# Pharmacy Practice Newsletter

*"Know what's new… Optimize care"*

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## *Introduction*

**The Central Administration of Pharmaceutical Care in the Egyptian Drug Authority** is keenly interested in upgrading the pharmaceutical services provided to the patients and boosting the pharmacotherapy-related knowledge of all healthcare providers, which will positively impact the patient's health and safety.

From this point, **the General Administration of Drug Utilization and Pharmacy Practice (DU&PP)** is pleased to publish the *Pharmacy Practice Newsletters*, which aims to aid practitioners in their mission to optimize care. Topics related to pharmacotherapy and pharmacy practice will be addressed in our newsletter. The newsletter will provide an up-to-date, concise summary that fits perfectly into the healthcare provider's tight schedule.

**We utilize accredited resources and indexed journals** integrating the best available research into clinical care, to support the decision-making process for healthcare professionals. To optimize patients' treatment plans and ensure their safety and efficacy, clinicians must closely follow the literature for any updates related to their practice, given the dynamic nature of the clinical research.

## *In the issue*

## EDA Publications

# National Guidance of Rational Antimicrobial Use in the Management of Skin and Soft Tissue Infection

**Skin and soft-tissue infections SSTIs** are infections of the skin and underlying tissues, ranging from superficial (impetigo/erysipelas) to deeper infections like cellulitis and severe necrotizing disease.

Skin damage allows endogenous or environmental pathogens to enter, spread via lymphatics, and cause different diseases depending on infection depth.

Most SSTIs are caused by Gram-positive cocci (S. aureus and streptococci), including toxin-producing strains and MRSA, which can cause abscesses, necrosis, and systemic spread.

They affect all ages worldwide; cellulitis is most common, with millions of new cases yearly, and severe infections are more likely in immunocompromised patients (e.g., diabetes, HIV).

The Egyptian Drug Authority developed the National Guidance of Rational Antimicrobial Use in the Management of Skin and Soft Tissue Infection. This guidance provides a practical framework for the rational antimicrobial use in the empiric treatment of skin and soft tissue infections (SSTIs), integrating the WHO AWaRe antibiotic classification to support antimicrobial stewardship and reduce antimicrobial resistance.

The AWaRe classification of antibiotics was developed in 2017 by the WHO Expert Committee on Selection and Use of Essential Medicines as a tool to support antibiotic stewardship efforts at local, national and global levels, antibiotics are classified into three groups, Access, Watch and Reserve, taking into account the impact of different antibiotics and antibiotic classes on antimicrobial resistance, to emphasize the importance of their appropriate use.

**Access** antibiotics group includes those that have activity against a wide range of commonly encountered susceptible pathogens while also showing lower resistance potential than antibiotics in the other groups. Selected Access group antibiotics are recommended as essential first or second choice empiric treatment options for the most infectious syndromes.

**Watch** antibiotics group are classes that has higher resistance potential and includes most of the highest priority agents among the Critically Important Antimicrobials for Human Medicine and/or antibiotics that are at relatively high risk of bacterial resistance. These medicines should be prioritized as key targets of stewardship programs and monitoring. Selected Watch group antibiotics are recommended as essential first or second choice empiric treatment options for a limited number of specific infectious syndromes.

**Reserve** antibiotics group includes antibiotic classes that should be reserved for treatment of confirmed or suspected infections due to multidrug-resistant organisms. Reserve group antibiotics should be treated as "last resort" options.

**N.B.**, the antibiotics highlighted below in green fall under the **Access** category, those in yellow are classified as **Watch** antibiotics, and the ones in red belong to the **Reserve** group.

Here are some key recommendations from the guidance on managing cellulitis, erysipelas, and pressure ulcers.

**For getting the full guidance: access this LINK or the QR https://edaegypt.gov.eg/media/wvqldwxa/guidance-for-the-use-of-antibiotics-in-skin.pdf**

## Management of Skin and Soft Tissue Infections in a Hospital Facility

| | Management Strategy | Empiric Antibiotic Regimens | Duration |
|---|---|---|---|
| **Cellulitis and Erysipelas** | • **Hospitalization is recommended in the following conditions:**<br>- There is concern for a deeper or necrotizing infection<br>- Patients with poor adherence to therapy<br>- Infection in a severely immunocompromised patient<br>- Failed outpatient treatment (moderate or severe)<br>- Unstable comorbid illnesses<br>- Signs of systemic sepsis<br>- If surgical intervention is under anesthesia.<br><br>**N.B., in purulent cellulitis, incision and drainage are recommended as primary management for abscesses with associated cellulitis. In these cases, antibiotics are generally suggested.**<br>• **Systemic antibiotics are indicated in the following conditions:**<br>- Moderate infection: Typical cellulitis/erysipelas with systemic signs of infection.<br>- Severe infection: Patients who have failed oral antibiotic treatment or those with systemic signs of infection, or those who are immunocompromised, or those with clinical signs of deeper infection such as bullae, skin sloughing, hypotension, or evidence of organ dysfunction. | **Erysipelas or cellulitis (non-purulent), moderate infection**<br>• Cefazolin<br>OR<br>• Amoxicillin-clavulanate<br>OR<br>• Ceftriaxone<br>**Erysipelas or cellulitis (non-purulent), moderate at risk for (CA-MRSA)** including critically ill and immunocompromised status, personal or household contact with MRSA infection or colonization in the past 12 months, with prior antibiotic use for 5 days during the last 90 days, with cellulitis associated with penetrating trauma especially from illicit drug use or who do not respond to first-line, add one of following intravenous antibiotics:<br>• Vancomycin<br>OR<br>• Linezolid<br>**Purulent cellulitis**<br>One of the following intravenous antibiotics:<br>• Vancomycin<br>OR<br>• Linezolid<br>**In patients at risk for Gram-negative infection and MRSA (polymicrobial) or severe infection** (erysipelas/cellulitis purulent or non-purulent): Patients who do not respond to first line therapy or | • The recommended duration of antibiotic therapy for hospitalized patients is 7-14 days.<br>• A longer course length (up to 14 days in total) may be needed based on clinical assessment. However, skin may take some time to return to normal, and full resolution of symptoms at 5 to 7 days is not expected.<br>• Intravenous antibiotics should be continued until the clinical picture improves, the patient can tolerate oral intake, and drainage or debridement is completed. |

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| | | those with systemic signs of infection, or those who are immunocompromised, or those with clinical signs of deeper infection such as bullae, skin sloughing, hypotension, or evidence of organ dysfunction:<br>• Vancomycin<br>+<br>• Piperacillin/Tazobactam<br>• If monomicrobial: *Streptococcus Pyogenes or Clostridial sp.:*<br>• Penicillin<br>+<br>• Clindamycin<br>*Vibrio vulnificus:*<br>• Doxycycline<br>+<br>• Ceftazidime<br>*Aeromonas hydrophila:*<br>• Doxycycline<br>+<br>• Ciprofloxacin | |
| **Pressure Ulcers** | • Standard care for adults with pressure ulcers includes correct prevention and management.<br>• Prevention of pressure ulcer formation is directed at alleviating the risk factors for the individual patient. It is primarily focused on minimizing episodes of prolonged pressure either by placing appropriate padding at pressure points or by frequent patient repositioning.<br>• Debridement of devitalized tissue and biofilm, and abscess drainage are necessary in the treatment of pressure ulcers. | • If there are signs of systemic infection, a second-generation cephalosporin antibiotic should be selected until the results of bacterial culture become available.<br>• Once the causative bacteria are identified, it is important to select agents with a limited spectrum based on antibiogram results of antibiotic sensitivity testing.<br>• If antibiotics are not effective, their use should not be continued aimlessly, but rather the causative microorganisms and | |

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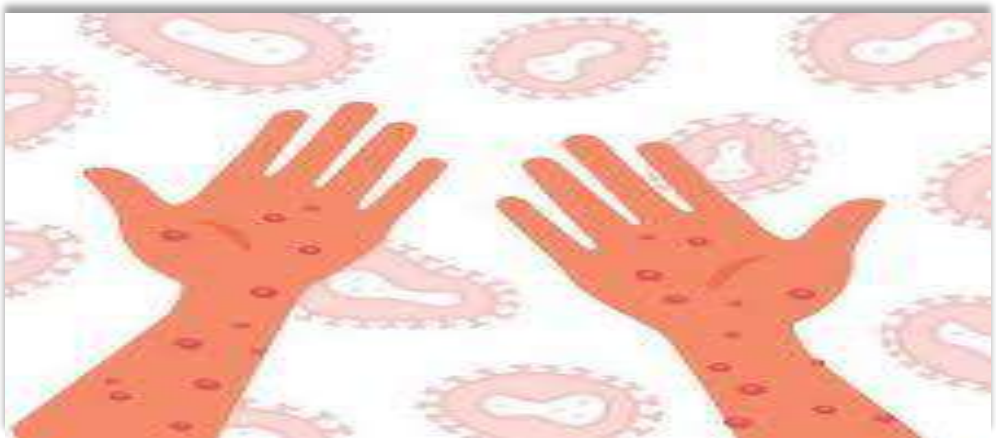
|---|---|---|---|
| | • Systemic antibiotics should be administered only when there are systemic signs of serious infection, spreading cellulitis (deep skin infection), or underlying osteomyelitis. | their foci (e.g., is there an abscess below the ulcer, is there sepsis) should be reevaluated.<br>• If an MRSA infection is suspected, the drug should be promptly changed to an anti-MRSA drug.<br>**Topical agents that should be used as local treatments for controlling infection:**<br>Silver sulfadiazine, iodine ointment. | |

CA-MRSA: Community-Associated Methicillin-Resistant Staphylococcus Aureus
MRSA: Methicillin-Resistant Staphylococcus Aureus




## Clinical Pharmacy Tips

# Fibromyalgia

**Fibromyalgia (FM)** is a syndrome of persistent widespread pain, fatigue, nonrestorative sleep, and cognitive difficulties ("Fibro-Fog"), often accompanied by other unexplained symptoms, anxiety, depression, and functional impairment in activities of daily living (ADLs).

It's a neurosensory disorder with an unclear etiology characterized by abnormal pain processing in the central nervous system (CNS); its symptoms come and go in periods called flare-ups.

It typically presents in middle-aged women, but it can affect patients of either gender and at any age.

## Fibromyalgia Management

(EULAR Guidelines) Recommend that: Initial management must involve patient education and focus on non-pharmacologic therapies.

No cure exists for fibromyalgia, but education, lifestyle changes, including regular physical activity, and proper medications can help the individual to regain control and achieve significant improvement.

**Non-Pharmacological Treatment**

| Psychological and Behavioral Therapy | Physical Therapy and Movement | Dietary Recommendations |
|---|---|---|
| Recognizing psychosocial variables is critical; strictly pharmacologic approaches are of limited benefit without this.<br><br>Depression in fibromyalgia should be treated aggressively. | The goal is to overcome deconditioning and fear of activity.<br><br>•Graded aerobic exercise.<br><br>Target Regimen: Build slowly towards 20-30 minutes, 4-5 times per week.<br><br>Heat and massage can be useful adjuncts. | Focus on sound nutrition and weight management.<br><br>•Avoid: Caffeine (wean slowly), tobacco, aspartame, monosodium glutamate, carbohydrate-rich foods.<br><br>•Encourage: A diet rich in vegetables, fish, and fiber.<br><br>•Screen for: Vitamin D deficiency, which is common, and supplementation can improve outcomes. |

**Pharmacological Treatment:** Approved Medications by the Egyptian Drug Authority

| Drug (Class) | Primary Benefits | Administration Considerations |
|---|---|---|
| **Pregabalin** (Anticonvulsant) | Reduces pain, improves sleep. | Often causes sedation; start with low doses at night. |
| **Duloxetine** (SNRI Antidepressant) | Relieves pain, fatigue, and sleep problems, irrespective of comorbid depression. | SNRI class can cause nausea. They should be taken with food. |
| **Milnacipran** (SNRI Antidepressant) | Relieves pain, fatigue, and sleep problems. | SNRI class can cause nausea. They should be taken with food. |

SNRI: Serotonin–Norepinephrine Reuptake Inhibitors

FM: Fibromyalgia

**Medications used for co-existing symptoms**

| | |
|---|---|
| **Antidepressants (for mood, sleep, pain)**<br>**SNRIs** such as milnacipran and duloxetine.<br>**TCAs** (e.g., amitriptyline): Low dose at bedtime can improve sleep/fatigue but is limited by anticholinergic side effects.<br>**Bupropion**: Activating properties can be helpful for fatigue. | **Analgesics (for co-existing pain)**<br>**NSAIDs/Acetaminophen**: Limited efficacy for FM pain but useful for co-existing pain like osteoarthritis.<br>**Tramadol**: A second-line option for patients with moderate to severe pain that is unresponsive to other treatments.<br>**Note on Opioids**: Generally, not recommended as routine therapy. |
| **Antianxiety agents**<br>Used frequently for anxiety and panic, and as a sleep aid.<br>• Benzodiazepines<br>• Buspirone<br>• Trazodone | **Anticonvulsants (for pain, sleep, anxiety)**<br>**Pregabalin and gabapentin**<br>Can be combined with antidepressants (e.g., pregabalin + milnacipran) for improved efficacy and tolerability. |

SNRI: Serotonin–Norepinephrine Reuptake Inhibitors
TCAs: Tricyclic Antidepressants
NSAIDs: Nonsteroidal Anti-Inflammatory Drugs

•While a complete "cure" may not always be possible, a significant improvement in symptoms and quality of life is absolutely achievable.
•30% decrease in pain scores, which can mean the difference between being bedridden and being able to engage in daily activities.

**The good news is that treatment helps "retrain" the nervous system. Just as it learned to be in pain, it can learn to be more comfortable again.**

## Analysis

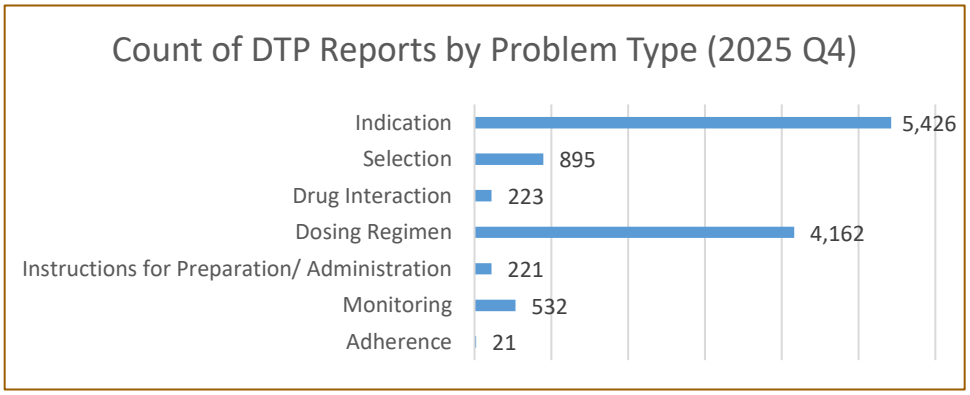
# NO HARMe Reports Summary

**About NO HARMe:**

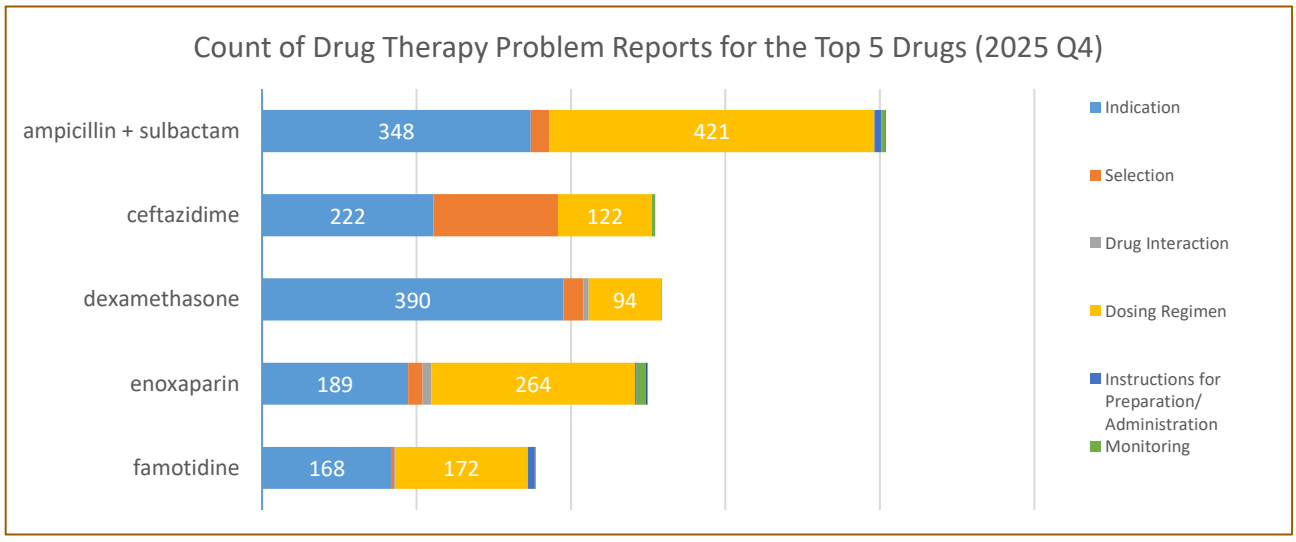
The National Office for Handling and Reducing Medication Errors system (NO HARMe) was established in 2014 for gathering national data on errors of medication use. Since then, NO HARMe has been receiving voluntary reports on clinical pharmacy interventions and medication errors from pharmacists in ~~public~~ healthcare facilities. The system classifies medical errors into decision errors called drug therapy problems (DTP), process errors (ME), and a third category of (DTP/ME overlap). In the following section, we showcase a quick summary of the reports sent to NO HARMe in the last quarter of 2025. For a detailed description of taxonomies and codes deployed by NO HARMe for statistical purposes, refer to the Drug Therapy Problems and Medication Errors Codes Reference on EDA's website.

In the last quarter of 2025, NO HARMe received a total of 11,523 reports, of which 8,404 reports were DTPs (decision errors), 42 were medication errors (process errors), and 3,073 were DTP/ME overlaps.

Problems involving decision (DTP + Overlap) occurred mostly at the indication checkpoint (deciding whether drugs should be prescribed), as shown in the figure below.




Dexamethasone was the most commonly reported drug in problems related to indication (n=390), followed by ampicillin/sulbactam (n=348), and pantoprazole (n=259). Clinical pharmacists frequently reported that dexamethasone was prescribed without a valid indication in patients with respiratory conditions, which is why we decided this issue will summarize guideline recommendations on the use of corticosteroids in respiratory conditions in critical care. The figure below depicts the most commonly reported drugs.



## An Overview of Dexamethasone Use in Common Acute Care Respiratory Conditions

### Management of Asthma Exacerbations in Acute Care [15]

Systemic corticosteroids decrease time to resolution in asthma exacerbations and should be used in all cases except for mild cases.

Route:

- The parenteral route has no benefits over the oral route.
- The oral route is preferred because it is less invasive and less expensive.
- The intravenous route is warranted in case the patient cannot swallow, suffers from vomiting, or requires ventilation.

Dose in adults and 6- to 12-year-old children:

- 12 – 16 mg once daily for 1 – 2 days.
- Consider switching to prednisolone if the symptoms do not resolve after 2 days.

Dose in 5-year-old pediatrics or younger:

- 0.3 – 0.6 mg/kg (maximum 12 mg) once daily for 1 – 2 days.

### Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbations in Acute Care [16, 17]

Benefits from systemic glucocorticoids in the management of COPD exacerbations include:

- Shorter time to recovery and reduced length of hospital stay.
- Improved lung function, forced expiratory volume (FEV1), and oxygenation.
- Lower risk of treatment failure and relapse.

Dose:

- 6 mg per day (equivalent to 40 mg prednisone).

### Management of Community-Acquired Pneumonia (CAP)

Guidelines by the American Thoracic Society (ATS) and Infectious Disease Society of America (IDSA), and guidelines by the American Academy of Family Physicians (AAFP) recommend against the routine use of corticosteroids in patients with community acquired pneumonia regardless of case severity [18, 19] due to lack of evidence to support their use in mild-to-moderate cases, and limited evidence on benefits in severe cases.

On the other hand, guidelines by the National Institute for Health and Care Excellence (NICE) decided the benefits from corticosteroids in severe CAP (CURB-65 score ≥ 3) outweigh the risk, and thus, recommend the use of IV hydrocortisone for 4 – 7 days [20] (or an alternative such as dexamethasone).

### Management of COVID-19 [21]

IDSA guidelines recommend the use of dexamethasone for COVID-19 patients who are either critically-ill or have severe disease due to COVID's large inflammatory component that can lead to acute respiratory distress syndrome (ARDS), longer time on ventilation, and higher mortality.

IDSA definitions of disease severity:

- Critically ill: patients on mechanical ventilation with end-organ dysfunction, most commonly ARDS.
- Severe illness: patients with SpO2 ≤ 94% on room air or supplemental oxygen.
- Mild-to-moderate illness: patients with SpO2 > 94% who do not require oxygen.

Dose:

- Dexamethasone: 6 mg PO or IV daily for 10 days or until discharge.

### Management of Acute Respiratory Distress Syndrome (ARDS) [22]

- ATS guidelines recommend the use of glucocorticoids for ARDS patients with PaO2/FiO2 ≤ 300.
- ATS does not recommend a specific regimen, but rather, treatment regimens should be tailored based on ARDS etiology, i.e., one should refer to guidelines for conditions that respond to corticosteroid treatment, while for other patients, dosing regimens from controlled trials can be used.
- ATS warns that corticosteroid therapy can be associated with an increased risk of harm when initiated 14 days or later after mechanical ventilation.

# DU&PP News
# Pharmaceutical Care Initiatives

In this issue of the Pharmacy Practice Newsletter, we highlight pharmaceutical care initiatives implemented between December 2025 and February 2026. Throughout this period, the Drug Utilization and Pharmacy Practice Administration team remained dedicated to enhancing medication awareness and strengthening pharmacy training programs. This was achieved through a series of targeted sessions tailored to the public, pharmacy students, community pharmacists, and hospital pharmacists. These initiatives included:

### 1) EDA Experience Exchange Hub (Triple E's Hub)

Triple E's Hub aims to strengthen national efforts by promoting and sharing best pharmaceutical practices across healthcare institutions in Egypt. Guided by the EDA's vision and aligned with Egypt Vision 2030, the Hub emphasizes building sustainable partnerships to support long-term development.

The scientific meetings held in December 2025 and February 2026 brought together hospital and clinical pharmacists to highlight their contributions to patient care, focusing on antimicrobial stewardship and oncology precision medicine. Through educational case studies, these sessions enhanced patient outcomes and reinforced evidence-based practice, reflecting the EDA's commitment to advancing pharmaceutical services and rational medication use.

Aligned with the Hub's strategy, these meetings promote experience sharing among healthcare institutions from various sectors and governorates. They showcase clinical interventions across diverse disease areas and foster collaboration among pharmacists, academics, and healthcare experts, strengthening knowledge exchange within the profession.




# DU&PP News:
# Pharmaceutical Care Initiatives

### 2) *(Safe Medication....Save Life)* Initiative

The initiative seeks to improve public awareness of the safe and effective use of medications through a community engagement approach, aiming to build healthier, well-informed populations and optimize therapeutic outcomes. The sessions address a broad spectrum of topics related to non-communicable diseases, including diabetes, hypertension, respiratory disorders, correct inhaler use, safe use of analgesics, potential side effects of cancer therapies, and the rational use of antimicrobials.

On-site awareness campaigns are conducted in public venues such as cultural centers, libraries, sports clubs, hospital outpatient clinics, and university community service centers across various Egyptian governorates. Community sessions held at locations including Green Garden Cultural Library, Sakkara Cultural Library, Ein Helwan Cultural Palace, El Dokki Cultural Library, Om Khenan Cultural Library, and El Bahr Al Aazam Cultural Library have engaged diverse groups of adults, women, and students. These sessions foster meaningful dialogue and form a key part of the EDA's efforts to strengthen drug awareness, enhance pharmaceutical services nationwide, and promote the optimal and rational use of medications.






# DU&PP News:
# Pharmaceutical Care Initiatives

### 3) *(An Aware Pharmacist, an Aware Community)* Initiative

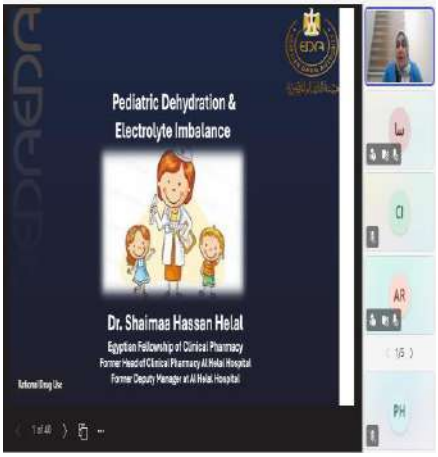
The initiative is designed to promote and sustain high-quality pharmaceutical practices while supporting continuous professional development. Implemented in alignment with the EDA's vision and its capacity-building strategies, it also reflects Egypt's broader commitment to advancing healthcare services.

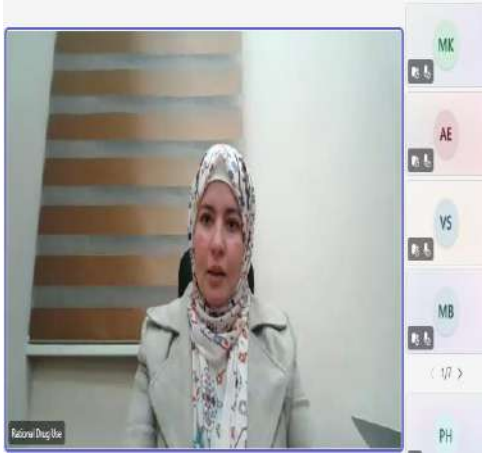
Special emphasis is placed on community pharmacists, who serve as the frontline of public health and play a critical role in enhancing medication safety and accessibility. The program is delivered through a series of monthly online webinars organized by the General Administration of Drug Utilization and Pharmacy Practice, frequently featuring contributions from professional experts and academic leaders across diverse disciplines.

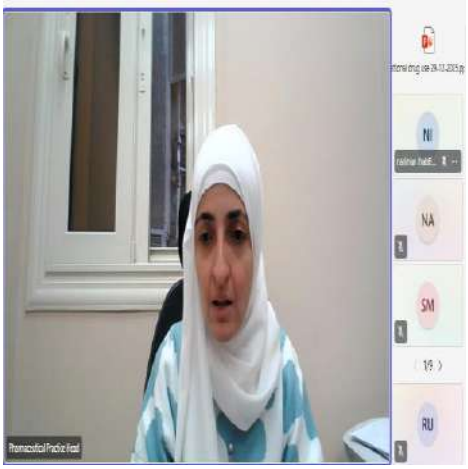
**The selected topics include:**

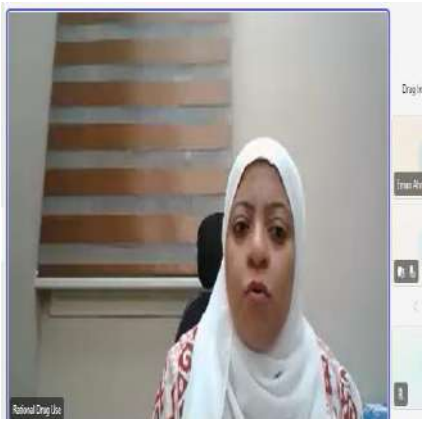
- Drug dose adjustment
- Rational drug use in hypertensive patients
- Disease-specific patient counseling
- Rational drug use for heart failure
- Types of drug information resources
- Pediatric dehydration and electrolyte imbalance

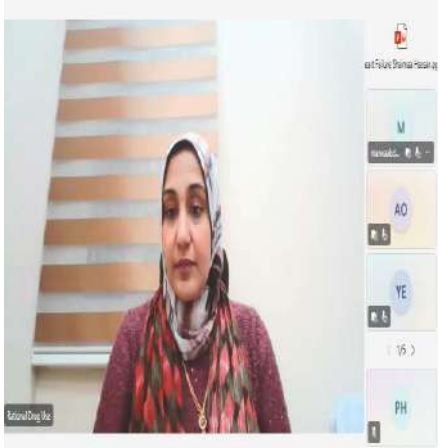
This comprehensive approach ensures participants receive up-to-date knowledge and best practices in the field.







# DU&PP News:

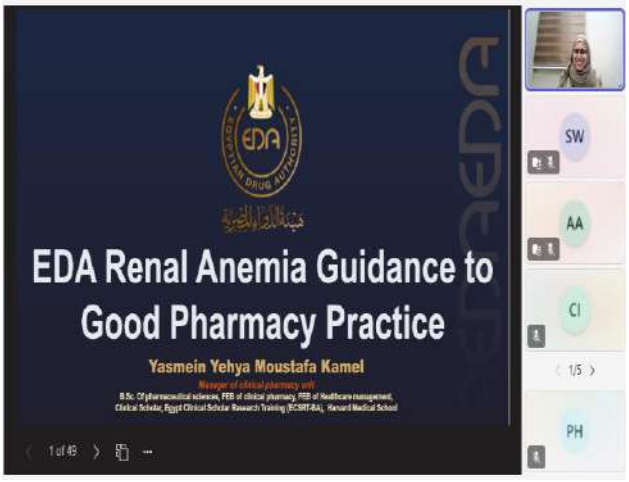
# Guide to Guide Approach

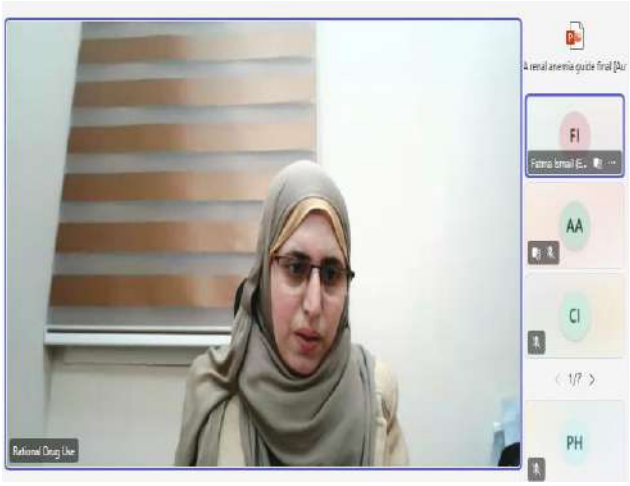
**The Guide-to-Guide (G2G)** initiative aims to enhance awareness among hospital and community pharmacists of the practice guides issued by the General Administration of Drug Utilization and Pharmacy Practice at the EDA. Developed in line with scientific evidence and international standards, these guides are intended to strengthen pharmaceutical practice, improve healthcare quality, and promote patient safety.

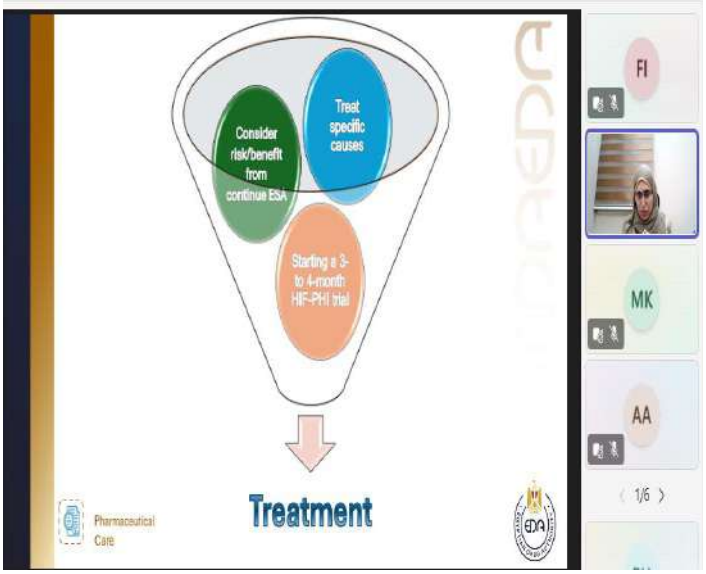
As part of this initiative, the EDA organizes virtual sessions to provide structured overviews of its published guides. In January 2026, the focus was on the **Renal Anemia Guide to Good Pharmacy Practice,** which serves as a key reference for implementing evidence-based approaches in managing anemia among patients with chronic kidney disease, while supporting the safe and effective use of essential therapies.

All EDA guides undergo a rigorous scientific review led by expert committees comprising academic specialists in pharmacy and medicine, along with experienced healthcare professionals. This collaborative process ensures that the guides remain scientifically robust, clinically relevant, and aligned with current evidence.

To access the **Renal Anemia Guide to Good Pharmacy Practice,** follow this link:
**https://www.edaegypt.gov.eg/media/k0mb41s4/eda_guide_anemia_in-_ckd-pharmacy-practice.pdf**





## About DU&PP

The Drug Utilization and Pharmacy and Pharmacy Practice General Administration (DU&PP) is concerned with rationalizing medication use and reducing medication errors. The General Administration is also concerned with developing pharmaceutical practices, enhancing Egyptian pharmacists' skills, issuing pharmacy practice guidance, preparing national drug lists and the Egyptian drug formulary, and providing numerous training programs. It also aims to raise community awareness and promote the safe and effective use of medications by conducting awareness campaigns and pharmaceutical care initiatives among all segments of society to ensure patient safety and achieve optimal drug use.

Our publications, including clinical practice guides, newsletters, and the Egyptian National Formulary, are available at the official EDA website and can be accessed via the following hyperlinks or QR codes: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