Remarks Bulletin

Bil 2/2025

Pharmacy Department
Hospital Sultanah Bahiyah

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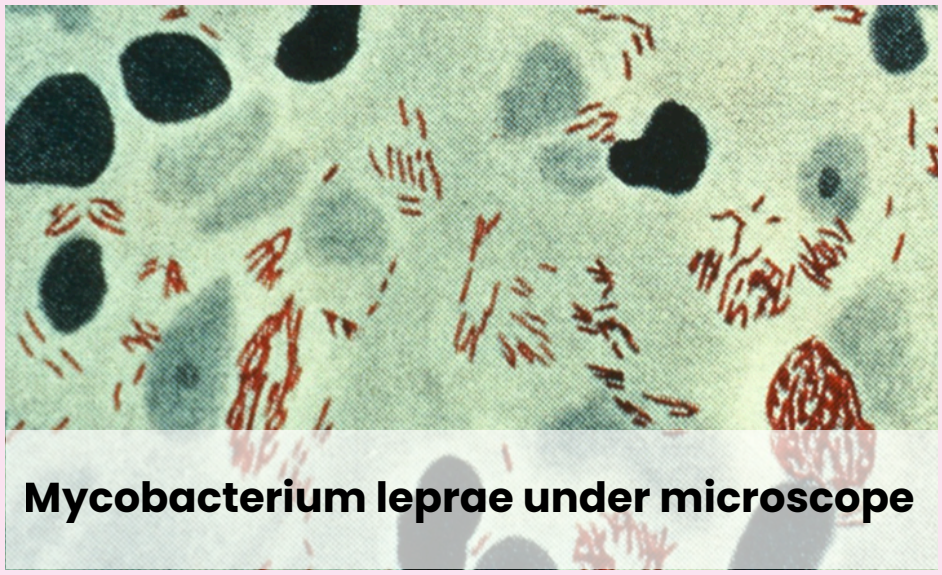
LEPROSY: CURABLE, NOT A CURSE

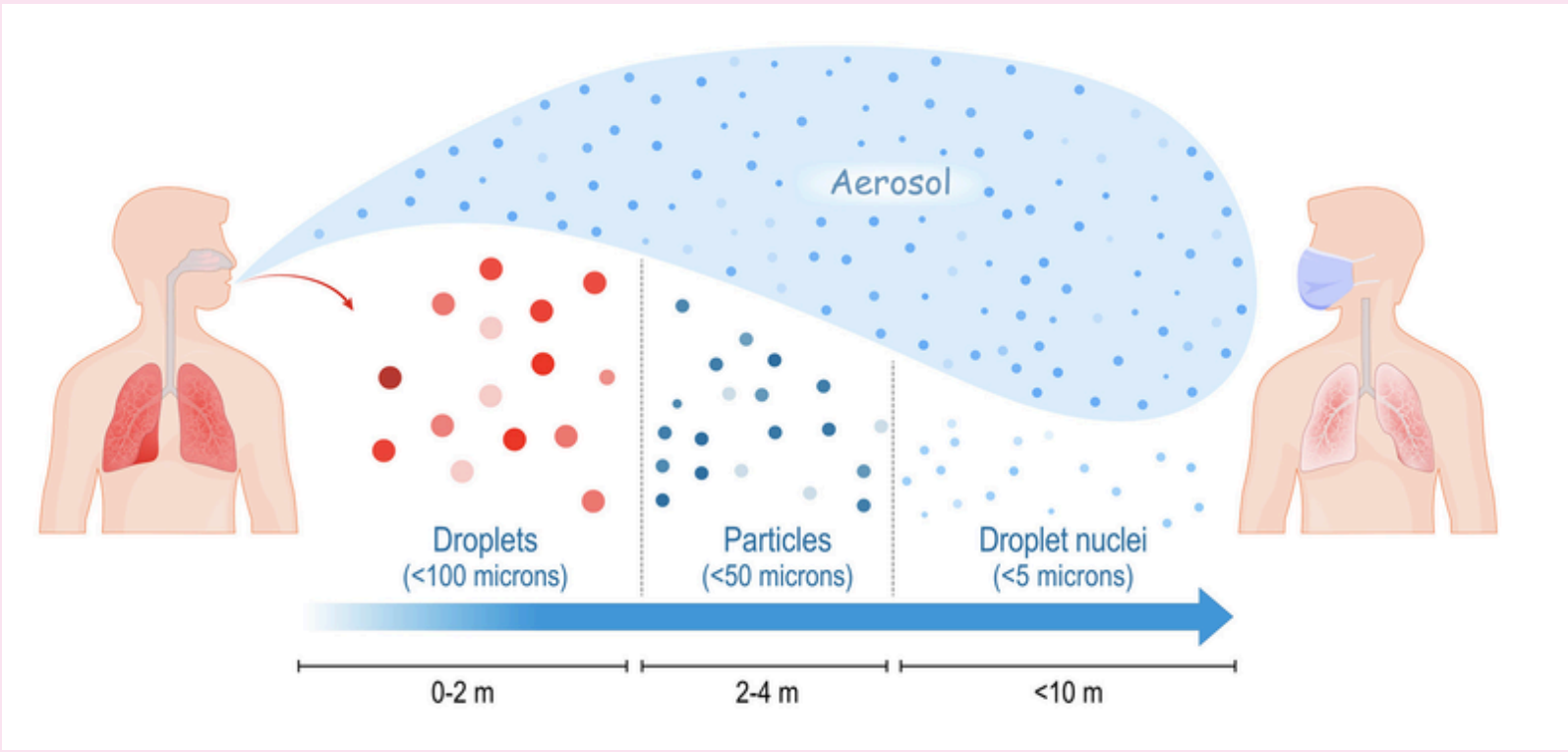
WHAT IS LEPROSY?



Mycobacterium leprae under microscope

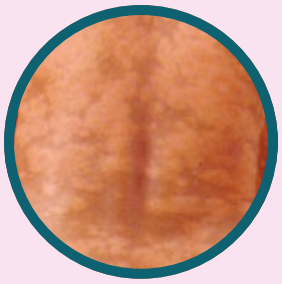
Leprosy is a chronic infectious disease caused mainly by a type of bacteria called *Mycobacterium leprae.* It is an acid-fast, gram-positive obligate intracellular bacillus that demonstrates tropism for phagocytes in the skin and Schwann cells within peripheral nerves.[1] The incubation period is long, usually 3 to 5 years but can be up to 20 years before symptoms appear.If left untreated, leprosy can cause progressive and permanent damage to the skin, nerves, limbs and eyes .[2]

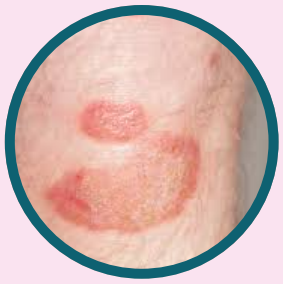
MODES OF TRANSMISSION

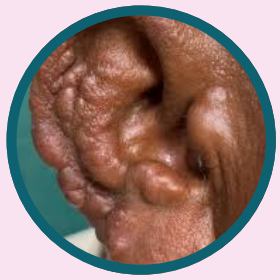


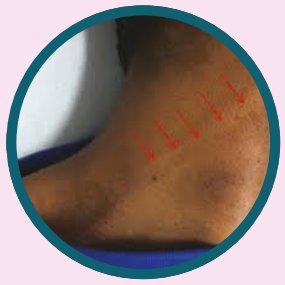
The primary mode of transmission is through prolonged close contact with an infected person, particularly through inhalation of respiratory droplets (nasal secretions) that contain M. leprae [3]. When an untreated person with leprosy sneezes or coughs, the bacteria can be released into the air and inhaled by a close contact, leading to potential infection. After entering the host, M. leprae primarily infects macrophages and Schwann cells (supportive cells of the peripheral nerves). The infection of Schwann cells is what leads to nerve damage, a hallmark of leprosy's clinical presentation[4].

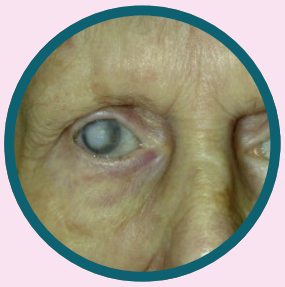
SIGNS AND SYMPTOMS


Hypopigmentation


Reddish patches

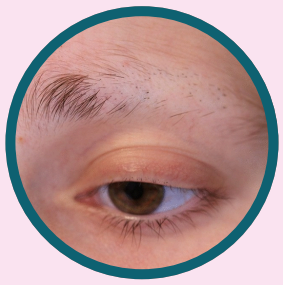

Swelling of the earlobe


Enlarged peripheral nerves


Vision loss


Muscle weakness


Nasal stuffiness


Loss of eyebrows and eyelashes

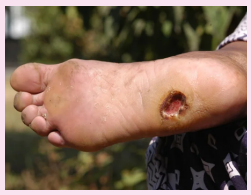

Loss of sensation


Numbness or tingling

Leprosy is not highly contagious. It spreads only through prolonged, close contact (months to years) with an untreated person, usually via droplets from the nose & mouth.

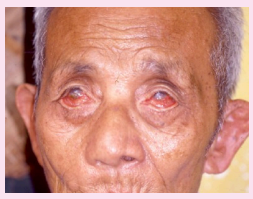
COMPLICATIONS

If left untreated, leprosy can cause severe and permanent complications primarily due to nerve damage and secondary infections.[5,6]

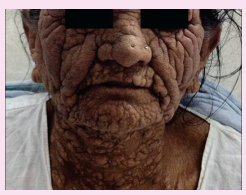


Nerve damage leading to loss of sensation (touch, pain, temperature), which increases the risk of unnoticed injuries such as cuts, burns, and ulcers.

Muscle weakness and paralysis, causing deformities such as clawed hands (due to ulnar nerve damage) and foot drop (due to peroneal nerve damage).



Eye complications such as iritis, glaucoma, corneal insensitivity, scarring, and blindness.



Disfigurement of the face and nose, including permanent swelling, bumps, and collapse of the nasal septum from mucosal damage.

TREATMENT[7]

	Adult	Paediatric
Preferred	Rifampicin 600mg PO once a month **PLUS** Dapsone 100mg PO OD **PLUS** Clofazimine 300mg PO once a month and 50mg PO OD	**< 10 years old or < 40kg** Rifampicin 10mg/kg PO once a month **PLUS** Dapsone 2mg/kg PO OD **PLUS** Clofazimine 100mg PO once a month, 50mg twice weekly **10-14 years old** Rifampicin 450mg PO (max. 600mg/day) once a month **PLUS** Dapsone 50mg PO OD (max. 100mg/day) **PLUS** Clofazimine 150mg PO once a month & 50mg on alternate days
Alternative	**Bacterial resistance or hypersensitivity to first line:** Can be substituted with one of the following: Ofloxacin 400mg PO OD **OR** Minocycline 100mg PO OD **OR** Clarithromycin 500mg PO OD	-
Comment	**Duration:** Paucibacillary: 6 months Multibacillary: 12 months	**Duration:** Paucibacillary: 6 months ; Surveillance:5 years Multibacillary: 12 months; Surveillance: 15 years

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Topical Corticosteroids: Potency & Practice

Prepared By Muhammad Firdaus Bin Sabri

- Topical Corticosteroids (TCS) are synthetic anti-inflammatory agents used to treat various inflammatory and pruritic skin conditions (e.g., eczema, psoriasis, dermatitis).[1,2]
- They work by reducing inflammation, vasoconstriction (narrowing blood vessels to reduce redness/swelling), and immunosuppression locally in the skin. [1,2]
- It aim to control the skin condition and relieve symptoms, not cure the underlying disease.
- Side effects : Skin atrophy (thinning), striae (stretch marks), telangiectasias (spider veins), acne, perioral dermatitis, and increased risk of infection.[3,5]
- Cautions: Children have a higher body surface area-to-weight ratio and thinner skin, making them more susceptible to systemic absorption. Only low-potency agents should be used for short durations.[3,5]

Potency, Frequency & Sites [1,2,5]

POTENCY	DRUG	FREQUENCY	SITES
Very Potent	Clobetasol Propionate cream/ointment 0.05%	Once daily	Thick lichenified, palm or sole and scalp
Potent	• Mometasone Furoate cream/ointment 0.1% • Betamethasone Valerate cream/ointment full strength (0.1%) • Betamethasone Valerate cream/ointemnt 1:2 (0.05%)	Once daily	Body and limbs
Moderate Potent	• Betamethasone Valerate cream/ointmetn 1:4 (0.025%) • Clobetasone Butyrate 0.05% cream/ointment	3 times daily 2 times daily	Any site
Mild Potent	• Hydrocortisone cream/ointment 1% • Betamethasone Valerate cream/ointment 1:8 (0.0125%)	3 times daily 3 times daily	Face, ear or flexural, elderly with thin skin

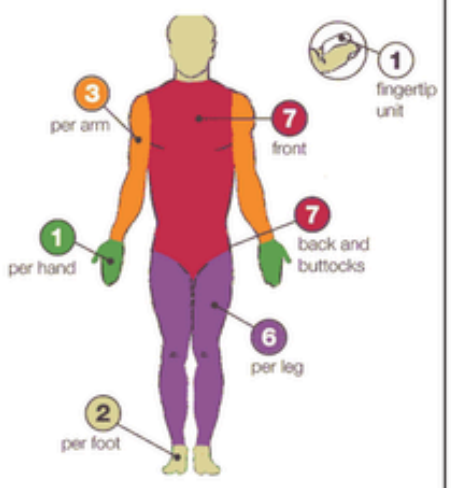
Based on UK classification: Creams are generally less potent than ointments of the same medication

Finger tips unit [5]

- A Fingertip Unit (FTU) is a guide used to estimate the required amount of topical medication for a specific treatment area.
- One FTU is the quantity of topical medication dispensed from a standard 5-mm nozzle that covers the length of an adult's index finger, from the very tip to the first crease (the distal interphalangeal joint).

Table 5: Fingertip units for different areas of the body

FTU	Area
2.5	Neck & Face
7	Front
3	Per arm
7	Back & Buttocks
1	Per hand
6	Per leg
2	Per foot



(The Medicing Box)

Types of vehicles [2]

Ointment	• Thick, greasy, highly occlusive (barrier). • Dry, thick, scaly, or hyperkeratotic lesions (e.g., palms, soles). • Highest potent
Cream	• Mixture of oil and water, less greasy, "vanish" upon rubbing. • Moist, weeping lesions; general use on most body areas. • Medium potent
Lotions/ Solutions	• Thinnest consistency, minimal residue, easy to spread. • Hairy areas (e.g., scalp, beard) or large areas. • Lowest potency
Gel/ foams	• Non-greasy, dry quickly. • Scalp and hairy areas (Gels can sting on inflamed skin).

Counseling Points [6]

- Topical cortiosteroids should not be used to provide emollient effect , but ideally applied shortly after bath/shower.
- 1 FTU cream to be applied to skin lesion as large as 1 side of the hand
- Short term therapy with potent and very potent topical corticosteroid may be used to gain rapid clearance. These preparations should be avoided on the face, genitalia and skin folds.
- Limit use of super potent corticosteroids to less than 30g/week.
- Limit use of potent corticosteroid to less than 60g/week
- Continuous use of super potent corticosteroids should not exceed 2 weeks.
- Mild Potency corticosteroids may be use for face, genitalia and body folds.

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OPIOID CONVERSION & SAFE SWITCHING

Prepared by : Wan Nur Anis Bt Wan Azam

WHAT IS OPIOID CONVERSION?

Opioid conversion refers to the process of calculating an equivalent dose of a different opioid to achieve a similar analgesic effect while minimizing the risk of adverse effects. It is commonly used in clinical practice when:

- Switching from one opioid to another due to ineffective analgesia or intolerable side effects. [1]
- Changing the route of administration (e.g., oral → intravenous, oral → transdermal) [1]

Adjusting therapy in patients with organ impairment (renal or hepatic) or drug interactions [1].

SUGGESTED DOSE CONVERSION RATIO

***Additional conversions**: [5]*

- PO dihydrocodeine 90 mg/day = PO morphine 10 - 12 mg/day
- PO tramadol 150 mg/day = PO morphine 15 - 30 mg/day
- TD fentanyl 25 mcg/hour =continuous SC/IV infusion fentanyl 25 mcg/hour
- SC morphine = IV morphine

FROM \ TO	Oral morphine mg/day	SC morphine mg/day	Oral oxycodone mg/day	SC oxycodone mg/day	TD fentanyl mcg/h
Oral morphine mg/day		2	1.5	3	3
SC morphine mg/day	2		0.7	1.5	1.5
Oral oxycodone mg/day	1.5	0.7		2	2
SC oxycodone mg/day	3	1.5	2		1
TD fentanyl mcg/h	3	1.5	2	1	

MULTIPLY DIVIDE

Note:

1. When changing from one opioid to another, consider a dose reduction of 25 - 50% due to incomplete cross-tolerance.
2. Consider reduced doses in the elderly and in patients with renal or significant hepatic impairment.
3. Calculate the total 24-hour opioid dose in mg (for fentanyl, note that the hourly rate is in mcg).
4. Divide 24-hour dose according to the dosing frequency required (for example divide by 2 for BD dosing and divide by 6 for 4-hourly dosing).
5. Calculate the rescue dose for breakthrough pain for each opioid as approximately 1/6 to 1/12 of the total daily dose.

OPIOID CONVERSION & SAFE SWITCHING

EXAMPLE OF CONVERSION 1

Conversion of oral morphine to oral oxycodone
Oral morphine mg/day (20 mg 4-hourly = 120 mg per day)
Conversion factor = divide by 1.5
Equivalent dose of oxycodone = 120 ÷ 1.5 = 80 mg per day
Reduce equivalent dose by 25% = 60 mg per day (due to incomplete cross-tolerance)
Therefore, **dose of CR oxycodone = 30 mg twice daily**

EXAMPLE OF CONVERSION 2

Conversion of oral morphine to transdermal fentanyl
Oral morphine mg/day (16 mg 4-hourly = 100 mg per day)
Conversion factor = divide by 3
Equivalent dose of transdermal fentanyl = 100 ÷ 3 = 33 mcg per hour
Reduce equivalent dose by 25% = 25 mcg per hour (due to incomplete cross-tolerance)
Therefore, **dose of TD fentanyl = 25 mcg per hour**

Incomplete opioid cross-tolerance is the concept that the patient might have developed tolerance to one opioid without having developed full tolerance to another.

OPIOID TOXICITY [1]

When changing dose or switching opioids, always monitor the patient for pain control and signs of opioid toxicity as below:

- .Respiratory depression
- Extreme somnolence progressing to stupor or coma
- Hypotonia
- Cold and/or clammy skin
- Miosis
- Bradycardia
- Hypotension
- Apnoea
- Pulmonary oedema
- Circulatory collapse
- Death

.

OPIOID TOXICITY can cause respiratory depression which can be FATAL when not treated in time

TREATMENT [5]

Administration of IV Naloxone
Massive overdose (coma/respiratory depression):
Adult: 0.4 to 2mg
Paediatric: 0.01mg/kg
Repeat the dose at 2 minutes intervals if no response
Less severe overdose:
0.2mg followed by increment of 0.1mg every 2 min if no response

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DRUG SAFETY ALERT

Prepared by : Kang Zi xUAN

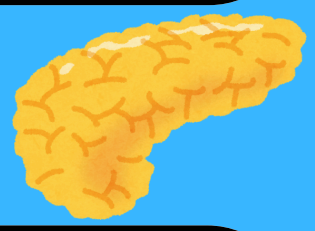
1 ISOTRETINOIN: ALERT ON PSYCHIATRIC ADVERSE EFFECTS

Isotretinoin, a retinoid derived from the active form of vitamin A (13-cis-retinoic acid), is prescribed for severe acne—particularly nodular acne, cases likely to cause permanent scarring, or acne unresponsive to conventional systemic antibiotics and topical treatments. While highly effective, concerns have been raised about a possible association between isotretinoin therapy and psychiatric adverse effects including depression, anxiety, mood alteration and psychotic symptoms. A meta-analysis 2024 involving over 1.6 million patients reported that 4.57% of isotretinoin users developed a psychiatric disorder over a one-year. The onset of psychiatric symptoms in patients taking isotretinoin varies but typically occurs within the initial months of therapy.

Advices for Health Care Professionals

1. Conduct a mental health assessment before starting isotretinoin, including screening for a history of psychiatric illness.
2. Counsel patients and their caregivers on the potential risk of psychiatric adverse events, such as depression, anxiety, and mood alterations.
3. Monitor mental health status throughout the treatment period, paying close attention during the initial months.
4. If psychiatric symptoms develop, consider dose reduction, discontinuation of therapy, and/or a referral to mental health services.

2 ASPARAGINASE IN CHILDREN: RECOGNISING EARLY SIGNS OF PANCREATITIS



Asparaginase, a key component in treating paediatric acute lymphoblastic leukaemia (ALL), is known to cause asparaginase-associated pancreatitis (AAP), a potentially serious inflammatory reaction of the pancreas that often occurs within the first few weeks of therapy. AAP typically presents with abdominal pain, vomiting, and elevated pancreatic enzymes, and although most cases are reversible, severe complications such as pseudocysts, necrosis, or shock may develop, sometimes requiring discontinuation of therapy. Local National Pharmaceutical Regulatory Agency (NPRA) has documented 232 adverse drug reaction reports, largely featuring skin-related issues such as pruritus, urticaria, and rash. More concerning, though, are the reports of pancreatitis, particularly in pediatric patients, which align with the global data from the World Health Organization's VigiBase. As of May 2025, this database has recorded 868 cases of acute pancreatitis linked to L-asparaginase, with a majority occurring in children and adolescents.

Advices for Health Care Professionals

1. Monitor baseline and periodic amylase/lipase levels, especially in the early weeks of asparaginase therapy.
2. Educate patients and caregivers about early symptoms of pancreatitis and when to seek urgent care.
3. Discontinue asparaginase immediately if AAP is suspected; manage according to severity with supportive care.
4. Evaluate risk–benefit carefully before reintroducing asparaginase, and avoid re-challenge in severe or recurrent cases.

References

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3 TACROLIMUS ALERT: TOXIC LEUKOENCEPHALOPATHY RISK IN TRANSPLANT PATIENTS

Tacrolimus is a macrolide calcineurin inhibitor primarily used for immunosuppression in liver and kidney transplant recipients and in cases of organ rejection resistant to conventional treatments. It functions by binding to the intracellular protein FKBP12, forming a complex that inhibits calcineurin, thereby suppressing T-cell activation and other immune responses. In Malaysia, there are 16 registered tacrolimus products, with most intended for oral use. Despite its efficacy, tacrolimus has known adverse effects, including neurotoxicity, which can manifest as tremors, headaches, or more severe issues like leukoencephalopathy. The exact mechanism of this neurotoxicity is unclear but may involve the drug's ability to cross the blood-brain barrier, inducing vasogenic and cytotoxic edema. Symptoms can appear shortly after starting therapy or even years later. Early detection is crucial, as neurotoxicity can occur even at therapeutic levels. As of May 2025, the National Pharmaceutical Regulatory Agency (NPRA) has documented 115 reports involving 181 adverse events related to Tacrolimus use. The most prevalent issues include tremors, with 21 reported cases, followed by diarrhea and kidney transplant rejection. Notably, there has been one local case of toxic leukoencephalopathy reported to the NPRA, a serious neurological condition. On a global scale, the World Health Organization's VigiBase database has recorded 17 cases of toxic leukoencephalopathy and 140 cases of toxic encephalopathy overall.

Advices for Health Care Professionals

1. Monitor patients closely at tacrolimus initiation and during the early post-transplant period.
2. Continue periodic monitoring thereafter, as neurotoxicity may also occur months or years later.
3. Consider referral to a neurology team and conduct investigations such as brain MRI if patients present with neurological symptoms.
4. If tacrolimus-induced toxic leukoencephalopathy is suspected and other causes have been excluded, consider discontinuing tacrolimus, as diagnosis is typically confirmed by neurological improvement following drug withdrawal. Consider switching to an alternative immunosuppressive agent if clinically indicated.

4 DUPILUMAB-INDUCED ARTHRALGIA: JOINT PAIN RISK FOR PATIENTS

Dupilumab, a human monoclonal antibody that blocks the IL-4 and IL-13 signalling pathway for inflammatory conditions, is indicated in Malaysia for treating atopic dermatitis, asthma, chronic rhinosinusitis with nasal polyposis (CRSwNP), and prurigo nodularis. Arthralgia (joint pain) is a reported adverse event associated with dupilumab, observed in clinical trials, post-marketing reports, and local cases in Malaysia, including two reports from severe asthma patients where the drug-reaction causal relationship was assessed as possible. The onset of arthralgia can range widely, from days to over a year after starting treatment. While the exact mechanism is not fully understood, one hypothesis suggests that blocking the IL-4/IL-13 axis may inadvertently disrupt its protective role against the IL-23/IL-17 axis, which is linked to joint inflammation. Symptoms, which can include swelling, stiffness, and radiating pain, may resolve with continued treatment and supportive care (e.g., NSAIDs, corticosteroids) or following discontinuation of dupilumab. As of December 2024, the National Pharmaceutical Regulatory Agency (NPRA) has received five Malaysian case reports of arthralgia suspected to be related to dupilumab.

Advices for Health Care Professionals

1. Be aware of the risk of arthralgia associated with dupilumab, noting that it can occur at various times, from days up to over a year after treatment initiation.
2. Educate patients to report any new or worsening joint symptoms to their healthcare provider for timely evaluation.
3. If arthralgia is suspected:

- Assess its severity and engage in shared decision-making with the patient.
- Consider continuing dupilumab if the benefits outweigh the risks, managing symptoms with appropriate pharmacological options like analgesics, NSAIDs, or corticosteroids.
- If joint symptoms persist or worsen, consider a rheumatological evaluation and/or discontinuation of dupilumab.

References
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Pharmacy APPRECIATION NIGHT & Dinner SESSION 2025

Prepared by: Janessa Khor Jia Xuan

PROGRAMME OVERVIEW

The Pharmacy Appreciation Night & Dinner 2025, organised by the Welfare and Recreation Club (KKR) of the Pharmacy Department in collaboration with the Provisionally Registered Pharmacists (PRP) Batch 1 & 2/2024 of Hospital Sultanah Bahiyah, was held on Thursday, 12 June 2025 at The Jerai Hotel, Alor Setar.

The event carried a White/Floral theme and was attended by unit heads, pharmacists, assistant pharmacists, KKR members, PRPs from the 2024 batch, and staff from across the Pharmacy Department.

PRE-CEREMONY

Guests began arriving as early as 7.30 pm for registration at the designated counter. During this time, attendees also had the opportunity to visit the photobooth and the “Flower Bar” area to capture memorable moments.

A formal photography session with unit heads was conducted before the programme officially commenced.

OPENING CEREMONY

At 8.20 pm, the event began with a prayer recitation by En. Abdul Rashid bin Rosli, followed by welcoming remarks from the KKR Chairman, En. Sareh Safwan bin Abu Seman.

The PRP Batch 2024 representative, Cik Nur Yuhaniz binti Mohd Fauzi then delivered a speech on behalf of the cohort.

Batch 1 & 2/2024 Provisionally Registered Pharmacists (PRP)

TOKEN OF APPRECIATION PRESENTATION

The programme continued with the presentation of appreciation gifts to the various Unit Heads in recognition of their leadership and continuous support throughout 2024.

Recipients included representatives from the Chief Pharmacist’s Office, Inpatient Pharmacy, Logistics Unit, Manufacturing Unit, Quality & Training Unit, Drug Information Centre, Clinical Pharmacy Unit, and Ambulatory Care Pharmacy (ACC). This was followed by the presentation of tokens of appreciation to members of PRP Batch 2024, presented by En. Sareh Safwan accompanied by Cik Afifah binti Anuar.

Flower bar area

Guests enjoying the buffet-style dinner

DINNER PROCEEDINGS

Dinner was then served at 8.45 pm. As guests enjoyed their meal, a special montage video featuring PRP Batch 2024 was screened, showcasing their journey, activities, and achievements throughout the year.

The event continued with two performances: a group performance by the Assistant Pharmacists and a solo performance by En. Sareh Safwan, both of which were warmly received with enthusiastic applause.

Pharmacy APPRECIATION NIGHT & Dinner SESSION 2025

INTERACTIVE ACTIVITIES

Several interactive activities added excitement to the evening, including a Kahoot quiz, Bingo session, and a series of lucky draws where participants won prizes ranging from electrical appliances to hampers and other attractive gifts.

The highlight of the evening was the announcement of the King and Queen of the Night, awarded based on creativity, thematic elegance, and standout appearance. The titles were awarded to En. Muslim bin Mukhtar and Cik Farrah Syazana, with prizes presented by En. Sareh Safwan.

Guests posing for photos while enjoying the buffet

Group photo with PRPs

Quick photo session with guests and their complimentary flowers

INTERACTIVE ACTIVITIES

KAHOOT QUIZ

BINGO SESSION

LUCKY DRAW

SPECIAL PERFORMANCES

KING AND QUEEN OF THE NIGHT

CLOSING CEREMONY

The event concluded with a final photography session involving all attendees at 10.20 pm, and guests gradually dispersed between 10.30 pm and 11.00 pm.

CONCLUSION

Overall, the Pharmacy Appreciation Night & Dinner 2025 was a vibrant and meaningful occasion that successfully achieved its objectives of recognising contributions, strengthening camaraderie, and fostering unity among all units within the Pharmacy Department of Hospital Sultanah Bahiyah.