A Quarterly Newsletter of Krupanidhi College of Pharmacy, Bangalore | For Private Circulation Only

SYNERGIA

UPDATES ZEITGEIST FUN

VOL8.ISSUE1

JANUARY - MARCH 2019

WISH YOU ALL HAPPY & HEALTHY NEW YEAR 2019

FDA APPROVALS

FOR ONCOLOGY

BRAND NAME (ACTIVE INGREDIENT)	INDICATION	SPONSOR /APPROVAL
Mektovi (binimetinib)15mg Tab+ Braftovi (encorafenib) 50mg & 75mg capsule	Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation	Array BioPharma Inc June 2018
Tibsovo (ivosidenib)	Relapsed or refractory acute myeloid leukemia(AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation	Agios Pharmaceuticals,Inc. July 2018
Poteligeo (mogamulizumab-kpkc)	Relapsed or refractory mycosis fungoides(MF) or Sézary syndrome(SS)after at least one prior systemic therapy in adults	Kyowa Kirin, Inc August 2018
Lumoxiti (moxetumomabpasudotox-tdfk)	Relapsed or refractory hairy cell leukemia (HCL) who received at least two prior systemic therapies, including treatment with a purine nucleoside analog (PNA) in adults.	AstraZeneca Pharmaceuticals September 2018
Copiktra (duvelisib)	Relapsed or refractory chronic lymphocytic leukemia, small lymphocytic lymphoma and follicular lymphoma	Verastem, Inc September 2018
Vizimpro (dacomitinib)	Approved as first-line treatment for patients with metastatic non-small-cell lung cancer (NSCLC)	Pfizer Inc September 2018
Libtayo (cemiplimab-rwlc)	Metastatic cutaneous squamous cell carcinoma (CSCC) or locally advanced CSCC who are not candidates for curative surgery or curative radiation.	Regeneron pharmaceuticals,Inc September 2018
Talzenna (talazoparib)	Deleterious or suspected deleterious germline BRCA-mutated (gBRCAm), HER2negative locally advanced or metastatic breast cancer	Pfizer Inc October 2018
Lorbrena (lorlatinib)	To treat patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer	Pfizer Inc November 2018
Daurismo (glasdegib)	The drug in combination with low-dose cytarabine, is approved for the treatment of newly-diagnosed acute myeloid leukemia (AML) in adult patients who are >75 years old or who have comorbidities that preclude use of intensive induction chemotherapy	Pfizer Inc November 2018
Xospata (gilteritinib)	Relapsed or refractory acute myeloid leukemia (AML) with a FLT3 mutation in adults	AstellasPharma US Inc November 2018

SOURCE: Center-watch, USFDA, Current as on December 2018 Compiled by Meghanadh Manyam, Rakshith reddy Katta, Navya Vaddavalli (Pharm D interns, KCP)

Dr. Sunil Kumar G Patil
Asst. Professor, Dept. of Psychiatry
MVJ Medical College & Research Hospital
Hony.Secretary
Indian Psychiatric Society-Karnataka Chapter
Past Editor
MINDS Newsletter for Medical Undergraduates

EXPERT REVIEW

DISSOCIATIVE DISORDERS

Dissociative disorders are under diagnosed by or misdiagnosed by physicians due to unfamiliarity with symptomatology and diagnosis. Eventhough the concept of dissociative disorders is little complex it is necessary to know about it due to frequent presentations to primary care physicians.

The tenth edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) classifies the dissociative disorders among the neurotic, stress-related, and somatoform disorders. The ICD-10 explicitly states that the term hysteria should be avoided because of its lack of precision. The ICD-10 dissociative [conversion] disorders include dissociative amnesia, dissociative fugue, dissociative stupor, trance and possession disorder, and dissociative disorders of movement and sensation. The latter includes dissociative motor disorders, dissociative convulsions, and dissociative anesthesia and sensory loss. Ganser syndrome and multiple personality disorder are classified under other dissociative disorders.

HISTORY

Hippocrates coined the term "Hysteria" meaning the "wandering womb". Jean martin charcot demonstrated that dissociative symptoms are produced by hypnotic suggestions, later Hilgard gave neodissociation theory. The word conversion was coined by Sigmund frued which means presentation of unconscious emotional conflict with somatic complaints. The word "hysteria" is no more used instead word dissociative(conversion) is used.

AETIOLOGY

Psychodynamic model: Frued explained that the repressed unconscious emotional conflicts causing anxiety get converted to physical symptoms which have symbolic value to those conflicts. Repression is a primary ego defense mechanism which represses anxiety provoking emotional conflicts into unconscious part of mind.

Sociocognitive model: also called as behavioral model, it states that dissociative symptoms are learned unconscious responses about certain illnesses after witnessing it in friends or relatives. Occurs in susceptible individuals under severe stress.

Neurobiological theories: Information processing theory(Oakley), Somatic marker hypothesis(Damsio) and the striatothalomocortical hypotheses(Vuilleumier) none of which are confirmatory.

CLINICAL FEATURES

The essential feature of the dissociative disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The usual onset is sudden often associated with temporally related stressor.. The symptoms are not intentionally produced or feigned.

General Clinical Phenomenon in Dissociative Disorders

- ☐ Secondary gain: This is found in the form of extra attention by relatives after appearance of symptoms, also relief from role obligations and making others to listen to his demands.
- ☐ Primary gain : There will be relief from anxiety associated with internal emotional conflicts since symptoms will have symbolic value for conflicts.
- ☐ La belle indifference: Patient will show a lack of concern to serious symptoms with unusual calm facial expression.
- ☐ La belle indifference: Patient will show a lack of concern to serious symptoms with unusual calm facial expression.
- ☐ Modeling or Identification: On detailed evaluation there may be modeling of symptoms of disease of some of their friends or relatives.

Often the recovery is also fast depending upon the type and severity of stressor. Physical evaluation reveals no medical illnesses.

Dissociative amnesia: Inability to recall important personal information usually of traumatic or stressful event, that is too much to be explained by ordinary forgetfulness with no underlying medical problem. This is most common type of dissociative disorder which is more prevalent among females. Amnesia could be circumscribed (inability to recall all personal events during particular period of time)which is very common, Selective (only some selective material), Continuous (all personal events after stressor), Generalised (personal events of whole life) which is very rare.

Dissociative fugue: episodes of sudden unexpected travel from home with amnesia for original identity and living purposefully by adopting new identity. The person is unaware of amnesia. Common in males.

Dissociative identity disorder: Also called as multiple personality disorder, here a person can have two or more distinct personalities which are unaware(amnesia) of each other and function independently with wide range of behaviors.

Trance and possession disorder: Here there is temporary loss of both the sense of personal identity and awareness of surrounding, sometimes as if controlled by some spirit. Commonly seen India and African contries. More common among females.

EXPERT REVIEW

Dissociative disorder of movement and sensation: Here there is loss or interferences in movments or sensations. Includes dissociative motor disorder(*astasia abasia, aphonia*), dissociative convulsions (*psuedoseizures*), dissociative anesthesia and sensory loss (*psychogenic deafness or blindness*), Mixed dissociative disorder if all above occurs in combination.

Ganser's syndrome: complex disorder described by Ganser , charecterised by "*approximate answers*" usually associated with other dissociative symptoms

ASSESSMENT

The main objective of assessment is to rule out any medical condition by detailed physical examination and investigation if required. Usual differential diagnosis include, substance intoxication, psychotic and mood disorders, head trauma, dementia, neurological disorders like convulsions(Temporal lobe epilepsy) hemiplegic, paraplegic, coma.

TREATMENT

Behavior therapy: removal of secondary gain by *tactfully neglecting* the dissociative symptoms which will reduce the reinforcement of symptoms and finally reduction in symptoms.

Abreaction : here the persons unconscious conflict is brought to conscious awareness and strong suggestions are given. This can be done by psychoanalysis (free association) or by interview under the guidance of intravenous Thiopentone injection (narcoanalysis).

Supportive treatments: supportive psychotherapy, counseling to increase coping skills to face stressors and problems in day today life.

Medications : may require short term anti-anxiety drugs (benzodiazepines), rarely require long term drug treatment.

MEDIA AND DISSOCIATIVE DISORDER

Multiple personality disorder has major attention of media since long time. This is portrayed in movies like the "*Three Faces of Eve, Eybil*", also in regional movies like "*Aparichith*", originally made in Tamil as "*Anniyan*" which became very popular.

COURSE AND PROGNOSIS

In most cases these disorders are of short duration and disappear completely, but in some cases recurrences occur despite good efforts to treat.

Clinical Pearls for Dissociative Seizures (Psuedoseizures)

- Sudden in onset.
- Occurs in presence of people, never occurs in sleep.
- Often preceding stressor present.
- Atypical feature and symptoms and signs vary from attack to attack
- Prolonged seizure duration, no tongue bite or self injury, more pelvic thrust.
- Absence of autonomic signs like salivation, incontinence, dilated pupils, and plantar positive reflex.
- May avoid noxious stimuli during attack.
- No preictal phenomenon or post ictal confusion, patient may remember all events occurred during the attack without memory impairment
- EEG will be normal and there will be no increase in prolactin levels
- It is always better to depend upon multiple source of data like, video EEG monitoring, recording ictal and interictal EEG, subjective and objective clinical characteristics, course of seizures, induction procedures for seizure and even Brain imaging studies in doughtful cases.

Clinical Pearls for Dissociative Motor and Sensory Disorders

- The symptoms cannot be explained on current anatomical and physiological principles for eg. Stock and glove distribution.
- Symptoms are based on patients knowledge and concept of disease.
- In dissociative blindness patient can have tubular or tunnel vision, can able to do his basic works without any injuries or falls. All objective signs in dissociative blindness or deafness will be normal.
- Astasia-Abasia is gait disturbance in dissociative disorder which is wide based, bizarre, jerky, and dramatic, with exaggerated body movements, may not fall not fitting into any description of known gait disorder.
- Tremors and other movement disorder in dissociative may worsen with attention.
- In dissociative paresis or paralysis classical neurological signs are absent- passive resistance to movements, normal reflexes, occasional body movements. Avoid injuries-Arm release sign-when affected limb is raised and released it usually falls right angle to body in hemiplegic but by the side in dissociative paralysis, legs when released also fall rapidly in hemiplegic but not so in dissociative. Hoovers sign can be tested in hemiplegic.
- In dissociative unresponsive patient – patient resists eye opening, there is fluttering of eyelids when eyelashes are stroked, rigid body posture, there will be normal brain stem reflexes when examined along with normal papillary response, may respond to painful noxious stimuli

Dr. Sharon Derek
Clinical Pharmacist
Vikram Hospital, Bangalore

Alumni Speak

MY EXPERIENCE AS A CLINICAL PHARMACIST

My first Job experience right after I finished my Pharm D 6th year was as a Clinical Pharmacist at Vikram Hospital, Bangalore. During the initial days of my work I was posted in the pharmacy to understand role of Clinical Pharmacist in developing the Essential Drug List/Formulary. The clinical pharmacist along with other members of Pharmacy and Therapeutic Committee decide the approval and addition of any new drug in the Formulary based on the Cost effectiveness and Therapeutic outcome of the drug. It is the Clinical pharmacist who creates the code for any new drug in the Hospital. As a clinical pharmacist it is important to understand the management and storage of Controlled drugs in the pharmacy as well as in the wards. I was involved in regular auditing of Narcotics, its documentation, Storage and Disposal of empty ampoules. The pharmacy gave me the opportunity to understand the process of Inventory control and determine the Fast- and Slow-moving drugs based on the Utilization of drugs. After my initial few days in the pharmacy, I started going to the wards where I was involved in Prescription auditing which required me to check the Consultants orders for any therapeutic duplication, possible drug interactions and Adverse drug reactions as each patient had cross references with doctors of different department. It is the responsibility of the Clinical Pharmacist to monitor and review the use of Restricted Antibiotics such as Meropenem, Linezolid, Vancomycin. The Consultant has to give proper justification before starting on any Restricted antibiotics. Its only after the significant reasoning the restricted antibiotic is dispensed from the pharmacy for use. Myself along with the Microbiologist were able to bring down the abrupt use of these restricted antibiotics and preserve them for patient with high end infections and in patient resistant to other antibiotics. I was also involved in monitoring the use Prophylactic antibiotics before any surgery. The Clinical pharmacist has to determine the choice of Antibiotic based on the case and monitor the real time administration of antibiotic before any incision and also to determine redosing of antibiotic based on the duration of surgery and half-life of the antibiotic. The patients are monitored Post-op for any Surgical Site Infections (SSI's) specially in cases where prophylactic antibiotic is not been used. The data collected is analysed by the Clinical pharmacist and Microbiologist and presented in the Infection Prevention Control Committee (IPCC). I was also given an opportunity in teachingand educating staff from the nursing department, pharmacy department and resident doctors on how to identify, manage and report any Adverse Drug Reaction. Nurses being the backbone of hospital, they can play a vital role in identifying and reporting ADR based on patient's drug therapy and when to rechallenge and dechallengea suspected drug based on the severity of the reaction. Team based care is theKey to help prevent some of the Adverse Drug Reactions. I was involved in medication counselling for discharged patient and also checking for the appropriateness of drug and duration of therapy. We have to be empathetic towardspatients' problems to optimize the medication therapy according to patient's needs. We also educate patients on how to use medical devices such as Glucometers, Nebulizers, inhalers, Insulin pens. We pay special attention when it comes to educating Diabetic patient. We also educate them on how they can monitor andregulate their insulin doses based on the blood sugar level. It makes me immensely happy and proud of my career choice as Clinical pharmacist when patient comes back to you with a great smile for helping them understand their medication therapy and adhere to it.

I also had the privilege of being a part of Consultants discussion class on every Saturday, where we pick topics from different department and discuss bout their current guidelines, new available drugs to treat the condition as well as the Doctors insight on how they diagnose and treat a condition. Such classes were always a great learning experience for me to improve and expand my abilities in patient care.

I would like to conclude by saying that my first job gave me lot of exposure on how a Clinical pharmacist plays a pivotal role in dealing with patient's problems and in deciding the best therapeutic outcome by providing critical input on medication use and dosing. I am very grateful to have worked with all the great Consultants in my Hospital who have only helped me grow in my field and considered me as one of their team members. I would also like to thank all my teachers for guiding and encouraging me throughout my 6 years of study and transforming us into Confident and Responsible human being and preparing us for the world outside.

Dr. Venkatraghavan Sundaram
M.Pharm, PhD
Research Associate
PCCI (Parkland Center for Clinical Innovations)
USA

How Effective Medication Management Can Improve Clinical Outcomes?

Annually, 1.5 million Adverse Drug Events (ADEs) occur in the United states alone and prior studies indicate 70% of the ADEs arise from preventable medication errors. Globally, many patients suffer from ADEs although the incidence is hard to calculate. This lack of focus on the underlying causes of ADEs can result in patient harm, longer hospital stays and higher costs. To date, although several specific attempts have been made to curtail the problem caused by ADEs, comprehensive approaches that manage the complexity of the situation remain elusive. During hospital admissions especially in an emergency room, clinicians often lack the timely recognition and ability to intercede ADE's through appreciating -, causal relationship with, real time correction of errors, and communication of ADEs. Such deficiencies often prolong harmful medication use. Clinical pharmacists however with training, expertise and professional practice dedicated to medication management may be better positioned to effectively intervene on preventable scenarios that could lead to medication-related adverse events. Unfortunately, it is difficult to screen all patients during hospital admission, or at discharge to identify ADEs.

A strategy targeting high risk patients can empower and focus the clinical pharmacist's team efforts to ensure better clinical interventions by early identification and elimination of potential ADEs. The first step in the process is to stratify the patients into risk levels for developing ADE. This is accomplished through predictive analytics. Known risk factors that are associated with development of ADEs must be accessed and analyzed from medical records. These include high risk drugs (including but not limited to anti-infectives, anticoagulants, diuretics, antihyperglycemics, analgesics, etc.), polypharmacy, previous history of ADE, comorbidities, certain diseases conditions, age greater than 65 years and laboratory values. Risk prediction models for a hospital setting are predominantly developed retrospectively and tested prospectively using patient health care clinical data. A few models used in predictive data analytics are Logistic Regression, Decision tree and Random Forrest etc. The technological approach to target the right patient at the right time is a part of informed clinical decision making which has been proven to improve hospital outcomes. Informed clinical decision making is being thoroughly researched across various facets of clinician- patient interaction, diagnosis, prognosis and disease management. Technology assistance in medication management is a highly active area in healthcare research to drive outcomes.

Given the steady gains in the adoption of electronic health records, it is prime time for Indian healthcare leaders to advocate connecting the information across hospital and health systems on secure cloud- based platforms. Doing so, would bring in a significant amount of rich clinical information needed for healthcare data analytics. Given that medication reconciliation through medical & medication history interviews along with targeted pharmaceutical care during hospitalization by pharmacists have been shown to prevent ADES, risk model stratification driven workflows during hospitalization can significantly enhance their efficiency and effectiveness towards the goal of reducing ADEs. This strategy will address two prevailing healthcare issues. One, it provides the necessary training and employment opportunities for clinical pharmacists. Second, by allowing the pharmacist to function at the top of her license, so too can the clinical provider expertise be better leveraged for patient care assessment, decisions and treatment. This new phenotype of a clinical pharmacist working with predictive care models is termed a "medication therapy management (MTM) pharmacist". In addition to performing medication reconciliation maneuvers on high risk individuals for ADE, the MTM pharmacists provide targeted counselling/education during patient discharge from the hospital on disease management, medication and life style modifications. All of which are necessary together to improve quality of care and outcomes. Finally, follow up of high-risk patients post-discharge would complete a holistically focused process needed to comprehensively reduce the incidence and impact of ADEs. An Informed clinical decision making process along with trained MTM pharmacists are needed to handle the current complex ADE epidemic and to improving healthcare outcomes.

The comprehensive approach to reduce ADE burden: empowering clinical pharmacists with technology assistance

Dr. Samuel Gideon George P

Assistant Professor
Department of Pharmacy Practice
Krupanidhi College of Pharmacy,
Bengaluru.

EMBRACING PHARMACOGENETICS IN THE INDIAN HEALTH STRATEGY: WHY ARE WE STILL IN THE QUEUE?

EMBRACING PHARMACOGENETICS IN THE INDIAN HEALTH STRATEGY: WHY ARE WE STILL IN THE QUEUE?

The global health care sector has witnessed paradigm shifts ever since the accomplishment of Human Genome Project in 2003. The tremendous information generated on human genome has enlightened our existing understanding of human disease molecular pathogenesis and provided substantial insights for Personalized Medicine (PM). Since then, PM has burgeoned with progress in high-throughput technologies (though expensive!) which made biological data generation facile, rapid and reliable. However, transition to the era of PM is often disfavored by our inability to effectively integrate and inter-operate high-throughput data which often requires multidisciplinary research. Therefore, a huge gap between progress in high-throughput technologies and our ability to manage, process and interpret biological data exists.

PERSONALIZED MEDICINE IN THE INDIAN HEALTHCARE SCENARIO

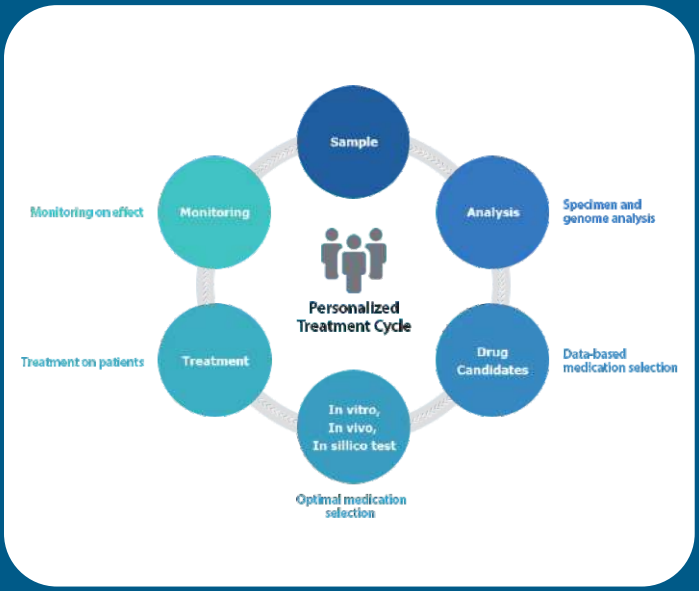
The Indian sub-continent is home to approximately 133 crore people with a life expectancy and healthy life expectancy of 66 and 57 years respectively. Despite sharing 17.74% of the world's population, the global health expenditure of India is very minimal when compared to countries with lesser population and higher life expectancy. It is evident that the relationship between population and global health across geographical regions is inconsistent with huge disparity. PM may further increase this disparity as generation of large volume biological data through advanced high-throughput techniques such as next generation sequencing, microarrays and real-time medical imaging etc., are highly expensive. Therefore, in developing countries like India, having genetic information in the clinical records would only be possible if pharmacogenetic tests are afforded to patients through cost-effective or cost-saving strategies such as free genetic testing.

WHERE DO WE LAG IN THE PATH TO GENOMIC MEDICINE?

India has significantly invested in the area of pharmacogenetics with the hope of reaping long-term benefits. Several genetic research consortiums such as the Indian Genome Variation (IGV) have been powered by funding agencies including Council for Scientific and Industrial Research (CSIR), Indian Council for Medical Research (ICMR) and Department of Biotechnology (DBT). As of today, outcomes of those funded researches have produced tangible health benefits to the general public. Despite huge financial support, clinical trials to investigate inter-individual variability in drug responses are still in pipeline due to lack of regulatory guidelines. The Central Drugs Standard Control Organization (CDSCO) has not established any specific guideline for conduct of trials to study the effect of genomic or other clinical variables on treatment responses. There is increasing demand for guidelines to regulate population pharmacokinetic and genetic association studies as the outcomes would provide a real picture of how the molecule would behave in the target population.

ASSESS AND DEVELOP STRATEGIES TO OVERCOME EFFECTIVE IMPLEMENTATION

Acceptance of personalized medicine by patients and health care providers (HCPs) is what decides its success. It is arbitrary to assume that acceptance of personalized medicine in the developed world would guarantee acceptance and success in the Indian health care system. Clinical implementation of personalized medicine is governed by diverse social and ethical issues which are unique for the nation. Ethnic beliefs, customs, values and traditions of the country form the basis of acceptance towards personalized medicine. Hence, crucial concerns such as awareness, attitude and acceptance of patients and HCPs towards personalized medicine need to be explored to develop optimized framework for successful implementation of personalized medicine into Indian healthcare system. Moreover, acceptance of PM by patients will depend primarily on the cost-effectiveness. Positive impact of pharmacogenetics informed health care could only be achieved if the end-consumer finds it cost-effective and expresses willingness to afford for it.



INTERNATIONAL CONFERENCE ON DRUG DEVELOPMENT AND CLINICAL RESEARCH : CURRENT SCENARIO & OPPORTUNITIES

12 -13 October 2018, Bengaluru, India

KrupaPharmaCon 2018: International Conference on Drug development and Clinical Research: Current Scenario & Opportunities was held at Krupanidhi College of Pharmacy, Bangalore on 12 & 13 October 2018, in collaboration with Indian Society for Clinical Research and Rajiv Gandhi University of Health Sciences, Karnataka.

KrupaPharmaCon 2018 was inaugurated on 12 October 2018 by Prof. B Suresh, President Pharmacy Council of India & Vice Chancellor JSS University, Mysuru. In his address Dr. Suresh reiterated the importance of setting higher goals for professional Development. He lauded the Krupanidhi Group of Institutions for having started a first of its kind PG Diploma in Healthcare Analytics. He added events such as KrupaCon helps fill the void in the vacuum in the pharmacy curriculum, and addresses the changes in industry trends and helps the students to meet the industry expectations he said.

In his presidential address, Prof. Suresh Nagpal, Chairman Krupanidhi Group of Institutions, elaborated the need for creating newer courses to meet the industry requirements. Dr. Nagpal enunciated the vision of KrupaCon was to create meaningful engagement with Clinical Trials industry and to offer a learning opportunity to aspirants as well seasoned professionals.

The Key Note speakers in this event were Prof. James F Jordan, Distinguished Service Professor of Healthcare and Biotechnology Management and senior Director of Healthcare And Biotechnology Programs &President & CEO at the Pittsburgh Life Sciences, USA and Mr. Kothandaraman Sridharn, CEO – Mindshare Learning Centre and Clever Insight Menlo Park, California, USA.

Apart from the key note speakers 12 resources persons from industry and academia addressed the delegates. Over 600 delegates from 60 colleges and universities from India and aboard participated in the deliberations. During this of this two-day event 200 scientific papers were presented across 5 tracks and moderated panel discussions were conducted during the duration of the event.

Dr. B Suresh, President - Pharmacy Council of India felicitating Prof. James F Jordan, Carnegie Mellon University

Dr. Sam Paul Isaac felicitating ISCR Team

Day 1: Speakers and Panel members with core organising committee

Day 2: Speakers and Panel members with core organising committee

Organising Committee

CENTER FOR PHARMACEUTICAL PROFESSIONAL ADVANCEMENT (CPPA)

FINISHING SCHOOL PROGRAMME

Bret Morrison once said, "Of all the life skills available to us, communication is perhaps the most empowering." We, at Krupanidhi College of Pharmacy second this thought and how. The institute has been committed to imbibing within its students' not just communication, but many more life skills that would equip these big fishes from small pond to venture into a big ocean.

The Center for Pharmaceutical Professional Advancement is KCP's flagship wing headed by Director Prof. Prakash V Mallya for more than a decade now. The center has been the force driving the motor towards its goal. Prof. Prakash V Mallya, along with his team of trainers has conducted innumerable soft skill development courses, famously termed as "Finishing School "for all the outgoing batches of pharmacy including M Pharm, Pharm D, B Pharm and D Pharm.

Supported by fellow Pharmacy Colleagues and trainers Dr. Trushitkumar Patel and Dr. Riju Pathak, the "finishing school" sessions by CPPA have spread all over Krupanidhi Group of Institutions in collaborations with other trainers in the institute for students of MBA as well as Degree. The programs are all an amalgamation of various communication, presentation and life skill sessions that are elegantly and exuberantly spread over a period of three - four weeks. The main objective has always been to enable the transformation of our students from timid shy individuals to vibrant and confident graduates.

Finishing School final year Pharm D, B. Pharm & Diploma

Recent Academia-Industry seminar by CPPA

Krupanidhi College of Pharmacy routinely organises seminars, inviting eminent pharma industry expert as a part of CPPA activity under the leadership of Prof. Prakash V Mallya, Director – CPPA to fill the gap of Industry- Academia.

Dr. G. JAGADEESH, Senior Pharmacologist

Division of Cardiovascular and Renal Products, Center for Drug Evaluation and Research, US Food and Drug Administration (USFDA/USA); gave an educative and illuminating seminar on the 3 important topics

- **Getting started in Research Project**
- **Innovative New Drug Therapy**
- **Approaches to Submitting Manuscript for Publication**

Mr. JATISH N SHETH

Managing director of Srushti Pharmaceuticals

delivered a vibrant talk on the topic "**ENTREPRENEURSHIP** – challenges and opportunity in design – building – operation of pharma plant" on 01/12/18. The speaker highlighted the major requirements to establish a Pharma Plant.

Mrs. SEEMA MAHESHWARI, Director Unireg solutions

delivered an informative talk **on Regulatory Affairs in Pharma Domain**. The speaker familiarized the participants with the current scenario in drug development and discovery and the role of regulatory affairs in these areas.

These programme were coordinated by Mrs Ashwini M and Mrs Anjali Nayak, faculty members from Krupanidhi College of Pharmacy

NSS activities

KERALA FLOOD RELIEF PROGRAM (AUG-2018)

DAAN UTSAV:CELEBRATING THE SPIRIT OF DONATION (2-8 OCT-2018)

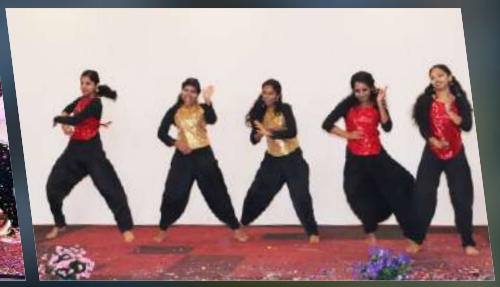
DIABETES SCREENING (14 NOV-2018)

WORLD AIDS DAY AWARENESS (01 DEC-2018)

FREE EYE CAMP (04 DEC-2018)

Cultural & Community out reach events





GALENICAL 2018 - FRESHERS' DAY (01 SEP-2018)



TEACHERS' DAY (05 SEP-2018)

WORLD PHARMACIST DAY (25 SEP-2018)
(Theme:Pharmacist Your medicine Experts)





NATIONAL PHARMACY WEEK (18-24 NOV-2018)

RANK HOLDERS

Hearty Congratulations

to all the rank holders and wishing all great Success in upcoming endeavors.

Rajiv Gandhi University of Health Sciences, Bangalore, Karnataka

Doctor of Pharmacy(PharmD) 2017-2018

VADDAVALLI NAVYA
3rd Rank
PharmD 5th Year

RIHANA NAWAB JAN
4th Rank
PharmD 5th Year

CHRISTY SUSAN MATHEWS
9th Rank
PharmD 5th Year

RAMESH DATTA PANT
9th Rank
PharmD 5th Year

THEJASWINI KARANTH
10th Rank
PharmD 5th Year

Drugs Control Department, Board of Examining Authority, Bangalore, Karnataka

II Year Diploma in Pharmacy (D.Pharm) 2017-2018

KAVERI N
6th Rank in Karnataka State
D.Pharm 1st Year

ANUSHA C
10th Rank in Karnataka State
D.Pharm 1st Year

NAVYA S P
2nd Rank in Karnataka State
D.Pharm 2nd Year

TEAM SYNERGIA

PATRON: Dr. Suresh Nagpal, Mrs. Geetha Nagpal, Prof. Sunil Dhamangini, Ms. Neha Nagpal, Mr. Akash Nagpal, Dr. Sam Paul Isaac
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Please send your contributions, feedback and suggestions to : synergia.kcp@gmail.com