

Conclusion

Either skin prick tests or RAST can accurately determine the presence of allergen-specific IgE. Skin prick testing is the preferred method as it is more sensitive, quicker and simpler. False negatives are very unusual and a negative skin prick test makes the presence of IgE mediated allergic reactivity most unlikely. Conversely specific IgE may well be present in the absence of clinical sensitivity and positive tests must always be interpreted in conjunction with the clinical findings.

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REFERENCES

1. Wide L, Bennich H, Johansson SG. Diagnosis of allergy by an in-vitro test for allergen antibodies. *Lancet* 1967;2:1105-7.
2. Ishizaka K, Ishizaka T. Identification of gamma-E-antibodies as a carrier of reaginic activity. *J Immunol* 1967;99:1187-98.
3. Roberts-Thomson PJ, McEvoy R, Gale R, Jovanovich S, Bradley J. Quality assurance of immunodiagnostic tests in Australia: II. Five year review. *Asian Pac J Allergy Immunol* 1993;11:29-37.

4. Yunginger JW, Ahlstedt S, Eggleston PA, Homburger HA, Nelson HS, Ownby DR, et al. Quantitative IgE antibody assays in allergic diseases. *J Allergy Clin Immunol* 2000;105:1077-84.

Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 99)

5. The usefulness of skin prick tests is limited by the large proportion of false negative results.
6. Skin prick testing should only take place when resuscitation equipment is immediately available.

Web site review

Database of Individual Patient Experiences (DIPEX) web site: www.DIPEX.org

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DIPEX is an internet-based multimedia resource. It tries to respond to the needs of people recently diagnosed with an illness by providing both clinical information and the experiences of individual patients. 'To be diagnosed with an illness can be bewildering and frightening, especially if there is no-one around to tell you the things you really want to know'. DIPEX includes video clips, sound (testimonies of patients), and links to web sites which are reliable, but have a more specific focus, such as cancer. DIPEX itself represents an unusual collaboration between health professionals and consumer groups. It is a not-for-profit organisation funded by the UK Department of Health, Macmillan Cancer Relief, the Citrina Foundation, the Consumers Association and the Lord Ashdown Trust.

Scope

The web site is divided into modules based on particular conditions. As funding becomes available it is intended to include 'experiences of all the main illnesses'. Topic information is organised into categories of diagnosis, such as colorectal cancer, together with relevant tests, investigative procedures and links to condition-specific web sites, for example Cochrane and CancerBACUP. Links to patient experiences are a key feature of the site which also invites people to volunteer to tell their own story. The focus of these 'stories' is patient responses to particular treatments, yet the web site does not include evidence about risks of these treatments or procedures. The patient comments do include concerns and experiences of, for example, adverse effects.

Audience

Although its stated aim is to meet the needs of patients, DIPEX is also intended to play an educational role for health workers. It is likely that the site will be more successful in achieving this aim than in its more ambitious aims. In particular it is questionable to what extent it can substitute as a support group for people who are looking for timely answers to non-medical questions. However, links are provided to various support groups.

Limitations

The web site does not acknowledge that what people often need is immediate support and information about what might be available. In addition, because DIPEX aims at that 'window of opportunity' between diagnosis and treatment it is health-system focused and does not cater for the concerns of people with long-term illness.

The site uses DISCERN quality criteria for evaluating medical information on treatment choices. DIPEX claims to provide 'balanced encounters between patients and health care professionals'. However, the site content appears to be written by health professionals accompanied by links to patient testimonies. A more robust approach might be to establish an advisory group for each illness dealt with, giving both patients and practitioners equal say in the content and design of the site.

The partnership approach is badly let down in two further ways. Firstly, the background provided by health professionals is not supported by evidence or referenced. Secondly, patient testimonies consist of one person's experience rather than a range of experiences. Yet the experience of one patient invariably differs from the experience of another person. There is no evidence or discussion about factors that may influence different experiences of the same procedure or diagnosis, for example socio-economic status, current health status and life experiences.

The links to patient experiences are strangely disembodied. They do not offer the patient's story as such. Rather they are snippets of people's experiences provided in response to predefined questions. For example, 'What will it be like having this operation or taking these drugs?'

Currently, the DIPEX web site does not capture the iterative process between people in self-help groups. This means that

the site itself cannot provide the kind of 'mutual support and information sharing' in the rehabilitation process that self-help groups offer. However, DIPEX is innovative in its attempts to bring together professional concerns and consumer responses. This may be particularly useful to isolated consumers who do not have access to support groups. In addition DIPEX may prompt others to seek out actual rather than virtual support groups.

New drugs

Some of the views expressed in the following notes on newly approved products should be regarded as tentative, as there may have been little experience in Australia of their safety or efficacy. However, the Editorial Committee believes that comments made in good faith at an early stage may still be of value. As a result of fuller experience, initial comments may need to be modified. The Committee is prepared to do this. Before new drugs are prescribed, the Committee believes it is important that full information is obtained either from the manufacturer's approved product information, a drug information centre or some other appropriate source.

Bisoprolol fumarate

Bicor (Alphapharm)

1.25 mg, 2.5 mg, 5 mg and 10 mg tablets

Approved indication: heart failure

Australian Medicines Handbook Section 6.4.3

Some patients with heart failure will benefit from the addition of a beta blocker to their other treatments (see 'Beta blockers in heart failure' Aust Prescr 2000;23:120-3). Bisoprolol is one of the beta blockers which can be used in patients with stable, chronic, moderate to severe heart failure.

The drug is selective for beta-1 receptors. This selectivity is reduced at higher doses so the lowest effective dose should be used. Bisoprolol is lipophilic and hydrophilic. It has no intrinsic sympathomimetic activity.

First-pass metabolism reduces the bioavailability of bisoprolol to 80%. As half the dose is excreted unchanged in the urine and half is metabolised, lower doses should be used in patients with renal or hepatic impairment. The half-life of bisoprolol is normally 9-12 hours.

In the first Cardiac Insufficiency Bisoprolol Study (CIBIS) there was no significant difference in patient mortality between bisoprolol and placebo.¹ The second study (CIBIS II) enrolled more patients.² After an average of 1.3 years of treatment 228 (17%) of the 1320 patients given a placebo were dead compared with 156 (12%) of the 1327 patients given bisoprolol. A significant fall in sudden deaths suggests that the benefits of bisoprolol may be related to an antiarrhythmic action. Bisoprolol also resulted in significantly fewer admissions to hospital for deteriorating heart failure. The effects of bisoprolol were greatest in patients who had ischaemic heart disease and (New York Heart Association) class III heart failure.

It is important to begin with a low dose of bisoprolol and monitor patients closely as some patients' heart failure will get worse. The adverse reactions include bradycardia, hypotension and other effects typical of beta blockers.

In clinical trials, carvedilol and metoprolol have also reduced mortality when added to conventional treatment. There is no evidence to say which beta blocker is the most effective.

REFERENCES

1. CIBIS investigators. A randomised trial of β -blockade in heart failure: the cardiac insufficiency bisoprolol study (CIBIS). *Circulation* 1994;90:1765-73.
2. CIBIS-II investigators. The cardiac insufficiency bisoprolol study II (CIBIS II): a randomised trial. *Lancet* 1999;353:9-13.

Ertapenem

Invanz (Merck Sharp & Dohme)

vials containing 1 g as powder

Approved indication: specified infections

Australian Medicines Handbook Section 5.1.3

Ertapenem is one of the carbapenem antibiotics. These drugs have a broad spectrum of activity so are held in reserve for severe infections.

By inhibiting cell wall synthesis, ertapenem has a bactericidal action. *In vitro* it is active against anaerobes, Gram positive and Gram negative aerobic bacteria. Ertapenem is resistant to some beta-lactamases, but its *in vitro* activity against enterococci is limited and it is not effective against methicillin-resistant strains of staphylococci. Ertapenem is not active against *Pseudomonas aeruginosa*.

Although ertapenem can be used for infections caused by susceptible micro-organisms that are resistant to all other antibiotics, it has specific approval to be used empirically in acute pelvic infections and complicated intra-abdominal infections. It can be infused intravenously or injected intramuscularly. Infusions should take 30 minutes and should not be mixed with dextrose or other medications. Lignocaine 1% is used to reconstitute ertapenem for intramuscular injections.

Although the half-life of ertapenem is four hours, only one daily dose is needed. Most of the drug and its metabolites are excreted in the urine.