

Remuneration to rise by 3.6 per cent

A REVISED offer of a 3.6 per cent increase in community pharmacy remuneration has been accepted by the Pharmaceutical Services Negotiating Committee.

The offer, backdated to 1 April, is expected to turn a nearly £5m underpayment from last year into a £5m overpayment by the end of this financial year because the Department of Health does not intend to change any of the current professional fees for National Health Service dispensing.

Sue Sharpe, PSNC chief executive, said: "We were very surprised to learn that they had made no dispensing volume forecast. At present the trend suggests a 6 per cent increase and the Department now suggests that it will be 6.25 per cent. We have had no discussions about how, or if at all, there should be any fee adjustments."

Making it clear that the PSNC is not going to propose cuts, Mrs Sharpe added: "The issue for them is at what point they are going to come to us to make changes."

Other matters considered at the PSNC November meeting are reported below.

Cost modelling Thirty representative pharmacies will get a test questionnaire in the next few weeks to help develop a model for the costing of NHS pharmaceutical services. The PSNC and the Department want to arrive at a common understanding and to develop a model that can be used to test changing demands and workforce configurations. The outcome is not expected until the end of 2003. "We hope that future fund-



No changes are proposed to the fees for dispensing prescriptions. This will lead to a £5m overpayment by the end of this financial year

ing can be negotiated from a rational evidence base," said Mrs Sharpe. "There is general acknowledgement and understanding in Government that the global sum does not provide reward for services or cover the full cost of providing them."

Three-year planning The newly constituted local pharmaceutical committees will want to see the planning at an early stage. "This could be detrimental for quite a period of time if there isn't funding for locally negotiated pharmacy services," Mrs Sharpe warned (*PJ*, 16 November, p701).

Workforce The PSNC is to support in broad terms the Department's proposals for delegating tasks to pharmacy technicians (*PJ*, 5

October, p469) and the regulation of NVQ level 3 technicians by the Royal Pharmaceutical Society. Of more concern to the PSNC is the proposal to require all pharmacy support staff to be qualified to NVQ level 2. This could create a catch-22 because no one would be able to work in a pharmacy without the qualification and no one would be able to get the qualification because it requires job-based training, said Mrs Sharpe. The proposal would be acceptable if trainees were to be allowed and if employers were to be allowed six to eight weeks to assess new staff before embarking on training. The PSNC rejected the proposal that pharmacies should continue to operate while pharmacists are absent for short periods because this would jeopardise patient safety and convenience.

Repeat dispensing The Department has increased its offer for pharmacies involved in repeat dispensing pilots to a startup fee of £150 per pharmacy, plus £100 a month and funding for any increase in prescription volume. It expects there to be low take-up among general practitioners and patients. "We've accepted this as an interim arrangement for pathfinder sites on the basis that the Department will fund the increased prescription volume," Mrs Sharpe said. "There is no agreement on a long-term basis for funding." The PSNC has asked for an assurance of full funding for any amendments to the terms of service that might be necessary to introduce repeat dispensing nationwide.

Prescribing given official go ahead

PHARMACISTS will be able to prescribe medicines on the National Health Service from next year and nurses will be able to prescribe a wider range of medicines.

Following consultations on its proposals for supplementary prescribing powers for pharmacists (*PJ*, 26 October, p593), the Department of Health announced full details of the scheme on 21 November, after *The Journal* had gone to press.

The announcement was made by Parliamentary Under-Secretary of State Lord Hunt at St Thomas' Hospital, London. In its consultation paper [MLX 284], the Department proposed that supplementary prescribers should share responsibility for the management of individual patients under a written clinical management plan agreed by the independent and supplementary prescribers and the patient.

Full details of the Department's announcement will be analysed in next week's issue of *The Journal*.

The outline curriculum for pharmacists wishing to become supplementary prescribers is also now available on the Royal Pharmaceutical Society's website (www.rpsgb.org.uk) having been agreed by the Society's Council.

LPS assessments are appallingly inadequate — PSNC vice chairman

ASSESSMENTS by primary care trusts of the impact of local pharmaceutical services proposals on existing pharmacy services are appalling, according to Pharmaceutical Services Negotiating Committee vice-chairman Steven Williams.

Speaking at a Dispensing Doctors' Association conference on November 16, Mr Williams said that LPS applicants could move into any area and destabilise the provision of existing NHS pharmaceutical services by bypassing the new contract controls built into the national pharmacy contract.

"The only safety net for existing contractors is that PCTs should consider an

impact assessment which sets out how existing services would be affected should the LPS application be granted," he said. "I have to say that that the PSNC is, quite frankly, appalled at the way such assessments are being carried out."

Mr Williams said that assessments had been carried out with as little as a single telephone call with two questions and no opportunity for existing contractors to make any comments. PCT staff conducting the assessments were adopting a cavalier and arrogant attitude. The PSNC was sufficiently concerned about this to take it up with the Department of Health.

YPG to call for SGM on modernisation

THE Young Pharmacists Group annual general meeting heard that the group would be writing to the Royal Pharmaceutical Society soon asking for a date for a special general meeting to discuss the Society's modernisation programme. If the Society does not call one, the YPG will seek the support of individuals in other pharmacy bodies to call one themselves.

The Society's membership needs to have an adequate say, said Noel Wicks, YPG chairman, and to discuss other options to the one put forward by the Society's Modernisation Group. The YPG has also written to the chief pharmaceutical officer at the Department of Health, Dr Jim Smith, requesting a meeting to discuss the YPG's concerns.

Doubts over prescribing training funds

FUNDS from the global sum will not be siphoned off and given to primary care trusts to pay for pharmacists to undertake supplementary prescribing training, Sue Sharpe, chief executive, Pharmaceutical Services Negotiating Committee, said during a question time session at the Young Pharmacists Group annual conference in London this week.

The issue is whether or not pharmacists are included when funds are allocated by the Government for training, she said. The training of nurses was funded by the Government, but the Government would say that nurses are all in the employed sector. "Just as they will fund nurses within secondary care, and some in primary care, so they will fund people who are directly employed within the managed service, but cases where they get ambivalent include community pharmacists," she commented.

Mrs Sharpe said that the first training courses on supplementary prescribing should start in the spring. Community pharmacists, together with primary care and hospital pharmacists, are expected to be included in these early programmes. "If community pharmacists with diplomas want to claim exemptions from parts of the training programme, that is going to be for them to sort out with the accrediting bodies."

It will be primary care trusts who will decide who they want to train in primary



Sue Sharpe: training will not come from the global sum

care and secondary care trusts for secondary care. "The issue may come within community pharmacy of whether PCTs will be happy to fund wholly the private sector," she added.

However, Gul Root, Principal Pharmaceutical Officer at the Department of Health said at another session during the conference that funding for training would be available through the workforce confederations from April.

Martin Anderson, commercial director, Association of the British Pharmaceutical Industry, said that training requirements and the potential use of supplementary pre-

scribing pharmacists will differ between primary and secondary sectors. Although he thinks that it can work in both sectors, he said: "It is easier for me to see it working a secondary care environment because of the access to records, than in primary care."

Tony West, chief pharmacist, Guy's and St Thomas' Hospitals, said: "I think it would be a failure for the profession if there was not legitimised supplementary prescribing by pharmacists, wherever they may be based, by this time next year."

Answering a question on whether technicians dispensing and handing prescriptions to patients in the absence of a pharmacist is a risk or an opportunity for pharmacists, Mr West said that it is a case of whether safe systems at work can be provided without the pharmacist present and how far away you can take the pharmacist from the process. Pharmacists still need to be there for prescriptions that do not fit protocols, he said.

Mrs Sharpe added that there is a need to consider what is best for the patient and that is for the patient to have access to the pharmacist for clinical input. She questioned why the pharmacist should be moved out of the pharmacy. "The PSNC thinks that there is an enormous amount that the pharmacist can do in the pharmacy and it simply does not make best use of the pharmacist resource if they are not there."

Start steroids early in meningitis

EARLY treatment with dexamethasone improves outcome in patients with acute bacterial meningitis, a new study shows.

Researchers randomly assigned adult patients with acute bacterial meningitis to receive either dexamethasone 10mg (n=157) or placebo (n=144), taken 15 to 20 minutes before or with the first dose of antibiotic and then every six hours for four days.

Adjuvant treatment with dexamethasone reduced the risk of an unfavourable outcome (death, a vegetative state or moderate or severe disability) by 10 per cent (absolute risk reduction) compared with placebo (15 per cent versus 25 per cent). The proportion of patients who died was 7 per cent in the dexamethasone group and 15

per cent in the placebo group. Although dexamethasone was found to be of benefit in those with pneumococcal meningitis it did not provide a significant benefit in those with meningitis due to *Neisseria meningitidis*. Of the 108 patients with pneumococcal meningitis, 26 per cent in the dexamethasone group had an unfavourable outcome compared with 52 per cent in the placebo group. However, the researchers recommend that a four-day regimen of dexamethasone 10mg given every six hours, starting before or with the first dose of antibiotics, should be given to all patients with acute bacterial meningitis.

The study is published in *The New England Journal of Medicine* (2002;347:1549).

Model pharmacy project progresses

NEARLY £80,000 has been raised for the Young Pharmacists Group model pharmacy project.

Project manager Mark Koziol said at the YPG conference last weekend that he was confident that the amount raised would exceed £100,000 by the spring, when the fundraising officially ends.

During 2003, the group will decide where to open the pharmacy.

It is likely that the group will opt for an inner city location, so it is possible that the pharmacy could be eligible for development grants, and one which is near a school of pharmacy, so that academic links could be established.

Irish post-deregulation review to curb monopolies

MEASURES to curb the growth of monopolies in pharmacy in the Irish Republic are likely to be recommended by a review group currently drafting a new regulatory system in the aftermath of market liberalisation.

The group, which is due to report to Health Minister Micheal Martin before the end of the year, is understood to be considering capping the number of pharmacies which can be operated by any one company. It is believed that any one company will also

be limited to 10 per cent of pharmacy contracts in each health board area.

The Republic's pharmacy sector is currently dominated by Gehe, which has some 50 outlets following its delayed takeover of the Unicare chain last summer. Because the proposed capping will not be introduced retrospectively, Gehe's position as market leader will not be directly affected.

The group is also expected to recommend that pharmacy contracts be

reviewed on a periodic basis and that the transferring of contracts be banned. It will also voice opposition to the locating of pharmacies within doctors' surgeries, on the grounds that so-called one-stop-shops represent unfair competition.

The minister is expected to include most, if not all, of the recommendations in new legislation that will go before the Irish parliament early next year.

WHO calls for more international aid to pay for vaccination programmes

MORE international aid is needed to pay for vaccination programmes in developing countries, according to the World Health Organization.

Currently, nearly three-quarters of the world's children are being reached with essential vaccines, but there are wide variations. Children in developed nations have access to newer and more expensive vaccines against major childhood infections, including hepatitis and *Haemophilus influenzae* infection.

But only half of children in sub-Saharan Africa have access to basic immunisation against common diseases such as tuberculosis, measles, tetanus and whooping cough. In poor and isolated areas of developing countries, vaccines reach fewer than one in 20 children.

A joint WHO, UNICEF and World Bank report, published this week, cites low donor investment as one of the major reasons for the gaps in coverage. External aid to developing countries for immunisation currently stands at approximately \$1.56bn a year. An extra \$250m a year would mean

that at least 10 million more children could have basic vaccinations, and a further \$100m a year would cover the cost of newer vaccines, including hepatitis B and Hib. "In wealthy countries we tend to take the absence of certain illnesses for granted," said Dr Gro Harlem Brundtland, WHO director-general.

"But in many regions of the world it is more the rule than the exception for children to die of common childhood conditions such as measles, which alone causes about 700,000 deaths a year. We need to act fast and effectively to ensure that children and adults everywhere have access to life-saving vaccines. From a global perspective, this is the only way of avoiding major epidemics of new and old diseases," she said.

It is estimated that hepatitis B causes 520,000 deaths every year worldwide and *Haemophilus influenzae* type B kills 450,000 children in developing countries, but the report says that a low level of investment in immunisation within developing countries themselves is another contributing factor to low vaccination coverage. Links to the

report can be found on the *Pfj Online* links page (www.pjonline.com/links).

Ciprofloxacin resistance is on the increase, latest PHLs data show

GONOCOCCAL resistance to ciprofloxacin has increased, according to data gathered by a Public Health Laboratory Service surveillance programme.

The gonococcal resistance to antimicrobials surveillance programme 2001 report, published last week, shows that 3.1 per cent of isolates were resistant (1mg/L) in 2001, compared with 2.1 per cent in 2000. In addition, a further 2.6 per cent of isolates showed intermediate resistance to ciprofloxacin (0.125 to <1mg/L).

The report also notes that prevalence of ciprofloxacin resistance was relatively high in the north west (8.6 per cent) and south east (5.2 per cent) of England last year, but low London (1.8 per cent). Fewer isolates collected in 2001 showed penicillin resistance — 8.1 per cent compared with 9.2 per

cent in 2000 — and although tetracycline resistance decreased, it remained relatively high last year — 32.5 per cent of isolates, compared with 37.6 per cent in 2000.

All gonococcal isolates were susceptible to spectinomycin and ceftriaxone and only six (0.3 per cent) were resistant to azithromycin.

Current guidelines recommend penicillin or fluoroquinolones (ciprofloxacin or ofloxacin) for the treatment of uncomplicated gonococcal infection, and the PHLs says that both the increase in ciprofloxacin resistance and the pockets of high prevalence are a cause for concern, because ciprofloxacin remains the first line treatment in many genitourinary clinics.

Links to the report can be found on the *Pfj Online* links page (www.pjonline.com/links).

Two winners for Prix Galien award 2002

HERCEPTIN (trastuzumab) and Glivec (imatinib) share this year's United Kingdom Prix Galien award for innovative pharmaceutical products, it was announced last week.

Trastuzumab, manufactured by Roche, is licensed for the treatment of metastatic breast cancer where tumours overexpress human epidermal growth factor receptor 2 (HER2). Imatinib, manufactured by Novartis Oncology, is licensed for the treatment of chronic myeloid leukaemia and malignant gastrointestinal stromal tumours.

Other finalists for the award included Avandia (rosiglitazone), Dovobet (calcipotriol and betamethasone), Enbrel (etanercept), Keppra (levetiracetam), Malarone (atovaquone and proguanil) and Viraferon-Peg (peginterferon alpha-2b).

Pharmacies will not be sent compendiums

COMMUNITY pharmacies will not receive free copies of the 2003 edition of the Medicines Compendium. Instead they will have to purchase them through the Pharmaceutical Press.

Steve Mott, executive director of Data-pharm, publishers of the compendium, said that an error had been made in information given to *The Journal* last week (*Pfj*, 23 November, p699). "We are trying to move people away from the printed book. We make over 12,000 changes a year to the elec-

tronic compendium and pharmacists need access to the most up-to-date information," he said.

Funding from the pharmaceutical industry will only cover distribution of free copies to hospital pharmacies and general practitioners' surgeries. However, Mr Mott added that a number of requests for the compendium had already been received from pharmacies and the matter would be kept under review. The electronic compendium can be found at www.emc.vim.net.

BRIEFLY

Arthritic pain follows body clock

Levels of pain intensity and stiffness in arthritis appear to follow the body's circadian rhythms. Three-quarters of the 21 patients in the study felt most pain and stiffness in the morning and at bedtime, and least during mid-afternoon. The authors say the predictability of arthritic pain could be used to time treatment for maximum effect (*Annals of the Rheumatic Diseases* 2002;61:1075).

GMC rules will match other regulators'

THE Government has made minor changes to the proposed regulations which will govern the modernised General Medical Council, following public consultations.

The main objective of the GMC in exercising its functions will be "to protect, promote and maintain the health and safety of the public". This is in line with the provisions made for the Nursing and Midwifery and the Health Professions Councils.

The GMC will have to co-operate with public authorities and other bodies concerned with the employment and training of doctors, including the medical colleges. It will have a duty to inform the public about its work and will have to publish a register of members' interests.

However, the GMC will not have to consult the Council for the Regulation of

Health Care Professionals about every change it wants to make to its own rules.

The changes were announced by the Department of Health after formal consultation on a draft Order drawn up under Section 60 of the Health Act 1999. These drafts must be published at least three months before being laid before Parliament and the results of any consultations must also be published.

The Department said that only around 70 responses had been received from over 1,200 invitations to comment on the draft Order. However, it also noted that the proposals were subject to earlier consultation by the GMC itself.

The changes will now be incorporated in the Medical Act 1983 (Amendment) Order 2002. Most of the major changes

announced in the draft Order remain substantially as proposed (*PJ*, 25 May, p709). These include the need for doctors to have licences to practise medicine, which must be revalidated periodically.

Under the General Medical Council (Constitution) Order 2002, the GMC will be reduced from 104 to 35 members, of whom 19 will be elected, two appointed (one by university medical schools and one by the colleges), and 14 nominated (or lay) members. All the existing members of the GMC will have to stand down but they can seek re-election, appointment or nomination as appropriate.

Copies of the consultation documents and the proposed Order can be downloaded via the *PJOnline* links page (www.pjonline.com/links).

NHS to target health inequalities

THE National Health Service is to give a greater emphasis to tackling health inequalities following a review carried out by the Department of Health and HM Treasury.

There will be an accelerated drive to combat smoking, the principal cause of avoidable death in the United Kingdom. There is to be greater use of smoking cessation products following a "cash-back" agreement with the four main pharmaceutical companies which manufacture these products. The companies will give rebates

to the Government when products purchased by the NHS exceed certain thresholds. This will allow local health services to invest in these products, the Department says.

The cross-cutting review on health inequalities says that the top priorities should also include improving homes and reducing accidents, and improving the support for young children and teenagers.

Copies can be downloaded via the *PJOnline* links page (www.pjonline.com/links).

Lambourn Pharmacy wins business award



Graham Jones (right) receives his award from Chris Etherington, managing director of UniChem

GRAHAM JONES, proprietor of Lambourn Pharmacy in Berkshire, is the overall winner of UniChem's Great Business awards, which were announced last week.

The judges praised Mr Jones for making his pharmacy an integral part of the community. He has been involved in a number of local health campaigns, including establishing a dental practice and an action group to tackle increased drug-use among young

people. Mr Jones won £1,000 and two places at UniChem's next convention in Dubai.

Other winners were Iain Ashby and Andrew Burr of Primary Care Pharmacy, Tamworth, in the business development category; Yogesh Patel of Prime Care Pharmacy, Telford, in the promoting the business category; and Vrinder Mehta of H. A. McPharland Pharmacy, Slough, for building relationships in the community.

BRIEFLY

Executive boosts diabetes funding

Diabetes services in Scotland will get £1.55m of new investment, Health Minister Malcolm Chisholm announced last week. Mr Chisholm said he would be taking advice from the Scottish Diabetes Group as to how the money should be spent. The funding will be over three years, starting with £300,000 in 2002-03, followed by £700,000 and £550,000 in the following two years.

AAH Point on internet

AAH Point, the customer information service for AAH Pharmaceuticals, is now available to pharmacies through the internet (www.aah-point.com), as well as via the AAH intranet.

Lloyds high achievers

Twelve employees of Lloydspharmacy have recently completed its 18-month management development programme for high achievers. The scheme consists of four modules, projects and mentoring with external assessments leading to the Open University's professional certificate in management. Several of the employees have already been promoted.

Lexon opening

Jacqui Smith, Minister of State for Health and Member of Parliament for Redditch, opened a new 80,000 sq ft distribution centre at Redditch for short-line wholesaler and importer Lexon last week. The company now employs 165 people.

PIs 15 per cent of NHS drugs spend

Parallel imports account for 15 per cent of all medicine sales to the National Health Service, Parliamentary Under-Secretary of State for Health David Lammy said in a written answer in Parliament.

Statins not to be withheld in the elderly

THERE is no longer any justification for withholding statin therapy from older patients, Professor James Shepherd, University of Glasgow, said this week at the American Heart Association annual scientific sessions in Chicago.

He was presenting data from the prospective study of pravastatin in the elderly at risk (PROSPER), a trial designed to examine whether the benefits of statin therapy in reducing cardiovascular events in middle age can be extended to the elderly.

"Until now, physicians have not had the clinical evidence to demonstrate the benefits of statin therapy in older patients," Professor Shepherd said.

Data from the trial, in which 5,804 men and women aged 70–82 years were randomised to receive either pravastatin (Lipostat) 40mg or placebo daily, show that elderly patients treated with pravastatin for three years suffer fewer coronary events than those given placebo. Pravastatin lowered low-density lipoprotein cholesterol levels by a third and reduced the combined end point of coronary death, non-fatal heart attack, and fatal stroke by 15 per cent (408 events versus 473 for placebo, $P=0.014$).

When risks were analysed separately, the researchers noted a 19 per cent reduction in coronary events ($P=0.006$) but no significant reduction in cerebrovascular events. Professor Shepherd explained that the lack of observed benefit in stroke reduction was likely to be because patients were only followed for an average of 3.2 years (previous statin trials have shown benefits in terms of stroke prevention only after five years of treatment). He added that the trial was

designed to follow patients for a shorter period because it was recognised that most of the patients would be in their last decade of life.

On average, patients in the study were already being treated with three or four different medicines each day. "If we added another drug in the form of pravastatin, would we create an increased risk of drug-drug interaction as a consequence of that polypharmacy," Professor Shepherd asked.

Professor Peter Macfarlane, another of the Glasgow study investigators, told *The Journal* that pharmacists involved in chronic disease management could be reassured by the study. "Patients were taking up to 16 different drugs but we saw no increase in the risk of myopathy, no cases of rhabdomyolysis and no increase in liver function abnormalities," he said.

One finding that is likely to provoke some debate is the increased incidence in newly diagnosed cancer seen among patients treated with pravastatin (hazard ratio 1.25, 95 per cent confidence interval 1.04–1.51, $P=0.020$). However, Professor Shepherd pointed out that this finding was likely to be due to chance because there was no pattern to suggest that a particular tissue was being affected. In addition, a meta-analysis of cancer rates in randomised placebo controlled trials including PROSPER showed no association between use of pravastatin, or other statins, and an excess risk of cancer.

Results from previous observational trials have also suggested that statins might slow cognitive decline in patients with vascular disease. This was not observed in

PROSPER, a finding that is in line with results from the Heart Protection Study (*P7*, 6 July, p4).

Data from PROSPER, which was sponsored by Bristol-Myers Squibb, are also published this week in *The Lancet* (2002; 360:1623).

n Heart costs analysis A suggestion in last week's *Journal* (p706) that a cost analysis of the Heart Protection Study was to be presented at the American Heart Association scientific sessions in Chicago this week was incorrect. An economic analysis of the PROSPER trial had originally been planned but was not presented.

Enoxaparin and tirofiban fail to show benefit for MI

A TRIAL designed to determine whether enoxaparin (Clexane) and tirofiban (Aggrastat) could reduce the risk of adverse outcomes in heart attack patients who were either ineligible or too late for thrombolytic therapy has shown that neither therapy adds any benefit compared with unfractionated heparin.

Presenting the results at the American Heart Association scientific sessions in Chicago, Dr Marc Cohen, Newark Beth Israel Hospital, New Jersey, said: "There are clearly too many patients who are too late [for standard treatment]. The question is what do you do? There are no guidelines because there's been a relative paucity of information on this sizable group of patients." He added that at least one in five patients who experience a myocardial infarction (MI) and arrive at hospital in time to receive reperfusion therapy are not treated with a thrombolytic agent.

The study involved 1,224 patients with ST-segment elevation MI (STEMI) who

had not received reperfusion therapy (thrombolytics or coronary intervention). Patients were randomised to one of four treatment options: enoxaparin plus placebo; enoxaparin plus tirofiban; unfractionated heparin plus placebo; or unfractionated heparin plus tirofiban.

The incidence of death, a second MI or recurrent angina at 30 days was similar for all treatment strategies (15.7 per cent for all patients treated with enoxaparin versus 17.3 per cent for all unfractionated heparin patients, $P=0.471$, and 16.6 per cent for all tirofiban patients versus 16.4 per cent for all placebo patients, $P=0.896$). There were no significant differences in the rates of major haemorrhage among the treatment regimens. "The primary endpoint of the study [to show that enoxaparin reduces adverse outcomes at 30 days] was not met in this challenging population. But it is fair to say that enoxaparin had a similar efficacy and safety profile to unfractionated heparin," Dr Cohen said.

He went on to say that adding tirofiban to the treatment regimen also failed to reduce adverse outcomes, although a *post hoc*

analysis of patients treated within 12 hours appeared to show some benefit for tirofiban.

Commenting on the trial, Dr Sidney Smith, Chapel Hill, North Carolina, said that presentation of negative data was critical for improving patient care. "We need to turn to other therapies for this group of patients. And we need to educate patients to seek care sooner after the onset of symptoms," he concluded.

BRIEFLY

Low-dose doxycycline for the heart

A sub-antimicrobial dose of doxycycline could be used to modulate inflammation in acute coronary syndromes.

Researchers randomised 50 patients to receive doxycycline 20mg or placebo twice daily for six months and found that levels of C-reactive protein and interleukin-6 (markers of inflammation) were reduced by 46 per cent and 34 per cent, respectively, in the doxycycline group.

The *Journal* attended the American Heart Association scientific sessions courtesy of Bristol-Myers Squibb.

Patients with coronary heart disease should consider fish oil supplements

PATIENTS with coronary heart disease (CHD) should consume one serving of oily fish or three fish oil supplement capsules a day, according to new recommendations from the American Heart Association.

The AHA already advises that everyone should eat at least two servings of fish each week but has now expanded its guidance to include recommendations for patients with documented CHD and for patients with raised triglyceride levels.

Dr Penny Kris-Etherton, professor of nutrition at Pennsylvania State University, and Dr William Harris, from the AHA nutrition committee, put forward the recommendations at the AHA annual scientific sessions held in Chicago earlier this week. They said that people with CHD should consume 1g of the omega-3 fatty acids eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) every day. Patients with raised triglyceride levels should consume 2–4g of EPA/DHA per day.

The AHA says that a dietary approach to increasing omega-3 fatty acids is preferable but acknowledges that for patients with CHD or raised triglyceride levels these doses may be greater than can be readily

achieved through diet alone. "For these individuals who cannot or will not eat fish the evidence supports the use of supplements to decrease the risk of heart disease and stroke," Dr Harris said.

Dr Harris pointed out that most fish oil supplements contain about 0.3g of EPA/DHA, so three capsules would be needed to approximate the recommended daily dose for patients with CHD. He added that one capsule of Omacor, launched last week in the United Kingdom (*Pf*, 16 November, p700), provides 1g of EPA/DHA.

The recommendations are also published this week in *Circulation* (2002; 106:2747).

n Omega-3 fatty acids for children with high cholesterol Data presented at the AHA meeting suggest that DHA supplementation in children with high cholesterol levels improves endothelial function.

A total of 14 children were given either a supplement of DHA or placebo for six weeks after eating a low fat diet for a similar period.

Using an ultrasound technique the researchers measured changes in the size of blood vessels in response to increases in

blood flow. They found that dilation of the blood vessels increased from 6.0 (± 2.1) per cent to 6.3 (± 2.8) per cent after six weeks of a low fat diet and then increased to 8.2 (± 3.0) per cent after DHA supplementation ($P < 0.001$).

Clopidogrel of benefit in coronary intervention

PATIENTS undergoing percutaneous coronary intervention (PCI) benefit from long-term treatment with clopidogrel (Plavix), researchers report. In addition, pretreatment with the drug can increase the beneficial effects if given early enough before PCI.

Dr Steven Steinhubl, University of North Carolina, Chapel Hill, speaking at this year's American Heart Association scientific sessions in Chicago, said that compared with two to four weeks of clopidogrel, clopidogrel therapy that is continued for one year after PCI is associated with a reduction in the incidence of ischaemic events.

He explained that 2,116 patients were randomised to receive a 300mg loading dose of clopidogrel or placebo three to 24 hours before PCI. All patients received daily clopidogrel 75mg and aspirin at the time of the procedure and for 28 days after that. After this four-week period, patients who had not received a loading dose of clopidogrel were switched back to placebo. Those who had been given clopidogrel continued to receive the drug. All patients were treated with aspirin for the duration of the study.

The researchers found that for patients on long-term clopidogrel treatment, the combined risk of death, myocardial infarction or stroke was reduced by 27 per cent (95 per cent confidence interval 3.9–44.4, $P = 0.023$). "There was a 3 per cent absolute reduction in risk from 11.5 per cent to 8.5 per cent and importantly the benefit was similar in all sub-groups studied," Dr Steinhubl said. He added that the degree of benefit was similar for individual components of the combined endpoint.

There was an increase in the incidence of major bleeds in patients randomised to long-term clopidogrel, although nearly all were associated with an invasive procedure.

"If the results from this trial were applied to the 1.5 million people expected to undergo a PCI this year, over 50,000 patients who would otherwise have suffered a heart attack or stroke, or died, would not," Dr Steinhubl concluded.

Heart disease is the most costly condition in the UK

CORONARY heart disease (CHD) cost over £7bn in 1999, making it the United Kingdom's most expensive medical condition, according to health economists.

Researchers from the Institute of Health Sciences in Oxford calculated that the cost of CHD to the National Health Service was £1.73bn, while informal care costs and/or revenue lost due to decreased productivity amounted to about £5.3bn. Just over half of NHS cost was attributed to hospital inpatient care (£917m) and about a third to drug treatment (£558m) (*Heart* 2002;88:597). This latest estimate for the total cost of CHD is some seven to 10 times higher than that calculated by previous studies. The researchers say this is because previous studies have not taken lost productivity and earnings into account when calculating the total financial burden of the disease.

CHD is followed by back pain as the next most expensive condition, which cost the UK about £6.8bn in 1999, and rheumatoid arthritis, costing £2bn. Alzheimer's disease and lower respiratory tract infections cost the NHS alone approximately £2bn and £1.8bn, respectively — more than back pain and CHD. However, there are no data on other costs, so the total burden of these conditions on the UK economy is not known.

n Myocardial infarction audit Data from the first Myocardial Infarction Audit Project has revealed that hospitals in the UK are, on average, meeting Government targets for prescribing aspirin, beta-blockers and statins to patients who have had a heart attack. However, they fare less well in terms of the time it takes to initiate thrombolytic treatment when a patient first arrives at the hospital. The Government says that three-quarters of those needing thrombolysis should receive it within 30 minutes of arrival, however only 28 per cent of hospitals met this target in the first half of this year.

The audit was published this week by the Royal College of Physicians clinical effectiveness and evaluation unit, and can be viewed via the *Pf Online* links page (www.pfonline.com/links).