

6. Young JM, Ward JE. Improving survey response rates: a meta-analysis of the effectiveness of an advance telephone prompt from a medical peer [letter]. *Med J Aust* 1999; 170: 339. □

## Withdrawal of methylphenobarbitone

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**TO THE EDITOR:** The recent information that methylphenobarbitone (60 mg tablets) will be unavailable after 1 January 2003 has caused anxiety in patients with epilepsy previously treated satisfactorily with this drug. The suggested substitution of phenobarbitone, primidone or a newer antiepileptic agent seems appropriate. However, patients and perhaps practitioners may assume, as my patients have, that phenobarbitone and primidone are equivalent to methylphenobarbitone on a milligram-for-milligram or a tablet-for-tablet basis. This may not be so. The equivalence is close to 30 mg of phenobarbitone for 60 mg methylphenobarbitone, and probably around 200 mg of primidone for 60 mg of methylphenobarbitone.<sup>1</sup> Plasma phenobarbitone concentrations should be checked before and after any changeover.

In recent years, several other old, but therapeutically satisfactory, neurological drugs have also been withdrawn from the Australian market (oral neostigmine, several anticholinergic antiparkinsonian agents, ethosuximide and some phenytoin preparations, and the only ergotamine preparation not also containing caffeine).

Subject to safety issues, ethics committees usually will not approve a clinical trial of a new drug unless patients who benefit from it are guaranteed supplies until the drug is marketed. Surely similar considerations should apply for patients who have had completely satisfactory long-term responses to marketed drugs. If such drugs must be withdrawn, except for safety reasons, there should be extensive prior consultation with prescribers and patient groups, prescribers should know the situation before their patients discover it from other sources, and there should be a sufficient lead time for everyone receiving the drug to return for another prescription (and for advice) before the drug becomes unavailable (a minimum lead time of six months in the case of drugs subsidised under the Pharmaceutical Benefits Scheme).

The withdrawal of useful neurological drugs in Australia has reached the stage where therapeutic options are becoming limited. In the case of drugs required for

long-term use, to protect the interests of new patients it has become necessary to consider whether the drug will continue to be available for the expected duration of the patient's therapy. In this regard, the prescriber's only guide may be the track record of the firm which markets the drug otherwise chosen.

1. Eadie MJ, Hooper WD. Other barbiturates — methylphenobarbital. Chapter 55. In: Levy EH, Mattson R, Meldrum BS, Perucca E, editors. *Antiepileptic drugs*. Philadelphia: Lippincott-Williams and Wilkins, 2002. □

## Prevalence of pain among nursing home residents in rural New South Wales

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**TO THE EDITOR:** The recent article by McLean and Higginbotham<sup>1</sup> and the accompanying editorial by Melding<sup>2</sup> highlight the problems faced by elderly people in aged-care facilities. It is likely that many elderly people living alone in the community are suffering equal, if not worse, pain.

At a recent strategic planning meeting, the Australian Pain Society identified this group of people as a high priority for the development of pain management treatment strategies. These strategies are now well into the development process.

While it is appropriate for the Journal to focus on medical practitioners' care of these patients, it must be remembered that most direct care for people in aged-care facilities is delivered by nurses and nurse assistants/carers. The Australian Pain Society will be focusing its strategies on non-drug techniques that can be used by this group of healthcare workers. Assessment and documentation of pain-related behaviour, particularly in people with cognitive impairment, is critical if progress is to be made. It is also

important to appreciate the contribution in this area from other allied health professionals, such as physiotherapists, psychologists and occupational therapists. These practitioners have much to offer this patient group and have been important contributors to the Australian Pain Society's management strategies.

It is hoped that State and federal funding can be made available for nurse educators to deliver these low-tech, non-drug management strategies within aged-care facilities.

The two articles quite rightly focus on the regular use of simple oral analgesics, such as paracetamol, and low-dose opioids. Oral analgesics, together with more widespread use of non-drug treatments (eg, exercise, transcutaneous electrical nerve stimulation, hot and cold topical applications, relaxation, distraction, mental stimulation, lifestyle modification) and increased awareness among aged-care workers of the problems and solutions, should lead to an enhanced quality of life for this growing sector of our community.

1. McLean WJ, Higginbotham NH. Prevalence of pain among nursing home residents in rural New South Wales. *Med J Aust* 2002; 177: 17-20.  
2. Melding PS. Can we improve pain management in nursing homes [editorial]? *Med J Aust* 2002; 177: 5-6. □

## Pain management programs in residential aged care

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**TO THE EDITOR:** The articles by Melding<sup>1</sup> and McClean and Higginbotham<sup>2</sup> highlight the important problem of chronic pain in residential care.

We have conducted two studies to investigate factors related to depression in

### Self-reported pain frequency and severity among residents of aged-care facilities

	Study 1 (1994) (n = 513)	Study 2 (2000–2001) (n = 148)
<i>Pain frequency</i>		
Not at all	230 (44.8%)	54 (36.5%)
Rarely/occasionally	115 (22.4%)	52 (35.1%)
Frequently/constantly	168 (32.8%)	42 (28.4%)
<i>Pain severity*</i>		
Minimal/mild	58 (20.5%)	27 (28.7%)
Moderate	98 (34.6%)	36 (38.3%)
Severe/bad as could be	127 (44.9%)	31 (33.0%)

\*Severity rated only for residents experiencing pain.