Founded 1905

National Association of Women Pharmacists

Celebrating Women in Pharmacy

Issue Seven - April 2009

In This Issue

Working Globally

Annual Report 2008

and more...

The President's Letter

Dear Colleagues,

As I look back over 2008 it has been a momentous year for NAWP and I would like to highlight just a few of the areas in which the organisation and its members have featured.

Early in the year the Clarke Inquiry report was published and this led to the setting up of the Transitional Committee (Transcom) to decide on the prospectus for the New Professional Body. NAWP was represented at all the public meetings of Transcom and had input into four of the smaller subcommittees. Following on from this RPSGB has sought the views of NAWP on a number of important documents including the prospectus for the New Professional Body, CPD, Responsible Pharmacist and the Draft Pharmacy Order.

NAWP has always been interested in the needs of those pharmacists returning to practise after a career break. To this end NAWP has been working with ICCA, BOOTS and other organisations and individuals to provide support to those considering returning to practise or moving from one area of practise to another. This support can vary from putting 'returners' in touch with prospective employers to providing 'shadowing' opportunites and information about relevant courses etc.

The Carers Project has moved on to the next stage following the initial pilot and the team are currently looking for funding to roll the scheme out across Cardiff and establish Carers' Champions in each pharmacy. In addition to this, approaches have been made from other centres in South Wales who are looking to run similar schemes. This year for the first time Wales has its own Pharmaceutical Care Awards and the work of the Carers' Project has been submitted for an award.

The Welsh Chemist Review featured an article on NAWP in one of its early editions and this has been very useful in raising the profile of NAWP within Wales. I was privileged to attend the first Council dinner held in Wales by RPSGB back in October. More recently I attended a workshop looking at developing a toolkit covering the requirements for the Responsible Pharmacist.

NAWP has demonstrated that it can keep up with modern technology by upgrading its website and making it more interactive as well as providing more links to other organisations. For those who are familiar with 'Facebook' NAWP now has its own profile known as 'NAWP Quick' which hopefully will reach those who prefer to get information electronically.

It is always good to win an award and especially if it has been in recognition of past achievements. In May 2008 Christine Heading, a former President of NAWP and present Executive Committee member, was awarded the Charter Silver Medal by the outgoing President of RPSGB in recognition partly for her work in aspects of pharmacy of particular interest to female members of the profession. Also Jennifer Archer, Honorary member of NAWP, received the CPP Bayer Schering Pharma Award for her outstanding contribution to pharmacy education in England.

NAWP continues to forge links with colleagues in the EU and a number of NAWP members plan to attend the 'dpv' conference in Leipzig in September.

Many of you will have noticed the new, fresh look to NAWP's website. We have set up several links and hope this will stimulate fresh interest in our Association.

This is just a taster of the things that NAWP has been involved with over the past year. My thanks go to the Executive Committee and others for their input into these and other initiatives over the past year.

Regards,

Hazel Baker

President of the National Association of Women Pharmacists

2008

NAWP was one of very few organizations who were not only invited, but attended every Transcom (Transitional Committee) meeting

The year started with the end of Hemant Patel's term of office as President of the Royal Pharmaceutical Society of Great Britain. He had been a great supporter of NAWP and we wished him success in his future career.

Hazel Baker (President), Renata Inglis (Hon. Secretary) and Christine Heading attended Hemant's farewell Council dinner in April 2008. The political tensions were already apparent.

The Royal Pharmaceutical Society's Charter silver medal for 2008 was presented to Dr Christine Heading in May 2008 at the Society's AGM. This was in recognition of their contribution to the profession of pharmacy, supporting and leading women pharmacists and particularly her contribution to the National Association of Women Pharmacists. Jeremy Holmes was appointed as CEO and the Executive Committee had a brief introduction to him at one of our quarterly meetings at Lambeth.

Steve Churton was appointed President. It soon became apparent that monumental changes were in store for all pharmacists in the UK, as we have all been informed in the pages of the Pharmaceutical Journal.

The Clarke Enquiry was high on our list of priorities and NAWP made a response, ably put together by Christine Heading.

NAWP was one of very few organizations who were not only invited, but attended every Transcom (Transitional Committee) meeting in the persons of Hazel Baker, Christine Heading and /or Veronica Pearson. Our representatives contributed evidence to four of the smaller groups. They reported back to the Executive Committee in great detail which gave us a rare insight into the workings of RPSGB during 2008.

The Annual Conference was held at Tankersley Manor, Barnsley in April. It was organised efficiently by our Registrar, Ann Munday and Treasurer, Veronica Pearson.

Fourteen NAWP members attended the European Women Pharmacists Conference in Heidelberg, Germany. The topic was "Gender Medicine" and the event was organized jointly by the "dpv" the German women pharmacists group and the Baden-Württemberg Women Doctors regional group.. It provided an excellent opportunity to meet pharmacists from other countries and with different aspects on the same problems.

Anita White continued to make great progress with her project for the Princess Royal Trust for Carers in Wales and was presented to the Princess Royal in Cardiff in the Autumn of 2008.

There has been considerable progress in NAWP's joint venture with ICCA, Boots Alliance, MRS and RPSGB for pharmacists wishing to return to community practice. A series of articles is planned in the Pharmaceutical Journal.

Many of you will have noticed the new, fresh look to NAWP's website. We have set up several links and hope this will stimulate fresh interest in our Association.

We certainly get regular information from RSPGB and organizations such as the Women's National Commission (WNC).

A notice has been received in accordance with the Association's Rules from the Treasurer proposing an amendment to Rule 18 by adding the sentence "The Association is a not-for-profit association and any monies raised will be used by members in the interests of the Association only." The purpose of this addition is to clarify our position with respect to the Data Protection Acts. This proposal will be put to the AGM on 24th April 2009.

I hope you feel that the Executive Committee has worked hard in your interest this year.

There will be a few changes from April 2009. Virginia Watson will be acting as Vice-President;. Anita White will take over as Treasurer from Veronica Pearson; Dr Christine Heading will become Public Relations/ Promotions Officer, Sue Symonds will be our Publicity Officer, Mary Gwillim-David will act as Social Secretary. One or two council members are invited to join the committee each year; for the past year Dorothy Drury has been the council representative.

Renata Inglis and Pat Hoare have decided not to stand for re-election to the Executive Committee.

Last, but not least, we would offer our thanks to PHOENIX for sponsoring the magnificent NAWP newsletter, for which we have had many plaudits.

Renata Inglis

Miscellany

Best wishes to everyone in 2009, a year when we certainly need some good news. A reassuring landmark in the NAWP calendar is our annual conference. This year it will be held in Gloucester on 25th and 26th April. The programme will, we hope, be stimulating, and there is always the pleasure of meeting old friends and fellow professionals.

Branch membership

Being a member of one of the Society's branches has also been both interesting and useful, but if they are to survive they need our support. Other professional bodies have a branch structure, and as a member of the Librarians' Institute (CILIP) I was interested in a recent debate on whether its members could choose to opt out of Branch membership. The CILIP Council realised that if Branches were weakened in this way, it would become harder for them to represent those members whose concerns were with wider professional issues, rather than the matters that the existing specialist groups deal with. This could lead to centralised policy making that would not properly reflect the concerns of many members. All this seems relevant to the Society's Prospectus, which appears to take away from its members any say in the direction the proposed framework is moving. The participation of members must surely help towards better governance.

Médecins sans Frontières

Every year MSF publishes a list of the top 10 under-reported humanitarian stories, showing that many have received little or no attention from the world's media. Two projects involve hospitals in Sri Lanka where the road has to be swept for mines every day, before casualties and medical supplies can be brought in. Food aid is insufficient, but ready-to-eat food packs are most valued because mothers can go on working in the fields while feeding their children. The World Health Organisation estimates that there are 20 million young children with severe malnutrition, yet at any one time only 3% were receiving food packs. Even to reach the most vulnerable will cost £500 million a year.

'Living with Germs in Sickness and in Health', by John Playfair.

At Christmas I was given this fascinating book for lay people. The author was the chairman of the Immunology Department at UCH in London. He describes Koch, Pasteur and Ehrlich as the Bach, Mozart and Beethoven of infectious disease! It is reassuring that however much we fear the spread of infections, the author is optimistic about our ability today to manage both old and new diseases. We know how to prevent most old diseases; all that is lacking is the will and the money to protect the poor world as well as the rich. We can now discover how to combat new diseases as well, provided the world's scientists, with all their different specialist skills – immunology, biology, pharmacology and so on – work together. It took two years to identify the virus of AIDS; the virus of SARS was identified in 15 days.

Health advice from library staff?

With the fast increasing number of information sources, I hope that this will stimulate a greater interest in science, both in schools and among adults who have not been very science-literate in the past. I noticed that public library staff can now attend a course that will help them give health advice to library users. Is this a good sign, or does it suggest that we are failing in some way?

Brenda Eccelstone

POM to P and P to GSL

Reclassifications during 2008

POM to P

Azithromycin 500mg tablets	For confirmed asymptomatic chlamydia infection and for epidemiological treatment of sexual partners. For those aged 16 years and above.
Diclofenac potassium 12.5mg	Tablets for short term relief of headache, dental pain, period pain, rheumatic and muscular pain, backache and symptoms of cold and flu. For those aged 14 years and above.
Naproxen 250 mg tablets	For dysmenorrhoea. For those aged 15 to 50 years.

P to GSL

Nicotine patches 25mg/16 hours	
Sodium cromoglicate 2% eye drops	For those aged 6 years and above.
Paracetamol 5% oral suspension	Bottles of up to 80 ml
Loperamide	Can now be sold for acute episodes of diarrhoea associated with irritable bowel syndrome.
Diclofenal gel	Permitted pack size increased to 50 g
Nicotine inhalators	

The Editor would like to thank everyone who has contributed to this issue of the Newsletter and PHOENIX for their continued Sponsorship.

If you would like to contribute to the next issue, please contact the Newsletter Editor or any member of the Executive Committee.

Plans for a restructured profession

With so much happening in terms of re-organisation of the profession, perhaps a summary of the current status would be useful.

The plan for the future

RPSGB as we know it will cease to exist and will be replaced by a new-RPSGB (now referred to as the new Professional Leadership Body; PLB), and the General Pharmaceutical Council. The split will require alteration of the RPSGB Charter. (PLB is a working title – the new body is expected to be called RPSGB)

Timing

The official expected date for the split is now March 2010 (formerly January 2010), although many people are predicting January 2011.

The Register

The GPhC will register pharmacists and pharmacies and pharmacy technicians. There will be only one register for pharmacists– for practising pharmacists.

Consultations and voting

Consultation on the GPhC intentions closed on 9th March. Consultation on the Charter revision is ongoing (in March 2009) and everyone will be asked to vote on these.

Assuming the revisions are accepted by two thirds of those voting, development of the PLB to implement the Charter will be ongoing up to and perhaps beyond the date it starts to function.

A website www.pharmacyplb.com will allow exchange of ideas and information.

Membership of the PLB

Membership of the PLB will be voluntary. It will be available to those who are registered with the GPhC and all those who have been registered pharmacists (covering those who are retired, on career breaks, changed their occupation etc). Pharmaceutical scientists and pharmacy technicians will not be eligible for membership. In future, if two thirds of members wish, they could allow others to join the PLB. Organisations can become affiliates.

Post-nominals and the title pharmacist

Members of the PLB will probably be allowed to refer to themselves as MRPharmS (or FRPharmS, if appropriate). Other pharmacists will not. Whether a new post-nominal for everyone on the GPhC register will be devised is still under discussion. The original view was 'no', but there are changes in the wind.

The GPhC seems a little more relaxed about use of the term 'pharmacist' than the PLB. This is being hotly debated, as the pages of the PJ show. The GPhC seems happy for individuals to describe themselves as 'retired' or 'former' pharmacists, where appropriate.

CPD and re-validation

The GPhC is responsible for ensuring this happens, but it seems to suggest re-validation should not be regarded as imminent. It also take a more relaxed view of CPD than we have been accustomed to, and will only be expecting CPD that relates to an individual's work. Work is in hand to simplify CPD recording.

Concerns and consequences

These are numerous, and no attempt will be made to summarise them. Perhaps the biggest concern is whether enough pharmacists will want to voluntarily join the PLB. This will be an enormous challenge. The idea is that by joining the PLB, pharmacists will be signalling their commitment to quality, high levels of practice etc. The overall change will, though, lead to MRPharmS 'branded' pharmacists and 'generic' pharmacists, who haven't joined.

Unfortunately, pharmacists are regularly assured that generics are as good as brand.

Christine Heading

enquiries@nawp.org.uk

Working Globally

It was 4.15 am when my alarm went off. How I longed to carry on sleeping, but no, I had yet another early morning journey to Heathrow! At 5 am I was in the taxi to London, in Terminal 5 about 6. 45 am and by 2 pm local time (noon, UK time) I was setting up my laptop in a meeting room in a pharmaceutical company in Sofia, ready to give a 3–day training course. When we broke mid-afternoon for a tea break, I realised that not only was I feeling travel weary and desperate for a cup of tea, but I was also rather hungry having had nothing since breakfast. Who said international business travel was exciting or even glamorous!!


9.4.2005 EN Official Journal of the European Union L 91/13

COMMISSION DIRECTIVE 2005/28/EC

of 8 April 2005

laying down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorisation of the manufacturing or importation of such products

(Text with EEA relevance)

THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Community,

Having regard to Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use (1), and in particular Article 1(3), Article 13(1) and Article 15(3) thereof,

Whereas:

(1) Directive 2001/20/EC requires the adoption of principles of good clinical practice and detailed guidelines in line with those principles, minimum requirements for authorisation of the manufacture or importation of investigational medicinal products, and detailed guidelines on the documentation relating to clinical trials to verify their compliance with Directive 2001/20/EC.

(2) The principles and guidelines for good clinical practice should be such as to ensure that the conduct of trials on investigational medicinal products, as defined in Article 2(d) of Directive 2001/20/EC, is found protection of human rights and the dignity of being.

(3) Manufacturing requirements to be applied tional medicinal products are pro Commission Directive 2003/94/EC of laying down the principles and guidel facturing practice in respect of me human use and investigational me human use (2). Title IV of Directi European Parliament and of the 2001 on the Community cod products for human use (3) applied for the authorisation medicinal products as part for the application for a m 3(3) of that Directive estab are not applicable for

(1) OJ L 121, 1.5.2001, p. 34.
(2) OJ L 262, 14.10.2003, p. 22
(3) OJ L 311, 28.11.2003, p. 6 2004/27/EC (OJ L 136,

research and development trials. It is therefore necessary to lay down minimal requirements regarding applications for and management of authorisations to manufacture or import investigational medicinal products, as well as for the granti of the content of the authorisations, in order to the quality of the investigational medicin clinical trial.

(4) W

INTERNATIONAL CONFERENCE ON HARMONISATION OF TECHNICAL REQUIREMENTS FOR REGISTRATION OF PHARMACEUTICALS FOR HUMAN USE

ICH HARMONISED TRIPARTITE GUIDELINE

STRUCTURE AND CONTENT OF CLINICAL STUDY REPORTS

E3

Recommended for Adoption at Step 4 of the ICH Process on 30 November 1995 by the ICH Steering Committee

This Guideline has been developed by the appropriate ICH Expert Working Group and has been subject to consultation by the regulatory parties, in accordance with the ICH Process. At Step 4 of the Process the final draft is recommended for adoption to the regulatory bodies of the European Union, Japan and USA.

Little did I realise, back in 1996, when I decided to try to move back into the pharmaceutical industry after almost 20 years working as a locum, how much my working life would change.

Today, working in the pharmaceutical industry means working in a multinational environment. One might be based in the UK, but the chances are that your head office will be in another county or continent. Communicating with colleagues oversees is much easier now that it was back in the 1970s when I first worked in the industry. In those days one relied on phone calls, telex and postal services. Today we have email, teleconferences, video conferences and WebEx – even the fax is dying out and being replaced by scanned email attachments. International travel is now much easier and more widespread, with day trips to Europe for a meeting commonplace.

I work primarily in clinical development, which includes organising and managing clinical trials, writing documentation related to all aspects of clinical trial activities and preparing substantial clinical documents for submission to the regulatory authorities for marketing authorisation. Gone are the days when clinical trials were single-centre or multi-centre trials in a single country; today they are large, multi-centre and multi-national. Although English is the accepted language of the industry, working documents for clinical trials such as the protocol and patient informed consent have to be translated into local language (and back translated to verify the translation). Normal ranges for clinical laboratory safety parameters i.e the standard battery of biochemical, haematological and urine tests, will differ slightly across laboratories and these differences have to be accounted for, or a decision made to use a central laboratory with all that that entails

I try to mimimise the amount of travelling that I do, relying on telephone calls and teleconferences as much as I can.

in terms of shipment of biological samples, their correct handling during transit, documentation etc.

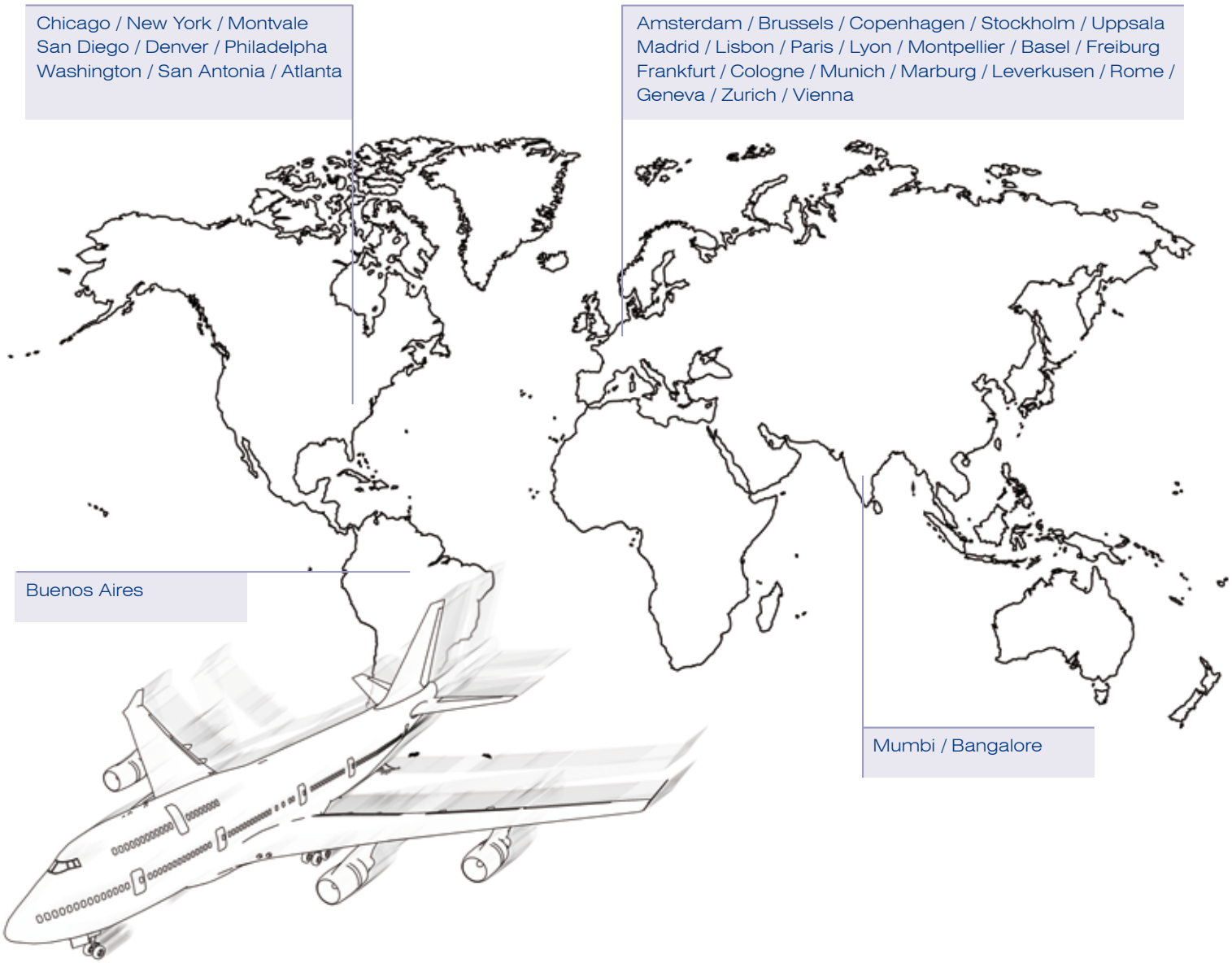
As an international manager, I have been responsible for staff based in other countries. Not only does one have to overcome the problems of remote management, but differences in culture have to be considered and, more importantly, employment law and employee rights differ, as do salary levels and structures. Face-to-face meetings are supplemented with regular telephone meetings and feedback from country managers, but it can be difficult to pre-empt potential problems or to deal with a difficult situation from a distance.

Likewise projects, whether they are internal or external, require interaction with colleagues, clients and contractors in different parts of the world. Again there are cultural considerations and language difficulties. Email is a very useful communication tool, but it is important that these are worded clearly and unambiguously. Very short emails can be abrupt, misinterpreted and can cause offence when none is meant.

Many non-native speakers have a better reading knowledge than spoken English skills, and some lack confidence in their ability to use the language. This can be a problem in teleconferences. Other problems can arise when participants speak English with a very strong accent, there are too many people on the call, or the line is bad. Some participants may be very loquacious, whereas others will remain silent throughout and it can be difficult to draw them into the discussion. One cannot pick up subliminal signals from facial expressions or body language. For some areas of the world finding a mutually convenient time can be difficult due to different time zones – Australia and Japan being prime examples. This can be further complicated when the clocks change: for example the time difference between UK and Brazil can be 2, 3 or 4 hours depending on when the clocks change in the respective countries. Even a call involving continental Europe, the UK and the west coast of America means that this will be at the end of the working day in continental Europe (5 pm) and before the beginning of the working day in the US (8 am).

From a financial perspective one has to work in different currencies. Before the introduction of the Euro, when I was working in a contract research organisation I was pricing projects in local currencies, but my monthly revenues had to be reported in US dollars. I could be generating revenue in Danish kroner, German marks, French francs, Australian dollars and UK pounds. Currency fluctuations between the time of the quotation to the final invoice impact the profit margin. In the same way, currency fluctuations affect departmental overheads and hence operating costs. The Euro has made life somewhat simpler, but we still have to work across many currencies. However, at least now when I travel I don't have to worry quite so much about forgetting to purchase currency before I go – to keep a reserve supply of Euros and US dollars is so much easier.

We hear a lot about standard operating procedures (SOPs) these days as they are now in place in the pharmacy. However, I have been working to SOPs for years. Ideally, company SOPs should cover all sites across the world and I have been involved in harmonising SOPs globally. It is not easy to reach consensus when there are



differences in working practices in different countries and regions of the world, whether these are for historical reasons or because of local legislation, regulatory or local ethics requirements. It is therefore important that the SOPs are written in such a way that everyone, wherever they are, can adhere to them.

Complete harmonisation is probably impossible. In the clinical trials environment we have to work in accordance with Good Clinical Practice (GCP) and have done so for very many years. A few years ago, when the EU Clinical Trials Directive was implemented into national law in 2004, it became apparent that the legislation differed slightly from country to country even for GCP.

Of course working globally, does mean there are opportunities to travel. The novelty wears off and airports, meeting rooms and hotels can look the same wherever you are in the world. Nevertheless, travel has brought me into contact with so many different people and cultures. As a result, and particularly through my voluntary activities in organisations such as the European Medical Writers Association (EMWA) and the Drug Information Association (DIA), I have a number of friends scattered throughout the world.

I try to mimimise the amount of travelling that I do, relying on telephone calls and teleconferences as much as I can. Travelling takes up a lot of time, is very tiring and frequently means very long days. Staying in hotels can be lonely, and arriving late at a hotel without room service is not much fun. As a woman travelling alone I try to ensure that I always stay in hotels with a restaurant; going out at night in a strange city/town to find somewhere to eat can be daunting.

I have to admit that I have had many memorable experiences, good and bad. I remember vividly being stuck on the runway at Munich airport for 4 hours due to heavy snow, waiting for the runway to be cleared and to take off. Due originally to leave Munich late afternoon, it was after 11 pm when we finally arrived at Heathrow, and then I had to drive home!

I remember being stopped by security when entering the departure area at Philadelphia airport. My shoes and passport were taken

> *I try to mimimise the amount of travelling that I do, relying on telephone calls and teleconferences as much as I can.*

away from me without explanation and I was left, for what seemed like hours, standing at the side without any of my possessions in sight. Eventually someone came back and said I could go.

There was the time I was presented with a large bouquet of flowers, at a conference in Vienna, which I was determined to bring home with me – the flowers travelled on the flight deck with the pilot! Again in Vienna, after another conference for which I had organised the programme, and which had been quite stressful because it took place 2 or 3 weeks after 9/11 and several speakers dropped out at the last minute, a group of us went on a coach tour of Vienna after the conference had ended. I fell asleep and can only remember being woken up to make sure I followed everyone into a restaurant!

I have memories of superb food in Brussels, where in my previous job we frequently met for international management meetings; of Copenhagen, a city I love and which I visited and worked in for a client on numerous occasions; of 48 hours in Buenos Aires where in addition to a full day meeting, a visit to a hospital which had facilities for clinical trials, and a breakfast meeting, I managed a taxi tour of the city, a tango lesson and an evening visit to a tango show.

I recall arriving at the Four Seasons Hotel in New York and being engaged in conversation by the room maid who wanted to talk at length about the wedding of the Duchess of Cornwall and HRH The Prince of Wales.

I've been to a ball game in Atlanta, travelled through the New Jersey countryside in Spring, visited the Alamo in St Antonio, walked along the shores of Lake Michigan, had an evening wine tasting in a castle somewhere along the Rhine valley, managed to see an opera in Budapest, a ballet at the Kennedy Centre in Washington, a concert at the Musikverein in Vienna, and in Rome tried to see as many sites as I could in one hour. These opportunities help to compensate for working late into the night to prepare for a talk or a meeting the following day, for arriving back in a hotel room after a busy day and then spending the next few hours checking and responding to emails, for being woken in the middle of the night by a phone call from a colleague in the UK, for arriving without luggage and papers and having to manage, of getting off a long haul flight and going straight to a meeting, of endless delays at airports, struggling to adjust to more than one time zone per trip and the many business trips where I literally see nothing more than the airport, the meeting room and a hotel.

It may seem that my work is far removed from the local pharmacy, which is why I like to keep in touch as a locum, but there is always a patient focus in clinical development. However, I now also understand and appreciate the difficulties in getting a new drug through all stages of development and the stringent regulatory requirements that have to be fulfilled before marketing authorisation is granted. I see the disappointment when a clinical trial does not demonstrate the hoped for efficacy. I see the relief on the tired and strained faces of staff, who have worked long hours in the preceding weeks, when a dossier is finally sent off to the regulatory authorities for licence approval. But, most notably, I have witnessed on so many occasions the multinational team effort behind so many of the activities undertaken within the industry.

Virginia Watson

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6613996	DOVOBET OINTMENT	60G	£33.63	£29.99	11%
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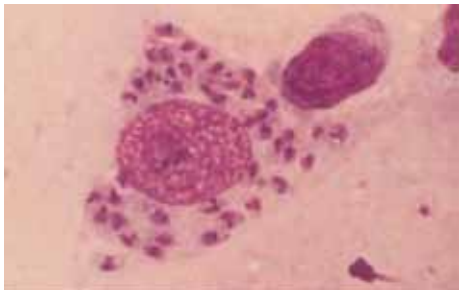
Millions Suffering from Neglected Diseases

A press release from Médecins Sans Frontières (MSF) and the Drugs for Neglected Diseases initiative (DNDi) highlighted the need for more sustainable funding for research and development to tackle deadly, yet neglected diseases, such as sleeping sickness, visceral leishmaniasis, and Chagas disease, that affect millions of people around the world.

Dr. Christopher Fournier of MSF said, "We have patients suffering from diseases such as sleeping sickness who are forced to endure toxic and dangerous treatments just to have a limited chance at survival; at the same time, treatments for those living with visceral leishmaniasis remain prohibitively expensive, and treatments for chronic Chagas patients are non existent. DNDi has demonstrated through its work how innovative, needs-driven collaborative R&D can produce medicine adapted to our patients. DNDi and other public-private partnerships, however, cannot substitute for strong political leadership and commitment of governments to ensure people have access to lifesaving treatments for neglected diseases."

Although research into neglected diseases has improved since 2003, less than 5% of worldwide R&D funding for neglected diseases has been directed towards the most neglected diseases, such as sleeping sickness, visceral leishmaniasis, and Chagas. More than 500 million people are at risk from these three parasitic diseases.

Visceral Leishmaniasis (VL)



Leishmaniasis is caused by infection with the protozoan parasite *Leishmania* which is transmitted by sandfies. With more than 20 species of the protozoan parasite identified and approximately 30 species of sandfly which can transmit the infection, the disease is diverse and complex.

Leishmaniasis is a poverty-associated disease with several forms, of which visceral leishmaniasis (VL) is the most severe. Without treatment it is fatal. VL, also know as Kala-Azar, affects poor populations in 70 countries across Asia, East Africa, South America and the Mediterranean region. Approximately 500,000 new cases are reported to occur each year, though it is estimated that only 30% of cases are reported. The seven most affected countries – Bangladesh, Brazil, India, Ethiopia, Kenya, Nepal and Sudan – represent over 90% of new cases.

VL is characterized by prolonged fever, enlarged spleen and liver, substantial weight loss and progressive anemia. These symptoms occur progressively over a period of weeks or even months. Co-infection with other infectious diseases such as HIV or malaria is a becoming an increasing concern: HIV-VL co-infection has been reported in 35 countries.

Treatments available include pentavalent antimonials, amphotericin B, liposomal amphotericin B (AmBisome®), paromomycin and miltefosine, Unfortunately there are a number of drawbacks to each of these treatments. For example antimonials and amphotericin are given parenterally and therefore patients require hospitalization; amphotericin B is associated with dose-limiting toxicity; there is increasing parasitic resistance to antimonials; liposomal amphotericin B and miltefosine are expensive (miltefosine is also teratogenic; paromomycin is licensed in India but its efficacy in patients in Africa has not been determined; long courses of treatment of antimonials and amphotericin B may be needed to be effective.

There is a need to provide patients with safe and effective treatments, of short duration and which can be given orally.

Chagas Disease

Chagas disease is a form of trypanosomiasis which is endemic in Latin America and kills more people in this region that any other parasite-born disease, including malaria. Patient numbers are growing in non-endemic countries such as Australia, Canada, Japan, Spain due to increased migration of Latin –American immigrants who are unknowingly carrying the parasite in their bloodstream.

Caused by the protozoan parasite Trypanosoma cruzi, Chagas disease is transmitted primarily by large blood- sucking insects widely known as "the kissing bug." Infection may also occur through blood transfusion, organ transplantation as well as by congenital and oral transmission.

The disease has two clinical stage - acute (in which 5% of children die) and chronic. The acute illness is characterised by fever, malaise, facial oedema, generalized lymphadenopathy, and hepatosplenomegal ; it often spontaneously resolves in four to six weeks. Chronic disease has two phases:

- chronic asymptomatic "indeterminate" disease, during which patients can transmit the parasite to others while showing no signs of the disease. This can last for 10 years,

– chronic symptomatic disease which develops in 10% to 30% of infected patients and most often involves the heart or gastrointestinal tract. Chagas disease is a leading cause of infectious cardiomyopathy worldwide.

It is estimated that there are 14,000 deaths per year from Chagas disease

The two current treatments available, benznidazole and nifurtimox, are effective in acute infections and early indeterminate disease with highest efficacy seen when treatment is started during early infection. One of the biggest drawbacks currently is that treatment has to be given for 30- 60 days which leads to poor compliance. There is no treatment for chronic disease.

Improved treatment options are needed for all stages of the disease

but there is a particular need for a paediatric formulation and an age-based dosing regimen for treatment of the acute disease, and the development of an effective treatment for patients with chronic disease.

Human African Trypanosomiasis (HAT)

Also known as sleeping sickness, HAT is caused by two sub-species of *Trypanosoma brucei* - *T. b. gambiense* (West African), *T. b. rhodensiense* (East African)- which are transmitted by which are transmitted by tsetse flies. Endemic in sub-Saharan Africa, the 7 most affected countries represent 97 % of the 50,000 to 70,000 cases reported annually, with the Democratic Republic of the Congo (DRC) alone accounting for 2/3 of these. As a disease affecting the poorest most rural areas of Africa, where difficulty of diagnosis, political instability and lack of health surveillance, estimates of disease prevalence are difficult to ascertain.

HAT occurs in two stages:

Stage 1 - the haemolymphatic phase – includes non-specific symptoms such as headaches and bouts of fever which means that, unless there is active HAT surveillance, the disease generally remains undiagnosed at this stage.

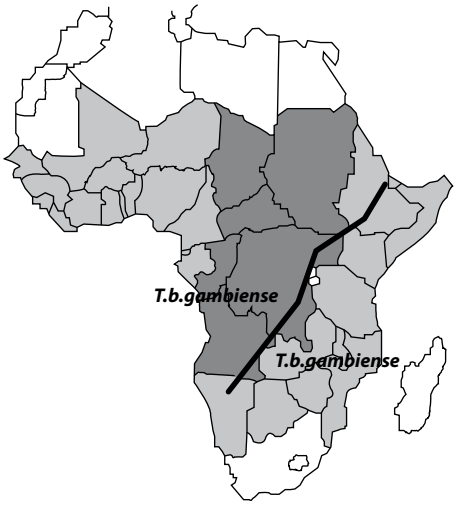
Stage 2 - the later, neurologic phase – occurs when the parasite crosses the blood-brain barrier and can lead to serious sleep cycle disruptions,paralysis, progressive mental deterioration. Without effective treatment, death results.

It is estimated that there are 48,000 deaths from HAT each year.

Available treatments for HAT are few, old and stage-specific. For stage 2 disease, which is when most patients are diagnosed and therefore treated, melarsoprol and eflornithine are used. Melarsoprol, an arsenic derivative is painful, toxic and becoming increasingly ineffective. Eflornithine requires 56 infusions of 2 hours over 14 days and therefore is difficult to administer and requires hospitalization. Again parasitic resistance to this treatment is an increasing concern.

Again there is a need for improved treatment options for both stages of disease. Earlier diagnosis and a readily available, simple and safe treatment that could be used in stage 1 disease as well as an effective treatement to reduce fatalities in patients with Stage 2 disease is much needed.

This information has been extracted from the website www.dndi.org and reprinted with the kind permission of DNDi, Geneva.



DNDi is involved in addressing unmet treatment needs in these and other neglected diseases. In the short term they aim to make better use of existing treatments e.g. research into combination therapies, producing new formulations including paediatric products and increasing access to licensed products in other geographic areas. Long term goals are aimed at developing new drugs and sustaining research improvements.

The editor would like to thank DNDi for use of the above text and use of images within this article.

Data Protection Act

NAWP holds on computer file, the names, postal and email addresses and information about payment details of its members. This information is used solely to print address labels, to facilitate mailing within the organisation, to contact members about the Association affairs and to keep a record of fees paid. Under the Data Protection Act, a member may object to their name being on computer file. Objections should be sent in writing, to the Registrar.

Letters to the Editor

please send letters to the Newsletter Editor to email: watson639@gmail.com

If you would like a copy of the NAWP Constitution and Rules please contact the Registrar.

NAWP Annual Conference

24 - 26 April 2009

Hatherley Manor, Gloucester

Affairs of the Heart - A Cardiovascular Approach

Have you booked?.If not, there may still be the opportunity to make a last minute booking.

The conference is now nearly upon us and there is a full programme of speakers and activities for the weekend.

The programme will take the usual format of a Law and Ethics update on the Friday evening, followed by the AGM at 9 pm. On Saturday topics covered include heart failure and vascular risk assessment. Mark Pitt of the PDA will explain how the organisation provides support to pharmacists. The Conference Dinner is on Saturday evening and a social programme has been organised for Sunday morning.

We hope to see you there.

The Responsible Pharmacist

A number of NAWP members were spotted during the lunch break at the PDA Conference in Birmingham on 1st March.

The main topic was the role of the Responsible Pharmacist and the associated legal obligations. The presentations and discussion gave us much to think about. Other topics covered during the day included stress in the workplace and the forthcoming consultation on remote supervision which is expected later this year.

The conference proceedings were reported in the PJ of 7 March 2009.

NAWP in London

A reminder from our last Newsletter that we are seeking the opinions of our London members on the formation of a London group. Do you think it would be good to meet up sometime, perhaps on a social basis – or maybe form an electronic grouping who could share information and experiences? If so please contact enquiries@nawp.org.uk with any ideas or comments.

Additionally, is there anyone in community pharmacy in North London who might be able to provide work experience/ work shadowing for an experienced, suitably registered UK pharmacist wanting to return to practice after a career break?

If so, again please contact enquiries@nawp.org.uk.

Annual Subscriptions 2009

A reminder that, if you have not already paid, your Annual subscription for 2009 is now due.

Full time	£25
Associate Member	£25
Part time	£15
Retired	£5

Associate Membership is open to individual healthcare professionals (including pharmacists in other countries and technicians) who support the objectives and activities of the Association. Associate members may attend and speak, but not vote at the Annual General Meeting of the Association.

Cheques should be made payable to NAWP

If you pay by standing order, please ensure that you amend your mandate before then. It would be helpful if you could notify the Registrar when you have done this.

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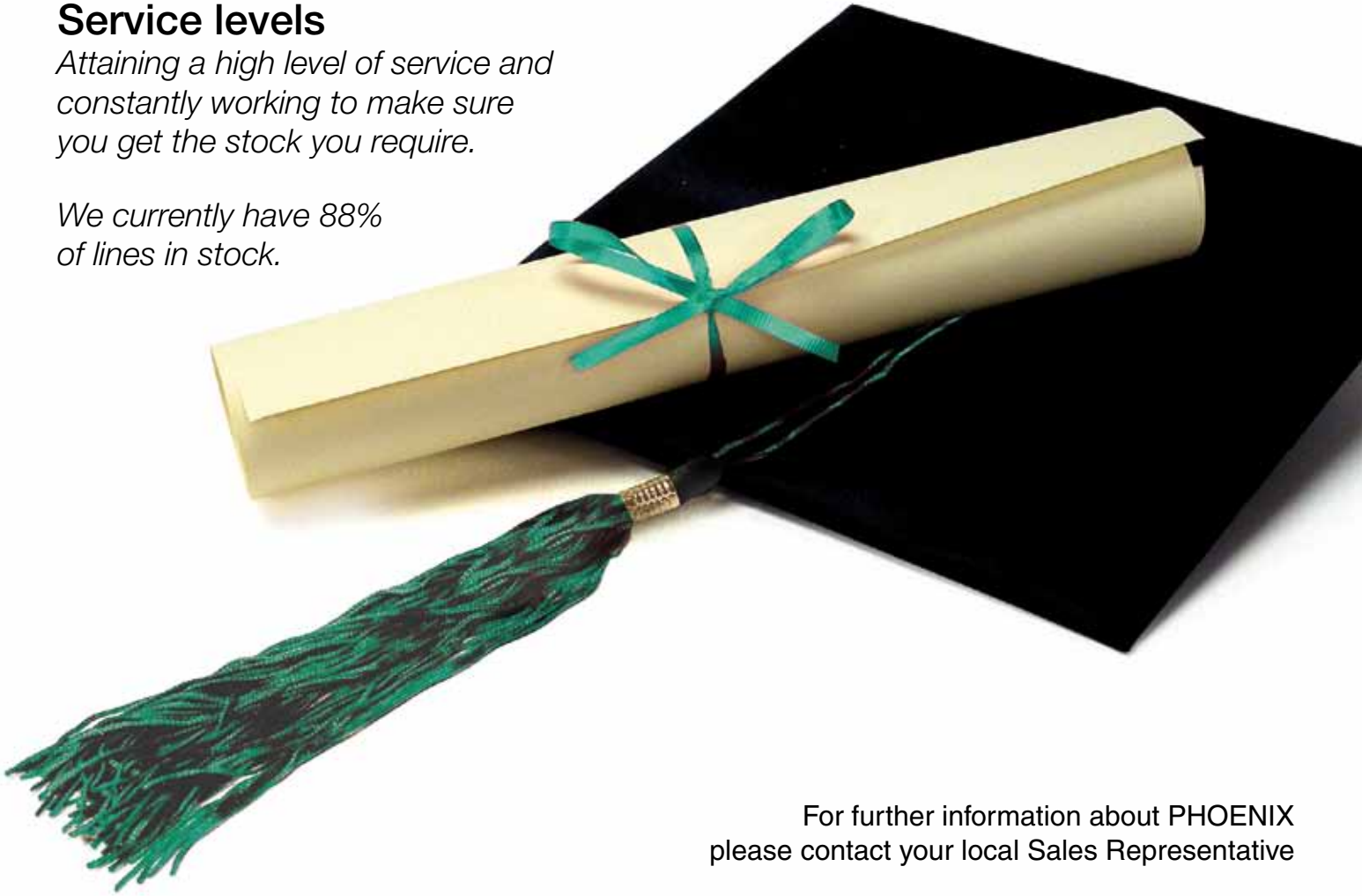

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(year to retire in brackets)

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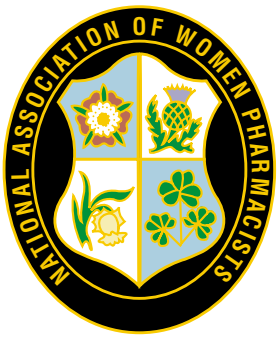

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