on its packaging). Compounds which make more serious claims (disease prevention, modification or management) are evaluated for efficacy in addition to the mandatory review of safety and quality. If these claims are accepted a registered compound will have AustR, with a number, on its packaging and label.

Good manufacturing practice is comparatively easy to assess and ensure; safety on the other hand is often dependent on the **absence** of data in any of the worldwide databases. The Adverse Drug Reactions Advisory Committee has a close link to CMEC, and wants to increase reporting of suspected adverse responses to complementary medicines. In Australia, we rely on voluntary reporting from health professionals, many of whom do not yet ask about what patients are taking apart from their prescription drugs.

There is little readily available and reliable information on complementary medicines for health professionals. Free information lines such as the Therapeutic Advisory Information Service* of the National Prescribing Service are helpful, and the recommendations of CMEC are accessible on the TGA web site.†

* Freecall 1300 138 677, e-mail tais@nps.org.au

† http://www.health.gov.au/tga/cm/cm.htm

If 50% of our patients are taking complementary medicines, neither patients nor prescribers can afford to be ignorant. Unbiased education is required for health professionals and consumers alike. Who is to collate and provide it? Perhaps this is a future task for the National Prescribing Service in conjunction with its member organisations?

E-mail: smith@mail.newcastle.edu.au

ACKNOWLEGEMENTS

I thank Dr Fiona Cumming, Director of the TGA Office of Complementary Medicines, and Professor David Roberts, former Chair of CMEC, for helpful advice.

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Emeritus Professor Smith is Chair of the Complementary Medicines Evaluation Committee.

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.

Hypertension in diabetes

Editor, – I refer to the article 'Hypertension in diabetes' (Aust Prescr 2002;25:8-10).

The author suggests that while AT_1 receptor antagonists may have the same benefits as ACE inhibitors, this has yet to be shown in clinical trials. I would draw your attention to the recently published PRIME program[1,2], which evaluated the effects of irbesartan on morbidity and/or mortality in patients with hypertension and type 2 diabetes across the continuum of early and advanced stages of diabetic renal disease.

The PRIME program consisted of two trials, IRMA 2 and IDNT.

In IRMA 2, the irbesartan 300 mg group demonstrated a 70% relative risk reduction in the primary end-point of progression to overt proteinuria, compared with a control group (placebo in addition to other non-excluded antihypertensive therapies), $p = 0.0004$.[1]

In IDNT, the primary end-point was the time until the first occurrence of doubling of serum creatinine, or end-stage renal disease, or all-cause mortality. The irbesartan group demonstrated:

- a 20% relative risk reduction in the primary end-point compared with the control group (placebo in addition to other non-excluded and antihypertensive therapies), $p = 0.02$
- a 23% relative risk reduction versus the amlodipine group, $p = 0.006$.[2]

In a recently updated position statement by the American Diabetes Association on diabetic nephropathy[3], the recommendation is that in treatment of albuminuria/nephropathy both ACE inhibitors and the AT_1 receptor antagonists can be used. The recommendations are as follows:

- in hypertensive and non-hypertensive type 1 diabetic patients with microalbuminuria or clinical albuminuria, ACE inhibitors are the initial treatment of choice
- in hypertensive type 2 diabetic patients with microalbuminuria or clinical albuminuria, AT_1 receptor antagonists are the initial drugs of choice.

While the AT_1 receptor antagonists are a newer class of drug, and data in the past have been limited, there is certainly a growing body of evidence such as PRIME on their use in hypertensive diabetic patients.

Victoria Elegant

Medical Director

Sanofi-Synthelabo Australia

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2. Lewis EJ, Hunsicker LG, Clarke WR, Berl T, Pohl MA, Lewis JB, et al. Renoprotective effect of the angiotensin-receptor antagonist irbesartan in patients with nephropathy due to type 2 diabetes. N Engl J Med 2001;345:851-60.
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Dr Julia Lowe, author of the article, comments:

I am grateful for the opportunity to comment on three studies which have evaluated the effects of AT_1 receptor antagonists on morbidity and/or mortality in patients with hypertension and diabetes. These studies were published after I had completed my article for *Australian Prescriber* and are concerned with patients who already have either microalbuminuria[1] or overt nephropathy.[2,3] My article was concerned solely with cardiovascular outcomes in patients with hypertension and diabetes, rather than the more specific question of patients who have already developed complications such as microalbuminuria or nephropathy. I note that none of these studies used an ACE inhibitor in the placebo group. Comparison with amlodipine in one of these trials[2] was interesting given the uncertainty about the value of calcium channel antagonists in prevention of diabetic nephropathy. Only the RENAAL trial of losartan addressed death as part of its composite primary outcome.[3] There was no difference in deaths in the losartan group (158/751) compared to controls in the placebo group (155/762). In the other two studies there was no difference in the number of deaths between groups, but the studies were not designed with sufficient power to detect a difference in deaths as an outcome.[1,2]

In summary, I see no need to change the statement in my article that 'While AT_1 receptor antagonists may have the same benefits as ACE inhibitors, this has yet to be shown in clinical trials'.

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Missed doses

Editor, – I was fortunate to read the excellent article about missed doses (Aust Prescr 2002;25:16-8) but I did find myself questioning the advice given in the table 'Information for consumers' for progestogen-only contraceptives. This indicated that if a dose of the progestogen-only pill is delayed for more than three hours then back-up contraception is required for 14 days. This would seem contrary to the evidence that the cervical mucus protection afforded by this method begins after only about three hours and that the suppressive effect on the endometrium only takes a few days to occur. It is accepted practice in most family planning organisations worldwide that women are advised that should they be more than three hours late taking a dose of their progestogen-only pill they should use additional contraceptive cover for two days, not 14 as stated in the article. I agree that many of the recommendations around the use of progestogen-only contraceptives are 'fuzzy' to say the least! Perhaps at some stage in the future someone will have the energy to apply to the appropriate authorities to lift the restrictions on the use of progestogen-only contraceptives in women who are lactating or have thrombophilia. It is hard enough for the poor doctor just trying to do the right thing without having product information that is palpably inaccurate as well.

Terri Foran
Medical Director FPA Health
Ashfield, NSW

Dr Andrew Gilbert, one of the authors of 'I've missed a dose; what should I do?', comments:

We thank Dr Foran for her comments. Our article presented information as it is printed in the Consumer Medicine Information (CMI) sheet for levonorgestrel (Microval). The information in the CMI is required to be consistent with the Australian approved product information. It is clear from Dr Foran's comments that the product information, and therefore the CMI, does not reflect current clinical knowledge about the use of progestogen-only pills. With regard to missed doses, the product information for Microval states that in cases where a woman misses either one or two tablets 'she should use a mechanical method of contraception until 14 consecutive tablets have been taken'. The product information for the Micronor brand of norethisterone states even more strongly that if one dose is missed the pill 'should be discontinued immediately and a method of non-hormonal contraception should be used until menses have appeared or pregnancy has been excluded'.

We believe that it is extremely important that the product information and CMI reflect the evidence we have about the safe, effective and convenient use of these products in practice. We support strongly Dr Foran's contention that a mechanism needs to be found to require the pharmaceutical companies to update their product information in light of good practice-based evidence.

Influenza immunisation

Editor, – In an otherwise excellent article ('Influenza immunisation' Aust Prescr 2002;25:5-7) Dr Robert Hall dismisses antiviral drugs as 'conferring little public health benefit'. While this may be true under normal circumstances, it may not be so during an influenza pandemic which could strike with little warning and at any time of the year. The long lead time necessary for large-scale vaccine production against a pandemic influenza virus implies that at least in the initial stages we will have to rely on organisational strategies and antiviral drugs. A pandemic virus of high virulence would constitute a public health emergency with potentially severe

consequences including breakdown of social order. Selective antiviral prophylaxis then becomes a very important public health measure. To quote the World Health Organization influenza pandemic preparedness plan[1] 'it would be appropriate… to maintain a supply [of anti-influenza drugs] adequate for critical needs which might arise, such as protection of health care staff and laboratory workers'.

Peter Lake
Senior Medical Officer
Port Adelaide Community Health Service
Port Adelaide, SA

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Drug promotion

Editor, – Dr Herxheimer rightly said in his editorial 'The importance of independent drug bulletins' (Aust Prescr 2002;25:3-4) that some over-enthusiastic colleagues talk about their preferred treatment. This is done not out of enthusiasm or devotion, but because of inducements offered by drug companies. There is now an unhealthy practice of drug companies hiring specialists to speak about their new products to select groups of medical practitioners especially invited to hill stations or costly hotels. How do medical associations and medical councils allow such a partisan practice by their members?

Wishvas Rane
Pune
India

CD review

Electronic Therapeutic Guidelines: complete (eTG complete). January 2002. Melbourne: Therapeutic Guidelines Limited.

Price: $220 subscription per year includes 3–4 updates. (Subsequent years approx. half any advertised initial subscription)*

John Fraser, Associate Professor and Director, New England Area Rural Training Unit, Tamworth, NSW

'eTG complete' is an interactive CD-ROM allowing easy access and searching of peer-reviewed Australian clinical guidelines produced by Therapeutic Guidelines Limited. Topics include analgesia, antibiotics, cardiovascular, respiratory, endocrinology, neurology, gastroenterology, dermatology, palliative care, psychotropics and drug prescribing in pregnancy and breastfeeding.

I have regularly subscribed to the paper-based versions of these guidelines for the last 10 years. They are an invaluable resource as an aid to clinical practice particularly in rural areas where access to specialist advice may be limited and some medical conditions are encountered infrequently. I now recommend these texts to my general practice registrars preparing for their examinations as a useful means of updating and revision. All versions are endorsed by the Royal Australian College of General Practitioners and other relevant discipline-specific specialist organisations and colleges. New versions are peer-reviewed, evidence-based and referenced.

Converting from a paper-based reference system to the electronic version, I found the software installed easily without difficulties. The software allows on-screen access to the familiar paper-based versions of guidelines. I found the pregnancy and breastfeeding guidelines to be a very useful addition allowing drugs to be searched alphabetically. The capacity to cross-reference and search topics which are discussed in more than one guideline is one of the main advantages of combining the guidelines into one electronic version.

A list of topics containing the search word are listed after each search. Alternatively, you can scroll down an index of topics. Consideration of bolding the main listing of the topic would be useful as some searches I conducted listed over 20 topics containing the word of interest. This would detract from its utility in checking details, when I am consulting, if I needed to scroll through multiple screens.

On average, 2–3 new editions of guidelines are developed each year. The subscription price of the CD compares with the paper version as it includes several updates to accommodate these new versions. After the first year, the price will be around $110 per year which equates with buying three new guidelines. My present versions of the guidelines include my own personal list of notes, writings and exceptions to 'rules' I have encountered in implementing them in practice. The CD-ROM version does not offer scope for you to add this same information. Consideration of a personal notes file on the C: drive linked to the CD-ROM may be considered to get around this problem. The 'eTG complete' is a useful addition to general practice, improving access to up-to-date peer-reviewed information in primary care.

Minimum system requirements
CD-ROM drive and mouse
32 MB of RAM, 60 MB free HDD space
Windows 95/98me/2000/XP: Pentium processor
Macintosh: Power Macintosh 7100/80 or equivalent
Unix/Linux/Posix: Pentium processor

* For more information contact Therapeutic Guidelines Limited 1800 061 260.