Scottish Healthcare Review

ISSUE 136 - 2022

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ACUTE HOSPITAL DEMAND

Finding the capacity to cope

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WELCOME

EDITOR'S LETTER

Welcome to the latest edition of Scottish Healthcare Review!

I recently returned to my old secondary school for its annual end-of-year prize-giving to present. While it feels like mere days since I last raced through the crowded corridors, stood in the canteen queue, and hid my Nokia phone in the lining of my blazer, the creases around my eyes as I got ready that morning served as a reminder of the 15-plus years that have since scurried by.

During the ceremony I sat among the proud parents and watched in awe as teachers took to the stage to pour praise upon the exceptional students. While a lot of individuals were top of the class in the subject categories, to my surprise, joint winners and full teams were announced in abundance.

Rather than showcasing even a hint of resentment at sharing the spotlight with their peers, these kids seemed to revel in it – swapping excited smiles and nervous nudges as they posed for the photographer. Their joint-up jubilation was infectious.

Remembering my own competitive spirit in my school years, I don't know if I would have been quite as graceful as these winners – but then, it was only later in life that I really appreciated that age-old sentiment, 'There's strength in numbers'. Now in my job, I feel confident and cushioned when surrounded by colleagues who are experts in their own fields. They make me better as a result.

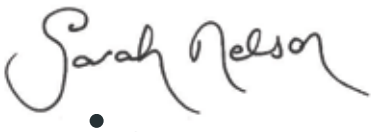
I'm clearly not the only one who sees the merits of this connected working, as the effects of teamwork have been, and continue to, take the sector's potential from strength-to-strength. For example, in this edition of SHR we shine a light on how healthcare leaders are uniting to reduce the environmental harm caused by prescribing (page four), as well as the crucial role of co-operation within the medicines to Ukraine initiative (page 40). The Get your Belly Out campaign is demonstrative, too, of the power of shared voices in making life easier for people affected by IBD (page eight).

Our columnists provide important insights into the current state-of-play of the profession too. The President of the Royal College of Physicians of Edinburgh, Professor Andrew Elder, details how we can tackle acute hospital bed demand (page 12), and Laura Fulton, Director for Scotland, introduces the role and remit of the General Pharmaceutical Council (page 10).

Also in this edition we look at the support required for family members whose loved ones are at high risk of drug-related death (page 44), and share both the expert and patient insights into the cognitive symptoms which can be experienced as a result of MS (page 14).

We are thrilled to unveil the categories for the 2022 Scottish Healthcare Awards too (beginning on page 21) – make sure you get involved!

Happy reading!



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ROYAL
PHARMACEUTICAL
SOCIETY
Scotland

RPS is advocating for pharmacists and pharmacy in Scotland every day

Advocating best practice within pharmacy across our profession

Promoting pharmacy to politicians, Scottish Government, healthcare professionals and the public

Representing pharmacy at various national groups

Working with other organisations to promote pharmacy

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A TURN OF EVENTS

As the Royal Pharmaceutical Society Scotland continues to support, promote and lead the profession across all sectors of pharmacy, SHR surveys some of the organisation's recent raft of work.

HEALTHCARE LEADERS UNITE IN CALLING FOR BOLD ACTION TO REDUCE THE ENVIRONMENTAL HARM CAUSED BY PRESCRIBING

Healthcare leaders from across Scotland have issued a rallying call for bold action to reduce the environmental impact caused by medicine prescribing.

Medicines account for around 25 per cent of carbon emissions in the NHS. If Scotland is to achieve net-zero, strategies for reducing carbon emissions from prescribing and medicines need to be tackled. Medicines also have an ecological impact when they get into our waste water system and are discharged into our rivers and oceans.

To ensure that prescribing is made more environmentally sustainable, the bodies representing healthcare professionals who prescribe have issued a joint statement calling for wide-ranging action to be taken, by policy-makers, education providers, NHS leaders and the pharmaceutical industry.

The statement, which has been signed by the Academy of Medical Royal Colleges and Faculties in Scotland, the Royal Pharmaceutical Society (RPS) and the Royal College of General Practitioners (RCGP) Scotland, calls for the following action to be taken:

- We call on policy-makers to enable a more sustainable approach to prescribing. This includes prioritising the introduction of electronic prescribing across the NHS, introducing the requirement for an environmental impact in NHS medicines procurement and improving the availability of data about the environmental impact of medicines
- We call on the Scottish government, including the Chief Medical Officer, to enable the delivery of a Realistic Medicine approach to prescribing by developing a supportive infrastructure for green social prescribing across Scotland
- We call on the pharmaceutical industry to make information about the environmental impact of medicines readily available in a standardised data format
- We call on the Scottish Intercollegiate Guidelines Network and the Scottish Medicines Consortium to make information about the environmental impact of medicines available in their guidelines
- We call on education providers to support prescribers by including environmental sustainability in education and training for health professionals
- We call for fresh thinking and innovation within the NHS and NHS suppliers in areas, such as reducing medicines waste, reducing the use of paper, plastics and unnecessary packaging, and increasing recycling

The professional leadership bodies for prescribers also recognise their responsibility in supporting prescribers to reduce their environmental impact and in doing so, commit to encouraging prescribers to take a Realistic Medicine approach to prescribing by involving patients in prescribing decisions and reducing unnecessary prescribing, and also promoting the increasing use of green social prescribing initiatives.

Commenting on the publication of the joint statement, Clare

Morrison, RPS Director for Scotland, said, 'Health professionals in Scotland have chosen to come together to create a new national movement to reduce the environmental harm of prescribing and medicines use. Now we are calling on others to join us: the Scottish government, producers of NHS guidelines, the pharmaceutical industry, all health and care professionals, and of course patients.

'Every one of us needs to take action to tackle climate change. What this joint statement demonstrates is how seriously we are taking the climate crisis: we can no longer assume someone else will take responsibility, we must all play our part.

'As professional leadership bodies, we believe that by acting together and focusing on the key areas described in our statement, we can and we will make a difference that will contribute to net-zero and reduce the ecological harm from medicines.

'We call on other health professional leadership bodies to join us and sign up to the joint statement.'

Dr David Shackles, Joint Chair of the RCGP Scotland, reflected, 'Radical action is required if Scotland is to reach its target of net-zero and as individual prescribers, we have an important role to play in ensuring that our health service significantly reduces its carbon footprint.

'However, we can't do this alone and we need to see bold action at a national level to embed the structures that will lead to change.

'The climate crisis is a public health crisis and as healthcare professionals we are committed and united in our calls for action. Our joint statement is a significant step forward and I very much look forward to engaging with the Scottish government and others to make progress in this important area. This is essential if we are to achieve the very best outcomes for the health of our patients and the planet.'

SCOTTISH PARLIAMENT RECEPTION HIGHLIGHTS IMPORTANCE OF PHARMACY'S NEW VISION

A parliamentary reception, 'Pharmacy 2030: A Vision for the Future of Pharmacy' was held at Holyrood to raise awareness and highlight the importance of 'Pharmacy 2030,' an exciting new professional vision for the whole of pharmacy in Scotland. The document was jointly published in February this year by pharmacy's professional leadership body, the RPS, and National Pharmacy Technician Group Scotland.

'Pharmacy 2030' describes a future in which pharmacy teams will work together, using their expertise to make the best use of medicines. They will take a person-centred approach, providing care holistically rather than by clinical condition.

The reception, which was hosted by Gillian Martin MSP, Convener of the Health, Social Care and Sport Committee, brought together MSPs, ministers, civil servants, healthcare professionals and representatives from across health and social care, to celebrate the publication of the new vision and to begin discussing the steps which need to be taken to make it a reality.

Maree Todd MSP, Minister for Public Health, Women's Health and Sport, who worked as a pharmacist before becoming an MSP, provided a speech at the event. Chief Pharmaceutical Officer for Scotland, Alison Strath, and National Clinical Director, Jason Leitch, were also in attendance.

Convener of Health, Social Care and Sport Committee, Gillian Martin MSP, said, 'It was a huge pleasure to be able to host this really positive event on behalf of the RPS this evening.

'As Chair of the Health, Social Care and Sport Committee, I understand the important contribution which pharmacy teams make to improving the healthcare outcomes of our constituents every single day.

"Pharmacy 2030' is an outstanding vision statement which looks to the future. It was wonderful to hear so many examples this evening, particularly from patients, of how pharmacists are already achieving so much right now. By implementing the ideas from 'Pharmacy 2030' in full, ultimately pharmacists will be even better utilised to enhance patient care, experience and safety.'

Speaking about the reception, Clare Morrison, Director for Scotland at the RPS, reflected, 'It was fantastic to bring together pharmacists, parliamentarians and partners from across government and healthcare to celebrate the publication of 'Pharmacy 2030', and to begin discussing how to make the ideas within the vision a reality.

'It was particularly pleasing to have the Convener of the Health, Social Care and Sport Committee, Gillian Martin, hosting our event and the Minister for Public Health, Women's Health and Sport, Maree Todd, providing a speech. I'd like to thank them both for their support for pharmacy and to raise awareness of 'Pharmacy 2030'.

'Now we've brought everyone together, the hard work to implement the vision must begin. The RPS looks forward to working with all our partners across parliament, government and health and social care to make this vision a reality, which we believe will be transformation for patient care in Scotland.'

Minister for Public Health, Women's Health and Sport, Maree Todd MSP, providing a speech at the 2030 Parliamentary Reception

Convener of Health, Social Care and Sport Committee, Gillian Martin MSP, holding the 'Pharmacy 2030' report

NEWS

PROFESSION'S CHARITY SHOWCASES ITS IMPACT

Celebrating its 180th anniversary, Pharmacist Support marked this significant milestone and its evolution from a small benevolent fund to a modern day independent charity by investing in digital and expanding its wellbeing offering, as well as focusing on equality, diversity, and inclusion and its environmental impact.

During the year the charity launched a new website that provides an improved and more intuitive user experience. Development of a new Customer Relationship Management system has also enabled the organisation to improve and streamline delivery of its support, its data collection and monitoring and evaluation.

In response to issues highlighted in the charity's joint workforce wellbeing survey with the Royal Pharmaceutical Society, Pharmacist Support also expanded its wellbeing offering.

'Thanks to funding from the COVID-19 Health Support Appeal, in April the charity was able to address the increased need for mental health support, through the launch of a new counselling service and expansion of its Listening Friend peer support scheme,' commented Pharmacist Support Chair, Esther Sadler-Williams.

Other wellbeing developments included the launch of a new wellbeing learning platform – facilitating individuals' access to the charity's wellbeing workshop content – as well as the expansion and segmentation of its ACTNow wellbeing campaign.

'During the year we have also focused on strengthening our board, as well as honing our overall approach to diversity and inclusion. In May 2021, Pharmacist Support signed the RPS' Inclusion and Wellbeing Pledge: a commitment to be inclusive, celebrate diversity, create a culture of belonging and support pharmacy teams' health and wellbeing. To support this commitment, the charity continued to work on our equality, diversity and inclusion plan. In the latter half of the year the board led a trustee recruitment exercise, welcoming applications from across the profession, and highlighting that 'lived' experience was more important than previous board or trustee experience. We were delighted at the end of the year to welcome five new members to our board,' continued Esther.

Following a landmark judgement from the High Court at the end of April, which clarified guidance that charity trustees can choose to invest ethically, Pharmacist Support trustees also reviewed the charity's investment policy. Acknowledging that there is a climate crisis, they made the decision to divest from producers of fossil fuels by the end of 2022 and will consider the impact on the climate of the decisions they make in line with their charitable objectives.

Esther Sadler-Williams

NEW NATIONAL TARGETS TO TACKLE LONG WAITS FOR PLANNED CARE

Ambitious new targets have been set out for NHS Scotland to address the impact of the pandemic on long waiting times for planned care.

Health Secretary Humza Yousaf announced that NHS Scotland will aim to eradicate waits of more than two years, and then one year in most specialities by September 2024.

Mr Yousaf has asked health boards to take a focussed approach to tackle the waiting lists now that activity in the NHS is beginning to recover from the pandemic.

The targets are to treat those patients waiting longer than:

- Two-year waits for outpatients in most specialities by the end of August 2022
- 18 months for outpatients in most specialities by the end of December 2022
- One year for outpatients in most specialities by the end of March 2023
- Two years for inpatient / daycases in most specialties by the end of September 2022
- 18 months for inpatient / daycases in most specialities by the end of September 2023
- One year for inpatient / daycases in most specialities by the end of September 2024

Mr Yousaf explained, 'We know that waiting times have grown as a result of the pandemic, which is why we now need to focus on treating these people that are waiting too long for treatment. That's why I am announcing some of the most ambitious targets in the UK.

'From speaking to patients and clinicians across the country, I know there is a physical and mental consequence in having to wait a long period to be treated, that is why addressing long waits is a key focus of our plans for NHS recovery.'

BLOOD TEST COULD PREDICT FUTURE RISK OF LEUKAEMIA

A blood test could predict the risk of developing leukaemia in the elderly population years in advance by identifying changes in blood cell production, according to new research.

Leukaemia is often the result of the disruption to the fine balance in blood cell production where new cells are manufactured and old blood cells die. As we age, mutations in blood stem cells can mean that the altered cells can have a growth benefit over other blood cells and outnumber them in what is referred to as fitness advantage.

Researchers from the Universities of Edinburgh and Glasgow investigated how changes in fitness advantage that occur in blood production might provide clues to the risk of developing leukemia depending on the type of mutation that occurs.

Dr Tamir Chandra, a Chancellor's Fellow at the MRC Human Genetics Unit in Edinburgh, said 'We measured changes in the blood samples of 83 older individuals of the Lothian Birth Cohorts, taken every three years over a 12-year period. Using the combined knowledge of mathematicians, biologists and genome scientists, we set out to understand what these changes mean for our risk of developing leukemia as we grow older.'

The team then combined these complex genomic data with a machine-learning algorithm to link different mutations with different growth speeds of blood stem cells carrying these mutations.

It was found that specific mutations give distinct fitness advantages to stem cells measured in people without leukaemia – this can then be used to forecast how quickly the mutated cells will grow, which determines leukaemia risk.

The team have said that further research is needed to validate these results in a larger population due to the limited sample size in the current study.

For Scottish & Welsh Healthcare Professionals Only

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JARDIANCE is indicated in adults for the treatment of symptomatic chronic heart failure

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Reference: 1. JARDIANCE® (empaglifozin) Summary of Product Characteristics

Prescribing Information (Great Britain) JARDIANCE® (empagliflozin)

Film-coated tablets containing 10 mg or 25 mg empagliflozin. **Indication:** Type 2 diabetes mellitus: Jardiance is indicated for the treatment of adults with insufficiently controlled Type 2 diabetes mellitus as an adjunct to diet and exercise: as monotherapy when metformin is considered inappropriate due to intolerance; in addition to other medicinal products for the treatment of diabetes. For study results with respect to combinations, effects on glycaemic control and cardiovascular events, and the populations studied, refer to the Summary of Product Characteristics. Heart failure: Jardiance is indicated in adults for the treatment of symptomatic chronic heart failure. **Dose and Administration:** Type 2 diabetes mellitus: The recommended starting dose is 10 mg once daily. In patients tolerating empagliflozin 10 mg once daily who have eGFR ≥60 ml/min/1.73 m^2 and need tighter glycaemic control, the dose can be increased to 25 mg once daily. The maximum daily dose is 25 mg. *Renal impairment:* The glycaemic efficacy of empagliflozin is dependent on renal function; efficacy is reduced in patients with moderate renal impairment and likely absent in patients with severe renal impairment. If empagliflozin is used for cardiovascular risk reduction as add on to standard of care, a dose of 10 mg empagliflozin once daily should be used in patients with an eGFR between 30 and 60 ml/min/1.73 m^2. If further glycaemic control is needed, the addition of other anti-hyperglycaemic agents should be considered. Dose adjustment recommendations according to eGFR or CrCL: In patients with type 2 diabetes mellitus and an eGFR 45 to <60 ml/min/1.73 m^2 or CrCL 45 to <60 ml/min; do not initiate, but in patients already taking empagliflozin continue with 10 mg empagliflozin. In patients with type 2 diabetes mellitus with an eGFR below 45 ml/min/1.73 m^2 or CrCL below 45 ml/min empagliflozin is not recommended. In patients with type 2 diabetes mellitus and established cardiovascular disease with an eGFR 30 to <60 ml/min/1.73 m^2 or CrCL 30 to <60 ml/min; initiate or continue with 10 mg empagliflozin. Empagliflozin is not recommended in patients with an eGFR <30 ml/min/1.73 m^2 or CrCL <30 ml/min. Heart failure: The recommended dose is 10 mg empagliflozin once daily. *Renal impairment:* For treatment of heart failure in patients with or without Type 2 diabetes mellitus, empagliflozin 10 mg may be initiated or continued down to an eGFR of 20 ml/min/1.73 m^2 or CrCl of 20 ml/min. For patients with an eGFR <20 ml/min/1.73 m^2 or CrCl <20 ml/min empagliflozin is not recommended. All indications: When used with sulphonylurea or insulin, a lower dose of these may be considered to reduce the risk of hypoglycaemia. If a dose is missed, it should be taken as soon as the patient remembers; however, a double dose should not be taken on the same day. *Renal impairment:* Empagliflozin should not be used in patients with end stage renal disease (ESRD) or on dialysis. *Monitoring of renal function:* Assessment of renal function is recommended prior to initiation and at least annually; prior to initiation of any concomitant medicinal product that may have a negative impact on renal function. *Hepatic impairment:* No dose adjustment is required for patients with hepatic impairment. Not recommended in severe hepatic impairment. *Elderly patients:* No dose adjustment is recommended based on age. In patients 75 years and older, an increased risk for volume depletion should be taken into account. *Paediatric population:* No data are available. *Method of administration:* The tablets can be taken with or without food, swallowed whole with water. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and Precautions:** *Ketoacidosis:* Rare cases of ketoacidosis, including life-threatening and fatal cases, have been reported in patients with diabetes mellitus treated with SGLT2 inhibitors, including empagliflozin. The risk of ketoacidosis must be considered in the event of non-specific symptoms such as nausea, vomiting, anorexia, abdominal pain, excessive thirst, difficulty breathing, confusion, unusual fatigue or sleepiness. Assess patients for ketoacidosis immediately, regardless of blood glucose level. In patients where ketoacidosis is suspected or diagnosed, treatment with empagliflozin should be discontinued immediately. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or acute serious medical illnesses. Monitoring of ketones is recommended in these patients. Measurement of blood ketone levels is preferred to urine. Treatment with empagliflozin may be restarted when the ketone values are normal and the patient's condition has stabilised. Before initiating empagliflozin, factors in the patient history that may predispose to ketoacidosis should be considered. Use with caution in patients who may be at higher risk of ketoacidosis. Restarting SGLT2 inhibitor treatment in patients with previous ketoacidosis while on SGLT-2 inhibitor treatment is not recommended, unless another clear precipitating factor is identified and resolved. Jardiance should not be used for treatment of patients with Type 1 diabetes. *Renal impairment:* See under 'renal impairment' of Dose and administration section. *Monitoring of renal function:* See under 'monitoring of renal function' of Dose and administration section. *Risk for volume depletion:* Osmotic diuresis accompanying glucosuria may lead to a modest decrease in blood pressure. Therefore, caution should be exercised in patients with known cardiovascular disease, patients on anti-hypertensive therapy with a history of hypotension or patients aged 75 years and older. In case of conditions that may lead to fluid loss (e.g. gastrointestinal illness), careful monitoring of volume status and electrolytes is recommended. Temporary interruption of treatment with empagliflozin should be considered until the fluid loss is corrected. *Elderly:* See under Dose and Administration; special attention should be given to volume intake of elderly patients in case of co-administered medicinal products which may lead to volume depletion (e.g. diuretics, ACE-inhibitors). *Complicated urinary tract infections:* Temporary interruption of empagliflozin should be considered in patients with complicated urinary tract infections. *Necrotising fasciitis:* Cases of necrotising fasciitis of the perineum (Fournier's gangrene), have been reported in patients with diabetes mellitus taking SGLT2 inhibitors. This is a rare but serious and potentially life-threatening event that requires urgent surgical intervention and antibiotic treatment. Patients should be advised to seek medical attention if they experience a combination of symptoms of pain, tenderness, erythema, or swelling in the genital or perineal area, with fever or malaise. Be aware that either uro-genital infection or perineal abscess may precede necrotising fasciitis. If Fournier's gangrene is suspected, Jardiance should be discontinued and prompt treatment should be instituted. *Lower limb amputation:* An increase in cases of lower limb amputation (primarily of the toe) has been observed in long-term clinical studies with another SGLT2 inhibitor, counsel patients on routine preventative footcare. *Hepatic injury:* Cases of hepatic injury have been reported with empagliflozin in clinical trials. A causal relationship between empagliflozin and hepatic injury has not been established. *Elevated haematocrit:* Haematocrit increase was observed with empagliflozin treatment. *Chronic kidney disease:* There is experience with empagliflozin for the treatment of diabetes in patients with chronic kidney disease (eGFR ≥30 mL/min/1.73 m^2) both with and without albuminuria. Patients with albuminuria may benefit more from treatment with empagliflozin. *Infiltrative disease or Takotsubo cardiomyopathy:* Patients with infiltrative disease or Takotsubo cardiomyopathy have not been specifically studied. Therefore, efficacy in these patients has not been established. *Urine laboratory assessments:* Due to its mechanism of action, patients taking Jardiance will test positive for glucose in their urine. *Lactose:* The tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product. *Sodium:* Each tablet contains less than 1 mmol sodium (23 mg), essentially 'sodium free'. **Interactions:** Use with diuretics may increase the risk of dehydration and hypotension. Insulin and insulin secretagogues may increase the risk of hypoglycaemia therefore, a lower dose of insulin or an insulin secretagogue may be required. Empagliflozin may increase renal lithium excretion and the blood lithium levels may be decreased. Serum concentration of lithium should be monitored more frequently after empagliflozin initiation and dose changes. The effect of UGT induction (e.g. induction by rifampicin or phenytoin) on empagliflozin has not been studied. Co-treatment with known inducers of UGT enzymes is not recommended due to a potential risk of decreased efficacy. If an inducer of these UGT enzymes must be co-administered, monitoring of glycaemic control to assess response to Jardiance is appropriate. Interaction studies suggest that the pharmacokinetics of empagliflozin were not influenced by coadministration with metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, warfarin, verapamil, ramipril, simvastatin, torasemide and hydrochlorothiazide. Interaction studies conducted in healthy volunteers suggest that empagliflozin had no clinically relevant effect on the pharmacokinetics of metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, simvastatin, warfarin, ramipril, digoxin, diuretics and oral contraceptives. **Fertility, pregnancy and lactation:** There are no data from the use of empagliflozin in pregnant women. As a precautionary measure, it is preferable to avoid the use of Jardiance during pregnancy. No data in humans are available on excretion of empagliflozin into milk. Jardiance should not be used during breast-feeding. No studies on the effect on human fertility have been conducted for Jardiance. **Undesirable effects:** Frequencies are defined as very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1,000 to <1/100), rare (≥1/10,000 to <1/1,000), very rare (<1/10,000). Very common: hypoglycaemia (when used with sulphonylurea or insulin), volume depletion. Common: vaginal moniliasis, vulvovaginitis, balanitis and other genital infections, urinary tract infection (including pyelonephritis and urosepsis), thirst, constipation, pruritus (generalised), rash, increased urination, serum lipids increased. Uncommon: diabetic ketoacidosis, urticaria, angioedema, dysuria, blood creatinine increased/glomerular filtration rate decreased, haematocrit increased. Rare: necrotising fasciitis of the perineum (Fournier's gangrene). Very rare: tubulointerstitial nephritis. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** 10 mg; 28 tablets £36.59, 25 mg: 28 tablets £36.59. **Legal category:** POM. **MA numbers:** 10 mg PLGB 14598/0192; 25 mg PLGB 14598/0193. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, 55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared in June 2022.**

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 Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

Boehringer Ingelheim

PC-GB-106837 July 2022

Lilly

BETTER TOGETHER

While adjusting to the daily challenges aligned with a life of Crohn's Disease / Ulcerative Colitis, Victoria Marie recognised the need for enhanced support, education and advocacy for others affected by the chronic condition too. Here, the Founder and Director of GetYourBellyOut details how she has used her diagnosis for fuel in creating the awareness-raising community – and the power of this connection.

Victoria Marie

My life changed forever, when, at the age of 21, I was diagnosed with a chronic illness called Ulcerative Colitis.

At first, I was too afraid of the unknown and highly embarrassed to talk about my symptoms, so I stuck my head in the sand and did nothing about it. A big mistake! I threw up continuously, suffered numerous fevers, and ran back and forth to the bathroom, all day and night long. I crumbled from the pain, broke my heart when my hair started to fall out, struggled with chronic fatigue, and had no appetite although I was starving inside.

I shoved my head under the duvet, where I spent every day, too weak to move, thinking the worst. Sleeping on pillows with one wedged between my knees or sitting on towels in the bath became the norm, as means of trying to find comfort. In the end, all that was left of me was a six-stone skeletal frame which was way beyond the point of dehydration and exhaustion by the time I eventually checked myself into the hospital.

My first ever hospital stay also consisted of X-rays, a CT scan, a scope, three days' worth of being hooked up to IV fluids, nutrients, and a blood transfusion. I was poked with so many needles that I started to resemble a pin cushion and shed enough tears to last me a lifetime.

My mother and I would spend our days trying to convince the doctors of how I didn't have an eating disorder. I had my mental health evaluated and tried in vain to

#GetYourBellyOut

explain how it wasn't that I was avoiding food, I simply couldn't stomach it, despite the burning hunger pains inside. A torturous, unending circle of misery, with no-one really listening. I was at my wits end.

Finally, I was released from the hospital two weeks later... knowing nothing more of my chronic illness, other than its name!

There I stood, with this life-long, destructive, chronic illness which had taken away everything I had once known, and in its place, I was handed a one-page leaflet then sent back out into the world. Somehow, I was left to figure things out on my own.

Life now consisted of hospital appointments, iron infusions, anger, debilitating fatigue, anxiety, daily medication, isolation, and frustration.

SHARING MY STORY

Over time, as my physical health improved, I saw my mental health deteriorate, as I tried to process the emotional whirlwind of what I had been through. With no real support or any real understanding of my illness, I grew angry – angry at having been left to fend for myself.

So, I took to social media to post a photo of my belly and share my story with the world. The #GetYourBellyOut hashtag was created, and others were invited to do the same.

Before long, I was inundated with photos of people's bellies, some with scars, some with an ostomy and others, like myself, with no outward signs of this destructive disease. Immediately I had a sense of belonging – I was no longer alone.

In 2014, GetYourBellyOut was established as a not-for-profit organisation, devoted to providing support, education, and advocacy for Inflammatory Bowel Disease.

I'm delighted to say that the standard of our work over the last eight years has been recognised by some phenomenal names, such as winning a Pride of Britain Award, being chosen to work with Facebook on this year's Communities Accelerator Programme, getting shortlisted for a Queen's Award for Voluntary Service and recognised as a Digital Women's Community of the Year. Though, most importantly, our biggest achievement overall must be the impact GetYourBellyOut has made on thousands of lives touched by Inflammatory Bowel Disease (IBD).

Sadly, the reality is, that every 22 minutes, someone in the UK receives a diagnosis of IBD, which means, by the end of today another 66 families will be left in turmoil, with little to no support, as they come to terms with a loved one's diagnosis. It's a figure which will have risen to over 25,000 newly-diagnosed, in the UK alone, by the end of the year.

AS SEEN ON SCREEN

As an organisation, our experiences lead us to believe this disease is massively underreported, is a growing issue, and is more likely, a 'hidden pandemic' that will continue to affect millions of people worldwide. So, we must act now!

This year, to mark World IBD Day, we shouted louder and prouder than ever before with a world exclusive premiere of GetYourBellyOut's mini documentary at a quaint movie theatre in London, followed by an action-packed social activity and delicious community dinner.

As an overwhelmed young adult, with no real IBD support team in place, making a film to raise awareness and improve people's understanding of what life is really like living with IBD would have been something I could only ever dream of – it felt too far out of reach – yet was always something I could one day work towards.

Within the documentary, James, Yvonne, and Keith bravely share their honest, raw, and emotional accounts of how this cruel, life-long illness has shaped them and their lives. We, too, get to hear from James' parents and Yvonne's partner to gain their perspectives as to how IBD can affect the whole family, not only the individual diagnosed.

We're so incredibly proud of all who featured within this film and do hope it helps others on their journey to feel less alone. Together, through collaboration, we're all making life that little easier for people affected by IBD.

Our aim is for GetYourBellyOut to one day become the world's leading digital and physical destination for people affected by IBD.

Watch GetYourBellyOut's film via our website – www.GetYourBellyOut.org.uk/film – and please feel free to share this with others on social media. Thank you!

GENERAL PHARMACEUTICAL COUNCIL

IN SAFE HANDS

In the General Pharmaceutical Council's first instalment, Laura Fulton, Director for Scotland, shares her entrance to the role, experience thus far – and introduces the extensive responsibilities undertaken by the organisation.

Laura Fulton

It's nearly three years since I started in my role as Director for Scotland at the General Pharmaceutical Council (GPhC) following a career based in various roles across community pharmacy. I started in September 2019 and settled in, getting to know my key stakeholders both internally and externally, familiarised myself with the current projects and key priorities before the pandemic took hold in March 2020. Since then, it has been a whirlwind of many highs and some lows as I am sure is the case for most, if not all, of us.

As a registered pharmacist I was excited to take on the role and to deliver on a key aspect of my remit, to ensure that both the work of the GPhC is highlighted and communicated to our key Scottish partners and equally that their points, views and opinions are heard and furthermore used to inform our work.

The GPhC are a statutory organisation, the regulator, set up by the UK and Scottish parliaments, and are independent from government and those we regulate. We regulate pharmacists, pharmacy technicians and pharmacies in Great Britain. Our role is to protect the public and give them assurance that they will receive safe and effective care when using pharmacy services. We set standards for pharmacy professionals and pharmacies to enter and remain on our register. We ask pharmacy professionals and pharmacies for evidence that they are continuing to meet our standards, and this includes inspecting pharmacies. We act to protect the public and to uphold public confidence in pharmacy if there are concerns about a pharmacy professional or pharmacy on our register. Through our work we help to promote professionalism, support continuous improvement and assure the quality and safety of pharmacy.

From the outset I had to remind myself, and still do, of the organisation's remit as I often found myself with my 'pharmacist hat' on and considered any discussions, questions etc. through that familiar lens. I am fortunate that the GPhC has staff from a diverse range of backgrounds, consisting of pharmacists, pharmacy technicians, people with experience of other regulatory worlds and other healthcare professions. This helps us look at issues from a wide range of perspectives before finalising our approach with the consistent aim of improving patient safety. It has, however, made me reflect on my practice and now when I occasionally work in a community pharmacy I do it with a much wider perspective.

Furthermore, this brings me to an observation I have made, particularly when interacting with fellow registrants or talking to students or foundation trainees, as well as key stakeholders, which is that often the role and remit of the GPhC as the regulator is misunderstood. It can sometimes be confused with the professional leadership body, the Royal Pharmaceutical Society (RPS). You may be aware that the RPS of Great Britain, operated until 2010. Its role was as the statutory regulatory and professional body for pharmacists, so essentially both functions by the one organisation. This split into the GPhC, the statutory regulator and the RPS, the professional leadership body. This still causes confusion and therefore another key part of my role is to raise awareness of what we and the likes of the RPS do and what is different about us, albeit often complementing each other's work.

Over the coming editions I am going to explore some of the key areas of work that we participate in and highlight the complementary roles key partners play in helping us to work towards achieving our own organisation's vision as well as how our statutory work influences and supports other organisations too.

Our vision for 2030 is to ensure safe and effective pharmacy care at the heart of healthier communities. We plan to achieve this by being a good quality, independent regulator of pharmacy for the public, by practising an anticipatory and proportionate approach to regulation and by operating as a professional and lean organisation. Further details can be found on our website, GPhC Vision 2030 (www.pharmacyregulation.org).

I am still thoroughly enjoying the role, thrive on using my knowledge and networks to influence and help develop policy as well as support the organisation.

We have also all become accustomed to navigating the virtual world on the likes of teams and Zoom where mute buttons, raising hands as well as remembering to lower them are still challenging but it has allowed us to connect more frequently and get things moving forward at pace.

Throughout the pandemic I have been based at home, and I am fortunate that my relationships are all well-established and that the trust and integrity, as well as the pragmatic approach, I demonstrate is recognised and valued.

It has, at times, been a particularly challenging two-and-a-half years, where we have faced scenarios never seen before, resulting in adaptations or solutions at pace and when things have gone wrong key learnings and modifications for the future have been identified, considered and scrutinised.

Overall, I am most proud of the collaborative work we have done to enable the introduction of the new initial education and training standards for pharmacists. We were set to publish our new standards in early 2020 but at the onset of the pandemic we considered if they were progressive enough to realise the benefit of pharmacists in the future. As a result, we have enhanced them to include the ability to prescribe upon registration from 2026.

My next article will feature the details surrounding this work and consider what it means for both pharmacy professions moving forward.

General Pharmaceutical Council

Motusol

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Job Code: MED-GB-00136. **Date of Preparation:** June 2022.

Job Code: MULTI-GB-00069. **Date of Preparation:** June 2022.

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SAFETY IN NUMBERS

Do we have enough acute hospital beds? The President of the Royal College of Physicians of Edinburgh, Professor Andrew Elder, investigates.

Professor Andrew Elder

The most recent data from Public Health Scotland, published in autumn 2021, showed an average of 12,869 available staffed beds in Scotland for acute specialties in 2020 / 2021. This represented a 2.5 per cent decrease on 2020 and an almost eight per cent decrease compared to 2015. Over the last decade, acute beds have declined by 9.5 per cent, or 1,358 beds in actual numbers, meaning that Scotland now has the lowest number of acute beds in at least 10 years.

Most medical professionals understand that developments in medical practice, innovation and technology have driven much of this decline – many procedures formerly involving hospital stays are carried out without the need for a hospital stay or with a much shorter stay required.

But such developments apply predominantly to the surgical specialties, and more and more physicians – who work in the medical specialties – are telling the Royal College of Physicians of Edinburgh that demand for medical specialty hospital beds is unprecedented. Many are questioning whether current bed capacity is sufficient to meet the needs of patients and provide the best possible levels of care.

So, what's gone wrong? Have we misjudged the number of beds we need, in the face of an ageing population, or is there some other issue? As a geriatrician working in our NHS wards I see first-hand the level of demand for beds. There is little doubt that the complexity of care has increased – multimorbidity, and increased survival rates from once fatal conditions, means that it is not unusual for one patient to have half a dozen active problems that need attention during an in-patient stay. And we can do more than we used to be able to do – older people who were not previously judged suitable to undergo some treatments or interventions, now are. Some decline what we offer, but most accept. And, when interventions happen, recovery times in older age are invariably longer. The care journey is not over when the patient is taken out of the operating theatre, has their radiotherapy or chemotherapy – it is just beginning.

Superimposed on complexity and longer recovery times is the problem of 'delayed discharge', levels of which are now back to, or above, pre-COVID levels. But the discharge delays no longer relate to the funding of packages of care – that has undeniably improved – it is quite simply, finding the human beings to act as carers. We seem to have the financial resource, but not the human resource available.

Less well-known are delays – sometimes of up to six months – in processing guardianship orders for older patients in hospital. I outlined this concern to the Cabinet Secretary for Health, Humza Yousaf, in a recent meeting and in our college response to the consultation on the proposals of the Mental Health Law Review Group. We need to see this system reformed – and urgently. None of us would want to spend one half of the rest of our life in a hospital ward, when we could be in a more homely setting. However, current guidance prevents patients who lack capacity to make welfare decisions – most commonly due to dementia – from moving between 'health' and 'social' care facilities until the guardianship process is complete. Somewhat perplexingly, such patients can be moved between different health facilities – and many visit many different hospital wards while they wait.

Pressures on 'front door' emergency medicine understandably attract a large amount of media coverage and political focus, not least in the weekly accident and emergency waiting time statistics. Long waits in Emergency Departments and queues of ambulances outside them are bad advertisements for our NHS – and even worse for individual patient care. But solutions do not lie at the front doors of our hospitals – they lie in the 'downstream beds' and 'back doors'. Were we to be able to do what our patients and their families want – get them home when they are well and able enough to do so – our front door problems and flow through the system would ease substantially. They may even disappear. But achieving this means supporting the relevant workforce – the workforce that provides domiciliary and residential care. Would you take on responsibility for the care of frail older people for less pay – and less respect – than you might get working at the checkout of your local supermarket?

Our population has aged and will continue to do so. Until we appreciate that care of the elderly requires increasingly significant investment, and give more thought and resource to the back door as we do to the front, we will struggle with capacity in acute hospitals. With faster discharge, and more initiatives to prevent unnecessary admission in the first place, I believe that we do have the acute hospital bed capacity to cope. Time will tell.

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BENEATH THE FOG

Manifesting in different forms and severity from person-to-person, cognitive symptoms associated with MS warrant greater awareness in the public arena. SHR explores the 'fog' further – from its onset, disruption to daily life, and efforts to harvest hope in management strategies for it.

THE EXPERT VIEW

Morna Simpkins, Director of MS Society Scotland, casts a light on the variation of cognitive difficulties which may be experienced as a result of an MS diagnosis.

MS affects more than 15,000 people in Scotland. The neurological condition damages nerves in the brain or spinal cord, leading to people living with MS experiencing a wide range of different symptoms.

While eye problems, numbness, fatigue and pain are some of the most common symptoms of MS, many people also experience problems relating to cognition. Like other symptoms of MS, cognitive symptoms vary greatly from person-to-person.

Dealing with cognitive difficulties, particularly on top of other MS symptoms, can be frightening and frustrating and can also impact on family life, relationships, employment and education, as well as other aspects of a person's life. However, there are a number of ways people can be supported to manage their symptoms.

There is a wealth of information, advice and tips available on our website to help people deal with problems linked to memory and thinking. We have also produced a film on the topic. In Scotland, our Wellbeing Hub offers a variety of free virtual sessions, including one-to-one support, counselling, and peer support.

If cognitive symptoms are repeated and are having a significant impact on daily life, we recommend people speak to their GP or MS nurse and ask to be referred for a neuropsychological assessment with a clinical psychologist.

There are four common cognitive difficulties that people living with MS are most likely to experience:

LEARNING AND MEMORY

MS can affect the memory and, in particular, remembering recent events and remembering to do things. Some people with MS also say it can take more time and effort to recall a memory.

ATTENTION, CONCENTRATION AND MENTAL SPEED

Some people living with MS find it difficult to concentrate for long periods, have trouble keeping track of what they're doing, and struggle to multitask. They may also feel they can't function as quickly as they used to and they process information more slowly.

PROBLEM-SOLVING

MS can make it difficult for people to make plans or solve problems. People know what they want to achieve but find it difficult to work out the steps they need to take to reach their goals.

WORD-FINDING

People with MS may also experience difficulties in recalling the right word to use – the 'tip of the tongue' phenomenon. This can make it difficult for people to take part in conversations.

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

NICKY'S STORY

Nicky Cowsill, 54, lives in North Tolsta on the Isle of Lewis. She was diagnosed with relapsing remitting MS in 2013.

Nicky suspects she may now have secondary progressive MS, although as she hasn't seen her consultant since May 2019, she hasn't been able to get confirmation of this.

Nicky gave up work as a manager for a care charity the year after her diagnosis and became a full-time student with the University of the Highlands and Islands. She completed an online degree in Sustainable Development, which helped when she became part of the team that set up the charity, Neuro Hebrides.

Nicky Cowsill

MS

Speaking about her diagnosis, Nicky said, 'In July 2013 I lost the sight in one eye. Prior to that I'd lost a lot of feeling in my right side and just had difficulty trying to function; with my brain, it's really difficult thinking. This relapse triggered the start of my diagnosis and a change in my life. I had to have an MRI and a lumber-puncture and I had been diagnosed by the November, which I thought was pretty quick really.'

In addition to physical symptoms, such as problems with balance, co-ordination and fatigue, Nicky lives with a number of cognitive symptoms.

She continued, 'I describe my brain now as being like a rusty bucket; because it's full of holes. I like to think I'm quite an intelligent person, I've done quite a lot of academic study, but I can't retain information anymore. I can read loads, if I've got the energy for it, and I can take in a lot of information, but it disappears quite quickly. I can read a page of a book and not remember, by the time I get to the second page, what I've read on the first page. I can remember things from years ago very clearly though.

'It feels like my head's full of syrup as well, if that makes sense: I know the information's in there somewhere but I can't find it.

'If you didn't know about my cog fog you'd think 'she looks like a bit of a zombie' or 'she's being downright rude' because you can be talking to me, and I'll be looking at you, but I won't be processing it and I won't be registering what you're telling me.

'I can't do lots of tasks in one go. The job I used to do involved processing lots of information throughout the day and having to deal with things happening very spontaneously; I just can't do that anymore. I have to do one task at a time, otherwise the information just doesn't go in and I can't process it.

'I've learned over the years that I have to complete one task before moving onto the next one, whether that's making a sandwich or loading the washing machine or writing an email. I have to completely focus myself on that one thing to get it done, otherwise it won't get done or I end up causing a bit of a hazard for myself by leaving things on the floor or sharp knives on the work surface because I go off and forget what I'm doing.

'Another thing I've learned is to allocate my energy levels or my concentration time for certain activities. Even having this conversation today, I had to go and lie down for half an hour beforehand because I had such a mad morning I had to do a bit of mindfulness, a bit of decompression, and come back to where I need to be to speak to someone.

'Another thing I struggle with is face recognition. I'm alright with people I see on a very regular basis but sometimes people come up to me when I'm out and about and say, 'Hi Nicky' and I'm thinking, 'Okay, who are you?'. Ultimately, it makes me feel quite vulnerable, because I have to question myself the whole time: why do I know this person? What do they need from me? What have I forgotten to do?

'If you put me in a strange place or leave me, I'm likely to forget where I am. If I go to the big Asda in Inverness with my husband and he walks off to get something from another aisle that's me, I'm completely panicked. I have no idea where I am. It can be really scary and very challenging.

'I sort of knew cognitive symptoms could be part of MS because of the work I did, I dealt with a lot of people with MS. But I didn't relate it to myself. I put the cognitive symptoms I was experiencing before my diagnosis down to stress and lack of sleep.

'I always say, I'm not disabled at home, because I live in an enabling environment, we've made it that way for me. But as soon as I get out of the front gate I feel disabled because the path might not be level or there's lots of people to deal with.'

Nicky's cognitive symptoms can be affected by a number of factors. She explained, 'With my MS it's all related to fatigue. If I'm having a bad fatigue day, everything will be really difficult. The syrup in my rusty bucket of a brain will be even worse than ever. Related to that is insomnia, which a lot of people with MS live with. I don't sleep very much and if I have a really bad night that makes my fatigue worse so that makes my thinking worse.'

Speaking about the support she has received from healthcare professionals, as well as the gaps she sees in provision in terms of support for cognitive symptoms, Nicky continued, 'When we had an MS specialist nurse in the Western Isles it was great. She ran a fatigue management course and the MS Society ran one too and they really helped me learn to pace myself throughout the day. I now know I need to allocate energy for thinking as well, not just for physical things. The MS Society and Neuro Hebrides also provide an opportunity for people to offer each other support and tips on how we've got through things. The MS Society enables a sense of community and normalises how disabling cog fog can be, it makes me feel that I am not alone.

'Now we no longer have an MS nurse in the Western Isles, it has affected all the support we receive, including for cognitive symptoms. Even something as simple-sounding as I now have no one to remind me about appointments for blood tests etc. so I have to try to set myself reminders on my phone or remember to write them on my calendar. I'm lucky that my husband is really good at reminding me too. But it was also the fact that she would reassure me that, yes, you are going to have these problems but she would give us tips, such as breaking things down into small tasks.

'There's still a huge amount to be done, though, and not just for people living with MS: people with a range of neurological conditions live with cognitive problems. I think a lot of people suffer in silence, because it's not a physical disability, but it is very disabling as well. I think a lot of the support is more to do with the physical and practical aspects of MS, as far as occupational therapy involvement and physiotherapy. Even though that helps with the mental health and wellbeing and reduces your stress, which is really important in terms of cognitive function, I still think there's a lot more work that can be done.

'People living with MS could benefit from support with strategies to help them simplify daily routines, reduce information overload and manage fatigue. Ultimately, to try to reduce stress and that panicky feeling when cog fog kicks in.

'MS patients either need someone to accompany them to appointments or to have them recorded because patients may forget what's discussed due to cog fog. A prompt sheet of questions to be given to patients prior to appointments so they can prepare what they want to ask would also be really useful.

'I also think there needs to be support for carers, both paid and unpaid, and families, to help them recognise and understand cog fog. This goes for the wider community too, such as employers or any role dealing with the public.'

For more information about Neuro Hebrides, visit www.neurohebrides.org.

NHS Western Isles announced earlier this year that it plans to replace a full-time MS nursing post and a part-time epilepsy nursing post with an advanced clinical nurse specialist-neurology, who will support people living with a wide range of neurological conditions. MS Society Scotland, Neuro Hebrides, Epilepsy Scotland and Parkinson's UK Scotland are working together with people living with neurological conditions in the Western Isles to try to get this decision reversed.

BMS has commissioned this article, selected the topic, and reviewed the content for compliance with the ABPI code. BMS has had no other editorial input into the writing of the article, and no involvement with the selection or interviews with healthcare professionals, patients or members of the public.

EPILEPSY: A TIPPING POINT

Hot on the heels of the approval of the Intersectoral Global Action Plan on Epilepsy and other Neurological Disorders, Epilepsy Research UK is leading the response and aiming to accelerate change with the #Every1EndingEpilepsy programme. Maxine Smeaton, Chief Executive, Epilepsy Research UK, gives us the lowdown.

Maxine Smeaton

In May 2022, the World Health Organisation's (WHO) 131 Member States unanimously approved the Intersectoral Global Action Plan on Epilepsy and other Neurological Disorders (IGAP) at the 75th World Health Assembly in Geneva, Switzerland. Governments around the world will now be tasked with responding to the recommendations, potentially bringing about international changes in policy and practice for epilepsy.

WHAT WILL THE IGAP ACHIEVE?

This is the first time that epilepsy and other neurological disorders have been recognised as a distinct field by the WHO, representing a unique opportunity for changes to policy and practice that will undoubtedly inform future research into epilepsy and brain health. Importantly, the IGAP has highlighted the imperative of research into epilepsy, with one of its key strategic objectives being to '…foster research and innovation and strengthen information systems.'

The IGAP will cover a 10-year period from 2022-to-2031 and will build on existing global resolutions, commitments and reports which have previously highlighted the below challenges presented by epilepsy:

- There are 65 million people worldwide and 600,000 people in the UK with a known diagnosis of epilepsy
- Up to 70 per cent of people with epilepsy could live seizure-free if properly diagnosed and treated
- The risk of premature death in people with epilepsy is up to three times higher than for the general population
- The cost of epilepsy on the NHS is estimated to be at least £2 billion annually
- There are a staggering 100,000 emergency admissions due to epilepsy each year

HOW ARE THE EPILEPSY AND RESEARCH COMMUNITIES RESPONDING?

As the only UK charity dedicated to driving and enabling research into epilepsy, Epilepsy Research UK is preparing to leverage the momentum of the IGAP and other recent initiatives. By bringing together those working in epilepsy and those affected by epilepsy to develop a programme of work, the aim is to radically advance research through investment, collaboration and action.

As a first step, this national epilepsy research collaborative, led by three of the UK's leading clinicians and researchers – Professor Helen Cross OBE (UCL Great Ormond Street Institute of Child Health), Professor Mark Richardson (King's College London) and Professor Tony Marson (The Walton Centre, University of Liverpool) – will identify, prioritise and deliver a programme aimed at driving research breakthroughs in diagnostics, treatments and the prevention of epilepsy.

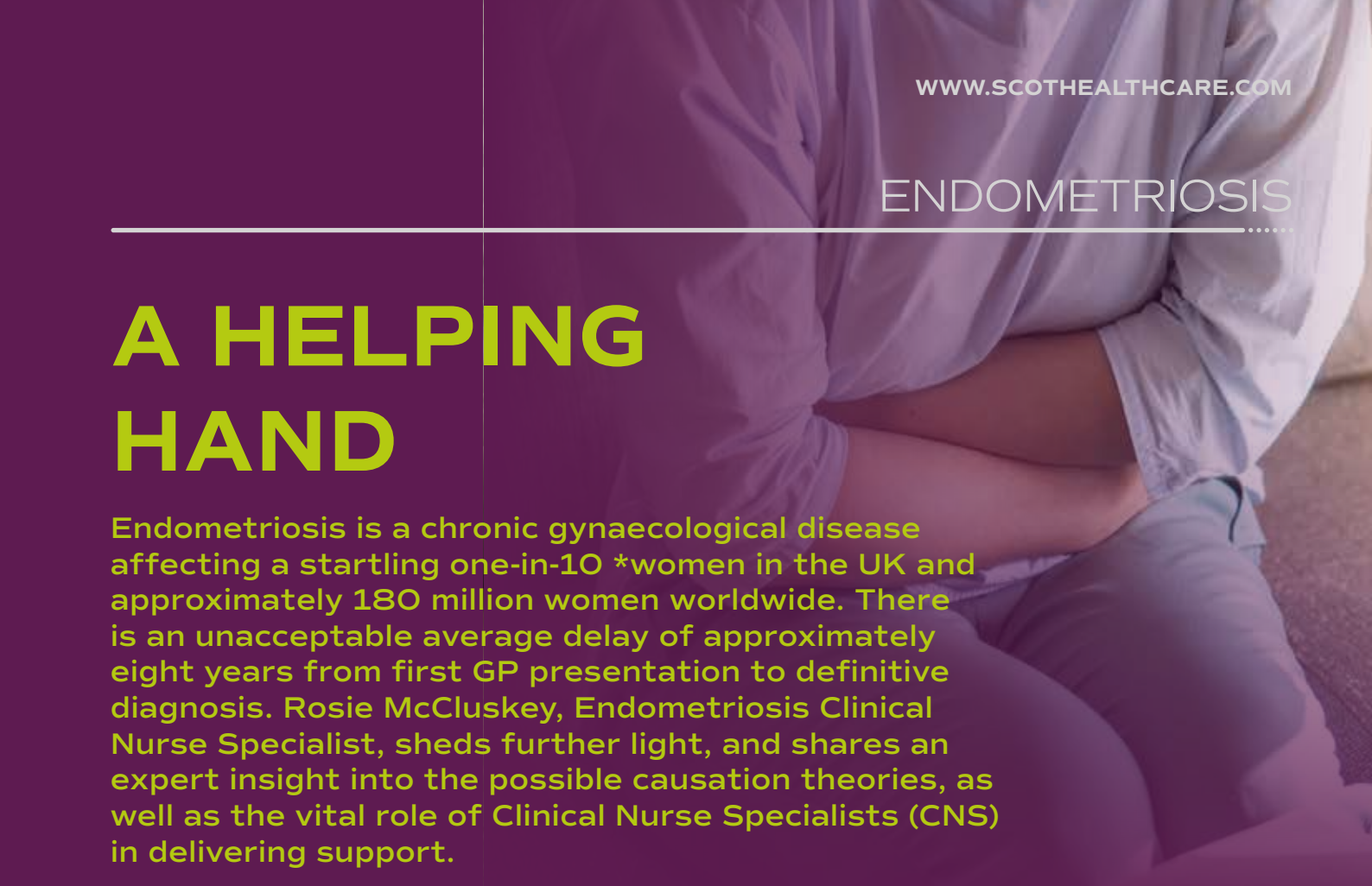
The #Every1EndingEpilepsy programme will provide a road map to the UK government to enable them to implement the recommendations from the IGAP. The programme will inform the approach that will be made to the government through a strategic communications campaign led by people affected by epilepsy and will seek a commitment to a research investment of £100 for each of the estimated 600,000 people living with epilepsy in the UK. That's £100 for every one-in-100 – £60 million in total.

#Every1EndingEpilepsy will also raise awareness of the impact of epilepsy and demonstrate how, by working collaboratively, we can bring about a radical change within a generation.

Learn more about #Every1EndingEpilepsy in this film: https://youtu.be/L8UgV8nYst8 or visit the Epilepsy Research UK website: www.epilepsyresearch.org.uk/we-are-at-a-tipping-point.

EPILEPSY RESEARCH UK

A HELPING HAND



Endometriosis is a chronic gynaecological disease affecting a startling one-in-10 *women in the UK and approximately 180 million women worldwide. There is an unacceptable average delay of approximately eight years from first GP presentation to definitive diagnosis. Rosie McCluskey, Endometriosis Clinical Nurse Specialist, sheds further light, and shares an expert insight into the possible causation theories, as well as the vital role of Clinical Nurse Specialists (CNS) in delivering support.

Endometriosis is defined as a non-malignant, chronic condition, in which ectopic endometrial-like tissue, cells and stroma grow outside the uterus. These deposits are mainly found in the pelvis, fallopian tubes, ovaries, bowel, bladder and peritoneum, however they can be found in other more distal sites in the body, such as the diaphragm and lungs. Visually, endometriosis can vary in appearance from the clear, white, red, pink, tan, brown or black colourations of very small blister-like formations to polyploid masses. (Klondike-Pafitis, 2012)

Endometriomias are growths on the ovaries characteristically known as chocolate cysts. Adenomyosis is when the endometriosis is within the endometrium, which is the muscular layer of the uterus. Research has shown that many women experience a significant delay in an accurate diagnosis, due to the lack of knowledge and real understanding among some clinicians about the disease process and its presentation. Often patients are misdiagnosed with other conditions, such as irritable bowel syndrome, bladder pain syndrome or labelled as having psychosomatic illness and overlay.

Endometriosis is a long-term condition for which there is sadly no definitive cure. It can have a significant impact on a patient's quality of life and every day functioning, with negative impacts on their interpersonal relationships, and far-reaching consequences on women's mental and physical health, including employment and financial implications due to absences from paid employment. Symptoms are one aspect and may or may not be intertwined with issues relating to fertility.

The aetiology and pathophysiology of endometriosis is both complex and multi-factorial and not completely understood. Endometriosis remains a 'disease of theories', the definitive cause or causes remain elusive, though associations with hereditary, environmental, epigenetic and menstrual functions have been proposed.

The possible causation theories include:

MULLERIOSIS – EMBRYONIC CELL TRANSFORMATION

Hormones such as oestrogen may transform embryonic cells, cells in the earliest stages of development, into endometrial-like cell implants during puberty. (Redwine, 1982)

SAMPSON'S THEORY OF 'RETROGRADE MENSTRUATION'

In retrograde menstruation, menstrual blood, containing endometrial cells, flows back through the fallopian tubes and into the pelvic cavity instead of out of the body. (https://www.nice.org.uk/guidance/NG73) These endometrial cells stick to the pelvic walls and surfaces of pelvic organs, where they grow and continue to thicken and bleed over the course of each menstrual cycle.

TRANSFORMATION OF PERITONEAL CELLS

In what is known as the 'induction theory', experts propose that hormones or immune factors promote transformation of peritoneal cells, cells that line the inner side of the abdomen, into endometrial-like cells.

SURGICAL SCAR IMPLANTATION

After a surgery, such as a hysterectomy or caesarean birth, endometrial cells may attach to a surgical incision.

ENDOMETRIAL CELL TRANSPORT

Cells from outside the uterus, moving through the lymphatic system, may change in a process called 'metaplasia', from the specific site cells into endometrial cells.

AUTOIMMUNE SYSTEM DISORDER

A problem with the immune system may make the body unable to recognise and destroy endometrial-like tissue that is growing outside the uterus.

A CENTRE FOR SUPPORT

Patients with complex deep infiltrating disease should be offered surgery and support at a British Society for Gynaecological

ENDOMETRIOSIS

Endoscopy (BSGE) centre. BSGE specialist centres were deemed necessary to allow women to access specialist care for such a complex condition. The West of Scotland (WOS) service, based at Queen Elizabeth University Hospital, Glasgow, was granted an accredited centre status in 2019 and is only one of three BSGE centres in Scotland, with the other sites found in Edinburgh and Aberdeen.

Although laparoscopy is the gold standard for diagnosis, magnetic resonance imaging is usually requested at the endometriosis WOS centre, with the aim of identifying deep infiltrating endometriosis. This allows for better planning of surgery and involvement with all the specialities, including colorectal and urology teams. Only patients with confirmed deep infiltrating endometriosis who wish surgery to be performed in a tertiary referral basis are seen at the Endometriosis WOS centre. Referrals with suspected endometriosis will continue to be seen at established less specialist gynaecology clinics.

The surgical management at BSGE centres is excision surgery of deep endometriosis involving the bowel, bladder or ureter and / or endometriosis outside the pelvic cavity. The severity of symptoms does not necessarily correlate with the extent of lesions (McCance & Huether, 2014) or the objective staging of the disease.

The most common symptoms of severe deep infiltrating endometriosis are pelvic pain, cyclical and non-cyclical pain and bleeding, dyschezia, deep dyspareunia, infertility and pelvic floor dysfunction. Pelvic floor physiotherapy can often effectively treat the chronic pelvic pain, dyspareunia, subsequent central sensitisation and pelvic floor muscular dysfunction.

There are also some medical treatments that can help ease the symptoms, such as hormonal and pain-relieving agents. Treatments include pain-relief medication, hormonal progesterone drug for endometriosis, hormonal contraceptives drugs and gonadotrophin-releasing hormone analogues. These drugs can be effective as endometriosis is known to be driven by oestrogen. However, women who are trying to become pregnant will have a more limited range of medical treatments. NICE in 2017 published a very welcome decision aid to support women in making an informed choice for endometriosis. Visit www.nice.org.uk/guidance/ng73/resources/patient-decision-aid-hormone-treatment-for-endometriosis-symptoms-what-are-my-options-pdf-4595573197.

There has been considerations that lifestyle interventions, such as anti-inflammatory diet, exercise, sleep and fatigue management, may have an effect on the symptoms of endometriosis. These lifestyle interventions include anti-inflammatory diet, pelvic stretches, use of TENS machines and mindfulness / CBT strategies, delivered by appropriately-trained clinicians. Pelvic floor physiotherapy has an ever-increasing evidence base regarding interventions with this population and the endometriosis CNS is well-placed to identify and refer patients to this speciality.

THE ROLE OF THE ENDOMETRIOSIS CNS

In the commissioning of the accredited BSGE centre it was deemed imperative for patients to have direct access to an endometriosis CNS. (NICE 2017) The role is working within a multidisciplinary team as an autonomous practitioner. The Endometriosis CNS' role is ultimately to be a crucial point of contact during the patient's journey, to support the patient from the point of approval at vetting at the BSGE centre, and to offer support in managing symptoms until surgical excision surgery and post-operative care. As part of the BSGE, the nurse's role encompasses data collection and management of the quality-of-life questionnaires the patient completes pre-operatively then six / 12 / 24 months post-excision surgery. This questionnaire is documented into a national endometriosis database, allowing for wider and further audit and research into endometriosis and treatments.

The patient has regular pre-operative contact to support symptom management of the disease, both at their specialist endometriosis consultant appointments and at the nurse-led clinics. Endometriosis has a significant impact on patients' sexuality and sexual function, on their self-esteem and self-worth. Endometriosis often affects women's perception of their own bodies and highlights the cognitive dissonance that can exist between women's ideas of what their bodies 'should be' and the reality of living with stage four DIE.

The nurse-led clinics are offered as face-to-face, telephone consultations or video calls to support women with symptom management. As non-medical prescribers, the CNS is also able to provide hormonal therapies, such as the contraceptive hormonal implant and gonadotropin-releasing hormone. If the woman has undergone bilateral oophorectomy then hormone replacement therapy is offered following immediate surgery to support ongoing cardiac, brain and bone health.

The CNS role requires clinical experience in gynaecology, expertise in endometriosis and motivational interviewing for patient support in empowerment and self-management of symptoms. It is imperative to demonstrate real empathy and understanding for the patients' embodied experience of endometriosis. This compassionate empathy is fundamental to the therapeutic relationship and nurse-patient alliance. This is vital for women who have often suffered years of 'battling' for accurate diagnosis, with their symptoms belittled, trivialised, minimised or dismissed as psychosomatic to rebuild faith in healthcare professionals. In some cases, women have suffered significant medical trauma, leading to feelings of hopelessness, disempowerment, brokenness, guilt, shame, self-blame and inadequacy. The CNS-patient therapeutic relationship can help women to come to terms with these feelings and to ultimately move on and feel empowered.

Furthermore, the CNS has a wider teaching and advisory role and is often called on to answer complex questions and give specialist advice to nursing colleagues, the wider multidisciplinary team, such as pelvic floor physiotherapists, patients' GPs and community pharmacists in primary care, with education of this specialist complex condition. The endometriosis nurse specialist will also take every opportunity to challenge pervasive myths surrounding the condition and decrease the stigma surrounding endometriosis. Given the high prevalence of 10 per cent of all women having endometriosis and the subsequent co-morbidities, there is a significant urgent need for high-quality (qualitative and quantitative) research into short and longer-term outcomes, enhancing the body of evidence-based care and best practice guidelines.

In view of the current pandemic and the subsequent pressures this has for the patients on increasing already lengthy waits for excision treatment surgery, this has understandably increased the need for emotional and psychological support, a role fulfilled by the CNS. Crucially, the endometriosis nurse is there as a sounding board, for advice and emotional support, to listen to the patient and work through the patient's expectations and how symptoms can be managed with alternative approaches and self-management of the condition. Being the patient's advocate and being a crucial part of the patient's unique support network comes with both onerous responsibility and accountability, but it also entails a great privilege, as the CNS can make positive and lasting improvements in quality of life.

Zalkya® 2 mg

film-coated tablets

dienogest

A significant progress in the **treatment of endometriosis**[1]

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Suitable for vegetarians and vegans

Dienogest is a 4th generation selective progestin having anovulatory and anti-proliferative effect in endometrial cells, as well as anti-inflammatory and anti-angiogenic actions.[2]

- Reduces endometrioma volume[3]
- Preserves the ovarian reserve[4]
- As effective as GnRH agonists in relieving pain associated with endometriosis[5]
- Presents a favourable adverse events profile vs GnRH agonists[5]

In addition to a significant pain reduction, **women treated with Zalkya® 2mg experienced hypoestrogenic symptoms less frequently** than women treated with Leuprolide acetate.[5]

References

1. Vercellini et al., Fertility and Sterility Vol. 105, No. 3, March 2016. **2.** Sasagawa S et al, Steroids 2008; 73: 222-231. **3.** Angioni et al. Gynecological Endocrinology 2019. **4.** Muzii et al., Gynecological Endocrinology 2019. **5.** Strowitzki T. et al, Human Reproduction, Vol.25, No.3 pp. 633–641, 2010.

Prescribing information

Please refer to the Summary of Product Characteristics (SmPC) before prescribing.
Name and active ingredient: Zalkya® 2mg film-coated tablets. Each tablet contains 2mg of dienogest. **Indications:** Treatment of endometriosis. **Posology and method of administration:** One tablet daily without any break, taken preferably at the same time each day with some liquid as needed. The tablet can be taken with or without food. For oral use. **Contraindications:** Zalkya® should not be used in the presence of any of the conditions listed and should any of the conditions appear with first use of Zalkya® treatment must be discontinued: active venous thromboembolic disorder, arterial and cardiovascular disease, past or present (e.g. myocardial infarction, cerebrovascular accident, ischemic heart disease), diabetes mellitus with vascular involvement, presence or history of severe hepatic disease as long as liver function values have not returned to normal, presence or history of liver tumours (benign or malignant), known or suspected sex hormone-dependent malignancies, undiagnosed vaginal bleeding or hypersensitivity to the active substance or to any of the excipients listed (see section 6.1 of the SmPC). **Special warnings and precaution for use:** Precautions should be taken regarding serious uterine bleeding, changes in bleeding pattern, circulatory disorders, tumours and osteoporosis (see SmPC section 4.4). **Interactions:** Inducers or inhibitors of CYP3A4 may affect the progestogen drug metabolism. An increased clearance of sex hormones due to enzyme induction may reduce the therapeutic effect of Zalkya® and may result in undesirable effects e.g. changes in the uterine bleeding profile. Substances increasing the clearance of sex hormones (diminished efficacy by enzyme-induction), e.g.: phenytoin, barbiturates, primidone, carbamazepine, rifampicin, and possibly also oxcarbazepine, topiramate, felbamate, griseofulvin, and products containing St. John's wort (Hypericum perforatum). See section 4.5 of the SmPC for full information. **Adverse reactions:** The most commonly reported adverse reactions of Zalkya® are: weight increase, depressed mood, sleep disorder, nervousness, loss of libido, altered mood, headache, migraine, nausea, abdominal pain, flatulence, abdominal distension, vomiting, acne, alopecia, back pain, breast discomfort, ovarian cyst, hot flushes, uterine / vaginal bleeding including spotting, asthenic conditions, irritability. See section 4.8 of SmPC for full information. **Presentation:** 2 x 14 white film-coated tablets packed in PVC (250 µm)-Aluminium (20 µm) push-through-blister. Pack Size: 28 film-coated tablets. NHS Cost: £20.68. **Legal Classification:** POM. **MA Number:** PL 21844/0037. Distributed by Kent Pharma UK Ltd. Date of preparation: June 2021. UK21/007/SmPC Sept 2019.

Adverse events should be reported: Reporting forms and information can be found at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Kent Pharma UK Ltd on 01233 506574 or medical@kent-athlone.com. For a copy of the SmPC or further medical information, please contact: medical@kent-athlone.com. Additional information available on request.

For further information on this product, please contact your Kent Pharma Hospital Key Account Manager or our customer service team.

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Date of Preparation: April 2022 Ref: UK22/17/00

CHOLESTEROL

ON HIGHER GROUND

In this article, Emma Elvin, Senior Clinical Advisor at Diabetes UK, homes in on the potentially risky relationship between diabetes and cholesterol and offers key advice for how pharmacists can support patients to manage their blood fats.

Emma Elvin

High blood glucose levels (hyperglycaemia) in diabetes can make it harder for blood to flow around the body.

The blood vessel walls, and blood cells, can become sticky and the blood more viscous, making it more likely for plaques to form – and having high cholesterol can make things even worse.

There are different types of cholesterol (or lipids), including; LDL (low density lipoprotein), HDL (high density lipoprotein) and triglycerides. HDL cholesterol is protective and often referred to as good cholesterol, whereas LDL and triglycerides are bad forms of cholesterol. If the levels of LDL and triglycerides become too high and HDL becomes too low, this increases the risk of developing cardiovascular disease, including heart attack and stroke.

This is because too much LDL and triglycerides cause fatty material to build up in the blood vessels, making them narrower. Added to the blood vessel complications caused by high glucose levels, this can lead to a blockage in blood vessels, which can lead to a heart attack or stroke.

As we have blood vessels all over our bodies, the damage from high glucose levels and high cholesterol can lead to other serious complications, such as poor circulation in the feet (peripheral arterial disease), which can lead to poor wound healing, infections, and ulcers. So, it is vitally important that people with diabetes have their cholesterol levels checked every year.

The NICE Clinical Guidelines outline the healthcare checks for people with diabetes. According to these guidelines, every person over 12 years old with diabetes should receive nine healthcare checks at least once a year, and cholesterol is one of the checks.

UNDERSTANDING THE RISK OF HIGH CHOLESTEROL

NICE guidelines say that for people with type 2 diabetes, their overall cardiovascular disease (CVD) risk should be calculated using a QRISK calculator. For primary prevention of CVD, people with type 2 diabetes who have a 10 per cent or greater 10-year risk of developing CVD should be offered statins.

People with high cholesterol levels should have a blood test to measure total cholesterol, HDL cholesterol, and non-HDL cholesterol three months after starting statin treatment, with an aim of 40 per cent reduction in non-HDL cholesterol. Pharmacists can help people with diabetes to understand their individual cholesterol targets set in conjunction with their GP and nurse.

Many people who have type 1 diabetes should be prescribed statin treatment for the primary prevention of heart disease. The person may not have high cholesterol levels, but statins help to keep them in a healthy range and reduce the risk of heart disease.

People with type 1 diabetes who should be offered statins, regardless of their cholesterol levels, include:

- People older than 40 years
- Those who have had diabetes for more than 10 years
- Those with established kidney damage or other CVD risk factors

At Diabetes UK, we recommend steps that people can take to help manage their blood fats. Pharmacists can support people with these steps:

- Ask when they last had their blood fat levels checked, this should normally happen once per year
- If appropriate and with the person's consent, signpost to support with weight loss
- Encourage a healthy diet based on more fruit and vegetables, nuts, oily fish and wholegrains
- Discuss the health risks linked to alcohol consumption (even though evidence suggests that drinking alcohol in moderation can protect against heart disease, drinking an excessive amount can increase the risk)
- Support people to stop smoking
- Discuss the benefits of keeping active and signpost to local activity programmes

It may also be helpful for the person to see a dietitian who can give specialist advice on how diet can help to manage cholesterol levels. GP surgeries can arrange a referral.

You can find free resources and information for healthcare professionals on the Diabetes UK website at www.diabetes.org.uk.

Scottish
Healthcare
Awards 2022

THURSDAY 24TH NOVEMBER

THE CROWNE PLAZA HOTEL, GLASGOW

Let the Countdown Begin

As the Scottish Healthcare Awards kick off for 2022, drive your hard work to the centre of the stage and enter for a chance to secure one of this year's titles.

It's impossible to capture the towering heights that Scotland's healthcare professionals have reached over the last 12 months – from the innovative efforts to overcome COVID-enforced barriers to care, to the dedication and sacrifices upheld by members of teams every day.

However, as the launch of the Scottish Healthcare Awards gets underway, we encourage you to save the date and allow us the chance to celebrate the remarkable work undertaken by you and your peers.

The annual event will be taking place on 24th November, with the Crowne Plaza Hotel, Glasgow, providing the backdrop for the unveiling of the victors.

With accolades up for grabs in a multitude of categories – spanning the varied corners of the sector – and a plethora of key industry representatives making appearances, you won't want to miss out. Please don't hesitate in putting your team's expertise and experience forward. We can't wait to see you there!

Turn the page for this year's categories and details on how you can enter. Good luck!

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Scottish Healthcare Awards 2022

The Crowne Plaza Hotel, Glasgow

Thursday 24th November

INNOVATIVE TECHNOLOGY PROJECT OF THE YEAR

SPONSORED BY

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Cegedim is delighted to be sponsoring the 2022 Scottish Healthcare Awards. It is a great opportunity to formally recognise, celebrate, and reward the achievements of outstanding Scottish healthcare professionals who have made a real difference to the profession and to the lives of their patients, which often goes unnoticed. The independently-judged Scottish Healthcare Awards recognise excellence and outstanding dedication to a profession that Cegedim are proud to be involved with.

Last year's winner, The Mackie Pharmacy Team, Dumbarton, with Kenny Lawton, Cegedim Healthcare Solutions, and George Romanes, Romanes Pharmacy

MANAGEMENT OF SUBSTANCE DEPENDENCY IN THE COMMUNITY

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

SPONSORED BY

Ethypharm

Ethypharm is proud to sponsor an award which recognises the vital work healthcare professionals do with this vulnerable group of patients. These have been challenging times but excellence will always generate opportunities where excellence will always stand out. This award recognises those who have made a difference to these patients and those who strive for excellence to ensure these patients receive the best possible care and therefore the best likelihood of desired outcomes. At Ethypharm we are fortunate to be able to work with and support professionals who make a valuable contribution to the substance dependency community and we hope that by working together we can achieve better results for these patients. Congratulations to all the nominees in this category as well as the deserving winner. You have all demonstrated excellence and a commitment to enhance the services offered by your collaboration.

To apply, visit www.scottishhealthcareawards.info.

Scottish Healthcare Awards 2022

The Crowne Plaza Hotel, Glasgow

Thursday 24th November

DEVELOPMENTS IN FEMALE HEALTH

NEW CATEGORY

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Kent Pharma is a leading sales and marketing distributor of branded generic and generic medicines both within the UK and internationally – delivering solutions that make a difference to patient care within the UK over the past three decades.

PHARMACY STUDENT LEADERSHIP

Last year's winner, Jack Murphy, Robert Gordon University, with Professor Anne Boyter, University of Strathclyde, and Maurice Hickey, The Pharmacists' Defence Association

SPONSORED BY

pda

The PDA is the largest pharmacists' membership organisation and only independent trade union exclusively for pharmacists in the UK. The not-for-profit organisation is proud to represent employed and locum pharmacists across all areas of practice and is the long-standing sponsor of the Student Leadership Award category. The PDA recognise that the student leaders of today may one day be the leaders of the profession. This category highlights examples of the positive difference that these individuals are already making for their peers and communities.

To apply, visit www.scottishhealthcareawards.info.

Scottish Healthcare Awards 2022

The Crowne Plaza Hotel, Glasgow

Thursday 24th November

HOSPITAL PHARMACY TEAM OF THE YEAR

SPONSORED BY

Ethypharm

Ethypharm is proud to sponsor an award which recognises the vital work hospital pharmacy teams do. These have been challenging times but excellence will always generate opportunities where excellence will always stand out. This award recognises those who have made a difference to patients and those who strive for excellence. At Ethypharm we are fortunate to be able to work with and support professionals who make a valuable contribution to hospital pharmacy and we hope that by working together we can achieve better results for patients. Congratulations to all the nominees in this category as well as the deserving winner. You have all demonstrated excellence and a commitment to enhance the services offered by your collaboration.

Last year's 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)

COMMUNITY PHARMACY PRACTICE OF THE YEAR

Last year's winner, the Cadham Pharmacy Team, Glenrothes, with Richard Stephenson, Edinpharm, and Stephen McBurney, Associate Director of Pharmacy (NHS Lothian)

The Community Pharmacy Practice of the Year Award is targeted at pharmacies who have demonstrated high standards of healthcare delivery. The pharmacy may display excellence in a particular professional aspect which ensures outstanding service to the consumer.

To apply, visit www.scottishhealthcareawards.info.

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Kyron Media

GP PRACTICE BASED PHARMACY TEAM

NEW CATEGORY

GP PRACTICE OF THE YEAR

NEW CATEGORY

Scottish Healthcare Review

To apply, visit www.scottishhealthcareawards.info.

Scottish Healthcare Awards 2022

The Crowne Plaza Hotel, Glasgow

Thursday 24th November

DIABETES PROJECT OF THE YEAR

NEW CATEGORY

Since 1996, the number of people diagnosed with diabetes in the UK has risen from 1.4 million to 3.5 million. Taking into account the number of people likely to be living with undiagnosed diabetes, the number of people living with diabetes in the UK is over four million. Diabetes prevalence in the UK is estimated to rise to five million by 2025. Applications are invited from primary and secondary care professionals, and their teams, who have implemented or developed a programme, strategy or project which has had a positive impact on their patients' wellbeing and management / self-management of their condition.

SPECIAL RECOGNITION

The 2022 Special Recognition Award will be honouring one inspiring individual. The recipient will not only have forged a better path for the profession through their expertise and hard work, but throughout their years of working have identified the importance of collaborative team-working and communication. Against the particular COVID-related challenges of the last few years, the impact of our healthcare sector has never been as vital — and we are thrilled to be able to bestow this honour on one formidable representative.

To apply, visit www.scottishhealthcareawards.info.

TAKE IT TO HEART

Used to lower the level of cholesterol in the blood and protect the insides of the artery walls, statins are key to preserving the quality of many patients' lives. The British Heart Foundation help SHR to further carve out the impact of the medication and the advice which can help individuals garner optimal benefits from it.

Statins are drugs that lower the body's cholesterol level. They work by reducing the production of cholesterol in the liver and therefore reduce the individual's risk of heart disease. Cholesterol is essential for the body to work, although too much 'bad cholesterol' (called low-density lipoprotein or LDL) can lead to fatty deposits building up in the arteries. These fatty deposits can increase the individual's risk of developing conditions, such as coronary heart disease, heart attack and stroke.

People who have had a heart attack or stroke will be advised to take a statin to help reduce the risk of them having another event. Patients can also be advised to take a statin if they're considered to be at significant risk of developing cardiovascular disease, or of having a heart attack or stroke. Even if their cholesterol level isn't high, they may be prescribed statins to help protect them.

About one-in-250 people in the UK have familial hypercholesterolaemia, an inherited condition that causes high levels of cholesterol and which can also be treated with statins.

STATINS: COMMON QUESTIONS ANSWERED

Statins are prescribed to people with cardiovascular disease and to those at high risk. Some people ask whether statins are safe and are worried about side-effects. Senior Cardiac Nurse at the British Heart Foundation, June Davison, puts some of the patient population's questions to Professor Richard Hobbs, Head of Primary Care (Health Sciences) at the University of Oxford and a part-time GP.

ARE STATINS SAFE?

These are very powerful drugs and in the early days of statins, understandably, some people were concerned about potential undiscovered risks associated with them. They're now one of the most investigated drugs, and we have lots of reliable data – some of which originated from work that's been funded by the British Heart Foundation – that show they are very safe and effective to take.

HOW WILL TAKING A STATIN HELP INDIVIDUALS?

It can significantly delay the onset of atherosclerosis (narrowing of the arteries) and reduce the risk of having a serious event, such as a heart attack or stroke. Statins also slow down the progression of disease so they can help delay symptoms, such as angina (chest discomfort or breathlessness). They won't reverse the symptoms but they can prevent them from getting worse.

WHAT ARE THE DIFFERENCES BETWEEN STATINS?

The main differences are in how much they lower cholesterol. They can be split into two groups – low-intensity statins (for example, pravastatin and simvastatin) and high-intensity statins (such as atorvastatin and rosuvastatin). For most people, a lower-intensity statin will be enough to reduce their cholesterol sufficiently, but if it's not, their doctor may want to increase the dose or switch to a higher-intensity one.

WHAT SIDE-EFFECTS ARE THERE?

Muscular aches and pains are the most common. It's natural to associate symptoms with a new tablet but we all get muscle aches from time-to-time, so it's difficult to know if they are due to medication or just to do with everyday life. Most people experience no side-effects from statins. For some, though, they are an issue. If this is the case, they should ask their doctor about trying a different statin.

An exceptionally rare, but serious, side-effect is severe muscle damage, producing pain and weakness in the muscles. It can be reversed if treatment is stopped and most people who develop it make a rapid recovery.

Statins act on the liver so, for a few people, they can affect its function but, again, this is rare. Any side-effects need to be weighed against the positives in that statins are generally safe to take and dramatically reduce the risk of heart attacks and strokes, which could be fatal.

CAN INDIVIDUALS TAKE A STATIN IF THEY'RE 80?

A criticism of statins is that the earlier trials didn't include many women and elderly people, so there was a suggestion that they didn't work in these groups. However, there have been many studies since, which show them to be hugely beneficial in reducing heart attacks and strokes in older age groups and women.

HOW DO THEY KNOW IF THEIR STATIN IS WORKING?

The patient will need a blood test to check that their blood cholesterol level has come down. After starting a statin, it takes about six weeks for cholesterol levels to stabilise, so most doctors would re-check the patient's cholesterol after about eight weeks. The patient should have a check-up at least once a year or more often if their doctor thinks it is necessary.

STATINS: A PATIENT'S VIEW

Trevor Clarke, 80, started taking statins in 1995 following his coronary bypass surgery.

'I started on simvastatin, 40mg. It was increased to 80mg, because my cholesterol wasn't coming down enough. Three years ago, I changed from simvastatin to atorvastatin.

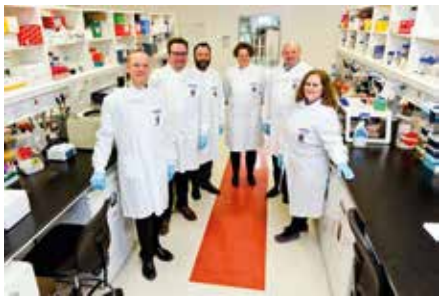
'My cholesterol is much better, but it's still not quite low enough. I'm due to go back for a check-up in a few weeks' time. High cholesterol runs in my family and there is a history of heart disease.

'I've got friends who say that they've had muscle aches but I've had no problems with taking statins. I avoid foods that might have an adverse effect on my cholesterol. I also get out and about a lot.'

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

PULLING NO PUNCHES

Sepsis can kill a previously healthy adult or child in hours. While early diagnosis plays a crucial role in saving the lives of those who contract the condition, Sepsis Research FEAT understands that another key part of the fight against sepsis is supporting research to help find improved treatments. Here, the charity delves further into how these efforts can cultivate a brighter future for patients.



Sepsis Research FEAT is the only UK charity fundraising for research into sepsis, while also working to raise awareness of this life-threatening condition. Sepsis occurs when the body's response to an infection spirals rapidly out of control, injuring its own tissues and organs which can result in multiple organ failure and death. The biological processes that cause the condition are not well understood and that is why the charity is championing the need for more research. Sepsis Research FEAT is working with some of the best researchers in the world to understand the processes that lead to sepsis and identify new drugs, treatments and equipment which will lead to better outcomes for patients.

The primary research the charity supports is GenOMICC – a global collaboration to study genetics in critical illness – led by the University of Edinburgh in partnership with Genomics England. This pioneering study, led by Professor Kenneth Baillie, researches how genes can influence the body's response to critical conditions, such as sepsis. The study is comparing the DNA from those who survive the condition with those who die.

'GenOMICC is seeking to discover specific genes that influence how vulnerable we are to sepsis and other illnesses,' explained Colin Graham, Sepsis Research FEAT's Chief Operating Officer.

'It seeks to understand why some people are more seriously impacted by sepsis than others. If scientists can find patterns in our DNA, then this will help us understand what causes someone to become seriously ill or die from sepsis, leading to improved treatments and more lives being saved.'

WHAT IS GenOMICC?

GenOMICC uses DNA samples from sepsis and COVID-19 patients in intensive care units (ICU) throughout the UK and has gathered over 18,700 DNA samples to date. When the coronavirus pandemic struck, the GenOMICC study had been gathering DNA samples from sepsis patients. Because there are similarities between sepsis and COVID-19, the work being carried out was pivoted to help in the fight against COVID-19. The study was extended to include DNA samples from COVID-19 patients and these offered early data to scientists searching for treatments for COVID-19. Sepsis Research FEAT continued its support of GenOMICC, knowing that the findings can also be used to develop further understanding of sepsis.

'The research by GenOMICC shows the considerable promise of genetics to help understand critical illnesses, including sepsis,' said Colin Graham.

'Discoveries made by studies like GenOMICC can highlight the drugs which should be at the top of the list for clinical testing, potentially saving thousands of lives.'

In 2021, the GenOMICC team identified five genes which, when faulty, lead the body's immune response to go into overdrive, putting patients at risk of damaging lung inflammation, potential systemic organ failure and, ultimately, death. In March 2022, GenOMICC scientists published ground-breaking findings which identified a further 16 new genetic variants associated with severe COVID-19, including some related to blood clotting, immune response and intensity of inflammation.

Commenting on the recent findings, Professor Kenneth Baillie, the GenOMICC study's chief investigator and a Consultant in Critical Care Medicine at the University of Edinburgh, said, 'Our latest findings point to specific molecular targets in critical COVID-19. These results explain why some people develop life-threatening COVID-19, while others get no symptoms at all. But more importantly, this gives us a deep understanding of the process of disease and is a big step forward in finding more effective treatments.

'It is now true to say that we understand the mechanisms of COVID better than the other syndromes we treat in intensive care in normal times – sepsis, flu, and other forms of critical illness. COVID-19 is showing us the way to tackle those problems in the future.'

IMPROVING LIVES

GenOMICC is now recruiting in 212 ICUs across the UK, with an estimated total of 5,900 intensive care beds. During COVID-19 it became the single best-recruiting consented research study in the history of UK critical care medicine.

Professor Baillie is clear on the role that Sepsis Research FEAT's support has played in the research study, 'It's important to note that the whole GenOMICC study owes its success to the support we've received from Sepsis Research FEAT in two ways. Firstly, by providing flexible funds to extend the study, and secondly by keeping our whole team sharply focused on the primary aim: using genetics to find better treatments for critical illness.'

Having supported GenOMICC since 2018, Sepsis Research FEAT more than doubled its investment in 2022.

'Sepsis Research FEAT is very proud to have been one of the original funders of GenOMICC and to continue to invest in this study,' said Colin Graham.

'We believe sepsis is a medical emergency – it kills 50,000 people in the UK every year. Our charity's aim always has been and always will be to invest in research to help save and improve the lives of people affected by sepsis. The research carried out by the GenOMICC team is playing a crucial part in the fight against this devastating condition.'

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Atorvastatin Oral Suspension is also indicated to reduce total-C and LDL-C in adults with homozygous familial hypercholesterolaemia as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) or if such treatments are unavailable. Prevention of cardiovascular disease Prevention of cardiovascular events in adult patients estimated to have a high risk for a first cardiovascular event, as an adjunct to correction of other risk factors. **Posology and method of administration: Posology** The patient should be placed on a standard cholesterol-lowering diet before receiving Atorvastatin Oral Suspension and should continue on this diet during treatment with Atorvastatin Oral Suspension. The dose should be individualised according to baseline LDL-C levels, the goal of therapy and patient response. The usual starting dose is 10 mg (2.5 ml) once a day. Adjustment of dose should be made at intervals of 4 weeks or more. The maximum dose is 80 mg (20 ml) once a day. Primary hypercholesterolaemia and combined (mixed) hyperlipidaemia. The majority of patients are controlled with Atorvastatin Oral Suspension 10 mg (2.5 ml) once a day. A therapeutic response is evident within 2 weeks, and the maximum therapeutic response is usually achieved within 4 weeks. The response is maintained during chronic therapy. Heterozygous familial hypercholesterolaemia. Patients should be started with Atorvastatin Oral Suspension 10 mg (2.5 ml) daily. Doses should be individualised and adjusted every 4 weeks to 40 mg (10 ml) daily. Thereafter, either the dose may be increased to a maximum of 80 mg (20 ml) daily or a bile acid sequestrant may be combined with 40 mg (10 ml) atorvastatin once daily. Homozygous familial hypercholesterolaemia. Only limited data are available. The dose of atorvastatin in patients with homozygous familial hypercholesterolemia is 10 to 80 mg (2.5 to 20 ml) daily. Atorvastatin should be used as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) in these patients or if such treatments are unavailable. Prevention of cardiovascular disease. In the primary prevention trials the dose was 10 mg/day (2.5 ml/day). Higher doses may be necessary in order to attain (LDL-) cholesterol levels according to current guidelines. Renal impairment No adjustment of dose is required. Hepatic impairment Atorvastatin Oral Suspension should be used with caution in patients with hepatic impairment. Atorvastatin Oral Suspension is contraindicated in patients with active liver disease. Co-administration with other medicines. In patients taking the hepatitis C antiviral agents elbasvir/grazoprevir or letermovir for cytomegalovirus infection prophylaxis concomitantly with atorvastatin, the dose of atorvastatin should not exceed 20 mg/day (5 ml). Use of atorvastatin is not recommended in patients taking letermovir co-administered with ciclosporin. Elderly Efficacy and safety in patients older than 70 using recommended doses are similar to those seen in the general population. Paediatric population Hypercholesterolaemia Paediatric use should only be carried out by physicians experienced in the treatment of paediatric hyperlipidaemia and patients should be re-evaluated on a regular basis to assess progress. For patients with Heterozygous Familial Hypercholesterolemia aged 10 years and above, the recommended starting dose of atorvastatin is 10 mg (2.5 ml) per day. The dose may be increased to 80 mg (20 ml) daily, according to the response and tolerability. Doses should be individualised according to the recommended goal of therapy. Adjustments should be made at intervals of 4 weeks or more. The dose titration to 80 mg (20 ml) daily is supported by study data in adults and by limited clinical data from studies in children with Heterozygous Familial Hypercholesterolemia. There are limited safety and efficacy data available in children with Heterozygous Familial Hypercholesterolemia between 6 to 10 years of age derived from open-label studies. Atorvastatin is not indicated in the treatment of patients below the age of 10 years. Currently available data are described in the SmPC but no recommendation on posology can be made. Other pharmaceutical forms/strengths may be more appropriate for this population. **Method of administration:** Atorvastatin Oral Suspension is for oral use only. Each daily dose of atorvastatin is given all at once and may be given at any time of day with or without food. Shake well before use. For instructions for use of the medicinal product before administration, see section 6.6 of the SmPC. **Contraindications:** Atorvastatin Oral Suspension is contraindicated in patients: with hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SmPC; with active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal; during pregnancy, while breast-feeding and in women of child-bearing potential not using appropriate contraceptive measures; treated with the hepatitis C antivirals glecaprevir/pibrentasvir. **Special warnings and precautions for use:** Liver effects Liver function tests should be performed before the initiation of treatment and periodically thereafter. Patients who develop any signs or symptoms suggestive of liver injury should have liver function tests performed. Atorvastatin Oral Suspension should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) In a post-hoc analysis of stroke subtypes in patients without coronary heart disease (CHD) who had a recent stroke or transient ischemic attack (TIA) there was a higher incidence of haemorrhagic stroke in patients initiated on atorvastatin 80 mg compared to placebo. Skeletal muscle effects Atorvastatin, like other HMG-CoA reductase inhibitors, may in rare occasions affect the skeletal muscle and cause myalgia, myositis, and myopathy that may progress to rhabdomyolysis, a potentially life-threatening condition characterised by markedly elevated creatine kinase (CK) levels (> 10 times ULN), myoglobinaemia and myoglobinuria which may lead to renal failure. Before treatment Atorvastatin should be prescribed with caution in patients with pre-disposing factors for rhabdomyolysis. A CK level should be measured before starting statin treatment in the following situations: renal impairment; hypothyroidism; personal or familial history of hereditary muscular disorders; previous history of muscular toxicity with a statin or fibrate; previous history of liver disease and/or where substantial quantities of alcohol are consumed; in elderly (age > 70 years), the necessity of such measurement should be considered, according to the presence of other predisposing factors for rhabdomyolysis, situations where an increase in plasma levels may occur, such as interactions and special populations including genetic subpopulations. In such situations, the risk of treatment should be considered in relation to possible benefit, and clinical monitoring is recommended. If CK levels are significantly elevated (> 5 times ULN) at baseline, treatment should not be started. Concomitant treatment with other medicinal products Risk of rhabdomyolysis is increased when atorvastatin is administered concomitantly with certain medicinal products that may increase the plasma concentration of atorvastatin such as potent inhibitors of CYP3A4 or transport proteins (e.g. ciclosporin, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole, letermovir and HIV protease inhibitors including ritonavir, lopinavir, atazanavir, indinavir, darunavir, tipranavir/ritonavir etc). The risk of myopathy may also be increased with the concomitant use of gemfibrozil and other fibric acid derivates, antivirals for the treatment of hepatitis C (HCV) (boceprevir, telaprevir, elbasvir/grazoprevir), erythromycin, niacin or ezetimibe. If possible, alternative (non-interacting) therapies should be considered instead of these medicinal products. In cases where co-administration of these medicinal products with atorvastatin is necessary, the benefit and the risk of concurrent treatment should be carefully considered. When patients are receiving medicinal products that increase the plasma concentration of atorvastatin, a lower maximum dose of atorvastatin is recommended. In addition, in the case of potent CYP3A4 inhibitors, a lower starting dose of atorvastatin should be considered and appropriate clinical monitoring of these patients is recommended. Atorvastatin must not be co-administered with systemic formulations of fusidic acid or within 7 days of stopping fusidic acid treatment. In patients where the use of systemic fusidic acid is considered essential, statin treatment should be discontinued throughout the duration of fusidic acid treatment. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving fusidic acid and statins in combination. The patient should be advised to seek medical advice immediately if they experience any symptoms of muscle weakness, pain or tenderness. Statin therapy may be re-introduced seven days after the last dose of fusidic acid. In exceptional circumstances, where prolonged systemic fusidic acid is needed, e.g., for the treatment of severe infections, the need for co-administration of atorvastatin and fusidic acid should only be considered on a case-by-case basis and under close medical supervision. Paediatric population No clinically significant effect on growth and sexual maturation was observed in a 3- year study based on the assessment of overall maturation and development, assessment of Tanner Stage, and measurement of height and weight. Interstitial lung disease. Exceptional cases of interstitial lung disease have been reported with some statins, especially with long term therapy. Presenting features can include dyspnoea, non-productive cough and deterioration in general health (fatigue, weight loss and fever). If it is suspected a patient has developed interstitial lung disease, statin therapy should be discontinued. Diabetes Mellitus. Some evidence suggests that statins as a class raise blood glucose and in some patients, at high risk of future diabetes, may produce a level of hyperglycaemia where formal diabetes care is appropriate. This risk, however, is outweighed by the reduction in vascular risk with statins and therefore should not be a reason for stopping statin treatment. Patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI >30kg/m^2, raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines. **Undesirable effects (summary only, see SmPC for full details):** The following undesirable effects are common (≥1/100, < 1/10): nasopharyngitis, allergic reactions, hyperglycaemia, headache, pharyngo-laryngeal pain, epistaxis, constipation, flatulence, dyspepsia, nausea, diarrhoea, myalgia, arthralgia, pain in extremity, muscle spasms, joint swelling, back pain, liver function test abnormal, blood creatine kinase increased. The following undesirable effects are considered serious: thrombocytopenia, peripheral neuropathy, hearing loss, pancreatitis, hepatitis, hepatic failure, cholestasis, angioneurotic oedema, Stevens Johnson syndrome, toxic epidermal necrolysis, myopathy, myositis, rhabdomyolysis, muscle rupture, tendinopathy (including rupture), lupus-like syndrome, immune-mediated necrotizing myopathy. **Legal classification:** POM (Prescription Only Medicine). **Marketing authorisation holder:** Rosemont Pharmaceuticals Ltd, Yorkdale Industrial Park, Braithwaite Street, Leeds, LS11 9XE, UK. **Marketing authorisation number:** PL 00427/0256. **Date of text:** January 2022. **Cost:** £198.76.

Reference: 1. Statista. Leading chemical substances dispensed in England in 2020. Available at: https://www.statista.com/statistics/378445/prescription-cost-analysis-top-twenty-chemicals-by-items-in-england/ Accessed 28 February 2022.

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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400

DTM364 March 2022

PROMOTION

STEPPING UP A GEAR FOR OUR SCOTTISH MEMBERS!

Edinpharm have been supporting Scottish pharmacies for over 20 years now, and would love to support your pharmacy moving forward. We have a small, but extremely effective, team ready to support your pharmacy. We like to think of ourselves as your extended team!

WHICH WHOLESALERS DO WE PARTNER WITH FOR 2022 ONWARDS?

We are delighted to announce our newly-formed partnership with AAH from 1st July, giving members even better prices and service. Adding to our already robust supplier line-up of Phoenix, Alliance, Ethigen and Bestway, there has never been a stronger support package for members in Scotland.

ORDERING THAT ALLOWS AN EXTRA TEA BREAK! (OKAY, MAYBE NOT ALWAYS...)

Our ordering cascade system allows you to build your order through the morning or afternoon and, when ready to do so, press send, and await the email reply to tell you where your items are coming from, and what may need attention – things like over tariff blocking, out-of-stocks, quota issues etc. The aim of our system is very much to make life easier, but still ensure the most efficient and cost-effective route for placing your order.

OUR MEMBERSHIP... NUMARK MEMBERSHIP... ALL THINGS REBATE

Our membership costs are simple and transparent. You pay a once-a-year fee, and that's it! It's nice and simple and with no hidden charges. We also offer group discount for those with five or more pharmacies.

As part of your Edinpharm membership, we also take care of your Numark membership and rebates. We process your rebates in-house and credit your bank account accordingly. We also ensure that our cascade directs any brand support deals and reduced wholesaler deals to the correct supplier to maximise your income.

If that wasn't enough, for us taking care of this in-house we offer a compliance bonus paid by Edinpharm towards your Numark membership making your membership even better value.

A NOT-FOR-PROFIT MEMBERSHIP GROUP

As a not-for-profit membership group Edinpharm are here to focus on YOU as the member. Every decision we make, and every penny we spend, has the member in mind, and at the end of every financial year we take any surplus funds and pass these back to members equally! On average over the past three years members have seen around £1,500 returned to them just for being a compliant member of Edinpharm. Could you be the next member to gain from our membership?

Want to chat to us more? Get in touch now! Email joinus@edinpharm.co.uk, visit www.edinpharm.com or call 0131 441 3773.

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"Less hassle on ordering and more time speaking to your patients"

Edinpharm is a not for profit membership group founded in 1996 looking after over 200 members across the UK. We are an organisation who protect and promote the growth of independent pharmacies via our buying power and maximising the return on investment to the members of the group.

Key benefits of our membership include:

Become part of the Edinpharm family for access to excellent pricing from our top suppliers

AAH PHOENIX Alliance Healthcare ethigen BESTWAY MEDHUB

Edinpharm has a lot to offer, why not contact us now to find out how we can help your business enhance it's profitability.

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Place one single order through your PMR and it routes to the best price supplier, freeing your time to do more.

Fixed pricing for the month

Stability of pricing for the month which secures a better overall basket price.

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Check where stock is coming from, what is unobtainable and what's over tariff.

No low spend surcharges.

Numark Membership

Gain all the benefits of a Numark membership with an Edinpharm based compliance bonus for routing your membership through us.

Annual low-cost membership fee of £550. (discounts for groups)

Support Network

Collective knowledge, shared experience, and advice from other independent pharmacists via our messaging system.

PAIN

BACK TO BASICS

Bearing the brunt of back pain can take its toll on patients. The BackCare Team helps SHR uncover the causes of its presence and advice for alleviation.

We think of back pain in three ways. Firstly, conditions with serious or systemic pathology, such as cancer or axial spondyloarthritis. Secondly, those conditions with a specific pathology, examples of which include spinal stenosis, spondylolisthesis, prolapsed disc, spondylosis etc. Finally, we have chronic low back pain (CLBP), pain lasting more than three months and which, depending on the studies you read, could affect 30-to-40 per cent of the UK population.

It is this last category that absorbs much of our time – sufferers who have been through many rounds of attempted diagnosis and treatments with various practitioners, often to no avail. When identifiable causes have been ruled out, what are we left with?

A further confounding factor with non-specific low back pain is that evidence of disc degeneration obtained by imaging is not necessarily a predictor of back pain. A systematic study by Brinjikji and colleagues in 2015 showed that degenerative changes in the spine, commonly found in people with back pain, are also found in pain-free subjects.

One possible explanation, for some sufferers at least, could in simplistic terms be summarised as 'mindset'. There are those that believe chronic pain can be a learned response – there may be an original cause of pain but a negative mindset can create a space for chronic pain to develop. Perhaps the pain is an indicator of the subject's mental, physical and even financial health. Stress from various causes can lead to sleep deprivation, low mood and feelings of general lethargy. These allied to poor physical condition, diet and lack of activity, can create a perfect storm.

A 2019 study by Dr Peter O'Sullivan and his team (https://bjsm.bmj.com/content/54/12/698) challenged some widely-held beliefs about back pain. They suggested that negative beliefs could be associated with increased levels of pain and inactivity. Such people are also more likely to be absent from work, often adopting a strategy of prolonged rest and avoiding movement. We can summarise the findings as follows:

- Persistent back pain can be scary but it is rarely dangerous
- Getting older is not a cause of back pain
- Persistent back pain is rarely associated with tissue damage
- Scans rarely show the cause of back pain
- Pain with exercise and movement does not mean you are doing harm
- Back pain is not caused by poor posture
- Back pain is not caused by a weak core
- Backs do not wear out with everyday loading and bending
- Pain flare-ups do not mean you are damaging yourself

Trying to reset people's state of mind is not going to be a quick fix. Individuals need to focus on positive strategies and not the pain. The often-long road to restoring normality will require the attaining and maintaining of a healthy lifestyle. Plenty of sleep, good diet and exercise to achieve a good strength / weight ratio for the body will all be essential. Eliminating external causes of stress will often be difficult but by adopting a healthy lifestyle, along with a positive outlook, it should be easier to manage this stress.

BackCare also exists to promote research into back pain and we have recently become involved in a study that is trialling a new treatment for certain types of CLBP. To give some context, back pain experts Dr Hanne Albert and Professor Manniche discovered that a significant percentage of patients with CLBP did not respond to exercise-based therapy. It was noticed that these patients had pathological changes in the vertebrae of their spine – Modic changes – visible on their MRI scans. Further extensive research led to a breakthrough hypothesis: that low-grade bacterial infection in the discs of the vertebrae was the cause of disabilities for this patient group. In 2013, a paper published in the European Spine Journal described a double-blind, placebo-controlled and randomised clinical trial with 162 patients which demonstrated that oral antibiotic treatment (a 100-day course) offered a substantial benefit for these CLBP patients by removing the cause of their pain, i.e. a bacterial infection.

Despite a good outcome, there are obvious associated problems with a long course of oral antibiotics. A collaborative partnership including Dr Albert and Professor Manniche have developed an injectable formulation that is delivered directly to the target site in the patients' spines. We wait with interest to see whether this develops past clinical trial stage – a clinical trial that BackCare is helping to recruit for.

There are many aspects of spinal health in which BackCare has involvement. We receive requests for assistance from people who have lived with chronic back pain, as well as from those whose brush with back injury is short-term. To this end we are currently investigating ways in which we can expand our support for these queries through regional, triaged helplines that are underpinned by healthcare professionals and those with local knowledge for signposting to other organisations where appropriate.

For further information, visit www.backcare.org.uk.

Backcare

Potential cost savings of up to **25%** by switching to **Opiodur®** (fentanyl)

from Durogesic® /generic fentanyl transdermal patches[1,2]

Opiodur® is indicated for the treatment of severe chronic pain that requires continuous long term opioid administration.

Opiodur® is available in strengths of 25 µg/h, 50 µg/h, 75µg/h and 100 µg/h transdermal patches in packs of five.

Opiodur® is bioequivalent to Durogesic.[3]

Switching to **Opiodur® patches** every time a fentanyl transdermal patches script is required will provide **potential savings of up to 25%** when compared to fentanyl transdermal patches.[1,2]

	100µg/h (5)	75µg/h (5)	50µg/h (5)	25µg/h (5)
PIP Code	123-6553	123-6595	123-6587	123-6579
Opiodur® NHS list price[1]	£25.94	£21.05	£15.09	£8.07
Drug Tariff[2]	£34.59	£28.06	£20.12	£10.76
Potential savings per pack %[1,2]	25%	25%	25%	25%

ZENTIVA

For more information contact **zentiva.specialty@zentiva.com** or visit **Zentiva.co.uk**

Opiodur® 12µg/h, 25µg/h, 50µg/h, 75µg/h and 100µg/h Transdermal Patch (fentanyl) Prescribing Information. Prescribers should consult the SmPC before prescribing.
Presentation: Each transdermal patch contains 1.375mg, 2.75mg, 5.5mg, 8.25mg or 11.0mg of fentanyl, releasing 12.5µg, 25µg, 50µg, 75µg or 100µg of fentanyl per hour, respectively.
Indications: Opiodur® is indicated in adults for the management of severe chronic pain that requires continuous long term opioid administration, and in children receiving opioid therapy from 2 years of age for the long term management of severe chronic pain.
Dosage and administration: Doses should be individualised based upon the status of the patient and should be assessed at regular intervals after application. The lowest effective dose should be used. *Initial dose selection:* should be based on the patient's current opioid use. It is recommended that fentanyl be used in patients who have demonstrated opioid tolerance. *Opioid-tolerant adult patients:* To convert opioid-tolerant patients from oral or parenteral opioids to fentanyl refer to the SmPC. *Opioid-naive adult patients:* Not recommended. *Dose titration and maintenance therapy for all patients:* The Opiodur® patch should be replaced every 72 hours. The dose should be titrated individually on the basis of average daily use of supplement analgesics until a balance between analgesic efficacy and tolerability is attained. *Discontinuation:* Replacement with other opioids should be gradual, starting at a low dose and increasing slowly. *Children aged 16 years and above:* Follow adult dosage. *Opioid-tolerant paediatric patients (ages 2 to 16 years):* should be administered only to patients who are already receiving at least 30mg oral morphine equivalents per day. To convert paediatric patients from oral or parenteral opioids to Opiodur® refer to the SmPC.
Method of Administration: Opiodur® is for transdermal use and should be applied to non-irritated skin on a flat surface of the torso or upper arms. In young children, the upper back is the preferred location to minimize the potential of the child removing the patch. Should be applied immediately upon removal from the sealed package. May be worn continuously for 72 hours. A new patch should be applied to a different skin site after removal of the previous patch. Patients should be prompted to follow the instructions for proper application of the patch that are included in the patient information leaflet.
Special Populations: Children: should not be used in children <2yrs. Should not be administered to opioid-naive paediatric patients. Elderly: Data from intravenous studies with fentanyl suggests that elderly patients may have reduced clearance and a prolonged half-life and may be more sensitive to the active substance than younger patients. Observe elderly patients carefully for signs of fentanyl toxicity.
Fertility, pregnancy and lactation: Pregnancy: should not be used during pregnancy unless clearly necessary. Breastfeeding: should be discontinued during treatment and for at least 72 hours after the removal of the patch. Not recommended for use during childbirth. Fertility: No data available.
Contraindications: Hypersensitivity to the active substances or to any of the excipients. Contraindicated in patients with severe respiratory depression and acute or postoperative pain.
Special warnings and precautions: Patients and their carers must be instructed that Opiodur® contains an active substance in an amount that can be fatal, especially to a child. Therefore, they must keep all patches out of the sight and reach of children. Use in *opioid-naive and not opioid-tolerant* patients has been associated with very rare cases of significant respiratory depression and/or fatality when used as initial opioid therapy, especially in patients with non-cancer pain. Some patients may experience *respiratory depression* and must be observed for these effects. May have more severe adverse effects in patients with *chronic obstructive or other pulmonary disease*. Should be used with caution in patients who have brain tumours and *central nervous system conditions* including increased intracranial pressure. Drug dependence and potential for abuse may develop upon repeated administration of opioids. Fentanyl may produce cardiac disease such as bradycardia and should therefore be administered with caution to patients with bradyarrhythmias. Opioids may cause *hypotension*, especially in patients with hypovolemia. Underlying, symptomatic hypotension and/or hypovolaemia should be corrected before treatment is initiated. Patients with *hepatic impairment* should be observed carefully for signs of fentanyl toxicity. Caution is advised in patients with renal impairment because fentanyl pharmacokinetics has not been evaluated in this patient population. Fentanyl concentrations may increase if the skin temperature increases. Therefore, patients with *fever* should be monitored as there is a potential for temperature-dependent increases in fentanyl released from the system resulting in possible overdose and death. All patients should be advised to avoid exposing the application site to direct *external heat sources*. Caution is advised for co-administration with medicinal products that affect the serotonergic neurotransmitter systems. If *serotonin syndrome* is suspected, treatment should be discontinued.
Drug Interactions: Concomitant use with *CYP3A4 inhibitors* may result in an increase in fentanyl plasma concentrations, which could increase or prolong both the therapeutic and adverse effects, and may cause serious respiratory depression. Concomitant use with *CYP3A4 inducers* may result in decrease in fentanyl plasma concentrations and a decreased therapeutic effect. Concomitant use with *sedative medicines such as benzodiazepines or related drugs* may result in sedation, respiratory depression, coma and death. *Accidental transfer* of a fentanyl patch to the skin of a non-patch wearer (particularly a child), while sharing a bed or being in close physical contact with a patch wearer, may result in an opioid overdose for the non-patch wearer. Opioids increase the tone and decrease the propulsive contractions of the smooth muscle of the *gastrointestinal tract*. Non-epileptic (myo)clonic reactions can occur in *patients with myasthenia gravis*. Concomitant use of *mixed opioid agonists/antagonists* such as buprenorphine, nalbuphine or pentazocine is not recommended. Concomitant use of *centrally-acting medicinal products and alcohol* may produce additive depressant effects, hypoventilation, hypotension and profound sedation, coma or death. Not recommended for use in patients who require the concomitant administration of *Monoamine Oxidase Inhibitors (MAOI)*. Coadministration of fentanyl with *serotonergic medicinal products* may increase the risk of serotonin syndrome. Concomitant use with *sedative medicines such as benzodiazepines or related drugs* increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. Interaction studies have only been performed in adults.
Effects on ability to drive/use machines: May impair mental and/or physical ability required for the performance of potentially hazardous tasks such as driving or operating machinery. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988.
Undesirable effects: Somnolence, dizziness, headache, nausea, vomiting, constipation, hypersensitivity, anorexia, insomnia, depression, anxiety, confusional state, hallucination, tremor, paraesthesia, vertigo, palpitations, tachycardia, hypertension, dyspnoea, diarrhoea, dry mouth, abdominal pain, abdominal pain upper, dyspepsia, hyperhidrosis, pruritus, rash, erythema, muscle spasms, urinary retention, fatigue, oedema peripheral, asthenia, malaise, feeling cold, convulsion (including clonic convulsions and grand mal convulsion), loss of consciousness, bradycardia, cyanosis, respiratory depression, respiratory distress, ileus, erectile dysfunction, drug withdrawal syndrome, apnoea, hypoventilation, anaphylactic shock, anaphylactic reaction, anaphylactoid reaction, delirium, drug dependence, serotonin syndrome.
Pack size and UK list price:
Opiodur® 12µg/h (PL 17780/0944) pack size: 5, £5.64
Opiodur® 25µg/h (PL 17780/0945) pack size: 5, £8.07
Opiodur® 50µg/h (PL 17780/0946) pack size: 5, £15.09
Opiodur® 75µg/h (PL 17780/0947) pack size: 5, £21.05
Opiodur® 100µg/h (PL 17780/0948) pack size: 5, £25.94
Legal category: POM
Marketing Authorisation Holder: Zentiva Pharma UK Limited, 12 New Fetter Lane, London, EC4A 1JP, UK
Manufacturer: Lavipharm S.A., Agias Marinas street, GR-190 02 Peania, Attica, Greece
Date of Preparation: 01 Jul 2021 **Ref:** 12228

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 Zentiva via email to PV-United-Kingdom@zentiva.com or via phone on 0800 090 2408.

1 NHS DM+D browser. https://services.nhsbsa.nhs.uk/dmd-browser/search (Accessed 9th June 2022)
2 Scottish Drug Tariff https://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff/Drugs-and-Preparations-with-Tariff-Prices.asp (Accessed 9th June 2022)
3 Data on File

Date of Preparation: June 2022 Ref: 20110

SCOTTISH MEDICINES CONSORTIUM

CROSSING THE LINE

Explore Scotland's scope for innovation and expertise head-on with the Scottish Medicine's Consortium's latest insights.

The Scottish Medicines Consortium, which advises on newly-licensed medicines for use by NHS Scotland, has published advice on five new medicines.

Crizanlizumab was accepted for use in patients with sickle cell disease on an interim basis subject to ongoing evaluation and future reassessment. Sickle cell disease is a rare genetic condition where the red blood cells become sickle-shaped. This can block the flow of blood in blood vessels, causing painful episodes known as vaso-occlusive crises.

The medicine was considered through the Scottish Medicines Consortium's Patient and Clinician Engagement (PACE) process, which is used for medicines for end-of-life and rare conditions. PACE participants highlighted that these painful crises can be frequent and unpredictable, with the most severe episodes requiring hospitalisation for treatment and analgesia. Treatment options are extremely limited and crizanlizumab may offer a step forward in managing the condition and reducing the number of crises. The clinical evidence in the company submission had some limitations and the committee therefore accepted crizanlizumab on an interim basis subject to ongoing evaluation. The Scottish Medicines Consortium will consider further evidence on its effectiveness once this is available. Further information on interim acceptance is available on the Scottish Medicines Consortium's website.

An initial assessment report has been published for odevixibat, which can be used to treat progressive familial intrahepatic cholestasis (PFIC). This medicine has been assessed through the ultra-orphan pathway for medicines that treat very rare conditions. PFIC is a rare group of conditions that cause bile acids to build up in the liver causing damage, with many patients progressing to end-stage liver failure and needing a liver transplant. The severe itchiness caused by the condition has a big impact on quality of life, leading to skin damage, sleep deprivation, irritability, poor attention and difficulties at school. The condition also has a considerable impact on carers and siblings. Clinical trials showed that odevixibat may reduce serum bile acids and itchiness leading to an improved quality of life.

However, there is still uncertainty about whether it delays the need for liver transplant, and despite the confidential discount offered by the company, the cost in relation to the health benefits of odevixibat remains high. The submitting pharmaceutical company is now required to provide a plan detailing how further data on the effects of the medicine, including those on the patient and carer lived experience, will be collected. Odevixibat will then be available through NHS Scotland for three years while the information is gathered. Following this, the Scottish Medicines Consortium will review the evidence and make a decision on routine availability in NHS Scotland. Further information on the ultra-orphan approach can be found in Scottish government guidance.

Solriamfetol was accepted for the treatment of narcolepsy, a rare, life-long neurological disorder that causes involuntary napping, excessive need for sleep, difficulty sustaining attention and brief involuntary sleep episodes. Through the PACE process, the Scottish Medicines Consortium committee heard that narcolepsy has a daily chronic disabling impact on people's relationships and work and home life. Solriamfetol may help improve wakefulness, most likely where current treatments have been unsuccessful or are unsuitable for the individual. Less sleepiness could result in improved quality of life for some patients.

Delafloxacin, an antibiotic, was accepted for the treatment of acute (short-term) bacterial skin infections such as cellulitis, skin abscesses and wound infections. It can be used when other commonly-prescribed antibiotics have not worked or are not considered suitable. Pegcetacoplan was accepted for the treatment of adults with paroxysmal nocturnal haemoglobinuria (PNH), a rare and potentially life-threatening condition where part of the body's immune system is overactive and breaks down too many red blood cells. This can lead to anaemia, tiredness, difficulty in functioning and swallowing, pain and blood clots. The medicine can be used for those who are still anaemic despite receiving treatment with another type of medicine used to treat PNH.

The Scottish Medicines Consortium Chairman, Mark MacGregor, reflected, 'The committee is pleased to be able to accept these medicines for use by NHS Scotland.

Sickle cell disease is a condition that has a severe impact on patients' health and wellbeing and affects all aspects of daily activities including education or work. We are pleased to be able to accept crizanlizumab as it may reduce the frequency of crises, relieving the severe pain and distress and the associated risks. It may improve the experience of care and wellbeing of patients who experience fewer unpredictable pain crises, allowing them to participate more fully in daily and social activities. This in turn may improve their quality of life, mental health and independence.

'Odevixibat will now move to the next stage of the ultra-orphan pathway. This will allow patients with PFIC to access treatment while more information on its clinical effectiveness is gained. The Scottish government will announce when this medicine will be available for prescribing in NHS Scotland.

'Solriamfetol offers another treatment option to help people with narcolepsy maximise their lives on a day-to-day basis.

'Antibiotic resistance is an ongoing concern and the availability of another antibiotic, delafloxacin, is to be welcomed.

'For those with PNH, pegcetacoplan, offers another treatment option for a very serious condition and the potential for improved levels of wellbeing.'

SAVE THE DATE: THE PHARMACY SHOW 2022

The Pharmacy Show returns to the NEC, Birmingham, on 16th and 17th October 2022 and is the major gathering for the pharmacy professionals of the sector for over a decade featuring two days of education, networking opportunities and of course, fun.

Make the most of two days packed with the very latest thinking and get ahead as you soak up over 200 expert industry speakers, a world-class conference programme and more than 300 leading suppliers.

Your ticket gets you access to all eight theatres, covering a huge range of topics as well as big issue discussions around the current issues. You'll also get the chance to explore a lively exhibition, meet with suppliers and test products and innovations. There's also plenty of time to meet up with friends and explore the area or kick back in Resort World.

And because The Pharmacy Show is now celebrating its 15th astonishing year, it all adds up to the most unmissable industry event of the year.

Register for your complimentary ticket at www.thepharmacyshow.co.uk/Kyron.

REPORT COMMISSIONED BY OMNICELL INTERNATIONAL CALLS FOR A NEW LEGAL FRAMEWORK FOR THE MANAGEMENT OF CONTROLLED DRUGS IN HOSPITALS SETTINGS

97 per cent of pharmacy staff believe that current guidance on Controlled Drugs (CD) needs to be updated to provide instructions on how best to manage CDs digitally[1], according to survey results which coincide with the launch of an advisory paper around the handling of CDs in hospitals using automation and digital systems.

The result is a widespread call for greater degree of support in reference sources, such as a 'Medicines, Ethics & Practice Guide' to drive real change and progress. This guide would recommend the optimal way to order, store and manage CDs using a closed loop digital system. Harnessing technological systems and automated drug cabinets will improve the audit trail and create a consistency in processes across the health service.

A survey of pharmacy staff went on to find that 40 per cent of staff believe that a lack of resources is one of the main reasons preventing them from managing CDs digitally – a similar number believe it's due to a lack of guidance and resource. Additionally, 31 per cent of pharmacy staff think that it's due to a lack of awareness and 29 per cent point to funding issues[2].

The opinion poll reinforces this with 55 per cent of pharmacy staff believing that current CD guidance should be updated to recommend paper CD registers are replaced with electronic CD registers. Additionally, 41 per cent of pharmacy staff believe that current CD guidance should be updated to recommend paper CD registers replaced with electronic CD registers so long as the electronic register meets the current CD guidance requirements[3].

The report calls on the Home Office to set a legal framework supported by the General Pharmaceutical Council and the Care Quality Commission. Agreeing governance arrangements for CDs with clear lines of responsibility and accountability which include harnessing technology to digitalise and automate processes.

References

1-3: 153 respondents (pharmacists/pharmacy staff) Clinical Pharmacy Congress 17/18 September2021 https://www.surveymonkey.com/results/SM-PFZW7HRY9/

OMNICELL: A COMMITMENT TO IMPROVEMENT

Ed Platt, Automation Director of Omnicell UK & Ireland, commented, 'The benefits of automation and digitalisation were analysed and reviewed within the document. These included the fact that a digital recording system provides an audit trail showing who has handled what, when. A cabinet can secure stock from access to all but authorised healthcare professionals via fingerprint technology, with each CD supplied having a unique code associated with it.

'CD cabinets in clinical areas are linked to pharmacy cabinets creating a unique order process with a full paper trail. The digital system also allows for end-to-end tracking, ordering and restocking negating the need for a timely, arduous manual stock take. Finally, the automated system can connect to the ePMA and determine which drugs are needed for which patients on the ward.'

Since 1992, Omnicell has been committed to transforming the pharmacy care delivery model to dramatically improve outcomes and lower costs. Through the vision of the autonomous pharmacy, a combination of automation, intelligence, and technology-enabled services, powered by a cloud data platform, Omnicell supports more efficient ways to manage medications across all care settings.

Omnicell

IN THE NEXT BREATH

As greater clarity emerges on the magnitude of the climate footprint carved out through healthcare, so, too, does awareness on the changes which we can make towards improvement. SHR takes a look.

KEY SOURCES OF HEALTHCARE EMISSIONS

PRESCRIBING

It has been estimated that pharmaceuticals contribute around 20 per cent of the NHS England carbon footprint of which 79 per cent is prescribed in primary care and community services, 13 per cent in acute services and five per cent in mental health services. Prescribing represents the major carbon hotspot for primary care with the carbon footprint from the manufacture and use of pharmaceuticals (excluding inhalers) contributing to around 40 per cent of the total carbon footprint of primary care and metered-dose inhalers (MDIs) contributing 22 per cent. Pharmaceuticals have wider impacts on the environment and pharmaceutical products have been found in measurable concentrations in soil samples and drinking water. It has been estimated that over £300 million of medicines go unused each year in England which has both economic and environmental impacts as well as representing a potential threat to patients' health through sub-optimal therapeutics. Over-prescribing and over-medicalisation have been highlighted by the 'Too Much Medicine' 'Choosing Wisely' campaigns while the risks posed by 'medical excess' in threatening the sustainability of healthcare systems are outlined in a recent call to action by the Cochrane Library.

HEALTHCARE DELIVERY

The environmental impact of healthcare is influenced by the setting in which it is delivered. Secondary care is associated with an inherently higher impact as well as higher costs than primary care; for example, the carbon footprint of an average GP appointment is 6kg CO_2e (18kg CO_2e with prescribing) whereas each elective inpatient stay is estimated at 708kg CO_2e (not including patient, visitor and staff travel). Therefore, transforming health systems to have a stronger focus on disease prevention and chronic disease management in order to reduce emergency admissions can result in lower environmental impacts as well as lower financial costs. Ensuring that low value healthcare procedures are avoided (for example, using the NICE 'Do Not Do' list) and ensuring that the care delivered is based on high quality evidence is crucial in aligning the economic, health and environmental goals of healthcare through the avoidance of wasted clinical activity.

TRAVEL

There are over 9.5 billion NHS-related road miles per year in England which makes up around 3.5 per cent of all road travel in England. Staff, visitor and patient travel therefore also negatively impacts on air quality and an economic impact figure of £345 million has been estimated for the potential mortality effects and costs to society of air pollution from NHS-related travel. Adopting active transport can have health co-benefits for staff and changing where healthcare is delivered through providing consultations by phone or online can also reduce 'care miles' and therefore a reduction in the emissions associated with patient travel.

FROM THE FRONTLINE

Practice-based pharmacist Maeve Devlin discusses the vital position that healthcare professionals represent in helping to support a net-zero NHS – particularly in relation to choices surrounding inhaled therapies.

With the NHS having set a target of reaching net-zero by 2040 for the greenhouse gases which it can control, it is imperative that we start making changes in our day-to-day practice as healthcare practitioners in order to achieve this. There is no disputing that inhaled therapies have been invaluable in improving the health and quality of life of patients with respiratory disease. However, pressurised MDIs, frequently referred to as pMDIs, contain hydrofluoroalkanes (HFAs) which help to propel the medication into the patient's respiratory system. These HFAs have been identified potent greenhouse gases with a high global-warming potential.

Optimising care during each patient's annual respiratory review, especially for those with poorly-controlled disease, must remain our first priority. However, going forward we must also embrace this as an opportunity not only to improve health outcomes, but to significantly reduce the carbon impact of inhalers by optimising the quality of our prescribing in conjunction with national guidance and local formularies.

Proper environmentally-safe disposal of inhalers is another area in which effective patient education can help us reach our NHS target. Used inhalers should not be put into household waste as this allows for remaining HFAs to be released into the atmosphere. Instead, inhalers for disposal, whether used or unused, should be returned to a pharmacy which can forward the device onwards for recycling or incineration.

Ultimately, the responsibility to deliver a net-zero NHS lies in our hands and thus we need to optimise our prescribing, substitute high carbon products for lower carbon alternatives and campaign for improvements in both production and waste processes in an effort to achieve this target. SHR

The 1st carbon neutral pMDI[1-3]

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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_1 <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. Certifications of carbon neutrality for Luforbec pMDI. **2.** Carbon Footprint Limited, Carbon Assessment Report 2022. Data on File. **3.** MIMS: Inhaler Carbon Emissions. https://www.mims.co.uk/inhaler-carbon-emissions/respiratory-system/article/1739635. Accessed: May 2022. **4.** NHS BSA. Drug Tariff. https://www.nhsbsa.nhs.uk/pharmacies-gppractices-and-appliance-contractors/drug-tariff Accessed: May 2022. Fostair® is a registered trademark of Chiesi Ltd

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PTSD

A LASTING IMPACT

With signs of Post-Traumatic Stress Disorder (PTSD) differing in timing, effects and intensity within each individual, it's important that sufficient vigilance and treatment is assigned to those struggling. In their latest exploration, PTSD UK shed light on the onset and force of the condition's symptoms.

It's estimated that 50 per cent of people will experience a trauma at some point in their life, and although most people exposed to traumatic events experience some short-term distress, around 20 per cent of people go on to develop PTSD or Complex PTSD (C-PTSD). In the UK, that equates to around 6,665,000 people, yet it is still an incredibly misunderstood, often misdiagnosed and stigmatised condition.

At their core, both PTSD and C-PTSD are essentially 'memory-filing errors' caused by the brain suspending normal functions during a traumatic situation.

If someone is exposed to an intensely fearful and traumatic situation, many systems in the body are put on hold or adapted to allow the body to cope as well as it can in order to survive. This might involve reactions, such as 'freezing to the spot' or instead the opposite 'flight away' from the danger (it's been recognised that there are five main reactions to trauma – fight, flight, freeze, fawn and flop). Additionally, the digestive system pauses, muscles may tense up to be ready to flee or fight, heart rate will increase, pupils dilate and the 'unimportant' task of memory creation is put on hold. This means that the mind does not produce a memory for this traumatic event in the 'normal' way.

In these cases, the body and mind are doing things they SHOULD do when presented with a threat. But humans are 'designed' for this to be an immediate fix, a short-term solution which allows the body to settle once the threat has been resolved. But with PTSD and C-PTSD, it is almost perpetual. The trauma can physically injure the brain, meaning that it stays in the alert state for so long that it gets 'stuck' there, and so begins to affect other systems of the body and mind.

When the body and mind get 'stuck' in this perpetual trauma mode, it can cause a huge variety of life-altering and intrusive physical, cognitive and emotional symptoms, alongside substantial distress and disruption of social and occupational functioning, with major problems in relationships and jobs.

Symptoms usually begin within three months of the traumatic incident, but sometimes they begin years afterward, and the symptoms can vary in intensity over time.

PTSD and C-PTSD symptoms vary from person-to-person, but these are some common signs and symptoms to look out for:

RE-EXPERIENCING SYMPTOMS

Re-experiencing is the most typical symptom of PTSD and C-PTSD.

- Flashbacks – reliving the traumatic event, and feeling like it is happening right now, including physical symptoms, such as a racing heart or sweating
- Reoccurring memories or nightmares related to the event
- Distressing and intrusive thoughts or images
- Physical sensations like sweating, trembling, pain or feeling sick

Thoughts and feelings can trigger these symptoms, as well as words, objects, or situations that are reminders of the event.

AVOIDANCE SYMPTOMS

Trying to avoid being reminded of the traumatic event is another key symptom of PTSD and C-PTSD: avoiding certain people or places that remind them of the trauma, or avoiding talking to anyone about their experience.

- Staying away from places, events, or objects that are reminders of the experience
- Feeling that they need to keep themselves busy all the time
- Using alcohol or drugs to avoid memories
- Feeling emotionally numb or cut off from their feelings
- Feeling numb or detached from their body
- Being unable to remember details of the trauma

Avoidance symptoms may cause people to change their routines.

ALERTNESS AND REACTIVITY SYMPTOMS

They may be 'jittery', or always alert and on the lookout for danger. They might suddenly become angry or irritable.

- Being jumpy and easily startled
- Feeling tense, on guard, or 'on edge' – this is called hypervigilance
- Having difficulty concentrating on even simple and everyday tasks
- Having difficulty falling asleep or staying asleep
- Panic attacks
- Feeling irritable and having angry or aggressive outbursts
- Self-destructive or reckless behaviour
- Aversion or difficulty in tolerating sound

FEELING AND MOOD SYMPTOMS

The way they think about themselves and others may change because of the trauma.

- Trouble remembering key features of the traumatic event
- Feeling like they can't trust anyone
- Distorted thoughts about the trauma that cause feelings of blame and guilt
- Overwhelming negative emotions, such as fear, sadness, anger, guilt, or shame
- Loss of interest in previous activities
- Feeling like nowhere is safe
- Difficulty feeling positive emotions, such as happiness or satisfaction

C-PTSD

A diagnosis of C-PTSD includes the same symptoms of PTSD, but also has three additional categories of symptoms: difficulties with emotional regulation, an impaired sense of self-worth, and interpersonal problems such as:

- Constant issues with keeping a relationship
- Finding it difficult to feel connected to other people
- Constant belief that you are worthless with deep feelings of shame and guilt
- Constant and severe emotional dysregulation (you find it difficult to control your emotions)

AWARENESS IS KEY

Some people actually learn to 'manage' their symptoms and so have long periods when their symptoms are less noticeable, followed by periods where they get worse. Other people have constant severe symptoms, or may only have symptoms when they're stressed in general, or when they run into reminders of what they went through.

Many symptoms of PTSD and C-PTSD seem to bear no relation or correlation to the original trauma, so they often get overlooked, but can have severe life-impacting results. As such, it is vital that healthcare professionals are aware of the symptoms to look out for in their patients to allow a correct diagnosis, which can then lead to sustained treatment and recovery.

FLASHBACKS

One of the most well-known symptoms of PTSD and C-PTSD are flashbacks. It's important to understand, this isn't a 'reimagining' of the trauma, but an actual re-experiencing of it.

Under 'normal' or non-traumatic circumstances, when information comes into our memory system (from sensory input, such as what we can see, hear, taste, and smell), it needs to be changed into a form that the system can cope with, so that it can be stored. If the encoding doesn't take place due to a traumatic situation – the memory can't be processed. Instead, it is stored randomly, in pieces, in a variety of places within the brain.

Eventually, when the mind presents the fragments of the memory of the trauma for 'filing', or it is triggered by a smell, a place, or a person etc., it does not recognise it as a memory. As it understands, 'the brain is in the middle of the dangerous event – it is not 'outside' looking in at this event and therefore the entire system is not easily subject to rational control.'

These flashbacks are incredibly distressing. Reliving the trauma as if it were happening RIGHT NOW. The elements, such as the facts of what happened, the emotions associated with the trauma, and the sensations like touch, taste, sound, vision, movement and smell, are presented by the mind as real-time information. They may also present as nightmares and intrusive unwanted memories.

These re-experiences and flashbacks are a result of the mind trying to file away the distressing memory and understandably can be very unpleasant and frightening because they repeatedly expose the sufferer to the original trauma. The body enters a state of hypervigilance so it is acutely (and sometimes inappropriately) aware of other 'dangers' around it, with increased startled responses.

PROGRESS OVER TIME

This danger response also sets off other stress reactions in the body which can cause deranged cortisol and adrenaline levels and so may present as other conditions, such as high blood pressure, skin conditions, such as eczema or psoriasis, increased heart rate, hair loss, allergies, high blood sugar levels, unexplained weight gain or loss, icy hands or feet, digestion issues, joint pain, and hearing issues, such as hyperacusis, phonophobia, and tinnitus.

As the mind continues to try to repeatedly process the memory and the brain keeps re-triggering itself into 'danger' mode, people also find that their levels of awareness might change.

They can find it difficult to control their emotions and suffer intense symptoms of anxiety. This can present itself as both physical; shortness of breath, tight muscles, profuse sweating and a racing heart, as well as emotional: feeling on edge, hypervigilance (looking out for signs of danger all the time), avoidance of reminders of the trauma, self-destructive behaviours, or feeling panicky. Many people with PTSD or C-PTSD also feel emotionally numb and have trouble communicating with others about the way they feel – this may make them more anxious and irritable.

Ultimately, the brain is programmed to process memories and so the more the person avoids thinking about the trauma, the less likely is it that any memory processing will actually occur, and the more likely that further attempts at 'filing' a memory will occur automatically.

This will lead to further nightmares, flashbacks and intrusive memories which lead on to further hyperarousal and emotional numbing and this in turn leads on to more avoidance and so on. This is how the symptom clusters perpetuate themselves in a vicious cycle which can go on for years – and when it goes untreated, PTSD and C-PTSD can last for decades.

In some cases, symptoms can have a cumulative effect and can get worse rather than better over time, which is why some PTSD and C-PTSD sufferers 'manage' for such a long time without help, but they then worsen over time and eventually the symptoms become unmanageable.

A WAY FORWARD

The good news is that there are effective treatments for PTSD and C-PTSD. Unfortunately, many people do not know that they have the condition or do not seek treatment due to stigmatisation, they don't believe they can be helped, they fear discussing their trauma or not wanting to acknowledge their problems in coping.

For treatment to be successful, information and memory processing must be completed. This is why therapies such as EMDR, aimed at helping the individual to process and work through the traumatic material, are extremely beneficial. For some people, treatment can get rid of PTSD or C-PTSD altogether. For others, it can make symptoms less intense.

PTSD is as ancient as humankind and can occur in all people, of any ethnicity, nationality, gender, occupation or culture, and at any age and despite its prevalence across the world, is still a very misunderstood condition and many people have pre-conceived ideas of what it is, and particularly what can cause it.

It's vital that healthcare providers are aware if they (or a patient or even loved one) have suffered any trauma, they should be mindful of trauma symptoms, and the possibility of PTSD or C-PTSD.

Thanks to this publication, throughout the year, we'll be bringing you more information about PTSD and C-PTSD to help you support not only patients or clients, but also your friends and family around you who may be affected by it. We'll be taking a more in-depth look at a variety of aspects of PTSD – but if you'd like more information in the meantime, please do visit our website: www.PTSDuk.org.

If you or your workplace would be willing to have a stand with / hand out leaflets and booklets about PTSD – drop us an email at info@ptsduk.org with your name, address and some information about what you need.

ptsduk
TOMORROW CAN BE A NEW DAY

THE PHARMACISTS' DEFENCE ASSOCIATION

COMMUNITY PHARMACISTS FROM THE EPHEU FEDERATION ARE SUPPORTING THE SUPPLY OF THE REQUIRED MEDICINES TO UKRAINIAN HOSPITALS

EPhEU (European Association of Employed community Pharmacists in Europe) is the European-wide federation of trade unions representing community pharmacists. The UK affiliate to EPhEU is The Pharmacists' Defence Association (PDA) and The PDA Chairman, Mark Koziol, is also the Secretary General of EPhEU from 2021-to-2024.

The conflict in Ukraine is the first war within the geography covered by EPhEU and it was quickly apparent that medicines would be needed. Pharmaciens Sans Frontières Comité International (PSF), also known as 'Pharmacists Without Borders', ceased operating globally in 2009. Until then it had been active in humanitarian activity in countries in Africa, the Balkans, Central Asia, the Far East, and Latin America. As PSF no longer exists globally, there was no organisation to which The PDA and other EPhEU members could look to co-ordinate efforts.

Instead, EPhEU has acted and are co-ordinating a pan-European scheme. Each EPhEU-affiliated union has sought a national charity partner with whom funding can be raised to assist pharmacists in Ukraine to care for patients. The EPhEU Executive, led by Mark, also liaised with appropriate stakeholders in Ukraine and neighboring states to determine what medicines were actually needed and reached agreements as to how supplies will be purchased and delivered where they are needed.

The regular medicines supply infrastructures in parts of Ukraine and around 100 hospitals have already been destroyed. With military and civilian casualties getting more numerous each day, the Ukrainian pharmacist profession need all the help they can get. The EPhEU initiative is about establishing a long-term supply programme that can keep the medicines coming for many months to come.

Mark Koziol accompanied the initial consignment of nearly £200,000 worth of medicines which were delivered to Ukrainian hospitals.

In his report of the trip, Mark explained, 'Although it had been done with the collaboration of the Polish and Ukrainian authorities, with the temperature at 36 degrees and a security briefing fresh in the mind, the journey was atmospheric and filled with foreboding. We were required to leave our mobile phones and laptops behind due to hostile monitoring of networks...'

You can read Mark Koziol's full report of his journey accompanying the first consignment of medicines here: www.the-pda.org/wp-content/uploads/Marks-Ukraine-Report-1.pdf.

To find out more or donate to this initiative, visit www.medicinestoukraine.com.

The PDA recently sent a poster promoting the medicines to Ukraine initiative to every community pharmacy in Scotland, enclosed with the latest issue of the PDA 'INSIGHT' magazine. If you would like further supplies of the poster to display in your pharmacy, or anywhere else that might encourage donations, please contact the PDA at enquiries@the-pda.org.

UKRAINIAN HOSPITALS URGENTLY NEED SPECIALIST MEDICINES.

PHARMACIST VOLUNTEERS ARE WORKING TO DELIVER THEM BUT WE NEED YOUR FINANCIAL SUPPORT.

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Pharmacists Without Borders / Pharmaciens Sans Frontières

EPhEU

pda the pharmacists' defence association

www.medicinestoukraine.com

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hfd

Montenegro FKCG

The Norwegian Association of Pharmacists

VAAO

Związek Zawodowy Pracowników Farmacji

SKIN CANCER

UNDER THE SUN

With the temptation to soak up the sun's rays escalating during the summer months, skin safety is paramount. With this in mind, Macmillan Cancer Support bolster your ability to answer some of the most frequently asked questions about skin cancer that may be posed by your patients and advise on how you can help them navigate the risks.

MACMILLAN CANCER SUPPORT

Most skin cancers are caused by skin damage that happens from exposure to ultraviolet (UV) light from the sun. The damage can happen from sun exposure over a long period of time or from a history of getting sunburnt, but even people who have never experienced sunburn are still at risk. Exposure to UV light from sunbeds and sun lamps also damage the skin and increase the risk of skin cancer.

People with a history of sunburn or over-exposure to the sun in childhood also have a greater risk of developing basal cell carcinoma, squamous cell carcinoma and melanoma. All types of skin are at risk of sun damage and skin cancer. But fair-skinned people who tend to burn easily or go red or freckle in the sun are most at risk of developing skin cancer.

People with darker skin have a lower risk of developing skin cancer. But they still have a risk. It is important for everyone to follow skin protection advice and to check their skin regularly, including areas that don't get sun exposure.

ADVICE FOR YOUR PATIENTS

PREVENTING SKIN CANCER

• The best protection is to cover up. Wear clothing made of cotton or natural fibres that have a close weave. These give you more protection against the sun
• Keep your arms and legs covered by wearing long-sleeved tops and trousers. Wear a wide-brimmed hat to protect your face and neck
• Always wear sunglasses in strong sunlight
• Stay out of the sun during the hottest part of the day. This is usually between 11am-and-3pm
• Do not use a sunbed or sun lamp. If it is important for you to look tanned, use fake tan lotions or sprays
• Protecting yourself from the sun is important. But regular exposure to a small amount of sunshine helps our bodies make vitamin D. Remember not to let your skin go red or burn

SUN PROTECTION

Individuals should use sun cream with a high sun protection factor (SPF) of at least 30. They should choose one that protects against UVA and UVB, with four or five stars. They should follow the instructions on the bottle and re-apply as recommended, particularly after swimming. They should remember to apply sun cream on and behind the ears.

Many people do not use enough sun cream. Experts say an average-sized adult needs at least six-to-eight teaspoons of lotion to give the SPF coverage it says on the bottle. Don't forget to apply sun cream to those easy-to-miss places – lips, tops of ears, back of neck, feet and scalp.

Protection can rub off when it comes into contact with sand, water, towels or sweat, so should be reapplied every two hours. Individuals should make sure they apply to clean and dry skin and apply sun cream about 20-to-30 minutes before they go out into the sun. Ideally they should do this before they get dressed for the day. This ensures that they don't miss any areas and also makes sure it doesn't get on their clothes.

They should reapply every two hours, or immediately after swimming, towelling dry or if they've been sweating a lot.

Top tip: Make sure your sun cream is not out-of-date. Most sun creams have a shelf life of two years. If the product is seeping liquid or smells 'off', it should be replaced.

CHECKING SKIN REGULARLY FOR ANY CHANGES

Different types of skin cancer can vary in how they look. Skin cancer can appear anywhere on your body but is most likely to occur on skin that is exposed to the sun, such as the face and neck. Most commonly, non-melanoma skin cancer can appear as:
• Smooth and pearly-white
• Waxy
• A firm, red lump or may look sunken in the middle
• A pearly brown or black lump if you have darker skin
• A flat, red spot that is scaly and crusty
• A pale non-healing scar
• Look out for areas of skin that never completely heal, feel itchy and bleed sometimes, develop a crust or scab or develop into a painless ulcer
• Melanomas either start with a new, abnormal-looking mole in normal-looking skin. This usually looks like a dark area or a new mole that changes over weeks or months. Or they develop from a mole that you already have. There is a checklist that can help you check changes in a mole or normal looking skin that might be melanoma, called the ABCDE list

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

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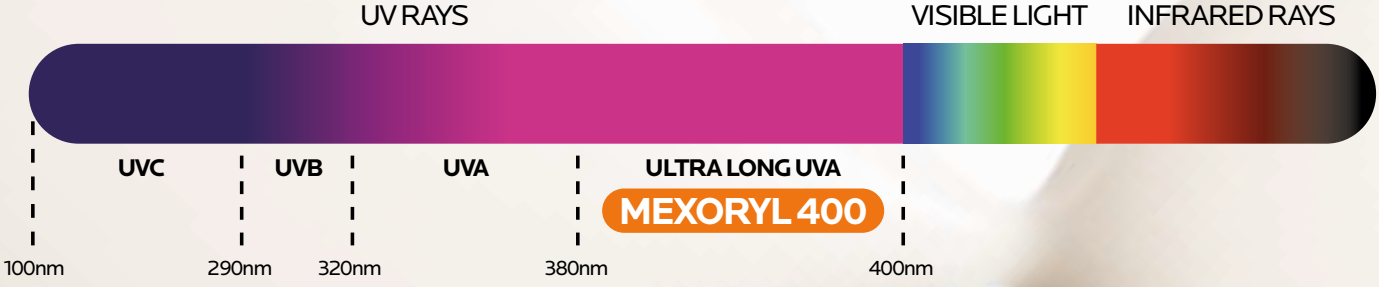

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ADDICTION

CLOSE TO HOME

Each year, as the Scottish drug-deaths and alcohol-deaths are announced, it's heartbreaking that many are left behind grieving for their lost loved ones. It's therefore critical that increased support is provided for families across Scotland impacted by someone else's alcohol or drug use, explain the Scottish Families Affected by Alcohol and Drugs team.

At Scottish Families Affected by Alcohol and Drugs, we continue to support family members across Scotland (3,402 people were supported by us in 2021-to-2022) through our national helpline, national one-to-one support services and bereavement service, our local support services, and our online click and deliver naloxone service.

Our 'Ask the Family' research (2021) found that an average of 11 people were harmed for every person using substances, reaching across a wide range of family members and social relationships (e.g. friends, neighbours, work colleagues). The research also found that families were harmed by substance use for an average of 16 years, but it took eight years to reach support for the first time. Most families who are harmed by someone else's substance use remain hidden from sight. Even those closest to them can be unaware of what is going on. This is due to the secrecy, shame and stigma of addiction in the family, as well as a lack of visible and high-quality local support, feelings of isolation and loneliness, and a sense of powerlessness and disconnection.

We continue to hear the same stories from families about their desperate attempts to keep their loved ones alive. In this article, we're going to focus on our Holding on Support service which supports family members whose loved ones are at high risk of drug-related death. In this service, we hear of the level of complexity that comes with supporting a loved one with a drug problem. Families face severe and debilitating consequences through every aspect of their lives. Families are living with extreme levels of anxiety, stress, exhaustion, chaos and trauma on a daily basis, due to the high risk of drug-related death within their family.

Their loved ones commonly demonstrate:

- High levels of poly drug use (i.e. using multiple drug types including alcohol) with street benzodiazepines a common feature
- Poor mental health, including suicidal ideation, which is not recognised or treated by services
- A history of non-fatal overdoses
- Chaotic and unpredictable behaviour, including verbal and physical aggression
- Lack of support from care and treatment services, which are characterised by fixed appointment systems, high staff turnover, limited treatment choice, and infrequent contact
- Regular engagement with the criminal justice system, including periods in and out of prison (in itself a high overdose risk due to reduced tolerance to substances while in custody)

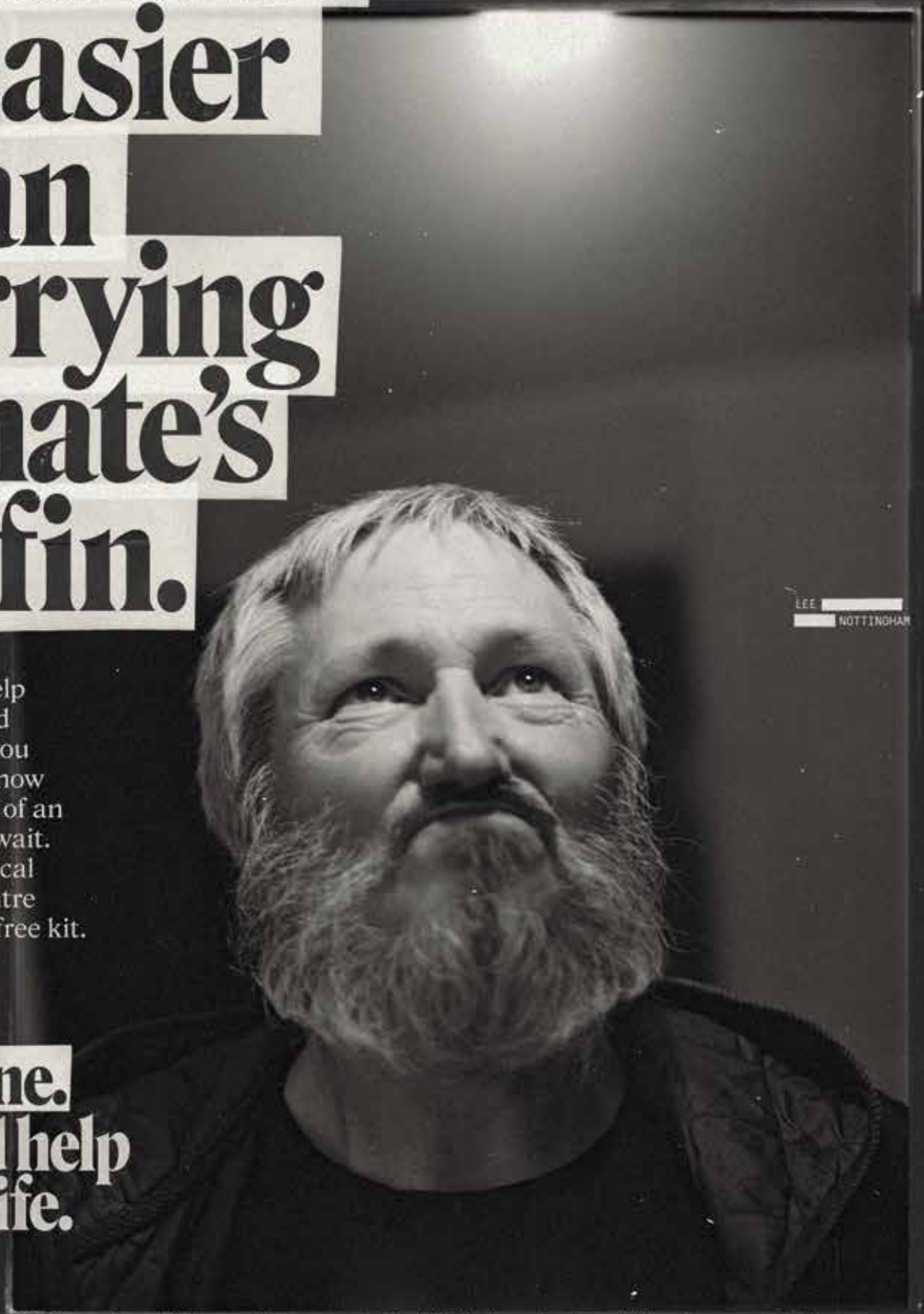
All of this chaos is then put onto the family members who support their loved ones. When we hear stories from family members that show this complexity, it is sad and frustrating. Sad that they are going through this but also frustrating when we hear that they and their loved ones are not getting the support that they need. But there lies some hope for families when they are supported and listened to. Our Holding on Supprt service acknowledges that families are already experiencing chaos at home, and we fit support in where it suits them. Our intensive support includes a safe space for people to talk, education on drugs and their effects, access to life-saving naloxone through our online Click and Deliver service, and peer support including a virtual group for families to feel less alone.

One family member has shared, 'My son lives with me because I don't want him to die in the street. I isolate myself from family and friends because my life is consumed by my son's drug problem and the chaos it brings every day. I sometimes wish one of us would die because at least one of us would find some peace… six months later, I now attend a weekly (Scottish Families) group with other people in similar situations. I don't feel so alone, and I feel stronger. My son is still using drugs and is not getting support but there are less arguments.'

Scottish Families Affected by Alcohol and Drugs is an award-winning national charity that supports anyone concerned about someone else's alcohol or drug use in Scotland. We give listening support and information to many people and help them with confidence, communication, general wellbeing, and we link them into local support. We also help people recognise and understand the importance of looking after themselves.

If an individual is concerned about someone else's alcohol or drug use, they can contact our helpline by phone on 08080 10 10 11, email helpline@sfad.org.uk or use the webchat at www.sfad.org.uk.

Carrying naloxone is easier than carrying a mate's coffin.



Naloxone can help reverse an opioid overdose. So if you use opioids or know someone at risk of an overdose, don't wait. Speak to your local drug service centre about getting a free kit.

Carry naloxone. It could help save a life.

Opioid overdoses kill thousands every year in the UK.[1] But those deaths could have been prevented – with naloxone. It's a drug that can help reverse an opioid overdose and help save lives. Signs of an opioid overdose include pinpoint pupils, unconsciousness, or breathing problems. Always call an ambulance first if you think someone is having an opioid overdose. For more information, go to naloxone.org.uk.

This campaign is sponsored by Ethypharm and made in conjunction with real naloxone carriers.

1. Parsons G. Prescriber 2019; 30(12):19–23. Date of preparation: February 2021 | Job number: UK-PREN-17a

A DIFFERENT APPROACH

When it comes to mental health, we have been getting it wrong, asserts Nick Ward, CEO of Support in Mind Scotland.

Nick Ward

Mental health and mental illness are complex issues that affect millions every year but our system, the way we think about the issues and how we support people, simply aren't working. The evidence for this is pretty clear. If we were addressing mental health issues and mental illness appropriately then the number of incidences of severe and long-lasting mental health issues would be going down. Instead, we have seen an exponential increase in people who have a mental health issue and are taking medication for it.

There are two main issues as I see it. One, our misunderstanding of the causes of mental illness and two, our then subsequent poor attempts at addressing those causes.

For the first issue, I would argue that that there is a 'fundamental attribution error' when it comes to the causes of poor mental health. The traditional theory for some time is that poor mental health certainly, is caused by chemical imbalances in the brain and that primarily the issue lies 'within' the individual and that other factors play a more periphery role.

This has been a convenient attribution for many. For the drug companies it has allowed them to promote pharmacological intervention as the primary way to address mental health issues. For the NHS it has allowed a relatively inexpensive course of treatments to be developed. For society it has allowed us to place mental health issues as an individual issue, or problem to be solved. In our attempts to address stigma, we have put forward that poor mental health is something that can unluckily strike you down, such as cancer or the flu.

The truth is, of course, much more complicated. When looking at the evidence it would seem there are two massive correlating factors when looking at mental health and mental illness. Trauma, poverty and, although the evidence is less clear, potentially a third factor in genetics. If you experience severe trauma this can act as a trigger for developing mental illness and if you live in poverty, where you

struggle for the necessities of life, compare your life to more affluent peers and or live in an area of deprivation then you are more likely to experience poor mental health. In addition, there are some genetic factors that may predispose some towards mental illness and poor mental health.

So to sum it up, as my granny would say, you are more likely to have poor mental health if your life is ****.

Why don't we say that more often? We don't we, as a society, acknowledge that outside factors can create and exacerbate mental health issues?

Because then we would have to do something about it.

It is relatively easy to proscribe drugs, it is incredibly difficult to change someone's social and economic circumstances, much less the society that has created them. The NHS can't provide the wrap-around care and support someone needs to be become more economically active, to build their self-esteem, gain new skills, move them to better accommodation.

However, the third sector and charities like Support in Mind Scotland can start to do some of that work if given the opportunity to do so. We support thousands across Scotland with their mental health and we are taking a new approach to how we provide support and care. We want to deliver holistic support that considers the lived experience and complex needs of the people we work with. It is clear from the evidence that just one intervention, be that pharmacological or not, is unlikely to change the circumstances that someone finds themselves in and subsequently their mental health. Our approach is to work with individuals and build around them the network of support that they need from the community.

I want to be clear though, whether the science knows how or why anti-depressants in particular work, doesn't necessarily matter for most people we support. They do work in allowing people to reach a more stable place to be able to take control however they can never be the only solution, particularly because we don't often talk about the downsides. They are often less affective and significantly more addictive than people think. They can build dependences and ultimately, they address the symptom and ignore the cause. They absolve society of its responsibility.

The same can be said the NHS. I, and many other, wouldn't be here without the incredible care and treatment that the NHS has offered and often with a scarcity of resources. However, the NHS is huge. It is a one-size-fits-all approach, a conveyer belt of clinical interventions one after another until one sticks. Of course, it also over-privileges pharmacological interventions because that is all the resource there is.

There can be another way though and the launch of the National Care Service in Scotland gives us the opportunity to start to advocate for it. The NHS, local authorities and the Scottish government should be working hand-in-hand with the third sector to deliver the wrap-around support that people need. We should be providing this support in communities and on high streets. We should be giving people accessible support to talking therapies and counselling and breaking down the stigma of accessing them.

Support in Mind Scotland will be launching our new strategy at the end of this year and at its heart will be the commitment to championing and providing this type of holistic and accessible support wherever we can.

As I said above, you are more likely to have poor mental health if your life is ****. Let's work together to make people's lives less ****. Maybe then we will start to see the change in the numbers of people experiencing poor mental health we all want to see.

Support in Mind Scotland is a Scotland-wide charity supporting people with severe and long-lasting mental illness and mental health issues.

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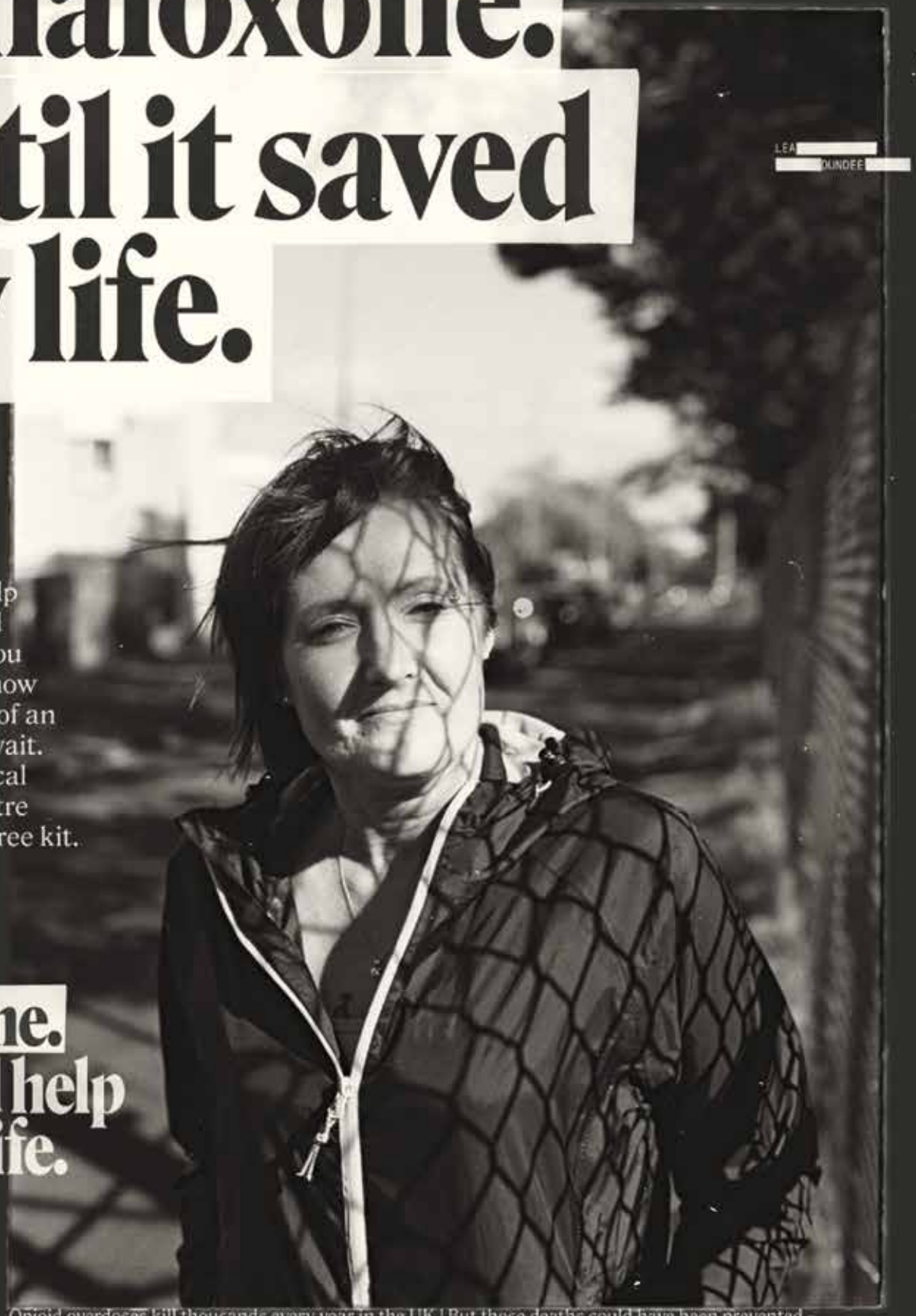
I'd never heard of naloxone. Until it saved my life.



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