

Value of goodwill disputed in contract

A DISPUTE between the Pharmaceutical Services Negotiating Committee and the Department of Health over goodwill values is going to be central to negotiations over funding for the new pharmacy contract.

The PSNC believes that the goodwill value of pharmacy businesses is part of the capital employed in providing pharmacy services, while the DoH believes that the NHS should not pay for that aspect.

The PSNC and the Department have agreed the principle that the payment due to pharmacists under the new contract should cover the cost of providing the contract plus a fair return. This will be met by a global sum or equivalent, plus purchasing incentives (retained profit on NHS buying).

Godfrey Horridge, financial executive at the PSNC said last week: "We are a long

way off agreement on fair return and purchasing incentives. We have agreed that there will be a global sum and our objective is that it should be uncapped." But the Department might insist on a capped global sum, as it has done with the new general medical services contract.

The DoH position is understood to be that it should not pay a return on goodwill because it is not a tangible asset. The PSNC position is that goodwill is a major part of the capital cost of buying a pharmacy business, even though there is no goodwill cost in setting up a new pharmacy.

In accounting terms, goodwill is the difference between the value of a business as a going concern and its liquidated value. In the case of pharmacy businesses this can be a considerable sum.

The Department has accepted that purchasing incentives are needed if community pharmacists are to continue to try to drive down costs by seeking better deals on generics and parallel imports. The issue at stake is how much profit there should be and how much the NHS will allow contractors to keep.

Confirmation that negotiations are going to be tougher than first hoped was given by the minister with responsibility for pharmacy, Rosie Winterton, at a meeting of the All-Party Pharmacy Group on 1 December. Mrs Winterton said: "Discussions will last longer than expected and longer than we hoped. We prefer to get it right. We will have an agreement by the end of March and implementation as soon as possible after that."

GMS money available to pharmacy

MONEY given to primary care trusts under the new general medical services (nGMS) contract to pay for enhanced services is available to pharmacies.

Chris Town, chairman of the NHS Confederation team which is negotiating the new pharmacy contract with the Pharmaceutical Services Negotiating Committee, said at the PSNC's community pharmacy conference last week: "We haven't said that enhanced services money must go to GPs. It's a budget for primary care trusts, but they can commission the services from anywhere in primary care."

Mr Town's message was reinforced by Dr David Colin-Thomé, the Department of



Chris Town: pharmacists can bid for nGMS money

Health's national clinical director for primary care, and Felicity Cox, chief executive of Watford and Three Rivers PCT and a member of Mr Town's negotiating team.

Dr Colin-Thomé told pharmacists at the conference: "We will be giving more resource to practices — and that could include you."

Ms Cox said: "The nGMS contract is not a GP contract. It's about appropriate services from a range of professionals across the whole PCT."

Under the nGMS contract, enhanced services are the equivalent of

what are currently to be termed additional services under the new pharmacy contract. The terminology may be changed to reduce confusion.

NHS to cut quangos

THE Secretary of State for Health, John Reid, has launched a review of all NHS and social care quangos in a bid to reduce their collective workforce of 19,000 (our Lobby correspondent writes).

The scrutiny will examine their roles, efficiency and reducing demands on frontline services, a Department of Health spokeswoman said. She confirmed that the review includes the Prescription Pricing Authority, the Medicines and Healthcare products Regulatory Agency, the Counter Fraud Management Service and the Family Health Services Appeals Authority.

The NHS chief executive, Sir Nigel Crisp, is to provide a progress report on the review by April 2004.

Dr Reid signalled the review in October when he announced plans to reduce Departmental core jobs by 1,400 posts by October 2004. He told the House of Commons Health Select Committee: "As well as reducing the numbers at the centre, I believe we need also to reduce the numbers of people working in arm's length bodies. We will be looking harder at all of the health and social care bodies at a national level."

MEPs try to block unregulated European free movement plan

MEMBERS of the European Parliament's Legal Affairs Committee have voted against a plan to allow pharmacists and other health professionals to work anywhere in Europe for up to 16 weeks a year without having to register in the country they are in.

The free movement plan is opposed by the Alliance of UK Health Regulators on Europe (AURE), which includes the Royal Pharmaceutical Society. AURE said that without prior registration regulatory bodies will be unable to assess individuals' fitness to practise or to take action in the event of a complaint. Dr Gill Hawksworth, President

of the Society, said before the vote: "While we welcome the free movement of professionals throughout the European Union, we are seriously concerned at the proposal to allow an individual to work unregistered for any period of time and for the impact that this could have on patient safety."

The Legal Affairs Committee approved amendments last week that will require professionals to register in host member states before being allowed to practise. The move has been welcomed by AURE. Lobbying of MEPs will continue ahead of a full vote in the parliament on 17 December.

ROYAL PHARMACEUTICAL SOCIETY NEWS

Media campaign

The Society is to run a festive season campaign to promote pharmacists' services through local media (p793).

New fellows

Nine pharmacists have been designated as fellows of the Society (p794).

Library and information service

An article explains how pharmacists can make use of the Society's library and information service to keep themselves up to date (p795).

Over 1,000 call for Charter referendum

OVER 1,000 pharmacists have supported a petition calling on the Royal Pharmaceutical Society to hold a referendum on its proposed new Royal Charter. Their call has been rejected by the Society's Council.

The petition was organised by Hassan Argomandkhah on behalf of the Save Our Society campaign (*PJ*, 25 October, p570). Speaking at a press briefing immediately before the December meeting of the Society's Council, at which the revised draft new Charter was discussed, Mr Argomandkhah called on the Council to delay making a final decision. It should "allow an appropriate period for reflection among both Council and the membership, and seek alternative independent legal advice. Only then can it seek members' approval through a referendum before submitting any documents to the Privy Council," he said.

Mr Argomandkhah said that pharmacists had sent messages supporting his call for a referendum by letter, fax, e-mail or text. He received 620 printed responses, 412 e-mails and 64 text messages in total. Copies of these were handed to the Society on 2 December.

Mr Argomandkhah was supported by six members of the Society's Council: Martin Astbury, Sultan Dajani, Hemant Patel, Douglas Simpson, Noel Wicks and



Hassan Argomandkhah (centre), with a copy of responses sent by fax to his petition, and (from left) Council Members Nicholas Wood, Martin Astbury, Noel Wicks, Douglas Simpson and Sultan Dajani

Nicholas Wood. Asked how many pharmacists might vote if a referendum were held, Mr Wood suggested that turnout might be similar to those in recent Council elections, which have averaged around 20 per cent in recent years. He understood that the annual cost of holding the Council election is around £25,000, but this was cheaper than the special general meeting held in June.

A motion asking for a ballot of members of the Society seeking their approval for the proposals incorporated in the new Charter was lost at the Society's Council meeting on 2 December. The Council agreed to petition the Privy Council for a new Charter.

Full details in next week's Council report.

Medicines Act confidentiality to go

A SECTION of the Medicines Act 1968 that stops the Medicines and Healthcare products Regulatory Agency releasing information is to be repealed (*PJ*, 7 December 2002, p801). Section 118 of the Act will be repealed in January 2005, to coincide with the full implementation of the Freedom of Information Act 2000. Revision will remove a blanket ban on releasing information and replace it with the exemptions and public interest tests in the Freedom of Information Act.

The Medicines and Healthcare products Regulatory Agency said: "This is an important better regulation and open government measure, which will remove from the statute books a bar to disclosure of information that may have been appropriate 30 years ago when medicine legislation was in its infancy, but is out of step with both the government policy on openness and legitimate public interest about medicine."

The Freedom of Information Act 2000 allows public bodies to refuse to release information, unless it is clearly in the public interest to do so. These exemptions include safeguards for commercial confidentiality and trade secrets.

An Association of the British Pharmaceutical Industry spokesman said: "We are aware of the reasons and accept that it is bound to happen," he said: "We are going to be talking to the MHRA about what areas the exemptions will apply to."

Patient forums must give written notice of pharmacy inspections

PATIENTS' forums will need to give written notice before they can inspect community pharmacy premises.

Forums set up by primary care trusts in England gained the right to enter and inspect premises used by community pharmacy contractors to provide pharmaceutical services under the National Health Service from 1 December. Directions sent by the Department of Health to PCTs make it clear that contractors and other independent service providers only have to allow inspections following a written request and at reasonable times. In addition, persons making inspections have to be named in

advance and must produce written evidence of authority on request.

Contractors do not have to allow entry or inspection if they believe that it will compromise the effective provision of health services or patients' safety, privacy or dignity. Inspection is restricted to the parts of premises used to provide services and cannot include parts used for residential accommodation.

Patients' forums can also request relevant information from contractors, but this must not breach patients' rights to confidentiality unless individuals have consented to such information being disclosed.

Charge fraud pharmacist loses appeal

A COMMUNITY pharmacist found guilty of defrauding the National Health Service of £2,000 has had her appeal against the conviction dismissed.

Lay Ean Atkinson was convicted on 15 counts of false accounting after she kept prescription charges paid by patients and endorsed prescriptions to suggest that multiple small packs had been supplied instead of larger ones (*PJ*, 1 February 2003, p140).

At the same trial, Ms Atkinson was cleared of two further counts of false accounting and two of giving false information.

Arguing in the Court of Appeal that her convictions were unsafe, counsel for Ms Atkinson said that the trial judge had been wrong to refer to possible reckless behaviour in his jury directions and had undermined the definition of false accounting, which required deliberate acts. Dismissing the appeal, Lord Justice May said that although he could see force in the criticism of the trial judge's summing up, the jury had been in substance properly directed and that the appeal should fail. Other grounds for appeal — that the conviction and acquittal verdicts were inconsistent — were also dismissed.

New hospital pharmacist job profiles under Agenda for Change raise concern

THE Guild of Healthcare Pharmacists raised significant concerns this week about five job profiles it received from the Agenda for Change job evaluation working party.

Ron Pate, chairman of the GHP terms and conditions committee, told *The Journal*: "Our concerns were predominantly about the process by which the job profiles were prepared, which was not consistent with how we believed job analysis would be taken forward within Agenda for Change." In particular, the GHP is concerned that the profiles have been produced without going through the full job analysis process.

Mr Pate added: "Dave Miller, vice-chairman of the GHP terms and conditions committee, and Tony West, vice-president of the GHP, have worked particularly hard in examining the job profiles sent to us. We believe all five job profiles were underscored and we have mounted a robust objection to them." The five job profiles are all clinical pharmacist roles, varying in degree of seniority. "It should be possible to match a majority of pharmacists' jobs to these five



Hospital pharmacists will vote on Agenda for Change in the first half of next year

profiles," said Mr Pate. A number of job profiles were being considered by the job evaluation working party but only five of these have been sent to the GHP for comment. Two job profiles that the GHP is still

waiting to receive are those for preregistration trainees and chief pharmacists.

"Our comments will now be considered by the job evaluation working party and either accepted or referred back to us. Ultimately we have to reach an agreement by the end of December," said Mr Pate. This is because the deadline for agreement of national profiles that will be used within the 12 early implementation sites of Agenda for Change is likely to be 31 December.

The GHP is also concerned that many hospital trusts have asked pharmacists to provide updated job descriptions in preparation for roll-out of Agenda for Change. Although the GHP is in favour of updating job descriptions, it does not support early pursuit of Agenda for Change in sites that are not early implementers. It recommends pharmacists do not use Agenda for Change language in job descriptions but rather produce an outline of everything that they are required to do.

A final ballot on roll-out of Agenda for Change is due in spring or summer 2004.

Report examines changes in community pharmacy

HOW community pharmacy is developing is examined in a new report published by the Community Pharmacy Research Consortium.

The report — "Change and evolution in community pharmacy" — covers changes in the ownership of community pharmacies, the role of the community pharmacist, a shift in the focus of professional activity and the use of technology to enhance the pharmacist's role. Its findings are based on a systematic literature review including 324 papers. The research was conducted by Professor Christine Bond and colleagues at the departments of general practice and management studies, University of Aberdeen.

In terms of the market environment, the report identified ongoing decline in the number of independent pharmacies and an expansion in the multiple and supermarket

chains. The report predicts a polarisation between these two groups, with the chains operating as low-cost, low-service commodity product providers and the independent pharmacies concentrating on added value services. This will have major implications on patterns of consumer usage of community pharmacy, the report notes. "There is a need to ensure appropriate consumer access to pharmacy services, to preserve choice and at least maintain if not improve the current level of service," it recommends.

In discussing the ability of pharmacists to extend their roles, the report suggests that two factors are important: increased use of pharmacy technicians and the introduction of technology into the dispensing process.

Another factor that will have important implications for community pharmacy is the changing attitudes of consumers, it says. In

particular, consumers are becoming increasingly assertive and have higher expectations of service standards.

Georgina Craig, head of National Health Service service development at the National Pharmaceutical Association, comments: "This report is essential reading for anyone working to develop the role of community pharmacists. It outlines the challenges community pharmacy faces in the context of both developments in primary health care and the retail environment."

The Community Pharmacy Research Consortium produced the report in collaboration with a number of other pharmacy organisations. The report is available at www.rpsgb.org.uk/pracres and can also be purchased from the Royal Pharmaceutical Society's practice research division, price £25 (tel 020 7572 2276).

Charities question control of entry reform

TWO public health charities, Pharmacy-HealthLink and the United Kingdom Public Health Association, have questioned the value of bringing in reforms to control of entry at a time when there is already great change being made in pharmacy.

In response to the Department of Health proposals to change the regulations governing new pharmacy contracts, the two bodies say that they have serious reservations about the proposed exemption criteria. "We feel that the provision of special exclusions fundamentally undermines the ability of primary care trusts to undertake their vitally impor-

tant role of planning health care services for their local populations," they say. Instead, primary care trusts should have the freedom to determine pharmaceutical services in their localities. Overall, the charities believe that the Government's approach may result in increased health inequalities.

NuCare has also responded to the consultation. It says the proposals amount to "deregulation by stealth" and would have exactly the opposite result to the stated reasons for change. Market consolidation would lead to reduced competition and the closure of small independent pharmacies.

BRIEFLY

OFT recommendations

How the high street may be affected if the OFT recommendations are implemented is considered by Andrew Simms, policy director at the new economics foundation, in this week's *Journal* (see p786). Meanwhile, the Government has received 180 responses to its "balanced package of measures" for control of entry to pharmacy contracts, health minister Rosie Winterton told an All Party Pharmacy Group meeting this week.

Clare Mackie appointed the first head of new pharmacy school at Medway

PROFESSOR Clare Mackie, currently at the school of pharmacy, The Robert Gordon University, Aberdeen, has been appointed the first head of school at the new Medway school of pharmacy, which is due to open in September 2004. The new school is a joint venture between the universities of Kent and Greenwich, and is based at the Medway campus of the University of Greenwich in Chatham Maritime. Professor Mackie will also hold the Pfizer chair of pharmacy; the company is providing sponsorship worth £500,000 over five years.

Professor Mackie is currently professor of pharmaceutical care and head of the centre for partnerships in medicines and health

in Aberdeen. She is also director of the World Health Organization Collaborating Centre for Pharmaceutical Care and Curriculum Development, where she works with developing countries to advance their pharmacy training.

Professor Mackie will take up her new post from January 2004. She says: "I'm thrilled to be part of these two universities in Medway — it is a vibrant place with a lot of potential for the future. The region offers many opportunities for the new school to build strong partnerships with the health service and the pharmaceutical industry and I am really looking forward to living and working here."



Clare Mackie will take up her post in January

Use medicines for treatment not just to enhance health

USING medicines to enhance health, rather than for treatment or prevention of disease, is generally unacceptable, a survey of public attitudes in Denmark has revealed.

Researchers collected data from two sources, an internet-based survey and a telephone interview survey, to find out whether people perceive enhancement strategies as part of rational medicines use.

The researchers point out that over the past three decades medical practice has increasingly focused on prevention. More recently, the strategy of treating healthy individuals has been pushed further, with medicines being used to enhance normal capabilities. "The goal for the ordinary person can also be to become better than well," they argue.

Of the internet survey respondents (462 from an estimated 1,600 people contacted), only around one-third thought it was acceptable for healthy individuals to use medicines

to optimise their quality of life. A much larger number (around 80 per cent) thought that society generally accepted such usage.

The telephone survey focused on specific examples of medication, and produced mixed results. Most people (around 60 per cent of the 961 people who participated) accepted use of preventive influenza vaccination, but there were less positive views on treatment for baldness, performance anxiety, sexual enhancement and memory enhancement.

Younger respondents had a less negative attitude generally than older age groups. Respondents aged 60 years and older had a more positive attitude towards 'flu vaccination and memory enhancement. Nearly everyone said that doping in sports was unacceptable.

The authors suggest that the tendency to use medicines for enhancement may become stronger as the public abandon the traditional

patient role and adopt a more consumer-oriented role. They propose the term "Medically enhanced normality" (MEN) to describe healthy individuals' use of medicines as enhancement and suggest it could become a framework for analysing perceptions of what is seen as rational medicines use in contemporary society (*International Journal of Pharmacy Practice* 2003;11:243).

Article p785

BRIEFLY

IDIS goes online

IDIS Ltd, an international supplier of unlicensed medicines for use on a named-patient basis, has launched an online ordering service. The new service can be found at www.idisonline.com.

SSRIs may reduce the effectiveness of tamoxifen

NEWER antidepressant drugs such as paroxetine may reduce the effectiveness of tamoxifen by interfering with the breakdown of the drug into its active metabolites, suggest American researchers.

Dr Vered Stearns and colleagues from Georgetown University Medical Centre, Washington, and Indiana University School of Medicine, Indianapolis, point out that up to 80 per cent of women treated with tamoxifen complain of hot flashes. Several studies have demonstrated that antidepressants from the selective serotonin reuptake inhibitor and selective noradrenaline reuptake inhibitor classes are effective for the treatment of hot flashes.

"Given these recent results, it is likely that the frequency of administering tamoxifen with drugs of the SSRI and SNRI classes will increase," they say.

However, the researchers note that tamoxifen and these newer antidepressants are metabolised by a shared pathway. "Because venlafaxine, paroxetine and fluoxetine are all metabolised by CYP2D6 and are potent inhibitors of this enzyme, we hypothesised that SNRIs and SSRIs might alter tamoxifen metabolism."

The researchers examined the effect of paroxetine on levels of tamoxifen and its metabolites in blood samples from 12 women with breast cancer who were being treated with adjuvant tamoxifen.

The women received paroxetine for the treatment of hot flashes for four weeks during their standard course of tamoxifen.

The researchers identified a previously uncharacterised active metabolite, which they named endoxifen. Endoxifen was present in substantially higher concentrations

than 4-hydroxy-tamoxifen, which is thought to be the most potent of tamoxifen's metabolites. The researchers observed that, after paroxetine treatment, endoxifen levels decreased, whereas levels of 4-hydroxy-tamoxifen did not. Endoxifen concentrations decreased by 64 per cent in women with a normal CYP2D6 genotype but by only 24 per cent in women with a variant CYP2D6 genotype.

The authors say that these findings "raise the possibility that pharmacogenetic variation in CYP2D6 activity may influence therapeutic outcomes from tamoxifen treatment". However, they add: "Until further data become available, the results of this small study should not alter treatment recommendations." The study is published in the *Journal of the National Cancer Institute* (2003;95:1758).

Pharmacists advised to read updated malaria prevention recommendations

PHARMACISTS are being urged to read new malaria prevention guidelines published by the Health Protection Agency.

The updated guidelines, which contain specific recommendations for individual countries, now have greater emphasis on mefloquine, doxycycline and atovaquone/proguanil as the three options for highly chloroquine-resistant *falciparum* malarious areas.

Dr Barbara Bannister, clinical head of service, infection and immunity at the Royal Free Hospital, London, and one of the guideline authors told *The Journal* that travellers may not realise their knowledge could be out of date. "People may remember times when relatively simple measures were effective, such as taking chloroquine once a week, but the susceptibility of malaria to these regimens has diminished." She added: "If a patient goes into a pharmacy to buy chloroquine the pharmacist is in an excellent position to check that chloroquine is the correct drug for their destination."

Writing in an editorial to accompany the guidelines, which are due to be pub-

lished in the journal *Communicable Disease and Public Health* (2003;6:180), Dr Bannister says that widespread self-medication, which may include suboptimal dosage and inadequate duration of treatment, leads to the rapid emergence of drug resistance. She says that longer-term antimalarial treatment is safe as long as contraindications such as pregnancy are observed.

"Continuing prophylaxis can be confidently advised for those intending to live or work long term in malaria endemic countries," she writes.

Pharmacists are advised to read in particular the section of the guideline that covers the health care workers' consultation with prospective travellers. This section includes information about the risks of getting malaria and about malaria prevention.

Dr Bannister pointed out that people returning to malarious regions are highly represented among cases of malaria diagnosed in the United Kingdom. "People who originate from that area may feel they are resistant to malaria, or may remember the country from a time when malaria was well controlled."

The guidelines also note that pharmacists are entitled to make yellow card reports to the Medicines and Healthcare products Regulatory Agency of adverse events believed to be related to use of antimalarials. Dr Bannister commented: "It is important for pharmacists to know that catching malaria when on prophylactic treatment counts as an adverse event."

The guidelines can be accessed via *PJ Online* (www.pjonline.com/links/pj).

Scots to cut postcode prescribing

A STRENGTHENED role for the Scottish Medicines Consortium should reduce postcode prescribing in Scotland, it was announced last week.

The SMC was set up in 2002 to provide an authoritative source of advice about the effectiveness of new drugs. From next spring, it will classify them into two categories: unique drugs for specific conditions and drugs for conditions where drugs with the same clinical properties already exist.

Under the new arrangements, an agreed national programme will be introduced for unique drugs so that, once the SMC has given a drug its approval, every health board will be required to make these drugs available at the same time across Scotland. This will normally be within three months. For new drugs falling into the other category —

where alternatives exist — it will be up to individual health boards to make decisions based on local need.

Scottish Executive health minister, Malcolm Chisholm, said: "Public concern has rightly been over novel treatments for which there are no alternatives available. There will be an obligation on boards to make such drugs available once approved by the SMC."

Alongside the new requirement, a system to provide up to 12 months' advance warning of innovative drugs that are in the pipeline will be introduced.

The SMC currently has representatives from drug and therapeutic committees on all 15 health boards in Scotland. From next year, there will also be greater representation of health board chief executives and finance directors.

SMC endorses four and rejects four drugs

THE Scottish Medicines Consortium has issued advice on eight medicines to the National Health Service in Scotland.

It has endorsed the use of methyl amonolevulinate (Metvix cream) for actinic keratosis. The same medicine is approved for treatment of basal cell carcinoma but use is restricted to specialist dermatologists and to superficial lesions.

Other drugs accepted for restricted use are interferon beta 1a (Avonex) for ambulatory patients with relapsing multiple sclerosis and olmesartan (Olmotec) as an alternative treatment in patients with essen-

tial hypertension unable to tolerate an angiotensin converting enzyme inhibitor. Mometasone furoate (Asmanex Twisthaler) has been endorsed as a second-line agent for patients with asthma following treatment failure on first-line inhaled steroids.

The following drugs were not recommended for use: pimecrolimus (Elidel) for eczema, sertraline (Lustral) for post traumatic stress disorder, ketotifen hydrogen fumarate (Zaditen) eye drops for hay fever, and *Clostridium botulinum* toxin type A (Botox) for focal spasticity associated with stroke.

NICE to produce shorter guidelines

SHORTER versions of technology appraisals and guidelines published by the National Institute for Clinical Excellence will be produced for health professionals too busy to read the full guidance, NICE announced last week. Following a review of its dissemination practices, NICE says there will now be a greater emphasis on allowing stakeholders a choice between guidance formats and mode of delivery.

For all future technology appraisals, NICE will produce a quick reference version available electronically via e-mail or in print format. This document will contain the main recommendations (Section 1 of the full guidance), together with brief details on implementation as well as signposting to further information. The full guidance will only be available electronically and via the NICE website (www.nice.org.uk). From January 2004, NICE will also produce a quick reference version of its clinical guidelines.

A guidance module aimed at health care professionals working in primary care will also be launched in January 2004. Called "Update for primary care", it will contain the quick reference versions of all relevant NICE technology appraisal guidance.

□ **R&D programme** NICE has also published a draft strategy outlining proposals for its new research and development programme. The programme will organise and prioritise research recommendations made by NICE in its appraisals. Comments on the draft strategy available at www.nice.org.uk, can be sent to NICE until 2 March 2004.

Children's colds do not improve with echinacea

ECHINACEA is not effective in decreasing the severity or shortening the duration of upper respiratory tract infections (URTIs) in children, according to the authors of a study published in *JAMA* (2003;290:2824). Furthermore, they say that use of echinacea is associated with an increased risk of a rash developing.

Dr James Taylor, University of Washington, Seattle, and colleagues, randomised 524 children aged two to 11 years to receive either *Echinacea purpurea* or placebo for up to three URTIs over a four-month period. The study treatment was started at the onset of symptoms and continued for a maximum of 10 days. A total of 337 URTIs were treated with echinacea and 370 with placebo.

For both treatment groups the median duration of symptoms was nine days, the researchers report. "There was also no difference in the overall estimate of severity of upper respiratory tract infection symptoms between the two treatment groups," they add. The researchers note that rashes occurred during 7.1 per cent of the upper respiratory tract infections treated with echinacea and 2.7 per cent of those treated with placebo.

"Given its lack of documented efficacy and an increased risk for the development of rash, our results do not support the use of echinacea for treatment of URTIs in children aged two to 11 years old. Further studies using different echinacea formulations, doses,

and dosing frequencies are needed to delineate any possible role for this herb in treating colds in young patients," they conclude.

One intriguing result observed by the researchers was that children treated with echinacea had fewer subsequent URTIs than children given placebo. "It is conceivable that echinacea stimulated an immune response in study children that was too late to modify the URTI for which it was given but provided a window of protection against another URTI," they say.

Misleading results from imported blood glucose testing strips

PHARMACISTS are advised to check their stocks of Lifescan OneTouch glucose test strips and not to dispense plasma-calibrated test strips.

The Medicines and Healthcare products Regulatory Agency has issued an alert regarding plasma-calibrated versions of these strips that have been imported and distributed in the United Kingdom.

Plasma-calibrated strips give results 12 per cent higher than the whole blood-calibrated strips which are normally marketed. This may lead to patients being unaware that their blood glucose level is low or to inappropriate alteration of treatment. Pharmacists should identify any patients who have been supplied with plasma strips and replace the strips with whole-blood strips. Patients should be advised to retest their blood glucose using whole-blood strips.

The words "Genuine 25 OneTouch test strips Plasma Calibrated" appear on the vials of plasma strips, but not on the external packaging.

The words "whole blood calibrations" appear predominantly on the front and back of the boxes of whole blood calibrated test

strips. The strips are used with Lifescan OneTouch II, Lifescan OneTouch Profile or Lifescan OneTouch Basic blood glucose meters.

□ **Patient reporting** This week an initiative was launched by the MHRA and Pharmacy-HealthLink to encourage patients to report problems with medical devices directly to the MHRA (see p780).

PJ Online

PJ Online contains the editorial contents of *PJ* publications.

Christmas page

This sets out company Christmas closures. It will also list the Society's holiday office hours, when known. Currently it includes a request for volunteers to work in a homeless shelter in London, gift ideas from the Society's museum and the National Pharmaceutical Association's Christmas cards.

www.pjonline.com/xmas

BRIEFLY

Updated HRT prescribing advice

Hormone replacement therapy should no longer be recommended as first choice therapy for prevention of osteoporosis, according to new advice from the Medicines and Healthcare products Regulatory Agency. Full details are available from the MHRA website (www.mhra.gov.uk).

Nurse prescribing extended

Extended formulary nurse prescribers will be able to prescribe six new medicines from 10 December. They are: codeine phosphate for oral administration; co-phenotrope for oral administration; diazepam for oral, parenteral or rectal administration in palliative care; oral dihydrocodeine tartrate; lorazepam and midazolam, both for oral or parenteral administration in palliative care. The change is made through the Prescription Only Medicines (Human Use) Amendment (No 2) Order 2003.

Consider cost-effectiveness

National treatment guidelines should consider cost-effectiveness, says the author of a study published in the *BMJ* (2003;327:1264). Dr Tom Marshall analysed the cost-effectiveness of treatments for preventing coronary heart disease and concludes: "A more efficient prevention strategy [than current national guidelines] would be to offer aspirin and initial antihypertensive treatment to all people at over 7.5 per cent five-year coronary risk before offering statins to patients at 30 per cent five-year risk," he says.

NICE restricts use of anakinra

Anakinra (Kineret), an interleukin-1 inhibitor, is not recommended for the treatment of rheumatoid arthritis, except in the context of a controlled, long-term clinical trial, says the National Institute for Clinical Excellence. NICE suggests that patients currently treated with anakinra for rheumatoid arthritis should continue therapy until they and their consultant consider it appropriate to stop. The full guidance is available on the NICE website (www.nice.org.uk).

Adrenal insufficiency

A link to the Addison's Disease self-help group.
www.pjonline.com/links/adrenal

National Reporting and Learning System

A new four-part series on the NRLS that is being introduced in England and Wales by the National Patient Safety Agency. Articles include a new standard coding system for reporting patient safety incidents.
www.pjonline.com/noticeboard/series

BRIEFLY

AAH takeover on hold

The planned takeover of East Anglian Pharmaceuticals by national wholesaler AAH Pharmaceuticals has been referred to the Competition Commission because the Office of Fair Trading fears a substantial reduction of competition in East Anglia, along with parts of the east Midlands and south east England.

Pharmacist nets £150m

PJB Publications, publisher of *Scrip* magazine has been sold for £150m. PJB Publications was set up by Dr Philip Brown, FRPharmS, in 1976 with an investment of £2,000. The company, owned by Dr Brown together with his wife and two children, was sold to Informa, a publisher of trade magazines and conference organiser.

NPA criticises offer

The National Pharmaceutical Association has described as "miserly" the Department of Health's offer of a 3.1 per cent remuneration increase for pharmacy contractors in England. It adds that the offer has to be considered alongside a 5 per cent increase in workload.

Science minister opens £6m Bradford institute



Mr Thorning and Lord Sainsbury at the opening of the IPI

LORD SAINSBURY, Minister for Science, officially opened the University of Bradford's new £6m Institute of Pharmaceutical Innovation (IPI) recently.

The five-storey institute includes analytical, laboratory and computer facilities for use by the university and pharmaceutical companies. The IPI aim is to reduce the time taken to develop new medicines by allowing much of the design, formulation and manufacturing processes to be optimised by computer simulation rather than conventional testing.

The institute's top floor will house a "business incubator" unit, set up with £2m of funding from Yorkshire Forward, the regional development agency. The institute aims to create a number of spin-off companies based on its work. Bradford University has already established Bradford Particle Design (now Nektar Therapeutics), which was recently sold for £117m.

The institute is led by Paul Thorning, formerly director of Stratalyst, a consultancy offering advice on optimising the life-cycle and profile of blockbuster drugs.

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