LETTERS

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Hazards of codeine plus paracetamol compounds

Sir,

Codeine phosphate is a popular drug of abuse and is commonly taken in preparations combined with either aspirin or paracetamol. Preparations containing larger amounts of codeine (30 mg) are especially popular. Opiate tolerance may result in dependent individuals needing to ingest large amounts of these drugs, thus risking potentially fatal paracetamol or aspirin toxicity.

A 37-year-old woman recently attended the drug clinic at the Southern General Hospital, Glasgow as a result of dependence on Tylex® (Cilag) (containing codeine 30 mg and paracetamol 500 mg). She had initially been prescribed this for sciatica but she found that in addition to providing analgesia it also improved her mood. Her consumption increased and she supplemented her prescription by buying the preparation from 'street sources', taking up to 30 tablets daily and experiencing opiate withdrawal symptoms if unable to obtain them. Despite being warned of the dangers of this, she admitted at a subsequent appointment to having consumed 100 of these tablets over the previous week, 35 having been taken in the previous 24 hours, in order to improve her mood. A serum paracetamol level of 328 mg l^{-1} was detected seven hours after the last dose and she was admitted for treatment with acetylcysteine. Her liver enzymes were elevated (alanine aminotransferase 48 IU l^{-1} and gamma glutamyl transpeptidase 235 IU l^{-1}) but fortunately her coagulation indices remained normal and she was well enough to be discharged after two days.

We have also had anecdotal reports from other drug abusers attending the drug dependency clinic of increasing availability of Tylex on the street.

It has previously been reported that opiate addicts abuse combinations of codeine and aspirin and are apparently able to remove some of the latter;[1] with preparations such as Distalgesic® (Dista) (co-proxamol — dextropropoxyphene hydrochloride and paracetamol) concern has largely been focused on the opiate component[2] and there has been a resultant alteration in prescribing habits.[3] The increasing popularity of codeine and paracetamol preparations urges us to warn prescribers to be mindful, not only of the addiction potential and street value of codeine, but also of the potential toxicity of paracetamol in combination analgesics.

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Pharmacist–GP liaison

Sir,

A research project involving a pharmacist and a suburban group practice was undertaken in 1992 to quantify and evaluate clinical and pharmaceutical interventions made by the pharmacist as a result of a medication review of elderly patients. Patients included in the study were those aged 75 years or over, living independently in the community and taking at least one regular medication. Computer held medication records for 85 patients were reviewed by the pharmacist and for another group of 66 patients, a home visit was made by the pharmacist in addition to a review of the medication record.

Among the 85 patients whose records were reviewed, there were 40 instances where a drug was being prescribed which, according to the literature, had the potential to cause adverse drug reactions in elderly people. This represents 14.5% of the total number of 275 regular prescribed medicines being taken by these patients. Action was taken by the doctor to modify or monitor treatment following discussion with the pharmacist in 11 of the 40 cases (27.5%). Among the 66 patients visited by the pharmacist, the number of drugs similarly identified from literature sources, as above was 24 out of a total of 238 prescribed medicines (10.1%). Of these 24 medications, symptoms suggestive of an adverse reaction were reported by the patient in 17 cases (70.8%). Additionally, a further 16 drugs possibly giving rise to adverse drug reactions were identified following the home visit (6.7% of total prescribed medication). Of the 40 drugs identified among the group of patients visited by the pharmacist, action was taken by the doctor to modify or monitor treatment in 13 cases (32.5%). Among the two groups overall, drugs particularly likely to lead to adverse drug reactions in elderly patients were being prescribed for 43.7% of patients (66/151). Following reporting by and discussion with the pharmacist, the doctor modified or monitored treatment with 30.0% of these drugs.

The pharmacist was able to make a recommendation regarding some aspect of the medication for more than 80% of the patients; 28.8% of these recommendations (64) were taken up by the doctors. Action was taken most often (10 cases, 45.5%) when the suggestion concerned the dosage form, pack size or quantity of drugs prescribed. These were details which could easily be changed on the patient's computer record at the time of the doctor–pharmacist discussion. Recommendations for modifications to or monitoring of therapy which necessitated action at a future time, probably when the patient next visited the surgery, were less likely to have been acted upon (a total of 134 recommendations were made concerning medication

review, 56 of which were acted upon (26.9%)).

The finding that 44% of patients were receiving drugs likely to cause adverse reactions in elderly people is a cause for concern, in view of the numbers of elderly people admitted to hospital as a result of their medication.[1-3] It is also noteworthy that for 71% of the potential adverse drug reactions identified by a surgery-based medication review, symptoms likely to arise from the drug were being experienced by the patient.

The study has shown that a pharmacist can make a useful contribution to both the medication review process and adverse drug reaction monitoring for elderly patients in the community. As the differences between the two groups of patients in terms of numbers of recommendations made and reports of drugs likely to cause adverse drug reactions were not statistically significant, there is no need for a pharmacist to undertake visits routinely to patients aged 75 years and over; review of the notes would seem to be sufficient.

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Treating acute asthma

Sir,

Patients commonly present to general practitioners with acute asthma associated with respiratory tract infection. The British Thoracic Society guidelines condemn the use of antibiotics in the absence of bacterial infection, and are unclear about the best dose, length of course and method of stopping oral steriods in such situations.[1]

A postal questionnaire, checked for face validity, was sent to all 205 general practitioner principals in Bath District Health Authority in March 1993 and a reminder sent to non-respondents four weeks later. Respondents were asked to outline their management of case histories of an adult and a child presenting with acute asthma associated with respiratory tract infection. The cases were constructed in such a way that they could be managed according to British Thoracic Society guidelines in a general practice setting, without admission to hospital.

Replies were received from 185 doctors (90.2% response rate) of whom 83.2% stated that there was an asthma clinic in their practice and 36.7% reported that they had a special interest in asthma.

Of 179 respondents, 93.3% reported that they would prescribe oral steroids to the adult with acute asthma associated with respiratory tract infection, and of 169 respondents, 87.6% reported they would prescribe oral steroids for the child. With one exception the oral steroid of choice was prednisolone. The modal initial dosage of prednisolone was 40 mg for the adult and 30 mg for the child. The modal duration of treatment with prednisolone was five days for both the adult and the child (Table 1).

Of 167 respondents, 89.2% stated that they would not tail off the course of steroids if the course lasted five days or less, but 46.7% stated that they would tail off the prednisolone if the course lasted between five and 14 days.

Oral antibiotics would have been prescribed for the adult by 66.5% of 179 responding general practitioners and for the child by 58.0% of 169 respondents.

There is some evidence that a 10–14 day course of prednisolone is required to produce maximal response in adults and hence a five day course may represent undertreatment in adults.[2] A study by O'Driscoll and colleagues suggests that tailing off steroid therapy is unnecessary if the course of treatment is less than 10 days, providing that inhaled steroids are continued. The prescription of antibiotics is contrary to the British Thoracic Society guidelines which are based on hospital studies suggesting that oral antibiotics offer little benefit in acute asthma management.[1]

These findings suggest that there is a need to evaluate the common practice of prescribing oral antibiotics in asthma attacks associated with respiratory tract infection in general practice. Clarification of the duration of oral steroid therapy and the need for tapering the course of oral steroids would also be welcome.

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GPs and minor surgery

Sir,

I agree with Dr Kneebone on the training of general practitioners in minor surgery, in that well conducted and organized training courses are necessary to improve the practical skills of general practitioners (editorial, March *Journal*, p.103). However, as well as a sound foundation of basic surgical principles and stitchcraft, I feel that emphasis should also be placed on improving anaesthetic skills.

Correctly used local anaesthetics can provide excellent surgical anaesthesia. However, nerve and field blocks require anatomical and pharmacological knowledge, together with practical skills, to ensure safe administration of local anaesthetic in the correct dose and at the correct anatomical site. Only when so

Table 1. Doctors' reported length of oral steroid therapy for a child and adult presenting with acute asthma associated with respiratory tract infection.

	No. of GPs reporting length of treatment for	
No. of days of oral steroid therapy	Child	Adult
1	6	3
2	13	9
3	43	36
4	8	8
5	60	59
6	1	6
7	9	27
9	1	1
10	1	7
11+	0	2
Until peak flow returns to normal	3	3