NEWSPAPER POST

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MEDICAL IMAGING

Deep Venous Thrombosis of the Lower Limbs

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Lower limb deep venous thrombosis (DVT) is a condition in which fresh thrombus (blood clot) forms in the deep veins of the legs and pelvis. Besides causing local symptoms including calf pain, swelling and oedema, thrombus in the lower limb veins is also a source of emboli that may lead to life-threatening pulmonary embolism (PE).

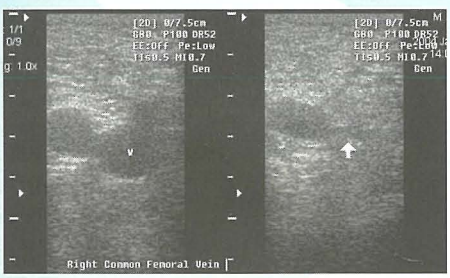

Figure 1: *Transverse scan through a normal right common femoral vein (CFV): (a) without compression the lumen of the CFV (v) is visible, while (b) with compression the lumen disappears (arrow).*

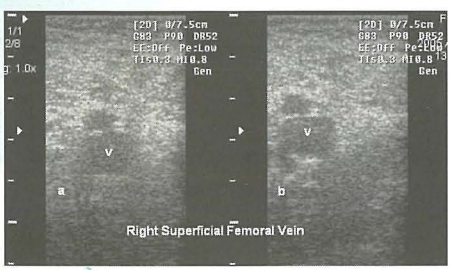

Figure 2: *Transverse scan through a thrombosed left CFV: (a) without compression the lumen of the CFV is visible, and remains visible with compression (b).*

DVT and consequently PE are most commonly seen in patients with reduced mobility and underlying medical illness. Immobilisation, surgery in the past 3 months, stroke, previous history of venous thromboembolism and malignancy are the most important risk factors. The incidence of DVT also increases exponentially with age. In patients with extensive or recurrent DVT/PE (especially under 50 years of age), genetic prothrombotic disorders such as factor V Leiden mutation, excess factor VIII, antithrombin 3 deficiency and protein C and S deficiencies are often present. Other important risk factors include the oral contraceptive pill, smoking, obesity and hypertension. 'Economy class syndrome' (or traveller's thrombosis) is rare, occurring in one in 400 000 passengers in flights longer than 8 hours. An increased risk of thrombosis has not yet been confirmed in flights of less than 4 hours.

The likelihood that a patient with a history of DVT will present with repeat symptoms within 1 year is reported to be as high as 20%. Repeat symptoms are largely determined by the extent of venous reflux, the presence of persistent popliteal obstruction and the rate of recanalization, all of which may determine the presence of postphlebitic syndrome. Postphlebitic syndrome is caused by impaired venous valve function from prior thrombosis. Particularly in the erect position, the retrograde venous flow leads to chronic venous hypertension, which induces superficial varicosities, chronic swelling, hyperpigmentation from stagnant red blood cell breakdown and in severe cases ulceration.

In patients with symptoms of lower limb DVT or PE, the diagnosis of DVT is routinely established with venous ultrasound (US). Compression venous US is the venous procedure of choice in patients with suspected DVT as it is non-invasive and has a high sensitivity (95%) and specificity (98%).

The principle of compression venous US is simple; normal veins compress fully so that the anterior and posterior walls touch under pressure of the examining probe (Figure 1), while those containing thrombus do not (Figure 2).

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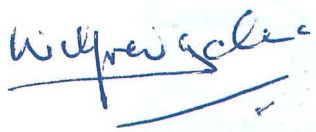
Editor's Word

'An issue to be remembered ...' – these were the concluding remarks of our Scientific Editor when we finalised the compilation of this issue. Indeed this is a special issue because it coincides with the fifth anniversary of this magazine. These five years has seen a progressive metamorphosis in quality to the standards achieved to date. Not only is this issue full of articles of interest to all members of the medical professions but this issue coincides with the launch of the Association of Surgeons of Malta's **on-line Continuing Medical Education Service** which is being delivered through TheSYNAPSE Portal. This innovative project leads the way to new and more convenient modalities of CME that compliment existing methods. TheSYNAPSE Portfolio has now expanded to include TheSYNAPSE Portal, TheSYNAPSE Direct, TheSYNAPSE eCME and TheSYNAPSE Magazine. More vehicles are planned to be added to this portfolio in the coming months.

This is our contribution to you as Maltese Health Care Professionals and our Healthcare system.



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continued from page 1

Deep Venous Thrombosis of the Lower Limbs

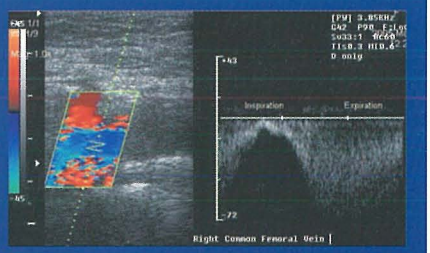

Figure 3: *Normal phasic flow in the right CFV during respiration.*

Colour and Spectral Doppler ultrasound are also used to detect flow patterns in the common femoral (Figure 3) and popliteal veins; abnormal flow patterns in these veins indicate pelvic and more distal calf vein thrombosis respectively. Abnormal flow patterns on Doppler ultrasound include lack of flow, lack of phasic variation with respiration and lack of flow during calf compression; all are indirect signs of more proximal or distal venous occlusion.

In patients with a history of DVT who present with recurrent symptoms due to postphlebitic syndrome or recurrent DVT, US may in some cases not distinguish acute thrombus from prior or chronic thrombus. In addition, a non-occlusive clot may go undetected because of its location, small size and non-occlusive nature. X-ray venography is invasive and technically very difficult, while having limited accuracy due to incomplete venous filling with contrast particularly in the calf. X-ray venography has been largely replaced by US.

New scintigraphic techniques may assist in distinguishing post-thrombotic change from fresh thrombosis. The radiopharmaceutical Technetium-99m apcitide is a complex of the radionuclide Tc-99m and the small synthetic peptide apcitide. Apcitide binds to glycoprotein IIb/IIIa receptors, which are expressed on the surface of activated platelets, making the radiopharmaceutical specific for acute thrombi but not chronic thrombi. These attributes may make Tc-99m apcitide imaging a potential complementary test for differentiation of acute from chronic DVT and detection of segmental DVT which does not show up with US in selected patient populations (Figure 4).

The prevalence of postoperative DVT has been reported to be as high as 60% in patients who have undergone arthroplasty. This high prevalence has led to prophylaxis with postoperative anticoagulation therapy, pneumatic leg compression and early physiotherapy, and in some institutions routine ultrasound is used to detect subclinical DVT. Administration of heparin, warfarin or low-molecular-weight heparin may make US visualization of a thrombus more difficult because the thrombus may be segmental, hypo-echoic and less likely to occlude the lumen. Tc-99m apcitide scanning may be helpful in these patients if they have a positive ventilation/perfusion scan. A more efficient way to evaluate PE and DVT simultaneously is with spiral CT. Rapid consecutive post-intravenous contrast spiral CT scanning of the pulmonary arteries followed by the lower limb veins has been shown to confirm the presence of both PE and DVT in a single examination (Figure 5).

Another situation in which diagnosis of acute DVT is problematic is isolated calf vein thrombus. 88% of calf thrombi occur in the asymptomatic population. Isolated calf vein thrombus is rarely a cause of PE. US can be used for direct detection of calf thrombi or for assessment of propagation into the femoral-popliteal system, which occurs in approximately 20% of patients.

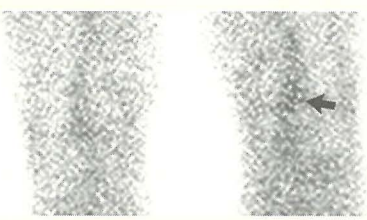

Figure 4: *Tc-99m apcitide showing tracer accumulation (arrow) consistent with acute thrombus in the right popliteal vein .*

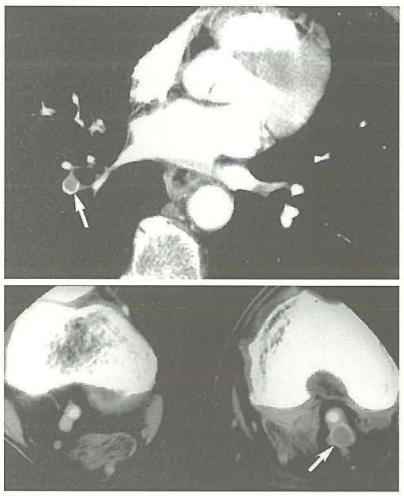

Figure 5: *Spiral CT scans following a single injection of IV contrast material showing (a) PE (arrow) and (b) left popliteal vein DVT (arrow).*

In summary, there are a number of imaging techniques available to help us detect DVT in patients at risk and in those with evidence of PE. Venous US has been used clinically for over 2 decades with hundreds of published studies confirming is validity. Despite the shortcomings of venous US in some cases of chronic DVT and following arthroplasty, no body of knowledge exists that unequivocally points to replacing venous US in day-to-day clinical practice. Tc-99m apcitide imaging may have a role in cases with equivocal US findings. Spiral CT is useful in patients with clinically suspected PE, as it will confirm PE and identify the source of emboli (DVT) in one sitting; however, larger studies will be required to statistically confirm the efficiency of this technique.

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Novel Vaccines – What's in the pipeline?

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Scientists worldwide are striving without heed in order to develop new vaccines which protect the human race against old and emerging diseases.

However it is not only the menu of these vaccine preventable diseases which is being extended but the quality and efficacy of these vaccines are improving tremendously. Researchers are today studying vaccine adjuvants which improve the immunogenicity of the product, aiming to create a vaccine which provides lifelong immunity and which is well tolerated and free from side effects. The problem of the pin cushion effect with multiple injections during one and subsequent visits to the family doctor and pediatrician will soon be a thing of the past with the introduction of combination vaccines. Also in the twenty first century the use of edible vaccines, nasal sprays or skin lotions may eliminate the use of needles completely.

The following information will focus on three novel vaccines which should be stocked in pharmacies in Malta and Gozo in the very near future. These vaccines are against (1) Rotavirus, a common cause of gastroenteritis in children, (2) Human Papilloma Virus (HPV) which may lead to carcinoma of the cervix and (3) Malaria, a parasitic disease which kills more than one million people every year.

Rotavirus

The Rotavirus vaccines are a new generation of vaccines which are fast making their way into our clinics. These are already licensed in some countries and have been given the go ahead by the European Medicines Agency (EMEA). These live attenuated vaccines will provide lasting protection when given in two doses as an oral preparation, with the first dose given at six weeks and the second dose given 14 weeks later. These new vaccines are not associated with episodes of intussusceptions, which had caused the only US-licensed rotavirus vaccine to be removed from the market in 1999. The three currently registered rotavirus vaccines are the Rotarix™ (GSK), Rotashield™ (Wyeth/Biovirx) and LLR™ (Lanzhon Institute of Biological Products, China). Rotateq (MSD) is in its phase III trials and is just about to be registered.

Human Papilloma Virus (HPV) Vaccines

HPV-Deoxy Ribo Nucleic Acid (DNA) is present in 90-100 % of carcinoma of the cervix, with the most common HPV types being HPV 16 and 18. It is now well established that HPV is the leading cause of carcinoma of the cervix and the progression may take years or even decades, and it may even regress spontaneously.

Table 1: Basic table of main HPV types and the associated lesions.

Lesion	HPV type
Plantar warts	1,2,4
Hand warts	2,4
Genital warts	6,11
Cervical carcinoma	16,18,31,45

In fact 60% to 80% of CIN 1 dysplasia resolve spontaneously and only 1% of cases progress to invasive cervical cancer. However, carcinoma of the cervix is the second commonest carcinoma in women, after breast.

On the forefront in HPV clinical trials for the HPV vaccine are Merck and Co. (with a current clinical trial of 25,000 women) and GSK (with a current clinical trial on 30,000 women). The results are very promising where 100% antibody responses are being achieved to HPV types 6, 11 and 16, with a lower response to type 18.

The HPV 16 and 18 prophylactic vaccines are showing good tolerance and immunogenicity and it is recommended that prophylactic vaccination should start in young adults prior to, or at the time of sexual initiation.

Of course, cervical screening programmes will still remain as important as they are today and the vaccine is intended to complement, and not to replace cervical screening.

Malaria

An innovative vaccine whose mode of action is not to treat someone infected with malaria, but to make the infected person non-infective to others. Once the *Anopheles* mosquito feeds on the infected person, the vaccine blocks the replication of the parasite in the mosquito, hence blocking the life cycle and preventing infection in other hosts. Hence the use of this vaccine in controlling malaria disease will be invaluable.

Conclusions

We are currently enjoying a feast of new combination vaccines in the market, and these exhibit improved immunogenicity and tolerance. Many of these are already in phase III trials or registered for licence. However there are many other innovative vaccines in phase I trials (Human Immunodeficiency Virus, tuberculosis, zoster, breast cancer and prostate cancer) and Phase II trials (Epstein Barr Virus, Dengue, lung cancer and melanoma). Current pre-clinical trials include Cytomegalovirus, Respiratory Syncytial Virus, Chlamydia, SARS, *Staphylococcus aureus* and Avian Influenza.

With such extended menus for vaccine preventable diseases and the provision of better quality vaccines we are keeping our fingers crossed so that future generations will enjoy a better quality of life where the child who is still present as a foetus in utero may be protected against infections such as Group B Streptococcus and Respiratory Syncytial Virus by vaccinating pregnant mothers.

Adult immunisation – an overview

by **Tonio Piscopo** *MD MRCP(UK) DTM&H(Lond)*
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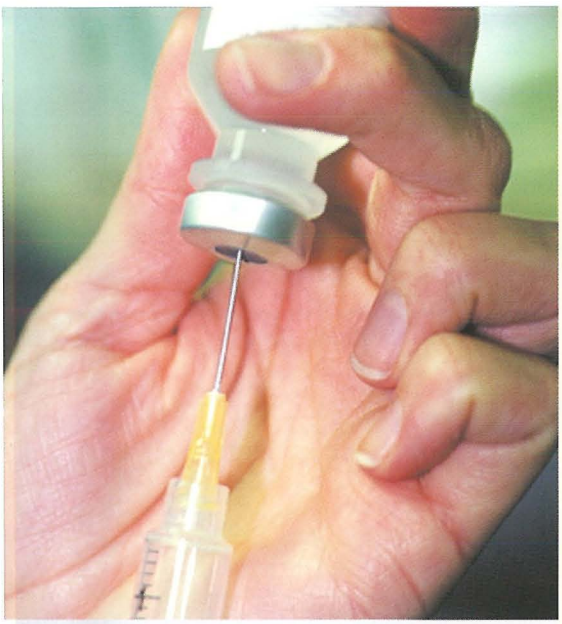

This year in particular saw the potential influenza pandemic fuel the uptake of immunisation against annual influenza. Judging from reports that both public and private sector vaccines ran out beforehand, the uptake must have been higher than usual, although no official reports are available to date. There were no significant reports of influenza illness in the community probably as a result of this.

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The benefits of this exercise however went beyond. The logistics of an eventual possible nationwide pandemic influenza immunisation have been made easier, and the general population have been made aware of the benefits of this particular immunisation. This should inevitably create ripple effects into the potential benefits of other vaccines amongst the general population, aided by increased awareness amongst physicians.

Adults who did not contract chicken pox as children are often faced with the prospect of being exposed to this virus when their children or other contacts contract it. In adults the risk of developing varicella pneumonia is higher, especially in pregnant females, smokers and immunosuppressed patients. One would consider anti-viral treatment in adults, but pregnancy poses a particular challenge. The risk of foetal malformation increases if the illness develops in the first trimester, but the risk to the mother from the disease is greater in later pregnancy. Thus weighing the benefits and risks of treatment revolves mainly around these facts.

These difficult situations could be easily avoided if individuals are immunised. The two dose vaccination schedule in adults provides about 75% protection. Being a live-attenuated virus vaccine, there is a potential risk of transmission to non-immune close contacts but this risk is very small. Non-immune health care workers and women of child-bearing potential should be offered the vaccine. Immunosuppressed patients cannot have live virus vaccines, but their non-immune contacts can. A vaccine-associated rash may develop in 10% of adults, and the vaccine virus strain may establish latent infection and reactivate as zoster at a later stage, but this is uncommon.

Pneumococcal vaccine is probably under-prescribed. Besides being one of the most commonly reported cause of bacteraemia and meningitis, *streptococcus pneumoniae* frequently causes pneumonia and exacerbations of chronic obstructive pulmonary disease. Since 2003, pneumococcal vaccine has been recommended for adults >65 years in the UK. Other immunocompetent adult groups who should receive it include those who are at increased risk of pneumococcal disease or its complications because of chronic illnesses like chronic respiratory disease, chronic heart disease, chronic liver disease, diabetes, individuals with cochlear implants and individuals with the potential for cerebrospinal fluid leaks.

Immunosuppressed patients with asplenia or dysfunction of the spleen, chronic renal disease, HIV, and long term use of steroids, should also be recommended for this vaccine, although the antibody response may be suboptimal. A good time to consider or plan immunisation would be during the annual flu vaccination. The polysaccharide vaccine is effective in those >2 years old (in younger children, the conjugate vaccine is used). Re-immunisation is not routinely offered but this is recommended in certain high risk groups like asplenic patients after five years.

The hepatitis vaccines may be other examples of underutilised vaccines. The commonest indication for hepatitis A vaccine would be for contacts of an index case where the diagnosis is made within one week of the onset of symptoms. However this vaccine should also be considered in cases of chronic liver disease (including hepatitis B and C infection), intravenous drug users, men who have sex with men, travellers to certain risk countries, persons with clotting disorders receiving regular blood products, and in potential occupational exposure as in healthcare or sewage workers. It is highly immunogenic and efficacious and booster doses after the primary two dose immunisation need not be given before 20 years. A combination vaccine with hepatitis B is available and sometimes, it would be more convenient when both need to be given.

Since July 2002, hepatitis B vaccine is being offerred to all children in Malta during the fifth year. Older persons would have missed this and so need to be assessed for indications for the vaccine. Potential candidates include intravenous drug users and their close contacts, persons with multiple sexual partners, close family contacts of a hepatitis B carrier, individuals receiving regular blood or blood products, patients with chronic renal or liver disease, persons in certain institutions like prisons, travellers having high risk behaviour going to high risk areas, and individuals at occupational risk like health care workers. Pregnant hepatitis B positive females would need to immunise their babies at birth, along with hepatitis B immunoglobulin in some instances. In the case of accidental needle stick injury where the status of the blood on the needle is unknown, a risk assessment will need to be done prior to immunisation.

Occasionally, situations arise where the routine immunisation status of an adult individual is unknown, and the individual comes forward to have these vaccines. The more important vaccines to be given would be three doses of tetanus, diphtheria and inactivated polio vaccine with one month in between, with the fourth dose given one year later. Also, two doses of MMR are needed with three months in between immunisations.

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1. Fowler J, et al. The Effect of Pimecrolimus Cream 1% Twice Daily on Pruritus in Pediatric Patients with Mild to Moderate Atopic Dermatitis. J Am Acad Dermatol 2004;50(3):P62 **2.** Eichenfield LF, et al. Safety and Efficacy of Pimecrolimus (ASM 981) Cream 1% in the Treatment of Mild and Moderate Atopic Dermatitis in Children and adolescents. J Am Acad Dermatol 2002;46(4):495-504 **3.** Data on file, Novartis Pharma AG **4.** Wahn U, et al. Efficacy and Safety of Pimecrolimus Cream in the Long-Term Management of Atopic Dermatitis in Children. Pediatrics 2002;110(1):1-8

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ELIAD 04/06 MT

Diagnosis and Treatment of Fungal and Non-Specific Vaginitis

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Vaginal symptoms are a common and recurring problem affecting about 10% of women in general practice. There is an increase in vaginal discharge with puberty, sexual activity and the oral contraceptive pill. The most common infective causes are Candida, bacterial vaginosis, Trichomonas, Gonorrhoea and Chlamydia. Symptoms are of little diagnostic value. A detailed sexual history and examination followed by vaginal pH, saline/10% KOH wet mount, cervical cytology and microbiological examination will guide appropriate treatment.

Vaginal symptoms are a common and recurring problem that affect about one in 10 women who present to a general practitioner[1]. The diagnosis of vaginitis is based on the presence of symptoms of abnormal discharge, vulvovaginal discomfort or both. The presence of lower abdominal pain, cervical excitation or adnexal tenderness raises the possibility of pe lvic inflammatory disease. Discharge flows from the vagina daily as the body's way of maintaining a healthy environment. The composition of vaginal flora changes with age, stress, hormonal influence and sexual activity. Over-zealous douching washes away lactobacilli which maintain acidic vaginal pH. Normal discharge is usually odourless, clear or milky. There is a physiological increase in vaginal discharge with puberty, sexual activity and being on the oral contraceptive pill. A change in the amount, colour and smell of vaginal discharge and symptoms of irritation, itching or burning could be due to an imbalance of healthy bacteria in the vagina, leading to vaginitis. Non-infective vaginitis may be due to ectropion, polyps, neoplasm, irritants (soaps, antiseptics, detergents), retained tampons and condoms. In post-menopausal women with chronic vaginitis, atrophic vaginitis (often blood stained) must be considered. The aetiology of vaginitis is not always easy to establish, primarily because the symptoms or subjective description are of little value. A detailed sexual history, followed by a full physical examination (including that of the husband, partner or both), should ideally be followed by vaginal pH, saline/10% KOH wet mount, cervical cytology and microbiological examination of cervical, anal and penile areas. These investigations are often not undertaken in family practice[2]. The most common infective causes of vaginitis include Candida, bacterial vaginosis (mostly due to Gardnerella), Trichomonas, Gonorrhoea, and Chlamydia[3]. Threadworm should also be considered in kids. Gonorrhoea and Chlamydia will not be considered in this article.

Candidiasis is a fungal infection common in women of childbearing age that causes pruritus, with a thick, white vaginal discharge. The Gram positive yeast is a normal commensal in the mouth, GI tract and vagina[4]. Candidiasis is not necessarily sexually transmitted: there is often a history of recurrent yeast infections or recent antibiotic treatment. Symptoms often begin just before menses. Precipitating factors include steroids, diabetes mellitus and pregnancy. Partners are often asymptomatic. The vaginal pH is 4.5-4.8 and hyphae are seen on 10% KOH wet mount. Candida is treated using pessaries (and cream for the partners) containing nystatin, clotrimazole, miconazole alone or using oral fluconazole or itraconazole. Sexual intercourse should be avoided until both partners have been treated. Miconazole and econazole have an adverse effect on latex condoms.

In a randomized study, Lactobacillus preparations taken orally or vaginally during and for four days after short term antibiotics for non-gynaecological infections were not effective in preventing post-antibiotic vulvovaginitis[5].

Many women self-diagnose and self-treat episodes of vaginal infections with over-the-counter treatment, and later present with a history of recurrent thrush, never having had the diagnosis confirmed microbiologically. 5% of healthy women have four or more infections annually necessitating maintenance treatment regimens for six months[6]. Apart from excluding predisposing causes, simple approaches such as avoiding chemicals around the vulva (bath salts etc), front-to-back wiping and wearing double-rinsed cotton underwear (or even better, no underwear in hot humid climates) may be helpful in minimizing recurrences.

Trichomoniasis is often associated with risk factors for other sexually transmitted diseases (STDs), especially a history of multiple sexual partners. The discharge is usually copious, greenish, frothy and smelly, resulting in local pain, irritation and occasionally pruritus. Symptoms often peak just after menses. External genital examination may be normal in men and women. Vulvar and vaginal wall erythema may be present; the "strawberry cervix" appearance caused by inflammatory punctate haemorrhage is uncommon. Infection during pregnancy has been associated with preterm deliveries and low birth weight infants. The pH is usually between 5.0-6.0 and motile trichomonads are visible on saline mount. Both partners should be treated with Metronidazole (400mg bd or a single dose of 2 g). A test of cure should be done after one week with microscopy and culture.

Vaginal symptoms are often assumed to be due to thrush, but bacterial vaginosis has been found to be associated with up to half of patients with vaginal symptoms[7]. Bacterial vaginosis has a polymicrobial aetiology including the gram negative anaerobe Gardnerella vaginalis. It is often asymptomatic except in the pre- and post-menstrual period[8]. Three out of four of the following criteria should be present to diagnose bacterial vaginosis: Vaginal pH 4.5; homogeneous grey discharge; fishy odour with 10% KOH; clue cells on wet mount (epithelial cells with bacilli attached to their surface).

Bacterial vaginosis has been associated with pelvic inflammatory disease after abortion, endometritis after caesarean section, amniotic fluid infections, and preterm or low birth weight delivery[9]. Treatment is with oral (400mg bd for 5 days, or 2 g single dose) or topical metronidazole (0.75% gel for 5 days) or clindamycin (2% cream for 7 days, 100mg ovules daily for 3 days, or 300 mg orally bd for 7 days). Treatment regimens have similar cure rates of 70-80% after four weeks, but 60% of women relapse in three months[6]. Recurrent symptoms may result in psychosexual problems. It is essential to review intimate hygiene practices and to avoid douching as this removes the healthy lactobacilli in the vagina.

In conclusion, although many women with vaginal discharge often seek medical advice, this common condition is poorly predictive of sexually transmitted diseases. The advantage of managing this common condition in a genitourinary clinic is that microbiological tests are readily available to establish an accurate diagnosis. If a sexually transmitted disease is diagnosed, contact tracing through a genitourinary clinic is mandatory (One may contact Dr Carabot at Boffa Hospital on 22987115).

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Current Status of Avian/Pandemic Influenza

by Tanya Melillo Fenech *MD MSc*
Principle Medical Officer at Disease Surveillance Unit, Department of Public Health

As of 12 May 2006, there have been 208 cases with 115 deaths with a case fatality rate of 56%. People who have been infected with avian influenza virus might be especially susceptible to avian virus because they are genetically predisposed to it There have been many family clusters involving blood relatives but not a single case of infection involving husband and wife.

Avian influenza may be capable of infecting people through the gut, not just the respiratory system, and diarrhea is sometimes the first symptom. Particles of the lethal H5N1 virus contained in the meat and blood of infected poultry may have been ingested by some patients, possibly causing their infection. In a number of patients the only exposure risk has been drinking raw duck blood, which could imply that the gastrointestinal tract is also a route of transmission or a route of first infection.

Both influenza A and B viruses survived for 24-48 hours on hard, nonporous surfaces such as stainless steel and plastic but survived for less than 8-12 hours on cloth, paper, and tissues. Studies have shown that influenza A virus present on stainless steel surfaces was transferred to hands for up to 24 hours and from tissues to hands for up to 15 minutes. This indicates the importance of disinfecting common surfaces during a pandemic with alcohol wipes and washing hands with soap and water very frequently. The virus survived on hands for up to 5 minutes after transfer from environmental surfaces. These observations suggest that the transmission of the virus from infected persons who are shedding large amounts could occur for 2-8 hours via stainless steel surfaces and for a few minutes via paper tissues.

For further information check the Disease Surveillance Unit Web Portal on *http://www.health.gov.mt/dsu/* and TheSYNAPSE Web Portal on *http://www.thesynapse.net/*

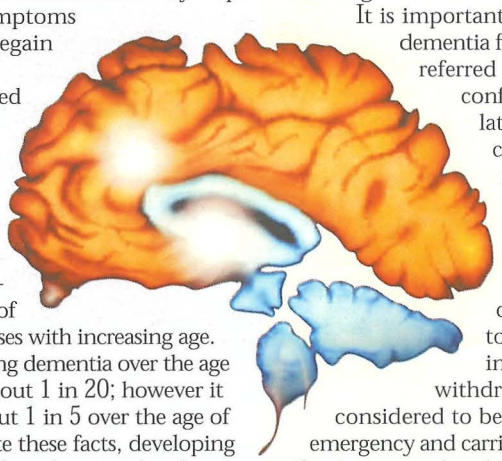
The information is correct as on 13/5/06.

Assessment of People with Memory Symptoms

by Stephen Abela
MD MRCP(UK) MPhil MHSc HSM
Consultant Geriatrician, Department for the Elderly and Community Care

This article forms part of a series of articles dealing with the management of people presenting with symptoms suggestive of dementia. They are directed in particular to primary care professionals and serve to highlight some important principles and newer approaches that are being recommended. This first article in the series will focus on the initial assessment at the presentation stage whereas in the second article, some important points on the management of behavioural and psychological symptoms will be highlighted.

Dementia is a term that refers to those disorders of the brain that result in progressive impairment of brain functions such as memory, language, judgement and thinking. Dementia affects the ability of the person to function and creates difficulties in performing familiar and previously known tasks, eventually even impairing the person's ability to take care of oneself. The commonest cause of dementia is Alzheimer's Disease, accounting for some 50 - 60% of all cases of dementia. Other common conditions resulting in dementia are Vascular Dementia and Lewy Body Disease. There is currently no definite cure from dementia, but treatment is now available that may help some of the symptoms and may help regain some abilities, delaying the need for nursing home care.



The single most important risk factor for dementia is age - the prevalence of dementia increases with increasing age. The risk of having dementia over the age of 65 years is about 1 in 20; however it increases to about 1 in 5 over the age of 80 years. Despite these facts, developing dementia should not be considered as an inevitable result of growing older. In an effort to invite early recognition of the symptoms and signs of dementia, the Alzheimers' Association has set up a fact sheet explaining the different presenting symptoms that many be experienced by people with dementia. It is important that these symptoms are not taken as if it is '*what to expect at this age*'. Each case merits appropriate assessment and investigation in order to identify potentially remediable causes and to confirm the diagnosis. Patients and their families will need appropriate advice and support if a diagnosis of dementia is made.

The initial assessment of a person presenting with memory symptoms primarily entails a good and comprehensive medical history and physical examination. It is important to identify when symptoms had started and how these have progressed over the subsequent months. Alzheimer's disease has an insidious onset and the condition advances progressively and slowly over months to years. Vascular Dementia classically advances in a stepwise fashion. The aim of the initial assessment is to identify any physical or psychiatric condition that may present similarly as or may be mistaken for dementia. There are many physical conditions that may be recognised on careful examination.

It is important to distinguish dementia from delirium, also referred to as an acute confusional state. The latter is usually caused by an acute medical illness example, myocardial infarct, or infection or else can be secondary to drug or alcohol intoxication or withdrawal. Delirium is considered to be an acute medical emergency and carries a high mortality if not managed and treated appropriately. A cranial space occupying lesion may also cause a confusional state but the history here follows a shorter course.

The differential diagnosis for someone presenting with a dementia syndrome also includes psychiatric conditions. In particular, patients should be screened for the possibility of depression. The psychomotor retardation that may accompany depression may be difficult to distinguish from dementia. However with experience, the physician will be able to distinguish the 'negative' responses of a depressed person from the inappropriate replies of a person with dementia. However, it is important to note that depression may coexist with dementia as both of these conditions are common. In this case, a trial of antidepressant therapy is warranted as patients respond well to treatment. Hypothyroidism may cause a gradual deterioration in mental function and can also lead to psychiatric symptoms and thus needs to be excluded.

Another aspect of the assessment is to scrutinize and review the current medication. Older people are susceptible to polypharmacy because of their multiple pathologies and failure to keep off unnecessary medication. They are more susceptible to adverse side effects of drugs due to altered pharmacodynamics and pharmacokinetics and more prone to drug interactions. There are many drugs that can precipitate confusion or worsen cognitive decline in the elderly. Hyponotics, sedatives and psychotropic drugs should be prescribed with caution, and if really necessary, should be given in the least possible dose that controls symptoms. Anticholinergic drugs which are sometimes used to treat Parkinson's disease or to control drug-induced parkinsonism are nowadays less favoured because of their adverse effects. It is important to realise that anticholinergic effects may also result from the use of other drugs such as tricyclic antidepressants, antihistamines (often prescribed for their hypnotic effects) and certain classes of analgesics.

The Mini-Mental State Examination is a useful tool in determining the severity of the cognitive decline and to provide a baseline with which to compare and measure the effect of interventions and treatment. Other assessment tools are frequently administered to assess behavioural symptoms, functional ability and caregiver stress.

This comprehensive assessment also serves as an opportunity to identify any underlying and unrecognized physical problems. In geriatric medicine, it is very common for patients not to seek treatment for their disabilities because they perceive these as normal for their age. Screening and management of problems associated with vision, hearing, gait and continence contribute a lot to improving the quality of life and to restoring functional ability.

continues on page 18

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The dynamic role of the antibiotic pharmacist

by Peter Zarb B. Pharm. (Hons.)
Antibiotic Pharmacist
St. Luke's Hospital
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Antibiotics are unique among medicines by virtue of the fact that their use in an individual patient can directly impact on the health and well being of other patients, as well as society as a whole.

Optimal use of antimicrobials is essential in the face of escalating antibiotic resistance, and requires cooperation from all sectors of the health care system. Antibiotics are used in most hospital specialities and approximately 20-25% of patients take antibiotics at any one time during a hospitalisation period. This varies from 40-50% in ITU's to 10% in ENT.[1]

The Role of the Antibiotic Pharmacist

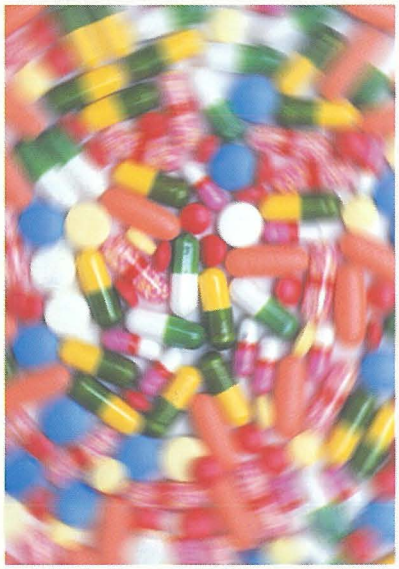
The Antibiotic Pharmacist plays a vital role in developing, implementing and monitoring initiatives to promote prudent antibiotic use in the hospital. In Malta, the Antibiotic Pharmacist is part of the Antibiotic Team (ABT). The other members are the Hospital Infection Control Consultant, Infectious Disease Consultant and Consultant Microbiologist. The ABT issued prescribing guidelines in 2004 and the Antibiotic Pharmacist monitors antibiotic prescriptions at the 'General Dependency Ward' (GDW) and also monitors prescriptions for restricted, non-formulary, antibiotics. The Clinical Pharmacists, occasionally, also refer to the Antibiotic Pharmacist for advice.

The daily duties of the Antibiotic Pharmacist include providing advice on management of specific patients, monitoring and auditing antimicrobial use and promoting compliance to established guidelines.

In the UK, unlike in Malta, the Antibiotic Pharmacist, is also involved in:

- Promoting IV to Oral switch;
- Antibiotic Stop Order Policy;
- Therapeutic Substitution;
- Attending ward rounds with the Infectious Disease team;
- Outpatient parenteral antimicrobial therapy (OPAT);
- Streamlining to narrow spectrum agents according to culture and sensitivity results on a daily basis.

The role of the Antibiotic Pharmacist at St. Luke's Hospital was the subject of various poster presentations at International Conferences.[2,3]



Monitoring Consumption / International Collaboration

Malta participates in two EU funded projects which deal with Surveillance of Antibiotic Consumption namely European Surveillance of Antimicrobial Consumption (ESAC) which deals exclusively with consumption both in the hospital and ambulatory setting in Europe and the ARMed which deals with other related issues in Infection Control, Resistance and Consumption in the hospital setting.

The ARMed is coordinated locally and the Antibiotic Pharmacist, acting as research assistant, deals with the management of antibiotic consumption data submitted by the participating hospitals from Mediterranean countries (Cyprus, Egypt, Jordan, Tunisia and Turkey). There are also Algeria, Morocco and Lebanon which participate in other parts of the ARMed project.

Another European project to which the Infection Control Team, including the Antibiotic Pharmacist, actively participated is ARPAC (Antimicrobial Resistance Prevention and Control).

Both ESAC, ARMed and ARPAC are projects funded by the EU.

A perspective on the Community

Although antibiotic-restriction policies in the hospital setting are important in altering microbial susceptibility patterns, an overall reduction in antibiotic prescriptions in the outpatient setting is more likely to significantly impact antibiotic resistance. Patients must change their perception of the need for these drugs. With cooperation of healthcare teams, the effectiveness of available antibiotics may be sustained and the threat of resistance minimised. However, in Malta, we have no real estimates of the actual antimicrobial consumption in Ambulatory Care. In fact, our participation in the ESAC is only for the Hospital Care part. On the other hand some other countries, like the UK, only participate in the AC part since they lack reliable hospital consumption data.

Conclusion

The role of the Antibiotic Pharmacist is a difficult, dynamic and challenging one, but undeniably rewarding. Work can be extremely satisfying from a professional and personal perspective. The Antibiotic Pharmacist can make a significant contribution to patient care as an integral part of multidisciplinary infection control teams.

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Launch of On-Line Learning and Continuing Medical Education Programme

Life long learning is an essential requisite of any professional. Doctors, Pharmacists and Dentists, have to keep up to date with rapid advances in modern technology and knowledge. These Medical Professionals usually have to juggle their tight time-tables to leave space for essential Continuing Medical Education (CME). Advancement in modern technologies now make it possible for medical professionals to follow on line training courses in the comfort of their home using Internet Technology.

The Association of Surgeons of Malta has recently launched a new programme of Continuing Medical Education for the medical profession. Co-Financed by the European Social Fund and Malta Government the programme consists of a series of modules, each dealing with conditions that are often encountered in medical practice.

The first module in this series deals with Vertigo, a common clinical condition that presents to all practicing medical professionals from whatever specialty. The second module deals with the Acute Abdominal Pain. The third module that will be launched in the coming weeks tackles the Pre-Operative assessment of patients with respiratory problems

The modules are aimed at both established medical practitioners practicing in any specialty including family practice as well as doctors in training, clinical year medical students, pharmacists and allied professionals. This is the first time that formal continuing medical education modules are being totally designed and implemented in Malta and made available to all on the Internet. Mr Adrian Agius, Vice-

President of the Association of Surgeons and coordinator of the e-learning programme, stated that "*Due to rapid advances in surgical techniques and technology, medical professionals need to learn more in a shorter length of time. Efficient use of their time is a must.*

The interactive internet-based learning modules enable individuals to home in onto the important practical points that they need to assimilate into their practice. An online course can be completed at a time convenient for the participant and one can progress at one's own pace.

Another feature is online discussion with the training faculty. Certification follows successful completion of the module. The courses have been endorsed by the

eCME
electronic continuing medical education
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Departments of Surgery, Medicine and Family Medicine of the University of Malta and by the Malta College of Family Doctors and the Malta College of Pharmacy Practice.

Internet-based learning knows no boundaries and will minimize the need to travel abroad, while enriching our professionals with learning that is peer-reviewed by both local and international contributors".

Commenting on the launch, Dr Kenneth Grech, project manager,stated that "*This is a unique opportunity for specialist associations to benefit from these funds to promote and consolidate structured specialist training in Malta and the Association of Surgeons of Malta have been particularly active in this programme".*

The implementation of this programme has been entrusted to Medical Portals Ltd, a company that for the last ten years have been operating TheSYNAPSE – a portal for medical professionals.

Dr Wilfred Galea, managing director of Medical Portals Ltd stated "*The eCME programme is another service in the long list of services and tools for medical professionals, we are proud to launch this service as part of TheSYNAPSE eCME and we are proud of our relationship with the Association of Surgeons of Malta. For the last 10 years, TheSYNAPSE has been a source of Practical Solutions for Effective Health Care'.*

This programme allows medical professionals to enrich their knowledge portfolio and in the comfort of their home, it allows for interaction between tutors and participants and is a great way of adult learning, we are confident that this will play a major role in medical education in Malta".

The ASM eCME modules can be accessed through direct links from *www.thesynapse.net*

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Attard & Co. Foodstuffs Ltd. Wines & Spirits Division, has joined the ever growing number of companies using TheSYNAPSE as one of their major vehicles to reach the medical profession. This has been possible following an agreement, signed recently between the two companies. Information on Fine Wines marketed by Attard & Co. will be featured in the 'lifestyle' section of TheSYNAPSE.

Marco Vella, Wines & Spirits Division Manager at Attard & Co. comments *'we are very pleased of having the opportunity to reach a clientele that we are very confident that many of them already enjoy our wines in various Restaurants and Wine Bars spread trough out our Islands'.*

This agreement will not only help enrich the content of TheSYNAPSE but will also be a catalyst for members of TheSYNAPSE to physically meet in organised events over the coming months thereby enriching the community feel

About Attard & Co Foodstuffs Ltd

Attard & Co. Foodstuffs Ltd. Wines & Spirits imports are focused on quality Wines. Attard & Co. are committed to importing into Malta not just wines of prestige but also wines chosen for their character, exquisite flavour and still good value.

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a. They have to be imported directly from the producer so as to ensure that there is first hand contact between the wine producers and vine growers.
b. Wines are made from grape varieties that are either indigenous to that region or have been growing there for decades. Some examples: Lagrein Dunkel from Trentino, Greco from Campania and Calabria; Pecorino from Abruzzo, Primitivo and Verdeca from Puglia, Cannonau from Sardegna, Pinotage from South Africa; Carmenere from Chile and Malbec from Argentina.
c. Wines must all be bottled at source, namely not only from country of origin but from the same region of cultivation of the grapes, thus ensuring that the quality and character of the wine remain unspoilt.

Winning with TheSYNAPSE

Join the Winners... take the eQUIZ

We invite all doctors to participate in regular eQUIZes that are held regularly on TheSYNAPSE portal, these eQUIZes serve as an opportunity for some fun and great prizes. A selection of eQUIZes that were held over the last few weeks were:

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Congestive Cardiac Failure

by Albert Fenech MD(Malta) MD(Aberd) FRCP(Glasg) FRCP(Lond)
Department of Cardiology
St Luke's Hospital

'Common, costly and deadly'. This in a nutshell describes the condition we traditionally refer to as Cardiac Failure. Indeed 'Circulatory failure' would be a more appropriate term as it is a combination of factors that involve not only the heart but other organs such as the kidney and brain as well as the peripheral circulation. The management of this condition includes pharmacological and surgical approaches as well as a number of devices that have been developed in recent years in order to improve the significant morbidity as well as mortality associated with it.

Prior to outlining the various therapies, it is relevant to emphasise the clinical advice that patients should be encouraged to follow. The 'usual' lifestyle changes such as smoking cessation and weight loss are imperative in order to help respiration and reduce the cardiac workload. It is relevant to remember that fluid retention is one of the features of this condition and that every litre of excess fluid will increase the body weight by 1 kilo thus increasing the load inherent in mobility. Restricting the daily fluid intake to 1.5 litres will help controlling the oedema and reduce the need for increasing the diuretic medication with its inherent problems. Gentle exercise limited to the individual's capabilities is of proven benefit, as is a positive attitude. Raising the head of the bed by around 4 inches may also improve the problems associated with orthopnoea and paroxysmal nocturnal dyspnoea resulting in an improved sleeping pattern. Simply increasing the number of pillows is of limited value as the body tends to slide down to the horizontal position once asleep.

Loop and Thiazide diuretics have an important place in the management of heart failure and it is pertinent at this point to remember that most patients with cardiac failure die from ventricular tachycardia and/or ventricular fibrillation without any prior evidence of clinical deterioration. It is therefore imperative to avoid low levels of serum Potassium as well as Magnesium, both of which are important for myocardial cellular electrical stability. Nitrates and direct acting vasodilators can be useful in modifying preload and afterload and after a long period of controversy Digitalis has again found a place in the therapeutic armamentarium – albeit in a very limited role. All these drugs can improve symptoms but do nothing for the overall mortality.

Drugs that have an impact on both morbidity and mortality include ACE inhibitors and Beta Blockers, both of which should be prescribed (unless contraindicated) as first line on a 'some better than none' basis. ACE inhibitors are indicated in all classes of heart failure (New York Heart Association I to IV) whereas Beta Blockers are contraindicated in NYHA class IV patients. If ACE inhibitors are not tolerated because of untoward side effects then Angiotensin-II Receptor Blockers can be used. Spironolactone is another drug that improves mortality though it is used as a third line drug and can be limited by side effects which appear to be less with its successor Epelrenone. For a number of years the use of Amiodarone was suggested as being of potential benefit in reducing mortality due to its antiarrhythmic properties. It is now established that this drug offers no benefit whatsoever in patients with cardiac failure.

Despite all the measures hitherto mentioned a considerable number of patients do not respond adequately or have such a degree of left ventricular impairment that the use of certain devices is indicated. Up to half the patients with congestive heart failure have intra ventricular conduction defects which can result in 'Ventricular Dysynchrony'. This label describes the situation when the septal portion of the left ventricle contracts before the lateral wall (of the left ventricle). These normally contract simultaneously (in synchrony) ejecting blood out of the ventricle into the Aorta so the lack of synchrony results in a portion of blood inside the left ventricle being pushed from one side of the ventricle to the other instead of through the Aortic valve into the circulation. In addition, left ventricular dysynchrony causes inefficient closure of the Mitral Valve which results in functional Mitral Regurgitation, thus further elevating the pulmonary pressure.

It is possible to correct this situation by inserting a pacemaker that paces both the septum and the lateral wall of the left ventricle simultaneously thus 'synchronising' the contraction and improving Mitral valve closure with a resultant improvement in cardiac output and pulmonary pressure. Keeping in mind that these patients are prone to ventricular tachycardia and/or ventricular fibrillation the pacing function of these devices is supplemented with an anti-tachycardia and defibrillation capability that has significantly improved the patient's symptoms as well as improving morbidity and mortality.

Cardiac surgical techniques are available for patients with relenting cardiac failure, the most successful of which has been cardiac transplantation. The major problem is a lack of suitable donors with the majority of patients dying while waiting for a suitable heart. In this context a number of left ventricular assist devices (LVADs) have been developed which can help the individual for a period of time thus 'bridging' the time to clinical improvement or transplantation. The most commonly available device is the intra-aortic balloon device (IABD) which is a balloon counterpulsation device inserted percutaneously into the descending aorta. Its rapid inflation during diastole helps boost the blood pressure as well as the coronary circulation and the rapid deflation during systole helps in offloading the left ventricle.

More recent mechanical devices that can generate a cardiac output of up to 4.5 litres/minute include the 'Impella' device (Figure 1) that is a miniature turbine inserted across the aortic valve into the left ventricle ejecting blood into the aorta.

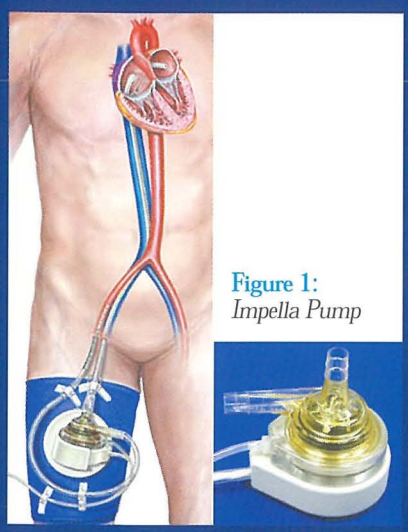


Figure 1: *Impella Pump*

continues on page 18

The #1 Globally Prescribed ARB*

Powerfully Effective... Proven Cardioprotective

DIOVAN® VALSARTAN Co-Diovan® VALSARTAN + HCTZ

Powerfully Effective... Proven Cardioprotective

DIOVAN®

Presentation: Valsartan: film-coated tablets of 80 mg and 160 mg.
Indication: Hypertension, post-myocardial infarction, heart failure.
Dosage - Hypertension: Recommended dose is 80 mg once daily. If the fall in blood pressure is inadequate, dosage may be increased to 160 mg, or another antihypertensive (e.g. diuretic) may be added. Treatment of post-myocardial infarction: Starting dose is 20 mg twice daily. Uptitration to a maximum of 160 mg twice daily as tolerated by patient. Heart failure: Starting dose is 40mg twice daily. Uptitration to 80 and 160mg twice daily as tolerated by patient.
Contraindication: Known hypersensitivity to the components of this product, pregnancy.
Precautions/Warnings/Interactions: Risk of hypotension in sodium- and/or volume-depleted patients. Caution is advised when administering valsartan to patients with renal artery stenosis, severe renal impairment (creatinine clearance < 10 mL/min), biliary cirrhosis or obstruction. Caution should be observed with the triple combination of an ACE-inhibitor, beta-blocker and Diovan. In patients with severe heart failure, treatment with Diovan may cause impairment of renal function. Concomitant treatment with potassium-sparing diuretics or potassium supplements may increase serum potassium levels. Caution is advised when driving or operating machines. Avoid use whilst breast-feeding.
Adverse reactions: Generally similar in incidence to patients receiving placebo in placebo-controlled clinical trials, e.g. headache, dizziness, fatigue. The observed incidence of cough with valsartan in controlled clinical trials was significantly less than that observed with ACE inhibitors and similar to that seen with placebo. The most common adverse reactions are: viral infections, postural dizziness (reported in heart failure indication), orthostatic hypotension (reported in heart failure indication), neutropenia, upper respiratory tract infection, pharyngitis, sinusitis, hyperkalaemia (reported in post-myocardial infarction and heart failure indications), insomnia, libido decrease, vertigo, hypotension (reported in post-myocardial infarction indication and uncommon in heart failure indication), cough, diarrhoea, abdominal pain, back pain, fatigue, asthenia, oedema, syncope (reported in postmyocardial infarction indication), cardiac failure (reported in post-myocardial infarction indication). Very rare adverse reactions but potentially serious are: thrombocytopenia, hypersensitivity including serum sickness, vasculitis, angioneurotic oedema (uncommon in post-myocardial infarction indication), renal impairment (common in heart failure indication), renal insufficiency, acute renal failure (uncommon in post-myocardial infarction indication). Some patients with heart failure have developed increases in blood urea nitrogen, serum creatinine and potassium, usually minor and transient
Packs and prices: Country specific. **Note:** This product is a POM, before prescribing consult full prescribing information.

* Diovan® is the # 1 globally prescribed ARB in terms of value according to IMS Health, IMS MIDAS Quantum/ MAT 2004

Co-Diovan®

Presentation: Coated tablets containing 80 mg valsartan (an angiotensin II receptor antagonist) and 12.5 mg hydrochlorothiazide (a thiazide diuretic) or 160 mg valsartan and 12.5mg hydrochlorthiazide or 160mg valsartan and 25mg hydrochlorthiazide.
Indication: Hypertension.
Dosage: One tablet of Co-Diovan 80/12.5 mg or 160/12.5 mg or 160/25mg daily.
Contraindication: Known hypersensitivity to the components of this product, pregnancy.
severe hepatic impairment, biliary cirrhosis and cholestasis, anuria, severe renal impairment (creatinine clearance < 30 mL/min), refractory hypokalemia, hyponatremia, and hypercalcemia. Symptomatic hyperuricemia.
Precautions/Warnings: Risk of hypotension in sodium- and/or volume-depleted patients,
Caution is advised when administering Co-Diovan to patients with renal artery stenosis, renal and liver disease. Disturbance of serum electrolyte balance. Concomitant treatment with potassium-sparing diuretics or potassium supplements may increase potassium levels. Caution if combined with other antihypertensives or lithium (serum lithium monitoring). Caution in driving or operating machinery. Avoid use while breast-feeding.
Adverse reactions: headache, dizziness, fatigue. For the hydrochlorothiazide component, other reported adverse reactions include hypokalemia, hyperuricemia and other electrolyte disturbances, postural hypotension and rise in blood lipids. Rare: jaundice, cardiac arrhythmias, blood dyscrasias. Very rare: vasculitis, pancreatitis, pneumonitis, pulmonary edema. Post-marketing experience revealed very rare cases of hypersensitivity reactions (e.g. angioedema), and impaired renal function, myalgia and thrombocytopenia. Laboratory findings: Neutropenia, elevations in creatinine and blood urea nitrogen.
Packs and prices: Country specific. **Note:** This product is a POM, before prescribing, consult full prescribing information.

Co-Diovan® 160/12.5mg & Co-Diovan® 160/25mg are now available locally.

NOVARTIS

Full prescribing information is available from: Novartis Pharma Services Inc.

Novartis Pharmaceuticals UK Ltd.,
Frimley Business Park, Frimley, Camberley
Surrey GU16 7SR,
United Kingdom.

Local Representative of the MAH:
Novartis Pharma Services,
P.O. Box 124,
Valletta. CMR 01. Malta
Tel. : +35622983217

The Scars

by **Philip Carabot**
Consultant in GU Medicine
GU Clinic, Boffa Hospital

Sexually Transmitted Infections (STIs) are very common, with an estimated 330 million new cases yearly. They are the cause of serious morbidity (e.g. pelvic inflammatory disease, tubal infertility and ectopic pregnancies), as well as congenital and neonatal complications and even death. WHO estimates that, in Malta there could be up to 13,000 new cases per year, but this remains speculative.

This short report summarises the STIs and related conditions, seen in 2005 at the GU Clinic. This, of course, cannot be extrapolated to gauge any trends in the country as a whole and should not be interpreted as such. We need national prevalence studies for this information.

There were a total of 1832 attendances, a 15% increase over 2004. 74% were new patients, in keeping with the clinic's policy of offering follow-up visits only if strictly indicated. More time can then be thus dedicated to new cases.

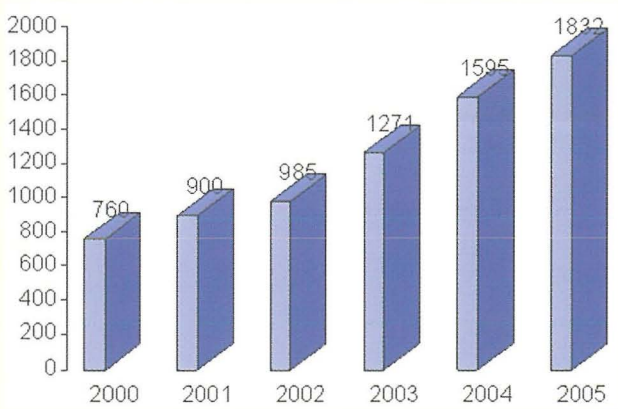
174 of the new patients were non-residents. The male: female ratio was 1.6:1. The female attendances have gradually increased over the years, compared to a preponderance of males (M: F 2.3:1) in 2000.

Patient self- referral remains the most popular at 78% of the total. Caritas referrals account for 4.6% and doctor referral remains low at 16.8% (precisely the percentage for 2004).

As to sexuality 89% were heterosexual, 8% MSM (men who have sex with men) and 3% bisexual. Only one patient admitted to being lesbian.

The young (13-25 years) remain a significant group accounting for 48 %. The youngest patient was 13 years old and the oldest was 78.

Total attendances 2000-2005



15.8% of heterosexuals admitted to having anal sex, at least occasionally, whereas 89% of MSM performed anal sex regularly.

The failure to attend rate was 21%. GU patients are well known to expect prompt consultation, and do not keep appointments considered to be too long. Ideally patients should not wait for more than 48 hours for an appointment. Urgent cases *are* seen within 48 hours. These are:

1. males with a urethral discharge;
2. males and females with genital ulcers;
3. patients 16 years old and younger, (especially if female);
4. if pregnant;
5. victims of sexual assault.

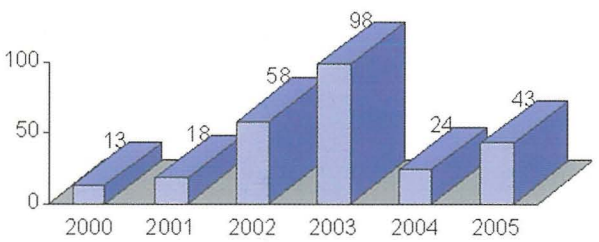
1. CHLAMYDIA

Globally *Chlamydia trachomatis* is the most prevalent sexually transmitted bacterial infection. Approximately 70% of the infections in women and 50% in men are asymptomatic or subclinical.

Up to 2003 testing was done with an EIA, which has well known limited sensitivity and specificity. 2004 saw the introduction of PCR testing which is much more accurate.

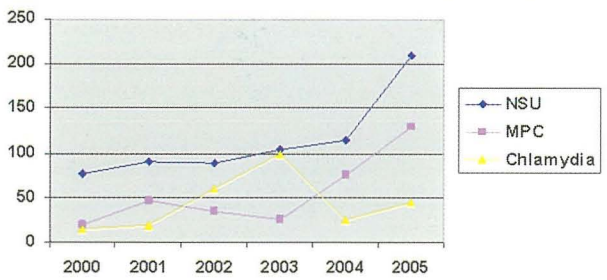
The GU Clinic report of 2004 expressed concern about the seemingly low numbers of chlamydia positives which coincided with the introduction of NAAT.

The 43 cases diagnosed in 2005 are a significant increase over 2004.



Chlamydia positives 2000-2005

On the other hand there were 209 cases of non-specific urethritis (NSU) and 129 cases of muco-purulent cervicitis (MPC). Chlamydia should be the cause in 30-50% of NSU and 25-45% of MPC. However in our patients the rate of chlamydia positivity was 11% and 0.2% respectively. We are therefore either over-diagnosing non-specific infection or under-diagnosing chlamydia. The problem highlighted in 2004 persists.



Non-specific infection 2000-2005 (NSU: non-specific urethritis, MPC: muco-purulent cervicitis,)

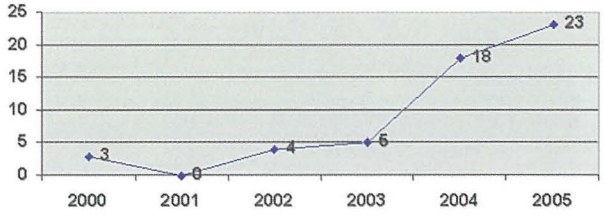
2. GONORRHOEA

There were 23 cases of gonorrhoea diagnosed; 20 in males and 3 in females. Although the actual total is small there has been an increase of 28% over 2004. The number almost certainly does not reflect the national prevalence. Many, if not most, of patients with acute symptoms, both male and female, are treated by other practitioners with broad-spectrum

# of Venus

antibiotics and without investigations. Many patients attend the clinic having already had different antibiotics often prescribed, but also bought over the counter.

Of concern are that 4 cases of the 23 (17%) were resistant not only to penicillin but also ciprofloxacin which is the current first line treatment. First line treatment is dependent on the premise that more than 95% of the local strains are sensitive to it. The numbers are too small to suggest changing treatment policy, but we do need national prevalence studies to evaluate the true state of affairs.

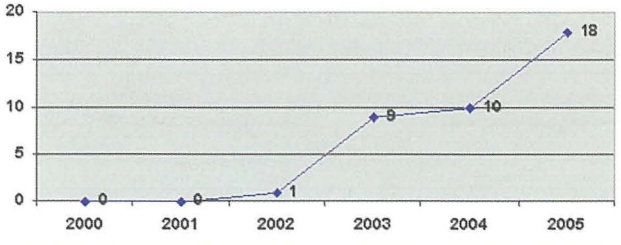


Gonorrhoea 2000-2005

3. SYPHILIS

With the safer sex practises brought about by the fear of AIDS, syphilis had become almost extinct in the mid-1980's. However human nature being what it is, and people becoming complacent about HIV disease, mistaking the advances in treatment for a cure, all acute STIs especially syphilis have made a dramatic come-back reaching epidemic proportions in Eastern Europe, but not confined there. In 2002 the U.K. reported a 73% increase in males and 33% in females.

In Malta there were only 3 cases of syphilis diagnosed in the 25 years, (and none for the 15 years), before the year 2000. The situation has changed.



Cases of syphilis 2000-2005

Cases of syphilis rose by 80% (from 10 cases in 2004 to 18 cases in 2005). 14 cases were early disease and therefore infectious, while the other 4 were late and by definition probably not. While 4 patients were non-Maltese they were all permanent residents.

Of note is one patient who was also HIV positive. Contact tracing could only be done with 3 patients.

continues on page 20

Assessment of People with Memory Symptoms

continued from page 8

The initial assessment of a person presenting with a dementia syndrome continues with blood investigations and imaging to exclude secondary and potentially reversible causes. These should include a complete blood picture, erythrocyte sedimentation rate, electrolyte and renal function tests, liver function tests, serum calcium, thyroid function tests, serum Vitamin B12 and folate levels. A CT scan of the brain is indicated to exclude a space occupying lesion or to detect features of a normal pressure hydrocephalus. A SPECT scan is particularly useful to see whether decreased tracer uptake is diffuse or focal. In vascular dementia, it is possible to identify a patchy loss of tracer uptake corresponding to the ischaemic regions. MRI and functional imaging techniques e.g. functional SPECT are becoming increasingly used in specialised centres.

Although there is no definite cure for dementia, the availability of specific anti-dementia drugs such as the cholinesterase inhibitors rivastigmine and memantine can lead to improvement in cognitive function and symptomatic improvement, thus delaying the need for institutionalization. Dementia care has become a specialized subject, necessitating the collaboration of the primary care team and specialists in geriatric medicine, neurology and psychiatry. Education, training and support of persons with dementia and caregivers, but also of healthcare staff constitute a major area in need of attention if we are to face the challenges that lie ahead.

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Congestive Cardiac Failure

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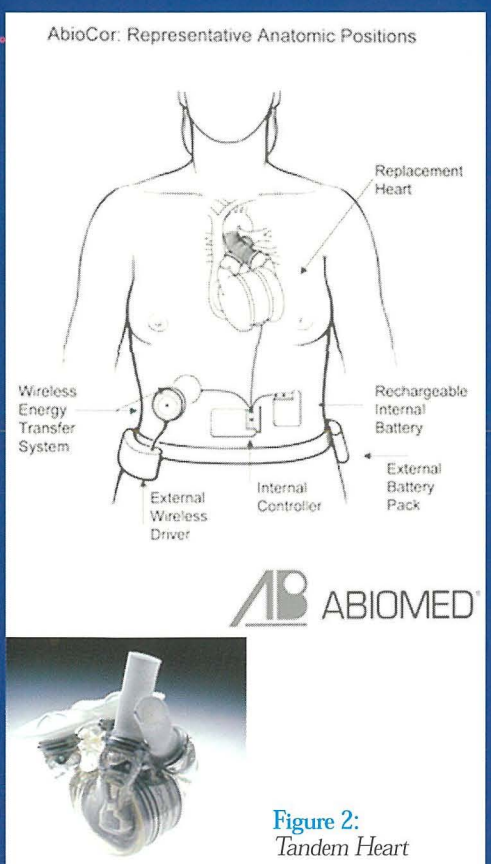

Figure 2: *Tandem Heart*

Another device is the 'Tandem Heart' (Figure 2) which is an external pump which through percutaneous catheters (one placed through the femoral vein, across the atrial septum into the left atrium, the other into the femoral artery) 'sucks' oxygenated blood out of the left atrium and pumps it into the femoral artery.

The lack of donors has also stimulated the development of artificial hearts – the most established of which include the 'Jarvic' heart' and the 'AbioCor' heart' (Figure 3). Both these amazing mechanical hearts require the patient to be constantly 'connected' to an external power source. This considerable limitation has encouraged research into the possibility of using pigs as heart donors. The porcine heart is very similar to the human one and if the problem of rejection can be overcome it promises to be of significant clinical value. With this in mind a colony of genetically modified pigs has been grown. These have been genetically engineered so that the human body will not recognise their hearts as being 'incompatible'.

I'll leave you with a sobering thought. There is some evidence that cardiac transplant recipients can show behaviour signs of their dono...gives a new dimension to the phrase 'making a pig of oneself'!

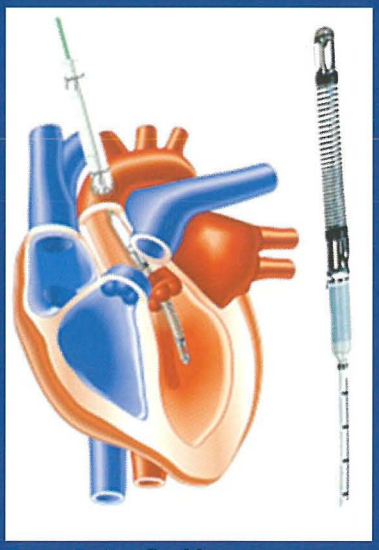

Figure 3: *AbioCor Heart*

New contra-indications and warnings regarding all COX-2 selective inhibitors, including etoricoxib, are available on the MHRA website at http://www.mhra.gov.uk

ARCOXIA®
etoricoxib

ARCOXIA® (etoricoxib)
ABRIDGED PRODUCT INFORMATION
Refer to Summary of Product Characteristics before prescribing

PRESENTATION
Tablets: 60 mg, 90 mg and 120 mg tablets each containing 60 mg, 90 mg or 120 mg of etoricoxib respectively.

USES
Symptomatic relief of osteoarthritis, rheumatoid arthritis (RA) and the pain and signs of inflammation associated with acute gouty arthritis. Base the decision to prescribe a selective COX-2 inhibitor on an assessment of the individual patient's overall risks.

DOSAGE AND ADMINISTRATION
Take orally with or without food. Onset of action may be faster when administered without food, and should be considered when rapid relief is needed. *Osteoarthritis:* 60 mg once daily. *Rheumatoid arthritis:* 90 mg once daily. *Acute gouty arthritis:* 120 mg once daily for the acute symptomatic period only and limited to a maximum of 8 days. Each dose above is the maximum recommended dose for each condition and should not be exceeded. As the cardiovascular risks of etoricoxib may increase with dose and duration of exposure, use for the shortest duration possible and use the lowest effective daily dose. Re-evaluate periodically the patient's need for symptomatic relief and response to therapy, especially in osteoarthritis patients. *Hepatic insufficiency: mild (Child-Pugh score 5-6):* do not exceed a dose of 60 mg daily; *moderate (Child-Pugh score 7-9),* **do not exceed 60 mg every other day**. *Renal insufficiency:* No dosage adjustment necessary for patients with creatinine clearance 30 ml/min.

CONTRA-INDICATIONS
History of hypersensitivity to any component of this product. Active peptic ulceration or gastro-intestinal (GI) bleeding. Patients who have experienced bronchospasm, acute rhinitis, nasal polyps, angioneurotic oedema or urticaria or allergic type reactions after aspirin or NSAIDs including COX-2 inhibitors. Pregnancy and lactation. Severe hepatic dysfunction (serum albumin <25 g/l or Child-Pugh score 10). Estimated creatinine clearance <30 ml/min. Children and adolescents under 16 years of age. Inflammatory bowel disease. Congestive heart failure (NYHA II-IV). Patients with hypertension whose blood pressure has not been adequately controlled. Established ischaemic heart disease and/or cerebrovascular disease.

PRECAUTIONS
Gastro-intestinal effects: Upper GI complications (perforations, ulcers or bleedings), some with fatal outcome have occurred in patients taking etoricoxib. Caution is advised in patients most at risk of developing a GI complication with NSAIDs: elderly, those on any other NSAID or aspirin concomitantly, or those with a prior history of GI disease. There is a further increase in the risk of GI adverse effects (GI ulceration or other GI complications) when etoricoxib is taken together with aspirin (even at low doses). A significant difference in GI safety between selective COX-2 inhibitors + acetylsalicylic acid vs NSAIDs + acetylsalicylic acid has not been demonstrated in long-term clinical trials. *Cardiovascular:* Clinical trials suggest that the selective COX-2 inhibitor class of drugs may be associated with a risk of thrombotic events (especially MI and stroke), relative to placebo and some NSAIDs. As the cardiovascular risks of etoricoxib may increase with dose and duration of exposure, use for the shortest duration possible and use the lowest effective daily dose. Re-evaluate periodically the patient's need for symptomatic relief and response to therapy, especially in those with osteoarthritis. Patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking) or peripheral arterial disease should only be treated with etoricoxib after careful consideration. COX-2 selective inhibitors are not a substitute for acetylsalicylic acid for prophylaxis of cardiovascular thromboembolic diseases because of their lack of antiplatelet effect. Therefore antiplatelet therapies should not be discontinued. *Renal effects:* Consider monitoring renal function in patients with pre-existing significantly impaired renal function, uncompensated heart failure, or cirrhosis. *Fluid retention, oedema and hypertension:* Exercise caution in patients with a history of cardiac failure, left ventricular dysfunction, or hypertension and pre-existing oedema from any other reason, as fluid retention, oedema and hypertension have been observed in patients taking etoricoxib. Take appropriate measures, including discontinuation of etoricoxib where there is clinical evidence of deterioration in the condition of these patients. Etoricoxib may be associated with more frequent and severe hypertension than some other NSAIDs and selective COX-2 inhibitors, particularly at high doses. Pay special attention to blood pressure monitoring during treatment with etoricoxib. If blood pressure rises significantly, consider alternative treatment. *Hepatic effects:* Elevations of ALT and/or AST (>3 times the upper limit of normal) have been reported in approximately 1% of patients treated in trials with etoricoxib 60 mg and 90 mg for up to one year. Monitor any patient with symptoms/signs of liver dysfunction or in whom an abnormal liver function test has occurred. Discontinue etoricoxib if signs of hepatic insufficiency occur, or if persistently abnormal liver function tests (3 times the upper limit of normal) are detected. *General:* Take appropriate measures and consider discontinuation, if during treatment, patients deteriorate in any of the organ system functions described above. Maintain appropriate medical supervision when treating the elderly and patients with renal, hepatic or cardiac dysfunction with etoricoxib. Use caution when initiating treatment in patients with considerable dehydration. Rehydrate patients prior to starting therapy with etoricoxib. Serious skin reactions including exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis have been reported associated with the use of NSAIDs including other COX-2 inhibitors and cannot be ruled out for etoricoxib. Discontinue at the first signs of hypersensitivity as hypersensitivity reactions (anaphylaxis, angioedema) have been reported. Etoricoxib may mask fever. Use of etoricoxib is not recommended in women attempting to conceive. 'Arcoxia' tablets contain lactose: do not use in patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption. *Interactions (pharmacodynamic): Oral anticoagulants:* Exercise caution when coadministering with warfarin and other oral anticoagulants. Closely monitor the prothrombin time INR when therapy with etoricoxib is initiated or the dose changed in patients receiving oral anticoagulants or similar agents, particularly in the first few days. *Diuretics, ACE-inhibitors and Angiotensin II Antagonists:* NSAIDs may reduce the effect of diuretics and antihypertensive drugs. In some patients with compromised renal function, the co-administration of an ACE inhibitor or AIIA and cyclo-oxygenase inhibitors may result in further deterioration of renal function including possible acute renal failure, which is usually reversible. Administer cautiously, especially in the elderly. Patients should be adequately hydrated. Consider monitoring renal function at initiation of therapy and periodically thereafter. *Aspirin:* etoricoxib can be used concomitantly with aspirin at doses used for cardiovascular prophylaxis (low dose aspirin). However, concomitant administration of low dose aspirin with etoricoxib may result in an increased rate of GI ulceration or other complications compared to use of etoricoxib alone. Concomitant administration of etoricoxib with doses of aspirin **above** those for cardiovascular prophylaxis, or with other NSAIDS is not recommended. *Ciclosporin/tacrolimus:* monitor renal function when etoricoxib and either ciclosporin or tacrolimus is used in combination. *Interactions (pharmacokinetic): The effect of etoricoxib on the pharmacokinetics of other drugs: Lithium:* the plasma concentration of lithium is increased by NSAIDS, therefore monitor and adjust blood lithium and lithium dosage if necessary. *Methotrexate:* adequate monitoring is recommended for methotrexate-related toxicity when etoricoxib and methotrexate are administered concomitantly. *Oral Contraceptives (OC):* Administration of etoricoxib 60 mg with an OC containing 35 mcg ethinyl estradiol (EE) and 0.5 to 1 mg norethindrone for 21 days increased the steady state AUC0-24hr of EE by 37%. Administration of etoricoxib 120 mg with the same OC, concomitantly or separated by 12 hours, increased the steady state AUC0-24hr of EE by 50 to 60%. Consider this increase in EE concentration when selecting an oral contraceptive for use with etoricoxib. An increase in EE exposure can increase the incidence of adverse events associated with oral contraceptives. *Hormone Replacement Therapy:* 120 mg etoricoxib administered with 0.625 mg Premarin™ (Wyeth) for 28 days increased the mean steady state AUC0-24hr of unconjugated estrone (41%), equilin (76%) and 17-α-estradiol (22%). Although the clinical significance is unknown, take into consideration the increase in estrogenic concentration when selecting HRT as the increase in estrogen exposure might increase the risk of adverse events associated with HRT. *Digoxin:* Patients at high risk of digoxin toxicity should be monitored for an increase in digoxin Cmax when etoricoxib and digoxin are administered concomitantly. *Effect of etoricoxib on drugs metabolised by sulfotransferases:* Etoricoxib is an inhibitor of human sulfotransferase activity, particularly SULT1E1 and has been shown to increase the serum concentrations of ethinyl estradiol. It may be prudent to exercise care when administering etoricoxib concurrently with other drugs primarily metabolised by human sulfotransferases (e.g. oral salbutamol and minoxidil). *Effect of etoricoxib on drugs metabolised by CYP isoenzymes:* Based on *in vitro* studies, etoricoxib is not expected to inhibit cytochromes P450 (CYP) 1A2, 2C9, 2C19, 2D6, 2E1 or 3A4. In a study in healthy subjects, daily administration of etoricoxib 120 mg did not alter hepatic CYP3A4 activity as assessed by the erythromycin breath test. *Effects of other drugs on the pharmacokinetics of etoricoxib:* The main pathway of etoricoxib metabolism is dependent on CYP enzymes. CYP3A4 appears to contribute to the metabolism of etoricoxib *in vivo*. *Ketoconazole:* a potent inhibitor of CYP3A4, dosed at 400 mg once a day for 11 days to healthy volunteers did not have any clinically important effect on the single-dose pharmacokinetics of 60 mg etoricoxib (43% increase in AUC). *Rifampicin:* Co-administration of etoricoxib with rifampicin, a potent inducer of CYP enzymes, produced a 65% decrease in etoricoxib plasma concentrations, an interaction which may result in recurrence of symptoms. *Antacids:* Antacids do not affect the pharmacokinetics of etoricoxib to a clinically relevant extent. *Pregnancy:* contraindicated in the first, second and third trimesters of pregnancy. *Lactation:* contraindicated.

SIDE EFFECTS
The following undesirable effects were reported at an incidence greater than placebo in clinical trials in patients with OA, RA or chronic low back pain treated with etoricoxib 60 mg or 90 mg for up to 12 weeks, or in post-marketing experience: *[Very common (≥1/10) Common (≥1/100, <1/10) Uncommon (≥1/1000, <1/100) Rare (≥1/10,000, <1/1000) Very rare (<1/10,000) including isolated cases)]* ***Infections and infestations:*** *Uncommon:* gastro-enteritis, upper respiratory infection, urinary tract infection. ***Immune system disorder:*** *Very rare:* hypersensitivity reactions including angioedema, anaphylactic/anaphylactoid reactions. ***Metabolism and nutrition disorders:*** *Common:* oedema/fluid retention. *Uncommon:* appetite increase or decrease, weight gain. ***Psychiatric disorders:*** *Uncommon:* anxiety, depression, mental acuity decreased. ***Nervous system disorder:*** *Common:* dizziness, headache. *Uncommon:* dysgeusia, insomnia, paraesthesia/hypaesthesia, somnolence. ***Eye disorders:*** *Uncommon:* blurred vision. ***Ear and labyrinth disorders:*** *Uncommon:* tinnitus. ***Cardiac disorders:*** *Uncommon:* congestive heart failure, non-specific ECG changes. *Very rare:* myocardial infarction. ***Vascular disorders:*** *Common:* hypertension. *Uncommon:* flushing. *Very rare:* cerebrovascular accident. ***Respiratory, thoracic and mediastinal disorders:*** *Uncommon:* cough, dyspnoea, epistaxis. ***Gastro-intestinal disorders:*** *Common:* gastro-intestinal disorders (e.g. abdominal pain, flatulence, heartburn), diarrhoea, dyspepsia, epigastric discomfort, nausea. *Uncommon:* abdominal distention, acid reflux, bowel movement pattern change, constipation, dry mouth, gastroduodenal ulcer, irritable bowel syndrome, oesophagitis, oral ulcer, vomiting. *Very rare:* peptic ulcers including gastro-intestinal perforation and bleeding (mainly in the elderly). ***Skin and subcutaneous tissue disorders:*** *Uncommon:* ecchymosis, facial oedema, pruritus, rash. *Very rare:* urticaria. ***Musculoskeletal, connective tissue and bone disorders:*** *Uncommon:* muscular cramp/spasm, musculoskeletal pain/stiffness. ***Renal and urinary disorders:*** *Uncommon:* proteinuria. *Very rare:* renal insufficiency, including renal failure, usually reversible upon discontinuation of treatment. ***General disorders and administration site conditions:*** *Common:* asthenia/fatigue, flu-like disease. *Uncommon:* chest pain. ***Investigations:*** *Common:* ALT increased, AST increased. *Uncommon:* blood urea nitrogen increased, creatine phosphokinase increased, haematocrit decreased, haemoglobin decreased, hyperkalaemia, leukocytes decreased, platelets decreased, serum creatinine increased, uric acid increased. The following serious undesirable effects have been reported in association with the use of NSAIDs and cannot be ruled out for etoricoxib: nephrotoxicity including interstitial nephritis and nephrotic syndrome; hepatotoxicity including hepatic failure and jaundice, cutaneo-mucosal adverse effects and severe skin reactions.

PACKAGE QUANTITIES AND BASIC NHS COST
60 and 90 mg Tablets: packs of 28 tablets £22.96, 120 mg Tablets: packs of 7 tablets £6.03 and packs of 28 tablets £24.11 **Marketing Authorisation numbers** Tablet 60 mg PL 0025/0422. Tablet 90 mg PL 0025/0423. Tablet 120 mg PL 0025/0424 **Marketing Authorisation holder** Merck Sharp & Dohme Limited Hertford Road, Hoddesdon, Hertfordshire EN11 9BU, UK **PDate of review:** June 2005 ® denotes registered trademark of Merck & Co., Inc., Whitehouse Station, NJ, USA. © Merck Sharp & Dohme Limited 2005. All rights reserved. Merck Sharp & Dohme Limited Hertford Road, Hoddesdon, Hertfordshire EN11 9BU

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Adult immunisation – an overview

continued from page 4

Some would recommend meningococcal vaccine as well, especially in persons over 25 years of age and university attendees. BCG is not usually recommended to persons aged over 16 years as the data for its effectiveness is not available. However, it may be recommended to high risk groups where risk of exposure is high.

Travel related immunisations have increased in proportion with travel to areas at risk of specific infections. This is especially important in travel to Africa, South-East Asia and South America but not exclusive to these areas. Some travellers to forests in Northern Europe for example, may need cover for tick-borne encephalitis. It is thus important to consult the latest travel advice according to the destination and planned activities in that country.

The challenges of the future include vaccines for HIV and hepatitis C. Up till now, these remain elusive, although graded successes are recorded in both fields. One of the latest HIV vaccines on trial showing promise uses a disabled form of an adenovirus to ferry three specific HIV genes into the body. Other organisms being targeted include malaria and leishmania, now that both their genomes have been sequenced.

Some vaccines may protect against tumour development. The most well known is hepatitis B vaccine protecting against hepatoma. Other potential targets include papilloma virus, Ebstein-Barr virus, and human T-cell lymphotropic virus I and II. Vaccines against diseases which are non-communicable, like Alzheimer's disease, have also shown some promising results in animal studies.

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The Scars of Venus

continued from page 17

Details of VDRL/TPHA serology (2004 cases)

Patient	VDRL	TPHA
1	1:32	1:2560
2	Negative	1:320
3	Negative	1:160
4	Negative	1:320
5	Negative	1:80
6	Negative	1:320
7	1:8	1:5120
8	1:8	1:40960
9	1:16	1:40960
10	1:4	1:40960

It is still common practicse to screen for syphilis with only a VDRL. This can often be negative, in both early as well as late disease. The international guidelines are to use VDRL and TPHA/or EIA. The VDRL, when positive is useful to monitor treatment.

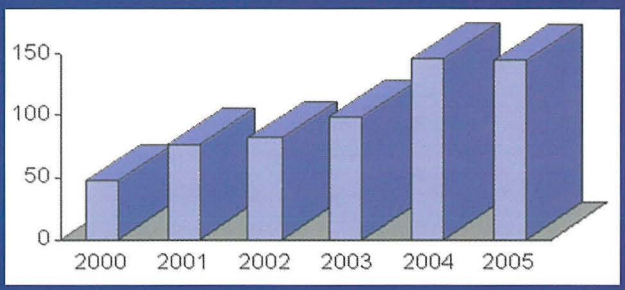
5 of the patients had a persistently negative VDRL, and the diagnosis would have been missed.

Clinicians need to be made aware of the reappearance of this insidious disease, and to screen appropriately.

4. ANO-GENITAL WARTS

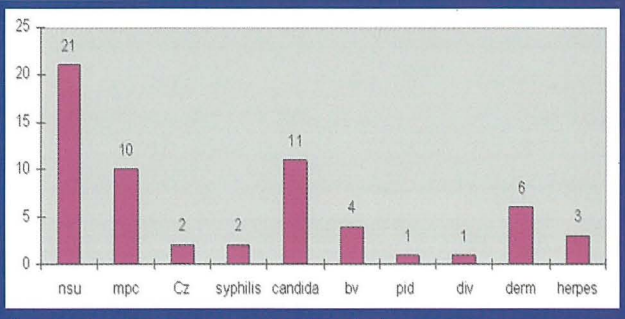
There were 145 cases of ano-genital warts which is a 32% increase over 2003.

Ano-genital warts (first presentation) continue to be a significant proportion of the total number of diagnoses (14%). The increase over the years has been maintained.



Ano-genital warts 2000-2005

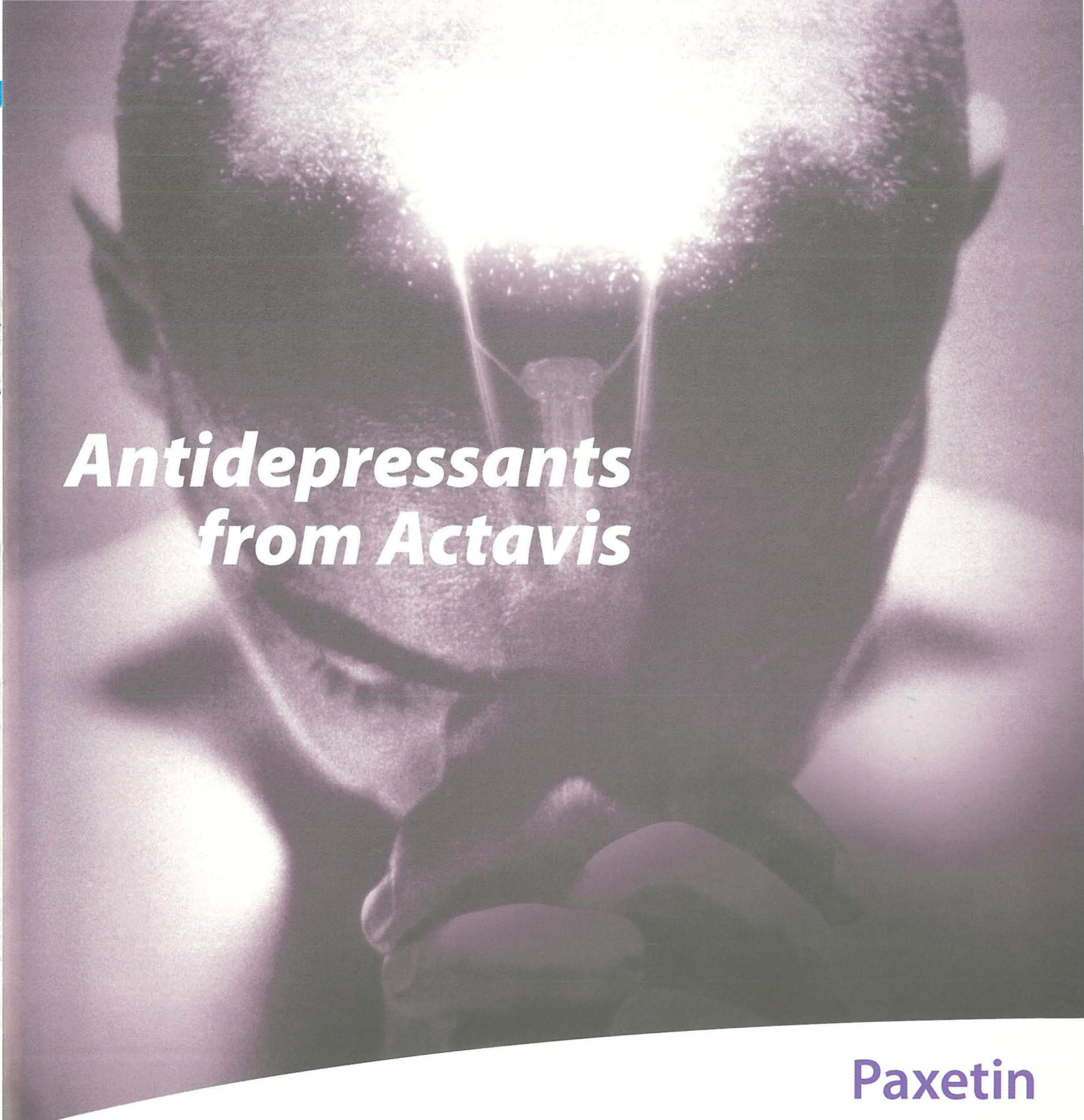
Genital warts are associated with other significant pathology in 22% of cases. In this series the following additional (and unsuspected) conditions were found.



Ano-genital warts- associated pathology

This again highlights the importance of fully screening all new presentations of genital warts, before embarking on ablative therapy.

Part II will be published in the next issue



Paxetin

– More affordable SSRI treatment

Paroxetine 20mg tablets

Compositon: Paroxetine HCl equivalent to Paroxetine 20 mg. **Therapeutic indications:** Treatment of symptoms of depression, obsessive-compulsive neurosis, panic/panic attacks, social phobia/social apprehension, general anxiety disorder and post-traumatic stress disorder. **Posology and method of administration:** Paxetin should be administered once a day, in the morning, with or without food. The maximum effects of the drug may be achieved in 3-4 weeks. *Dosage for adults:* The initial dose of Paxetin is 20 mg per day. For patients who do not respond to a dose of 20 mg per day, it should be considered to increase the dose gradually to 40mg per day. The recommended maximum dose for depression, social phobia/social apprehension, general anxiety disorder, post-traumatic stress disorder is 50mg per day. The recommended maximum dose for obsessive-compulsive neurosis and Panic/panic attacks is 60mg per day. *Elderly:* A lower initial dose should be considered for elderly and weak patients. The dose may be increased, if required, up to 40 mg per day. *Children:* Paxetin is not recommended for individuals under 18 years of age. *Impaired renal and/or hepatic function:* Paxetin should be used with caution in patients with impaired renal or hepatic function. The maximum dose is 40 mg per day. **Contra-indications:** Paxetin is not intended for patients who are hypersensitive to the drug or to any of its excipients. Paxetin should not be used concurrently with MAO inhibitors, and not within two weeks from the time, treatment with MAO inhibitors was discontinued. Subsequently, treatment with Paxetin should be started with caution, and the doses should be raised progressively until maximum response is achieved. Treatment with MAO inhibitors should not be initiated within two weeks from the time treatment with Paxetin has been discontinued. **Special warnings and special precautions for use:** Patients considered to be at risk of suicide should be kept under close observation during the entire time of treatment. It is recommended that caution should be observed in patients who have previously had convulsions and been subject to mania. Patients who have recently suffered from myocardial infarct or heart disease should be kept under appropriate observation. **Interaction with other medicaments and other forms of interaction:** As is the case with other serotonin reuptake inhibitors, paroxetine inhibits the specific hepatic enzyme cytochrome P450 isoenzyme (2D6). Drugs that are metabolised by cytochrome P450 (2D6) include specific tricyclic antidepressants (e.g. nortryptiline, amitryptiline, imipramine and dexipramine), specific serotonin reuptake inhibitors (e.g. fluoxetine), sedative phenothiazine drugs (e.g. perphenazine and thioridazine) and drugs for arrhythmia (e.g. propaphenone and flecainide). Caution should be observed with the administration of Paxetin concurrently with sedatives (neuroleptics) and oral anticoagulants. Drugs that inhibit (e.g. cimetidine) or activate (e.g. phenytoin) microsomal enzymes that are necessary for the metabolism of paroxetine can affect its metabolism and pharmacokinetic properties. The adaptation of doses at the start of the treatment is not considered necessary when the drug is to be administered together with a drug that activates enzymes necessary for the metabolism of drugs. If doses are adapted later, this should be done on the basis of the clinical effects. Patients should be advised to avoid taking alcohol during Paxetin treatment. The use of Paxetin together with tryptophan is not recommended as it can lead to side effects, mainly headache, nausea, increased perspiration and dizziness. The use of paroxetine together with anticonvulsive drugs (e.g. phenobarbitol) can lead to an increased frequency of side effects. Paroxetine can interact with drugs that are mostly bound to plasma proteins thus leading to increased side effects. Utmost caution should be observed when administering Paxetin together with lithium as the experience with such patients is limited. Following repeated doses, a study of the interaction between paroxetine and diazepam showed no changes in the pharmacokinetic properties of paroxetine which would recommend changes in the dosage for patients taking both drugs. **Pregnancy and lactation:** Paxetin should not be used during pregnancy and lactation. **Effects on ability to drive and use machines:** Patients should be advised not to drive a car or operate dangerous machinery until they are sure that Paxetin does not affect them. **Side effects:** The most common: Malaise, pains, Hypertension, syncope, tachycardia. Pruritus. Nausea and vomiting. Weight gain, weight loss. Stimulation of the nervous system, impaired concentration, depression, emotional instability, vertigo. Increased coughing, rhinorrhea. **Overdose:** A wide margin of safety is evident from available data. Experience of paroxetine in overdose has indicated that, in addition to those symptoms mentioned under Side Effects, vomiting, dilated pupils, fever, blood pressure changes, headache, involuntary muscle contractions, agitation, anxiety and tachycardia have been reported. Treatment should consist of general measures employed in the management of overdose with any antidepressant. Early administration of activated charcoal may delay the absorption of Paxetin.

For full prescribing information please contact the local representative of the Marketing Authoristion Holder.

actavis
creating value in pharmaceuticals

Marketing authorisation holder: Actavis hf. Reykjavíkurvegur 78 - IS-220 Hafnarfjördur - Iceland

Choosing Funds: is it the Singer or the Song?

by **Matthew Bonello**, *F.A.I.Q. (C.I.I.) – Independent Financial Adviser since 1988*
and **Elaine Bonello**, *A.C.I.I., A.P.F.S., Chartered Financial Planner – Independent Financial Adviser since 1990*
Directors – Financial Planning Services Limited

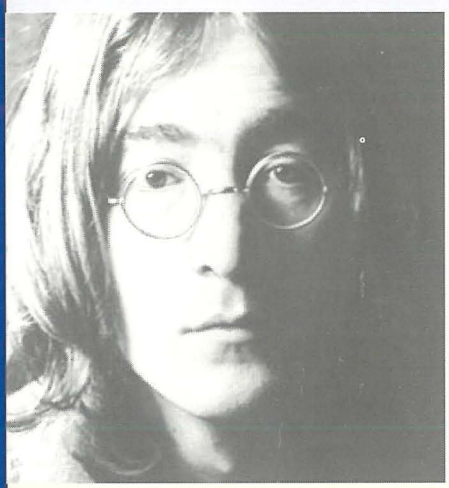
Before deciding which fund to invest in, check out the fund manager first. A fund manager's track record is the most important factor when a stockbroker or investment consultant makes asset allocation assessments about clients' investments.

This is in sharp contrast to the approach taken by private investors. When individual investors select funds, they are generally unaware of the faces behind the funds, and therefore choose largely on the strength of the brand, past performance and fund charges. Investors who choose to go it alone are generally at a disadvantage, since they do not tend to be familiar with the names of star fund managers. Neither do they usually have the time (or inclination) to follow their hiring, firing or retirement. That is why they end up judging funds on the wrong criteria. On the other hand, the reputation of the fund manager holds a big sway in an investment consultant's fund selection criteria.

Significantly, fund charges came 8th in the list of priorities of investment consultants polled on their fund selection process. Allow us a parenthesis about fund charges, the role of financial planners and "no-load" funds. The point was very cleverly hammered home by an American fund management company's CEO, at an MDRT meeting in Toronto. He compared financial planners to airline pilots: "You don't build the airplane; the fund management company does that. There are three things you want to do: 1) take off and land safely; 2) get to the right destination; and 3) get there on time."

Whether it's the singer or the song, we suggest this tune: before you invest, investigate. Better still, choose an investigator who knows his onions, and can guide you through the plethora of product peddlers' publicity

About so-called "no-load" funds, he quipped: "Let's say that you are in Los Angeles Airport, leaving for New York. There are two planes going to New York: one has a pilot, one does not. Hop on, it's your choice."



The Singer – John Lennon

Our process when selecting a fund, after having decided on the geographic and/or industry criterion, and the percentage allocation per sector, is to then double-check the short, medium and long-term performance of potential funds to be included in the client's portfolio. Then, specifically, to ensure that the same fund manager is still at the helm. As a matter of selection procedure, should it happen that a manager has left the fund – be it because of retirement or his having been head-hunted by another fund management group – we put all such funds on hold.

We generally find out about such moves from the intermediary press. We do not really expect the fund management company, who has just lost a star fund manager, to notify us. Understandably, the acquiring fund management company wastes no time in communicating their star acquisition. After such moves, advisers require a breathing space within which to look at the fund from a fresh perspective; to see what effect the new face at the fund management company has – especially on the fund's performance. This could lead us to move client assets away to another fund.

A recent major example is the retirement (now postponed to 2007) of Fidelity's superstar, AAA-rated fund manager, Anthony Bolton. A poll of U.K. advisers showed that the major beneficiary of Fidelity's loss (of Anthony Bolton) is the Artemis fund management group.

A more up-to-the-minute news item is that, effective 5th June 2006, Fidelity International has hired Nicky Richards away from Schroder Investment Management, as its new chief investment officer for European equities. One would be excused for possibly not being too familiar with Schroder's particular expertise in specific market niches. Possibly even more for asking: "Nicky who?" However, all European and U.K. equity analysts and portfolio managers will be reporting to ...her!

Incidentally, in the U.S., Fidelity International's parent, Fidelity Management & Research, has also been hurt by the sub-par performance of some of its largest, most visible funds in recent years. Could this be a consequence of their moving away from the "star" approach, and leaning towards the "team" approach?

When interviewing fund managers on their *modus operandi*, investment consultants differentiate between fund management companies which, instead of promoting their individual star managers, prefer to follow a team approach. In this way, the departure of a member of the team does not have an overbearing effect on the fund's performance or asset selection style.

Among such fund management groups are JP Morgan Fleming, Investec and Newton. With such firms, financial advisers feel that a change of one member of the choir will create much less concern than the departure of a *prima donna*.

We also follow the thinking of fund management groups as it relates to different market segments. Most readers will by now have become aware that, in investment terms, BRICs have nothing to do with property or "bricks and mortar" investments.

continues on page 24

- A systematic review published in the British Medical Journal has determined that up to 21% of adult asthmatics are sensitive to aspirin.[1]
- It is widely recognized that asthmatics who are sensitive to aspirin are also highly cross-sensitive to other non-steroidal anti-inflammatory drugs (NSAIDs) including ibuprofen, naproxen sodium, and diclofenac.[1]
- That's why Panadol* (paracetamol) is regarded as a more suitable alternative to NSAIDs in aspirin-sensitive asthmatics.[+,1,4,5]

So the next time she needs pain relief, play it safe and recommend Panadol.

[+]Less than 2% of asthmatics are cross-sensitive to paracetamol, but reactions tend to be less severe[1,4] and of shorter duration.[5]

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Choosing Funds: is it the Singer or the Song?

Imagine there's no Heaven
It's easy if you try
No hell below us
Above us only sky
Imagine all the people
Living for today

Imagine there's no countries
It isn't hard to do
Nothing to kill or die for
And no religion too
Imagine all the people
Living life in peace

You may say that I'm a dreamer
But I'm not the only one
I hope someday you'll join us
And the world will be as one

Imagine no possessions
I wonder if you can
No need for greed or hunger
A brotherhood of man
Imagine all the people
Sharing all the world

You may say that I'm a dreamer
But I'm not the only one
I hope someday you'll join us
And the world will live as one

The Song – Imagine

Given the tremendous performance of – and clients' exposure to – emerging markets, BRICs has become the acronym for Brazil, Russia, India, and China which, as we write, are up, so far this year, as follows: Brazil – 38%, Russia – 53.2%, India – 31.5% and China – 24.7% (in U.S. Dollar terms).

The statistics on India are certainly impressive with a rise in the Sensex index of 380% in the last 3 years, thus making it one of the most expensive markets in Asia. In fact, Julian Thomson, head of global markets at Threadneedle Investments, believes that India should be avoided at present in anticipation of an imminent correction. At First State, the fund has halved its exposure to India and the Asia-Pacific region as a whole.

About emerging markets in general, Justin Urquhart Stewart of Seven Investment Management, expresses some serious concerns, and has trimmed back his weighting in India. However, he still prefers India to China. The difference between the two nations is that India's is a young population, whereas China's is an ageing one.

On the other hand, Nick Smith of Allianz Global Investors, believes that the worries may be over-egged because, on a P/E basis, India is only marginally higher than the average across Europe. His view: "There could be a correction around the corner, but our argument is about the long-term story in India."

In developed markets, F & C (Foreign & Colonial), which has £131 billion of assets under management, said in mid-April that it is no longer bullish on equities and has moved to cut its risks. F & C is currently overweight in U.S., Japanese and Continental European stocks. It is neutral on British equities, and underweight in emerging markets and Pacific ex-Japan equities.

Whether it's the singer or the song, we suggest this tune: before you invest, investigate. Better still, choose an investigator who knows his onions, and can guide you through the plethora of product peddlers' publicity.