Continuing Education:
Therapeutic Options Focus on Sexually Transmitted Infections:
Chlamydial And Gonococcal Urethritis And Cervicitis

The Last Word:
The Evolving World of Data Security:
For Health Professions, New Standards of Data Safety

March/April 2007
Vol. 32, No. 4

The 129th
Manitoba Pharmacy Conference
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Perceptions about Pharmacists

We all know that in the eyes of the consumer, perception is reality. When you slip on your white coat before the start of a shift, you are creating an image, a “dress for success” symbol of trust that has been cultured for years.

Non-prescription Products Demystified: Menthol – the cooling compound

This article will review the uses of menthol available in a variety of non-prescription products together with recent information about the physiologic and pharmacologic mechanisms behind its use in cold preparations.

The Annual White Coat Ceremony

The University of Manitoba, Faculty of Pharmacy, Annual White Coat Ceremony was held on Jan. 9th, 2007.

MSP Negotiating Committee Reaches PCH Agreement

In case you weren’t aware the MSP PCH Negotiating Committee recently concluded negotiations for compensation payable to pharmacy providers for services provided to residents in personal care homes in Manitoba.

NIHB Audits A Growing Concern for Manitoba Pharmacies

The Non-Insured Health Benefits (NIHB) Program spent $50 million dollars on prescription and over the counter drugs in Manitoba in 2004/2005, according to the most recent annual report. In all likelihood the cost is now closer to $60 million.

2007 Award of Merit Winner: Marian Kremers

It will become very difficult to say the words, “I don’t have time”, to anyone requesting a favour, after getting to know Marian Kremers, this year’s Award of Merit winner, an award presented by The Manitoba Society of Pharmacists.

The Evolving World of Data Security: For Health Professions, New Standards of Data Safety

In the world of dispensing, there are digital bad guys who can do virtual stickups for prescription information that can be used for tailored marketing of drugs to patients.
Perceptions about Pharmacists

We all know that in the eyes of the consumer, perception is reality. When you slip on your white coat before the start of a shift, you are creating an image, a “dress for success” symbol of trust that has been cultured for years. But what other perceptions do your customers have, and for that matter, are they all as positive as the white coat? Let us perceive:

• You are never busy: Heaven forbid you are a well-organized and calm individual, because the only message that the patient approaching the counter is getting is that you have nothing else to do other than answer their question without delay or fill their prescription in 5 minutes or less. Better you should look frazzled at all times, as it will potentially gain you more time in your day.

• A Question is Just “Quick”: Has anyone ever come up to you and asked you to answer a “long” question? No, of course not. All questions are “quick”. Especially once they finish the monologue of the past 4 days that may actually lead to the true question (although you may still have to fish for that…put on your frazzled look…)

• All we do is “Lick and Stick”: First off, I just want to say I’m sorry to any pharmacists out there that ever actually had to “lick”. I used to get sick just from mailing a couple of letters back with the old stamps. Back to the subject at hand, this age-old persona of what we do behind the counter still exists. We are a conveyer belt of medicine, and why should it take so long when you “just have to put a label on it”? This is when you use your calm, cool, collected look, and add another 5 minutes on to the wait time…

• We are all Millionaires: Congratulations to the ones who are, but do you really think we would all be working so much at all hours of the day if we were all set for life? Whenever we hear this perception, it is at those exact moments that we actually feel underpaid. Now on the other hand, if I had a nickel for every time I heard someone call a pharmacist “moneybags”, well, maybe then I could retire…

• Our Fee is Negotiable: I guess we created this one ourselves, and as long as we continue to compete on price (prediction = forever), I guess this perception will persist. But people please; you know where the “bargains” are. If you want the lowest price, more power to you, go out and get it, but please do not come up to us and ask us to lower our price to match the discount because you would rather deal with us. Do you ask your Lawyer to lower his/her fee because the guy running one-page ads in the newspaper promising to get you off your traffic ticket charges less? Of course not, but then again, not everyone will choose the “least expensive” lawyer…we just save this decision for our healthcare…

Now there are many positive perceptions about pharmacy that I have not listed here (mainly because they are not as fun to write about…). The key is to continue to try and strengthen those positive ones while minimizing the negative, but whether we like it or not, the white coat of the 21st century has its pockets lined with both. As for which pocket contains more, well, it’s just a matter of perspective…

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MSP Pharmacare Committee Year in Review

As our term is nearing its end, the MSP Board of Directors wanted to provide members with a review of some of the activities that the Board has been engaged in and in particular the Pharmacare Committee. The past year was a particularly busy and challenging year and on the behalf of the Board I wanted to detail some of the meetings we have attended. Unfortunately to many Manitoba pharmacists the duties of the Board of Directors go unnoticed so I felt it necessary to answer the question that is often asked by many pharmacists. “What does MSP really do?”

The Pharmacare Committee

In June 2005 the chair of the MSP Pharmacare committee wrote to the Deputy Minister of Health to request a meeting to discuss a number of issues relating to Pharmacare that affected Manitoba pharmacists and this led to a meeting with Manitoba Health (MB Health) in July 2005. At this meeting MB Health committed to include MSP as well as other stakeholders on discussions with respect to potential changes to the Pharmcare Program. At the time this involvement was imperative since MB Health had recently announced possible ways to reduce Pharmcare costs without consulting pharmacists first (bulk purchasing from generic companies, eliminating professional allowances, maximum allowable cost, and accelerating the approval of generic products).

As a result of this meeting the Assistant Deputy Minister (ADM) suggested that the Pharmacare Committee meet with MB Health on a quarterly basis. MB Health’s commitment to meet with MSP on a regular basis has been an ongoing discussion and they finally agreed to meet with MSP regularly. Although MSP was reassured that MB Health would not move forward with any major changes to Pharmcare that would impact Manitoba pharmacists without further analysis, regular communication with MB Health is imperative since it is a vehicle to remain informed on possible changes as well as provides a forum to voice the collective interests of the membership.

The following issues were raised at the meetings:

1) The need to streamline the current requirements to amend the formulary and the potential savings to MB Health by accelerating the listing of new generic drugs.

Accelerating the listing of new generic drugs on the formulary was discussed in some detail. The MSP Committee stressed that government was not maximizing savings to the drug program by not listing new generic equivalents on a timelier manner. The MSP Committee referred to B.C., which has been fast tracking new generic drugs for several years, and Ontario, which updates their formulary every 30 days, as models that MB Health should consider.

MSP gave various examples where Manitoba was far behind the other provinces in listing new generic drugs. Examples include Risperidone and currently Ramipril. MB Health indicates that they are developing a plan to update formulary bi-monthly on pre-determined dates.

2) Economic impacts to pharmacists due to delay in amending formulary.

The generic Losec, Apo-omeprazole issue was discussed and the impact it had on Manitoba pharmacies. MSP emphasized how important it is that formulary changes be made on a timely/immediate basis. MB Health outlined changes to Pharmcare Branch, which will now be divided into 3 distinct units which will work cooperatively, Operations, Committees & Policy Group which will focus on long term policy (sustainability of Pharmcare program). It is anticipated that with these changes it will be easier to make amendments to the formulary.

MSP also recommended that if generic companies are unable to supply their products (especially if they are the only generic available) they are delisted immediately to ensure that only the lowest cost available is compensated by Pharmcare. As well the formulary should be amended more timely when companies institute immediate price increases. Specific examples were provided to MB Health and the impact on pharmacists/pharmacies explained. MB Health should not assume that Manitoba pharmacies are compensated for any losses they incur by the generic companies if their product is not available.

MB Health stated they were working on a new policy to address generic companies that are unable to supply drugs that are listed on the formulary and there was a possibility that there would be fines levied. Representatives with MB Health commented that the formulary will be updated quarterly and there was discussion about not posting updates during the month of March to avoid conflicting with Pharmcare year end.

3) EDS Part 2 and 3:

At several meetings Part II EDS was discussed and recommended to be eliminated or shrunk. We recommended that there should be a requirement for the prescriber to identify the treatment goals on the prescription to establish that the prescription satisfies Part II as opposed to the pharmacist guessing. For Part III it was recommended that pharmacists be alerted to upcoming expiries in order to avoid patients interrupted coverage.

In December 2005 the Pharmcare committee was contacted by MB Health to provide feedback relating the Apo-Omeprazole and Losec Court Trial specifically relating to the interchangeable formulary. As a result the committee had a teleconference to discuss options to the formulary that would address these issues. Although MB Health did not specifically take our recommendations it is worthy to note that they approached us in the first place. Amendments to the PPI’s (Part III) were the direct result.

... continued on page 9
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Government is clearly looking to make changes and the PPI’s were highlighted as an example of shifting products to Part III. Shifting more products to Part I was also mentioned. The ADM indicated that changes to EDS were part of “renewal phase” for DPIN and that stakeholders such as MSP will be consulted. MSP stressed the potential for pharmacists to take a more active role.

4) Pharmacer Auditor

MSP requested information about the newly appointed Pharmacer auditor and requested a meeting in an effort to establish a relationship. MSP wants to be proactive before numerous audits are underway and has informed MB Health of the willingness to work with the auditor.

The MB Health auditor will be or is conducting audits on Part II drugs and claims. Information is being gathered, e.g. Check DPIN Claims, pharmacy procedure and review claims and pharmacies are randomized.

5) Appointment to the Manitoba Standards and Therapeutics Committee.

MSP requested to have a representative on the Manitoba Drug Standards and Therapeutics Committee who is currently responsible for the Manitoba formulary. MB Health’s response was to wait for the Expert Review Panel’s report. There may be changes recommended from that report that might determine its fate. Later, MSP received a letter from the MB Drug Standards and Therapeutics Committee stating that they were not expanding the committee at this time.

“Pharmaceutical and Therapeutics Committee is independent of government. It includes two physicians and three pharmacists. Committee members provide recommendations on drug interchangeability and on the therapeutic and economic value of drug benefits. Nominations for committee membership are provided by the College of Physicians and Surgeons of Manitoba, Manitoba Medical Association, Manitoba Pharmaceutical Association, and the University of Manitoba.

Based on the Committee’s recommendations, the Minister of Health gives the final approval for benefits under the Pharmacer Drug Benefit program.”

6) 3rd Party Payors shifting the burden

It was also noted to government that 3rd party insurers are shifting the burden on to the Pharmacer program by insisting their clients enroll in the Pharmacer program. According to the Manitoba Pharmacer program you qualify if you meet all of the following criteria:

- You are eligible for MB Health coverage.
- Your prescriptions are not paid through other provincial or federal programs.
- Your prescription costs are not covered by a private drug insurance program.
- Your eligible prescription drug costs exceed your Pharmacer deductible.

We asked MB Health to consider enforcing point 3 in order to reduce their costs.


After the release the auditor general’s report on the Pharmacer program an Expert Review Panel was to be struck to deal with the issues raised by the auditor. MSP requested to have a representative on this panel and was granted one position that was appointed to one of the Board of Directors.

What was supposed to be 4 meetings initially turned out to be 10 and was a large commitment by our Board of Director. However, it was very important that Manitoba pharmacists be directly involved in any changes to the Pharmacer program which would directly affect our practice of pharmacy. Our top recommendation to reduce the cost of the Pharmacer program was the accelerating of generic products to the formulary.

MB Health advised MSP that we would be providing written comments on the Auditor’s recommendations at the Expert Review Panel. The Auditor General gave several recommendations that mimicked MSP’s concerns about the Pharmacer program such as MB Health’s inability to “utilize its abundance of data in the Drug Program Information Network to analyze specific factors impacting Pharmacer costs in order to effectively manage and contain expenditures. Nor did they have adequate procedures in place to manage the performance of Pharmacer”. As well, “MB Health did not monitor physician’s prescribing practices, nor did it actively promote the most appropriate and economical prescribing practices to physicians through the communication of best practice information”. In addition MB Health failed to analyze the actual cost savings of the drugs after being added to the Formulary as compared to the proposed cost savings.

Other recommendations that MSP endorse include the periodic review of drugs on the formulary, fast tracking changes to the formulary, and a better review process utilizing objective drug information for which drugs are to be covered.

However there were also recommendations that could negatively impact Manitoba pharmacists such as bulk purchasing of generic products thereby eliminating professional allowances, and capping dispensing fees. The impact on pharmacists of these recommendations were highlighted in MSP’s written response to the Expert Review Panel. In light of the recent changes in Ontario with Bill 102, MSP realizes that MB Health may want to follow with similar changes and therefore was vigilant in addressing these concerns in the written response to the Expert Review Panel.

Overall one of the frustrating elements of meeting with Government officials regarding the Pharmacer program is that their schedules change regularly and meetings often are cancelled last minute and rescheduled several times. However, it is very important that we continue to meet regularly and carry on a good relationship with MB Health so that we maintain an influence on our current practice of pharmacy.

Over the summer of 2006 I was contacted by several pharmacists that had concerns over Bill 41, the new Pharmaceutical Act. I was grateful that I was contacted by these pharmacists and hope that in the future more pharmacists will take the time to contact individual MSP board members or the general MSP office to voice concerns. In order to represent Manitoba pharmacists we need to know your feelings and on behalf of the Board of Directors I welcome calls or e-mails from Manitoba pharmacists or pharmacy stakeholders. The board of directors of MSP volunteers their time on behalf of all Manitoba pharmacists and we want to make the time meaningful. In order to do so we need to be informed of members thoughts. So please send me an e-mail and I’m looking forward to hearing from you.

Respectfully submitted,

Michelle Glass, Pharmacist, MSP Board of Director

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<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>1:30pm – 2:00pm</td>
<td>Opening Remarks</td>
<td>Centennial 3</td>
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<tr>
<td>2:00pm – 3:00pm</td>
<td><strong>SESSION A</strong></td>
<td>Centennial 3</td>
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<tr>
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<td>Breaking New Ground: The Role of the Clinical Assistant</td>
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<td><strong>BREAK</strong></td>
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<td>3:30pm – 5:00pm</td>
<td><strong>SESSION B</strong></td>
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<td>PPIs: should we put them in the water supply?</td>
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<td>5:00pm – 7:30pm</td>
<td>Wine &amp; Cheese Reception Hosted by Exhibitors</td>
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<td><em>Presentation by the Faculty of Pharmacy / Young Leaders Award Presentation</em></td>
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<td><strong>SATURDAY, APRIL 14, 2007</strong></td>
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<td>8:30am – 9:00am</td>
<td>Continental Breakfast</td>
<td>Centennial 3 Hall</td>
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<td>9:00am – 10:00am</td>
<td><strong>Manitoba Society of Pharmacists Annual General Meeting</strong></td>
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<td>10:00am – 10:30am</td>
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<tr>
<td>10:30am – 12:00pm</td>
<td><strong>Manitoba Pharmaceutical Association Annual General Meeting</strong></td>
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<td>12:00pm – 1:00pm</td>
<td>Exhibitor Hosted Buffet Lunch</td>
<td>Embassy</td>
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<td>1:00pm – 5:00pm</td>
<td><strong>ISSUES FORUM</strong></td>
<td>Centennial 3</td>
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<td>1. Leading Change in Pharmacy Practice: Where we are &amp; where we need to go</td>
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<td>2. The new Pharmaceutical Act: What does it mean to patient care &amp; safety &amp; the practice of Pharmacy?</td>
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<td>3. Open Discussion</td>
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<td>6:00pm – 7:00pm</td>
<td>Conference Chair Reception/Exhibitors Venue</td>
<td>Embassy</td>
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<tr>
<td>7:00pm – 11:00pm</td>
<td>Annual Awards Banquet &amp; Silent Auction</td>
<td>Wellington</td>
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<td><strong>SUNDAY, APRIL 15, 2007</strong></td>
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<td>8:30am—9:00am</td>
<td>Continental Breakfast</td>
<td>Embassy Hall</td>
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<td>9:00am – 10:00am</td>
<td><strong>SESSION C OPTION 1</strong></td>
<td>Embassy A</td>
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<td>Add Some Tools to Your “Preceptor Toolkit”: A Preceptor Development Workshop</td>
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<td><strong>SESSION C OPTION 2</strong></td>
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<td>Review of the latest Canadian Hypertension &amp; Dyslipidemia Guidelines: Role of the Pharmacist</td>
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<td>It’s Safe to Ask: The Role of Pharmacists in Improving Communication &amp; Patient Safety</td>
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<td><strong>SESSION D OPTION 2 Limited Enrolment</strong></td>
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<td>Evidence Based Medicine: Basic Principles for the Practicing Pharmacist</td>
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<td>12:00pm – 1:30pm</td>
<td>Manitoba Pharmaceutical Association Awards Luncheon</td>
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<td>PPIs: should we put them in the water supply? (Repeat of Session B)</td>
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<td><strong>SESSION E OPTION 2</strong></td>
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<td>All Stressed Up and Everywhere to Go</td>
<td>Carlton</td>
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<td><strong>SESSION E OPTION 3</strong></td>
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<td>PEB/C/OSCE Preparations (Students Only)</td>
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<td>3:00pm – 4:00pm</td>
<td><strong>SESSION F</strong></td>
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<td>Drugs &amp; Renal Failure: Cautions &amp; Contraindications</td>
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Happy 100th Birthday

Love, 
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Non-prescription Products Demystified: 
**Menthol – the cooling compound**

Non-prescription products are used in the self-treatment of a self-diagnosed, self-limiting condition. These terms, as defined by Health Canada, were provided in a previous article covering oral decongestants.1 This article will review the uses of menthol available in a variety of non-prescription products together with recent information about the physiologic and pharmacologic mechanisms behind its use in cold preparations.

**History**

Menthol is a natural product isolated from plants of the *Mentha* species. In Asia, menthol was a traditional herbal product used to treat respiratory conditions for centuries.2 However, menthol was introduced to the West only about a century ago. Scientific literature documented this cooling phenomenon as early as 1886.6 Today it is an ingredient in chewing gum, cough syrups, inhalers, lozenges, nasal sprays, and vaporubs for the symptomatic treatment of rhinitis associated with chest and nasal congestion (Figure 2) and is a highly successful herbal product.3,4

**Chemistry of menthol**

Menthol, a terpene, has three asymmetric carbon atoms in the six-membered cyclohexane ring and occurs as four pairs of optical isomers shown in Figure 3.

The isomer most abundant in nature is (−) menthol. It has a peppermint odor and produces a cooling sensation when applied to the skin and mucosal surfaces. The other isomers of menthol are similar in odor but do not have the same cooling properties of menthol. This dependence on chemical structure is indicative of a receptor interaction.

**Physiologic and pharmacologic effects**

The most prominent biological effects of menthol are its coolant sensation on the skin and the relief of nasal and respiratory congestion during the common cold. In 2002 a menthol receptor on sensory nerves that modulate the cooling sensation associated with menthol was discovered.5 The cooling sensation is triggered by menthol interacting with trigeminal nerves and thermogenic receptors in the upper respiratory tract. Trigeminal nerve branches mediate the sensations of cold and warmth from the nose to the brain. There is evidence that menthol binds to the thermoreceptors that mediate the sensation of warmth and coldness. Researchers have concluded that “menthol caused receptor depolarization and increased nervous discharge by inhibiting the efflux of calcium from the cold receptor.”5

Inhalers, rubs and lozenges are frequently used as decongestants. The effect of menthol on the nasal sensation of airflow is not as straightforward as it first appears. While everyone with a cold has experienced the feeling of airflow relief obtained from the use of menthol containing cold products, studies show that menthol does not decrease nasal congestion but paradoxically has the opposite effect and increases congestion. Nevertheless, the cooling sensation gives a subjective sensation of improved airflow which is highly desirable for the patient. However, studies clearly demonstrate “that menthol caused a subjective nasal decongestant effect without any objective decongestant action.”7,8 Patients, however, experience their nasal passages becoming clearer.

Why menthol provides this subjective benefit is not understood. In a study comparing menthol lozenges versus placebo it was found that the subjective sensation of nasal congestion was significantly reduced but airway resistance as measured by rhinomanometry was unaffected. This is not a placebo effect. Similar relief of nasal congestion occurs with other terpenes, such as, camphor, eucalyptus and terpene hydrate, which are also used in cold remedies.8

... continued on page 15

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**Figure 1. Which one should I choose? Which one is best for me?**

**Figure 2. The Mentha piperita plant and chemical structure of menthol shown in 2- and 3-dimensional drawings.**
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Menthol was used as an antitussive and in 1890 Lunsford Richardson developed a topical rub for the treatment of whooping cough. This product is still available as a “vaporub” but is ineffective in the treatment of whooping cough. There is little evidence to support the use of menthol as an antitussive.

The production of mucous and mucociliary removal of foreign matter from the upper respiratory tract are a defense mechanism against infection. Menthol may enhance this process. Steam inhalations incorporating menthol promoted as expectorants in the treatment of cough may be beneficial because of the moist air rather than the menthol. The menthol does provide the vapor with a pleasant odor, a cooling sensation and a sense of increased air flow. Information in the literature about menthol as an expectorant is conflicting and in vivo studies in humans are lacking.

Metabolism

The metabolism of menthol has been shown to induce the liver microsomal enzymes cytochrome P450 and NADPH-cytochrome c (P450) reductase. Hydroxylation and glucuronide formation to more water soluble products are the main pathways for its excretion.

Toxicology

Menthol is the third most important flavor in the food and pharmaceutical industry following vanilla and citrus. For such a commonly ingested chemical, there are few toxicological studies in man. However, skin and eye irritation is noted. Menthol appears to have a very low toxicity in acute studies in animals. There is no evidence to suggest that it is a carcinogen. More information is required before a safe daily intake level for chronic use in humans is defined.

The bottom line

Menthol was a traditional cough and cold remedy in Asia for centuries. Its use in the West spans about a century. Today a wide variety of non-prescription products promoted for the relief of common cold symptoms such as cough and nasal congestion incorporate menthol in the formulation (Figure 4). Menthol products are safe for the symptomatic cooling effect and subjective benefit in the treatment of nasal congestion. Scientific evidence does not support any antitussive or decongestant activity. Patient preference may be the best guide to a choice of product.

References:

Figure 3. Optical isomer pairs of menthol.

Figure 4. Clear, prismatic, fragrant crystals - menthol can cause skin and eye irritation.

The Medication Information Line for the Elderly (MILE) invites you to visit us at the University of Manitoba

Room 111 University Centre
(204) 474-6493
Toll Free 1-800-432-1960
(ask for MILE; ext 6493)
9:30am to 2:30pm Monday to Thursday
email: mile_resource@umanitoba.ca
The University of Manitoba, Faculty of Pharmacy, Annual White Coat Ceremony was held on Jan. 9th, 2007. The event is organized by the student council and welcomes the first year students into the pharmacy program and the profession of pharmacy. During the ceremony the students receive their white coats symbolizing professionalism and recite the “Oath of a Pharmacist” showing their commitment to serving as future health professionals. The event was presided over by Dean Collins and the students were welcomed by Health Minister Teresa Oswald. Manitoba Society of Pharmacists President Nancy Remillard participated as a Draper and addressed the first year students.

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MSP Negotiating Committee Reaches PCH Agreement

In case you weren’t aware the MSP PCH Negotiating Committee recently concluded negotiations for compensation payable to pharmacy providers for services provided to residents in personal care homes in Manitoba. The culmination of 18 months of struggles, frustration, and determination lead to the first long term agreement in 15 years.

The PCH Negotiating Committee deserves acknowledgement for their commitment to the negotiation process. Chair Brent Havelange, Jane Alderdice, Bonnie Coombs, Brent Hazlewood, and Bob Paul demonstrated unwavering commitment. Many Committee members served on the previous Negotiating Committee that achieved the most recent agreement in December, 2004, following two years of negotiations. In total the majority of these volunteers have been involved in negotiations for almost 4 consecutive years.

So was it all worth it? While admittedly, MSP had set goals higher than what was ultimately achieved. The new agreement provides for a 15% increase over a 44 month period. A reasonable increase particularly given that the previous 16 month agreement provided a 20% adjustment.

In addition to the increased capitation fees there were other notable developments. The agreement is effective August 2, 2005, the day following the expiry of the previous agreement. For the first time in more than a decade, an agreement with government provided retroactivity back to the expiry date of the previous agreement. This was a priority for the Negotiation Committee because far too often government benefits when negotiations are not concluded in a timely manner. Retroactivity is not provided, and effectively government is rewarded for delaying the negotiation process. Ensuring the two agreements provided for a seamless transition establishes a precedent which will assist MSP in future negotiations with the Manitoba Government.

In addition, with the new agreement pharmacy providers maintained their property rights to drug returns, and the regional health authorities now join Manitoba Health and MSP as a party to the agreement. The agreement also allows for regional health authorities in certain circumstances to provide additional compensation to pharmacy providers when economic efficiencies are achieved. While not perfect, the MSP Negotiating Committee was able to reach the best agreement that was available.

Once the agreement has been fully implemented across the Province and retroactive payments have been processed, the PCH file can be closed until January, 2009 which is when the parties have agreed to initiate the next round of negotiations. Hopefully future negotiations will be concluded more quickly………but not likely.

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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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NIHB Audits a Growing Concern for Manitoba Pharmacies

The Non-Insured Health Benefits (NIHB) Program spent $50 million dollars on prescription and over the counter drugs in Manitoba in 2004/2005, according to the most recent annual report. In all likelihood the cost is now closer to $60 million. Ontario is the only Province in which the NIHB program spends more on drugs.

Given the significant amount the NIHB program spends on drugs in Manitoba, it is not surprising that many pharmacies are increasingly concerned with the pharmacy audit program.

The MSP office has been involved with more than a dozen NIHB audits in recent years. The support we provide members varies depending on the circumstances. Recently a member contacted the office with respect to an audit reclaim in excess of $80,000; this was a stressful situation given that pharmacy providers are given less than 30 days to respond to the audit report. In this case the first action MSP took was to arrange for a more reasonable 90 day period to respond to the audit report.

Arranging for a longer period to respond is generally a good first step. Trying to find the time necessary to fully respond to an audit report within a short period is often impossible. The importance of thoroughly responding to the audit report should not be underestimated, because this is the only reconsideration available to the pharmacy provider.

Whenever a member contacts the office about an audit reclaim, they are advised that if they want to retain legal counsel, the may want to take advantage of the MSP Legal Assistance plan. Some members retain a lawyer, but more often they decide to prepare their own response with the support of the MSP staff. The decision to involve MSP is that we have become familiar with the various recovery codes and in some cases are aware of precedents that have been established when pharmacy providers have been successful in reversing audit decisions.

The best example of establishing a useful precedent concerned prescriptions where the prescriber did not include the date it was written. The pharmacy worked in close proximity with the prescriber as was aware that in most cases the prescription had been written only moments earlier. The auditors identified that the dates were missing from the prescriptions and as a result found that the prescriptions were not valid, resulting in a very large reclaim. Eventually, MSP and the pharmacy provider were able to convince the auditor that in Manitoba a prescription does not require that the prescriber date the prescription in order for it to be valid. Several months later this precedent was used to successfully respond to another pharmacy's audit report.

Unfortunately, far too often the response to the audit report process does not fully satisfy the impacted pharmacy. The question then becomes “what can I do now?”. In a couple of cases, First Canadian Health (FCH) because of unique circumstances has accepted further information. However, in most cases, once FCH has considered the pharmacy’s response to the audit report, they make a final decision and will not accept any further information.

The lack of an impartial third party appeal process is perhaps the greatest flaw to the current NIHB audit program. The audit reclaims are significant; often the amounts are in excess of $30,000. The auditors exercise their judgement and make their audit findings and there is no ability to appeal their decisions to a neutral third party, other than the Court of Queens Bench which is arguably not equipped to effectively resolve these matters.

MSP believes that an independent appeal process has to be introduced and if that does not occur, there will be no other choice but for some pharmacies to seriously consider taking legal action. If for no other reason someone needs to challenge the penalties that are consistently imposed when auditors determine that billing requirements have not been satisfied.

In almost all cases when there is a problem with a prescription the penalty is the same; FCH reclaims the dispensing fees and the value of all of the medications dispensed. This would be an appropriate penalty when the medication dispensed is not a covered benefit. However, when there is a technical problem with a prescription such as the prescriber’s address is not included should the penalty imposed be the recovery of all the dispensing fees and the value of the medications dispensed? No one disputes that the prescriber wanted the patient to receive the medications prescribed, or that the patient wanted the medications, or that the pharmacy provided the medications. Why should the NIHB program escape having to pay for these medications simply because of a minor defect with the documentation or the prescription itself?

In most sectors where penalties are imposed, discretion is exercised based on all the circumstances. The decision maker normally has a range of possible penalties. All “offences” are not of equal significance and the penalties imposed should not always be the same. After all you are fined differently if you are found speeding 10, 20, or 30 km over the posted speed limit.

NIHB Pharmacy Provider Audit

The Non-Insured Health Benefits (NIHB) Audit Program conducted 71 pharmacy provider audits during 2003. The majority (94%) of the audit findings relate to these five categories.

1. Incorrect Billing or Pricing (54% of findings)
   As stated in Section 5.12.2 of the NIHB Pharmacy/MS&E Provider Information Kit: “The total amount billed for the identical prescription, including cost of drugs, mark-up (if applicable) and professional fee must be consistent with the costs and fees established pursuant to the NIHB Program.”

2. Unauthorized Prescription or Refill (28% of findings)
   This category applies to instances where the dispense is not according to the prescription and there is insufficient documentation to support the dispense.
   The NIHB Program requires:
   a) That all federal and provincial legislation be applied to each dispense
   b) That the requirements of the NIHB Program be met as outlined in the NIHB Pharmacy/MS&E Provider Information Kit, Pharmacy/MS&E Provider Agreement and other NIHB Program documents issued to pharmacies, such as the First Canadian Health/NIHB Program Newsletters and NIHB Program Drug Bulletins.
   c) That faxed prescriptions contain the fax transmission details, such as the date and the sender's information, to adequately verify the prescription during an on-site audit.

3. Prescription Not Found on Site (7% of findings)
   As per provincial regulations and NIHB Program requirements, providers are expected to retain original or faxed prescriptions for review during an on-site audit. If the original or faxed prescription is not found while the auditors are on-site, providers can submit the prescriptions to FCH within a fixed period of time following the on-site audit. Providers can also submit the prescriptions with their response to the letter of audit findings sent to them by FCH following the on-site audit.

4. Fill Too Soon (3% of findings)
   A concurrent Drug Utilization Review (DUR) program is part of the NIHB on-line claims adjudication system. When claims are submitted to the NIHB Program, they undergo DUR to identify potential drug-related problems or interactions. The results of the analysis are returned to the provider, in the form of CPHA standard response codes.
   A DUR message will be received by the pharmacist if the patient has used less than two-thirds of the medication, based on the days supply from the previous dispense.
   Examples of unacceptable supporting documentation used in the case of overrides include:
   • Pharmacist is going on vacation
   • Patient requested blister pack
   • Use of override code only
   • Documentation of overrides provided after the on-site audit (documentation was not written at the time of the dispense to support the override)

5. Discrepancies between quantities prescribed and packaging size (2% of findings)
   Audit findings will identify situations where the quantity prescribed does not match the packaging format available on the market, therefore the pharmacist will have to intervene and ensure that the changes are documented properly.
   The NIHB Program's billing requirements are detailed in the NIHB Pharmacy/MS&E Provider Information Kit, First Canadian Health/NIHB Program Newsletters, and NIHB Program Drug Bulletins. These documents are accessible through the Health Canada website at: www.hc-sc.gc.ca/fnhb-dgsph/fnhb/index.htm
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It will become very difficult to say the words, “I don’t have time”, to anyone requesting a favour, after getting to know Marian Kremers, this year’s Award of Merit winner, an award presented by The Manitoba Society of Pharmacists (MSP). Marian is a remarkable woman who has delved into nearly every facet of Pharmacy.

At the age of 15 Marian worked her first job at Snell’s Drugstore, now the European Shoe Shop on Academy Road. She worked as a clerk until George Edmunds, the pharmacist and soon to be mentor, at Snell’s noticed her taking an interest in his job. He quickly made her his assistant and introduced her to the world of Pharmacy.

After graduating from Miles Mac High school, Marian enrolled at The University of Manitoba with the dream of becoming a pharmacist. She graduated from the Faculty of Pharmacy in 1966.

“I went into pharmacy because I knew I wanted to work in healthcare. I didn’t want to be a nurse and I didn’t have the money to go into Medicine”, says Marian.

After graduating, she spent many years at the Winnipeg Clinic Pharmacy. In 1993 Marian became a part-time staff pharmacist at Seven Oaks Hospital, during which time she also joined the Faculty of Pharmacy at The University of Manitoba as a part-time lecturer responsible for curriculum development in Communications.

In 1994 Marian took on the challenge of developing the Non-Prescription Medications course for third year and running the program for the community pharmacy section in all four years. She was also trained as a facilitator for the Glaxo Pathways program in 1994, fulfilling part of the requirement for career counseling.

From 1995 to 2000 she served on the Pathways advisory board. While managing everything else on her plate Marian also found time and served as the Manitoba representative to the Board of Directors, Canadian Pharmaceutical Association from 1992-99. From 1995-99, she was Chair of the Publications Committee and in 1997-98 she was elected vice-president.

The list of commitments continues throughout the 80’s and 90’s. Marian served as councilor with The Manitoba Pharmaceutical Association from 1980-82, was the Chair of the Standards of Practice Committee from 1985-88, Chair, Continuing Education Committee 1977-81; Chair, Speakers Bureau as a sub-committee of Professional Relations Committee 1990- present and served on the Discipline Committee 1984-94 Chair, 1995-97.

In 1992, her dedication to improving the field of Pharmacy was recognized and she was awarded the Manitoba Pharmaceutical Association, Pharmacist of the Year award.

Marian served as President of the Manitoba Society of Pharmacists from 2002 to June 2004, a demanding time when Pharmacists’ roles were beginning to expand and time restraints meant many Pharmacists were not able to use the skills they had been taught.

“It was a hectic but very interesting time. We had a relatively new board, we had just hired a new executive director and the Romanow report had just been commissioned. Many of the challenges we faced then still exist.”

Marian played a key role in the formation of the MSP Government Relations Committee and has served as the Chair since its inception in 2004. The mandate of the committee is to develop strategies to promote and advance with government officials, specific priorities of the Manitoba Society of Pharmacists. This past year the committee was extremely busy with the issue of Bill 41, the new Pharmaceutical Act.

Marian is also Chair of the Manitoba Chapter, Osteoporosis Canada. As a representative of Osteoporosis Canada for ten years, she is responsible for making presentations to professionals in our community, as well as the public. In addition to these roles, she continues to be involved in Toastmasters Speechcraft, a program she was instrumental in receiving funding for and worked so diligently to have recognized as part of the communications curriculum in Pharmacy.

“It’s really fantastic the level of engagement the people I’ve worked with have had, it’s been quite special”, says Marian describing her experiences.

Marian attributes her interest and passion for Pharmacy to being able to play a role in the maintenance of people’s health, guiding them in the area of prescription and non prescription use and encouraging people to ask questions of their Pharmacists.

Being given the Award of Merit will be another gratifying experience to add to her list of accomplishments.

Marian says that being given the Award of Merit puts her in phenomenal company and she is humbled by the announcement.

“I can remember giving this award to Ralph Whitfield when I was president, it is very gratifying and humbling that in some small way I’ve contributed to the profession, but I think it’s easier to give the award than to be on the receiving end.”

Time management is undoubtedly one of Marian’s keys to success, but her passion for and dedication to advancing the role of Pharmacists is clearly what drives her. Through her commitment and hard work she has managed to bring about positive change in her profession.

According to MSP policy, “The Award of Merit is bestowed upon an active member of the Manitoba Society of Pharmacists in recognition for active participation and promotion contributing to the benefit of the Manitoba Society of Pharmacists and the Profession of Pharmacy.”

Past recipients of the Award of Merit are:

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join our team – apply online
www.drugstorepharmacy.ca
Family: Husband Guy and son Rémi, a.k.a. les boys
Hobbies: Gardening and exploring the chemistry of cooking.
Community activities: I’ve just finished up a graduates study-
ies program while holding down a full time job, so I haven’t had much time for outside activities in the last few years. The community work I managed to do has largely focussed on helping out at Rémi’s school.

Favorite thing about Manitoba: The huge, bright sky. The sunsets are wonderful.

Most relaxing vacation choice: In the backyard working in my flower garden. When I travel I want to see things, which can be tiring. So a relaxing holiday is time off work that I can spend in my garden.

Pet peeves: Pretentious and dishonest people
Favorite fictional character and why: Adam Dalgliesh, the investigator/poet in P.D. James’ mystery novels. He is very professional and highly competent in his work, but he is also a published poet who is extremely private and even somewhat mysterious. He also has human frailty and flaws which come through which make him even more interesting.

What could you do without forever: Dishonesty
What couldn’t you do without even a day: A big hug from Rémi.

What you love about pharmacy: The opportunities for different career paths. As a profession we are just starting to realize the possibilities of what we can do.

Do you know someone who is making a difference in the pharmacy community? We would like to highlight them in this article!
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THE UNIVERSITY OF MANITOBA, Faculty of Pharmacy, Class of 1972 is organizing their 35th Class Reunion at Brio Restaurant, Penthouse of the Winnipeg Art Gallery, 300 Memorial Blvd. on Friday, April 13th, 2007. For attendance or more information please contact Joseph Yuen by fax at 779-9981 or email at candjyuen@mts.net.

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The Evolving World of Data Security: For Health Professions, New Standards of Data Safety

In the world of dispensing, there are digital bad guys who can do virtual stickups for prescription information that can be used for tailored marketing of drugs to patients. It can and does happen, witness reports in business publication IT World Canada that bogus internet pharmacies have sought and obtained privileged patient information by identity pretense, often called phishing.

What may happen emerges from a supposition from a study by Gordon Atherley, a physician in Ontario, who produced a report for health authorities.

“Consider a pharmacy record that falsely states that a patient is on a life-critical drug,” Dr. Atherley wrote. “Suppose a physician relies on the pharmacy record for reliable information on [the] patient’s medication history. Imagine the consequences if the physician is misled to the point of failing to prescribe the drug, with deadly consequences.”

The internet has become a pipeline for script fraud. After all, the web tends to be more a sieve than a vault when it comes to data security. Therefore a new operating system with increased levels of data security from Microsoft Corp. is worth a look and, indeed, a good deal more. Called Vista, it was launched at the end of November, 2006. Vista is significant not only because it is part of the world’s dominant operating system, but because it indicates the direction in which computer security is moving.

Over time, one can expect not just MS-based computers but others running competing operating systems to match or exceed the revised security standards in evolving Microsoft operating systems. Note – this is not a pitch for MS software. Even in the Linux, Unix, Apple and mainframe world where MS lacks fans, the sheer momentum of the MS-dominated desktop and notebook computing world will be very influential.

Bill Gates, who styles himself Chief Software Architect at Microsoft, explained a few years ago that the penetrability of the internet to spammers, hackers, phishers, virus writers and other creators of malware resides in the net’s design. The internet’s earliest form was created in 1969 as the Advanced Research Projects Agency Network to link scientists involved in American defense research and development. Called ARPANET, it was designed to be open, not closed. That intrinsic accessibility is behind the huge industry of bad guys trying to steal from and deceive the good guys – that’s practically everyone else.

The new design of Vista puts security curtains around the intrinsic openness of MS operating systems from the 1980s onward. According to e-industry publication BetaNews, Windows Vista is the first operating system from Microsoft to be built from the ground up that scrutinizes every bit of code to ensure that security compliance checkpoints are met along the way.

“Spyware and malware threats are contained by the operating system’s built-in scanning engine,” reports BetaNews. “The Vista firewall extends the functionality added in Windows XP Service Pack 2 to provide full directional filtering and application blocking.” Translation: tainted code does not get in.

The new Vista system changes the security environment in significant ways. In the new Vista system, major settings can only be changed with a password. Roaming through directories and toggling off security features will no longer be possible. In this respect, Vista is going to do what Apple and Linux have long done and what many Unix operating systems have limited to system administrators.

Vista will also allow system administrators to turn off USB ports that might be used to copy data to flash drives. That will limit nefarious attacks by anyone with physical access to computers. Of course, attacks that begin with getting passwords to various forms of wireless networks will be unaffected.

Vista raises the level of privilege required to perform system commands or writing to sensitive directories. What’s more, Internet Explorer 7 in Vista can run in a protected mode in order to prevent malicious web sites from compromising an entire system. Vista also has a phishing filter.

Is this enough? Well, no, not if a web-based pharmacy operation convinces someone to provide medical information and access to script. But it does mean that phisher to pharmacy attacks can be thwarted by the quarantine procedures built into Vista.

Making the security features of Vista work right will take some careful use of other security programs. George Heron, chief scientist at McAfee Inc. of Santa Clara, California, which makes widely-used anti-virus
and web security products, notes that previous Microsoft approaches to security tend to crash the computer when they detect specific internal data structures. But if a virus or other form of malware or spy or other attack does not have a characteristic signature, perhaps because it has not yet been studied by virus research teams, the attack may work. Yet it still can be stopped if its behaviour can be identified – a strategy that McAfee has developed. It worries McAfee and other makers of security programs that MS security programs may prevent third party security programs from working. The question McAfee has raised re Vista and for earlier MS operating systems is who will be the captain of the data guard. MS, for its part, wants to remain in charge and not yield the role to third party data security chiefs.

It would be a tempest in a teapot if the stakes were not so high. Pharmacies are obliged by PIPEDA, Canada’s Personal Information Protection and Electronic Documents Act, which went into effect in 2001, to use reasonable measures to protect patient information. Using up to date technology is pretty reasonable. And given the power of MS and its pervasive influence in the entire data environment, what happens in Seattle, where MS has its headquarters, is not likely to stay in Seattle. Vista’s standard of data protection will become an industry minimum standard.

Where does this leave the security issues? First, no software program can stop identity theft, which is really what phishing is about. But the Vista operating system relies not just on updates of known hacking programs and other forms of invasive code, but adds high level encryption algorithms, compartmentalization of data processing through routing tables (like directions signs for traffic), and filtering engines within the operating system.

Will this be enough? Probably not. Some simple spyware codes and very elementary viruses can be written into a single pixel of a data display. That kind of tiny code is not what Vista looks for in hunting down invaders. But, says a MS spokesman, the amount of harm this kind of very small code can do is limited.

Most of the data theft cases that appear in the press relate to absence of technology rather than any particular computer programming error. Human error – failing to be vigilant - not programming error, tends to be the problem. By changing the operating system to default settings that capture and isolate malware, Vista will help to rebuild the internet as a more secure environment. And that will help keep medical records, insurance information and prescription under virtual lock and key.
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