On behalf of the European Society of Clinical Pharmacy we acknowledge your participation in the 44th ESCP Symposium in Lisbon, Portugal.

The main theme of the symposium is “Medicines Information – making better decisions” with the focus on Medicines Information. Regardless of which definition of clinical pharmacy is used, clinical decision making is fundamental to improving the current drug therapy of patients and also to drug therapy outcomes. However due to the rapid growth of the therapeutic portfolio, a clinical pharmacist may not have enough knowledge to make some clinical decisions.

Medicines information is usually defined as a knowledge that a healthcare professional lacks, and has to access during the clinical decision-making process. It is essential to assess the quality of the information by considering its accessibility, reliability, completeness and applicability. New technologies may improve access to medicines information, but are associated with new requirements related to their special characteristics.

The scientific components of the Symposium begin with a Master Class of Excellence in Pharmacy as a pre-conference day focussing on “Practice Research: easing the progress from research idea to research proposal”. Developing a research idea into a research proposal can appear a daunting task, whether it relates to a project to be conducted as part of everyday clinical practice or an application to a grant awarding body for large sums of money.

On the first day, Wednesday 28th, the Symposium will start the morning discussing the role and the characteristics of “Official Medicines Information Sources”, those approved by a regulatory agency, e.g. summaries of product characteristics in Europe or drug labelling in the United States. These sources have a differential characteristic: their content should be known by all the healthcare providers. So, accessibility and reliability are guaranteed. Some studies have identified low applicability and completeness as major weaknesses of these sources.

In the afternoon the challenge is to design “The future of medicines information”. Three inter-linked topics constitute this session: the role of clinical decision support systems that can help the clinical pharmacists; the importance of creating specific datasets to nourish these computerised aids; and obviously, how should we teach future clinical pharmacists to acquire the skills required to fulfil with these new medicines information roles.

Thursday 29th will start the morning with a quite controversial discussion: “Drug Industry as medicines information providers”. This point will be debated with speakers with very different points of view that will present their positions on the potential risks, but also the potential benefits of using drug companies as information providers.

Thursday afternoon will be devoted to a very traditional activity of the clinical pharmacist: the drug information centres. It is commonly accepted that clinical pharmacy started between the University of Michigan and that first drug information centre in the University of Kentucky Medical Center. In the recent days, the existence of drug information centres has been questioned based on the idea that the Internet allows having a huge amount of information to accessible to every professional everywhere. If so, why do we study the pernicious effects of the so-called ‘paradox of the information’: the more information we have accessible, the more difficult to find the information we need to make a decision. The role of these centres associated with active information, creating evidence, and translating other sources will be discussed in this afternoon session.

The Friday 30th morning will be specifically devoted to a crucial topic: “Evidence-Based decision making”. Clinical pharmacists cannot base their decisions on their own knowledge or what can be retrieved in unfiltered information sources. Modern healthcare systems require decisions based on filtered information, which guarantees the compensation of potential bias of each of the primary sources. How to interpret the evidence, the association of evidence and health economics for decision making, and the role of the patient when creating the evidence will be the topics under discussion.

As in all ESCP Symposia, afternoon workshops are an important element. Lisbon 2015 will provide with 20 different workshops, each running twice to facilitate attendance.

The afternoons will have another of the important elements of ESCP symposia: oral presentations and poster discussion sessions. Close to 350 communications have been accepted, being 24 selected to be presented as oral communication and 36 more will be in a poster discussion panel.

With this programme we hope to open a room for discussion and raise expectations of the role of clinical pharmacists making decisions based on accurate, complete and applicable medicines information. Let us discuss all these topics in Lisbon and learn to make the correct decisions that patients need to achieve the best outcomes with safe medicines.

Fernando Fernandez Llimos
President of the Lisbon Symposium
Margarida Caramona
President of Scientific Committee
Isabel Vitoria Figueiredo
President of Organising Committee
Why I became interested in medicines information?

I love explaining that my way into clinical pharmacy was not the typical one. I discovered the term ‘pharmaceutical care’ during 1992 in a business school studying for my MBA. At that time my interests were managerial control, ratios, processes design, and measuring performance. After a value chain analysis, comparing pharmacy distribution with hard-discount supermarkets, and by using an Ishikawa diagram, I realized that the role of the pharmacist was the different bone between both fishbone designs. So I had to discover which was the ‘role’ that justified such an added value (the strict definition of added value, is the extra amount of money that the market pays for a specific good or service).

Among the articles I read at that time, were the papers of the PhD thesis of my current friend, Prof. Karen Farris. These papers introduced me into the Donabedian’s SPO paradigm, which I immediately loved due to my background. ‘Drug information sources’ was one of the structure elements that popped up since the very beginning. So, I started my academic path using this area as my first research interest. Then, my first paper also came also from this area.

One of the things I learnt at that time was that data or knowledge are not synonyms of information. To name a piece of knowledge as information, it has to be directly associated with making a decision. The information is the knowledge that the professional lacks, and when received, helps the professional to make a specific decision in a specific moment. As I do not believe in super-pharmacists with an encyclopaedic knowledge, medicines information becomes a crucial element to the making of appropriate decisions. Medicines information will never convert a dummy into a good clinical pharmacist, but the lack of medicines information can convert a good clinical pharmacist into a dummy!

Obviously, when the GC suggested Lisbon for the 44th Symposium, and asked me to coordinate it, I was very clear in my mind that medicines information had to be the theme. Clinical pharmacy was associated to medicines information since the pioneers. Which came first – the chicken or the egg? Did the University of Kentucky Medical Center create the first drug information centre to support clinical pharmacy activities? Or, was clinical pharmacy possible because the University of Kentucky Medical Center had created the first drug information centre? I love drug information as a topic. However, some colleagues think that medicines information is an old-fashioned topic. We have the Internet at our fingertips. Books are items for museums. Journals are folders packed with pdf files. And, I have thousands of pages in a memory stick. These are some of the criticisms we often hear when talking about medicines information. Sorry, you may have a lot of data in your memory stick and these folders, but a minuscule part of them will become information, just when you retrieve it, and use it for making a clinical decision. This may not be an easy job.

In addition to this accessibility problem, we have to face three other potential issues: is the information reliable? Is it complete? and, is it applicable? Assessing these four characteristics, and designing solutions to improve them, became my major research interest. I wish is that Lisbon-2015 will shed some light into medicines information area to improve the decision making processes of clinical pharmacists.

Fernando Fernandez-Llimos

f-llimos@ciipf-es.org

Who’s who? Maria Margarida Caramona

I am a Full Professor of Pharmacology in the Faculty of Pharmacy, of Coimbra University, Portugal. I have the degree in Pharmacy and the Ph.D. in Pharmacology (1985) both obtained at University of Coimbra and has been a Full Professor in the same faculty since 1998.

The main scientific research areas in the first years of my academic career related to the studies in pharmacokinetics and pharmacodynamics processes mainly in neuropharmacology with animal models but in the last 20 years have been more devoted to clinical pharmacy and pharmaceutical care with patients data for a more rational use of drugs.

I teach the courses of pharmacology in the Pharmacy Faculty of Coimbra and is responsible for the training of students in the community and in hospital pharmacies during the pregraduate career. Those particular tasks are very well supported with a very good relationships with community and hospital pharmacists.

I was involved with different tasks in the European Society of Clinical Pharmacy structure being member of the Education Committee in the 90’s (1990-1994) and later in the General Committee between 1995 to 2000 with an active participation in the organisation of the previous Lisbon Symposia in May 2003. This time in October of 2015 I am president of the Scientific Committee of the 44th ESCP, Lisbon, Portugal, where the main topic is Medicines Information – Making better decisions.

Other things that I can mention about my teaching and scientific experience is excellent relationships with students, pharmacists, and others health professionals. Always conscious of the correct, rational and economic use of drugs by patients and the public in the treatment of illness.

Another things to mention is my membership in the editorial team of pharmacy journals both Portuguese and international titles.

I have been member of the directory of the professional team of the Portuguese Pharmaceutical Society (Ordem dos Farmacêuticos), President of the Portuguese Pharmacological Society between 1997-2000 and president of the Portuguese Society of Laboratory Animals where I am active in different boards. In addition I have been a Member of British Pharmacological Society, the European Society of Clinical Pharmacy since 1986.

To put an end on this small report I would like to thanks all the colleagues that have opportunity to come to Lisbon and also inviting them to stay one more day to visit Coimbra, my town and my university... not far from Lisbon, and there are very good connection by train or by bus.

Enjoy your stay and have a very nice time in Lisbon!

Sincerely

Maria Margarida Caramona
caramona@ci.uc.pt
The role of pharmacists involved in patient care has been undergoing change in Switzerland in parallel to international developments. It has become more clinically or patient-oriented. Targeting individuals and not a population or society as a whole is a key concept of pharmaceutical care, which can be viewed as an individualised clinical pharmacy service delivered to a specific patient. These services are not determined to the setting: pharmacists working in community pharmacies or in hospitals can provide pharmaceutical care.

Academic teaching has tracked followed this change. We all know that assessment drives learning. However, assessment of pharmaceutical care skills and competencies with the aim of preparing students to fulfil new roles is challenging. Traditional exams fail to assess care competencies and more sophisticated methods are needed to assess clinical performance. In 1976, Harden R. et al (1) conceptualised a new exam for medical students called OSCE (Objective Structured Clinical Examination): Candidates rotate through a series of stations based on clinical skills applied in a range of contexts. By now, OSCEs are an accepted part of the education, testing and certification of students and candidates in a wide variety of health professions, including pharmacy. At the University of Basel, Switzerland, we have used OSCEs since 2011 for teaching and for the final federal examination and we have gained valuable experience from over 1000 exams and development of > 60 OSCE stations.

With this background we ran a workshop twice during the ESCP spring conference in Nice 2015 with the following aims:
- Participants know the concept, advantages and drawbacks of an OSCE as an option to test clinical skill performance and competence in patient oriented care.
- Participants gain first experiences in designing an OSCE examination.

Scenario development
For introduction we used a showcase free available on www.youtube.com/watch?v=mgEuw4t53MU. First, participants had the task of developing in small groups a scenario on “emergency with angioedema” or “first prescription for allergy emergency kit (incl. adrenaline injection)”. A template for scenario development was available covering the following steps:
I. Mapping of the situation / Background (eg. request of a newly prescribed medicine.)
II. Aims of the station (teaching or assessment)
III. Resource provided to the student (eg. web based product information, demonstration material)
IV. The Case clip (Date, time, person age & sex, situation)
V. Task for the student (eg prescription validation, medication review, patient education)
VI. References (eg. current guidelines)

In the plenary discussion experiences from the exercise and from personal practice allowed for a very rich exchange on different approaches used for the development of OSCE cases. Different key aspects can be identified and they need to be clearly defined. Assessment of communication skills and attitudes can also be attempted and, in order to get a valid assessment at least 8 stations are needed, with different scenarios, challenges and patient situations. A so called “blueprint” enables mapping of key issues across the different stations of a whole OSCE exam.

Development of the assessment
The second task during the workshop comprised the development of an assessment checklist for the predesigned scenario. Again a template was provided for inspiration (see box) and participants discussed specific issues arising from such checklists and with assessments in general.

References

Moderators
Dr. Vera Bernhardt, PhD, senior lecturer and project leader for examination of pharmacy students, University of Basel
Dr. Saskia Bruderer, PhD and Bachelor in Medicine; lecturer and examiner in clinical pharmacy

Prof. Dr. Kurt E. Hesberger, Head Pharmaceutical Care Research Group and all patient directed teaching activities at the Department of Pharmaceutical Sciences in Basel.
In total 387 abstracts have been reviewed. After the peer review process, 346 were accepted (41 rejected (10.6%). Of these 346, 24 authors were invited for an oral communication, 36 for a poster discussion forum and 286 for a poster presentation.

30 countries have participated. Table 1 shows the distribution of the accepted abstracts in each topic. The abstracts of all communications and posters presented will be published in UCP. They will also be available on the Springer website www.springerlink.com and the ESCP website www.escpweb.org.

### Clinical Case from the ESCP SIG Paediatrics

The SIG Paediatrics presents a clinical case. If you cannot find the answer ... see page 5.

We present the case of a two year old boy (13 kg) with “refractory focal epilepsy of frontal origin”, referred to the paediatric neurology service.

The patient was recently admitted for a routine follow-up of his antiepileptic treatment and discharged.

Three days later, the patient was readmitted as an emergency with significant weakness, ataxia, loss of appetite and vomiting.

Physical examination revealed asthma, but otherwise the patient was conscious with normal vital signs.

On admission to the paediatric emergency room, current treatment includes:
- Zonisamide Zonegran® capsule 35 mg; 35 mg 2 per day
- Sodium valproate Micropakine LPS® per os 100 mg: 200 mg 3 per day
- Phenytoin Epanutin® oral suspension 30 mg/5 ml: 60 mg 3 per day
- Diazepam Vialum® injectable ampoule 10 mg / 2 ml: 6 mg in case of seizures usage by intracerebral route
- Paracetamol Doliprane® oral suspension 2.4%: 1 dose based on weight per 6 hours if fever or pain
- Macrogol Forlax® 4 g packet: 1-3 packets per day, depending on stool consistency
- Vitamins Hidrosol polyvitaminé® drops: 15 drops per day

Phenytoin was started three weeks before emergency hospitalisation and gradually increased over two weeks (from 120 mg at first to 180 mg per day). The other drugs had been taken long term without modification during Phenytoin initiation.

Blood levels were performed. The results were:
- Phenytoin = 156 μmol/L [28-60 μmol/L]
- Valproic acid = 204 mmol/L [347-694 mmol/L]
- Albumin = 64 g/L [65-80 g/L]

Phenytoin was discontinued for 2 days and the patient’s clinical condition improved particularly with regard to the digestive disorders (Phenytoin level = 99 μmol/L). The patient was then transferred to the paediatric neurology department and the dose of phenytoin was halved after monitoring blood levels and dose adaptation (Phenytoin level = 69 μmol/L). There was no change of other drugs.

The medication history (three weeks before his visit to the emergency room) shows the use of different dosage forms containing phenytoin. This is the medication history in chronological order:
- First, Sodium Phenytoin Dilantin® 250 mg/5 mL injectable solution for intravenous (IV): 7 days (120 mg to 150 mg per day divided into 3 doses). (Phenytoin level = 41.59 μmol/L) [Albumin level = 65 g/L].
- Then, Phenytoin Sodium Diphenytoin® tablets 100 mg tablets: 10 days (165 mg to 180 mg per day divided into 3 doses). (Phenytoin level = 41.58 μmol/L) [Albumin level = 66 g/L].
- Ultimately, Phenytoin Epanutin® 30 mg/5 ml oral suspension: 4 days (180 mg per day divided into 3 doses). Curiously, there was a cessation of phenytoin assays from the introduction of the oral form, and no pharmacological control before discharge. Nevertheless, the patient felt good without clinical problems.

In short, this is the evolution of phenytoin levels over time (figure 1).

To conclude: a statement to Regional Pharmacovigilance Centre was made by a pharmacist. 3 cases are listed in the database in France involving Phenytoin Epanutin® including 2 cases of overdose in a context of dosage form transition. Eventually, after several days of monitoring, the patient was discharged with a lower dosage (45 mg three times daily of Phenytoin Epanutin®), controlled epilepsy and no clinical sequelae.

**Question 1**: Is epilepsy prevalent in children?

**Question 2**: What is partial epilepsy?

**Question 3**: Which is the drug of choice for epilepsy in this paediatric population?

**Question 4**: What is Phenytoin Epanutin® and do you know the dosage recommended for children?

What do you think about giving this patient 60 mg three times a day?

**Question 5**: What must be done before administration of an oral suspension? Why?

**Question 6**: What is the half-life of phenytoin?

**Question 7**: What are the main pharmacokinetic differences between phenytoin and phenytoin sodium?

**Question 8**: What do the clinical status and the associated treatment suggest?

**Question 9**: What do you conclude about the diagnosis?

**Question 10**: What are the possible etiologies behind this intoxication? (Accountability)

**Question 11**: How to treat this patient with high phenytoin level (156 μmol/L)? In case of severe intoxication, is it possible to accelerate drug elimination?

**Question 12**: What is the role of the pharmacist in prescribing this drug with a narrow therapeutic index?

![Figure 1](http://www.springerlink.com)
The patient was drowsy and had difficulty walking along with a history of refractory symptomatic partial epilepsy. The introduction and the recent increase of phenytoin associated with a toxic blood level led to a phenytoin overdose. That’s why Phenytoin Epapustin® was interrupted.

**Answer 8:** The clinical presentation of the patient and the dose level suggest intoxication by phenytoin.

**Answer 9:** The patient was drowsy and had difficulty walking along with a history of refractory symptomatic partial epilepsy. The introduction and the recent increase of phenytoin associated with a toxic blood level led to a phenytoin overdose. That’s why Phenytoin Epapustin® was interrupted.

**Answer 10:** First, maladministration at home by parents could be suspected. Was the medicine thoroughly mixed? Was the correct dose taken? Was it the appropriate dosage? There are other possibilities like drug interaction: in fact, Valproate acid is an enzyme inhibitor and is likely to slow down the metabolism of phenytoin which may result in higher than expected phenytoin levels. Another point, Phenytoin binds primarily to albumin in plasma: however, the albumin level was normal all the time. In this case, the main hypothesis would be a non-equivalence of bioavailability between different dosage forms of phenytoin (dose too high) without blood monitoring.

**Answer 11:** We have to discontinue the drug, make pharmacological and clinical controls before restarting the treatment. In case of massive ingestion, phenytoin can be eliminated by hemodialysis.

**References:**

Alexandre Acramel
(alexandre.acramel@gmail.com)
Elodie Bourguignon
(elodie.bourguignon@aphp.fr)
Olivier Bourdon
(olivier.bourdon@aphp.fr)
Erwin Tae Suk Kwun
(erwin.tae@doctors.org.uk)
Lorenzo Nona
(lorenzo.nona@aphp.fr)
UNITUXIN to prolong survival in young patients with high-risk neuroblastoma

Neuroblastoma is a rare cancer that forms from immature nerve cells. It is usually seen as a lump in the abdomen or around the spine and typically occurs in children under five years of age. In many cases it is present at birth, but is diagnosed only later when the cancer has already spread to other parts of the body and the child begins to show symptoms of the disease. Patients with neuroblastomas classed as ‘high risk’ have a lower survival rate than for other neuroblastomas.

Unituxin contains dinutuximab, a monoclonal antibody (a type of protein) that has been designed to recognize and attach to a specific structure (an antigen) called disialoganglioside (GD2), which is present in high amounts on the surface of neuroblastoma cells, but in lower amounts in normal cells. When the medicine attaches to the neuroblastoma cells, it marks them out as targets for the body’s immune system, which is then expected to attack the cancer cells and thereby reverse or slow down the progression of the disease.

The safety and efficacy of Unituxin were evaluated in a clinical trial in children with high-risk neuroblastoma who had already responded to chemotherapy (at least a partial response) and were further treated with myeloablative therapy and autologous stem-cell transplantation. The study randomly assigned 230 patients to receive Unituxin combined with other immunotherapy (GM-CSF and IL-2) and an oral retinoid medicine (isotretinoin) or isotretinoin alone. After two years, 66% of patients receiving the Unituxin combination were alive and free from recurrence or tumour growth, while this was the case only in 48% of patients treated with isotretinoin alone during the same time period.

Unituxin is to be administered in combination with granulocyte-macrophage colony-stimulating factor (GM-CSF), interleukin-2 (IL-2), and isotretinoin.

The most common side effects of Unituxin are pain, allergic reactions and hypotension (low blood pressure). Because GD2 is also present on normal nerve cells, Unituxin causes irritation and severe pain of the nerve cells. It is therefore recommended that pain relief is given before and during treatment with Unituxin. Despite prophylaxis, two-thirds of children experience pain and about 40% experience severe pain. The Committee for Medicinal Products for Human Use (CHMP) recommended that the safety profile of Unituxin be further assessed post-authorisation and required the company to include this in their risk management plan for Unituxin.

Gert Laekeman
Past President ESCP (2006-2008)
Co-opted member of the Herbal Decisions by CHMP

Cardiovascular risks of ibuprofen

EMA’s Pharmacovigilance Risk Assessment Committee (PRAC) reviewed a possible dose-related cardiovascular risk of ibuprofen. It concluded that there exists a small increase of cardiovascular problems, such as heart attacks and strokes, in patients taking high doses of ibuprofen (= at or above 2,400 mg per day). The review clarifies that the risk with high-dose ibuprofen is similar to the risk seen with some other non-steroidal anti-inflammatory drugs (NSAIDs), including COX-2 inhibitors and diclofenac.

No increase in cardiovascular risk is seen with the generally accepted highest recommended dose for over the counter use (= up to 1,200 mg per day).

Cardiovascular risks can be minimized by avoiding 2,400 mg ibuprofen per day or higher in patients with serious underlying heart or circulatory conditions, such as heart failure, heart disease and circulatory problems or in those who have previously had a heart attack or stroke.

Risk factors include smoking, high blood pressure, diabetes and high blood cholesterol.

The review also looked at data on the interaction between ibuprofen and low-dose aspirin when the latter is taken to reduce the risk of heart attacks and strokes. Laboratory studies have shown that ibuprofen reduces the blood-thinning effects of aspirin. However, it remains uncertain whether long-term use of ibuprofen in clinical practice reduces the benefits of low-dose aspirin in preventing heart attacks and strokes. Occasional use of ibuprofen should not affect the benefits of low-dose aspirin.

Gert Laekeman
Past President ESCP (2006-2008)
Co-opted member of the Herbal

Medication adherence: from theory to daily patient care

The theme of the conference “Medication adherence: from theory to daily patient care” is currently in vogue: this topic has been an area of high interest since the 1980s when the US Surgeon General C. Everett Koop famously stated “Drugs don’t work in patients who don’t take them”. Non-adherence remains the rate-limiting step between effective treatment and optimum health outcomes, and burdens society and the health care system.

Pharmacists have the relevant knowledge relating to medicines and health to provide patients with the information they need to improve health outcomes. They can coach and motivate patients to increase health literacy, use medications correctly, and adhere to treatment regimens. Thus, they represent the transitional zone between theory and patient care.

In this Spring conference, our wish and vision is to promote methods of improving adherence to healthcare professionals, such as, but not limited to, pharmacists, physicians, nurses, dentists, psychologists, who think “A bird in hand is worth two birds in a bush”. We offer to exchange ideas, share practice and take action. Be part of the adherence forces! We look forward to welcoming you to Basel in June 2016.
ESCP International Workshop
Basel, Switzerland
13 -14 June 2016
Medication adherence: from theory to daily patient care

President of the Workshop
Isabelle Arnet (CH)

Organising Committee
Isabelle Arnet (CH) - chair
Markus Lampert (CH)
Edwin van Aalten (NL) - ESCP International Office

International Office
Sonia Amini (NL)

Scientific Committee
Bart van den Bemt (NL) - chair, GC and SIG-member
Kurt E. Hersberger (CH)
Helga Gardarsdottir (NL)
Daniela Scala (IT) GC and ComCom-member
Przemyslaw Kardas (PL)

Preliminary Programme:
Plenary lectures
• Setting the scene of non-adherence
• Interventions to improve adherence
• Patient involvement/shared decision making
• Tele-health (e-health)

Interactive workshops
• Measuring adherence/detecting non-adherent patients
• Communication techniques
• Tele-health / e-health
• Implementation of interventions

Clinical pharmacy tackling inequalities and access to health care
45th European Symposium on Clinical Pharmacy, jointly organized with NSF
Oslo, Norway, 5-7 October 2016
Clinical pharmacy tackling inequalities and access to health care

Presidency
Frank Jørgensen (NO)

Organising Committee
Anne Gerd Granås (NO) - Chair
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Anne-Lise Sagen Major (NO)
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Carole Kaufmann (CH)
Reidun L.S. Kjome (NO)
Derek Stewart (GB)
Janne Kutschera Sund (NO)
Kirsten K. Viktil (NO)

Clinical pharmacists are frequently asked to advice on appropriate therapies, from either pharmaceutical/medical or economic perspectives. The main theme of the symposium reflects the increasingly widening gap between what is technologically possible to achieve with medicines, their increasing cost, and what is affordable to society and individual patients. The final day of the symposium concerns long-term conditions in children and antimicrobial resistance, two major public health issues where appropriate use of medicines is vital to achieve good outcomes for patients and the society.

ESCP Conferences
# Announcements

## For Your Diary

### 2015

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<td>28-30 October</td>
<td>44th ESCP Symposium on Clinical Pharmacy</td>
<td>Lisboa (Portugal)</td>
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### 2016

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<td>13-14 June</td>
<td>ESCP International Workshop</td>
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<td>5-7 October</td>
<td>45th ESCP Symposium on Clinical Pharmacy</td>
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## New Members

- **Danmark**
  - Awad Saill                   Copenhagen
- **Israel**
  - Rola Makhoul-Farah         Zefat
- **Netherlands**
  - Bram Mertens                Leiden
- **Portugal**
  - Anabela Silva             Lisboa
- **Sweden**
  - Matts Balgard            Uppsala

## Membership 2015 & 2016

### Membership fees

- **2015 & 2016**
  - 1 year Full Membership ......................... € 85
  - 3 years Full Membership ...................... € 215
  - 5 years Full Membership ....................... € 340
  - Student Membership ................................ € 25

### Dual membership (SFPC or SIFO)

- 1 year ....................................................... € 70
- 3 years ................................................... € 175
- Student fee ................................................. € 20

Address: [http://www.escpweb.org](http://www.escpweb.org)