

Letters

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Fungal toenails and terbinafine

Editor, – Professor Kamien recently wrote (Aust Prescr 1999;22:135) about the high cost of using terbinafine in people with suspected tinea of the toenails who are negative on microscopy or culture but who wish to purchase the drug privately. The cost of the treatment can be halved by using terbinafine 250 mg twice a day for one week in every four week cycle.^{1,2} This is continued for a total period of 12–16 weeks, i.e. three or four weeks of treatment over three or four months.

The regimen is apparently as effective as the current 250 mg a day for the same period, and effectively cuts the cost of the treatment down by a half.

K. Dallimore
Dermatologist
Mt. Lawley, WA

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Perioperative management of anticoagulation

Editor, – The article ‘The perioperative management of anticoagulation’ (Aust Prescr 2000;23:13–6) discusses surgical procedures in patients who for one reason or another are on long-term warfarin. Whilst there may be some indications for warfarin that can be stopped for a few days without risk, there are others in which the warfarin must be ceased and heparin begun so the operation can take place. The patient then requires to be put back on warfarin at a suitable time, a process which is not easy and takes several days, often as an inpatient.

When Professor Hughes from Wales was in Australia many years ago he mentioned to me that he had performed certain operations without stopping the warfarin. Since then I have done a number of perianal procedures, hernias and even a laparotomy without stopping the warfarin and in only one hernia was there a significant haematoma. It is important of course to check that the INR is in therapeutic range before operating on patients on warfarin, and haemostasis must be meticulous, while careful observation of the patient postoperatively is also essential.

There would appear to be considerable merit in certain cases, in experienced hands, for keeping the patient on oral anticoagulant for selected surgical procedures.

Kevin Orr
Surgeon
Kogarah, NSW

Dr Andrew Grigg, one of the authors of the article, comments:

Unfortunately there are few prospective studies which address the issue of what constitutes a ‘safe’ INR for various surgical procedures. A study performed almost 40 years ago¹ randomised 60 patients undergoing cholecystectomy or gastric resection to either no anticoagulation or anticoagulation to achieve a thrombotest concentration of 15–20% of normal, equating to an INR of 1.6–2.1. There was no overall significant difference in operative, 24 hour or 72 hour blood loss between the two groups; four of 30 patients in the treated group had blood loss exceeding 1500 mL in the first 24 hours compared with one of 30 in the control group. I put this issue to Professor Jack Hirsh, co-author of a review article on management of anticoagulation before and after elective surgery.² His reply was, ‘If a surgeon chooses to do so, it would be reasonable to continue warfarin at an INR of about 1.5 during surgery. However, I know of no hard data supporting the safety of this approach.’

The paucity of data gives the opportunity for surgeons and haematologists to collaborate in a prospective study so that anecdotal experience could be replaced by evidence-based medicine.

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Drug-induced neuropathy

Editor, – While a short article cannot be encyclopaedic, ‘The use of anticonvulsants for neuropathic pain’ (Aust Prescr 1999;22:140–1) omits to mention prescribed drugs in the potential causes of peripheral neuropathy. Exclusion of a pharmacological cause should be one of the earliest steps in the management of this disorder, although in some cases symptoms continue to worsen for some time after ceasing the culprit drug.

The association with certain antineoplastic drugs is well known, but there are many other medications that may cause neuropathy, including commonly prescribed drugs such as metronidazole, nitrofurantoin, isoniazid and dapsone, as well as some anti-HIV drugs. Phenytoin and pyridoxine, which may be used in the treatment of neuropathy, may themselves, albeit rarely, cause the condition.

These patients are often desperate for relief of symptoms, and there is a natural desire on the part of their doctors to ‘do something’. As the author points out this can be unhelpful or harmful.

Toby Nichols
Registrar
Sexual Health Unit
Alice Springs, NT