

there are only four instances of transmission and all contact cases were mild. Therefore, there is no need to give varicella zoster immunoglobulin to any contact of a definitely vaccine-associated rash, whether pregnant, immunocompromised or otherwise. If a clinical illness consistent with varicella subsequently occurred in a pregnant or immunocompromised contact, it would be sensible to treat early with aciclovir.

How to decide if the rash is vaccine-associated? Most vaccine-associated rashes occur several weeks after immunisation (median about three weeks), consist of just a couple of papules or vesicles, and are not associated with systemic symptoms. If there are more than just a few lesions, or there are systemic symptoms, and especially if the rash occurs in the first week or two following immunisation, then it is more likely to be due to infection with a wild virus. If you are really uncertain, then err on the side of assuming a wild infection, and give zoster immunoglobulin to high-risk contacts, provided the exposure fits within the guidelines recommended in the Immunisation Handbook.¹

Reference

1. National Health and Medical Research Council. The Australian Immunisation Handbook. 8th ed. Canberra: Department of Health and Ageing; 2003. <http://www.immunise.health.gov.au/handbook.htm> [cited 2005 May 10]

Isomers – correction

Editor, – I need to inform readers of a correction to the article 'Inside the isomers: the tale of chiral switches' (Aust Prescr 2004;27:47-9). On page 47 under Introduction, I cited salmeterol as a single enantiomer drug, however, it is currently marketed as the racemate – noting that the R enantiomer is the active species.

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Book review

Therapeutic Guidelines: Endocrinology. Version 3. Melbourne: Therapeutic Guidelines Limited; 2004.

312 pages. Price \$39, students \$25.30, plus postage

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This familiar yellow book with the metamorphosing tadpole on the cover has further matured and also experienced an expansion in girth (80 pages in three years). It has been extensively revised.

The book aims to provide 'what a clinician needs to know to manage a patient with a given condition'. For commonly encountered clinical conditions in general practice such as diabetes, obesity, thyroid disorders, osteoporosis, contraception, ovarian replacement therapy and menstrual disorders, the guidelines provide excellent summaries of current management recommendations, including drug therapies. It answers

questions that arise in clinical practice. How do you choose between sulfonylureas for a person with diabetes? How do you manage hypoglycaemia in a person on acarbose? How do you monitor and adjust the dose of carbimazole for a person with thyrotoxicosis? How do you interpret bone mineral density results? When should you screen for thrombophilia in a woman who wants the combined oral contraceptive pill? What are the important drug interactions with the combined oral contraceptive pill? How do you overcome the skin irritation when testosterone impregnated adhesive skin patches are used? What happens if a woman with diabetes gets pregnant while on an ACE inhibitor?

These guidelines are well written and easy to read and there are lots of practical points. They are minimally but appropriately referenced with canonical papers. Although the style is definitive, it is not didactic. Where clinical practice is not based on evidence, this is indicated. There are a few minor errors, but these do not detract from the book overall. It represents good value for the money and will be useful for busy practising clinicians, and also medical students. Although time is a valuable resource, I would encourage general practitioners to read through the chapters on conditions they manage frequently.