Correspondence

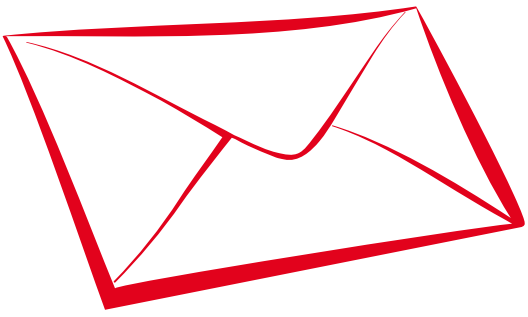
Could I have some CoQ10 please?

Dear Editor

I refer to your article about co-enzyme Q10 in "Upfront", Best Practice September issue. This article was very well presented and I'm quite sure that we'll have to "watch this space" on CoQ10 as research emerges and pharmaceutical companies grapple on how to curb the profits made by supplement manufacturing companies.

The importance of CoQ10 as an anti-oxidant in cell membrane protection and mitochondrial protection is well established. It is also known to be an "energy stimulant" and "has a potential role as a neuroprotectant" (quotes from your article). It is also well established that oxidative stress or free radical damage plays a major part in degenerative disease. The statin drugs inhibit HMG-CoA reductase (the rate limiting enzyme for the synthesis of mevalonic acid), this results in decrease in mevalonic acid, which consequently leads to a decrease in cholesterol and CoQ10.

I would therefore agree with your author that statins lower CoQ10 and I will accept that it is not the low Q10 levels that are the cause for myopathy or myalgic pains. However, it still lowers CoQ10 (an important anti-oxidant). It will therefore make "perfect sense" to advise our patients to take it as a supplement because we are giving them a drug that lowers their bodies' production of this important nutrient. Do we really have to wait for "evidence" when we advise "common sense" in GP practice all the time?



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Correspondence, PO Box 6032, Dunedin
or email editor@bpac.org.nz

While I could agree with the author that a healthy diet should provide enough Q10 for the healthy person, I do not agree that the diet will be providing enough of this nutrient if we are giving a drug that lowers CoQ10. You could just the same argue that pregnant women should get enough folate from green-leaf veggies or red meat is enough to treat iron-deficiency anaemia or rest home patients should spend their afternoons bathing in the sun for their vitamin D needs.

I believe that knowing of this potentially harmful effect of statin drugs, it may in future be unethical or even negligent not to advise patients of using co-enzyme Q10.

Yours truly

Dr Werner Pohl
Gore Medical Centre

As always, we welcome alternative points of view on our material.

However scientific evidence can often be interpreted in opposing ways. It may be that a role for CoQ10 is found in the future but currently there is a lack of evidence for the claims being made. The ethical responsibility of a clinician, is to provide unbiased evidence in order for the patient to make a fully informed decision about their health.

Betaloc CR change

Dear Editor,

While we fear that feedback from the supplier of Betaloc CR is likely to be *a priori* discredited we would like to nonetheless offer the following feedback.

First, the Cardiovascular Sub-Committee of PTAC at their March 2007 meeting noted with respect to dividing anti-hypertensive medications that: "the Subcommittee was concerned about elderly patients who may not be able to break the tablet and pharmacists not providing them with divided tablets without an extra charge." This practical concern is arguably worth noting with respect to Slow-Lopresor as it would potentially directly impact on patients either clinically or financially.

Second, the quality of the advice is somewhat diminished by omitting a cost comparison with other key options. A number of the suggested alternatives are in fact more expensive than Betaloc CR. For example, the cost of Lopresor 50 mg bid is $0.33 versus Betaloc CR 47.5 mg od at $0.26. Similarly, Lopresor 100 mg bd costs $0.66 versus Betaloc CR 95 mg od at $0.44

We hope that these comments assist in your ambition for "Better Medicine".

Dr Lance Gravatt, AstraZeneca