REFERENCES

1. Tideman PA, Tirimacco R, St John A, Roberts GW. How to manage warfarin therapy. Aust Prescr 2015;38:44-8. http://dx.doi.org/10.18773/austprescr.2015.016
2. Jiang X, Williams KM, Liauw WS, Ammit AJ, Roufogalis BD, Duke CC, et al. Effect of St John's wort and ginseng on the pharmacokinetics and pharmacodynamics of warfarin in healthy subjects. Br J Clin Pharmacol 2004;57:592-9. http://dx.doi.org/10.1111/j.1365-2125.2003.02051.x

Benzodiazepines

Aust Prescr 2016;39:33
http://dx.doi.org/10.18773/austprescr.2016.016

I congratulate the authors of the recent article on benzodiazepines[1] for highlighting that, although not as bad as in the 1980s,[2] benzodiazepine abuse and misprescribing remain a problem, especially in the area of polysubstance abuse.

I would like to make a suggestion. Regarding the Table, I tend to classify flunitrazepam (also now a Schedule 8 drug) and nitrazepam as long-acting benzodiazepines. There are usually three groups of benzodiazepine cited for clinical action: short-, intermediate- and long-acting. The authors have grouped short and intermediate, but this can give a misleading impression to prescribers, especially regarding these two benzodiazepines notorious for their accumulation and morning-after effects. For example, the product information for nitrazepam states 'elderly debilitated patients may show a significant increase in elimination half-life.'

The other minor point I would make is that the approximate half-life of diazepam in the Table (20–80 hours) is misleading. Its active metabolite nordiazepam has a half-life of 96 hours according to the product information, and is marketed as an active compound in some countries.

Finally, a little mnemonic to help students, GP trainees and addiction trainees with outpatient benzodiazepine withdrawal is TTT i.e. Ten per cent reduction in dose per week over Ten weeks with an exponential/terminal Taper.

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REFERENCES

1. Brett J, Murnion B. Management of benzodiazepine misuse and dependence. Aust Prescr 2015;38:152-5. http://dx.doi.org/10.18773/austprescr.2015.055
2. McNamara K, Lewin T. General practitioners' recognition and management of psychiatric illness. Med J Aust 1989;151:250-1.

Bridin Murnion and Jonathan Brett, the authors of the article, comment:

Thank you for your observations regarding the half-lives of nitrazepam and flunitrazepam. Indeed we feel that any use of benzodiazepines in elderly debilitated people carries a significant risk regardless of half-life. The Table is perhaps an arbitrary division of benzodiazepines based on half-life as there is a degree of inter-individual variability and, as you say, active metabolites are also important. The pharmacodynamic effects of each drug may also differ to some degree and this may also impact on toxicity.

Prescribing for people in custody

Aust Prescr 2016;39:33–4
http://dx.doi.org/10.18773/austprescr.2016.013

I read the article on prescribing for people in custody[1] with interest. It raised many valid points and covered several narcotics and other sedatives among high-risk medicines. I would like to draw attention to antihyperglycaemic drugs, especially insulin which requires expertise on site to monitor its use and potential misuse. This is more important for inmates with type 1 diabetes in high-security facilities who mostly do not have access to diabetic meals, and where food provided after hours is mostly not diabetes friendly. In my experience dealing with patients on insulin in custody is really challenging. Rigid schedules and limited availability of healthcare staff add to the complexity of this situation.

It is unfortunate that in spite of the high prevalence of diabetes in the community, especially in those who are disadvantaged, there is no specific policy on management of people with diabetes in custody.

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REFERENCE

1. Hampton S, Blomgren D, Roberts J, Mackinnon T, Nicholls G. Prescribing for people in custody. Aust Prescr 2015;38:160-3. http://dx.doi.org/10.18773/austprescr.2015.057

LETTERS

Stephen Hampton, Donna Blomgren, Jill Roberts, Tobias Mackinnon and Gary Nicholls, the authors of the article, comment:

We thank Dr Chaubey for his response. He has identified a number of challenges which make managing diabetes in the custodial environment more difficult when compared to the community. Systems vary between jurisdictions, facilities and patient security classifications, but the schedules mandated by the secure environment do not always coincide with the most appropriate testing and dosing times. Patients may not have access to glucometer testing without supervision by nurses. Meals can have high caloric loads and be given at unusual times. Also extra snacks can be 'purchased' by patients, which can be unhelpful for diabetic control. Specialist reviews may take some time to arrange through already burdened public systems and patients may be disinclined to travel to them.

Having said this, many of the people entering prisons have had little or no diabetic care or may not have known they are diabetic. Local chronic disease programs have been developed from national guidelines. Nursing care is available on a daily basis, and GPs and specialist nurses visit on a sessional basis. Finally, it should be said that staff and patients are very grateful for the support and advice from hospital specialist colleagues on the management of complex medical problems for people in custody.