References

1. Wetherell J, Richards L, Sambrook P, Townsend G. Management of acute dental pain: a practical approach for primary health care providers. Aust Prescr 2001;24:144-8.
2. Abbott PV. Dental first aid for the medical practitioner. Mod Med Aust 1989;32:43-50.
3. Hargreaves K, Abbott PV. Drugs for pain management in dentistry. Aust Dent J 2005;50(4 Suppl 2):S14-22.
4. Uluibau IC, Jaunay T, Goss AN. Severe odontogenic infections. Aust Dent J 2005;50(4 Suppl 2):S74-81.
5. Abbott PV. Selective and intelligent use of antibiotics in endodontics. Aust Endod J 2000;26:30-9.
6. Abbott PV, Hume WR, Pearman JW. Antibiotics and endodontics. Aust Dent J 1990;35:50-60.
7. Therapeutic Guidelines: Antibiotic. Version 13. Melbourne: Therapeutic Guidelines Limited; 2006. p. 167-72.

Further reading

Therapeutic Guidelines: Oral and dental. Version 1. Melbourne: Therapeutic Guidelines Limited; 2007.

Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 83)

7. Most dental pain is caused by tooth infection.
8. Most of the bacteria causing dental infections are resistant to penicillin.

Patient support organisation

The Australian Lung Foundation

The Australian Lung Foundation promotes understanding, management and relief of lung disease. It has over 100 patient support groups in metropolitan and regional areas of all the states and territories. For patients and carers the Foundation produces a range of fact sheets and illustrations, written in non-scientific language, about respiratory diseases and lung health. These fact sheets can be ordered or downloaded from the website, which also contains lists of pulmonary rehabilitation programs, internet support groups, links to further information, and materials for healthcare professionals.

Contacts

Phone 1800 654 301
Website www.lungnet.com.au
Email enquiries@lungnet.com.au

New drugs

Some of the views expressed in the following notes on newly approved products should be regarded as tentative, as there may have been little experience in Australia of their safety or efficacy. However, the Editorial Executive Committee believes that comments made in good faith at an early stage may still be of value. As a result of fuller experience, initial comments may need to be modified. The Committee is prepared to do this. Before new drugs are prescribed, the Committee believes it is important that full information is obtained either from the manufacturer's approved product information, a drug information centre or some other appropriate source.

Darunavir

Prezista (Janssen-Cilag)

300 mg tablet

Approved indication: HIV infection

Australian Medicines Handbook section 5.4.3

Darunavir is a new protease inhibitor that can be used in combination with other antiretroviral drugs to treat patients infected with HIV.[1] It works by selectively inhibiting the cleavage of viral polyproteins in infected cells, which prevents the formation of mature virus.

Darunavir is extensively metabolised by CYP3A. Ritonavir inhibits this enzyme and, when co-administered, increases the bioavailability of darunavir 14-fold. After an oral dose of 600 mg darunavir with 100 mg ritonavir, peak plasma concentrations are reached within 2.5–4 hours. The terminal half-life is around 15 hours and most of the drug is excreted in the faeces. This drug should be taken with ritonavir and food to increase its bioavailability.

The efficacy of darunavir (with ritonavir 100 mg) has been compared to other protease inhibitors in a phase II dose-finding trial. The 318 patients who were enrolled had previously been treated with antiretroviral drugs and many of them had HIV that was resistant to commercially available protease inhibitors. Before the patients were allocated to a treatment group, they were prescribed an optimised background regimen of two