of perindopril arginine. This is factually incorrect and the current product information does not explain the dosing conversion. We cannot be absolutely certain that the clinical trial would have had the same result if a different formulation had been used.

The regulatory events that have transpired appear to be in contrast to the intention of the Australian government to encourage greater use of generic medicines and to develop the generic drug industry in Australia. As the regulatory precedent has now been established, other companies with 'blockbuster' medicines reaching the end of their patent life may apply for the listing of an alternative formulation of their drug. The patents will soon expire on drugs such as amlodipine, atorvastatin and olanzapine.

When strategies are used to prolong the patent lifespan of 'blockbuster' drugs, prescribers should consider the rationale and trial evidence for minor variations before prescribing the 'new' drugs. It is difficult to give practical advice about how individual prescribers can respond to evergreening. One proposal is that prescribers discuss the issue with their patients and consider changing therapy to a different drug in the same class. This is a possible action in the context of an ACE inhibitor because the drugs in the class have similar therapeutic effects. Regulatory authorities need to respond to the strategies of drug patent evergreening to encourage competition. The general community also needs to be better informed of this practice. Our focus must remain on access to affordable drugs for all Australians rather than prolonging patents for profit.

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Further reading

New drugs from old. Drug Ther Bull 2006;44:73-7.

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.

Serotonin syndrome

Editor, – In the case report on serotonin syndrome precipitated by an over-the-counter cold remedy (Aust Prescr 2006;29:71), several mechanisms that may have caused this were proposed. I would like to add another contributing mechanism which relates to the patient taking methadone 70 mg daily. Although not a cytochrome P450 2D6 (CYP2D6) substrate, methadone is a potent CYP2D6 inhibitor.[1] It is possible that methadone is able to convert a CYP2D6 extensive metaboliser to a poor metaboliser. This process is known as phenocopying. There are very few data on methadone altering the pharmacokinetics of dextromethorphan in plasma. However, another CYP2D6 inhibitor, quinidine, can raise plasma dextromethorphan concentrations about 40-fold.[2] Hence, the combination of several drugs individually increasing the brain serotonin concentration and the likelihood of methadone increasing the dextromethorphan concentration may also have contributed in part to the patient developing serotonin syndrome.

Andrew Somogyi
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Assisting Aboriginal patients with medication management

Editor, – I agree with the letter from Dr Peter Lake regarding assisting Aboriginal patients with access to medicines (Aust Prescr 2006;29:59–60). I work in an Aboriginal Health Service in Port Augusta and we are often the first point of call of people coming down from Anungu Pitjantjatjara Lands. They often present with an empty dosette which is meant to be full of cardiovascular drugs. Sometimes there is no dosette at all. We then have to find, amongst other things, their Centrelink Health Care Card number before we can even think about prescribing.

They generally, and not surprisingly, have no idea as to the bureaucratic requirements of the Pharmaceutical Benefits Scheme. In the interests of compliance, our health service will pay for the drugs, provided they have their Health Care Card. We spend around $100 000 on this each year – none of which we receive funding for. Surely Section 100 should be attached to the patient and not to their address?

Jon Hunt
General practitioner
Pika Wiya Health Services
Port Augusta, SA

Managing painful paediatric procedures

Editor, – Further to the article 'Managing painful paediatric procedures' (Aust Prescr 2006;29:94–6), a recent Cochrane review[1] affirms what many breastfeeding mothers know instinctively: '…that neonates undergoing a single painful procedure should be provided either breastfeeding or supplemental breast milk for analgesia when available compared to positioning/pacifier/holding and swaddling. If it is not available/feasible to give breastfeeding or supplemental breast milk alternatives such as glucose or sucrose should be considered.'

Tricia Taylor
Pharmacist, Counsellor MotherSafe
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Editor, –The methods and techniques outlined in the article 'Managing painful paediatric procedures' (Aust Prescr 2006;29:94–6) were excellent and relevant and are used on an almost daily basis in mixed and paediatric emergency departments. However, I feel that the minimisation of pain arising from the procedure of intravenous cannulation was inadequately covered. Intravenous cannulation of ill and injured children and adolescents is common and is often required as an emergency procedure within minutes of the patient presenting.

The use of subcutaneous local anaesthetic has been shown to significantly decrease the pain of intravenous cannulation[1,2,3], while not decreasing the success rate of intravenous cannulation attempts.[4] In children less than 24 months of age, the success rate with subcutaneous local anaesthetic was 73% versus 77% without subcutaneous local anaesthetic ($p = 0.5$).[5]

After skin preparation, the skin overlying the target vessel is pulled laterally and a small volume (approximately 0.2 mL) of 1% lignocaine is injected into the subcutaneous tissue using an insulin syringe. After allowing the skin to return to its former position, the cannula is inserted.

I would urge clinicians to investigate the use of subcutaneous local anaesthetic for intravenous cannulation in both adult and paediatric patients and to incorporate the technique into their practice.

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Adjunct Professor John Murtagh, author of the article, comments:

I do agree with the use of subcutaneous local anaesthetic to minimise the pain of intravenous cannulation. However, space precluded me from devoting more time to the issue. The use of this method also applies to the common emergency procedure of an intravenous cutdown. A combination of topical anaesthesia and subcutaneous injection is optimal, but not always practical.