The Golden Mortar

Newsletter of the Southern Gauteng Branch of the Pharmaceutical Society of South Africa and Associated Sectors

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EPISTAXIS

by Nthabiseng Tshiki and Stacey Nheera

B.Pharm lll University of the Witwatersrand

ABSTRACT

Nosebleeds are seldom a cause for alarm. However, they can be life-threatening in rare cases. Most people will experience at least one nosebleed during their lifetime. Certain medicines may cause nosebleeds as may dry climates. Trauma to the face may also cause nasal injury and therefore bleeding.

INTRODUCTION

Epistaxis, the medical term for a nosebleed, is defined as a haemorrhage of varying severity from the nasal cavity, nostrils or nasopharynx. The nose has a high density of blood vessels and delicate mucosal tissue which makes it easily prone to rupture.

Up to 60 percent of the general population experience nasal bleeding at some point in their lifetime. There are incidence peaks from ages 10 and below, as well as 50 years and above. Epistaxis occurs more commonly in males than in females and is more likely in elderly patients with hypertension.

Epistaxis may be divided into anterior and posterior nosebleeds.

- Anterior nosebleeds start in the front of the nose on the lower wall of the septum. It is the most common type of nosebleed since the lower wall of the septum is more reachable and likely to be injured. Anterior nosebleeds occur mostly in children. They are not always severe and are usually treatable at home.
- Posterior nosebleeds are caused by the rupturing of the larger blood vessels deep inside the nose – this is at the back of the nose near the throat, hence the possibility of a backflow of blood. Posterior nosebleeds are more common in adults. They can be more serious than anterior nosebleeds due to heavier bleeding and may result in the need to refer the patient to a doctor or the emergency room.

CAUSES

The most frequent causes of nosebleeds include local trauma, foreign bodies placed in the nose, inhalation of dry air and nasal/sinus infections. Two less common causes include tumours and vascular malformations.

An individual is also more susceptible to a nosebleed if they are on any

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INTRODUCTION

David Sieff

- We start with an informative article on the common occurrence of nosebleeds by two B.Pharm students at Wits University.
- Amayeza has provided an update on the ever-present and recurring need for family planning information for the pharmacist in community or hospital practice, to be able to have a good background for their patients of child-bearing age.
- "How to survive Covid-19" gives us Howard Armistead's research and study conclusions on the preventive augmentation of treatment with Selenium supplements.
- A very useful and welcome feature is a website for current information about the availability or otherwise, new and discontinued, pharmaceutical products, etc., with links to access the site and/or register as a continuing recipient.
- The regular notices and adverts for services are included for readers' reference.

.../ Epistaxis continued

medicines that prevent blood from clotting e.g. warfarin, aspirin or nonsteroidal anti-inflammatories. Table 1 lists factors that may predispose to nosebleeds.

Nthabiseng Tshiki

Stacey Nheera

Table 1. Nosebleeds - Predisposing factors

Local causes	Systemic causes
Trauma Digital manipulation Deviated septum Chronic nasal cannula use	Alcoholism Hypertension Vascular malformations Coagulopathies
Environmental factors	**Medications**
Allergies Environmental dryness	Nonsteroidal anti-inflammatories (NSAIDs) Anticoagulants (warfarin) Platelet aggregation inhibitors (clopidogrel) Topical steroid nasal sprays Illicit drugs e.g. cocaine

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PREVENTION

Drying of the nasal membranes is a common cause of nosebleeds. To prevent drying of the nasal mucosa, a lubricating ointment may be recommended, especially if the patient is prone to recurrent nosebleeds. Direct the patient to apply the ointment carefully inside the nose with a clean fingertip. The ointment should be applied to the septum of the nose. Another option to help prevent drying of the nasal mucosa is the use of a saline nasal spray.

Other preventative measures include:

- Avoid putting anything (other than prescribed medication) into the nose.
- Using a humidifier to moisten the air.
- Stop smoking – smoking can dry and irritate the nasal mucosa.

SIGNS AND SYMPTOMS

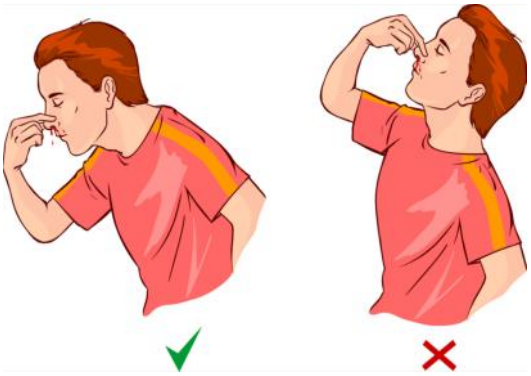
Blood dripping from the nose is the main symptom of epistaxis. The bleeding may range from light to heavy bleeding. The blood usually only comes out of only one nostril.

TREATMENT

The treatment goal when managing nosebleeds is to control blood loss and to maintain an open airway.
Topical vasoconstrictors such as oxymetazoline (in the form of a nasal spray) can be used to constrict blood vessels in the nasal mucosa and may significantly reduce or stop bleeding. Oxymetazoline is a schedule 1 intranasal decongestant that can be given over-the-counter.

Procedure of treatment:

- Sit the patient down with thee head tilted forward. Do not let the head tip back / tipping the head back may result in blood running down the throat and inducing vomiting.
- Tell the patient to refrain from talking, swallowing, coughing, spitting and sniffing, as this may disturb the developing blood clots. Ensure that the patient has a clean cloth or tissue to mop up any dribbles.
- Apply pressure to the nose by pinching the bridge of the nose. After 10 minutes of applied pressure, release pressure and observe if the bleeding continues. If the bleeding has not stopped, reapply pressure for a further 10 minutes.
- If the bleeding is severe or lasts more than 30 minutes, refer the patient to the doctor or the casualty department.
- Once the bleeding is under control, gently clean around the nose and mouth with lukewarm water.
- Remind the patient to rest quietly for a few hours and not to blow the nose, as this may disturb the blood clot that has formed.



CONCLUSION

Epistaxis is a common medical condition. Many episodes occur in the anterior nasal cavity and are self-limiting. It is important observe the patient's progress. Persistent or recurrent bleeding despite therapeutic measures may indicate the need to refer the patient to the doctor or emergency room.

REFERENCES AVAILABLE UPON REQUEST.

Please be on the alert for SAACPSG Branch CPD announcement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THE WAITING GAME

some personal reflections and thoughts.

by David Sieff

There are several types of this prevalent activity, whether voluntary or dictated by circumstances.

One's earliest experience of this phenomenon is the nine-month *wait* to enter the outside world, and the simultaneous experience of the
mother-in-*waiting* - even this expression reveals the topic of this essay.
Next follows the stages of the early growing up period, *waiting* for our first teeth to appear and then disappear, to be replaced by our permanent set and the lovely smiles enabled.

The transition through the growing up and education process leads to the eagerly *awaited* graduation and release into the world of business or a professional career, or even service in the armed forces - an education and maturing time in itself - and maybe marriage and kids, to start the process again.

After our aging, hopefully in good health, we can hardly *wait* for our retirement and enjoying a more leisurely life, and spoiling and indulging our grandkids.
We might now require the support of our family, "pay-back time !" for those whom we fondly brought up.

Let's now explore the day-to-day examples of *waiting :* in queues at the bank or ATM, the supermarket for food and groceries, the pharmacy for medicines, the doctor's or dentist's *waiting* room for a consultation, on the substitutes' bench in team sports events, the theatre or movie ticket office and the popcorn and 'Coke' counter, the restaurant or cafe for the waiter (!) to bring a meal or cup of coffee, the petrol station for fuel, the vaccination site for a jab, the Post Office for a parcel or vehicle licence renewal, the bus stop or train station for transport, the elections hall for casting your vote, and hopefully never in the soup and bread line.

So, in the end, we are all caught in this mostly not-too-unpleasant game of *waiting* for things to happen, and for fate to take it's inevitable course.

SAACP (SG)

South African Association of Community Pharmacists (Southern Gauteng Branch)

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ORAL EMERGENCY CONTRACEPTION:

What are the Choices?

by Lynda Steyn (BPharm)
Amayeza Info Services

Emergency contraception (EC) refers to the contraception method adopted to prevent pregnancy after unprotected sexual intercourse (UPI), or after a regular method of birth control has failed.

Until recently, the only option a pharmacist had to offer a customer seeking emergency contraception, was levonorgestrel (LNG). While insertion of a copper-bearing intrauterine device (Cu-IUD) is the most effective of all ECs available, it does require a referral for insertion. Ulipristal acetate (UPA) has been available internationally for several years and is now available to South African pharmacists to offer as an alternative to levonorgestrel.

This article will focus on oral EC, levonorgestrel (e.g. Norlevo®, Plan B®, Hy-An®) and ulipristal (Ella®), available over-the counter.

HOW LONG DO LNG AND UPA PREVENT PREGNANCY?

Essential for ovulation to occur, is luteinising hormone (LH). The luteinising hormone rises and peaks to induce ovulation.

The highest risk for pregnancy, therefore, is in the two days before ovulation and the day of ovulation, which coincides with the LH rise and peak (see Fig. 1).

Table1. Mechanism of action of EC

Levonorgestrel	Ulipristal
LNG is a synthetic progestin	Ulipristal acetate is a selective progesterone receptor modulator
Prevents or delays ovulation by suppression of the luteinising hormone (LH) surge. Prevents ovulation only if taken in the pre-ovulatory period	Inhibits or delays ovulation in both pre-ovulatory period and after the LH surge has started, but not at the LH peak
Will not prevent ovulation if taken on the day of the LH peak or later	Will not prevent ovulation if taken on the day of the LH peak or later
Will not prevent implantation	Will not prevent implantation
Will not interrupt an existing pregnancy	Will not interrupt an existing pregnancy

EFFICACY OF EC

There are a few factors affecting the efficacy of EC, or which may increase the risk of pregnancy, such as:

- A high body mass index (BMI)
- The window period in which the EC is taken after UPI
- Continued unprotected sexual intercourse after EC use

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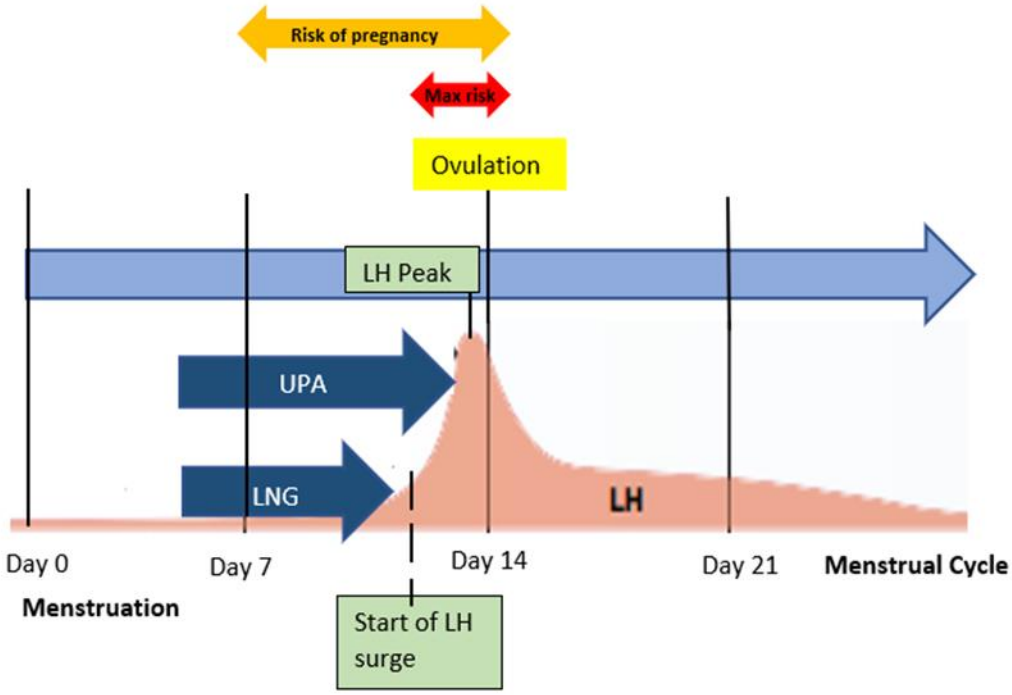
The efficacy of both UPA and LNG may decrease with increasing BMI in women. Overweight or obese women should not be denied access to oral EC when requested. However, it may be advisable to refer for IUD insertion if preventing pregnancy is of utmost concern.

Table 2 Efficacy of EC

Levonorgestrel	Ulipristal
LNG inhibits ovulation if taken up until the beginning of the LH surge, which excludes approximately two days in the cycle where the woman is at highest risk of pregnancy (see Fig. 1). Therefore, LNG must be taken prior to the LH surge, as it is no longer effective after the LH surge has begun	UPA continues to inhibit ovulation through the onset of the LH surge, but not at the LH peak. This excludes approximately one day in the cycle where the woman is at highest risk of pregnancy (see Fig. 1)
A single dose of 1.5mg LNG should be taken as soon as possible, up to 72 hours after unprotected sexual intercourse	A single dose of 30mg UPA should be taken within 120 hours (5 days) of unprotected sexual intercourse
Pregnancy rate 2 to 3%	Pregnancy rate 1.5%
Both LNG and UPA have similar effectiveness if taken within 72 hours of UPI. However, UPA has been shown to be more effective than LNG when taken 3-5 days after UPI.	

Figure 1: Action of UPA and LNG in the menstrual cycle



Adapted from Figure 1 McKay R, Gilbert L. Use of IUDs for emergency contraception: current perspectives. Open Access Journal of Contraception. 2014 Aug 25;5:53-63 and Adapted from Fig 1. Webb A. Emergency contraception- which option when: part 1.

STARTING REGULAR CONTRACEPTION AFTER EC USE

Emergency contraception should not be used as a regular method of contraception, as repeated use of ECs is less effective than most regular contraceptive methods. A request for EC is an ideal opportunity for the pharmacist to discuss ongoing contraceptive needs.

There are a few factors to consider when counselling a woman on resuming or starting regular contraceptive methods.

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Levonorgestrel	Ulipristal
Any regular hormonal contraception may be started immediately after LNG use	Due to a risk that the effectiveness of the UPA in blocking ovulation is decreased, regular progestin-containing hormonal contraception should not be started or resumed earlier than 5 days after UPA has been used
Abstinence or a barrier contraceptive method should be adopted for 7 days after starting or resuming hormonal contraception	Abstinence or a barrier contraception method should be adopted for the next 7 days after starting or resuming hormonal contraception, or until the next menses, which ever comes first
	Nonhormonal contraceptive methods may be started immediately after UPA use

INTERACTIONS

Cytochrome P450 (CYP450) 3A hepatic enzyme inducers, (e.g., carbamazepine, rifampicin, phenytoin, efavirenz) may decrease the efficacy of both LNG and UPA. A Cu-IUD may be an alternative method of EC for women who are using CYP450 3A-inducing medications.

Routine counselling key points:

- EC should be taken as soon as possible after unprotected sexual intercourse
- Repeat EC should be considered if vomiting has occurred within 3 hours of EC use
- Neither LNG nor UPA will offer protection if additional unprotected intercourse occurs in the same menstrual cycle
- ECs may shorten or prolong the menstrual cycle
- If menses has not started within 3 weeks of EC use, a pregnancy test should be advised
- If unprotected sexual intercourse took place more than 5 days previously, the woman should be referred to a doctor for possible Cu-IUD insertion
- There are no absolute contraindications to the use of EC
- Side effects may include nausea, vomiting, irregular vaginal bleeding, and fatigue

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HOW TO SURVIVE

by © Howard Armistead
Director of the Selenium Education and Research Centre (CERC)
Johannesburg

As Southern Africa braces for the third wave of the Covid-19 pandemic, statistics reveal that mortality rates for the disease in Africa range from 3% to 5% of those infected compared to 1.5% to 2.5% in the developed world. While a fully vaccinated population is the ultimate safeguard, what can people do to protect themselves from infection, especially if they do get sick? Today this is critically important as new, more contagious and deadly variants rapidly predominate, and vaccination programs lag.

Obviously, social distancing, avoiding large crowds, and wearing a mask are essential. However, scientists now say disinfecting hands is less important than once thought because airborne transmission accounts for virtually all cases.
What else can a person do to prevent or fight infection? Obviously boosting the immune system is important, but most products sold as immune booters show little benefit. Despite popular perceptions, Vitamin C, Zinc and Vitamin D3 provide little or no protection from infection, and only a slight benefit if one becomes infected. Herbs do nothing; the two medicines scientifically proved to boost CD4 count and immunity are aspirin-like NSAID drugs and selenium.

I have been studying viruses and the immune system since 1990. Working with Dr Sibanda, one of Zimbabwe's top immunologists, in 2002 we demonstrated that for over six months, aspirin alone could significantly increase the CD4 count of HIV patients who were not on any other drugs. People forget that for 100 years doctors and mothers used aspirin to treat colds and flus. Nobody understood how aspirin exerted its antiviral effect until Nobel laurate Dr David Baltimore discovered the human protein NF-*k*B in 1986. NF-*k*B is one of two key factors that explain how viruses cause the damage they do. Acting directly on the thymus gland, selenium shows an even greater, more sustained effect increasing CD4 than aspirin does. The Lancet medical journal reports that selenium can prevent some RNA viral infections from taking hold in the body. It also slows down and reduces the severity of many viral infections. In short, selenium can save lives.

The NF-*k*B protein is like a jet-fuel stimulant for both viral replication and inflammation. Viruses unlock and release this jet-fuel that is normally stored in the cell's cytoplasm. They flood the cell's nucleus with this potent viral stimulant. That sends both viral replication and inflammation into overdrive. Inhibit or reduce this stimulant and viral replication, inflammation, and the destructive force of the viral disease itself will diminish. Aspirin, ibuprofen, indomethacin, and selenium all inhibit NF-*k*B and slow down Covid-19 disease progression, giving the body more time to mount an effective immune response. These affordable medications also help reduce cellular damage, reduce blood clotting, and the frequency of pneumonia. Hospitals already use the strongest NF-*k*B inhibitors, the steroid drugs prednisone, hydrocortisone, and dexamethasone, to treat advanced Covid-19 cases. It is remarkable that physicians do not apply the same strategy earlier in infection when less potent jet-fuel inhibitors with fewer side effects than steroids might prevent many patients from needing hospitalisation.

Besides inhibiting the NF-*k*B protein, what other scientific insight should be applied to save lives during this pandemic?
Most viruses that make people sick are "enveloped" viruses. Viral envelopes protect viruses like skin protects humans. These envelopes are composed in part of selenium-containing proteins. Each virus produced in a cell robs the cell and the immune system of a minute portion of the essential selenium supply the immune system requires to do its job. When viral load increases, selenium reserves become depleted. Falling selenium levels cause the thymus to switch production from making CD4 cells towards making more CD8 cells. Loss of CD4 cells causes the immune system to collapse into an uncontrolled cytokine storm, often resulting in death. Supplement enough selenium back into the body and this process reverses and lives will be saved. This has been shown repeatedly with other viral diseases. But full strength 200 microgram (mcg) must be used at adequate doses for each stage of thee disease.

In 2006 Nigerian researchers proved that adding 200mcg selenium to ARVs more than doubled the increase in CD4 count and tripled the increase in oxygen carrying haemoglobin in AIDS patients compared to ARVs alone.

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In the 1990s, German doctors in Angola reported that high-dose selenium eliminated expected fatalities in an outbreak of deadly Marburg virus. Chinese scientists demonstrated that high-dose selenium (2.0mg) reduced the mortality rate of patients hospitalised with deadly haemorrhagic fever Hantavirus by 63.4%. The Liberian Ministry of Health requested me to bring selenium in 2014. After Dr Jerry Brown added moderately high-dose selenium (1.2mg) to the WHO standard of care, the fatality rate at the Monrovia Ebola treatment unit immediately fell by 44.4% compared to the previous WHO standard of care alone. **Now we urgently need to apply this same strategy against SARS-CoV-2.**

Is the medical establishment so blind to arcane science and medical history they fail to recognise the need to innovate and use old-school, broad-spectrum, anti-viral, NF-*k*B inhibitors against emerging viruses like SARS-CoV-2? Such negligence results in a self-inflicted Pandemic Failure of monumental, historic proportions. Far too many will die.

Why do doctors utilise high side-effect steroid drugs to treat patients hospitalised with Covid-19 but fail to use safer NF-*k*B inhibitors like ibuprofen and selenium to slow down disease progression earlier in the disease? How long will it take before national and international medical authorities act wisely to use proven science to save people's lives?

For more information visit winagainstcorona.com or sercsa.org

WEBSITE FOR MEDICINES - CURRENT AVAILABILITY OR OTHERWISE, NEW AND DISCONTINUED PRODUCTS, ETC.

The website was first launched in 2011 as "Medical News & Events", which had over 600,000 pageviews. In 2019 we decided that a new "face" was required and we updated the website to PharmaNews, click on the link to view.

Our mission is to supply information that is fast, reliable, and accurate, regarding Scheduled products that directly impact on the medical and pharmaceutical professions, using push notifications.

A Healthcare Professional (Pharmacist, Pharmacist Intern, Community Service Pharmacist, Pharmacist's Assistant, Doctor, Intern, and Nurse) will be able to check on New Products as they are launched, the availability, should there be a supply problem, and the withdrawal of a drug for whatever reason. This is of particular interest to pharmacists in the Community Pharmacy Sector, and Locum pharmacists. We have seen an increase in readership since Covid restrictions on Company Representative visits.

In order to comply with the National Code of Marketing, the website is secure and the Healthcare Professional needs to register with their respective "P" Numbers. This prevents the consumer from seeing sensitive information. (The number you use is, e.g. "11585", without the "P". I cannot see your password, in terms of the POPI Act and you can generate a new one if so desired).

The log-in link is https://pharmanews.co.za/wp-login.php/?redirect_to=https://pharmanews.co.za/ and for those colleagues that want to register the link is : https://pharmanews.co.za/register/ .

SAAPI Online Workshops - What's Coming Up?

"RESPONSIBLE PHARMACIST TRAINING "
DAY 1: 17 August 2021 (8:30am – 12:30pm)
DAY 2: 19 August 2021 (2pm – 4:30pm)
Venue: Microsoft Teams
Presented by: Rosemary Kietzmann

"SAAPI/MCA WEBINAR – MARKETING CODE TRAINING WORKSHOP"
DATE : 24 August 2021 (9am – 11am)
Venue: Microsoft Teams
Presented by: Val Beaumont

Please visit www.saapi.org.za to register.

"GOOD WAREHOUSE PRACTICE"
DATE : 26 August 2021 (8:30am - 12:30pm)
Venue: Microsoft Teams
Presented by: Rosemary Kietzmann

The PSSA Book Department

Do you know that the Book Department has a range of essential publications for pharmacists at preferential prices for members of the PSSA?

From overseas publications such as Martindale, Merck Manual and Dorland's Illustrated Medical Dictionary to local publications such as the Daily Drug Use, South African Medicines Formulary (SAMF) and the Scheduled Substance Register.

Ordering is as simple as 1, 2, 3.
1. Go to the PSSA website, **www.pssa.org.za** click on Membership and then Member Services.
2. Complete the order form and submit it.
3. Make payment via EFT.

Or contact Dinette at PSSA National Office on (012) 470-9559 or at dinette@pharmail.co.za

ICPA (NPC), Unit 3, Mews 2, Rosmead Centre, 67 Rosmead Avenue, Kenilworth, Cape Town, 7708
Tel: +27 21 671 4473 | Fax: +27 86 5152 000 | Website: www.icpa.co.za.
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Appeal to pharmacy stakeholders to assist looted independent pharmacies

Following a week of protest action which escalated into looting and violence spreading across KwaZulu-Natal, Gauteng, and Mpumalanga, many independently owned community pharmacies have been left counting the costs as their pharmacies have been destroyed. As essential primary healthcare providers we have a duty of care to our thousands of patients who rely on us for the comprehensive pharmaceutical care we provide. To date we have reports of 56 independent pharmacies that have been looted, 39 in KZN, 16 in Gauteng and 1 in Mpumalanga. It is critical that we support these pharmacies as they rebuild their businesses and restore essential health services to their communities as quickly as possible.

ICPA has setup the Independent Pharmacy Emergency Fund (IPEF) to raise funds to assist these devastated pharmacies. ICPA will collect the funds which will be equitably distributed to pharmacies that need financial support with oversight from a specialist team within B4SA.

Our target is R20 million to which we have already received pledges from Aspen Pharmacare R1,5 million, Adcock Ingram R1 million, Austell Laboratories R500 000 and Transpharm R250 000 totaling R3,25 million.

We call on all our stakeholders to assist in whatever capacity they can. Financial donations can be pledged to the Independent Pharmacy Emergency Fund, and if financial support is not possible then assistance with shop fitting, IT hardware, merchandising, stock, extended credit terms are just a few examples of it required. No gesture is too small and will be gratefully accepted.

Send your pledges to info@icpa.co.za or contact us on 021-671 4473.
IPEF Banking Details:

ABSA Account Name	Independent Community Pharmacy Association NPC
ABSA Account Number	9059458146
Account Type	Savings
Branch Code	632005
SWIFT Code	ABSAZAJJ

Kind regards

Jackie Maimin
CEO

20 July 2021

INTERNSHIP APPLICATIONS

Meneisa Kudzai Jena, a pharmacist who completed her degree with distinction in November 2020 is looking for Internship. She is a PSSA member and registered with Pharmacy Council. She stays in Northcliff, so any community pharmacy around Roodeport would be ideal though she is willing to relocate and stay close to where she is placed.
Anyone who could assist please contact Cecile on 0114423615 or ceciler@pssasg.co.za

Noeline Malenga is currently completing her final year of pharmacy at the University of the Witwatersrand and she is the student representative with the SAACP Southern Gauteng Branch. She is willing to relocate to any Province. Anyone who could assist please contact Cecile on 0114423615 or ceciler@pssasg.co.za

BREAKING NEWS ON IVERMECTIN.

Dr. Tessa Lawrie is a University of the Witwatersrand graduate and a Director of The Evidence-Based Medicine Consultancy in Bath, the UK.
She holds the qualification of Doctor of Philosophy (Ph.D.) Obstetrics and Gynecology, 1995, and a research Doctor, provide evidence to the WHO (World Health Organisation.)
She compiled a Meta-analysis, analysing 21 'freaks' on Ivermectin,_reaching the following findings in her research.

[This is information in advance of the pending Cocherin report.]

The following is a summary made by me of the studies and findings.

- Ivermectin has antiviral properties against Covid 19 in the viral stage and the inflammatory stage of the disease.
- In the Dr. Andrew Hill study, there was a clear reduction in deaths; a 68% reduction was found in a review of the available data.
- In disagreement with the WHO assessment of the studies that they review and their outcomes.
- Studies show possible action against yellow fever, dengue, Silas, and others
- Ivermectin reduces viral load in mild to moderate disease.
- Preventing death and prevention infection.
- Working against DNA and RNA viruses.
- 88% reduction in infection rates.
- Safe drug. Medicine used for over 40 years, and is one of the WHO's essential medicines.
- Over this period there have been 4,600 adverse events and 26 deaths recorded.
- Shown to be safe at more than 10 times the recommended dose.
- Inexpensive treatment.
- Protection given from contacts and workers.

The Chairman of the Editorial Board is David Sieff and the members are Tabassum Chicktay, Stephanie De Rapper, Gary Kohn, Tammy Maitland-Stuart, and Cecile Ramonyane, - Branch Secretary. All articles and information contained in The Golden Mortar of whatsoever nature do not necessarily reflect the views or imply endorsement of the Editorial Board, the Branch Committee, the PSSA, it's Branches or Sectors. The Editorial Board and the aforesaid cannot therefore be held liable. Every effort is made to ensure accurate reproduction and The Golden Mortar is not responsible for any errors, omissions or inaccuracies which may occur in the production process.

The Editor reserves the right to amend punctuation or text for correctness, and to summarise where necessary.

We welcome all contributions and as space permits, these will be published.

The Golden Mortar
P O Box 2467, Houghton, 2041
Tel: 011 442 3615
pssa@pssasg.co.za

Your PSSA SG Branch Chairman: Lynette Terblanche

Your PSSA Southern Gauteng Branch Sector representatives are:

Community Pharmacy:	Richard Barry & Winny Ndlovu
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Contact them through the Branch Office: Tel: 011 442 3615

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