

Is Australia headed for an epidemic of nicotine replacement therapy addicts?

346 Christine L Paul, Flora Tzelepis, Raoul A Walsh, Billie Bonevski

Will Australian rural clinical schools be an effective workforce strategy? Early indications of their positive effect on intern choice and rural career interest

346 Louise Rice, Marie-Louise Stokes, Mark A Brown, Kirsten A Campbell, Cassandra Smith

The prevention and management of herpes zoster

347 Sanjaya N Senanayake

Consent in paediatric research: an evaluation of the guidance provided in the 2007 NHMRC *National statement on ethical conduct in human research*

347 Adam Jaffe, Roxanne E Strachan, Katrina J Williams

Anorexia nervosa and senna misuse: nephrocalcinosis, digital clubbing and hypertrophic osteoarthropathy

348 Andrew F McLaughlin

What has happened to clinical leadership in futile care discussions?

348 Thomas R Solano, James D Fratzia

349 Peter M Brooks

349 Mathew Piercy, Graeme Duke

Impact of specialty on attitudes of Australian medical practitioners to end-of-life decisions

349 Diego De Leo, Jacinta L Hawgood

Management of adrenal insufficiency during the stress of medical illness and surgery

350 Ian J Woodforth

350 Ann M Maguire, Maria E Craig, Christopher T Cowell

350 James A Mitchell

351 Caroline Jung, Warrick J Inder

Premature ejaculation: a clinical update

351 Paul T Dignam

352 Neil R Palmer, Bronwyn G A Stuckey

Is Australia headed for an epidemic of nicotine replacement therapy addicts?

Christine L Paul, Flora Tzelepis, Raoul A Walsh and Billie Bonevski

TO THE EDITOR: Growing revenue from the sale of products for nicotine-replacement therapy (NRT), such as nicotine patches, has fuelled media interest in the likelihood that “reformed smokers” are “getting hooked on nicotine replacement”.¹ While there may be anecdotal evidence of long-term use, there are no current population-based data to indicate whether this is the case in Australia.

Overseas data suggest long-term use of NRT is low.^{2,3} For example, a United States study found the median duration of patch use decreased from 30 days to 21 days following over-the-counter NRT availability.² Another study found that more than 75% of NRT purchases were for 1 month, while only 5% of smokers purchased NRT for more than 3 consecutive months and less than 1% of purchases continued to 24 months.³ An Australian survey conducted in 2000 suggested that most NRT use (61%) was short-term, lasting less than 2 weeks.⁴

More recently, our 2004 telephone survey of smoking-related perceptions and practices included an item on length of NRT use. The survey involved households selected at random from the New South Wales electronic white pages, with quotas applied to the sample based on NSW census proportions. The study was approved by the University of Newcastle Human Research Ethics Committee.

Of the 3503 participants (response rate, 43%), all 539 current smokers and 1013 former smokers were asked about NRT use. Those who had made their most recent quit attempt in the previous 2 years reported on their NRT use during that quit attempt. Of the 138 who had used NRT on their most recent quit attempt, only three (2%) used an NRT product for 12 weeks (the recommended length of use). Only four NRT users (3%) reported using the product for more than 3 months, and none reported using NRT for more than 6 months.

It appears that fears of widespread addiction to NRT products are probably unfounded. In fact, lack of compliance with use recommendations, resulting in inappropriately short episodes of use, is probably a bigger problem, and one that may help explain the disappointing effectiveness of

NRT under “real world” over-the-counter conditions.⁵ Data on frequent repeated short-term use of NRT products would be useful to round out the picture on NRT use in the over-the-counter environment.

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Will Australian rural clinical schools be an effective workforce strategy? Early indications of their positive effect on intern choice and rural career interest

Louise Rice, Marie-Louise Stokes, Mark A Brown, Kirsten A Campbell and Cassandra Smith

TO THE EDITOR: In the 4 February issue of the Journal, Playford and colleagues highlighted that clinical schools are encouraging interns and postgraduate year 2 (PGY2) trainees to complete some training in rural locations,¹ a good strategy considering the link between living in a rural area and working there later.²

Prevocational training in New South Wales and the Australian Capital Territory is undertaken in 15 training networks administered by the NSW Institute of Medical Education and Training (IMET). Networks typically include a city tertiary referral hospital, a metropolitan district hospital and a rural hospital. Until now, all trainees were allocated to a network by an “optimised-preference” algorithm that maximises trainees’ preference for a particular network but does not guarantee their first choice. Intern and PGY2 rotations occur in the hospitals throughout the network, including rural sites.

Over the past few years, IMET has received requests to expand the number of rural sites accredited to provide trainees with all or most of their prevocational training in a rural site because:

- graduates with an interest in rural medicine want more opportunities for rural-based training;
- rural hospitals associated with a rural clinical school want to “retain” their rural students after graduation; and
- investment in rural clinical schools and the expanding service roles of rural hospitals has increased the attractiveness and viability of rural postgraduate training.

In 2006, as part of its review into the delivery of prevocational training in NSW, IMET piloted the Rural Preferential Recruitment (RPR) process:

- Accredited rural hospitals advertise positions under RPR.
- Interested trainees apply directly to these hospitals while applying for network optimised-preference allocation.

- These hospitals run a merit-based selection process before the main allocation process.
- Trainees who receive and accept an offer from a rural hospital are removed from the main allocation list.
- Trainees who do not gain a position from the RPR process remain in the main allocation process.

In 2006, four rural hospitals were involved in RPR and recruited 15 interns for the 2007 clinical year. In 2007, 11 rural hospitals attracted 122 applications from 58 applicants, and 35 doctors began a rural internship in January 2008.

IMET recently evaluated the RPR scheme, and there is clear demand for quality prevocational training in rural areas, particularly when applicants can choose their hospitals. We hope this increase in rural exposure during the prevocational years will result in more doctors spending all or part of their careers in rural practice.

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The prevention and management of herpes zoster

Sanjaya N Senanayake

TO THE EDITOR: Cunningham and colleagues discussed the rationale for using a live attenuated vaccine against varicella zoster virus (VZV) in preventing herpes zoster (HZ) in an older population.¹ They also noted the difficulties in using a live vaccine in immunocompromised adults.

Although generally considered less immunogenic than its live counterpart, an inactivated VZV vaccine would be ideal for vaccinating immunocompromised hosts.

There is little information in the medical literature on inactivated VZV vaccines. However, the studies that do exist tested inactive vaccine on adult populations and showed favourable performance when compared with a live vaccine.^{2,3} Despite these promising results, the inactivated vaccine seems to have gone out of favour. Furthermore, if an inactivated VZV vaccine was used in the childhood vaccination programs against varicella, then it would simultaneously solve two problems caused by the vaccine strain of the virus, namely the development of infectious varicella and the reactivation of the vaccine strain as HZ.⁴

Cunningham and colleagues discussed the benefits of vaccinating an older population with VZV vaccine,¹ but did not raise the intriguing possibility that the vaccination program might reduce rates of listeriosis in older people.⁴ A recent study examined the T-cell response in mice to latent herpesvirus infection, and found that it led to activation of macrophages that, surprisingly, protected the host against subsequent infection with other pathogens such as *Listeria monocytogenes*.⁵

Given that protection from HZ through vaccination is achieved by stimulating T-cell numbers above a critical threshold for HZ,⁶ it could be hypothesised that VZV vaccinees may be protected against listeriosis, an infection to which older people are more susceptible. The basis of this hypothesis is that macrophage activity would be stimulated by the T-cell response to the VZV vaccine, thereby providing cross-protection against *L. monocytogenes*. Prospective follow-up of vaccinees in Australia over time could refute or confirm this hypothesis.

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Consent in paediatric research: an evaluation of the guidance provided in the 2007 NHMRC National statement on ethical conduct in human research

Adam Jaffe, Roxanne E Strachan and Katrina J Williams

TO THE EDITOR: Spriggs and Gillam¹ recently evaluated the updated guidance on ethical conduct in human research from the National Health and Medical Research Council (NHMRC),² with particular reference to paediatric consent. The introduction in 2007 of the National Ethics Application Form (NEAF; <http://www.neaf.gov.au>) represented an attempt to streamline the process of obtaining ethics approval from multiple human research ethics committees (HRECs) for multicentre research.

In 2007, just prior to mandatory introduction of the NEAF, we submitted identical NEAFs to 13 HRECs, covering all Australian states and territories, for an epidemiological study into childhood empyema. All but one HREC accepted the NEAF, but, despite use of the same form by the majority, we identified a variety of inconsistencies.

With regard to child consent or assent, 11 HRECs required a single child information sheet and consent form; one required two separate age-appropriate forms; and one questioned the planned involvement of children in the consent/assent process and did not require a child's consent. This latter response arguably contravenes the United Nations Convention on the Rights of the Child, which provides for a child's right to information in a form they can comprehend, whether or not they have the ability to make decisions.³

Other inconsistencies included the time taken to obtain approval, which ranged from 1 day to 197 days (median, 31 days). One HREC defined a child as being aged less than 18 years; the others used a cut-off of 16 years. One HREC responded that the application did not specifically address local Aboriginal and Torres Strait Islander peoples' issues, which suggests that the NEAF may

not be sufficient to cover such site-specific requirements. One HREC required plain-language translation of consent and information sheets, and another required Aboriginal translation.

Also of concern, the NEAF requires justification for the inclusion of Aboriginal or Torres Strait Islander children and other groups where ethical considerations may be different, such as children with intellectual impairment or mental illness. This approach places the wrong emphasis on the desired outcome, which is to give due consideration to cultural, social, health, psychological and local issues that may introduce ethical concerns that are not the same for all children, and it risks exclusion of some children from research that is relevant to them. We suggest the NEAF should instead include a justification for *exclusion* of any children as a result of cultural or religious background or social or psychological problems. This would provide an alternative way of gathering information about ethically relevant issues, to ensure best practice in ethical conduct or research.

Clearly, there is a lack of consistency across Australia in engaging children in research, including the consent/assent process. We believe that use of the NEAF alone is insufficient to rectify these inconsistencies, and now is the time to consider a single national ethics committee for Australia, similar to the National Research Ethics Service recently introduced in the United Kingdom (<http://www.nres.npsa.nhs.uk>).

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Anorexia nervosa and senna misuse: nephrocalcinosis, digital clubbing and hypertrophic osteoarthropathy

Andrew F McLaughlin

TO THE EDITOR: I read with interest the letter by Lim and colleagues on anorexia nervosa and senna misuse.¹ I have seen abnormal whole body bone scans in patients with severe eating disorders of exactly the same pattern (except for the avid bilateral apical lung and gastric uptake) as the case described.

However, I disagree with the interpretation of the bone scan. There was increased periarticular tracer uptake involving long bones. The pattern was not that of hypertrophic osteoarthropathy (HOA). The pattern in HOA is linear tracer uptake by the periosteum, particularly along the distal ends of long bones.² The scan in the case reported did not show uptake of this pattern, despite radiological evidence showing periosteal reaction and new bone formation of the tibia and fibula at the ankle. The pattern exhibited in this patient was more consistent with metabolic bone disease (increased tracer uptake by the ends of long bones periarticularly, the axial skeleton, calvaria, mandible, sternum and "beading" of costochondral junctions, with faint, or absent, renal uptake),³ although not all of these features were present in this case.

Metastatic calcification of the gastric wall (not mentioned by the authors) and upper lobes of the lung was present in this patient. Metastatic calcification of the lungs can be diffuse⁴ or localised (most commonly) to the upper lobes, as in this case.⁵

With regard to the bone mineral density results in this case, the authors state that the lumbar and femoral neck T scores were elevated (1.2 and 1.3, respectively). The normal range of the T scores is ± 1.0 standard deviation of young adult normal values.⁶ Elevated bone mineral density measurements are generally not of pathological significance and are therefore clinically not relevant. In my experience they are usually decreased, and are often osteoporotic, in patients with severe eating disorders.

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What has happened to clinical leadership in futile care discussions?

Thomas R Solano and James D Fratizia

TO THE EDITOR: We share the sentiments of Murphy's article in the 7 April issue of the *Journal*.¹ As intensive care physicians, the issue of futile care is an almost daily consideration. We agree with his assertion that "the community looks to the (senior) medical practitioners for the security they need to accept decisions of great moment, such as withholding futile treatment".¹

It is common for a referral to an intensive care unit to be made because "We asked the family, and they want everything done". This is the least confrontational manner of "sorting out the resuscitation status" with the next of kin. Unfortunately, it shifts end-of-life decision making to others, particularly the family in crisis.

This places additional stress on an already stressful situation. It often results in undignified, ultimately futile medical interventions and prolongation of dying. It is also a potential pastoral and mental health disaster for families. It is our duty of care to such patients to minimise the iatrogenic damage to their families by having senior clinicians communicate which therapies are appropriate, and thereby help families accept the likely prognosis. Ethically, we believe doctors should not harm families in crisis.

Establishing when treatment is futile is difficult. The decision is often qualitative, with differing thresholds for futility. Personal and religious beliefs and anecdotal experience all affect the ability of a clinician to determine when a therapy is futile.

We believe it is the duty of the clinician who performs an intervention, not the referring clinician, to determine its utility. A patient should not be referred to an inten-

sive care unit if the intensivist believes the multitude of life-supporting therapies are not of clear benefit. If initiated, the intensivist should determine when such therapies are no longer of benefit. A framework for debate and review of contentious cases should be established within institutions as a matter of process.

Sadly, intensive care units are increasingly seen as locations for palliative care. When a patient dies, it is unreasonable for referring clinicians to claim a clear conscience by saying “we did everything we could”, when the outcome is a prolonged, undignified death in an intensive care unit. Such deaths are not just wasteful of resources, but cause unnecessary distress to patients, their families and staff who care for them.

We must not mistake “treating” our patients for “caring” for them. Doctors should be part of the solution, not part of the problem.

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1 Murphy BF. What has happened to clinical leadership in futile care discussions? *Med J Aust* 2008; 188: 418-419. □

Peter M Brooks

TO THE EDITOR: Congratulations to Murphy¹ for raising the important and sensitive issue of when to stop trying. This is an issue that needs to be discussed more widely in the community and in hospitals, and presented sensitively to all health students.

We know that a significant proportion of the health dollar is spent on the last 12 months of life,² but, more importantly (as Murphy points out), a clear decision, discussed openly with patients and their families, can save significant pain — both physical and emotional — to all concerned. Advance treatment orders can aid decision making in these situations, but need to be backed up with support for patients' families when they are to be followed.

This issue is with us now but will become more widespread in the future. Health professionals need to be well schooled in this important area of caring. We have to understand when to cease the desire to keep a patient alive. Modern health care has provided incredible advances but we are still not good at knowing and being “strong” in our beliefs and behaviour about when to stop.

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Mathew Piercy and Graeme Duke

TO THE EDITOR: In the 7 April issue of the Journal, Murphy encouraged the medical profession to be more proactive about discussing end-of-life care options with family members (or next of kin) with a view to withholding care that may be considered futile by the clinical team.¹

While we agree that it is important to offer advice about what course of action the clinical team recommends in a particular case, it is equally important that this advice be based on good evidence and sound clinical judgement. This can be difficult, even for experienced clinicians.

Further, it is unwise to leave the family without any alternative but to accept that advice, because this can lead to distrust and disagreement between the family and the treating team. This is not a matter of acquiescing to a family's unrealistic expectations — often the prognosis is not clear-cut, and there are times when a planned but limited trial of therapy is warranted. In complex situations, the prognosis often becomes obvious, and families can and do draw comfort from the fact that every effort was made, and are then more willing to accept limitation or withdrawal of therapy.

In the case of withholding cardiopulmonary resuscitation, the treating team has sole responsibility for the medical opinion, but the family should be involved in the final decision and not have it enforced unilaterally.

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Impact of specialty on attitudes of Australian medical practitioners to end-of-life decisions

Diego De Leo and Jacinta L Hawgood

TO THE EDITOR: We support the conclusions reached by Parker and colleagues in their study on the attitudes of Australian medical practitioners to end-of-life decisions.¹ They recommend the inclusion of decision-making theory and practice within medical ethics curricula, and highlight the need “to facilitate more discussion between specialties about medical decisions at the end of life”.¹

An investigation commissioned to the Australian Institute for Suicide Research and Prevention by the Australian Government Department of Health and Ageing in 2006 aimed to verify receptivity towards, and possible ways of implementing, suicide prevention education in the medical curricula of Australian universities. This mandate also provided the opportunity to assess potential interest in and feasibility for education on end-of-life decisions.² Our exploratory investigation included interviews of key academics in curriculum or accreditation committees of 10 out of 15 Australian medical schools, 24 general practitioners from six Australian states, and 373 medical students from the University of Queensland.²

Representatives of the medical schools considered it a “very high priority” to implement adequate education on end-of-life issues, including euthanasia, in medical curricula. Most of the interviewed GPs (21/24) and 80% of medical students agreed with this sentiment.

Common themes that emerged from the study were the need for good preparedness in coping with difficult situations, and the desired capacity in competently handling decisions that are perceived to be requested with increasing frequency in clinical scenarios.²

End-of-life issues nearly always involve aspects that go beyond the treatment of somatic conditions. Moral convictions, religious beliefs, and self-identification processes (with the patient) all compound the challenge physicians face in their practice. The very complexity of the challenge should push towards more knowledge, and this should be obtained through modern medical curricula.

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Management of adrenal insufficiency during the stress of medical illness and surgery

Ian J Woodforth

TO THE EDITOR: In their recent "Clinical Update" on adrenal insufficiency, Jung and Inder¹ state:

In patients with adrenal insufficiency who are fasting before procedures, glucocorticoid therapy must be continued, by parenteral routes if necessary. A recent case report has highlighted the adverse consequences of omitting oral steroid therapy in a patient who was fasting before a surgical procedure. The patient developed hypotension and acute renal failure.

The patient described in the case report² was admitted with septic arthritis. His usual cortisone dose of 12.5 mg had been omitted that evening, and his morning dose of 25 mg was not given the next day until after he had returned from the operating theatre. Over the next 3 days, he became overtly septic, and returned to theatre for another knee washout. Cortisone was not given during this time. When he developed acute renal failure on Day 5, dehydration and gentamicin toxicity were listed as possible causes.

The article by Jung and Inder does not make it clear that the case report contains nothing of relevance to the management of patients with adrenal insufficiency who are fasting for routine surgical procedures, as this man's hypotension and acute renal failure actually developed over 5 days in the context of sepsis, dehydration and possible gentamicin toxicity, in addition to prolonged withholding of cortisone and two operations.

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Ann M Maguire, Maria E Craig and Christopher T Cowell

TO THE EDITOR: The recent article by Jung and Inder¹ provides sensible advice for the safe management of adults with adrenal insufficiency (AI) during illness and surgery, without risking adrenal crisis or excessive steroid dosing. However, the authors make no reference to paediatric practice and no guidelines have been provided for the body-size-related steroid doses required in paediatric patients with AI, either for routine steroid replacement or during illness and surgery. It is important that doctors be aware that the doses recommended by Jung and Inder are not suitable for children with AI.

In keeping with recent studies of daily cortisol production, daily hydrocortisone replacement doses of 6–8 mg/m²/day are now recommended for children with secondary AI (eg, due to adrenocorticotropic hormone deficiency), provided the patient has no hypoglycaemia or symptoms of cortisol deficiency.² In children with primary AI, higher hydrocortisone doses are often necessary (up to 10–15 mg/m²/day) — for example, to minimise adrenal androgen secretion in children with congenital adrenal hyperplasia.³

During minor illness (as defined in Box 3 of Jung and Inder's article¹), a child's usual daily oral dose of glucocorticoid should be doubled or tripled until recovery.^{3,4} However, for children with secondary AI who are on the lower doses of daily hydrocortisone (about 6–8 mg/m²/day), these multiples may not constitute adequate doses during stress. In these patients, per-m² dosing is more accurate (ie, 30–40 mg/m²/day for minor illnesses).

During moderate-to-severe illness, for patients who are vomiting, those who have experienced trauma and those undergoing anaesthesia and surgery, the following doses of intravenous hydrocortisone are recommended:

- For children aged <3 years: 25 mg initial dose then 25–30 mg/day;
- For children aged 3–12 years: 50 mg initial dose then 50–60 mg/day; and
- For adolescents and adults: 100 mg initial dose then 100 mg/day.

These doses are in keeping with national⁴ and international³ recommenda-

tions, and equate to doses of 60–100 mg/m²/day of hydrocortisone. The more accurate per-m² dosing should be used for children who are not within the normal weight range for their age.

These recommendations for children are extrapolated from adult studies and also based on expert consensus. Attention to the specific body-size dose adjustments required in paediatric prescribing can provide safe levels of steroid cover while avoiding exposure to excessive steroid doses.

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James A Mitchell

TO THE EDITOR: The excellent article by Jung and Inder¹ in a recent issue of the Journal contains a detailed discussion of different regimens proposed for glucocorticoid supplementation in the perioperative period and makes recommendations for the use of hydrocortisone therapy according to the degree of "surgical stress". It is worth noting that, in many cases, these recommendations and the detailed advice of endocrinologists regarding individual patients are rendered moot by the changes in routine perioperative antiemetic therapy that have occurred in the past decade.

The use of intravenous dexamethasone as an antiemetic has been the subject of much clinical research. The IMPACT study² showed that it has an antiemetic efficacy similar to that of ondansetron or droperidol when given prophylactically. Dexamethasone is less expensive than either of these drugs and is ineffective as rescue therapy in

the setting of postoperative nausea and vomiting (PONV), unlike the alternative drugs. As a result, it is used routinely on induction of anaesthesia in many cases of surgery associated with an increased risk of PONV or where PONV would pose a risk of injury or delayed discharge.

A range of doses of dexamethasone for antiemetic prophylaxis has been investigated without finding superior efficacy from higher doses (of up to 1.0 mg/kg).³ The dose typically used in clinical anaesthesia practice is 0.05–0.1 mg/kg. This is equivalent in glucocorticoid activity to more than the highest dose of hydrocortisone described in the guidelines of Jung and Inder¹ and should provide a self-tapering effect over 2–3 days, consistent with their recommendations for hydrocortisone dosing.

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- 1 Jung C, Inder WJ. Management of adrenal insufficiency during the stress of medical illness and surgery. *Med J Aust* 2008; 188: 409-413.
- 2 Apfel CC, Korttila K, Abdalla M, et al. A factorial trial of six interventions for the prevention of postoperative nausea and vomiting. *N Engl J Med* 2004; 350: 2441-2451.
- 3 Kim MS, Cote CJ, Cristoloveanu C, et al. There is no dose-escalation response to dexamethasone (0.0625–1.0 mg/kg) in pediatric tonsillectomy or adenotonsillectomy patients for preventing vomiting, reducing pain, shortening time to first liquid intake, or the incidence of voice change. *Anesth Analg* 2007; 104: 1052-1058. □

Caroline Jung and Warrick J Inder

IN REPLY: We thank Woodforth for his interest in our article.¹ The cited case report² involved a patient with panhypopituitarism who had septic arthritis following a total knee replacement, requiring knee washout. As stated by Woodforth, the patient was without glucocorticoid replacement for 5 days, during which time he underwent two surgical procedures. Symptoms of cortisol deficiency were described on Days 1 and 2 postoperatively, with overt sepsis not manifesting until Day 3. The absence of adequate glucocorticoid replacement while the patient was under a “nil oral” instruction and suffering sepsis was undoubtedly a contributory factor in his decline, given that his condition improved significantly after he had received 24 hours of intravenous hydrocortisone treatment and other supportive care. It appears that the cortisone acetate was withheld because of concerns about

administering it without food, as other medications were in fact given.

We stand by our assertion that patients with proven or suspected cortisol deficiency should receive adequate glucocorticoid replacement before and after surgery, according to the likely stress of the procedure. Often, for minor procedures, an oral route of administration will suffice. Doses of oral glucocorticoids given under these circumstances do not need to be taken with food. If there are sound clinical reasons for the patient not to have any medications orally, then parenteral administration is appropriate.¹

Maguire and colleagues correctly point out that the glucocorticoid dosage recommendations in our article are suitable only for adults. They have made a significant contribution to the literature on the investigation and management of paediatric adrenal insufficiency and we would like to thank them for providing the appropriate glucocorticoid doses for paediatric patients under stress.

We are aware of the use of dexamethasone as a perioperative antiemetic, as outlined by Mitchell, although it is not clear how widespread this practice is. He is correct in stating that in cases in which dexamethasone is used for this purpose, the glucocorticoid dose thereby provided is likely to be more than adequate for adrenal replacement. However, dexamethasone has no mineralocorticoid activity, and this must be taken into account when treating patients with primary adrenal insufficiency. Doses of hydrocortisone greater than 50–75 mg per 24 hours provide adequate mineralocorticoid replacement. If dexamethasone is used for patients with primary adrenal insufficiency undergoing surgery, it is imperative that the patient continue to take oral fludrocortisone throughout the perioperative period to provide mineralocorticoid replacement. This highlights the need for good communication between the patient's general practitioner, endocrinologist, surgeon and anaesthetist to ensure the best patient outcome.

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- 1 Jung C, Inder WJ. Management of adrenal insufficiency during the stress of medical illness and surgery. *Med J Aust* 2008; 188: 409-413.

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Premature ejaculation: a clinical update

Paul T Dignam

TO THE EDITOR: We all privately seek statistics that enable us to put ourselves in perspective (even if we keep the results to ourselves!), but I am now unsure where my sexual performance stands.¹ On the one hand, I am told premature ejaculation affects at least one, and from time to time two, of every three males (is that the <2 minutes version?), and on the other that there is a skewed distribution with a median of 5.4 minutes and a range of 0.55–44.1 minutes. I'm impressed by the aerobic fitness, never mind the sex.

It seems we have a continuously distributed, perhaps skewed, normal distribution of an apparently genetically determined variable, with which individual players (?70%) and their partners are dissatisfied at times. Is that not like height, or IQ? “Premature” ejaculation may not be *caused* by individual psychology, but it is *defined* by it: from our beginnings in the Garden of Eden we have always wanted more than we have!

The early sperm may not get the bird but historically it got its share of the ovum and thus has persisted over millennia. There may be a role for medicine in some extreme cases (as for “constitutional” dwarfism and gigantism, where being very different carries a significant psychological disadvantage), but for the rest are we not colluding to some extent with an escape from the reality of our limitations? How much of this is treatment and how much is performance enhancement?

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- 1 Palmer NR, Stuckey BGA. Premature ejaculation: a clinical update. *Med J Aust* 2008; 188: 662-666. □

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IN REPLY: Dignam queries the validity of treating early ejaculation that may simply be a variant of normal. However, if one in three men complain to us of premature ejaculation and how it affects their relationships, we listen. They may regard themselves as very different from other men and may become psychologically disadvantaged.

In our article we detailed various presentations of premature ejaculation (PE), including that of a subjective perception of PE although the intravaginal ejaculatory time is normal.¹ In such cases, reassurance is an appropriate response. However, for men with primary PE, for whom ejaculation consistently occurs within 1 minute or even before vaginal penetration, there is a problem. This problem can be treated successfully to improve a relationship that may have been foundering. And, yes, this may mean performance enhancement unrelated to aerobic fitness.

If men are unsure where their sexual performance stands, they should ask their partner. After all, communication improves a loving relationship.

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¹ Palmer NR, Stuckey BGA. Premature ejaculation: a clinical update. *Med J Aust* 2008; 188: 662-666. □