

The small number of available high quality trials for this most recent review led the authors to say, "Available trials are too small and the results too inconsistent to form any firm conclusions", and suggests that more trials are needed to produce a conclusive result.³

We should be careful not to lose the positive effects of improved chronic disease management in asthma by over-responding to this one review of one component of comprehensive care.

1. Gibson PG, Coughlan J, Wilson AJ, et al. The effects of self-management education and regular practitioner review in adults with asthma. The Cochrane Library, Issue 4, 1998. Oxford, Update Software.
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COMMENT: A Cochrane systematic review identified the beneficial effects of planned asthma management and education that includes a written action plan.¹ These findings have now been adapted for primary care and implemented as the Asthma 3+ Visit Plan. This involves a systematic assessment of asthma symptoms, lung function, and current treatment at each visit. Treatment and management skills are optimised and the patient is given written instructions on how and when to increase treatment when asthma deteriorates (a written action plan).

A recent Cochrane review asked whether one can get the same benefits by doing less — by simply supplying a patient with a written action plan.² The review found that the literature was inconclusive. This doesn't mean that written action plans are not effective; it means that there is not enough evidence to be able to answer the question. The result of "no evidence of effect" is completely different to "evidence of no effect".^{3,4} This is a crucial distinction, as many systematic reviews find insufficient evidence to be able to assess a treatment. This is a statement about our ignorance rather than a statement about whether a treatment works or not.

The review also highlights the need to carefully evaluate the control intervention. For example, the control groups in two studies in the systematic review² received regular medical review, with assessment of severity and optimisation of inhaled steroid therapy. It is not surprising that these studies found it difficult to identify any additional effect of an action plan.

Cochrane systematic reviews conclude with recommendations for clinical practice that highlight effective treatments,¹ and with recommendations for research that indicate where more information is needed.² The review looking at just supplying patients with written action plans² exemplifies the latter.

1. Gibson PG, Coughlan J, Wilson AJ, et al. The effects of self-management education and regular practitioner review in adults with asthma. The Cochrane Library, Issue 4, 1998. Oxford, Update Software.
2. Toelle BG, Ram FSF. Written individualised management plans for asthma in children and adults. The Cochrane Library, Issue 3, 2002. Oxford, Update Software.
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Death and paramethoxyamphetamine — an evolving problem

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TO THE EDITOR: I read with great interest the article by Byard et al,¹ as well as the previous work by these authors on paramethoxyamphetamine (PMA)-related fatalities in South Australia.² In 2001, I encountered a similar fatal "outbreak" in Belgium: six fatal cases, four of them in the Antwerp metropolitan area.^{3,4} Striking similarities between the Belgian and Australian fatalities include the clinical symptoms, the autopsy findings and the history of alleged "ecstasy" intake. Pure PMA tablets were found on a victim with an "xTc" logo pressed onto the surface of the tablets.³

I agree with Byard et al¹ that the sudden "outbreaks" of death from PMA intoxication probably do not result from contamination during the synthesis of 3,4-methylenedioxymethamphetamine (MDMA). In Belgium, there are strong indications that the resurgence of PMA resulted from a legal loophole. Early in 2001, PMA was encountered for the first time in the blood sample of a young girl who presented to an emergency department for alleged ecstasy intoxication.

A few weeks later, the first fatal case was reported, and over a period of a few months five other fatal cases were seen.

After the first two deaths, PMA captured a lot of media attention and even evoked some political disturbance. By the end of 2001, PMA and its precursor molecule, *p*-methoxyphenylacetone, were placed on the list of regulated and restricted substances (and hence the unauthorised possession of these products became a criminal offence). Afterwards, no more fatalities were reported. I therefore hypothesise that illicit amphetamine manufacturers were aware of the (temporary) legal vacuum in Belgian law before the deaths occurred and substituted PMA for MDMA because PMA precursors were easier to obtain and less strictly controlled by legislation. It has been suggested in the *Australian illicit drug report 1994*,⁵ as well as by Byard et al,³ that manufacturers of PMA may have been deliberately marketing it as another drug (eg, MDMA) or may have promoted it specifically as a drug to augment the effects of MDMA. If this is the case, there may be serious implications for criminal liability, as we now know that PMA intoxication has a significantly worse clinical outcome than MDMA intoxication (including a greater likelihood of QRS-interval prolongation, extreme hyperthermia, seizures and a significantly lower score on the Glasgow Coma Scale).⁶

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Hospital locums: expensive and problematic

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TO THE EDITOR: I read with interest the *MJA* supplement *The student and junior doctor in distress — "our duty of care"*.¹ It is encouraging to see the time, effort and research currently being devoted to the health and mental wellbeing of our colleagues.