



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

10 October 1980.

## CLINICAL SERVICES LETTER No. 196

To Medical and Dental Practitioners

(Copy to Proprietors of Retail Pharmacies)

### AVAILABILITY AND ABUSE OF PRESCRIPTION MEDICINES

In Clinical Services Letter No. 193 the co-operation of all practitioners was sought to carefully control the quantities being prescribed of those prescription medicines subject to abuse.

Medicines particularly being abused include the following:

Barbiturates—Tuinal, Seconal.

Anorexiant—Duromine, Tenuate, Tenuate Dospan.

Benzodiazepines—Valium, Serepax, Ativan, Mogadon.

Analgesics—Digesic, Doloxene, Fortral.

Anticonvulsants—Dilantin.

Controlled Drugs—Morphine, Methadone, Pethidine, Cocaine.

Sedative and Hypnotic—Hemineurin.

It should be remembered that people who abuse one drug will usually abuse others. Prescribing Valium for such a person instead of Tuinal will not prevent that person abusing the Valium, or selling it to obtain Tuinal illegally.

A practitioner's task is to detect such people and direct them to a drug dependency clinic or other authorised treatment source.

Suggested action when in doubt about a patient includes the following:

1. Telephone the district health office and ask for the medical officer of health or public health pharmacist. They have files available on the better known abusers with descriptions, typical stories, preferred drugs, etc.

2. If the patient is previously unknown, offer to ring their regular doctor and check details. This can be very effective. Be suspicious of a patient who claims to have had previous treatment with a drug likely to be abused.

3. Keep up-to-date records of circular letters distributed by the Department of Health. They are a quick reference for the better known abusers.

4. Ask to see the bottles in which the last supply of medicines were dispensed. From these, information can be obtained by ringing the pharmacist.

5. Check the height, weight, sex and obvious distinguishing marks of the patient and record these.

6. If the patient becomes abusive or threatens violence, offer to call the police.

7. If you do prescribe medicines, give the least quantity possible and ask the patient to return when you have had time to check. Such a check should include discussion with the medical officer of health.

### **PRESCRIBING OF BARBITURATES AND GLUTETHIMIDE**

As from 1 October 1980, glutethimide and barbiturate hypnotics other than phenobarbitone must be prescribed on a controlled drug prescription form. Combination products are excluded from this requirement if the barbiturate is combined with any active drug other than another barbiturate of this group.

Prescriptions for these class C, part IV controlled drugs may provide for a 3-month extended supply, but the drugs will be dispensed only 1 month at a time.

This action has been taken to enable easier identification of prescriptions for glutethimide and barbiturates when information relating to these is required. Agreement has been reached with the New Zealand Medical Association and the Pharmaceutical Society of New Zealand that this should be part of the effort to control the availability of these products.

The drugs concerned are:

Amylobarbitone.

Amylobarbitone sodium.

Butobarbitone.

Glutethimide.

Quinalbarbitone sodium.

Amylobarbitone sodium with quinalbarbitone sodium.

### **SPECIALIST RESTRICTION**

In July 1978 (Clinical Services Letter No. 182), practitioners were first advised of the requirement of annotating a prescription with the year of authorisation as well as the name of the specialist when continuing therapy recommended by a specialist.

It was indicated that recommendations would remain valid until the end of the second calendar year following the initial recommendation by a specialist. Those recommendations which were current in 1978 and were not reviewed at that time were allowed to be annotated as having been recommended in 1978.

Practitioners are now reminded that many of these recommendations will expire at the end of 1980. In order to avoid undue pressure on specialists, it is recommended that arrangements for review of therapy by specialists should, in many cases, be made in advance. As before, it is requested that both general practitioners and specialists should keep a record of all therapy recommended in this manner. This record should include the date of recommendation and whether given in writing or by telephone.

### **PRACTICE NURSES AND PRESCRIBING**

Recurring complaints are being received concerning the use of practice nurses in arranging repeats of prescriptions, both in writing and by telephone.

Some prescriptions, apparently written by practice nurses, are so incorrectly written and spelt that it becomes unreasonable to expect a pharmacist to interpret them. It is even more surprising that practitioners have been prepared to sign them.

In other cases, pharmacists have complained about continuing telephone calls by nurses reordering repeat prescriptions. There is no indication whether a doctor has sanctioned these repeats or is even aware of them. Furthermore, in the case of prescription poisons or controlled drugs, such telephone ordering by nurses is not permitted.

While such arrangements are no doubt convenient and time saving, practitioners are reminded of their responsibilities in regard to prescribing. Trust between a practice nurse and the employing practitioner is an individual matter, but the ultimate responsibility for prescribing rests firmly with the practitioner.

### **U100 INSULIN**

Practitioners are again reminded of the changeover, as from 1 March 1981, from 40 units and 80 units per ml insulin to 100 units per ml insulin. It is intended that this changeover should be virtually complete by 1 August 1981 and payment under the Drug Tariff will be made only for the new strength after that date.

All insulins, other than protamine zinc insulin, are expected to be available in the new strength by 1 March 1981. Every patient requiring insulin will need a syringe graduated for the new U100 insulin.

New disposable syringes will be of 1 ml capacity and will be marked with 50 divisions, each representing 2 units of insulin. Syringes with a low dead space will have fixed needles and the others will have detachable needles. Patients will be able to obtain supplies from the same sources that they now use.

New glass syringes are also expected to be available and will be supplied free under current arrangements.

A publicity programme to accompany the changeover is being arranged. More details will be supplied at a later date.

### **MATERNITY BENEFITS: TERMINATION OF PREGNANCY**

Clinical Services Letter No. 189 mentioned the type of benefit payable for services relating to the termination of pregnancy. However, there may be some confusion about the benefit payable for counselling prior to therapeutic abortion.

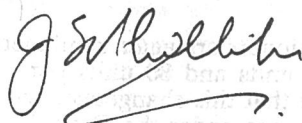
The maternity benefit is payable up to and including the antenatal visit when the decision is made to seek a termination of pregnancy. Further services, such as counselling after this occasion, are payable as general medical services. The visit to the certifying consultant and the actual termination of pregnancy are payable by the Abortion Supervisory Committee. The post-termination examination is payable under maternity benefits.

## INTENSIFIED ADVERSE DRUG REACTION REPORTING SCHEME

The following medicines are currently included in the scheme:

Cimetidine (Tagamet).  
Nifedipine (Adalat).  
Perhexiline maleate (Pexid).  
Sodium valproate (Epilim).  
Sotalol hydrochloride (Sotacor).

Nifedipine (Adalat) is a calcium antagonist for the treatment of angina pectoris. It should not be regarded as an anti-anginal medicine of first choice and should be used only after more established treatments have failed. Adverse drug reactions reported in association with its use include headache, vasodilatation, oedema, rash, dizziness, tachycardia, nausea and dyspepsia, precipitated angina, sleep disorders, and dyspnoea. Myocardial infarction and death have been recorded in association with its use but this must be weighed against the health status of patients receiving such therapy.



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