Welsh Pharmacy Review

ISSUE 53 - 2022

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EDITOR

SARAH NELSON

sarah.nelson@kyronmedia.co.uk

MANAGING DIRECTOR

CHRIS FLANNAGAN

chris.flannagan@nimedical.info

BUSINESS DEVELOPMENT MANAGER

NICOLA MCGARVEY

nicola.mcgarvey@nimedical.info

HEAD OF DESIGN

MEGAN BUCKLEY

design@nimedical.info

ACCOUNTS

accounts@nimedical.info

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WELCOME

EDITOR'S LETTER

Welcome to the latest edition of Welsh Pharmacy 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 WPR we take a look at how the British Oncology Pharmacy Association have been developing a roadmap to help contend with workforce issues (page 11), as well as the crucial role of co-operation within the medicines to Ukraine initiative (page 20). The Get your Belly Out campaign is demonstrative, also, 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, as the All Wales Therapeutics and Toxicology Centre highlight their work in developing a suite of documents for care home and pharmacy teams (page 15), and the Royal Pharmaceutical Society's Director for Wales, Elen Jones, shares the organisation's ambitions for the profession in Wales (page four).

Also in this issue we delve into the new strategy for a smoke-free Wales (page 39), and the potentially risky relationship between diabetes and cholesterol (page 10).

Happy reading!

Sarah Nelson

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ROYAL PHARMACEUTICAL SOCIETY

STEPPING STONES

In the latest column from the Royal Pharmaceutical Society (RPS) in Wales, Director for Wales, Elen Jones, provides an insight into key priority areas for the work of the RPS in 2022 and beyond.

Elen Jones

It's hard to believe that we are now over halfway through another incredibly demanding year for our profession. To date, 2022 has been a year of balancing the continuity of patient services while simultaneously managing the tremendous impact of the pandemic.

At the RPS our work continues to be focused on supporting our members and the wider profession at this challenging time, while taking time to look over the horizon and to plan strategically for the exciting future of the profession and pharmacy services in Wales.

WORKFORCE PRESSURES

Our first priority is the wellbeing of the profession. Informed by our annual wellbeing survey and engagement with our members, we are acutely aware of the pressures currently facing the pharmacy workforce and the demands on staffing and recruitment.

Our Workforce Wellbeing Action Group of RPS members from across Great Britain with a key interest in health and wellbeing continue to meet regularly and we encourage members to join this group to get involved in discussions. Our website also has a wellbeing hub that provides the latest information, guidance and training resources to support you and your teams. We have also published blogs and run events in partnership with Pharmacist Support to highlight examples of coping strategies and workforce wellbeing in action. Check out our website for further information.

Meanwhile in Wales we've focused on making sure those in power appreciate and understand the pressures you're facing. In March we hosted a 'drop in' event at the Senedd and invited every elected member to meet us. This allowed us to have detailed, one-on-one conversations with politicians to highlight current pressures and to outline how the situation can be improved through investment in the pharmacy workforce, protected learning time and improved access and enabling pharmacy teams to take rest breaks.

The conversations with MSs proved fruitful and led to an hour-long debate on the floor of the Senedd focused on how best to support pharmacists. Nine MSs from across all parties spoke in the debate with Eluned Morgan, the Minister for Health and Social Care, replying on behalf of the government. There was widespread agreement between all parties of the crucial role the profession plays in the health service and that the steps outlined by us must be taken to support the profession in the coming months and years.

2025 GOALS FOR PHARMACY

The RPS Wales is proud to be taking a leading role on behalf of the Welsh Pharmaceutical Committee and the pharmacy workforce in Wales to develop 2025 goals as part of the strategic plan outlined in 'Pharmacy: Delivering a Healthier Wales'.

Published in 2019, 'Pharmacy: Delivering a Healthier Wales' has become a roadmap for change to enhance the delivery of pharmaceutical care and to ensure the patient is always put at the centre of their care. This flagship document, which we project managed in 2018 / 2019, was the result of extensive engagement and consultation with the pharmacy team across Wales.

Since the launch of the vision, there have been notable changes to pharmacy services, including the new community pharmacy contract's focus on clinical services, the expansion of the common ailments service and independent prescribing, technology-enabled care, including a national video consultation platform for all pharmacy teams, and transforming access to medicines in secondary care.

Our task now is to build on action taken to date and establish a set of 2025 goals as stepping stones to the ambitions for 2030. Since April we have engaged extensively with pharmacy teams and other key stakeholders, including other professional bodies and patient representative organisations. It has been an absolute pleasure to engage with colleagues through a series of face-to-face events across Wales as well as virtual events. The insight we have gained has been extensive and has enabled us to clearly identify areas that require attention and development over the next three years.

We are aiming to distribute the draft 2025 goals for consultation during the summer and are eager to capture the views of all members of the pharmacy team, so please look out for opportunities to share your views.

CREATING STANDARDS FOR PALLIATIVE CARE

The RPS has a long-term commitment to ensure that people approaching the end of life have timely access to medicines and clinical support from a skilled pharmacy

team. We are proud, therefore, to be taking important action on palliative care in Wales by working in collaboration with the leading end-of-life charity, Marie Curie, to develop professional standards for palliative care to be published later this year.

The standards will be available for community pharmacy teams across the whole of the UK and will provide a free, evidence-based framework to help community pharmacies self-assess and continuously improve their end of life and bereavement care for patients and carers.

Even though these standards will be available for pharmacies across the UK, I'm proud to say that they are being developed by our team in Wales, led by Darrell Baker and Karen Hodson.

EXPANDING SCOPE OF PRESCRIBING PRACTICE

Another important UK project delivered by us in Wales was new national guidance for expanding scope of prescribing practice. Commissioned by the Welsh government for the benefit of all prescribers across the UK, the guidance provides a structured approach for those wanting to change or expand their scope of prescribing practice. Crucially in Wales it will support the delivery of the new community pharmacy contractual framework, which includes a community pharmacy national independent prescribing service

We're very grateful to Reem El-Sharkawi who acted as lead author for the guidance during her clinical fellowship, as well as numerous colleagues from the Welsh government, Health Education and Improvement Wales and members from across Wales who supported the development of the work.

PHARMACY'S ROLE IN THE PHARMACOGENOMICS REVOLUTION

We're clear that pharmacy must be at the forefront of new genomic innovations and services. That's why in May we published a position statement with recommendations to support pharmacy and pharmacogenomic implementation across healthcare systems.

This is a substantial and important piece of work that once again benefited from Welsh expertise via Sophie Harding who was recently appointed RPS lead for pharmacogenomics in a part-time role alongside her role at Velindre NHS Trust.

SUSTAINABLE HEALTHCARE

We are committed to tackling climate change and have been taking steps in Wales and across Great Britain to ensure pharmacy can play its part in creating sustainable and ecologically supportive services.

Our activity began in September 2021 when we formally recognised the scale and importance of the situation by publishing a declaration of a climate emergency.

With medicines accounting for 25 per cent of NHS carbon emissions, we subsequently published a policy which outlines how pharmacists' expertise must be used to take a leading role in reducing the environmental impact of medicines use.

We recently published a climate change charter for pharmacy, focusing on five key things that pharmacy professionals can do to help tackle climate change. We have contributed to the Greener Primary Care Wales Framework and Award Scheme, and engaged with National Resources Wales, Welsh Water, the Future Generations Commissioner and Welsh antimicrobial pharmacists to discuss the potential of research on pharmaceuticals in our waterways and the impact on the environment. We have also joined forces with other royal colleges and patient representative groups via the Welsh NHS Confederation's Wellbeing Alliance to specifically look at sustainability issues.

DELIVERING FOR WALES

Delivering on these strategic priorities and other core tasks is entirely depending on the hardworking team of staff and board members that we have in Wales.

Recently we have seen some changes to the team. Following a recent election to our RPS Wales Board, it has been a pleasure to welcome three new pharmacists onto the board. They are:

- Rhian Lloyd-Evans, a hospital pharmacist at Aneurin Bevan University Health Board
- Liz Hallet, a GP practice pharmacist in Cardiff
- Lowri Puw, a community pharmacist in Pen Llyn.

It has also been a pleasure to recently welcome Alwyn Fortune to the team as Policy and Engagement Lead for Wales. Alwyn brings a wealth of experience in in community pharmacy at local and regional levels and has added to the enthusiasm and commitment that we all have for the pharmacy profession in Wales.

I would like to thank all outgoing board members and staff who have moved on to new ventures for their dedication, tenacity and passion in helping to drive the agenda for the RPS Wales over the past years.

GET INVOLVED

My final plea to readers of Welsh Pharmacy Review is to get involved in our work. There is huge agenda facing us and we want to represent your views and understand the issues that are important to you. So, if any of the issues in this article resonate, please get in touch.

ROYAL PHARMACEUTICAL SOCIETY
Wales Cymru

NEWS

NHS WALES AWARDED HIGHEST HONOUR BY THE QUEEN

The Queen recently presented the George Cross to NHS Wales Chief Executive, Judith Paget, and Intensive Care Consultant, Dr Ami Jones, at a ceremony in Windsor Castle.

They received the award on behalf of the entire team of NHS Wales workers – the nurses, doctors, pharmacists, cleaners, paramedics, porters, therapists – in recognition of their courage, compassion and skill.

The Queen was accompanied by the Prince of Wales for the presentation.

Commenting on the achievement, Judith Paget said, 'I'm honoured to join Dr Jones to accept the George Cross on behalf of the NHS in Wales. It is the UK's highest civilian gallantry medal which recognises the dedicated service shown by the NHS since it was set up 74 years ago, including the great courage, devotion and duty that staff displayed during the pandemic.

'I saw the bravery of the staff who are the heartbeat of the NHS in caring for our friends and family at first-hand. This is a great honour and a great day for all who work and who have worked for the NHS in Wales.'

Dr Ami Jones added, 'It gives me enormous pride to join Judith in representing all staff across NHS Wales to accept the George Cross medal. As someone who serves in the military, I appreciate that only the very best receive this medal and our amazing NHS staff are certainly worthy recipients.

'Our staff would have never imagined that such a daunting pandemic would take place in their lifetimes, but they put their own fears aside to provide excellent care to their patients and find solutions to the unprecedented problems that they faced on a daily basis.'

LIGHT SHED ON HOW SARS-COV-2 EVADES THE IMMUNE RESPONSE IN EARLY INFECTION

A new study led by Cardiff University has provided an insight into how the COVID-19 virus 'interferes' with the body's initial immune response to avoid detection.

In the lab scientists showed how SARS-CoV-2 can evade natural killer (NK) cells – a type of white blood cell and a crucial part of the early immune response – by shutting off several ways these cells recognise the virus.

However, they also found that the virus is unable to dodge NK cells that have been activated by antibodies to recognise viral proteins on the infected cell – meaning their findings, published in the journal, eLife, could have important implications for vaccine design.

'Our research suggests vaccines could be improved and bolstered to ensure we better equip the body's own defences to attack the virus,' explained lead author Dr Ceri Fielding, a Lecturer from Cardiff University's School of Medicine.

The innate – or initial – immune response to COVID-19 is a crucial but complex process and the virus has a broad range of strategies to avoid being detected. In the initial immune response, NK cells recognise viral targets through stress-induced molecules on the surface of infected cells.

As part of the adaptive – or more powerful, longer-lasting – immune response, they then recognise infected cells by harnessing virus-specific antibodies. This mechanism is known as antibody-dependent cellular cytotoxicity (ADCC).

The team screened proteins expressed on the surface of infected cells to show how the virus evades NK cells by preventing the synthesis of several molecules, known as ligands, that bind to its receptors. Further experiments revealed viral proteins Nsp1 and Nsp14 could be responsible for that effect.

They then showed how NK cells could be triggered by antibodies bound to SARS-CoV-2-infected cells, via the ADCC mechanism, marking out the cell for destruction.

In most of the current vaccines, the spike protein is used as the key component – but this study suggests other viral proteins would induce different aspects of the immune response.

NEW BLOOD TEST CLINIC SET TO OPEN

A new blood test clinic is to open its doors as the service at the Bay Field Hospital comes to an end.

The community hub at the Port Talbot Resource Centre in Baglan is due to open in August, with appointments available via the health board's online or telephone booking system.

It will be in addition to the current outpatient blood test clinics at Morriston, Singleton and Neath Port Talbot Hospitals, which will also increase the number of appointments they offer when the Bay blood test clinic closes.

The Port Talbot Resource Centre clinic is also the first stage of a long-term health board plan to provide routine blood tests, such as those requested by GPs, at community hubs across the Swansea and Neath Port Talbot areas.

A temporary blood testing service will also run at Central Clinic in Swansea city centre in the coming months, while the health board seeks a permanent venue for blood testing within the city centre and in Neath town centre.

A second community blood test hub is due to open at Gorseinon Hospital in the autumn.

Senior Blood Test Service Manager, Rhodri Davies, said the goal is to move the blood test service nearer to the people it serves, but at venues that can handle the huge demand.

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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).

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PC-GB-106837 July 2022

Lilly

INFLAMMATORY BOWEL DISEASE

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

INFLAMMATORY BOWEL DISEASE

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!

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.

PUTTING IT ON THE MAP

Rhiannon Walters-Davies MPharm MRPharms, Principal Pharmacist, Velindre Cancer Centre, Cardiff, reflects on the oncology pharmacy workforce, the impact of increased pressures, and the development of the British Oncology Pharmacy Association Roadmap to help propel workforce planning forward.

Pharmacy's greatest resource has always been its workforce, and it is difficult to imagine any other healthcare system not reliant on its staff. This is also true of specialist sectors within pharmacy, where specialist knowledge and skills are gained through experience and continued professional development. The specialist area that I work within is oncology pharmacy and having worked within this area for over 10 years, I have seen the challenges to the workforce become more and more difficult to overcome.

We know the pharmacy workforce is struggling with regards to the ability to recruit and retain sufficient numbers of trained competent staff. We have seen the impact over the past 10 years of the increasing awareness of the role pharmacy can play in supporting patients to maximise the benefits from medication, manage their disease symptoms, and to deliver the best quality of life. The primary care sector have recognised the benefits of pharmacists and pharmacy technicians within the primary care practice team to support the management of patients with chronic conditions. This has seen a significant increase in employment of pharmacists within primary care within Wales and across the whole of the UK. There is also increasing demand for pharmacy services within the acute sector. The role of the pharmacy technician has widened, increasing technician scope of practice, with this set against an increasing demand for pharmacy technicians within primary care. Another workforce demand is for pharmacist independent prescribers which has increased drastically in all sectors, including acute, primary and community.

There is a recognised increase in demand for skilled pharmacy staff and this should absolutely be viewed as a success for the pharmacy profession in getting pharmacy staff skills recognised, along with the direct benefit to patients and the healthcare service. However, the increased demand for pharmacy staff is not being met by either the current staff or the number of new staff coming through the training pipeline. The increased demand for pharmacists is not being met by the numbers recruited into the undergraduate Master of Pharmacy Degree. Even established high performing Schools of Pharmacy have been unable to increase student numbers and have struggled to even maintain the current pipeline of student numbers. In addition, changes to the curriculum, although recognised as positive by the profession, has led to some uncertainty, both for the trainers and the trainees. This situation with significant training changes, alongside the number of training posts not meeting demand, is mirrored within the pharmacy technician sector, leading to a further stretched and strained workforce.

We now have a situation where pharmacy workforce numbers are now becoming critical and it is now being recognised nationally. In response to this in March 2021, the role of the pharmacist was added to the Home Office's Shortage Occupation List.

ONCOLOGY PHARMACY

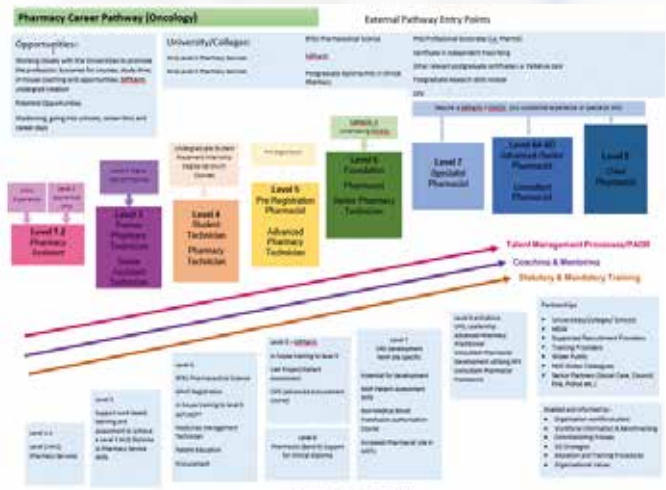


Diagram One

Diagram One illustrates the current pharmacy career pathway for pharmacy staffing groups (including registrant and non-registrant staffing groups).

The challenges in the pharmacy workforce are being felt across the board but it may be being felt more acutely in those more specialised areas where further skills and training are needed to ensure patient safety. One such area is oncology pharmacy services, which encapsulates both clinical oncology and aseptic services, both services which require staff to have significant training and experience in addition to 'standard' pharmacy training. The struggles seen in the oncology pharmacy workforce is made acutely worse by the surge in demand for oncology services we have seen post-COVID pandemic.

In order to overcome some of these workforce challenges faced within oncology pharmacy the British Oncology Pharmacy Association (BOPA) has been developing the BOPA Roadmap. This was initially developed from the BOPA vision document launched ISOPP / BOPA 2019 which intended to:

- Showcase the significance of the contribution of oncology pharmacy practitioners
- Highlight to the pharmacy workforce, the potential roles for oncology pharmacy practitioners UK-wide
- Demonstrate the various education and training pathways that can support the evolving careers of oncology pharmacy practitioners
- Define pathways of impact for the future and outline the requirements of the oncology pharmacy workforce to meet increasing future challenges
- Create opportunities for oncology pharmacy practitioners and increase the appeal of oncology pharmacy practice as a career
- Celebrate the excellence and innovation of oncology pharmacy practice
- Increase public understanding of what oncology pharmacy practitioners do and how they can benefit patients
- Have alignment with other key stakeholder visions within the wider pharmacy and oncology arenas

The BOPA Roadmap will combine the BOPA vision into a visual interactive 'build your own' map for oncology practice which can be built by an individual or an oncology service (or even multi-service / regional-build). There can be individual paths or they can be overlaid to allow multiple paths to be visualised. BOPA members are provided with information relating to:

- Different roles / skills likely to be required within oncology pharmacy
- BOPA support available through the education and training aligned to these roles / skills
- Transferable skills / roles and how pharmacists can move sectors

This will allow individuals utilising the BOPA Roadmap to review their educational and training needs and more robust workforce planning, along with knowledge of educational requirements at trust and health board level. The planned go live for the roadmap is early 2023.

As we have discussed, workforce challenges within pharmacy continue to be felt within the service, including oncology pharmacy. Innovative projects such as the BOPA Roadmap will hopefully be one tool to improving the workforce planning and therefore workforce within oncology pharmacy.

Another launch from Teva

LENALIDOMIDE

Lenalidomide from teva (lenalidomide) 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg, 25mg Oral Capsules

- *Lenalidomide from teva provides significant associated cost efficiencies Vs the brand originator*
- *Teva is your trusted partner for stable supply*
- *Lenalidomide from teva does not contain lactose making it a suitable alternative for lactose intolerant patients*[1]

Lenalidomide from teva is indicated for the treatment of Multiple Myeloma, Myelodysplastic syndromes, Mantle cell lymphoma & Follicular Lymphoma[1]

Multiple Myeloma:

•As monotherapy for the maintenance treatment of adult patients with newly diagnosed multiple myeloma who have undergone autologous stem cell transplantation (ASCT)

•In combination therapy with dexamethasone, or bortezomib and dexamethasone, or melphalan and prednisone for the treatment of adult patients with previously untreated multiple myeloma who are not eligible for transplant

•In combination with dexamethasone for the treatment of multiple myeloma in adult patients who have received at least one prior therapy

Myelodysplastic syndromes:

•Lenalidomide as monotherapy is indicated for the treatment of adult patients with transfusion-dependent anaemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with an isolated deletion 5q cytogenetic abnormality when other therapeutic options are insufficient or inadequate.

Mantle cell lymphoma:

•Lenalidomide as monotherapy is indicated for the treatment of adult patients with relapsed or refractory mantle cell lymphoma

Follicular lymphoma:

In combination with rituximab (anti-CD20 antibody) for the treatment of adult patients with previously treated follicular lymphoma (Grade 1 – 3a)

All strengths, capsules aesthetics and pack sizes match the Originator product Revlimid®▼ (lenalidomide)[2] Lenalidomide teva has been brought to market through the route of a bioequivalence study vs Revlimid®

Strength	**2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg, 25mg Oral Capsules**
Pack size / format	All strengths are in packs of 21 Capsules. 2.5mg is the only strength that also comes in a pack of 7
Presentation	Hard capsules
Colour of pack	Teva hospital livery
Shelf life	3 years
Administration	Capsules should be swallowed whole, preferably with water, either with or without food. Capsule should not be opened, broken or chewed. Take capsules at about the same time on the scheduled days. To reduce capsule deformation or breakage, press only one end of the capsule from blister. Healthcare professionals or caregivers should wear disposable gloves when handling blister or capsule. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule. Treatment should be supervised by a physician experienced in the use of anticancer therapies.

In order to show the essential similarity with the innovator product Revlimid® (Celgene Europe Limited, UK), Teva conducted **2 bioequivalence studies** with the test product Lenalidomide capsules (Pliva) and the reference product Revlimid® (Celgene Europe Limited, UK) under fasting conditions.

The 25mg dose was selected for bioequivalence testing covering lower dose strengths of 5mg, 7.5mg, 10mg, 15mg and 20mg (Study No. 2015-3914), and bioequivalence of 2.5mg strength was tested in a separate study (Study No.: 2016-4006).

Prescribing information and adverse event statement can be found overleaf

The bioequivalence between Lenalidomide Teva 2.5mg and 25mg hard capsules and the reference product Revlimid® 2.5mg and 25mg hard capsules was demonstrated.

Results from the bioequivalence study conducted with 25mg strength were extrapolated to the lower strengths (5mg, 7.5mg, 10mg, 15mg and 20mg). Thus, the two drugs (Revlimid® and Lenalidomide Teva) **are regarded equivalent in terms of efficacy and safety[2].**

Additional Risk Minimisation Measures include:

Pregnancy Prevention Programme (PPP)
Educational Healthcare Professional Kit
Educational materials for patients, including Patient Card

References
1. Lenalidomide. www.SmPC 2. Revlimid SmPC 3. Data on file LEN3-UK-1481

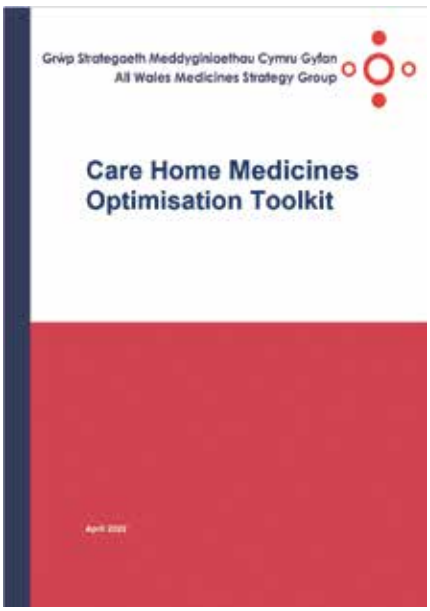
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Teva UK Limited on 0207 540 7117 or medinfo@tevauk.com

Please refer to the Summary of Product Characteristics (SmPC) for full details of Prescribing Information.

Lenalidomide 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg and 25mg Hard capsules Abbreviated Prescribing Information. **Presentation:** Each hard capsule contains lenalidomide hydrochloride hydrate corresponding to 2.5mg, 5mg, 7.5mg, 10mg, 15mg 20mg or 25mg of lenalidomide. **Indications:** As monotherapy for the maintenance treatment of adult patients with newly diagnosed multiple myeloma who have undergone autologous stem cell transplantation, as combination therapy with dexamethasone or bortezomib and dexamethasone, or melphalan and prednisone for the treatment of adult patients with previously untreated multiple myeloma not eligible for transplant, in combination with dexamethasone for the treatment of multiple myeloma in adult patients who have received at least one prior therapy in combination with rituximab (anti-CD20 antibody) for the treatment of adult patients with previously treated follicular lymphoma (Grade 1 to), as monotherapy for the treatment of adult patients with transfusion-dependent anaemia due to low- or intermediate-1 risk myelodysplastic syndromes associated with an isolated deletion 5q cytogenetic abnormality when other therapeutic options are insufficient or inadequate, as monotherapy for the treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL). **Dosage and administration:** Take orally at same time on the scheduled days. Swallow capsule whole, preferably with water, either with/without food. Capsules should not be opened, broken or chewed. Healthcare professionals or caregivers should wear disposable gloves when handling blister or capsule. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule. Treatment should be supervised by a physician experienced in the use of anti-cancer therapies. Dose is modified based upon clinical and laboratory findings (see SmPC for dose reduction steps). Dose adjustments during treatment and restart of treatment are recommended to manage Grade 3 or 4 thrombocytopenia, neutropenia or other Grade 3 or 4 toxicity related to lenalidomide. Growth factors should be considered in case of neutropenia management. Refer to SmPC for dosing recommendations and adjustments during treatment for all therapeutic indications Adults: newly diagnosed multiple myeloma (NDMM): Lenalidomide in combination with dexamethasone until disease progression in patients not eligible for transplant: Lenalidomide treatment must not be started if the ANC is < 1.0 x 10^9/L and/or platelet counts are < 50 x 10^9/L. Lenalidomide in combination with bortezomib and dexamethasone followed by lenalidomide and dexamethasone until disease progression in patients not eligible for transplant: Initial treatment: Lenalidomide in combination with bortezomib and dexamethasone must not be started if the ANC is < 1.0 x 10^9/L and/or platelet counts are < 50 x 10^9/L. Continued treatment: Lenalidomide in combination with dexamethasone until progression: Continue lenalidomide 25mg orally once daily on days 1-21 of repeated 28-day cycles in combination with dexamethasone; Lenalidomide in combination with melphalan and prednisone followed by lenalidomide maintenance in patients not eligible for transplant: Lenalidomide treatment must not be started if the ANC is < 1.5 x 10^9/L and/or platelet counts are < 75 x 10^9/L. Lenalidomide maintenance in patients who have undergone autologous stem cell transplantation (ASCT): Lenalidomide maintenance should be initiated after adequate haematologic recovering following ASCT in patients without evidence of progression. Lenalidomide must not be started if the Absolute Neutrophil Count (ANC) is < 1.5 x 10^9/L and/or platelet counts are < 75 x 10^9/L. Multiple myeloma with at least one prior therapy: Lenalidomide treatment must not be started if the ANC < 1.0 x 10^9/L and/or platelet counts < 75 x 10^9/L or, dependent on bone marrow infiltration by plasma cells, platelet counts < 50 x 10^9/L. Myelodysplastic syndromes (MDS): Lenalidomide treatment must not be started if the ANC < 0.5 x 10^9/L and/or platelet counts < 25 x 10^9/L. Patients without at least a minor erythroid response within 4 months of therapy initiation, demonstrated by at least a 50% reduction in transfusion requirements or, if not transfused, a 1g/dl rise in haemoglobin, should discontinue lenalidomide treatment. Follicular lymphoma (FL): Lenalidomide treatment must not be started if the ANC is < 1 x 10^9/L and/or platelet count < 50 x 10^9/L, unless secondary to lymphoma infiltration of bone marrow.Children: should not be used. Elderly: take care in dose selection and monitor renal function. Renal impairment: take care in dose selection and monitor renal function.mild: no dose adjustment; moderate or severe: see SmPC for dose adjustment. Hepatic impairment: no dose recommendations. **Contraindications:** Hypersensitivity to active substance or excipients; women who are pregnant; women of childbearing potential unless all conditions of the Pregnancy Prevention Programme are met. **Precautions and warnings:** When lenalidomide is given in combination with other medicinal products, the corresponding SmPC must be consulted. The conditions of the Pregnancy Prevention Programme must be fulfilled for all patients, including males (refer to SmPC) prior to prescribing. If lenalidomide is taken during pregnancy, a teratogenic effect is expected. Women of childbearing potential must use at least one effective contraception method for at least 4 weeks before therapy, during therapy, and after finishing therapy and dose interruption. Combined oral contraceptive pills are not recommended due to increased risk of venous thromboembolism. Implants and levonorgestrel-releasing intrauterine systems are associated with an increased risk of infection – prophylactic antibiotics should be considered particularly in patients with neutropenia. Copper-releasing intrauterine devices are not recommended. Medically supervised pregnancy testing should be performed prior to starting treatment and repeated at least every 4 weeks during treatment and 4 weeks after end of treatment. Patients should not donate blood during treatment or for at least 7 days after discontinuation. Myocardial infarction, venous and arterial thromboembolic events has been reported. Patients with known risk factors, including prior thrombosis, should be closely monitored and action taken to minimise all modifiable risk factors. The decision to take antithrombotic prophylactic measures should be considered. If patient experiences any thromboembolic event, treatment must be discontinued and standard anticoagulation therapy started. A complete blood cell count should be performed at baseline and during treatment (see SmPC) to monitor for cytopenias. Evaluate patients for signs and symptoms of underlying cardiopulmonary disease prior to initiating and during lenalidomide treatment. Co-administration with other myelosuppressive agents should be undertaken with caution. Close observation for signs and symptoms of bleeding, including petechiae and epistaxis is recommended. Optimal control of co-morbid conditions influencing thyroid function is recommended and monitored throughout treatment. Caution advised in patients at risk of tumour lysis syndrome (TLS) or tumour flare reaction (TFR). Careful monitoring and evaluation is recommended. All patients receiving lenalidomide treatment for MCL or follicular lymphoma should receive TLS prophylaxis and be well hydrated. Allergic reactions/hypersensitivity reactions and severe skin reactions have been reported – monitor closely. Treatment must be discontinued if angioedema, anaphylactic reaction, exfoliative or bullous rash, Stevens-Johnson Syndrome (SJS), Toxic epidermal necrolysis (TEN) or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is suspected and treatment must not be resumed. Interruption or discontinuation should be considered for other forms of skin reaction depending on severity. Patients who had previous allergic reactions while treated with thalidomide should be monitored closely as possible as cross-reaction has been reported.Patients with a history of severe rash associated with thalidomide treatment should not receive lenalidomide. An increase of second primary malignancies (SPM) has been observed. The risk must be taken into account. Evaluate and monitor patients before and during treatment. Monitoring of liver function is recommended. Patients with known risk factors for infections should be closely monitored. Caution is recommended in patients previously infected with hepatitis B virus – monitor closely. Signs and symptoms for Progressive multifocal leukoencephalopathy (PML) should be monitored. If PML is confirmed, discontinue lenalidomide treatment. The patients' ability to tolerate lenalidomide in combination, with consideration to age, ISS stage III, ECOG PS ≥ 2 or CLcr<60 mL/min should be assessed. Regular monitoring of visual ability is recommended. **Interactions:** Erythropoietic agents or other agents that may increase the risk of thrombosis, should be used with caution. Efficacy of oral contraceptives may be reduced. Close monitoring of warfarin and digoxin concentration is advised. Increased risk of rhabdomyolysis with statins – enhanced clinical and laboratory monitoring is warranted. **Pregnancy and lactation:** Contraindicated in pregnancy. Breast-feeding should be discontinued. **Effects on ability to drive and use machines:** Minor or moderate influence. Caution recommended. **Adverse reactions:** pneumonia, neutropenia, infection, lung infection, sepsis, bacteraemia, myelodysplastic syndrome, neutropenia, febrile neutropenia, thrombocytopenia, leukopenia, pancytopenia, hypokalaemia, peripheral neuropathy, pulmonary embolism, deep vein thrombosis, cellulitis, opportunistic infections, enterocolitis infections, basal cell carcinoma, squamous skin cancer, acute myeloid leukaemia, T-cell type acute leukaemia, Tumour lysis syndrome, haemorrhagic disorder, haemolytic anaemia, autoimmune haemolytic anaemia, thyroid disorders, hyperuricaemia, diabetes mellitus, cerebrovascular accident, intracranial haemorrhage, transient ischaemic attack, cerebral ischaemia, cataract, blindness, deafness (including hypoacusis), atrial fibrillation, bradycardia, myocardial infarction (including acute), congestive cardiac failure, cardiac failure, myocardial ischaemia, QT prolongation, arrhythmia, venous thromboembolic events, intracranial venous sinus thrombosis, respiratory distress, hypoxia, gastrointestinal haemorrhage (including rectal haemorrhage), haemorrhoidal haemorrhage, small intestinal obstruction, peptic ulcer haemorrhage, cholestasis, hepatotoxicity, hepatocellular injury, hepatic failure, drug reaction with eosinophilia and systemic symptoms, renal failure (including acute), renal tubular necrosis, acquired Fanconi syndrome, tumour flare, acute kidney injury, hepatitis B reactivation, acquired haemophilia, solid organ transplant rejection, pulmonary hypertension, pancreatitis, gastrointestinal perforation (including diverticular, intestinal and large intestine perforations, acute hepatic failure, cytolytic hepatitis, cholestatic hepatitis, mixed cytolytic/cholestatic hepatitis, Stevens-Johnson Syndrome, Toxic epidermal necrolysis, very Common: respiratory tract infection, bronchitis, influenza, gastroenteritis, sinusitis, nasopharyngitis, rhinitis, anaemia, lymphopenia, paraesthesia, cough, dyspnoea, rhinorrhoea, diarrhoea, constipation, abdominal pain, nausea, abnormal liver function tests, rash, dry skin, muscle spasms, fatigue, asthenia, pyrexia, bacterial, viral and fungal infections (including opportunistic infections, pharyngitis, hypercholesterolaemia, hypocalcaemia, hyperglycaemia, dehydration, decreased appetite, weight decreased, depression, insomnia, peripheral neuropathies, paraesthesia, dizziness, tremor, dysgeusia, headache, blurred vision, epistaxis, cough, vomiting, dyspepsia, dry mouth, stomatitis, alanine aminotransferase increased, aspartate aminotransferase increased, rashes, pruritus, muscular weakness, muscle spasms, bone pain, musculoskeletal and connective tissue pain and discomfort (including back pain), pain in extremity, myalgia, arthralgia, oedema (including peripheral), influenza-like illness syndrome, blood alkaline phosphatase increased, decreased appetite, Common: infection, lower respiratory tract infection, herpes zoster, hypothyroidism, hyperuricaemia, gout, hypomagnesaemia, hypercalcaemia, ataxia, balance impaired, agitation, neuralgia, dysaesthesia, reduced visual acuity, tinnitus, tachycardia, hypertriglyceridaemia, arrhythmias, vasculitis, dysphonia, pleuritic pain, gingival bleeding, dysphagia, hyperbilirubinaemia, urticaria, hyperhidrosis, skin hyperpigmentation, eczema, erythema, skin discolouration, photosensitivity reaction, joint swelling, haematuria, urinary retention/incontinence, erectile dysfunction, chest pain, lethargy, c-reactive protein increased, fall, contusion, hypophosphataemia, oropharyngeal pain, night sweats, neck pain, malaise, chills, blood bilirubin increased (consult the SmPC in relation to other side effects. **Overdose:** Supportive care is advised. **Price:** Pack Quantity: 21 tablets (all strengths), 2.5mg (Pack Qty 7): £1037.95, 5 5mg (Pack Qty 7): £3083.40, 7.5mg: £3215.00, 10mg: £3452.00, 15mg: £3512.10, 20mg: £3711.65, 25mg: £3931.20 **Legal category:** POM. **Marketing Authorisation Number:** PL 00289/1162-66. **Marketing Authorisation Holder:** Teva UK Limited, Ridings Point, Whistler Drive, Castleford, WF10 5HX. **Job Code:** MED-GB-00004. **Date of Preparation:** January 2022

A GUIDING FORCE

In their latest WPR column, the All Wales Therapeutics and Toxicology Centre highlight their work in developing a suite of documents for care home and pharmacy teams.



The All Wales Therapeutics and Toxicology Centre (AWTTC) worked with colleagues from Aneurin Bevan University Health Board and the All Wales Consultant Pharmacist for Community Healthcare to produce an All Wales Care Home Medicines Optimisation Toolkit, which has been endorsed by the All Wales Medicines Strategy Group (AWMSG).

The toolkit brings together a suite of guidance documents, tools and useful resources, all accessible in one place. The toolkit can serve as an easy access resource library for care home staff and pharmacy teams who provide advice and support to care homes.

MANAGING MEDICINES IN CARE HOMES

Care homes have a legal responsibility to ensure that all aspects of medicines management are covered within written policies and procedures and that these are regularly reviewed to ensure that they are up-to-date, and based on current legislation and the best available evidence. NICE Social Care guideline (SC1): Managing Medicines in Care Homes, covers good practice guidelines for managing medicines in care homes, and highlights a number of areas which should be included within a care home's medicines policy. Feedback from pharmacy teams working with care homes, and care home managers, highlighted variation in the policies and documentation available within care homes. A lack of appropriate policies and procedures in addition to poor documentation and record-keeping can lead to errors within care homes. In order to try and address this issue and support care homes who may not have access to appropriate documentation, the All Wales Care Home Medicines Optimisation Toolkit was developed.

The draft toolkit was circulated for wide consultation in order to gather feedback from care home managers and staff, patients and the public, and pharmacy teams supporting care homes. Overall feedback was positive, with requests for additional resources to be included within the toolkit. Resources within the toolkit were updated in line with consultation comments, before presentation to the AWMSG for endorsement.

ALL WALES CARE HOME MEDICINES OPTIMISATION TOOLKIT

The toolkit is available on the AWTTC website (www.awttc.nhs.wales) and can be downloaded in full as a reference source, or as individual resources as required. The toolkit includes information on homely remedies, self-administration of medicines, bulk prescribing, storage of medicines, swallowing difficulties and covert administration of medicines, as well as a number of template charts and forms.

It is anticipated that the toolkit will promote good practice, reduce inappropriate variation, avoid duplication of effort and help ensure that the NHS Wales makes the best use of medicines across all care home settings. The resources are freely available and are intended to support the safe and effective use of medicines within care homes, and ultimately support the residents who live there.

AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

THAT FIGURES

When it comes to substance dependency in Wales, is there hope behind the numbers? Martin Blakebrough, CEO of Kaleidoscope, shares his insight.

Martin Blakebrough

The drug-related death figures released by the Office for National Statistics in August (1) show the tragic truth that substance use is an issue that has an increasing impact not just across Wales, but across the whole UK.

In 2021 in Wales alone 210 people who use drugs lost their lives. The spike in figures over 2020 is exaggerated, as COVID-related reporting delays mean some data from 2020 appeared in the 2021 report. Nonetheless the upward trend continues at present. Sadly, concurrent with the release of these figures, the Westminster government has doubled down on talk about 'tough action' and 'tough consequences' for people who use drugs. This includes a 'three strikes and you're out' approach which could see some substance users being electronically tagged and having passports and driving licenses removed.

Looking at the trends in drug-related deaths it appears that the tougher the rules on punishment and consequences, the worse the figures get. An internet search shows that there were more articles about the draconian removal of civil liberties than there were about the drug-related deaths themselves. Such a focus does nothing to promote awareness of why people might take drugs. It fails to involve people with living experience of drug use in the discussion about how to affect change. Indeed, it exacerbates the stigma that substance users experience. Social stigma forgets that behind every drug-related death figure is a life, a name, a family. Someone's son or daughter. With one-third of drug-related deaths reported as being from among people who had 'no known contact' with any of the health service providers that could have helped them in the 12 months prior (2), recent figures demonstrate clearly that stigma, separation and isolation arising from the 'them and us' approach is itself a killer. Yet at Kaleidoscope we know that a different, user-led approach can produce remarkably different outcomes.

SO, IS THE OUTLOOK ENTIRELY BLEAK HERE IN WALES?

In a word, 'no'. Over the last couple of years Kaleidoscope has seen there is hope behind the numbers, particularly where solutions involve people with living experience of drug use in the design, delivery and improvement in service provision. Innovations in dealing with opiates – which are present in over half of all drug-related deaths – are particularly promising.

Driven by our work in Kaleidoscope, this year Wales will claim a world-first in terms of drug services. This summer we will become the first nation not just in the UK but across the globe to have nationwide peer-to-peer coverage of the overdose reversal drug Naloxone. Peer provision of Naloxone is vital because the negative image and stigma associated with being a substance user means users who are not in treatment are challenging for services to engage with. Having peers – volunteers who are substance users themselves – trained to supply Naloxone and train others to supply and administer it means its benefits can reach a far greater proportion of the opiate-using population. As it is service-user led, it is transformative in terms of dealing with stigma and enhancing self-esteem. In Wales peers have trained not just other substance users, but NHS staff and members of the police in how to use Naloxone. And as one peer trainer who has successfully used Naloxone to save four lives said, 'There is nothing quite like meeting someone in the street whose life you've saved, and having their kids run up and hug you'.

Peer Naloxone is relatively new here in Wales – but the hope behind the numbers is that we will see the drug death figures start to be impacted by innovations such as this in the years ahead.

ABOUT KALEIDOSCOPE

Kaleidoscope is a Wales-based charity which runs substance use projects across Wales and supports upwards of 10,000 people a year with drug, alcohol and mental health issues.

Contact details:
Email: info@kaleidoscope68.org
Web: www.kaleidoscope68.org
Twitter: @Kaleidoscope68
Facebook: @Kaleidoscope68
Instagram: kaleidoscope1968

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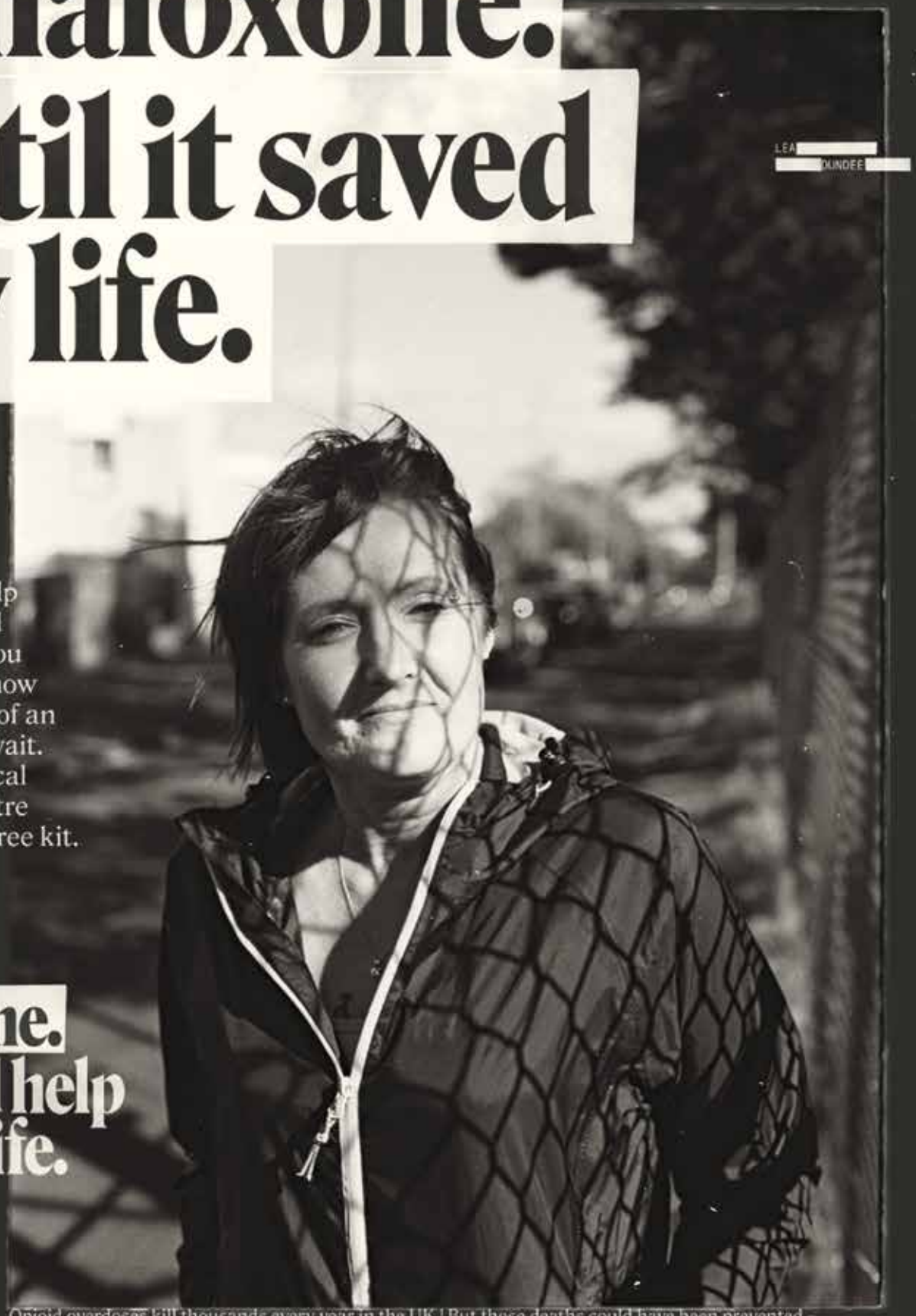
2. www.phw.nhs.wales/news/drug-deaths-at-their-highest-ever-levels-in-wales/

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



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-17e

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 role 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

HEALTH ON THE HIGH STREET

PUBLIC HEALTH WALES HAS OPENED ITS FIRST HIGH STREET SCREENING CENTRE.

Public Health Wales has opened its doors to the first screening centre of its kind on a high street in Wales.

The dedicated screening centre is part of a brand new approach to help boost accessibility and uptake of screening, post-COVID-19 and houses multiple screening services all under one roof.

Based in Mountain Ash, the centre is the result of a person-centred, partnership approach supported by Rhondda Cynon Taf CBC, and has been designed with public accessibility as a priority, making it easier for people to attend screening appointments.

Public Health Wales hopes this new model can be the blueprint for the future of health screening in Wales. It is the first time that the trust has leased and rejuvenated a building specifically to offer multiple screening programmes under one roof, in the heart of the community. It brings together services for three national programmes: diabetic eye, abdominal aortic aneurysm and newborn hearing screening. Just under 8,000 people will be invited to screening at the centre in its first year.

By taking screening onto the high street, the aim is to make it easier for people to attend appointments. With easy transport links nearby, the centre also offers more flexible appointments, allowing people to attend at a wider range of times outside the usual 9am-to-5pm, Monday-to-Friday. It will provide increased screening capacity to the local authority areas of Rhondda Cynon Taff, Merthyr and Caerphilly.

The new screening centre contributes to the Welsh government's commitment to deliver better public access to health professionals.

Minister for Health, Eluned Morgan, explained, 'I'm delighted to officially open the new centre, screening plays a vital role and anything that makes it more convenient for people to attend appointments is something I very much welcome. I look forward to seeing how the centre progresses and whether the blueprint of a high street location could perhaps be replicated in other parts of Wales.'

NEUROPAD RECOMMENDED IN NEW UK NATIONAL GUIDANCE FOR CARE HOMES

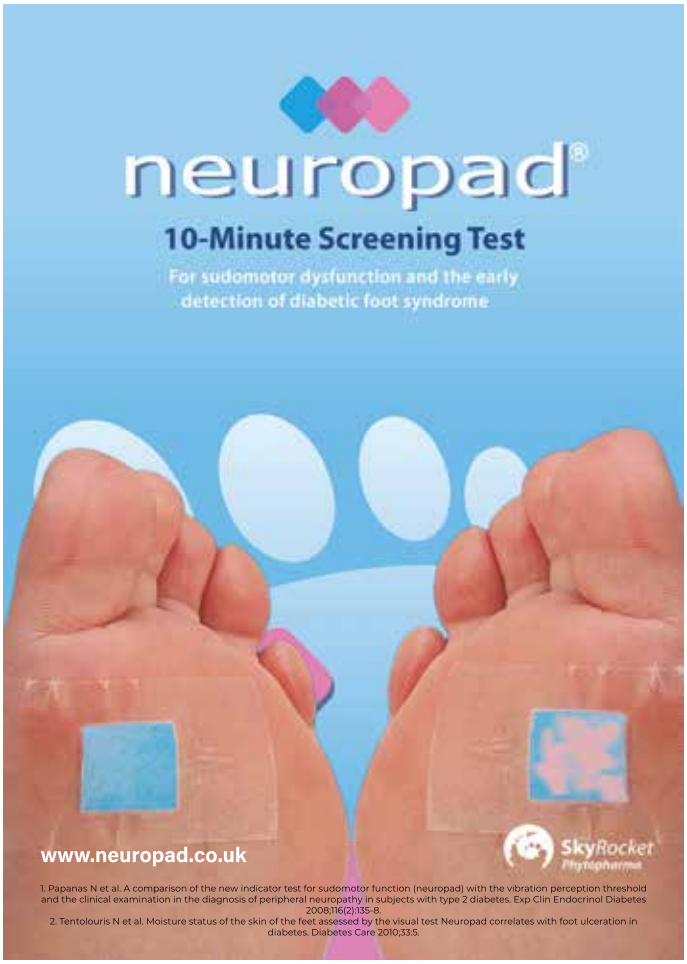
Nerve damage to the feet is a common and much-feared complication of diabetes but often goes unnoticed. Neuropad® helps solve this problem with a simple colour change test that provides an early warning sign. Neuropad® has recently been recommended by the National Advisory Panel for Care Home Diabetes (NAPCHD) in its new national guidance for care home operators and their staff.

The NAPCHD guidance is the work of an eminent panel of UK healthcare professionals led by Professor Alan Sinclair of Kings College London. The panel also included Professor Gerry Rayman MBE, who is an expert in diabetic foot disease and pioneer of the Touch the Toes Test (TTT) for the detection of sensory neuropathy, which is a complementary test to Neuropad® in the guidance and this is explained in Appendix A of the guidance. Half of all people with diabetes may develop peripheral neuropathy, including peripheral autonomic neuropathy. Often complications develop before treatment starts and early identification of possible problems is an advantage, allowing interventions to commence when they are most needed.

Data published by the Office for Health Improvement and Disparities looked at the three years leading up to the pandemic and found that 13 out of 135 local areas in England had significantly higher rates of foot amputations. It is believed up to 80% of foot amputations could be avoided with earlier interventions.

Professor Alan Sinclair, an internationally and nationally recognised expert in the field of diabetes In older people and aWorld Health Organization-recognised expert In diabetes states, "Neuropad® offers the opportunity to test for the early signs of distal neuropathy which is an important risk factor for diabetic foot disease. In people with diabetes who because of moderate to severe frailty, dementia, or sensory deficits affecting the eyes or hearing, the Neuropad® test provides an assessment of nerve function that does not require verbal input from the individual being examined. As such, it can be seen as a complementary test to other more established tests of neuropathy."

For more information, visit www.neuropad.co.uk.



COMMUNITY PHARMACISTS FROM THE EPHEU FEDERATION ARE SUPPORTING THE SUPPLY OF 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 neighbouring 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.

Members of the Senedd supporting the campaign

The PDA took their campaign to the Senedd Cymru in June and received significant interest from parliamentarians from across the political parties. For example, Paul Davies MS wrote to his constituents encouraging them to support the campaign, saying, 'As the crisis continues, casualties are needing much more specialist medication. Hospitals treating casualties need medicines that are available only from specialist suppliers and those which due to their nature must be stored and transported under optimum conditions.

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 Wales, enclosed with the latest issue of The PDA 'INSIGHT' magazine. If you would like further supplies of the poster to display in pharmacy, or anywhere else that might encourage donations, 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.

SCAN THE QR CODE.
PLEASE GIVE GENEROUSLY

CAFOD Catholic Agency for Overseas Development

Pharmacists Without Borders / Pharmaciens Sans Frontières

EPhEU

pda the pharmacists' defence association

www.medicinestoukraine.com

ADEXA Die Apothekergewerkschaft

hfd

Montenegro FKCG

The Norwegian Association of Pharmacists

VAAO

Związek Zawodowy Pracowników Farmacji

Welsh Pharmacy Awards 2022

THE COUNTDOWN IS ALMOST OVER

Wednesday 7th September 2022
The Vale Resort, Glamorgan

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Sponsored by Ethypharm UK

INNOVATIVE TECHNOLOGY PROJECT OF THE YEAR

Sponsored by Cegedim Healthcare Solutions and Willach

PHARMACY STUDENT LEADERSHIP

Sponsored by The Pharmacists' Defence Association

PATIENT SAFETY DEVELOPMENT IN SECONDARY CARE

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GP PRACTICE PHARMACY TEAM OF THE YEAR

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BUSINESS DEVELOPMENT OF THE YEAR

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Welsh Pharmacy Awards 2022

WHO WILL BE THIS YEAR'S WINNERS?

Wednesday 7th September 2022
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INNOVATIONS IN SERVICE DELIVERY IN COMMUNITY PHARMACY (INDEPENDENT)

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MANAGEMENT OF SUBSTANCE DEPENDENCY IN THE COMMUNITY

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LOCUM OF THE YEAR

Sponsored by New Directions Pharmacy

INNOVATIONS IN SERVICE DELIVERY IN COMMUNITY PHARMACY (MULTIPLE)

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A PLAN OF ACTION

Incorporating early intervention and ongoing evaluation, the roll-out of the All Wales Diabetes Prevention Programme is aiming to improve the future of the condition.

The All Wales Diabetes Prevention Programme (AWDPP) has commenced implementation in Wales.

The national programme, which offers targeted support to people at an increased risk of type 2 diabetes, is now being delivered in the GP practices involved in the first phase of the programme nationwide.

The AWDPP sees dedicated, trained healthcare support workers, with oversight from dietitians, deliver a brief intervention to people who have had a blood test that shows they are at an increased risk of type 2 diabetes. The intervention helps individuals to understand their level of risk and supports them to reduce it through key changes to their diet and level of physical activity.

The AWDPP is being rolled out in phases with an embedded evaluation, which will assess the outcomes of the programme and the effectiveness of the intervention. In the first half of 2022, the programme is being rolled out in two primary care clusters in each of Wales' seven health board areas.

Tracey Cooper, Chief Executive of Public Health Wales, explained, 'More than 200,000 people in Wales are living with diabetes, and nine-in-10 of them have type 2. Type 2 diabetes can have a severe impact on individuals and their families.

'Evidence suggests that, by supporting people to make key changes to their lifestyle, in over half of people living with type 2 diabetes, their condition could be prevented or delayed. The AWDPP will support people who are at an increased risk of type 2 diabetes to make changes that could reduce this risk.'

The Deputy Minister for Mental Health and Wellbeing, Lynne Neagle, who visited staff and patients in Port Talbot, commented, 'The new programme will focus on prevention, providing tailored care and support at an earlier stage, resulting in better care for patients and less people requiring urgent care. Our Healthy Weight: Healthy Wales strategy focuses on helping people to make healthier choices and this new programme will support this vital work and help reduce the number of people living with type 2 diabetes in Wales.'

Dr Amrita Jesurasa, Consultant in Public Health Medicine at Public Health Wales, added, 'The AWDPP builds on excellent work done locally by GPs to create a standardised approach to diabetes prevention for the whole of Wales. The programme is aligned with NICE guidance, the All Wales Weight Management Pathway, prudent healthcare principles and insights from behavioural science.

'The AWDPP has been developed in consultation with healthcare professionals, third sector organisations and people living with type 2 diabetes. Its impact, reach and effectiveness will be evaluated from the start, and we will use learning from this first phase of the programme's roll-out to inform its development going forward.'

To coincide with the programme's launch, Public Health Wales has published the AWDPP Intervention Protocol, which provides detailed information and support to professionals involved in the programme's delivery.

WHY DO WE NEED THE AWDPP?

Wales has the highest prevalence of diabetes in the UK and, with excess weight and obesity becoming more common, the number of people at an increased risk of type 2 diabetes is rising. The impact of type 2 diabetes on the health and wellbeing of individuals and their families is severe. There is a financial cost as well: treatment of type 2 diabetes accounts for around 10 per cent of the NHS budget.

Evidence suggests that, by supporting people to make key changes to their diet and level of physical activity, over half of type 2 diabetes cases could be prevented. There is therefore a clear need and opportunity for a national programme that supports people to make changes to their lifestyle that can delay or prevent the onset of type 2 diabetes.

WHAT IS THE INTERVENTION?

In areas where the programme is being rolled out, people who have had a blood test that shows that they are at an increased risk of type 2 diabetes will be invited for a 30-minute consultation with a trained healthcare support worker. The healthcare support worker will talk to people about their risk of developing type 2 diabetes and what they can do to reduce it. They may also refer them to additional sources of support from which they could benefit. A follow-up appointment will take place 12 months later.

IS THE INTERVENTION EFFECTIVE?

The design of the intervention draws on successful pilots carried out in primary care clusters in North Ceredigion and Afan Valley. The evaluation of these pilots showed that there was a decrease in average blood sugar (glucose) levels between people receiving the brief intervention and their follow-up appointment, with a smaller number than expected going on to develop type 2 diabetes. The AWDPP will be evaluated on an ongoing basis. Learning from the initial phase of the programme's roll-out will be used to optimise the programme as it develops over the coming years.

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

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

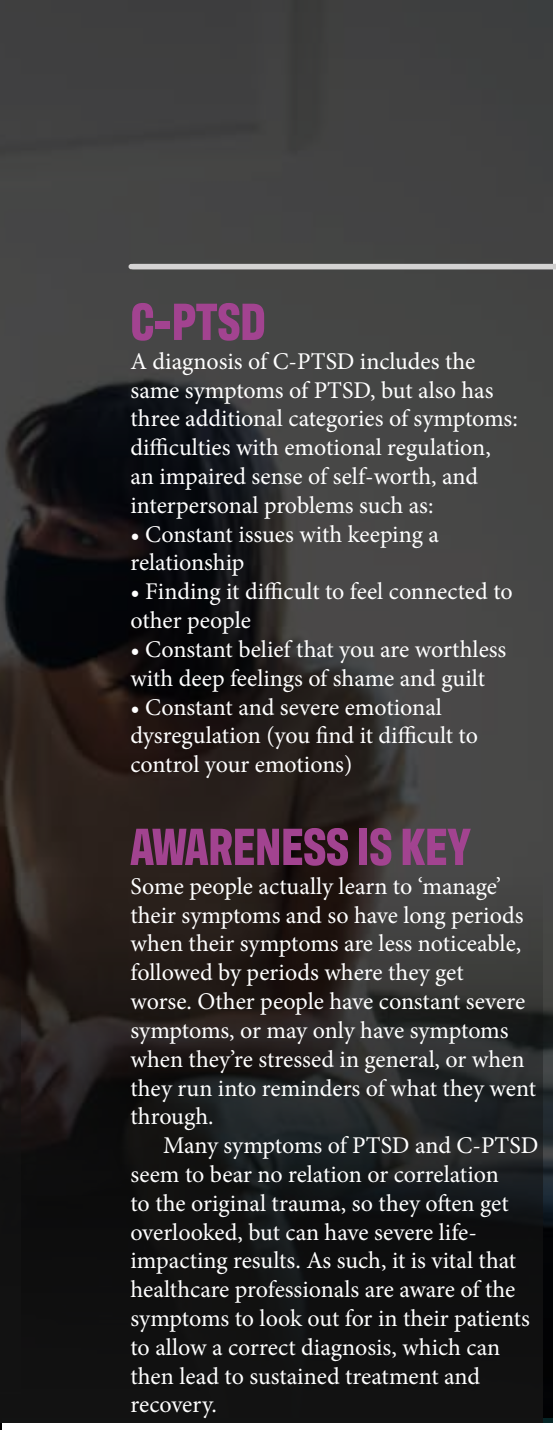
They may be 'jittery', or always alert and on the lookout for danger. They might suddenly become angry or irritable.

- 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

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 that 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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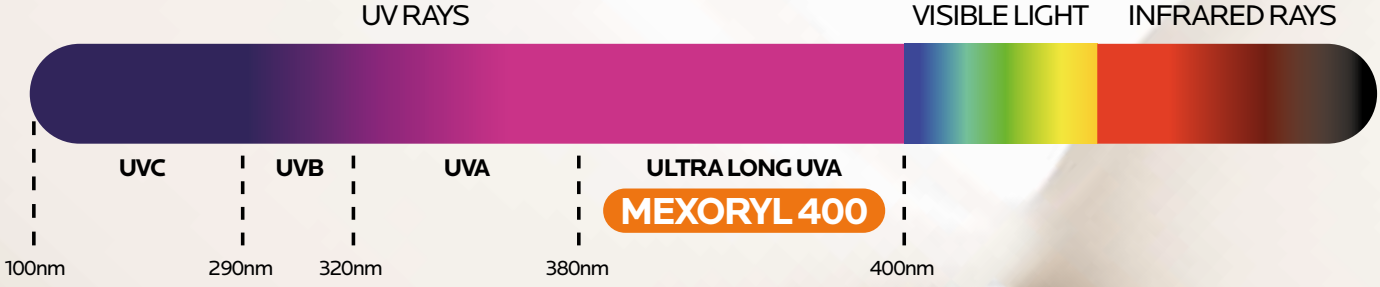

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PROMOTION

PRIDE OF PLACE

Having worked as a locum pharmacist for 35 years, Laurence Middleton Jones shares his experience with WPR, and reflects on how his role has been supported and strengthened by New Directions Pharmacy.

Laurence Middleton Jones

With more than 18 years of sector-specific experience, New Directions Pharmacy is the perfect place for locum pharmacists to progress their careers. It's one of the UK's leading recruitment and training providers to the pharmacy sector, with exciting opportunities to make a difference in communities in all corners of the country.

There are 8,500 branches registered with New Directions Pharmacy and more than 4,000 locum pharmacists trust them to find fulfilling work placements.

WHAT ARE THE MAIN BENEFITS OF LOCUM WORK FOR YOU?

For me, the main benefit of locum work is definitely the ability to be flexible and have the time to focus on other interests. I'm able to take a break from pharmacy whenever it suits me so I can work on other projects and passions, such as cycling. Locuming even gave me the flexibility to study for and complete two other degrees. It means I have another career alongside pharmacy which keeps my pharmacy work fresh and enjoyable.

HOW DOES WORKING AS A LOCUM FIT IN WITH YOUR PERSONAL COMMITMENTS?

I have always taken the view that locums should embrace the flexibility on offer, so I have always been happy to travel. This has often led to stays away from home and this is something I have really enjoyed. It's an opportunity to see new places and meet new people. It's not like being a sailor and going away for months!

HAS WORKING AS A LOCUM HELPED YOU TO GAIN EXPERIENCE AND SKILLS IN DIFFERENT SETTINGS?

Being a locum has introduced me to experiences, from the sublime to the extraordinary, which have extended my experience and skills immeasurably. I can now walk into any pharmacy and feel at home within five minutes. The more prescribers and prescriptions you have worked with, the more interesting and educational experiences you will benefit from. And the larger the range of staff you work with, the greater your interpersonal knowledge and skills will develop. I always feel like I can learn as a locum.

HOW HAVE YOU BEEN ABLE TO CONTRIBUTE TO THE COMMUNITY IN YOUR ROLE AS A LOCUM?

It's the same as being a pharmacist in a single location in that we all aim to make life better for our patients and the public. We all want to contribute to the community and leave it a better place than we found it. What is different about being a locum is that you get the opportunity to come in with a different perspective, so we provide another point of view. That has allowed me to fix things that have been overlooked and improve patient care across many locations, which is always rewarding.

WHY WOULD YOU RECOMMEND WORKING AS A LOCUM TO OTHERS?

Working as a locum for New Directions Pharmacy has given me incredible experiences, options, and opportunities. I have support from a great and creative account manager who can geo-locate me wherever I want, it is better than any travel agent! It makes every week seem fresh. I genuinely can't imagine ever using any other agency or ever not being a locum.

TAKING THE NEW STEP TO LOCUMING

You can register with New Directions Pharmacy today and speak to its specialist account managers.

As a preferred supplier to local and independent community pharmacies, large national high-street companies and supermarkets, and public sector organisations, the agency uses its expertise and experiences to put the right people in the right places.

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IN THE NEXT BREATH

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

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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. 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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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A NEW TRAIN OF THOUGHT

In line with the planned reforms to pharmacists' education and training, how will the profession and patients alike benefit from the changes?

Students training to become pharmacists at universities in Wales will benefit from extra time spent on clinical placement during their degrees.

The new plans, developed between Health Education and Improvement Wales and the Schools of Pharmacy at Cardiff and Swansea Universities, will see every pharmacy undergraduate given extra days of supervised placements in hospitals, GP practices, and community pharmacies across their four-year undergraduate programme.

The development has been agreed by the Welsh government's Health Minister Eluned Morgan, and aims to ensure that all pharmacists in the future will have the training and skills needed to take on new clinical roles as medicines experts.

From the next academic year, Welsh Schools of Pharmacy will be able to access funding to support this educational supervision. Additional funding will be aligned to the medical tariff for training student doctors and dentists in the NHS. Funding will also be available to help meet the costs of students' travel and accommodation when on placements that will be provided in every health board in Wales.

The additional investment will rise to over £2.7 million per year by April 2025 and will ensure that universities in Wales can meet new standards for initial education and training of pharmacists set by the General Pharmaceutical Council last year. Importantly it means that newly-registered pharmacists will have the skills and expertise they need to meet patients' and the NHS' needs in the future, including the ability to prescribe medicines from the start of their career. Pharmacists that are able to prescribe increases services and the care patients can receive in their local community.

Chief Pharmaceutical Officer Andrew Evans explained, 'Pharmacists are experts in medicines, and they are playing an increasingly important role in the delivery of NHS services in our hospitals, community pharmacies and GP practices. Wales is at the forefront of creating new and exciting opportunities for pharmacists to use their clinical skills. These changes will help us achieve our aspirations for the profession and make a real difference for patients.

'These changes will compliment NHS Wales' profession-leading pharmacist foundation programme and make the undergraduate programmes offered by the Schools of Pharmacy at Cardiff and Swansea Universities, even more attractive to potential students. This investment reinforces Wales is a great place to train, work and live for pharmacy professionals.'

Welcoming the decision, Professor Pushpinder Mangat, Executive Medical Director at Health Education and Improvement Wales, said, 'This key decision by the Minister to support our plans is great news for current and future pharmacy students in Wales. Increasing the number and quality of clinical placements will ensure we meet the reformed initial education and training standards for pharmacists and that we produce pharmacists with enhanced clinical skills and the ability to independently prescribe medicines after five years of training rather than the minimum of eight years it takes currently.

'Historically pharmacy courses have been viewed as science rather than health degrees meaning they do not attract additional funding for clinical placements. These changes bring the training of pharmacists in line with doctors, nurses and other healthcare professionals.'

To register as a pharmacist, the General Pharmaceutical Council requires students complete a five-year programme of academic and practice-based teaching. Currently this comprises a four-year Master's degree in pharmacy (MPharm) at a School of Pharmacy followed by a one-year foundation training year – which in Wales provides multisector experience in community pharmacy, GP practices and hospital pharmacy

There are two Schools of Pharmacy in Wales at Cardiff University and Swansea University.

Funding of £0.6 million will be available for the academic year starting in September 2022 to support clinical placements for students in the third and fourth year of the pharmacy degree. This will increase to £2.7 million per year by September 2025 and will support around 1,200 pharmacy students at Wales' two Schools of Pharmacy across the first four years of the training.

Students will complete at least 55 days over four years at sites approved by Health Education and Improvement Wales. These sites will be hospitals, community pharmacies and GP practices, as well as other locations where pharmacists work.

For more information regarding pharmacy pre-registration and post-registration education and training for the whole pharmacy workforce in Wales, visit www.heiw.nhs.wales/education-and-training/pharmacy.

SWANSEA BAY HEALTH CHARITY

MAKING A DIFFERENCE

Managing around 265 funds for equipment, research, training and patient care, Swansea Bay Health Charity provides integral support to patients, staff and services within Swansea Bay University Health Board. Here, they update us on their change-achieving actions.

AN INTRODUCTION

Swansea Bay Health Charity is the official NHS charity that supports patients, staff and services provided by Swansea Bay University Health Board. The health board provides a wide range of services for Swansea and Neath Port Talbot areas, plus lots of specialist services for South West Wales, as well as South West England.

The money raised for our charity is used to support patients, staff and services, for example, buying equipment, funding research, the training of staff and improving patient care.

The charity doesn't replace NHS funding but uses the generous donations received to provide additional services, facilities and support above and beyond what the NHS offers.

Swansea Bay Health Charity have made a big difference across the health board, such as funding a new summer house in our learning disabilities service, allowing patients time away from a ward environment and helping fund a cutting-edge 3D printing project that designs and creates equipment to aid people with disabilities.

FAR-REACHING SUPPORT

Swansea Bay Health Charity includes a fund for the South West Wales Cancer Centre at Singleton Hospital, Swansea, which treats patients from the M4 corridor and South West Wales with lifesaving chemotherapy and radiotherapy treatment.

This fund supports the Radiotherapy Unit, Chemotherapy Unit, Ward 12, The Cancer Institute and Seaview Hostel for travelling patients from as far as Aberystwyth. This is for patient care and comfort, along with additional specialist equipment. We also support specialist training for our doctors, nurses and all other healthcare staff.

We couldn't do the great work without our incredible supporters, who raise funds for us in all sorts of ways. Whether it's selling crafts / art work for the charity, running for us at sporting events or setting up a JustGiving page for people to donate to a challenge, the options are endless.

ON THE HORIZON

We have a number of events coming up where you can support us:

- You could take part in Jiffy's Cancer 50 Challenge on 4th September, a 50-mile bike race raising monies for cancer services
- You could take part in the Mumbles Triathlon on 1st October by raising at least the value of the entry price for the charity

If you want to fundraise for your local NHS services and staff, email us at swanseabay.healthcharity@nhs.wales.uk.

Registered Charity number: 1122805

ENDOMETRIOSIS: WHY THE WAIT?

It's clear that taboos and stigmas associated with menstrual health are still rife within society, and we all have a part to play in raising awareness of endometriosis and the symptoms. The Endometriosis UK Team help us delve further into the condition and the significance of standing together to call for change in care provision, pathways and research; empowering anyone experiencing symptoms to seek medical help, and ensuring that when help is sought, the right care is provided.

Despite affecting one-in-10 women and those assigned female at birth, it takes an average of eight years to get a diagnosis of endometriosis in the UK. There is also no known cause for the disease, and there is no cure.

A recent survey by Endometriosis UK also found that 76 per cent of all women would put off going to the doctor if they were experiencing painful periods which were interfering with their day-to-day activities.

The most common reasons cited included 'I think painful periods are a normal part of life', 'I don't think the doctor would take me seriously' and 'I don't want to trouble the NHS during the COVID-19 pandemic'.

Endometriosis is a condition where cells similar to the ones lining the womb are found elsewhere in the body, usually within the pelvic cavity. Each month these cells react to the menstrual cycle in the same way to those in the womb, building up and then breaking down and bleeding. Unlike the cells in the womb that leave the body as a period, this blood has no way to escape. This leads to inflammation, pain, and the formation of scar tissue (adhesions). The condition affects 1.5 million in the UK. The condition is most active from puberty to menopause, although the impact can be felt for life.

Symptoms of endometriosis can include chronic pelvic pain, painful periods, painful bowel and bladder movements, and fatigue. While some symptoms are more common than others, this disease affects everyone differently.

A WORLD APART

In recent years, there has been significant progress around the globe looking to improve care for endometriosis. The Scottish government in its Women's Health Plan launched in 2021 has committed to driving down diagnosis times, as well as plans to improve care, education and awareness, and investing in research. France recently launched a national plan to invest in research, raise awareness and educate healthcare practitioners. And the Australian government launched a National Action Plan on endometriosis, and committed funds for research.

Globally we are seeing huge progress, but right here in the UK, more needs to be done. If the government wants us to be world-leading in endometriosis care, it needs to commit to reviewing, improving and implementing the existing NHS guidelines for endometriosis care, along with investing in research to find new treatments, support and solutions.

NICE Guideline NG73 on Endometriosis Diagnosis and Management is the current baseline for how care should be provided for those with endometriosis. However, there are notable gaps that need filling to ensure that all those with the disease have access to the right care at the right time. The guideline does not include access to mental health support, pain management, or care pathways for those with endometriosis outside the pelvis (such as thoracic endometriosis).

The Department for Health and Social Care has recently confirmed that NICE is committed to reviewing the guideline and that the review is now underway. We hope NICE will amend the guideline to ensure that all healthcare practitioners have the right information on how to treat and manage endometriosis, and patients are given the confidence that their needs will be met.

The COVID-19 pandemic has also had an inevitably huge impact on endometriosis care. The Royal College of Obstetricians and Gynaecologists released a report in April 2022 which reveals that gynaecology waiting times across the UK have soared by 60 per cent, the biggest increase in any service. This leaves over half a million women waiting for gynaecology treatment, including many with endometriosis.

TIME FOR CHANGE

Endometriosis UK regularly hears from those with endometriosis who are not able to access the care and treatment they need, including surgery, or get a diagnosis, due to long waiting times. Some may have debilitating symptoms and chronic pain while they wait. Those who had surgery or other appointments cancelled are in some cases still waiting for a new date, while others are given a new date several months ahead and do not always get the support they need to manage symptoms while they wait. The negative impact of this on their daily life, physical and mental health can be massive. An overhaul is required of the way the NHS prioritises treatment to address not only clinical need, but also wider impacts, such as quality of life and fertility.

It's clear that the UK has huge steps to take in ensuring everyone with endometriosis has access to the right care at the right time. We hope you will join us in calling for change, and being part of the movement fighting for better care for the 1.5 million with endometriosis in the UK.

ABOUT ENDOMETRIOSIS UK

Endometriosis UK is the UK's leading charity supporting those affected by endometriosis. It's here to provide vital support services, reliable information and a community for those affected by endometriosis.

For more information, visit www.endometriosis-uk.org.

Zalkya® 2 mg

film-coated tablets

dienogest

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

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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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Tel 0845 437 5565 | Email: customer.service@kent-athlone.com
www.kentpharma.co.uk

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

SUBSTANCE DEPENDENCY

A DIVIDING OF OPINION

Consider the complexities of substance dependency and the strides which must be taken to secure better support for those impacted, with the help of the Barod team.

Substance use is a topic that often divides opinion. While many will not condone such behaviour, they will be compassionate and empathetic as to the reasons behind it, while others will instinctively see drugs as 'bad' and therefore view people that use them, in the same light. What is a matter of fact though is substance use has been part of our society for a long time. There is a human instinct to often see, and view the world, in a different light to normal or to experience a different level of consciousness. This can ultimately be achieved from most drugs, from alcohol to heroin, and what people's expectations and needs are, can determine which substance they use.

Barod is a harm reduction organisation that supports anyone affected by substance use across South Wales. People from all walks of life enter through our doors, from those within highly-respected professions, to people who are experiencing homelessness and significant mental health issues, and everyone else in-between. There has yet to be a case where the person seeking support outlined that one day, they woke up wanting to be reliant and dependent upon a substance. It just doesn't happen. And yet, there are still shouts of why can't people just stop using? It's not that simple and the complexities of dependency means that for people to have the best chance possible in overcoming such health issues, multiple factors need to be considered from social, biological and environmental to current brain function. Drug use can change the way a person's brain develops and operates in terms of their neurotransmitter functions, resulting in once natural pleasures no longer hitting the spot, at least, not in comparison to the use of certain substances.

Substance use, and more so dependency, can often be a reaction to something. A coping mechanism. What we tend to hear too often is a story of trauma, abuse and neglect at a young age. Stories of families going through the vicious cycle from one generation to the next. Many who seek support for their substance use are trying to end this cycle. Trying to end the social marginalisation and isolation that often comes with such behaviour. Some with success, others not so much. But for the latter, many will return, to try again. A report by Public Health Wales in relation to Adverse Childhood Experiences (ACEs) in 2015 found that people who experience four or more ACEs, such as parents getting divorced, at least one parent being incarcerated, mental health issues in the family, history of drug use in the family, experience of any form of abuse, and so on, are 16 times more likely to go on to use heroin or crack cocaine within their lifetime, compared to someone who has experienced none. Often, many are fighting an uphill battle from the start. From services point of view, this correlation is as clear as day, confirmed by the fact many are now taking a more trauma-informed approach in their delivery.

Services are forever trying to realign, innovate and develop, to break down barriers in accessing support and provide best-practice provisions. In the last two years, given the pandemic, Barod has significantly increased its digital, online services, from a Wales-wide Live Webchat Service open seven-days a week, to a national click and deliver service for Naloxone, a lifesaving medication that temporarily reverses the effects of an opioid overdose, that can be delivered for free, to any door in the country. Dyfed Drug and Alcohol Service, a consortium service led by Barod, has recently launched 'Spike on a Bike', a unique provision delivering harm reduction interventions throughout Dyfed, a service not seen elsewhere throughout Europe.

What is always at the forefront of service design and delivery is that we are dealing with, and supporting, people. Every person that walks through our door and every person that uses substances, is a person. They are someone's daughter, someone's son. They deserve to be treated with dignity and respect and without judgement, just like the next person. These are fundamental messages that need to be conveyed and repeated, none more so than when the annual drug-related-death figures are announced every August.

This year saw an increase of nearly 44 per cent of drug poisoning fatalities in Wales. This shows that more needs to be done and more can be done, to support those affected by substance use and to reduce and end preventable fatal overdoses and early mortality. As we say in this game, you can't recover if you are dead.

For more information, visit www.barod.cymru.

PLAYING WITH FIRE

Efforts to significantly reduce the harms inflicted through smoking are picking up pace as an ambitious new strategy has been revealed by the Welsh government.

The Welsh government has launched a new tobacco control strategy, which sets the pathway for a smoke-free Wales (less than five per cent of the adult population smoking) by 2030. The strategy lays out firm actions and polices, with the aim of finally ending the tobacco epidemic in Wales.

The smoking addiction has gripped the nation for over 100 years, and despite the known risks, still kills over 5,000 people in Wales every year. Smoking is the leading cause of premature death and preventable ill-health in the country and is estimated to cost the Welsh NHS £302 million each year.

The National Survey for Wales currently places adult smoking prevalence in Wales at 13 per cent. While this figure slowly declines, reaching five per cent by 2030 will require a significant upturn in actions and commitment. Modelling by Cancer Research UK in 2020 indicates that if the current pace of actions continue, Wales will not reach a smoke-free future until 2037.

Wales' leading tobacco control action group, ASH Wales, has said that the nation is firmly behind the new strategy which provides a solid blueprint for achieving a smoke-free society.

Providing a peek into society's views, Suzanne Cass, CEO of ASH Wales, said, 'Public support for an Endgame target is overwhelming, 73 per cent of Welsh adults want Wales to become smoke-free. The Welsh government's commitment to this target is welcome, however, this bold strategy is going to need bold and decisive action to hit that five per cent target by 2030.'

The publication of the new strategy has been eagerly awaited by other health charities across Wales.

Katie Till, Cancer Research UK's Public Affairs Manager in Wales, added, 'Smoking remains the biggest preventable cause of cancer and is responsible for around 3,100 cancer cases in Wales every year. Achieving a smoke-free Wales by 2030 would save lives. For Wales to hit this target, we need to see ambition in the way we support people to quit and prevent people from starting.

'Smoking is also the single biggest driver of inequalities in life-expectancy in the UK. It's critical the plan addresses this, so fewer people are affected by the harms of smoking in the future.'

AN EPIDEMIC

Nearly 140 years have passed since the first UK manufactured cigarettes entered the market. Since then, sales soared in the first half of the 20th Century and brought with it what health organisations coined as the 'global tobacco epidemic'. This epidemic has waged for decades, and currently claims the lives of eight million people globally each year.

A recent review of tobacco control commissioned by the UK's former Health Secretary, Savid Javid, speculated that if cigarettes were to enter the British market today, they would simply be turned away and would not be legalised.

Despite decades of research, lobbying and national stop smoking campaigns, tobacco remains on the UK market, and remains the only legal consumer product that kills up to half of its users when used as intended.

THE ROAD AHEAD

As the Welsh government launches its new tobacco control strategy, it embarks on a road which carries the potential to end smoking's hold on national health. The Welsh government has been bold with this task, which is reflected within its five per cent Endgame target.

On a global scale, other countries have pledged similar ambitions in achieving a five per cent smoking rate: including England, Scotland, Ireland, New Zealand, Canada, and Sweden. Internationally, five per cent is often regarded as the benchmark in which the tobacco epidemic is considered unsustainable.

Wales' new strategy carries the promise of addressing smoking through a range of robust tobacco control measures. These measures have been categorised within five key priority areas within the strategy's first delivery plan. All priority areas will be shown equal importance and will be reviewed by the Welsh government every two years. The priority areas are as follows:

- Smoke-free environments
- Continuous improvement and supporting innovation
- Priority groups
- Tackle illegal tobacco and the tobacco control legal framework
- Working across the UK

The new strategy can be found in full at gov.wales. For more information about smoking's impact on Wales, and advice on how to quit, visit www.ash.wales.

NEWS

GLANGWILI HOSPITAL IS FIRST IN WALES TO ADMINISTER NEW OSTEOPOROSIS MEDICATION

Glangwili Hospital has become the first in Wales to administer a new medication that will help patients suffering from osteoporosis. It was approved by the National Institute for Health and Care Excellence and is the first new osteoporosis drug treatment of its kind for over a decade.

The new treatment is now available in Wales for preventing future fractures in patients suffering from osteoporosis.

The bone-building drug is given as a simple injection under the skin. It is highly effective for preventing fractures by the way it acts on bone cells, particularly in postmenopausal women with severe osteoporosis. It is one of only two treatments that help to promote bone formation, and the first to reduce bone loss at the same time.

Dr Abhaya Gupta, Consultant Physician at Glangwili Hospital, commented, 'The availability of this drug in Wales is an additional option for treating patients with osteoporosis, many of whom suffer devastating consequences from hip fractures, spine and wrist fractures.'

Catrin Beddoe, a Pharmacist at Glangwili Hospital, added, 'This is a simple injection given once a month for one year to appropriate elderly female patients suffering from the devastating consequences of fractures, and I am pleased to be part of the specialist osteoporosis team involved in this exciting work.'

NEW PLAN TO BOOST WELSH LANGUAGE IN HEALTH AND SOCIAL CARE

A health and social care service in which people are actively offered their care in Welsh is the ambition of a new plan launched by the Health Minister, Eluned Morgan.

Workforce planning, staff training, digital systems and changing the culture are key elements of the More Than Just Words five-year action plan, working towards the Welsh government's aim of ensuring that everyone who wants to can receive their care in the Welsh language.

Speaking at the Eisteddfod Genedlaethol in Tregaron, the Minister said, 'When people are receiving or trying to access care, it is usually when they are at their most vulnerable, so being comfortable in their own language is important. Our research found that for many Welsh speakers, being able to access services in Welsh significantly improved their overall experience and, in many cases, improved their health and wellbeing outcomes. It also showed people often found it difficult to access services in Welsh and were reluctant to ask when Welsh language services were not offered.

'At the core of our strategy is the principle of the Active Offer. It places a responsibility on health and social care providers to offer services in Welsh, rather than on the patient or service-user to have to request them. While progress has been made since our original plan was launched five years ago, we now need to offer more and be faster to deliver that offer.'

The plan has been developed by an expert group, following an independent evaluation of the first More Than Just Words five-year plan.

The plan is made up of several actions under these themes:

- Culture and leadership
- Welsh language planning and policies
- Supporting and developing Welsh language skills of the workforce
- Sharing best practice

Progress against the actions will be monitored by a new advisory board.

CALL FOR BREASTFEEDING DATA COLLECTION TO MEASURE MEDICINE IMPACT

A new paper from Swansea University in collaboration with ConcePTION, an innovative medicines initiative, has called for breastfeeding data to be routinely collected in healthcare databases so that the long-term impacts of medicines taken by women during pregnancy and when breastfeeding, can be better understood.

In the paper, which has been published in the International Breastfeeding Journal, researchers argue that the lack of data collection on breastfeeding represents a significant 'blind spot' leading to an 'information desert' in understanding the impact that taking medicines during and after pregnancy, has on breastfeeding rates and long-term infant development.

Researchers recommend that it should now be a priority that data on breastfeeding and medicines used by women during and after pregnancy and in labour are included in population databases, along with data on subsequent child neurodevelopment, so that meaningful research can take place into the benefits and harms of medicines.

The authors report that population databases should link data on three factors: medicine exposure; breastfeeding; and infant development. It notes that across Europe, few population databases hold data on all three together, and there is little uniformity in outcomes, definitions, methods and timing of assessments.

Professor Christine Damase-Michel, Pharmacologist at the Faculty of Medicine and University Hospital of Toulouse, reflected, 'There is an urgent need to have high-quality linked data on medicines, long-term childhood outcomes and modifiable risk factors, including breastfeeding, so that robust analyses of medicine-related benefits and harms can take place, which will ultimately allow women to take informed decisions when making choices on their own medical treatment, and breastfeeding.'

TAKE IT TO HEART

STATINS

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 assist WPR in further carving 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.

HEALTH AND CARE RESEARCH WALES

THE WHOLE WORKS

From set-up to delivery, Health and Care Research Wales discuss how they are taking a Wales-wide approach to research – and the motivation underpinning this plan.

When you're faced with the reality of having only hours and days to set up and deliver urgent public health research, collaboration is essential.

The global pandemic has taught us many things, including how we can work better together across Wales to deliver safe and effective research.

Through our One Wales approach, we have been able to set up and deliver 119 COVID-19 studies, including seven vaccine trials, providing an opportunity for around 60,000 people in Wales to take part in research.

This approach is integral to our research delivery plans as we move forward.

ONE WALES

In Health and Care Research Wales our mission is to promote, support and provide collective oversight of health and social care research in Wales to ensure that it is of the highest international scientific quality, is relevant to the needs and challenges of health and social care in Wales, and makes a difference to policy and practice in ways that improve the lives of patients, people and communities in Wales.

Through our nationwide, collaborative response to the pandemic, we have successfully implemented and improved a range of approaches to research delivery under the One Wales model. These include a range of efficient ways of working across our country to ensure quick turnaround and faster study set-up and delivery in Wales. Our national oversight means that quality remains paramount within our service for our research teams, for study leads and sponsors wanting to carry out research here.

'We were used to having months to set up research studies but suddenly we were faced with the prospect of only having days to do this, while meeting all the same strict regulations,' recalled Dr Nicola Williams, Director of Support and Delivery at Health and Care Research Wales.

'For vaccine research, we set up a national vaccine hub, introduced a Wales lead principal investigator, and we also established a single site for Wales, Public Health Wales. Our model means we can do things once for Wales, including national standard contracts, which helped speed up the process.

'We're proud to have delivered seven vaccine studies, the results of which have helped to inform the COVID-19 vaccination programme across the UK. We've also delivered key COVID-19 treatment studies – including PRINCIPLE, RECOVERY and REMAP-CAP – that have determined which drugs are effective and importantly which drugs are not effective.'

BETTER ACCESS TO RESEARCH

Around 60,000 people took part in COVID-19 research studies in Wales during the pandemic. Access to research opportunities varied from attending mass vaccination centres to taking antiviral medication at home.

'Thanks to our One Wales collaborative approach, people have had better access to research where they live and that means more people have been able to take part in research, ultimately meaning we've been able to answer more questions through research,' said Dr Williams.

LEARNING FROM COVID-19

Our One Wales model is not just relevant to COVID-19, it is designed to be used across all research areas.

One of the first non-COVID studies to be rolled out using the model is SYMPLIFY, which is evaluating a new multi-cancer early detection test that can detect over 50 types of cancers.

The aim of the SYMPLIFY study is to demonstrate how the test could be used to increase cancer detection rates and simplify diagnosis.

The SYMPLIFY trial has recruited 1,164 participants at 19 district hospitals, across all seven Health Boards in Wales, co-ordinated by Velindre University NHS Trust, as the single site for Wales.

OUR REPUTATION AND SERVICES

Our One Wales model allows us to make sure we have oversight of research studies across Wales, so we can make sure we follow the studies through from set-up to delivery.

'Our proactive, national approach means we have greater opportunity to meet recruitment targets, on time, with a fast escalation process to rapidly spot and resolve study performance issues. This is demonstrated by our proven track-record for study delivery during the pandemic,' said Dr Williams.

'Due to the volume and scale of the studies we've set up and delivered, we've also been able to develop new skills within our experienced research delivery teams.

'We also plan to build on this through our new Health and Care Research Wales Faculty, which makes sure health and social care researchers have the right training and support to develop their careers – creating a clear professional pathway and strengthening our ability to deploy the best research people when and where they're needed.'

Our One Wales approach allows us to:

- Increase public access to research opportunities
- Provide researchers and industry colleagues with a single-access streamlined service
- Attract and deploy the best research staff

ABOUT HEALTH AND CARE RESEARCH WALES

Health and Care Research Wales is a networked organisation, supported by the Welsh government, which brings together a wide range of partners across the NHS in Wales, universities and research institutions, local authorities, and other agencies.

For more information, visit www.healthandcareresearchwales.org, email healthandcareresearch@wales.nhs.uk and tweet @ResearchWales / @YmchwilCymru.

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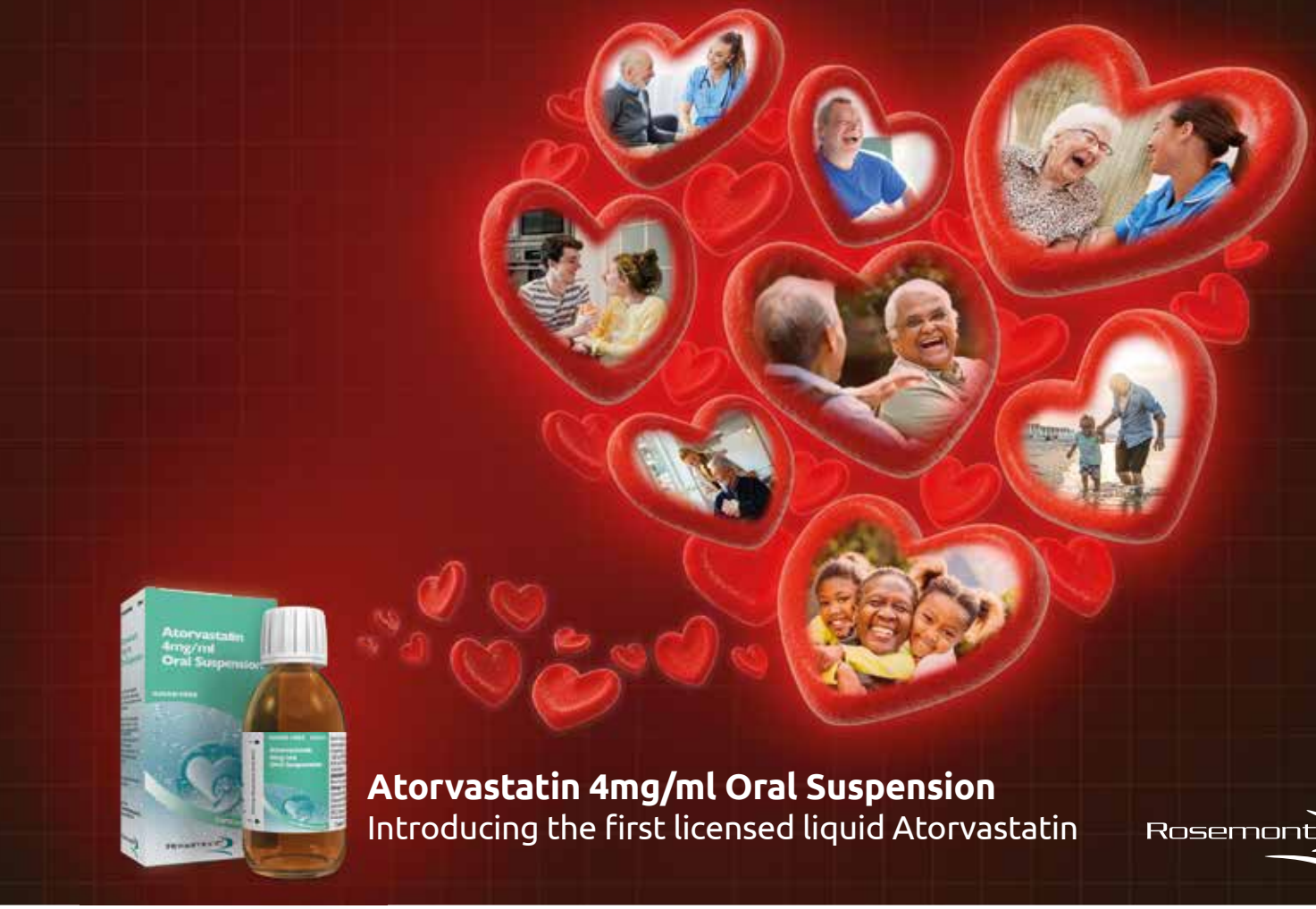

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Abbreviated prescribing information. See SmPC for full details (www.medicines.org.uk). Name of the medicinal product: Atorvastatin 4mg/ml Oral Suspension. **Qualitative and quantitative composition:** Each 1 ml contains 4mg of Atorvastatin (as 4.14 mg atorvastatin calcium trihydrate). **Pharmaceutical form:** Oral Suspension. White to brownish white Suspension. **Therapeutic indications:** Hypercholesterolaemia Atorvastatin Oral Suspension is indicated as an adjunct to diet for reduction of elevated total cholesterol (total-C), LDL-cholesterol (LDL-C), apolipoprotein B, and triglycerides in adults, adolescents and children aged 10 years or older with primary hypercholesterolaemia including familial hypercholesterolaemia (heterozygous variant) or combined (mixed) hyperlipidaemia (Corresponding to Types IIa and IIb of the Fredrickson classification) when response to diet and other nonpharmacological measures is inadequate. 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/m², 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.

Rosemont Pharmaceuticals Ltd. Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds LS11 9XE **T** +44 (0)113 244 1400 **F** +44 (0)113 245 3567
E infodesk@rosemontpharma.com Sales/Customer Service: **T** +44 (0)113 244 1999 **F** +44 (0)113 246 0738 **W** www.rosemontpharma.com

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

BACK TO BASICS

Bearing the brunt of back pain can take its toll on patients. The BackCare Team helps WPR 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, a 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 **55%** 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 12 µg/h, 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 55%** when compared to fentanyl transdermal patches.[1,2]

	100µg/h (5)	75µg/h (5)	50µg/h (5)	25µg/h (5)	12µg/h (5)
PIP Code	123-6553	123-6595	**123-6587**	123-6579	123-6561
Opiodur® NHS list price[1]	£25.94	£21.05	**£15.09**	£8.07	£5.64
Drug Tariff[2]	£57.86	£46.99	**£33.66**	£17.99	£12.59
Potential savings per pack %[1,2]	55%	55%	**55%**	55%	55%

ZENTIVA

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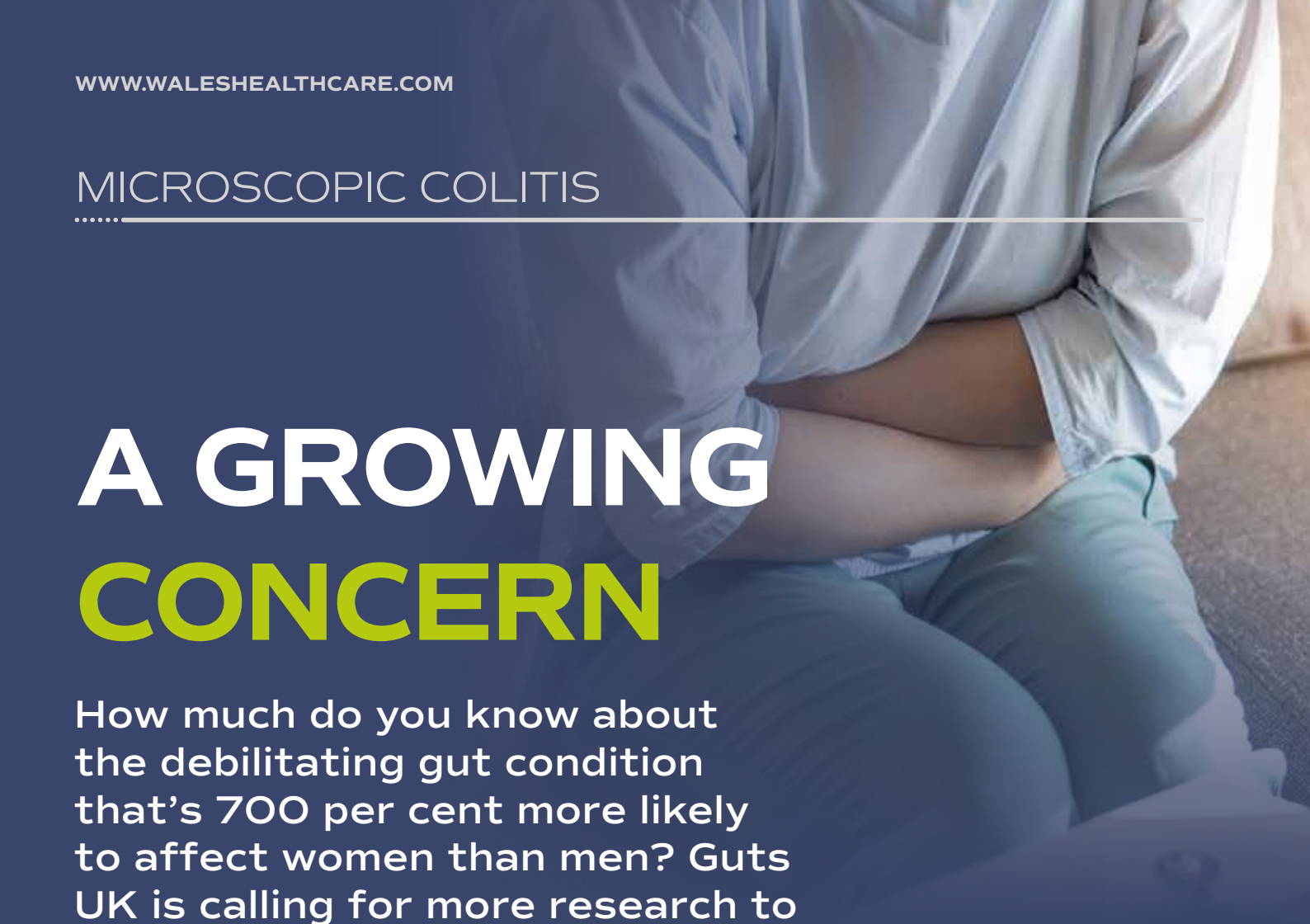
Opiodur® 12µg/h, 25µg/h, 50µg/h, 75µg/h and 100µg/h Transdermal Patch (fentanyl) Prescribing Information. Prescribers should consult the SmPC before prescribing.
Presentation: Each transdermal patch contains 1.375mg, 2.75mg, 5.5mg, 8.25mg or 11.0mg of fentanyl, releasing 12.5µg, 25µg, 50µg, 75µg or 100µg 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. C*hildren 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 NHS Business Services Agency. Drug Tariff Category C price. NHS Electronic Drug Tariff. https://www.drugtariff.nhsbsa.nhs.uk/#/00817113-DC/DC00816569/Part%20VIIIA%20products%20M (Accessed 9th June 2022)
3 Data on File

Date of Preparation: June 2022 Ref: 19985

MICROSCOPIC COLITIS



A GROWING CONCERN

How much do you know about the debilitating gut condition that's 700 per cent more likely to affect women than men? Guts UK is calling for more research to determine the reasons behind this gender disparity in microscopic colitis in the hope that it will lead to prevention, faster diagnoses, and developments in treatments.

Microscopic colitis is an inflammation of the large intestine (bowel) that causes persistent, frequent and watery diarrhoea (throughout the day and night), stomach pain, fatigue, faecal incontinence and weight loss. The charity, Guts UK, has chosen to create specific resources for women after research has shown that 87.5 per cent of people suffering with the condition are female – most of whom are diagnosed between the ages of 50-and-70.

Microscopic colitis is a leading cause of diarrhoea in older adults and it can have a devastating impact on a person's quality of life. Scientists estimate that around 67,200 people are living with microscopic colitis in the UK.

Patients often find it difficult to manage jobs, socialise, travel and take part in family life because of the urgent nature of their symptoms and their need to be near to toilet facilities at all times. Coping with this often leaves sufferers feeling very isolated and can have a significant and detrimental effect on their mental wellbeing.

Many people suffer for years with microscopic colitis but the correct diagnosis and treatment can make a huge and dramatic difference to a person's quality of life.

THE PATIENT IMPACT

Julie, aged 42 from Sidcup in Kent, was diagnosed with microscopic colitis in 2020.

Julie said, 'The symptoms of microscopic colitis are awful. I experienced crippling stomach pain, nausea, as well as watery diarrhoea, which lasted for several weeks and only stopped when I was diagnosed and began a treatment of steroids. It all had a massive impact on my mental health since this was during lockdown and I worried about what could be wrong.

'It's a very isolating condition and I can understand why it's called a hidden disability. It's been over a year since I was diagnosed and I'm still having flare-ups. I am constantly thinking about what I am eating and when I am out where the nearest facilities are – it's exhausting.

'There is very little awareness of microscopic colitis, but I am sure there are many people suffering with it without knowing. My message for anyone with symptoms is that if you feel that things aren't quite right and you're struggling to get a diagnosis then persevere and push for an appointment with a gastroenterologist. The treatments available can certainly improve symptoms.'

IS THERE CLARITY ON THE CAUSES?

At least one-in-1,000 people are thought to have microscopic colitis in the UK, with 17,000 new cases being diagnosed each year, but the real number could be a lot higher because it's often underreported and misdiagnosed. One study showed that one-in-three patients with microscopic colitis were initially incorrectly diagnosed with Irritable Bowel Syndrome. It is also a growing disease and the number of patients diagnosed has been increasing over the past 20 years.

Microscopic colitis is named because, unlike other inflammatory bowel diseases, like Crohn's Disease or Ulcerative Colitis, it can't be diagnosed with a colonoscopy alone and a sample of tissue taken from the bowel must be examined under a microscope to identify the condition. However, once confirmed, treatment with prescribed medicine (a steroid called budesonide) is available and has shown to be very effective and often life-changing.

The causes of microscopic colitis and the reason it affects women disproportionately are still unclear. As it is a relatively new disease (first described in 1976) it has led to a presumption that it is environmental, as opposed to genetic, factors that are responsible for its occurrence.

TIME FOR CHANGE

Prior studies have suggested that a range of medications including proton pump inhibitors – which are used to reduce stomach acid – nonsteroidal anti-inflammatory drugs such as ibuprofen, statins, antidepressants, aspirin, and beta blockers may be associated with the disease, as well as cigarette smoking and a co-diagnosis of an auto-immune disease.

What is clear is that women are at substantially higher risk of having microscopic colitis than men. Despite this marked gender discrepancy, the literature on reproductive and hormonal factors is very limited. Some scientists have hypothesised that there is a link with microscopic colitis and the use of oral contraceptive pills and HRT but more research is needed for this to be conclusive.

Julie Harrington, CEO of Guts UK, said, 'Thousands of people across the country are quite literally housebound with symptoms of microscopic colitis and we now know that the rates are increasing and are likely to grow further as the population ages.

'Further research is desperately needed to identify risk factors and find out why women are far more likely to suffer from microscopic colitis so we can move to a place where prevention and faster diagnosis is possible.'

Professor Shaji Sebastian, Consultant Gastroenterologist at Hull University Teaching Hospitals NHS Trust and Guts UK trustee, added, 'Scientists still don't fully understand what causes microscopic colitis and further research is clearly needed to determine what could be a combination of factors.

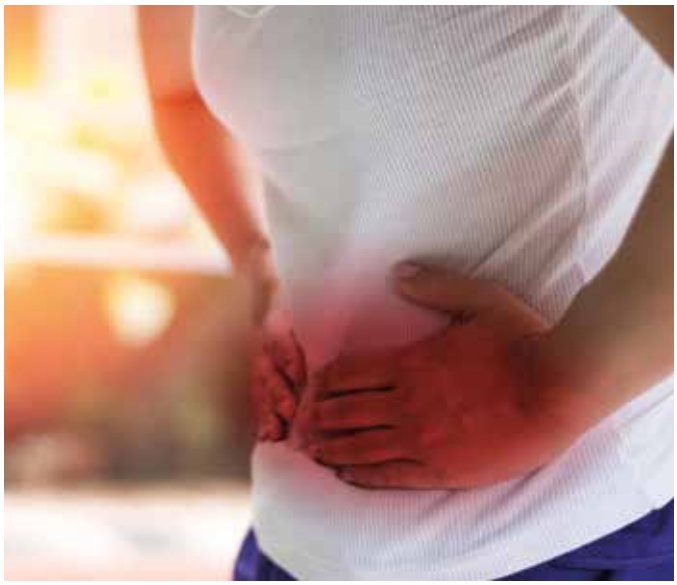
'What we do know is that the condition can be very debilitating but with the right tests it's also very treatable. Early diagnosis is crucial to prevent patients from suffering when they don't have to, so my main message is don't suffer in silence and seek help from your GP if you're experiencing symptoms.'

ABOUT GUTS UK

Guts UK is the UK's charity for the digestive system from top to tail; gut, liver and pancreas. Through strong connections with the British Society of Gastroenterology and membership of the Association of Medical Research Charities it is able to support a diverse portfolio of research work that is of the highest quality.

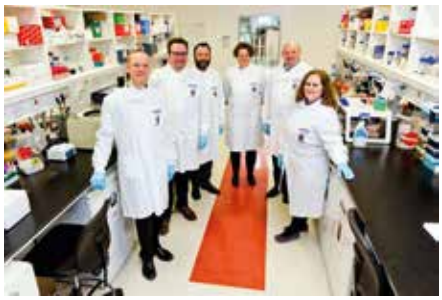
Guts UK also provides expert information on a range of digestive conditions and symptoms for patients, and raises awareness of digestive health.

For more information, visit www.gutscharity.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.'

Telephone: 0737 998 9191
Email: info@sepsisresearch.org.uk
Website: www.sepsisresearch.org.uk

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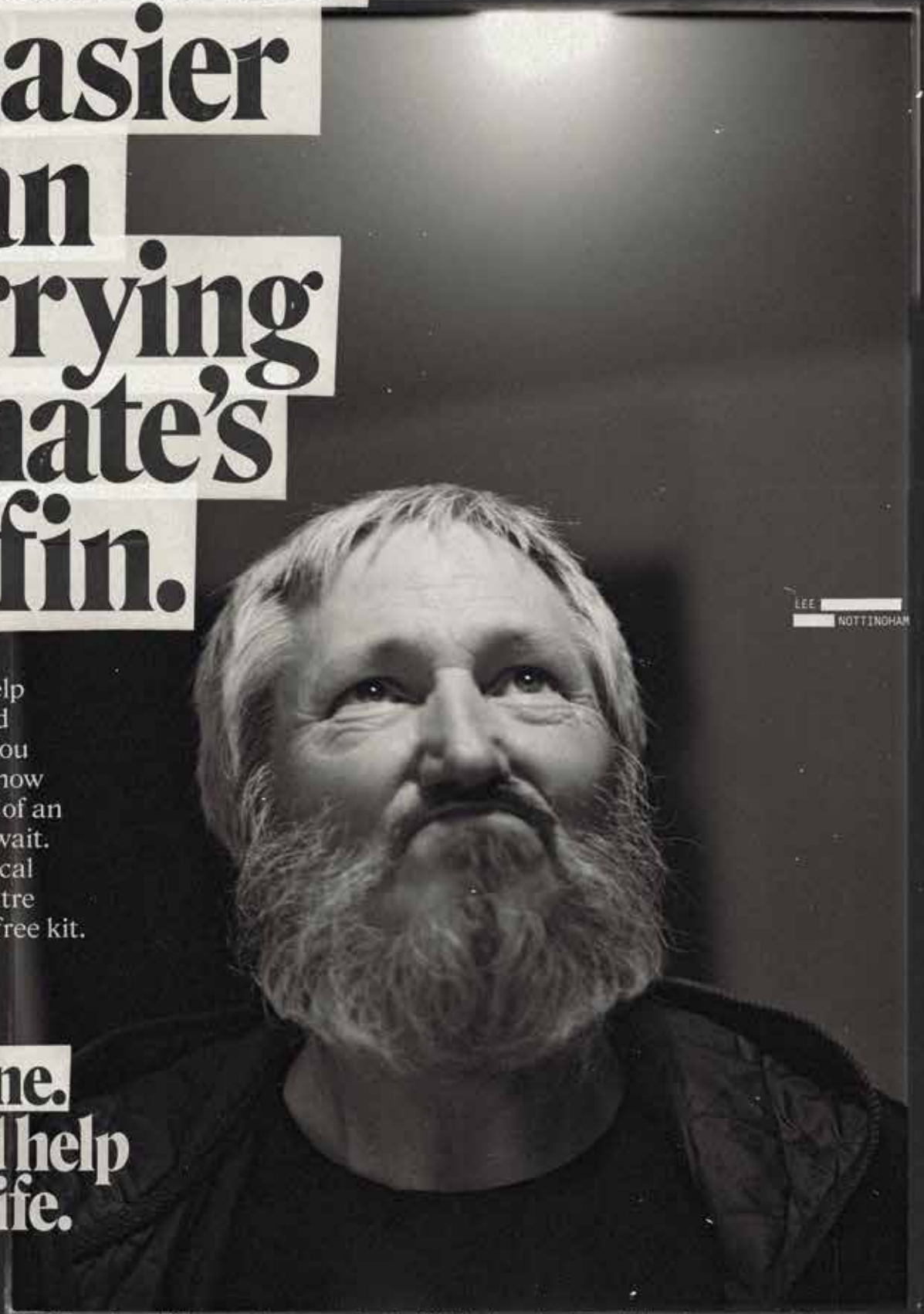
Carrying naloxone is easier than carrying a mate's coffin.



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 preperation: February 2021 | Job number: UK-PREN-17a