

Home oxygen hits problems days into new service

The new home oxygen service, which came into effect on 1 February, has run into problems within days of its introduction and community pharmacists are being asked to continue to provide a service.

"The principal cause has been disregard of the Department of Health's advice to GPs on when to issue a new Home Oxygen Order Form (HOOF)," the Pharmaceutical Services Negotiating Committee said. "In many areas the transfer of the oxygen service to the new providers is utterly chaotic, particularly where GPs have issued the new HOOFs for all their patients with effect from 1 February. . . . These initial problems highlight the fragility of a system based on having only a single provider for a large region," PSNC chief executive Sue Sharpe added.

HOOFs are not being filled in correctly and there are delays in the generation of an electronic order receipt, John D'Arcy, National Pharmacy Association chief executive, explained to *The Journal*. "People are then phoning to see what has happened to orders — and this is all leading to increased demand on the system."

The DoH said it is reinforcing messages to GPs that orders for oxygen should clearly

state the service required to enable suppliers to meet response times. "We are also advising GPs, if they are concerned about possible delays to their patients who are using oxygen cylinders, that they can arrange with local pharmacies to continue to provide this service. . . . We recognise that some pharmacists have made plans to withdraw from the service but that many pharmacists remain ready to maintain a service to patients," a spokeswoman said.

NHS Primary Care Contracting commented: "Pharmacy contractors that supply against an FP10 prescription will be paid until the patient transfers to a new supplier. Gas suppliers will continue to supply community pharmacies. . . . Pharmacies should continue with arrangements to wind down cylinders stocks and return to suppliers as patients transfer to new suppliers over the six-month transition period. Pharmacy contractors should also advise patients that they do not need to contact the supplier — the supplier will contact them in good time."

Air Products and Vitalair have acknowledged that the high volume of calls has caused delays. Both companies have increased their resources to meet demand. In a statement Air



New oxygen supply system is in chaos

Products added: "A period of transition had always been built into the new service arrangement. This included the continuation of GPs prescribing cylinder supplies for patients which they then obtain from pharmacists."

The companies should have foreseen problems, however, Mr D'Arcy believes. "Pharmacists are doing their best and the extra cylinders that some pharmacies ordered are proving crucial. . . . And as yet, as far as I am aware, no patient has gone without oxygen, but that is purely down to the efforts and goodwill of pharmacists," he told *The Journal*.

Care home staff failing to administer drugs to patients appropriately

Some care home managers are failing to ensure that staff use basic training given by community pharmacists in how to administer medicines to patients. This is according to the head pharmacist, Hazel Sommerville, at the Commission for Social Care Inspection following its damning report into medicines management in care homes published this week. The problem is compounded by the decision by some primary care trusts to move away from contracting community pharmacists to give advice on medicines management to care homes, preferring to commission medicine use reviews instead, said Mrs Sommerville.

Her comments following the disturbing report by the CSCI that revealed that half of all care and nursing homes in England are failing to meet minimum national standards in medicines management. People are often given the

wrong medicine, somebody else's medicines, medicine in the wrong dose or no medicine at all, it said. Medication records were not being kept and staff were poorly trained or not trained at all, the inspectors found.

The report comes nearly two years after similar conclusions were reached about the standards and provision of medicines management in care and nursing homes by the CSCI's predecessor, the National Care Standards Commission.

Mrs Sommerville said: "There has been a reduction in the number of community pharmacists providing advice to care homes over the past few years as PCTs and the medicines management services collaborative have replaced contracts for advice with those for medicines reviews." She added that some pharmacists are being contracted by their PCT to train care home staff in basic medi-

cines management skills but the care home managers are then failing to follow this up.

She said: "The pharmacists can give the training but what they can't do is wander around the homes to ensure that staff are acting on the training. A care home manager who has been told that a pharmacist will train staff, may assume that the home's training responsibility has been met. Some care homes are failing to follow through and they must acknowledge that."

David Pruce, director of practice and quality improvement at the Royal Pharmaceutical Society, said it was PCTs' responsibility to ensure that patients in care homes received appropriate medicines advice and support. He said: "This is not the responsibility of pharmacists and it is very clear from this report that advice from community pharmacists is not universal."

Medication management has not improved in two years

Parliament has been told that the management of medication in care homes is no better than it was two years ago, when the National Care Standards Commission found the same failings as this week's report by the Commission of Social Care Inspection.

Paul Burstow (LibDem, Sutton and Cheam) said that the reasons behind the failing had not changed. "Lessons have not been learnt and attitudes have not changed," he said.

Sandra Gidley (LibDem, Romsey) pointed out that the medication management standards set out in the National Service Framework for Older People were higher than those in the Quality Outcomes Framework for GPs. This meant that there was no incentive to achieve NSF milestones.

Health minister Jane Kennedy said that the CSCI report would be fed into a review of standards and regulations.

The Society

CPD support materials

The Society is offering CPD support materials (p183) as the President urges pharmacists to record their CPD (p185).

Society's integrated roles

The way in which the Society fulfils its integrated roles is good for patients, the public and the profession, says Council member Graham Phillips (p186).

Self-monitoring of anticoagulation cuts mortality

Self-monitoring of oral anticoagulants leads to fewer thromboembolic events and lower mortality than with standard monitoring, according to a paper published in *The Lancet* this week (2006;367:404).

Carl Heneghan, University of Oxford, and colleagues conducted a meta-analysis of 14 randomised controlled trials involving 3,049 patients. They looked at trials that assessed the effects of self-monitoring (self-testing) or self-management (self-testing plus self-dosage) of anticoagulation compared with standard monitoring.

Self-monitoring was found to lead to a 55 per cent relative reduction in thromboembolic events, a 39 per cent relative reduction in all-cause mortality and a 35 per cent relative reduction in major haemorrhage.

Self-management resulted in a greater reduction in thromboembolic events (73 per cent) and death (63 per cent) but less reduc-

tion in major haemorrhage (7 per cent). No difference in minor haemorrhage was noted. Eleven of the studies reported improvements in international normalised ratio in the self-monitoring groups, six of which were significant, say the researchers.

"Self-monitoring can improve the quality of oral anticoagulation therapy, with patients more frequently in the therapeutic range, while improving benefits and decreasing harm," the researchers commented.

They add, however, that although self-monitoring offers independence and freedom of travel to selected patients, it is not feasible



Cristina Peurazini/Science Photo Library

Self-testing of anticoagulation reduces death rates

for all, and requires identification and education of suitable candidates. Intrinsic limitations include the reluctance of patients to participate and the high cost of the test strips used.

Anticoagulant risk assessment published

A risk assessment for anticoagulant therapy has been published by the National Patient Safety Agency. It provides the detailed background evidence for safer practice recommendations that will be made later this year.

Covering oral and injectable anticoagulants, it reviews incident reports and the published literature and risks and potential solutions. It also contains a report of a workshop held with patients, which offers insight into patients' feelings about the way that services are run. One participant said that medical consultants often did not understand the drugs he was using, even when the doc-

tors were offered explanations. As an example, there had been a lack of recognition that phenindione was an anticoagulant, confusing it with phenytoin: "You tell them and their eyes go blank," the patient said.

The report entitled, "Risk assessment of anticoagulant therapy", is available on the NPSA website (www.npsa.nhs.uk) and via *PJ Online* (www.pjonline.com/links/pj).

□ The National Patient Safety Agency plans to publish at least four patient safety alerts during 2006, one of which will focus on safer use of anticoagulants.

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Community pharmacy incident reports to increase

Community pharmacists are likely to report more incidents to the National Patient Safety Agency as the new contract beds in, Susan Williams, NPSA joint chief executive, said at its conference in Birmingham last week.

Mrs Williams added that the NPSA has been working with major chain pharmacies to ensure that IT systems minimise the chances of duplicate reporting. The national reporting and learning system (NRLS) now has 500,000 incidents reports logged and is receiving new reports at the rate of 17,000 per month.

"This shows that the reporting culture is beginning to take hold", said Ms Williams.

All 607 organisations in the NHS are now reporting incidents to the NRLS. The majority come through the risk management systems of acute trusts, but the number of reports coming through other routes is slowly increasing.

Boots Alliance deemed fair

The proposed merger of Boots and Alliance UniChem will not be referred to the Competition Commission by the Office of Fair Trading for further scrutiny.

The decision is subject to both parties agreeing to take measures — including the sale of certain pharmacies — to address concerns in around 100 regions where competition could be affected.

OFT chief executive John Fingleton said that there are many regulations that prevent suitable competition in the community pharmacy sector, and he called on the Government to reconsider how these regulations might prevent consumers from benefiting from the mercantile savings of such a merger.

□ **Boots shares rise** Boots shares rose before the announcement because of rumours that a number of private equity companies had appointed a merchant bank to advise on a possible rival takeover bid for Boots Group Plc.

EMA makes information more accessible to patients

Simple summaries of European Medicines Agency pre-licensing medicines assessment reports are now being published by the EMA.

The aim of the summaries is to make understandable information on new medicines available to patients and the public.

Called "EPAR summaries for the public", they are short, non-technical versions of the full European public assessment reports (EPARs) currently published for all centrally authorised products. Each summary provides information about how the medicine works, its indications, how it was studied, its benefits and risks, and the reasons why it received a positive recommendation for authorisation from the EMA.

The summaries are written in a question-and-answer format, and are intended to give the general public enough information to understand the basis for the granting of the marketing authorisation.

The publication of EPAR summaries is one of the new provisions of European pharmaceutical legislation concerning the availability of better information about medicines.

In the first instance, the summaries will only be published for newly authorised medicines, but the database will gradually be built up to include retrospective summaries for all centrally authorised medicines.

The first group of medicines to be included in the catching-up exercise will be medicines acting on the alimentary tract and metabolism.

The first summaries to be published are for Ionsys and Yttriga.

Both the summaries and the full assessment reports are available on the EMA website (www.emea.eu.int).

Teams to be sent to NHS trusts to tackle MRSA bug

Support teams are to be sent into 20 NHS trusts to advise them on how to reduce levels of methicillin-resistant *Staphylococcus aureus*, the Department of Health has announced.

The news came as the Health Protection Agency released figures showing that the number of cases of MRSA bloodstream infections reported between April and September 2005 (3,580) has risen by 55 cases compared with the same period in 2004.

The DoH says that only half of trusts are on target to achieve a 50 per cent reduction in MRSA infections by 2008. Around 20 trusts face a "significant challenge" and it is these trusts that will be targeted by the support teams. The teams will help trusts to diagnose issues preventing them from reducing MRSA infections, to develop and implement practical action plans and to demonstrate to other trusts that, by adopting best practice, rates can be reduced to lower levels, and at a faster rate than previously thought.

In addition, a performance improvement network — a network of trusts with a mixed record of delivery against their local delivery plans — will meet quarterly to share best practice.

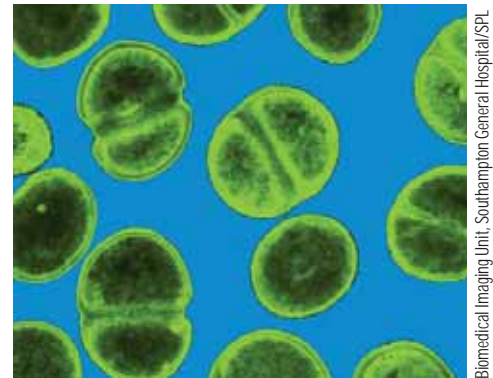
A new data reporting system was also previewed by the DoH and the HPA this week.

The system allows trusts, the DoH and the HPA to monitor where the MRSA infection occurs, the location of the patient, the stage of infection and the specialty under which the patient is being cared for.

Commenting on the HPA figures, Jamie Rentoul, head of strategy at the Healthcare Commission, said: "The Commission will be undertaking a national study over the next few months to assess exactly what differentiates trusts that are succeeding in lowering the incidence of MRSA from those that aren't." He added that the Health Bill aims to strengthen the Healthcare Commission's powers to enforce necessary standards of good practice on the prevention of hospital-acquired infections.

Figures obtained by the Conservative Party under the Freedom of Information Act reveal that 34,432 cases of MRSA (not only systemic infections) were reported in 63 trusts in 2004. If this figure is extrapolated to all trusts, it would reach almost 100,000, the party says.

□ **MRSA screening** A new molecular screening test that aims to reduce the time taken to identify patients infected with MRSA has been tested in 1,053 patients admitted to an intensive care unit. The test is a



Biomedical Imaging Unit, Southampton General Hospital/SPL

Electron micrograph of MRSA

rapid polymerase chain reaction assay that allows for same-day diagnosis of MRSA carriage through detection of the *mecA* gene.

The study, published in *Critical Care* this week (2006;10:R25), found that the test decreased overall time to notification from four days to one day. In surgical ICU patients no effect on MRSA infection rates was observed but 1,227 pre-emptive isolation days were saved. In medical ICU patients a substantial decrease in infections was seen when the test was combined with systematic on-admission screening and a pre-emptive isolation policy.

Public misinterpret MRSA figures

Better public education about the meaning of methicillin-resistant *Staphylococcus aureus* figures was called for at a meeting held in London this week. Jane Kennedy, minister for quality and patient safety, told the Westminster Diet and Health Forum seminar that patients need to understand how high MRSA figures can arise. For example, a higher rate in one hospital may reflect the fact that more complicated clinical cases are referred there from other hospitals.

Ms Kennedy said that it is important that patients understand what their hospital is doing to tackle the problem and they should be encouraged, for example, to ask members of staff treating them whether they have washed their hands. Other issues discussed at the meeting include the need for hospitals to have more isolation rooms, the need for behavioural scientists to research reasons for poor levels of hand-washing and better collaboration with the private sector.

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Mental health pharmacy team recognised

A pharmacy team working for a mental health and disability trust has won a top award in recognition of the contribution it makes to patient safety and improvements in care. The Tees and North East Yorkshire NHS Trust named its pharmacy advice and support team as overall winners of its annual Celebrating Success awards.

Announcing the awards, which are in their third year, trust chairman Eileen Grace said: "This is a small team who work quietly behind the scenes and thanks to the skill of each individual member they have had a huge impact on the trust."

The team, made up of four pharmacists and two technicians, were also winners of the trust's governance award category.

Trust chief pharmacist Sue Hunter said: "I'm thrilled for the team. What I am really proud of is the work they have done in governance, in safe practice and in reducing risk in terms of medicines management. They have been particularly good in the way they deal with the complex nature of our patients' medication requirements."

Sexual health clinics lack capacity to deal with increasing number of chlamydia infections

Chlamydia remained the most common sexually transmitted infection between 2000 and 2004 in the UK, with new cases per 1,000 patients attending genitourinary clinics up from 117 to 175, according to figures published by the Office for National Statistics last month. The highest rates of increase occurred in young women aged between 16 and 19 years and in men aged 20 to 24 years.

However, research published in the journal *Sexually Transmitted Infections* last week suggests that the sharp increase in reported *Chlamydia trachomatis* infections could be down to the use of more sensitive testing methods

(2006;82:24). The researchers looked at more than 81,000 test results obtained in one Scottish health board between 1992 and 2003. After 1998, testing methods were changed from cultures to more sensitive nucleic acid amplification testing, the researchers explained.

The increase in positive results when the tests were switched equates to 62 per cent for women and 56 per cent for men, they said. They argue that analysis of the results shows that the increase is strongly linked to the type of test used (odds ratio 1.61, 95 per cent confidence interval 1.33–1.94; $P < 0.001$),

irrespective of the year of the test or the sex and age of the patient — both known risk factors for infection.

In the same issue (*ibid*, p3) it is reported that sexual health clinics will need to triple their capacity in order to meet the 48-hour access target set by the Government for 2008. Researchers reviewed demand for appointments over five days at a large sexual health clinic in Leeds that operates a 48-hour closed appointment system. They calculated that 626 appointments would have been required to meet the demand, however only 181 new appointment slots were available.

Community pharmacies should not have to segregate waste

All medicinal waste returned to community pharmacies should be disposed of as if it were hazardous waste, the Pharmaceutical Services Negotiating Committee and the Company Chemists' Association suggest in their responses to the Department of Health consultation on safe management of health care waste (*PJ*, 5 November 2005, p564).

The DoH plans to replace current ways of classifying health care waste with a system of colour codes, which will be used alongside European Waste Catalogue (EWC) codes. Pharmacy organisations have welcomed the attempt to simplify and clarify regulations but highlight several concerns.

The DoH proposes that hazardous and non-hazardous waste should be segregated with hazardous waste given a purple/yellow code and non-hazardous waste given a yellow code. The PSNC argues that, since medicines are often mixed before being returned to pharmacies, handling waste to identify and segregate hazardous from non-hazardous poses too great a risk to the staff involved. "Therefore the ideal position in community pharmacy would be for no segregation to take place, and for all medicines returned from patients to be sent for incineration as if they were hazardous waste," it says.

Similar concerns are raised about the classification of sharps. The Royal Pharmaceutical

Society, the CCA and the National Pharmacy Association believe that pharmacies should not be expected to sort through sharps to separate those contaminated with hazardous waste and suggest that one sharps box (yellow with a purple lid) should be used for all sharps. In contrast, the PSNC believes that sharps handed to a pharmacy in a patient's sharps container should not be classified as hazardous waste.

Cytotoxic and cytostatic medicines are the only medicines classified as hazardous waste in the EWC. Both the Society and the PSNC state that if the NHS is to offer constructive guidance to health care providers about handling waste a definitive list of hazardous waste should be established. They suggest that this list should contain all products listed in chapter 8 of the British National Formulary.

The responses draw attention to another issue, which was also highlighted in responses to a Department for Environment Food and Rural Affairs consultation on waste management regulations last month (*PJ*, 14 January, p32). The DoH proposes that only a dedicated vehicle should be used to transport health care waste, something that is not practical for pharmacies, the PSNC says. "Pharmacies should be permitted to . . . carry unwanted medicines presented to them by patients in their own homes or in nursing or residential homes," says the CCA.

Society to submit evidence on workforce

Evidence on the pharmacy workforce is to be submitted by the Royal Pharmaceutical Society to a House of Commons Health Committee inquiry into NHS workforce needs and planning.

Commenting on a call for evidence when the inquiry was announced last week, Rob Darracott, director of corporate and strategic development, said: "We plan to let the committee know how the Society has, over the past couple of years, co-ordinated a project supported by the three Departments of Health in England, Scotland and Wales to examining in detail the pharmacy workforce.

The work, which has been undertaken by a team from King's College London, under Professor David Guest, has included the development of a detailed pharmacy workforce planning model, enabling us to plot the effect of various impacts on supply and demand drivers. We hope to publish the full report shortly."

Two of the questions the committee wishes to address are whether or not workforce planning has been undertaken in the past and how it should be done in the future.

Written evidence has to be submitted to the committee by 15 March,

Candidates announced for PSNC regional elections

The Pharmaceutical Services Negotiating Committee regional representative elections are currently being held, with results expected at the beginning of March.

The Northern, Yorkshire, East Anglia, North-east Thames, South-west Thames, Wessex, Oxford and Mersey regions remain uncontested. The following candidates are standing in the other regions: for Trent re-

gion, Ketan Patel and Gary Myers; for North-west Thames region, Muhamad Hanif Seedat, Elizabeth Hopkins, Mahesh Shah and Robert Curd; for South-east Thames region, Dilip Joshi, Ashwin Tanna and Sunil Chopra; for West Midlands region, Gamdur Singh Amar, Rakesh Panesar and Raj Morjaria; for North-western region, Mark Collins and David Ralph Bethell.

Affordability drives prescription charge exemptions

Government policy on who should be exempt from prescription charges is driven by patients' ability to pay and not the conditions from which they suffer.

This was made clear to the House of Commons Health Committee at the end of January by Felicity Harvey, head of the Department of Health's medicines, pharmacy and industry group. Dr Harvey was giving evidence to the committee's inquiry into NHS charges.

She told the committee that there were no plans to review the current disease-based exemption categories.

Dr Harvey added that recent reviews of charge exemptions had been based on prescription costs, affordability and the NHS Low Income Scheme and that these were not currently under review either.

At a separate evidence session last week (*PJ*, 4 February, p125 and 128), Ellen Schafheutle, research fellow in the drug usage and pharmacy practice group, University of Manchester, who has examined prescription



No research has been done on whether prescription charges hinder treatment

charges internationally (*PJ*, 8 March 2003, p336), said that no research had been done in the UK on whether patients who could not afford to have prescriptions dispensed then cost the NHS more in further treatment.

Howard Stoaie (Lab, Dartford) said that it was important to know that figure because if it was £450m or more a year it would wipe

out the £450m that was raised from prescription charges.

During the same evidence session, Rob Darracott, director of corporate and strategic development, Royal Pharmaceutical Society, said that it favoured a system of monthly payments for prescription charge prepayment certificates.

News in brief

Penciclovir reclassification

Novartis Consumer Health has asked the Medicines and Healthcare products Regulatory Agency to reclassify Fenistil cold sore cream (penciclovir 10mg/g) as a pharmacy medicine for use by adults and children aged over 12 years.

New antifungal launched

A new broad spectrum antifungal has been launched by Schering Plough. Posaconazole (Noxafil) is licensed for the treatment of serious refractory invasive fungal infections in patients intolerant to certain other treatments, or in whom they have failed. **Notice-board p163**

Out-of-pocket expenses claims

Pharmacies in England must declare the total amount and the number of claims for out-of-pocket expenses on FP34C forms from this month. Individual prescriptions must still be endorsed with the amount claimed and the reason for the claim. A ceiling on total monthly claims is under consideration.

New CMO for Wales

Tony Jewel, currently clinical director and director of public health for Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, has been appointed chief medical officer for Wales.

£3m recovered from prescription charge frauds 2001–05

Nearly £3m has been recovered from 160,000 civil prosecutions for wrongful free prescription claims up to 31 March last year.

In a Parliamentary written reply, Minister of State for Health Jane Kennedy revealed that £2,950,000 had been recovered. "Since August 2001 a penalty charge system has been in place in respect of those falsely claiming exemption to NHS pharmaceutical

charges. This has resulted in a considerable increase in civil action being instigated for first time offenders with repeat offenders subsequently dealt with through criminal proceedings," she said. "Penalties are sanctioned through the civil courts as criminal prosecution of offenders would not be a cost effective way of dealing with such high volume but low-value frauds."

Health funding increase will not be spent on service improvements, King's Fund warns

Nearly half of the £4.5bn increase in health spending promised for the next financial year will be absorbed in staff pay rises, according to a King's Fund analysis published this week.

General price rises — including capital expenditure — increased costs associated with recommendations from the National Institute of Health and Clinical Excellence (NICE) and claims for negligence are expected to account for another third of the extra money pledged by the Government for the NHS during 2006–07, it said.

Another £1.26bn will be needed to help meet hospital waiting time targets and other Government deadlines, which leaves just 2.5 per cent of the extra billions promised for new development, researchers concluded.

But the King's Fund said the Department of Health was confident that trusts could save £1.2bn from the current financial year, which could go towards helping to meet next year's spending plans as well as ensuring that services were run more cheaply.

The report "Where's the money going?" comes at a time when a quarter of NHS trusts in England have forecast a total deficit of £948m by the end of this financial year. In the analysis, the King's Fund admits that although year-end deficits are not new the amount of money trusts expect to be in the red at the end of this financial year is the highest since Labour came to power in 1997.

The report said: "As in previous years, next year a significant proportion of the extra cash will go on higher pay. This is not in itself a bad thing — helping to attract and retain staff, for example. However, with consultant and nurse pay rates already near the top of the international league table, it raises questions about value for money."

The King's Fund also warns that the squeeze on hospital budgets will be tighter next year as the DoH has increased the tariff price for hospital work by just 1.5 per cent, which is less than the level of inflation.

Child medicines need better labelling, say Lords

Medicines need to be properly labelled to indicate their suitability for children, a House of Lords Committee said last week.

This was one of the committee's conclusions after an investigation into the planned European Regulation on paediatric medicines (*PJ*, 17 September 2005, p327). Another was that 50 per cent of medicines given to children are untested.

One of the problems that flows from the lack of testing is a lack of information on safe paediatric use. A project to try to address this is about to be launched by Medicines Partnership and NHS Direct. The aim is to find a way of meeting parents' needs for in-

formation about children's medicines and enhancing existing medicines information available through NHS Direct Online and the Patient Information Bank. The project will determine the scope, format and processes for producing information for parents and adult carers about children's medicines and develop some prototype information.

A specific area of interest will be off-label and unlicensed use of medicines because of the lack of information in this area. The information needs of parents and adult carers of children are being addressed first because they are the ones who have to explain things to children after having understood it themselves.

Dinesh Mehta, executive editor, BNF and BNF for Children, said: "The vast majority of medicines that community pharmacists dispense for children are licensed and backed by an enormous body of evidence. However, general practitioners and pharmacists will inevitably come across medicines that they will not have seen used in children."

He added that even though a manufacturer's summary of product characteristics might not include information on paediatric use, the BNF for Children included unlicensed doses and indications for medicines that were effective for treating childhood illnesses.

Antiepileptics in pregnancy

Major congenital malformations (MCMs) occur in as little as 4.2 per cent of newborns exposed to antiepileptic drugs *in utero* (*Journal of Neurology, Neurosurgery and Psychiatry* 2006;77:193). Antiepileptic polytherapy was associated with a higher rate of MCMs than monotherapy, and regimens containing sodium valproate resulted in significantly more MCMs than those not containing the drug. Exposure to carbamazepine monotherapy was associated with the lowest risk of MCM, the researchers found.

Depression therapy a dilemma in pregnancy

Women who discontinue antidepressants during pregnancy are more likely to have a relapse of their illness than those who do not, a study has found (*JAMA* 2006;295:499). In contrast, two recent studies have examined the association between various neonatal conditions and antenatal use of selective serotonin reuptake inhibitors.

In the *JAMA* study, investigators enrolled 201 pregnant women with major depression and found that 68 per cent of those who stopped taking their antidepressant medicines experienced a major depressive relapse during pregnancy, compared with 26 per cent of those who continued their treatment (hazard ratio 5, 95 per cent confidence interval 2.8–9.1; $P < 0.001$). This, the authors state, refutes the "common belief that characteristic hormonal changes associated with pregnancy are inherently 'protective' with respect to . . . risk of depressive relapse and that discontinuation of psychiatric medications should be almost uniformly pursued given concerns regarding prenatal exposure". However, the authors admit that risk of relapse could indeed be lower for pregnant women with less severe depression who discontinue treatment.

The first of the other two studies (*Archives of Pediatrics and Adolescent Medicine* 2006;160:173) found that neonatal abstinence syndrome — in which withdrawal from substances present in maternal blood results in neuro-behavioural changes in a neonate — occurs in 30 per cent of babies exposed to SSRIs during pregnancy, compared with



Pregnant women who stop treatment may experience relapse of depression

none of the babies unexposed to SSRIs ($P < 0.001$). The second study found an association between the development of persistent pulmonary hypertension of the newborn (PPHN) and SSRI use in late pregnancy (*New England Journal of Medicine* 2006;354:579). The case-control study looked at 377 cases of PPHN and 836 matched controls and found that, after week 20 of gestation, 14 infants exposed to an SSRI had PPHN, compared with six of those who had not been exposed to an SSRI (adjusted odds ratio 6.1, 95 per cent confidence interval 2.2–16.8).

Neither antenatal exposure to non-SSRI antidepressants nor exposure to SSRIs during the first half of pregnancy was associated with PPHN. This suggests, say the authors, that maternal depression itself is unlikely to be independently associated with PPHN.

News in brief

Antidepressant time of onset

Antidepressants can elicit a response within two weeks and even within the first three days of treatment, contrary to the currently accepted timeframe of several weeks. This is the conclusion reached by the author of an editorial in the *British Journal of Psychiatry*, which examines available data (2006;188:105).

HIV diagnoses still increase

HIV diagnoses in the UK have continued to rise between 2004 and 2005. The reports so far received by the Health Protection Agency account for 5,560 new cases in 2005, but the total could be around 7,700, which is higher than the 7,328 cases reported for 2004.

Chief Medical Officer announces inclusion of Prevenar in childhood vaccination schedule

Prevenar pneumococcal conjugate vaccine (PCV) has been added to the UK childhood immunisation schedule on the advice of the Joint Committee on Vaccination and Immunisation.

Chief medical officer, Sir Liam Donaldson, who announced the changes this week, said: "Pneumococcal infection can

cause very serious illness such as meningitis and pneumonia. The new vaccine will save lives and prevent hundreds more cases of serious illness and disability."

PCV will be given at two and four months of age, and the first meningococcal group C (MenC) injection — currently given at two months — is subsequently being removed. A

third MenC injection will now be given at 12 months, alongside a fourth *Haemophilus influenzae* type b booster — expected to become available as a combined injection. A booster PCV will be given at 13 months with the combined measles, mumps and rubella vaccine. Changes to the schedule will come into effect later this year or in 2007.

Correction

The national reporting and learning system is receiving new reports at the rate of 70,000 per month and not 17,000 per month (p156).