For example, in the SUPPORT Study some patients with heart failure had been predicted to have a greater than 50% chance of surviving six months, but died just three days later.[4]

Not knowing how long the patient will live creates a situation of uncertainty that can, in theory, 'paralyse' doctors, potentially preventing them from implementing palliative care.[1] In all probability there is no solution to such 'treatment paralysis' without specific, professional guidelines and an increase in consumer expectations to prompt appropriate end-of-life care.

Palliative care represents holistic management that has moved beyond medical cure. It focuses on the physical, psychological, social and spiritual problems of the patient at the end of their life.[2] In simple terms, it equates to providing a good quality end to life by whatever means possible.[1] This includes enabling people to put their affairs in order and to prepare for the future.

Although palliation has historically focused on terminal malignancy, most people who are physically deteriorating and approaching the end of life experience similar problems. Four main issues are common to all patients who are expected to live less than 12 months:

- deficits in basic self-care
- emotional distress
- pain and chronic symptoms
- malnutrition.[5]

In COPD and heart failure, persistent dyspnoea, with associated limitations on all activities of daily living, is particularly distressing. Dealing with such problems requires a multidisciplinary approach combined with the core palliative care values of open and sensitive communication, a whole patient and carer approach, attention to symptom control and therapeutic dialogue.

Although it is clear we are responding inadequately to an increasingly important issue seen in clinics and wards all over the developed world, we are currently witnessing a shift in our thinking about extending palliative care to non-malignant, terminal disease. Applying palliation on the basis of 'need' rather than 'diagnosis' raises a number of difficult issues for clinicians and their patients alike. However, the potential benefits of palliative care can ensure a quality end of life for more individuals, and should not be denied on the basis of being too hard.

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Professor Stewart holds the National Heart Foundation/ Roche Chair of Cardiovascular Nursing.

Self-test questions

The following statements are either true or false (answers on page 119)

1. Patients with chronic obstructive pulmonary disease may have a poorer quality of life than patients with lung cancer.
2. Predicting the duration of survival is harder to do for patients with congestive heart failure than for patients with lung cancer.

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.

Hypertension: how low to go?

Editor, – Articles which challenge accepted orthodoxy are usually good reading, and Suzanne Hill's article on hypertension (Aust Prescr 2003;26:53-5) is no exception. A number of interesting points emerge from her critique of the HOT study.

I take it that Table 1 deals with the whole population studied, including the 20% who were no longer using felodipine by the end of the study. The reason for cessation was not given in the study, but if it was due to adverse effects (few people enjoy having swollen legs) the results do not flatter felodipine as a first-choice drug.

Although the risk reductions shown in Table 1 all fail to reach statistical significance, seven out of nine favour the target groups with higher diastolic blood pressure. It is very hard indeed to see how they can be interpreted as showing 'the benefits of lowering the diastolic blood pressure down to 82.6 mmHg'. Dr Hill rightly rejects that conclusion.

Perhaps the study can be classified with the many which assess the effect of a single treatment regimen on a single selection of end-points (or surrogate end-points). The authors of such studies seem to forget that it is possible to die of something other than the disorder they are investigating. Indeed, the more proficient we become at preventing death

from the big killers, the more of us will be left to die of something more painful, prolonged and expensive, such as cancer or dementia. Dr Hill rightly remarks that we should discuss quality issues with our patients, and not merely try to preserve them from this or that disease. In other words, we should treat patients, not statistics.

Dr Hill tells us that the diabetic sub-group definitely benefited from a more intensive effort to reduce their diastolic blood pressure. That means that the non-diabetic sub-group contributed more than their fair share to the non-benefit (or harm). It would be interesting to know if any of the comparisons in the non-diabetic sub-group showed significant harm.

Half the study population was given aspirin and the other half placebo. It would be useful to know if aspirin, used as primary prevention, contributed in any way to the good or bad effects, and if so in combination with which antihypertensives.

Bringing down the blood pressure with a calcium channel blocker may not be the same as bringing it down with (say) an ACE inhibitor. It is risky, therefore, to infer from the HOT study (or any other) that setting a target blood pressure, and achieving it **by any means** is a good or bad idea.

Alasdair Livingston
Surgeon
Mitcham, SA

Editor, – The hypertension article in *Australian Prescriber* (Aust Prescr 2003;26:53-5) reports the HOT study in which the emphasis is on the diastolic blood pressure whereas a recent report, of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure in the USA, emphasises the systolic blood pressure. I understand current thinking is that emphasis should be on the systolic blood pressure as, if the systolic blood pressure is the aim of treatment the diastolic blood pressure will be satisfactory. Emphasis on diastolic blood pressure can leave the patient with a systolic blood pressure which is at a dangerous level.

John H. Hill
General practitioner
Moruya, NSW

Dr Suzanne Hill, the author of the article, comments:

Dr Livingston identifies a number of interesting points around the interpretation of data from blood pressure trials. One of the difficulties about writing review articles in this area at the moment is that the literature is moving very quickly, with the recent publication of two more large clinical trials (Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) and the Second Australian National Blood Pressure Study (ANBP2)) as well as the publication of meta-analyses.[1]

Specific issues raised by Dr Livingston that I am not able to address include the question of whether there was particular harm in the sub-group of patients without diabetes. This is not reported in the original paper. The question of the role of aspirin would also have to be addressed by further analyses of the data, and indeed this is being addressed by ongoing studies[2] looking at the combinations of treatment for cardiovascular disease. The question of class effects and therapeutic group effects is a topical area and may need to be addressed by an article that more comprehensively reviews the current 'state of play' in thinking about treatment of hypertension.

Dr Hill noted the question of identifying risk based on systolic blood pressure versus diastolic blood pressure. This was not a question addressed by the HOT study, as he rightly identifies, and the answer would require a comprehensive review of current blood pressure literature to address completely.

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Serotonin syndrome

Editor, – I would like to reinforce the message about the spectrum of serotonin toxicity (Aust Prescr 2003;26:62–3). This term represents a more productive descriptive model than serotonin syndrome because there is a spectrum progressing from serotonergic adverse effects through to toxicity (hyperthermia and death). Severity is proportional to the degree of elevation of serotonin concentrations. The loose usage of the term serotonin syndrome continues to produce great confusion.[1,2] For instance, the frequently made statement 'serotonin syndrome is rare' is nonsensical because it is like saying 'poisoning is rare in those who do not ingest poisons'.

General physicians will be reassured to be reminded that life-threatening/fatal serotonin toxicity related to therapeutic drugs has been reported only when monoamine oxidase inhibitors (MAOIs) are combined with serotonin reuptake inhibitors.

I maintain a current synopsis about serotonin toxicity and implicated drugs (i.e. what drugs act as serotonin reuptake inhibitors, or MAOIs, in humans) at www.psychotropical.com/SerotoninToxicity.doc I also draw your readers' attention to other original Australian research.[3] The 'HATS' database continues to make a valuable contribution to all aspects of serotonin toxicity and the interesting deductions that ensue.[4]

Clinical advice from experts may be accessed via the toxicology services whose 24 hour telephone number in Australia is 13 11 26.

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Editor, – The review of serotonin syndrome (Aust Prescr 2003;26:62-3) explores drug interactions as a cause of serotonergic toxicity. We have noticed a significant number of enquiries regarding the concomitant use of the commonly used migraine medication sumatriptan and selective serotonin reuptake inhibitors (SSRIs). The article implies that any combination of serotonergic drugs should be avoided. While sumatriptan is regarded as 'serotonergic', the isolated case reports of apparent serotonin syndrome are not convincing and do not, in our clinical practice, constitute a reason for avoiding the combination.

A review failed to locate clinical evidence supporting a contraindication for sumatriptan and SSRIs.[1] Sumatriptan, a 5-HT agonist, does not appreciably cross the blood-brain barrier and has a significantly lower affinity for 5-HT_{1A} than for 5-HT_{1D} receptors, thereby limiting its intrinsic ability to mediate a serotonergic response. Nevertheless, as the *Australian Prescriber* article suggests, patients should be educated about the possibility of interactions between serotonergic drugs. Before starting therapy, they also need to be informed of the signs and symptoms of serotonin toxicity and what to do if an adverse reaction develops.

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Dr M. Hall and Dr N. Buckley, the authors of the article, comment:

As stated in our original article, sumatriptan has been linked to mild serotonin syndrome in a number of case reports. We deliberately did not include it in the table of drugs implicated in severe serotonin syndrome. We do not believe that the article suggests that any combination of serotonergic medications should be avoided, but merely points out that the potential for such an interaction exists, and prompts education of the patient, and the physician, about these possibilities.

Radiosynovectomy in rheumatoid arthritis

Editor, – 'Disease modifying drugs in adult rheumatoid arthritis' (Aust Prescr 2003;26:36–40) is an informative article, however, I would appreciate comments on the therapeutic applications of beta-emitting radionuclides like Holmium-166.

M.A. Taher
Director, Centre for Nuclear Medicine & Ultrasound
Bangladesh Atomic Energy Commission, Rangpur-5400
Bangladesh

Dr Anita Lee and Dr Kevin Pile, authors of 'Disease modifying drugs in adult rheumatoid arthritis', comment:

Intra-articular instillation of a radioactive isotope, to perform a non-surgical synovectomy of persistently inflamed solitary joints, has been proposed as an adjunctive therapy for rheumatoid arthritis and spondyloarthritis. The theoretical ideal agent is a beta-emitter that can be delivered in a colloidal or particulate form, that is small enough to be phagocytosed by the macrophage synovial lining cells, yet large enough to reduce systemic absorption. In practice radiosynovectomy has primarily been trialled in knee synovitis so as to ensure intra-articular placement. Yttrium 90 and Dysprosium 165 are available for intra-articular use in Australia. Holmium 166 is a short half-life beta-emitter that has been used overseas.

Despite its theoretical utility, a systematic review of Yttrium 90 radiosynovectomy of the knee in patients with rheumatoid arthritis found that there was little support for its use, in comparison to saline or corticosteroid injections.[1]

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Withdrawal of useful drugs from the market

Editor, – The editorial 'Withdrawal of useful drugs from the market' (Aust Prescr 2003;26:50–1) makes a cogent observation about discontinuation of old drugs. The newer antidepressants, antipsychotics, antihypertensives and drugs for diabetes may have some advantages, but they are certainly not worth the high cost.

Most of the useful old drugs are included in the essential drugs lists of the World Health Organization or of developing countries. If it was compulsory for the drug manufacturers to inform people about the discontinuation of essential drugs, it would be easier for governments to make the drugs available as generics or as generic brands.

Wishvas Rane
Pune
India

Editor, – I found Dr Lyndon's editorial (Aust Prescr 2003;26:50–1) on the withdrawal of drugs very pertinent.

Dr Lyndon correctly states there are many reasons for pharmaceutical companies to discontinue supply of a drug. Although their reasons are generally understandable, this does not help those patients for whom the remaining commercially available alternatives are less effective. I would like to advise prescribers that there is a route available in Australia, perhaps not widely known, to obtain most discontinued medication.

Compounding pharmacies prepare and supply medication (known as extemporaneous preparations) for individual patients. As long as the pharmacists can source raw material and do not infringe any patents, they are able to produce

virtually any medication. They can produce medication that is no longer available here or that is available overseas but has not been released in Australia (often due to a perceived lack of sufficient demand).

I believe Dr Lyndon is quite right in his concerns that there is no co-ordinated process involving all interested parties, to discuss the discontinuation of products. Such a forum would certainly be a worthwhile development.

Although not a perfect alternative (the cost of individually compounded medication will be higher), prescribers will now be aware that all is not lost if an effective treatment is removed from the marketplace.

Alan Hewitt
General manager
Stenlake Compounding
Bondi Junction, NSW

Declaration of interest/affiliation

Editor, – Many letter writers declare their affiliations. Sometimes their significance is obscure to me. For example, what sort of a body is 'Medicines Australia' (Aust Prescr 2003;26:51)? It sounds official and important but the title is suspiciously trendy, like Cricket Australia rather than the Australian Cricket Board. It has a whiff of spin doctoring and public relations about it. Is it an industry lobby group perhaps, or maybe the antipodean arm of Médecins Sans Frontières? We need to know if we are to judge the communication.

G. Wise
Staff specialist
Neurology
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Randwick, NSW

Editor's note:

Medicines Australia is the new name for the Australian Pharmaceutical Manufacturers Association. Its mission statement is 'to create a favourable environment for the profitable growth of the prescription pharmaceutical industry in a socially responsible manner for the benefit of the Australian community'.

And next: a flask of wine for Daddy? *

Editor, – Last year I sent a complaint to the Australian Self-Medication Industry (ASMI) about the promotion of Ponstan (mefenamic acid) by Pfizer in community pharmacies. Pfizer was providing dispenser units with Ponstan packs at the bottom, lip gloss jars at the top, and the claim 'Buy Ponstan and receive a free lip gloss'. I stated in my letter of complaint that 'If ASMI authorises the use of gifts to consumers as promotional techniques, it sets a precedent for other abuses of the system, e.g. giving away a Teddy Bear with every sale of children's paracetamol'. Pfizer responded that 'the complaint is without merit and that the promotion is appropriate'. ASMI dismissed my complaint on the ground that there was no provision in their code of practice to ban this type of promotion. They stated they would consider amending their code in this regard, but their new code released in March 2003 has not been changed.

I was amazed this morning to find in a My Chemist's shop that Pfizer had taken seriously the idea of teddy bears and displayed a full box of colourful Benadryl Teddy Bears with the claim 'Free Benadryl Bear with any Benadryl purchase'. This kind of promotion encourages the public to equate medicines with ordinary articles of commerce. Such promotion is inappropriate for responsible health professionals and encourages unprofessional behaviour by community pharmacists. Pharmacist organisations, pharmacy boards and regulatory authorities should take immediate action to stop this type of promotion as the self-medication industry appears incapable of regulating its members properly.

Agnes Vitry
Quality Use of Medicines and Pharmacy Research Centre
University of South Australia, Adelaide
Member of Healthy Skepticism

* In 1995 in Peru Parke-Davis promoted its cough and cold remedy Sinutab with the promise to pharmacists of a complimentary bottle of red wine to celebrate Father's Day if they sold three boxes of Sinutab Maximum Strength or Sinutab Non-Drowsy.[1]

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