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.

Drugs in sport

Editor, – I have been the representative of the Internal Medicine Society of Australia and New Zealand on the Advisory Editorial Panel of *Australian Prescriber* for some time. I am writing to you both in this capacity and as a clinical pharmacologist who has had considerable interest in drugs and sport over a long period of time.

The recent article by Professor Fricker (Aust Prescr 2000;23:76–8) is certainly interesting and timely, but it really deals with drugs in elite sport rather than addressing the more serious problem of drug abuse in sport as it relates to the wider community. Many years ago, I wrote an article for *Australian Prescriber* on this topic.[1]

There is an error in Professor Fricker's article which does need correction. On two occasions he quotes the prohibited urinary caffeine concentration as >12 nanogram/mL. This is incorrect; the correct concentration is >12 microgram/mL.

Fortunately the error was not in the 'other' direction, as such articles can often be quoted as a defence in tribunals. In a recent article published in the Medical Journal of Australia[2], I have added a disclaimer so that such errors do not carry over into the rather complex setting of sports tribunals.

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REFERENCES

1. Kennedy M. Drugs and sporting performance. Aust Prescr 1989; 12:57-9.
2. Kennedy MC. Newer drugs used to enhance sporting performance. Med J Aust 2000;173:314-7.

Cisapride: new restrictions

Editor, – In view of the safety concerns about cisapride (Aust Prescr 2000;23:59), the Pharmaceutical Benefits Advisory Committee has considered details of the use of the drug in Australia. This included a summary of the situation overseas in relation to the incidence of cardiac arrhythmias or sudden cardiac arrest associated with cisapride.

The Committee recommended that the current Pharmaceutical Benefits Scheme restricted benefit listing for gastroparesis and reflux oesophagitis be amended to an authority required listing for the treatment of gastroparesis where the diagnosis has been made or confirmed by a consultant physician. In addition, the Committee recommended that the caution: 'Cisapride may cause serious cardiac arrhythmias' be added to the amended listing. This amendment is to be implemented in the November 2000 Schedule of Pharmaceutical Benefits. A 'Dear Doctor' letter of explanation will also be included in this edition of the schedule.

The Committee considered that cisapride only has a role in the treatment of gastroparesis. Members were of the view that it is inferior to the proton pump inhibitors in the treatment of reflux oesophagitis.

The Therapeutic Goods Administration has restricted the approved indication for cisapride in reflux oesophagitis to patients with severe disease who have not responded to a proton pump inhibitor. There are, however, no data to show that cisapride is cost-effective for this indication.

Although the dosage of cisapride recommended in Australia differs from the product information in the USA, no evidence was provided by the sponsor to show that lower doses are used in Australia.

Diana MacDonell
Secretary
Pharmaceutical Benefits Advisory Committee

Methotrexate

Editor, – I refer to the interesting article 'Perils and pitfalls of methotrexate prescription' (Aust Prescr 2000;23:44–5) in which Dr Kanagarajah highlights the significant compliance problems that a prescriber should be aware of when using this therapy in elderly patients. Indeed, the increasing use of methotrexate is likely to centre on older patients, who may have concurrent multi-organ system impairments. Renal function is impaired in many of these patients, even though the serum creatinine remains in the normal range. A similar situation exists in other organ systems where reduced reserve function remains silent and subclinical until challenged and exposed by disease or medication.

Underlying deficits in haematological, nutritional (including folate) and immunological reserve may become overt when challenged with a potent immunomodulator such as methotrexate. A sinister danger is that, through the mechanism of convergence, where multiple system factors impact on key physical functions, an older person may not present with adverse effects usually ascribed to that drug, but rather with ailing function. The use of ever more powerful medications, aiming for symptom reduction in an ageing patient population, requires increasing levels of clinical awareness and prudence.

Tuly Rosenfeld
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Treating acute sinusitis

Editor, – I appreciate such articles as Professor Wormald's (Aust Prescr 2000;23:39–42). I have been a general practitioner for all of my working life, but I have a particular interest in otorhinolaryngology.

I was slightly irked when I read that antihistamines and antihistamine-pseudoephedrine combinations were downgraded and were considered to be of little use. This attitude to histamine and the allergic processes in the body's defence mechanisms against environmental factors is prevalent today. However, it ignores some basic physiology, pathophysiology and pharmacology. Mucosal cell inflammation, whatever the cause, results in cell damage. This results in the release of histamine and other inflammatory mediators. The pharmacological properties of histamine are numerous, the most significant being inflammation of surrounding tissue and more tissue damage. To ignore this pathological sequence of events when tissue damage occurs is basically erroneous.

When treating acute sinusitis, would it not be of great help to know about how the patient reacts to environmental pollutants. This knowledge could be of great help in recurrent sinusitis. I'll not get into IgE levels in various periods in a person's life, nor the RAST screens (very limited these days), and other tests for allergy. The article says to leave these to the specialists.

When considering the need for antibiotic therapy with or without antihistamine-decongestant medication, I would also look for post-nasal discharge during my examination.

Celine Aranjo
General Practitioner
Kingsgrove, NSW

Editor, – The excellent article by Professor Wormald makes no mention of the use of bromhexine as an adjunct to the treatment of sinusitis. *Respiratory Medicine*[1] discusses the use of bromhexine to alter the physical characteristics of the mucus and to give an increase in sputum amoxycillin levels. A number of local general practitioners order this combination and in our practice we recommend the use of bromhexine for milder cases. Could Professor Wormald please comment?

John W.M. Williams
Pharmacist
Mosman, NSW

REFERENCE

1. Taskar VS, Sharma RR, Goswami R, John PJ, Mahashur AA. Effect of bromhexeine on sputum amoxycillin levels in lower respiratory infections. Respir Med 1992;86:157-60.

Editor, – I wish to add some facts to Professor Peter John Wormald's article 'Treating acute sinusitis' (Aust Prescr 2000;23:39–42).

Firstly, I would like to re-emphasise the fact that dental infections can cause maxillary sinusitis. Selden referred to such a manifestation as the endo-antral syndrome (EAS).[1] This is a pathological condition resulting from the spread of infection from the root canal apices near the maxillary sinus into both the antral and periapical tissues. The degree of sinus involvement is related to the proximity of the involved apex to the sinus.[2] Reported frequencies of sinusitis of dental origin vary considerably, between 4.6 and 47.0%.[3]

Because of these facts, I would like to suggest that patients suffering from maxillary sinusitis be referred to the dental surgeons to rule out dental infection as the source of their problem.

Dr Wei Cheong Ngeow
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REFERENCES

1. Selden HS. The endo-antral syndrome: an endodontic complication. J Am Dent Assoc 1989;119:397-8, 401-2.
2. Matilla K. Roentgenological investigations into the relation between periapical lesions and conditions of the mucous membrane of maxillary sinuses. Acta Odontol Scand 1965;23 Suppl 42.
3. Melen I, Lindahl L, Andreasson L, Rundcrantz H. Chronic maxillary sinusitis. Definition, diagnosis and relation to dental infections and nasal polyposis. Acta Oto-Laryngologica 1986;101:320-7.

Professor P.J. Wormald, the author of 'Treating acute sinusitis', comments:

In reply to Dr Aranjo, I am not aware of any scientific evidence that antihistamines or antihistamine-pseudoephedrine combinations provide any benefit in the management of acute sinusitis.

The study quoted in Mr Williams' letter showed that bromhexine increased the levels of amoxycillin in the sputum significantly and that the clinical outcome in the short term was better in this group of patients. Unfortunately there were one or two problems in the methodology of this study, so these findings would need to be repeated and corroborated before being accepted. In addition, it is unknown whether levels of amoxycillin in nasal mucus would be similarly increased and whether this would have a clinical impact on the outcome of sinusitis. I feel that saline douches would probably afford as much benefit as any other medication regarding the viscosity of mucus.

In response to Dr Ngeow's comment, certainly we do see maxillary sinusitis as a consequence of root canal infections. However, I think the reported frequency of sinusitis due to dental origin would be in the region of less than 5% rather than in the higher range.

Electronic prescribing

Editor, – I refer to Frank Quinlan's editorial 'Electronic prescribing in general practice: one small step' (Aust Prescr 2000;23:50–1). More and more general practitioners are computerising their practices. With the expanding repertoire come errors in writing computer scripts. These include writing the wrong drugs, the wrong dose and strength, and errors in dose instructions and patient names.

Writing the wrong drugs can occur when a general practitioner enters the first three letters of a drug name and the software anticipates the choice without the doctor having to type the entire name. A whole list of drugs is then generated, potentially causing errors. This can be obviated by typing more than the first three or four letters to refine the selection of the drug name.

Incorrect dose strength is generated if a drug has more than one strength in the Drug Selection Screen. Using the arrow keys on the keyboard to highlight the required strength is likely to reduce such mistakes.

It is helpful to make a list of your commonly prescribed medications and save them as favourites. All subsequent prescriptions of these drugs will then have the correct dose, frequency and instructions at the click of a mouse.

An incorrect patient name on a script can be minimised by making sure that the correct new patient's name appears on the screen after the previous patient has left.

Obviously the surest way of avoiding prescribing errors is to check the script after it has been printed to make sure it is for the right patient, the right drug, the right strength and with instructions clearly marked.

Farooq Qureshi
General Practitioner
Glenelg East, SA

Editor, – Dr Nolan's article on advertising in electronic prescribing (Aust Prescr 2000;23:52–3) suggests Australians have yielded to the natural and fashionable idea that drug ads might be to some degree acceptable. The bulk of evidence is leaning the other way. The monitoring network we have in France has consistently shown for 10 years that industry-based information is misleading and biased. I refer your readers to the recent eLetter launched by Public Citizen in Worst Pills Best Pills (www.citizen.org/eletter/currentissue.htm) about the impact of ads on the prescribing habits of psychiatrists. They can also refer to the Medical Lobby for Appropriate Marketing (www.camtech.net.au/malam).Do you really expect advertising is going to be any different in an electronic format?

C. Kopp
La Revue Prescrire
Paris
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Treating head lice

Editor, – I refer to Dr Orli Wargon's article 'Treating head lice' (Aust Prescr 2000;23:62–3). I was surprised by the recommendation that all clothes, head gear etc. be washed on the grounds that head lice can survive away from the host for three days and eggs can survive for 10 days.

I had understood this advice to be outdated on the basis that live lice which become detached from the head are at the end of their days anyway. Eggs should not be acquired from fomites as there is no glue to attach them to a hair shaft. Further, egg hatching is highly dependent on temperature and humidity with few eggs hatching at under 22ºC. If a few do, they would need lottery-winning style luck to find a human for that all-important first blood meal.

Fraser M. Hadden
Suffolk
UK

Editor, – Dr Orli Wargon's article 'Treating head lice' (Aust Prescr 2000;23:62–3) was useful, as this is a common problem which disrupts schools and disturbs parents, but it was not comprehensive enough in its approach.

Professor Richard Speare of James Cook University has conducted extensive tests to determine the effectiveness of current products on the market to treat head lice and has concluded that, while resistance is growing towards permethrin and maldison, those products containing pyrethrum together with aromatic oils and natural repellents not only kill the head lice, but also dissolve the glue that sticks them to the hair.

This is advantageous for children with long hair, where fine-tooth combing with vinegar/water solution to remove the eggs after treatment is a painful experience. Herbal oils which dissolve the glue allow simple shampooing after treatment to remove the eggs.

A recent addition to the market is preventive headbands, cap inserts and scrunchies impregnated with pyrethrum, rosemary and citronella. These can be worn to school and discourage the spread of head lice by direct contact in much the same way as a dog flea collar!

Richard Lord
Pharmacist
Narooma, NSW

Dr Orli Wargon, the author of 'Treating head lice', comments:

In reply to Dr F. Hadden, there are references to support washing clothes and headgear, for example, the most recent edition (1999) of Fitzpatrick's Dermatology in General Medicine (page 2683) which also refers (page 2681) to transmission by shared towels, brushes and combs playing a significant role.

Regarding Richard Lord's interesting letter, the textbook also mentions that natural pyrethrin products containing refined kerosene or petroleum distillates may cause eye irritation and that care must be exercised to avoid eye contact, but this is difficult in children. Other references mention using 30–40 g of standard petrolatum to the entire surface of the hair and scalp left overnight with a shower cap to clog the respiratory spiracles of the adult louse and block efficient air exchange.[1] This, however, then requires 7–10 days of diligent shampooing to remove the residue.

REFERENCE

1. Schachner LA. Treatment resistant head lice: alternative therapeutic approaches. Pediatr Dermatol 1997;14:409-10.

The ethics of rational prescribing

Editor, – The Health Insurance Commission encourages doctors to prescribe rationally and cost-effectively. The golden rule of medicine is to do one's best for the patient. The silver rule is to do so without bankrupting the country. For those who take the silver rule seriously, it is profoundly depressing to prescribe a cheap non-steroidal anti-inflammatory drug and have the patient return with an unfilled prescription and a request for a COX-2 inhibitor because the pharmacist has told the patient that this new (and four times as costly) drug is better and is subsidised by private health funds. Pharmacists are a necessary and welcome safeguard against prescribing error, but this type of occurrence is more than an isolated incident. Is this type of advice to patients a new form of marketing which is neither socially responsive nor ethical?

Max Kamien
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Warwick Plunkett, Pharmaceutical Society of Australia, comments:

Professor Kamien raises the difficult subject of the dilemma facing both medical practitioners and pharmacists every day of the 'cost' versus 'technology' weighting in best care delivery to the patient. To fulfill both his gold and silver rules in the incident quoted by Professor Kamien, the pharmacist's advice to the patient was probably correct having first ascertained the patient's private health fund status. The patient would receive the newest anti-inflammatory therapy with arguably less adverse effects and at no cost to the public purse.

The possible error committed by the pharmacist was the lack of professional courtesy in not discussing his advice first with the medical practitioner concerned. Of course, sometimes titles can be intimidating. Perhaps, therefore, the real issue demonstrated by this anecdote is that the general standard of inter-professional communication remains poor and should be a priority for both practitioners and their professional organisations to resolve.

Morphine and methadone use in cancer pain

Editor, – Changing to methadone may be beneficial for some patients with cancer pain who are suffering the adverse effects of morphine. We are concerned that there is confusion about the dose of methadone to prescribe when making this change.

Methadone is a useful second-line analgesic for cancer pain but has its own problems. A report into methadone-related deaths in South Australia between 1984 and 1994 showed that while methadone used for drug dependence was relatively safe, this was not the case when methadone was used for pain.[1] A potential danger is the view that the dose of methadone, required to produce the same analgesic effect, is identical to the dose of oral morphine.

The view that the dose ratio is 1:1 was mainly developed from single dose studies. Individual variation in the pharmacokinetics of methadone should raise concern about using this ratio when replacing morphine with methadone.[2,3] Studies focusing on chronic opioid use in cancer pain have reported varying equianalgesic dose ratios. These reports suggest that:

- the comparative pharmacology of morphine and methadone is incomplete
- the equianalgesic dose ratio varies with the dose of morphine before the change to methadone (at higher morphine doses methadone is relatively more potent)[4,5]
- for analgesia, the dose of methadone should be carefully titrated, preferably in hospital.[6]

We believe that there is currently no reliable morphine to methadone equianalgesic dose ratio. There is little evidence to support any protocols for starting methadone. The safest way to replace morphine with methadone is therefore by individual titration over a number of days, preferably in a hospital setting. Furthermore, we suggest that this titration should only be carried out by a clinician experienced in prescribing methadone.

If the titration takes place in hospital the patient's general practitioner must be informed of the possibility of late onset adverse effects (half-life may vary from 40 to 600 hours).

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REFERENCES

1. Williamson PA, Foreman KJ, White JM, Anderson G. Methadone-related overdose deaths in South Australia, 1984-1994. How safe is methadone prescribing?. Med J Aust 1997;166:302-5.
2. Inturrisi CE, Colburn WA, Kaiko RF, Houde RW, Foley KM. Pharmacokinetics and pharmacodynamics of methadone in patients with chronic pain. Clin Pharmacol Ther 1987;41:392-401.
3. Meresaar U, Nilsson MI, Holmstrand J, Anggard E. Single dose pharmacokinetics and bioavailability of methadone in man studied with a stable isotope method. Eur J Clin Pharmacol 1981;20:473-8.
4. Ripamonti C, Groff L, Brunelli C, Polastri D, Stavrakis A, De Conno F. Switching from morphine to oral methadone in treating cancer pain: what is the equianalgesic dose ratio? [see comments in J Clin Oncol 1998;16:3213-5]. J Clin Oncol 1998;16:3216-21.
5. Bruera E, Pereira J, Watanabe S, Belzile M, Kuehn N, Hanson J. Opioid rotation in patients with cancer pain. A retrospective comparison of dose ratios between methadone, hydromorphone, and morphine. Cancer 1996;78:852-7.
6. Ripamonti C, Zecca E, Bruera E. An update on the clinical use of methadone for cancer pain [see comments in Pain 1997;73:114-5]. Pain 1997;70:109-15.