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RATIONAL USE OF MEDICINES IN PAEDIATRIC RESPIRATORY DISTRESS: EVIDENCE, CHALLENGES, AND FUTURE

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INTRODUCTION:

Paediatric respiratory distress (RD) ranks as a top cause of childhood morbidity and mortality globally, driven by conditions like asthma, bronchiolitis (often viral in infants), pneumonia (bacterial or viral), and acute respiratory distress syndrome (ARDS). Rational prescribing—delivering the right drug, dose, and duration—is essential to optimize outcomes while curbing harm, yet irrational practices such as unnecessary antibiotics and polypharmacy remain widespread. This review outlines evidence-based pharmacological strategies for key paediatric RD syndromes, key guideline recommendations, common irrational prescribing patterns, and approaches to overcome barriers for better medicine use.

ASTHMA:

Asthma, a chronic inflammatory airway disease with wheezing, cough, and reversible obstruction, sees rising prevalence in children worldwide. Stepwise management prioritizes inhaled corticosteroids (ICS) as the cornerstone for persistent cases, paired with short-acting β-agonists (SABA) for relief; guidelines like GINA emphasize controllers over SABA monotherapy.

For ages 5-6 years, GINA 2024 allows as-needed low-dose ICS-formoterol (Track 1) or daily ICS with SABA (Track 2), while under-5s need daily low-dose ICS for frequent symptoms; severe cases may add long-acting β-agonists (LABA), leukotriene receptor antagonists (LTRA), or biologics like omalizumab. Evidence from systematic reviews confirms ICS superiority over LTRA for symptom control, with acute exacerbations treated via inhaled SABA, oxygen, and steroids.

BRONCHIOLITIS:

Bronchiolitis, typically RSV-induced lower respiratory tract infection in infants under 2 years, manifests as cough, wheezing, and distress, with supportive care as the mainstay. Guidelines (AAP 2014, NICE) reject routine bronchodilators, steroids, or antibiotics; a Cochrane review notes modest outpatient benefits from nebulized epinephrine plus dexamethasone but no inpatient stay reductions. High-flow nasal cannula aids moderate-severe cases, yet irrational use persists—25% of US cases receive antibiotics despite rare bacterial co-infections.

COMMUNITY-ACQUIRED PNEUMONIA (CAP):

Paediatric CAP varies from mild viral to severe bacterial forms, assessed by tachypnea, chest indrawing, and hypoxia. Non-severe cases warrant oral amoxicillin (WHO-recommended dispersible form); severe ones need IV ampicillin/gentamicin plus oxygen. Trials support 3-day over 5-day courses (NICE 2025), with high-dose amoxicillin equaling broader agents; glucocorticoids are limited to complications like effusions. Indian Academy of Pediatrics (IAP) and British Thoracic Society endorse amoxicillin first-line.

PAEDIATRIC ARDS (PARDS):

PARDS involves life-threatening failure from triggers like pneumonia or sepsis, managed via lung-protective ventilation, PEEP, and underlying cause treatment. PALICC-2 (2023) guides adjuncts like prone positioning, ECMO, or surfactant (meta-analysis shows mortality reduction, RR 0.67); steroids and inhaled nitric oxide have mixed evidence. Rational use demands de-escalation of broad antibiotics and judicious sedation.

IRRATIONAL PRESCRIBING PATTERNS:

Antibiotic overuse dominates: 92% in viral upper respiratory infections, 90% in unconfirmed pneumonia, and 25% in bronchiolitis. Polypharmacy includes unneeded cough syrups, sedating antihistamines, and broad-spectrum drugs over narrow ones like amoxicillin. Factors include diagnostic uncertainty, caregiver pressure, and "just-in-case" habits, fostering resistance and costs.

BARRIERS TO RATIONAL USE:

Key hurdles encompass pediatric formulation shortages, off-label dosing risks, provider knowledge gaps, time constraints, parental expectations, poor health literacy, absent stewardship, and drug unavailability in low-resource areas. Fragmented records and weak oversight exacerbate issues.

PROMOTION STRATEGIES:

Implement age-specific guidelines via apps, EHR prompts, and training; establish stewardship for audits and WHO Access-Watch-Reserve frameworks. Educate families on antibiotic limits, provide dosing tools, ensure essential medicines lists, and use decision-support tech. Audits, peer feedback, and antibiograms drive accountability.

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FUTURE DIRECTIONS:

Prioritize pediatric trials for antivirals, biologics, and surfactants; advance implementation research on behavior change. Update guidelines dynamically, integrate precision medicine, bolster AMR policies, enhance curricula, launch awareness campaigns, and leverage AI/telehealth for remote optimization. Aligning practice with GINA, WHO, NICE, and IAP promises safer care.

CONCLUSION:

Rational pharmacotherapy in paediatric respiratory distress is indispensable, matching the importance of accurate diagnosis to enhance outcomes, curb antimicrobial resistance, and avert harm from superfluous drugs. Success hinges on synchronizing clinical practice with authoritative guidelines from WHO, NICE, IAP, and GINA, alongside comprehensive education for stakeholders and resolution of systemic obstacles like formulation gaps and stewardship deficits. Through unified advances in research, policy reforms, and educational initiatives, more secure and efficacious care can be delivered to every child facing respiratory illness.

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Latest Clinical Findings on Zitomenib for Acute Leukemia

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INTRODUCTION:

Acute myeloid leukemia (AML) is the most common leukemia in adults and is characterized by the clonal expansion of myeloid precursors in the peripheral blood and bone marrow, which results in ineffective hematopoiesis and bone marrow failure. Until recently, the management of AML has largely remained unchanged since the development of intensive induction chemotherapy and allogeneic stem cell transplantation therapies. However, advances in the molecular profiling of AML and identification of specific subpopulations by their mutational status have enabled the development of several targeted therapeutics against these identified driver mutations.

PARTICIPANTS:

Eligible participants were healthy men, aged 18–55 years, who weighed 50–100 kg and had a body mass index of 18.0–32.0 kg/m2. Healthy status was determined by the absence of clinically significant findings from medical history and by physical examination, 12- lead electrocardiogram (EGC), vital signs, and clinical laboratory evaluations, as assessed by the investigator at screening and check-in. Important exclusion criteria included: history or presence of liver disease, pancreatitis, cholecystectomy, or respiratory or cardiovascular disease; abnormal liver function tests; estimated glomerular filtration rate < 90 mL/min/1.73 m2; and any history of stomach or intestinal surgery/resection or use of medications/products that would affect drug absorption, metabolism, and/or excretion.

RESULTS:

Following the administration of a single oral dose of ziftomenib 400 mg,moderately rapid absorption phase was observed witha median tmax of 3.5 h (range 1.5–24 h) in plasma. The concentration time profile of ziftomenib appeared to decline in biphasic manner with a geometric mean t1/2 of 61.5 h (range 48.5–107 h ,Table 1 and Figure 2a). Ziftomenib pharmacokinetics were similar in parts A and B of the study; however, the minor differences between the two parts are likely due to interindividual differences in a parallel group study.

METABOLIC PROFILING:

Ziftomenib underwent minimal metabolism following the administration of a single oral dose of ziftomenib 400 mg. Of the 19 total metabolites observed in plasma, eight were identified and further characterized. Representative AMS radio chromatograms of pooled plasma, urine, and feces . The remaining 11 metabolites represented < 2% of total radioactivity and were not characterized as these are not expected to have any meaningful impact on ziftomenib pharmacokinetics or ADME profile.

SAFETY:

Three participants reported a total of seven TEAEs; all TEAEs were mild in severity. These included diarrhea (n = 2), headache (n = 2), constipation, migraine, and dermal cyst (n = 1 each). Three TEAEs reported in two (25%) participants (headache, diarrhea,

and migraine) were considered related to ziftomenib by the investigator. No deaths or serious adverse events were reported. No TEAE led to study discontinuation. One participant in study part B reported myalgia of mild severity, which was not considered related to ziftomenib. No clinically significant findings were noted in clinical laboratory evaluations, vital signs, 12-lead ECGs, or physical examination data that would indicate any safety concerns with ziftomenib.

CONCLUSION:

The drug shows moderately rapid absorption, minimal metabolism, and is primarily excreted unchanged through feces, indicating predictable and stable behavior in the body. The long half-life supports the potential for convenient dosing schedules. Importantly, ziftomenib was well tolerated, with only mild and transient adverse events reported and no serious safety concerns observed. Overall, these findings support the continued clinical development of ziftomenib as a novel therapeutic option for acute myeloid leukemia, particularly for genetically defined patient subgroups.

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BREAKTHROUGH IN ALZHEIMER'S TREATMENT: UNDERSTANDING DONANEMAB'S IMAPCT

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INTRODUCTION:

Donanemab is a monoclonal antibody treatment for early-stage Alzheimer's disease. It targets and helps clear amyloid beta plaques from the brain, slowing cognitive decline.
These analyses aimed to identify factors impacting donanemab exposure, amyloid plaque, and clinical efficacy in early symptomatic Alzheimer's disease using a population pharmacokinetic/pharmacodynamic (PK/PD) approach.

BACKGROUND

Alzheimer's disease (AD) is an age-related neurodegenerative disorder characterized by an inexorable progressive decline in cognitive and functional abilities. This fatal disease affects an estimated 7 million Americans over the age of 65 years. Donanemab is a monoclonal antibody therapy approved for the treatment of early symptomatic AD, targeting amyloid plaques, a key pathological hallmark of the disease, Based on recent compelling data from several amyloid plaque-lowering antibodies, the Food and Drug Administration has established significant amyloid reduction as a surrogate biomarker that is reasonably likely to predict clinical benefit for patients with AD.
We previously reported on the pharmacokinetics (PK)/pharmacodynamics (PD), safety, and efficacy of donanemab based on the phase 1 (NCT02624778) and phase 2 TRAILBLAZER-ALZ (NCT03367403) studies. Different doses (10–40 mg/kg, 700 mg, and 1400 mg) and dosing regimens (single dose, every 2 weeks, and every 4 weeks) were evaluated across both studies. In the investigated dose range, the PK of donanemab was dose-proportional and exhibited time-linear kinetics.

METHODS

1.Participants and study design

Models were generated using data from participants enrolled in four donanemab clinical trials.
The donanemab phase 1b trial was a randomized, double-blind, placebo-controlled study involving men and women with mild cognitive impairment (MCI) due to AD or mild to moderate dementia due to AD. Inclusion criteria included Mini-Mental State Examination (MMSE) scores of 16 to 30 and the presence of amyloid pathology. Placebo or donanemab was administered by IV as a single (10, 20, or 40 mg/kg) or multiple (10 mg/kg every 2 weeks for 24 weeks or 10 or 20 mg/kg every 4 weeks for 72 weeks) doses.

2.Exposure-response (amyloid plaque) model

An indirect response model was used to fit the amyloid plaque level data as previously described. Individual post hoc participant parameters from the final population PK model were added to the amyloid PET dataset to obtain predicted drug concentrations for individual participants. The model was parameterized in terms of amyloid plaque degradation half-life and individual participant baseline amyloid

plaque level as an initial condition for response at time 0. The effect of the drug was described by a treatment effect stimulating the degradation rate constant. Several models, including threshold, slope, and nonlinear (E_{max}-type), were used to fit the data and estimate the impact on the plaque degradation rate.

3.Disease progression model development

Disease progression models were developed for the iADRS and CDR-SB as previously reported. For base model development, Richard's logistic model was used to describe nonlinear disease progression. Decreasing variance in residual error as data approached the boundaries (0 to 18 for CDR-SB and 0 to 144 for iADRS) was accounted for using beta regression. Treatment effect models driven by donanemab dosing information were tested as a predictor of disease progression.

CONCLUSION:

3.1 Population pharmacokinetics
Data from 2131 donanemab-treated participants across several studies were used in the population PK model, including the phase 1b study (n = 46), TRAILBLAZER-ALZ (n = 131), TRAILBLAZER-EXT (Part B; n = 54), and TRAILBLAZER-ALZ 2 (placebo-controlled portion and safety addendum; n = 1900). Baseline characteristics 55.0% of participants were female, 89.9% were White, and 66.4% were *APOE* ε4 carriers.

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SILENT SIGNALS: UNDERSTANDING COLON CANCER BEYOND THE OBVIOUS

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INTRODUCTION:

Colon cancer, also known as colorectal cancer when it includes the rectum, is one of the most common malignancies affecting the gastrointestinal tract worldwide. Despite advances in diagnostic tools and treatment modalities, colon cancer remains a major cause of cancer-related morbidity and mortality. What makes this disease particularly dangerous is its often silent progression—early stages may present with minimal or no symptoms, allowing the cancer to advance unnoticed. This article explores colon cancer in depth, examining its causes, risk factors, pathophysiology, clinical presentation, diagnostic strategies, treatment approaches, prevention, and the importance of early detection.

UNDERSTANDING THE COLON AND ITS ROLE:

The colon, or large intestine, is the final part of the digestive system. Its primary functions include absorption of water and electrolytes from digested food and storage of waste before elimination. The inner lining of the colon consists of epithelial cells that continuously divide and regenerate. While this rapid cell turnover is essential for normal function, it also makes the colon vulnerable to genetic mutations that can lead to cancer.

Colon cancer typically begins as a benign growth called a polyp on the inner lining of the colon. Over time, certain types of polyps—particularly adenomatous polyps—can undergo malignant transformation, eventually developing into invasive cancer if left untreated.

TREATMENT STRATEGIES

Treatment depends on the stage of disease, patient health status, and tumor characteristics.

Surgical Management

Surgery is the cornerstone of curative treatment for localized colon cancer. The goal is complete removal of the tumor along with regional lymph nodes.

Chemotherapy

Adjuvant chemotherapy is used to eliminate microscopic disease and reduce recurrence risk. Common regimens include fluoropyrimidines combined with oxaliplatin.

Targeted Therapy

Agents targeting specific molecular pathways (e.g., EGFR or VEGF inhibitors) are used in advanced cases.

Immunotherapy

Checkpoint inhibitors have shown promise, particularly in tumors with high microsatellite instability.

Palliative Care

In advanced stages, treatment focuses on symptom control and quality of life.

PREVENTION AND RISK REDUCTION:

Colon cancer is one of the most preventable cancers.

Lifestyle Modifications

Diet rich in fruits, vegetables, and whole grains

Regular physical activity

Maintaining healthy body weight

Limiting alcohol and avoiding smoking

Chemoprevention

Evidence suggests that aspirin and calcium supplementation may reduce risk in certain populations, though medical supervision is essential.

Regular Screening

Routine screening allows detection and removal of precancerous polyps, preventing progression to cancer.

CONCLUSION:

Colon cancer is a significant global health challenge, yet it is largely preventable and highly treatable when detected early. Understanding its risk factors, recognizing early warning signs, and participating in regular screening can dramatically reduce its burden. As medical science continues to advance, a combined approach involving prevention, early diagnosis, effective treatment, and patient-centered care offers hope for reducing the impact of this silent but formidable disease.

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DEPARTMAENTAL ACTIVITIES

INTERNATIONAL CONCLAVE 2025

The Erode Pharmacy College, Erode, successfully organized the "International Conclave 2025" on 30th October 2025 at the ECP Auditorium. The event was conducted by the Placement Cell of the college in association with Eazy Link Academy, Coimbatore, Tamilnadu, and witnessed the enthusiastic participation of 560 students and 28 faculty members from various pharmacy colleges across Tamil Nadu.

The Conclave served as a vibrant platform for students to interact directly with representatives from 15 reputed international universities across 4 countries, such as Germany, Dubai, Ireland and United Kingdom, . The following Universities such as Griffith College Dublin, Coventry University, University of Greenwich, University of Liverpool, Anglia Ruskin University, University of Surrey, Dundalk Institute of Technology, University of Europe, Arden University, Britts Imperial University, and MWT Global.

The conclave featured insightful sessions, interactive discussions, and one-on-one interactions, enabling students to gain valuable guidance on international education pathways, scholarships, and global placement prospects.

Expressing his gratitude, Dr. Sambathkumar congratulated the faculty members, organizing committee, and student volunteers for their meticulous planning, teamwork, and dedication in making International Conclave 2025 a grand success.

> He remarked, "Today's event is not merely a gathering but a gateway to the future of our students. It is a proud moment for The Erode Pharmacy College to host such a mega international event that connects our students with the global academic community."

ENVIRONMENTAL PROTECTION & PLASTIC CONTROL DAY

Our 4th Pharm.D students along with the NSS and JRC coordinators conducted an Environmental Protection & Plastic Control Day Rally at Mettukadai Panchayat.

Panchayat officials — Mr. Thangapandi (Secretary) and Mr. Santhosh (PCO, Erode Block) along with sanitary workers and staff actively participated.

WORLD UNITY DAY 2025

The Principal, Faculty Members, and Students of The Erode College of Pharmacy proudly observed World Unity Day on 31st October 2025 by participating in a pledge-taking ceremony held at the institution.

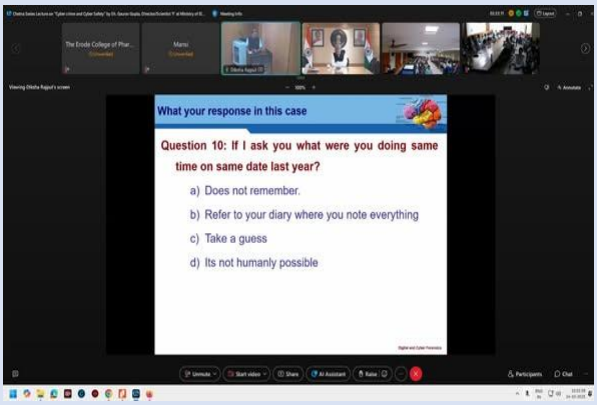
The day marks the birth anniversary of Sardar Vallabhbhai Patel, the Iron Man of India, and celebrates the spirit of unity, integrity, and national integration.

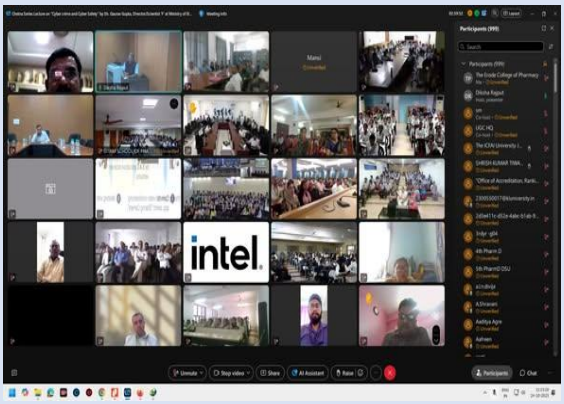
The event inspired everyone to uphold the values of togetherness, respect, and patriotism, reminding us that our nation's greatest strength lies in its diversity and unity.

OBSERVANCE OF NATIONAL CYBER SECURITY AWARENESS

The Erode College of Pharmacy, Erode, actively participated in the observance of National Cyber Security Awareness Month (NCSAM) – October 2025, organized by the University Grants Commission (UGC), Ministry of Education, Government of India.

This initiative aimed to enhance awareness about cyber hygiene, digital safety, responsible online behavior, and protection of digital assets among students and faculty.





THE DIVINE MEDITATION PROGRAM

Acharya Siksha Mandir, Erode, organized a spiritually enriching program titled “Mahasambala – The Divine Meditation Program” to promote inner peace, mindfulness, and holistic well-being among students and staff. The event aimed to introduce participants to the power of meditation and its role in achieving mental clarity and emotional balance in daily life.

40 students of II-Year Pharm.D, III-Semester B.Pharm and our faculty Dr. S. Allimalarkodi were attended the Meditation Program on 11.10.2025 - 4 pm to 7 pm.