

## LETTERS

---

- Lymphoedema in breast cancer patients**  
Graeme N Brodie 244
- Human fasciolosis acquired in an Australian urban setting**  
Andrew J Hughes, Terry W Spithill, Rebecca E Smith,  
Craig S Boutlis, Paul D R Johnson 244
- Community-acquired MRSA bacteraemia: four additional cases including one associated with severe pneumonia**  
Graeme R Nimmo, E Geoffrey Playford 245
- Ventricular tachycardia following ingestion of a commonly used antihistamine**  
Philip T Sager, Enrico P Veltri 245  
Dennis L Kuchar, Bruce D Walker, Charles W Thorburn 246
- Indigenous health: chronically inadequate responses to damning statistics**  
Paul Bauert, Elizabeth McMaugh, Carmel Martin, Janet Smylie 246
- Inhaled steroids — too much of a good thing?**  
Dianne P Goeman, Susan M Sawyer, Michael J Abramson,  
Kay Stewart, Francis C K Thien, Rosalie A Aroni, Jo A Douglass 247
- Attention-deficit hyperactivity disorder: divergent perspectives**  
Alison Poulton 247  
George Halasz, Alasdair L A Vance 247
- Doctor shoppers' rights: privacy or lunacy?**  
Max Kamien 248



a reduction in size of the liver lesions. The patient remained well six months later.

This case demonstrates that fasciolosis may present to urban medical practitioners in Australia. Ingestion of watercress is an important clue to the aetiology.<sup>2</sup> Serological diagnosis is possible before eggs appear in faeces using a new specific ELISA test that detects the IgG4 response to cathepsin L antigen.<sup>5</sup>

1. Mas-Coma S, Bargues MD, Esteban JG. Human fasciolosis. In: Dalton JP, editor. Fasciolosis. Wallingford: CAB International, 1999: 411-434.
2. Torresi J, Richards MJ, Taggart GJ, Smallwood RA. *Fasciola hepatica* liver infection in a Victorian dairy farmer. *Med J Aust* 1996; 164: 511.
3. Boray JC. Experimental fascioliasis in Australia. *Adv Parasitol* 1969; 7: 95-210.
4. McCausland I, Vandegraaff R, Nugent L. Fascioliasis in dairy cows on irrigated pasture. *Aust Vet J* 1980; 56: 324-326.
5. O'Neill SM, Parkinson M, Strauss W, et al. Immunodiagnosis of *Fasciola hepatica* infection (fascioliasis) in a human population in the Bolivian Altiplano using purified cathepsin L cysteine proteinase. *Am J Trop Med Hyg* 1998; 58: 417-423. □

## Community-acquired MRSA bacteraemia: four additional cases including one associated with severe pneumonia

Graeme R Nimmo,\* E Geoffrey Playford†

\*Director, Division of Microbiology, Queensland Health Pathology Service; †Infectious Diseases Physician, Infection Management Services; Princess Alexandra Hospital, Woolloongabba, Brisbane, QLD 4102. Graeme\_Nimmo@health.qld.gov.au

TO THE EDITOR: Collins and colleagues<sup>1</sup> reported a case of bacteraemic community-acquired MRSA (CAMRSA) infection that they believed to be the first reported in Australia. One of us (GN) published a reference to a case of septicaemia and osteomyelitis in Brisbane caused by CAMRSA in 2000.<sup>2</sup> This severe case occurred in a previously healthy 16-year-old boy with no risk factors for MRSA infection who, after prolonged ventilatory and inotropic support and vancomycin therapy, required a long period of rehabilitation. A further two cases of septicaemia occurred in Ipswich and will soon be published as part of a study of CAMRSA conducted in 2000–2001.<sup>3</sup>

We recently encountered another case involving a previously well 23-year-old man who presented to the emergency department with a large abscess on his upper lip and extensive cellulitis of the

surrounding face and neck, and with left-sided pleuritic chest pain and associated fevers and rigors. The patient denied previous antibiotic use or contact with healthcare facilities at any time in the past. There was no history of injecting drug use or trauma. *Staphylococcus aureus* was isolated from blood cultures, and resistance to oxacillin and susceptibility to erythromycin, clindamycin, tetracycline, gentamicin, ciprofloxacin, fusidic acid, rifampicin, and vancomycin was shown. Specimens from operative debridement of the facial abscess yielded *S. aureus* with the same susceptibility pattern. Chest x-rays showed extensive consolidation of the left lower lobe and an associated loculated pleural effusion. Clinical, radiological, and echocardiographic evaluations did not reveal another focus of infection. The patient was treated with intravenous vancomycin for three weeks followed by oral clindamycin, with complete clinical resolution.

It is now clear that CAMRSA infection may result in severe, life-threatening sepsis. The possibility of pneumonia associated with CAMRSA is of particular concern. A 1999 report from Minnesota and North Dakota documented four deaths in children from CAMRSA, including two with necrotising pneumonia.<sup>4</sup> A further two fatal cases of necrotising pneumonia caused by CAMRSA were recently reported from France.<sup>5</sup> The strains involved in all of these cases carry the gene for Panton-Valentine (P-V) leukocidin, a staphylococcal toxin that has been shown to be strongly associated with cases of severe superficial abscesses and necrotising pneumonia.<sup>6</sup>

As the strain of CAMRSA most commonly encountered in Eastern Australia also carries the P-V leukocidin gene (Professor J Etienne, Faculty of Medicine, Claude Bernard Lyon 1 University, personal communication), doctors should be aware of the possibility of severe community-acquired pneumonia caused by this organism.

1. Collins N, Gosbell IB, Wilson SF. Community-acquired MRSA bacteraemia. *Med J Aust* 2002; 177: 55-56.
2. Nimmo GR, Schooneveldt J, O'Kane G, et al. Community acquisition of gentamicin-sensitive MRSA in south-east Queensland. *J Clin Microbiol* 2000; 38: 3926-3931.
3. Munckhof WJ, Schooneveldt J, Coombs GW, et al. Emergence of community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) infection in Queensland, Australia. *Int J Infect Dis* 2003. In press.

4. Four pediatric deaths from community-acquired methicillin-resistant *Staphylococcus aureus* — Minnesota and North Dakota, 1997–1999. *MMWR Morb Mortal Wkly Rep* 1999; 48: 707-710.
5. Dufour P, Gillet Y, Bes M, et al. Community-acquired methicillin resistant *Staphylococcus aureus* infections in France: emergence of a single clone that produces Panton-Valentine leukocidin. *Clin Infect Dis* 2002; 35: 819-824.
6. Jarraud S, Mougel C, Thioulouse J, et al. Relationships between *Staphylococcus aureus* genetic background, virulence factors, agr groups (alleles), and human disease. *Infect Immun* 2002; 70: 631-641. □

## Ventricular tachycardia following ingestion of a commonly used antihistamine

Philip T Sager,\* Enrico P Veltri†

\*Clinical Project Director, Cardiovascular Department, †Vice President, Clinical Research, Schering-Plough, 2015 Galloping Hill Road, Kenilworth, NJ 07033, USA. philip.sager@spcorp.com

TO THE EDITOR: Kuchar et al<sup>1</sup> describe a patient who received an implantable defibrillator discharge after a single ingestion of loratadine. We are concerned that their conclusion — that this patient “probably” had drug-induced *torsade de pointes* — is incorrect.

Review of the intracardiac electrograms from this patient (shown in Box 2 of their article) with known monomorphic ventricular tachycardia (VT; shown in their Box 1) shows a relatively fixed rate of the VT without the large variations in cycle length consistent with *torsade de pointes*.

While there are no established guidelines for determining *torsade de pointes* based on intracardiac electrograms, it is clear that during monomorphic VT, electrocardiograms can show variability in amplitude and orientation. Consistent with the early stages of monomorphic VT,<sup>2</sup> the first three electrograms have a different orientation compared with the remaining electrograms, which are largely similar. Unfortunately, as the transition from supraventricular rhythm to tachycardia was not shown, it cannot be ascertained whether the tachycardia began with a pause-dependent mechanism, an important criterion to help diagnose *torsade de pointes*.<sup>3</sup> Given that this patient's implantable defibrillator intracardiac electrograms do not show a continually changing electrogram pattern, that the cycle length is relatively constant, and that there is a lack of documented QT prolongation, there is

no evidence of the patient's arrhythmia being *torsade de pointes*.

Incidentally, it is unclear whether these electrograms were recorded before (as specified in the discussion) or after defibrillator discharge (title of Box 2). It is well documented that a defibrillator discharge can have significant effects on the recording of intraventricular electrograms. Most likely, this patient, with documented pre-existing monomorphic VT (their Box 1[b]), had an episode of VT (not *torsade de pointes*) appropriately treated by the implanted defibrillator, probably having no direct relationship with loratadine. Notably, their Box 3 shows *torsade de pointes* in another patient, not receiving loratadine.

In summary, Kuchar et al<sup>1</sup> correctly state that there have been no documented episodes of *torsade de pointes* after ingestion of loratadine. Similarly, their report does not appear to document an episode of *torsade de pointes*.

1. Kuchar DL, Walker BD, Thorburn CW. Ventricular tachycardia following ingestion of a commonly used antihistamine. *Med J Aust* 2002; 176: 429-430.
2. Roelke M, Garan H, McGovern BA, Ruskin JN. Analysis of the initiation of spontaneous monomorphic ventricular tachycardia by stored intracardiac electrograms. *J Am Coll Cardiol* 1994; 23: 117-122.
3. Mazur A, Anderson ME, Bonney S, Roden DM. Pause-dependent polymorphic ventricular tachycardia during long term treatment with dofetilide; a placebo controlled, implantable cardioverter-defibrillator-based evaluation. *J Am Coll Cardiol* 2001; 37: 1100-1105. □

**Dennis L Kuchar,\* Bruce D Walker,† Charles W Thorburn\***

\*Cardiologist, †Research Fellow, Cardiology Department, St Vincent's Hospital, Darlinghurst, NSW 2010.  
eps@stvincents.com.au

**IN REPLY:** We agree that there are no guidelines defining *torsade de pointes* based on intracardiac electrograms, but there are several reasons why the likelihood of *torsade de pointes* (as opposed to any other arrhythmia) in our patient is high.

The electrogram shows the arrhythmia just before delivery of direct current shock, this being about 30 minutes after the patient took her first ever dose of loratadine. There are marked variations in electrogram morphology, despite minimal variation in RR interval, in a short strip of recording in this patient with documented QT prolongation. Further, she had no history of monomorphic ventricular

tachycardia, no inducible monomorphic ventricular tachycardia at electrophysiologic examination, and no evidence of structural heart disease. Neither was a mechanism for supraventricular arrhythmia identified.

The absence of initiating beats showing pause-dependence is unfortunate, but this is not provided by the generation of device implanted in this patient. Hence, we believe the word "probable" is an apt description for the observation made. □

### Indigenous health: chronically inadequate responses to damning statistics

**Paul Bauert,\* Elizabeth McMaugh,† Carmel Martin,‡ Janet Smylie§**

\*Chair, Task Force on Indigenous Health, †Senior Policy Adviser, and Secretary, Task Force on Indigenous Health, ‡Director, Public Health and Ethics Department, Australian Medical Association, PO Box E115, Kinston, ACT 2604; §Assistant Professor, Department of Family Medicine, University of Ottawa, Ottawa, Ontario, Canada  
cmartin@ama.com.au

**TO THE EDITOR:** We welcome Ring and Brown's editorial comment<sup>1</sup> on the Public Report Card 2002 *No More Excuses*,<sup>2</sup> produced by the Australian Medical Association's Task Force on Indigenous Health. We hope that drawing attention to the poor outcomes of Indigenous Australians will catalyse Federal and State governments to take action, particularly as international comparisons demonstrate the likelihood of success.

Australia's poor performance in relation to its Indigenous people is a complex phenomenon, involving political, sociocultural and historical factors, as well as health factors. Levels of ill health among Indigenous communities in

post-colonial Australia, Canada and New Zealand are particularly disturbing from a global health perspective, as they persist despite the relative affluence and excellent health status enjoyed by the general population in these nations. One of the difficulties in assessing progress is the lack of high-quality data for comparative purposes.

The types of indicators of Indigenous health in common use in Australia, Canada and New Zealand range from central indicators (such as the age-standardised rate ratios for Aboriginal people) to secondary indicators (such as change in the prevalence and incidence of chronic diseases, like diabetes, in Aboriginal communities). It would be useful to develop additional indicators that more closely reflect Aboriginal community knowledge models and values.<sup>3</sup> Existing indicators emphasise outcomes rather than opportunities for early intervention, such as early childhood development and youth resilience. Finally, there need to be greater attempts to explore how to use and compare international experiences to help Indigenous people most effectively. The Memorandum of Understanding between the Canadian Institutes of Health Research, the Medical Research Council of Australia, and the Health Research Council of New Zealand may provide a framework for international collaboration.<sup>4</sup>

1. Ring I, Brown N. Indigenous health: chronically inadequate responses to damning statistics. *Med J Aust* 2002; 177: 629-631.
2. Australian Medical Association. Public Report Card 2002. Aboriginal and Torres Strait Islander Health. No more excuses. Canberra: AMA, 2002. Media releases 24 May 2002. Available at: <http://www.ama.com.au/>
3. Macaulay AC, Comanda LE, Freeman WL, et al. Participatory research maximises community and lay involvement. North American Primary Care Research Group. *BMJ* 1999; 319: 774-778.
4. Memorandum of Understanding between the Canadian Institute of Health Research the National Health and Medical Research Council of Australia and the Health Research

### Correspondents

We prefer to receive letters by email (editorial@ampco.com.au). Letters must be no longer than 400 words and must include a word count. All letters are subject to editing. Proofs will not normally be supplied. There should be no more than 4 authors per letter. Each author should provide current qualifications and position and full details of postal address, telephone and facsimile numbers.

There should be no more than 5 references. The reference list should not include anything that has not been published or accepted for publication. Reference details must be complete, including: names and initials for up to 4 authors, or 3 authors et al if there are more than 4 (see [mja.com.au/public/information/uniform.html#refs](http://mja.com.au/public/information/uniform.html#refs) for how to cite references other than journal articles).

Council of New Zealand on Cooperation on Health Research for Indigenous Populations. Available at [http://www.dfait-maeci.gc.ca/aboriginalplanet/resource/canada/mou/mou\\_aus\\_new\\_can-en.asp?prn=1](http://www.dfait-maeci.gc.ca/aboriginalplanet/resource/canada/mou/mou_aus_new_can-en.asp?prn=1) (accessed December 2002). □

## Inhaled steroids — too much of a good thing?

Dianne P Goeman,\* Susan M Sawyer,†  
Michael J Abramson‡ Kay Stewart,§  
Francis C K Thien,¶ Rosalie A Aroni,\*\*  
Jo A Douglass<sup>1</sup>

\*Research Officer, Department of Allergy, Asthma and Clinical Immunology; ‡Associate Professor, Department of Epidemiology and Preventive Medicine, Monash University Central and Eastern Clinical School; ¶Physician, Department of Allergy, Asthma and Clinical Immunology; Alfred Hospital, Commercial Road, Melbourne, VIC 3004. †Associate Professor, Centre for Adolescent Health, Royal Children's Hospital, Parkville, VIC. §Senior Lecturer, Victorian College of Pharmacy, Monash University, Parkville, VIC. \*\*Lecturer, School of Public Health, La Trobe University, Bundoora, VIC.  
j.douglass@alfred.org.au

**TO THE EDITOR:** Our recent study of patients' priorities for asthma care<sup>1,2</sup> provides additional evidence supporting the concerns of Wilson and Robertson in their editorial questioning the possible overuse of inhaled corticosteroids.<sup>3</sup>

We have reported a qualitative study of 62 individuals who presented to an emergency department at either a central city, suburban or rural hospital, in which we explored individuals' perceptions about their asthma, its care and the impact of asthma on their lives.<sup>1,2</sup> We also asked participants to complete a questionnaire on the use of medications and sought to amplify this information by further probing the use of medications in our qualitative data collection.

Of the 82% of participants in our study currently using inhaled corticosteroid medication (51), 30% (16) were taking 1000 µg of fluticasone or equivalent daily and another 19% (10) were taking more than 1500 µg or equivalent. Current product information for fluticasone suggests a maximum dose of 1000 µg twice daily, whereas National Asthma Council (NACA) guidelines recommend that 500 µg fluticasone or equivalent daily may be the upper limit of useful effect.<sup>4,5</sup>

We also asked patients how long their medication lasted. Eleven (18%) stated that inhaled corticosteroid devices lasted three weeks or less. Use above recommended doses did not only occur

for inhaled corticosteroids, but also for symptom controller medications. Twenty-four (35%) of the 31 (50%) patients receiving this medication reported that a device lasted three weeks or less, indicating use above usual recommended doses.

Most patients in our study voiced concerns about the cost of asthma and drug side effects, some adjusted their medication use to manage these issues.<sup>1</sup> In such individuals, high use or overuse of preventive and controller medication would increase both costs and side effects, partly explaining these patients' concerns.

Doctors may be overprescribing inhaled corticosteroid medication because there is a discrepancy between dosages recorded in published drug information and newer recommendations for optimal inhaled corticosteroid dose.<sup>4,5</sup> Our findings show that, in some patients, the risks associated with the use of inhaled corticosteroids are likely to be compounded by using them at higher doses than those recommended. Doctors need to be aware of this in managing patients with asthma who have severe symptoms, in whom overuse, rather than underuse, is likely to be a problem.

1. Goeman D, Aroni R, Stewart K, et al. Patients' views of the burden of asthma: a qualitative study. *Med J Aust* 2002; 177: 295-299.
2. Douglass J, Aroni R, Goeman D, et al. A qualitative study of action plans for asthma. *BMJ* 2002; 324: 1003-1007.
3. Wilson J, Robertson C. Inhaled steroids — too much of a good thing? The goal is to achieve optimal asthma control with the lowest effective dose. *Med J Aust* 2002; 177: 288-289.
4. Asthma management handbook 2002. Melbourne: National Asthma Council, 2002: 43.
5. MIMS Australia 2002. Issue No. 4. Sydney: MediMedia Australia Pty Ltd, 2002: 278. □

## Attention-deficit hyperactivity disorder: divergent perspectives

Alison Poulton

Paediatrician, Nepean Hospital, Penrith, NSW.  
tbraj@bigpond.net

**TO THE EDITOR:** Halasz and Vance<sup>1</sup> are correct to point out that there is a diversity of causes that can contribute to a child exhibiting symptoms of attention-deficit hyperactivity disorder (ADHD), as defined in the *Diagnostic and statistical manual of mental disorders* (DSM-IV).<sup>2</sup> In their article, they

describe a child who meets the DSM-IV criteria for diagnosis of ADHD and in addition has been affected by environmental factors including poor bonding (due to maternal depression), domestic violence and parental separation. The child also exhibits developmental disability, as exemplified by delayed language development. The message is that, by explaining his symptoms in terms of his early experiences and his developmental disability, a diagnosis of ADHD can be excluded.

Children with ADHD frequently come from families with disharmonious parental relationships. This may be associated with ADHD in one of the parents, perhaps the violent father in the case described.

As clinicians our aim is to ameliorate symptoms as promptly and effectively as possible, and I am frequently impressed by the dramatic improvement that stimulant medication can make to a child's functioning both at school and within the family, with follow-on improvements in mood and self-esteem. Behavioural interventions and family therapy are important adjuncts to medication, but families such as the one described can be difficult to work with and this can limit the effectiveness of such interventions.

A carefully monitored one-month trial of stimulant medication, with behavioural rating scales completed by the class teacher, may be appropriate in cases such as the one described. On the other hand, to deny a child a trial of stimulant medication on the basis of adverse early experiences and developmental disability may be to keep from the child the treatment that would help most.

1. Halasz G, Vance ALA. Attention deficit hyperactivity disorder in children: moving forward with divergent perspectives. *Med J Aust* 2002; 177: 554-557.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed (DSM-IV). Washington, DC: American Psychiatric Association, 1994. □

George Halasz,\* Alasdair L A Vance<sup>†</sup>

\*Honorary Senior Lecturer, †Senior Lecturer, Department of Psychological Medicine, Monash Medical Centre, c/- Burke Road Medical Suites, 30 Burke Road, East Malvern, VIC 3145.  
geohalasz@aol.com

**IN REPLY:** We believe the core symptoms of attention-deficit hyperactivity disorder (ADHD) in children reflect a behavioural "final common pathway"

of developmental risk factors,<sup>1</sup> which can include transgenerational associations of core symptoms, as Poulton notes. Current scientific evidence suggests both genetic and environmental contributions, such as verbal and visuospatial executive dysfunction<sup>2</sup> and/or early patterns of attachment deficits.<sup>3</sup> Increased levels of parental psychopathology, associated with (in the child) deficiencies in problem solving, affect regulation, emotional communication and secure attachment, may contribute to the child's symptoms. For this reason, we advocate that medical management be based on a thorough assessment, to ensure that appropriate psychological interventions (eg, parent and teacher management training) are offered alongside psychostimulant medication.

In a recent speech at a scientific meeting of the Faculty of Child and Adolescent Psychiatry, Dr A Mawdsley, a distinguished child psychiatrist, expressed his belief that "prescribing medication in the absence of a careful emotional state assessment is inferior medical practice". He went even further to state that "prescribing medication in the absence of a behavioural modification program should be considered medical negligence".

1. Cicchetti D. Reflections on the past and future of developmental psychopathology. In: Green J, Yule W, editors. Research and innovation on the road to modern child psychiatry. Vol. 1: Festschrift for Professor Sir Michael Rutter. Glasgow: Gaskell and the Association of Child Psychology and Psychiatry, 2001: 37-53.
2. Vance ALA, Luk ESL. Attention deficit hyperactivity disorder: progress and controversies. *Aust N Z J Psychiatry* 2000; 34: 719-730.
3. Halasz G, Anaf G, Ellingsen P, et al. Cries unheard. A new look at attention deficit hyperactivity disorder. *Common Ground*, 2002: 75-91. □

## Doctor shoppers' rights: privacy or lunacy?

**Max Kamien**

Professor of General Practice; and Head, Department of General Practice, University of Western Australia, 328 Stirling Highway, Claremont, WA 6010.  
mkamien@cyllene.uwa.edu.au

**TO THE EDITOR:** I wish to draw attention to a draconian anomaly in the *National Health Act 1953* (Cwlth).

All GPs encounter patients "shopping" for narcotics and/or tranquillisers. The Doctor Shopper phone line (which enabled GPs to rapidly obtain informa-

tion from the Health Insurance Commission to identify non-genuine patients) was a boon in guiding GPs' management of such situations. Concern over the new private sector amendments to the *Privacy Act 1988* (Cwlth) led to an examination of the legal standing of the Doctor Shopper phone line, and it has now been cancelled.

Concerned GPs are now limited to requesting that a "patient" sign a voluntary release of their Pharmaceutical Benefits Scheme record. This tells the "patient" that they have been rumbled, and they move on to the next practice on their list.

If they have signed the Privacy Release Form, then the GP will receive a printout of the drugs they have received under the Pharmaceutical Benefits Scheme in the previous six months. This is accompanied by a letter informing the doctor that he or she "cannot make a record of, divulge or communicate to any person, any information with respect to the affairs of the person whose information has been released. To do so attracts a penalty of \$5000 and/or imprisonment for a period not exceeding two years".

So, under the provisions of the National Health Act (subsection 135A), even putting this information in the medical records of a multidocor practice would appear to be illegal. It is clearly illegal to warn other doctors outside the practice. There is no corresponding legislation which affects doctor shoppers. So the "right-doers" can finish up in jail, while the "wrong-doers" can, with impunity, continue to play their dissembling, time-consuming, and sometimes harassing, games. □

## MJA Advertisers' Index

### Corinth Healthcare

Medical Recruitment . . . . . p202

### Johnson and Johnson

Neutrogena . . . . . p194

### Schering Pty Limited

Yasmin . . . . . Inside front cover

Mirena . . . . . Inside back cover

Primolut N . . . . . Outside back cover

# The Medical Journal of Australia

## Editor

Martin Van Der Weyden, MD, FRACP, FRCPA

## Deputy Editors

Bronwyn Gaut, MBBS, DCH, DA

Ruth Armstrong, BMed

Mabel Chew, MBBS(Hons), FRACGP, FACHPM

Manager, Communications Development

Craig Bingham, BA(Hons), DipEd

## Senior Assistant Editor

Helen Randall, BSc, DipOT

## Assistant Editors

Elsina Meyer, BSc

Kerrie Lawson, BSc(Hons), PhD, MASM

Tim Badgery-Parker, BSc(Hons)

Josephine Wall, BA, BAppSci, GradDipLib

## Proof Reader

Richard Bellamy

## Editorial Administrator

Kerrie Harding

## Editorial Assistant

Christine Tsim

## Production Manager

Glenn Carter

## Editorial Production Assistant

Melissa Sherman

## Librarian, Book Review Editor

Joanne Elliot, BA, GradDipLib

## Consultant Biostatistician

Val Gebski, BA, MStat

**Content Review Committee.** Leon Bach, PhD, FRACP; Adrian Bauman, PhD, FAFPHM; Flavia Cicuttini, PhD, FRACP; Marie-Louise Dick, MPH, FRACGP; Mark Harris, MD, FRACGP; David Isaacs, MD, FRACP; Paul Johnson, PhD, FRACP; Jenefer Martin, MEd, FRACS; Adrian Mindel, MD, FRACP; Michael Solomon, MSc, FRACS; Campbell Thompson, MD, FRACP; Tim Usherwood, MD, FRACP; Owen Williamson, FRACS, GradDipClinEpi; John Wilson, PhD, FRACP; Jeffrey Zajac, PhD, FRACP

## Australasian Medical Publishing Co Pty Ltd

Advertising Manager: Peter Butterfield

Media Coordinator: Stephanie Elliott

*The Medical Journal of Australia (MJA)* is published on the 1st and 3rd Monday of each month by the Australasian Medical Publishing Company Proprietary Limited, Level 2, 26-32 Pyrmont Bridge Rd, Pyrmont, NSW 2009. ABN 20 000 005 854. Telephone: (02) 9562 6666. Fax: (02) 9562 6699. E-mail: ampc@ampco.com.au. The Journal is printed by Offset Alpine Printing Ltd, 42 Boorea St, Lidcombe, NSW 2141.

MJA on the Internet: <http://www.mja.com.au/>

None of the Australasian Medical Publishing Company Proprietary Limited, ABN 20 000 005 854, the Australian Medical Association Limited, or any of its servants and agents will have any liability in any way arising from information or advice that is contained in *The Medical Journal of Australia (MJA)*. The statements or opinions that are expressed in the Journal reflect the views of the authors and do not represent the official policy of the Australian Medical Association unless this is so stated. Although all accepted advertising material is expected to conform to ethical and legal standards, such acceptance does not imply endorsement by the Journal. All literary matter in the Journal is covered by copyright, and must not be reproduced, stored in a retrieval system, or transmitted in any form by electronic or mechanical means, photocopying, or recording, without written permission.

Published in 2 volumes per year.

Annual Subscription Rates for 2003 (Payable in Advance) to:

AMPCo, Locked Bag 3030, Strawberry Hills, NSW 2012

Individual Subscriptions (includes 10% GST)

Australia—\$A291.50. Medical students (Australia only)—\$A60.00

Overseas Economy Air—\$A370.00. Airmail—\$A505.00

NZ & PNG Economy Air—\$A340.00

Indexes are published every 6 months and are available on request as part of the current subscription.

Single or back issues contact: AMPCo (02) 9562 6666.

Advice to Authors—

<http://www.mja.com.au/public/information/instruc.html>



27,787 circulation as at  
30 September, 2002



ISSN 0025-729X