The UKCPA promotes expert practice in medicines management for the benefit of patients, the public and members by establishing standards, workforce development and advancing innovation in all health care settings.

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Thank you!

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Prestigious awards for UKCPA members

We are delighted and proud to hear that two of our long standing UKCPA members have been presented with the most prestigious national pharmacy awards this year.

Dr Gillian Hawksworth was presented with the Royal Pharmaceutical Society Lifetime Achievement Award at the recent RPS Conference in September.

Ash Soni, president of the Royal Pharmaceutical Society, described Hawksworth as a “passionate and tireless advocate for the profession for decades”.

Gillian is a Trustee for UKCPA and is certainly one of our most fervent supporters.

A former President of the Royal Pharmaceutical Society, Gillian was a community pharmacy practitioner for many years, and was most recently Senior Lecturer at the University of Huddersfield.

She is currently Chair of the RPS Panel of Fellows and a visiting fellow at the University of Huddersfield.

At the awards ceremony, Ash Soni told conference delegates that he wasn’t sure that “any other member of the Royal Pharmaceutical Society could demonstrate a commitment and involvement that is anywhere near that shown by Gill’s CV. The profession is reaping the rewards of Gill’s hard work now, with the growing recognition of the role of pharmacists”.

Professor Ian Bates has been given the Charter Award for 2017 by the Royal Pharmaceutical Society in recognition of his outstanding service and contribution to pharmacy. The Charter Award is made by the RPS and is awarded annually by the Society on the recommendation of its President and approval by the Assembly.

Amongst his many roles, he is Professor of Pharmacy Education at University College London, Professor of Integrated Care Education at the Whittington Health NHS Trust and Expert Advisor on Education for the Royal Pharmaceutical Society. He is also a Trustee for UKCPA.

Professor Bates is well known and respected for his international work, chiefly as the Director for Education Development for the International Pharmaceutical Federation (FIP) and Coordinator for the international UNESCO UNITWIN network for Global Pharmacy Education, a transnational network spanning universities and countries worldwide.

His work focusses on workforce and education development research and evaluation for both national and global perspectives and associated policy formation, and he provides advice on workplace education and workforce development for many domestic and international institutions and agencies.

His work has resulted in the publication of strategies for transforming the global pharmacy workforce.
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Educational events to support your practice

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**Clinical Pharmacy Training Day**
23 November 2017: Leeds

**UKCPA Conference**
24 & 25 November 2017: Leeds

**Starting out in critical care**
8 December 2017: Manchester

**Foundation course**
19 & 20 January 2018: Leeds

**Respiratory medicines optimisation**
(Joint event with Journal of Medicines Optimisation)
1 February 2018: Birmingham

**Managing pain: Make it matter**
7 February 2018: London

**Gastroenterology and infection**
9 February 2018: Birmingham

**Starting out in critical care**
9 March 2018: London

**Diabetes medicines optimisation**
(Joint event with Journal of Medicines Optimisation)
15 May 2018: Manchester

**Starting out in critical care**
15 June 2018: Newcastle

**Women’s health**
22 June 2018: London

**Infection masterclass**
21 September 2018: Birmingham

“The speakers were superb and inspirational, delivering content at exactly the right level for me to understand and learn more.”
Baguiasri Mandane attended the UKCPA Clinical Pharmacy Training Day last year as a junior pharmacist:

“A range of different activities kept the training very lively and interesting, from lectures, to case-based scenarios, open debates and interactive discussions around the various clinical topics. The teaching sessions generated great opportunities for interaction between delegates and facilitators.

The training really enabled us to gain a deeper insight into pharmacy practice and further developed our skills of critically questioning the current practice and comparing it to more recent evidence-based practice. Overall, the experts delivering the sessions really helped to unravel the different clinical topics in much greater depth in a relaxed and friendly learning environment.

Continuous development is key to every clinician’s growth; as a result of this ongoing acquisition of knowledge, skills, confidence and competence the clinician is able to provide better care to all his or her patients. The UKCPA Clinical Pharmacy Training Day precisely helped with this, and as a result strongly empowered the next generation of clinical pharmacy leaders to provide up-to-date, evidence-based, safe and quality driven excellent care to all patients.

In an era where healthcare professionals are very much expected to engage in self-directed learning, the UKCPA Clinical Pharmacy Training Day really helped to guide delegates in their lifelong professional development journey. “

The Clinical Pharmacy Training Day has been specifically designed to give you an opportunity to attend educational sessions which are most appropriate for your specific practice.

Each session is run by expert clinical pharmacists so you can be assured that you will receive the best information and support.

You’ll be able to move between sessions in order to get the most out of the topical issues on offer across a number of therapeutic areas.

The day will be fantastic for:

- Pharmacists working in primary care
- Pharmacists working in community
- Pharmacists working in secondary care
- Pharmacy technicians
- Healthcare professionals involved in medicines management
Conference 2017
Core skills training for every practitioner

KEYNOTE TALKS
To inform and inspire

GPhC Revalidation Consultation: results and update
Presented by Osama Ammar, Head of Continuing Fitness to Practise, General Pharmaceutical Council

Are you wondering what you will need to do to stay on the GPhC register?
We can offer you the opportunity to hear directly from the GPhC about the new revalidation processes, and for you to have your questions answered.

What can different generations learn from each other?
Presented by Nicholas Butler, Education Supervisor, General practice pharmacist training pathway, CPPE, and Baguiarsi Mandane, Junior Resident Pharmacist, University Hospitals of Leicester NHS Trust

Do the older generation struggle with technology?
Will the younger generation have to work harder to keep their jobs?
The older generation have decades of life and work experience. What have they learnt, what are their words of wisdom, what do they wish they had done differently?
And what advice can the younger generation give to those older than them, to help them navigate a very different world?

WORKSESSIONS
A choice of 18 workshops delivered by experts

Management skills
Identifying and prioritising medication safety issues: Yogini Jani
How to effectively measure medication safety: Gillian Cavell
Managing risks with medicines in e-prescribing: Caroline Anderson & Emma Ritchie
Hierarchical vs network leadership: Richard Cattell

Effective leadership
Informed consent: whose problem is it anyway? Ewan Maule
Clinical prioritisation: Doing more with less: David Gibson & Jan Forlow
Different perspectives on change: Chris Green

Sharing expertise
Speed coaching: Developing yourself and others: Aamer Safdar
Delivering multidisciplinary team training and education: Hayley Wickens
Ten ways to be a safe and effective prescriber: Wasim Baqir, Ewan Maule & Roisin O’Hare

Strengthening research skills
Developing your critical appraisal skills: Deborah Layton
How to present your research and audit at conferences: Tejal Vaghela
How to develop a multitude of skills through conducting research: Richard Keers
Writing a research grant application: Rachel Jaynes, Ivana Knyght & Helena Rosado

Building effective relationships
Introduction to assertiveness: Marian Wood
How to think creatively to improve patient care: Clive Jolliffe
Improving discharge medication prescriptions: Raliat Onatade
Making the most of the whole pharmacy workforce: Joela Mathews & Jo Smith

Book now at: ukclinicalpharmacy.org/events/ukcpa-conference
Call us on: 0116 2714894
Email us at: admin@ukcpa.com
A paper recently published in the European Journal of Hospital Pharmacy has concluded that ward-based hospital pharmacists may improve the appropriateness of medications, seamless care and drug safety for geriatric inpatients whilst being cost effective.

The authors at the University Hospital of Munich in Germany reviewed research from over twenty research studies conducted in seven European countries on pharmaceutical interventions in geriatric inpatients.

They wanted to investigate the available evidence on the effect of pharmaceutical interventions on geriatric patients, their medications and healthcare costs in clinical settings across Europe.

The review demonstrated that pharmaceutical care leads to more appropriate medication use and might reduce outcomes like drug-related readmissions.

Intensified pharmaceutical care showed additional effects, even in countries with established pharmaceutical care in hospitals.

Reference:
Kiesel E, Hopf Y. Hospital pharmacists working with geriatric patients in Europe: a systematic literature review. Eur J Hosp Pharm
http://ejhp.bmj.com/content/early/2017/08/02/ejhpharm-2017-001239

Researchers at Johns Hopkins University School of Medicine in the USA have found that people with mild cognitive impairment show a loss of serotonin transporters compared to a healthy control group.

Whilst the degeneration of the serotonin system as a part of aging and in Alzheimer’s Disease is well known, there is little evidence for its demise in mild cognitive impairment.

In this study, 28 adults with mild cognitive impairment and 28 healthy, cognitively normal matched control adults underwent a number of brain imaging procedures.

The results showed that serotonin transporter levels in patients with mild cognitive impairment were 10-19 percent lower in the cortical regions and the raphe nuclei and 10-38 percent lower in the striatum and the thalamus, compared with the control group.

The researchers note that the loss of serotonin transporters in mild cognitive impairment may have “a significant impact on brain function and behaviour” given their widespread distribution in the brain and previous evidence identifying serotonin degeneration in Alzheimer’s Disease.

They conclude that serotonergic agents could be potentially used to prevent cognitive decline and the emergence of neuropsychiatric symptoms in patients with mild cognitive impairment.

However, they admit that further investigation is needed to establish whether serotonin degeneration is a causative factor or a downstream effect of Alzheimer’s Disease.

Reference:

Derek Taylor, Chair of the Care of the Elderly Group, reviews recent research in this area of practice.
The important point about cancer awareness and cancer screening is the need to detect cancer earlier so that more lives can be saved.

Cancer is the second biggest killer in England. The UK’s five year survival rates are lower than the average across Europe, so improving early cancer diagnosis is a key priority. Screening does not reduce the risk of developing cancer, nor does it definitively diagnose cancer, but it looks for the presence or absence of a disorder in an otherwise healthy person.

Community pharmacists have an important role in both raising cancer awareness and referral for cancer screening, and it is important to understand the differences between these two elements. LPCs have already developed or are planning cancer awareness or screening referral services and CPPE have a supporting workshop and distance learning programme.

Cancer awareness involves an understanding of the risk factors and symptoms for each cancer type so that, as a pharmacist, you can signpost or refer patients who may be at risk or who may have symptoms as early as possible. This might be through routine conversations with customers, via a public health campaign, or as part of a local or national initiative, such as the Lung Cancer Awareness campaigns held in November each year.

Cancer screening focuses on local or national screening services to which patients or customers can be referred by a healthcare professional, or to which they can self-refer. There are currently three NHS cancer screening programmes which look at breast, bowel and cervical cancer. In addition, there is an ‘informed choice’ programme for prostate cancer. Local screening services might include a mobile screening unit or it could be a service commissioned locally for healthcare professionals such as pharmacists to refer customers to.

Ask yourself how confident you are in helping patients to identify symptoms of specific cancers. Good communication skills are vital for initial conversations around such sensitive topics and when speaking to people to identify barriers that they may have or to help them spot symptoms of cancer and encouraging them to visit their GP.

Cancer Research UK states that as many people now survive cancer as die from it and 4 in 10 cancers can be prevented with lifestyle changes. But worrying statistics such as a projected 80,000 additional new cases of cancer by 2030 and 15,400 new cases of melanoma skin cancer in 2014 make it a key area of development for targeted public health campaigns and Healthy Living Pharmacies which may have different priorities depending on location. The range of topics to cover may be breast cancer, colorectal (bowel) cancer, lung cancer, female cancers (ovarian and cervical), skin cancer, oesophageal and stomach cancer, or bladder and kidney (renal) cancer.

It is important for community pharmacists to be able to identify and engage people who may benefit from a public health campaign which helps to reduce the risk of cancer, and to know where to locate useful resources to support it.

Explaining the benefits of earlier detection of cancers is also important, through recognising common signs and symptoms of seven key cancer types and signposting customers to resources and organisations designed to support the early detection, diagnosis and examination of these key cancer types.

With this in mind community pharmacists should be aware of the follow-up and referral procedures to local primary and secondary care specialists, and to national NHS screening programmes as part of the primary healthcare team. Look out for what is happening in your area to help you achieve this.

Further resources

- Cancer Research UK
  www.cancerresearchuk.org
- CPPE learning resources
  www.cppe.ac.uk
- Cancer screening programmes
  www.gov.uk/topic/population-screening-programmes

"Good communication skills are vital for initial conversations around such sensitive topics"
Baseline pharmacist prescribing activity in critical care units published

Critical care pharmacists in Sheffield have published baseline pharmacist prescribing activity in their general critical care units in the European Journal of Hospital Pharmacy.

In a retrospective evaluation of e-prescribing undertaken over a one month period, they analysed pharmacist prescribing activity including rate, indication, therapeutic class and error rate. With 60 percent pharmacist prescriber coverage of units during the evaluation period, pharmacists accounted for just over 10 percent (576/5374) of medicines prescribed in 65 percent (126/193) of patients.

The majority (59 percent) of pharmacist prescriptions were for new medicines. Infections, CNS and nutrition/blood were the top three BNF therapeutic categories, accounting for just over 60 percent of all pharmacist prescriptions. The critical care pharmacist prescribing error rate was 0.18 percent (1/550).

These results provide some insight into the extent, wide ranging scope and safety of pharmacist prescribing in general critical care patients at a single centre. They also provide some early indication of where pharmacist prescribing adds value in our specialty as we develop our understanding nationally of the importance of advanced level practice underpinning pharmacist reviews that lead to pharmacist medicines optimisation and then prescribing opportunities.

Reference:

How do pharmacists develop into advanced level practitioners?

Ruth Seneviratne and colleagues have recently published a report on learning from critical care pharmacists on how to develop advanced level practice. They found that support was required by pharmacists and that this support should involve developing face-to-face access to expert critical care pharmacists within a national training programme.

The importance of mentorship and peer review programmes were also emphasised, as was a local ethos to support advanced level practice which chief pharmacists needed to underpin.

The results from this study give us some direction in the educational strategy required to provide the advanced-level pharmacist workforce needed nationally to meet GPICS recommendations.

Reference:

Congratulations to Alison O’Prey and David Drennan from the Queen Elizabeth Hospital in Glasgow who have won the Scottish Intensive Care Society Audit Group/NRS Research Award for their project on the validation of a pharmacokinetic equation for individualised phosphate replacement in critically ill patients. The project results were included in the last edition of In Practice.
Hepatitis C (HCV)
The new round of Hepatitis C treatment tenders have been agreed and started in September 2017. If you work with a Hepatitis C Operational Delivery Network, ensure that you are using the treatments that are approved for funding by liaising with your Hub pharmacy. The British Viral Hepatitis Group pharmacy network can also assist with queries around the delivery of Hepatitis C treatments (see www.basl.org.uk).

Hepatitis B (HBV)
Tenofovir is now available as a generic which is part of the Medicines Optimisation CQUIN. Given the international shortage of HBV vaccine, Public Health England have provided the following guidelines to help with prioritisation have provided the following guidelines to help with prioritisation of patients and dosing schedules. (see www.gov.uk/government/publications/hepatitis-b-vaccine-supply-during-crisis-

New NICE guidance for ustekinumab
Ustekinumab has been recently approved by NICE for Crohn’s disease. Ustekinumab is an anti-interleukin 12 & 23. Anti-Interleukins (anti-IL) are monoclonal antibody that neutralize IL 12/23 by targeting the p40 shared subunit which has been shown to be effective in colitis. This prevents IL-12/23 cytokine binding with IL-12Rβ1 receptor, thereby reducing immune cell activation.

Ustekinumab is a fully humanized IgG1k monoclonal antibody that binds to p40 shared unit of unbound IL-12 and IL-23. The IM-UNITI trial showed effectiveness in CD. It is administered as a loading infusion of approx. 6mg/kg and followed by 90mg injections subcutaneously 8 weeks later and after this 90mg every 12 weeks. The dosing interval can be reduced to 8 weekly depending on symptom control. The safety profile is favourable, with nasopharyngitis and headaches as the most common side effects, and infection rates were similar to the placebo group. As a new drug it will have to find its place in therapy over the next few years, most likely as a second line treatment for anti-TNF failures. The patient should be reviewed at weeks 6-8 after the initial infusion to assess for adequate response prior to the subsequent subcutaneous injections.

NHS England commissioning for orphan drugs in hepatology
The new drug for PBC, Obeticholic acid has been approved by NICE. NHS England has restricted its use to certain centres (similar to the Hepatitis C treatment operational delivery hubs) because only a very small cohort of patients will need it. This may cause access problems for patients who do not live near a designated centre as all dispensing must be done centrally and VAT free.

Trientine for the treatment of Wilsons Disease is now commissioned centrally via NHSE through an interim arrangement for all existing patients. New patients require an IFR for to secure funding.

Masterclass highlights
In July the Gastroenterology & Hepatology Group delivered a masterclass for both generalist and specialist practitioners looking after gastroenterology patients. Here are some highlights of the day:

* Presenters from across the speciality discussed current topics and shared advice on how to look after gastroenterology patients on the ward and in clinic.

* Sarah Cripps provided an excellent overview of liver patients on the ward and ran a workshop on alcoholic liver disease. Generalists and specialist practitioners discussed how to manage a patient ward and picked up knowledge on how to improve their daily practice.

* Dr Sumita Verma provided an in depth talk about drug induced liver injury and encouraged us to use the LiverTox database, a comprehensive resource of idiosyncratic drug induced hepatotoxicity (www.livertox.nih.gov)

* Dominic Moore provided an excellent talk on how to go about changing therapies and used the infliximab biosimilar switch as a practical example.

* Archna Parmar introduced the concept of Therapeutic Drug Monitoring in IBD and presented the innovative work her team is doing in Brighton with pharmacist led outpatient and infusion clinics.

* Sarah Black from Succint Medical Communications provided very helpful advice on writing skills and Dr Rachel Joynes from the RPS encouraged us all to undertake research and set up a research program for pharmacists in gastroenterology.

The UKCPA Gastroenterology & Hepatology Group would like to set up a research subgroup to support practitioners in research. If you are interested in joining this group, led by Mikin Patel from Imperial College London, please contact us at anja.st.clair-jones@bsuh.nhs.uk
In the UK about 2500 babies per year are born to women with epilepsy (0.3-0.5 percent of all births). During pregnancy approximately one fifth of women experience a deterioration of seizure control and one fifth improve. Babies born to women with epilepsy have a greater risk of major congenital malformation than the general population (2.8 percent compared with 1-2 percent), and in those taking anti-epileptic drugs (AEDs) the risk is doubled (4-9 percent).

Epilepsy can present as generalized (for example, tonic-clonic, absences) or focal seizures. In two thirds of people with epilepsy, seizures can be effectively controlled using one or two drugs. The remaining third may never achieve seizure-freedom and are designated drug-resistant, or refractory.

Whilst focal or absence seizures are unlikely to pose additional risks, a tonic-clonic seizure during pregnancy poses potential health risks, for the woman and for the baby. The risks to the baby include impaired foetal development, hypoxia, lactic acidosis, bradycardia, intracranial haemorrhage, and poor cognitive performance in childhood.

Abdominal trauma can result in ruptured foetal membranes with the attendant risks of infection or premature labour. Status epilepticus may trigger intra-uterine death.

Effects of seizures on maternal health include injury from accidents or falls, and death from drowning or Sudden Unexpected Death in Epilepsy (SUDEP). The cause of SUDEP is unknown but is thought to result from alterations in cardiac or respiratory function induced by a tonic-clonic seizure during sleep. To reduce these risks it is recommended that people with epilepsy take showers rather than baths, and avoid swimming or sleeping alone.

Ideally women should be referred to a neurologist a year before pregnancy because major congenital malformations occur during the first trimester, often before a woman is aware she is pregnant. This allows time to re-assess the diagnosis, discuss the risks and harms of treatment, and optimize the AED regimen. Any changes to AEDs should be made prior to conception.

All AEDs are likely to be teratogenic, but exposure to valproate poses the greatest risk in terms of neural tube defects and neurodevelopmental disability, as highlighted by a recent MHRA alert. It should be avoided unless there are no effective alternatives. Women taking it should be informed of the risks. As pregnancy progresses some drugs such as lamotrigine, phenytoin, phenobarbital and topiramate, may need gradual dose increases to counteract the increased volume of distribution and metabolism.

As always, to avoid destabilizing seizure control, it is important to ensure that patients taking phenytoin, primidone, phenobarbital and carbamazepine are maintained on their same brand. To a lesser extent this also applies to those treated with valproate, lamotrigine, perampanel, topiramate, oxcarbazepine, eslicarbazepine or zonisamide.

Ultimately, the safest policy, for both mother and baby, is for the mother to take medication and be seizure-free.

Further guidance:

- Royal College of Obstetricians and Gynaecologists. Epilepsy in Pregnancy Green-top Guideline No. 68, June 2016

The Federation of Infection Societies (FIS) Conference is in Birmingham this year from 30 November until 2 December. We will be delivering a workshop on Antimicrobial stewardship quality indicators for hospital and primary care, which will feature the following speakers:

- Quality indicators and outcomes in the devolved nations - Wales: Nicholas Reid, All Wales Consultant Antimicrobial Pharmacist, Public Health Wales
- Quality indicators and outcomes in the devolved nations - Scotland: Jacqueline Sneddon, Project Lead SAPG, Healthcare Improvement Scotland
- Quality indicators and outcomes in the devolved nations - Northern Ireland: Cairine Gormley, Chair of the Northern Ireland Antimicrobial Pharmacist Network and Lead Antimicrobial Pharmacist, Altnagelvin Hospital

The closing date for abstracts for oral presentations is the 30 September 2017 and the deadline for abstracts considered for poster presentation is the 4 November 2017.

The next European Congress of Clinical Microbiology and Infectious Diseases (ECCMID) is in April 2018 in Madrid. There was a great PIN representation at this year’s meeting and it is always a great conference. The abstract deadline is 30 November 2017 so write those posters and ask your trust to fund you!

Providing expertise to NICE

The UKCPA Pharmacy Infection Network has responded to NICE on two recent guideline consultations: acute sore throat, and sinusitis. The main points made were on the choice of penicillin over amoxicillin. While penicillin is preferred, amoxicillin is generally better tolerated and less awkward to dispense. Issues over the dose and duration of antibiotics as well as the use of the FeverPAIN score were also raised.

We look forward to the guidance when it comes out later this year.
Respiratory Group news

Toby Capstick, Chair of the Respiratory Group committee, highlights what you need to know about new products and guidelines.

New products and guidelines: Essential information you need to know

Launch of first triple therapy inhaler licensed for COPD

This summer has seen the launch of the first triple therapy inhaler licensed for COPD: Trimbow® MDI (beclometasone/formoterol/glycopyrronium 87/5/9 micrograms).

Other triple therapy inhalers are expected to be launched over the next few months and offer benefits to patients by simplifying inhaler regimens and to the NHS through reduced drug expenditure.

Pharmacists should be aware of their place in therapy: the licence for these inhalers is as a step up in treatment in people with moderate to severe COPD uncontrolled by an ICS and a LABA. However, due to concerns about over-prescribing of inhaled corticosteroids in people with COPD (such as pneumonia risk, uncertain benefit in non-exacerbators), it is likely that they may be more suitable as a step up from LABA/LAMA, which reflects an off-licence treatment approach.

Roflumilast for treating chronic obstructive pulmonary disease: NICE Technology Appraisal [461]

Despite receiving a marketing authorisation in 2010, roflumilast has not been available to prescribe on the NHS due to lack of data on its place in therapy. Now recommended as add-on therapy for treating severe COPD (post-bronchodilator FEV1 <50%) in adults with chronic bronchitis with at least two or more exacerbations in the previous 12 months despite triple inhaled therapy, this represents a new treatment option. Pharmacists should be aware of the NICE recommendations and patient educational risk minimisation materials.

The recommendations are based largely on the pivotal 12-month placebo-controlled REACT study that demonstrated a small reduction in moderate-severe exacerbation rate when roflumilast is added to ICS/LABA or triple therapy (ICS/LABA + LAMA; 70 percent of the study population).

NICE stipulate that roflumilast should only be prescribed by specialists after consideration of potential benefits and risks. Treatment should be avoided in people with severe immunological diseases or immuno-suppressive therapies, severe acute infections, cancers, congestive heart failure (NYHA grades 3 and 4) and mild hepatic impairment.

All patients should be issued with a patient card advising about these cautions, to report side effects of sleeplessness, psychiatric disorders and to weigh themselves every two weeks due to weight loss of around 2kg in studies.

Reslizumab for treating eosinophilic asthma: NICE Final Appraisal Determination

In July NICE proposed recommending reslizumab as an add-on therapy for the treatment of severe eosinophilic asthma inadequately controlled in adults despite high-dose ICS plus another drug, where blood eosinophil count has been recorded as exceeding 400 cells/microlitre, and with three or more asthma exacerbations in the past year. Reslizumab is the second anti-interleukin-5 monoclonal antibody licensed for severe eosinophilic asthma, after mepolizumab, and there are practical differences between these two drugs that pharmacists should be aware of.

Firstly the cut-off for blood eosinophil count is higher for reslizumab (400 vs. 300 cells/microlitre), but there is no time period that this applies to (in contrast to mepolizumab which mandates a count of 300 cells/microlitre within the past 12 months).

Secondly, patients require to have experienced fewer exacerbations to be eligible for reslizumab (3 vs. 4), although they may be eligible for mepolizumab if they are currently taking oral corticosteroids.

Finally, mepolizumab may be simpler to administer to patients as a fixed dose monthly subcutaneous injection, whilst reslizumab is licensed as a weight-based monthly intravenous infusion.

As there are no comparative trials between reslizumab and mepolizumab, these practical differences are likely to dictate treatment choice for adults with severe uncontrolled eosinophilic asthma.

Further reading


Prescribing pharmacists at Betsi Cadwaladr University Health Board West have integrated within our pre-operative assessment clinics (POAC) since 2012. Initially our main prescribing remit involved anticoagulation and bridging management, anti-platelet management and prophylactic antibiotics, but in 2015 an audit identified anaemia to be one of the main causes of delays in patient pathway through POAC.

Traditionally POAC patients who were identified with iron deficient anaemia were referred to primary care for treatment and optimisation prior to elective surgery. Pre-operative identification and optimisation is recommended by the Department of Health, National Blood Transfusion Committee and the NHS Enhanced Recovery Partnership. (1)

In November 2015 NICE stated that iron treatment was not consistently prescribed and that increasing iron prescribing pre-operatively should show a reduction in blood transfusion. (2)

A working group compromising of anaesthetists, nurses and pharmacists collaborating with a consultant haematologist, gastroenterologist and renal physicians, resulted in the service introduction in 2016.

Following initial meetings a guideline was written. The anaemia evaluation and the decision to treat or refer for advice by others (such as renal physicians) is conducted by the pharmacist. If iron deficiency is identified the treatment choice compromises oral iron or IV iron.

The IV iron is reserved for severe iron deficiency and patients whose surgery is within four weeks of POAC appointment. The IV iron is administered by POAC nurses, and administration and observation documentations were developed to aid this process. GPs are informed of our action via letters.

Within the assessment period 25 patients were treated with fernject® 1g, 24 patients were treated with ferrous fumarate 210mg three times a day, and two patients were referred for specialist renal advice. Eight of the 51 patients received red blood transfusion in the peri-operative period. The average time available between POAC and day of surgery in patients who received red blood transfusion was 35 days. Five of these eight patients received IV iron while three were prescribed oral iron replacement therapy.

The main limitation to the service is the difficulty in managing patients who have less than 10 days for POAC appointment to surgery. POAC pharmacists within our anaemia service hope to work with surgeons to identify anaemic patients listed for surgery earlier within the pathway.

We hope that future projects for POAC pharmacists will involve chronic disease optimisation (such as hypertension, diabetes, frail elderly) with the aim of avoiding delays in referral to treatment time and over burdening GPs with referral for optimisation when they are already under pressure in primary care.

Further reading
Masterclass success
The first UKCPA Women’s Health Group Masterclass was held in London in June. The event had a good turnout of pharmacists from all over the UK and Ireland and covered aspects of epilepsy and infection during pregnancy and the peripartum period.

The day focused on the management of anti-epileptic drugs during pregnancy, the obstetric risks to women, and the risks to the foetus and newborn resulting from exposure to anti-epileptic drugs. It also covered the management of maternal and neonatal sepsis, the management and pharmacological treatment of HIV positive women during pregnancy and the peripartum period, and the risks to the foetus and newborn from exposure to anti-retrovirals.

MHRA Valproate Alert
The MHRA released an alert in April 2017 regarding the risk of valproate in pregnancy to the unborn baby. The alert calls for all organisations to undertake a systematic identification of girls and women who are taking valproate and to use the toolkit provided to support them in making informed choices regarding their management.

Further information can be found here: https://improvement.nhs.uk/uploads/documents/Patient_Safety_Alert_-_Resources_to_support_safe_use_of_valproate.pdf

Contributing to the professional curriculum
Following on from the first meeting of the new committee, one of the group’s priorities over the next year is to work with the Royal Pharmaceutical Society (RPS) to contribute to the Knowledge Interface Tool (KIT).

The KIT is a database of knowledge, skills and behaviours required to practice and advance. It is essentially your pharmacy professional curriculum. It is hosted by the RPS, contributed by the RPS Affiliated Partners, and quality assured and validated by the RPS Faculty Curricula Panel.

It is a constantly evolving resource, with changes in practice requiring updates in the curriculum. The Women’s Health Group standards and accreditation team aim to help the development of a structured and consistent approach to knowledge that will support pharmacy staff, across all sectors of practice, when dealing with women’s health queries.

Work has already begun engaging with local, national and international colleagues to start the process of contributing knowledge, skills and behaviours relating to pharmacy practice in women’s health.
Company profile

AOP ORPHAN
FOCUS ON RARE DISEASES

Who is AOP Orphan?
AOP Orphan is a European Pioneer in the area of Orphan Diseases; the company researches, develops, produces and markets innovative solutions for rare diseases worldwide. With over 20 years of experience in the field, AOP Orphan's strategic goal is to deliver new treatment options for rare diseases by recognising early on new trends and challenges.

Where is AOP Orphan based?
The company was established in Austria in 1988 and has its headquarters in Vienna. Privately owned and led by natural scientists, AOP Orphan is involved in supplying individualised therapies for patients with rare diseases. Today, AOP Orphan is active on the international stage, with an export ratio of around 70%.

AOP Orphan Pharmaceutical AG UK office, Colmore Plaza, 20 Colmore Circus Queensway, Birmingham B4 6AT, UK.
Medical Information +44 (0)121 262 4110.

What is the current research focus of AOP?
A key priority is haematology, specifically myeloproliferative disorders, where the mutated haematopoietic stem cells form too many blood cells:

- Essential thrombocytopenia (ET): Since 2001, AOP Orphan has provided patients with ET, across various countries, with anagrelide. AOP Orphan has developed an improved formulation, which was submitted for approval in 2016.
- Polycythemia vera (PV): In clinical trials, encouraging results have been shown for imatinib, which is currently under review by regulatory authorities.

UK activities:
AOP is committed to giving patients in the UK access to medicines, that improve their quality of life.

UK licensed products:
Adapex® (naltrexone)  Esmolol hydrochloride*  Naloxone*  Naltrexone*  Tardiben®(tetrabenazine)  Tetrabenazine*
(*supplied as generic)

...Watch this space, more in pipeline for 2018 and beyond!