



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

17 June 1981.

CLINICAL SERVICES LETTER NO. 203

To Medical and Dental Practitioners
(Copy to Proprietors of Retail Pharmacies)

SECURITY IN THE STORAGE OF DRUGS

As indicated in Clinical Services Letters 193 and 196 there has been an increase in the detection of prescription medicines on the illicit market and measures are being taken to identify cases of inappropriate prescribing.

Another source of these medicines has been through theft from any point in the chain of distribution of medicines.

Recent meetings with manufacturers, wholesalers, retail pharmacists, and the New Zealand Medical Association have highlighted areas of concern to both the New Zealand Police and the Department of Health.

It is clear that there has not been enough consultation with the local crime prevention officer of the police when designing new or remodelling old premises. Modern space-monitoring alarm systems are suitable for all types of buildings including medical consulting rooms, and even come in a form suitable for protection of a motor vehicle.

Retail pharmacies remain particularly vulnerable targets unless adequate security is provided. Medical practitioners' premises usually offer very little defence against burglary, although they now contain fewer stocks of drugs, and this has been recognised by the drug-seekers.

Pilfering by staff should always be considered a possibility and stock control should be as thorough as possible. This particularly applies in the group practice situation where all too often one practitioner's supply order is used to replenish the stocks and the practitioner who has signed the order has no idea how the drugs are being used.

Controlled drugs, when stored in a controlled drug cabinet, should not be jointly used by practitioners without records being kept, and it would be preferable for each practitioner to order and be responsible for his own controlled drugs.

Prescription pads are stolen and the damage is compounded when prescription pads are pre-signed and left for the practice nurse, industrial nurse, or receptionist to complete. This clearly contravenes the Poisons Regulations.

The pharmacist has a responsibility to satisfy himself that a prescription is genuine and should always be alert to alterations from the original.

Medical practitioners are permitted to destroy any surplus controlled drugs which come into their possession, such as the medication returned by patients and their relatives. The public health pharmacist is available to destroy surplus stock from pharmacies and all stocks should be kept at a minimum.

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WASTAGE OF MEDICINES

It is well known that many patients, when newly prescribed a medicine for long-term use, find that they are intolerant of the medicine and present themselves for a change in the prescription. This can lead to accumulation of unwanted medicines, with all its inherent problems. It can also be a costly exercise if every initial prescription is for a minimum of 1 month's supply as seems so often to be the case.

Particularly when prescribing anti-depressants, anti-hypertensives, or non-steroidal anti-inflammatory drugs, an initial short course of treatment would be an appropriate test of tolerance.

SODIUM VALPROATE (EPILIM)

Sodium valproate has been included and is still maintained in the Intensified Adverse Drug Reaction Reporting Scheme due to concern for its potentially fatal hepatotoxicity. Non-fatal liver dysfunction is fairly common in patients on valproate therapy, generally presenting as a rise of serum transaminases only. In some cases, however, it may develop into a serious and life-threatening condition with abnormal values of other liver function tests.

Although none has been reported in New Zealand so far, world-wide over 40 cases of fatal hepatotoxicity have been reported, mainly in children and mostly occurring within 6 months of starting valproate therapy. Clinical signs and symptoms of hepatic dysfunction were obvious in some cases, but were often non-specific, e.g., encephalopathy. The presenting signs and symptoms and/or abnormal biochemical values have not yet been clarified.

It seems advisable, however, not to give valproate to patients with a previous history of liver disease, and to monitor liver function in other epileptic patients before and after starting valproate therapy at least monthly up to 6 months and less often afterwards. A careful watch for any unusual clinical signs and symptoms should also be kept. If significantly abnormal biochemical values and/or unusual clinical signs and symptoms are apparent, it seems advisable to withdraw valproate gradually while substituting with alternative anticonvulsant(s) if necessary.

In addition to reports of hepatotoxicity, other adverse effects associated with valproate therapy have been reported, including leucopenia, thrombocytopenia, hyperammonaemia, and pancreatitis.

Any adverse events associated with valproate therapy should be reported to the Medical Assessor, P.O. Box 913, Dunedin.

BREAST PROSTHESES REQUIRED FOR BREAST RECONSTRUCTION OPERATIONS

The Minister of Health has recently approved an extension of the provisions/interpretation of the Social Security (Breast Prostheses) Regulations 1977 to provide a benefit of \$30 towards the cost of breast prostheses required for breast reconstruction operations carried out in private hospitals for women who have had a mastectomy.

The same terms and conditions will apply for these implanted prostheses as for externally worn prostheses. A certificate to the effect that the operation has taken place and a prosthesis provided should be signed by the appropriate person, as presently applies to externally worn prostheses. The patient should then claim the benefit through the local district health office. This extension of the benefit is available to those cases where the prosthesis has been implanted on or after 1 April 1981. It will not be available if the patient has already received a benefit for an externally worn prosthesis.

Where a breast reconstruction is performed in a public hospital there is no charge to the patient.

PRESCRIBING OF BARBITURATES AND GLUTETHIMIDE

Prescribers are reminded that prescriptions for the following are required to be written on a controlled drug prescription form:

Amylobarbitone

Amylobarbitone sodium

Butobarbitone

Glutethimide

Quinalbarbitone sodium

Amylobarbitone sodium with quinalbarbitone sodium

These forms should not be used for other hypnotics.

RETURNING PRESCRIPTION TO PHARMACISTS

From time to time pharmacists are required to return a prescription to the prescriber for alteration or for confirmation of telephoned advice. Until the prescription is in order and accepted by the department's pricing office, the pharmacist will not be reimbursed with the cost of the medicine dispensed. Please ensure that these prescriptions are returned to the pharmacist promptly.

COST/EFFICACY REVIEW OF THERAPEUTIC GROUPS

The beta blocker group of medicines will be reviewed again at the next meeting of the Pharmacology and Therapeutics Advisory Committee. Any comments received before 15 July will be referred to the committee.

REVISION OF THE DRUG TARIFF 1979

There was a gratifying response from a large number of doctors, dentists, and pharmacists to our request for comments on the proposed revision of the Drug Tariff outlined in Clinical Services Letter No. 200.

It became apparent that there are still available stocks of a number of products whose manufacture ceased some time ago. The opinion generally expressed, that the use of old and simple therapy is much cheaper and often just as effective as more expensive modern remedies, is endorsed by the Department of Health. In general, those items which are still prescribed by practitioners will be retained on the Drug Tariff.

The Pharmacology and Therapeutics Advisory Committee has considered the proposed list of deletions in the light of comments received. The final

decision will be published in a later Clinical Services Letter and should prove satisfactory to all concerned.

CONTINUING THERAPY

Both the Pharmacology and Therapeutics Advisory Committee and the Medical Services Advisory Committee recommend that medical practitioners review the current treatment for those patients who have been on continuing therapy for some years. It is apparent that therapy is often continued more from habit than from necessity. The supply of repeat prescriptions without seeing the patient can inadvertently lead to the continuation of therapy which is no longer necessary.

It is recommended that when specialist therapy is commenced in hospital, discharge letters to the general practitioner should indicate whether this therapy is intended to be of a temporary or continuing nature. Private specialists are also requested to include this information in their letters to general practitioners.

GLYCERYL TRINITRATE TABLETS

Glyceryl trinitrate tablets are stable for 2 years from the date of manufacture as long as the original container is not opened.

Deterioration and loss of potency can occur once the original container has been opened, particularly if the tablets are inappropriately packed. With inappropriate storage and packaging, it is unlikely that the tablets are stable for longer than 3 months.

Glyceryl trinitrate, also known as nitroglycerine, is volatile and readily migrates from tablets into cotton wool, rayon, or plastics used in packaging. The tablets should be dispensed only in a dark glass container closed by means of a screw closure lined with aluminium or tin foil. The container should be the smallest size available consistent with the number of tablets prescribed. Cotton wool and other organic packaging materials should not be included in the container.

The Pharmaceutical Code recommends that no more than 100 tablets be prescribed at one time and the patient should be advised that the tablets should be stored in the original container, tightly closed and protected from sunlight. A fresh tablet should produce a slight tingling sensation when placed under the tongue.



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