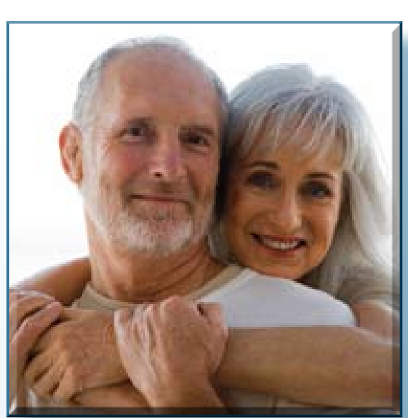
Communication

A Publication of the Manitoba Society of Pharmacists Inc.

Continuing Education:
Therapeutic Options
Focus On ASA/NSAID Sensitivity Reactions

The Last Word:
Bottled up in the Pipeline:
A Few Modest Suggestions to Cure the Drug Supply Crisis

March/April 2011
Vol. 36, No. 4



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Manitoba Society of Pharmacists

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Show Me the Money

There is a lot that can be said about the progress pharmacists have made to date for being paid for non-dispensing services. The bottom line, unfortunately for the profession, is that the progress achieved has been minimal. A recent American article addressed the progress which pharmacists have made south of the border respecting payments for pharmacist provided "professional/cognitive services".

Despite many attempts through trials and studies to establish identifiable health benefits by providing pharmacists a larger role in the health care system, there are no good success stories involving new payment models for anything other than dispensing services. Not to the extent needed to demonstrate a sustainable payment model which both pharmacy and payers are prepared to adopt on a very widespread basis. Until such a payment model exists, community pharmacy will continue to rely almost exclusively on the monies paid on the volume of dispensing, and distribution which occurs. There will continue to be limited revenue generated for providing services other than dispensing.

The question that many involved with the profession have been trying to answer is how does a payment get generated for the services provided by the pharmacist? If the health benefits that can be achieved are real, how can the payment for the service provided also become real? These questions have gone unanswered for decades, but the answers likely need to be found very quickly given the current threats to existing sources of revenue to community pharmacy.

Three of the Ontario/Western Provinces have "reformed generic prescription drug pricing" in their respective jurisdictions in an effort to save hundreds of millions of dollars. It is way too premature to pass judgment on what is actually being accomplished by seeking these savings. It is worth noting that without exception, those payers who generally pay for the vast majority of dispensing services in jurisdictions with "reformed generic prescription drug pricing", expect to cumulatively save substantial dollars.

It isn't hard to understand the excitement created when "savings" are found in a health care system which on a daily basis seems overpowered by current demands and underfunded to satisfy or respond to existing identifiable health needs.

Unfortunately for all pharmacists the majority of the "savings" which are being sought will come directly from funding which currently flows for payment of pharmacy services. We all know that savings have to come at someone's expense. The professional allowances have become a fundamental component to the operation of community pharmacy. How community pharmacy responds to these reduced revenues is not known, and in all likelihood there will be many different forms of response depending on a community's circumstances.

Community pharmacy always manages to respond.

MSP

The MSP *Communication* Committee is seeking a hospital pharmacist to contribute regular articles regarding hospital pharmacy related topics for the newsletter. If you are interested in submitting articles with a hospital pharmacy focus for publication in *Communication* please contact MSP at info@msp.mb.ca or call the office at (204) 956-6680.

Congratulations to MSP Vice-President, Michelle Glass and her husband Roni Estein on the birth of their daughter, Gabrielle Hannah, a little sister for Miriam. Gabrielle weighed in at 5 lbs 13 oz. and arrived on Jan.11, 2011.

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Pharmacist Awareness Week

WHEREAS this year's theme is *Pharmacists' advice: helpful with every dose;* and

WHEREAS pharmacists are consistently ranked as one of the most trusted and respected professionals in our health care system, making important contributions to the health of our residents; and

WHEREAS pharmacists provide valuable front-line services, including programs such as medication reviews, antibiotic awareness programs, seniors' safe medication programs, children's safe medication programs, and smoking cessation services, to help promote and maintain our health; and

WHEREAS during Pharmacist Awareness Week, pharmacists in the Province of Manitoba will promote the many ways that pharmacists help people live healthy lives through medication counselling, disease management and health education;

Now therefore let it be known that I, Theresa Oswald, Minister of Health for the Province of Manitoba, do hereby proclaim the week of March 6 – 12, 2011, as

Pharmacist Awareness Week

in Manitoba and do commend its thoughtful observance to all citizens of our province.

Minister

Pharmacists-at-Risk: Thirty Years of Service

For thirty years Pharmacists-at-Risk has been providing support for Manitoba pharmacists facing personal problems. Established in 1981 to help struggling pharmacists, Pharmacists-at-Risk assists with compassionate help and understanding instead of the stigma of punishment.

Vernon Cooke, Pharmacists-at-Risk co-founder and long standing committee member, remembers how pharmacists faced a growing need for support in their profession before the formation of the program.

"Pharmacy was different than it is now," Cooke recalled. "The Manitoba Pharmaceutical Association had no means to help pharmacists that were in trouble. At that time there was no resource to help pharmacists before they went in front of council and maybe faced suspension or the loss of their license."

Until the establishment of Pharmacists-at-Risk, professionals dealing with personal issues faced their problems in isolation. The inability to identify an individual's problem, combined with the lack of motivation to seek treatment, created further challenges. As well, the underlying cause of a pharmacist's personal problem often went unaddressed or unnoticed.

With no independent body to address these issues the Manitoba Pharmaceutical Association was responsible for disciplining pharmacists when a member's conduct became the subject of a hearing held by the Discipline Committee. As a result of these cases, pharmacists were often faced with fines or suspensions instead of personal assistance and support.

Realizing that pharmacists in Manitoba could benefit from a professional support network, Mr. Cooke, Mr. Don Braun and the late Mr. Norm Taylor, together with assistance from an allied medical 'at risk' program, formed Pharmacists-at-Risk with the support of the Manitoba Pharmaceutical Association.

"The committee felt that if we could reach people before the Association stepped in they could go back to their jobs without having any disciplinary action taken," Cooke said. "Before that pharmacists weren't able to make a mistake without it going on their permanent record."

Mr. Cooke remembers that when the program started in 1981 the most prevalent problem was alcohol abuse. Today the program has expanded to provide a number of supports for individuals struggling with a host of issues including drug addictions, financial difficulties, marital issues and other personal problems. The program strives to work in the pharmacist's best interest by keeping all cases and inquiries strictly confidential.

While the program continues to make headway, there are still challenges.

"It's not easy to approach someone with an addiction problem and intervene," said Cooke. "What we try to do is intervene at the early stage and get the person into treatment and monitor them afterwards for varying periods of time depending on individual cases."

Pharmacists-at-Risk receives some of their funding through the annual Manitoba Pharmacy Conference silent auction which is made possible through donations and support from the Manitoba Society of Pharmacists, the Manitoba Pharmaceutical Association as well as conference sponsors. The funds raised help support a webpage and an emergency phone line. The program also has a relationship with the Faculty of Pharmacy at the University of Manitoba and brings in speakers to fourth year students to raise awareness for the services that Pharmacists-at-Risk provides. The committee meets eight times a year.

Pharmacists provide an essential service for the well being of the community. Pharmacists-at-Risk, for the past thirty years, has acknowledged this service by remaining committed to the health and well being of Manitoba's pharmacy community.

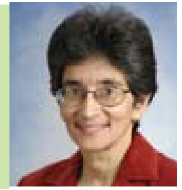
Celebrating 30 Years

The Pharmacists-at-Risk committee was established in 1981 by Mr. Verne Cooke, Mr. Don Braun, and Mr. Norm Taylor. Their vision was to provide a support group for pharmacists experiencing personal problems that could affect their competency in practicing their profession. We are proud to have been able to serve the pharmacists of Manitoba for 30 years.

"let us help...YOU...keep it together"

Halitosis

MEERA B. THADANI
M.Sc.(Pharm.)



What is halitosis?

Halitosis or bad breath [Latin, *halitus*, breath + Greek –*osis*, condition] is defined as an offensive, foul breath odor caused from a variety of etiologies such as poor oral hygiene, dental or oral infections, or the ingestion of certain foods.[1]

What causes bad breath?

Bad breath is the result of the breakdown and fermentation of food left in the mouth by anaerobic gram-negative bacteria. The by-product of this metabolism produces vile smelling sulfur compounds (hydrogen sulfide, methyl mercaptan). These bacteria may be present in gum (gingival) disease or periodontal disease especially if there is any ulceration or dead tissue present (Figure 1). The bacteria can accumulate in pockets or sometimes deposit onto the back of the tongue.

Other factors such as Sjögren's syndrome, drugs that dry the mouth (anticholinergics) and increased buccal pH can contribute to bad breath (Figure 2). Foods such as garlic and onions, beverages (coffee) and spices with strong flavors or odors (assafoetida) can leave behind smells that last long after the food or spice has been consumed. Alcoholic beverages can also contribute to halitosis.

Most cases (~85 %) of bad breath are from oral problems:

- Gum (gingival) disease
- Periodontal disease
- Smoking

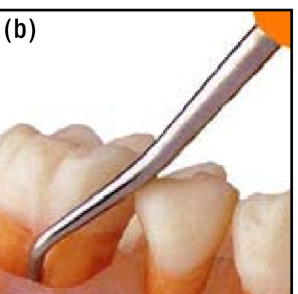


Figure 1. This patient needs a dentist (a). Lack of proper dental hygiene can cause gingivitis, periodontal disease, bad breath and ultimately loss of the teeth (b).

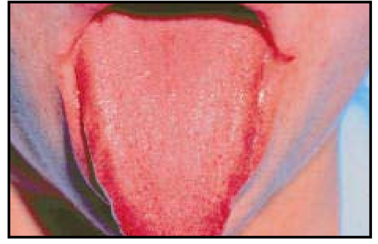


Figure 2. Extraoral conditions or medications can cause dry mouth. The tongue is red, tissues irritated and can look tough and leathery.

- Foods, spices and beverages that have strong odors
- Dental cavities
- Yeast infections in the oral cavity

Other health issues can cause halitosis, for example:

- sinus or naso-pharyngeal infections
- cancers affecting the oral cavity
- pulmonary infections
- regurgitation of food when lying down or bending over (diverticulitis)

Stomach upsets do not cause bad breath. While passing gas may be equally malodorous, bad breath is not a reflection of digestion in the stomach or lower bowel function.[2] Not considered halitosis, diabetic ketoacidosis produces a fruity scent, hepatic failure may have the smell of sulfur and renal failure the odor of urine.

How is bad breath evaluated?

The patient may complain of halitosis or perhaps their family or friends have clearly stated that their breath smells bad. The first step is to ask the patient about their oral health and hygiene habits:

- Do you use dental floss or some method of cleaning inter-dental spaces?
- Do you eat foods that have strong odors?
- Do you smoke, drink coffee or alcoholic beverages?
- Are you using any prescription or non-prescription medicines?
- Do you floss and brush your teeth after each meal?
- Do you wear dentures?
- Have you had a cold or sinus infection recently? Do you have a fever?
- How often do you visit the dentist?

The sniff test

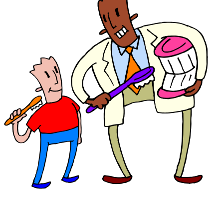
Patients are asked to avoid strong smelling foods for 48 hours. For 2 hours prior to the test avoid eating, chewing, drinking, smoking, gargling or rinsing the mouth. The patient exhales 10 cm away from the examiners nose first with the mouth open and then with the mouth closed. Halitosis caused by oral problems smells strong, rotten or pungent. Halitosis caused by systemic problems can have a less pronounced odor that is abnormal (fruity, sulfurous or urine-like).

When should the patient seek medical or dental help?

Suggest a visit to the dentist or doctor if there is:

- a discharge from the nose
- foul smelling sputum

- fever present
- a lesion(s) present



How is bad breath treated?

1. Prevention is the best treatment. Oral hygiene that includes flossing and brushing at least twice daily with toothpaste and toothbrush with soft or ultra soft bristles will reduce halitosis. Keeping a toothbrush at work to brush teeth after eating is highly recommended. Dentists will suggest replacing the toothbrush every 3 months. Remove dentures at night and clean them well before placing into the mouth for the day.
2. Visit the dentist for cleanings and check-ups every 6 months to prevent periodontal disease and dental caries.
3. Stop smoking or chewing tobacco. Ask the pharmacist to help you QUIT!
4. Drink plenty of water during the day to avoid a dry mouth. The use of sugarless gum or candy will stimulate the production of saliva that will help to remove food particles and bacteria from the oral cavity.
5. If there are foods that are causing the bad breath, try to avoid them.
6. Keep a list of the medications you take. Those that cause dry mouth can contribute to bad breath.
7. Oral health is part of your overall well-being. Loss of teeth can affect the way a person looks, speaks, eats and socializes. This can have a negative impact on the quality of life. Visit your dentist regularly. They will suggest the best type of toothbrush, flossing aids, toothpastes and mouthwashes best suited to the individual.

The bottom line

Most cases of halitosis are the result of the breakdown and fermentation of food left in the mouth by anaerobic gram-negative bacteria.

Other disorders may cause halitosis and are accompanied by other symptoms and findings.

Bad breath is not a reflection of digestion in the stomach or lower bowel function.

Mouthwashes mask halitosis. They help only for a short time and their repeated use does not solve the problem. The best treatment for halitosis is to prevent it with good oral hygiene. This includes bi-annual visits to the dentist who will also check for any underlying causes at each visit. An ounce of prevention is a pound of cure!

References:

1. J. H Dirckx, Stedman's Concise Medical Dictionary for the Health Professions, 3rd edition, Williams & Wilkins, Baltimore, 1997.
2. Thadani, M.B., Gone With the Wind, Communication, August, 2010.
3. http://www.cda-adc.ca/en/oral_health/oral_health_life.asp?intPrintable=1

The importance of asset allocation

Asset allocation is the key to investment success

By following a well-formulated asset allocation strategy, you can stabilize your portfolio and increase your peace of mind at the same time.

What is asset allocation? Simply put, it is a strategy for answering two basic questions:

(a) What type of assets should I have in my portfolio?

(b) How much of each should I have?

I cannot overstate the importance of asset allocation when it comes to building a successful portfolio. Asset allocation provides you with a roadmap for selecting appropriate investments, and for re-balancing your portfolio before, during, and after market volatility. As such, it is one of the cornerstones of successful investing.

The rationale for asset allocation

The idea of asset allocation is an old one (at least as old as the saying "don't put all your eggs in one basket"). But the idea really took off in the late 1980s, when investment whiz Gary Brinson (whose financial research in the subject has become one of the cornerstones of modern investment strategy) discovered in one investigation that more than 90% of portfolio performance could be attributed to how assets were allocated. Slightly less than 5% was accounted for by the actual securities held, while less than 2% was due to market timing. In other words, asset allocation decision turned out to be ten times more important than everything else put together!

Successful asset allocation begins with a simple rule: we should all look for the combination of assets that gives us the greatest potential return for an appropriate level of risk. The right asset allocation for you may not be the right allocation for me, depending on the difference in our personal risk tolerance, but the principle comes down to this: take on as much risk as you have to in order to accomplish your investment goals. And no more.

How do I begin?

You can start by asking yourself a simple question: "Given my personal risk tolerance, and individual objectives, what portion of assets should I allocate for growth, what portion for income, and what portion for liquidity?". This is the secret to successful asset allocation—figure out what you are trying to accomplish with your investments, and then organize your portfolio in the way that is most likely to make those goals a reality.

Putting asset allocation to work

Once you've outlined your investment objectives, you should be able to determine an appropriate asset mix. If it's growth you're after, you'll want to allocate a significant amount of your wealth to equities, which have historically outpaced other assets when it comes to growth. If your objective is income, you'll want fixed-income investments such as bonds, preferred shares, and perhaps income trusts or real estate. These investments offer the most consistent income flow. And if the goal is safety and liquidity, short-term investments such as GICs, T-Bills, or money-market mutual funds will dominate.

No matter what your objective, you'll want to reserve a portion of your portfolio for each of these main categories. Such a balance will make market volatility a lot less of a problem in your portfolio, and will help you sleep better at night.

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TEAM PHARMACY – The Multiple Sclerosis 2011 Walk

The Faculty of Pharmacy students have made a tremendous effort to raise money in hopes of finding a cure for multiple sclerosis (MS). They have created a team for the annual MS Walk in Canada called, 'Team Pharmacy', which has currently raised over $24,000 this year alone. They have already raised over $50,000 over the last three years! This makes them the largest contributor in Manitoba, and second in Canada.

Recently, the team reached their first goal of raising $20,000 for MS. To encourage the team to reach this goal Mike Namaka, a clinical specialty MS pharmacist and professor at the Faculty of Pharmacy promised to dye his hair red in front of many students, staff, and media personnel. On February 14, 2011 he did just that! If Team Pharmacy reaches their second goal of $30,000 Mike will also be a mascot for the team on the day of the walk, and he will shave the letters MS into his newly dyed red hair.

The Professional Relations Committee urges you to help support our students and to follow their admirable lead to help Manitobans find a cure. You can help by either joining the walk with the pharmacy team or creating a team on your own. Go to http://mssociety.ca/en/events/scwalk/default.htm for information.

Students from the Faculty of Pharmacy are joined by Kelly Butler from the Blue Bombers and Chrissy Troy from HOT 103 (first row 2nd from left) and Kristine Petrasko from the Faculty of Pharmacy (first row, far right).

To donate under Team Pharmacy, click 'Top Fundraisers' on the left hand side, then 'Top 100 teams', then 'Team Pharmacy', and finally, click 'Pledge my Team Online'. You can also go online directly to http://msofs.mssociety.ca/2011WALK/SponsorTeam.aspx?&PID=1244671&L=2.

Help our students become the #1 team in Canada and raise money towards a cure for MS!!!

Manitoba Society of Pharmacists

ANNUAL GENERAL MEETING AGENDA

Saturday, April 16, 2011, 9:00 am

The Delta Hotel, 350 St. Mary Ave., Winnipeg, Manitoba

Chair – To be announced

1. Minutes of the Annual General Meeting, April 10, 2010
2. Business Arising
3. President's Address . . . . . M. Baxter
4. Auditor's Report
5. Finance Report . . . . . A. Desjardins
6. Executive Director's Report . . . . . S. Ransome
7. MSP Committees
   - 7.1 Communications Journal Committee . . . . . A. Desjardins
   - 7.2 Membership Committee . . . . . J. Ell
   - 7.3 Economics Committee . . . . . G. Harochaw
   - 7.4 Professional Relations Committee . . . . . G. Romanetz
   - 7.5 Government Relations Committee . . . . . M. Baxter
   - 7.6 Pharmacare Committee . . . . . M. Glass
   - 7.7 Insurance Committee . . . . . E. Kuber
   - 7.8 Good Governance Committee . . . . . T. Pattern
8. Liaison Reports
   - 8.1 Canadian Pharmacists Association Liaison . . . . . K. Petrasko
   - 8.2 Student Liaison . . . . . K. Ens
9. New Business
10. Closing Resolution

Students and MS

The power of student energy is an amazing thing to capture. They have so much drive, dedication and will. The challenging part is to seize the right moment. There are so many charities out there that can be helped. Why MS?

Well for one thing, Manitoba happens to have one of the highest rates of MS in Canada. There are over 3,000 people in Manitoba living with the disease. We all know someone that is affected by it, and that is why we chose MS. We also discovered that MS research is a big part of the Faculty. Dr. Mike Namaka (Professor and Neuroscientist) works directly with these patients through the End MS program, his clinic and his research.

KRISTINE PETRASKO

Team Pharmacy has grown into something quite large. With over 100 members helping over the last three years, the team has already raised over $50,000! This year alone, they have already raised over $24,000. By walking, the students are helping to raise awareness for people living with MS, and at the same time, they are gaining a much better understanding of how the disease can affect so many lives around them. By giving just a little of their own time, they have given back so much more to their community.

The Manitoba Society of Pharmacists (MSP) has also honed in on this opportunity and has joined forces with the students at the faculty for Pharmacist Awareness Week (PAW) 2011!

For each PAW event that the students put on for the pharmacies in Manitoba, they will receive a minimum of $150 towards the MS walk fundraising. It's a win-win situation. The pharmacy hires a student and they arrive with all the materials set to go! The pharmacy receives a receipt for their donation. You can't lose.

The topics of choice for this year were: Smoking Cessation, the Manitoba Medication Return Program, Cough & Cold, and It's Safe to Ask. For next year bookings, please contact Sara Smith, third year Pharmacy student, at smitty4321@hotmail.com or umsmi278@cc.umanitoba.ca.

We are asking Manitoba Pharmacists to tell us about their PAW event. Your success story and collaboration with a student just might be the catalyst for bigger change in the future. We want to share your experience with colleagues and inspire others to strive for excellence. Take pictures and send them in to: info@msp.mb.ca!!

For more information about Team Pharmacy, or to help with the cause, please go to: http://msofs.mssociety.ca/2011WALK/SponsorTeam.aspx?&PID=1244671&L=2

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As part of that mandate, **D'ARCY & DEACON LLP** is proud to provide legal services to Members of the Manitoba Society of Pharmacists ("MSP"). In consultation with the MSP, the Firm has developed a unique Legal Assistance Program to maximize advantages available to Manitoba Pharmacists. Written information regarding **D'ARCY & DEACON LLP** and the Legal Assistance Program is available to all Members from both the Firm and MSP.

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Multiple Sclerosis (MS)

Professional Relations Committee

Overview:

1. What is MS?
2. Symptoms of MS
3. MS Information Tidbits
4. Types of MS
5. Potential Causes of MS
6. Diagnosis of MS
7. Treatment of MS
8. Role of the Pharmacist
9. Summary

PAM JOHNSON
B.Sc. Pharm.

1.) What is MS?

Multiple Sclerosis is a disease affecting the central nervous system (CNS) which includes the brain and spinal cord. It is characterized by the destruction of myelin, which is a protective layer that surrounds the axons (nerve fibres) responsible for the conduction of electrical messages throughout the body. The myelin sheath is thought to be attacked by the body's immune system, resulting in inflammation, plaques, lesions, and the disruption of communication signals travelling along the axons. This disruption can occur in any area of the nervous system and therefore can lead to an array of different MS symptoms.

2.) Symptoms of MS

The symptoms of MS vary from person to person depending on the severity of the disease and the area of the axons that are affected. Hence, patients with MS may present with very different symptoms than one another. The main symptoms of MS include:[1]

- Balance and dizziness
- Bladder dysfunction
- Bowel constipation, diarrhea, incontinence
- Cognitive impairment
- Depression
- Dry mouth
- Dysarthria or difficulty speaking
- Dysphagia (difficulty swallowing)
- Fatigue and Fatigability
- Gait (difficulty walking)
- Hormonal influences for women with MS
- Inappropriate affect (also known as pseudo bulbar affect, emotional incontinence, involuntary emotional expression disorder – IEED) characterized by involuntary or uncontrollable laughter or crying (occurs in 10% of patients, is treatable with TCAs or SSRIs)[1]
- Incoordination
- L'hermitte's (Electric shock sensation radiating down spine and neck flexion)
- Mood Lability/Bipolar Disorder
- Optic Neuritis (inflammation of the optic nerve)
- Pain
- Paroxysmal Symptoms
- Sensory Impairment, Numbness/Tingling
- Spasms
- Spasticity
- Tremor
- Uhthoff's Phenomena (Heat Intolerance)
- Useless Hand Syndrome (of Oppenheimer)
- Weakness

3.) Multiple Sclerosis Tidbits of Important Information:

MS is considered a young adults disease because it is primarily diagnosed in men and women between the ages of 15 and 40 years of age. It occurs more than 3 times more in women than in men, but men often have the more debilitating forms of the disease. MS has been found in patients as young as 2 years old.[1] The following information was taken from the MS Society of Canada's website:[1]

- 'Canadians have one of the highest rates of multiple sclerosis in the world.
- MS is the most common neurological disease affecting young adults in Canada.
- Every day, three more people in Canada are diagnosed with MS.
- MS was first identified and described by a French neurologist, Dr. Jean-Martin Charcot, in 1868.
- We don't know what causes MS but researchers are closer to finding the answer.
- 55,000 to 75,000 Canadians have multiple sclerosis.
- Prevalence rates range from one MS case per 500 people to one MS case per 1,000 across the country.
- The MS Society estimates, based on current prevalence rates, that approximately 1,000 new cases of MS are diagnosed in Canada each year.
- MS is not a fatal disease for the vast majority of people with MS. Most people who have MS can expect to live a normal or near normal life span, thanks to improvements in the treatment of symptoms and in other therapies for people with MS.'

4.) Types of MS

There are 4 types of multiple sclerosis, and they all have different decline patterns. The figures defining the different types of MS were taken from the Canadian Multiple Sclerosis Society's website at: http://mssociety.ca/en/information/types.htm.

1.) Relapse-Remitting MS (RRMS): This is the most common form of MS (about 85% of patients start with this type), and also is the mildest form. In this type of MS, the patient experiences episodes of acute attacks referred to as relapses, exacerbations, or flare-ups.[3] The attacks can be new symptoms, or the worsening of pre-existing symptoms.[1] The attacks are stable and are not

considered to be a progression of the disease, and the patient generally recovers completely (figure 1a) or nearly completely (figure 1b).[1] RRMS is categorized into two different forms:

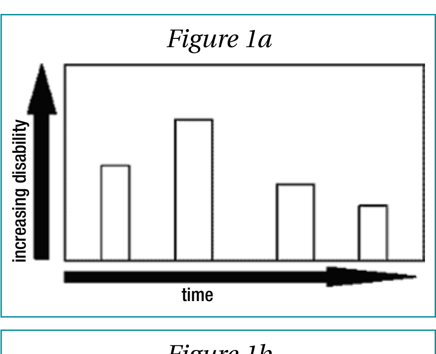

Figure 1a

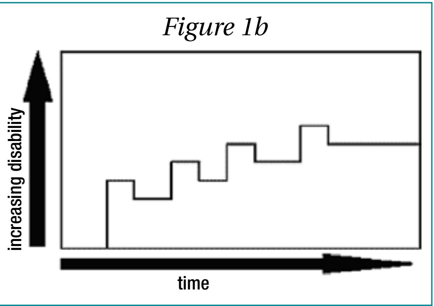

Figure 1b

Benign MS: in which a patient experiences an episode of MS symptoms, but then goes through remission for 15-20 years after diagnosis. Sight and touch are primarily affected in these types of patients.[1] It is difficult to predict this type of MS so treatment still must be considered.[1]

Clinically Isolated Syndrome (CIS): Also referred to as 'probable MS', this type of RRMS is characterized by a single episode of neurological symptoms. It is usually diagnosed when a physician finds laboratory evidence that suggests the patient has had a second relapse of the disease.[1] 'In very early MS, it may be necessary to follow-up with the patient and repeat investigations a few months later to find evidence of a second defining MS attack.'[1]

2.) Primary-progressive MS (PPMS): this form of multiple sclerosis is characterized by the lack of remission episodes. The patient continues to have symptoms of MS that tend to get worse and worse over time. Figure 2a represents a steady decline, while figure 2b represents temporary improvements which are possible during the course of this type of MS. Approximately 10% of people diagnosed with MS have PPMS and it is the only form of MS to affect men and women equally. PPMS tends to be diagnosed after age 40.

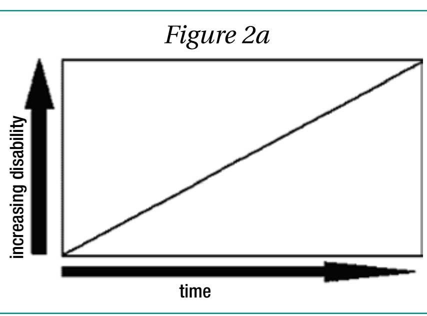

Figure 2a

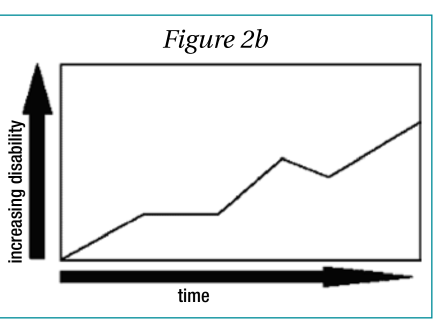

Figure 2b

3.) Secondary-progressive MS (SPMS): Patients typically present with RRMS first, and may eventually advance to secondary-progressive MS. Patients with SPMS continue to have relapses, and no longer recover completely. Gradually their MS symptoms accumulate and lead to the progression of the disease and eventually disabilities. More than 50% of patients with RRMS will eventually progress to SPMS within the first 10 years, 90% within 25 years.[3] Figure 3a represents MS in the early stages when there are periods of remission, then the disease progresses, while figure 3b represents accumulating disability.

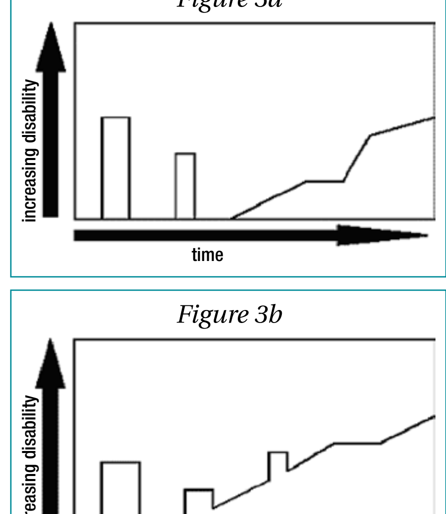

Figure 3a

Figure 3b

4.) Progressive-Relapsing MS (PRMS): is the least common form of MS (5%).[3] This type shows progression from onset with clear acute relapses with (Figure 4a) or without (Figure 4b) recovery.[3]

5.) Potential Causes of MS:

The exact cause of MS is unknown, and **there is no cure**. However, there are many theories that have come to light with regard to the cause of MS:

- Immunological disease: It is thought that MS is an autoimmune disease in which the body attacks the central nervous system, destroying the myelin sheath and disrupting messages between the body and brain.[3]
- Environmental: It has been found that people born in an area with a high incidence of MS that move to an area with a lower incidence of MS

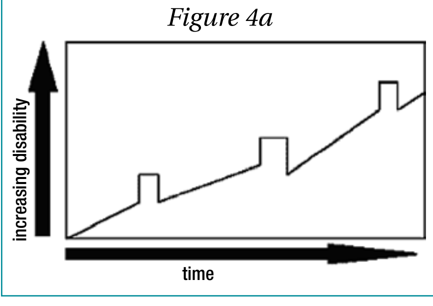

Figure 4a

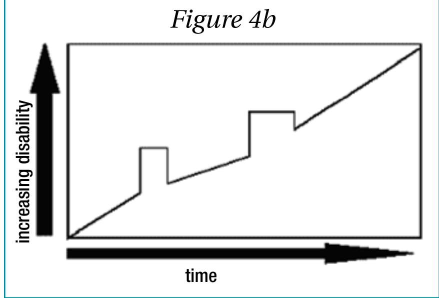

Figure 4b

before the age of 15 acquire the risk level of their new home; however, people who move after the age of 15 keep the risk of their original birth place.[3] This indicates that an environmental factor to MS is extremely likely. It has been thought that a deficiency of Vitamin D could be a culprit for MS due to the fact that the prevalence of MS is a lot less close to the equator, and the highest incidence of MS is in the Northern hemispheres.

- Infectious: It is thought that a particular bacteria or virus may be responsible to cause MS to become active.[3] Many bacteria and viruses have been studied, but none thus far have proven to be the cause of MS.
- Genetics: MS is not considered to be a genetic disease, but it has been found that if you have a parent with MS you are 20-40 times more likely to develop the disease yourself.[2] 'Scientists theorize that MS develops in individuals who are born with a genetic predisposition to react to some environmental or infectious agent.'[3]

6.) The Diagnosis of MS:

'The diagnosis of patients with RRMS usually involves a review of the patient's medical history, a physical exam, a neurological exam, an MRI scan, electroencephalogram (EEG) and, occasionally, other procedures such as a lumbar puncture.'[2] The lesions and plaques found on the myelin sheaths are evident in an MRI of the brain and present as white spots in the MRI. In order to be diagnosed with MS, other medical conditions must be ruled out, and there must be at least 2 MRIs showing lesions, taken at least 3 months apart. The patient also has to present with symptoms with certain specifications separated by time and space. This means that the patient must have symptoms that are typical of MS that last more than 24 hours (and could last several days, weeks or months), relapses of symptoms must occur at least 1 month apart from one another, and the symptoms must be located in two different areas of the body to showcase the problem is throughout the body and not in just one area. For example, a patient may exhibit symptoms in the optic nerve leading to temporary vision loss, and at least a month later may exhibit a tingly feeling down their leg for an extended period of time.

Type of Medication	Medication Name	Approved for What types of MS?	How it Works	Side Effects	Dose	Neutralizing Antibodies?
Interferon beta-1a	Avonex	Relapsing forms of MS. Also for treatment of people at risk for developing clinically definite MS (CDMS).	A protein derived from cells of mammals, via recombinant DNA techniques. This protein is normally made by the body to block both the activity of certain immune system cells and the passage of these cells into the central nervous system, therefore preventing these cells from causing Inflammation and damaging the myelin.	The most common side effects include flu-like symptoms (fatigue, chills, fever, muscle aches, and sweating) and injection site reactions (swelling, redness, discolouration, and pain). Most of these symptoms tend to improve over time. Less common side effects include some liver, blood and thyroid problems, as well as allergic reactions and depression.	30mcg IM every week.	Yes, but seems to be less than the other beta-interferons.
	Rebiff	Treatment of relapsing forms of MS (RRMS and SPMS). Although Rebiff did not affect progression of disability In SPMS, clinical trials have shown that people with SPMS with relapses experience benefits with respect to relapses and MRI disease activity compared to those receiving placebo.	A protein derived from cells of mammals, via recombinant DNA techniques. This protein is normally made by the body to block both the activity of certain immune system cells and the passage of these cells into the central nervous system, therefore preventing these cells from causing inflammation and damaging the myelin.	Same	44mcg sc 3x/ week, doses of 22mcg 3x/week also available.	Yes
Interferon beta-1b	Betaseron	Treatment of people with RRMS who are ambulatory to reduce the frequency of attacks. Treatment of SPMS and for treatment of people at risk of developing clinically definite MS (CDMS).	Made from bacterial cells using recombinant DNA techniques.[1] It works in the same way as the Avonex, protecting the body from certain immune system cells.	Same	250mcg sc q 2 days.	Yes
	Extavia	Approved for the treatment of patients with a single demyelinating event with 2 lesions on MRI to delay progression to definite MS. Also approved for RRMS and SPMS.	Made from bacterial cells using recombinant DNA techniques.[1] It works in the same way as the Avonex, protecting the body from certain immune system cells.	Same	0.25mg (8 MIU) sc q 2 days.	Yes
Glatiramer	Copaxone	Treatment of people with RRMS who are ambulatory. Also for the treatment of people at risk of developing clinically definite MS (CDMS).	A synthetic protein made up of a combination of four amino acids that chemically resemble a component of myelin.[1] Copaxone induces the production of Immune cells that are less damaging to myelin.[1]	Less common side effects include some liver, blood and thyroid problems, as well as allergic reactions and depression.[1]	The dose is 20mg sc/day.	GA-reactive antibodies are not neutralizing and do not alter the principal Immunological effects of GA.[1]
Natalizumab	Tysabri	Tysabri is Indicated as a monotherapy (not combined with other therapies). Recommended for people with MS who have not responded adequately to other disease-modifying therapies or who are unable to tolerate them. Later option due to increased risk of progressive multifocal leukoencephalopathy (PML) a rare brain disease with no treatment options caused by the JC virus that can cause severe disability or death, usually affecting people with suppressed immune systems. The drug's manufacturers recommend that people who take Tysabri should enrol in the Canadian Tysabri care Program at 1-888-827-2827.	Is a type of protein called a monoclonal antibody that is produced from mammalian cells using recombinant DNA techniques. First In a class of agents called selective adhesion molecule inhibitors. In MS, inflammatory T cells enter the central nervous system by attaching to the blood-brain barrier with "Sticky molecules", called alpha-4 Integrlns. Tysabri blocks alpha-4 integrin and prevents T cells from entering the central nervous system, where they cause Inflammation and damage to myelin.	The most common serious side effects of Tysabri therapy are infections and allergic reactions (rash, swelling, difficulty breathing). Three cases of PML, including 2 deaths, have been reported. Treatment may be associated with Infusion-related reactions (headache, dizziness, fatigue, rash). Less common side effects include anemia, cough, muscle cramps and depression. Increased risk of PML. Healthcare professionals must monitor people on Tysabri for any new sign or symptom that may be suggestive of PML, and treatment should be withheld immediately at the first sign or symptom suggestive of PML.	300mcg q 4 wks via iv infusion.	Yes. Persistent NAbs to Tysabri are associated with a lesser treatment effect and an increased risk of hypersensitivity reactions and/or Infusion-related reactions. Antibody testing should be performed if NAbs are suspected

Table 1: Treatment Options for Multiple Sclerosis

Source: Canadian Society of Multiple Sclerosis: Treatments: Modifying the Disease Course. Website: http://mssociety.ca/en/treatments/modify.htm. Accessed February 6, 2011.

7.) Treatment

There is NO cure for MS. Therefore, it is important that a patient's quality of life is especially considered with regard to this debilitating disease.

a.) Non-Pharmacological Treatment

Treatment should be facilitated by a team of healthcare professionals and support systems including physicians, pharmacists, physiotherapists, psychologists, occupational therapists, dieticians, social workers, nurses, and family. It has been shown that heat slows down the conduction of signals through the nerves, so a patient with MS may benefit from avoiding heat. Living a healthy lifestyle with diet and exercise can also be beneficial.

Support programs are also available for patients and families of those with MS. The Multiple Sclerosis Society of Canada provides information and referral, supportive counselling, support and self-help groups, recreational and social programs, and financial assistance. Go to http://mssociety.ca/en/help/services.htm for more information.

b.) Pharmacological Treatment

There are different classes of medication that are used to treat MS. Some medications are immune modulators, which help to slow down the progression of the disease. Steroids are given to decrease the severity and duration of symptoms, and symptoms are managed with many different medications.

Immune Modulating Medications:

Currently there are 3 different types of immune modulators, including 5 different medications for the treatment of MS: interferon beta-1b, interferon beta-1a, and glatiramer acetate. A sixth medication called natalizumab is also available, and is considered to be a selective adhesion molecule inhibitor. These therapies can cost between $20,000 and $40,000 a year. Before initiation of these therapies, other possible diagnoses must be ruled out. Consult the above chart for basic information about MS immune modulators and natalizumab. For more detailed explanations please go to the following website through the MS Society of Canada: http://mssociety.ca/en/treatments/modify.htm.

Neutralizing Antibodies:

Some of the immune modulator treatments have been associated with neutralizing antibodies (NAb). 'It is not known if NAbs completely "neutralize" the clinical benefits of therapy. Some research has found that a higher NAb level may be associated with a lesser treatment effect . . . Studies are continuing in this area, as is the development of a standardized NAb test.'[1]

Steroid Management:

Steroids including prednisone and iv methylprednisolone are used during relapses to treat inflammation of the myelin sheath. This helps to reduce the severity and duration of the relapse and speed up the return of function.[1] Side effects include difficulty sleeping, stomach upset, and irritability.[1] Long term use can affect the liver, kidneys and bone density and therefore, is not recommended.[1]

Other Medications:

Methotrexate, cyclophosphamide and mitoxantrone are other agents found to decrease the activity of the immune system.[2] These agents are usually reserved for patients not benefiting from or tolerating other first-line therapies.[2] Cladribine and Fingolimod are two other medications currently being studied for the treatment of MS.[2]

Symptom Management:

Patients with MS often have many different symptoms that sometimes need to be treated individually. Please visit the following webpage from the Multiple Sclerosis Society of Canada website to see excellent charts with symptom management options: http://mssociety.ca/en/treatments/managesymptoms_chart.htm.

8.) Role of the Pharmacist

Pharmacists are the most accessible health care professionals, and are readily available to answer any questions about multiple sclerosis from patients and family. It is important that as a pharmacist you recognize your patient's needs and help them with the management of their symptoms. Many patients will need supplemental medications to their immune modulator medications including antidepressants, antispasmodics, pain medications, and others. You can inform your patients about the various risk/benefit ratios with the medications, and teach them how the medications are going to help them. The most important goal is to improve the patient's quality of life, so that must be considered in all aspects.

9.) Summary

MS is a debilitating disease, characterized by the destruction of the myelin sheath surrounding the axons responsible for conducting electrical messages between the body and the brain. It is thought to be an immunological disease with possible environmental, genetic, and infectious factors. MS affects 3 times more women than men, and affects 1 out of every 500-1000 people in Canada. There are four different types of MS which represent different rates of decline, and there is no cure. Treatment options include symptom management, steroids for relapses, and immune modulators. Pharmacists can help by answering the questions and concerns of MS patients and their families, as well as informing the patients and their families about the benefits and side effects of the medications. The most important goal for MS patients is to improve their quality of life.

References:

1) The Multiple Sclerosis Society of Canada. Website: http://mssociety.ca/en/information/default.htm. Accessed Feb 5, 2011.
   a. Treatments: Modifying the Disease Course: Website: http://mssociety.ca/en/treatments/modify.htm. Accessed February 6, 2011.
   b. Treatments: Treating Relapses (Exacerbations, flare-ups, attacks). Website: http://mssociety.ca/en/treatments/treat_relapse.htm. Accessed February 6, 2011.
   c. About MS: Types of MS: Website: http://mssociety.ca/en/information/types.htm. Accessed February 6, 2011.
   d. About MS: MS Symptoms: Why do MS Symptoms Develop Website: http://mssociety.ca/en/information/symptoms.htm. Accessed February 6, 2011.
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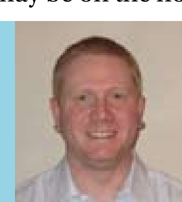
   f. Living with MS: Services for You and Your Family: Website: http://mssociety.ca/en/help/services.htm. Accessed February 6, 2011.
2) Wenjun Zhu, Ph D Candidate, BSc. Pharm., MSc, Josee-Anne Le Dorze1, BSc.Pharm, Michael Prout, BSc. Pharm, Emma Frost, Ph.D, Mike Namaka, Ph.D.Pharmacy Practice National Education Program: CE lesson. An Overview of Relapsing Remitting Multiple Sclerosis (RRMS) and Current Treatment Options. November, 2010.
3) Kalb, Rosalind, PhD, Editor. MS: The Genetic Connection: 2006 North American Education Conference. Multiple Sclerosis Society of Canada.

Should We All Pay?

Recently, there was a survey conducted by MSP on a number of current topics. One of the questions asked if members thought that all Manitoba pharmacists should pay dues to MSP, because of the benefits that all pharmacists receive from MSP's efforts. I am sure the results of the survey are very interesting and many people will be on either side of the fence, but one thing is certain: All pharmacists benefit from MSP, some more directly than others, and pharmacists make a good living in this province. No one can argue that. So, should only some pay while all benefit?

ALAN LAWLESS



MSP is the economic and professional promotion wing of the profession. Much like Doctors Manitoba and the Manitoba Dental Association, MSP is responsible for getting and keeping money in our pockets and for promoting what pharmacists can do, through print, radio and television ads. The services provided come at a cost and EVERY pharmacist in this province benefits (wages have doubled since I graduated 10 years ago). It will be even more important in the future for the advocacy organization to have sufficient funds available to ensure pharmacy's voice is heard. MSP also negotiates with government, publishes Communication magazine and is the voice of pharmacists in Manitoba. The benefits of an MSP membership were promoted to me first by my boss, and I suggest that all employers should do the same with their staff.

You may not always agree with what MSP does, or the decisions that are made, but the profession will need extra revenue going forward as there will be many battles to fight. We will be lobbying government to reduce impacts of drug reform and kiosks, promoting an expanded scope of practice to the public and to other health professionals, and ensuring that pharmacists have access to the education and training necessary for fulfillment of our evolving professional responsibilities.

Is it fair that only some people via membership dues are funding these efforts? I have not always been a member of MSP, and I now feel that letting my membership lapse in years past was a mistake. When the going is good we sometimes forget or are unaware of all the time and effort that went into making things as such. We only need to look at nearby provinces to predict that generic pricing reform may be on the horizon in Manitoba – are you ready to manage that change by yourself? I suggest that now is the time for all pharmacists to lend their support to MSP.

It is a crucial time for the practice of pharmacy. We need to ensure the long term sustainability of the profession. No matter what side of the fence you sit on, one thing is for certain: Whether you practice in hospital, community, in an academic or administrative setting, or elsewhere, support of each other's initiatives going forward will be imperative.

Please Note: MSP has had several requests for hospital content in Communication. This is an excellent idea and we need someone to help out. If you are interested in writing a hospital-related article, or a regular column, for Communication magazine, please contact the MSP office at info@msp.mb.ca. Personally, I would like more updates on what is happening in the hospitals around the province. I hear great feedback from pharmacy students that have done rotations in the hospitals, but more first-hand information on the program and clinical services being administered by hospital pharmacists would be insightful.

CLASSIFIEDS

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MANITOBA PHARMACY CONFERENCE

PROGRAM AT A GLANCE 2011

FRIDAY APRIL 15, 2011

Time	Event	Location
12:30-7:00 pm	Registration Desk Open	2nd Floor Lobby
1:00-2:00 pm	Session A - Improving Patients' Lives	Ballroom B
2:00-3:00 pm	Session B - Dementia: Pharmacist's Role in Alzheimer's	Ballroom B
3:00-3:30 pm	Refreshment Break	2nd Floor Lobby
3:30-5:00 pm	Session C - Medication Safety	Ballroom B
5:00-7:00 pm	Wine & Cheese Reception	Victoria
	Young Leaders Award Presentation	

SATURDAY APRIL 16, 2011

Time	Event	Location
8:00 am-7:00 pm	Registration Desk Open	2nd Floor Lobby
8:00-8:30 am	Continental Breakfast for Pharmacy Technicians	Ballroom C
8:30-9:00 am	Continental Breakfast	2nd Floor Lobby
8:30-12:00 pm	Pharmacy Technician Program	Ballroom C
9:00-10:00 am	MSP Annual General Meeting	Ballroom A
10:00-10:30 am	CPBA Update	Ballroom A
10:30-11:00 am	Refreshment Break with Exhibitors	Victoria
11:00-12:00 pm	MPhA Annual General Meeting	Ballroom A
12:00-1:30 pm	Buffet Lunch with Exhibitors	Victoria
1:30-4:30 pm	Issues Forum: Where are the drugs and how do I get them?	Ballroom A
2:45-3:15 pm	Refreshment Break with Exhibitors	Victoria/Albert
6:00-7:00 pm	Conference Chair Reception & Silent Auction	Ballroom A
7:00-11:00 pm	Annual Awards Banquet	Ballroom B

SUNDAY APRIL 17, 2011

Time	Event	Location
8:30 am-4:00 pm	Registration Desk Open	2nd Floor Lobby
9:00-9:30 am	Continental Breakfast	2nd Floor Lobby
9:00-4:00 pm	Q.U.I.T Workshop	Kildonan
9:30-11:45 am	Concurrent CE Sessions	
	Session D1 - The Nerve to Serve/Dare to Care	Ballroom A
	Session D2 - Clear Thinking on Opioids and Pain	Campaign B
10:30-10:45 am	Refreshment Break	2nd Floor Lobby
11:45 am - 1:30 pm	MPhA Awards Luncheon	Ballroom B
1:30-3:00 pm	Concurrent CE Sessions	
	Session E1 - Get Better Together	Ballroom A
	Session E2 - Diabetes Strategy for Pharmacists	Campaign B
2:15-2:30 pm	Refreshment Break	2nd Floor Lobby
1:30-4:30 pm	Welcome to the Profession: Frequently Asked Questions	Campaign A
3:15-4:30 pm	Session F1 - Ovarian Cancer Survivors	Campaign B
3:15-4:30 pm	Session F2 - Headline News for Pharmacists	Ballroom A

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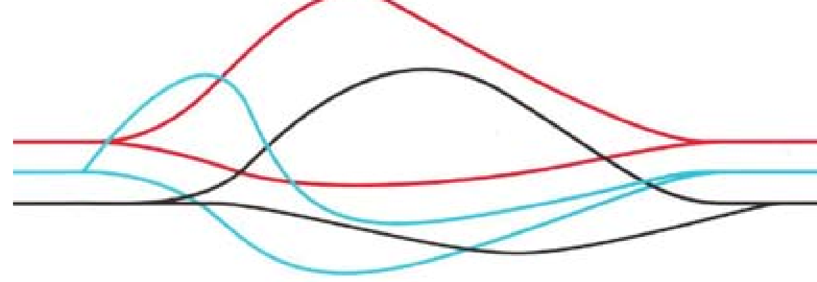
- Professional Liability Protection



CAPT 2011 Conference

The Canadian Association of Pharmacy Technicians is pleased to present the
2011 Professional Development Conference
May 13th to 15th
at the Delta Bessborough Hotel in Saskatoon.

The CAPT conference is an annual national event which offers pharmacy technicians the opportunity to learn different scopes of practice, new techniques and new ideas in the profession.

For complete details on this year's program go to the CAPT website at www.capt.ca and click on the PDC tab.

Friday, May 13, 2011	
7:00-9:00 pm	Welcome Reception
Saturday, May 14, 2011	
8:00-9:00 am	Continental Breakfast
8:30-9:00 am	Annual General Meeting (CAPT members only)
9:00-9:15 am	**Welcome Message**
9:15-10:15 am	**Session A - Profession Update**
10:45-12:00 pm	**Session B - TBA**
12:00-1:30 pm	Buffet Lunch Hosted by the Exhibitors
1:30-3:00 pm	**Session C - Issues Forum: Women's Health**
3:30-4:30 pm	**Session D - Therapeutic Laughter**
6:30-11:30 pm	Gala Dinner & Casino Night
Sunday, May 15, 2011	
8:00-9:00 am	Hot Buffet Breakfast
9:00-10:00 am	**Session E - Helping Parents Manage Common Pains of Childhood**
10:15-12:30 pm	**Session F - Short & Snappy**

Q&A: GETTING TO KNOW YOUR MANITOBA PHARMACISTS

Name: **Vernon Cooke**

Place/Year of Graduation: University of Manitoba, 1948

Years in Practice: 40

Currently Working: Retired

Accomplishments in pharmacy: 1981 Pharmacist of the Year, 1983 MPhA Centennial Award (Pharmacists at Risk), 1994 MPhA Centennial Award (Pharmacists and Friends Winnipeg Harvest), 1987 MPhA Honorary Life Membership, 1995 Bowl of Hygeia. Worked as a pharmacist at Sinclair Pharmacy from 1948 to 1952. Medical Service Representative at Eli Lilly from 1952 to 1965. Owner of Chapman Pharmacy Ltd. from 1965 to 1984. Between the years of 1950 and 1990 served in the following roles:

1950-52 Member of MPhA Education Committee
1958 Entertainment Chairman – CPhA Conference
1971 General Chairman – CPhA Conference
1972-74-76-78 Elected Member of MPhA Council
1975-78 Member of Faculty of Pharmacy Council, University of Manitoba
1976-78 Member of CPhA Council of Delegates,
1975-78 Member of Manitoba Drug Standards & Therapeutics Committee
1979 Member of Committee to Evaluate Drug Distribution and Pharmacy Service in Manitoba Nursing Homes
1980-85 MPhA Continuing Education Committee
1981 Formation of Pharmacists at Risk Committee (Chairman from 1981-90)
1986 MPhA By-Law Committee
1988-90 Board of Manitoba Health Organization and Board of Canadian Long Term Care Organization

Family: Wife Arlyn, 3 daughters, 8 grandchildren, 3 great grandchildren

Hobbies: Curling, gardening, reading, working out at the Wellness Centre

Community activities: Long term care.

Favorite thing about Manitoba: Diverse landscapes and seasons

Pet peeves: Politics

Favorite fictional character and why: Sherlock Holmes's Dr. Watson for his ability to solve cases

What could you do without forever: Peanut butter

What couldn't you do without for even a day: Newspapers

What you love about pharmacy: It gave me the opportunity to attend University; and an opportunity to meet and work with a tremendous number of interesting people (both within pharmacy and those who were customers) who made it all worthwhile. Also, the opportunity to give something back through the Pharmacists at Risk Committee.

Do you know someone who is making a difference in the pharmacy community? We would like to highlight them in this article! Please contact the MSP office at (204) 956-6681 or info@msp.mb.ca.

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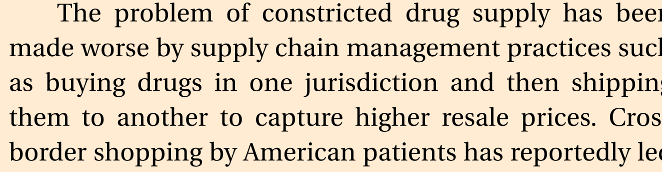
Bottled up in the Pipeline: A Few Modest Suggestions to Cure the Drug Supply Crisis

Pharmacists across Canada have reported shortages of commonly prescribed drugs. In December, the Canadian Pharmaceutical Association issued a report that showed that on a national basis, 81.2 per cent of dispensing pharmacists had trouble finding medications needed to fill a prescription. The number of pharmacists reporting problems in the week prior to the survey rose to 93.7 per cent.



ANDREW ALLENTUCK

The CPhA survey attempted to identify the causes of shortages and found many. Viewed as a supply chain, the problem of lack of availability breaks down into lack of overall management of the chain by any single authority or management system, shortages of raw materials, regulation that leads to production delays, problems in specific manufacturing plants that delay delivery of supply, shortages of containers and the politically potent problem that "new pricing regimes in provinces…act as a disincentive to production of particular drugs." There was no mention of underproduction of some drugs that become very popular, such as shingles vaccine, Zostavax, sales of which exceeded the manufacturer's estimates.

The problem of short supply is getting worse, CPhA data show. In 2004, 63% of pharmacists said they had trouble getting product during one shift. In 2004, 80% of pharmacists said they had trouble getting product in the week prior to the survey.

The CPhA survey is vital in its implication that the drug supply chain of the country is breaking down. While there are supply chain problems in Europe and the U.S. as well, the Canadian situation is distinct. The causes cluster into a single hub of issues.

The problem is most acute in the production of old generics such as tetracycline, for which there are few makers and little money to be made. "In 2010, the total sales of tetracycline in Canada amounted to $800,000," says Jeff Connell, spokesman for the Canadian Generic Pharmaceutical Association in Toronto. "The problem begins with prescribers, who do not use it much anymore," he explains. Few scripts, few sales. Few sales, scant production.

When shortages develop, queuing takes over. The effect of market regulation that restricts financial returns is to limit production. That's where delays and lineups begin. In the case of dispensaries, it means pharmacists have to shop their orders or in some cases find substitutes for what they cannot get from their wholesalers or other sources.

Drug supply management is not the same as managing warehouses of hardware staples such as nails. Shelf life limits discourage bulk buying on very large scale as does technological change.

Modest returns in much of the drug manufacturing industry and high risks of lawsuits for damages caused by drugs discourage investment. Michael Decter, formerly Ontario's Deputy Minister of Health and now a Bay Street investment banker, has called drugs "the next tobacco." Put the two together and the sensible conclusion for investors is to stay with safer products or services.

When all the issues are combined, the conclusion is that cost minimization, which is consistent with the idea that a single payer can wheedle costs down by market power, results in supply restriction. It is much like putting a finger in a leaking dam. Stop one leak and another appears.

The problem of constricted drug supply has been made worse by supply chain management practices such as buying drugs in one jurisdiction and then shipping them to another to capture higher resale prices. Cross border shopping by American patients has reportedly led to supply cuts by some U.S. name brand drug manufacturers.

Some modest suggestions:

Much of the price management that has been used by provincial drug formularies, including substitution of generics and substitution of therapeutic equivalents, has resulted in increased demands for some drugs and reduced demand for those less favoured.

It would be possible to set a time to market standard and allow makers of what authorities regard as excessively expensive drugs to supply their products when delays

become excessive. But in the Newtonian Law of Markets, which is that every regulatory measure has an equal and opposite countermeasure, one can be sure that some drug makers would game the system. If delays lead to higher pricing and more profit, then many drug makers would figure out that slow shipping is advantageous.

Adding more makers to the pool of companies that supply a given drug is also not a sure cure. Some makers of drugs supply inadequate or even counterfeit products. Sourcing drugs from unknown companies can require lengthy testing. It is not a quick fix. Moreover, Health Canada is not going to relax its standards to allow in drugs of unknown purity or efficacy, Mr. Connell says.

What, then, can be done? Here is a modest proposal: Rather than reward slowness, create rewards for carrying the costs of higher production, including the risk that some product may not be sold. That could be guaranteed sale programs that would relieve drug makers of the costs of overproduction. Leftover inventory could be bought by government. It would be a cost to the system, but it would encourage production.

There are other indirect rewards for enhanced supply chain management. Preferential tax rates available for companies that make designated drugs would also reward efficient or abundant production without allowing the makers to game the system by creating shortages and then, as some makers of brand name drugs do, selling their more expensive products. Drug makers, aware that increased sales would lower their taxes, would act predictably. But managing tax breaks by identifying and restricting eligible drugs might limit tax drain.

The downside of these modest measures is that the tax system would have to carry the costs of improving drug pipelines. But there is a tradeoff. If more drugs wind up being sold, there would be more taxes collected from entities in the supply chain.

The bottom line is just this: To eliminate or reduce drug pipeline shortages, pay the drug makers more, take off some of the handcuffs that have bound them, interfere less with supply-restricted drugs, encourage production not just with more profit (which presumably rises with unit sales) but with reduced taxes.

The problems that regulation has created can be reduced by careful reduction of regulations or payment of compensation for excessive regulation. While unavailability of drugs can be a big problem for patients, pharmacists and prescribers, a few small changes to the drug production and substitution systems and to taxation of manufacturers could fix many of them.

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