

patients from lower generic medicines prices or government support for an Australian generics industry had been the primary policy objectives, then more broadly framed legislation could have included pharmacy rewards for meeting generic dispensing targets, an incentive period of market exclusivity for the first generic market entrant, and financial incentives for patients who elect to be dispensed a generic, or for patients whose doctors are prepared to prescribe generic drugs. The role of the patented pharmaceutical industry in promoting and framing these changes is also controversial⁷, particularly if the new system allows price reductions to be deferred for some products.

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Conflict of interest: none declared

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.

Managing chronic obstructive pulmonary disease

Editor, – I wonder why alpha-1 antitrypsin deficiency was not mentioned in the article on 'Managing chronic obstructive pulmonary disease' (*Aust Prescr* 2007;30:59–63). There is worldwide evidence that this genetic problem is much more common than it was thought in the past. In fact the World Health Organization advises that everybody with chronic obstructive pulmonary disease should be tested for alpha-1 antitrypsin deficiency, especially since there is treatment for it, though no cure.

Michael A Kennedy
General practitioner, retired
Vaucluse, NSW

Professor Michael Abramson, Associate Professor Christine McDonald and Professor Nicholas Glasgow, authors of the article, comment:

We thank Dr Kennedy for drawing attention to the role of alpha-1 antitrypsin deficiency in chronic obstructive pulmonary disease (COPD). This genetic disorder is evidence for the elastase–anti-elastase hypothesis of emphysema. The prevalence of severe homozygous (ZZ) alpha-1 antitrypsin deficiency has been estimated at around 1/4,727 in European populations.¹ Although 75–85% of such individuals will develop emphysema, tobacco smoking is still the most important risk factor for COPD even in this group. Targeted

screening suggests 1–4.5% of patients with COPD have underlying severe alpha-1 antitrypsin deficiency.² The index of suspicion should be high in younger patients with predominantly basal disease and a family history. The diagnosis can be made by measuring serum levels of alpha-1 trypsin. If they are reduced, genotyping should be performed. Whether people who are heterozygous (MZ, MS) are also at an increased risk of COPD remains controversial.

Although replacement therapy is available, trials conducted to date have been underpowered to confirm beneficial effects on the rate of decline in lung function or on survival. One placebo-controlled randomised trial suggested some reduction in the loss of lung tissue as assessed by CT scan.³ Therapy involves intravenous administration of alpha-1 trypsin concentrate purified by fractionation of normal human plasma or recombinant alpha-1 trypsin. These products can restore alpha-1 trypsin levels above the protective threshold for some weeks. Replacement therapy is available through the Special Access Scheme. A national patient support group can be contacted at <http://health.groups.yahoo.com/group/Alpha1-ANZ>.

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A century of concern about complementary medicines

Editor, –The comment in *Australian Prescriber* (2007;30:91) draws unhelpful and misleading parallels between complementary medicines today and 'dangerous and useless medicines' available 100 years ago.

The author is right to point to the establishment of the Therapeutic Goods Administration (TGA) as an important landmark for the regulation of pharmaceuticals and complementary medicines. The Complementary Healthcare Council (CHC) fully supports a regulatory process that safeguards consumer interests. However, to suggest that complementary medicines as therapeutic goods are somehow compromised by false or misleading advertising or that barriers exist to understanding them because sponsors hide behind 'commercial-in-confidence' is inaccurate.

All advertisements for therapeutic goods are subject to the Therapeutic Goods, Trade Practices and other relevant laws. The Therapeutic Goods Advertising Code, which applies to advertisements directed to consumers and where sanctions apply for breaches, requires material to be truthful, balanced, not contain misleading or exaggerated claims, and all descriptions, claims and comparisons must be able to be substantiated.

With regard to 'commercial-in-confidence', it is hard to see how concerns regarding transparency would not equally apply to pharmaceutical companies. Companies responsible for marketing products are obliged to make available all evidence regarding claims in relation to their products, should they be asked to do so by the TGA.

What does concern the CHC, is the outdated attitudes demonstrated towards complementary medicines, despite repeated and compelling evidence demonstrating their health benefits. Let's imagine for one moment the implication for pregnant women globally, if folate supplementation in preventing neural tube defects had not become accepted mainstream practice.

Tony Lewis
Executive Director
Complementary Healthcare Council
Canberra

Dr JS Dowden, the author of the comment, responds:

There is Level 1 evidence to support the use of folate supplements by women planning pregnancy. It is doubtful

that such strong evidence exists for many complementary products. Given the plethora of complementary medicines it is unlikely that the TGA has the resources to assess the evidence for many of these products. Evidence of a product's safety and efficacy should not be 'commercial-in-confidence' irrespective of whether it is a prescription or a non-prescription drug.

Despite the somewhat confusing regulatory system, there are plenty of complaints about the advertising of complementary medicines.¹ The usual sanction for an unacceptable advertisement seems to be a request for the advertisement to be withdrawn, but it is unclear how effectively this is enforced.²

Octavius Beale was concerned about the outrageous claims being made by medicines manufacturers in the early 20th century.³ The number of justified complaints in 2007 suggests that there is still a problem.¹

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Magnesium

Editor, – In the article on magnesium by Dr Wu and Dr Carter (*Aust Prescr* 2007;30:102–5) there is little attempt to address the issue of cramps and magnesium ingestion by the public. My clinical experience has been that every aged patient who has any problem with cramping, has either tried, or is on, oral magnesium usually from the supermarket or health store. This is often magnesium phosphate.

Could the authors comment on the issue of cramping and adults over the age of fifty years? Is there any evidence that lack of magnesium causes this, or that oral magnesium is of any benefit?

Chris Commens
Dermatologist
Pennant Hills, NSW

Dr J Wu and Dr A Carter, authors of the article, comment:

In response to Professor Commens, a literature search performed in consultation with our pharmacology unit failed to raise any conclusive evidence that magnesium phosphate is useful in preventing cramps in the elderly. This is not to say that biochemically proven hypomagnesaemia would not respond to supplementation, in the same way as hypocalcaemia or hypokalaemia would require calcium or potassium supplementation respectively.