EDITORIAL Classifying drugs in pregnancy

be helpful in women who find it hard to stop smoking during pregnancy.

The US Food and Drug Administration has been considering removing the letter categorisations and radically revising the product information in pregnancy.[6] This has proven to be extremely time consuming and has not yet been implemented despite years of discussion and planning.

In Australia, thought should be given to improving product information. More narrative style information of fetal risks in the context of background risk could be included, as well as what data the risks are based on, such as animal or human studies. Information about drugs in breastfeeding along the lines of LactMed[7] monographs could also be included in the product information and would help to inform healthcare providers and women about exposures during pregnancy and breastfeeding.

Sound evidence-based advice regarding pregnancy exposures is currently available to both healthcare professionals and consumers through obstetric drug information services located in most Australian states accessed via the Therapeutics Goods Administration* and through databases like REPROTOX† and The Teratogen Information System‡.

Conflict of interest: none declared

* www.tga.gov.au/hp/medicines-pregnancy-odis.htm (see also the table on page 44)

† http://reprotox.org

‡ http://depts.washington.edu/terisweb/teris

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Letters to the Editor

The Editorial Executive Committee welcomes letters, which should be less than 250 words. Before a decision to publish is made, letters which refer to a published article may be sent to the author for a response. Any letter may be sent to an expert for comment. Letters are usually published together with their responses or comments in the same issue. The Committee screens out discourteous, inaccurate or libellous statements and sub-edits letters before publication. Authors are required to declare any conflicts of interest.The Committee's decision on publication is final.

Topical corticosteroids

Editor, – I enjoyed the article 'Rational use of topical corticosteroids' (Aust Prescr 2013;36:158-61). I did, however, find the sentence 'Topical treatment in children should be used with extreme caution' surprising. In general, topical corticosteroid treatment in children is remarkably safe – so safe that some products are available without any prescription. Possibly the authors were referring to more potent corticosteroids such as mometasone or methylprednisolone. Even then, 'extreme' caution is unnecessary given their excellent safety record, even when substantially misused. The article was otherwise excellent and appreciated.

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Pablo Férnandez-Peñas, one of the authors of the article, comments:

Thank you for your letter. The use of topical corticosteroids may induce atrophy and other adverse effects. If we consider that kids have a thinner skin, with higher absorption, the use of topical corticosteroids in this population should be more cautious. However, we are not saying that topical corticosteroids should be avoided. As we say in the article, 'Topical corticosteroids are safe and effective drugs. Always establish a clinical diagnosis before prescribing an appropriate topical corticosteroid according to the affected area, patient's age, clinical presentation and predicted responsiveness to treatment'.

One big problem with the 'perceived' effect of topical corticosteroids is adherence to treatment. Patients (and relatives) tend to largely exaggerate their use of topical products. This gives some doctors a false sense of security, and it is probably behind the concept of 'tachyphylaxis'. This is when patients say they are using the topical product when they are not, and suggests the disease is 'resistant' to treatment.

Controlled studies have found that atrophy changes appear after seven days of use with moderate potency topical corticosteroids. We should always

keep the risk of atrophy and patients' compliance in mind when prescribing topical corticosteroids, and always give clear guidelines including appropriate treatment duration.

Chronic non-cancer pain

Editor, – Surely in his reply to Dr Vanlint (Aust Prescr 2013;36:184-5) Dr Cohen who wrote the article on prescribing for persistent non-cancer pain (Aust Prescr 2013;36:113-5) would not be endorsing the long-term use of opioids for chronic non-cancer pain in residential aged-care facilities as the quality use of opioid medicines. Any insinuation that long-term opioids are effective or safe for chronic non-cancer pain lacks evidence[1] outside industry-funded research or guidelines. The practice may increase patient suffering by sentencing our patients to opioid-induced hyperalgesia, tolerance and withdrawal. These latter two problems have recently been determined to be physiological and not contributing towards the definition of dependence.[2]

In a US observational study in the elderly, the all-cause mortality hazard ratio of opioids was 1.87 compared to non-selective non-steroidal anti-inflammatory drugs with increased risk of falls, fractures, cardiovascular events and acute renal injuries.[3]

Those with heroin dependence rarely make it to residential aged-care facilities, but I have had two people on methadone programmes admitted for care through their final illnesses, including one who continued injecting during visiting hours. Nursing staff found illiberal opioid provision challenging.

The current increase of opioid use in residential aged-care facilities puts pharmacists and nursing staff at risk during supply and storage. Even their disposal may lead to 'dumpster diving' or fossicking for discarded opioid patches.

Opioids do not cure chronic non-cancer pain. They frequently usurp quality multimodal care as outlined in Dr Cohen's article which may include psychotherapies and physical therapies such as Tai Chi.[4] Whether or not 'addiction is not an issue in the elderly', long-term opioids should be avoided in chronic non-cancer pain as they are ineffective, may increase pain and cause morbidity and mortality.

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Milton Cohen, the author of the article, comments:

It is clear from Dr Holliday's language – 'insinuation that long-term opioids are effective' and 'sentencing our patients' – that he takes a very strong anti-opioid stance in the management of chronic non-cancer pain. I do not argue that this is unjustified, especially given the great difficulty in actually performing studies to determine the long-term effectiveness of opioids in this context.

However, I would argue for a pragmatic perspective. Chronic non-cancer pain is not 'curable' and a multimodal approach to management is likely to be associated with a better quality of life for the patient compared with a single modality drug-based approach. In my article, the importance of reducing distress by controlling symptoms was emphasised, as was the principle that drug therapy – any drug, including opioids – is an ongoing trial of therapy.

In this area, there is a tension between inappropriate prescriber behaviour and unsanctioned user behaviour.[1] Dr Holliday's example of the latter is indeed distressing and challenging and may well be a consequence of inappropriate prescribing. This is all the more reason for disseminating pragmatic principles for prescribing.[2] In the hands of a conscientious, well-informed prescriber, why should a resident in an aged-care facility be denied a **trial** of opioid under these principles? Given the limited therapeutic options in this population, surely this is an **opportunity** for the quality use of medicines.

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