



Are prescribing restrictions for oxycodone appropriate?

Dear Editor,

Thank you for the excellent article on oxycodone prescribing by Jeremy McMinn. My only quibble is the title – sadly it is not “a disaster in the making”, the disaster is here already. My simple question is why in the world can PHARMAC not make this a Special Authority Drug as soon as possible with strict prescribing criteria. I have NEVER had reason to initiate this drug and am regularly appalled by its careless prescription – often by very junior hospital doctors. Obviously existing dependent patients would need to be catered for but there is no reason in the world why this shouldn't have very tight PHARMAC restrictions placed on it.

Dr Paul Corwin

General Practitioner

Greymouth

We asked Medical Director of PHARMAC, Dr John Wyeth to respond to this letter. His response is as follows:

We appreciate the opportunity to respond to the concerns that have been outlined above on prescribing of oxycodone. We have been aware of the increased use of oxycodone over the last few years and have provided a range of support tools and information to prescribers in order to support appropriate pain management.

PHARMAC's major function is to manage the pharmaceutical budget. The use of the Special Authority mechanism is primarily as a tool to manage pharmaceutical expenditure by targeting access to subgroups of the population who will benefit the most from a medicine, and not to manage appropriate prescribing.

PHARMAC is cognisant of the administrative burden that is required for initiating Special Authorities and we have been spending some

time looking at ways that we can reduce this burden over time, by removing those Special Authorities where we consider they have little to no effect on pharmaceutical expenditure. Having no Special Authority should not indicate to prescribers that the medicine is more effective, safe, or appropriate than any other medicines funded on the Pharmaceutical Schedule – a Special Authority is primarily there to manage expenditure by targeting access to subgroups of the population who will benefit most.

PHARMAC considers that practice issues, such as prescribing of oxycodone over morphine, should be addressed by the medical profession and should be questions that health professionals should consider every time they prescribe a medicine – just because a medicine is available funded doesn't necessarily mean it is appropriate to prescribe in all circumstances.

We are open to further dialogue on this and other issues around appropriate prescribing. The more the medical profession questions the utility and appropriateness of medicines in certain circumstances, the better medicines management will be.

Dr John Wyeth

Re-infection with *H. pylori* does occur

Dear Editor,

As usual I appreciated your publication [Best Tests, May 2014]. My question: after an *H. pylori* eradication programme on a patient from a high prevalence community, do they become re-infected? If not, why not? Presumably antibodies would have been present while they were infected.

Dr J. L. Sarfati

General Practitioner

Wellington

Research has shown that humans do develop an antibody response to infection with *H. pylori*, however, this natural immune response is insufficient to either clear an infection or to prevent re-infection.^{1,2}

Rates of re-infection with *H. pylori* vary widely throughout the world. In people who have had eradication treatment, re-infection rates range from 1% or less in developed countries to 11.5% or more in developing countries, reflecting the


underlying prevalence rate within those countries and therefore a varying risk of re-exposure.^{3,4} Factors associated with a higher risk of re-infection are similar to those that are reported to increase the initial prevalence of *H. pylori* and include lower socioeconomic status, overcrowding and poor sanitation, ethnicity, age and gender. Re-infection rates, for example, appear to be higher in children aged < 10 years and in adult males.^{5,6} Presumably the risk factors that increase re-infection within a high prevalence country will be similar to those that are at work within a high prevalence community.

There is limited data on re-infection rates in New Zealand, however, a small Auckland based study from 1998 reported a rate of 4% per year of follow up in patients treated for *H. pylori*.⁷ The rate referred to in the study is the recrudescence rate (see below) because follow up of patients began at six months after eradication treatment. The authors acknowledge that in other studies if patients who are followed up less than one year since treatment are excluded, the rate decreases significantly and is likely to be due to re-infection rather than recrudescence.

Many studies looking at recurrence rates of *H. pylori* make a distinction, largely based on the time since initial eradication, between two distinct mechanisms – recrudescence and re-infection. Recrudescence refers to a reappearance of the original strain of *H. pylori*, usually within one year of initial eradication treatment.^{3,4} This generally reflects a failure of the eradication treatment* (estimated to be successful in approximately 80% of patients),² due to factors such as antibiotic resistance and poor patient compliance with the initial treatment regimen.^{3,4} Re-infection with *H. pylori*, at least one year after successful eradication, is regarded as the presence of a new infection usually with a new strain of *H. pylori* or with a true re-infection with the original strain (as determined by DNA analysis).^{3,6}

If a patient has a recurrence of symptoms within one year of eradication treatment, it is likely that this will reflect a relapse with the original strain of *H. pylori* and therefore an alternative treatment regimen should be considered, e.g. bismuth-based quadruple treatment. Ensure that the patient understands the importance of completing the course of treatment and that they are able to adhere to the dosing regimen. A further option is to refer the patient for endoscopy. There is limited advice on what treatment should be offered to patients who present again after more than one year since eradication and,

depending on the individual circumstances, discussion with a Gastroenterologist is recommended.

 For more information on *H. pylori* testing, see: "The changing face of *Helicobacter pylori* testing" Best Tests, May, 2014.

* New Zealand guidelines do not recommend routine confirmation of eradication after triple treatment, however, if patients have a recurrence of symptoms, important co-morbidities or complications such as peptic ulceration, confirmation of cure with faecal antigen testing can be requested.

Thank you to **Dr John Wyeth**, Gastroenterologist, Clinical Leader, Capital & Coast DHB, Medical Director PHARMAC and **Dr Rosemary Ikram**, Clinical Microbiologist, Christchurch, for expert review of this answer.

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