significant and appropriate reduction in these prescriptions. Prescription of psychotropic drugs fell from 59% to 48.5% while benzodiazepine prescriptions fell from 32% to 23%.

The Australian Pharmaceutical Advisory Council and the Pharmaceutical Health and Rational Use of Medicines Committee are government initiatives to encourage judicious, appropriate, safe and evidence-based drug prescribing. An independent body, the National Prescribing Service, is also beginning to work in this area[6] along with existing resources such as *Australian Prescriber*. The Department of Veterans' Affairs funds health reviews for veterans where the doctor or a consultant pharmacist carries out an annual medication review. The accreditation process for nursing homes under the new Aged Care Reform will also require review of medication use. All these initiatives are to be applauded and supported.

This year is the International Year of the Older Person. Now is the time to review what we have been doing in the past and aim for the best available care for our seniors. Their future is in our hands. Quality use of medicines will increase quality without reducing quantity of life!

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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.

Asthma treatments

Editor, - Professor Seale provides an informative and helpful account of the role of anti-leukotriene drugs in asthma (Aust Prescr 1999;22:58-60), contrasting with the somewhat irrational claims of their benefits in the lay press. It raises the issue of how to assess the benefits of asthma medication. A recent study[1] advocated use of inhaled budesonide to prevent asthma relapse following discharge from the emergency department. Improved outcomes were measured by reduced relapse (defined as unscheduled visits for worsening symptoms), improved scores on an Asthma Quality of Life Questionnaire, and improved symptom scores. However there were no differences between treatment groups in measures of peak expiratory flow rates. If there is no difference in measured respiratory function, what is the significance of the other outcome measures, and what is the optimum method to assess if a patient is helped by a new intervention? If a patient says they feel better, possibly from a placebo effect of a perceived 'wonder drug', should they be continued on a new and expensive medication if there is no other measure of improvement?

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Dr Helen Reddel, Research Scholar, Institute of Respiratory Medicine, Royal Prince Alfred Hospital and University of Sydney, comments:

Dr Smith raises an important issue about how we should assess response to asthma medications. As there is no 'gold standard' for asthma, we need to assess both subjective (symptoms, quality of life) and objective (lung function, airway responsiveness) aspects of asthma control. A marked discrepancy between the results for different outcome measures may be due to methodological problems, as seems likely in the quoted study.

The methodology for assessing relapse rate, symptoms and quality of life in this study appear to be valid, but there may be problems with the assessment of lung function. The study was designed to examine risk of asthma exacerbations, so the most appropriate lung function measure would have been peak expiratory flow performed on waking, as 'morning dipping' is associated with risk of asthma exacerbation. Lung function rises during the day even in poorly-controlled asthma, so spirometry measured at clinic visits (as in this study) would be less likely to show a difference between treatment groups. In addition, it is not clear from the paper whether lung function was measured in patients who experienced relapse and were therefore withdrawn before the 21 day assessment; if not, censoring of data from treatment 'failures' would significantly reduce the chance of observing a difference in lung function between the groups.

Dr Smith's comments about the 'placebo effect of a perceived "wonder drug" ' highlight the importance of assessing the value of a new medication from a series of well-designed randomised controlled trials rather than from anecdotal reports.

New drugs

Editor, - John Watson's professor of old, ('Letters' Aust Prescr 1999;22:77) used an important dictum about using new and old drugs, but he could not claim originality. I thought it was a paraphrase of a couplet in Polonius's advice to Laertes (Hamlet, by William Shakespeare) and my doctor brother Michael thought it was from Sir William Osler. The latter probably would have invented it if it had not been originally phrased by Pope, in his Essay on Criticism (lines 335-6):

'Be not the first by whom the new are tried
Nor yet the last to lay the old aside'.

David Grounds
Psychiatrist
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Sertraline and statins

Editor, - Two issues arise from Vol 22, No. 5. The article by John Tiller ' The new antidepressants - clinical applications' (Aust Prescr 1999;22:108-11) omits reference to sertraline as an agent approved for treatment of panic disorder. Panic disorder has been an approved indication for sertraline since December 1997.

In the article by Eve Hurley 'Assessing the statins' (Aust Prescr 1999;22:114-7) the self-test question 8, about primary prevention, correctly answered as 'true', could amount to less than the 'whole truth'. I suggest it would be more accurate to say that, based on studies reported to date, there is more evidence of benefit from statins in secondary prevention than there is in primary prevention (i.e. three trials versus one published to date). The statement offered is too absolute, and might get a pharmaceutical company into trouble with the Code of Conduct Committee if offered for promotional purposes.

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Managing subclinical hypothyroidism

In a patient with overt primary hypothyroidism, management is usually straightforward: treatment with thyroxine should be offered to anyone with characteristic clinical features, a raised serum thyroid stimulating hormone (TSH) concentration and a low serum thyroxine (T4) concentration. More difficult is the management of a patient with subclinical hypothyroidism, in whom serum TSH is raised but T4 level is normal, and who is either asymptomatic or has only non-specific symptoms. Left untreated, some of these patients will eventually develop overt hypothyroidism. Here we discuss the use of thyroxine in patients with subclinical hypothyroidism.

Background

What is subclinical hypothyroidism?

Patients are described as having subclinical hypothyroidism when their serum concentrations of T4 and triiodothyronine (T3) are normal, the serum TSH concentration is raised (i.e. above the typical reference range 0.5-5 mU/L) and they have no specific symptoms or signs of thyroid dysfunction. Many with these features will have had hyperthyroidism and developed hypothyroidism following treatment given to destroy the function of the overactive thyroid gland. Most, however, will be diagnosed after investigation of non-specific symptoms, such as tiredness or weight gain.

Prevalence

Spontaneous subclinical hypothyroidism is more common in women and the incidence increases with age and is associated with the presence of antithyroid antibodies. However, serum TSH concentrations do not increase as a direct result of ageing in women or men. In community surveys, around 10% of women over 55-60 years of age have been found to have a serum TSH concentration over 5 or 6 mU/L.[1-3] Although subclinical hypothyroidism can develop spontaneously, the condition is more common in patients who have been treated for hyperthyroidism with either iodine-131 or surgery, and in those with organ-specific autoimmune diseases such as pernicious anaemia, insulin-dependent diabetes mellitus or Addison's disease.

Natural history of subclinical hypothyroidism

In a community survey of 2779 patients in the U.K., in which patients were followed up after 20 years, women with subclinical hypothyroidism were more likely to develop overt hypothyroidism if they had antibodies to the enzyme microsomal thyroid peroxidase.[4] The annual rate of progression in women was 4.3% if TSH was above 6 mU/L and thyroid peroxidase antibodies were detected, 2.6% if the serum TSH concentration alone was raised, and 2.1% if antibodies were present but the serum TSH concentration was normal. Men were less commonly affected by subclinical hypothyroidism than women but more likely to experience disease progression.[4] The risk of developing hypothyroidism within 20 years increased with the initial serum TSH level: 1% where it was 2.5 mU/L (in antithyroid-antibody negative patients); 4% where it was 5.0 mU/L. Progression to overt hypothyroidism is also more common when the patient is over 60 years old[5] or when the serum TSH concentration is raised following iodine-131 therapy.[6]