Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

Sulfur allergy

Editor, – I refer to the article ' 'Sulfur allergy' label is misleading' (Aust Prescr 2008;31:8–10). In ophthalmology, it has been customary to use acetazolamide tablets for raised intraocular pressures not responding to local therapy. I note that your article does not mention acetazolamide.

I would be grateful for your advice about possible allergic reactions to acetazolamide. My concern relates to one patient who had a severe anaphylactic reaction, presumed to be due to acetazolamide.

Roger McGuinness
The Eye Institute
Bondi Junction, NSW

Dr William Smith, one of the authors of the article, comments:

The essential question is whether a patient who has a history of an allergic reaction to a sulfonamide antibiotic (sometimes inappropriately referred to as 'sulfur allergy') is at increased risk of an allergic reaction to acetazolamide compared to a patient with a history of allergy to an unrelated drug, or with no drug allergy history.

It is known that being allergic to one drug increases the risk of allergy to other drugs, regardless of the structural difference or similarity of the second drug. In fact the more drugs one is allergic to, the greater the risk that one will have a reaction to any other drug. This is a separate issue to cross-reactive allergy, which depends on the structural relatedness of the drug, such that the immune system, primed to respond to one drug, will react with a second structurally similar drug.

Firstly, acetazolamide, although a sulfonamide, is not a sulfonylarylamine sulfonamide and is therefore thought to be not sufficiently structurally similar to sulfonamide antibiotics to be cross-reactive to the immune system. Secondly, a survey of patients with a history of sulfonamide antibiotic allergy did not show an increased incidence of allergic reactions to non-antibiotic sulfonamides (including acetazolamide) above that conferred by a history of allergy to unrelated drugs.[1]

The patient who had anaphylaxis to acetazolamide constitutes anecdotal evidence. It is most likely that this allergic reaction was coincidental and not specifically related to a previous history of allergy to sulfonamide antibiotics.

Current expert opinion, based on the evidence, would be that a history of sulfonamide antibiotic allergy should not be considered an absolute contraindication to the use of acetazolamide. (I acknowledge that this is contrary to the current product information; it would be wise for medicolegal reasons to employ caution in such patients.) Doctors should always be prepared to deal with allergic reactions to the medications they prescribe, although these reactions are rare. Intravenous drugs carry a risk of causing more severe anaphylaxis although not at any greater incidence compared with oral administration. The risk of such reactions will be increased above background levels in patients with a history of allergy to other drugs, particularly multiple other drugs, whether sulfonamide or not.

Reference

1. Strom BL, Schinnnar R, Apter AJ, Margolis DJ, Lautenbach E, Hennessy S, et al. Absence of cross-reactivity between sulfonamide antibiotics and sulfonamide nonantibiotics. N Engl J Med 2003;349:1628-35.

Editor, – I agree that the term 'sulfur allergy' (Aust Prescr 2008;31:8–10) is misleading in relation to allergic reactions to sulfonamide drugs and the confusion is contributed by the American custom of substituting 'f' for 'ph'.

John Walker
Ear, Nose and Throat Specialist
Edgecliff, NSW

Editor, – I was interested in the article on sulfur allergy (Aust Prescr 2008;31:8–10), not only for its content but by the metamorphosis of 'sulphur' to 'sulfur'. I acknowledge that language is in a constant state of flux but is this spelling an editorial decision or are we now all to use the American pharmacopeia for drug nomenclature?

Ross MacPherson
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Editorial note:

The Therapeutic Goods Administration publishes the Australian Approved Terminology for Medicines (at www.tga.gov.au/docs/html/aan.htm). For more than a decade 'sulfur' has been the Australian approved name.

Eye drops

Editor, –The excellent article by Michael Steiner (Aust Prescr 2008;31:16–17) prompts me to submit an alternative method demonstrated by an ophthalmologist many years ago. It is particularly useful when drops are to be administered to children and elderly people.

It involves approaching the eye from across the nose into the corner near the nose so that the dropper is unseen and the tendency to blink is reduced. Even with the eye closed the drops eventually enter the area around the eye as shown by a study with pilocarpine at the time.

- Tilt the head back or lie down to face the ceiling.
- Approach the eye from across the nose and hold the dropper above the inner corner without touching it.
- Squeeze out a drop and feel the liquid run into the eye.
- Gentle pressure on the bridge of the nose for 1 to 2 minutes will slow draining and increase effect. Rubbing the eye decreases it.
- The eye may be closed while instilling the drops, especially for children, as drops flow into the eye on opening.
- Leave 5 minutes between different drops.

Peter Bayly
Consultant pharmacist
Burnside, SA

Dr Steiner, author of the article, comments:

There are of course many ways that eye drops can be instilled and that described by Peter Bayly is especially useful in fractious, frightened children. The only minor problem with it is the small risk of washing skin flora into the conjunctival sac. However, it is useful when more traditional techniques are not possible.

Subsidised medicines for Aboriginal and Torres Strait Islander people

Since August 2006, the Pharmaceutical Benefits Scheme (PBS) has been including new listings specifically for the treatment of common conditions in Aboriginal and Torres Strait Islander people. Some listings are medicines new to the PBS, while others vary the restrictions for prescribing existing PBS items. For the most up-to-date information on relevant PBS-subsidised items, and their conditions for prescribing, see the current list in the fact sheet at www.pbs.gov.au.

New listings include antimicrobial drugs for fungal and yeast infections, otitis media and whipworm. Vitamin supplements have also been added.

The items in Table 1 are available as 'Authority PBS prescriptions'. For more information about PBS access by Aboriginal and Torres Strait Islander people, send an email to pbs-indigenous@health.gov.au

For changes to this list and other listings, readers can subscribe to news alerts from the PBS at www.pbs.gov.au/html/healthpro/subscription/manage

Table 1

PBS listings as at 1 July 2008

Treatment of a fungal or a yeast infection
1. Bifonazole cream (1%) *
2. Clotrimazole lotion (1%) *
3. Ketoconazole cream (2%) and shampoo (1%, 2%) *
4. Miconazole nitrate (2%) as cream, powder, lotion and tincture *
5. Nystatin cream (100 000 units per g) *
6. Terbinafine cream (1%) *
Prophylaxis of thiamine deficiency
7. Thiamine tablet (100 mg) *
Treatment of whipworm infestation
8. Albendazole tablet (200 mg) *
Treatment of chronic suppurative otitis media
9. Ciprofloxacin ear drops (0.3%)
Treatment of a dermatophyte infection where topical treatment has failed
10. Terbinafine tablet (250 mg)

* streamlined authority listing