BRITISH MEDICAL JOURNAL

SATURDAY 3 MARCH 1984

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NEWS AND NOTES

SUPPLEMENT

NO 6418 BRITISH MEDICAL JOURNAL 1984 VOLUME 288 659-734
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.
WEEKLY. ISSN 0007-1447
ASTM CODEN: BMJOAE 288 (6418) 659-734 (1984)

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Local formularies and good patient care

SIR,—Your leading article (4 February, p 348) suggests that local formularies can play a major part in encouraging rational prescribing and ensuring good patient care. It also raises the difficulties of implementing such a strategy—namely, that the formulary must represent a consensus among doctors and that they must be willing to use it.

We have been investigating these problems, including the actual mechanics of compiling formularies for general practice, as part of a research project initiated by the late Professor Crooks. To ensure the interest of the general practitioner we use his own prescribing habits as a basis for discussions on the selection of drugs for inclusion in the formulary. Using specially designed duplicate prescription pads[1] we record all the drugs prescribed over three months. We then present a summary of the drugs prescribed, arranged by therapeutic class, to the general practitioner, and in discussion with us and his colleagues a list of recommended drugs is compiled. The review and assessment of the GP's own prescribing also provides an opportunity for self audit and education: some general practitioners express surprise at the variety of drugs they have prescribed. One additional benefit accrues in group practices, where joint discussions on prescribing patterns and policies may lead to consensus prescribing within the practice, which is particularly important given the modern trend towards shared patient care.

It is important that the formulary that results from these discussions is orientated towards the problems seen in general practice and the types of prescribing carried out there. GPs will refer only to a formulary that allows obvious and rapid access to drug and disease groups of interest. The new *British National Formulary* provides a drug classification based on therapeutic class, and there are obvious benefits to structuring a local formulary to be compatible with such an important reference text. Some modifications to meet the particular needs of GPs should, however, be considered.

Finally, this research has important national implications. With the computerisation of the Prescription Pricing Authority a summary of each GP's prescribing patterns could be produced. The most acceptable method for presentation requires investigation but continuing opportunities for self audit would be provided. Further, the local drugs and therapeutics committees[2] could collaborate with GPs on the construction of practice formularies. Given the approval and encouragement of the relevant organisations, we now have the opportunity to achieve the aim of "improving patient care by the more rational prescribing of drugs."

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[1] Hamley JG, Brown SV, Christopher LJ, *et al.* Duplicate prescriptions: an aid to research and review. *J R Coll Gen Pract* 1981;**31**:648-50.
[2] George CF, Hands DE. Drug and therapeutics committees and information pharmacy service: the United Kingdom. *World Development* 1983;**11**: 229-36.

Intravenous aminophylline in acutely ill patients receiving theophylline

SIR,—We support the cautionary note sounded by Dr M Felicity Stewart and others (11 February, p 450) on the use of intravenous aminophylline in acute asthma.

In a continuing study of acute asthma in this hospital 18 of the first 110 consecutive paediatric admissions were receiving maintenance theophylline preparations. The median age of the patients was 3·5 years (range 2-14). Fifteen patients were taking Slo-Phyllin, two Phyllocontin, and one Nuelin. Only three patients were taking a dose of less than 8 mg/kg, and median dose was 10·7 mg/kg (range 4·7-15·5) twice daily. The median plasma theophylline concentration on admission was 5·7 mg/l (range 0-15·4 mg/l). Four patients had no detectable plasma theophylline and five patients had a concentration in excess of 14 mg/l.

We adhere closely to the regimen of Mitenko and Ogilvie for intravenous aminophylline treatment, giving a loading dose of 5·6 mg/kg and a maximum maintenance dose of 0·9 mg/kg/h[1]. For those receiving long term maintenance theophylline preparations half the loading dose is given. Thus toxic or subtherapeutic plasma concentrations may result in half of our acutely ill patients supposedly receiving long term theophylline.

The problem of gauging the required aminophylline dose is underlined by the fact that four of our patients were obviously non-compliant, having no detectable plasma theophylline; also one patient with no change in prescribed treatment had plasma theophylline concentrations of