciitis of the perineum (Fournier's gangrene) (frequency not known), bone fracture, renal failure (mainly in the context of volume depletion), lower limb amputations (mainly of the toe and midfoot, incidence rate of 0.63 per 100 subject-years, vs 0.34 for placebo). **Refer to SmPC for details and other side effects. LEGAL CATEGORY:** POM. **PACK SIZES, MARKETING AUTHORISATION NUMBER(S) & BASIC NHS COSTS *Invokana* 100 mg film coated tablets:** 30 tablets; EU/1/13/884/002; £39.20. ***Invokana* 300 mg film coated tablets:** 30 tablets; EU/1/13/884/006; £39.20. **MARKETING AUTHORISATION HOLDER:** Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. ® INVOKANA is a registered trade mark of Janssen-Cilag International NV and is used under licence.

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FURTHER INFORMATION IS AVAILABLE FROM: Napp Pharmaceuticals Ltd. Cambridge Science Park Milton Road, Cambridge, CB4 0AB, UK. For medical information enquiries, please contact medicalinformationuk@napp.co.uk © 2017 Napp Pharmaceuticals Limited. **UK/INV-18164(1) Date of Preparation** January 2019. **References: 1.** Invokana® Summary of Product Characteristics. Napp Pharmaceuticals. 2018 **2.** Dapagliflozin Summary of Product Characteristics. Astrazeneca. 2018. **3.** Empagliflozin Summary of Product Characteristics. Boehringer Ingelheim. 2018. **4.** Ertugliflozin Summary of Product Characteristics. Merck Sharp & Dohme. 2018 **5.** Perkovic V., et al. The Lancet. 2018;6(9):691-704. **6.** Neal B., et al. N Engl J Med. 2017;377(7):644-57.

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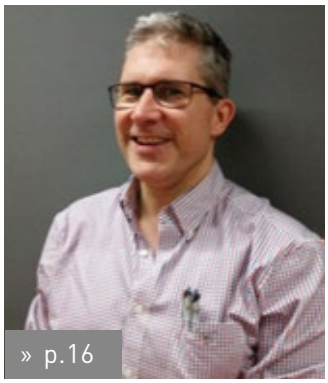
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NEWS

CASH INJECTION ANNOUNCED FOR KEY HEALTH PROJECTS

Edinburgh Napier University has been awarded £772,000 for three initiatives which could transform the lives of patients suffering from a range of illnesses.

Dr David Whiteley

Researchers from Edinburgh Napier University's School of Health and Social Care will use grants from the Chief Scientist Office (CSO), part of the Scottish government health directorates, to pursue breakthroughs in the treatment of psychosis, abnormal heart rhythm, and hepatitis C.

The latest funding round saw the CSO – which works with the NHS to support research and maximise its impact – award the university £287,000 towards developing a psychological intervention which helps people with psychosis make their own decisions about treatment.

In the last 10 years in Scotland, people diagnosed with schizophrenia or related disorders have been judged to lack 'capacity' or be unable to understand or weigh up information relevant to their treatment more than 22,000 times.

With clinicians obliged to respect patients' autonomy where possible, health bodies have called for trials which will drive progress towards them being more capable of having a say.

The school's Dr Paul Hutton remarked, 'We are delighted the CSO is supporting this project, which will mark the first attempt to use innovative 'umbrella' trial methodology in mental health research.

'This approach, which essentially involves running multiple trials at the same time, thus saving time and money, has had remarkable success in accelerating interventions for cancer and other health conditions, but it has never before been used in mental health research.

'If it works, we hope other researchers will be able to use it to speed up the development of effective interventions for other mental health conditions.'

A second grant of £283,000 will support efforts to develop a digital aid which helps sufferers of atrial fibrillation – an abnormal heart rhythm affecting more than two million in the UK – to take their medication.

A further grant of £202,000 will support research which aims to develop GP-led treatment for the hepatitis C virus; an infection which attacks the liver and mostly affects people who have injected drugs.

Dr David Whiteley said, 'Hepatitis C disproportionately affects those marginalised in society, and finding ways to improve access to treatment is vital if Scotland is to meet the World Health Organisation target of eliminating hepatitis C as a public health concern by 2030.'

STARTING FROM SCRATCH

Although atopic eczema (or atopic dermatitis) affects about 1.6 million adults in the UK (1), and one-in-five children, its impact is vastly underestimated by the general public. Get acquainted with the reality of the condition for sufferers and their families – and the scope of treatment, potential triggers, and summer-related tips – via Eczema Outreach Support's expert insight.

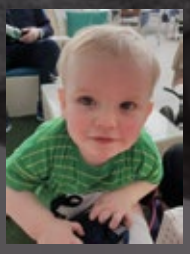
'Eczema is far more than dry skin or a bit of an itch; it demands an all-consuming lifestyle and coping techniques which need to be embraced by not only the sufferer, but their family as well.'
– Mother of a child with eczema

A 2017 survey (2) of adults with eczema found 88 per cent of patients saying that the management of their disease impacts on their daily lives; 58 per cent feeling that it affects their personal relationships; 73 per cent stating that their social life is impacted; and over 70 per cent were feeling depressed as a result of the disease.

The reality for families living with moderate-to-severe eczema is often shaped by painful flares and constant itch, time-consuming treatments, sleepless nights, infections, days off school, and work for parents. It also affects confidence and may lead to social isolation. While clinicians strive to provide the right treatments for patients, the long waiting times and lack of ongoing support can have a profound impact on the patient's health and wellbeing.

Eczema Outreach Support (EOS), a UK-wide charity, aims to fill this gap by providing free practical and emotional support to families affected by eczema; many of whom join at crisis point. The charity was set up in 2011 in Scotland by the mother of a young girl with eczema and has since been supporting over 1,300 families across the UK.

MEET KIRSTY AND RUARIDH – MEMBERS OF EOS



'There was a point that I never believed his eczema would get better.'

'Nothing can prepare you for the sad and helpless way you feel when you experience your child scratching himself until he bleeds. I would find myself saying, 'Stop scratching, please, stop scratching.' on repeat until it made us both cry.

'Ruaridh was around four months old when his eczema started. We were prescribed 'light' creams and 'weak' steroids while we waited the long wait to see the dermatologist.

'A friend recommended getting in touch with EOS. The support and information was invaluable to help get us through the most difficult times. We attended an EOS event, and what an eye-opener it was.

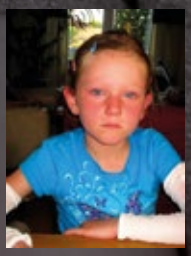
'Long before we were able to be seen at dermatology (who are absolutely brilliant), the team at EOS were giving us lots of practical tips and calling us to make sure that we were managing okay with the whole workload that comes with a child with eczema.

'For Ruaridh it included stripping him down and creaming him four-to-five times a day; blasting his skin with a selection of four steroid creams on top of the base layer as required. That is, while trying to look after him as a baby, looking after his insanely jealous (but still wonderful) sister whose life had been turned upside down by the arrival of this little guy, cooking, cleaning, nursery runs, work, and generally keeping sane.

'While all this madness was going on, EOS would call to see how we are doing. It made the eczema world feel a lot less lonely.

'After a year of perseverance (and just pure luck, we think), Ruaridh's skin is wonderful. He is still creamed twice a day, but this is the preventative measure we may always have to keep. Here's to the next year and more progress, and a huge thank you to EOS – especially for the emotional support received when we most needed it.'

MAGALI AND GAELLE'S STORY – FOUNDERS OF EOS



'Breaking isolation makes a massive difference.'

'Two months into Gaelle's life, her skin started looking red and angry, and she was clearly very itchy. She was diagnosed with eczema. That was the start of six years of struggle.

'One of the hardest things is to see your child suffer. You just want to take the pain away, but you can't.

'It never felt like the treatments actually worked as the flares kept happening, but that's actually the nature of eczema. You do end up questioning your ability as a parent.

'I remember taking Gaelle to parties in her princess outfits on top of full body bandages. People would ask, 'Have you hurt yourself? What happened to you?' We got used to educating people about eczema.

'Over time, I realised that eczema is not taken seriously. That's a problem. People think that 'it's not life-threatening like allergies or asthma', but they don't understand the impact.

'When Gaelle was five, she said to me that she was the only scratchy girl in the world. That broke my heart, but to be honest I was feeling the same and wondered how we could meet families like us. There was no way to connect face-to-face that I could find. That's when we had the idea of setting up this charity, EOS.

'Breaking isolation makes a massive difference. You see families coming to the charity's events; they don't know each other but then you see them again and they've formed a friendship; they support each other. This alone can change your outlook on life and help the whole family when dealing with eczema.'

ECZEMA

Over the past seven years, EOS has grown arms and legs to meet a wide range of needs and we now have a staff team dedicated to supporting and empowering our members so that they can cope better with the impact of eczema on their life.

'With the right treatments and support, families with eczema can regain control over their life and thrive.' – Magali Redding, CEO of EOS

ABOUT ECZEMA

By Professor Sara Brown, Consultant Dermatologist, Ninewells Hospital, Dundee

WHAT IS ECZEMA?

Eczema, also called atopic dermatitis, is an itchy inflammatory skin condition, which follows a relapsing and remitting course.

Exacerbations or 'flare-ups' of eczema can be unpredictable and they are particularly troublesome for patients and carers.

Eczema often begins in childhood – more than 50 per cent of cases arise before the age of two years – and an estimated 10 per cent of cases may persist into adult life. Skin affected by eczema shows redness and scaling with an ill-defined edge.

Excoriations (scratch marks) are often visible. Weeping lesions may become infected with Staph. aureus and atopic skin has a lower immunity to bacterial and viral infection.

When examined down the microscope, eczema is characterised by spongiosis – a sponge-like appearance – reflecting intercellular oedema (see Figure 1). The fluid collecting between cells can leak onto the skin surface, which is why acute eczema appears weepy and sometimes forms tiny blisters.

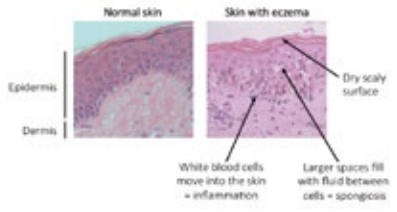


Figure 1: Histological features of eczema

WHAT CAUSES ECZEMA?

Eczema is a complex disorder arising from a combination of genetic and environmental effects (Figure 2). Genetic predisposition to eczema is inherited, often (but not always) along with a predisposition to asthma, hay fever, and food allergy. The environmental changes which may have led to a rapid rise in atopic diseases remain unknown. However, there is evidence that washing with soap or harsh detergents can damage the skin's protective barrier, leading to inflammation. We also know that the balance of bacteria on the skin surface is important to skin health. And environmental air pollution may be linked to skin inflammation.

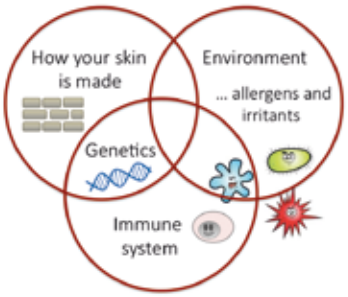


Figure 2: Genetic and environmental factors which together can cause eczema

PRINCIPLES OF TREATMENT FOR ECZEMA

Just as eczema is caused by a combination of factors, its treatment requires a stepwise and combined approach:

- Avoid allergens and irritants (including detergents, soap, bubble bath, shampoo)
- Replace waterproofing on the skin, using emollients
- Treat inflammation with topical corticosteroids, using a potency that is appropriate for the level of inflammation and the body site – but not applied at the same time as emollients
- Manage infection (bacterial and / or viral) when necessary

There is understandable concern about using topical corticosteroids, especially in children. However, the balance of risks and benefits must be considered in light of the impairment in quality of life that may accompany eczema, and the long-term damage to skin that can occur when eczema is not adequately treated. Research has shown that prompt treatment with a topical steroid of an appropriate strength to quickly control a flare-up of eczema, then stepping down to a less potent steroid, means that less steroid is used in the long-term when compared with the opposite strategy of gradually increasing from a mild-to-moderate steroid which may not adequately control the disease.

Other treatments are available to reduce skin inflammation, including topical calcineurin inhibitors, phototherapy and systemic immunosuppressants. Biologic agents have recently been licensed, targeting specific immune pathways in atopic inflammation. These are currently only available in secondary care.

Are you a healthcare professional in the UK? Signpost families with eczema to EOS now, or get in touch to speak to the team via the following contact details:
Website: www.eos.org.uk
Telephone: 01506 840 395
Email: info@eos.org.uk
Joining is free and confidential.

EOS
Eczema Outreach Support

ECZEMA: TIPS FOR THE SUMMER

By Christine Roxburgh, Head of Services at EOS

- Patch test sun creams to avoid skin reactions
- Moisturise before and after swimming
- Avoid allergens, such as pollen or animal hair
- Keep cool during the day with a thermal water spray, wet towel, and light bedding
- Stick with your skin maintenance regime by moisturising everyday to keep flares at bay
- Stress can make your skin worse so relax and have fun

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PHARMACIST SUPPORT ANNOUNCES WELLBEING PARTNERSHIP

Pharmacist Support – the profession's independent charity – has announced an expansion of its partnership work with Boots UK.

Following a successful coaching pilot in 2017, both Boots UK and Pharmacist Support have shared an aspiration to develop this work further to reach more of those in the profession who are encountering difficult times.

A survey in 2016 of Boots Pharmacists Association members highlighted a need for a service that helped them to help themselves, build resilience, and enable them to find solutions to problems and to deal with emotional distress.

Boots funded the charity to carry out a coaching pilot. This offered individuals access to six one-to-one hour-long sessions with a trained coach, focussed on work-related and personal issues, including dealing and negotiating with colleagues, and enhancing their assertiveness and confidence, as well as managing stress and anxiety. The pilot was extremely well-received, in which clients reported that the coaching had 'improved all areas of my life'.

Speaking of the new development, Pharmacist Support Chief Executive, Danielle Hunt, said, 'We are absolutely delighted that Boots is supporting the charity to explore ways to expand our coaching work, allowing us to support more pharmacists across Great Britain. As the profession's independent charity, we encounter daily the struggles those in the profession are facing which means we are well-placed to develop solutions that empower an individual to make choices that lead to positive change and personal growth.

'In a time that continues to be challenging for the profession, it is crucial the charity works in partnership with organisations, such as Boots, to tackle head-on the issues facing pharmacists, trainees' and MPharm students today. It is down to donations such as this one that allow us to continue to make a difference.'

Danielle Hunt

PARKINSON'S DISEASE: GET IT ON TIME

Parkinson's is the second most common neuroprogressive condition after Alzheimer's. About 12,400 people in Scotland have Parkinson's – around one-in-every-375 adults – and the main symptoms are tremor, slowness of movement, and rigidity. Medication routines can be complex, and as Parkinson's is a progressive condition, these routines need to be reviewed and adjusted to maintain their benefits. Katie Goates, Professional Engagement Programme Manager at Parkinson's UK, outlines crucial medicine management tips for Parkinson's, and how you can help.

Parkinson's UK launched its Get it on Time campaign in 2006 to make sure that everyone with Parkinson's in a care home or hospital gets their medication on time, every time.

Getting the right medication at the right time and dose can be as crucial for someone with Parkinson's as insulin is for those with diabetes. But the latest audit from Parkinson's UK, carried out in 2017, shows that fewer than half of people admitted to hospital always got their Parkinson's medication on time.

If people don't receive their medication at the right time and dose, the results can be catastrophic. People may go from being mobile and articulate to being unable to move, speak, or swallow. They may also experience uncontrolled movements and psychotic symptoms.

There are also long-term implications – some people have permanently lost their ability to walk after a hospital stay. For those who do recover, it can take months for them to feel in control of their symptoms again.

Whether in the community or in hospital, pharmacists can play a key role in Parkinson's medication management.

Parkinson's UK established the UK Parkinson's Excellence Network in 2015. It brings together health and care professionals to enable them to share best practice. In Scotland, more than 300 health and care professionals are members, and there are three regional groups covering the West, East, and North.

The Excellence Network online learning hub offers free training programmes for professionals to improve the quality of care for people affected by Parkinson's.

Resources include key information booklets for community and hospital pharmacists.

These can be downloaded or ordered on our website by visiting www.parkinsons.org.uk/professionals/resources.

Daiga Heisters, Head of the UK Parkinson's Excellence Network

To support peer learning and networking for pharmacists with an interest in Parkinson's, the Excellence Network has also launched the Parkinson's Specialist Pharmacy Network.

This network will hold an initial meeting in October 2019 in Birmingham. Presentations will come from neurology specialist pharmacists, palliative care specialists, and community pharmacists with an interest in Parkinson's.

To find out more and express interest in this first meeting, visit the Parkinson's Specialist Pharmacy Network page on the Parkinson's UK website – www.parkinsons.org.uk/professionals/parkinsons-disease-specialist-pharmacy-network – or email excellence@parkinsons.org.uk.

TIPS FOR EVERYDAY PRACTICE

There are a number of things which community pharmacists can do to help your patients take control of their Parkinson's.

These tips come from Parkinson's UK's key information for community pharmacists.

SUPPORT MAINTENANCE OF PRESCRIBED MEDICATION ROUTINES

- Ensure there is no delay in dispensing the range of prescribed Parkinson's medications and that you are aware of how and where to get them quickly
- Prescribed medication is dispensed in containers that the person can open. Parkinson's can affect fine finger dexterity
- Branded preparations are issued where prescribed and are not substituted with generic versions unless absolutely necessary. Where substitution does occur, explain to the patient and carer why a different preparation has been dispensed to help reduce any anxiety or confusion

HELP PEOPLE TO UNDERSTAND THEIR MEDICATION ROUTINES, WHAT MEDICATION THEY ARE TAKING, AND POSSIBLE SIDE-EFFECTS

- Perform a Medicines Use Review with your Parkinson's patients or an equivalent service (where applicable and appropriate)

THINK THROUGH THE MECHANISMS OF ACTION WHEN A PERSON WITH PARKINSON'S IS PRESCRIBED, OR IS CONSIDERING PURCHASING, A NEW OVER-THE-COUNTER MEDICINE

- Any drug that blocks dopamine receptors could make the symptoms of Parkinson's worse or even mimic Parkinson's symptoms without the condition being present

HELP CARE HOME STAFF TO GIVE MEDICATION ON TIME

- Print out timings on the pharmacy label, adding them to any blister packs issued and printing out timings on the medication administration record
- Make sure that the care home staff and domiciliary staff you work with understand the importance of keeping to the prescribed medication routine

SUPPORT PEOPLE WITH HOSPITAL ADMISSIONS

- Make sure your patients have an up-to-date list of their medication on them at all times with clear information about the preparation, dosage, and timing
- Provide information to support people with Parkinson's to administer their medication themselves in hospital if they are able to
- Review medication of a person with Parkinson's in your community after they are discharged as their needs may have changed

SUPPORT FROM PARKINSON'S UK

Speak to the Parkinson's UK helpline (0800 800 0303) if you have any queries about Parkinson's medications. The helpline is staffed by trained Parkinson's nurses who can provide medication advice. The opening times are Monday-to-Friday: 9am-to-7pm, and Saturday: 10am-to-2pm (closed Sundays / bank holidays). Alternatively, you can email hello@parkinsons.org.uk.

Community-based Parkinson's UK local advisers can offer one-to-one information and emotional support to people with Parkinson's, their families, and carers. Our network of more than 40 local groups in Scotland enables people with Parkinson's and their carers to meet others and get involved in activities.

FIND OUT MORE ABOUT PARKINSON'S – EDUCATION AND TRAINING

Parkinson's UK not only provides information and support to people affected by Parkinson's, we also provide specific support to professionals.

You can view and order our full range of professional resources at www.parkinsons.org.uk/professionals.

ABOUT PARKINSON'S UK

Parkinson's UK is the UK's leading charity supporting those with the condition. Its mission is to find a cure and improve life for everyone affected by Parkinson's through cutting-edge research, information, support, and campaigning.

ABOUT PARKINSON'S UK SCOTLAND

Parkinson's UK Scotland's staff team is largely home-based in communities across the country. Find out more about Parkinson's UK Scotland, and read our 2019 report 'People. Parkinson's. Scotland' online.

Visit www.parkinsons.org.uk/scotland, or email scotland@parkinsons.org.uk.

APO-go® PUMP

apomorphine hydrochloride

Continuous, reliable 'ON'
for Parkinson's disease

"MY APO-go PUMP HAS GIVEN ME CONTROL OVER MY PARKINSON'S, ALLOWING ME TO GET BACK TO THE IMPORTANT THINGS, LIKE SEEING MY GRANDCHILDREN."

APO-go® Apomorphine hydrochloride. **PRESCRIBING INFORMATION.** Consult Summary of Product Characteristics before prescribing. **Uses** Treatment of motor fluctuations ("on-off" phenomena) in patients with Parkinson's disease which are not sufficiently controlled by oral anti-Parkinson medication. **Dosage and Administration** Apomorphine hydrochloride is administered subcutaneously either as an intermittent bolus injection or by continuous subcutaneous infusion. Its rapid onset (4-12 mins) and duration of action (about 1 hour) may prevent an "off" episode which is refractory to other treatments. Apomorphine should be initiated in the controlled environment of a specialist clinic. The patient should be supervised by a physician experienced in the treatment of Parkinson's disease (e.g. neurologist). Please refer to the Summary of Product Characteristics for full details before initiating therapy. Patients treated with apomorphine will usually need to start domperidone at least two days prior to initiation of therapy. The domperidone dose should be titrated to the lowest effective dose and discontinued as soon as possible. Before the decision to initiate domperidone and apomorphine treatment, risk factors for QT interval prolongation in the individual patient should be carefully assessed to ensure that the benefit outweighs the risk. The optimal dosage of apomorphine HCl has to be determined on an individual patient basis; individual bolus injections should not exceed 10mg and the total daily dose should not exceed 100mg. Do not use if the solution has turned green. The solution should be inspected visually prior to use. Only clear, colourless and particle free solution should be used. **Contraindications** Children and adolescents (up to 18 years of age). Known sensitivity to apomorphine or any other ingredients of the product. Respiratory depression, dementia, psychotic disease or hepatic insufficiency. Intermittent apomorphine HCl treatment is not suitable for patients who have an "on" response to levodopa which is marred by severe dyskinesia or dystonia. **Pregnancy and lactation** Apomorphine should not be used in pregnancy unless clearly necessary. Breast-feeding should be avoided during apomorphine HCl therapy. **Interactions** Patients should be monitored for potential interactions during initial stages of apomorphine therapy. Particular caution should be given when apomorphine is used with other medications that have a narrow therapeutic window. It should be noted that there is potential for interaction with neuroleptic and antihypertensive agents. It is recommended to avoid the administration of apomorphine with other drugs known to prolong the QT interval. Apomorphine can increase the antihypertensive effects of domperidone. **Precautions** Use with caution in patients with renal, pulmonary or cardiovascular disease, or who are prone to nausea or vomiting. Extra caution is recommended during initiation of therapy in elderly and/or debilitated patients. Since apomorphine may produce hypotension, care should be exercised in patients with cardiac disease or who are taking vasoactive drugs, particularly when pre-existing postural hypotension is present. Neuropsychiatric problems co-exist in many patients with advanced Parkinson's disease. There is evidence that for some patients neuropsychiatric disturbances may be exacerbated by apomorphine. Special care should be exercised when apomorphine is used in these patients. Apomorphine has been associated with somnolence and episodes of sudden sleep onset, particularly in patients with Parkinson's disease. Patients must be informed of this and advised to exercise caution whilst driving or operating machines during treatment with apomorphine. Haematology tests should be undertaken at regular intervals, as with levodopa, when given concomitantly with apomorphine. Patients should be regularly monitored for the development of impulse control disorders. Patients and carers should be made aware that behavioural symptoms of impulse control disorders, including pathological gambling, increased libido, hypersexuality, compulsive spending or buying, binge eating and compulsive eating, can occur in patients treated with dopamine agonists, including apomorphine. Dose reduction/tapered discontinuation should be considered if such symptoms develop. Dopamine dysregulation Syndrome (DDS) is an addictive disorder resulting in excessive use of the product seen in some patients treated with apomorphine. Before initiation of treatment, patients and caregivers should be warned of the potential risk of developing DDS. Since apomorphine, especially at high dose, may have the potential for QT prolongation, caution should be exercised when treating patients at risk for torsades de pointes arrhythmia. When used in combination with domperidone, risk factors in the individual patient should be carefully assessed. This should be done before treatment initiation, and during treatment. Important risk factors include serious underlying heart conditions such as congestive cardiac failure, severe hepatic impairment or significant electrolyte disturbance. Also

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A paradigm shift is required

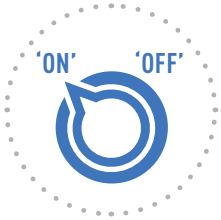
Oral medication can be unreliable due to narrowing therapeutic window and GI dysfunction.[1,2]

Identify patients

When oral/transdermal medication is no longer sufficient for your patients' needs, consider APO-go PUMP.

Rapid, reliable 'ON'

APO-go PUMP bypasses the GI tract and provides continuous drug delivery and helping to overcome pill burden.[3,4]



Receive Britannia support

The Britannia Nurse Service is available to help with patient initiation, support patients with APO-go and train NHS nurses to initiate patients.

CELEBRATING 25 YEARS
of apomorphine treatment in Parkinson's disease

For further information, contact Britannia Pharmaceuticals on:

01189 209500
bplwebmaster@britannia-pharm.com
www.britannia-pharm.co.uk

medication possibly affecting electrolyte balance, CYP3A4 metabolism or QT interval should be assessed. Monitoring for an effect on the QTc interval is advisable. An ECG should be performed prior to treatment with domperidone, during the treatment initiation phase and as clinically indicated thereafter. The patient should be instructed to report possible cardiac symptoms including palpitations, syncope, or near-syncope. They should also report clinical changes that could lead to hypokalaemia, such as gastroenteritis or the initiation of diuretic therapy. At each medical visit, risk factors should be revisited. Apomorphine has been associated with local subcutaneous effects that can be reduced by rotation of injection sites or use of ultrasound on areas of nodularity and induration. Contains sodium metabisulphite which rarely causes severe allergic reactions and broncospasm. **Side Effects** Local induration and nodules (usually asymptomatic) often develop at subcutaneous site of injection, leading to areas of erythema, tenderness, induration and panniculitus. Irritation, itching, bruising and pain may also occur. Rarely, injection site necrosis and ulceration have been reported. Pruritus may occur at the site of injection. Drug-induced dyskinesias during "on" periods can be severe, and in a few patients may result in cessation of therapy. Postural hypotension is seen infrequently and is usually transient. Transient sedation following each dose of apomorphine may occur at the start of therapy, but this usually resolves after a few weeks of treatment. Dizziness and light-headedness have also been reported. Nausea and vomiting may occur, particularly when APO-go treatment is initiated, usually as a result of the omission of domperidone. Neuropsychiatric disturbances including transient mild confusion and hallucinations – seeing, hearing or feeling things that are not there have occurred during apomorphine therapy and neuropsychiatric disturbances may be exacerbated by apomorphine. Positive Coombs' tests, haemolytic anaemia and thrombocytopenia have been reported in patients receiving apomorphine. Local and generalised rashes have been reported. Eosinophilia has occurred in only a few patients during treatment with apomorphine HCl. Patients treated with dopamine agonists, including apomorphine, have been reported as exhibiting signs of pathological gambling, increased libido and hypersexuality, compulsive spending or buying, binge eating or compulsive eating (especially at high doses), syncope (fainting), aggression, agitation and headache. Apomorphine is associated with somnolence. Yawning and breathing difficulties have been reported, as has peripheral oedema. Apomorphine has been associated with sudden sleep onset episodes. *Prescribers should consult the Summary of Product Characteristics in relation to other side effects.* **Presentation and Basic NHS Cost** APO-go pens (disposable multiple dosage injector system) contain apomorphine hydrochloride 10mg/ml, as follows: 30mg in 3ml – basic NHS cost £123.91 per carton of 5 pens. APO-go Pre-filled syringes contain apomorphine hydrochloride 5mg/ml, as follows: 50mg in 10ml – basic NHS cost £73.11 per carton of 5 syringes. APO-go ampoules contain apomorphine hydrochloride 10mg/ml as follows: 50mg in 5ml – basic NHS cost £73.11 per carton of 5 ampoules. **Marketing Authorisation Numbers:** APO-go® Ampoules: PL 04483/0072. APO-go® Pen: PL 04483/0073. APO-go® Pre Filled Syringes: PL 04483/0074. **Legal Category** POM. **SmPC Revision Date** February 2018. **API Revision date** June 2018. **Marketing Authorisation Holder in the UK** Britannia Pharmaceuticals, 200 Longwater Avenue, Green Park, Reading, Berkshire, RG2 6GP. **Full prescribing information** and further information is available from Britannia Pharmaceuticals at Enquiries@medicalinformation.co.uk or 01483 920 763.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Britannia Pharmaceuticals Ltd at dso@britannia-pharm.com or 01483 920 763.

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APO1-0419-10343. Date of preparation: May 2019

ATRIAL FIBRILLATION

TAKING IT TO HEART

Around 1.3 million people in the UK have been diagnosed with atrial fibrillation, and it's estimated that there are many more living with it undiagnosed – but why are the statistics not catalysing greater public concern? SPR – with help from the British Heart Foundation – explores the need for, and current work in, enhanced detection and management.

Karen McCammon

Atrial fibrillation (AF) is one of the most common abnormal heart rhythms. In a normal heart the heart's pumping action is controlled by regular electrical messages produced by part of the heart called the sinus node. However, AF occurs when additional, irregular electrical messages are sent from other places in and around the atria (the upper chambers of the heart). These irregular messages make the atria quiver or twitch, which is known as fibrillation.

AF can increase the risk of a blood clot forming inside the heart. If the clot is swept up out of the heart and into the blood vessels of the brain, it can cause a stroke. AF increases the risk of a stroke by around four-to-five times.

SEARCHING FOR THE SIGNS

Karen McCammon, Health Service Engagement Lead with British Heart Foundation (BHF) Northern Ireland, has explained that many people with AF have no symptoms.

'AF leads to an increased risk of stroke, heart failure, vascular dementia, hospitalisations, and, in some cases, death. The most common symptoms are palpitations, breathlessness, dizziness, and syncope. However, as many as 25-to-30 per cent of people do not have symptoms,' she said.

'This means that many patients fail to present for treatment, despite having a greatly elevated risk of stroke.'

A QUEST FOR IMPROVEMENT

BHF Professor, Barbara Casadei, combines her role as a heart doctor at the John Radcliffe Hospital in Oxford with pioneering research to improve our understanding of AF. Her team at the University of Oxford have found that changes in the heart muscle of the atria start before AF occurs, and could be a cause of it. AF tends to come and go before it becomes persistent.

The team have found that in cases where AF is persistent, the atria have lower levels of two proteins – 'dystrophin' and 'neuronal nitric oxide synthase'. Professor Casadei is studying whether these changes can be prevented or reversed to stop AF from occurring and becoming persistent.

Karen said, 'BHF is the biggest independent funder of heart and circulatory disease research in the UK. All of our work is due to public support because we don't receive any government funding. Professor Casadei's work is just one of many BHF-funded projects happening throughout the UK researching AF.

'We have made history in research and believe that by improving our understanding of AF and finding new ways to treat it, fewer people will be at risk of heartbreak from a stroke.'

TIME FOR ACTION

BHF believes that the key to improving the lives of people living with AF right now is the assessment and management of the condition.

'Initial priority must be to ensure those patients with known AF are managed appropriately, and as per NICE guidelines, which will improve patient outcomes and decrease the number of AF-related strokes locally,' Karen explained.

'Importantly, the risk of someone with AF having a stroke can be reduced by treatment with anticoagulation medication. Appropriate use of anticoagulation can reduce stroke risk in AF by two-thirds.

'Unfortunately, there is currently no cure for most cases of AF. NICE guidelines recommend that the first consideration when treating AF should be a decision on the need for anticoagulation medication to reduce the person's risk of stroke.

'Anticoagulation medication is a well-evidenced way to reduce the risk of AF-related strokes. Not everyone with AF has the same risk of stroke. The presence of certain factors increases the risk of an AF-related stroke and this risk can be assessed using checklist scoring systems.'

IN HARM'S WAY

While stroke is the most common complication, AF is associated with a number of other conditions, including heart attack and dementia. Less is understood about AF and these complications, but recent studies suggest that anticoagulant medications can reduce the risk.

Karen has said that BHF Northern Ireland is currently working to improve the lives of those living with AF.

'The national screening committee currently do not recommend screening for AF; however, there is a study underway to determine if there would be a benefit to this. Until we know the results of that we should use every opportunity to improve AF management for those individuals living with this condition.

'We are currently working to support the delivery of a structured AF educational programme, new care models / pathways to support healthcare professionals and anticoagulation monitoring and decision-making tools – incorporating the patients lived experience to guide how best to improve AF management and patient outcomes.'

For more information on AF, visit www.bhf.org.uk/informationsupport/conditions/atrial-fibrillation. To contact Karen McCammon, email mccammonka@bhf.org.uk.

BY THE NUMBERS

- AF is a contributing factor to one-in-five strokes
- There are more than 100,000 strokes in the UK each year
- That is a stroke at least every five minutes

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How much could you save with the Zeroderma range?

The Zeroderma range now includes five creams, one ointment, one gel, two bath additives and a barrier cream. All Zeroderma products are gentle on the skin and do not contain the harmful irritant sodium lauryl sulfate (SLS).

Zeroderma products are similar in formulation to around 31% of emollients currently prescribed by Health Boards and offer cost savings of up to 39%, with no compromise on patient care. Around 80% of formularies and prescribing guidelines already include at least one Zeroderma product.

The Zeroderma emollient & barrier cream range is available on prescription.

A CCG who recently started using the Zeroderma range commented:

'Emollient prescribing has been a useful area to address as part of QIPP. The focus has been on optimising patient care by offering emollient products that patients are happy to use. Feedback from GPs has been positive and changes have been simple to implement. Patient care has not been compromised and changes to the product prescribed have been acceptable to most patients.'

Zeroveen® Cream – a 2-in-1 emollient containing natural oatmeal.

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Zeroveen is a non-greasy, silky, 2-in-1 moisturising cream and wash containing natural oatmeal. With proven 24-hour moisturisation[1], Zeroveen has both occlusive and humectant properties, as it contains glycerol to actively draw moisture into the skin. The 500g airless pump dispenser offers less than 2% wastage.

Zerolon® Barrier Cream – helps to prevent irritation from bodily fluids.

Up to **29%** cost saving per pack

Zerolon Barrier Cream moisturises and protects damaged, intact or inflamed skin, and is suitable for use with incontinence pads[2]. Zerolon barrier cream is available in a 28g and 92g tube and only requires pea-sized amounts for application, and is resistant to wash off[2].

Survey shows the benefits of Zerodouble® Gel

Up to **16%** cost saving per pack

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QIPP TOOLKIT

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THE FULL PICTURE

Are you seeing beyond your patient's pain and cultivating a management approach catered to their individual needs?

KEEPING IN MIND

Patients' pain-orientated complaints can differ in many ways – complex or straightforward; taking the form of flare-ups or a consistent presence. But they're all bound by a common thread in that if the condition is directly impeding the quality of the individual's life, then their mental health is vulnerable to threat too.

The toll which pain can take psychologically has long been suspected, but new data is starting to decipher the extent to which we should be cautious. In fact, adolescents who experience back pain more frequently are seemingly more likely to smoke cigarettes, drink alcohol, and report problems like anxiety and depression, as reported by a study in the Journal of Public Health.

During adolescence, the prevalence of musculoskeletal pain (pain arising from the bones, joints, or muscles) in general, and back pain in particular, rises steep – and although often dismissed as trivial and fleeting, it can yield substantial healthcare use, and the absence from, and interference of, day-to-day activities.

Back pain and unhealthy behaviours not only occur together, but they can also filter into adulthood – representing significant implications for future health. As outlined by the researchers, appropriate intervention must be conducted as soon as possible as the developing brain may be susceptible to negative influences of toxic substances, and use in early adolescence may increase the risk of substance abuse and mental health problems in later life.

'Findings like this provide an argument that we should be including pain in the broader conversation about adolescent health,' remarked the paper's lead author, Steven Kamper.

'Unfortunately, our understanding of the causes and impacts of pain in this age group is quite limited; the area is badly in need of more research.'

OF MICE AND MEN (AND WOMEN)

As representatives of the health service, it's already ingrained in us to frame our course of patient treatment in line with their individual requirements. But what if this approach needs to be even more specific than we originally thought? New findings have suggested that pain's origins can be somewhat linked to gender.

Scientists increasingly believe that one of the driving forces in pain appears to be the memory of earlier pain, and now new insights suggest that there may be variations, based on sex, in the way that pain is remembered in both mice and humans.

The research team, led by colleagues from McGill and University of Toronto Mississauga, found that men (and male mice) remembered earlier painful experiences clearly. As a result, they were stressed and hypersensitive to later pain when returned to the location in which it had earlier been experienced. Conversely, women (and female mice) didn't seem to be stressed by their earlier experiences of pain – and this translational nature can potentially aid future treatments.

Shedding more light on the human factor, Jeffrey Mogil, the EP Taylor Professor of Pain Studies in McGill's Department of Psychology, and Alan Edwards Centre for Research on Pain, who is the senior author on the study, commented, 'We set out to do an experiment looking at pain hypersensitivity in mice and found these surprising differences in stress levels between male and female mice. So we decided to extend the experiment to humans to see whether the results would be similar.

'We were blown away when we saw that there seemed to be the same differences between men and women as we had seen in mice.'

Loren Martin, the first author on the paper, and an Assistant Professor of Psychology at the University of Toronto Mississauga, added, 'What was even more surprising was that the men reacted more, because it is well-known that women are both more sensitive to pain than men, and that they are also generally more stressed out.'

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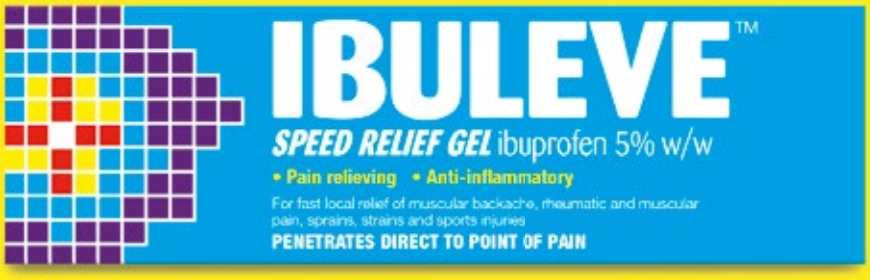

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IBS: CHANGES FOR THE BETTER

Irritable Bowel Syndrome (IBS) affects up to 20 per cent of the population – around 12 million people – and for those living with the condition, it can be extremely debilitating and isolating. Tying in with IBS Awareness Month's recent arrival, Dr Simon Smale, Gastroenterologist and Medical Adviser to The IBS Network, discusses the condition, diagnosis, and treatment options.

Dr Simon Smale

EPIDEMIOLOGY

IBS is common, in which one-in-five people will experience some symptoms. Many patients with the condition will attempt to self-manage, trying to identify their dietary and environmental triggers, while others will consult their pharmacist, general practice, or seek expert opinion from dietetic or other professionals.

IBS appears to affect women more commonly than men – although men are less likely to seek help from their GP or pharmacist. Although it often presents in young people, it may occur at any age.

WHAT IS IBS?

IBS is a chronic disorder characterised by abdominal pain and change in bowel habit as a consequence of abnormal visceral sensation and / or motility, arising as a result of abnormalities within the enteric or central nervous systems, or both. Usually this occurs in the absence of 'organic' disease, but association with other gastrointestinal disease is common.

Disturbances in the gastrointestinal microbiome have been identified in patients with IBS, and it is often the case that symptoms may be triggered by events which lead to changes in microbiome, emotional context, and enteric nervous function in tandem.

DIAGNOSIS

The diagnosis of IBS should be considered in any patient presenting with the combination of abdominal pain, altered bowel habit, and / or abdominal bloating. Patients may complain of constipation, diarrhoea, or may fluctuate between the two. In order to meet the current diagnostic criteria, patients should have had symptoms for at least six months, although patients with identical symptom complexes for a shorter period are clearly likely to have similar pathology, while not strictly meeting the current diagnostic criteria. Many patients also complain of associated symptoms, such as faecal urgency and incomplete evacuation, and extra gastrointestinal symptoms, including fatigue and poor concentration.

ibsnetwork

In all patients with symptoms consistent with a diagnosis of IBS the presence of 'red flags' or symptoms that may suggest another pathology should be specifically sought and excluded.

Red flags include a new change in bowel habit lasting for more than six weeks in a person aged 60 years or older, the occurrence of rectal bleeding, unexplained weight loss, and a history of ovarian or bowel cancer within the immediate family. If any red flags are present they should be explored and further details sought. An assessment should then be made, and consideration given as to whether a referral to a gastroenterologist should be undertaken.

In patients who are presenting for the first time, a number of routine tests should be arranged, including a full blood count, to exclude anaemia, coeliac serology, inflammatory markers, and probably a faecal calprotectin. The reason for undertaking these investigations is to ensure that organic disease which requires specific investigation or therapy is not missed. Inflammatory Bowel Disease, occult neoplasia, and coeliac disease can all mimic many of the symptoms of IBS. However, in the context of a suggestive history, in the absence of red flags, if these investigations have been normal they do not need to be repeated; nor do patients with typical symptoms require further invasive endoscopic investigations.

TREATMENT OPTIONS AND MANAGEMENT OF IBS

While healthcare professionals have an important role in excluding other disease, and in providing education and empowerment for people who are struggling with their symptoms, people with IBS should be encouraged to take an active role in identifying their individual symptom triggers and in managing the dietary, lifestyle, and psychological factors which may exacerbate their symptoms.

THE IBS NETWORK

The IBS Network is the national charity that supports people in self-managing their IBS. People can be confident that the information is from a trusted source as the charity works alongside specialist healthcare professionals working in the NHS. Medicines are not usually the mainstay of effective management for people with IBS, but rather should be used to target and alleviate specific symptoms.

DIET MANAGEMENT

Approximately 40 per cent of people with the condition will already recognise dietary triggers. For many, a dietary review and basic advice and support may be sufficient to alleviate symptoms. Initial review should assess the frequency of meal and food intake and make sure that common precipitants are minimised. People with IBS should be encouraged to eat regularly and not leave long gaps between meals.

Common dietary triggers include caffeine, fizzy drinks – which often cause bloating, alcoholic beverages, and diet drinks that often contain indigestible sugars that may ferment within the large bowel and cause bloating and erratic bowel habit. Foods containing resistant starches, commonly encountered in some pre-prepared and processed meals, may also reach the large bowel where they may be fermented by colonic bacteria and cause similar symptoms. Reducing these foodstuffs where they form a large part of the diet may be sufficient to relieve symptoms.

If diet remains a likely trigger then the expert support of an appropriately trained healthcare professional (such as a dietitian) should be sought to explore the possibility of exclusion diets.

Common exclusion diets include those excluding wheat, dairy produce, or FODMAPs (fermentable oligosaccharides, disaccharides monosaccharides and polyols) – but these are advised to be undertaken with the support of a dietitian.

Continued onto next page

IRRITABLE BOWEL SYNDROME

PROFESSIONAL SUPPORT

Professional support from an appropriately trained individual is key, not necessarily because these things are hard to exclude, although a low FODMAP diet is very challenging to execute well, but because all exclusion diets should be continued for a limited period. Therefore they require the structured re-introduction of foods to ensure that the diet is replete in the required nutrition, while avoiding the provocation of symptoms.

GOOD SLEEP HYGIENE AND RELAXATION

Diet is clearly important, but other lifestyle factors also influence the genesis of symptoms in IBS. We can't always influence the stresses that we face, however, a number of factors can exacerbate symptoms, including poor sleep, and lack of exercise and relaxation. These three factors are inextricably linked to each other and to the normal functioning of the gut.

For people who are sleeping poorly, good sleep hygiene is important. Several online apps are available to support patients in this regard. Similarly, it is important for patients to find time to relax. The NICE guidance suggests that we should all find 20 minutes to relax on a daily basis, and there are numerous apps available to try and facilitate this; while some may simply prefer to relax with a good book.

REGULAR EXERCISE

Exercise is underrated as a therapy. Again the national guidance advises we take 150 minutes of exercise (that makes us slightly short of breath) every week. This often aids bowel habit, sleep, and relaxation.

Nevertheless some forms of exercise may provoke urgency, in which case it is best for people to either be near an accessible toilet or to find forms of exercise that don't provoke urgency. If patients are currently taking no regular exercise then they should start slowly and increase the length and frequency of exertion slowly, mindful of any co-morbidities.

PSYCHOLOGICAL INTERVENTION

Psychological intervention may also be of benefit, and a range of psychological treatments have been shown to be effective. In general, psychological interventions may be simple, or more complicated for those with more complex psychological disease. In general, one-in-four to one-in-five people with IBS will benefit from psychological intervention. This is a similar number needed to treat as for antidepressants.

MEDICATION

A number of drugs are available to treat IBS. While these are targeted at specific symptoms, they broadly fall into three overlapping categories as follows: drugs which affect bowel sensitivity, such as peppermint oil; and drugs which affect bowel motility and stool consistency. These can be sub-classified into aperients, antidiarrheals – such as loperamide – and anti-spasmodics, such as mebeverine, alverine, or hyoscine butylbromide. In general, lactulose should be avoided, since it is a FODMAP and tends to cause bloating and occasionally abdominal pain. Often PEG based laxatives such as Laxido or Movicol are a good starting point for patients with constipation. In such people, measured regular use combined with lifestyle change is a better approach than sporadic use of large doses which often leads to oscillation between loose and constipated stools.

Lastly a number of drugs may affect the nervous processing of visceral sensation and can be used to modulate abdominal pain. These often have side-effects that alter bowel habit so this needs to be borne in mind when they are prescribed. There is reasonable evidence for the use of tricyclics, such as amitriptyline, at a dose of 10mg at night (increasing to a maximum dose of 30mg), but people need to be made aware that such drugs may have significant side-effects. Medication which has no clear benefit should be stopped.

PROBIOTICS

Probiotics are not drugs, however, there is a growing body of evidence to support their use. The effects are likely to be strain specific so if after a month people have seen no benefit it is sometimes worth trying an alternative. The commonest side-effect is bloating. Gut-directed hypnotherapy is a well-established intervention with a good evidence base but unfortunately is only available in a limited number of areas.

SUMMARY

In summary, IBS is a common condition affecting one-in-five of the population, which presents with symptoms of abdominal pain, bloating, and change in bowel habit, often associated with other systemic symptoms. The diagnosis can usually be confirmed by a careful history and examination, which excludes red flag symptoms, combined with non-invasive testing (coeliac serology, bloods, and faecal calprotectin), to exclude conditions that commonly present with similar symptoms.

Symptom triggers are often varied and difficult to elucidate clearly, but a range of treatments are available to help address the often intrusive and upsetting symptoms that disrupt the lives of many people living with the condition.

People may be signposted to www.theibsnetwork.org for advice and ongoing support.

ABOUT THE IBS NETWORK CHARITY

The IBS Network is the national charity that helps people living with IBS and has provided support to those with the condition and to healthcare professionals for over 27 years.

Funding for the charity is received from a number of sources including annual memberships and an online shop for purchasing the Can't Wait card, radar keys, and other useful aids. The charity receives no funding from the government or NHS and relies wholly on donations.

Members of the charity's community can gain access to a whole range of services from just £2 / month, including the IBS Self-Care Programme, a specialist IBS nurse helpline, individual advice from healthcare professionals, a growing network of support groups, an online forum, plus factsheets, research, and updates via the charity's magazines, email newsletters, and other supporting material.

For more information, or to become a member, get in touch via the following contact details:
Email: info@theibsnetwork.org
Tel: 0114 272 3253
Website: www.theibsnetwork.org
Twitter: www.twitter.com/IBSnetwork
Facebook: www.facebook.com/TheIBSNetwork
Linkedin: www.linkedin.com/company-beta/4601772
Address: The IBS Network, Unit 1.16 SOAR Works, 14 Knutton Road, Sheffield, S5 9NU

GALEN

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- ✔ **Proven**, well-tolerated active ingredients[1]
- ✔ **Simple**; easy-to-mix

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3. MIMS. March 2019.

MAT-LAX ORG-UK-000018
Date of Preparation: April 2019

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BEST FOOT FORWARD

Bearing the brunt of our everyday lives, we often take the health of our feet for granted. However, with the soaring temperature opening up new, and building on already existing, potential pathways for harm – now is the time to bring the different ailments to light. Matthew Fitzpatrick, Consultant Podiatrist, College of Podiatry, offers advice as to what to look out for, and how to curb the further deterioration of foot pain.

Matthew Fitzpatrick

Foot pain in the summer months – when the feet come out from hibernation – can be for a number of reasons, but the most common are corns, ingrown toenails, and heel pain; all of which can affect an individual's ability to get out and enjoy the, hopefully, better weather.

It is also fair to note that the extent to which these ailments affect a person can vary.

Accessing advice from a pharmacist can be where a person may initially seek first-line treatment, and may include:

CALLUSES OR DEAD SKIN

Calluses or dead skin – that build up over areas of friction or pressure – can be kept under control with a pumice stone or foot file, and the use of a foot cream regularly will help improve their condition. In cases of a thicker build up, or for a longer lasting effect, the recommendation would be to see a podiatrist who can reduce this with a scalpel and advise on ways of minimising the recurrence and / or consider other adjunctive treatments, such as orthosis (if required).

CORNS

Corns are dense plugs of callus which form over the areas with the most pressure. Off-loading pads and hydrocolloid-based dressings can ease discomfort; however, corns should only be removed by a Health and Care Professions Council-registered podiatrist.

In both cases acid-based removal treatments (such as corn plasters) or knives should not be advised for self-administered treatment. These can cause severe damage to the patient – especially those with compromised skin, vascular supply (diabetics), and those who may be immuno-suppressed.

ATHLETE'S FOOT

Another condition that is more noticeable in the summer, warmer times, and when people may be more 'active' is athlete's foot (tinea pedis). If this doesn't resolve within three rounds of over-the-counter treatment, or if it frequently recurs, then a podiatrist can assess the patient to determine if it is a fungal infection that may have a compounding bacterial involvement or if, for example, there is a secondary nail infection that is causing the issue.

VERRUCAE

A really common – and for some – quite frustrating condition we see are verrucae. These are viruses and will often disappear of their own accord within six-to-12 months but can last for up to two years, especially in children. If they are rapidly spreading or causing pain, then options to treat them can be discussed. Over-the-counter treatments are available, and instructions should be followed carefully.

Treatments can take many months to cure verrucae due to the nature of the virus. A podiatrist can also offer a range of other topical or mechanical treatments that are not available at the pharmacy.

PLANTAR FASCIITIS

A commonly referenced condition is plantar fasciitis, and its effect on walking. However, it may not always be the fascia that is directly involved, but a more generic heel pain as there are different types of heel pain that can present with a similar location, yet not the same pathology.

If a person has heel pain which lasts longer than three weeks and has tried a footwear change or simply off-loading (resting) – along with maybe topical NSAIDs – then they should seek the advice of a podiatrist for diagnosis and treatment.

In the early stages, though, the person should refrain from long periods of standing and long walks; they should wear supportive footwear; and they may find over-the-counter supports to be of benefit, along with anti-inflammatory medication.

KIDDING YOU NOT

David Reading, Co-Founder of the Anaphylaxis Campaign, shares how serious allergy to cow's milk can be, and reports on the latest findings with regard to thresholds and reference doses.

A 10-year-old boy took one bite of a pre-packed apple dessert and suffered anaphylaxis. It transpired that the pie contained 0.006 per cent milk protein. It had been correctly labelled, but the boy – who knew he was allergic to cow's milk – made a mistake and did not check. Fortunately, he recovered thanks to prompt medical treatment.

A six-year-old girl suffered a severe reaction in a restaurant to an ice-cream labelled as 'non-dairy'. After the girl recovered, enquiries revealed that a major ingredient of the ice-cream was skimmed milk.

These two cases – taken from our files – demonstrate clearly how serious a milk allergy can be. Although allergy to peanuts and tree nuts is still frequently in the news, it must not be forgotten that other foods are occasional causes of anaphylaxis.

Cow's milk allergy is one of the most common food allergies in the UK and throughout the world. The first adverse reactions to cow's milk were described 2,000 years ago, but it was only in the mid-to-late 20th Century that research groups began the analysing of cow's milk allergens.

The Anaphylaxis Campaign's factsheet on cow's milk allergy can remind us how complex this subject is.

Immediate allergic reactions to cow's milk – sometimes referred to as 'a true allergy' – are just part of a wider picture. Helpline staff working for food companies should, perhaps, be aware that customer complaints of 'allergic' reactions to milk may have other causes.

Immediate cow's milk allergy – fairly common among children – is well-understood by doctors. It occurs when the body's immune system wrongly perceives some of the proteins in cow's milk to be a threat and, as a result, produces antibodies of the Immunoglobulin E class (known as IgE for short). These antibodies are specifically targeted against one or more of the cow's milk proteins.

Subsequently, whenever the person with the allergy comes into contact with milk, these antibodies trigger certain chemicals, such as histamine, to be released from special immune system cells in the blood and tissues where they are stored. It is the sudden release of these chemicals in the body that causes the symptoms. Symptoms can be mild, but for some there is a potential for anaphylaxis.

However, there are numerous other conditions triggered by milk, making the overall subject much more complex. These include:

- Delayed cow's milk allergy (non-IgE milk allergy)
- Cow's milk-induced proctocolitis
- Cow's milk protein-induced enteropathy syndrome
- Eosinophilic gastrointestinal disorder
- Food protein-induced enterocolitis syndrome
- Lactose intolerance

For more information about immediate cow's milk allergy and these other conditions, visit www.anaphylaxis.org.uk.

GUIDING THE WAY

The question that the food industry will be asking relates to labelling: what is the level of cow's milk beneath which the risk of an allergic reaction is negligible and Precautionary Allergen Labelling (PAL) is not required?

The answer is that scientific studies have reached firm conclusions on this. In 2011, the VITAL Scientific Expert Panel was tasked with identifying reference doses for allergens by the Allergen Bureau of Australia-New Zealand. It was able to access the results of 17 published studies, as well as some unpublished data, encompassing in total 351 food challenges, most of them in children.

These data were sufficient to define a robust reference dose of 0.1 mg of milk protein per serving, which would protect 99 per cent of those with a milk allergy against any reaction. (1)

As was done successfully with peanut, challenges with single doses of milk (protective of 95 per cent rather than 99 per cent, for statistical reasons) are currently underway to validate the milk reference dose.

Another key question is: is there any sign that regulators are reaching the point when they can offer robust guidance to the food industry on action levels?

The answer is that while regulatory bodies have welcomed the proposed reference doses (for milk and other allergens) as a major step forward, formal adoption has been much slower. Authorities in Belgium and Germany have produced documents supporting their use in allergen management. Anecdotally, other regulatory authorities have used them as a starting point for their risk assessment and management actions.

In the UK, the Food Standards Agency (FSA) is supportive and insists that the use of PAL must be based on a thorough risk assessment. A current initiative to bring allergen management within the ambit of the Codex Alimentarius, with which the FSA is actively involved, may also help to move things forward in the future.

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PROMOTION

THE P WORD

Go into any trampoline park in the UK and you are guaranteed to hear talk of 'pelvic floors' among the mothers standing at the sidelines, watching their kids leap, spring, and bounce. But what are the medical connotations of this term, and how can we help educate and support patients? The Femeda experts discuss.

Julia Herbert, Clinical Director at Femeda

PELVIC FLOOR MUSCLE WEAKNESS

'Pelvic floors' is the code often used by women for pelvic floor muscle weakness that leads to bladder leakage, which affects as many as one-in-three women. The National Institute for Health and Care Excellence (NICE) recommends that the best treatment for women with bladder leakage (urinary incontinence) is a programme of pelvic floor muscle exercises. However, up to 50 per cent of women find it difficult to identify and exercise their pelvic floor muscles.

WHERE ARE THE PELVIC FLOOR MUSCLES?

The pelvic floor is a layer of muscles, blood vessels, nerves, and fibres that runs from front-to-back under the pelvis. It is attached to the pelvic bones and looks a bit like a shallow bowl. Its job is to help control the bladder and bowel so when it weakens, you lose that control.

HOW DO YOU DO PELVIC FLOOR MUSCLE EXERCISES?

To be effective in strengthening the muscles, pelvic floor muscle exercises should be performed three times every day for at least three months. (NICE, 2019)

There are two types of pelvic floor muscle exercise:

1. LONG, SLOW CONTRACTIONS

Imagine that you are trying to stop yourself passing wind or urine. Start by tightening the muscles around the back passage, then squeeze and lift your pelvic floor muscles upwards and forwards. You may not feel that much is happening at first, but keep trying.

Hold the squeeze for a few seconds and then relax for a few seconds. Don't hold your breath.

Gradually increase the hold time and the number of contractions you do until you can hold the squeeze for up to 10 seconds, and repeat it up to 10 times.

2. SHORT, STRONG CONTRACTIONS

Because it's important for your pelvic floor muscles to be able to react quickly to stop you leaking when you cough, sneeze, jump, laugh, or shout, you need to do these contractions too. Tighten your muscles as quickly and strongly as you can, then relax. Repeat this up to 10 times.

You might prefer to start doing your exercises lying down, or sitting on a rolled-up towel, so that you feel the pressure underneath the pelvic floor muscles as you try to contract them upwards and forwards away from the towel. As you get stronger you should be able to do your exercises in any position.

THE PROBLEM

Pelvic Floor Muscle Specialist, Julia Herbert, explained, 'Women often come to me with weak pelvic floor muscles and say that they know that they're meant to be squeezing their pelvic floor but don't actually know what they are supposed to be squeezing.

'Many say that they have tried exercises for months and months but to no avail – their bladder leaks have not improved. There are many reasons for this; some women can't exercise effectively because their muscles have become too weak, a common result of pregnancy and carrying the growing weight of a baby for nine months.

'However, weakening also occurs as a result of hormonal changes during the menstrual cycle, the menopause, increased weight, heavy lifting, strenuous exercise, straining with chronic constipation, or just getting older. Some women may lose the connection between the brain and the pelvic floor.'

PELVIVA

Julia is Clinical Director at Femeda, which has recently launched Pelviva – an award-winning pelvic floor muscle re-trainer that targets the cause of bladder leaks. The Pelviva treatment has been clinically proven to improve bladder leakage in 84 per cent of women.

'As there are so many women struggling to find and exercise their pelvic floor muscles, Pelviva has taken the principles of an NHS treatment to help women retrain their pelvic floor muscles and, using the latest technology, developed it into a clinically-effective product, that has been tested for safety. Pelviva is discreet and is easy to use at home. It helps women understand where their pelvic floor muscles are and what a correct pelvic floor muscle contraction feels like,' Julia concluded.

Pharmacy teams are ideally placed to support and educate female customers on the benefits of using Pelviva alongside recommended exercise. Female urinary incontinence is the single largest condition in female health and this pioneering medical device targets the root cause of the problem for women – weak pelvic floor muscles – providing a treatment for the condition and the opportunity to improve quality of life.

It is a highly sensitive condition where, up until now, women have been forced to accept that most solutions have just helped them cope with the condition or alleviate symptoms.

Pelviva provides a new clinically-proven treatment for pharmacy staff to support women to rapidly reduce bladder leaks over a 12-week period.

For more information, visit www.pelviva.com.

Launching Pelviva . . . a totally new category in Pharmacy: Positive Pelvic Health

Pelviva is a life changing treatment for women, addressing one of the most prevalent conditions in women's health, and up to now limited treatment options have been available.

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"Pelviva thank you for coming into my life, I feel like a new woman, happy, strong and confident!! 11/10"

Please call Sorcha Montgomery on 07908 989411 or email sorcha.montgomery@femeda.com

PEL/00051/UK April 2019

WINNER
STUDENT LEADERSHIP

Marie-Anne Durham
Robert Gordon University

Sponsored by The Pharmacists' Defence Association

Marie-Anne believes that in order for pharmacy to thrive, it's imperative that an inclusive and non-judgmental environment where patients can access all the support they need is created – and already, she has played a key role in helping to craft this setting.

In particular, Marie-Anne has reaped important experience by taking up the post of social media co-ordinator of the Robert Gordon University Pharmacy Law and Ethics Group in which she competently interacts and assists a wide-ranging audience of fellow students and alumni through social media outlets, including Twitter and Facebook.

Always eager to utilise opportunities to boost the confidence of her peers, Marie-Anne presents articles and journals which highlight issues affecting pharmacy practice. As most students do not sift through online journals and news sites – preferring instead to use their social media apps to obtain instantly-updated information – she has tapped into their needs and identified this direct access as an important avenue for improving participation and involvement. For example, Marie-Anne spends considerable time sourcing and selecting topics which are relevant to the budding service representatives, such as the availability of e-cigarettes on the NHS, and the first pharmacy-based needle exchange vending machine.

Also fueled by a determination to empower students, Marie-Anne employs the social media platforms to encourage them to express themselves by way of engaging with important topics; and liking and commenting on various posts.

This focus on engagement filters through to her responsibility in emailing the student body monthly newsletters which focus on student achievements; the discussion of relevant topics in more detail; and the advertising of events by other student-led organisations. The regular alert distils lengthy articles into shorter, more accessible, segments which often encourages readers to research further – and is a prime tool for bolstering collaboration between the Robert Gordon Pharmacy Law and Ethics Group and others within the university.

The extent of the diversity of Marie-Anne's attributes came to the fore during recent months when, as social media co-ordinator, she promoted a debate hosted by the group on self-injecting facilities. Applying her social media and email-orientated skills, Marie-Anne was able to embolden hesitant participants who have since described how much they enjoyed speaking and how they would now be more confident to take part in other discussions on divisive topics which they feel passionately about. During the debate she also facilitated discussions between students of all year groups, and encouraged individuals to voice their opinions on the debate material to promote collaboration and pass the debate motion.

Marie-Anne's leadership skills were demonstrable during her younger years as well, when, as a mentor to younger students in high school, she learned to recognise uncertainty and aimed to decipher different ways to inspire confidence through developing abilities and attempting to visualise problems from another person's point of view.

Marie-Anne's potential further flourished throughout a World Challenge expedition to Vietnam in which she volunteered in a centre for the homeless and disabled; organising activities and encouraging isolated residents to socialise. The necessity of teamwork was highlighted here as she shared leadership responsibilities and worked together with peers to devise strategies for overcoming language barriers.

'I'm very overwhelmed and excited that I've won.'
Marie-Anne Durham
Robert Gordon University

'Our winner has demonstrated what is certainly material for future pharmacy leadership. Keep up the great work. Well done!'
Mark Koziol
The Pharmacists' Defence Association

Student Leadership Award winner, Marie-Anne Durham, Robert Gordon University, with Mark Koziol, The Pharmacists' Defence Association, and Alima Batchelor, The Pharmacists' Defence Association

WINNER
INNOVATIONS IN PRESCRIBING, QUALITY AND EFFICIENCY IN SCOTLAND

Leanne Drummond and the Wigtownshire Prescribing Support Team
NHS Dumfries & Galloway

Sponsored by Napp Pharmaceuticals Limited

Combining their in-depth experience of the industry, with visions for its future path, the team decided to develop an innovative training model – which entailed 'growing their own' pharmacy technician within the primary care team.

A key step of the project's implementation regarded the team ascertaining if it was at all possible, as traditionally technicians are trained in a community or hospital pharmacy setting. Advice was thus sought from the General Pharmaceutical Council as to the requirements, and on clarification authorisation was granted from the team's director of pharmacy and locality manager to devise the training model.

To register with the General Pharmaceutical Council, it was outlined that the trainee must complete a minimum of two years' relevant work-based experience under the supervision, direction, or guidance of a pharmacist or pharmacy technician for not less than 14 hours per week. Although the team comprises practicing pharmacy technicians, this is a very specialist role, so it was deemed that the trainee would benefit from experience in an additional setting.

Prompted by this insight, it was agreed that the trainee would spend two days each week in the community pharmacy and three days with the prescribing support team. While in the pharmacy, supervision was to be provided by the pharmacist manager, and when with the prescribing support team, supervision was upheld by the trained pharmacy technician or pharmacists. Additionally, the overall managerial responsibility was wielded by the locality lead pharmacists.

A thorough review of the training packages available nationally was subsequently carried out, however there were none focussing on the role of a primary care technician. If the chosen candidate had not already done so, they would have to complete the pharmacy dispenser qualification as an introduction to the technician course.

Gleaning the impact of the initiative, a comprehensive business plan was written depicting the benefits of enhancing the workforce by this method. It was targeted towards potential cost savings which could be made by increasing their influence on GP prescribing, and reviewing potential efficiencies across the care at home sector, in particular, the allocation of care packages. As a result, funding was approved for the training post, and they went out to advert.

The next stage of the process centred on the narrowing down of around 30 applicants from local people with a wide range of backgrounds – the majority with no previous pharmacy experience. Prior to the interview, the applicants had to pass a numeracy and literacy test which reflected the level required to gain access to the pharmacy technician qualification course. In the end a psychology graduate was employed who was looking to move to the area, could not find work in her chosen background, and had always possessed an interest in pharmacology.

In terms of the strides undertaken as a result of the project, they are currently two years in, in which the first trainee qualified in October 2018 and commenced a band four primary care pharmacy technician post straight away.

Showcasing the success of the initiative, and the nature of its longevity, there is now another trainee in post – one year into her course – and other localities within NHS Dumfries & Galloway are now seeking to repeat the model. Additionally, based on the learning from their first candidate, more study time is allocated during prescribing support team time as it has been recognised that the workload is intensive due to a vested interest in getting the candidates through their course in a timely fashion.

Ultimately, the experience to date demonstrates that this is an effective model to train pharmacy technicians within primary care, and the significance of this member of the pharmacy team – especially with the development of pharmacotherapy – can't be emphasised enough.

'We'd like to thank the whole team for all of their hard work and effort.'
Leanne Drummond and the Wigtownshire Prescribing Support Team
(NHS Dumfries & Galloway)

'It's a delight to be here this evening and sponsoring this award. Congratulations to the very worthy winner!'
Christine Allan
Napp Pharmaceuticals Limited

Innovations in Prescribing, Quality and Efficiency in Scotland Award winner, Leanne Drummond and the Wigtownshire Prescribing Support Team (NHS Dumfries & Galloway), with Christine Allan, Napp Pharmaceuticals Limited, and Fiona Thomson, Lead Pharmacist at Argyll & Bute HSCP (NHS Highland)

WINNER
PHARMACY PRACTICE OF THE YEAR INDEPENDENT

Sam Falconer and Team
Townhead Pharmacy, Kilwinning

Sponsored by Scottish Pharmacy Review

As a result of the strength of their provision of patient care – and passion in forging links with the community – the pharmacy have attained a highly-respected reputation.

The team are particularly notable for their innovative insight and swift reaction to necessary change. In fact, in 2017 they started to consider options for expanding their resources at Townhead Pharmacy sparked by the rise in prescriptions being dispensed since the business was acquired in 2009, and a desire to upskill the pharmacists to a more patient-facing, clinical role.

They had previously invested in the Methameasure system for methadone dispensing, but with this pursuit for improvement in mind, and a relatively large retail unit, the pharmacy decided to install a dispensary robot to streamline the dispensing function. A full refit of the pharmacy was simultaneously conducted around the robot, aiming to transform the site into an environment which would be more recognisable to the public as a health centre. In line with this objective, the project encompassed the development of a dedicated waiting area with health information screens and two consultation rooms; in which one of the rooms is smaller and allocated as a consultation room. The other is somewhat larger and designated as a treatment room which can be utilised by the pharmacist or any number of visiting health professionals.

Tremendously impactful, the introduction of automation in the dispensing process naturally cuts down on dispensing errors. This will be further advanced as a result of the pharmacy's industriousness in training up one of the technicians to become an accuracy checking technician. It's therefore anticipated that these changes will combine to free up more pharmacist time to enhance their clinical role, and allow them to spend more time with patients on dealing with everyday medication issues, as well as run specific clinics.

Committed to instilling collaboration in their continued service, over the last few years the pharmacy have established a close working relationship with two GP surgeries, and one in particular – Kilwinning Medical Practice – have demonstrated a willingness for the team to work with them in helping to deliver primary care services. For example, the pharmacy's recent pre-registration pharmacist visited the surgery two months ago to host a presentation on pharmacy services.

The instigation of a local meeting group with the two local surgeries and two other local pharmacies – in which meetings are held every eight weeks – has proven to be a vital forum for improving processes. A number of discussion points are brought to attention during this time, such as supply issues, stock shortages, and any upcoming initiatives. They have also developed a group email system that everyone can see to discuss common issues and health promotion campaigns. The benefits witnessed as a result of co-operation are set to increase, too, due to the fact that the recent EMIS patient record system pilot with the health board and the surgery has opened up more possibilities of collaboration with the surgery.

With regards to the pharmacy's future endeavours, a major focus is on decoupling the pharmacist from a number of the technical and mechanical aspects of the procurement and supply of medicines, and to present them with greater opportunities to utilise their clinical role, and promote the setting to patients as the first port-of-call for their acute and medicine-related issues, as well as for the management of long-term chronic conditions.

In line with this mission, annual – or more regular – asthma and COPD reviews will be conducted to lower exacerbations and reduce hospital admissions as a result.

'I just want to say a big thanks to all of the team. We're so pleased!'
Sam Falconer and Team
Townhead Pharmacy, Kilwinning

'The breadth of work and involvement of staff – and what the team do – is just outstanding. Congratulations.'
Dr John McAnaw
Royal Pharmaceutical Society Scottish Pharmacy Board Chair

Pharmacy Practice of the Year Independent Award winner, Sam Falconer and Team, Townhead Pharmacy, Kilwinning, with Dr John McAnaw, Scottish Pharmacy Board Chair

WINNER

INNOVATIVE USE OF TECHNOLOGY IN COMMUNITY PHARMACY

Bernadette Brown and Team
Cadham Pharmacy, Glenrothes

Sponsored by Cegedim Rx

The pharmacy's integration of technology has picked up significant pace, propelled by the team's vision to evidence that they can – and should – be improving the quality of lives of the people they serve. Their mission has also been to change the hearts and minds of the public regarding the skills held by the pharmacist, demonstrating why they should choose pharmacy as their first port-of-call for minor illness and advice as to how to manage their long-term conditions.

Vast improvements have been made to the pharmacy's provision of care as a result of the installation of three robots installed over two years, in addition to the employment of V screens. The screens have been impactful in communicating with visitors to the pharmacy; expressing public health messages; promoting the range of services; and outputting stock from the BD Rowa.

Robotik Pouch dispensing has emerged as an important asset for increasing the pharmacy's capacity of supporting their rising demand for nomad supplies. They're working on a target of 100 a day being possible by streamlining the process and ensuring that the sequence of tasks, from popping to running the productions, has the least amount of stops or down time. This means that they will experience no capacity issues and can fulfil all requests from hospitals or GP practices to support the community and practices when required. A local care home now also utilises the site for all their patients coming back to the community; and has praised the team for their professionalism and quality of the care to their resident.

The team have found technology to be effective in fostering patient independence, and FeNO and HBA1c in particular have been key in guiding patients to see how well they are currently controlling their asthma or diabetes.

This level of innovation has been immersed in the other range of services too. In terms of the embedding of diagnostics into the day-to-day running of the pharmacy, the use of new technology has been introduced, such as the Roche Cobas machine; enabling the measurement of whole blood samples for HBA1c and full LIPID profiles. The offering of private skin consultations is additionally in line with the pharmacy's focus on quality and convenience. To enhance the service-user's experience of these, the team purchased the Callegari skin analysis system which helps to examine levels of dehydration, sebum, PH, and elasticity, in which they can then advise from the Eucerin Skincare range and look at acne, psoriasis, eczema, and rosacea.

The pharmacy now partakes in private insurance work – a development which occurred following their networking with pharmacists in London and Belfast who have found new innovative ways of using the time and skills of their team. The team thus now partner with a firm, and provide an easy online platform and booking system which is garnering positive results, in that the pharmacy is steadily getting busier as their reputation grows.

To meet society's burgeoning emphasis on ease of access – and after considerable research into what added value it would bring to the public's journey – an online booking system has been put in place. This initiative assists patients in taking responsibility for booking follow-up appointments, and sends reminders to them, which has resulted in a 100 per cent rate of attendance. A cloud-based interface has been set up, too, which allows the team to code safely the packages – and six months on, the time-saving efficiency can be seen through the big changes in the amount of footfall.

'Innovation has meant so much to us. It's such a privilege to have more time with patients; meaning that we can truly put our expertise into action and show people what we're made of.'
Bernadette Brown and Team
Cadham Pharmacy
(Glenrothes)

'The team aren't just putting technology in to make the business more efficient – they're investing in more time for the benefit of patients. Their work really stood out.'
Steve Bradley
Cegedim Rx

Innovative Use of Technology in Community Pharmacy Award winner, Bernadette Brown and Team, Cadham Pharmacy (Glenrothes), with Steve Bradley, Cegedim Rx, and Philip Galt, Lindsay & Gilmour Pharmacy

WINNER

EDUCATION AND SELF DEVELOPMENT IN COMMUNITY PHARMACY

Sinead Collins
Holburn Pharmacy, Aberdeen

Since qualifying as an independent prescriber in 2010, Sinead has been steadfast in her dedication to maximise educational opportunities for both herself and her team.

Representative of her provision of continual self-development opportunities, the staff have recently completed the National Pharmacy Association Accuracy in Dispensing course, as well as the Buttercup dispensing courses. These learning outlets are all-encompassing as new members of staff are enrolled onto accredited courses immediately, and encouraged to attend local training / CPD courses as a team – resulting in an impressive uptake.

Sinead's determination to bolster the abilities of her team is due to her recognition that by training staff to a high level, the pharmacy are subsequently delivering a better quality of care to patients, and reinforcing their strong relationship with the extended multidisciplinary team. It also ensures that the members feel fully supported in their roles within the pharmacy team, as well as being motivated to embrace change within the profession.

Sinead has seen her own skills soar for the benefit of the community in that as an independent prescriber she was determined to utilise her prescribing capabilities and open a private travel and vaccination clinic within the pharmacy. After completing the TREC travel course in 2014, she decided to update and extend her knowledge by embarking on the National Pharmacy Association travel / vaccination course in July 2018. The overall aim was to open a travel / vaccination clinic and provide private travel and varicella zoster vaccinations to infants.

Spurred on further, Sinead decided to spend time with another pharmacist who was already providing private varicella vaccinations to children. This training was hugely valuable and helped her to develop a list of further training requirements – injection technique in infants, distraction techniques in infants while vaccinating, the timing of live vaccinations, the study of the Green Book of Vaccination, and the establishment of consent forms / promotional material.

Although the enhanced education of the pharmacy team has been identified as an integral area of focus – so, too, is maintaining their confidence in delivering this new knowledge. As a result, staff meetings are regularly conducted in order to ensure that they are all fully aware of the new services, and that they can assuredly discuss options with patients and refer to the pharmacist where appropriate.

Showcasing just some of the progress attained thus far, staff have been trained to provide general travel advice and to distribute advice to patients on the over-the-counter management of chickenpox. Their second pharmacist has also recently completed the National Pharmacy Association vaccination / anaphylaxis course, and plays an important role in counseling patients. Other changes include the recently-qualified accuracy checking technician taking a lead in the dispensary, allowing more time for Sinead to counsel patients and provide subsequent vaccination. As a pharmacy, they have also become Travax registered so that all vaccine / travel advice is up-to-date and vaccine shortages can be planned for in advance.

The transferable potential of Sinead and the team's knowledge is advantageous too. For example, with her initial independent prescribing qualification concentrating on psychiatry, she can utilise important skills when dealing with nervous patients, with the feedback from patients reinforcing this.

'I just think it's very important for pharmacists to push themselves in today's society and push the limits of prescribing. I'm so happy to win.'
Sinead Collins
Holburn Pharmacy
(Aberdeen)

'It's tremendously inspiring to get young pharmacists who have vision, and the command to take that vision forward and get the whole team involved. It really came through in this work.'
Jenny Macdonald
Lead Pharmacist, Education and Training
(NHS Greater Glasgow & Clyde)

Education and Self Development in Community Pharmacy Award winner, Sinead Collins, Holburn Pharmacy (Aberdeen), with Jenny Macdonald, Lead Pharmacist, Education and Training (NHS Greater Glasgow & Clyde), and Deborah Stafford, Principal Pharmacist for Education (NHS Tayside)

WINNER

SPECIAL RECOGNITION

Chris Nicolson
Director of Pharmacy, NHS Shetland and NHS Orkney

Sponsored by EMIS Health

With the ballroom abuzz with gleeful laughter and excitable mumblings, it was clear that another Scottish Pharmacy Awards chapter was nearing its end. But before the congratulatory conversation could kick off further, there was one final honour to bestow – the 2018 Special Recognition Award.

The annual accolade is awarded to a member of Scotland's pharmacy service who has demonstrated immense dedication and forward-thinking throughout their extensive career in the field.

A fitting tribute was paid to this year's recipient – an astonished Chris Nicolson – not just in acknowledgement of his role as Director of Pharmacy for NHS Shetland and NHS Orkney, but also in light of his career-long accomplishments.

A native of Kirkwall, Chris has spent most of his career in Orkney and Shetland, and completed his high school education at Kirkwall Grammar School where his passion for chemistry and decision to study pharmacy was inspired by his teacher, George Blance.

Chris' footing in the sector commenced upon his pharmacy studies in Aberdeen from 1978-to-1982, following which he undertook his pre-registration year in Glasgow, qualifying as a pharmacist in 1983. From his first job in the Western Isles hospital, to relocating to Orkney with the opportunity to work in community pharmacy, Chris has been persistent in his enhancement of pharmaceutical care.

Chris' innovative mindset is also an asset to colleagues and patients alike – in with Chris has overseen new models for dispensing medicines in the islands which place community pharmacists at the hub; believing that technology is the future and expressing an eagerness to link practices with pharmacies.

Chris also continues to work towards establishing more formal training and career pathways for remote pharmacy practice.

Recognising the importance of networking – despite the obstacles which may emerge as a result of living on an island – Chris does as much as he can to support other pharmacy leaders across Scotland. He took up a stint recently as vice chair of the Scottish Directors of Pharmacy, and has been a member of the Scottish Medicines Consortium, in addition to providing input into the Yellow Card Scheme.

Chris' influence goes beyond the realms of Scotland alone. In fact, just days before receiving the Special Recognition Award, Chris addressed a conference of pharmacists in Copenhagen on the Scottish approach to bringing pharmaceutical care closer to the patient. His work has been propelled into the spotlight by his peers nationally, too, in which he was made a Fellow of the Royal Pharmaceutical Society.

Commenting on the mark which Chris continues to make on the sector – and the wider impact of his win – Gerry O'Brien, Chief Executive of NHS Orkney, said, 'Chris richly deserves this recognition for a distinguished career in pharmacy. It is an essential part of a modern NHS. This award recognises not just Chris, but the superb teams he leads here and in Shetland.'

'I'm honoured and delighted. Thank you very much.'
Chris Nicolson
Director of Pharmacy
(NHS Shetland and NHS Orkney)

'Sponsoring this award reflects how we are looking to work with every pharmacist across Scotland to help them innovate and move pharmacy forward.'
Stuart Kearney
EMIS Health

Special Recognition Award winner, Chris Nicolson, Director of Pharmacy (NHS Shetland and NHS Orkney), with Stuart Kearney, EMIS Health, and Angela Timoney, Director of Pharmacy (NHS Lothian)

CERVICAL CANCER

TO WHOM IT MAY CONCERN

Fuss-free, quick, and, most importantly, the source of a multitude of life-saving benefits – so why is the number of patients attending for cervical screening dwindling? Robert Music, Chief Executive of Jo's Cervical Cancer Trust, weighs in, and details how we can fulfil the much-needed duty of raising awareness and addressing some of the barriers to participation.

Robert Music

In the UK, we are fortunate to have a fantastic cervical screening programme that saves thousands of lives every year. If used to its full potential, it is estimated by Public Health England that screening could prevent 83 per cent of cervical cancer cases.

Recent modelling by King's College London suggests that screening in England has prevented around 65,000 cancers between 1988-and-2013. In 2013 alone, there were nearly 5,000 fewer cases of cervical cancer than there would have been without our screening programme.

Despite this, the uptake of cervical screening is falling and has been for a decade. Across the UK, around one-in-four women are not taking up their invitation. At Jo's Cervical Cancer Trust, we regularly carry out research into the reasons that cause women and people with a cervix of all ages to delay or miss their cervical screening, so we can reverse this trend.

Cervical screening is the best protection we have against cervical cancer, yet for many women, attending is not always easy. Life gets very busy, and while it's true that making appointments can easily slip peoples' minds, this is far from the only factor contributing to declining attendance. Psychological, physical, literary, and cultural barriers can all impact a woman's intention to book a test, and for healthcare professionals, being aware of such obstacles is vital.

New research that we released during Cervical Cancer Prevention Week in January focussed on what young women – the demographic least likely to attend – think of screening and what has caused them to delay. Worryingly it found that, among 25-to-35-year-old women who do not attend or delay their test, 71 per cent say that they feel scared, and 75 per cent feel vulnerable at the thought of going. 81 per cent said that they also feel embarrassed at the thought of a test, with three-quarters saying that this is one of the main reasons they have delayed.

Among women over 50, lack of awareness and understanding is also contributing to low attendance. Previous research we carried out found that 32 per cent do not think that cervical screening is part of the healthy upkeep of a woman's body, and 21 per cent don't agree that regular cervical screening reduces the risk of cervical cancer. For post-menopausal women, pain can be a significant barrier to attendance, so understanding that there are ways to make screening more comfortable post-menopause, including through the use of oestrogen cream, is essential.

These psychological factors pose a huge barrier to what is already a very invasive test, yet we know for those eligible for screening there can be a plethora of other, often complex, factors. Sadly one-in-five women have experienced some type of sexual assault since the age of 16 and our research has found that three-quarters (72 per cent) of women who have experienced sexual violence have not attended or have delayed cervical screening as a result of their experience. For other women mental health issues, a previous bad experience, or a physical disability can make booking or accessing a test challenging.

CERVICAL CANCER

While cervical screening is not always easy, it's a test that saves thousands of lives every year and also prevents many people from having to go through the trauma of cervical cancer. Two women die every day from the disease, and many more go through painful treatment, often with long-term consequences (which can be physical, mental, and financial) that affect them for the rest of their lives. However, it is truly exciting that cervical cancer could one day be eliminated, with a robust screening programme and continued high uptake of the HPV vaccine.

We work with healthcare professionals who carry out cervical screening to share best practice. There are lots of tips you can give which will help to empower your patients with knowledge about how to make a smear test easier or more comfortable.

ENCOURAGE QUESTIONS

Understanding the purpose of cervical screening, what will happen during the test, the instruments used, and what the results might mean, will ensure that women feel far more in control. Your patient may never have heard of HPV or may be frightened thinking that they will be told they have cancer – 50 per cent of young women we surveyed indicated that their top screening worry was that they would be told that they have cancer, and this fear was also cited by many as a reason for not attending.

Pharmacists and other frontline healthcare professionals can help by proactively asking questions about cervical screening and giving information about the test. For example, there are misconceptions about the length of time that the test takes, so informing them that the test should only take a couple of minutes might be very welcomed by your patient, and encourage them to book an appointment.

LET THEM KNOW THEY'RE IN CONTROL

Worryingly, two-thirds (67 per cent) who delay or don't attend say that they would not feel in control at the prospect of a test.

Young women also say that they feel uncomfortable raising concerns during the test, 28 per cent would feel uncomfortable asking the nurse to stop, and 27 per cent wouldn't like saying if it hurt. 19 per cent wouldn't raise their worries as they don't think the nurse would be able to do anything about it anyway. Letting your patient know that the test shouldn't hurt, but may feel a bit uncomfortable, might help to assuage worries. Ask them to tell you if it does hurt, and always ensure to find out any pre-existing conditions which could cause greater discomfort.

You could have a great positive psychological impact by letting the patient know that they are able to say 'stop' if they want.

They might also not know that they are able to ask for a smaller speculum – and this knowledge may make them feel better, even if they don't need to use it. Pharmacists are in a great position to relay this kind of information to women who have concerns about screening so that they feel less nervous at the prospect of the test.

TELL THEM THEY'RE NOT ALONE

Feeling embarrassed and awkward is perfectly normal, so let your patient know that. 81 per cent of young women who delay or do not attend cervical screening feel embarrassed at the thought of going. While this is a worrying figure, it may reassure your patient that they are far from the only person who feels that way.

Telling them that they are normal for having these thoughts is a really simple step to make them feel less isolated in their worries, and is reassuring to hear from a healthcare professional.

TAKING THE TEST

Before you start, talk through what the test will entail and check if there are any questions. Always ensure that the woman is comfortable and that you have obtained permission to begin the test. Make sure that when you are taking the sample you observe facial expression and body movement. Talk through what you are doing until you have removed the speculum.

INCREASING ATTENDANCE

While ensuring cervical screening is as good as possible an experience for patients is essential, we must not forget that we are currently at an all-time low uptake. This presents another challenge altogether.

There are a wide range of initiatives that healthcare professionals can undertake to improve attendance in their area. This can be as simple as displaying literature on notice boards or screens in the practice or pharmacy. However, accessibility and ease of appointments remains an issue for lots of patients regardless of their opinions on the procedure itself. Assess when your practice offers screening and whether it is suitable for those who work, and if there is a hoist available for those with a disability. Drop-in clinics, evening, and weekend appointments can all significantly increase uptake, especially if advertised.

Understanding who your non-attenders are is also vital. You may be able to reach them through work with community groups, faith groups, or holding information sessions in different languages. Providing training to all frontline healthcare staff so they can positively and proactively promote cervical screening can further increase the reach of all your activities.

For more information, inspiration, resources, and support, visit www.jostrust.org.uk. To download or order information for free, visit www.jostrust.org.uk/shop/information.

SUMMER

A PLACE IN THE SUN?

In the UK, there are around 15,400 new melanoma skin cancer cases every year – that's 42 every day – with the biggest cause being too much ultraviolet (UV) radiation from the sun and sunbeds. All too aware of these risks, healthcare professionals are in a vital position to enlighten their patients about sun safety precautions, as almost nine-in-10 cases of melanoma could be prevented by implementing sensible safeguards and avoiding sunbeds. Katie Patrick, Health Information Officer at Cancer Research UK, tells us more.

Katie Patrick

After the clocks go forward, and spring gets under way, people look forward to making the most of the warmer weather and spending more time outside. Healthcare professionals can help members of the public and patients to protect their skin by taking opportunities to discuss how to enjoy the sun responsibly.

Both sunburn and suntan are signs that the skin has been damaged – and getting sunburn just once every two years can triple the risk of melanoma.

SUNBURN – WHO'S AT RISK?

Anyone can develop skin cancer so it's important for everyone to stay safe in the sun – especially those who are actively seeking a tan during the summer months.

Sunburn doesn't have to be raw, peeling, or blistering. If skin has turned pink or red, it's sunburnt. For people with darker skin, it may just feel irritated, tender, or itchy.

Some things mean that people have a higher risk of skin cancer and should take extra care in the sun.

These include having:

- Skin that burns easily
- Light or fair coloured skin, hair, or eyes
- Lots of moles or freckles
- A history of sunburn
- A personal or family history of skin cancer

TOP TIPS FOR SKIN PROTECTION

When the sun is strongest, people should spend time in the shade, cover up with loose clothing, and use sunscreen as a last line of defence for parts which clothing doesn't cover.

Whether at home or abroad, checking the UV index on the weather forecast is a sensible precaution. If it's moderate or high (higher than three), people should think about protecting their skin. In the UK the sun is strongest between 11am and 3pm.

If it's not possible to check the UV index, people can follow the shadow rule – it's simple and works anywhere in the world.

They can just look at their shadow and if it is shorter than them this means that the sun's UV rays are strong.

SUN AND SUNSCREEN – KNOW THE FACTS AND BEWARE OF THE MYTHS

Myth Number One: ***'You can only burn in the middle of summer.'***

The sun can be strong enough to burn in the UK from the start of April to the end of September, even if it doesn't feel that warm, or it's a cloudy day.

Myth Number Two: ***'Higher SPF sunscreens are much better than lower ones.'***

As SPF increases, the additional UV that sunscreen can absorb tails off, offering less added protection. People using sunscreen with a higher SPF may also stay out in the sun longer, increasing their risk of skin damage.

SPF15 should be enough to protect people wherever they are in the world, assuming it's applied properly and used alongside covering up and seeking shade. People should also look for a star rating of four or five.

Myth Number Three: ***'Putting sunscreen on once is enough.'***

This just isn't true. Even if it says once-a-day on the label, all sunscreens should be re-applied regularly. Some products rub, wash, or sweat off more easily than others. But it's also very easy to miss bits so people should put plenty on.

SKIN – CHANGES AND CHECKS

Although it's a good idea for people to know what their skin looks and feels like normally, there's no need for regular skin checks, or to map moles on diagrams or apps as this hasn't shown any benefits. Most moles remain harmless, but occasionally the cells can become abnormal and develop into melanoma skin cancer. Moles that get bigger or change in colour or shape are important to get checked out by a doctor.

But unusual or changing moles aren't the only thing to look out for when it comes to skin cancer. Other things include any change in a patch of skin or a nail; whether it's a mark or mole that has been there for some time, or something new that appears. In most cases, it won't be cancer, but it should still be checked out by a doctor.

For more information, or to find and order leaflets and posters on the sun, UV, and cancer, visit www.cancerresearchuk.org.

CROSSING THE LINE

As the Scottish Medicines Consortium continues to produce advice to NHS Scotland about the value for patients of every newly-licensed medicine, SPR drives those which have been accepted for use into the spotlight.

MARCH 2019

MEDICINE	FOR THE TREATMENT OF...
Liposomal daunorubicin / Cytarabine (Vyxeos)	Adults with a high-risk type of acute myeloid leukaemia; a rare, aggressive, and rapidly progressing, cancer of the white blood cells
Letermovir (Prevymis)	To prevent illness due to cytomegalovirus infection in patients who have received a stem cell transplant

APRIL 2019

MEDICINE	FOR THE TREATMENT OF...
Erenumab (Aimovig)	Patients with chronic migraine, in whom the use of at least three other preventive medicines has been unsuccessful
Lenvatinib (Lenvima)	A type of liver cancer called hepatocellular carcinoma
Certolizumab (Cimzia)	Moderate-to-severe plaque psoriasis in adults

SAVE THE DATE

Are you in-the-know with the latest Clinical Pharmacy Congress news?

We're proud to announce that SPR is taking up the role of media partner for the Clinical Pharmacy Congress, which will be taking place from 7th-to-8th June at London's ExCeL.

The Clinical Pharmacy Congress is the largest gathering for the clinical pharmacy profession held in the UK, and will provide you and your team with an unmissable opportunity to keep up-to-date with the latest pharmacy developments to help you improve patient outcomes.

If you are a registered pharmacist or pharmacy technician working in the NHS, private hospital, hospice, CCG, CSU, military, academic organisation, or secure environment, you are eligible for an education grant to attend the prestigious event.

For more information, or to register now, visit www.pharmacycongress.co.uk.

GOING THE EXTRA MILE

Are you considering starting up a travel clinic in community pharmacy? Community Pharmacist, Siân Humphreys, on behalf of ECG, takes a look at the organisation involved in setting up a travel service, and shares advice as to how you can make a success of your clinic without it having an adverse effect on your day-to-day community-focussed responsibilities.

Siân Humphreys

We're all under immense pressure to provide a sparkling service 100 per cent of the time – but how should we manage a situation when things go wrong? And what can we put in place to ensure that the same issue doesn't reoccur?

Incorrect vaccine selection is a potential error that I'm very aware of. Many of the vaccines we offer are made by the same pharmaceutical company – and the cause of many dispensing errors is that the packaging is very similar. An example of this is Typhim Vi (typhoid vaccine) and Avaxim (hepatitis A vaccine). Both come in identical boxes of 10; and there are no distinguishing features apart from the name and a green stripe vs a pink stripe. Also amazingly similar are adult and child vaccines – such as Engerix B and Twinrix.

It's very important to organise our fridge (and ourselves!) with the vaccine tasks ahead. We organise our dispensary alphabetically, so why not arrange the fridge in the same way? Limit staff access as you would the CD cabinet, and know your stock. It's back-to-basics, but start this way and you will continue in this manner. It's hard to put a process in place once a service has been running for six months, so instil the rules now and you won't go far wrong.

ORGANISATIONAL TIPS WHICH NEED TO BE SET IN STONE FROM DAY ONE

TAKE CONTROL OF YOUR STOCK

Know what you're ordering, and from where. Do you have a vaccine quota? Do you need to set up an account with a supplier? If a patient enquires about a full course of hepatitis B vaccines, your answer needs to be, 'Yes, we can offer that.'. If you can't answer confidently and truthfully on the spot, then you'll risk losing the custom.

At the point of agreeing to vaccinate (post-risk assessment etc.) make sure that you have the stock, or that you can easily obtain it within 48 hours. Often community pharmacies offer a discount if a full course is purchased – for example, typically 10 per cent discount is applied if all three vaccines are purchased at the point of dose one (hepatitis B, rabies etc.). If I don't have the vaccines in stock, I always call the suppliers in front of the patient before taking payment. Supply of vaccines is sometimes troublesome, so don't over-promise and under-achieve.

WHEN A PATIENT PAYS FOR A COURSE OF VACCINES, SEPARATE THESE FOLLOW-UP DOSES

Store in a basket at the bottom of the fridge with the patient's name and dose details, eg. Mr X, hepatitis B, dose two and three. I can't stress how imperative this is! I always show the patient when I do this – it creates reassurance and trust that their follow-up dose is ready and waiting. Just remember to check the date if the vaccine is due in a couple of months.

SCHEDULES

This brings us on to schedules. Each of my patients has their own plastic wallet which contains:

- All consent forms – one needed per vaccine appointment, stating the correct date
- A downloaded 'prescription' – although you're more than likely working from a PGD, you can usually print a list of vaccines to be administered which will help your vaccine plan. Like flu vaccines, travel vaccines have a peel-able sticker often with the vaccine name, expiry date, and batch number (I stick this on the print-out as a cross-reference and reassurance)
- Copies of till receipts – you will often see patients over a six-month period, so print a copy of each receipt at point of payment and write their name at the top. It's so simple, but it has supported me greatly when a patient has queried remittance. It's also hugely useful in keeping track if the patient prefers a pay-as-you-go approach
- Vaccine schedule planner – I fill this in as I go, and supply a copy to my patient so that we can work through the schedules together. My vaccine schedule planner is really useful, as I can see at a glance where I'm up to. Jane Chiodini's schedule reference guide is updated regularly and is a great source. ***Visit www.janechiodini.co.uk***

When running a travel clinic in community pharmacy, planning and organisation is paramount. Look after yourself, and work to your ability. If you start off organised and with a clear and achievable aim, the rest will fall into place – and in time you'll be running a successful service.

CALLS FOR UNIVERSAL OBESITY ADVICE FOR PARENTS

The Royal College of Physicians of Edinburgh have called on the UK government and the devolved administrations to provide universal nutritional education for parents, to help tackle childhood obesity.

They have said that education on healthy diet for children, and the importance of exercise, should be available at every opportunity – across all socio-economic groups – starting with antenatal classes, then nursery, pre-school, and primary and secondary school. The college have recognised that the vast majority of parents encourage a healthy diet and exercise for their children.

Statistics demonstrate that if a child starts school already obese, then they are more likely to be obese in adulthood. Just one-in-20 children, who are obese at age five, will return to a healthy weight by the age of 11. The obesity rate in adults in England and Scotland is 29 per cent, while in Northern Ireland, 27 per cent of the population is obese.

The college pointed to a successful scheme in Leeds, led by HENRY (Health, Exercise, Nutrition for the Really Young), where training has been provided for early-years workers and eight-week family programmes for 10 years. Leeds has subsequently seen a 6.4 per cent fall in obesity rates over recent years, and the college want to see investment in similar schemes right across the UK. They also said that investing in nutritional education for first-time mothers could help reduce their future risk of developing type 2 diabetes.

The college is placing an emphasis on exercise too – arguing that subsidised gym access, for example, could help under 18s keep active outside of school, but also when they leave school.

Commenting, Professor Derek Bell MD OBE, President of the Royal College of Physicians of Edinburgh, said, 'It's clear that by providing the right training for early-years workers, and the right information for families, real progress can be made on tackling obesity over time. This type of programme could be investigated and hopefully introduced nationally, or indeed locally through local authorities.'

Professor Derek Bell

AIMS TO WIPE OUT CASES OF HEPATITIS C WITHIN A DECADE

NHS Greater Glasgow & Clyde are treating record numbers of people with hepatitis C, with the real chance of eradicating the potentially fatal virus in the next decade.

Utilising the latest diagnostic tests and treatments, the board's clinicians have treated 1,213 people in the past year – 80 per cent more than the Scottish government target of 675 for the health board area.

The virus affects the liver and, if left untreated, can potentially lead to serious and life-threatening conditions, such as liver cancer or cirrhosis.

Treatment has changed dramatically, and since 2015 everyone with a positive diagnosis is eligible for treatment with simple once-daily tablets which cure over 95 per cent of cases, with no significant side-effects. This compares very favourably with the previous treatment of a 48-week course of injections which could be accompanied by serious side-effects. There are also no restrictions on who can be treated in that physical and mental health conditions, including alcohol and drug use, are no longer a barrier to accessing treatment.

Dr Linda de Caestecker, Director of Public Health, NHS Greater Glasgow & Clyde, said, 'In the last year we have treated more than 1,200 people and there is a real possibility that we could potentially wipe it out within the next decade.

'Our mantra is test, treat, eliminate, and through this, everyone involved in the care of patients who may have hepatitis C can play their part in preventing related liver disease, by offering a simple blood test.

'Our staff deserve enormous credit not only for being able to engage with so many people affected, but also for getting so many tested and into treatment.'

SUMMER

IN THE HEAT OF THE MOMENT

In summer, medical professionals may face different challenges to the rest of the year, for example, higher numbers of staff on leave, patients visiting from other countries, or local patients returning from their own holidays. Dr Sally Old, Medico-Legal Adviser at the Medical Defence Union, advises on how best to address these seasonal healthcare issues.

Dr Sally Old

INCREASING NUMBER OF TEMPORARY PATIENTS

You may find that you have an increase of temporary patients in the summer months.

Unfortunately, this may result in you not having access to their medical records, allergy, or drug history, so careful assessment and record-keeping is essential. You should be willing to contact a patient's own GP for further information, with the patient's consent, particularly if you are considering prescribing for a temporary patient, who may not provide an accurate or full drug history.

You should also pass a copy of your records to the patient's own GP after your consultation.

You might also have concerns about whether the patient is entitled to NHS treatment. The Department of Health advises that medical professionals can exercise their discretion to accept any person, including overseas visitors, to be fully registered, or as a temporary resident, if they are to be in an area between 24 hours and three months, but that does not necessarily entitle that person to free NHS hospital treatment.

With this in mind, if a doctor feels it is necessary to refer a temporary patient for hospital treatment, the doctor should explain this to the patient, and make it clear in the referral letter that they believe the patient is visiting from overseas so that the relevant NHS body can check their entitlement.

Medical professionals can refuse to treat temporary patients provided they have 'reasonable grounds for doing so that do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability, or medical condition' (standard General Medical Services contract – Schedule 3, Part 2, Section 21).

However, doctors have a duty to provide immediate necessary treatment and an ethical duty to treat in an emergency. If a patient is refused an appointment, you should make detailed notes with the reasons in case you are asked to justify this decision at a later date.

ARRANGING COVER WHEN YOU GO ON HOLIDAY

It's your responsibility to ensure that patients are appropriately cared for when you are not available, such as when on annual leave.

The General Medical Council says that doctors must share all relevant information with colleagues involved in their patient's care when handing over or delegating care. You must also be satisfied that the person providing care has the appropriate qualifications, skills, and experience to provide safe care for your patients.

You should therefore check that any locums that you employ are appropriately qualified, and that they receive a handover and induction so that they can work effectively.

CONSIDERING UNUSUAL DIAGNOSES

In summer time, many people will be traveling on their holidays and may not volunteer or think to share information about their recent travel to a GP or A&E department. It's always important to ask as if you don't, you may miss a diagnosis relevant to their recent travel.

The NHS advises the public to seek advice from their GP or travel clinic before traveling, so it is important that you are up-to-date and familiar with what advice to give.

For more information, visit www.nhs.uk/conditions/Travel-immunisation/Pages/Introduction.aspx and www.travelhealthpro.org.uk/countries.

BEING A GOOD SAMARITAN

You finally get away for your own well-deserved holiday when there is an announcement on the plane, 'Is there a doctor on-board?' Although there is no legal obligation to do so, the General Medical Council's guidelines state that doctors should offer help to an emergency.

If you are ever called upon to help, you should take into account:

- Your safety – don't put yourself at unnecessary risk
- Your competence – don't try to work outside your abilities
- The availability of other options – are more qualified or able people on the scene?

Where possible, you should also:

- Make a detailed record of the incident and your involvement
- Obtain consent from the patient
- Explain your actions and treatment to the patient
- If you don't have a licence to practice – for example, if you've retired or you're a student – you can still offer assistance in an emergency. The General Medical Council advises that not having a licence or registration shouldn't stop doctors from helping in emergencies
- Non-licensed doctors must, however, be clear about their General Medical Council status. It is a criminal offence to inaccurately present yourself as registered with or without a licence

HIV: LEADING THE WAY

With the roll-out of new HIV-related research eliciting renewed awareness and the need for continued progress, SPR takes a look at what's been happening in Scotland.

COCAINE INJECTING AND HOMELESSNESS CREATE PERFECT STORM FOR RAPID RISE IN HIV

A seven-year study by a team of blood-borne virus researchers has revealed for the very first time the scale and drivers of the UK's largest HIV outbreak in over 30 years in Glasgow.

Experts from Glasgow Caledonian University (GCU) and Health Protection Scotland (HPS) – working in collaboration with NHS Greater Glasgow & Clyde and the University of the West of Scotland – found that a significant rise in cocaine injecting in the city, which more than doubled between 2011-to-2012 and 2017-to-2018, in addition to homelessness and other key factors, combined to create a perfect storm for an HIV outbreak in 2015.

Dr Andrew McAuley, Senior Research Fellow / Senior Epidemiologist in Blood-Borne Viruses at GCU and HPS, and lead author of the research paper published in the Lancet HIV journal, explained, 'One of the key findings of our research is that we've detected a hugely significant increase in the prevalence of HIV infection in the population of people who inject drugs in Glasgow, largely driven by an outbreak of HIV first detected in 2015.

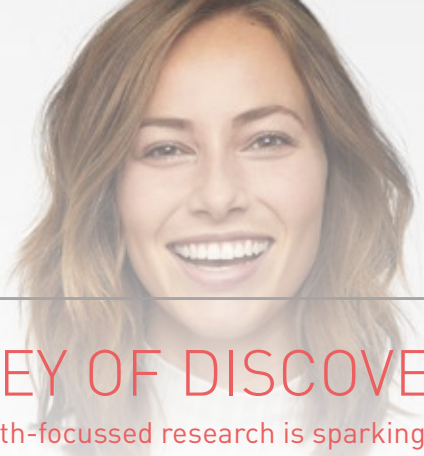
'The prevalence of HIV has been low and stable in this population since major outbreaks of HIV in the 1980s in Edinburgh and Dundee. However, the prevalence of HIV in Glasgow has increased 10-fold among people who inject drugs in the past seven years, from just one per cent to over 10 per cent in the city centre.'

HIV SCOTLAND WELCOMES DROP IN NEW HIV DIAGNOSES

Commenting on the new Quarterly Report recently published by HPS, Nathan Sparling, Chief Executive of HIV Scotland, welcomed the new figures.

Nathan said, 'The new figures published by HPS show the lowest levels of new HIV diagnoses in 10 years. We've seen a significant reduction in new diagnoses among men who have sex with men, which could be our first indication that PrEP is working to prevent new HIV transmissions, and we have the lowest level of HIV diagnoses among people who inject drugs since the outbreak in Glasgow began.

'Scotland has been leading the way in developing a comprehensive HIV prevention toolkit – with PrEP, treatment as prevention, needle exchanges, and access to testing. There's clearly more work to be done, but we're certainly on the right path to get to zero.'



A JOURNEY OF DISCOVERY

A raft of female health-focussed research is sparking new hope – as Wellbeing of Women-funded scientists have found a novel way of delivering drugs for the treatment of premature birth through 'trojan' peptides.

Dr Leo Gurney

A new study at the University of Newcastle has showcased exciting results – potentially paving a significant advancement for women's health – in which Cell Penetrating Peptides (CCPs) were able to deliver anti-inflammatory drugs which prevent pre-term birth to the uterine (womb) and placental cells. The anti-inflammatory drug attached to the CPPs worked in a short space of time, and at a low concentration, offering the chance of a new treatment to at-risk women.

Pre-term birth is a major pregnancy complication; and those born prematurely may suffer life-long health problems, posing a huge emotional and social burden for families.

Treatments aimed at preventing pre-term birth in at-risk women are referred to as tocolytic treatments, and the number of available tocolytic treatments remains limited, while existing therapies have not shown a major benefit in improving the health of mothers or their babies. There is an urgent need to develop new treatments.

Many cases of pre-term birth are caused by increases in inflammation in cells of the uterus (womb) and placenta, and a key obstacle is that the cell membrane acts as a barrier and prevents drugs from entering and taking effect.

CPPs are a novel solution to this problem; they are a class of peptides (small proteins) that can deliver drug cargo through cell membranes, causing minimal disruption to the cell, and therefore are often referred to as 'trojan' peptides. And although CPPs are used in the drug delivery method in many medical fields, never before has their potential been fully explored in the area of pre-term birth.

FINDING THE WAY

The study led by Dr Leo Gurney – and funded by women's health charity, Wellbeing of Women – has demonstrated that anti-inflammatory drug cargo (Nemo Binding Domain peptide, or NBD) attached to CPPs can enter uterine cells and work effectively. In uterine cells, the study discovered that CCPS can work within a short time and at a low concentration. A similar timeframe of cell entry was observed with the NBD peptide attached to CPPs, indicating that the attachment of drug cargo didn't adversely affect cell entry.

The NBD peptide was able to block key inflammatory changes in protein levels in uterine cells and also block the activation of inflammatory genes that have been previously associated with pre-term birth.

There is a very wide variety of potential drugs that can be attached to CPPs. Further research needs to be done on the exact mechanism of the NBD peptide within uterine cells.

TALES OF EXPERIENCE

CASE STUDY ONE

After suffering recurrent miscarriages – one as late as 11 weeks – Terri-Ann found out that she was pregnant with her third child. She was put on high-risk, and after an initially smooth pregnancy, she had a premature rupture of the membranes and Jaxon was delivered by C-section on 10th February 2018 at 30+5 weeks – weighing just 3lb 2oz at University Hospital Coventry and Warwickshire. Jaxon was in NICU for 33 days, and on the first day his mum was only allowed to see him for five minutes. He is now nearly one and is doing well.

Terri-Ann said, 'Jaxon is our rainbow baby. Jaxon has continued to amaze me and his dad and everyone else. I was particularly scared about winter and his chest but he was fine. He has had issues with constipation which is managed with suppositories which has now helped his once plateauing weight. He isn't too far behind on milestones either, but they are keeping an eye on him just in case. He is rolling, sitting, and babbling, and getting a right little character now.'

CASE STUDY TWO

A mother's waters broke at 17 weeks, and she was offered a termination but refused.

The baby was born at 28+5 weeks, and was in intensive care for 11 days. He spent three months in hospital on different breathing support, and has chronic lung disease. The baby is now doing well at home – there are no developmental delays and he will be weaned off oxygen this year.

ABOUT WELLBEING OF WOMEN

Founded 54 years ago, Wellbeing of Women is one of the only charities finding cures and treatments across the breadth of female reproductive health, including pregnancy and childbirth, fertility, gynaecological cancers, and overlooked areas like endometriosis, polycystic ovary syndrome, and the menopause. Many of the routine tests and treatments that form everyday clinical practice can be traced back to the charity's work, such as the use of ultrasound in pregnancy, and the importance of taking folic acid for the health of the unborn baby. Wellbeing of Women also funded Professor Henry Kitchener who linked HPV to cervical cancer which led to the HPV vaccination programme in schools, making cervical cancer preventable for the first time. Only 2.48 per cent of publicly-funded research is dedicated to reproductive health and childbirth which makes the work vital.

For more information, and to find out how you can support Wellbeing of Women's work, visit www.wellbeingofwomen.org.uk.

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* National Institute for Health and Care Excellence

References: 1. NICE. Gastro-oesophageal reflux disease: recognition, diagnosis and management in children and young people. 2015. Available at: www.nice.org.uk/guidance/NG1 [Accessed: February 2019]. **2.** Wenzl TG *et al.* Pediatrics 2003;111:e355-9. **3.** Nutricia Research, Data on File. **4.** Vandenplas Y *et al.* Eur J Pediatr 1994;153:419–23. **5.** Borrelli O *et al.* Ital J Gastroenterol Hepatol 1997;29:237-42.

IMPORTANT NOTICE: Breastfeeding is best for babies. Aptamil Anti-Reflux is a food for special medical purposes, for the dietary management of frequent reflux and regurgitation. It should only be used under medical supervision, after full consideration of the feeding options available including breastfeeding. Suitable for use as the sole source of nutrition for infants from birth, and as part of a balanced diet from 6-12 months.

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COPING WITH CYSTITIS

Cystitis (also known as urinary tract infection) is one of the most common infections seen in adults of all ages. Many women experience cystitis at some point in their life, while some get repeated infections which can be painful and stressful. Susannah Fraser of Bladder Health UK shares how you can help ease the discomfort for those dealing with the condition, and alleviate their level of pain.

Susannah Fraser

In the UK, around two million women suffer from cystitis each year. While it is less common in men, the symptoms can be equally troublesome.

Cystitis typically consists of pain over the bladder; discomfort or burning when passing urine; increased frequency of urination; and sometimes backache or a temperature. Many patients can end up feeling that it is something that they 'just have to put up with' – but this is not true. There are now numerous medical treatments, lifestyle changes, and alternative remedies that can help with the problem.

Cystitis is caused by bacteria entering the bladder via the urethra. Bacteria may be introduced to the urinary system for many reasons. For example:

SEXUAL ACTIVITY

Sexual intercourse may introduce bacteria to, or cause bruising of, the urethra and bladder.

To avoid cystitis following sexual intercourse:

- Pass urine before and after sex
- Wash before and after sex (this includes your partner). Remember that it is important to wash your hands as well as your genitals
- If natural lubrication is a problem, lubricating gels can be purchased from a pharmacy

POST-MENOPAUSAL CHANGES

The normal pre-menopausal vagina is colonised by lactobacilli, the presence of which is dependent on oestrogen, the female sex hormone. These lactobacilli or 'good bacteria' prevent the area from being invaded by 'bad bacteria', for example E-Coli.

After the menopause, when oestrogen levels decline, it is quite common for women to develop urinary infections. Inappropriate use of antibiotics also destroys lactobacilli, as does spermicidal gel. Decreasing hormones in post-menopausal women result in changes within the body. These changes reduce the normal defences of the urethra and allow harmful bacteria to grow.

DIABETES

The urine of diabetics can contain a lot of sugar, encouraging bacteria to grow.

PREGNANCY

Pressure from the uterus may result in incomplete emptying of the bladder, thus encouraging bacteria to grow.

PROSTATE

In men, an enlarged prostate prevents the bladder from emptying completely. A stagnant pool of urine can encourage the growth of bacteria.

KIDNEY / BLADDER STONES

These may cause urine to stagnate in the urinary system which encourages bacteria to grow.

SIMPLE TIPS TO PREVENT CYSTITIS FROM DEVELOPING

- Drink lots of fluids to make plenty of dilute urine – eight glasses a day of dilute squash, rather than pure fruit juice, tea, or coffee
- The bacteria that cause cystitis thrive in warm, moist conditions. Wearing loose fitting clothes made of natural material, such as linen or cotton, may prevent the bacteria from multiplying
- Ensure that you eat a healthy and nutritious diet to keep your immune system functioning effectively
- For women who have been through the menopause, oestrogen replacement treatment in the form of pessaries or topical cream may prove useful
- If necessary, revise your method of contraception as the use of spermicidal products can destroy lactobacilli (good bacteria)
- If you feel that cystitis episodes are precipitated by sex, it may be advisable to wash the genital area prior to and pass urine after sex to help flush bacteria away

WHEN AN ATTACK OCCURS

Alkalising the urine helps to eradicate germs and sooth the bladder. Always consult your GP if symptoms continue for more than two days. Men, children, and pregnant women should not attempt to treat themselves, but seek medical advice at the earliest opportunity. If symptoms persist and samples submitted for testing are coming back clear, you may need to be treated by a practitioner specialising in chronic infection of the bladder. Contact Bladder Health UK for details.

There are also some alternative supplements available to purchase which may help to clear bacteria from the bladder; the most well-known of which is probably D-Mannose. D-Mannose may be used in the prevention of cystitis caused by E-Coli bacteria.

D-Mannose is an essential simple sugar. It was discovered in the late 1980s that a small amount of D-Mannose is present in urine, apparently acting as a defensive mechanism against pathogenic bacteria. When D-Mannose is taken as a supplement, more passes through the urinary tract, coating the bacteria and flushing them out in the urine.

ABOUT BLADDER HEALTH UK

For further insights on urinary tract infection, contact Bladder Health UK.

Bladder Health UK gives support to people with all forms of chronic bladder illness, together with their families and friends. We are the largest bladder patient support charity in the UK with an informative website that includes a chat room / message board forum. We are also active on Facebook, Twitter, and Instagram, so look us up or give us a call!

For more information, visit www.bladderhealthuk.org, or call the confidential advice line on 0121 702 0820.

NEWS

A CYCLE OF REINFECTION

We can sometimes find ourselves caught up in a frustrating cycle of bladder infections without realising that we are succumbing to the same infection as before, explains Anna Sawkins, Managing Director of Sweet Cures.

Anna Sawkins

Bacteria from previous bladder infections survive deep in the bladder wall and once there, are protected by tough, impenetrable biofilms.

In fact, hardy bacteria secrete lipids around themselves (lipo-polysaccharides and lipo-proteins) and can also produce other substances, glyco-proteins and polysaccharides (very like 'mucus') to form a gooey covering layer which protects them from outside attack.

Even chemicals like antibiotics find it hard to get through this sticky, protective layer. In fact, the most important attribute of a biofilm is its ability to protect the organisms within it, making them resistant to most antibiotics. When conditions became favourable they re-emerge to colonise once again.

'This kind of organisation is the hallmark of biofilms formed by bacteria in the bladder. When conditions are right for growth,' 'the bacteria begin detaching from the biofilm and leave the cell to re-initiate an acute infection in the urinary tract,' stated Gregory G Anderson, Hultgren's Lab.

Despite biofilm research that goes back nearly 20 years, women are still, occasionally, subjected to humiliating lectures on wiping the bottom from front-to-back as if cleanliness were the problem, rather than the biofilms which we now know protect highly-resistant, deeply-embedded, opportunistic bacteria. And biofilms are not all that may be affecting our propensity for recurrent bladder infections.

It would seem that bacteria have responded to the worldwide overuse of antibiotics in farming and medicine by creating beta lactamase; an enzyme that can give the bacteria immunity to each new attack they encounter. Most people are already familiar with the superbug MRSA, and C. Difficile, but have not yet heard of ESBL producing bacteria. ESBL bacteria are different from other superbugs, because ESBL does not refer to a specific kind of bacteria.

ESBLs – Extended Spectrum Beta Lactamases – are enzymes made by some bacteria, including Klebsiella and E-Coli, among others, and refer to an antibiotic-resistance enabling enzyme that the bacteria are producing, as a means of protecting themselves against attack. Both are common culprits in recurrent urinary tract infections.

'E-Coli is now killing more than twice as many people as MRSA and Clostridium difficile combined, so the price of any further inaction will be measured in human lives,' said Cóilín Nunan, Scientific Adviser, Save Our Antibiotics.

COULD A HEART DRUG HELP LUNG DISEASE PATIENTS?

There is no cure for COPD – which is the fifth leading cause of death in the UK, resulting in 30,000 fatalities a year – and it can be hard to treat. However, now a trial, being run out of multiple centres across the UK, including Aberdeen and Dundee, will treat patients with beta-blocker drugs which are more commonly used to treat high blood pressure and heart disease.

There is evidence that beta-blockers can reduce flare-ups in people with COPD, even if they don't also have a heart condition. Older beta-blockers had lung side-effects, but newer so-called selective beta-blockers targeting the heart are safe for those with COPD to use.

The trial, funded by the UK National Institute for Health Research, will recruit more than 1,500 patients with COPD from 160 centres across the UK, in which half of the patients will be given a beta-blocker (bisoprolol), and the other half given a placebo in order to see if the beta-blocker reduces the number of flare-ups.

Professor Graham Devereux, from the University of Aberdeen, explained, 'One of the problems with COPD is that despite improvements in inhalers, COPD continues to be a major problem. The evidence that beta-blockers might help people with COPD is very exciting and a potential game-changer in our approach to this disease.'

Dave Bertin, of Chest Heart and Stroke Scotland, added, 'We are delighted to be involved in this important study. Through our Voices Scotland team we have used the views of people living with COPD to help shape the research.'

ANNIVERSARY OF IMPLEMENTATION OF MINIMUM UNIT PRICING OF ALCOHOL

May marked the first anniversary of the establishment of minimum unit pricing of alcohol in Scotland – which was the first country in the world to impose the initiative, following a 10-year campaign.

Shedding light on the milestone, Alison Douglas, Chief Executive of Alcohol Focus Scotland, said, 'Before minimum unit pricing was introduced you could drink more than your weekly units for less than the price of a cup of coffee. Now that's not the case which can only be a good thing.

'It's no secret that Scotland has an unhealthy relationship with alcohol. In 2017, 1,200 Scots lost their lives, while more than 35,000 people were admitted to hospital as a result of drink. This shocking impact on our health is accompanied by other social harms, such as violent crime. Something needed to change, and while everyone accepts that minimum unit pricing on its own will not solve our alcohol problem, it's a good start.'

And what shift has Scotland seen since the initiative's introduction?

Alison explained, 'Everyone is keen to know what the impact of the policy has been and we're just a few weeks away from seeing the next NHS Health Scotland Monitoring Report, which will be the first to include data on the amount of alcohol sold in Scotland since the introduction of the policy. However, it is important to remember that while we hope to see positive indicators in the first year, the effects are expected to build over time.

'An independent evaluation, led by NHS Health Scotland, will assess the impact of the policy on health, crime, and the industry over the next five years, making minimum unit pricing one of the most thoroughly-evaluated polices ever implemented in Scotland.'

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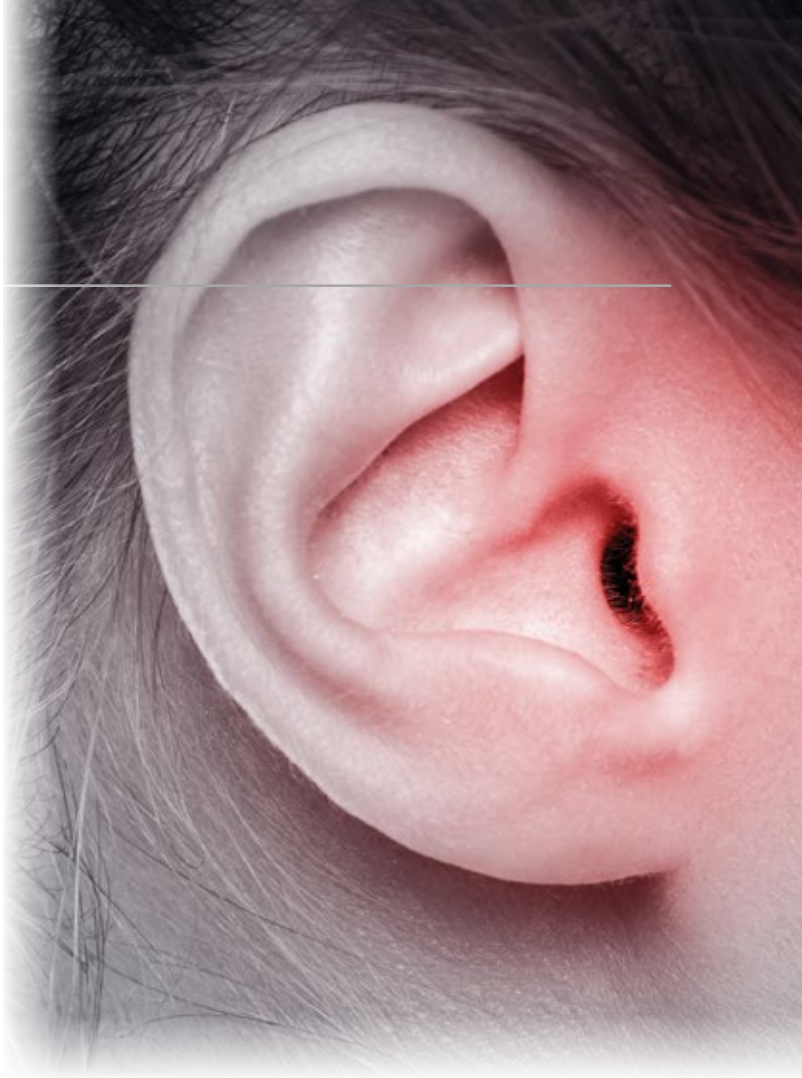

FROM EAR-TO-EAR

Despite producing irritability, difficulty sleeping, and, at times, hearing problems, ear infections are so often unnecessarily prolonged. Tap into the latest information, and help patients react accordingly to both their pain and any risks posed.

Whether it's due to the impact of modernity – and the faith in all internet-based medical information which has derived from it – or the fact that we're part of a population with a longer life-expectancy, when it comes to health issues, individuals' misplaced sense of invincibility often results in their reluctance to follow up ailments appropriately. Ear-related difficulties especially seems to be an area which goes overlooked – in which sufferers' refusal to 'inconvenience' the health service transitions into sheer ignorance.

It's time to make a change. Healthcare professionals attain responsibility in not only educating their patients about the potential implications of ear pain, but in ensuring that their own knowledge is up-to-date too.

WHO'S SUSCEPTIBLE?

While attention is principally drawn to the causes of ear infections, perhaps there's an unforeseen link which has simply gone unknown – such as a gene. In fact, researchers at the University of Colorado Anschutz Medical Campus have detected multiple genetic variants within the FUT2 gene that makes some people especially susceptible to middle ear infections.

Very common in the younger generation, middle ear infections are a source of great discomfort – a point reiterated by the study's lead author, Regie Santos-Cortez, MD, PhD, Associate Professor of Otolaryngology at the University of Colorado School of Medicine, who explained, 'By the time they are one-year-old, around half have fever, ear pain, or pus / fluid in the middle ear due to infection. Some of these infections may recur or become chronic thus requiring surgery.'

The FUT2 gene is expressed in the salivary gland, colon, and lungs, and while its expression in the middle ear has not been depicted previously, its role was revealed by initially examining DNA samples from 609 multi-ethnic families with the condition.

'A number of things predispose people to getting these infections, including a lack of vaccinations, lack of breastfeeding, and being around smoking caregivers,' further explained Regie Santos-Cortez.

Essentially, possessing the genetic variants prompts a much higher chance of getting the infection, in that – according to the study – the gene modifies the microbiome of the middle ear in a way that makes it more susceptible to infection by specific bacteria.

TO SEA OR NOT TO SEA?

As summer descends, sun-seekers are urged to carry out a series of precautions – but once again, ear health frequently drops off the radar.

With swimming being a summer activity of choice for many people, much care needs to be taken – especially as a large-scale research analysis led by the University of Exeter Medical School in collaboration with the Centre for Ecology and Hydrology showcased that spending time in the sea doubled the odds of developing general ear ailments, and the odds of reporting earache specifically rose by 77 per cent.

Despite significant investment resulting in an improvement in water quality in recent years, seawater is still polluted from sources, including industrial waste, sewage, and run-off from farmland.

So, where do we go from here in terms of the advice we provide to patients? Dr Will Gaze, of the University of Exeter Medical School, who supervised the research, has offered an insight, saying, 'We don't want to deter people from going into the sea, which has many health benefits, such as improving physical fitness, wellbeing, and connecting with nature.

'However, it is important that people are aware of the risks so they can make informed decisions. Although most people will recover from infections with no medical treatment, they can prove more serious for vulnerable people, such as the very old or very young, or those with pre-existing health conditions. We have come a long way in terms of cleaning up our waters, but our evidence shows there is still work to be done. We hope this research will contribute to further efforts to clean up our coastal waters.'

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PROMOTION

NAPP RESPIRATORY

A BREATH OF FRESH AIR

An array of the industry's leading healthcare representatives gathered under one roof for a respiratory training day, 'Revisiting Respiratory – Actioning Asthma', in a bid to share knowledge, formulate new ideas, and ultimately better shape the future of asthma care.

Asthma UK estimates that 5.4 million adults and children in the UK are living with asthma. Sparked by this prevalence, it may be presumed that the disease is commonly and appropriately treated – but sadly this just isn't the case. As many as half of asthma sufferers aren't taking their prescribed medicines properly, leading to an individual experiencing a potentially life-threatening asthma attack every 10 seconds. The beliefs and attitudes of the patients themselves are also a cause for concern, as it's only with adherence that their needs will be adequately addressed.

An exciting training day recently provided a much-needed platform for the industry to confront these major issues – as well as an opportunity to address the other mechanisms underscoring asthmatic behaviour, and to reflect on the strategies which can enhance the approaches adopted by patients and healthcare professionals alike.

The event – 'Revisiting Respiratory – Actioning Asthma' – took place at Palm Court Hotel, Aberdeen, and attracted an extensive audience comprising representatives from different corners of the sector.

In line with the company's vision of educating healthcare professionals and promoting high quality asthma care, the meeting was organised and funded by Napp Pharmaceuticals Limited.

THE LINE-UP

Reflective of the complexity of asthma – and how important it is to undertake a multidisciplinary ethos – various speakers deriving from different backgrounds shared the respiratory-related lessons which they've picked up along the way.

Those presenting included:

- Dr Iain Small, GP, Peterhead, and NHS Grampian MCN Respiratory MCN Lead
- Professor James Chalmers, Respiratory Consultant, Ninewells Hospital, Dundee
- Dr Omar Usmani, Respiratory Consultant, Imperial College, London
- Deirdre Siddaway, Respiratory Nurse Specialist, Suffolk
- Dr Kris McLaughlin, GP, Stonehaven
- Dr Graeme Currie, Respiratory Consultant, Aberdeen Royal Infirmary, Aberdeen

THE DISCUSSION POINTS

Despite targeting asthma from different angles, one common thread tied all of the presentations together – the healthcare professional's fundamental role in equipping patients with the tools and insights to properly manage their condition.

In particular, harnessing the knowledge of children, adolescents, and their parents – and heightening engagement in this age group – in order to improve compliance, was identified as a key area for attention. As a result, attendees were presented with tips as to how to effectively diagnose and treat these patients in question. A more in-depth exploration was also conducted in terms of what drives asthmatic behaviours – delving into the psychological and social reasons behind adherence to the medications.

Ensuring that the patient is prescribed the most effective inhalation device possible is a continuous process, and one which healthcare professionals must remain diligent about. Addressing how they can deliver this relevant information to individuals, Dr Omar Usmani, Respiratory Consultant, Imperial College, London, shared the benefits of using MDIs rather than dry powders; homing in on evidence indicating that the best health outcomes are derived from MDIs across all meta-analysis, in addition to the physics behind how devices work.

By drawing on the multiple issues highlighted throughout the day, Dr Kris McLaughlin, GP at Stonehaven, successfully summarised the important points to note when making the best decisions for patients; and how understanding their individuality is key to asthma optimisation. Dr McLaughlin also reiterated the significance of Respiratory Nurse Specialist at Suffolk, Deirdre Siddaway's talk on the National Review of Asthma Deaths, regarding how we must not be complacent with blue inhaler overuse from patients.

In reference to other change which must be executed immediately to mobilise results, Professor James Chalmers, Respiratory Consultant, Ninewells Hospital, Dundee, shed light on bronchiectasis. Increasing diagnosis of this condition needs to be considered now by primary care when they are looking at patients with suspected asthma / COPD, and they must be enlightened as to how to tell it apart and assist the individual.

As the day came to an end – concluding with closing remarks from Dr McLaughlin – the delegates departed with an optimistic outlook and a determination to implement this new evidence and advice into their real-life consultations. The future of asthma care is bright.

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The first and only ICS/LABA fixed-dose combination (FDC) delivered in a breath-actuated aerosol inhaler.[3]

References:

1. Mundipharma International Limited. flutiform k-haler. Summary of Product Characteristics. Available from: www.mhra.gov.uk/home/groups/spcpil/documents/spcpil/con1533874768129.pdf Last accessed September 2018.
2. Bell D et al. J Aerosol Med Pulm Drug Deliv 2017; 30:425–34.
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***flutiform® k-haler®* (fluticasone propionate/formoterol fumarate). 50 µg/5 µg and 125 µg /5 µg pressurised inhalation suspension**
Prescribing Information United Kingdom. Please read the Summary of Product Characteristics before prescribing.

Presentation Pressurised inhalation suspension, in a breath-actuated pressurised aerosol inhaler. **Indications** Regular treatment of asthma where the use of a combination product (inhaled corticosteroid [ICS] and long-acting β2-agonist [LABA]) is appropriate: (i) for patients not adequately controlled with ICS and 'as required' inhaled short-acting β2-agonist (SABA) (ii) for patients already adequately controlled on both an ICS and a LABA. For adults and adolescents aged 12 years and above. **Dosage and administration** For inhalation use. Patients should be shown how to use the inhaler correctly by a healthcare professional. Patients should be given the strength of *flutiform k-haler* containing the appropriate fluticasone propionate dose for their disease severity (note that ***flutiform k-haler*** 50 µg/5 µg per actuation is not appropriate in patients with severe asthma). The appropriate strength should be taken as two inhalations, twice daily (normally morning and evening) and used every day, even when asymptomatic. ***flutiform k-haler*** is not recommended in children under 12 years. Prescribers should be aware that in asthmatics, fluticasone propionate is as effective as some other inhaled steroids when administered at approximately half the total daily microgram dose. Patients should be assessed regularly and once asthma is controlled, treatment should be reviewed and stepped down to the lowest effective dose, or an ICS alone. ICSs alone are first line treatment for most patients. ***flutiform k-haler*** is not intended for initial treatment of mild asthma. For patients with severe asthma the ICS therapy should be established before prescribing a fixed-dose combination product. Patients on ***flutiform k-haler*** must not use an additional LABA. An inhaled SABA should be taken for immediate relief of asthma symptoms arising between doses. Patients should be advised to contact their prescriber when ***flutiform k-haler*** dose counter is getting near zero. **Contraindications** Hypersensitivity to the active substances or to any of the excipients. **Precautions and warnings** ***flutiform k-haler*** should not be used as the first asthma treatment, to treat acute asthma symptoms or for prophylaxis of exercise-induced asthma. It should not be initiated during an exacerbation, during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. If a patient experiences serious asthma-related adverse events or exacerbations, they should continue treatment and seek medical advice. Patients should be reviewed as soon as possible if there is any indication of deteriorating asthma control. In case of sudden and progressive deterioration, seek urgent medical assessment. Caution in patients with: pulmonary tuberculosis; quiescent tuberculosis; fungal, viral or other infections of the airway; thyrotoxicosis; phaeochromocytoma; diabetes mellitus (consider additional blood sugar controls); uncorrected hypokalaemia; predisposition to low levels of serum potassium; impaired adrenal function (monitor HPA axis function regularly); hypertrophic obstructive cardiomyopathy; idiopathic subvalvular aortic stenosis; severe hypertension; aneurysm or other severe cardiovascular disorders; unstable or acute severe asthma and other conditions when the likelihood for hypokalaemia adverse effects is increased. There is risk of potentially serious hypokalaemia with high doses of β2-agonists or concomitant treatment with β2-agonists and drugs that can induce or potentiate a hypokalaemic effect. Monitoring of serum potassium levels is recommended during these circumstances. Formoterol may induce prolongation of the QTc interval. Caution must be observed when treating patients with existing prolongation of QTc interval. ***flutiform k-haler*** should be discontinued immediately if there is evidence of paradoxical bronchospasm. Visual disturbance may be reported with corticosteroid use. Systemic effects with an ICS may occur, particularly at high doses for prolonged periods or when combined with potent CYP3A4 inhibitors, but are less likely than with oral corticosteroids. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density and cataract glaucoma. Children may also experience anxiety, sleep disorders and behavioural changes. Increased exposure can be expected in patients with severe hepatic impairment. Prolonged treatment with high doses of corticosteroids may result in adrenal suppression and acute adrenal crisis, particularly in children and adolescents or potentially as a result of trauma, surgery, infection or rapid dose reduction. ***flutiform k-haler*** contains a negligible amount of ethanol that does not pose risk to patients. Interactions Co-treatment with CYP3A inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nelfinavir, saquinavir, ketoconazole, telithromycin, cobicistat) should be avoided unless the benefit outweighs the increased risk of systemic side-effects. Caution is advised with concomitant use of non-potassium sparing diuretics (e.g. loop or thiazide), xanthine derivatives, glucocorticosteroids, L-Dopa, L-thyroxine, oxytocin, alcohol or other adrenergic drugs, including anaesthesia with halogenated hydrocarbons and digitalis glycosides, β-adrenergic drugs, known to prolong the QTc interval, such as tricyclic antidepressants or MAOIs (and for two weeks following their discontinuation), antipsychotics (including phenothiazines), quinidine, disopyramide, procainamide, antihistamines. **Furazolidone and procarbazine** ***flutiform k-haler*** should not normally be used with β-blockers including those that are used as eye drops to treat glaucoma. Under certain circumstances, e.g. as prophylaxis after myocardial infarction, cardioselective β-blockers could be considered with caution. **Pregnancy and lactation** ***flutiform k-haler*** is not recommended during pregnancy unless the benefits to the mother outweigh risks to the foetus. A risk to the breastfeeding infant cannot be excluded. **Side-effects** Uncommon (<1/100) but potentially serious side-effects: hyperglycaemia, agitation, depression, aggression, behavioural changes (predominantly in children), vision blurred, vertigo, palpitations, ventricular extrasystoles, angina pectoris, tachycardia, hypertension, dyspnoea, peripheral oedema. Please consult the SPC for a full list of side-effects and those reported for the individual molecules. **Legal category** POM **Package quantities and price** One inhaler (120 actuations) 50 µg/5 µg - £14.40 125 µg/5 µg - £28.00 **Marketing Authorisation numbers** PL 16950/0338-39 **Marketing Authorisation holder** Napp Pharmaceuticals Limited Cambridge Science Park Milton Road Cambridge CB4 0GW UK Tel: 01223 424444 For medical information enquiries, please contact medicalinformationuk@napp.co.uk. FLUTIFORM is a registered trademark of Jagotec AG, and is used under licence. 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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Napp Pharmaceuticals Limited on 01223 424444.

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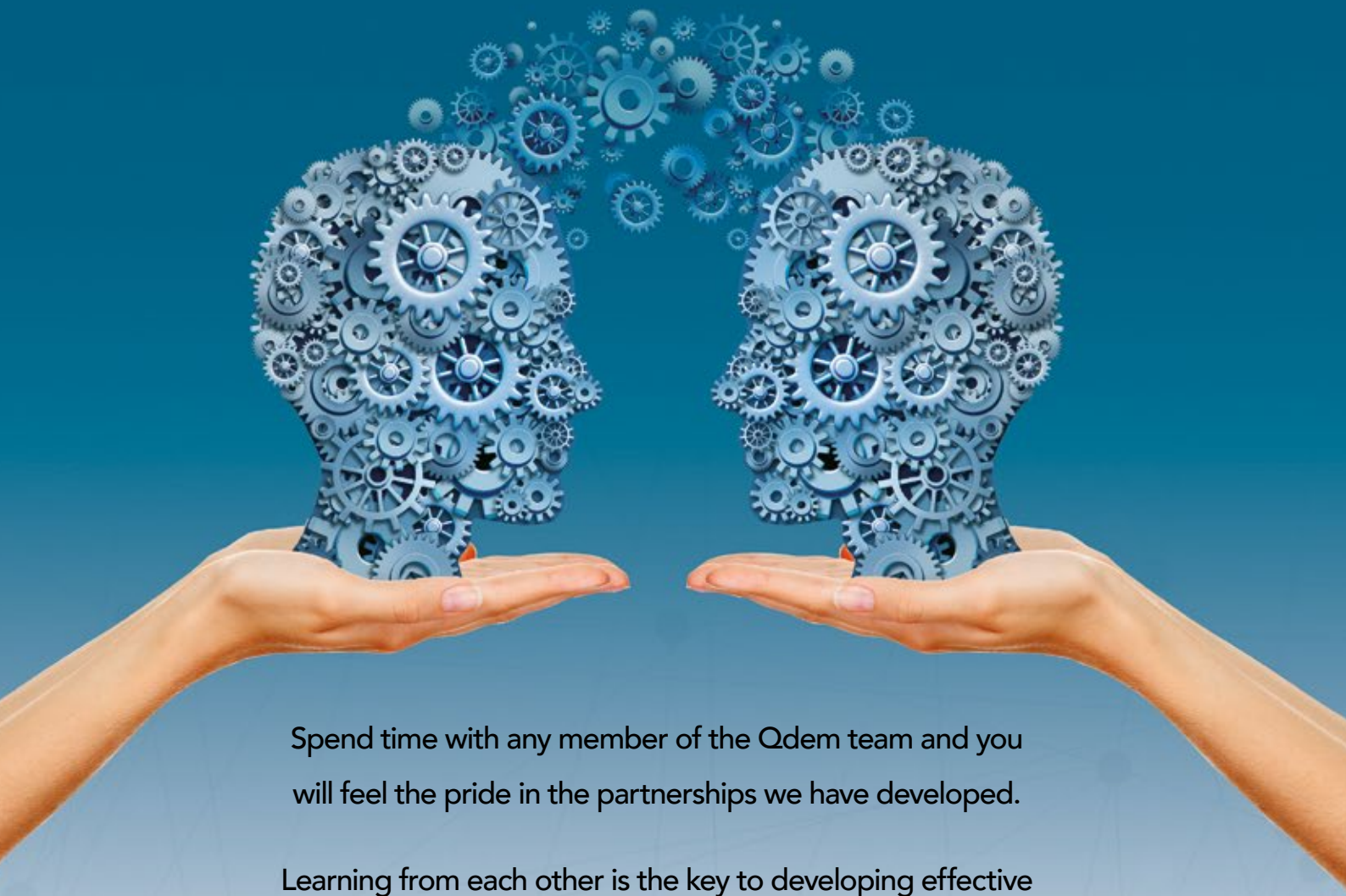

Spend time with any member of the Qdem team and you will feel the pride in the partnerships we have developed.

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