

Letters to the Editor

Securing the supply chain

Editor, – Thank you for Elizabeth de Somer’s clear article explaining the complexities involved in the supply chain of medicines (Aust Prescr 2011;34:105-7).

From a prescriber’s perspective, we are well informed when a medicine is discontinued, but temporary lack of supply is rarely advertised. Too often, we find out when a patient returns with an unfilled script. Similarly when supply returns to normal, prescribers are often the last to know.

It would be helpful to have access to a list of unavailable items, including at least the more common drugs. With the almost universal use of electronic prescribing, a simple alert of a supply problem could easily be incorporated into prescribing software.

Could Medicines Australia perhaps facilitate this process with the relevant software developers?

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Elizabeth de Somer, author of the article, comments:

 Medicines Australia is the peak body representing manufacturers of prescription medicines that are involved in the research and development of new medicines (www.medicinesaustralia.com.au).

Unfortunately, Medicines Australia would not be able to facilitate building an alert system into prescribing or dispensing software. The manufacturer is also unable to control or monitor the stock levels held by individual pharmacies.

When a product is listed on the Pharmaceutical Benefits Scheme, supply is a condition of listing. Any advance knowledge of expected supply interruptions or shortages to PBS listed items will therefore be communicated to the Pharmaceutical Benefits Division of the Department of Health and Ageing, and the Therapeutic Goods Administration. Strategies for managing supply will be agreed, and these include sponsors alerting healthcare professionals to the issue and providing advice on any agreed management approach.

Prescribers may not be made aware of short-term supply chain difficulties occurring at the pharmacy. It is also likely that the manufacturer would be unaware of these types of stock outages. With 5000 community pharmacies across Australia, local

supply shortages can occur in individual pharmacies unrelated to any action by the manufacturer, and may be caused by wholesaler and pharmacy ordering, stock decisions or unexpected spikes in local demand.

The Australian Government is progressing the development of electronic health records management with the aim of maximising electronic data linkages.¹

The Pharmacy Guild of Australia is the national peak body for community pharmacy and liaises with governments and software providers to develop pharmacy tools that meet the needs of the community.²

The NPS recently conducted a review that identified the most important features of prescribing software that impact patient safety.³ This was supported by the Medical Software Industry Association.⁴

The impact of short-term stock outages related to individual pharmacy supplies may be a significant problem for prescribers to track and may require some consideration by these groups.

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Pharmaceutical excipients

Editor, – The authors of the article ‘Pharmaceutical excipients – where do we begin?’ (Aust Prescr 2011;34:112-4) make a very important point regarding the role of excipients in medications. Nowhere is this more relevant than in the treatment of epilepsy.

This concept has major ramifications for the use of generic drugs, but most recently we came across a series of patients who actually had significantly elevated blood concentrations of lamotrigine while remaining on the parent compound.¹ Our initial worry was that these patients had been changed to a generic, but review of medication excluded that. Nothing in the way of measurement of their concentrations had changed. The pharmaceutical company producing the parent compound confirmed



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that they had sourced their product from a different manufacturing site. Consequently, the only plausible interpretation of the altered concentrations is that the excipient was altered, resulting in patients having altered bioavailability and hence marked increases in lamotrigine concentrations. Some patients experienced considerable toxicity.

The role of the excipient should not be underestimated and there is good reason to follow blood concentrations, particularly of antiepileptic medications, in patients who may be swapped from parent compound to generic. However, even the parent compound may equate to the equivalent of a generic if sourced from a different manufacturing site with possible different excipient.

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Vinflunine

Editor, - It was with interest that we read your opinion on vinflunine in the new drugs section of *Australian Prescriber* (2011;34:122). It is important however to also provide the information which formed the basis of the positive assessment of vinflunine's benefit-risk balance by the Therapeutic Goods Administration (TGA).

Vinflunine is the only drug registered for the treatment of advanced or metastatic transitional cell carcinoma of the urothelial tract after failure of a platinum-containing regimen. It received marketing approval from the TGA in 2011 and the European Medicines Agency in 2009.

Vinflunine's benefit is described as modest in your article. The TGA's clinical evaluator assessed the benefit of vinflunine as significant and meaningful over a range of efficacy parameters: response rate, disease control rates, progression free survival and overall survival.¹ A statistically significant 2.6 month increase in overall survival observed in the eligible population, which most closely reflects the population intended for treatment (6.9 months versus 4.3 months in the control arm)², is clinically meaningful in a rapidly progressing disease and similar to that of docetaxel, the standard treatment in castration-resistant metastatic prostate cancer (+ 2.4 months).³

The TGA concluded that vinflunine's safety profile was well characterised, acceptable and manageable by appropriate dose modifications leading to a low rate of discontinuation and treatment-related deaths.¹ Further, that vinflunine is generally well tolerated by patients. The main dose limiting toxicity associated with vinflunine is neutropenia but, as pointed out by the TGA, neutropenia is a familiar adverse event that oncologists are used to managing by a variety of medical measures.¹ Your opinion of myelosuppression as being a considerable problem with vinflunine and describing vinflunine's adverse effects as severe is not a fair assessment of the adverse effect profile of this drug. Your concluding quote that 'it is better to focus on individually tailored palliative care' is taken from a single French drug bulletin⁴ as opposed to numerous peer-reviewed oncology journals which conclude the contrary.⁵⁻⁹ The conclusion of the TGA's clinical evaluator, that the vinflunine data support a positive benefit-risk balance for its approved indication in patients who have few available therapeutic options, is more reliable.¹

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