

**Vaccines used in the Schedule**

<i>Disease</i>	<i>Vaccine</i>
Hepatitis B	hepB
Diphtheria, Tetanus, Pertussis	DTPa
Diphtheria, Tetanus, Pertussis, Hepatitis B	DTPa-hepB
<i>Haemophilus Influenzae</i> type B	Hib (PRP-OMP)
<i>Haemophilus Influenzae</i> type B, Hepatitis B	Hib (PRP-OMP)-hepB
Poliomyelitis	OPV
Measles, Mumps, Rubella	MMR
Diphtheria, Tetanus	Td
Pneumococcal disease	Pneumococcal vaccine
Influenza	Influenza vaccine

**Transition from the old to the new schedule**

All babies born on or after 1 May 2000 should commence the new Australian Standard Vaccination Schedule. Because of

logistics, funding and vaccine interchangeability issues, all children born before this date should commence or continue with the previous schedule.

## 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.

**Antidepressants**

Editor, – I agree entirely with the sentiments of Dr O'Dempsey (Aust Prescr 2000;23:5) that newer drugs are rarely, if ever, measured against the performance of 'active' placebos. I think very few would pass muster if they were. In the case of any antidepressant, I would personally be very surprised if any performed better than pheniramine *p*-aminosalicylate. I would be amazed if any hormone replacement therapy performed better than spironolactone 100 mg second daily. I would be astounded if any antipsoriasis treatment compared favourably against miconazole and zinc nappy ointment. I would also personally be stupefied if any ear drop could compare with half strength Burow's solution.

Peter Rout  
General Practitioner  
Darlington, NSW

**Digoxin interactions**

Editor, – During December 1999, I witnessed a case that motivated me to read the article 'Digoxin in the 21st century' (Aust Prescr 1999;22:136–7) with accentuated attention. The case was a 56-year-old woman who had suffered from

schizophrenia six years ago and had since remained mentally balanced. She has been hypertensive for the past two years and was placed on medications. She had minor congestive heart failure last October (attributed to non-compliance with antihypertensive medications) and was admitted to a rural hospital. After rapid digitalisation she was placed on digoxin (0.125 mg/day) and hydralazine, but when the doctor started noting some neurological imbalance, chlorpromazine was added. On discharge, chlorpromazine and hydralazine were discontinued while digoxin was maintained. Sinypress (dihydroergotoxine 0.6 mg, reserpine 0.1 mg, hydrochlorothiazide 10 mg) was added. However, around the middle of December, she reverted back to a schizophrenic state, for which she is still being treated.

Does Dr Semsarian think that this bout of schizophrenia may have been precipitated by the adverse effects of digoxin ('digitalis delirium', confusion and hallucination) or to digoxin's common drug interactions, say, with the components of the combination antihypertensive drug?

Hypokalaemia induced by potassium-depleting diuretics is known to be the cause of adverse drug interactions between digoxin and such diuretics. The first self-test question

(p. 137) may mislead readers to assume that all diuretics can provoke digoxin toxicity. After all, potassium-sparing diuretics such as amiloride may even be beneficial in digoxin therapy.

S. V. Nwafor

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*Dr C. Semsarian, the author of 'Digoxin in the 21st century', comments:*

The issue of determining whether or not a patient's clinical status is due to a drug effect is an important one. Unfortunately, this is often difficult to resolve in the setting of a patient with multiple diseases, taking several medications. The case presented by Dr Nwafor is interesting and could possibly be due to digoxin toxicity. 'Digoxin delirium' is seen rarely now because of more diligent efforts in prescribing correct doses of digoxin for individual patients based on factors such as age, gender and renal function. Furthermore, regular measurements of serum digoxin levels have become routine. The patient mentioned in Dr Nwafor's letter is taking a product containing two drugs, reserpine and hydrochlorothiazide, both of which can increase digoxin toxicity by lowering serum concentrations of potassium. We have no information on the patient's renal function, therefore the patient should have had an assessment of renal function, and their serum potassium and digoxin concentration measured. If all of these are normal, then it is less likely that digoxin is the cause of this patient's symptoms. If the combination product is to be continued, regular serum potassium measurements are recommended.

The second issue regarding the interaction of digoxin with diuretics is a common issue in clinical practice. Dr Nwafor seems unaware that **both** potassium-depleting (e.g. thiazides and frusemide) **and** potassium-sparing diuretics (e.g. spironolactone, which increases digoxin levels by prolonging its half-life) can result in altered digoxin levels. This is clearly shown in Table 3 of my article and the first self-test question aims to reflect this fact. Not **all** potassium-sparing diuretics, however, interact with digoxin.

### Conquering chemotherapy

Editor, – Notwithstanding your desire to provoke correspondence, your potboiling editorial on chemotherapy (Aust Prescr 2000;23:5) has missed the point. The palliative management of advanced cancers is extremely difficult and what you are criticising is not chemotherapy, but lousy judgement. Most treatments for cancer, including I am afraid the immunotherapy which you favour, have a low therapeutic ratio. Judgement can be enhanced by training and education programs, such as those provided by the Medical Oncology Group of the College of Physicians and the Faculty of Radiation Oncology. We should also not forget that 'merely

delaying the inevitable', albeit with unpleasant adverse effects, may be exactly what the patient wishes. The care of patients with advanced cancers must be individualised.

Roger Allison

Radiation Oncologist  
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Editor, – We would like to reply to your editorial 'Conquering chemotherapy' (Aust Prescr 2000;23:5). Although you acknowledge that chemotherapy can cure certain cancers, we believe that your references to chemotherapy in the palliative situation require comment. It is true that chemotherapy, like most drug treatment, has the potential for adverse effects. Most readers would be aware that the decision to proceed with chemotherapy in the incurable patient should follow careful, realistic consideration of the odds of palliating cancer symptoms and the impact of chemotherapy on the quantity and most importantly the **quality** of life. Modern phase II and III studies of chemotherapy in palliative settings now include quality of life measurements as major end points. This is in contrast to the image portrayed in the editorial in which 'patients are poisoned to the edge of their existence'. The use of growth factors such as G-CSF has developed and is approved under Section 100 of the Pharmaceutical Benefits Scheme for treatment given with **curative** intent in malignancies such as lymphoma and adjuvant breast therapy where there is strong evidence to support the need to maintain dose intensity. Caring for cancer patients on a daily basis, we look forward to the development of new cancer therapies such as immunotherapy. Until there is sound evidence to support its routine use, however, chemotherapy will remain the major thrust of treatment of many cancers into the 21st century. We believe that the judicious use of chemotherapy should be considered in the context of the large body of evidence, including quality of life data, which reveals its worth.

Keith Horwood

Medical Oncologist

David Wyld

Director of Medical Oncology

Royal Brisbane Hospital

Herston, Qld.

*Dr J.S. Dowden, Editor, and the author of 'Conquering chemotherapy', comments:*

Predicting the future is not easy. I hope that in that future we will be able to offer effective, well-tolerated treatments to patients with advanced cancer. The critical comments of the Queensland oncologists clearly reflect treatment in the dying days of the 20th century. Will chemotherapy still be as important at the end of this century? I am sure that all oncologists look forward to a time when patients will not suffer from severe toxicity or from 'lousy judgement'.