Erratum: clozapine no longer on IMMP

In "Prescribing atypical antipsychotics in general practice", BPJ 40 (Nov, 2011), Page 18, it was stated that clozapine is currently monitored on the Intensive Medicines Monitoring programme (IMMP). Clozapine is no longer monitored on this programme.

Prochlorperazine for nausea and vomiting in pregnancy

Dear Editor,

On reading your article on nausea and vomiting in pregnancy (BPJ 40, Nov 2011), I was alarmed to see that prochlorperazine was listed as a second-line antiemetic. I have worked in gynaecology wards and know that its use was commonplace. However, before prescribing it to a patient recently, I discovered that prochlorperazine is a category C medication. I am not sure if this category was changed recently. I also note that promethazine is a C category. Could you please clarify why prochlorperazine (a category C medication) would be recommended before cyclizine (category A) or why it is recommended at all?

Dr Cassie Granek, GPEP2,
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Antiemetics may be considered for managing nausea and vomiting during pregnancy, when symptoms persist despite dietary and lifestyle interventions. Metoclopramide, prochlorperazine, cyclizine, promethazine and ondansetron have all been used

during pregnancy and are considered effective and safe, although limited data is available in some cases. In the article a suggested order of preference was given, but it was noted that this was variable based on individual patient factors and potential adverse effects. Guidelines differ on recommendations about which order to try these medicines. Metoclopramide is a suitable first choice for many women given the lack of minor side effects associated with it (although it is rarely associated with extrapyramidal symptoms). Prochlorperazine, cyclizine and promethazine are all suitable and effective alternatives, but are also all associated with causing sedation, therefore may be less desirable for some women. Ondansetron is usually reserved for women with severe symptoms (e.g. hyperemesis gravidarum). It is commonly associated with constipation.

The Australian Therapeutic Goods Administration (TGA) has assigned a pregnancy category "C" to both promethazine and prochlorperazine. This category means that the medicine has been associated with (or suspected of) causing harmful effects to the foetus. However, for both promethazine and prochlorperazine, the rating is in relation to giving these medicines in high doses during late pregnancy.[1] There is no association with teratogenicity when these medicines are used at low doses, as an antiemetic during early pregnancy[2, 3, 4]

References:

1. The Australian Therapeutic Goods Administration (TGA). Prescribing medicines in pregnancy database. TGA, 2011. Available from: www.tga.gov.au/hp/medicines-pregnancy.htm (Accessed Nov, 2011).
2. Mazzotta P, Magee L. A risk-benefit assessment of pharmacological and non-pharmacological treatments for nausea and vomiting of pregnancy. Drugs 2000;59(4):781-800.
3. National Institute for Health and Clinical Excellence (NICE). Antenatal care: routine care for the healthy pregnant woman. 2008. Available from: www.nice.org.uk (Accessed Nov, 2011).
4. Australian Medicines Handbook (AMH). Adelaide; AMH Pty Ltd, 2011.

Lipid testing in people with stable angina

Dear Editor,

I note in my latest Personalised Report, "The medical management of stable angina", that you monitor the frequency of my lipid testing.

It has been my custom not to continue annual (or more frequent) testing, on patients who have been established on statins with good therapeutic response, in the belief that once the lipids were stable on a particular dose of statin, the blood profile would not change significantly, that is, unless a patient were to go on a fish-and-chips binge!

Blood pressure tends to drift up with age and warrants intermittent testing, even for those patients well controlled on antihypertensives. This I understand. Will lipids drift upwards too, even if once successfully controlled on statins? That is: is frequent re-testing (yearly or more frequent) necessary for this group of patients, as you seem to imply in your report?

Incidentally, in patients with initially good lipid profiles, I don't retest frequently in the belief that, similarly, unless their dietary habits changed drastically, their lipid profile would be unlikely to change in the short term. I tend to retest such patients after the passage of 4-5 years.

Am I out of step with recommended practice on these points? On the one hand, I don't want to neglect my patients. On the other, I see no point in frequently re-testing a stable lipid profile if it is unlikely to change in the short to medium term.

Dr Alan Kenny, General Practitioner
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It is appreciated that the clinical judgement of the General Practitioner and the patient's preference are likely to guide the need for re-testing on an individual basis, however, when developing a guideline, report or article, advice must apply to populations.

Current New Zealand guidelines recommend annual risk assessment for patients on lipid modification.[1] An annual fasting lipid test may be used to monitor the success of statin treatment and to check and enhance compliance.[2] It may also be used to trigger a discussion with the patient about their ongoing commitment to a low cholesterol diet, weight management and a regular exercise programme. Although these lifestyle factors can be incorporated into any consultation, some patients may be more inclined to listen and act on preventative health care advice if there is a target to achieve or a "bad" result to contemplate.

If a patient has achieved a "good therapeutic response" with statin treatment, annual lipid monitoring may not necessarily help to reduce their cardiovascular risk. However, this relies on several factors - the patient must:

- Remain compliant with statin treatment
- Continue to exercise regularly
- Make no major detrimental changes to their diet (i.e. avoid the fish and chips)
- Stay at a stable body weight
- Not develop any additional health problems that may influence exercise, diet and weight (such as osteoarthritis, depression or a respiratory condition)

If statins are used for primary prevention (rather than secondary prevention such as in a patient with stable angina), annual lipid testing is unnecessary.[3]

There is no evidence that lipid levels increase with age. However, it may help to consider the following points from an Australian study which assessed patients at high risk of cardiovascular events on their knowledge and attitudes about cholesterol and lipid lowering treatment. The study found that:[4]

- 67% of patients knew their most recent cholesterol level
- Of these patients, 69% had a total cholesterol level > 4.0 mmol/L
- 25% of patients were non-compliant with their lipid lowering medicine and 9% of this group thought they did not have to take their medicine because their cholesterol was "under control"
- Although the majority of patients were aware of the importance of a healthy lifestyle, 85% found lifestyle changes, such as a healthier diet and exercise, challenging
- Only 16% correctly identified high cholesterol as an important modifiable risk factor for cardiovascular disease

References:

1. New Zealand Guidelines Group (NZGG). New Zealand cardiovascular guidelines handbook: a summary resource for primary care practitioners. 2nd ed. Wellington: NZGG; 2009.
2. Doll H, Shine B, Kay J, et al. The rise of cholesterol testing: how much is necessary? Br J Gen Pract 2011;61(583):e81-8.
3. National Institute for Health and Clinical Excellence (NICE). Lipid modification. NICE, 2008. Available from: www.nice.org.uk (Accessed Nov, 2011).
4. Carrington M, Retegan C, Johnston C, et al. Cholesterol complacency in Australia: time to revisit the basics of cardiovascular disease prevention. J Clin Nurs. 2008;18(5):678-86.

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz