addition to writing medication lists on discharge summaries. In our hospital, discharge prescriptions are screened by clinical pharmacists and errors are detected for about 12% of patients.[5] Issuing PBS prescriptions from the hospital will require new systems to check discharge drugs and to transfer instructions about their use.

Accurate, timely transfer of discharge medication information from the hospital to the community requires co-operation between doctors, pharmacists and nurses in the hospital and in the community. Lists of discharge medications should be typed to improve legibility and include reasons for any changes. The drugs must be ordered in time for the pharmacist to check them, dispense them (or organise dispensing in the community) and provide the patient with the information to manage their medications. There should be timely transfer of the discharge information by as many routes as possible to the patient and/or carer and the general practitioner. The community pharmacist needs to know if a blister pack is required and the community nurse needs to be informed if administration is required. Medication cards can provide the patient with their own record on discharge.

Electronic systems can transfer computerised discharge summaries and medication lists rapidly by fax or email, but require new processes for checking and correcting discharge prescriptions. The Commonwealth Government has trialled a 'MediConnect' record for consenting patients.[6] An electronic medication list was stored by Medicare Australia and could be added to and accessed by doctors, pharmacists and hospital staff. The findings will be implemented as part of the 'HealthConnect' strategy for electronic health information. However, for all records, paper or electronic, accuracy depends upon timely and accurate data entry. For example, it is important that electronic prescribing records are updated to reflect changes in treatment. Ultimately the most useful and accurate record of patients' medications may be the 'plastic bag' or basket (Fig. 1) containing all their drugs, including discharge medications.[1]

Fig. 1

Medicines brought to a geriatric outpatients clinic by a patient

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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.

Assisting Aboriginal patients with medication management

Editor, –The article 'Assisting Aboriginal patients with medication management' (Aust Prescr 2005;28:123–5) included many useful suggestions. However, one of the most important barriers facing people with chronic ill health was only mentioned in passing, namely medication co-payments. A particular sub-group of the Aboriginal population is severely affected by co-payments. These are the growing number who normally live in remote communities but move temporarily or permanently into capital cities. By moving, they lose access to free medications provided under Section 100 (*National Health Act 1953*). Due to the high burden of chronic disease experienced by Aboriginal

people, many require multiple medications and, not surprisingly, come to grief being unable to afford the additional costs. Extension of Section 100 eligibility to the whole Aboriginal population of Australia has been the subject of a joint position paper by the National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Medical Association (AMA) and the Pharmacy Guild. This paper is available online.[1] Implementation of its recommendations would not be expensive, but would do much to improve the health status of Aboriginal people with chronic conditions.

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What now for Alzheimer's disease?

Editor, –The review of the AD2000 trial (Aust Prescr 2005;28:134–5) fails to note that this trial has been heavily criticised. It permitted enrolment of people with cerebrovascular disease, enrolled less than 20% of its recruitment target and carried on with too few patients for too short a time to tell whether the drugs delayed institutionalisation. There was a complicated double randomisation method with an extra four-week washout period every 12 months. Of 566 people entering the study only 111 completed two years of the trial and only 20 completed the third year of a planned five-year study. Many prominent researchers in the UK chose not to be involved because of the questionable ethics of offering treatment only as part of a randomised controlled trial. The researchers skirted this ethical dilemma by asking doctors to recruit only patients about whom they were 'substantially uncertain that the individual would gain a worthwhile clinical benefit from donepezil'! About the only conclusion that can be drawn from this study is that donepezil produces a measurable but small improvement in a crude cognitive measure which is sustained in individuals receiving treatment compared to those receiving placebo over at least one and possibly two years.

The review contains a footnote saying that the results of a recent study were 'very similar to those of the AD2000 trial'. This is misleading. The recent trial assessed the usefulness of donepezil and vitamin E for a completely different indication (mild cognitive impairment, not Alzheimer's disease) and returned negative, not weakly positive, results on measures of cognition.[1]

Cholinesterase inhibitors have modest efficacy for some patients with Alzheimer's disease, but it is not possible to tell in advance who will respond. It is therefore appropriate to offer people with mild to moderate Alzheimer's disease a trial of treatment, monitor their response and then decide about continuation. The requirement for at least a 2-point improvement in the mini-mental state examination goes some way towards ensuring that the patients who receive continuing treatment will be those who have shown some response.

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Henry Brodaty
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Reference

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Professor Ames and Professor Brodaty have both received research support, honoraria and financial assistance to attend conferences from companies marketing cholinesterase inhibitors.

Professor J. Attia and Professor P. Schofield, authors of the editorial, comment:

In our editorial, we clearly acknowledged the drawbacks of the trial, including the low recruitment and the complex design. Despite the contention that the trial was too short, it was the only trial up to that point to have looked at outcomes beyond one year. Despite criticism of the inclusion criteria, even Ames and Brodaty acknowledge the difficulty of prospectively identifying responders. We would contend that the study has some strengths, including the focus on clinical end points, caregiver burden, and economic analyses. It tempers the enthusiasm generated by the results from short-term, largely drug company-sponsored studies and this cautionary note has been sounded by others.[1]

The recent study examined the effect of donepezil and vitamin E on conversion rates from incipient to diagnosed Alzheimer's disease, and thus was concerned with the same disease entity as was AD2000, albeit at a milder stage. The similarity that we see between the two three-year trials is that they both indicated a small beneficial effect in primary outcomes at 6–12 months, which was not sustained in the long term.

However, 'evidence alone is never sufficient to make a clinical decision'.[2] The translation of evidence into practice is subject

to an evaluation of the risks and benefits, costs, patient values and circumstances. We agree with Ames and Brodaty that an N of 1 trial is the highest level of evidence to apply!

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Management of bite injuries

Editor, – The article 'Management of bite injuries' (Aust Prescr 2006;29:6–8) is helpful in determining appropriate antibiotics for bites, but the most important message is that all bite wounds, other than those where there is a clear cosmetic problem such as in the face, should be treated by wound excision and topical use of povidone-iodine, providing the patient is not allergic to iodine. Under no circumstances should wounds be sutured primarily.

Unless this point is stressed unfortunately tragedies will still occur because of the inexperience of emergency doctors who feel obliged to suture all wounds that present to the emergency department.

The primary treatment of the wound is far more important than the use of antibiotics, although they are an important adjunct to management.

Chris Haw
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Dr Marion Woods and Dr Jennifer Broom, authors of the article, comment:

Our article was concerned primarily with appropriate antibiotic management of bite wounds. We reiterate that debridement of devitalised tissue and thorough irrigation of bite wounds is an essential part of management. We made the point that early surgical consultation is advised for bite wounds, particularly for hand wounds, to prevent loss of function. Early surgical consultation will also optimise the cosmetic results of treatment particularly for bites on the face.

We agree that most bite wounds should not be primarily closed unless there is a specific need. Of note, however, is a best evidence topic report of closure of bite wounds[1] stating that dog bites on the hands should be left open (primarily closed hand wounds had double the infection rate [$p < 0.01$]), but that non-puncture wounds elsewhere may be safely treated by primary closure after thorough cleaning (7.6% infection rate in primary closure group vs 7.7% infection rate in open group).[2]

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Editor, – In addition to the useful information in the article 'Management of bite injuries' (Aust Prescr 2006;29:6–8), readers should be aware of the forensic implications of bite marks.

Marks made by the teeth may be inflicted either on skin or inanimate objects in cases of criminal assault, sexual assault, child abuse or homicide. Bite marks may be used as evidence in court, either to identify a perpetrator or exclude suspects.[1]

While prompt medical attention for bites is necessary, medicolegal consideration must also be given to correct documentation of the injury, with biological swabs for DNA testing and photographs (including scale).[2] Without good evidence collection criminal or civil legal proceedings may be hampered.

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MRSA: the storm clouds travel from hospital to community

Editor, – We read with interest the article 'Community-acquired methicillin-resistant *Staphylococcus aureus* infection' (Aust Prescr 2005;28:155). In a developing country like India, a significant number of methicillin-resistant *Staphylococcus aureus* (MRSA) infections are being acquired from the community.[1] We need to curtail infection as quickly as possible and alter any long established practices which may be enhancing the development and spread of MRSA.[2]

The major problem is the inappropriate use of antibiotics. Given the increasing ecological pressure of antibiotics globally, bacteria respond by becoming resistant. Faced with the established scientific evidence of a relationship between antimicrobial use and MRSA prevalence, we

suggest restricting the use of certain antimicrobial classes as an adjunct to infection control practices, which should be reinforced to fight MRSA in hospitals. The prescribing that led to the selection of MRSA can be identified by studying local retrospective data.

Basic hygiene is also important in the continued fight against pathogens.[3] One needs to consider the epidemiological and physical properties of staphylococci, and each component of their transmission cycle between man and the environment. There is evidence to support hygienic measures at every stage.[4]

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Medication overuse headache

Editor, – It is of great interest to note the high prevalence of medication overuse headache (Aust Prescr 2005;28:143–5) yet a corresponding paucity, or in many cases, absence, of warning statements on many common over-the-counter analgesics. Likewise, little prominence is given in consumer medication information leaflets about the potential for developing this disorder, signs and symptoms to be aware of, and the importance of seeking medical help should the disorder become apparent. Given the ready availability of codeine-containing combination analgesics without a prescription, the prevalence of this undiagnosed disorder in people who are unknowingly trapped in a vicious circle must be cause for concern. Moreover, it is disappointing to note a corresponding lack of suitable warnings in some of the 'triptan' product information for healthcare professionals – a factor which must be considered in the over-prescribing of these products in the first place.

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Transparency of drug information

Editor, – We have tried to emulate your T-score (Aust Prescr 2005;28:103) in our French drug bulletin, la revue Prescrire, in order to expose pharmaceutical companies' readiness to respond to our requests for information on their products.

Our rating system is similar to yours, but it specifies the provision of unpublished data and packaging information. We presented our rating system in January this year during our Pill Awards, a ceremony which recognises new drugs which have genuine benefits.

We wish you all the best with your T-score, and hope our approach will also improve access to key data. Thanks for showing the lead!

Christophe Kopp
Managing Editor
Prescrire International
Paris, France

1 - manufacturer provided detailed information, including unpublished data and packaging items

2 - manufacturer provided information limited to administrative and published data

3 - manufacturer provided minimal information, mainly administrative data

4 - manufacturer provided no information