

Can some reconciliation be achieved between the potential public benefit available from the release of currently confidential drug regulatory information, and the understandable commercial and possibly individual wish for continued secrecy of this information? The names of the ADEC members are already public knowledge and the identity of evaluators could be concealed when their evaluations were released. It would be no bad thing if investigators, and the pharmaceutical industry, expedited the publication of original data in the scientific literature.

From the commercial-in-confidence standpoint, the timing of the public availability of governmental-held information would be critical. The pharmaceutical industry might have relatively little problem with information becoming publicly available 20 to 30 years after it was lodged with government, yet its immediate public availability appears to be unacceptable to the industry in Australia. Some mutually agreed intermediate

position might be achieved. Perhaps pharmacological and clinical data could be released after PBS listing (a drug in Australia is unlikely to be widely used without such listing), or a certain time after ADEC has recommended its approval. The release of formulation data could be deferred until expiry of the drug's patent, or later, so that generic manufacturers were not advantaged. In all such matters, Australia would need to act in co-ordination with other nations.

Surely there is a case that the potential community benefit, and also ethical considerations, require that better use should be made of the treasure trove of drug information that government and industry in Australia currently keep secret?

REFERENCE

1. Marley J. Cost-effectiveness: the need to know. *Aust Prescr* 1996;19:58-9.
Professor Eadie was chairman of ADEC from 1985 to 1993.

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.

Search engines

Editor, – I read with interest *Australian Prescriber* Vol 25 No 1, 2002. In particular the letters section caught my attention. The comment on the search for information on immunisation stated that information retrieval was limited by the indexing of the databases and by databases being overburdened by too much content.

In fact the problem may simply rest with the manner in which the web page was set up. Keywords and key phrases are important factors in being found by a search engine. A search engine (e.g. Google, Lycos, Excite) is like a librarian that selects certain web pages in response to a search request according to the search engine's own criteria. Search engines rank web pages according to keywords or phrases:

- in the title
- in headings
- in the body text
- in the metatags provided for every web page as the source code or document code. You can access this code by going into 'View' on the menu bar of the browser (e.g. Netscape, Windows Explorer). This code gives instructions to browsers and search engines. It is written in HTML (Hypertext Markup Language).
- in the hyperlinks (links the reader can click on to go to other pages)
- in the URL and other tags.

How you place your keywords is integral to how easily your web site is found.

It is possible that the Webmaster of the Department of Health and Ageing did not consider 'vaccination' and 'guidelines' to be significant keywords and did not place them in a

prominent position in the necessary sections. Perhaps the computing expert simply needs to have further consultation with the content expert about essential keywords or phrases in order to remove any barriers to accessing the very important database about immunisation.

Leora Ross
Pharmacist
Sydney

Does pethidine still have a place in therapy?

Editor, – We read with interest the article 'Does pethidine still have a place in therapy?' (*Aust Prescr* 2002;25:12-3). The author concluded that pethidine 'can be used to treat acute pain for a short time' and suggests that it results in smaller increases in common bile duct pressures as well as less urinary retention and constipation when compared with morphine.

Our Drug Committee has debated whether or not there was a place for pethidine in acute pain management. We were not convinced that there was any good evidence to suggest that repeated doses (required if analgesia is to be maintained) resulted in clinically significant reductions in bile duct pressures compared with morphine. There was also no good evidence comparing effects on urinary retention and constipation. However, it is known that signs consistent with norpethidine toxicity can be seen within 24 hours of starting treatment with pethidine if higher doses are required.

A review of the use of opioids in pain management also expressed concerns about pethidine's continuing use.¹ It states 'Since use of pethidine is not associated with any

specific advantage, it is a poor choice if multiple doses are needed' and that '... there is no good evidence to suggest that pethidine has any advantage at equianalgesic doses over other opioids for biliary or renal colic'.

For these reasons, as well as the problems that can be seen when pethidine is used for chronic pain (as mentioned in the article), our Drug Committee has recommended that hydromorphone become the second-line choice of opioid after morphine for routine acute pain management when parenteral opioids are required. Where intravenous opioids are used, fentanyl may also be a useful alternative, especially in view of its lack of active metabolites.

P. Macintyre

Director, Acute Pain Service

F. Bochner

Chairman, Drug Committee

S. Wiltshire

Project Pharmacist, Drug Committee

Royal Adelaide Hospital

Adelaide

REFERENCE

1. McQuay H. Pain: Opioids in pain management. *Lancet* 1999;353: 2229-32.

Dr A. Molloy, author of the article, comments:

I concur with the concerns of the Royal Adelaide Hospital Drug Committee regarding the use of pethidine and the fact that norpethidine toxicity can occur after repeated doses within 24 hours if high doses are required. Now that hydromorphone is available, it is certainly reasonable to consider this as a second-line choice if parenteral opioids are required in the acute pain setting. Pethidine, however, should not be taken off the formulary as it still remains a useful drug for short-term treatment of acute pain.

APMA Code of Conduct

Editor, – I read with interest the article about breaches of the APMA Code of Conduct (*Aust Prescr* 2002;25:41). It is good that breaches are noted in a public forum. However, I

believe for completeness, there needs to be more detail about the actual advertisement and what the contentious point was rather than just reporting that the advertisement is never to be used again or the company has been fined.

I can envisage a situation where a doctor who has seen a misleading advert has its message entered into his or her consciousness where it may go on to influence prescribing habits. This is, after all, the purpose of medical advertising. The same doctor then learns that the promotional material is not to be used again, but which promotional material and what aspects of it? If you cannot recall the original advertisement how can the potentially defective prescribing practice based on that misinformation be corrected?

Mark Raines

Medical Intern and Pharmacist

Darwin

Editor's note: More details of each breach can be found in the Australian Pharmaceutical Manufacturers Association's Code of Conduct Annual Report. (The APMA is now named Medicines Australia.)

Support for Australian Prescriber

Editor, – At a recent meeting of the Hervey Bay Chapter of the Southern Queensland Rural Division of General Practice it was unanimously agreed to send a letter of support for *Australian Prescriber*.

Australian Prescriber appears to be the only publication that gives a balanced view of drugs and their use.

In general practice we all rely heavily on its independent views as a lot of our information comes directly from drug company representatives, which is by its nature extremely biased and incomplete.

Long may you continue to publish.

S. Rudd

Hervey Bay Chapter Co-ordinator

Southern Queensland Rural Division of General Practice

Hervey Bay, Qld.

Your questions to the PBAC

Australian Prescriber readers are invited to write in with their questions about decisions of the Pharmaceutical Benefits Advisory Committee. The segment 'Your questions to the PBAC' will publish selected questions from readers, and answers from the Committee itself. Questions may address issues such as regulatory decisions, pharmaceutical benefits listings, withdrawal of a drug from the market and Authority prescriptions.

This exclusive arrangement helps *Australian Prescriber* readers understand how the contents of the Schedule of Pharmaceutical Benefits are determined. The 'yellow book' is published quarterly by the Department of Health and Ageing, and is also available on the internet*. It provides

important information for doctors, dentists and pharmacists, including a summary of changes to listed items, which medicines are included or excluded from benefit, whether restrictions apply to medicines and how much patients should pay including price premiums for particular brands where applicable.

It may not be possible to reply to all individual questions to the PBAC. The usual editorial controls will apply so that only readers' letters and the responses selected by the Editorial Executive Committee will be published in the journal. Letters and responses may be edited before publication.

* www1.health.gov.au/pbs/index.htm