

Professional body needs strong regional structure, Society says

A strong regional structure will be key to the success of a professional body, the Royal Pharmaceutical Society believes. "We need to close the gap between a professional leadership body and what pharmacists are doing in practice, and one good mechanism to do that is to have a bottom-up governance structure," said the Society's Chief Executive and Registrar Jeremy Holmes at an oral evidence session held by the independent Clarke Inquiry last week.

The Society's written submission to the inquiry, published this week, says that the overarching council of the new professional body could derive some of its members from the devolved regional or national structures. The role of this council would be to allocate resources across the whole organisation, to co-ordinate the activities of the devolved structures and to make strategic decisions on GB/UK issues, it says.

The Society believes that it is the only pharmacy body with the necessary breadth and depth of expertise and experience to form the foundation of the new professional body. "We have to work with that. But we cannot do it alone," said Mr Holmes at a later press briefing. "We recognise that the Society in its current and historic guise is not the organisation we want for the future," he said. To change that, the Society wants to collaborate with other groups to produce a body that is fit for the future, he added.

Mr Holmes said that the focus of the new professional body should be on its members. "If that means we cannot undertake work under contract to the General Pharmaceutical Council, then so be it," he said. However, he stressed that the professional body should not have a trade union role.

The written submission says that the professional body should have two goals: to provide a clear, strong voice for pharmacy to maximise its profile and standing with the public, policy-makers and other stakeholders; and to lead and support pharmacy professionals to enable them to realise their professional aspirations and deliver the best possible service to patients and the public.

However, it stays silent on the issue of whether technicians and pharmaceutical sci-



Jeremy Holmes: Society in its current guise is not the organisation we want for the future

entists should be included in a new professional body, saying that that is for the profession to decide.

The Society proposes two possible models for a new professional body. The first is a network organisation, which builds strong links with pharmacy bodies that wish to remain independent. Members of the professional body would have access to these organisations. The second is a merger model, where the professional body joins or acquires the current independent support groups that agree to join it. "A key driver of which model emerges as the strongest is what those groups want to do," said Mr Holmes.

The Clarke Inquiry panel asked how, if the Society became the new professional body, it would manage its transition. President Hemant Patel said that he believes the professional body should parallel developments in the new GPhC, which is to have a shadow council from May 2009, before becoming fully operational in 2010.

The Society's full submission to the inquiry is available on its website at www.rpsgb.org and on the Clarke Inquiry website at www.theclarkeinquiry.com. The deadline for submissions to the Clarke Inquiry is 31 January. A final report will be presented by the inquiry to the Society's Council in May.

□ **Centre pull-out** A summary of the Royal Pharmaceutical Society's submission to the Clarke Inquiry is published as a four-page centre pull-out with this week's issue of *The Journal*.

Scotland plans own professional body

Preliminary steps towards forming a professional pharmacy body in Scotland were taken last week. Although no one would officially comment on what took place, *The Journal* understands that a meeting was organised on 17 January by the two schools of pharmacy in Scotland (the University of Strathclyde and the Robert Gordon University, Aberdeen).

The two heads of the schools of pharmacy were not available to comment before *The Journal* went to press this week but will do so for next week's issue.

The Journal understands that the new body will be called the Scottish Collegiate for Pharmacists and Pharmaceutical Scientists, and that a working party is being formed to develop the new body's remit.

Details of exactly what the new body aims to achieve or how it will be structured are sketchy. Even among the 35 leading pharmacists who attended the meeting, there appears to be confusion. Although some attendees believe that its focus will be to develop research, *The Journal* has been unable to confirm either this or a suggestion that the body will be partly funded by the Scottish Government.

Independent board would not end political meddling in NHS

Creation of an independent board to manage the NHS would not stop political meddling in the day-to-day running of the health service as proponents suggest, according to a new King's Fund report.

The report argues that an independent board would have limited ability to prevent politicisation, adding that the distinction between policy and operational decisions is difficult to apply in practice. However, it says: "What an independent board might do is create the impression of reduced politicisation that would bring its own benefits, particularly in terms of support by clinicians. Such political distancing could also be beneficial to the public's perception of the NHS."

Nevertheless, the authors describe plans for an independent board as "misguided" and discuss a number of alternatives.

PJ Online

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Retail Round-up

The January issue is available online.
www.pjonline.com/rr

Long service

A list of members and fellows of the Royal Pharmaceutical Society who have been on the Register for 50 years or more.
www.pjonline.com/longservice

Supervision consultation should be agreed first

Consultation on supervision requirements should be brought forward so that the question of a responsible pharmacist's absence from a pharmacy can be viewed as a whole before the regulations are drafted, according to bodies that represent community pharmacy owners.

In their joint response to the Government's responsible pharmacist consultation, the Pharmaceutical Services Negotiating Committee, the National Pharmacy Association, the Company Chemists' Association and the Association of Independent Multiple Pharmacies say that they found it impossible to come to a final conclusion about the amount of time that a responsible pharmacist should be permitted to be absent from the pharmacy due to uncertainty about provisions relating to supervision and NHS legislation, which are yet to be considered.

In addition, the bodies believe that there should be no requirement for extra qualifications or a minimum period of experience to become a responsible pharmacist and that this should be left to the discretion of the superintendent pharmacist. "Any stipulation of postregistration experience would be arbitrary and would take little account of the competence of the individual or of the quality of the experience," the joint response says. However, the Royal Pharmaceutical Society believes that specific competencies to fulfil the wider responsible pharmacist role will be required (see below).

The four bodies are also of the opinion that superintendent pharmacists should set company frameworks for standard operating procedures that are not intended to change either on a regular or frequent basis. "The



Pharmacist absences can not be agreed until supervision is sorted out

SOPs will incorporate guidance to cover a range of predictable eventualities, such as different staffing situations or when there is a technological failure." When these SOPs are issued they can then be tailored to local circumstances by the responsible pharmacist

who best knows that pharmacy, in consultation with the superintendent pharmacist. If the responsible pharmacist on a particular day deems that amendments are needed due to exceptional circumstances these should be discussed with the superintendent pharmacist or, if a unilateral decision is taken by the responsible pharmacist, he must take full responsibility for his actions.

The CCA and AIMp also issued the following joint statement: "From a multiple pharmacy perspective, the responsible pharmacist consultation is key. There is a robust legal and professional framework within which a pharmacy chain currently operates, directed by the superintendent pharmacist. The roles and responsibilities of the responsible pharmacist must dovetail with this existing framework." They added: "We hope that, taken together, the responsible pharmacist regulations and the reframing of supervision will deliver more flexibility for pharmacy teams working in practice to better meet the needs of patients."

Pharmacy manager and duty pharmacist suggested

The proposed roles of the responsible pharmacist are too broad, the Institute of Pharmacy Management says in its response to the consultation. It suggests that two distinct roles — those of the pharmacy manager and the duty pharmacist — need to be separately identified in legislation.

"The proposal to redefine personal control mainly through what are superintendent functions and duty pharmacist responsibilities for procedures and record keeping, ignores managerial lines of accountability and does not adequately cover the many other factors affecting safe practice that may be controlled in some pharmacies by a different pharmacy manager or his superiors," it says.

The IPM suggests that the role of pharmacy manager should be introduced with responsibility for premises suitability, equipment and resource levels, services contracted, staffing levels, staff competencies and training. The role of responsible pharmacist should be redefined as duty pharmacist or pharmacist in charge, it adds. The duty pharmacist will work with agreed staff levels to the pharmacy manager's policies and guidelines, and agreed levels of service provision.

Responsible pharmacists will need to have additional competencies

Extra competencies to fulfil the wider role of responsible pharmacist will be required, according to the Royal Pharmaceutical Society in its response to the Government's consultation on the responsible pharmacist regulations.

This proposal is in contrast to the views of other pharmacy bodies, which have stated that there should be no requirement for extra qualifications (see above).

The Society recommends that all pharmacists should be eligible to become a responsible pharmacist at the point of joining the Register but that in order to be absent, or to be responsible for more than one pharmacy, extra leadership and management competencies are required. "Confirmation of the additional competencies will have to be part of the consideration of the changes to supervision," it says.

The Society believes that the necessary competencies — which it proposes it will assess — will be able to be achieved in several ways, including through mentorship or peer support along with professional guidance or distance learning. It emphasises that no minimum period of experience should be necessary.

"By providing a number of ways in which these competencies can be achieved, the RPSGB does not believe it will be onerous or difficult to achieve the requisite competencies," the response says. It adds that every pharmacist who is registered when the regulations take ef-

fect will need to assess his or her competence to be a responsible pharmacist.

On absence, the Society proposes that periods of absence of up to two hours per day would be acceptable. But it believes that the responsible pharmacist must be on the premises for substantially more than the 50 per cent of opening hours suggested by the Government. It would prefer that a percentage of time is not specified in the regulations, but if this is deemed necessary, the Society believes it should be 75 per cent of the hours for which the pharmacy is open.

The Society believes that a pharmacist must only be responsible for one pharmacy at a time. However, it says that, if regulations did permit them to be responsible for more than one pharmacy, this must be only in truly exceptional circumstances or where they are responsible for one pharmacy and one automated machine.

The Society opposes any attempt to make the regulations "overly burdensome" and would be concerned if "breaches of the regulations were to result in potential for criminal prosecution". It proposes that 12 months are necessary to prepare for the introduction of the regulations. Although it supports the Government's proposed phased approach, the Society recognises that some areas, such as absence and remote supervision, cannot be fully considered without considering the proposed changes to supervision requirements.

Pre-osteoporosis treatment benefit is exaggerated

Potential benefits of drugs for treating pre-osteoporosis have been exaggerated and the side effects understated in recent post-hoc analyses, the authors of a *BMJ* article argue (2007;336:126).

Pharmaceutical companies in Europe have already started to market drugs to women with pre-osteoporosis, say the authors, a move that they believe raises serious questions about the benefit-risk ratio for low-risk individuals.

Pablo Alonso-Coello, a family practitioner in Barcelona, and colleagues explain that, in recent years, several research groups have re-analysed data from original trials of osteoporosis drugs, including alendronate, raloxifene, risedronate and strontium ranelate. The aim was to identify subgroups of patients who would benefit from treatment for pre-

osteoporosis, believed to affect half of all older women.

The authors argue that the reanalyses focus more heavily on the relative reduction in fracture risk than the absolute reduction, which is low for those without major risk factors. They also say that the reanalyses play down the known side effects of the drugs. In addition, all of the original trials were funded by pharmaceutical companies and in three out of four of the reanalyses, drug company employees were part of the team examining the data, say the authors.

“Notwithstanding the genuine value of these drugs in reducing risk fracture for some women, we need to ask whether the coming wave of marketing targeting these women with pre-osteoporosis will result in the sound effective prevention of fractures or the un-

necessary and wasteful treatment of millions of healthy women,” they conclude.

□ **Fracture risk** A change of focus in fracture prevention from osteoporosis to falls is needed, a separate *BMJ* paper suggests (2007;336:124). The authors argue that falling, not osteoporosis, is the strongest single risk factor for fractures in elderly people. They say that bone mineral density is a poor predictor of fracture risk and that drug treatment is expensive and will not prevent most fractures in elderly people. They add that some trials show falls in elderly people can be reduced by up to 50 per cent through various strategies. Evidence is most consistent for strength and balance training, ensuring sufficient intake of calcium and vitamin D, and reducing the number and doses of psychotropic drugs.

MRSA risk doubled by recent treatment with antibiotics

Patients who have used antibiotics in the past four months are almost twice as likely to acquire methicillin-resistant *Staphylococcus aureus* as those who have not been exposed to antibiotics, a study shows. The risk is almost three times greater if the antibiotics used were quinolones or glycopeptides.

Researchers carried out a systematic review of 665 studies. They performed a meta-analysis of the 76 studies that met their inclusion criteria, and included over 24,000 patients. They found that the risk of acquiring MRSA (either being colonised or infected with the bacteria) was 1.8 times higher in patients who had taken antibiotics in the previous 126 days \pm 184 (mean \pm standard deviation) than in those who had not (95 per cent confidence interval 1.7–1.9; $P < 0.001$).

The relative risk for quinolones was 3 (2.5–3.5), for glycopeptides 2.9 (2.4–3.5), for cephalosporins 2.2 (1.7–2.9) and for other beta-lactams 1.9 (1.7–2.2).

The researchers say that although many studies have reported an association between previous antibiotic therapy and MRSA, the size of this association has not been properly explored.

They acknowledge that significant heterogeneity was found in the studies analysed, the most relevant being the duration of antibiotic exposure before MRSA isolation (from seven to 1,080 days). However, they say that despite the limitations of the study, the data show a clear association between exposure to antibiotics and MRSA isolation.

“A controlled use of antibiotics may, thus, be one of the few modifiable factors offering potential for primary prevention of MRSA colonisation,” they conclude. The researchers add that meticulous attention to infection control practices is also important (*Journal of Antimicrobial Chemotherapy* 2008;61:26).

Similar outcomes for topical and oral ibuprofen

Patients with knee pain who are advised to use either oral or topical ibuprofen, or who make the choice themselves, record similar benefit after 12-months, but those patients using topical treatment are more likely to be prescribed oral anti-inflammatories as well, a *BMJ* study reveals (2008; 336:138).

A second, related, study (ibid, p142) suggests that patients' choices between topical and oral non-steroidal anti-inflammatory drugs tend to be logical and appropriate.

In the first study, patients over 50 years of age with chronic knee pain were invited to take part in either a randomised trial (where they were advised to take oral ibuprofen or topical ibuprofen; $n=282$) or a preference trial (where patients chose oral or topical administration; $n=303$). At one year there was no significant difference between any of the groups in terms of changes in pain and disability scores from baseline. However, in the topical group more participants had severe chronic pain at three months. Medical records revealed that over a quarter of patients who chose to be treated topically and over a third of patients who were assigned to topical treatment were also prescribed oral anti-inflammatories during the study.

In the randomised trial, more patients in the topical group reported changing their treatment because of inadequate pain relief than in the oral group, and more patients in the oral group reported changing treatment due to side effects. These trends were not seen in the preference trial.



More patients selected topical administration over oral

The second study looked at the rationale behind patients' decisions to take part in either of the two trials and 30 patients were interviewed. The authors suggest that choice of topical or oral treatment depends on the nature of the pain, patients' perceived risk of side effects, medical advice and practicalities.

In an accompanying editorial (ibid, p105), Paul Dieppe, Nuffield Department of Orthopaedic Surgery, University of Oxford, says: “The results from the preference data are fascinating. Firstly, more people chose the preference study than the randomised controlled trial, and nearly three times more of them opted for the topical preparation ($n=224$) than the oral preparation ($n=79$). . . . Another intriguing finding was that adverse events after oral ibuprofen occurred less often in participants who chose tablets than in those who were randomised to them.”

He suggests that, given options, patients will make sensible choices about how they want to be treated, and that their ability to choose may improve efficacy and reduce toxicity.

Northern research network seeks pharmacy input

Community pharmacists in Yorkshire and the north-east of England are being encouraged to register their interest in participating in practice-based clinical research.

The Primary Care Research Network Northern and Yorkshire is writing to over 500 pharmacies in the area and is seeking to establish a database of those who are interested in research so that it can keep them informed and invite them to participate in their areas of interest.

The PCRN wants to involve pharmacists in clinical research and is keen to ensure that all practitioners in primary care are able to participate in the initiative. Funding for these trials and studies will come from a variety of sources, including the Medical Research Council, the NHS, charities and industry, the letter explains. The major clinical research topics are cancer, dementia and neurodegenerative diseases, diabetes, medicines for children, mental health and stroke.

Hilary Edmondson, a community pharmacist who set up the Hull and East Riding

Pharmacy Research Network, which is now linked with the PCRN Northern and Yorkshire, told *The Journal* that pharmacy has a great deal to contribute to the evidence base for clinical practice. However, she said that although the network in Hull has demonstrated that community pharmacies can be involved in research projects there is not much experience of engaging pharmacists and their staff in practice research.

"I would encourage all pharmacists to contact their local PCRN or local comprehensive research network if they want to become involved in clinical research. Networks can provide information about research training and, most importantly, put people in touch with each other to discuss research ideas or how to recruit practitioners and patients into projects."

Local research networks were set up as part of the Government's strategy — "Best research for best health" — which established the National Institute for Health Research and aims to make the NHS the pre-eminent

location worldwide for undertaking clinical research. A progress report published last week reviews the work of the NIHR. "Transforming health research — the first two years" describes the progress the NIHR has made in developing the infrastructure, programmes and systems to facilitate health research in England. The report is available at www.nihr.ac.uk and via *PJ Online* (www.pjonline.com/pjlinks).

□ **PPRT research awards** Funding for pharmacy research is available from the Pharmacy Practice Research Trust, which is currently inviting applications from pharmacists for two of its funding schemes.

Community pharmacists interested in conducting research relating to everyday pharmacy practice can apply to the 2008 training bursary scheme. Pharmacists interested in starting or developing a career in research can apply for a 2008 practice research award.

Details of both schemes are available from Beth Allen, PPRT research programme coordinator (e-mail beth.allen@rpsgb.org).

Pilot shows pharmacists can provide alcohol consumption advice

Community pharmacists in Scotland have been successfully trained to provide advice to patients on alcohol consumption, the latest issue of the *International Journal of Pharmacy Practice* reports (2008;16:17).

In a pilot study, nine pharmacists underwent a two-day training course and recruited 70 subjects over a three-month period (*PJ*, 12 February 2005, p165).

The pharmacists assessed subjects' alcohol consumption against Scottish Intercollegiate Guidelines Network recommendations and provided information on health risks, as well as advice on reducing alcohol intake, to harmful or hazardous drinkers.

Researchers assessed the pilot using focus groups and semi-structured telephone interviews, finding that the pharmacists believed the project was worthwhile and experienced no strong negative reactions from clients. Only 19 of the 40 subjects who agreed to be

followed up by the researchers could be contacted.

"Most reported being happy to have taken part and were generally positive about the experience. Some found it valuable as they were not previously aware of the sensible drinking guidelines," the authors state.

Dorothy McCaig, senior lecturer, Robert Gordon University school of pharmacy, Aberdeen, was one of the study authors. She told *The Journal* that the researchers hope to do a full-scale trial in the future, but that funding for the work is not currently available.

She pointed out that the pilot was carried out in a select group of highly motivated individuals to assess the feasibility of the pharmacy scheme. There were not enough participants, nor was it the aim of the pilot, to evaluate the effectiveness of the interventions, she added.



Harmful drinking habits could be flagged up by community pharmacists

Scottish sexual health strategy highlights pharmacy services as examples of good practice

Two pharmacy services are highlighted as examples of good practice in a sexual health report published last week by the Scottish Government.

The report describes progress on achieving the aims of Scotland's national sexual health strategy "Respect and responsibility".

This week's report states: "NHS boards are making good use of sexual health strategy funding to employ more people and to provide targeted training for existing staff. Service redesign, making more use of healthcare professionals such as nurses and pharmacists in extended roles, has also transformed capacity in most areas of Scotland."

In NHS Ayrshire & Arran, pharmacists are being trained in child protection issues so that they can provide emergency hormonal contraception (EHC) to girls aged 14 and 15 years. This is an extension

to an existing pharmacy-based EHC service and, once the training has been completed, EHC will be offered by 79 pharmacies in the area.

In addition, a successful pilot of a chlamydia testing and treatment service involving 15 pharmacies in North Ayrshire will now be extended across the NHS board, the report states. In the first phase of the pilot, 76 chlamydia testing kits were given out to women who requested emergency contraception. Of these, 30 per cent were returned for testing and four positive results were obtained. The service was then extended to include anyone who considered themselves to be at risk from chlamydia infection. In the subsequent six months, 51 testing kits were given out and 55 per cent were returned for testing with two positive results. Pharmacists can provide treatment for people who receive a positive result.

EC probes industry over perceived innovation delays

European Commission investigators intent on discovering whether underhand practices are holding back competition in the proprietary and generic medicines sectors carried out unannounced inspections at pharmaceutical companies across Europe last week.

The visits follow an EC decision to launch an investigation into why fewer new medicines are coming to market than has historically been the case and why the introduction of generic equivalents often seems to take longer than the commission believes it should.

From 1995 to 1999 an average of 40 new active ingredients came to the market each year. From 2000 to 2004 the number fell to 28 a year. This is the first time that the commission has conducted what it calls a sector

inquiry, rather than an inquiry into a specific company, by visiting offices to seize papers and information without warning.

In the UK, AstraZeneca, GlaxoSmithKline, Pfizer and Wyeth have confirmed that their offices were visited by EC officials. Sanofi-Aventis has confirmed that its offices in France were raided. Sandoz, the generics division of Novartis, based in Germany, was also raided. Generics manufacturer TEVA would neither confirm nor deny that its offices had been visited. Each company that confirmed it was involved in the inquiry said that it was co-operating with the commission.

The commission wants to find out whether agreements between companies, such as patent dispute settlements, are illegal under European competition law. It also

wants to discover whether companies have tried to prevent competition through misuse of the patent system or vexatious litigation. It expects to produce an interim report in the autumn, with the final results of the inquiry being known in spring 2009.

Competition commissioner Neelie Kroes said: "If innovative products are not being produced and cheaper generic alternatives to existing products are, in some cases, being delayed, then we need to find out why and, if necessary, take action."

The commission said that the inquiry started with a series of unannounced inspections because companies treated the information it wanted as highly confidential and that it was easy for it to be withheld, concealed or destroyed.

Liberal Democrat plans include pharmacy

Community pharmacies feature in new policy proposals to be considered this year at the Liberal Democrats' spring conference.

The proposals, published this week, suggest the creation of a network of patient advocates employed by or on behalf of local health boards (which would replace primary care trusts in England) and based in community pharmacies, among other locations. The party plans that members of these health boards should be directly elected and that local services should be funded by a local income tax.

The role of patient advocates would be to help patients and carers navigate the health and social care systems and advise them on the best use of any direct payments or individual budgets they might have for their health or care.

"Despite information becoming much more readily available, many patients are still left bewildered by the sheer complexity of the health and social care systems, by the divide between health and social care and by their entitlement to benefits, as well as by how to choose a hospital," the policy paper says.

The party is also to be asked to support proposals to increase people's management of their own health.

"We propose to further expand and develop expert patient initiatives as a cost-effective way of facilitating enhanced self-care. Regular medicine reviews undertaken by pharmacists should also be developed further," the paper states.

New man at the top for AAH



Mark James

Mark James has been appointed group managing director of AAH Pharmaceuticals Ltd following the departure of Steve Dunn from the company.

The wholesaler has also announced the departure of finance director Ian Davidson. Mr Dunn and Mr Davidson joined the company in 1999 and 1993, respectively.

Mr James has held several senior management and board level roles within AAH over the past 15 years. He said: "In the coming year, AAH will prove itself to be the most progressive, innovative and customer-focused partner in the supply chain."

Former health secretary Hewitt lands advisory role at Boots

Former Secretary of State for Health Patricia Hewitt has joined Alliance Boots Ltd as a special consultant. She will work for the company for up to 24 days a year.

The Government's Advisory Committee on Business Appointments ruled that she could not take up the post until this month — six months after leaving her ministerial post — and that she should not personally be involved in lobbying the Government on

Alliance Boots's behalf for a further six months.

She will also be working for Cinven, a private equity company that recently acquired 25 hospitals from BUPA, subject to the same restrictions.

Two members of the seven-member committee that approved the terms of Ms Hewitt's appointments did not think that the six- and 12-month waiting periods were long enough.

BAPW raises focus on good distribution practice — and ensuring its members' adherence

Good distribution practice (GDP) is to be boosted by the British Association of Pharmaceutical Wholesalers with a new initiative, launched this week.

The Responsible Persons Committee, to be chaired by a representative of the Medicines and Healthcare products Regulatory Agency, will help to ensure that BAPW full members are self-auditing and

adhering to the association's standards for GDP. Each wholesaler has a "responsible person" who is approved by the MHRA to ensure GDP is followed.

BAPW executive director Martin Sawer told *The Journal* that the BAPW would invite the responsible person from each of its full members to sit on the committee. The committee's remit and processes are to be consid-

ered at its first meeting, expected to take place in the next six months, he added.

The BAPW has also confirmed the establishment of an affiliate membership category. Pharmacy chains as well as industry, pharmacy and medical representative bodies will be invited to become affiliate members, which will allow them to attend BAPW business days and work more closely with the association.

Drug development

Taranabant produces weight loss

Taranabant, an acyclic cannabinoid 1 receptor inverse agonist, can trigger weight loss in obese patients by increasing energy expenditure and reducing calorie intake, researchers have shown (*Cell Metabolism* 2008;7:68). Over 12 weeks, 368 patients received placebo or taranabant. On doses of 0.5mg, 2mg, 4mg or 6mg, patients lost an average of 2.9kg, 3.9kg, 4.1kg and 5.3kg, respectively. Patients on placebo lost 1.2kg on average. In separate studies taranabant 12mg reduced 24-hour calorific intake by 22 per cent and increased resting energy expenditure by 6 per cent.

Pain relief without sedation

New targets for drugs that relieve pain without producing unwanted sedation or impairing motor function have been identified (*Nature* 2008;451:330). Researchers from Germany, Switzerland and the US showed that specific subunits of γ -aminobutyric acid (GABA) receptors could be selectively activated. This activation was highly effective against inflammatory and neuropathic pain in mice and did not lead to the development of tolerance. The researchers suggest that their results could provide a rational basis for the development of new drugs for the treatment of chronic pain.

Perennial flu vaccine hope

An influenza vaccine which targets a part of the virus that does not vary across "A" strains has shown promise in early studies. Acambis's vaccine targets the M2e peptide, which is found unchanged on all "A" strains of influenza. The vaccine could, the company hopes, overcome the need to develop new vaccines every year to match circulating strains. A phase I clinical trial showed the vaccine to be well tolerated and immunogenic. Animal studies showed the vaccine could protect against the H5N1 strain of avian influenza.

HIV pre-exposure prophylaxis

Pre-exposure to antiretroviral drugs prevents vaginal transmission of HIV-1 in mice, a US study suggests (*PLoS Medicine* 2008;5:1). Researchers carried out intravaginal inoculation in mice genetically modified to make them susceptible to such infection. Mice given a seven-day course of emtricitabine and tenofovir were protected against infection. The researchers suggest that pre-exposure prophylaxis together with other behavioural interventions could provide protection to men and women at risk of HIV infection.

Colorectal cancer drug launched

Panitumumab, a new drug for colorectal cancer, has been launched this week.

Marketed by Amgen as Vectibix, panitumumab is a monoclonal antibody. It binds to and inhibits human epidermal growth factor receptor (EGFR). EGFR activates the KRAS gene, which stimulates other cell proteins to promote cell proliferation, cell survival and angiogenesis.

Panitumumab is licensed for patients who have EGFR-expressing metastatic colorectal cancer and the non-mutated (wild-type) KRAS gene and who have experienced failure of fluoropyrimidine-, oxaliplatin- or irinotecan-based chemotherapy regimens.

Amgen has launched a screening test to verify non-mutated KRAS expression. The company says that, by focusing treatment on patients with non-mutated KRAS, clinicians can maximise response rates and minimise



Vectibix is intended for patients who express the non-mutated KRAS gene

unnecessary side effects in patients for whom treatment is not appropriate.

Notice-board p79

Infliximab endorsed for severe psoriasis

Infliximab has been recommended as a treatment for severe psoriasis in the NHS in England and Wales by the National Institute for Health and Clinical Excellence.

It is recommended as a treatment option for adults with plaque psoriasis when the patient has a total Psoriasis Area Severity Index of 20 or more and a Dermatology Life Quality Index of more than 18 and has failed to respond to, or is unsuitable for treatment with, standard systemic therapies (such as ciclosporin, methotrexate or psoralen and long-wave ultraviolet radiation).

Infliximab treatment should be continued beyond 10 weeks only in people whose psoriasis has shown an adequate response to treatment within this time, NICE says.

In separate guidance, also issued to the NHS in England and Wales this week, pemetrexed is recommended as a treatment for malignant pleural mesothelioma.

NICE says that the drug's use should be limited to treatment of people with advanced disease whose cancer is not suitable for surgical removal and who have a World Health Organization performance status of 0 or 1.

NICE stresses that patients already taking pemetrexed when its guidance was issued should continue treatment until they and their specialists decide that it is the right time to stop.

Dasatinib use in Wales Dasatinib (Sprycel) has been recommended for restricted use within NHS Wales. The drug should be used to treat adults with chronic-phase chronic myeloid leukaemia (CML) and accelerated-phase CML, the All-Wales Medicines Strategy Group has recommended, but only where there is resistance, or intolerance, to prior therapy (including imatinib mesilate). The use of dasatinib for blast-phase CML or Philadelphia chromosome positive acute lymphoblastic leukaemia was not recommended.

The AWMSG decision was endorsed last week by Edwina Hart, Minister for Health and Social Services. The decision places an obligation on trusts and local health boards in Wales to fund treatment, but AWMSG advice is interim to any National Institute for Health and Clinical Excellence guidance subsequently issued.

Alert warns of risks associated with oral anticancer agents

Warnings about the risks of incorrect dosing of oral anticancer medicines have been issued by the National Patient Safety Agency.

In a Rapid Response Report published this week, the NPSA recommends that the prescribing, dispensing and administration of oral anticancer medicines should be carried out and monitored to the same standard as injected therapy.

Staff dispensing oral anticancer medicines should confirm that prescribed doses are appropriate and that patients are aware of mon-

itoring requirements. In addition, staff should have access to information from the hospital where treatment was initiated as well as to advice from a pharmacist with experience in cancer treatment at that hospital, the NPSA says.

To enable this, the NPSA recommends that written information, including details from the original protocol of the intended regimen, treatment plan and monitoring arrangements, should be given to patients and shared with pharmacists.

Society: displaying drug prices will not stop wastage

Displaying the price of drugs on packaging is unlikely to eradicate problems of medicines wastage, according to the Royal Pharmaceutical Society. Last week's Public Accounts Committee report called for an increase in generic prescribing (*PJ*, 19 January, p38) and suggested that putting drug prices on packaging might reduce wastage.

Responding to the report, David Pruce, director of practice and quality improvement at the Society, acknowledged that some of the waste of medicines is associated with patients failing to take prescribed medicines. However, he argued: "The reasons for this are complex and unlikely to be addressed by simply putting the price of the medicine on the box. It often has more to do with how the patient sees their illness, whether they have side effects, etc."



Fotografabasical/Stockphoto

Medicines wastage: is publicising the price on packaging the answer?

Mr Pruce said that pharmacists can contribute to a reduction of this waste through medicines use reviews — making sure pa-

tients are happy with their medicines, assessing whether they still need to be taking every medicine and by discussing any concerns.

But, he insisted, there are no quick fixes for reducing medicines wastage in the NHS.

The NHS Confederation has supported the idea of including drug prices on packaging. "When medication is dispensed for free or a charge not related to the cost, it is easy to forget how expensive treatments can be," David Stout, director of the NHS Confederation's primary care network, said. "Every pound wasted on a drug where an equally effective and cheaper alternative is available and clinically appropriate, is a pound that could be spent on another patient. If the public were made more aware of the cost of drugs to the NHS, this could result in less waste and make prescribed treatments more effective."

Cough medicines lack evidence, says Cochrane

There is no good evidence either for or against the effectiveness of over-the-counter cough medicines, an updated Cochrane review concludes.

Researchers examined data from 25 trials involving 3,492 people (2,876 adults and 616 children) with acute cough, and compared groups of medicines with similar modes of action. They found that antitussives, antihistamines, antihistamine decongestants and antitussive/bronchodilator combinations were no more effective than placebo. Data from one trial favoured mucolytics over placebo and one trial that tested two paediatric cough syrups showed a "satisfactory response" in

more of the children given the medicines than placebo (46 per cent and 56 per cent compared with 21 per cent). The reviewers were unable to assess the efficacy of expectorant cough medicines since no trials met their inclusion criteria.

The reviewers note that the results have to be interpreted with caution since study designs, populations, interventions and outcomes varied markedly between studies. "However, most preparations appear to be safe based on those studies reporting side effects which only described a low incidence of mainly minor adverse effects," they add (*Cochrane Database of Systematic Reviews* 2008; issue 1).

Assura seeks judicial review over three PCT refusals to award pharmacy contracts

Assura Pharmacy has sought judicial review of three decisions by the NHS not to award it contracts for community pharmacies in Tunbridge Wells, Kent, Freckleton, Lancashire and Todmorden, West Yorkshire.

Each refusal by the relevant primary care trust has already been backed by the NHS Litigation Authority's family health services appeals unit.

The High Court heard last week that Assura applied to set up a new pharmacy in Freckleton in March 2006, but was denied inclusion in the pharmaceutical list of Fylde Primary Care Trust, which said that there were already enough pharmacies in the area.

Assura challenged that decision, but the appeals unit concluded that the provision of pharmaceutical services and the choice of pharmacies were both adequate.

In the case of Todmorden, Assura's application was refused by Calderdale Primary Care Trust on the grounds that the area's two existing pharmacies meant that services were adequate, that there was sufficient choice and that a third, offering the same services, was neither necessary nor desirable.

In Tunbridge Wells, Assura was denied a contract by West Kent Primary Care Trust, although the trust granted a contract to a different company. Assura claims that the decision was based on an erroneous belief that the other company would offer better opening hours.

After a two-day hearing, the judge reserved his decision to a later date.

Assura is a recently established pharmacy company, which opened its first community pharmacy in 2006 and now operates 21 pharmacies. It specialises in co-locating pharmacies with GP practices in its own premises.

Other Cochrane reviews

The latest round of Cochrane systematic reviews consider evidence around the use of:

- Cranberries for urinary tract infections
- Hawthorn extract for chronic heart failure
- Alendronate for bone fractures
- Antioxidants for preventing pre-eclampsia
- Antidepressants for non-specific low back pain

Use of cranberries, hawthorn and alendronate are all supported by the reviews.

The other interventions do not fare so well. Evidence does not support routine use of antioxidants during pregnancy to reduce the risk of pre-eclampsia and other serious complications.

There is also no clear evidence that antidepressants are more effective than placebo in the management of patients with chronic low-back pain. However, the authors of the low-back pain review note that there is evidence for the use of antidepressant medicines in other forms of chronic pain.

Welsh CD guidance sets out new record-keeping demands

Controlled Drugs guidance for Wales has been updated by the Welsh Assembly Government. The guidance sets out and advises on regulatory changes to record-keeping requirements for CDs and the format of CD registers.

The regulations specify the information to be recorded in the register, rather than its specific format, and set out the information that should be recorded about people collecting

CDs. These changes come into force on 1 February. The guidance is available from the Royal Pharmaceutical Society's website (www.rpsgb.org).

Mechanisms for the introduction of electronic CD registers in Wales are currently being explored. Further guidance will be issued once electronic prescribing of CDs and electronic registers are widespread.