published guidelines to a hypothetical 79-year-old woman with chronic obstructive pulmonary disease, type 2 diabetes, osteoporosis, hypertension and osteoarthritis led to recommendations for 12 medications, with high risks of interactions and adverse reactions.[9]

When prescribing for a frail older patient, co-ordinate prescribing with others involved in the patient's care and, if possible, aim for one prescriber per patient. Medications should be reviewed regularly with respect to the indication, therapeutic aims, dose, efficacy and safety. Consulting with a pharmacist for a home medication review may improve clinical outcomes.[10] The benefits and risks of treatment, including the overall impact on function and quality of life, should be discussed with the patient and/or their carer. The time required to achieve outcomes relative to the patient's life expectancy should be taken into account.

This clinical judgement approach contrasts starkly with the proposal to prescribe everyone over the age of 55 a 'polypill' for primary prevention of cardiovascular disease.[11] The polypill contains a lipid-lowering drug, three blood pressure-lowering drugs, aspirin and folic acid. Comorbidities, co-medications and age-related changes in pharmacokinetics and pharmacodynamics are not considered with this strategy.

Prescribing and managing multiple medications appropriately and effectively is important to optimise function and to avoid adverse health outcomes, especially in older patients. The overall effect of a person's medicines is like the sound of a group of musicians. A listener's perception of beautiful music does not depend on the size of the group, but on the quality and combination of the players, carefully selected and managed by the conductor, and tailored to the musical tastes of the specific audience.

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Conflict of interest: Dr Hilmer holds a patent for the drug burden index with Drs Abernethy and Mager.

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.

Prescribing exercise for diabetes

Editor, – In the article 'Prescribing exercise for diabetes' (Aust Prescr 2007;30:130–3), the author adequately takes into account cardiovascular and neurological concerns when advising, for example, jogging or running. However, relative adult weight gain (weight gain compared to weight on reaching maximum height and general maturity) is seemingly not addressed other than in very general terms.

Patients may be at risk of considerable irreversible weight-bearing joint damage if this issue is neglected, since even prolonged walks in obese individuals could result in aggravated ankle, knee and hip degeneration due to the load-bearing involved.

If 'losing a pound results in a four-pound reduction in knee-joint load for each step'[1], then surely adding weight might also potentially damage the weight-bearing joints in a fourfold manner as well.

Ted Arnold
Medical officer
Executive Health Management
Sydney

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Ms Bronwyn Penny, author of the article, comments:

I appreciate Dr Arnold's opinion and am in complete agreement regarding excessive joint loading in obese individuals who may be involved in significant weight-bearing activities.

In this situation, very obese patients may benefit from undergoing initial weight loss coupled with lower limb resistance training to increase lower limb strength and improve mobility before undertaking weight-bearing aerobic modalities.[1]

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Isomaltulose

Editor, – Food Standards Australia New Zealand (FSANZ) has recently approved a new sugar substitute called isomaltulose, but this product may pose a risk to individuals with disorders of fructose metabolism.

FSANZ has assessed isomaltulose and concluded that it is safe for the general population. It is not suitable for those very few people with disorders in fructose metabolism or people with sucrase-isomaltase deficiency. People with these conditions are recommended to avoid foods containing isomaltulose.

We want the medical and dietetic professions to be aware of this and so are informing the peak professional bodies and the medical media about this product. In addition, FSANZ has prepared a fact sheet on isomaltulose which is available on its website (http://www.foodstandards.gov.au/newsroom/factsheets/factsheets2007/informationaboutisom3627.cfm).

Bob Boyd
Chief Medical Advisor
Food Standards Australia New Zealand
Wellington, New Zealand

Extending prescribing rights

Editor, – In response to Professor Gullotta's letter about nurse prescribing (Aust Prescr 2007;30:88–90), I would stress that pharmacists are not the 'lesser-trained' professionals with regard to medications. How many doctors could claim they possess four years training in pharmacology and pharmaceutical care?

A few years ago I was approached to train as a pharmacist prescriber in the UK. Throughout my dispensing training, I worked alongside a general practitioner who was both mentor and assessor. My specific area of practice was hypertension management where I was valued, not as a 'pretend doctor', but as an expert on medicines. My remit was to conduct a hypertension clinic with previously diagnosed patients, monitor blood pressure, counsel on lifestyle, and review and discuss medication use. The range of prescription drugs I could prescribe was restricted to a formulary and I was entrusted to work within the level of my competency.

Contrary to Dr Gullotta's concern, I would argue that the well-managed introduction of non-doctor prescribers can actually enhance patient care.

Juanita Westbury
PhD candidate
University of Tasmania
Hobart

Editor, –The inference in the letter (Aust Prescr 2007;30:88–90), that only medical practitioners should be afforded prescribing rights, is in my view a somewhat myopic vision for the future health care of the country. Furthermore, the assertion that potential non-medical prescribers are 'lesser-trained' health professionals is misleading. They are not lesser trained in medicine, rather differently, yet highly, trained in their respective healthcare fields. The question is not whether we should consider alleged 'lesser-trained' doctors to prescribe, but whether we should allow other health professionals to extend their skills into the area of prescribing.

Patients often tell me that they could wait for a week before they are able to visit their doctor for their health complaint or regular prescription. The introduction of suitably qualified non-medical prescribers could afford general practitioners more time to focus in a more advanced diagnostic role.

Stephen Carbonara
Community pharmacist
Albion Park, NSW