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.

Discharge medication

Editor, – In the editorial about discharge medication (Aust Prescr 2006;29:58–9), the authors state 'trials of interventions to improve the transfer of drug information from the hospital to the community have been disappointing'. We recently conducted a randomised controlled trial of a multi-faceted intervention called Med eSupport, which included information and communication technology solutions. This trial involved 487 patients across five sites, and included the following elements:

- a secure bi-directional electronic communication pathway between community and hospital pharmacies for the transfer of medication profiles to facilitate medication reconciliation
- supply of a comprehensive medication information sheet at discharge to the patient or carer, general practitioner and community pharmacist, which is uploaded to a secure website for viewing and printing
- a model system in which patients were automatically referred for a post-discharge medicines review within 5–7 days of discharge.

Initially, we found that 66% of all hospital drug charts contained at least one error. Significantly more patients in the intervention group had medication discrepancies resolved within 48 hours of their admission compared with control patients. Almost all of the medicines reviews started by the hospital were completed in a timely manner and were highly appreciated by patients and general practitioners. Only 0.6% of the intervention patients were re-admitted to hospital within five days of discharge compared to 3% of the control patients. An economic evaluation indicated potential savings of $60 million per year with a national roll-out to 50 sites.

We believe the results illustrate the value of developing a strategy for the national roll-out of a medication information sharing process and post-discharge medication reviews for high-risk patients.

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Editor, – We read with interest the editorial 'Discharge medication' (Aust Prescr 2006;29:58–9). Communication between hospitals and community-based providers with regards to patient medication is less than adequate.[1] This is of particular concern with warfarin therapy.[2,3]

We have conducted an audit of 51 consecutive electronic discharge letters of patients who started warfarin while in hospital. This focused on the clinically important issues of indication and dosing. Warfarin therapy and its indication were documented in 50 of the 51 discharge letters, but eight discharge letters (16%) had no dose information. INR test results were present in 29 letters (57%) but only four give a recommended duration of treatment.

While it is not feasible to list every single detail of a patient's medication regimen in a discharge letter, it is reasonable to mention that the patient is taking warfarin, the indication, the dose being taken, any INR results, the recommended target INR range and the next review date of warfarin therapy. We have therefore modified our electronic discharge summaries to include a mandatory field requesting this information. This should help general practitioners continue the clinical care with minimal harm and inconvenience to the patient.

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Editor, – Further to the editorial 'Discharge medication' (Aust Prescr 2006;29:58–9), readers may be interested to learn of South Australian initiatives on this topic.

As part of the careconnect.sa programme (formerly known as Open architecture clinical information system

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Adverse effects

Monoclonal antibodies have to be administered parenterally. The costs of cannulation and injection site reactions may be considerable.

New and unexpected serious adverse effects are emerging. Anti-TNF therapies are limited by serious infections including, but not restricted to, reactivation of latent tuberculosis. In addition, there are concerns that TNF inhibition might precipitate episodes of central nervous system demyelination, worsen heart failure, increase the risk of lymphoma, or trigger lupus-like syndromes. Natalizumab has been associated with progressive multiple leucoencephalopathy. Therapy aimed at depleting either B cells (rituximab) or T cells may lead to infections with opportunistic pathogens. There is therefore a need for patients to be informed of these problems when they are considering treatment.

Conclusion

Monoclonal antibodies collectively represent a significant advance in clinical medicine. Due to their expense and mode of administration they tend to be reserved for when conventional drugs have failed to elicit a response. Although these drugs are highly targeted, adverse effects do occur and clinicians should be aware of the risk of hypersensitivity reactions and infection. The future may see combinations of monoclonal antibodies being used to better target complex disease processes.

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Conflict of interest: none declared

Self-test questions

The following statements are either true or false
(answers on page 143)

1. Patients should have a chest X-ray before starting treatment with a tumour necrosis factor inhibitor.
2. By binding to the surface of platelets, abciximab reduces the risk of bleeding during angioplasty.

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(OACIS)), paper-based hospital discharge summaries are being replaced by a standardised web-based application. Summaries can be automatically faxed via computer to the relevant general practitioner or specialist, or emailed to desktop patient management systems.

Approximately 60% of all hospital discharge summaries in the eight major Adelaide hospitals are now completed this way. Over 125 000 completed summaries are stored within the system and are accessible to treating clinicians at Adelaide public hospitals. New summaries are being generated at a rate of approximately 220 per day.

Legibility problems are now avoided. Changes in discharge medication as well as reasons for these changes must be declared. The duration of treatments must also be stated. The summary may be accompanied by an interim medication list which can be reviewed by the hospital pharmacist before discharge. If a patient is re-admitted the previous discharge medications can be imported into the new summary, reducing errors.

South Australia has improved practice in this area, nevertheless thoroughness and timeliness in clinical practice remain paramount.

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