guidance and support about the selection process and about any significant health problems, directly or indirectly, which could result from the use of largely unproven remedies.

Expansion of the role of pharmacists in primary health care should be more than just assistance with the selection of complementary and over-the-counter medicines. Pharmacists should contribute in a more meaningful way as part of a team approach to health care so that referral to other members of the team, particularly general practitioners, is a key part of the process. Expansion of this 'triage' role is more likely to be limited by time and space constraints, and by perceived lack of adequate remuneration,[3] rather than by a need to develop a new role, because pharmacists are already providing millions of health-related consultations each year.[4]

In reality, payment for professional services other than the preparation and dispensing of pharmaceutical products will remain an unfulfilled goal until pharmacists unequivocally demonstrate they can contribute significantly to primary health care. At present they are 'off the radar' in this respect, largely because much of what is done is not recorded. In addition, there are few formal referrals of consumers to other healthcare providers, and there is seldom follow-up of the advice given by pharmacists.[5]

Community pharmacies are on the one hand small businesses and on the other are providers of a range of professional health services. While there is room for improvement, recognition and remuneration for their professional health services, the current arrangements have been successful in placing, at no cost to government, competent and respected healthcare professionals in the main streets of almost every suburb, town and city across Australia.

Nevertheless, the time has surely come for community pharmacists to decide once and for all if they are to embrace the changes necessary to improve substantially the 'non-prescription' services they offer. This would provide consumers with access to highly identifiable and accessible front-line healthcare professionals who are well equipped to decide if treatment or referral is necessary. Not to embrace the relatively straightforward changes which are necessary will mean that the tag given to community pharmacists by some commentators[6] as being the most over-qualified and underutilised of Australia's healthcare professionals will remain.

References

1. Pharmaceutical Society of Australia. National competency standards framework for pharmacists in Australia. 2010. www.psa.org.au/site.php?id=6782 [cited 2011 Mar 8]
2. Dooley M, Braun LA, Poole S, Bailey M, Spitzer O, Tiralongo E, et al. Pharmacy Guild of Australia. Investigating the integration of complementary medicines in community pharmacy practice: full final report. 2010. www.guild.org.au/research/4cpa_project_display.asp?id=1860 [cited 2011 Mar 8]
3. Chen F, Emmerton L. Pharmacists' experiences in the provision of screening and monitoring services. Aust Pharm 2007;26:250-3.
4. Berbatis CG, Sunderland VB, Joyce A, Bulsara M, Mills C. Enhanced pharmacy services, barriers and facilitators in Australia's community pharmacies: Australia's National Pharmacy Database Project. Int J Pharm Pract 2007;15:185-91.
5. Chapman CB, Marriott JL, van den Bosch D. The nature, extent and impact of triage provided by community pharmacy in Victoria. Pharmacy Guild of Australia. 2010. www.guild.org.au/research/4cpa_project_display.asp?id=1856 [cited 2011 Mar 8]
6. Menadue J. Extending the role of pharmacists: how to get the right balance between the business and the professional model [conference presentation]. Centre for Policy Development. 2009. http://cpd.org.au/2009/10/extending-the-role-of-pharmacists [cited 2011 Mar 8]

Conflict of interest: none declared

Letters

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 Editorial Executive Committee screens out discourteous, inaccurate or libellous statements and sub-edits letters before publication. The Committee's decision on publication is final.

Safe use of radiographic contrast media

Editor, – I would like to commend Kenneth Thomson and Dinesh Varma for their succinct discussion of the safety profile of iodinated radiographic contrast media (Aust Prescr 2010;33:19-22).

However a noticeable absence in the article is the discussion of oral contrast – particularly the increasing use of injectable iodinated radiographic contrast media as oral contrast (after dilution) for abdominal CT.

One of the issues related to iodinated media like iohexol or diatrizoate sodium is the alleged cumulative nephrotoxicity of these media when given orally in addition to the intravenous dose. This perception appears to be in error. From what I can tell, iohexol is poorly absorbed in the intact gastrointestinal tract and about 1% of the dose is excreted by the kidney. There is however a theoretical potential to cause renal dysfunction in a dehydrated patient as the hypertonic oral

iodinated media can cause excessive excretion of water into the gastrointestinal lumen, precipitating a body fluid loss into the third space.

I would appreciate it if the authors can comment on this as the use of oral iodinated media is becoming more common in Australia, replacing the cheaper but less palatable barium meal.

Shyan Goh
Locum orthopaedic registrar
Sydney, NSW

Dr Dinesh Varma, author of the article, comments:

We did not include oral contrast media mainly because the adverse effects and complications are extremely rare, as are the contraindications.

The most commonly used oral contrast media are barium sulfate-based agents or water soluble iodinated contrast agents. The use of injectable iodinated contrast media as oral contrast agent is extremely rare and if alternative contrast media are required for CT examinations, water is more commonly used as negative oral contrast media. Some centres have replaced positive oral contrast media with water in their CT abdomen protocols.

Some of the recognised adverse effects of iodine-based oral contrast agents are a mild laxative effect attributable to high osmolarity of diatrizoate meglumine and diatrizoate sodium. This can also result in dehydration with shift of fluid in the third space as you have mentioned. We also agree with your comments that renal impairment is usually a secondary effect of this phenomenon as these agents are sparingly absorbed from an intact gastrointestinal tract.

Other rare complications include aspiration, which may result in serious pulmonary complications. Anaphylactic reactions have also been reported.

Gentamicin: a great way to start

Editor, – The editorial by Robert Moulds and Melanie Jeyasingham (Aust Prescr 2010;33:134-5) states that 'For ongoing directed gentamicin therapy, other monitoring recommendations remain unchanged'.

Could the authors kindly clarify this statement, that is, what other recommendations remain unchanged, and unchanged compared to what?

Grace Abdini
Senior clinical pharmacist
Pharmacy department
Mount Druitt Hospital, NSW

Melanie Jeyasingham, an author of the article, comments:

Apart from plasma concentration monitoring, other monitoring recommendations for ongoing use of gentamicin remain unchanged from the previous recommendations in Therapeutic Guidelines: Antibiotic, version 13 (2006). This includes recommendations to monitor serum creatinine and calculate creatinine clearance two or three times each week, or more frequently if renal function is very unstable. Patients should be regularly asked about any hearing or balance problems and told to report immediately if they occur. For prolonged aminoglycoside courses (more than 5 days), formal vestibular function testing and high-frequency audiometric testing should be considered if available.

Bisphosphonates

Editor, – I read the letter by JF Walsh on bisphosphonates and osteonecrosis with interest (Aust Prescr 2010;33:167-70). Surely it is up to the treating clinician (for example the dental practitioner) to establish which medication a patient is on and assess their relative risks. Patients get overwhelmed with the list of potential side effects we inform them of. They quite rightly remember the common ones. A good drug history takes no time at all and dental practitioners should have this basic skill.

Andy Ryan
General practitioner
Seaford, SA

Collaboration between doctors and pharmacists in the community

Editor, – In her recent article (Aust Prescr 2010;33:191-3) Ms Rigby provides a timely, succinct analysis of the issues confronting the medical and pharmacy professions striving for better medication management in an era of increasingly complex health care. The necessity for a team approach in this environment is obvious. The challenge is defining relationships and boundaries for each of these health professionals and the patient. Trust is the touchstone upon which effective primary care operates. Any system promoting collaboration develops trust, not only with patients but between health professionals.

The Home Medicines Review system is challenged by administrative issues and poor reimbursement for quality reports. Current business rules restrict access. Where patients have no relationship with a pharmacy, the system breaks down, placing a barrier between general practitioner and accredited pharmacist. The referral process also takes no account of the skills and expertise of an accredited pharmacist (for example palliative care, geriatrics, de-prescribing, post-discharge and cultural issues).

In the face of an ageing population and overburdened hospitals discharging patients early, accredited pharmacists could develop expertise in areas where there are gaps in medication management. Allowing direct referral from general practitioners and giving consideration to co-location of pharmacists within a general practice will allow the growth

and development of this role for pharmacists. Any system is only as good as the people who participate in it. Trust and collaboration can only be achieved through patience, time and understanding while, above all, maintaining the interests of the patient.

Pradeep Jayasuriya
General practitioner
Cloverdale, WA

Deirdre Criddle
Consultant pharmacist
Dianella, WA

Debbie Rigby, author of the article, comments:

Thank you for your insightful comments and I agree that trust and confidence in pharmacists' clinical skills and knowledge is the key to collaborative patient-centred care. In July last year the Pharmacy Guild foreshadowed changes to the Home Medicines Review (HMR) model, including a direct referral model and post-discharge HMRs initiated by hospitals for high-risk patients. Direct referral to accredited pharmacists will provide greater flexibility to the HMR model and foster closer collaboration between general practitioners and pharmacists. This will be a welcome change to many general practitioners and accredited pharmacists. These proposed changes should not replace the existing HMR model which we know has produced many positive outcomes and satisfaction for patients. Ideally the direct referral model should always include the patient's preferred community pharmacy in the communication loop. This is especially important for hospital post-discharge medication reviews where medication reconciliation is a critical component.

For pharmacists to transition from the traditional role of dispenser to patient-centred practitioner, the culture of the pharmacy profession needs to move from a 'one size fits all' paradigm to allow role expansion for advanced practitioners in a collaborative environment.

Managing menopausal symptoms

Editor, – The article 'Managing menopausal symptoms' (Aust Prescr 2010;33:171-5) states that transdermal progesterone cream is minimally absorbed through the skin and there is no good evidence for its usefulness in relieving flushes, or in improving mood, libido or lipid profile.

Transdermal progesterone is poorly absorbed, which may explain the poor results obtained. However, if used transvaginally or rectally, absorption is much better.[1]

Progesterone does not relieve flushes. It is oestrogen which relieves flushes. However, it is an inhibitor of monoamine oxidase,[2,3] so it may well improve mood if absorbed in adequate quantities. It also remodels bone,[4] thus it is useful in counteracting osteoporosis. It has none of the adverse effects of synthetic progestogens, and I found it useful in patients with endometriosis who could not tolerate the synthetic progestins because of weight gain and irritability. Progesterone reversed these adverse effects.

The actions of the synthetic progestogens, apart from the effect on the uterine lining, are different from those of progesterone. Synthetic gestagens have been shown, in fact, to lower the body's production of progesterone.[5]

Iain Esslemont
General practitioner
Margaret River, WA

References

1. Dalton M, Ambrose CI, Balmer B, Bromham D. Individual variation in absorption of natural progesterone administered by different routes. Br J Fam Plann 1994;19(Suppl):2-3.
2. Lin YC, Kono H, Zuspan FP, Lee A, Yajima A. Progesterone as an inhibitor of monoamine oxidase. Br J Fam Plann 1994;19(Suppl):6-8.
3. Kono H, Lin YC, Yamaguchi M, Zuspan FP, Furuhashi N, Takayama K, et al. Effects of progesterone and gossypol on monoamine activity in human term placental explants. J Exp Med 1991;163:39-45.
4. Prior JC, Vigna YM, Kennedy SM. Progesterone's role in bone remodeling. Br J Fam Plann 1994;19(Suppl):13-17.
5. Johansson EDB. Depression of the progesterone levels in plasma in women treated with synthetic gestagens after ovulation. Acta Endocrinol 1971;68:779-92.

Dr Terri Foran, author of the article, comments:

I would like to thank Dr Esslemont for his comments regarding the use of topical natural progesterone for the management of menopausal symptoms. I appreciate that many clinicians and their patients attest to its effectiveness in relieving a range of menopausal and premenstrual symptoms. I stand by my comments however that no large well-designed clinical trials have demonstrated these benefits to date. The small trials that do exist have used different doses, regimens and delivery systems and the results have been extremely variable. I must also admit to some personal concerns as to the quality assurance that governs the manufacturing processes of some of the constituents used in these products.

I am prepared to be convinced by good quality medical evidence that topical natural progesterone cream has a useful role to play in the treatment of menopausal symptoms. I would certainly encourage the manufacturers of these products to undertake such trials. Until that time however I feel it is difficult to recommend natural progesterone, whether transdermal, vaginal or rectal, as an effective therapy in menopausal women.