

The Australian pharmaceutical industry sees increased transparency as the right to scrutinise the deliberations of the Pharmaceutical Benefits Advisory Committee (PBAC). Currently, companies are informed why their drugs are not recommended for subsidy on the Pharmaceutical Benefits Scheme. Increased transparency will give them an opportunity to interact with and scrutinise the basis of the decision.

Disclosing information about the PBAC may improve understanding of its decisions, but the corollary the industry makes is that increased transparency is meaningless unless there is a process for challenging a decision. The call for increased transparency can then be confused with calls for an appeals mechanism.

There are two sides to transparency. Drug companies have been reluctant to make public the information they have submitted to the PBAC, despite the argument that the data for drugs submitted for public subsidy should be open to public scrutiny. The free trade agreement has however enabled the PBAC to release a public summary containing information about how it reaches its decisions. Time will tell how useful this will be to clinicians.

The industry may be concerned about transparency because its dealings with the PBAC include commercially sensitive information about cost-effectiveness. There therefore should be less concern about data which do not include cost information. The data submitted to the Therapeutic Goods Administration (TGA) to support the registration of a drug in Australia deal only with quality, safety and efficacy. This is important information for health professionals and patients, but it is often deemed to be commercial-in-confidence. The TGA does not release any details of its evaluations, unlike the Food and Drug Administration in the USA and the European Medicines Evaluation Agency. We would expect that similar standards of transparency would apply in Australia to help good prescribing. Instead, Australian health professionals and patients often have to rely solely on published information. As the formulations or use of drugs overseas may be different, we cannot always depend on international information.

The withdrawal of rofecoxib in 2004 is a salutary reminder of the difficulty of identifying the adverse effects of a new drug. It is also salutary that the decision to remove rofecoxib from the market was made by the manufacturer, not by the regulatory authorities. The manufacturer was in possession of important safety information that even the regulatory authorities, let alone the prescriber or the public, were not. There have even been suggestions that some companies have tried to limit the dissemination of data for commercial reasons.³

The Editorial Executive Committee supports the call of the International Committee of Medical Journal Editors for a register of clinical trials.¹ The need for a register would be less urgent if the drug regulation process was as transparent as possible. Transparency should not be limited to industry's desire to scrutinise the PBAC. There is a far greater need for the clinical information supporting a new drug to be made public. To explore issues around access to information, National Prescribing Service is holding a seminar in September 2005.*

In future, when *Australian Prescriber* publishes its summary of a new product in the New Drugs section, it will inform readers whether or not the company involved was prepared to provide the journal with the clinical information which was evaluated by the TGA, but has not been made public (see page 103). Companies are gradually accepting the need for transparency and those that are willing to share their information should be recognised.

* Informing Judgements about Medicines. 7–8 September 2005, Sydney. <http://www.nps.org.au/events>

References

1. Clinical trial registration [editorial]. A statement from the International Committee of Medical Journal Editors. *Med J Aust* 2004;181:293-4.
2. Is this clinical trial fully registered? [editorial]. A statement from the International Committee of Medical Journal Editors. *Med J Aust* 2005;182:609-10.
3. Dyer O. GlaxoSmithKline faces US lawsuit over concealment of trial results. *Br Med J* 2004;328:1395.

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.

Intravenous potassium chloride

Editor, – Recommendations from the Safety and Quality Council regarding the 'High-risk medication alert: intravenous potassium chloride' (*Aust Prescr* 2005;28:14–16) warrant further comment.

Many elderly and frail patients requiring parenteral

potassium supplementation are readily at risk of volume overload if administered potassium salts in dilute infusions, as illustrated in the article. High dependency and intensive monitoring areas are now being approached to admit and supervise patients merely for the intravenous administration of concentrated potassium salt, or at worst to manage the

consequences of volume overload in those patients given the premixed but dilute solutions on general wards.

Unfortunately staffed beds in such acute areas are usually inconsistently available. The patient is then denied timely potassium replacement therapy or at worst suffers the consequences of delay or volume overload.

Could there not be a more practical approach to developing a safety checking protocol than the recommendations promulgated? It is difficult to believe that any clinically active medical or nursing staff were participants in the recommendations thrust upon and slavishly adopted as a mandate by hospitals nationwide.

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Yvonne Allinson, one of the authors of the article, comments:

Before the release of the first Safety and Quality Council high-risk medication alert, there were examples of innovative and successful risk minimisation projects for intravenous potassium initiated by hospital staff in Australia. The alert sought to raise awareness more broadly and make high level suggestions to assist other facilities, including those without dedicated risk management teams.

The alert asked all facilities to evaluate their current controls against a range of recommended actions. The actions suggested were compiled from the international literature and case studies, Australian adverse incident case studies, positive change management strategies from many hospitals, and consultation with key organisations.*

The alert covered a range of topics where there may be confusion when treating hypokalaemia. These included route of administration, intravenous doses in millimoles only, maximum concentration/rate and the availability of a variety of clinically appropriate premixed dilutions. Importantly it suggested roles for all hospital clinical staff as well as chief executives and key committees.

The alert has stimulated further innovation to make potassium use safer. Facilities need to do their own risk assessment and to develop protocols for safe preparation and use of intravenous potassium. Hospital and facility-based teams are encouraged to draw on local expertise at all levels so that this can be done to safely manage the different clinical risks of individual patients. The alert does not preclude this, rather it hopes to catalyse and encourage such action with follow-up audit, review, evaluation and improvement.

* <http://www.safetyandquality.org.au/index.cfm?page=ACTION#potasalert> [cited 2005 July 4]

Dr Ross Wilson, Chair, National Medication Safety Taskforce, comments:

Dr Cameron highlights a very important issue. That issue is hospitals creating new problems or risks for patients by the way they respond to high level policy recommendations.

The National Medication Safety Taskforce was established in October 2001 to advise the Australian Council for Safety and Quality in Health Care and hence Health Ministers from all jurisdictions, on the reduction of patient harm from the use of medications. It was hoped that the provision on the Council website¹ of case studies from four hospitals from different states would assist with implementation. In addition, the Taskforce hosted a meeting late in 2004 on the practical aspects of implementation of this policy with many key stakeholders, including clinicians. The variation in practice and even knowledge about available potassium products was marked. The other key observation of this group was that reducing the need for intravenous replacement of concentrated potassium should be the subject of major efforts by clinical groups. Recommendations from this meeting are currently being considered, and at the very least could set the scene for better sharing of implementation lessons, as well as agreement to assess the extent of effective reduction of patient risk by local changes in the availability of ampoules of concentrated potassium.

A US survey by the Institute for Safe Medication Practice² found that 96% of clinicians and pharmacists considered that concentrated potassium ampoules were a high-alert medication, with 90% of their organisations having put in place special precautions to reduce the likelihood of error.

If the changes that are made in response to the Australian alert are themselves problematic, then the alert will not have entirely served its purpose. Fortunately, with the passage of time and the sharing of experience this is becoming very much less of an issue. Addressing the clinical management of potassium replacement in hospitals will go a long way to reducing the 'apparent' need for ampoules of concentrated potassium, but will require significant clinical leadership at professional and jurisdictional level.

References

1. <http://www.safetyandquality.org.au/index.cfm?page=ACTION#potasalert> [cited 2005 July 4]
2. <http://www.ismp.org/MSAarticles/Survey3.htm> [cited 2005 July 4]

Editor, – We read with interest the report 'High-risk medication alert: intravenous potassium chloride' (Aust Prescr 2005;28:14–16) and felt it timely to describe our local experience in a tertiary paediatric hospital.

A small multidisciplinary team (medical, pharmacy and nursing) implemented changes on behalf of the Drug

Utilisation Review Committee over a 10-month period, in accordance with Australian Council for Safety and Quality in Health Care recommendations.¹

An initial intervention took place in March 2004, including the following: removal of excess supplies of potassium-containing ampoules from ward areas, with limited supplies placed in red-labelled boxes in locked medication cupboards. All potassium-containing ampoules were then ordered through the dangerous drugs register, rather than as ward stock. Three preparations of pre-mixed fluids were introduced, each containing 10 mmol KCl per 500 mL (all fluids were 500 mL bags). These changes were audited two and seven months after the intervention.

Adherence to new storage practices for potassium-containing ampoules was noted at the time of the audits in all wards of the hospital. The introduction of pre-mixed intravenous solutions led to a stepwise, substantial reduction in the need for ampoules of concentrated potassium on the wards. As a result, it was possible to remove the ampoules from the majority of general wards of the hospital, without compromising patient care.

The applicability of our project to other institutions presents several challenges. The choice of intravenous solutions varies considerably between the states of Australia, and there is currently no consensus regarding 'ideal' pre-mixed solutions for paediatric patients.

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Reference

1. Australian Council for Safety and Quality in Health Care. Medication alert: intravenous potassium chloride. Canberra: ACSQHC; 2003.
<http://www.safetyandquality.org.au/index.cfm?page=ACTION#potasalert> [cited 2005 July 4]

Protection of the public or protection of the pharmaceutical industry?

Editor, –The article 'Should consumers be warned about aspirin, alcohol and gastric bleeding?' (Aust Prescr 2005;28:18–19) contains some peculiar logic. It suggests there is evidence that the risk of upper gastrointestinal bleeding is increased in patients consuming at least three

to five drinks daily. However, it appears that commercial considerations dissuaded the Therapeutic Goods Administration (TGA) from adding an appropriate warning label to aspirin and non-steroidal anti-inflammatory drugs (NSAIDs). The primary concern of the TGA should be the health and protection of the public, not the commercial interests of the pharmaceutical industry. Why should marketing considerations enter into the TGA's deliberations at all? Have we not learned from the rofecoxib debacle?

If, as the US Food and Drug Administration (FDA) concluded, there is a problem with moderate–high alcohol intake in combination with the use of aspirin/NSAIDs, then a warning statement for consumers is required. Equally, a similar warning should be required for paracetamol if there is good evidence of an increased risk of hepatotoxicity with alcohol consumption.

It may have been acceptable to conclude that a warning label is not currently warranted because the literature is not clear on alcohol increasing the risk of gastrointestinal bleeding due to aspirin/NSAIDs. However, it is bizarre to conclude that there is a real problem with moderate–high alcohol intake yet not warn consumers because of a need to maintain commercial parity in the analgesic market.

Clinicians are recommended to identify 'at-risk' patients. Would not this be easier if there was an appropriate warning label on analgesic packages, particularly as health professionals may have no knowledge of their patients' consumption of analgesics purchased at supermarkets and other retail outlets?

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Dr J. McEwen, Principal Medical Adviser, Therapeutic Goods Administration, and Dr R. Whiting, Chairman, Medicines Evaluation Committee, comment:

Professor Peterson and Mr Bereznicki express concern that commercial considerations dissuaded the TGA from adding warning labels about alcohol consumption to aspirin and non-steroidal anti-inflammatory drugs. While that implication might be drawn from the article, they can be assured that such was not the case.

The TGA is advised on these matters by the independent Medicines Evaluation Committee (MEC).¹ This committee includes some of Australia's foremost academics and practising clinicians with expertise relevant to over-the-

counter medicines. The most recent consideration of the need for warnings about alcohol intake on analgesic products was in February 2003. At that meeting, the MEC considered a review on non-prescription analgesics.² That review includes at page 36 a speculative question about the reasons for warning statements in the USA, viz: 'Or is there an unstated commercial reason; namely, that if an alcohol warning has to go on paracetamol, it must be placed on aspirin and the NSAIDs so that none of these analgesics is perceived as having a marketing advantage over others in a highly competitive environment?'

It can be stated unequivocally that medical and scientific considerations were the sole determinants of the advice of the MEC to the TGA. Commercial matters were not taken into account.

References

1. <http://www.tga.gov.au/docs/html/mecinfo.htm#member> [cited 2005 July 4]
2. Newgreen DB. Medicines Evaluation Committee review of non-prescription analgesics: an update. Canberra: Therapeutic Goods Administration; 2003. <http://www.tga.gov.au/docs/html/analgupd.htm> [cited 2005 July 4]

Dispensing practices and labelling of drugs

Editor, – Ms McCullagh (Aust Prescr 2005;28:5–7) raises an important point and one that has been brought to the attention of the Pharmacists Board of Queensland. The Board recently undertook disciplinary action against a pharmacist who dispensed a prescription for methotrexate where no label was placed on the bottle holding the tablets. As a direct consequence of the lack of a label, the patient took the wrong dose of methotrexate and was admitted to hospital a few days later with severe toxic manifestations.

The Board subsequently received credible information indicating that the practice of labelling only the exterior packaging when dispensing methotrexate was a not infrequent occurrence. Subsequently it wrote to all Queensland pharmacists highlighting the inherent risks associated with such practice.

The Board supports the comments made by Ms Deans, of the Pharmaceutical Society of Australia. However, it would emphasise that there are very few instances where a pharmacy dispensing label is not able to be securely attached to the container holding the medicine and certainly none where a drug with a narrow therapeutic index is involved, where any patient confusion as to the dose may have dire consequences.

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Iron sucrose

Editor, – I read your brief few paragraphs on iron sucrose (Aust Prescr 2005;28:49–51) and felt the need to point out a few things:

- It states in the second paragraph that the sucrose is eliminated in the urine. As prescribing is restricted to patients having dialysis, I doubt very much whether this is true. Most dialysis patients have little or no urine and certainly do not manage to excrete anything worthwhile in their urine.
- The last paragraph regarding safety and efficacy reveals the blindness of Australian authorities. Iron sucrose has been used for over 30 years in more than 50 countries around the world and has a safety record far superior to the currently available iron polymaltose.

The prescribing should be limited to 'dialysis' patients, not just 'haemodialysis' patients – 23% of dialysis patients are peritoneal dialysis patients. Indeed 50+% of patients starting dialysis have commenced erythropoietic agents (legally, and according to guidelines) before they need dialysis. This group will also benefit from iron sucrose so 'chronic renal failure' is a more appropriate indication.

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Generic prescribing

Editor, – I am concerned about the ongoing push for semi-compulsory generic prescribing. Over many years I have had substantial clinical experience of observing the changed level of health of some patients on changing brands. I have reported some dramatic examples to the Adverse Drug Reactions Advisory Committee (ADRAC).

We should remember that we are NOT just prescribing the active ingredient when we prescribe. There is the issue of varying particle size and varying excipients that may make a difference. For example, I once had a psychotic patient with lactose intolerance and I had to work to identify which brands (or even which strengths of the same brand) of antipsychotics were lactose free. The Pan Pharmaceuticals experience tells us that this is still applicable today and not just a risk from the distant past.

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