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VISION

To emerge as one of the premier pharmacy colleges in the country and produce pharmacy professional of global standards.

MISSION

• To deliver quality academic programs in Pharmacy and empower the students to meet industrial standards.
• To build student community with high ethical standards to undertake R&D in thrust areas of national and international standards.
• To extend viable outreach programs for the health care need of the society.
• To develop industry institute interaction and foster entrepreneurial spirit among the graduates

A STUDY ON PREVALENCE OF URINARY TRACT INFECTIONS IN POST RENAL TRANSPLANT RECIPIENTS IN A TERTIARY CARE CENTRE

Dr Basily Joseph

Background:

Renal transplant recipients should receive immunosuppressants to prevent graft rejection. By suppressing the immune response of the recipient, it increases the risk of opportunistic infections.Among all infections urinary tract infections (UTI) are the most common. So, our study deals with the nature of post transplantation urinary tract infections, its prevalence.

Methods:

A retrospective observational study was carried out to retrieve data of renal transplantation patients to evaluate the incidence of Post renal transplant UTI. This study also focuses on Nature of UTI including relapse UTI, recurrent UTI.

Results:

The available data from the medical records of 87 renal transplantation patients suggests that 42.46% of 73 males and 50% of 14 females had developed UTI during their follow up.UTI is mostly observed in 21-40 age groups. Recurrent UTI is observed in 3 patients. Linezolid (12.19%) was mostly used as an antibiotic therapy in UTI.

Data of Urine culture sensitivity reveals E.coli is the major causative pathogen which accounts for 39.5% of UTI, followed by Klebsiella (16.6%), Pseudomonas(14.5%),Staphylococcusaureus (10.41%), Enterococcus(6.25%).

Parameter	Our study	Shams *et al*	DeepaR *et al*	MariosPapasotiriou *et al*	B Maraha *et al*
Sample size	87	247	50	122	192
No. of patients with UTI	38	56	21	74	71
Pathogens	Escherichia coli (39.5%) Klebsiella (16.6%) Staphylococccus aureus(10.41%)	Escherichia coli(55.3%)	Escherichia coli(33.3%) Klebsiella (23.8%) Proteus vulgaris(9.52%)	Escherichia coli(32.2%)	Escherichia coli(31.6%)

Table: **Comparative assessment on studies on UTI**

Conclusion:

UTI are one amongst the opportunistic infections unless treated UTI may lead to significance mortality. Hence patients should be monitored throughout the post transplant treatment period including Immunosuppressive therapy, such that the term patient safety is the utmost priority can be justified.

Reference:

1. Ostaszewska A , Wszola M , Kuthan R , Gozdowska J ,Towski A. UTI in Patients Risk Factors. MED tube science 2014;11(3):23-29.
2. Kumar A, Agarwal C, Ashok K , Shojha A, Dillon V, Kumar V. Profile of Infections in Renal transplant Recipients from India .Journal of Family Medicine and Primary Care 2016;5:611-4.

A REVIEW ON THE DOOR SYNDROME – A RARE DISEASE

E Niranjani (IV Pharm.D)

INTRODUCTION:

DOOR syndrome is a rare genetic disorder characterized by deafness at birth (congenital) due to the inner ear or auditory nerve; (sensorineural hearing loss). The various abnormalities in the finger nails and toes (onchodystrophy),dystrophic growth of the bones (oestodystrophy) of the fingers and toes and mental retardation. This syndrome may be associated with seizure disorder.

The syndrome may consists of the same of the additional features i.e.., polyhydramnios stands for the increased amniotic fluid during pregnancy and increased nuchal fold during pregnancy ; specific facial features such as a large nose, severe and sometimes refractory seizures, abnormalities on the magnetic resonance imaging of the brain, increased 2-oxoglutaric acid in the blood and urine, fingers like thumbs visual impairment and peripheral neuropathy stands for the nerves conducting sensation from the extremities to the brain and insensitivity to pain.

Epidemiology:

DOOR syndrome is a rare disorder ; its prevalence is unknown . Approximately 50 affected individuals have been described in the medical literature. This syndrome mainly appears to affect males and females in equal numbers.

Causes:

DOOR syndrome is inherited as an autosomal recessive trait. It can be caused by the mutations in the TBC1D24 gene. This gene provides instructions for making a protein whose specific function in the cell is unclear. The protein may have several roles in the cells.

TBC1D24 gene mutations that cause DOOR syndrome are thought to reduce or eliminate the function of the TBC1D24 protein but the specific mechanism by which loss of TBC1D24 function leads to the signs and symptoms of the door syndrome.

Diagnosis:

DOOR syndrome may be suspected shortly after birth by the identification of certain characteristic physical features (i.e.., bone, dermatoglyphic and nail abnormalities). A diagnosis of DOOR syndrome may be confirmed based upon a through clinical evaluation, a detailed patient history and specialized testing, such as x-ray studies. X-ray studies may reveal the presence of an extra bone in the thumbs and/ or great toes as well as underdevelopment of bones in other fingers and/ or toes. Per the medical literature, infants with these characteristics abnormalities should be tested for sensorineural deafness.

Standard Therapies:

The treatment of DOOR syndrome is directed toward the specific symptoms that are apparent in each individual. Treatment may require the coordinated efforts of a team of medical professionals, such as pediatricians, surgeons, specialists who assess and treat hearing problems, physicians who diagnose and treat neurological disorders (neurologists), and / or other health care professionals.

Hearing impairment should be assessed and treated as early as possible to help minimize possible speech difficulties or improve communication ability as an affected child ages. In addition, clinical evaluation should be conducted early in development and on a continuing basis to help determine the extent of intellectual disability.

In individuals with seizure episodes, treatment may include various medications that may help to prevent, reduce, or control seizures (anticonvulsants). Prolonged seizures accompanied by unconsciousness (status epilepticus) require immediate medical intervention. Early intervention is also important to ensure that children with DOOR syndrome reach their potential.

Special services that may be beneficial include special remedial education, speech pathology, special social support, physical therapy, and other medical, social, and /or vocational services.

Genetic counselling will be of benefit for affected individuals and their families. Other treatment for this disorder is symptomatic and supportive.

JEMPERIL (dostarlimab-gxly) INJECTION – A NEWLY APPROVED DRUG FOR`` ENDOMETRIAL CANCER''

B.Dinesh, Pharm-D 2ND Year

BRAND NAME : **JEMPERIL**

GENERIC NAME : **Dostarlimab- gxly**

MOLECULAR FORMULA : **C_{6420} H_{9832} N_{1690} O_{2014} S_{44}**

DRUG CLASS : **Antineoplastic**

MANUFACTURING COMPANY : **GlaxoSmithKline**

DATE OF APPROVAL : **March 22, 2021**

Dosage Form & Strength:

Injection: 500mg/10mL (50mg/mL) clear to slightly opalescent, colourless to yellow solution in a single-dose vial for intravenous infusion.

Indication:

Jemperil is indicated for the treatment of adult patients with mismatch repair deficient (**dMMR**) recurrent or advanced **endometrial cancer.**

Mechanism Of Action:

Dostarlimab is a monoclonal antibody targeted against Programmed death receptor – 1(**PD-1**) - it binds to the receptor and prevents interactions with **PD-L1** and **PD-L2**, thus allowing the anti-tumor immune response to proceed unimpeded.

Adverse Drug Reaction:

Fatigue/Asthenia, Nausea, Diarrhea, Constipation, Vomiting, Anemia, Urinary tract infection, Myalgia, Cough, Puritius, Decreased Appetite.

Drug Interaction:

- The severity of adverse effects can be increased when Anthrax immune globulin human is combined with Dostarlimab.
- The severity of adverse effects can be increased when Asfotase alfa is combined with Dostarlimab

PHARMACOKINETICS:

Absorption:

During the first cycle, and administered at 500mg intravenously every 3 weeks, the mean C_{max} and $AUC_{0\text{-}tau}$ of dostarlimab-gxly are 171 mcg/mL and 35,730 mcg.h/mL, respectively. When administered at 1000mg every 6 weeks, the mean C_{max} and $AUC_{0\text{-}tau}$ are 309 mcg/mL and 95,820 mcg.h/mL, respectively.

Distribution:

The mean (%CV) volume of distribution of dostarlimab-gxly at steady state is 5.3 L (12%).

Metabolism:

Dostarlimab-gxly is expected to be metabolized into small peptides and amino acids by catabolic pathways.

Elimination:

The mean terminal elimination half-life of dostarlimab-gxly is 25.4 days and its mean (%CV) clearance is 0.007 L/h (31%) at steady state.

Departmental Activities March-2021:

No of Patients Screened	Drug Information Queries	Adverse Drug Reactions	Medication Errors	No of Prescriptions Audited
862	24	04	11	834

Perfect Click

International Women's Day Celebrations

Campus Placemen Drive by Apollo Pharmacies