it at their own pace at home or they may have family members who can read it for them.

An often-voiced concern about CMI is that the information about the risk of harm does not indicate how frequently harm actually occurs and, as a result, consumers may be too scared to take their medication. The newer and better CMIs include such information. A good technique is to encourage consumers to come back with any queries they may have after reading the CMI. This then opens up opportunities to address any fears and correct any misunderstandings which may have prevented them taking the medicine.

CMI also does not contain information about how much a drug will cost. Failure to talk about costs may result in consumers not getting a prescription dispensed. If cost concerns are discussed there is then an opportunity to talk about cheaper options or the consequences of not going ahead with the treatment.

To make informed decisions about treatment consumers need comparative information about the pros and cons of the various options. CMI can help in this discussion to an extent, although an individual CMI only provides information about one particular medicine. It is also important that doctors explain when prescribing outside an approved indication, that the indication will not appear on the CMI, but information about adverse effects and interactions will still be relevant.

The internet is increasingly being used as a source of health information. In the USA up to 75% of internet users have used it to obtain health information and 41% of Americans say that material they found affected decisions about whether they should go to the doctor, how to treat an illness or how to question a doctor.[5] Australia may not be that different.

Doctors are right to be concerned about the quality of information available to consumers via the internet. Consumers may have difficulty distinguishing between good and poor quality information and independent versus promotional material. Doctors can play a key role in guiding consumers to good and reliable web sites relevant to Australian consumers. The Federal Government's health web site HealthInsite (www.healthinsite.gov.au) is a good starting point for health information that conforms to standards of quality and independence and is written for a consumer audience. The *Australian Prescriber* web site (www.australianprescriber.com) also has brief information for consumers on the topics of the main articles.

A new telephone medicine information service for consumers has just been set up by the National Prescribing Service. Staffed by pharmacists, Medicines Line operates Monday to Friday 9 a.m. to 6 p.m. AEST and offers an avenue through which consumers can get free reliable accurate information about their medication if they are unable, or unwilling, to ask their doctor or pharmacist. The Medicines Line number is 1300 888 763.

E-mail: sfogg@dot.net.au

REFERENCES
1. Coulter A. After Bristol: putting patients at the centre. Br Med J 2002;324:648-51.
2. National Health and Medical Research Council. General guidelines for medical practitioners on providing information to patients. Canberra: Australian Government Publishing Service; 1993. Currently being revised by the NHMRC.
   http://www.health.gov.au/nhmrc/
3. Australian Bureau of Statistics. Aspects of literacy: assessed skill levels, Australia, 1996. Catalogue No. 4228.0. Canberra: Australian Bureau of Statistics; 1996.
4. Lawrence A, Fogg S. 'In our country all medications had an instruction leaflet'. Older people from diverse linguistic and cultural backgrounds talk about Consumer Medicine Information and the quality use of medicines. Canberra: Australian Pensioners' and Superannuants' Federation; 1998.
5. Fox S, Rainie L. The online health care revolution: how the Web helps Americans take better care of themselves. Washington DC: The Pew Internet and American Life Project; 2000.
   http://www.pewinternet.org/reports/toc.asp?Report=26

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.

Can we afford intensive management of diabetes?

Editor, – The article 'Can we afford intensive management of diabetes?' (Aust Prescr 2002;25:102–3) presents an altogether different view of the management of diabetes. In developing countries the practicality of intensive control may be limited. The prevalence of type 2 diabetes mellitus is more than 11% in the urban population of India and is increasing.[1] In this context the interpretation of data from the United Kingdom Prospective Diabetes Study (UKPDS)[2] assumes great importance.

The authors correctly pointed out that six patients need to be treated intensively for blood pressure over 10 years to prevent one patient developing any complication.[3] However, the number needed to treat (NNT) to prevent one case of microvascular disease is **not** 196 patients treated for 10 years. From our calculations the NNT to prevent one microvascular complication is 42. The NNT is the reciprocal of absolute risk reduction, and the absolute risk reduction is the difference in the event rates between the control group (P_C) and the treatment group (P_T). In the UKPDS, the corresponding values for microvascular complications were 225 out of 2729 patients in the intensive treatment group ($P_T = 225/2729 = 0.082$) and 121 out of 1138 in the conventional treatment group ($P_C = 121/1138 = 0.106$). Absolute risk reduction ($P_C - P_T$) is therefore 0.024. This gives an NNT of 42 (1/0.024).

We agree that controlling blood pressure is more important for the prevention of complications, but the relative merits of intensive control of diabetes are greater than the article would make us believe. We also agree with the author that the UK results may not be generalisable to other countries, especially developing countries. The increased pressure on resources caused by an intensive approach would mean stretching the healthcare system to the limit and diverting resources away from other illnesses like infections and malnutrition that still remain number one killers in poor countries.

Samir Malhotra
Assistant Professor
P. Pandi
Professor and Head
Department of Pharmacology
Post Graduate Institute of Medical Education and Research
Chandigarh City
India

REFERENCES
1. Ramchandran A, Snehalatha C, Latha E, Vijay V, Viswanathan N. Rising prevalence of NIDDM in an urban population in India. Diabetologia 1997;40:232-7.
2. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). UK Prospective Diabetes Study. Lancet 1998;352:837-53.
3. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group. Br Med J 1998;317:703-13.

Ms B. Pekarsky, one of the authors of the article, comments:
We thank the authors for pointing out our error in the calculations. With regard to the generalisability of our conclusions, we agree that they are less relevant to the Indian situation, except to the extent that it is essential that the opportunity cost of an intervention that requires more intensive use of general practitioners' time is considered in the decision-making processes.

Top 10 drugs

These tables show the top 10 subsidised drugs in 2001-02. The tables do not include private prescriptions.

Table 1

Top 10 drugs by defined daily dose/thousand population/day*

Drug	PBS/RPBS [†]
1. atorvastatin	65.605
2. simvastatin	45.282
3. salbutamol	26.634
4. omeprazole	25.376
5. frusemide	23.768
6. ramipril	23.691
7. celecoxib	22.255
8. rofecoxib	20.667
9. irbesartan	19.179
10. amlodipine besylate	18.132

Table 2

Top 10 drugs by prescription counts

Drug	PBS/RPBS [†]
1. atorvastatin	5,512,101
2. simvastatin	5,138,175
3. paracetamol	4,850,202
4. omeprazole	4,160,725
5. celecoxib	3,850,345
6. salbutamol	3,591,854
7. codeine with paracetamol	2,931,715
8. ranitidine hydrochloride	2,882,721
9. atenolol	2,827,368
10. irbesartan	2,716,788

Table 3

Top 10 drugs by cost to government

Drug	PBS/RPBS [†] DDD/1000/day *	PBS/RPBS scripts	Cost to government ($A)
1. atorvastatin	65.605	5,512,101	287,876,894
2. simvastatin	45.282	5,138,175	286,570,094
3. omeprazole	25.376	4,160,725	192,954,689
4. olanzapine	3.151	634,682	132,686,315
5. salmeterol and fluticasone	0	1,948,027	121,027,026
6. celecoxib	22.255	3,850,345	110,969,962
7. pravastatin	12.981	1,757,528	97,574,529
8. insulin (human)	11.876	431,219	79,363,981
9. rofecoxib	20.667	2,549,886	76,327,930
10. pantoprazole	9.586	1,796,286	75,681,935

* The defined daily dose (DDD)/thousand population/day is a more useful measure of drug utilisation than prescription counts. It shows how many people, in every thousand Australians, are taking the standard dose of a drug every day.

† PBS Pharmaceutical Benefits Scheme, RPBS Repatriation Pharmaceutical Benefits Scheme

Source: Drug Utilisation Sub-Committee (DUSC): Drug Utilisation Database © Commonwealth of Australia