Missed doses of the oral contraceptive pill have been well studied. Women taking the pill need to be aware of the risk associated with missed doses and of what to do when a dose is missed (Table 1). Given the complexity of this information, and the risk of an unwanted pregnancy, it is important that any verbal counselling is supported with appropriate written material. Where a CMI sheet is available this can be used during the consultation. If no CMI sheet is available for the prescribed product, written notes based on the recommendations in the Australian Medicines Handbook are useful.[6]

Conclusion

For the vast majority of patients an occasional missed dose will have little impact on the outcome of therapy. Most CMI sheets include statements such as:

- If you forget to take one or more doses: take your next dose at the normal time and in the normal amount. Do not take any more than your doctor prescribed.
- If you miss one dose, skip it and continue with your normal schedule.

Having this knowledge when starting therapy may be a simple way to alleviate much patient anxiety and in some cases avoid unwanted clinical consequences.

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Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 23)

5. Patients who miss a dose of warfarin should take a double dose when the next dose is due.
6. Contraception becomes unreliable if a progestogen-only contraceptive pill is missed by more than three hours.

Book review

Therapeutic Guidelines: Palliative care. North Melbourne: Therapeutic Guidelines Limited; 2001. 308 pages. Price (postage not included): $33, students $25.30.

Peter Keppel, General Practitioner, Yarrawonga, Vic.

'Palliative care is active care.'

This statement rings true to me, having worked in a small rural town for over 16 years, in which the care of the dying is a large part of my practice. Whether it is severe chronic obstructive pulmonary disease, intractable congestive cardiac failure (less often seen now with newer drugs) or cancer, the process always involves a brief introduction, then breaking bad news, then a terminal phase in which shifting goals are negotiated and renegotiated.

The book attempts a lot more than a list of pharmacological options. It opens with general chapters covering principles of palliative care, ethical issues, communication, loss and grief, and analgesic guidelines. It makes the point that general practitioners are by default the co-ordinators of care, as well as being the gatekeepers to the health system. The place of self-care among providers is recognised.

With regard to pain management, the approach is one of identifying different types of pain, e.g. nociceptive (superficial somatic, deep somatic, skeletal muscle, visceral colicky, visceral constant) or neuropathic, rather than the traditional three stage 'ladder' approach.

The emotional, spiritual and social aspects of pain are not ignored. I particularly found useful the approach to delirium and confusion. The problems of the elderly demented patient are dealt with rather briefly, given the large cohort of these people now ageing. No mention is made of the practical problems accessing the newer antipsychotics because of the Pharmaceutical Benefits Scheme prescribing restrictions. The dose of morphine in terminal severe chronic obstructive pulmonary disease patients is stated to be 1 mg 4 hourly, increasing as needed. In my experience this is usually nowhere near enough.

There are useful chapters on medical oncology describing some newer regimens for particular cancers.

The book has been found useful by our active and busy palliative care team. It would not be sufficient on its own to answer all questions on the subject, but is written in a compassionate style, showing the wisdom of experience. There is extensive cross-referencing within the text. There is no list of other texts for reference that I could find.