

to tackle them. We use the term epidemic because (in the absence of objective documentation of rates of SAEs in the past) our impression is that this is a growing phenomenon, related to the increased use of major surgery in the elderly. We also consider that only the absence of SAEs would offer no scope for improvement. A rate of SAEs of 16.9% should, logically, offer much scope for improvement. Whether such improvement can be realised remains a matter for future interventional investigations.

1. Bellomo R, Goldsmith D, Russell S, Uchino S. Postoperative serious adverse events in a teaching hospital: a prospective study. *Med J Aust* 2002; 176: 216-218. □

Acute community-acquired meningitis and encephalitis

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TO THE EDITOR: The article on acute community-acquired meningitis and encephalitis by Beaman and Wesselingh¹ provides a comprehensive and up-to-date review of diagnostic and management issues relevant to general clinicians. However, the section on vaccines for preventing meningococcal C and pneumococcal diseases is not as contemporary. Contrary to the authors' statements that "a conjugate vaccine covering serogroup C [meningococcus] will be available in Australia shortly", and "a conjugate vaccine [for pneumococcus] is currently under trial in Australia", conjugate vaccines for both diseases are available and registered for use in Australia. Conjugate vaccines have the advantage that they can be used in children from six weeks of age and are expected to provide long-term protection.

Meningitec is a meningococcal group C conjugate vaccine approved for use in children from six weeks of age, adolescents and adults. Meningitec has been available from Wyeth Australia since October 2001, but is not part of the National Childhood Immunisation Scheme and, as such, can only be obtained on private prescription at present.

Prevenar (pneumococcal septavalent conjugate vaccine) is also approved for use and has been available from Wyeth Australia since January 2001. Prevenar is indicated for active immunisation of infants and children from six weeks to nine years of age against invasive disease, pneumonia and otitis media caused by *Streptococcus pneumoniae*.

1. Beaman MH, Wesselingh SL. Acute community-acquired meningitis and encephalitis. *Med J Aust* 2002; 176: 389-396. □

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IN REPLY: We thank Saltman for up-to-date information on Wyeth vaccines. Readers will appreciate that our article¹ was commissioned in January 2001, and the manuscript delivered in August that year, before the licensing of Meningitec. As the article discussed, group C meningococcus is a minority strain in most regions of Australia. Hence, the vaccine will not prevent most cases of what is already an uncommon disease. Conjugate pneumococcal vaccines should have much wider application in the future, but currently are subsidised for use in only a minority of the at-risk population.

1. Beaman MH, Wesselingh SL. Acute community-acquired meningitis and encephalitis. *Med J Aust* 2002; 176: 389-396. □

Short-term effectiveness of bupropion for assisting smoking cessation in general practice

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TO THE EDITOR: As noted in the letter by Chapman and Jamrozik,¹ there was substantial prescribing of bupropion sustained release (Zyban SR; GlaxoSmithKline) following its Pharmaceutical Benefits Scheme (PBS) listing from 1 February 2001. The drug has been the subject of extensive publicity following reports of adverse drug reactions and deaths of patients while taking bupropion. Although bupropion has been shown to be effective in two key

clinical trials,^{2,3} there are no studies of effectiveness when prescribed in the context of Australian general practice.

We conducted a study of short-term effectiveness involving 11 general practice registrars working in eight practices in south-west and southern Sydney. Each registrar identified from practice prescribing records 10-15 patients prescribed bupropion after 1 February 2001. These patients were followed up via a telephone questionnaire 10 weeks after the date of prescription. The questionnaire elicited information on the use of bupropion, patient-reported abstinence rates, adverse effects and use of support services. Biochemical validation of smoking status was not conducted.

Interviews with 151 patients were conducted between April and August 2001 (see Box). Patients completing seven weeks or more of therapy were significantly more likely to report both continuous abstinence ($P = 0.01$) and point-prevalence abstinence ($P = 0.002$). Eighty-three patients reported adverse effects, the five most common being insomnia (14%), headaches (11%), nausea (8%), dry mouth (5%) and irritability (4%). No convulsions were reported. Patients who made use of one or more support services for cessation counselling were no more likely to report point-prevalence abstinence at follow-up than those who did not ($P = 0.8$).

Our study was not based on a random sample of GPs or patients, and we did not collect data on the total number of patients treated with bupropion in these practices over the study period. Bearing in mind these limitations, the study has a number of notable findings. Despite the wording of the PBS authority "for use within a comprehensive treatment program", fewer than half the patients reported using any support service. There was also a low rate of completion of the recommended course of treatment (less than 20% of patients).

Ten-week follow-up survey of patients prescribed bupropion sustained release (Zyban SR) for smoking cessation ($n = 151$)

Patients taking all or part of course of drug therapy	124 (82%)
Mean duration of therapy (weeks)	4.6 (range, 1-12)
Patients completing at least seven weeks of therapy	24 (19% of those who took all or part of course)
Patients reporting continuous abstinence at 10 weeks	47 (31%)
Patients reporting point-prevalence abstinence at 10 weeks	57 (38%)
Patients reporting adverse effects	83 (68% of those who took all or part of course)
Patients accessing one or more support services (general practitioner, Quitline, ZAP*)	69 (46%)

*ZAP = Zyban Action Plan (trademark of GlaxoSmithKline)