World Health Organization data base for spontaneous reporting of adverse drug reactions. Pharmacotherapy 1997;17:348-52.
2. Roxanas M, Hibbert E, Field M. Venlafaxine hyponatraemia: incidence, mechanism and management. Aust N Z J Psychiatry 2007;41:411-8.
3. Fabian TJ, Amico JA, Kroboth PD, Mulsant BH, Corey SE, Begley AE, et al. Paroxetine-induced hyponatremia in older adults: a 12-week prospective study. Arch Intern Med 2004;164:327-32.
4. Marar IE, Amico JA. Vasopressin, oxytocin, corticotrophin-releasing factor, and sodium reponses during fluoxetine administration in the rat. Endocrine 1998;8:13-8.
5. Anderson IK, Martin GR, Ramage AG. Central administration of 5-HT activates 5-HT1A receptors to cause sympathoexcitation and 5-HT2/5-HT1C receptors to release vasopressin in anaesthetized rats. Br J Pharmacol 1992;107:1020-8.
6. Strachan J, Shepherd J. Hyponatraemia associated with the use of selective serotonin re-uptake inhibitors. Aust N Z J Psychiatry 1998;32:295-8.

Dr G Shannon, author of the article, comments:

I thank Dr Roxanas for his comments. My article specifically looked at the recognition and management of severe hyponatraemia, rather than the milder forms. In severe hyponatraemia, particularly if the patient is symptomatic, I think stopping of any medications known to be associated with hyponatraemia (e.g. selective serotonin reuptake inhibitors) is an essential part of the emergency management of this life-threatening condition. Consultation with the patient's psychiatric team about ongoing management of their psychiatric condition is important in the management plan.

In an asymptomatic patient with non-severe hyponatraemia, the possibility of continuing their selective serotonin reuptake inhibitor would depend on the availability of close monitoring and perceived compliance with fluid restriction, and should only be considered in consultation with the treating psychiatrist.

Book review

Therapeutic Guidelines: Rheumatology Version 2 (2010)

***Casey Maddren**, Academic general practice registrar, Department of General Practice, The University of Sydney, Westmead Hospital, Sydney*

When looking at a resource my first question is, do I need this? The title Therapeutic Guidelines: Rheumatology is music to my ears, a guidebook for often difficult to manage, chronic complaints.

The guidelines have undergone rigorous assessment and reassessment with feedback from practitioners to editors. The results of this 'closing the loop' are obvious in the text.

This edition has multiple new features. These are summarised in the electronic Therapeutic Guidelines (eTG) and as an insert in the book format. All these additions are clinically relevant.

I foresee this guide will be immensely useful within my own practice with potential application as a reference guide for diagnostic dilemmas, patient information handouts, red flags and drugs in pregnancy (including for men planning to conceive with their partner). Of particular note are clinical boxes throughout the text which provide an easily accessible guide to interpretation of results, comparison of presentation of arthropathies, doses of injectable steroid, joint aspiration and other common situations when a quick answer is needed. The electronic contents page improves accessibility.

A strength of the text is its holistic approach, reflecting the needs of general practice and including nonpharmacological methods, exercises (with pdf files for printing from eTG) and recommendations for ongoing monitoring of disease. Not only does the guide provide the means but also the evidence that this approach benefits patients.

Sound rheumatological management hinges on the doctor–patient relationship, with an emphasis on clear understandable information being provided by the practitioner. This text is succinct and comprehensible, enabling its use as a resource for such discussions.

Overall, Therapeutic Guidelines: Rheumatology is a useful resource for practitioners, students and allied health professionals.