Scottish Healthcare Review

ISSUE 133 - 2021

LONG COVID

The hidden health crisis

#STOPTHEDEATHS

The Scottish Drugs Forum initiative

SCOTTISH PHARMACY AWARDS

And the winners are...

HIGH CHOLESTEROL

Changes for the better

RPS SCOTLAND

A new vision for pharmacy

Sialanar®

(400mcg/ml glycopyrronium bromide equivalent to 320mcg/ml glycopyrronium)

Proveca
Medicines for Children

Sialanar® is the only glycopyrronium product licensed across Europe for the symptomatic treatment of severe sialorrhoea in children aged 3 years and older, with chronic neurological disorders.

Sialanar® as glycopyrronium should be considered for first line treatment:

'There is increasing evidence that 1st line anticholinergic therapy should be glycopyrronium'[1]

Where either hyoscine or glycopyrronium might be used, glycopyrronium should be the medication of first choice.[2]

Sialanar® has been designed for children.

A product designed for children in terms of taste, excipients and formulation:

- Concentrated solution (2mg/5ml glycopyrronium bromide) therefore relatively small volume to swallow
- Raspberry flavouring increases the palatability for the patient
- Easy to titrate the dose with the oral dosing syringe
- Licensed for use with PEG, GJ and nasogastric tubes

Prescribing Information UK

Sialanar® 320 micrograms /ml oral solution

Please refer to the full Summary of Product Characteristics (SmPC) before prescribing.

Presentation: Glycopyrronium oral solution in 250 ml or 60 ml bottle. 1 ml solution contains 400 micrograms glycopyrronium bromide, (equivalent to 320 micrograms of the active ingredient, glycopyrronium).

Indication: Symptomatic treatment of severe sialorrhoea (chronic pathological drooling) in children and adolescents aged 3 years and older with chronic neurological disorders.

Dosage: Start with approximately 12.8 micrograms/kg body weight of glycopyrronium per dose, three times per day. Increase dose weekly until efficacy is balanced with side effects. Titrate to maximum individual dose of 64 mcg/kg body weight glycopyrronium or 6 ml three times a day, whichever is less. Monitor at least 3 monthly for changes in efficacy and/or tolerability and adjust dose if needed. Not for patients less than 3 or over 17 years old as Sialanar® is indicated for the paediatric population only. Reduce dose by 30%, in mild/moderate renal failure. Dose at least one hour before or two hours after meals or at consistent times with respect to food intake. Avoid high fat food. Flush nasogastric tubes with 10 ml water.

Contraindications: Hypersensitivity to active substance or excipients; pregnancy and breast-feeding; glaucoma; urinary retention; severe renal impairment/dialysis; history of intestinal obstruction, ulcerative colitis, paralytic ileus, pyloric stenosis; myasthenia gravis; concomitant treatment with potassium chloride solid oral dose or anticholinergic drugs.

Special warnings and precautions for use: Monitor anticholinergic effects. Carer should stop treatment and seek advice in the event of constipation, urinary retention, pneumonia, allergic reaction, pyrexia, very hot weather or changes in behaviour. For continuous or repeated intermittent treatment, consider benefits and risks on case-by-case basis. Not for mild to moderate sialorrhoea. Use with caution in cardiac disorders; gastro-oesophageal reflux disease; pre-existing constipation or diarrhoea; compromised blood brain barrier; in combination with: antispasmodics, topiramate, sedating antihistamines, neuroleptics/antipsychotics, skeletal muscle relaxants, tricyclic antidepressants and MAOIs, opioids or corticosteroids. Sialanar® contains 2.3 mg sodium benzoate (E211) in each ml. Patients require daily dental hygiene and regular dental checks. Thicker secretions may increase risk of respiratory infection and pneumonia. Moderate influence on ability to drive/use machines.

Fertility, pregnancy and lactation: Use effective contraception. Contraindicated in pregnancy and breast feeding.

Undesirable effects: Adverse reactions more common with higher doses and prolonged use. In placebo-controlled studies (≥15%) dry mouth, constipation, diarrhoea and vomiting, urinary retention, flushing and nasal congestion. In paediatric literature; very common: irritability, reduced bronchial secretions; common: upper respiratory tract infection, pneumonia, urinary tract infection, agitation, drowsiness, epistaxis, rash, pyrexia. The Summary of Product Characteristics should be consulted for a full list of side effects.

Shelf life: 2 years unopened. 2 months after first opening.

MA number:
Sialanar® 250 ml bottle – EU/1/16/1135/001
Sialanar® 60ml bottle – EU/1/16/1135/002

Legal Category: POM

Basic NHS Price:
Sialanar® 250 ml bottle £320
Sialanar® 60ml bottle £76.80

Marketing Authorisation Holder (MAH):
Proveca Pharma Ltd. Marine House, Clanwilliam Place, Dublin 2, Ireland
Further prescribing information can be obtained from the MAH.

Date of last revision of prescribing information: April 2019

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 Proveca Limited. Phone: 0333 200 1866 E-mail: medinfo@proveca.com

References
1. McDermott C, Developing the evidence base for the management of drooling. Developmental Medicine & Child Neurology 2020, 62: 266–273. doi: 10.1111/dmcn.14373
2. Parr JR, Todhunter E, Pennington L, et al. Drooling Reduction Intervention randomized trial (DRI): comparing the efficacy and acceptability of hyoscine patches and glycopyrronium liquid on drooling in children with neurodisability. Arch Dis Child 2017;0: 1-6. Doi:10. 1136/archdischild-2017-313763

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WELCOME

EDITOR'S LETTER

Welcome to the latest edition of Scottish Pharmacy Review!

Anyone who steps into my house – whether they know it or not – will be greeted by clues of the pandemic's presence surrounding every surface. The labelled jars on my kitchen bench when boredom led to me channelling my 'inner Mrs Hinch' for a day or so. The books and jigsaws tucked into my shelving unit which served as entertainment (and frustration) during the particularly long days. Even the framed photographs of my niece Róise who was born during lockdown.

The changes to our lives have been unavoidable – from the trivial to major upheaval – but for many of us, the markings of COVID-19's turmoil aren't as physically apparent.

There are the frontline workers who continue to carry the weight of their experiences silently on their shoulders as they tend to their patients. The family members whose traumatic loss you wouldn't detect as they go about their daily commutes. And, as we can see in this edition, the increasing number of individuals who continue to be affected by Long COVID, with the latest figures from the Office of National Statistics suggesting that 970,000 people in the UK are currently living with the condition.

As its severity comes increasingly to light, find out more as UK organisations Action for M.E. and Long COVID Support review the latest evidence and share essential information, particularly under the glare of winter's force (page six).

Also in this issue, Professor Joanna Wardlaw takes a look at how emerging technology can be harnessed for the improvement of stroke healthcare delivery (page 17); Sarah Donaldson, Specialist Pharmacist in Substance Use and Senior Health Intelligence Analyst, NHS Tayside, overviews the #StopTheDeaths initiative (page 15); and the importance of providing support for cold weather-induced worsening skin conditions is discussed (page 36).

Elsewhere, catch up with the Royal Pharmaceutical Society's Director for Scotland, Clare Morrison, about the organisation's ongoing priorities, including workplace wellbeing and professional development (page four); and check out the campaign, 'Transform Lives: Prescribe', which has been launched by Pancreatic Cancer UK in collaboration with specialist health professionals (page 20).

Before you go, meet our phenomenal 2021 Scottish Pharmacy Awards winners, and find out what they had to say on the night (beginning on page 21).

Happy reading!

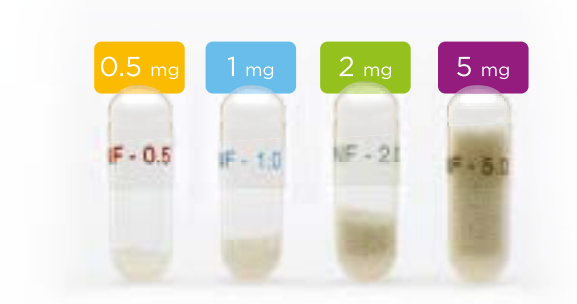
Sarah Nelson

@kyronmedia Kyron Media

Alkindi® for the Individual

Individualised, accurate and flexible dosing — without the need for compounding[1]

Alkindi®
hydrocortisone granules in capsules for opening



In the long term follow-up study for Alkindi, there were no trends for accelerated or reduced growth and no adrenal crises were observed[2]

Abbreviated Prescribing Information for Alkindi® 0.5 mg, 1 mg, 2 mg, and 5 mg granules in capsules for opening (Hydrocortisone)

Capsules for opening containing 0.5 mg, 1 mg, 2 mg or 5 mg of hydrocortisone respectively. **Indication** Replacement therapy of adrenal insufficiency in infants, children and adolescents (from birth to < 18 years old). **Dosage** Dosage must be individualised according to the response of the patient: the lowest possible dosage should be used. Recommended replacement doses are 8-15 mg/m²/day, in three or four divided doses. In minor illness or trauma, the total daily dose of Alkindi may need to be doubled or tripled. In more severe situations particularly with vomiting/diarrhoea, high fever or trauma/surgery parenteral administration of hydrocortisone and transfer to a facility with resuscitation facilities are necessary. **Administration** The capsule shell must not be swallowed but carefully opened. The granules are either poured directly onto the child's tongue, or a spoon, with or without soft food, can be used to place the granules in the child's mouth. Immediately after administration fluid should be given orally. **Contraindications** Hypersensitivity to the active substance or to any of the excipients. Patients with dysphagia or premature infants where oral feeding has not been established. **Warnings and precautions** Where a child is vomiting or acutely unwell parenteral hydrocortisone should be started immediately. Sudden discontinuation of therapy risks adrenal crisis and death. Relative adrenal insufficiency may persist after discontinuation and in any stress situation therapy should be reinstated. Any signs of infection should be treated seriously, with an increased dose of Alkindi being started promptly. Inaccuracy in dosing possible with conventional oral hydrocortisone crushed or compounded formulations can lead to adrenal crisis when switching from these to Alkindi. Close monitoring of patients is recommended for a week after switch, and extra doses of Alkindi should be given if symptoms of adrenal insufficiency are seen. If this is required, an increase in the dose of Alkindi should be considered and immediate medical advice should be sought. Growth and/or bone mineral density may be retarded during infancy, childhood and adolescence. Psychiatric disturbances have been observed in adult patients taking replacement doses of hydrocortisone. If this occurs parents should seek medical advice immediately. Rarely anaphylactoid reactions have occurred in patients receiving corticosteroids. Visual disturbances of various types have been reported in patients receiving oral corticosteroids. Should this occur, consult an ophthalmologist. Granule cores may sometimes be seen in stools, no additional dose is required. Alkindi must not be administered through nasogastric tubes. **Interactions** Hydrocortisone is metabolised by cytochrome P450 3A4 (CYP3A4). Concomitant administration of medicinal products inhibiting or inducing CYP3A4 may require dose adjustment of Alkindi and close monitoring. **Pregnancy and lactation** Hydrocortisone for replacement therapy can be used during pregnancy and breast feeding. **Adverse events** A total of 30 healthy adult male subjects in two phase 1 studies and 24 paediatric patients with adrenal insufficiency in two phase 3 studies have been treated with Alkindi. There were no adverse reactions seen in any of the studies. In adult patients receiving hydrocortisone replacement therapy adverse events have been reported with unknown frequency: psychosis with hallucinations and delirium, mania, euphoria, gastritis, nausea, and hypokalaemic alkalosis.

Legal classification: POM

Product (50 capsule bottle)	Basic NHS Cost	MA Number
Alkindi 0.5 mg granules in capsules for opening	£33.75	EU/1/17/1260/001
Alkindi 1 mg granules in capsules for opening	£67.50	EU/1/17/1260/002
Alkindi 2 mg granules in capsules for opening	£135.00	EU/1/17/1260/003
Alkindi 5 mg granules in capsules for opening	£337.50	EU/1/17/1260/004

Marketing Authorisation Holder
Diurnal Europe B.V., Van Heuven Goedhartlaan 935 A, 1181LD Amstelveen, The Netherlands.
Tel. +31 (0)20 6615 072. Email: info@diurnal.co.uk

Prescribers should refer to summary of product characteristics for full prescribing information.
Approval Code: Inf EU-GB-0153
Date of Preparation: March 2021

References: 1. Diurnal. Alkindi® Summary of Product Characteristics. Available from https://www.medicines.org.uk/emc/product/9032/smpc;
2. Neumann *et al. JCEM* 2021; 106(3):e1433–e40.
Date of Preparation: March 2021 **Code:** Inf EU-GB-0157

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 Diurnal on adverse-events@diurnal.co.uk Telephone +44 (0) 7917 334899

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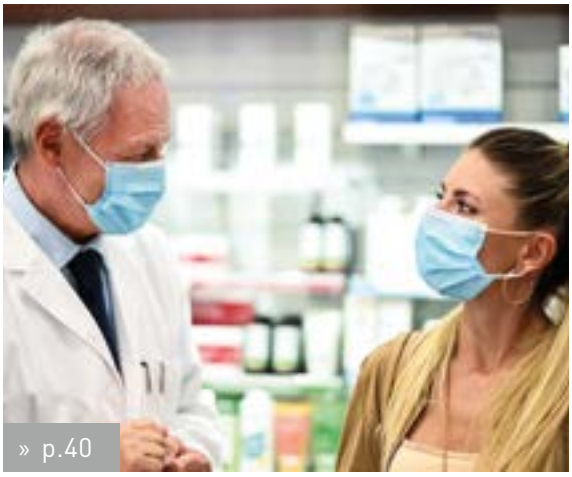
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ROYAL PHARMACEUTICAL SOCIETY

BETTER DAYS AHEAD

From workplace wellbeing and professional development, to the creation of a new vision for all of pharmacy, Clare Morrison, Director for Scotland at the Royal Pharmaceutical Society, shares an insight into the progress of a number of the organisation's key priorities – in addition to the steps which are key to securing a stronger future for the sector.

Clare Morrison

WHEN WAS YOUR INTEREST IN PHARMACY INITIALLY SPARKED?

I knew I wanted to do something health-related from a young age. I had been thinking about medicine but then had an inspirational chemistry teacher who introduced me to the idea of pharmacy to combine chemistry and health. That led to work experience in hospital pharmacy and from that moment on I knew pharmacy was right for me.

HOW HAS YOUR CAREER PATH LED TO YOUR CURRENT POST AS THE ROYAL PHARMACEUTICAL SOCIETY'S (RPS) DIRECTOR FOR SCOTLAND?

I've been fortunate to have a really varied career – I've worked in community pharmacy, pharmacy journalism, general practice, prescribing advice and NHS board leadership roles, plus a secondment in Scottish Government. I completed the independent prescribing training in 2007 and ran several prescribing services in community pharmacy. After that I became interested in quality improvement, completing the Scottish Quality and Safety Fellowship in 2016 and then studied improvement in America for six months. I think one of the best things about pharmacy is the opportunity to have a broad career. We're now seeing many pharmacists with portfolio careers, combing two or more sectors, which is great for professional development and job satisfaction.

ROYAL PHARMACEUTICAL SOCIETY

WHAT DOES A TYPICAL DAY IN THE LIFE LOOK LIKE FOR YOU – PARTICULARLY NOW, IN LIGHT OF THE CHANGES POSED BY THE PANDEMIC?

A lot of screen time! I spend most of my days in on-screen meetings. One of my aims coming into this role was to ensure that our work is done collaboratively with RPS members and pharmacy stakeholders across Scotland. And that means a lot of focus groups to ensure that we hear people's views. It's a real privilege to be able to talk to so many pharmacists and pharmacy technicians about what matters to them, and is absolutely the best part of my job.

I also represent RPS at meetings, both within pharmacy and with other health professions, and with politicians and government officials. It's not all meetings though, there's also policy-writing, answering queries, providing advice and promoting pharmacy. And finally, I think that wellbeing is really important so I always squeeze in a run with my dog, even if it means getting up half an hour earlier on really busy days.

WHAT ACTION MUST BE TAKEN TO TACKLE THE WORKFORCE DEMANDS AND SHORTAGES AFFECTING THE SECTOR?

First of all, we need to accept that there's a shortage of pharmacists across Scotland. Data from last year show a pharmacist vacancy rate of 11.6 per cent in community pharmacy and 7.6 per cent in NHS employed roles in hospitals and general practices. So, we absolutely need to train additional people to come into pharmacy but we need to be realistic that it takes time to train people and unfortunately there isn't a source of ready-trained pharmacists looking for jobs.

Therefore, on top of the training, we also need some immediate actions to relieve pressures now. The first of those is to focus on retaining the current pharmacy workforce by looking after them better so they don't leave the profession. And secondly, we need to improve the capacity of the current workforce by enabling them to work better. By that I mean better skillmix, IT and systems to reduce the pressures and parts of the job where time is wasted, thereby freeing up capacity.

There's a lot more detail in our workforce position statement we produced, and we used this as the basis for what we said to the Cabinet Secretary for Health at the SNP's conference in November.

• *Workforce position statement: www.rpharms.com/Portals/0/RPS%20document%20library/RPS%20Scotland%20Workforce%20Briefing%20November%202021%20(1).pdf?ver=6jJLDmjd9_6Lo43WgMRFaw%3d%3d*

TELL US MORE ABOUT YOUR WORKFORCE WELLBEING SURVEY AND WHAT ACTIONS ARE NEEDED?

The results of our workforce wellbeing survey published in December are really concerning. We found 89 per cent of respondents at high risk of burnout, with 68 per cent stating work is negatively impacting their wellbeing, 32 per cent considering leaving the profession, and a shocking 57 per cent said that they are not able to take a break at all during the working day.

Clearly we need action. We need pharmacy workplaces that are inclusive, have a culture of belonging and support wellbeing. Every pharmacist must be enabled to take a rest break during the working day: not having a break is as much a patient safety issue as it is a wellbeing issue. Also important is ensuring that pharmacists have protected learning time for professional development. We have heard from pharmacists who want to work flexibly, perhaps part-time or school hours, or have portfolio careers and we need pharmacy employers to find ways to embrace these options.

We also need a cultural change in pharmacy about wellbeing. The National Wellbeing Hub is a Scottish Government-provided resource for all health and care workers in Scotland, including every member of pharmacy teams. But our survey showed that pharmacy teams perceived barriers to accessing wellbeing services, including a feeling that they should just be able to manage. I think we need to be a lot more out in the open so that everyone feels it's absolutely fine to seek help when things are tough.

YOU MENTIONED PROFESSIONAL DEVELOPMENT, WHAT IS RPS DOING TO SUPPORT THIS?

Pharmacists have long called for clearer career development, and I think the new RPS post-registration development pathway is so important for this. It sets out a curriculum for three levels of practice: foundation, advanced and consultant level practice. The curricula for all three levels are structured within five domains which means it forms a continuum of practice. The five domains are: clinical practice (comprising person-centred care and professional practice), leadership and management, education, and research. As pharmacists work through the levels, they record evidence in an e-Portfolio and the final step is credentialing where the evidence is assessed. This development pathway is for all pharmacists working in any sector in patient-focused roles, so it provides a real opportunity for structured career development across the profession.

For more information, visit www.rpharms.com/development/credentialing.

WITH COP26 STILL AT THE FOREFRONT OF OUR MINDS, WHAT IS RPS DOING ON CLIMATE CHANGE?

In November, RPS launched an environmental sustainability policy. Medicines account for about 25 per cent of the carbon emissions within the NHS, so the policy focuses on the environmental harm from medicines. It's really important for RPS to support pharmacists to take a leading role in reducing the environmental impact of medicines and to campaign for change that we need governments and other stakeholders to take. As part of our commitment to sustainability, RPS have committed to cease all our remaining financial investments in fossil fuels as soon as possible.

Our policy focuses on four key priority areas: improving prescribing and medicines use, tackling medicines waste, preventing ill health, and infrastructure. In all four we set out actions we are calling for and the priorities for pharmacy teams. Take, for example, sustainable prescribing, we call for NHS prescribing guidance to include the environmental impact of medicines to enable informed choices at the point of prescribing; and for pharmacy teams to take person-centred approach to actively involve patients in decisions about their care.

For more information, visit www.rpharms.com/recognition/all-our-campaigns/policy-a-z/pharmacys-role-in-climate-action-and-sustainable-healthcare.

AS WE APPROACH THE END OF THE YEAR, WHAT ELSE HAS BEEN RPS SCOTLAND'S NOTABLE HIGHLIGHTS OF 2021?

A key action we took this year was to align our policy work to the Scottish Government's priorities which meant that we were clearly able to articulate pharmacy's role in these areas. This led to meetings with Scottish Government Ministers and MSPs, and parliamentary motions being lodged. Some of the key policies we developed were on pharmacy's role in reducing drug deaths, in mental health and in women's health.

We also responded to many consultations, including, most recently, the proposed development of a National Care Service in Scotland, in which there are key roles for pharmacists. Our manifesto for the Scottish parliamentary elections in May resulted in commitments for pharmacy in every political party's manifesto.

And really importantly we have been engaging with every part of pharmacy to develop a new professional vision for the future called Pharmacy 2030. We ran surveys and focus groups, and published draft mini-visions for consultation in each of the three patient-facing areas of pharmacy: community, general practice and hospital. We are now in the final stages of bringing this together into a vision for all of pharmacy, and plan to publish it in the next month.

• Drugs policy: www.rpharms.com/recognition/all-our-campaigns/policy-a-z/drug-deaths-and-the-role-of-the-pharmacy-team
• Women's health statement: www.rpharms.com/Portals/0/RPS%20document%20library/RPS%20Position%20Statement%20on%20Women's%20Health%20July%202021.pdf?ver=zrRRJ5AuVCLaKTsDfMH3xQ%3D%3D
• National Care Service statement: www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Consultations/2021/RPS%20National%20Care%20Service%20Position%20statement%20(1).pdf?ver=lW-beht-qaaDG06QBBB8uw%3d%3d
• Pharmacy 2030 vision: www.rpharms.com/scotland/pharmacy2030

SO IS THE VISION A PRIORITY FOR 2022?

Absolutely, completing the vision is just the first step. There's no point creating something that just sits on a shelf. One of the reasons we are setting Pharmacy 2030 out in two sections is so it's crystal clear what is needed to achieve the vision: we start by describing the professional role of pharmacy teams in 2030 and then the second section covers the underpinning infrastructure needed to make that a reality. Our work in 2022 will be focused around achieving those changes for pharmacy.

That's not the only thing on the agenda though. We'll also be looking at tackling health inequalities, independent prescribing, workforce wellbeing, pharmacogenomics and advancing professional practice. Bringing RPS members together to share best practice, network and reduce isolation will also be key through both digital and face-to-face developments.

And I want to keep that focus we have had in 2021 on ensuring our work is relevant and developed collaboratively with RPS members across Scotland. I hope pharmacy teams get involved with our work and really welcome feedback on what pharmacists think we should be prioritising.

M.E.

THE VIRUS LONG-TAIL

More than 80 per cent of the UK population have now been vaccinated against COVID-19. But the data on Long COVID presents a more worrying picture, with increasing numbers continuing to be affected. UK organisations Action for M.E. and Long COVID Support review the latest evidence, share essential information, and signpost to support for you and your patients living with viral-induced conditions.

Experts predict that the number of people living with Long COVID could dramatically rise by winter, with many already living with their symptoms for 18 months-plus. There's no link between COVID-19 symptom severity and getting Long COVID and, other than reducing the risk of catching COVID-19, there's currently no evidence that the vaccine roll-out will stop even more people becoming ill with Long COVID. The latest figures from the Office of National Statistics suggest that 970,000 people in the UK are currently living with Long COVID.

Some of those ill with Long COVID from the first wave of COVID-19 are starting to be diagnosed with M.E., also diagnosed as chronic fatigue syndrome, or M.E. / CFS, for which there still remains a need for greater recognition and research. This complex condition can occur following a viral infection – for example, around 10 per cent of people who are infected with Epstein-Barr virus have symptoms consistent with M.E. six months following the infection, according to the Centers for Disease Control in America. (www.cdc.gov/me-cfs/about/possible-causes.html)

While some patients infected by SARS-CoV-2 may go on to be diagnosed as having M.E., this is one of many outcomes of the disease course. Patients are being diagnosed with new conditions involving multiple organ systems and the long-term prognosis is as yet unclear.

UNDERLYING BIOLOGICAL MECHANISMS

In its second Living with COVID-19 review in March 2021, the National Institutes for Health Research says:

'Whilst there is a growing list of symptoms associated with Long COVID, we know little about different clusters and patterns of symptoms (sometimes described as phenotypes, syndromes or clusters). There is increasing evidence of organ impairment in both people who were admitted to hospital and those who stayed at home. The limited evidence of correlation between past history and current pathology would suggest a need to investigate anyone with persistent symptoms, including those who were never admitted to hospital.

'There is also evidence of a group of people with cognitive processing disorders and anxiety with some indication of neurological rather than social cause. A substantial number of people have symptoms not yet understood. Some are similar to [...] M.E. / CFS and others to orthostatic intolerance syndromes. There is some evidence suggesting Long COVID is a still active disease, with immunological evidence of continued inflammatory responses, lingering viral activity and / or blood clotting disorders. For some people with Long COVID, there appears to be the potential for further deterioration.'

(www.evidence.nihr.ac.uk/themedreview/living-with-covid19-second-review)

LOOKING AHEAD

Long COVID has shone a light on the need for a better understanding of ongoing viral-induced illness. With over a quarter of a million people living with M.E. and an increasing number of people living with Long COVID, this is no longer a public health crisis waiting to happen – it's happening now.

Action for M.E. and Long COVID Support are advocating for action to ensure that people with viral-induced conditions get the acknowledgement, support and treatment they need now and to secure change for the future. While the £37.6 million funding secured for Long COVID research and £134 million for services is a positive step, additional investment is required to ensure the continued growth, equity, and sustainability of post-viral research infrastructure, beyond the pandemic response.

Long-term conditions, such as Long COVID, M.E. / CFS and others, should be investigated as separate diseases in their own right. No parallels should be assumed until such time as there is robust and sufficient supporting scientific evidence. However, research findings and infrastructure from one disease should be leveraged to forward the understanding of another where relevant.

From a scientific perspective, the COVID-19 pandemic provides the greatest potential to understand why and how some people improve and / or fully recover from viral infections, and others do not. Only relatively small amounts of additional funding are needed to include people with M.E. in planned Long COVID research and we must seize this unique opportunity before it is too late.

MANAGING ENERGY AND ACTIVITY

You may have already seen that the long-awaited NICE guideline for diagnosing and managing M.E., supposed to replace the 2007 edition, was delayed at the 11th hour in August.

The 2021 update, published in draft at the end of last year, brought clinical practice up-to-date with current scientific knowledge regarding M.E., particularly around the now-discredited use of graded exercise therapy as a curative treatment.

Instead, the draft emphasised that people with M.E. should not be offered 'any therapy based on physical activity or exercise as a treatment or cure for M.E. / CFS [or] any programme based on fixed incremental increases in physical activity or exercise, for example graded exercise therapy.'

It also advised only offering cognitive behavioural therapy (CBT) to people with M.E. 'who would like to use it to support them in managing their symptoms of M.E. / CFS and to reduce the psychological distress associated with having a chronic illness. Do not offer CBT as a treatment or cure for M.E. / CFS.'

At the time of writing, NICE had scheduled a roundtable discussion for Monday 18th October to move the situation forward – you can find updates on this at www.actionforme.org.uk/news.

Co-published in December 2020 by the National Institute of Health and Care Excellence, the Scottish Intercollegiate Guidelines Network and the Royal College of GPs, the rapid response guideline for managing the long-term effects of COVID-19 has been updated, following a 14-day consultation with registered stakeholders, ending Monday 27th September. Both our organisations were in the process of reviewing this as we went to press.

YOUR PATIENTS WITH LONG COVID

Long COVID is a complex multisystem disease that is not yet well-understood. Over 200 symptoms have been reported including, but not limited to, respiratory, cardiovascular and neurological issues, autonomic dysfunction, tinnitus and skin rashes. People of all ages and previous levels of health and fitness are at risk of experiencing its life-changing effects – including children and adolescents.

A study by Patient-Led Research for COVID-19 found that after seven months of illness, 45 per cent of respondents reported requiring a reduced work schedule compared to pre-illness and 22 per cent were not working due to their health. The UK's Office of National Statistics estimates that 10 per cent of people who test positive for COVID-19 experience symptoms for 12 weeks or longer, with more than a third suffering from the condition for over a year.

Pacing, a strategy and rehabilitation technique that modifies activities in daily life, to manage symptoms such as fatigue and post-exertion symptom exacerbation, has long been used by people with M.E. / CFS. It is also proving beneficial in the management of some Long COVID symptoms. The Long COVID Physio website (www.longcovid.physio) contains lots of advice on pacing and has been specifically developed for people with Long COVID.

Long COVID Support produces and promotes a number of resources for health professionals and patients that you may find useful. These include:

- Website pages for doctors and other healthcare professionals at www.longcovid.org/resources/healthprofessionals
- Resources, including downloadable resources for patients at www.longcovid.org/resources/patients where you can signpost patients to information on symptoms, symptom management, getting help, support groups, mental health, bereavement, work, benefits and finances

Signpost patients to our international Long COVID Support Facebook Group (www.facebook.com/groups/longcovid), a private space for people experiencing the diverse, debilitating symptoms of Long COVID to share information and support each other.

For more information on the long-term effects of COVID-19 in children, signpost parents and professionals to the Long COVID kids website at www.longcovidkids.org.

YOUR PATIENTS WITH M.E.

There is no single diagnostic test for M.E. and health professionals tell us that they seek reliable information and education about managing symptoms and supporting patients.

Action for M.E. produce and promote a number of resources for health professionals that you may find useful. These include:

- Website pages for doctors and other healthcare professionals at www.actionforme.org.uk/clinical-care
- Downloadable resources for pharmacy teams at www.actionforme.org.uk/pharmacy
- Our Learn about M.E. podcast series featuring professionals and patients. This accompanies Dr Nina Muirhead's highly-rated Continuing Professional Development learning module on M.E., both of which you can find at www.actionforme.org.uk/learn-about-ME
- You can find Action's for M.E.'s resource library for professionals at www.actionforme.org.uk/resources-for-professionals

You can also refer your patients to Action for M.E.'s free information, support and advocacy service (see contact details below). Our experienced team can share information, support and resources around issues related to living with the impact of M.E. and / or Long COVID symptoms; and help people reflect on the challenges they're facing, talk them through options, and help them identify their priorities for action. They can also signpost to additional sources of support if needed.

Some key Action for M.E. resources may be particularly relevant / useful for people with Long COVID, including:

- Pacing for people with M.E., which includes guidance on activity analysis, establishing sustainable baselines, using rest and relaxation, managing sleep, daily and weekly planning, pacing versus real life and managing stumbling blocks. Find this at www.actionforme.org.uk/pacing
- M.E. and work, which includes guidance on identifying and communicating what you need, positively managing disclosure, reasonable adjustments and return to work planning. Find this at www.actionforme.org.uk/employment
- You can find Action's for M.E.'s resource library for patients at www.actionforme.org.uk/living-with-ME

CONTACT DETAILS

LONG COVID SUPPORT

- Email: info@longcovid.org
- www.longcovid.org
- @long_covid on Facebook and Twitter
- @longcovid on Instagram

LONG COVID WALES

- @LongCovidWales on Twitter

LONG COVID SCOTLAND

- www.longcovid.scot
- @LongCovidScot on Twitter

ACTION FOR M.E.

- 42 Temple Street, Keynsham BS31 1EH
- Information, Support and Advocacy Service: 0117 927 9551
- Email: questions@actionforme.org.uk
- www.actionforme.org.uk
- @actionforme on Facebook and Twitter
- @actionform.e on Instagram

PROMOTION

A GROWING SUCCESS

Since Edinpharm's formation 25 years ago, the non-profit buying group have cultivated a formidable presence throughout the sector – providing support and benefits to independent pharmacies across Scotland, Northern Ireland and Northern England. Here, the team share some of the values which underpin their success and how they continue to protect and promote the growth of their members, all the while allowing them to retain their independence and decision-making.

Richard Stephenson and Karen McCarrison

edinpharm
supporting independent pharmacies

CAN YOU TELL US ABOUT EDINPHARM'S ROOTS AND INITIAL AMBITIONS?

Edinpharm was founded in 1996, by a group of pharmacists, to create a space for sharing advice, providing support and improving pricing for the smaller independent operators. Since then, we have organically grown to over 240 members due to our reputation of putting the pharmacy first!

HOW HAVE MEMBERS BEEN BENEFITTING FROM EDINPHARM'S SERVICES SINCE?

Since these small beginnings Edinpharm have thrived and grown to a company with over 240 members, while retaining the personal touch and support for the independent pharmacies in the industry. The growth in membership has allowed us to ensure competitive pricing, but membership is much more than just pricing. It provides a platform for sharing collective knowledge and feeding back, and our strong relationship with our suppliers ensures that those voices and ideas are heard.

HOW DOES THE COMPANY DIFFERENTIATE ITSELF FROM OTHERS IN THE INDUSTRY?

As a 'not for profit' organisation, with no shareholders to answer to, we ensure that everything we do is for the benefit of our members first and foremost. We make ordering of stock easy with one click using five reputable suppliers. We source suppliers for everyday business essentials, and new technology, and free up the time pharmacists need to concentrate on patients and core services… plus much more. We like to think of ourselves as their support team!

HOW HAS EDINPHARM'S SUCCESS AND EVOLUTION LED TO ITS EXPANSION?

We work with our valued suppliers to ensure that members have the best possible offering, and along with this we ensure a close relationship with members to be able to react quickly to market changes, and local needs. We often get asked what the golden number is for members, and it is always a simple answer. We are happy to keep growing, but at the first sign of us losing touch with members and our suppliers we know it is time to put the brakes on! As a not-for-profit organisation, we don't have shareholders knocking at the door for more money. Everything we do is for members and they need to remain as number one!

WHAT HAVE BEEN THE GREATEST ACCOMPLISHMENTS THUS FAR?

Growing membership from just a few independents in the central belt of Scotland, to the wide membership that we have now, while keeping admin and running costs low. This allows higher end-of-year financial distributions to members. We have changed, and continue to change, our model to best suit the market, and can do this more easily due to our ability to change quickly with the market conditions and contract. Year-on-year we have distributed more and more of the end-of-year profits back to members, often resulting in this exceeding the yearly membership cost.

HOW CAN INTERESTED INDEPENDENT PHARMACIES FIND OUT MORE ABOUT BECOMING MEMBERS?

We're a small and friendly team, and would be happy to chat through details. You can email our Operations Manager, Karen (karen@edinpharm.co.uk) or call our office on 0131 441 3773, alternatively you can email our Managing Director, Richard (richard@edinpharm.co.uk) to find out more about how Edinpharm can work to ensure your business continues to build.

WHAT ELSE IS IN STORE FOR THE FUTURE?

Our aim has never been quick-fire growth, but instead we look to ensure that we support members through the onboarding process to Edinpharm. We will continue to ensure that our focus remains on what is best for Edinpharm members overall, and in turn this will help us achieve slow and steady growth as we go. We have exciting plans ahead to build on our membership across not just Scotland but Northern Ireland too, and this is only possible by having happy members and supportive suppliers.

For more information, visit www.edinpharm.com.

edinpharm

supporting independent pharmacies

"The buying power of a multiple, whilst retaining your independence."

Edinpharm is a buying group with over 235 members and growing. Founded in 1996, we support independent pharmacies while allowing members to retain their independence and unique identity in the marketplace.

Key Benefits of Membership

- Very Competitive Pricing
- Key Generic, PI and H&B lines tendered for monthly on your behalf
- Efficient Order Management System
- Place one single order via your PMR and it routes to the relevant suppliers
- Automatic cascading of orders for out of stock items, so no need for re-ordering
- Email with combined responses from all suppliers, making it easier to see where items are coming from
- Relationship with key suppliers - Alliance Healthcare; Phoenix Healthcare Distribution; Aver Generics; Ethigen; Bestway Medhub
- Exclusive agreements in place with Cegedim, PSL and EMIS for your PMR solution
- Professional and commercial support
- Partnerships with many suppliers of additional products and services for your business needs
- Close partnership with Numark to gain benefit from their membership offerings, with an Edinpharm based rebate for routing your membership via us
- Support Network - Benefit from the collective knowledge and experience of other independent pharmacies
- A stronger, collective voice for feedback of ideas or raising concerns to suppliers and CPS
- Make your own decisions about your business

Want to discuss our membership further? Get in touch...

info@edinpharm.co.uk | www.edinpharm.co.uk | 0131 441 3773

MATTERS OF THE HEART

To reduce the incidence of undiagnosed cases of atrial fibrillation, enhanced patient understanding is key – not just regarding the risks of the condition, but knowing how, and when, medical assistance is required. Experts speak to SPR about the importance of pharmacists utilising their frontline role to help individuals navigate this unfamiliar territory.

COMMUNITY PHARMACISTS RAYMOND ANDERSON AND ASIM ALI (IN COLLABORATION WITH HIS TRAINEE PHARMACIST, MISS LARAIB VASEEM)

WHY IS EARLY DETECTION OF ATRIAL FIBRILLATION (AF) SO ESSENTIAL?

R: Early detection can prevent a much more serious event as a result of a clot developing. This can lead to a life-changing event which not only affects the person involved, but their family, friends and colleagues as well.

A: To avoid future complications i.e. stroke, transient ischaemic attack and heart failure. Early detection is essential to prevent the deterioration of the condition and to act as early as possible for the best patient outcome. Education is key and it's important that the health professionals, as well as the general public, are aware of the signs and symptoms to be aware of.

HOW WOULD YOU IDENTIFY PATIENTS AT HIGH RISK OF AF?

R: Those at risk of AF include older people, those with high blood pressure or underlying heart disease. Other risk factors include those with a high alcohol intake, who smoke, are obese, or have a family history of AF.

A: AF is most commonly associated with patients who have an irregular pulse with any of the following symptoms: breathlessness, palpitations, chest discomfort with hypertension, coronary artery disease, and myocardial infarction. It's also associated with dietary and lifestyle factors. If patients do present with the classic symptoms of AF, past and current medical history should be reviewed. Patients suffering with cardiac disease, hypertension, diabetes and thyroid disease can have an increased exposure to it. Patients presenting symptoms suspect of AF should be assessed and referred as necessary.

WHAT ARE THE IMPLICATIONS OF THE DIAGNOSIS FOR PATIENTS?

R: AF can increase the risk of a stroke which has major implications for a person's health and wellbeing. Reducing this risk will benefit not only the patient and their family, but will ultimately save time and pressure on the health service as well. It will mean taking medication on an ongoing basis to prevent such an event taking place and making some lifestyle changes to help reduce the risk as well.

A: The condition can be associated with a reduced quality of life. It can also result in reduced exercise tolerance and impaired cognitive function. Medical intervention will be needed to stabilise the condition and to prevent the condition worsening. If AF is detected and treated early, the prognosis for the patient is greatly improved.

HOW CAN PATIENTS BE ADVISED TO ADHERE TO A HEALTHIER LIFESTYLE?

R: Carrying out a screening programme will help identify those patients at risk. This will then be helpful in counselling patients to reduce their risk. If this is then linked to other public health messages, such as smoking, obesity and alcohol consumption, it can provide the patient with information to help them make the right health choices. Ultimately the patient will make the decision but as healthcare professionals we need to provide them with the right information.

A: It's important that a shared agenda is discussed at the start of the consultation. Motivational interviewing allows patients to engage in the conversation and encourages them to decide on their current behaviours and future goals. Patients must be able to make informed decisions regarding their health.

WHAT PHARMACIST-CENTRED SERVICES CAN HELP SUPPORT THIS PATH TOWARDS IMPROVEMENT?

R: All initiatives linked with public health campaigns, smoking cessation, obesity, alcohol consumption, exercise and looking after your health, generally can help support this move to prevention, rather than always having to treat someone after an event has taken place.

A: The stop smoking service can be used by patients to help them stop smoking through the provision of NHS-endorsed stop smoking treatments. These are nicotine replacement products, and diagnostic testing is also available in the pharmacy which allows the patient to stay in touch with the vital signs.

REGINA GIBLIN, SENIOR CARDIAC NURSE AT THE BRITISH HEART FOUNDATION

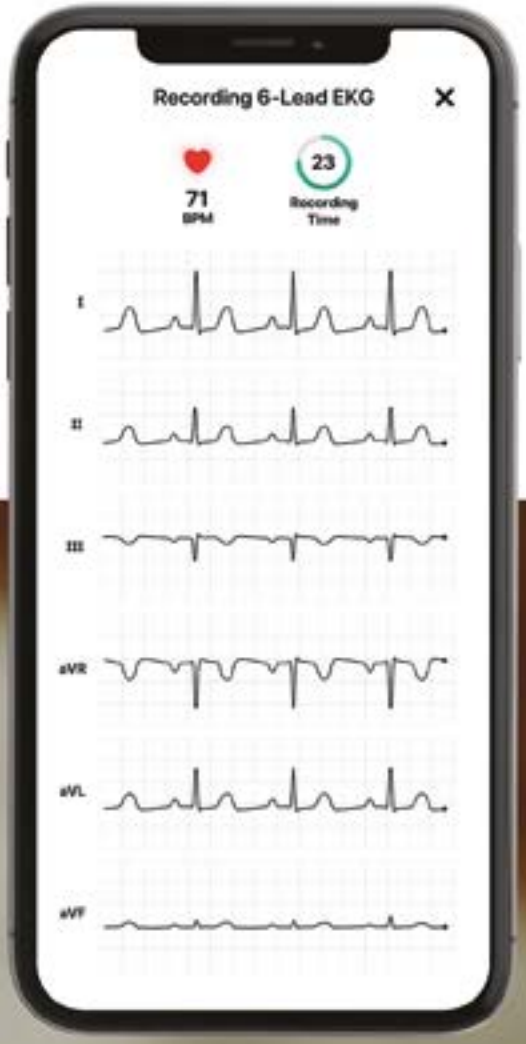
'AF is a common condition, but its symptoms can be overlooked. Often people don't experience any signs, with AF often being detected during a routine examination or check-up. If left undiagnosed and untreated, AF can lead to a devastating stroke, so opportunistic screening is vital.

'Pharmacists are perfectly placed to help identify this hidden danger. Manual pulse checks to identify irregular heart rhythms can be performed as part of blood pressure monitoring services, or during a flu clinic. Pharmacists can also show patients how to carry out their own manual pulse checks, help them become familiar with AF symptoms and how to manage them, and advise them if they need to consult a doctor about a formal diagnosis.'

THE IMPORTANCE OF TECHNOLOGY

The recent development of technologies for AF screening means that pharmacists can play a vital role in helping to reduce the occurrence of strokes and premature deaths, particularly in individuals with asymptomatic AF.

With an estimated 90 per cent of the population visiting a pharmacy at least once a year, and more frequently for patients with chronic diseases, pharmacies provide a perfect setting to perform screening for AF. Through technology e.g KardiaMobile, the pharmacy has now become enabled to perform rapid, remote diagnosis of cardiac arrhythmias.



6 is better than 1.

Detect atrial fibrillation remotely with KardiaMobile 6L, the world's first and only FDA-cleared, CE-marked, 6-lead personal ECG.

There are more than 96,000 people in Scotland living with AF*. What if they could monitor AF from home?

With KardiaMobile 6L, you'll receive an unparalleled view of your patients' heart activity in just 30 seconds. Get real-time, medical-grade ECGs sent directly to you—no appointment required.

Learn more about remote patient monitoring in Scotland with KardiaMobile 6L.

AliveCor®

alivecor.co.uk/sco

Please visit alivecor.com/guidestart for a complete listing of indications, warnings and precautions.

*Information on Atrial fibrillation in Scotland can be found at www.stroke.org.uk/sites/default/files/a_focus_on_atrial_fibrillation_in_scotland.pdf

COW'S MILK ALLERGY: FACING THE FACTS

Ensure that you're equipped to answer the key questions that families may have about a cow's milk allergy and help them to minimise the risks with The Anaphylaxis Campaign's need-to-know round-up.

IMMEDIATE COW'S MILK ALLERGY IN INFANTS AND YOUNG CHILDREN

THE CAUSES

Immediate cow's milk allergy 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 child 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's the sudden release of these chemicals in the body that causes the symptoms.

Immediate onset milk allergy often occurs when formula milk is introduced to the infant's diet or when the child is weaned on to solids and dairy products are introduced. There is often, but not always, a close family history of allergy, such as eczema, hay fever, asthma or food allergy in a mother, father, brother or sister.

THE SYMPTOMS

Symptoms of immediate cow's milk allergy usually occur within minutes of the milk protein being ingested, although uncommonly there can be a delay of up to two hours.

These symptoms may include:

- Widespread flushing of the skin
- Nettle rash (otherwise known as hives or urticaria)
- Swelling of the skin (known as angioedema) anywhere on the body
- Swelling of the lips
- Abdominal pain, nausea and vomiting

These symptoms aren't serious on their own but may be an early sign of anaphylaxis. It is vital to be alert to any deterioration.

More severe symptoms include:

- Swollen tongue
- Hoarse voice
- Difficulty swallowing
- Difficult or noisy breathing, wheeze, persistent cough
- Faintness, drowsiness, dizziness

When these symptoms occur, the child's breathing may be compromised with reduced oxygen levels.

In rare cases there may be a dramatic fall in blood pressure (anaphylactic shock). The person may become weak and floppy and may have a sense of something terrible happening. This may lead to collapse, unconsciousness and – on very rare occasions – death.

Most children with immediate onset milk allergy experience mild or moderate symptoms when they suffer their first reaction. However, experience shows that a subsequent accidental exposure to milk may cause more severe reactions in some, but not all, children, so care must be taken. It's important for individuals to participate in discussions with their healthcare provider regarding whether their child may be at risk of more severe allergic reactions.

GETTING A DIAGNOSIS

If a child experiences any untoward symptoms believed to have been triggered by cow's milk, it's important for them to see their GP. Some GPs have a clear understanding of allergy, but immediate onset allergy is a specialist subject, so it's more likely that their GP will need to refer them to an allergy clinic. The GP can locate an allergy clinic in their area by visiting the website of the British Society for Allergy and Clinical Immunology: www.bsaci.org/find-a-clinic/index.htm

Once a referral occurs, a member of the allergy team will discuss the child's symptoms with their carer in detail, as well as their family's possible wider history of allergy. Valuable information can be provided through allergy tests, such as skin prick tests and blood tests. These tests can help the doctor or specialist nurse predict the likelihood that a specific food, or substance, will cause an allergic reaction. They do not predict how severe such a reaction might be. Occasionally the allergy team may offer a 'food challenge' to confirm diagnosis of allergy to a specific food or to rule out food allergy. The person will be asked to eat small amounts of the suspect allergen, in this case milk, gradually increasing the amount until it is clear that he or she is not allergic, or else a reaction occurs. Such tests should only be done in an allergy clinic under controlled conditions unless the allergy specialist is sure it is safe to test at home.

IMMEDIATE COW'S MILK ALLERGY IN OLDER CHILDREN AND ADULTS

Cow's milk allergy may begin in adult life or persist from childhood. In the adult age group, however, this form of allergy is rare – with an estimated prevalence of approximately one adult in 200. (Woods RK et al, 2002) (Zuberbier T et al, 2004) Milk allergy in adulthood is likely to be severe and persistent and anaphylaxis (a life-threatening allergic reaction) is a possibility in many cases. Symptoms may affect the person's respiratory and cardiovascular systems, and there could even be a severe fall in blood pressure (anaphylactic shock).

The majority of adults with milk allergy also have asthma. Therefore, emergency treatment with adrenaline should always be considered and these patients should be under the care and monitoring of clinicians experienced in the care of severe food allergy in adults. (Luyt D et al, 2014)

DELAYED COW'S MILK ALLERGY (NON-IGE MILK

ALLERGY)

Formerly referred to as cow's milk protein intolerance, this form of milk allergy can occur with breastfeeding alone (exclusive breastfeeding) due to the small amount of cow's milk protein that passes across into the breastmilk when the mother herself consumes cow's milk or dairy products. However, this is uncommon.

It can occur later in such breastfed infants when the time comes for formula, dairy products or cow's milk to be added into the diet. However, it is much more likely to occur in infants who are only being bottle-fed.

As with immediate onset milk allergy, there is often, but not always, a close family history of allergy, such as eczema, hay fever, asthma or food allergy in a mother, father, brother or sister.

THE NEED FOR A DIETITIAN'S SUPPORT

The initial advice following the diagnosis of milk allergy is usually the complete avoidance of cow's milk and foods containing processed cow's milk, such as in cheese, yoghurt etc. in the child's diet.

Referral to a registered dietitian can be made by either the GP or allergy clinic. While waiting to be seen by the dietitian, it would be helpful if the doctor is able to give some initial verbal advice and supply some written advice on avoidance and what can be eaten instead.

The British Dietetic Association provide a helpful list of alternatives to cow's milk. This can be accessed at www.bda.uk.com/foodfacts under 'Babies, Children & Pregnancy'.

The Anaphylaxis Campaign can also provide information, advice and ongoing support. For more information, call the helpline on 01252 542 029 or email info@anaphylaxis.org.uk.

FEEDING

THE IMPORTANCE OF BREASTFEEDING

The incidence of cow's milk allergy is lower in exclusively breastfed infants compared to formula-fed or mixed-fed infants. Only about 0.5 per cent (one-in-200) of exclusively breastfed infants are allergic to the cow's milk in the mother's own diet and most symptoms are mild-to-moderate. (Vandenplas et al, 2007) Immediate onset milk allergy usually begins when cow's milk-based infant formula is introduced or when other sources of dairy products containing milk protein are introduced as the child is weaned onto solids.

If the breastfed infant has been diagnosed with a cow's milk allergy, the mother should continue to breastfeed and seek urgent specialist allergy help, including dietetic advice to ensure that they avoid all cow's milk from their own diet. (Isolauri et al, 1999) This is because some of the proteins from the cow's milk they drink will get into their breastmilk. The mother is likely to need calcium and Vitamin D supplements during this process to ensure that they still get these necessary nutrients in their diet. (NICE, 2014)

HYPOALLERGENIC FORMULAS

If the infant is allergic to cow's milk, they may be recommended a hypoallergenic infant formula where the protein content has been specially prepared, reducing the allergenicity of the milk proteins.

In very severe cases, it may be necessary to use an 'amino-acid formula'. These do not contain any cow's milk. These two groups of hypoallergenic formulas are available on prescription and the doctor will know which one to prescribe. They are all designed to be nutritionally complete milks for the child.

THE 'COMFORT' RANGE OF FORMULAS

There is a further group of special formulas where the cow's milk protein is only partially broken down. These are the 'Comfort' range of formulas, available over-the-counter. However, they are not sufficiently hypoallergenic to have any role in the management of cow's milk allergy in children. (NICE, 2014)

LACTOSE-FREE MILK

Lactose-free milk isn't suitable as it still contains the milk proteins which cause allergic reactions.

SOYA PROTEIN-BASED FORMULAS

These are not considered a suitable alternative to cow's milk for infants less than six months old. However, they can be used in some children over six months of age who have been shown to have no allergy to soya. (British Dietetic Association, 2010)

RICE MILK AND OTHER MILK SUBSTITUTES

Rice milk isn't advised before the age of four-and-a-half years. Ready-made soya, oat, coconut, almond, pea and other 'milk' substitutes may be used after two years of age or perhaps earlier in the second year of life at the discretion of their dietitian. A brand fortified with calcium should be used where possible. (NICE milk allergy guideline, 2014)

MILK FROM OTHER MAMMALS

The milks from all mammals share to varying extent similar proteins and therefore none of these alternative mammalian milks are recommended for use. The milk from those mammals that are most closely related to humans – goats, sheep, and buffalos – are the most likely to cause similar allergy symptoms. The milk from donkeys, horses and camels are perhaps a little less likely to cause such symptoms. (World Allergy Organisation milk guideline, 2010)

WEANING ONWARDS

Children with immediate cow's milk allergy should initially avoid milk in all forms. As well as the obvious ingredients (such as cream), they should avoid the following:

- Cheese
- Yoghurt
- Butter, butter fat, buttermilk or butter oil
- Ice-cream (even when sold as non-dairy – products called ice-cream in the UK must contain at least 2.5 per cent milk protein)
- Fromage frais
- Crème fraiche

This isn't a full list and there are many other food products that contain milk protein.

For more information, visit www.www.anaphylaxis.org.uk.

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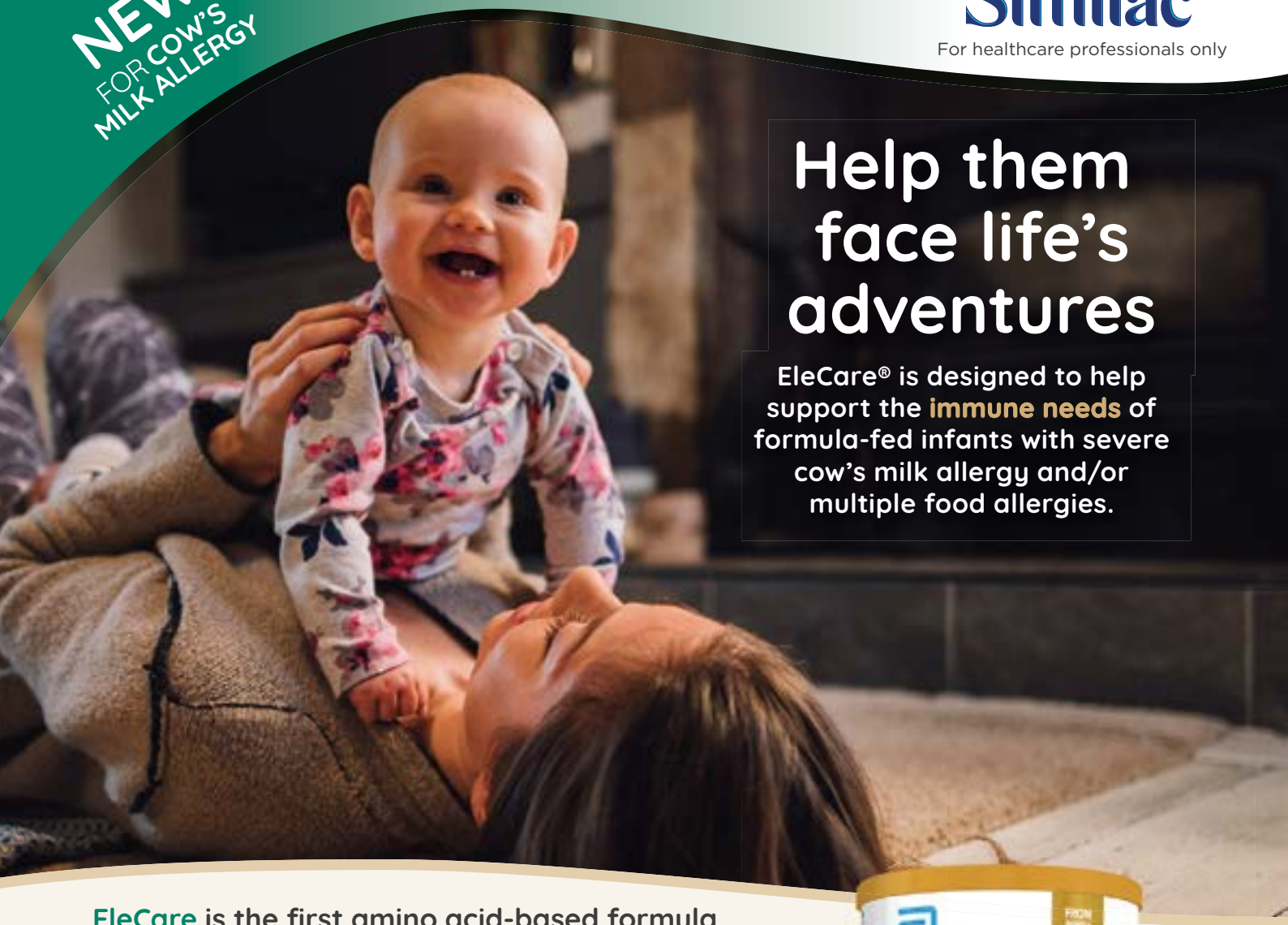
- World Allergy Organization (WAO) Diagnosis and Rationale for Action against Cow's Milk Allergy (DRACMA) Guidelines. April 2010

NEW FOR COW'S MILK ALLERGY

Similac®

For healthcare professionals only



Help them face life's adventures

EleCare® is designed to help support the **immune needs** of formula-fed infants with severe cow's milk allergy and/or multiple food allergies.

EleCare is the first amino acid-based formula to contain 2'-FL*†, a major component of most mothers' breast milk:[1]

Helps support the immune system in the gut and beyond[1-3]
Contains 2'-FL* which has proven benefits on the gut and systemic immune responses‡

Supports healthy growth and symptom resolution[§4-7]

Trusted by mums and healthcare professionals[8,9]

Contact your local Abbott Account Manager to learn more or call Freephone Nutrition Helpline on 0800 252 882

IMPORTANT NOTICE: Breastfeeding is best for infants and is recommended for as long as possible during infancy. EleCare is a food for special medical purposes and should only be used under the recommendation or guidance of a healthcare professional.

*The 2'-FL (2'-fucosyllactose) used in this formula is biosynthesised and structurally identical to the human milk oligosaccharide (HMO) 2'-FL, found in most mothers' breast milk.[1]
†MIMS. September 2020.
‡Studies conducted in healthy-term infants consuming standard Similac formula with 2'-FL (not EleCare), compared to control formula without 2'-FL.
§Studies conducted in infants fed standard EleCare formula without 2'-FL.

References. 1. Reverri EJ, *et al. Nutrients*. 2018;10(10). pii: E1346. **2.** Goehring KC, *et al. J Nutr*. 2016;146(12):2559–2566. **3.** Marriage BJ, *et al. J Pediatr Gastroenterol Nutr*. 2015;61(6):649–658. **4.** Borschel MW, *et al. Clin Pediatr (Phila)*. 2013;52(10):910–917. **5.** Borschel MW, *et al. BMC Pediatr*. 2014;14:136. **6.** Sicherer SH, *et al. J Pediatr*. 2001;138:688–693. **7.** Borschel MW, *et al. SAGE Open Med*. 2014;2:2050312114551857. **8.** RTI research. Abbott EleCare No.1 Dr Recommended. Final Results. 2019. **9.** Abbott. EleCare Promotional Claims Parent Survey. 2019.

UK—2000065 September 2020

Abbott

HOW TO SAVE A LIFE

#StopTheDeaths is a global call for a re-focus on drug deaths and what can be done to help prevent them. Sarah Donaldson, Specialist Pharmacist in Substance Use and Senior Health Intelligence Analyst, NHS Tayside, overviews the initiative and the importance of the sector growing the reach and impact of its message.

1,339 people died from a drug overdose last year, devastating families, friends and communities across Scotland. This figure has been steadily rising over the last 20 years with a sharp increase in rate over the last seven years. Many drug deaths are avoidable and having a little information can make all the difference in saving a life.

#StopTheDeaths is an initiative introduced by Scottish Drugs Forum to emphasise that drug deaths are preventable and this year the initiative was utilised for a joint campaign by the Scottish government and Scottish Drugs Forum to raise public awareness of how to recognise the signs of an overdose and to encourage people to carry naloxone. Posters have appeared on billboards, bus stops and buses across Scotland and a TV and radio campaign featuring the voice of Scottish actor Martin Compston has been released to raise awareness and direct people to www.stopthedeaths.com where people can access training and a take-home naloxone kit.

It is important that pharmacy, across all sectors, is aware of the role we have to play in increasing awareness and supporting efforts to reduce drug deaths.

WHAT IS NALOXONE?

Naloxone is the emergency antidote for overdose caused by heroin and other opiates (for example, methadone, morphine and codeine). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone temporarily blocks this effect, reverses breathing difficulties, and provides valuable time in which an ambulance can attend to provide further medical help.

In the UK, legislation allows anyone to administer naloxone to anyone where it is used with the intention to save a life.

There are two formulations currently used as take-home naloxone kits in Scotland, Prenoxad (intramuscular injection) and Nyxoid (intranasal spray).

WHY IS IT IMPORTANT?

We know that most overdose situations in Scotland involve multiple substances; however, opiates were implicated in 89 per cent of drug deaths in 2020. Reversing the effect of the opiate component of an overdose may be enough to get someone breathing again and save their life.

Naloxone only works on opiates – in an emergency you do not need to be sure that opiates have been taken before administering. If no opiates have been taken naloxone will have no effect.

Recognising the potential of naloxone to save lives, a national take-home naloxone programme was launched in 2011 by the Scottish government – the first programme of its kind in the world. The programme provides training to recognise an overdose, teaches appropriate first-aid actions to take, and allows supplies of naloxone to be given.

Anyone at risk of an overdose, or likely to be present at the scene of an overdose, can access training and a naloxone kit free of charge across Scotland.

IS IT A STICKING PLASTER?

Like many harm reduction activities, take-home naloxone can provoke debate and criticism that it is not addressing the root cause of drug deaths. Take-home naloxone is just one of many activities required to support people. Undoubtedly there is much work to do around addressing the drivers of problematic drug use, such as poverty, deprivation and trauma. There is also a need to reduce the number of overdoses happening in the first place by improving Medication-Assisted Treatment, however while that work is underway, we must be equipped to manage the emergency that we are currently faced with. Ensuring that naloxone is available for use in an overdose situation provides an opportunity to keep someone alive and the opportunity to access the support that they need.

HOW CAN COMMUNITY PHARMACY BECOME INVOLVED?

Community pharmacies are ideally situated to ensure that there is a naloxone kit available for use in an emergency in each local community. There are many examples up and down Scotland where community pharmacy staff have intervened and potentially saved a life by recognising overdose and supplying or administering naloxone.

There are also opportunities to widen the reach of local naloxone programmes through community pharmacies' relationships with people who use drugs and their friends and family. They provide an ideal opportunity to supply training and naloxone kits to people who may not use other services; normalising conversations about overdose and addressing stigma surrounding it.

For more information about naloxone and how you can become involved, contact your local health board naloxone lead or specialist pharmacist in substance use.
Visit www.stopthedeaths.com.

SPiSM
Specialist Pharmacists in Substance Misuse

Pharmacy Students:

Join the PDA for FREE & for every year you are a member, we will donate £1 to the charity that helps Pharmacists

Pharmacist Support
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defending your reputation

Professor Joanna Wardlaw

SHAPING THE FUTURE OF STROKE MANAGEMENT

In this article, Professor Joanna Wardlaw, Professor of Applied Neuroimaging, University of Edinburgh and NHS Lothian, and Foundation Chair, UK Dementia Research Institute, provides an overview of some of the exciting research and scientific advances that were presented at the seventh European Stroke Organisation Conference.

Stroke is a severe and life-threatening disease which currently affects 1.1 million individuals in the EU each year and causes around 440,000 deaths. Projections have suggested that unless we see rapid advancements in treatments, we could face a three per cent increase (from 1.12-to-1.16 million) in the number of EU stroke events, and a 27 per cent increase (9.53-to-12.11 million) in the number of people living with stroke, between 2017-and-2047.[1]

In the past, significant treatment challenges have compounded the impact of stroke. Fortunately, there have been major recent advances which were explored further at the European Stroke Organisation Conference (ESOC). I am particularly excited about the ongoing developments in the treatment of acute ischaemic stroke (AIS), as well as learning more from AIS management studies and studies for treating more chronic and diffuse vascular diseases in the brain. I also looked forward to hearing about the significant progress with haemorrhagic (ICH – intracerebral haemorrhage) stroke management, helping to minimise the risk of patients having further strokes, and the extraordinary capabilities of the latest artificial intelligence (AI) and robotic devices and their impact on stroke detection.

IMPROVING ACCESS TO LIFE-SAVING AIS TREATMENT

For AIS, thrombolysis and thrombectomy are now both considered to be safe and effective ways to treat the condition within a few hours of stroke onset. Thrombolysis, also known as thrombolytic therapy, is a treatment to dissolve clots in blood vessels to improve blood flow and prevent damage to tissues and organs. It's usually only given up to four-and-a-half hours after a stroke, although increasingly we are seeing it used where the time of stroke onset is not known, for example, if the patient woke up with a stroke or was alone when the stroke happened, when we can now use special scanning techniques to show if the brain can still be saved. As we know, timing is crucial with stroke treatment. With each passing minute following a stroke, the opportunity to recover brain function is reduced, so provision of these treatments is vital.

Although thrombolysis is mostly well-established across Europe, there remains patchy provision in certain areas. Positive study findings and clear guidance will encourage wider use and more specialised training to ensure that more patients are eligible to receive this life-saving treatment.

Thrombectomy is a newer procedure

used to treat some ischaemic stroke patients and involves using a specially-designed clot removal device inserted through a catheter to pull out the clot. As with thrombolysis, thrombectomy is most effective the faster it is used following a stroke and it is usually only performed up to six hours after symptoms start, although increasingly we are also seeing it used at later or unknown times of onset, guided as with thrombolysis, by scanning techniques. Again, there remain challenges with access to thrombectomy and research has suggested that this is often caused by organisational difficulties, such as a lack of expertise, training and infrastructure to support the use of this procedure.[2] This needs to be resolved as soon as possible if we are to optimise patient outcomes. The focus now needs to be on increasing availability of clot-removing experts and streamlining stroke services to ensure that as many patients as possible can benefit from these new cutting-edge procedures.

Several imminent trials were presented at ESOC 2021 from different regions within this topic area, including the SWIFT-Direct trial which is assessing the benefits of direct mechanical thrombectomy, to help drive improvements in the funding and implementation of these procedures.

LEARNINGS FROM AIS MANAGEMENT FOR WIDER BRAIN VASCULAR DISEASE PREVENTION

Cerebrovascular diseases and dementia are two leading contributors to impairment of brain health and neurological disability in older people.[3] Unfortunately, the prevalence of these neurological disorders is increasing rapidly due to the ageing population. Patients with cerebrovascular diseases, both acute and chronic, tend to have multidimensional functional impairments to the brain and an increased risk of cognitive impairment and dementia.

Our understanding of stroke has improved greatly over the last 20-to-30 years, with many studies focusing on strategies to prevent and treat AIS, in particular. However, some experts point out that cognitive impairment, rather than stroke, is the most common clinical impact of blood vessel disease, so we need greater long-term understanding of how to use our stroke skills to protect against dementia as well. There has been considerable progress in this area, looking at how vascular diseases affect the brain in more diffuse ways, causing untypical symptoms not previously recognised. We need to continue with this momentum and look beyond the blood vessels that cause stroke. Focus should be on how blood vessel disease affects the whole brain and how to improve the functioning of the vascular system to keep the brain functioning healthily for as long as possible.

Presentations at the conference included findings from large studies of statins in secondary prevention of patients with ischaemic stroke and cerebral microbleeds will certainly offer valuable insights into optimal management for these patients. The four-year follow-up data from the PROGRESS trial evaluating predictors for cognitive decline and dementia in women and men with prior stroke or transient ischaemic attack also provides important learnings in this area, vital for dementia prevention.

IMPROVING OUTCOMES FOR HAEMORRHAGIC STROKE PATIENTS

For haemorrhagic stroke (ICH – intracerebral haemorrhage), a condition which has historically seen less attention, there is also cause for encouragement with improvements to management, helping to reduce the risk of recurrent haemorrhagic stroke and also of ischaemic damage. This can often be a delicate balancing act between the urgency to find and control the initial cause of bleeding in haemorrhagic stroke patients and assessing the risk of a further stroke (ischaemic and haemorrhagic).

Much-anticipated results presented at ESOC 2021 include those from the multi-centre cohort study examining the risk of rupture of an intracranial aneurysm with growth detected during follow-up of over 5,000 patients, which may provide clinicians with more accurate prediction of absolute risk of rupture to improve treatment management. The important SoSTART and APACHE-AF trials will also provide clinicians with further clarity regarding whether to restart or avoid anticoagulation in the long-term for patients with atrial fibrillation who survived anticoagulation-associated intracerebral haemorrhage.

TRANSFORMING BLOOD VESSEL DISEASE CARE WITH NEW TECHNOLOGIES

Treatment for acute stroke has traditionally been focused on using drugs that were thought to protect parts of the brain from ischaemia. However, studies are now looking at how AI can improve early stroke diagnosis, including identifying risky features for haemorrhage, and management and, in so doing, may help to streamline diagnosis and assist with monitoring of treatment early after stroke.

For example, forthcoming studies are looking at improved cerebral microbleed detection in magnetic resonance using a multi-scale 3D convolutional neural network, or are testing automated AI haemorrhage detection software for the assessment of CT brain imaging in stroke, and may have significant impacts on speed of detection and referrals.

Increasingly, we are also now seeing ways of using robotic devices that help to stimulate various different nerves to aid recovery from stroke, for example to improve swallowing which is often damaged in stroke, or to speed up recovery of arm function. The NETS trial presented at ESOC also provided interesting findings evaluating how a device can stimulate neural regeneration in the brain with a non-invasive method.

Although these new technologies are exciting and offer promising results, it's important to keep in mind that most AI devices and technological innovations are very recent, still in evaluation, and are only relevant if they can improve patient outcomes. If these tools can make diagnostics easier, more consistent and faster, or facilitate recovery, and do it simply, then they will have a major impact on clinical practice.

New technologies also bring considerable training implications, particularly as stroke management requires a very broad multidisciplinary approach. Nevertheless, harnessing these technologies and learning how best to use them in practice will dramatically improve stroke healthcare delivery and maximise the chances of patients making a full recovery.

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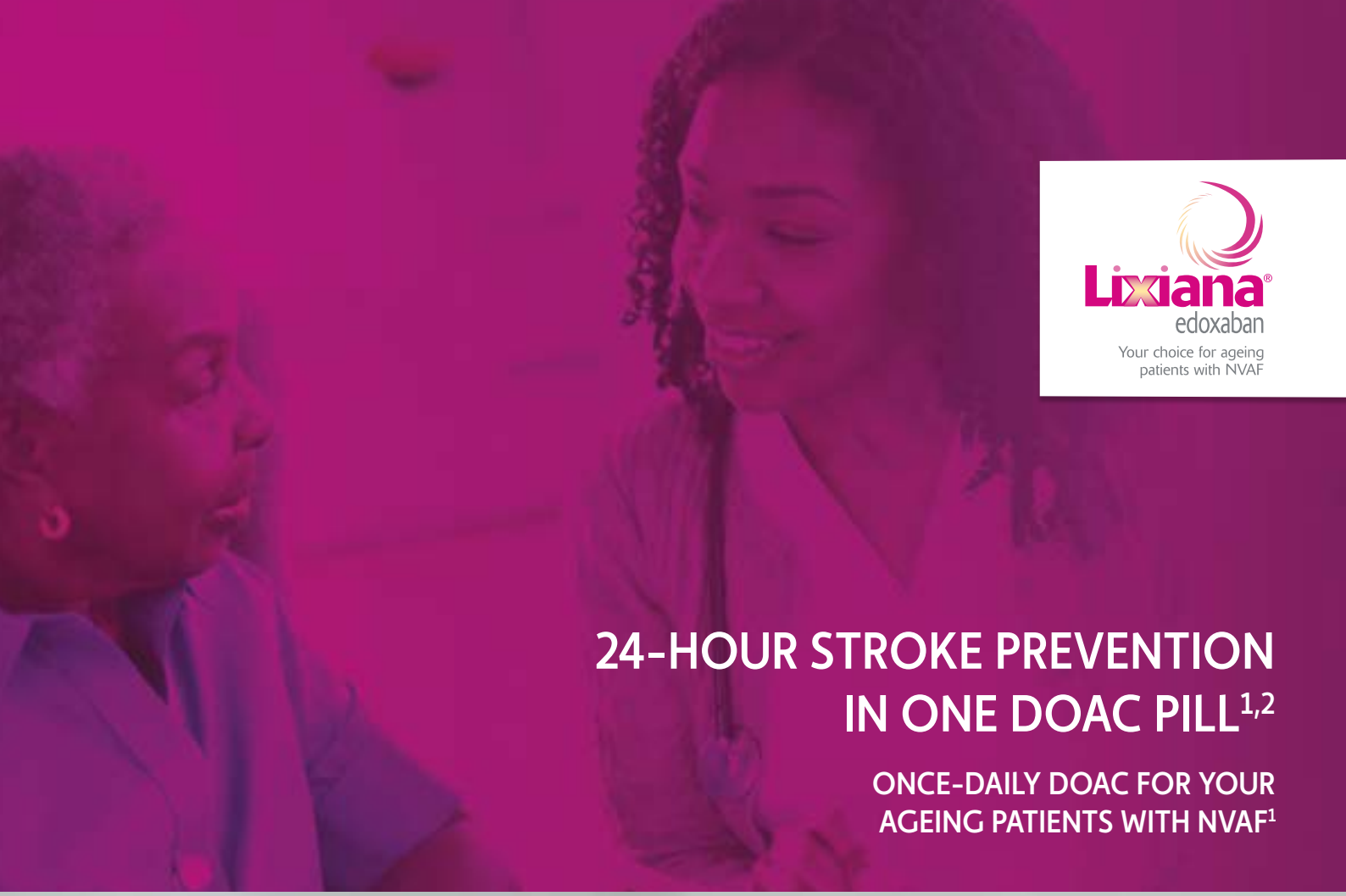

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LIXIANA® is indicated in prevention of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack (TIA).[1]

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Daiichi-Sankyo

LIXIANA (edoxaban) 60 mg / 30 mg / 15 mg film-coated tablets prescribing information. See Lixiana Summary of Product Characteristics (SmPC) prior to prescribing for full list of adverse events

Presentation: 60 mg (yellow) / 30 mg (pink) / 15mg (orange) edoxaban (as tosilate) film-coated tablets. **Indications:** Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack (TIA). Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults.**Posology and method of administration**: *NVAF:* Recommended dose is 60 mg edoxaban once daily with or without food. Continue therapy long term. *VTE:* Recommended dose is 60 mg edoxaban once daily with or without food following initial use of parenteral anticoagulant for at least 5 days. Duration of therapy (at least 3 months) should be based on risk profile of the patient. For NVAF and VTE the recommended dose is 30 mg edoxaban once daily in patients with one or more of the following: moderate or severe renal impairment (creatinine clearance (CrCL) 15 – 50 mL/min); low body weight ≤ 60 kg; concomitant use of the P-glycoprotein (P-gp) inhibitors, ciclosporin, dronedarone, erythromycin, or ketoconazole. The 15 mg dose of edoxaban is not indicated as monotherapy, and should only be used during a switch from edoxaban to VKA in certain patients (see SmPC for full details). Edoxaban can be initiated or continued in patients who may require cardioversion. For transoesophageal echocardiogram guided cardioversion in patients not previously treated with anticoagulants, edoxaban should be started at least 2 hours before cardioversion to ensure adequate anticoagulation. Cardioversion should be performed no later than 12 hours after the dose of edoxaban on the day of the procedure. Confirm prior to cardioversion that the patient has taken edoxaban as prescribed. If a dose of edoxaban is missed, the dose should be taken immediately and then continued once daily on the following day. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Clinically significant active bleeding. Hepatic disease associated with coagulopathy and clinically relevant bleeding risk. Lesion or condition, if considered to be a significant risk for major bleeding including current or recent gastrointestinal (GI) ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities. Uncontrolled severe hypertension. Concomitant treatment with any other anticoagulants e.g. UFH, low molecular weight heparins, heparin derivatives (fondaparinux, etc.), VKA or DOACs except under specific circumstances of switching oral anticoagulant therapy or when UFH is given at doses necessary to maintain an open central venous or arterial catheter. Pregnancy and breast-feeding. **Special warnings and precautions for use:** *Haemorrhagic risk:* Caution in patients with increased risk of bleeding such as elderly on ASA. Discontinue if severe haemorrhage occurs. The anticoagulant effect of edoxaban cannot be reliably monitored with standard laboratory testing. A specific anticoagulant reversal agent for edoxaban is not available. Haemodialysis does not significantly clear edoxaban. *Renal impairment:* CrCl should be monitored at the initiation of edoxaban and afterwards when clinically indicated. Not recommended in patients with end stage renal disease or on dialysis. *Renal function and NVAF:* A trend towards decreasing efficacy with increasing CrCl was observed for edoxaban compared to well-managed warfarin. Edoxaban should only be used in patients with NVAF and high CrCl after a careful benefit risk evaluation. *Hepatic impairment:* Not recommended in severe hepatic impairment. Caution in mild or moderate hepatic impairment. Caution in patients with elevated liver enzymes (ALT/AST > 2 x ULN) or total bilirubin ≥ 1.5 x ULN. Perform liver function testing prior to initiation and then periodically monitor for treatment beyond 1 year. *Surgery or other interventions:* discontinue edoxaban as soon as possible and preferably at least 24 hours before the procedure. If procedure cannot be delayed, the increased risk of bleeding should be weighed against urgency of the procedure. Restart edoxaban as soon as haemostasis achieved. *Prosthetic heart valves and moderate to severe mitral stenosis:* Not recommended. *Haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy:* Not recommended. *Patients with active cancer:* Not recommended in treatment and/or prevention of VTE. *Patients with a history of thrombosis diagnosed with antiphospholipid syndrome:* DOACs including edoxaban not recommended. **Drug interactions**: Concomitant use of the *P-gp inhibitors* ciclosporin, dronedarone, erythromycin, or ketoconazole requires edoxaban dose reduction to 30mg. Edoxaban should be used with caution with concomitant *P-gp inducers* (e.g. rifampicin, phenytoin, carbamazepine, phenobarbital, St John's Wort). Concomitant high dose ASA (325 mg) or chronic NSAIDs is not recommended. Concomitant ASA at doses > 100 mg and < 325 mg should be under medical supervision only. Very limited experience with dual antiplatelet therapy or fibrinolytics. Possibility of increased bleeding risk with concomitant SSRIs or SNRIs. **Adverse reactions:** *Common:* anaemia, dizziness, headache, epistaxis, abdominal pain, lower GI haemorrhage, upper GI haemorrhage, oral/pharyngeal haemorrhage, nausea, blood bilirubin increased, gamma GT increased, cutaneous soft tissue haemorrhage, rash, pruritus, macroscopic haematuria/urethral haemorrhage, vaginal haemorrhage, puncture site haemorrhage, liver function test abnormal. *Serious uncommon:* thrombocytopaenia, hypersensitivity, intracranial haemorrhage (ICH), intraocular haemorrhage, other haemorrhage, haemoptysis, surgical site haemorrhage. *Serious rare:* anaphylactic reaction, allergic oedema, subarachnoid haemorrhage, pericardial haemorrhage, retroperitoneal haemorrhage, intramuscular haemorrhage (no compartment syndrome), intra-articular haemorrhage, subdural haemorrhage, procedural haemorrhage. **Legal classification:** POM. **Package quantities, marketing authorisation (MA) numbers and basic NHS costs:** 60 mg – 28 tablets – EU/1/15/993/018 – £49.00. 30 mg – 28 tablets – EU/1/15/993/005 – £49.00. 15 mg – 10 tablets – EU/1/15/993/001 – £17.50. **MA holder:** Daiichi Sankyo Europe GmbH, Zielstattstrasse 48, 81379 Munich, Germany. **Date of preparation of Prescribing Information:** November 2020 EDX/20/1108

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 Daiichi Sankyo UK Pharmacovigilance on 0800 028 5122, pharmacovigilance@daiichi-sankyo.co.uk

DOAC, direct oral anticoagulant; NVAF, nonvalvular atrial fibrillation; TIA, transient ischaemic attack.

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PANCREATIC CANCER

TAKING CARE

A new campaign is propelling to the forefront of the sector – urging healthcare professionals to learn more about vital capsules for pancreatic cancer patients at risk of starvation.

Half of all people diagnosed with pancreatic cancer aren't prescribed inexpensive yet essential capsules without which they can't digest food, new research shows – leaving patients less able to tolerate treatment and at risk of starvation. (1) The alarming finding comes from an audit of 1,350 pancreatic cancer patients in the UK, led by researchers at the University of Birmingham, with funding from the charity Pancreatic Cancer UK.

Pancreatic Cancer UK worked closely with specialist health professionals to develop a new campaign, 'Transform Lives: Prescribe', urging health professionals to learn more about this vital medication and to ensure that everyone who could benefit from the capsules are prescribed them at the point of diagnosis.

The capsules, known as Pancreatic Enzyme Replacement Therapy (PERT), are already recommended by NICE for people with pancreatic cancer. PERT capsules replace vital enzymes ordinarily produced by the pancreas, and are therefore essential to help patients digest food, build tolerance to treatment and to manage debilitating digestive symptoms from the cancer – including diarrhoea and extreme weight loss.

Pancreatic Cancer UK are deeply concerned by the low prescription rates, but especially that so many people with incurable pancreatic cancer are not getting the medication – which could not only improve their quality of life, but also help them tolerate life-extending treatment. The audit found that patients who had been diagnosed too late to have surgery (the only potential cure for the disease) are two-times less likely to be prescribed PERT capsules. (2) The disease's vague symptoms, such as back pain and indigestion, mean that it often goes undetected until after it has already spread. Sadly, 80 per cent of people with pancreatic cancer are diagnosed too late to have surgery but their quality of life can still be greatly improved by taking PERT. (3)

Pancreatic Cancer UK commissioned qualitative in-depth interviews with health professionals involved in the care of people with pancreatic cancer across a range of settings and roles, in order to gain a deeper understanding of the perceptions, barriers and solutions to prescribing PERT.

The majority of the 10,000 people with pancreatic cancer in the UK receive a terminal diagnosis and, as a result, are more likely to be treated in a general hospital, rather than a specialist cancer hospital where health professionals will have more experience of pancreatic cancer and PERT. The research showed that low awareness and lack of standard training in PERT in these non-specialist settings are the most significant reasons why they are not prescribed more frequently. Pancreatic Cancer UK are encouraging everyone who treats and cares for people with pancreatic cancer to take responsibility to ensure that PERT is prescribed to all patients who could benefit from it, and to keep up-to-date on best practice.

CLOSE TO HOME

Marie Morris, 44, has seen the devastating impact of the disease. Her mum, Josephine, was diagnosed with pancreatic cancer at a late stage and was never prescribed PERT capsules. Josephine was offered six cycles of chemotherapy to prolong her life but she managed just two before being unable to tolerate anymore. She lost at least two stone in weight from being unable to digest food due to the cancer, leaving her badly malnourished. Josephine died in April 2020, just seven months after her diagnosis, aged 73.

Marie said, 'It's hard to see somebody who's confined to a bed and who can't eat anything without vomiting. In full health and fitness, she weighed about nine-and-a-half stone. A couple of stone off that… it makes quite a dramatic difference. By the end she was skeletal. There was nothing left, really. Maybe it (PERT) could have made a difference to the length of her life – but perhaps more importantly – also to the quality of her life.'

MAKING THE LINK

Through their 'Transform Lives: Prescribe' campaign, Pancreatic Cancer UK are urging the NHS across all four nations to implement targets to make sure that everyone with pancreatic cancer is considered for PERT capsules as standard, at the point of diagnosis. Cost should not be a factor in why prescription numbers are so low: at just £7 per patient per day, PERT capsules are inexpensive to the NHS. (4)

Pancreatic Cancer UK

Diana Jupp, CEO of Pancreatic Cancer UK, explained, 'Nobody should have to watch someone they love waste away from pancreatic cancer when proven, inexpensive medication is available to stop that from happening. It needs to become second nature to see people with pancreatic cancer and prescribe PERT capsules, in the same way an immediate link is already made between diabetes and insulin.

'Health professionals care for people with pancreatic cancer with great skill and compassion year-after-year, but many will typically see patients with this devastating disease far less frequently than other types of cancer. People diagnosed with pancreatic cancer can't wait for the expertise of specialist cancer hospitals to be shared naturally to other parts of the health service.

'We need targeted action now across the NHS to raise awareness of PERT capsules and ensure everyone who needs them is prescribed them – regardless of whether or not their cancer is curable. The majority of people with pancreatic cancer aren't able to have surgery and they shouldn't be denied a simple prescription which could give them more – and better quality – time with their loved ones.'

For more information about the 'Transform Lives: Prescribe' campaign, visit transformlives.pancreaticcancer.org.uk.

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Scottish **Pharmacy** Awards

AND THE WINNERS ARE...

The Scottish Pharmacy Awards ceremony recently returned – with the evening pulsating with more poignancy and importance than ever before.

Following the transition of last year's event online in response to COVID-19 restrictions, Scotland's pharmacists were once again able to come together in-person and be publicly recognised for their excellence throughout the last 20 months and beyond.

The Crowne Plaza Hotel, Glasgow, was the venue of choice for the 2021 ceremony, with esteemed presenter Laura McGhie taking the helm as host and commanding the 200-plus audience which encompassed a mix of the sector's professionals, students, and key industry representatives.

Over the course of the evening, the title-holders of the eight competitive categories were announced, including Independent Community Pharmacy Practice of the Year and Hospital Pharmacy Team of the Year.

Rounding off the proceedings was the announcement of the 2021 Special Recognition Award honouree – which, for the first time, was dedicated to the entire Scottish pharmacy community in tribute to their collaborative efforts, commitment and resilience in the face of unprecedented COVID-19 pressures.

Throughout the evening, funds were also raised for this year's nominated charity, SAMH, Scotland's national mental health charity.

All the winners and their reactions are featured over the following pages.

INDEPENDENT COMMUNITY PHARMACY PRACTICE OF THE YEAR

Independent Community Pharmacy Practice of the Year Award winner, the Cadham Pharmacy Team, Glenrothes, with Richard Stephenson, Edinpharm, and Stephen McBurney, Associate Director of Pharmacy (NHS Lothian)

Sponsored by Edinpharm

edinpharm
supporting independent pharmacies

'Thank you so much. This is amazing and after the last 20 months, the award just means the world to us. We hope that we can inspire as many pharmacists as possible with our work to realise that they matter and that they can make a difference.'

The Cadham Pharmacy Team
Glenrothes

'Edinpharm have looked after community pharmacies for over 20 years now, and the opportunity to sponsor such an amazing award was an honour! Celebrating all the amazing work that has been seen over the last 12 months was great to be part of.'

Richard Stephenson
Edinpharm

WINNER

PHARMACY STUDENT LEADERSHIP

Pharmacy Student Leadership Award winner, Jack Murphy, Robert Gordon University, with Professor Anne Boyter, University of Strathclyde, and Maurice Hickey, The Pharmacists' Defence Association

Sponsored by The Pharmacists' Defence Association

WINNER

'I would like to say thank you to my mum, my dad, my whole family, and everyone at the Pharmacy Society at Robert Gordon University – I couldn't have done it without them, especially Vivien Yu who has supported me and been my best friend and mentor. Vivien, this one is for you!'

Jack Murphy
Robert Gordon University

'It has been a pleasure to sponsor this award because leadership is so important, particularly given the last 20 months or so with COVID. All of the finalists showcased sublime leadership and are credits to their universities and themselves. The future is with them.'

Maurice Hickey
The Pharmacists' Defence Association

BUSINESS DEVELOPMENT OF THE YEAR

Business Development of the Year Award winner, the Murray Pharmacy Team, East Kilbride, with Brian Chambers, AAH Pharmaceuticals, and Fiona McElrea, Whithorn Pharmacy

Sponsored by AAH Pharmaceuticals

WINNER

'It has been a tough year for everybody and this award is dedicated to the whole team for their hard work. Thank you.'

The Murray Pharmacy Team
East Kilbride

'It's critical for us all to recognise the impact that pharmacy has had on communities, especially with the backdrop of COVID. It's been such a privilege to be a sponsor and to be here tonight. Congratulations to the worthy winner!'

Brian Chambers
AAH Pharmaceuticals

MANAGEMENT OF SUBSTANCE DEPENDENCY IN THE COMMUNITY

Ken Sutherland, Ethypharm UK, and Duncan Hill, Specialist Pharmacist in Substance Dependency (NHS Lanarkshire), collecting the Management of Substance Dependency in the Community Award on behalf of its winner, The Aberdeenshire Pilot Scheme

Sponsored by Ethypharm UK

Ethypharm

'The Pilot Scheme looks fantastic and I'm delighted that they have won this award. Well done.'

Ken Sutherland
Ethypharm UK

WINNER

PHARMACY ASSISTANT OF THE YEAR

Pharmacy Assistant of the Year Award winner, Janette Currie, Paton & Finlay Pharmacy, with Chris Miller, Primary Care and Community Pharmacy Co-Ordinator (NHS Lothian), and Leanne Birtwistle, L'Oréal Active Cosmetics UK

Sponsored by Vichy and La Roche-Posay

LA ROCHE POSAY
LABORATOIRE DERMATOLOGIQUE

VICHY
LABORATOIRES

'I'm gobsmacked! I love my job and getting to know the community is such a pleasure – my patients are more like friends. I work with a fantastic team and this award is for them as well because we're all in it together. Thank you so much!'

Janette Currie
Paton & Finlay Pharmacy

'I was delighted to have been asked to present the Pharmacy Assistant of the Year Award. Janette has been serving her community for over 20 years, and this award is more than deserved. I'm so proud of everything she has done for herself, her pharmacy and her community. She is a true (and humble) winner!'

Leanne Birtwistle
L'Oréal Active Cosmetics UK

WINNER

EXCELLENCE IN DELIVERING SELF-CARE AGENDA IN COMMUNITY PHARMACY

Excellence in Delivering Self-Care Agenda in Community Pharmacy Award winner, Right Medicine Pharmacy, with Graham Powrie, Johnson & Johnson, and John McAnaw, Head of Pharmacy at NHS 24

Sponsored by Johnson & Johnson

'It has really been a team effort from everyone – I'm proud of the whole team at Right Medicine Pharmacy, from the very top to the very bottom.'

Amy Gordon and Dean Lawson
Right Medicine Pharmacy

'Congratulations to Right Medicine Pharmacy! Self-care is so crucial for both the pharmacists and patients, and well done to the team for their excellent delivery of this.'

Graham Powrie
Johnson & Johnson

WINNER

INNOVATIVE USE OF TECHNOLOGY IN COMMUNITY PHARMACY

Innovative Use of Technology in Community Pharmacy Award winner, the Mackie Pharmacy Team, Dumbarton, with Kenny Lawton, Cegedim Healthcare Solutions, and George Romanes, Romanes Pharmacy

Sponsored by Cegedim Healthcare Solutions

'We're delighted. We carried out the project during COVID lockdown and used the latest technology to help patients and meet their needs throughout it which was incredible.'

The Mackie Pharmacy Team
Dumbarton

'It's great to sponsor this award and be back once again. The winning team are thoroughly deserving and have truly demonstrated their innovative use of technology. Congratulations!'

Kenny Lawton
Cegedim Healthcare Solutions

WINNER

HOSPITAL PHARMACY TEAM OF THE YEAR

Hospital Pharmacy Team of the Year Award winner, the Peri-Operative Medicines Management Project Team (NHS Greater Glasgow & Clyde), with Paul Concannon, Ethypharm UK, and Alison Wilson, Director of Pharmacy (NHS Borders)

Sponsored by Ethypharm UK

‘We’re very surprised and honoured to win. The other finalists are such high contenders so we’re really humbled. We wouldn’t be here without our great team leaders who have helped us from the beginning. Thank you.’

The Peri-Operative Medicines Management Project Team
NHS Greater Glasgow & Clyde

‘We are once again thrilled to be sponsoring this award. The number of entries reflect just how important the Hospital Pharmacy Team of the Year category is and we are delighted for the winning team.’

Paul Concannon
Ethypharm UK

WINNER

SPECIAL RECOGNITION

Andrew Carruthers, Royal Pharmaceutical Society Scotland, collecting the Special Recognition Award on behalf of its winner, the Scottish pharmacy community in tribute to their COVID-19 contributions, with Chris Flannagan, Kyron Media

Sponsored by Kyron Media

‘Pharmacy – like the rest of healthcare – was under significant pressure during the pandemic, but we have managed to keep our services open and help patients however we can. When you speak to patients, it comes across time and time again just how grateful they are for these efforts.’

Andrew Carruthers
Royal Pharmaceutical Society Scotland

‘Through the dark days of the pandemic, it was the sector’s collaborative ethos and sense of community which helped pave a way forward. As a result, this year it’s impossible for us to select just one standout representative as the winner of this evening’s Special Recognition Award. Instead, this honour is dedicated to each and every one of the Scottish pharmacy community who continue to cultivate improvements in hospitals, surgeries, pharmacies, care homes, and much more. Thank you on behalf of myself and the team.’

Chris Flannagan
Kyron Media

WINNER

Scottish **Pharmacy** Awards

A BURNING ISSUE

Antibiotic-resistant urinary tract infections are a type of infection that don't respond to most – or any – of the most common treatments. Here, the Antibiotic Research UK Team address some of the major questions surrounding the care which patients will receive.

WHO IS AT RISK FROM ANTIBIOTIC-RESISTANT URINARY TRACT INFECTIONS?

Those at greatest risk of antibiotic-resistant infections are often those with other underlying medical conditions, who have weakened immune systems either due to illness or as a side-effect of current treatment. Those often affected have already been taking antibiotics or have been in hospital. Older people, such as those in care facilities or those undergoing catheterisation, may also be affected by ongoing or recurrent resistant urinary tract infections (UTIs).

The biggest risk is that untreated or resistant infections can lead to kidney problems (like pyelonephritis), or even more serious conditions like sepsis (or urosepsis). However, it's also very difficult living with the ongoing symptoms of recurring or antibiotic-resistant UTIs.

WHAT TYPE OF BACTERIA USUALLY CAUSE UTIS?

The most common bacterial cause of UTIs are E coli. These bacteria usually live harmlessly in the gut of healthy people but can cause problems if they get into the bladder or other parts of the urinary tract. Uncomplicated infection of the bladder, also called cystitis, is common and can be very painful.

Some strains of E. coli bacteria have begun to produce enzymes called extended-spectrum beta-lactamases (often summarised to ESBL E coli). These can make the bacteria resistant to certain antibiotics, and so the bacteria continue to multiply and spread. This causes more severe infection which becomes much more difficult to treat. Another type of bacteria which often causes antibiotic-resistant UTIs is ESBL klebsiella pneumoniae.

E. coli belongs to the Enterobacteriaceae family of Gram-negative bacteria. This family of bacteria also include klebsiella pneumoniae and enterobacter cloacae. The Enterobacteriaceae family can all cause UTIs and are often treated with the beta-lactam antibiotic, carbapenem, for which there are specific ESBL enzymes. The carbapenem-resistant Enterobacteriaceae (CRE) that have developed, have become a real risk to health as the main antibiotic becomes useless and their presence increases in hospitals and care settings.

WHAT ARE THE SYMPTOMS OF AN ANTIBIOTIC-RESISTANT UTI?

The main difference between a regular UTI and an antibiotic-resistant UTI is that the medicines usually used to treat such infections don't often work against antibiotic-resistant UTIs. While the antibiotics may appear to work at first, they're only killing those bacteria sensitive to the antibiotic, but not dealing with the resistant organisms. This means that it is really important that if antibiotic-resistant bacteria are present, they are diagnosed and identified as early as possible so that the right antibiotics are used to kill them.

To identify if an individual has a UTI, their doctor will usually ask them to provide a urine sample which they will test with a dip stick. This is a quick way to establish if they have a urine infection. If positive, then a sample of their urine will normally be sent to the local microbiology laboratory for testing.

ARE UTIS CONTAGIOUS?

You can't pass a UTI on to another person. However, if an individual has an infection of any type – particularly one that is antibiotic-resistant – there is always a risk that the bacteria causing the infection could infect those around them if they don't adhere to proper hygiene standards. If an individual has an ESBL-resistant infection, they will often be kept in isolation in a hospital ward, to decrease the risk of spreading these bacteria to other vulnerable patients. For prevention of UTIs, it is particularly important that individuals wash their hands after using the bathroom and after sexual contact, and maintain a clean environment.

HOW ARE ANTIBIOTIC-RESISTANT UTIS USUALLY TREATED?

For most common UTIs, there is usually a 'first-line' antibiotic that is often used as standard, although these vary across the UK. If you have had a UTI, the chances

URINARY TRACT INFECTION

are you are familiar with these drugs. So GPs will usually follow guidance to treat a UTI immediately with first-line therapy according to local guidelines. If this doesn't eliminate the infection, a urine culture is often sent to the lab to test what the bacteria actually is and what antibiotic is likely to kill it. Other antibiotics, such as fosfomycin and pivmecillinam, might be used where first-line antibiotics have not worked. Fosfomycin is an oral broad-spectrum antibiotic that acts against many multidrug-resistant pathogens in the urinary tract.

WHAT IS COLONISATION AND BIOFILM?

When people have had several UTIs, and several courses of antibiotics for a UTI, antibiotics may initially appear to work and symptoms often resolve for a while. However, the more resistant organisms are known to sometimes attach themselves to the bladder wall, as well as forming colonies of resistant bacteria within other parts of the body, such as the kidney.

These colonies of resistant bacteria can multiply in number over time, and become immune to the effect of the antibiotics. The bacteria become harder to eradicate, even when taking powerful antibiotics, as they form a biofilm. This is where the colonies of resistant bacteria form a protective layer around themselves, making it even more difficult for antibiotics to reach and kill them.

An antibiotic-resistant UTI can then become a chronic condition and can often cause frequently recurring outbreaks of infection, with an increased risk of serious kidney infection (pyelonephritis) and even sepsis.

WHAT HAPPENS IF AN INDIVIDUAL HAS A MULTIDRUG-RESISTANT UTI?

Some strains of bacteria are now resistant to all of the most commonly-used antibiotics. When UTIs recur or don't go away with treatment, urine samples are usually tested at a microbiology lab, and if resistant organisms are discovered they are often found to be ESBL E. coli or ESBL Klebsiella. If an individual has a UTI with either of these resistant bacteria, they will probably be treated in hospital by an infectious disease doctor and their team. They will often prescribe a specific antibiotic via an intravenous (IV) drip (or combination of antibiotics) known to be active against ESBL-producing bacteria – such as a carbapenem antibiotic. These are considered 'last resort' antibiotics which are kept especially for those highly resistant bacterial infections.

If an individual has an antibiotic-resistant UTI, they're not alone. There are many different support groups online where people suffering with resistant UTIs can help one another.

PREVENTING UTIS USING NATURAL PRODUCTS

Many of those who suffer with recurring or resistant UTIs are keen to find ways of reducing the risk or occurrence by using natural products such as D-Mannose, cranberry products (like triple-strength tablets or juice), Kefir / probiotics, manuka honey and so on.

Anecdotally, many report finding some of these useful in the prevention of UTIs; however, there is very little published evidence to support the effectiveness of these natural products, and more research is needed.

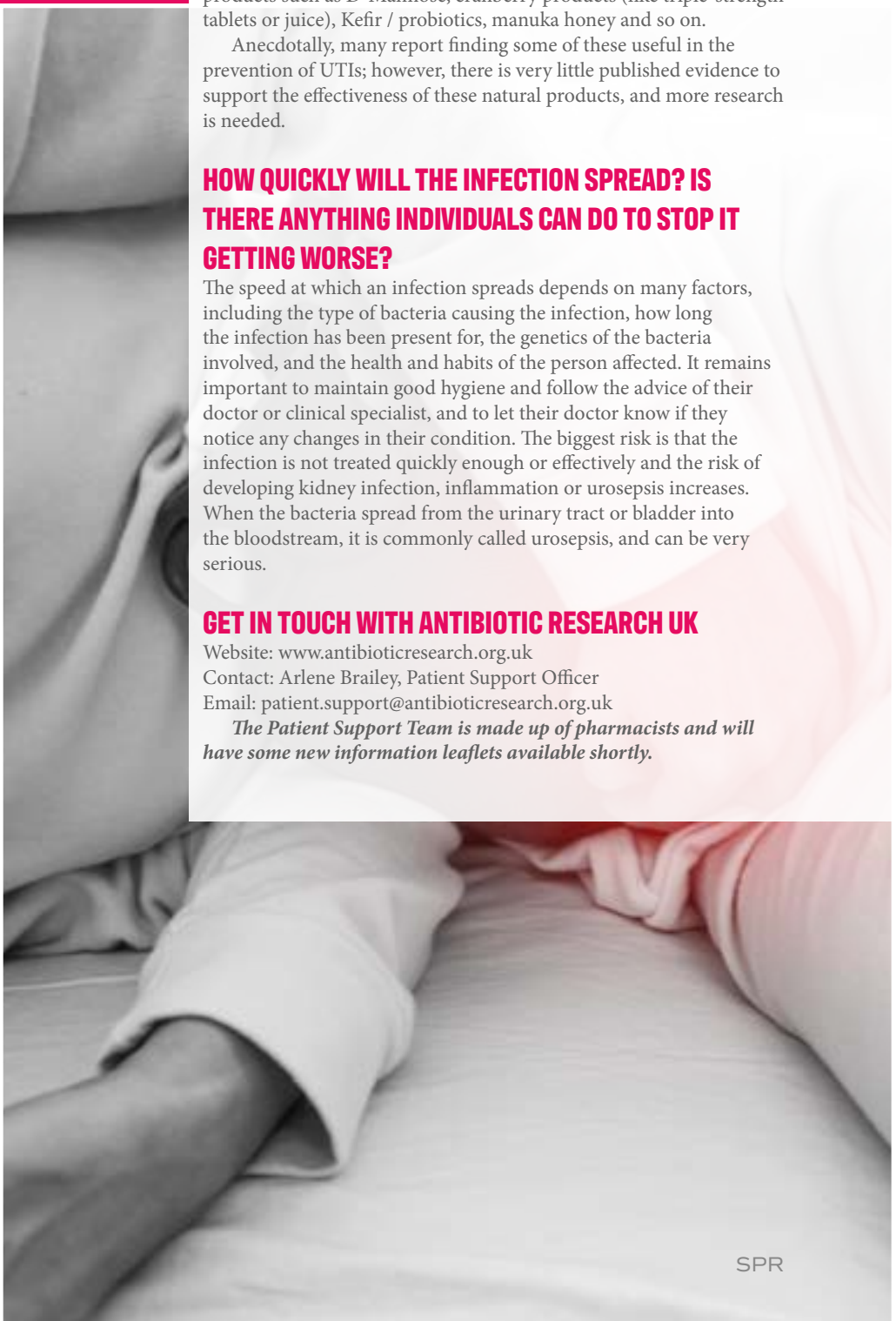
HOW QUICKLY WILL THE INFECTION SPREAD? IS THERE ANYTHING INDIVIDUALS CAN DO TO STOP IT GETTING WORSE?

The speed at which an infection spreads depends on many factors, including the type of bacteria causing the infection, how long the infection has been present for, the genetics of the bacteria involved, and the health and habits of the person affected. It remains important to maintain good hygiene and follow the advice of their doctor or clinical specialist, and to let their doctor know if they notice any changes in their condition. The biggest risk is that the infection is not treated quickly enough or effectively and the risk of developing kidney infection, inflammation or urosepsis increases. When the bacteria spread from the urinary tract or bladder into the bloodstream, it is commonly called urosepsis, and can be very serious.

GET IN TOUCH WITH ANTIBIOTIC RESEARCH UK

Website: www.antibioticresearch.org.uk
Contact: Arlene Brailey, Patient Support Officer
Email: patient.support@antibioticresearch.org.uk

The Patient Support Team is made up of pharmacists and will have some new information leaflets available shortly.



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For UK Healthcare Professionals only

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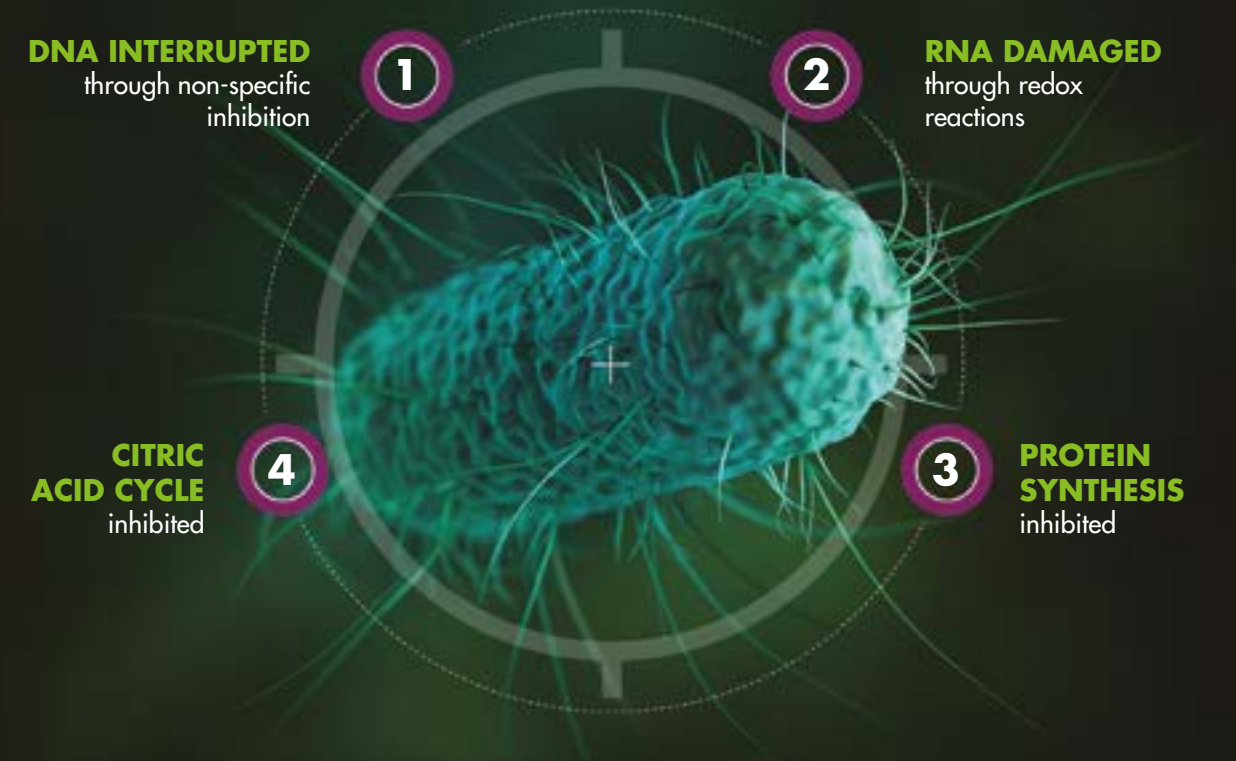
Anecdotal evidence from an observational study suggests antibiotic therapy should be initiated at first sign of symptoms of lower UTI.[2]
Data from a large case series of women with long-standing lower UTI symptoms (n=1996, mean duration of symptoms 6.5 years)[2]

Multiple modes of action help reduce the risk of resistance.[5,6]



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UTI: Urinary tract infection MacroBID® is indicated for the treatment of and prophylaxis against acute or recurrent, uncomplicated lower UTIs or pyelitis either spontaneous or following surgical procedures, in patients over 12 years of age[7]

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PRESCRIBING INFORMATION

Macrobid 100mg Prolonged-release Capsules (nitrofurantoin)

Presentation: Hard gelatin capsule containing the equivalent of 100mg of nitrofurantoin in the form of nitrofurantoin macrocrystals and nitrofurantoin monohydrate. **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. **Legal Category:** POM. **Basic NHS Price:** £9.50 per pack of 14 capsules. **Marketing authorisation number:** PL 12762/0052. **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 revision:** March 2021 [ADV/MAB/PI/0001]

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 **Advanz Pharma Medical Information** via telephone on **+44 0 8700 70 30 33** or via e-mail at **medicalinformation@advanzpharma.com**

Date of preparation: July 2021
ADV/MAB/PM/0289

CHILDHOOD OBESITY: THE BIG PICTURE

Elvira Verduci, lead author of ESPGHAN's latest childhood obesity guidelines and Secretary of the ESPGHAN Nutrition Committee, presents an exploration of childhood obesity, including the impact, triggers, and a pathway forward.

Childhood obesity is the most prevalent food-based disorder among children and adolescents worldwide, with the World Health Organisation regarding it as one of the most serious global health challenges of the 21st Century.[1,2] Previous studies have shown that around 41 million children in Europe under the age of five years are overweight or obese.[3] By 2050 obesity is predicted to affect 60 per cent of men, 50 per cent of women, and 25 per cent of children if current trends continue and serious action is not taken.[4] Childhood obesity is far more complex than people often assume, with a multitude of causes and risk factors associated with the disorder, making it hard to prevent and subsequently treat. Therefore, considering the intricacies of childhood obesity, new multicomponent approaches are required to make a real change, and reverse the rising trends.

THE IMPACT OF CHILDHOOD OBESITY

There are a range of health, social and economic impacts that stem from childhood obesity. Children with obesity have increased metabolic and cardiovascular risks in childhood through to adulthood, and may display early signs of metabolic syndromes, such as dyslipidaemia, and altered glucose metabolism.[5] Obesity in children can also result in serious psychological difficulties. These challenges can present in children as self-esteem issues and / or becoming victims of bullying. These psychological issues can in turn have negative impacts on education which hinder later development.[6] Furthermore, rising obesity rates have a significant impact on healthcare systems, with the estimated cost of obesity, both direct and indirect, in Europe being around €81 billion per year.[2] European countries are currently spending between 1.9-to-4.7 per cent of total annual healthcare costs on treating overweight or obese patients.[2]

THE TRIGGERS OF CHILDHOOD OBESITY

Childhood obesity can be triggered by many interconnected causes and risk factors. Certain children are at greater risk of obesity due to genetic factors, such as the make-up of their gut bacteria (gut microbiota). The gut microbiota affects hormones that influence metabolic function and specific brain areas associated with eating behaviour.[7] A previous study has suggested that individual gut microbiome configuration and long-term dietary habits together can be considered as a predictive tool for the development of obesity in children[8], which is important to note for possible intervention strategies and demonstrates the interconnectivity of causes.

Environmental factors can contribute to the development of childhood obesity, such as meal frequency and composition, physical activity, and parenting styles. ESPGHAN's latest guidelines on childhood obesity recommend that in the first two years of life, breastfeeding should be promoted for as long as possible, and that high protein foods should be limited when complementary feeding to help prevent childhood obesity.[9] Further to this, it's recommended that parents respond quickly to their child's needs, such as feeding and sleeping cues, as this helps to instil healthy eating behaviours and is associated with lower BMI scores at three years old.[9]

Experts suggest that from the age of two onwards, dietary patterns based on the principles of the Mediterranean diet should be adopted, which includes olive oil as the primary source of fat and an abundance of plant foods, such as fruits, vegetables, and whole grains.[9] Implementing a Mediterranean diet can act as an obesity prevention mechanism for early stages of life.[9] Further to this, healthy food options (fruit and vegetables) should be promoted for snacking in early stages of development, to avoid encouraging unhealthy habits of consuming high energy density foods (chips, sweets, biscuits) from a young age.[9] Therefore, parents play a significant role in ensuring that healthy eating behaviours are enforced from a young age.

Additionally, many people are unaware that eating behaviours, like skipping breakfast and eating in front of the TV, can also significantly increase risk of childhood obesity.[9] A review of recent observational studies found that around 94 per cent of all participants involved had reported a positive association between skipping breakfast and obesity.[10] This emphasises the importance of informing parents on the role their children's eating behaviours can play in the possible development of childhood obesity. Additionally, screen time and sedentary behaviour should be limited in children and the use of screen devices should be avoided during mealtimes. A meta-analysis of prospective studies showed a relationship between TV watching and childhood obesity, with an increased risk of 13 per cent for each one-hour / day increment in TV time.[11]

A PATHWAY FORWARD

Addressing childhood obesity is not a quick or simple process, but it is attainable if policy-makers and healthcare providers commit to taking swift and appropriate action. To achieve this, three key steps must be taken to help reduce the impact of childhood obesity, ensuring that infants, children, and adolescents can live the best and healthiest possible life.

Firstly, policy-makers and healthcare providers need to focus on improving public understanding of childhood obesity. This can be accomplished by leading positive, informative, and accurate public awareness campaigns. This will help improve perceptions of childhood obesity and encourage healthier eating and drinking habits, allowing for more co-ordinated interventions, and fighting off the stigma faced by patients.

Secondly, there needs to be an emphasis on improving our current policies. This can be achieved by working with a range of medical experts and institutions to ensure multidisciplinary evidence is placed at the core of policy development. This will help deliver more comprehensive and better-informed strategies for addressing childhood obesity to make real and lasting change.

Thirdly, a particular focus on funding future research is required to facilitate consistent, positive, and long-term change, creating a pathway for policies to follow. More support should be provided for research into whole systems which focus on the holistic and complex causation of obesity. This will help drive more robust evaluations of policies that are implemented, helping to both expand and develop prevention tools and effective treatments. This should consider factors such as, food environment (in school areas), what exercise is optimal for respective age groups, the role of demographics, the promotion of healthy eating and the use of revenue generation policies, like sugar taxes, as part of obesity prevention schemes.

The burden posed by the direct and indirect societal costs of childhood obesity across Europe is an increasingly alarming issue. However, reversing the rise in cases and overcoming this problem is achievable. We must recognise the complexity of obesity as a condition, as this lays the groundwork for the development of effective solutions. Focused and more robust action on education and public perception, changing current policies, and directing future research, are the key foundations for driving change on childhood obesity.

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PROMOTION

PRIDE OF PLACE

‘Pharmacy steps up, yet again!’ says Paul Insley, Head of Bestway Medhub & Wardles.

Paul Insley

National pharmacy wholesaler, Bestway Medhub, has been working hard behind-the-scenes stocking the independent pharmacy market with flu jabs since the middle of September.

Paul Insley, Head of Bestway Medhub & Wardles, said, ‘The annual flu jab service is another example of how the pharmacy sector adds real value and helps keep millions of patients protected from this virus, which can lead to serious illness. Pharmacies are in the heart of the communities and ideally placed to offer these important NHS and private healthcare services in a convenient and accessible way.

‘As a result of the pandemic, flu infection levels last year were low because of people not mixing, wearing masks, social distancing, and restricted travel. It’s anticipated that the winter flu season in the UK could be up to 50 per cent larger than usual. Flu can be a serious illness and the pharmacy sector has already shown they are highly experienced, trained and skilled to deliver large-scale vaccination programmes.’

On top of the busy flu season, many pharmacies are also supporting the NHS administering the COVID-19 Booster programme, which will protect millions of vulnerable people this winter.

Paul said, ‘I continue to be incredibly proud and inspired by our pharmacists and pharmacy teams who have stepped up, yet again, to play their part in the fight against COVID and continue to protect the communities they serve. As a pharmacist myself, I know how busy the flu season is. Administering the COVID-19 Booster service on top of the flu jab service is an incredible achievement. I would like to say a heartfelt thank you to all the pharmacy teams who continue to go above and beyond looking after the nation’s health and wellbeing.

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ASTHMA

UNDER THEIR BREATH

Lockdown was a truly monumental change in the way society operates. It was exciting but nerve-racking at first, but as time went on, increasingly damaging in so many ways to so many people. As we are emerging from under its shadow we are all changed – some are energised to accept the risk and live again, others are hiding away and lost to society.

CHANGES TO CARE

This has completely changed how we assess and follow up outpatients. Initially we cancelled all our face-to-face appointments and went 'virtual'. And it turns out not to have been such a bad thing. Okay – we couldn't examine patients, or do any tests, but taking a history has always been the most useful and important part of assessing a patient. Patients with work or caring commitments, or difficult travel arrangements, found it easier. But patients with communication issues or those with complex medical issues found it harder. Now we are opening things up again, many patients are keen to be seen in-person again, but often those we are most keen to see are terrified to leave the house.

In addition to difficulties in examining patients and getting tests done, monitoring medications has been difficult. Adherence is hard to judge, and we struggle to monitor side-effects and toxicities of medicines, such as oral glucocorticoids or immunosuppression. The fear is that we alter our prescribing practice – but is it safer to under-prescribe and under-treat? Or prescribe as normal and accept greater risk with reduced monitoring? This is now a real discussion complicating many treatment decisions. So we are trying to redesign clinics to balance convenience for patients, with the need for essential face-to-face contact and monitoring.

Dealing with fear and anxiety in patients has been a large part of our response to COVID. But at any point it has been difficult to know precisely what people should be afraid of. Dealing with rapidly-evolving knowledge, misinformation, and simply outright nonsense has become routine. When shielding was first introduced asthma was on the list of those who should shield, but little guidance as to which asthma patients this should apply to. Everyone? It felt like it with the number of patients and GPs getting in touch for guidance. In the end expert opinion was that those with poorly-controlled asthma were likely to be vulnerable. While there has been some difference in opinion of exactly what this means, the British Thoracic Society has issued guidance that:

The onset of COVID-19 presented unexplored – and worrisome – avenues for both asthma patients and their healthcare professionals. Dr Peter Kewin, Consultant in Respiratory and General Medicine, Queen Elizabeth University Hospital, reflects on the ensuing shifts to services and some of the specific issues that have affected patients.

'Poorly-controlled asthma in this context is defined as:
1. ≥2 courses of oral corticosteroids in the preceding 24 months OR
2. On maintenance oral corticosteroids OR
3. ≥1 hospital admission for asthma in the preceding 24 months.'

Are asthma patients more at risk of severe disease? Yes and no – the devil is in the detail. As with many viral illnesses patients with well-controlled asthma may still have an exacerbation, but are probably no more likely to become severely ill with COVID pneumonia. In fact, there is some evidence that those well-controlled on inhaled steroid are actually less likely to get severely ill, though the effect is small. Those with poorly-controlled asthma as defined earlier are felt to be at increased risk of COVID pneumonia and so are on the vulnerable list. Initially this meant shielding, now it means priority for vaccines and boosters.

VACCINES

A word about vaccines. Asthma patients often have allergies, and when vaccination was first introduced there were a couple of unfortunate serious allergic reactions very early on. This led to the bold (and ultimately unnecessary) move to exclude anyone carrying injectable adrenaline from having a COVID vaccine. But suddenly it seemed that anyone with any allergy was being told that they couldn't get a vaccine. As an allergy specialist this created a huge amount of work trying to offer advice to patients and GPs, and an education programme for vaccinators. In fact, data from yellow card reporting now shows that the COVID vaccine serious allergic reactions are no more common than flu or any other vaccine – about one-in-a-million doses. And it seems likely that the allergen in the mRNA vaccines from Pfizer / BionTech and Moderna is the stabilising agent polyethylene glycol (PEG; also called macrogol). This is a rare allergy and often unsuspected.

There is often a history of allergy to multiple seemingly unrelated drugs and / or cosmetics and skin creams as these often contain PEG at varying molecular weights – they appear in the list of excipients so are easy to identify. The non-replicating viral vector Astra-Zeneca (AZ) vaccine contains the related compound polysorbate 80, though it's not yet clear if this is the allergen. However, it's also in the flu vaccine – so if patients tolerate this they will tolerate the AZ vaccine. Most COVID vaccine reactions have in fact been much like any other vaccine – local reactions or appropriate febrile responses. So, we can now confidently advise most people on getting one of the COVID vaccines.

There have of course been many other seismic changes in the NHS and society as a whole and this article could be five-times as long. I guess we will continue to evolve to try and fit best practice into the situation we find ourselves in at the time.

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*Based on an NHS list price saving of 30% vs Fostair® 100/6 pMDI

Luforbec is indicated for the treatment of adult asthma and for the symptomatic treatment of COPD (FEV_1 <50% predicted normal)[3]

Prescribing Information: Luforbec® 100 micrograms/6 micrograms/actuation (beclometasone dipropionate/ formoterol fumarate dihydrate) pressurised inhalation solution. Consult the full Summary of Product Characteristics (SmPC) before prescribing. Presentation: Luforbec 100/6 pMDI: Pressurised inhalation solution. Each metered dose (ex-valve) contains beclometasone dipropionate (BDP) 100 mcg and formoterol fumarate dihydrate 6 mcg. This is equivalent to a delivered dose (ex-actuator) of beclometasone dipropionate 84.6 mcg and formoterol 5.0 mcg. **Indications:** ***Asthma:*** Regular treatment of asthma where use of an inhaled corticosteroid/long-acting $beta_2$-agonist (ICS/LABA) combination is appropriate: patients not adequately controlled on ICS and as needed short-acting $beta_2$-agonist, or patients already adequately controlled on both ICS and LABA. ***COPD:*** Symptomatic treatment of patients with severe COPD (FEV, <50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators. **Dosage and administration:** For inhalation in adult patients (≥18 years). Luforbec is not recommended for children and adolescents under 18 years. ***Asthma:*** **Maintenance therapy:** Luforbec 100/6 pMDI: 1–2 inhalations twice daily. The maximum daily dose is 4 inhalations. Luforbec may be used as maintenance therapy, together with a separate short-acting bronchodilator available for rescue at all times. Patients should receive the lowest dose that effectively controls their symptoms. **Maintenance and reliever therapy:** Luforbec can be taken as a regular maintenance treatment and as needed in response to asthma symptoms: 1 inhalation twice daily (morning and evening) plus 1 additional inhalation as needed in response to symptoms. If symptoms persist after a few minutes, an additional inhalation is recommended. The maximum daily dose is 8 inhalations. Patients should be advised to always have Luforbec available for rescue use. Close monitoring for dose-related adverse effects is needed in patients who frequently take high numbers of Luforbec as-needed inhalations. ***COPD:*** 2 inhalations twice daily. Luforbec pMDI can be used with the AeroChamber Plus® spacer device. BDP in Luforbec is characterised by an extrafine particle size distribution which results in a more potent effect than formulations of BDP with a non-extrafine particle size distribution (100mcg of BDP extrafine in Luforbec are equivalent to 250mcg of BDP in a non-extrafine formulation). When switching patients from previous treatments, it should be considered that the recommended total daily dose of BDP for Luforbec is lower than that for non-extrafine BDP containing products and should be adjusted to the needs of the individual patient. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and precautions:** Not intended for initial management of asthma. Treatment should not be initiated during an exacerbation, or if they have significantly worsening or acutely deteriorating asthma. Treatment should not be stopped abruptly. Medical attention should be sought if treatment is ineffective. Patients should be advised to take Luforbec every day even when asymptomatic. Treatment should be discontinued immediately if the patient experiences a paradoxical bronchospasm. Use with caution (which may include monitoring) in patients with cardiac arrhythmias, especially third degree atrioventricular block and tachyarrhythmias (accelerated and/or irregular heart beat), idiopathic subvalvular aortic stenosis, hypertrophic obstructive cardiomyopathy, severe heart disease, particularly acute myocardial infarction, ischaemic heart disease, congestive heart failure, occlusive vascular diseases, particularly arteriosclerosis, arterial hypertension, aneurysm, thyrotoxicosis, diabetes mellitus, phaeochromocytoma and untreated hypokalaemia. Caution should be used when treating patients with known or suspected prolongation of the QTc interval (QTc > 0.44 seconds). Formoterol itself may induce QTc prolongation. Potentially serious hypokalaemia may result from $beta_2$-agonist therapy and may also be potentiated by concomitant treatments (e.g. xanthine derivatives, steroids and diuretics). Particular caution is advised in severe asthma as this effect may be potentiated by hypoxia. Formoterol may cause a rise in blood glucose levels. Luforbec should not be administered for at least 12 hours before the start of anaesthesia if halogenated anaesthetics are planned as there is risk of arrhythmias. Use with caution in patients with pulmonary tuberculosis or fungal/viral airway infections. An increase in pneumonia and pneumonia hospitalisation in COPD patients receiving ICS has been observed. Clinical features of pneumonia may overlap with symptoms of COPD exacerbations. Systemic effects of ICS may occur, particularly at high doses for long periods e.g. Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, cataract and glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression. Consider referral of patients reporting blurred vision or visual disturbances to an ophthalmologist as causes may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy. Prolonged treatment with high doses of ICS may result in adrenal suppression and acute adrenal crisis. **Interactions:** Possibility of systemic effects with concomitant use of strong CYP3A inhibitors (e.g. ritonavir, cobicistat) cannot be excluded and therefore caution and appropriate monitoring is advised. Beta-blockers should be avoided in asthma patients. Concomitant administration of other beta-adrenergic drugs and theophylline may have potentially additive effects, therefore exercise caution. Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance towards $beta_2$-sympathomimetics. Concomitant treatment with MAOIs including agents with similar properties (e.g. furazolidone, procarbazine) may precipitate hypertensive reactions. Concomitant treatment with xanthine derivatives, steroids, or diuretics may potentiate a possible hypokalaemic effect of $beta_2$-agonists. Hypokalaemia may increase the likelihood of arrhythmias in patients receiving digitalis glycosides. There is a small amount of ethanol in Luforbec pMDI. There is theoretical potential for interaction in particularly sensitive patients taking disulfiram or metronidazole. **Pregnancy and lactation:** Use only during pregnancy or lactation if the expected benefits outweigh the potential risks. A risk/benefit decision should be taken to discontinue/abstain from therapy in the mother or discontinue breastfeeding. **Effects on driving and operating machinery:** Unlikely to have any effect on the ability to drive and use machines. **Side effects:** ***Common:*** Pharyngitis, oral candidiasis, pneumonia (in COPD patients), headache, dysphonia. ***Uncommon:*** Influenza, oral fungal infection, oropharyngeal candidiasis, oesophageal candidiasis, vulvovaginal candidiasis, gastroenteritis, sinusitis, rhinitis, granulocytopenia, allergic dermatitis, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, otosalpingitis, palpitations, electrocardiogram prolonged QTc interval, ECG change, tachycardia, tachyarrhythmia, atrial fibrillation (in COPD patients), hyperaemia, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dyspepsia, dysphagia, burning sensation of the lips, nausea, dysgeusia, pruritus, rash, hyperhidrosis, urticaria, muscle spasms, myalgia, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased, blood cortisol decrease (in COPD patients). ***Rare:*** Ventricular extrasystoles, angina pectoris, paradoxical bronchospasm, angioedema, nephritis, increased blood pressure, decreased blood pressure. ***Very rare:*** Thrombocytopenia, hypersensitivity reactions, including erythema, lips, face, eye and pharyngeal oedema, adrenal suppression, glaucoma, cataract, dyspnoea, exacerbation of asthma; growth retardation in children and adolescents, peripheral oedema, decreased bone density. ***Unknown frequency:*** Psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children), blurred vision. Refer to SmPC for full list of side effects. **Legal category:** POM **Price and Pack:** £20.52 1x120 actuations **Marketing authorisation (MA) No:** PL 35507/0204 **MA holder:** Lupin Healthcare UK Ltd, The Urban Building, Second Floor, 3-9 Albert Street, Slough, Berkshire, SL1 2BE, United Kingdom. **PI Last Revised:** August 2021. AeroChamber Plus® is a registered trademark of Trudell Medical International.

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search for MHRA Yellowcard in the Google Play or Apple App store. Adverse events should also be reported to Lupin Healthcare Limited on +44 (0)1565 751 378 or email us at EU-PV@lupin.com

Ref: 1. NHS BSA. https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff. Accessed September 2021. **2.** UK General Practice Prescribing Data June 2020 - May 2021 (http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3). **3.** Luforbec Summary of Product Characteristics. Lupin Healthcare UK Limited.

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UK-LUF-2108-00020 September 2021

IN THE COLD LIGHT OF DAY

The winter months can wreak havoc on patients' skin, particularly when they have an existing chronic dermatology condition. Online health community, talkhealth, home in on the support for people with winter skin conditions, and the resources which can aid dermatology during the colder days.

Chapped lips, dehydration and flaking are things that we can all experience in cold snaps, but throw psoriasis or eczema into the mix and some patients can have a real problem on their hands.

WHY DO SOME SKIN CONDITIONS GET WORSE IN THE COLD?

You, more than anyone, know about the increase in dermatology patients in winter. This surge in cases is due to the drop in moisture levels in the air as it gets colder. It's easy to forget how important humidity is for skin health. Studies show that when people move from areas of high to low humidity, their skin elasticity decreases and they are more vulnerable to mechanical stress and fracture.

In summer, there is a higher dew point in the air and lower pressure – this allows for the skin to remain hydrated and for more of the air's moisture to be absorbed. In the winter, the opposite happens, leaving dermatology patients with what is commonly called the 'winter itch'.

THE EFFECT OF WINTER WEATHER ON PSORIASIS

We might blame drier air for psoriasis flare-ups, but patients also miss out on one of their most natural remedies in winter – the sun! With less sunlight, increased winds and more air-con, psoriasis-prone skin is more likely to crack, become infected and cause discomfort.

On top of the usual treatment tips for psoriasis – like steering clear from hot showers, using a heavy emollient, and drinking plenty of water – it may be useful for your patients to take a look at the talkhealth forums.

A simple search on our platform will leave them with hundreds of anecdotal patient experiences at their fingertips. For example, back in 2018 one talkhealth member expressed their skin's discomfort in winter months and the British Skin Foundation's consultant dermatologist, Dr Sarita Singh, gave them brilliant advice about finding the right creams. This is just one example of a time when our online clinics helped a member of the public to manage their condition, easing the necessity for a visit to her doctor.

THE EFFECT OF COLD SNAPS ON ECZEMA

Often, families crank up radiators and heat their homes in winter, and this can pose an even bigger risk to patients with eczema. On top of creating an environment that is too hot – which causes increased itching anyway – a hot home is more prone to mould spores which trigger eczema symptoms in some patients and lay dormant in a humid household. Advising families to keep their thermostat at a steady temperature of 20°C throughout the year will aid better skin and maintain healthy hydration.

Keeping a healthy home is also key for eczema patients due to the effect that skin conditions can have on mental health and wellbeing. By ensuring that your patients feel safe in their homes, you can help them to live life as normal. In the knowledge that 50 per cent of adults with eczema are diagnosed with anxiety or depression, mental health is a vital topic covered in our free mydryskin support programme.

The 12-week programme is a downloadable, digestible programme that you can signpost to any of your patients who need a helping hand when it comes to self-management of their skin condition. As well as mental health, the weekly email PDFs cover topics like symptoms and treatments, patient stories, and there's even one full of tips for speaking with their GP!

THE BOTTOM LINE

With colder weather fast approaching, you will witness an increased number of dermatology complaints, as those with chronic skin conditions experience worsening symptoms. And, with the dermatology services still under increased pressure, we want you to use talkhealth's resources to push patient care to new realms. Whether it's signposting our digital clinics, encouraging patients to sign up to our free support programmes, or tuning into skin-related webinars yourself, we are dedicated to aiding dermatology primary care this winter.

For more information, visit www.talkhealthpartnership.com.

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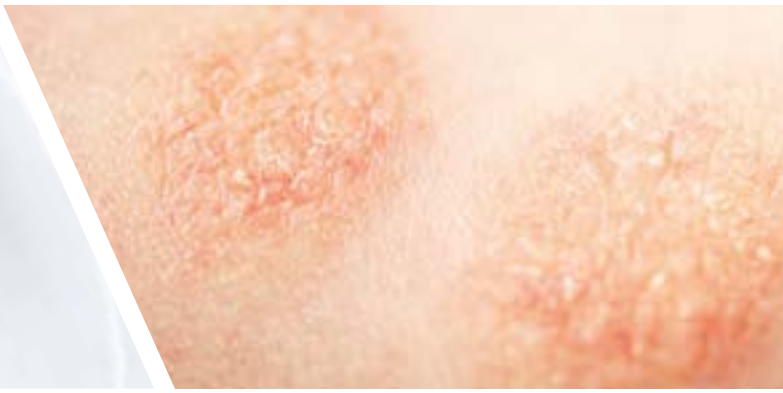

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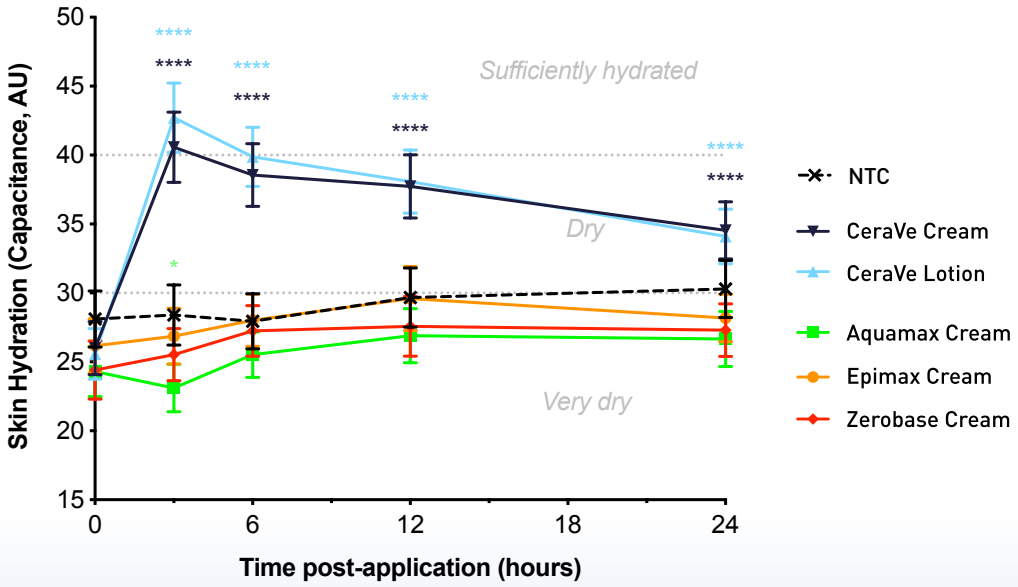

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[1]"An investigation of the skin barrier restoring effects of a cream and lotion containing ceramides in a multi-vesicular emulsion in people with dry, eczema-prone, skin: THE RESTORE STUDY PHASE 1" Danby SG, Andrew P, Kay L, Pinnock A, Chittock J, and Cork MJ

DYSPHAGIA: PLAYING IT SAFE

Ruth Sedgewick, Head of Northern Ireland Office, Royal College of Speech and Language Therapists, provides an insight into the practicalities and risks associated with a presentation of dysphagia, and enlightens as to how adherence among patients with a mental health illness can be encouraged.

Ruth Sedgewick

WHAT SIGNS AND SYMPTOMS ARE INDICATIVE OF DYSPHAGIA?

Dysphagia describes eating and drinking difficulties in children and adults which can occur in the oral (in the mouth), pharyngeal (back of the throat), or oesophageal (pipe passing from throat to stomach) stages of swallowing. Signs and symptoms include poor control orally, difficulty chewing, prolonged time to complete meals and difficulty moving food to the back of the mouth to be swallowed. These difficulties can result in coughing, throat clearing, weight loss, a wet-sounding voice, increased rate of breathing, recurrent chest infections, aspiration pneumonia and choking.

WHAT GROUPS OF PEOPLE ARE MOST SUSCEPTIBLE TO SWALLOWING PROBLEMS AND WHAT ARE THE KEY CAUSES?

Dysphagia in adults can occur as a result of a physical problem, such as a stricture, cancer treatment, some medications, or the presence of a tracheostomy for example, or from a neurological condition including (but not limited to) stroke, Parkinson's disease and other progressive neurological diseases, head injury and dementia. The muscles used for swallowing can become weaker as we age and therefore prevalence of dysphagia is high among the elderly. Babies (neonates) and children can also experience dysphagia for similar reasons as the adult population.

HOW PREVALENT IS THE CONDITION AMONG INDIVIDUALS WITH A MENTAL HEALTH ILLNESS?

There is a greater prevalence of dysphagia in acute and community mental health settings compared to the general population. There is also evidence of an elevated rate of death due to choking in acute mental health settings, partly due to the effects of medication. Furthermore, people with a diagnosis of schizophrenia are significantly more likely to die from choking than the general population. People can present with dysphagia because of their mental health disorder or as a result of the medication treatment for it. Additionally, when a person is acutely unwell, they may not have a physical swallowing difficulty but present with behaviours that increase their risk of choking when eating and drinking. These include, a fast pace of eating, over-filling mouth with food, eating non-food items and eating when lying down. The person's mental state does not allow them to regulate safe eating behaviours or respond to other people's requests to modify their eating and drinking patterns. They often need support from others to stay safe. Speech and language therapists (SLTs) can help promote safety during this time.

WHAT RISKS DO SWALLOWING ISSUES POSE IF EFFECTIVE INTERVENTION ISN'T CARRIED OUT?

Following a diagnosis of dysphagia, some people will be recommended texture-modified foods and / or thickened drinks by an SLT as per the International Dysphagia Diet Standardization Initiative. The SLT may also give advice on modifying the environment to support safe eating and drinking, for example, less distractions and supervision during mealtimes. Dysphagia, if left untreated and unsupported, can lead to malnutrition, dehydration, choking or aspiration pneumonia requiring hospital admission and, in some cases, death.

WHY IS THERE IN GENERAL POOR ADHERENCE TO ANTIDEPRESSANT THERAPY? TO WHAT EXTENT DO SWALLOWING DIFFICULTIES CONTRIBUTE?

Issues of adherence to any medication is complex. We do know, however, that dysphagia can impact on safe swallowing of medications and the extent to this will depend on the format of the medication and the severity of dysphagia. SLTs often discuss these issues with the medical team and pharmacist to troubleshoot alternative formats where necessary. Further difficulties will arise when the severity of the dysphagia and the format options of the medication are not compatible and risks will need to be considered.

HOW CAN THE HEALTHCARE COMMUNITY PROVIDE FURTHER SUPPORT FOR PATIENTS AND THEIR FAMILIES?

Be vigilant. Have an awareness of the signs of swallowing difficulties to look out for, including persistent throat clearing, wet voice post-swallowing, increases in shortness of breath at mealtimes, coughing, recurrent chest infections or choking. Monitor for changes and encourage the patients and their families to monitor swallowing ability when new medications are introduced or indeed removed. Seek support if concerned and request a referral to the local SLT department. Contact your local SLT department for advice leaflets or other resources that may be helpful for your patients and families.

For more helpful resources, visit www.rcslt.org and www.rcslt.org/members/clinical-guidance/dysphagia.

FOR VICTORY

AGAINST POOR ADHERENCE IN MAJOR DEPRESSION

If a patient is unable to swallow their medicines, they are unlikely to take them.[1] Poor adherence to antidepressant therapy has been shown to be particularly prevalent in patients with depression and a difficulty swallowing tablets and capsules.[2]

With a new liquid format that facilitates easier swallowing,[3] Rosemont Venlafaxine Oral Solution has been developed with improved adherence and better treatment outcomes in mind.

Venlafaxine Oral Solution

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Abbreviated Prescribing Information: Venlafaxine 37.5mg/5ml and 75mg/5ml Oral Solution. Consult Summary of Product Characteristics before prescribing. Presentation: A clear colourless to almost colourless solution, containing 37.5mg/5ml or 75mg/5ml Venlafaxine (as Hydrochloride). **Therapeutic Indications:** Treatment of major depressive episodes. For prevention of recurrence of major depressive episodes. **Posology and Method of Administration:** *Major depressive episodes:* The initial 75 mg/day dose may be increased up to a maximum dose of 375 mg/day. Dosage increases can be made after clinical evaluation at intervals of 2 weeks or more, but not less than 4 days. Treatment should continue for at least six months following remission. *Elderly patients:* No specific dose adjustments are considered necessary. *Hepatic and renal impairment:* A 50% dose reduction should be considered. *Withdrawal symptoms seen on discontinuation of venlafaxine:* The dose should be gradually reduced over a period of at least one to two weeks. For oral use, taken with food the same time each day. Suitable for administration via nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) tubes. **Paediatric population:** Not recommended for use in children and adolescents under the age of 18 years. **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients, concomitant treatment with irreversible monoamine oxidase inhibitors (MAOIs). Must not be initiated for at least 14 days after discontinuation of treatment with an irreversible MAOI, must be discontinued for at least 7 days before starting treatment with an irreversible MAOI. **Excipient warnings:** Contains sodium methyl and sodium ethyl parahydroxybenzoate, liquid maltitol and less than 1 mmol sodium per 5 ml. **Drug interactions:** MAOI's, triptans, SSRIs, SNRIs, lithium, sibutramine or St. John's Wort, fentanyl and its analogues, dextromethorphan, tapentadol, pethidine, methadone and pentazocine, medicinal agents that impair metabolism of serotonin, serotonin precursors or antipsychotics or other dopamine antagonists, CNS-active substances, ethanol, drugs that prolong the QT Interval, CYP3A4 inhibitors, lithium, diazepam, imipramine, haloperidol, risperidone, metoprolol, indinavir and oral contraceptives. **Special Warnings and Precautions for use:** Increased risk of suicide/suicidal thoughts or self-harm especially in early treatment and following dose changes. Should not be used in the treatment of those under the age of 18 years. Serotonin syndrome may occur, particularly with concomitant use of other serotonergic agents. Narrow-angle glaucoma patients should be closely monitored. Blood pressure should be monitored, especially after dose increases. Heart rate increases can occur. Should be used with caution in patients with cardiac disease and risk of arrhythmia. QTc prolongation and Torsade de Pointes, ventricular tachycardia and fatal cardiac arrhythmias have been reported. Treatment should be discontinued in any patient who develops seizures. Cases of hyponatraemia and/or the Syndrome of Inappropriate Antidiuretic Hormone (SIADH) secretion may occur. The risk of haemorrhage and the risk of skin and mucous membrane bleeding may be increased. Serum cholesterol levels may increase. Co-administration with weight loss agents is not recommended. Mania/hypomania or aggression may occur. Akathisia and dry mouth may develop. In patients with diabetes, venlafaxine may alter glycaemic control. May cause symptoms of sexual dysfunction. False-positive urine immunoassay screening tests for phencyclidine (PCP) and amphetamine have been reported. Withdrawal symptoms when treatment is discontinued are common, particularly if discontinuation is abrupt. Venlafaxine should be gradually tapered when discontinuing treatment according to the patient's needs. **Fertility, Pregnancy and Lactation:** The potential risk for humans is unknown. Venlafaxine must only be administered to pregnant women if the expected benefits outweigh any possible risk. As with other serotonin reuptake inhibitors (SSRIs/SNRIs), discontinuation symptoms may occur in the newborns if venlafaxine is used until or shortly before birth. Venlafaxine is excreted into breast milk. Therefore, a risk to the baby cannot be excluded. A decision must be made to breast feed or treat according to risk and benefit to both parties. Reduced fertility has been observed in rats. **Effects on Ability to Drive and Use Machines:** Any patient receiving venlafaxine should be cautioned about their ability to drive or operate hazardous machinery. **Undesirable Effects:** *Very common:* Dizziness, headache, nausea, dry mouth, hyperhidrosis. *Common:* Serum cholesterol increased, weight loss, decreased appetite, confusional state, depersonalisation, anorgasmia, libido decreased, nervousness, insomnia, abnormal dreams, paraesthesia, sedation, tremor, somnolence, hypertonia, accommodation disorder, mydriasis, visual impairment, including blurred vision, tinnitus, palpitations, hypertension, vasodilatation, yawning, constipation, vomiting, diarrhoea, dysuria, pollakiuria, ejaculation disorder, anorgasmia, erectile dysfunction, menstrual disorders associated with increase bleeding, asthenia, fatigue, chills, blood cholesterol increased. *Uncommon:* Ecchymosis, weight gain, hallucination, derealisation, agitation, orgasm abnormal (female), apathy, hypomania, bruxism, myoclonus, agitation, coordination abnormal, balance disorder, akathisia/psychomotor restlessness, syncope, dysgeusia, tachycardia, orthostatic hypotension, postural hypotension, dyspnoea, gastrointestinal haemorrhage, angioedema, photosensitivity reaction, rash, alopecia, urinary retention, weight increased, weight decreased. *Rare:* Mania, convulsion, manic reaction, urinary incontinence. *Not known:* Prolonged bleeding time, thrombocytopaenia, blood disorder, anaphylactic reaction, SIADH, abnormal liver function tests, hyponatraemia, hepatitis, prolactin increased, suicidal ideation and suicidal behaviours, delirium, aggression, NMS, serotonergic syndrome, delirium, extrapyramidal reactions, tardive dyskinesia, angle-closure glaucoma, vertigo, ventricular fibrillation, ventricular tachycardia, hypotension, bleeding, pulmonary eosinophilia, pancreatitis, hepatitis, liver function test abnormal, erythema multiforme, toxic epidermal necrolysis, Stevens-Johnson syndrome, urticaria, rhabdomyolysis, electrocardiogram QT prolonged, bleeding time prolonged, blood prolactin increased. *Paediatric population:* In general, the adverse reaction profile of venlafaxine (in placebo-controlled clinical trials) in children and adolescents (ages 6 to 17) was like that seen for adults. Particularly, the following adverse reactions were observed in paediatric patients: abdominal pain, agitation, dyspepsia, ecchymosis, epistaxis, and myalgia. **Overdose:** General supportive and symptomatic measures are recommended; cardiac rhythm and vital signs must be monitored. Gastric lavage may be indicated if performed soon after ingestion or in symptomatic patients. Administration of activated charcoal may also limit absorption of the active substance. No specific antidotes for venlafaxine are known. **Shelf Life and storage:** 24 months. Use within 30 days of opening the bottle. Does not require any special storage conditions. **Legal Category:** POM. **Pack Size and NHS Price:** 37.5mg/5ml x 150ml - £158.76, 75mg/5ml x 150ml - £207.37. **Marketing Authorisation Number:** Venlafaxine 37.5mg/5ml Oral Solution PL 00427/0253, Venlafaxine 75mg/5ml Oral Solution PL 00427/0254. **Marketing Authorisation Holder:** Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds, LS11 9XE, UK. **Date of Preparation:** July 2021.

Information about adverse event reporting can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400

References: 1. Greenwall RS. Medicines Management. Medicines management and older people – a guide for healthcare professionals. Aug 2017. **2.** Navarro V. Improving Medication Compliance in Patients with Depression: Use of Orodispersible Tablets. Adv Ther (2010) 27(11): 785-795. **3.** Llorca PM. Discussion of prevalence and management of discomfort when swallowing pills: orodispersible tablets expand treatment options in patients with depression. Therapeutic Delivery (2011) 2(5), 611-622.

DTM288 August 2021

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NEWS

MORE THAN TWO MILLION CONSULTATIONS WITH NHS PHARMACY FIRST

The NHS Pharmacy First Scotland service has carried out over two million consultations since the launch of the service in July 2020.

The service provides free access to a consultation with an appropriately-qualified member of the pharmacy team who provides advice on self-care, referral to another part of the NHS if they feel it is necessary and, if appropriate, will provide treatment. The community pharmacist can also treat certain conditions, such as urinary tract infections, shingles and impetigo, without the need for a prescription or to see a doctor. This is part of a co-ordinated series of measures to improve patient care and help reduce demand on A&E.

Pharmacists in the network have taken more than 200,000 appointments in the last year which would otherwise have gone to GP surgeries or hospital A&E departments.

Since its launch at the height of the pandemic, only four per cent of patients needed to be referred on to another healthcare professional, such as a GP or hospital unit. The majority were handled by the pharmacy team, advice on self-care or with treatment.

Health Secretary Humza Yousaf commented, 'The Scottish government introduced the NHS Pharmacy First service, backed by £10 million of investment. As part of the NHS Recovery Plan we will look to expand the range of common clinical conditions that can be treated by community pharmacists, avoiding unnecessary GP and out-of-hours appointments.

'We have also committed to establishing a community pharmacy hospital discharge and medicines reconciliation service to help speed up the process for people being discharged from hospital. New digital solutions, such as ePrescribing and eDispensing, will make prescribing paperless and free up capacity for healthcare professionals to see more patients, while making it easier for the public to access their medicines quickly and safely.'

TEMPORARY CONTRACEPTION AVAILABLE FROM PHARMACIES

Women will be able to access a temporary three-month supply of the progestogen-only contraceptive pill from community pharmacies. Also known as the 'mini pill', the national roll-out follows a successful pilot in pharmacies across Lothian and Tayside.

This step will complement existing services currently providing contraception to widen access and bridge the gap between emergency contraception and use of longer-term contraception. Patients will be advised to contact their own GP practice or sexual health service for ongoing contraception.

Ensuring women have the support they need to manage and improve their own health, including providing them with a choice of contraceptive options, is central to the Scottish government's UK-leading Women's Health Plan and is the first step to a woman's health and wellbeing service in community pharmacies.

Minister for Public Health and Women's Health, Maree Todd, explained, 'Our UK-leading Women's Health Plan demonstrates our ambition and determination to see change for women in Scotland, for their health and for their role in society. It's crucial that we recognise the importance of women in society and a key part of this is prioritising the health of women – it has a positive impact for us all. We want Scotland to be a world leader when it comes to women's health. The introduction of this service will increase the choice for women in the ways in which they can access contraception.'

NEW PRINCIPAL LEADS FOR PHARMACY SIMULATION ANNOUNCED

NES Pharmacy have recently appointed a team to promote pharmacy simulation across NHS Scotland.

The team marks a recognition of the huge potential for simulation-based education in pharmacy and will support the improvement, accessibility and quality of this training intervention for all stages and sectors of pharmacy practice.

The Pharmacy SimStart course, at the Scottish Centre for Simulation and Clinical Human Factors, is designed for those who have little or no experience in simulation but are interested in becoming simulation facilitators. The following dates in 2022 will be open soon:

- Friday 28th January
- Thursday 10th February
- Monday 14th March

Scott McColgan-Smith, National Principal Lead, commented, 'I am thrilled to be appointed as the National Principal Lead for Pharmacy Simulation. In my other role, I am a Senior Pharmacist in Prescribing Development & Education within NHS Ayrshire & Arran based in secondary care.

'I have knowledge and experience in designing and delivering simulation and I plan to use these skills to help advance simulation training opportunities for those working and training all over Scotland. My team and I look forward to collaborating with others across the country to bring this vision to life.'

FEELING THE PRESSURE

Anna Strzelecka

As the challenges and changes posed by the pandemic continue to unfold, Anna Strzelecka, SAS Doctor in Diabetes and Endocrinology, casts a light on the impact of COVID-19 on diabetes diagnoses and services.

The day-to-day routine of school drop-offs, going to work, meeting friends and family, going to theatres and cinemas and travelling around the world without any worry turned into being completely locked down and not being able to see even our closest relatives. Happiness caused by hugging, kissing, dancing and being together turned into loneliness and fearing for our beloved ones. As the coronavirus pandemic spread across the world, it introduced a considerable degree of fear, worry and concern, especially for our diabetic patients who were deemed extremely vulnerable.

The quarantine and its effects on many people's usual activities, routines or livelihoods causes elevated rates of mental health issues, namely increased stress and anxiety. The rates of loneliness, depression, harmful alcohol and drug use and self- harm are seen to be on the rise.

SO, WHAT IMPACT HAS COVID-19 HAD ON DIABETES DIAGNOSES AND SERVICES?

There has been an increased number of new diabetes diagnoses observed since COVID-19 started. (1) Patients with poorly-controlled diabetes have poorer morbidity and mortality than the general population. (2) Also, there is an increased risk of DKA incidence in diabetic patients suffering from COVID-19, as well as increased insulin resistance, making glucose management extremely challenging. (3,4)

COVID-19 has also had a major impact on the provision of how GP surgeries usually operate. There have been reduced face-to-face consultations, with an increased focus on virtual consultations. Also chronic disease management clinics were re-prioritised, resulting in much less routine diabetic clinics operating. There have been delays in podiatry review, retinal screening and routine diabetic blood monitoring. This has all had a major impact on the management of our diabetic patients.

Patients with acute on chronic complications have been presenting to hospitals later, with more advanced diseases, and therefore staying in hospital longer.

Secondary care clinics were also initially changed to virtual reviews, and only recently some face-to-face reviews have been reintroduced. Face-to-face clinic attendance, however, remains poor as patients are anxious to leave their homes that provide a safer environment.

Staff numbers have been reduced due to illness and isolating, thereby further increasing the pressure on an already under-strain service.

There has also been disruption to medical education, with many educational programmes and events being cancelled or moved to virtual learning. Overall, there has been much less available support for diabetic patients.

Lockdown also led to shortages of certain food supplies, leading to poorer diets. Patients increasingly suffer from poor mental health, leading to poor dietary and lifestyle choices. Those shielding and working from home are becoming poorly motivated in regards to healthy diet and physical exercise.

ON THE OTHER SIDE

On the other side, there are some positive outcomes of the COVID pandemic. There has been an increase in the use of online technology, such as LibreView. Diabetes UK and pharmaceutical companies developed a lot of fantastic online educational resources. However, to make the most out of these, patients have to be motivated, as well as being IT literate and having the available infrastructure available (laptop, tablet or smartphone).

As vaccines continue to be our first line of defence over the winter months, we need to continuously encourage our patients to get vaccinated.

The latest data from Public Health England shows that COVID vaccines are highly effective against hospitalisation from the Delta (B.1.617.2) variant, the dominant strain in the UK. Analysis shows the Pfizer-BioNTech vaccine is 96 per cent effective and the Oxford-AstraZeneca vaccine is 92 per cent effective against hospitalisation after two doses. (5) COVID-19 doesn't seem to be giving up and I suspect that the winter months will bring renewed challenges.

We are all exhausted and fed up but need to stay strong and optimistic and work as a team in order to defeat COVID-19 and bring our old lives back.

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Clinical utility of Ongentys® (opicapone) 50 mg confirmed by real-world data in Parkinson's disease patients with motor fluctuations

Clinical insights from principle investigator and lead author Prof. Dr. med. Heinz Reichmann, Department of Neurology, Technische Universitaet Dresden, Fetscherstrasse 74, 01307 Dresden, Germany

Heinz Reichmann is a member of the German Neurological Society, The European Neurological Society and is a fellow of the American Academy of Neurology. His major research interests cover etiopathogenesis and treatment in Parkinson's disease, premotor symptoms in Parkinson's disease, and neuroprotection.

OPTIPARK, a Phase IV, open-label study conducted in the UK and Germany under clinical practice conditions, supports the efficacy of Ongentys® 50 mg observed in the pivotal Phase III studies.[1]

Ongentys® 50 mg, as an adjunct to levodopa in patients with motor fluctuations, significantly improved perception of patients' global Parkinson's disease (PD) condition (≥70% as judged by clinicians and the patients themselves) 3 months after they started treatment with Ongentys® 50 mg.[1] Ongentys® is a once-daily catechol-O-methyltransferase (COMT) inhibitor. COMT inhibitor treatment is appropriate for PD patients taking levodopa/dopa decarboxylase inhibitor (DDCI) therapy where there is evidence of motor fluctuations.[1]

OPTIPARK: real-world clinical data in adult PD patients with motor fluctuations

Rationale for OPTIPARK

Findings from two pivotal Phase III studies, BIPARK I and II,[2,3] highlighted that global assessments using Clinician's Global Impression of Change (CGI-C) and Patient's Global Impression of Change (PGI-C) showed clinical improvements for Ongentys® 50 mg versus placebo[2,3] and entacapone[2] (CGI-C: p=0.0005 versus placebo, and p=0.007 versus entacapone; PCI-C: p=0.0091 versus entacapone).[2] The OPTIPARK open-label, prospective study set out to confirm these results in a real-life setting,[1] with CGI-C selected as the primary endpoint, and PGI-C as one of the secondary endpoints.

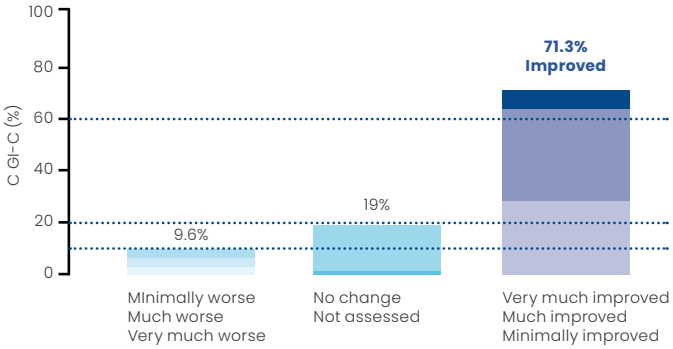
Study protocol and methodology for OPTIPARK (n=506 patients)[1]

- Key inclusion criteria: Men or women (≥30 years) with idiopathic PD reporting ≥1 symptom on the 9-symptom Wearing-off Questionnaire (WOQ-9), Hoehn and Yahr Stages I–IV (during ON), and treated with 3–7 daily doses of levodopa/DOPA decarboxylase inhibitor (DDCI)
- Treatment protocol: Ongentys® 50 mg once daily for 3 months (German sites) or 6 months (UK sites) in addition to current treatment with levodopa/DDCI. Total daily levodopa/DDCI dose could be adjusted according to the individual's condition throughout the study (except on Day 1)
- Primary endpoint: CGI-C after 3 months
- Secondary endpoints: PGI-C, the Unified PD Rating Scale (UPDRS), PD Questionnaire 8 items (PDQ-8), Non-Motor Symptoms Assessment Scale (NMSS)

Primary endpoint: OPTIPARK confirms the clinical utility of Ongentys® 50 mg

After 3 months treatment with Ongentys® 50 mg in a clinical setting of fluctuating PD patients, there were improvements in global PD condition: 71.3% of patients showed clinical improvement as rated by the CGI-C, with 43% reported as much or very much improved.[1]

Clinical Global Impression of Change (CGI-C) n=477

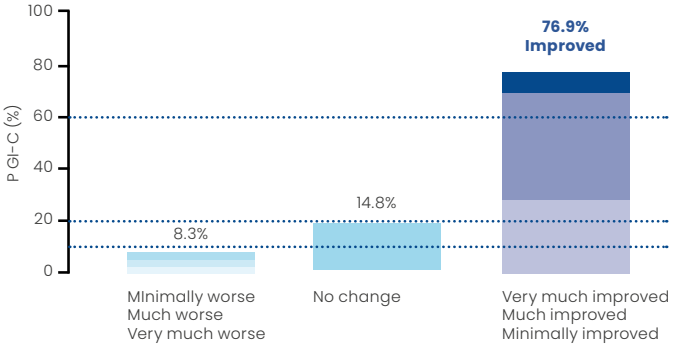


Source: Adapted from Reichmann H *et al. Transl Neurodegner* 2020[1]

Secondary endpoints: Ongentys® significantly improved motor scores, quality of life and non-motor symptoms

After 3 months treatment with Ongentys® 50 mg in UK and German PD patients, 76.9% self-reported a clinical improvement (PGI-C), with 48.1% of patients reporting they were much or very much improved.[1,4]

Patient's Global Impression of Change (PGI-C) (n=393)



Adapted from Reichmann H *et al. Transl Neurodegner* 2020[1,4]

"In routine clinical practice, once-daily Ongentys® 50 mg as an adjunct to levodopa-treated PD patients with motor fluctuations significantly improved patients' perceptions about their global PD condition", ***Heinz Reichmann***

Both clinical and statistical improvements were evident for activities of daily living (ADL) and motor scores after 3 months. UPDRS scores showed a statistically significant improvement from baseline for ADL (UPDRS Part II) during OFF periods: mean±SD, −3.0±4.6 (p<0.0001), and motor scores (UPDRS Part III) during ON periods (−4.6±8.1, p<0.0001), as well as total scores (UPDRS Parts II + III), −6.4±10.4, p<0.0001.[1,4]

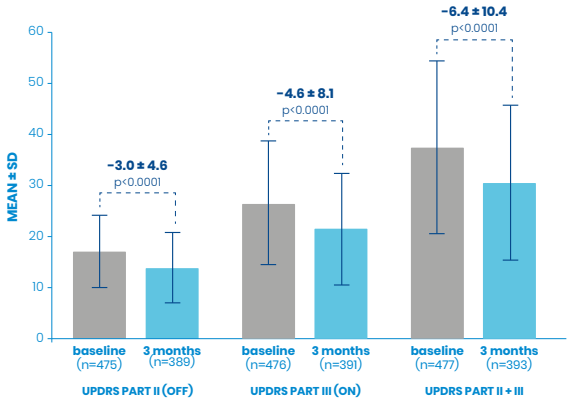
Prescribing information can be found on the following page

This article was developed by Prof. Dr. med. Heinz Reichmann with editorial and funding support from BIAL Pharmaceuticals.

UK/ON/2021/005(1) Date of preparation: October 2021

Motor scores in OPTIPARK[1,4]

Significant improvements in activites of daily living and motor scores (UPDRS II and III)

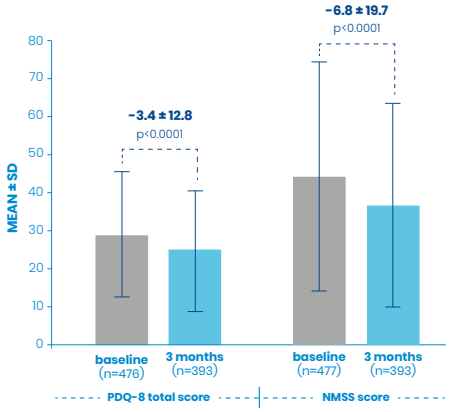


SD, standard deviation; UPDRS, Unified Parkinson's Disease Rating Scale.

There was also a statistically significant improvement in quality of life (PDQ-8) and non-motor symptoms (NMSS) versus baseline: PDQ-8 (mean±SD) −3.4±12.8 (p<0.0001); NMSS, −6.8±19.7(p<0.0001).[1]

Quality of life and non-motor symptoms[1]

Significant improvememts in quality of life (PDQ-39) and non-motor symptoms (NMSS)



NMSS, Non-Motor Symptom Scale; PDQ-8, Parkinson's Disease Questionnaire, 8 items; SD, standard deviation

Safety profile: The majority of drug-related treatment-emergent adverse events (TEAEs) were reported during the first week[5]

The safety profile in this large-open label study was comparable to adverse event data from the two pivotal studies.[2,3] In the 74.9% of patients who experienced TEAEs, the majority were mild or moderate in severity. Dyskinesia was the most common treatment-related TEAE (11.5%), leading to discontinuation in 1% of patients. The most common TEAE leading to withdrawal was nausea (2%).[1]

Clinical practice points:[1]

- This large real-life study in 495 patients treated with Ongentys® 50 mg mirrored a clinical setting through the inclusion of a broad population of fluctuating PD patients (Hoehn and Yahr I-III) compared to the two Phase III studies
- Despite optimised PD therapy (according to clinician's judgement), and most patients in OPTIPARK (78.8%) receiving levodopa/DDCI plus another PD medication, clinically significant improvements were reported for UPDRS motor and ADL scores
- More patients were judged by the clinician to have shown an improvement in OPTIPARK than reported in the pivotal Phase III studies (71.3% vs 59.6%)[6]

OPTIPARK confirms the clinical utility of Ongentys® 50 mg as an effective and generally well-tolerated adjunct option in patients with Parkinson's disease with motor fluctuations[1]

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Prescribing information

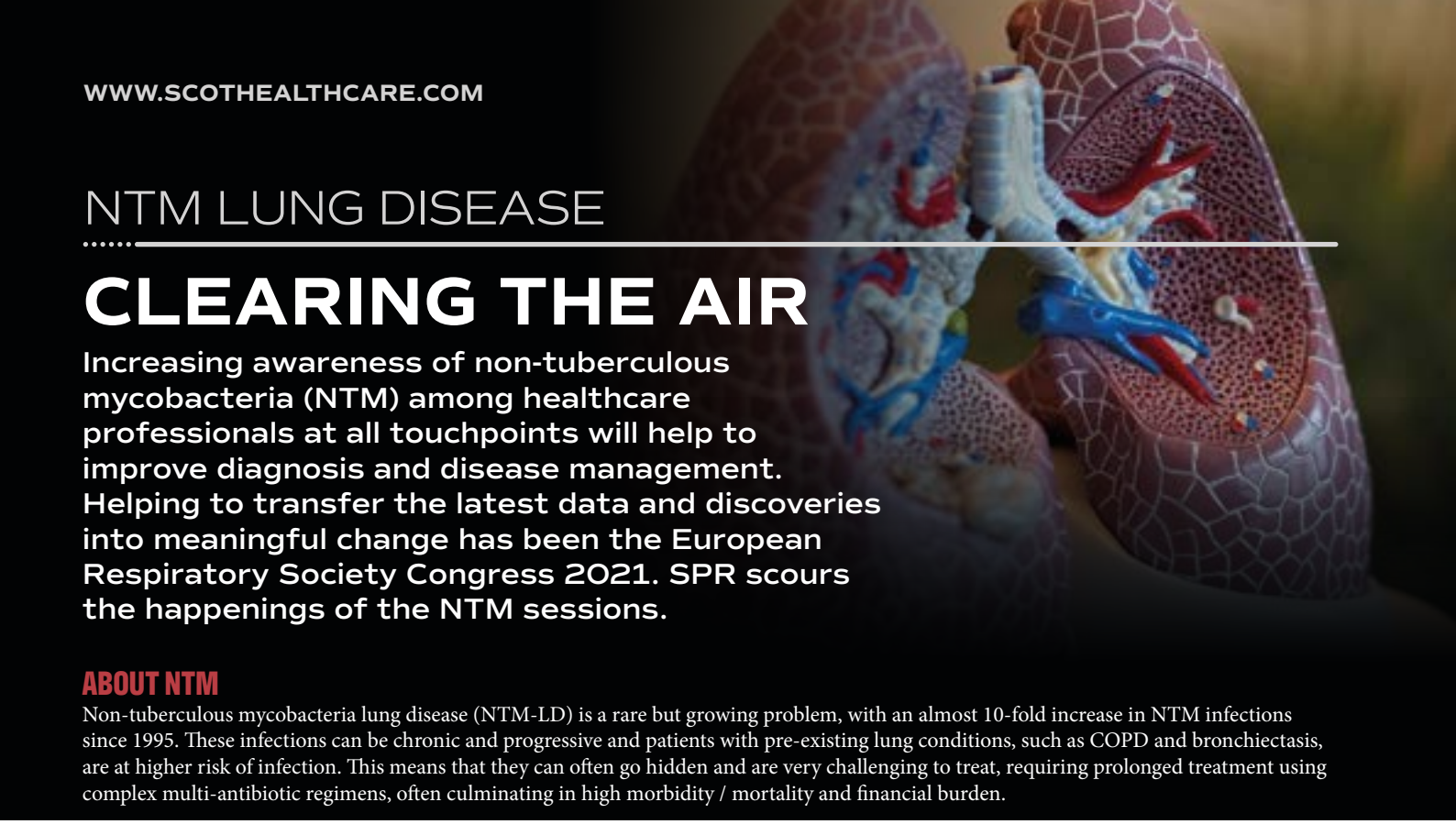
Ongentys® (opicapone)

Please refer to the SPC before prescribing. **Presentation:** Capsules containing 50 mg of opicapone. **Indication:** Adjunctive therapy to preparations of levodopa/DOPA decarboxylase inhibitors (DDCI) in adult patients with Parkinson's disease and end- of-dose motor fluctuations who cannot be stabilised on those combinations. **Dosage and administration:** The recommended dose is 50 mg of opicapone. It should be taken once daily at bedtime at least one hour before or after levodopa combinations. Ongentys is to be administered as an adjunct to levodopa treatment and enhances the effects of levodopa. Hence, it is often necessary to adjust levodopa dosage by extending the dosing intervals and/or reducing the amount of levodopa per dose within the first days to first weeks after initiating the treatment with opicapone according to the clinical condition of the patient. If one dose is missed, the next dose should be taken as scheduled. The patient should not take an extra dose to make up for the missed dose. **Elderly patients:** No dose adjustment is needed for elderly patients. Caution must be exercised in patients ≥ 85 years of age as there is limited experience in this age group. **Patients with renal impairment:** No dose adjustment is necessary in patients with renal impairment, as opicapone is not excreted by the kidney. **Patients with hepatic impairment:** No dose adjustment is necessary in patients with mild hepatic impairment (Child- Pugh Class A). There is limited clinical experience in patients with moderate hepatic impairment (Child- Pugh Class B). Caution must be exercised in these patients and dose adjustment may be necessary. There is no clinical experience in patients with severe hepatic impairment (Child-Pugh Class C), therefore, Ongentys is not recommended in these patients. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Phaeochromocytoma, paraganglioma, or other catecholamine secreting neoplasms. History of neuroleptic malignant syndrome and/or non-traumatic rhabdomyolysis. Concomitant use with monoamine oxidase (MAO-A and MAO-B) inhibitors (e.g. phenelzine, tranylcypromine and moclobemide) other than those for the treatment of Parkinson's disease. **Pregnancy:** Ongentys is not recommended during pregnancy and in women of childbearing potential not using contraception. **Lactation:** Breast-feeding should be discontinued during treatment with Ongentys. **Warnings and precautions:** Opicapone enhances the effects of levodopa. To reduce levodopa-related dopaminergic adverse reactions (e.g. dyskinesia, hallucinations, nausea, vomiting and orthostatic hypotension), it is often necessary to adjust the daily dose of levodopa by extending the dosing intervals and/or reducing the amount of levodopa per dose within the first days to first weeks after initiating treatment with Ongentys, according to the clinical condition of the patient. Patients and care-givers should be made aware that 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 and/or other dopaminergic treatments. Patients should be monitored regularly for the development of impulse control disorders and review of treatment is recommended if such symptoms develop. Increases in liver enzymes were reported in studies nitrocatechol inhibitors of catechol-O-methyltransferase (COMT). For patients who experience progressive anorexia, asthenia and weight decrease within a relatively short period of time, a general medical evaluation including liver function should be considered.

Excipients: Ongentys contains lactose. Patients with rare hereditary problems of galactose intolerance, the total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Drug interactions:** Concomitant use of opicapone with MAO inhibitors (e.g. phenelzine, tranylcypromine and moclobemide) other than those for the treatment of Parkinson's disease is contraindicated. Concomitant use of opicapone and MAO inhibitors for the treatment of Parkinson's disease, e.g. rasagiline (up to 1 mg/day) and selegiline (up to 10 mg/day in oral formulation or 1.25 mg/day in buccal absorption formulation), is permissible. There is no experience with opicapone when used concomitantly with the MAO-B inhibitor safinamide. Therefore, their concomitant use should be considered with appropriate caution. Opicapone may interfere with the metabolism of medicinal products containing a catechol group that are metabolised by COMT, e.g. rimiterole, isoprenaline, adrenaline, noradrenaline, dopamine, dopexamine or dobutamine, leading to potentiated effects of these medicinal products. Careful monitoring of patients being treated with these medicinal products is advised when opicapone is used. Concomitant use with tricyclic antidepressants and noradrenaline re-uptake inhibitors (e.g. venlafaxine, maprotiline and desipramine) should be considered with appropriate caution. Particular consideration should be given to medicinal products metabolised by CYP2C8 and their co-administration must be avoided. Particular consideration should be given to medicinal products transported by OATP1B1 and their concomitant use should be considered with appropriate caution. **Adverse events:** Refer to the SPC for all side effects. Very common side effects (≥ 1/10): Dyskinesia. Common side effects (≥ 1/100 to < 1/10): Abnormal dreams, Hallucination, Hallucination visual, Insomnia, Dizziness, Headache, Somnolence, Orthostatic hypotension, Constipation, Dry mouth, Vomiting, Muscle spasms, Blood creatine phosphokinase increased. Uncommon side effects (≥ 1/1,000 to < 1/100): Decreased appetite, Hypertriglyceridaemia, Anxiety, Depression, Hallucination auditory, Nightmares, Sleep disorder, Dysgeusia, Hyperkinesia, Syncope, Dry eye, Ear congestion, Palpitations, Hypertension, Hypotension, Dyspnoea, Abdominal distention, Abdominal pain, Abdominal pain upper, Dyspepsia, Muscle twitching, Musculoskeletal stiffness, Myalgia, Pain in extremity, Chromaturia, Nocturia, Weight decreased. **Legal Category:** POM. **Basic UK NHS cost:** Ongentys pack of 30: £93.90. **Marketing authorisation numbers:** PLGB 21566/0004 EU/1/15/1066/003. **Marketing authorisation holder:** Bial-Portela & Ca., S.A., A Avenida da Siderurgia nacional 4745-457 Coronado (S. Romao e S. Mamede) – Portugal. **Further Information from:** Bial Pharma UK Ltd., Admiral House, St. Leonard's Road, Windsor, SL4 3BL, UK.

Job code: UK/ON/2021/016(1). **Date of preparation:** October 2021.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk or in Ireland: www.hpra.ie. Adverse events should also be reported to BIAL on +44 (0)1628 531171 or bial@pharmalex.com



NTM LUNG DISEASE

CLEARING THE AIR

Increasing awareness of non-tuberculous mycobacteria (NTM) among healthcare professionals at all touchpoints will help to improve diagnosis and disease management. Helping to transfer the latest data and discoveries into meaningful change has been the European Respiratory Society Congress 2021. SPR scours the happenings of the NTM sessions.

ABOUT NTM

Non-tuberculous mycobacteria lung disease (NTM-LD) is a rare but growing problem, with an almost 10-fold increase in NTM infections since 1995. These infections can be chronic and progressive and patients with pre-existing lung conditions, such as COPD and bronchiectasis, are at higher risk of infection. This means that they can often go hidden and are very challenging to treat, requiring prolonged treatment using complex multi-antibiotic regimens, often culminating in high morbidity / mortality and financial burden.

A BETTER UNDERSTANDING

Climate change may be one factor driving increased reports of people suffering NTM-LD, according to presentations at the European Respiratory Society Congress 2021. The congress also heard that treatments are prolonged and tough for patients to bear and that better screening is needed for NTM-LD in at-risk patient groups.

Speaking at a symposium[1] devoted to NTM infections, Co-Chairs Professor Vitalii Poberezhets and Professor Raquel Duarte said that NTM infections were becoming an increasing challenge, adding that although new guidelines have been published, their implementation is lacking; leading to NTM infections becoming a worldwide threat.

Unravelling the complex epidemiology of NTM-LD, Professor Marc Lipman, Royal Free Hospital and University College, London, said that several factors[2] may help explain the apparent increase in NTM-LD, including the emergence of NTM genetic mutations conferring increased virulence, host susceptibility factors, such as increased life-span, an increase in the number of people suffering chronic lung disease or with immunosuppression, and environmental factors, such as climate change. It's also possible that better diagnostic techniques, such as CT scanning and molecular diagnostics, are improving clinicians' ability to detect NTM infection.[3]

In a related symposium[4] on NTM-LD caused by Mycobacterium avium complex (MAC), the Chair, Professor Michael Loebinger, Royal Brompton Hospital, London, said that managing M. avium complex lung disease (MAC-LD) can be challenging, 'The treatment journey is long – understanding how to support our patients manage side-effects can help us help them.'

Reviewing recent updates to NTM-LD treatment guidelines,[5] Professor Charles Daley, Division of Mycobacterial and Respiratory Infections, National Jewish Health, University of Colorado, said that a three-drug macrolide-containing regimen is recommended for 12 months beyond culture conversion for treating MAC-LD.

Professor Christoph Lange, Research Centre, Borstel, explained that guidelines recommend treatment intensification via the addition of a parenteral aminoglycoside (amikacin or streptomycin) to the initial treatment regimen in cases of severe MAC-LD or fibrocavitary disease.[6] However, parenteral aminoglycoside therapy extracts a high cost in terms of adverse events.[7] He added that another limitation of parenteral antibiotic treatment is that penetration into lung tissue is variable and may be limited.[8]

TRUST IS KEY TO SUCCESS

According to Professor Stefano Aliberti, University of Milan, the management of MAC-LD is a story of trust between patient and physician.[9] Treatment for MAC-LD is long and tough for patients – possibly harder than the disease in some cases. To be able to cope with adverse events and complete treatment, patients need strong support from family members, care-givers, physicians and patient associations. In a recent European Bronchiectasis Registry-European Lung Foundation survey the three leading patient concerns were found to be the long duration of treatment, worries about diagnosis / treatment, and the side-effects of the drugs used.[10]

Professor Aliberti said that it was important to take time to discuss the treatment burden with patients (on at least two occasions) to describe potential adverse events, to inform patients about the multidisciplinary team that will take care of them, to make sure that they are clear about all the visits and tests that will be involved in treatment, to discuss possible exit strategies and make sure that they are given a contact for the local patients' association.

Professor Aliberti also highlighted a need for better screening of bronchiectasis patients for NTM infection. He pointed to a recent study[11] showing that although physicians understand the potentially serious nature of NTM-LD, they rarely systematically screen bronchiectasis patients for NTM.[12]

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THE HIGH ROAD

With hypercholesterolemia possessing the potential to spark a myriad of health problems in the future, knowledge for its navigation and prevention is key. The HEART UK team tell us more.

HOW COMMON IS HYPERCHOLESTEROLEMIA?

High cholesterol affects over half the adult population.

WHAT FACTORS CONTRIBUTE TO ITS OCCURRENCE?

Cholesterol is a fatty substance which is made in the liver. It's found in some foods too. We all need some cholesterol in our bodies just to keep us ticking over, but having too much can clog up your arteries and lead to health problems in the future. By getting a simple cholesterol test and making positive lifestyle changes, most people can keep their cholesterol levels healthy.

Cholesterol plays a vital role in how the body works. There is cholesterol in every cell in the body, and it's especially important in your brain, nerves and skin.

An individual's blood fats (that is your cholesterol and triglycerides) can become raised for a number of reasons. For example:

- A diet high in saturated fats
- Not being active enough, so the fats that are eaten aren't used up for energy
- Genetic conditions which mean that the fats aren't processed in the usual way

WHAT SEVERE REPERCUSSIONS CAN BE ASSOCIATED WITH THE CONDITION?

High cholesterol means that there is too much cholesterol in an individual's blood. This can clog up their arteries – the large blood vessels that carry blood around the body. Over time, this can lead to serious problems.

Excess cholesterol can be laid down in the walls of the arteries. Fatty areas known as plaques can form, and these become harder with time, making the arteries stiffer and narrower. This process is called atherosclerosis.

When the arteries become narrower, it's harder for blood to flow through them. This puts a strain on the heart because it has to work harder to pump blood around the body. Eventually, the heart can become weak and can't work as well as it should.

Blood clots can form over the fatty, hardened parts of the arteries. The blood clots can block the artery completely, cutting off the blood flow. Bits of the blood clots can break away and become lodged in an artery or vein in another part of the body, which can cause a heart attack or stroke.

WHAT CAN HAPPEN IF THE ARTERIES BECOME CLOGGED UP?

If an individual's arteries become clogged up with blood fats, their blood can't flow around their body easily. This can lead to a number of diseases of the heart and blood vessels:

- Coronary heart disease (coronary artery disease)
- Angina (chest pain)
- A heart attack
- Heart failure
- Stroke
- Mini strokes (TIAs)
- Peripheral arterial disease (PAD)
- Vascular dementia

HOW IS A DIAGNOSIS OF HYPERCHOLESTEROLEMIA GENERALLY CONFIRMED?

The only way for individuals to know their cholesterol levels is to get a check.

High cholesterol doesn't usually have any signs or symptoms and it can be caused by your genes as well as your lifestyle, so we advise individuals to get a check even if they are young, fit and feeling healthy.

A cholesterol check involves a simple blood test. The patient's doctor should also check another blood fat called triglycerides, as these also affect heart health.

A test will show whether individuals need to make healthy changes. High cholesterol can lead to heart attacks and strokes. A cholesterol test, along with other simple tests, including a blood pressure test, BMI and waist measurement, will give them a good idea of their heart health and show whether they need to make any lifestyle changes or need treatment.

WHAT TREATMENT OPTIONS HAVE THE MOST SUCCESS RATE?

The most widely-used medicine to lower cholesterol is a statin, but there are other medicines available too and some may only be prescribed in a specialist lipid clinic.

IS THERE ANY LIFESTYLE ADVICE WHICH IS PARTICULARLY EFFECTIVE?

Individuals can be advised that making some simple changes to their lifestyle can keep their cholesterol levels and heart healthier. They should eat a healthy diet, keep active, cut down on alcohol, avoid smoking and look after any other health problems they may have to look after their heart.

ABOUT HEART UK

HEART UK's vision is to prevent early disease and deaths from cholesterol and other blood fat (lipid) conditions in the UK. Their aim is for people to know and understand their cholesterol and other blood fat (lipid) levels and take appropriate action.

For more information, visit www.heartuk.org.uk.

NEW PLATFORM WILL BENEFIT PHARMACY BUYERS

The Cambrian Alliance Group has recently launched e-CASS market, a new platform designed to enable pharmacy contractors to buy and sell stock from each other with ease.

The new platform is set to transform the way that contractors manage their surplus stock and also provide a vital new channel for contractors to source stock that may be in short supply via traditional methods. 'e-CASS is already the most widely used buying platform across independent pharmacy and this new additional platform continues to strengthen the Cambrian Alliance Group offer,' said Nathan Wiltshire, the Group's CEO.

Cambrian Alliance Group boasts a membership of over 1200 members across the UK. The group supports its members in achieving better purchasing margins by leveraging the buying power of its collective membership, which now exceeds £0.6Bn annually.

The group claims that what is commonly referred to as 'dead stock' costs the average pharmacy approximately £12K per year: a significant cost at a time when independent pharmacy has never been under more pressure to maintain margin. e-CASS market will allow contractors to list stock and make it available to buy to a chosen and specified group of buyers, or to the entire Cambrian Alliance Group membership of 1200.

'We are really pleased to be able to bring yet another new product to the independent pharmacy market,' Wiltshire continued.

'When we first launched e-CASS some ten years ago, it revolutionised the way that pharmacy thought about purchasing and delivered immediate benefits to our user community. We believe that e-CASS market will have a similar impact.'

The new platform includes an industry first 'market match' feature available to buyers, which matches all available stock in the market to buyers' specific requirements, based upon their most recent product usages.

The platform also ensures that buyers get notified every time relevant stock becomes available.

Use of the platform meets with current MHRA guidance with regard to the implications of the repeal of Section 10(7) for the supply of licensed medicines by pharmacy in that transactions are on a small and occasional basis, and not for profit.

'The new platform gives contractors a vital alternative to supply at a time when product shortages and availability have never been more prevalent,' Wiltshire added.

'In addition, we are pleased to be able to provide the market with a new tool that really enables contractors to help and support each other at such a challenging time.'

e-CASS market

from The Cambrian Alliance Group

- e-CASS market offers independent pharmacies the ability to trade stock with each other
- Use our unique Market Match feature to find stock available within our e-CASS market community based upon your usages
- Customer specific email notifications for new product listings that you use, including price and tariff detail

Join the hundreds of other independent contractors who are getting more from e-CASS market! You can list your dead stock and make it available to our 800+ platform users, or simply search listings to secure products at prices significantly lower then those offered by wholesalers.

e-CASS market will save you more time and money, **get in touch today!**

Just £15 per month, no Cambrian Alliance Group membership required.

Cambrian Alliance Group | e-CASS A Cambrian Alliance Innovation

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Scottish Pharmacy Review

Scottish Pharmacy Awards

Kyron Media

Formerly known as Medical Communications 2015 Ltd, the company is at the forefront of cross-platform publishing and events for pharmacists and healthcare professionals across the UK.

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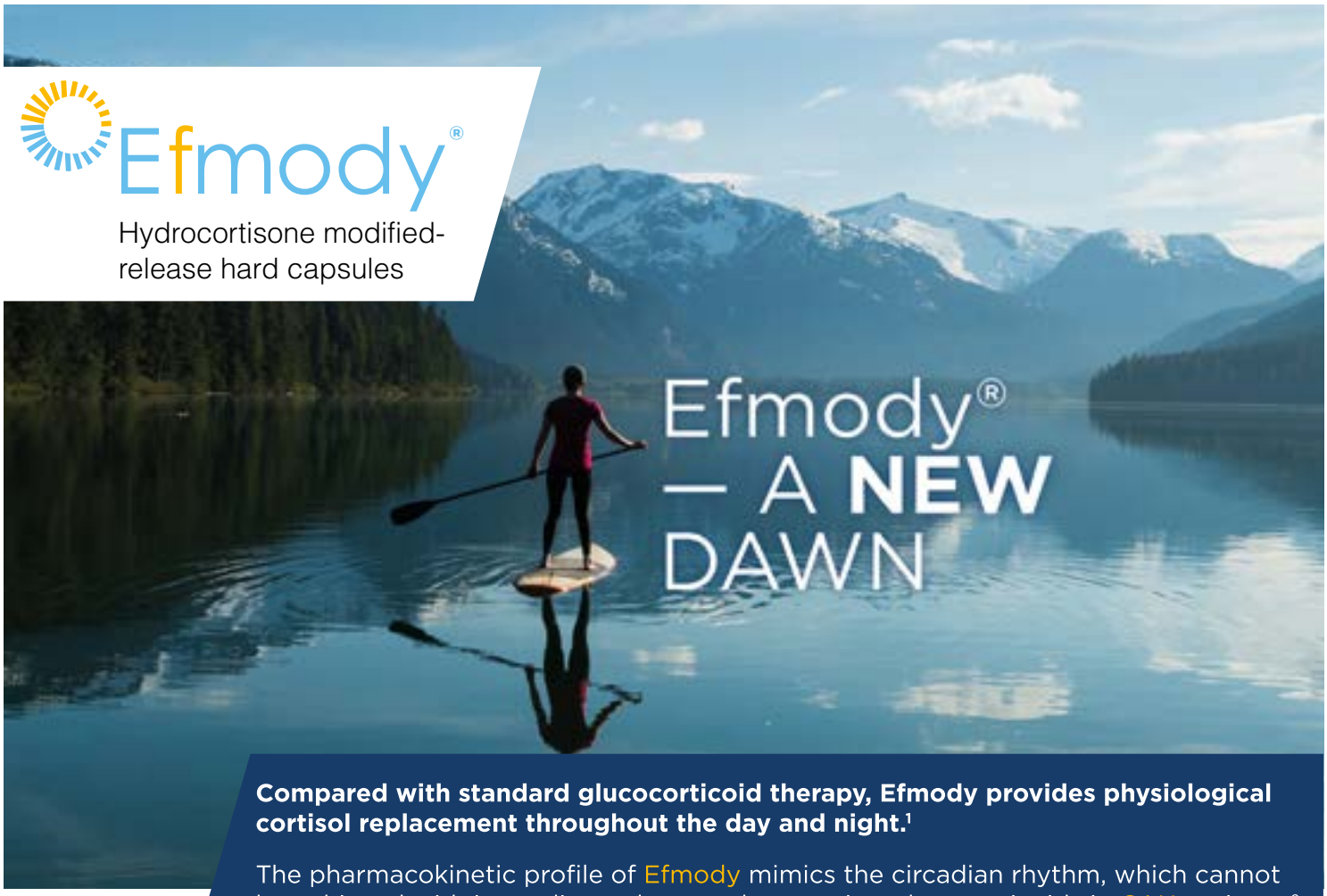

Compared with standard glucocorticoid therapy, Efmody provides physiological cortisol replacement throughout the day and night.[1]

The pharmacokinetic profile of Efmody mimics the circadian rhythm, which cannot be achieved with immediate release or long-acting glucocorticoids in CAH patients.[2]

Abbreviated prescribing information for Efmody® 5 mg and 10 mg modified-release hard capsules (hydrocortisone).

Modified-release hard capsules containing 5 mg and 10 mg of hydrocortisone respectively.

Indication Treatment of congenital adrenal hyperplasia (CAH) in adolescents aged 12 years and over and adults. **Dosage** Dosage should be individualised according to response & the lowest possible dose used. ⅔ to ¾ of the dose should be given at bedtime and the rest on waking. During excessive stress, it may be necessary to increase the dose of Efmody or add additional hydrocortisone as oral or parenteral treatment. **Contraindications** Hypersensitivity to the active substance or any of the excipients. **Warnings and precautions** Patients should be advised of symptoms of acute adrenal insufficiency and adrenal crisis and the need to seek immediate medical attention. Sudden discontinuation of therapy risks adrenal crisis and death. During adrenal crisis parenteral hydrocortisone in high doses should be administered according to current guidelines. Infection should be taken seriously and an increase in steroid dose initiated, and expert advice sought early. Efmody is not recommended in patients with increased gastrointestinal motility. No data are available in patients with reduced gastrointestinal motility. Impaired glucose tolerance, growth retardation, early sexual maturation, diabetes and reduced bone mineral density may occur with long term use of corticosteroids. Excessive weight gain, decreased height velocity or symptoms of Cushing syndrome indicate excessive glucocorticoid treatment. Children should be assessed frequently and their dose adjusted according to individual response. Visual disturbances have been reported in patients receiving oral corticosteroids. Should this occur, consult an ophthalmologist. **Interactions** Hydrocortisone is metabolised by cytochrome P450 3A4 (CYP3A4). Concomitant administration of medicinal products or foodstuffs inhibiting or inducing CYP3A4 may require dose adjustment of Efmody and close monitoring. **Fertility, pregnancy and lactation** Hydrocortisone for replacement therapy can be used during pregnancy and breast feeding. No data are available for any effect on fertility. **Ability to drive and use machines** Efmody has minor influence on ability to drive and use machines. **Adverse Events** The commonest adverse events in the trial programme were fatigue, headache, increased appetite, dizziness and increased weight. The most common serious adverse event was acute adrenal insufficiency.

Legal Classification: POM

Product (50 capsule bottle)	Basic NHS Cost	MA Number
Efmody 5 mg modified-release hard capsules	£135.00	PLGB 50616/0011 EU/1/21/1549/001
Efmody 10 mg modified-release hard capsules	£270.00	PLGB 50616/0012 EU/1/21/1549/002

Marketing Authorisation Holder
Diurnal Europe B.V.,
Van Heuven Goedhartlaan 935 A,
1181LD Amstelveen, The Netherlands.
Tel. +31 (0)20 6615 072. Email: info@diurnal.co.uk

Prescribers should refer to summary of product characteristics for full prescribing information.

Approval Code: CH EU-GB-0046
Date of preparation: July 2021

References: 1. Porter J, et al., Arch Dis Child 2016;0:1-7;
2. https://www.ema.europa.eu/en/documents/assessment-report/efmody-epar-public-assessment-report_en.pdf
Date of Preparation: August 2021 **Code:** CH EU-GB-0049

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 Diurnal on adverse-events@diurnal.co.uk Telephone +44 (0) 7917 334899

NEW & IMPROVED FOR COW'S MILK ALLERGY

Similac®

For healthcare professionals only

Help them face life's adventures

Alimentum® (previously Similac Alimentum) has been upgraded to further support the immune needs of formula-fed infants with mild-to-moderate cow's milk allergy, and other conditions where an extensively hydrolysed formula is indicated.

Alimentum is the first and only extensively hydrolysed formula to contain 2'-FL*†, a major component of most mothers' breast milk:[1]

Helps support the immune system in the gut and beyond[1-4]
Contains 2'-FL* which has proven benefits for the gut and systemic immune responses‡

Clinically shown to be hypoallergenic§ **and improve CMA symptoms fast**¶[5-7]

Well tolerated and highly trusted formula[7-9]

Contact your local Abbott Account Manager to learn more or call Freephone Nutrition Helpline on 0800 252 882

IMPORTANT NOTICE: Breastfeeding is best for infants and is recommended for as long as possible during infancy. Alimentum is a food for special medical purposes and should only be used under the recommendation or guidance of a healthcare professional.

*The 2'-FL (2'-fucosyllactose) used in this formula is biosynthesised and structurally identical to the human milk oligosaccharide (HMO) 2'-FL, found in most mothers' breast milk.[1]
†MIMS. August 2020.
‡Studies conducted in healthy-term infants consuming standard Similac formula with 2'-FL (not Alimentum), compared to control formula without 2'-FL.
§Studies conducted in infants fed standard Alimentum formula without 2'-FL.
¶Parent reports from a single-arm study, where all infants were consuming an extensively hydrolysed formula before being switched to Alimentum with 2'-FL for 60 days. After 7 days of switching to Alimentum with 2'-FL, the majority of parents reported that the following persisting symptoms had improved or resolved: 84% of infants with constipation, 71% of infants with eczema, 100% of infants with vomiting.[7]

References. 1. Reverri EJ, *et al. Nutrients.* 2018;10(10):1346. **2.** Goehring KC, *et al. J Nutr.* 2016;146(12):2559–2566. **3.** Marriage BJ, *et al. J Pediatr Gastroenterol Nutr.* 2015;61(6):649–658. **4.** Triantis V, *et al. Front Pediatr.* 2018;2;6:190. **5.** Borschel M. *Allergy.* 2014;69(Suppl. 99): 454–572. **6.** Sampson HA, *et al. J Pediatr.* 1991;118(4 Pt 1):520–525. **7.** Abbott. Data on File (AL32). April 2020. **8.** Borschel MW, Baggs GE. *T O Nutr J.* 2015;9:1–4. **9.** Abbott. UK Alimentum Market Research. 2018.

UK—2000071 August 2020

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