



Department of Health,
P.O. Box 5013,
Wellington.

18 October 1979.

CLINICAL SERVICES LETTER NO. 189

To Medical and Dental Practitioners

(Copy to Proprietors of Retail Pharmacies)

MINOR TRANQUILLISERS

The restriction on minor tranquillisers which commenced on 1 August is one of payment, which is now made only for a maximum quantity sufficient for 30 days treatment on any one prescription form. This means that payment is not made for any repeat supplies, even for short periods.

The intention of this restriction is to encourage cessation of long-term therapy wherever this is thought to be medically reasonable. It is apparent that a number of people are on continuing therapy with these products more from habit than from reasons of need. A number of practitioners have welcomed the restriction as strengthening the case they can put to patients and it is hoped that many more will take the opportunity of restricting this type of therapy to those cases where it is most needed.

The evidence of true drug dependency with benzodiazepines is not clear although there is a tendency for abuse of these products. There is more definite evidence of psychological dependency and habituation developing from long-term therapy. There are also indications of altered standards of driving skills especially if taken in association with alcohol.

Alternative forms of therapy include counselling, with its obvious demands on the available time of the counsellor. It is nevertheless clear that many patients are now both expecting and demanding this type of therapy. Many practitioners prefer to provide such a service themselves, but assistance from para-medical sources is increasingly available. Where treatment with medicines is nevertheless needed, short-term therapy to cover the acute situation or spasmodic therapy may often be sufficient.

For the patient who has been on continuing therapy for some time, withdrawal may provide some problems but is frequently possible with strong and patient medical support. Withdrawal symptoms may include headaches, weakness and tremors, nausea, insomnia, faintness, poor appetite, etc. Because of the long half-lives of most benzodiazepines and the production of active metabolites these symptoms may not appear for a week after therapy is ceased. Withdrawal of long-term benzodiazepine therapy should always be gradual and the occurrence of troublesome symptoms may call for reinstitution of therapy followed by even more gradual withdrawal.

The medicines affected by the restriction on minor tranquillisers are:

- Chlordiazepoxide and its hydrochloride
- Diazepam capsules, syrup, and tablets
- Lorazepam tablets
- Oxazepam tablets

PERIOD OF SUPPLY FOR ANTIBIOTICS

Comments have been made to the Department of Health that the current 5-day period of supply for antibiotic therapy is utilising an "overkill" which may be creating more problems than it is solving.

Suggestions received have ranged from the introduction of *stat* dose antibiotics for all pyogenic bacterial infections in patients outside hospitals to a general 4-day period of supply for antibiotics. It is stated that the optimum length of time for which any antibiotic should be administered is poorly documented and that there is no convincing evidence that a 5-day course of antibiotics is superior to a 4-day course. It is noteworthy that one major hospital now insists that all antibiotic therapy be reviewed after 3 days. Clearly, alternative arrangements would be needed to cover long-term antibiotic therapy and prophylaxis.

This subject will be reviewed at the next meeting of the Pharmacology and Therapeutics Advisory Committee and comments are sought. These should be forwarded before 15 November.

BARBITURATES

Prescribing of barbiturates decreased markedly for some time but more recently appears to have reached a plateau.

Figures for usage of barbiturates excluding phenobarbitone are:

April-June 1977	...	58 700 prescriptions
August-November 1977	...	42 700 prescriptions
December-March 1978	...	45 400 prescriptions

More recent figures available from monthly sales indicate a similar situation is continuing.

The Pharmacology and Therapeutics Advisory Committee is of the opinion that, following a prolonged period of publicity concerning the dangers of barbiturate usage, the time may now have come to consider firmer action. The possibility of withdrawal from the Drug Tariff of all barbiturates, other than phenobarbitone, will be considered at the next meeting. Any comments on this possible action will be welcomed and should be forwarded before 15 November.

CONTAINERS FOR MEDICINES SUPPLIED DIRECT BY PRACTITIONERS

Concern has been expressed about what appears to be a growing practice, especially in the dental profession, of supplying scheduled poisons and controlled drugs in paper envelopes, usually of the Seal Easi type. Pethidine and Penicillin V tablets are preparations commonly supplied in this way.

Practitioners are reminded that the Poisons Act requires any scheduled poison to be supplied in a container which:

- (a) Is impervious to the contents;
- (b) Can be readily and effectively resealed;
- (c) Is of a prescribed type; and
- (d) Is properly labelled.

The Poisons regulations specifically forbids the use of paper containers for First Schedule and prescription poisons. Furthermore every scheduled poison for internal use supplied by a doctor, dentist, or pharmacist for the needs of a particular patient must be labelled with the patient's name.

Pethidine is the controlled drug that appears to be most commonly dispensed in paper bags by practitioners. The Misuse of Drugs regulations require that the label bears the words "Controlled Drug. B. 3" together with the strength of the preparation and the name of the patient. Common prudence dictates that the standards for controlled drug containers should at least equal those required for containers for scheduled poisons.

The attention of all practitioners who supply scheduled poisons or controlled drugs to their patients is drawn to the requirements for the containers, of which only an outline has been given here. If you would like more information please consult your local medical officer of health or public health pharmacist.

For practitioners who habitually dispense these medicines, a glass or plastic container properly labelled is the usual answer. Cardboard skillets are available for strip packaged medicines.

Paper envelopes just will not do!

PRACTICE NURSE SUBSIDY—RELIEVING NURSES

Section 5 (h) (ii) of the Appendix to Clinical Services, Letter No. 168, limited the payment of subsidy for relieving nurses to practices employing only one practice nurse.

It has now been agreed that this limitation should be removed and, accordingly, subsidy in respect of relieving nurses will be paid regardless of the number of practice nurses employed.

MATERNITY BENEFITS—TERMINATION OF PREGNANCY

From recent inquiries it appears that some medical practitioners are unsure which type of benefit to claim for services relating to termination of pregnancy.

Services up to and including the actual consultation where the decision is made to seek termination are deemed to be antenatal services. Once such a decision has been made, should any subsequent services be required they would come under general medical services.

COST/EFFICACY REVIEW OF THERAPEUTIC GROUPS

The anti-inflammatory group of medicines will be reviewed at the next meeting of the Pharmacology and Therapeutics Advisory Committee.

INTENSIFIED A.D.R. REPORTING SCHEME

Medicines involved:

Acebutolol hydrochloride	...	...	(Sectral)
Atenolol	...	...	(Tenormin)
Cefoxitin sodium	...	...	(Mefoxin)
Cimetidine	...	...	(Tagamet)

Labetalol hydrochloride	...	...	(Trandate)
Metoprolol tartrate	...	...	(Betaloc, Lopresor)
Perhexiline maleate	...	...	(Pexid)
Sodium valproate ...	...	...	(Epilim)
Sotalol hydrochloride	...	...	(Sotacor)

A. G. Scott.

(A. G. Scott)
Director,
Division of Clinical Services

J. S. Phillips

(J. S. Phillips)
Deputy Director,