

*Australian Prescriber*, but also its national and international stature. It has always been our understanding that the outsourcing of *Australian Prescriber* had as its main driver, the isolation of the journal from the dynamics of the Government's annual budget cycle. In this context, tenure with the National Prescribing Service brings with it a minimum four-year guarantee of operational stability.

Another central concern in our negotiations with the Department of Health and Ageing has been to see sufficient funding allocated to *Australian Prescriber* to allow continued production of the journal along with the full roll-out of National Prescribing Service programs, without either impinging on the capacity of the other. The National Prescribing Service was able to convince the Department of the importance of these goals and has secured the funding needed to achieve them.

Two other factors were crucial to maintain the authority of *Australian Prescriber* in the transition to private ownership: continuity of expertise and editorial independence. The National Prescribing Service has been able to recruit key members of *Australian Prescriber* staff which in itself is a measure of their professional commitment to this public health enterprise. Our relationship with the Executive Editorial Board of *Australian Prescriber* has always been mutually productive, and an absolute commitment to its continued editorial authority has

been given by the National Prescribing Service Board. The National Prescribing Service has several policies and procedures which effectively deal with the potential conflicts of interest which may arise when multi-stakeholder activities are undertaken, and I am confident these will serve us well in our management of *Australian Prescriber*.

What of the future? Business as usual in respect of the core functioning of *Australian Prescriber*. However, evolution is essential for enhanced effectiveness. We will, in consultation with the new Editorial Executive Committee of *Australian Prescriber*, professional, consumer and other stakeholders, focus on issues including greater integration of QUM messages, better penetration of target constituencies, and more efficient and interactive methods of distribution.

In this new phase of *Australian Prescriber* operations, a sense of insecurity is understandable, caution is required and scrutiny will be welcomed. The National Prescribing Service looks forward however to bringing the power of this venture to the pursuit of QUM in Australia.

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#### REFERENCE

1. Executive Editorial Board. Changes at *Australian Prescriber*. *Aust Prescr* 2002;25:2.

## 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.

### Over-the-counter medicines in children

Editor, – Some of us have had serious reservations about the advisability and efficacy of over-the-counter medications in children for some time (*Aust Prescr* 2001;24:149-51). As stated in the article, there are few reliable sources of information. I thought your readers may be interested in some others.

There is an article showing the striking absence of efficacy data for cough and cold medicines in children, and the many non-scientific factors contributing to the frequency of their use.<sup>1</sup> I was interested to learn that healthy children, who have not had a respiratory tract infection within the past month, cough 1-34 times per day.<sup>2</sup>

Another article on antipyretic therapy states that neither the detrimental effects of fever nor the salutary effects of antipyretic therapy have been confirmed experimentally. Furthermore, carefully controlled efficacy studies have never quantified the degree to which antipyretic therapy enhances the comfort of patients with fever.<sup>3</sup>

Even the old dependable gripe water for the treatment of colic is a sham! It now seems that its soothing effect derives from its sweet taste, which can be duplicated with sugar solutions.<sup>4</sup>

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#### REFERENCES

1. Gadomski A. Rational use of over-the-counter medications in young children. *JAMA* 1994;272:1063-4.
2. Chang AB, Robertson CF. Cough in children. *Med J Aust* 2000;172:122-5.
3. Plaisance KI, Mackowiak PA. Antipyretic therapy: physiologic rationale, diagnostic implications, and clinical consequences. *Arch Intern Med* 2000;160:449-56.
4. Blumenthal I. The gripe water story. *J R Soc Med* 2000;93:172-4.

### Screening for thalassaemia

Editor, – The article 'Screening for thalassaemia' (*Aust Prescr* 2001;24:120-3) provided an excellent and concise overview of the thalassaemias and haemoglobinopathies in Australia.

A major point arises in relation to initial testing and how to identify a suspected carrier. While the thalassaemias and haemoglobinopathies are more prevalent in particular ethnic groups and geographical areas, the mutations causing these conditions can be found in virtually every country because of genetic drift and ethnic melding over the centuries.

Australia has a particularly heterogeneous population with an increasingly diverse pattern of these conditions. A positive family history is clearly an indication for testing, but this detects only a limited number of carriers. Clinical experience at our hospital shows that testing on the basis of name, place of birth or religion is unreliable for

detecting carriers. Furthermore, reliance on red blood cell indices (MCH and MCV) as a screening process is inadequate. Haemoglobin electrophoresis is essential for the diagnosis of  $\beta$  thalassaemia minor and the haemoglobin variants of clinical significance, the latter being seen with increasing frequency due to recent immigration from Asia, Africa and the Middle East.

Comprehensive testing is advisable to provide optimal detection of couples at risk of having children with severe thalassaemia, so that they can be offered genetic counselling and prenatal diagnosis if appropriate. This means that, at the very least, all antenatal patients should be tested by full blood examination and haemoglobin electrophoresis (or HPLC), plus ferritin in the presence of microcytosis, as early in pregnancy as possible. Ideally, testing should occur in primary care before conception. Partner testing can then be pursued in accordance with the recommendations in the article.

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### Coeliac disease

Editor, – Recently you published articles on irritable bowel syndrome (Aust Prescr 2001;24:68-71) and oesophageal reflux (Aust Prescr 2001;24:110-2). Over the years, these diagnoses have been made by three gastroenterologists as a consequence

of my epigastric reflux and colonic pains. A fourth endoscopy has now found evidence of coeliac disease in a duodenal biopsy. Since going on a gluten-free diet I am gaining weight. (Over the years, despite having a healthy appetite, I was close to being almost anorexic in appearance and my mental and physical energy was below average.) Now the pains have disappeared and I am feeling and reacting in a more appropriate way. (Even my tennis has improved!)

I write to tell your readers that coeliac disease is the 'great imitator'. It was late in life (I am 80) that it was discovered. As a student I suggested to a general practitioner that I had a malabsorption syndrome but this was discounted. (Lesson: listen to the patient.) A pathologist tells me that the physiology of the whole gastrointestinal tract is disturbed in coeliac disease. Pains, dysfunction, aphthous ulcers and bowel disturbances are the result. I now hear of increasing numbers of patients like myself being diagnosed late in life, after their symptoms had been diagnosed as something else. One wonders how many patients have had surgery and/or medications when the correct management should have been a small bowel biopsy<sup>1</sup> followed by a gluten-free diet.

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### REFERENCE

1. Selby W. Gluten enteropathy. Aust Prescr 2001;24:38-40.

## Book review

**Abnormal laboratory results.**  
**R. Dunstan, editor. Sydney: McGraw-Hill; 2001.**  
**216 pages. Price \$32.95 + \$6.60 postage.**  
**20% discount for Australian Prescriber readers.**

*Daniel L. Worthley, Medical Resident, Royal Adelaide Hospital, Adelaide*

'Abnormal laboratory results' is an established series in *Australian Prescriber*. It provides medical practitioners with current information on the role and implications of commonly ordered tests. These invaluable articles have now been re-evaluated and skilfully edited into a concise compilation.

This conveniently sized manual addresses a deceptively broad range of laboratory tests. Topics include routinely ordered assays such as thyroid function and electrolytes as well as more specialised investigations for hepatitis B and C viruses, autoimmune diseases, and *Helicobacter pylori*. In addition, the first three chapters provide sound advice about general interpretation of abnormal laboratory results, giving perspective to the notion of 'normality'.

With regard to the relative merit of the articles I shall keep my opinions brief, as all have been previously scrutinized by a far greater arbiter, namely the *Australian Prescriber* readership. This pre-publication validation is a great strength of this compilation, and should reassure potential purchasers.

Some limitations include repetition of information, particularly in the chapters 'Plasma creatinine' and 'Creatinine clearance and the assessment of renal function'. I also found the synopsis, included at the start of many chapters, of little value. Some articles briefly outline therapy, under the heading 'What action is needed if the result is abnormal?' Given the limited space, this is achieved with varying success. For example, in the chapter about potassium there is no reference to the use of intravenous calcium salts, for cardio-protection, or to glucose and insulin therapy for hyperkalaemia. These minor issues are, perhaps, inherent to the book's construction.

This compilation is an excellent guide to understanding the increasingly complicated array of laboratory tests. It is readily digestible yet sufficiently detailed to prove useful to medical students, hospital clinicians, and general practitioners.