

■ VETERINARY PHARMACY

## Pharmacy is an accessible, underused resource

From Mr P. T. Jobson, MRPharmS

I agree with Bob Michell (*PJ*, 27 March, p382) that veterinary pharmacy should be part of the core pharmacy undergraduate course, perhaps in the sense that the specific skills of pharmacists are recognised as having an important role in veterinary medicine and the undergraduate course should keep pace with such developments.

However, his assumptions ignore relevant parts of the existing syllabus that do provide pharmacists with the necessary competencies to provide additional advice to animal owners that they would not otherwise receive from pet shop or supermarket staff or, indeed, from veterinary surgeons, who would be engaged in diagnosis and treatment work or would be otherwise inaccessible to a casual purchaser.

I am sure that medicines counter assistants and dispensing technicians would not liken themselves to DIY car owners operating a garage. The point being made in the article (*PJ*, March 13, p321) clearly refers to the pharmacist-supervised delegation that is essential in all professional practices, including veterinary practices. However, the suggestion that veterinary nurses would be more competent to advise on the relative benefits of the use of one pharmaceutical product over another, than would a pharmacist whose five-year education has revolved around pharmaceuticals, is somewhat unrealistic. In addition, the inaccessible nature of veterinary practices has led to consumers choosing to seek animal medicines from retail outlets.

The articles in *The Journal* of 13 March make reference to the

## Letters to the editor

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Government-led legislation to encourage greater availability of veterinary medicines through pharmacies and the desire within the pharmacy profession to augment the existing pharmacy category. One of the criticisms that has been levelled at the profession from those who would seek to have a wider range of medicines distributed by non-graduate merchants is that pharmacists are not interested in this market. However, 1,500 pharmacies represents nearly 12 per cent of UK pharmacies in a non-exclusive market for pharmacy, and is therefore impressive under the circumstances. Every pharmacy has the potential to become involved using the existing undergraduate training of their pharmacists and the existing range of pharmacy, pharmaceutical merchant list and general sale list medicines. Thereby would the profession demonstrate to manufacturers the capability to add value to the sale of their products and expand the market to the benefit of animal owners, animal welfare and all those involved in the market, including

veterinary surgeons. This would strengthen the argument for a wider pharmacy classification of veterinary medicines.

There is a manpower shortage in many professions requiring the controlled and supervised use of para-professionals. Pharmacists have been recognised as an accessible, underused resource, not only in human health, but also in veterinary medicine by virtue of their understanding of drug use, accepting that there are important differences between human and veterinary use. Clearly there are training and competence issues (as there are in all professions) and the opportunities are there for pharmacists to exploit in order to satisfy their obligation to demonstrate competence in areas in which they practise. But for the veterinary profession to argue that only its members should distribute veterinary medicines would be viewed by the Government as clear protectionism.

**Phil Jobson**  
Longtown,  
Cumbria

■ INDEMNITY INSURANCE

## Premiums need to be paid after retirement

From Mr B. P. Threlfall, MRPharmS

As an owner of community pharmacies for many years, all of which were members of the National Pharmaceutical Association, my staff and I were covered by indemnity insurance provided by the Chemists Defence Association. This cover also extended to locum pharmacists employed. Not all pharmacies provide this insurance for locums and, apparently, over 9,000 have personal professional indemnity cover provided by one company alone.

However, how many of these 9,000 actually read and understand the policies where cover is usually provided on a "claims made" basis? This means that any claim needs to be made while the policy is still active. In other words, if an error occurred last month, and the policy expired at the end of that month and was not renewed, but a claim was not made until this month, the claim would not be covered. Claims can be made for up to six years after an event. How many of us know that premiums need to be paid for up to six years after retirement to ensure that we are covered for claims arising as a result of incidents that occurred before we retired?

### Brian Threlfall

Secretary  
Morecambe Bay Local Pharmaceutical  
Committee

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■ METHADONE

## Supply of methadone important for pharmacy in public health

From Dr P. J. Bates,  
MRPharmS

There has been much debate about whether community pharmacy is the right setting in which to supply methadone. It should be remembered that methadone supply and needle exchange schemes are public health policies aimed at minimising the risks to drug users and the general public. Recent correspondence perfectly demonstrates the typically polarised arguments about whether these policies really work and are worth the problems they can bring. The main concern I have is that pharmacy is in a position to have influence and involvement in public health but rejecting certain undesirable areas may be detrimental to our wider role.

One example of a public health initiative that pharmacy has embraced is nicotine replacement treatment. Tobacco smoking is considered an (almost) socially acceptable drug habit compared

with heroin yet overall it costs the country much more in terms of associated illness and subsequent treatment. The huge potential gain in public health that could be achieved by reducing smoking in the population means that there is little objection to NHS prescribing of nicotine replacements.

However tobacco is a difficult addiction to beat partly because of its important role in a smoker's lifestyle, which bears a similar but less extreme parallel with heroin. This also means that there are similar problems with its treatment. Nicotine replacement is a form of drug substitution; it is not ideal for every smoker and there is no guarantee that all smokers will be successful in long-term abstinence. There is variation in the surgeries and primary care trusts which participate, variation in how long a treatment course each patient receives and variation in the support and follow-up. It is not surprising that many smokers are unsuccessful in quitting and like many methadone users, a relapse in terms of weakening to the odd cigarette is considered fairly commonplace. It is therefore unfair to expect methadone patients to perform any better than smokers.

Why then do we treat heroin addicts so differently? Threats and criminal activity are unnerving and unacceptable but it is not fair to apply this behaviour to all methadone users and reject the entire concept of treating addiction in community pharmacy. Although private smoking cessation clinics exist, it would be equally unacceptable to force all smokers seeking help to be stigmatised in a regimented clinic rather than conveniently obtain their treatment through their doctor and pharmacist.

Instead there appears to be a difference in attitudes towards heroin addicts originating from our sociological perceptions and prejudices. We may all have friends or family that smoke but not everyone knows or understands a heroin addict. The methadone patients we see in community pharmacy are those addicts who have made the effort to try to help themselves. A pharmacist with a negative attitude transmits this to the methadone patient and problems can arise. This is not to say smokers and heroin addicts are exactly the same but they should all have the right to acceptable treatment. Are pharmacists in a position to judge who is acceptable and pick and choose what public health policies we want to be involved in? Modern public health should be about treating everyone in a population fairly and without discrimination.

**Philip Bates**  
Southampton

## Cut the condescending rhetoric

From Mr B. R. Sinclair, MRPharmS

Sometimes I despair. I would expect that "professional", supposedly intelligent people were open to debate. However, suggest a point of view that is not considered politically correct, and you are castigated by the usual holier-than-thous and hand-wringers.

I particularly enjoyed Martin Bennett's "simplistic" analogy comparing heroin addicts to asthma sufferers (*PJ*, 13 March, p314). As I understand it, asthma sufferers do not choose to inject themselves with an illegal substance, thus becoming a salbutamol "junkie".

If, as he suggests, we measure the success of the methadone programme purely on reduction of crime, is there not an argument for locking up all addicts, thus achieving a 100 per cent reduction,

and keeping them locked away until they are prepared to "give up"? Not very realistic. The methadone programme should be about reducing crime by weaning addicts off drugs, but does not work because too many GPs and pharmacists have lost sight of this.

The feedback (*ibid*) to Michael Hutchison (*PJ*, 6 March, p280) saddens me. I have been threatened with a knife, spat at and been assaulted for having the temerity to refuse needles to addicts who are on a methadone programme or who are "high", or because the pharmacy does not do needle exchange. Providing needle exchange to reduce transmission of infection is valuable, perhaps vital to society. I believe what Mr Hutchison was offering for debate was whether community pharmacies are really the place for it. Some of us seem less sympathetic to the feelings of other customers. When an addict brings in needles wrapped in bloody string, uses foul language, or is abusive to other customers, you have to question whether it is the right place.

I have worked in pharmacies with up to 60 methadone addicts. I have always treated them with respect. This does not always prevent shoplifting, abuse or threats. Mr Bennett has "little sympathy" for anyone who suffers problems with the methadone programme, presumably even when an addict turns up at closing time with an unsigned prescription, 30 minutes after the surgery has closed, and threatens violence if you do not dispense his methadone. Come on Mr Bennett: "sort out the problem and provide the service"? Is it too much to expect, to debate important issues without the condescending rhetoric?

**Barry Sinclair**  
Aberdeen

■ EXCIPIENTS

## Problems with excipients and Smith Lemli Opitz syndrome

From Mr A. J. Nunn, FRPharmS, and others

Most medicines contain excipients in order to improve palatability, to confer stability and to improve shelf life.

The potential adverse effects of some of these excipients (particularly colouring agents and antimicrobial preservatives) are well known. Many parents believe that

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these agents contribute to behavioural problems in their children and seek to avoid them.<sup>1</sup>

Rarely do pharmacists know which products contain particular excipients unless alerted to a problem requiring investigation of the formulation.

Recently a boy of 15 years (the son of RH) with Smith Lemli Opitz syndrome (a rare inborn error of cholesterol metabolism) was changed from extemporaneously prepared chloral hydrate (containing only the active ingredient, syrup and water) to Welldorm Elixir (containing chloral hydrate with saccharin, sodium benzoate, flavouring and colours Ponceau 4R E124 and Sunset Yellow E110). He had been maintained on a diet free of additives where possible and there were no other medication changes. Coincident with medication change was a significant deterioration in his behaviour which included hyperactivity, aggression and self-harm. He redeveloped photosensitivity, had recurrent infections and increased appetite. He was thoroughly investigated but no disease-related explanation could be determined. Withdrawal of Welldorm Elixir and replacement with excipient-free chloral hydrate produced a slow return to normal behaviour over several months. Brief rechallenge with Welldorm Elixir produced deterioration again. He is currently being investigated for temporal lobe epilepsy.

When asked if chloral hydrate syrup and Welldorm Elixir are equivalent, many pharmacists would first consider the equivalence of the active ingredient and might not consider the contribution of excipients unless they know that the patient is likely to have a problem with them.

Pharmaceutical excipients, well tolerated by the majority of patients, may produce significant adverse effects in a small minority. When asked questions about the equivalence of preparations, pharmacists should enquire whether the patient has allergies or sensitivities to foods or excipients. With drugs such as chloral hydrate, which are non-specific with regard to a main diagnosis, seeking further information about the patient's diagnosis may alert pharmacists to the need for further investigation.

Smith Lemli Opitz syndrome is a rare inherited illness which will be unknown to many pharmacists and doctors. There is a deficiency of 7-dehydrocholesterol reductase

with accumulation of 7-dehydrocholesterol and deficiency of cholesterol unless substituted. Patients with this syndrome will have suffered cellular damage through lack of cholesterol and exposure to high levels of cholesterol precursors *in utero*. Autistic spectrum and behaviour disturbances may be part of the syndrome.<sup>2</sup> The case history of this child suggests that excipients may have triggered a change in behaviour.

Further information about the Smith Lemli Opitz syndrome can be obtained at [www.cafamily.org.uk/Direct/s32.html](http://www.cafamily.org.uk/Direct/s32.html)

**Anthony Nunn  
Reginald Hunter  
Steven Ryan**

*Royal Liverpool Children' NHS Trust*

### References

1. Pawar S, Kumar A. Issues in the formulation of drugs for oral use in children — role of excipients. *Pediatric Drugs* 2002;4:371–9.
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### ■ SELF-PRESCRIBING

#### Check a doctor's status

From Mr M.-J. Whitehouse

One evening during my community preregistration secondment, a doctor approached the pharmacy counter wishing to write a private prescription. I asked for some form of identification and he produced an official hospital badge stating that he was a doctor. On further inspection of his ID, I noticed that he was in fact a preregistration house officer (PRHO) and, although still a "doctor", held only a "provisional licence" with the General Medical Council.

It is worth noting that although PRHOs possess a GMC registration number, they are legally prohibited from issuing prescriptions other than those issued under the supervision of their supervising consultant. Most hospital pharmacists are able to distinguish easily between PRHOs and those doctors permitted to self-prescribe, such as senior house officers and registrars. However, this is more difficult to discern in the community. In this instance, I contacted the GMC, which confirmed my suspicions.

Supplying prescription-only medicines without a valid prescription is an offence, and pharmacists should therefore consider seriously the prescribing status of the doctor before making a supply.

**Marc-James Whitehouse**  
*Preregistration Trainee  
Frenchay Hospital, Bristol*

### ■ PHARMACIST PRESCRIBING

#### Let us get on with it

From Ms J. Fawcett, MRPharmS

I cannot get excited about a hospital pharmacist prescribing a medicine for constipation under the guidance of a consultant geriatrician, with paperwork signed in triplicate and the patient reviewed daily and reassessed by the doctor after a week (*PJ*, 27 March, p369). Community pharmacists have been "prescribing" for constipation for just the price of the medicine since pharmacy began.

If we are to be allowed to prescribe in certain instances after obtaining the necessary qualification (a pharmacy degree and experience), let us get on with it.

**Jacqueline Fawcett**  
*Halifax, West Yorkshire*

### ■ SUGAR IN MEDICINES

#### Not such a problem

From Dr J. I. Wells, MRPharmS

Sucrose in liquid medicines, if it were not for consumer pressure, would still be the best choice of sweetener for a whole raft of technical, physiological and organoleptic reasons. Indeed most so-called sugar-free medicines contain a sugar, but not sucrose. Sorbitol and hydrogenated glucose syrup are but two examples. Hemant Patel (*PJ*, 20 March, p348) is promulgating a myth. Consider the following:

- Methadone DTF contains sucrose, not as Syrup BP (85%w/v) but at a loading of 18%w/v
- A normal diet is 3,000kcal
- 100ml methadone DTF supplies 72kcal from sucrose (ie, 2.4 per cent)
- Methadone causes anorexia
- Sucrose causes tooth decay, but the medicine is no different

from a sweetened cup of tea or coffee

- The usual dose of liquid medicines is 5ml (ie, 0.12 per cent)

In the same issue (*PJ*, 20 March, p341), a spokesperson from the Neonatal and Paediatric Pharmacists Group laments the "poor tasting medicines for children". It is well known that children prefer sweeter medicines more than adults do. However, medicines are taste-masked by suitably trained adult personnel who are exposed to risk through the consumption of low levels of active compounds — there is no point in taste-masking a placebo. I would question how many ethics committees in children's hospital would sanction the exposure of children to a similar risk in taste-masking trials.

**James Wells**  
*Rosemont Pharmaceuticals  
Leeds*

### ■ NMS

#### To avoid any misunderstanding . . .

From Mr L. E. Allum, MRPharmS

I write in response to the publication of my article "National Minimum Standards in care homes: what role do pharmacists have?" (*PJ*, 27 March, pp387–90).

I would like to address a few points that require correction to avoid any misunderstanding.

On p387, column 1, the opening sentence reads: "Since 2002, regulation of vulnerable people in residential and nursing care homes and in the wider community has undergone a huge change." This is an editorial error and the context implies that it is "vulnerable people" who are subject to regulation when of course it is the care homes and other establishments, as indicated in the article, that are subject to regulation.

On p388, column 2, the division of client groups made reference to "the other 24 per cent", this should have read 25 per cent.

On p389, Panel 1, the second and third items in the "Trigger" column should be classified in the "Level of importance" column as one star and not three star, as shown.

**Lawrie Allum**  
*Pharmacist Inspector  
National Care Standards Commission*