proportion of prescriptions dispensed on the PBS had declined relative to the number of prescriptions written by general practitioners.

Compared to 2010 the percentage change in concessional prescriptions was consistent with a reduced rate of dispensing from about August 2011. The change in concessional dispensing was also apparent with other antihypertensives. This suggests that concessional copayments may have been too high and fewer patients reached the safety net threshold. (Patients had to pay an extra $12 to reach the concessional safety net in 2011).

Even though the PBS has reduced the price of many commonly prescribed medicines, the cost to concessional patients did not change, because their copayment remains the same. In contrast, general patients derived significant savings from the lower prices, but only if their drugs were priced under the general copayment.

The current fixed copayment system has been around for more than 25 years and with all the PBS reforms taking place, it may be time to take a closer look at patient copayments. The current approach to PBS savings is that the government takes most of the cost savings, but increases copayments and safety net thresholds each year in line with inflation. Increasing copayments reduces medication adherance and ultimately may compromise the care of some patients.

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Letters to the Editor

Error in compounding imiquimod 0.1% cream for molluscum

Editor, – Imiquimod 5% cream (Aldara) is available in single use 250 mg sachets for genital warts and basal cell carcinoma. For some years, doctors have been prescribing imiquimod 'off-label' for the treatment of molluscum contagiosum in children. Because of the cost ($150–200 for 12 sachets) it is usually prescribed as compounded imiquimod 0.1% cream. To make this, one sachet of imiquimod 5% cream can be diluted 50-fold to 12.5 g of 0.1% cream.

I have seen four children who had been prescribed imiquimod 0.1% which was compounded incorrectly by three separate pharmacies. Each pharmacist had incorrectly assumed that the label '250 mg' on the packaging refers to the quantity of the active ingredient – imiquimod – in the sachet. In fact, it refers to the quantity of 5% cream.

As each dispensed jar of cream is labelled 'imiquimod 0.1%', clinicians need a high index of suspicion to detect this error. They will need to confirm with the patient how much cream was given and what it cost. For example, if a patient received a 250 g jar of '0.1% cream' for $49.95 (as in one of my cases), it is clear an error has been made as this would otherwise contain several hundred dollars worth of imiquimod.

Some months after it began being routinely used for molluscum treatment in Melbourne, imiquimod 0.1% was described to me as 'working well' and 'effective' in many children. To my knowledge, all those children had received their compounded cream from one pharmacy and the dilution was incorrect. As such they had only received imiquimod 0.005%, a 1 in 1000 dilution of the commercially available product. It is unlikely that this was effective and illustrates the difficulty of assessing treatments for molluscum. Molluscum lesions often flare (and hence present to the doctor) shortly before complete resolution so that clearing

The Editorial Executive Committee welcomes letters, which should be less than 250 words. Before a decision to publish is made, letters which refer to a published article may be sent to the author for a response. Any letter may be sent to an expert for comment. Letters are usually published together with their responses or comments in the same issue. The Committee screens out discourteous, inaccurate or libellous statements and sub-edits letters before publication. The Committee's decision on publication is final.

LETTERS

after presentation is common whatever treatment is used.

Rod Phillips
Paediatric skin specialist
Royal Children's Hospital
Melbourne

Opioids and constipation

Editor, – I refer to the article by Dr McDonough (Aust Prescr 2012;35:20-4). I was interested to see in Table 1 that he recommends non-osmotic laxatives to treat chronic constipation and I wondered why this recommendation is made.

Barry Werth
Faculty of Pharmacy
The University of Sydney

Michael McDonough, author of the article, comments:

Thank you for this important question concerning constipation. The recommendation pertains to chronic opioid-related constipation, which is often difficult to manage because of opioid-induced hypomotility. While the use of stimulant laxatives has been suggested,1 the possibility of longer-term adverse consequences (for example melanosis coli) probably should limit their use, if not exclude them. Regarding the use of bulking agents and osmotic and non-osmotic products, there appears to be limited evidence supporting which is the safest and most effective for long-term use.2 However in my clinical experience, osmotic products can cause problems – for example dehydration and electrolyte disturbance. Many patients experience occasional nausea and vomiting, and are often taking multiple medications.

I therefore recommend the strategy of least risk, that is fluids, bulking agents and non-osmotic products like stool softeners in conjunction with diet, exercise and bowel hygiene counselling. If such management fails, referral to a specialist should be considered. That process may include a review of why such commonly recommended management has apparently failed and then starting a trial of osmotic products with ongoing monitoring of safety and efficacy.

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Antivenom

Editor, – Your article on antivenom (Aust Prescr 2012;35:152-5) updates all physicians working in emergency departments in areas where envenomation cases are likely to be treated.

Most antivenoms have been removed from our rural emergency room. Given your wide readership, it would perhaps have been beneficial for smaller centres, which now have no antivenom, if the article had mentioned the change in policy on treatment, transport and stabilisation of patients in isolated, non-resourced centres.

Martes Alison
General practitioner
Trundle, NSW

Nick Buckley and Ian Whyte, the authors of the article, comment:

Management of snakebite in remote areas, particularly those without 24-hour laboratory facilities, presents many challenges. Point-of-care tests (for example iSTAT INR and d-dimer) do not substitute for laboratory studies and should not be used under any circumstances. The '20 minute whole blood clotting test' may detect coagulopathy, but requires small clean glass tubes. Even if these are available, in practice the test often will not detect envenomation. Most patients with suspected or confirmed snakebite should therefore be transferred to a larger hospital (with a pressure bandage on the bite and immobilisation) for diagnosis and monitoring.

Most remote hospitals will still be recommended to keep a minimal stock of antivenom. For symptomatic patients, a decision may be made to administer antivenom before or during transfer without laboratory confirmation. Weak evidence suggests early antivenom may reduce the incidence of some complications such as myotoxicity, but at the cost of potential adverse effects from the antivenom (if the patient is not envenomed). This should only be done if the doctor is prepared to treat anaphylaxis.

The NSW Health's snakebite guidelines recommend stocking of antivenom in Trundle (and the NSW Therapeutic Advisory Group lifesaving drugs register recommends that it is available). It is concerning if it is not, for it follows there is no current quick and reliable means of determining where the nearest hospital is with antivenom stocks.

This is another example of the urgent need for a national policy on stocking antidotes and a regularly audited antidote register with a search tool to locate them in an emergency.