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Cisapride to relieve dysphagia

Sir,
A case is reported of dysphagia in a patient suffering from a stroke which was greatly helped by cisapride.

An 81 year old man suffered a severe stroke associated with marked left sided facial paralysis, dysarthria and dysphasia. His condition progressed over one week to become a complete left sided paralysis. Initially his blood pressure was raised (220/120 mmHg), but settled without treatment to 140/75 mmHg. He is managed at home with the help of his family and medical support services.

After about four months he began to experience difficulty in swallowing which at that time apparently improved with a short course of metoclopramide syrup. His condition remained unchanged for about four years, when he again complained of difficulty in swallowing, with the sensation of food sticking in his oesophagus. His symptoms were quite marked and it was understood that they had essentially been present since his original stoke, although probably less severely. He was commenced on cisapride 10 mg three times daily before meals and at night. At review after four weeks' treatment he was much improved and according to the speech therapist he reported no swallowing difficulties. The patient has continued to receive regular cisapride for the last two years without recurrence of his symptoms.

Dysphagia is a common sequel to stroke particularly where there is a pseudobulbar palsy,[1] and it is often a difficult symptom to relieve. Although cisapride is most commonly used for disordered upper intestinal motility (for example dyspepsia and oesophageal reflux) it might well have a place in relieving symptoms referable to disordered pharyngeal motility, and thus perhaps reducing the risk of aspiration pneumonia.

I am aware of only one reference to the use of cisapride in patients with dysphagia (Awad R, abstract of the Dysphagia Research Society inaugural meeting, Milwaukee, United States of America, 1992). Three patients (two after proven stroke) who were receiving nutrition via a gastrostomy tube were given careful and full explanation of the principles of swallowing (biofeedback) together with cisapride 2.5 mg via the gastrostomy before breakfast. All three patients recovered their ability to swallow after a mean time of 56.6 days and continued to eat and drink normally for up to 33 months. It is difficult to know whether the biofeedback or the cisapride was the prime mover in these cases, but the cases highlight the need for further investigation.

Dysphagia is a common and unpleasant sequel to a stroke, and anything that helps to alleviate it is welcome.

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Reference

1. Kumar PJ, Clark ML (eds). *Clinical medicine.* 2nd edition. London: Balliere Tindall, 1990.

Repeat prescribing for cystic fibrosis patients

Sir,
The National Audit Office report on National Health Service repeat prescribing expressed concerns that repeat prescribing, by its nature, carries a higher risk of drug wastage than acute prescribing.[1] It cited the statistic that 60% of prescriptions were repeat prescriptions. We are led to believe that tight controls over prescribing will reduce the drug budget without reducing the quality of patient care. Patients with cystic fibrosis have a continuous need for prescribed therapy.

A random sample of the 119 attenders at a Southampton cystic fibrosis clinic were sent a postal questionnaire asking how, when and where they obtained their pancreatic enzyme replacement therapy, how much they used, how much was prescribed, and how long it took them to obtain it. Eight out of 10 questionnaires were returned.

All patients routinely received their pancreatic enzyme therapy from their general practitioner rather than the hospital: two made their requests by telephone, five by repeat prescribing cards and one when consulting the general practitioner. It was found that a box of 50 capsules lasted a mean five days. Prescriptions were repeated a mean of 16 times per year. Six patients reported that repeat prescriptions were requested when stocks were reduced to one week's supply. Seven patients reported having been given insufficient quantities to cover their use on at least one occasion. Half of the patients had run out of medication on at least one occasion. At the time of the survey, patients reported having between nine and 52 days' supply of treatment. Two patients relied on their community pharmacist to dispense enzymes in advance of receipt of the prescription. Three patients also reported having to justify their need for a repeat prescription, and two had to account for every capsule taken. This was distressing for them since all patients are actively encouraged to alter their dose of enzymes depending upon their stool output and consistency.

Pancreatic insufficiency in cystic fibrosis results in a lifelong requirement for pancreatic enzyme replacement therapy. Modern enzymes have a shelf life of about two years, and cystic fibrosis patients were not found to hoard enzymes. The National Audit Office report recommends that drugs without side effects that require minimal observation during administration should be prescribed in larger quantities in the face of continuing patient need.[1] Prescribing a year's supply in 16 instalments cannot be justified on the basis of side effects or drug stability. Frequent dispensing would only be necessary if a patient's home had insufficient storage capacity. Pancreatic enzyme replacement therapy is therefore an ideal candidate for repeat dispensing, where the prescriber writes one prescription which is dispensed in instalments by the pharmacist.

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