In this issue …

Renal disease reduces the production of erythropoietin by the kidneys. If patients then develop uraemic anaemia, Simon Rogers says they will benefit from treatment with a recombinant erythropoietin.

Renin is also produced by the kidney. Duncan Campbell and Karen Duggan explain how new drugs which inhibit renin can help in the management of hypertension.

The management of childhood coughs and colds may involve the use of over-the-counter medicines. Valerie Sung and Noel Cranswick question whether these products are of any benefit. Iodine is found in over-the-counter antiseptics, but is rarely a cause of allergy. Connie Katelaris and William Smith also dismiss iodine as the cause of seafood allergy.
wider curriculum. The skills of the doctors providing training should also meet minimum standards. The doctors should be centrally funded for this role (at present in the UK nurses and pharmacists sometimes have to pay for themselves, or defer training until one of the small number of bursaries becomes available). In some states in the USA, pharmacists are certified by the same board as physicians, which aids local acceptability.

Overall, there is a clear rationale to extend prescribing rights. While it needs continued evaluation, where it has been introduced it seems to have improved access, been liked and, on the evidence of a small number of case studies, been effective. Extending prescribing rights is also logical. The burden of knowledge associated with medicines is vast and expanding, so it makes sense to share the task of prescribing while retaining an integrated system of care.

The role of the doctor is in a transition akin to that which theatre went through in the last century. The doctor’s role has been like that of the great Victorian ‘actor-managers’ – controlling the whole show, making all the key decisions and being centre stage in the action. Medicine is getting too complex for that model to survive. Doctors should move to the equivalent of the theatre director of today. They can set direction, strategy and priorities, working with teams of colleagues, including non-medical prescribers.

References


Conflict of interest: none declared

Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

Warfarin pharmacogenetics

Editor, – Dr Martin has comprehensively reviewed the genetic and environmental factors contributing to the large inter-individual variability in warfarin requirements (Aust Prescr 2009;32:76–80). These factors explain about 50% of such variability which is quite impressive considering that for most drugs, 100% of the dose variability cannot be explained. It is very unlikely that additional genetic factors will be uncovered, as whole genome association studies have clearly identified CYP2C9 and VKORC1 genotype as the major genetic contributors to dosage requirements with a very small contribution by CYP4F2. Other factors that need to be considered are drug-drug interactions, medication adherence, psychosocial factors and the less than optimal system of care for people prescribed warfarin.

The Food and Drug Administration in the US refers to the genetic factors (CYP2C9 and VKORC1) which influence dosage requirements in the product information for warfarin, but Medicare and Medicaid will not pay for the genetic test (except as part of clinical trials) because of insufficient evidence of benefit. There is clearly a need for large scale prospective studies, including pharmacoeconomic studies, before any decisions are made to incorporate genetic testing into best practice guidelines.

In Australia, the situation is complex as some pathology services already advertise the test, but there are no known large prospective multicentre trials being conducted to determine feasibility, interpretation, dosage recommendations and cost-benefit. It is timely that this be done so that Australia, with its different spread of ethnicities and diets, can contribute to the evidence and importantly, that Australian-based cost-benefit analyses and dosage recommendations can be made to determine whether or not warfarin genetic testing should become part of treatment guidelines.

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References