NEWS IN BRIEF

INDIA BANS 344 COMBINATION DRUGS

The Ministry of Health and Family Welfare of Government of India (GoI) has prohibited the manufacture, sale and distribution of 344 fixed drug combinations (FDCs). Last year, the GoI reviewed some 6200 combination drugs, of which nearly 15-20% were deemed to be irrational or potentially harmful. The Expert Committee which evaluated the drugs has made a list of the drugs which it felt had "no therapeutic justification" and were likely to "involve risk to human beings." According to US healthcare provider IMS Health, almost half the drugs sold in India in 2014 were FDCs, making it a world leader in combination drugs. A study published in the Journal of Public Library of Science in May 2015 reported that 73% of non-steroidal anti-inflammatory drug combinations were being marketed in India without central government approval. In the banned list of 344 FDCs, 27 are anti-diabetic drug combinations with metformin, 16 have the anti-inflammatory drug nimesulide, 18 have diclofenac as one of the ingredient, and half a dozen are codeine-containing cough syrups. The list also includes commonly prescribed FDCs such as norfloxacin with metronidazole, and cefixime with azithromycin. (*The Times of India 12 March 2016*)

PREDICTION OF TUBERCULOSIS

Researchers from the Centre for Infectious Disease Research, Seattle, USA have evaluated a set of 16 genes which can be used as biomarkers to predict the development of active tuberculosis 6-12 months before they develop symptoms. They followed up healthy, South African adolescents (age 12–18 y) who were infected with *M. tuberculosis* for 2 years, and collected blood samples every 6 months. When they compared the whole blood RNA sequencing of participants who developed tuberculosis *versus* those who remained healthy, they discovered a characteristic signature of risk. After adaptation to multiplex quantitative real-time PCR (qRT-PCR), the signature was used to predict tuberculosis disease in untouched adolescent samples and in samples from independent cohorts of South African and Gambian adult progressors and controls. The signature predicted tuberculosis progression with a sensitivity of 66·1% (95% CI 63·2, 68·9) and a specificity of 80·6% (95% CI 79·2, 82·0) in the 12 months preceding tuberculosis diagnosis. (*The Lancet 23 March 2016*)

THE PARLIAMENTARY COMMITTEE REPORT ON THE MEDICAL COUNCIL OF INDIA

A parliamentary committee has tabled a 126-page report in the *Rajya Sabha*, which systematically dissects how and why the council has failed in its mandate. It has made a long list of the MCI's failures, including failure to create a curriculum that produces doctors suited to working in the Indian context, especially in the rural health services and poor urban areas; failure to maintain uniform standards of medical education; and devaluation of merit in admission, particularly in private medical institutions due to the prevalence of capitation fees. The report critiques the excessive focus on the nitty-gritty of infrastructure and human staff during inspections, but without a substantial evaluation of the quality of teaching, training and imparting of skills. It also points out the abysmal doctor–population ratio, and the failure to rationalize setting up of medical colleges in the country as per needs, resulting in geographical misdistribution with clustering in some states and the absence in several others. In what is perhaps one of the most telling statements, it describes what it terms the "failure to produce a competent basic doctor." (*Economic and Political Weekly 2 April 2016*).

YELLOW FEVER EPIDEMIC IN ANGOLA

There has been an unexpected yellow fever epidemic in Angola this year. The outbreak, which was first reported in the capital city Luanda in December 2015, has since spread to 5 of the country's 18 provinces. Yellow fever virus is transmitted by infected mosquitoes, the most common species being *Aedes aegypti* – the same mosquito that spreads the Zika virus. Symptoms include fever, headache, muscle pain, nausea, vomiting and fatigue. A small percentage of infected people experience a second more severe phase of illness which includes high fever, jaundice and internal bleeding. At least half of severely affected patients who do not receive treatment die within 10 to 14 days. The WHO has begun an urgent vaccination campaign. (*http://who.int/features/2016/angola-worst-yellow-fever/en/*).

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