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contrary to Australian law, reflect the difficulty of ensuring the safety of overseas online pharmacies.

The Therapeutic Goods Administration also warns consumers to be cautious, and points to the risk of unexpected and potentially serious adverse reactions. Given the potential for health risks for the unwary, it is concerning that there are no regulatory reviews of pharmacy sites. There is therefore a need for ongoing education by authorities on the risks of online pharmacies.

Wherever possible it is preferable for consumers to obtain their prescription medicines at a traditional pharmacy, particularly when the prescription is for a new drug or for a serious condition. Even for over-the-counter products, it is wise to buy from a pharmacy to hear of any safety advice first-hand.

The reality is that, for an increasing number of people, given population ageing and the rise in chronic illness, online pharmacies will likely become an ever more favoured option. In Australia the online market is already dominated by well-known, presumably safe, Australian pharmacy chains.

The proliferation of online pharmacy prescription services, and now online medical consultation services, points to another dilemma that seems set to become more prevalent. That is, the growing number of remote health assessments made possible by internet and telehealth where the doctor, pharmacist or other practitioner is not seeing the patient in person. It seems that circumstances, including time and commercial pressures, are combining to make these virtual consultations ever more frequent.

The question for consumers and practitioners is how do we ensure that the overall result of the shift to virtual consultations and prescriptions will benefit our health? <

Letters to the Editor

Concerns about quetiapine

As a psychiatrist in private practice, I share some of the concerns about quetiapine raised by Jonathan Brett (Aust Prescr 2015;38:95-7). However, I think there is a significant role for off-label prescribing in certain patient groups. Patients with major depression, particularly those with agitation, high degrees of inner distress, or sleep difficulties often benefit substantially when quetiapine, usually 12.5–100 mg, is added to their antidepressant. The 25 mg tablet is most appropriate for this use.

If it is claimed that 'quetiapine has proven safety and efficacy when used for its approved indications', which usually entail 400–800 mg doses, I do not think further studies are needed to conclude a 25 mg dose will be safer than a 400–800 mg dose. As it is, undertreating a depressed patient's distress also carries significant risks. These risks are difficult to analyse as depressed patients who become suicidal usually get booted out of depression studies. As a result, there is a significant validity issue regarding the 'evidence' because patients who participate in depression studies differ from many of those who come through a psychiatrist's door. Indeed, those most at risk of suicide are the ones we tend to have the least evidence about to guide our management. The 'no evidence, so don't use it' mantra may well work against the welfare of many depressed patients. Evidence is a tool, not a god, and the flaws in the evidence need to be fully understood before 'evidence' is used to formulate management guidelines.

Another area concerns personality disorders, which are difficult to treat. Psychological treatment should be the mainstay, but many patients are not very psychologically minded, and psychological treatment doesn't always work, even among those who want to change. Yet patients with personality disorders often have high levels of distress. The 'no evidence, so don't use it' mantra may again work against patient welfare, compared to the judicious use of low-dose quetiapine for such patients when they are in crisis.

Thus, quetiapine has its problems, but off-label use remains an important tool in certain clinical situations.

Alan Garrity
Psychiatrist
Dee Why, NSW

I would like to comment, as a GP, on Jonathan Brett's very timely article. I have a sizeable geriatric population in my practice, of which a fair number with evolving or full-blown dementia are in institutions. This is the area in which quetiapine use is relevant. Quetiapine 6.25–100 mg per day is very

effective to calm patients down and help them to coexist with other institution residents or family members at home.

It goes without saying that anxiety, insomnia and depression are all looked for and treated first. Quetiapine (and other antipsychotics) are not used willy nilly. There is not much else to use and the ubiquitous benzodiazepines have a bad reputation. Risperidone at its recommended dose (by the Pharmaceutical Benefits Scheme – PBS) is often not effective enough for the agitated, noisy patient who needs to be controlled quickly. If the patient is over-sedated, family members complain and staff report hazardous falls. We respond accordingly.

Drugs used off label are written as private scripts, so PBS attempts to curtail quetiapine's use will not be effective. Non-pharmacological interventions always sound good, but for Australia's evolving institutions that have to grapple with the growing dementia population, these interventions are often disappointing in effect because qualified personnel to execute them are not easily available.

What we need are studies into quetiapine's role in these types of patients, not roadblocks against its use. If the researchers did it for risperidone, why not for quetiapine?

Peter Foenander
GP
Port Adelaide, SA

I was interested to read the June article by Jonathan Brett on the increase in prescribing of quetiapine, particularly at lower doses.

I am a GP who has contributed to those statistics due to the new phenomenon of telehealth. I work in a rural country town and have an interest in mental health and psychological medicine. I have participated in telehealth sessions with consultant psychiatrists by sitting in and providing support and follow-up. This has involved quite a lot of work with adolescents and young adults. As the GP at the consultation end of the interaction, I am providing the prescriptions recommended in the psychiatrist's management plan.

The phenomenon of telehealth therefore may interfere with the statistics and information about who is prescribing quetiapine. I wonder how many other GPs are prescribing quetiapine in this way. The prescriber number statistics may not be truly reflecting the basis of these decisions.

Bronwen Howson
GP
Allora, Qld

I read with interest the article about the increasing off-label use of quetiapine. Indeed it is often used for insomnia, for example, and this is my focus. In general practice I do not see it used with personality disorders, dementia, or substance abuse, and only rarely in post-traumatic stress disorder and anxiety. That is not to say that it may not be useful in these disorders in specialised hands, but may not be indicated as prime therapy. It is nonetheless unfortunate when a medicine is denied to an individual when it suits them well, simply on the basis of esoteric and inclusion-criteria-limited epidemiological studies. The dicta of evidence-based medicine do not always serve us well in this regard.

In his article, Jonathan Brett commented that there was poor evidence for quetiapine in insomnia. He quotes one recent literature review that found only two placebo-controlled trials and concluded that the absence of safety and efficacy data precludes the use of quetiapine for insomnia.[1] Another review he quoted was from a nursing journal.[2] It in fact identified five studies, and three randomised controlled trials. All but one of them suggested sleep benefit from quetiapine. Two further studies reported the weight gain associated with quetiapine. The review goes on to say clinicians should consider individual patient health profiles in light of the potential weight gain with long-term quetiapine therapy.

The ascription 'off-label' seems to indicate a pejorative connotation. I would dispute this. Clinical judgement should always govern prescribing. Medication is always prescribed on balance. If the concern is sleep versus weight gain, and this seems the only concern mentioned, the lack of sleep and its deleterious effects may well transcend the appearance of weight gain. Nonetheless there seems to be more evidence in favour of usage in insomnia than was quoted.

Chris Andrews
GP
Chapel Hill, Qld

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Jonathan Brett, author of the article, comments:

The mantra that no evidence of effect is not the same as evidence of no effect rings especially true for quetiapine in the era of evidence-

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based medicine. For this reason quetiapine along with the other atypical antipsychotics has been identified as a priority area for research to support off-label uses.[1] The difficulties in conducting this research are well described by Dr Garrity. Exclusion criteria may limit the generalisability of a study and often patients do not neatly fall into diagnostic criteria such as those found in DSM-5. This can leave prescribers in doubt about whether findings apply to their patients.

A further complicating issue is that the risk–benefit profile of prescribing quetiapine depends upon the context in which it is prescribed. For example, the use of quetiapine to treat behavioural and psychological symptoms of dementia appears to have a poor risk–benefit profile.[2] Prescribing must also be considered within the context of access to alternative (predominantly psychological) management strategies. If quetiapine is being prescribed in nursing homes because non-drug interventions are not available due to lack of qualified staff,[3] then the reasons for this (such as funding) should be identified and addressed rather than exposing older people to the gamut of risks that accompanies these medicines.

The nature of policy decisions to improve quality prescribing as raised by Dr Foenander is an important one. Any changes in policy should involve an understanding of the factors influencing prescribing decisions.[4] An example given here is that the patient is unwilling to engage in psychological therapies. Another explanation may be that people are unable to access psychological therapies. Qualitative research would help give insights into patient, prescriber and systemic incentives that play a role in quetiapine prescribing. Policy decisions should ideally readjust prescribing incentives based on an understanding of prescribing decisions and engage prescribers and patients in the process rather than be a top–down authoritarian measure.

The prescriber may not be the practitioner who has recommended the treatment as in the case with telehealth. This is an important point and often missed in the absence of more in-depth review.

Regarding the use of quetiapine to treat insomnia raised by Dr Andrews, the cited review[5] found only two randomised controlled trials including a total of 31 patients for the treatment of insomnia at baseline. The other trials identified did not include patients meeting these criteria. On balance, given the apparent magnitude of use for insomnia and proven metabolic adverse effects at low doses,[6] my impression is that this is a ripe area for more research.

When operating in the real world where off-label use is often necessary, my feeling is that prescribers should be aware of the risk–benefit profile for this indication in this patient, the evidence gaps and the treatment alternatives. Discussing these with the patient is imperative for an informed decision to be made by the patient. Where there is significant uncertainty this should be communicated, and close monitoring with defined treatment outcomes and a strategy of treatment withdrawal are important.[7,8] It is unclear whether this is current practice with quetiapine prescribing. Patient decision support tools may be a useful resource in this setting.[9] An example is the NPS MedicineWise Choosing Wisely campaign that provides guidance developed by prescriber and patient stakeholders on a range of practices (including antipsychotics) with the aim of opening a dialogue between prescribers and patients in these situations.[10]

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