Management of atrial fibrillation

Dear Editor

Congratulations on the July issue of *AFP* focusing on arrhythmias. Of particular interest was the article by Kistler and Habersberger[1] focusing on management of atrial fibrillation. The complexities of warfarin are well known, centering around its narrow therapeutic window and requisite close monitoring by the treating clinician, which additionally relies on certain patient competencies.

In the interest of quality care for patients requiring anticoagulation with warfarin, clinicians should also consider and evaluate each patient's: cognition, as cognitive impairment has been associated with unintentional over- or under-dosing;[2] health literacy, as people with limited health literacy are less likely to understand side effects, interactions and dosing regimens;[3] compliance, the ability to manage requirements for regular INR monitoring; and access to continuity of care, as it is recognised that a collaborative doctor-patient partnership is essential for successful management of warfarin.[4]

Consideration of these factors will assist in providing a foundation for optimum patient safety and effective clinical outcomes.

Judy Lowthian, Sue Evans,
NHMRC Centre of Research Excellence in Patient Safety
Monash University, Vic

References

1. Kistler P, Habersberger J. Management of atrial fibrillation. Aust Fam Physician 2007;38:506–09.
2. Hutchison LC, Jones SK, West DS, Wei JY. Assessment of medication management by community living elderly persons with two standardized assessment tools: a cross sectional study. Am J Geriatr Pharmacotherapy 2006;4:144–53.
3. Fang MC, Machtinger EL, Wang F, Schillinger D. Health literacy and anticoagulation related outcomes among patients taking warfarin. J Gen Intern Med 2006;21:841–6.
4. Gallus AS, Baker RI, Chong BH, Ockelford PA, Street AM. Consensus guidelines for warfarin therapy. Recommendations from the Australasian Society of Thrombosis and Haemostasis. Med J Aust 2000;172:600–5.

Macular degeneration

Dear Editor

We read with interest the article on treatment options available for age related macular degeneration.[1]

The authors state that bevacizumab has a 'significant side effect profile'. This is true when administered at high doses intravenously for the treatment of various cancers. However, the side effect profile when used for intravitreal administration is minimal. Even the authors acknowledge that the literature to date indicates the intravitreal administration of bevacizumab to be relatively free from toxicity.

The authors also state that bevacizumab is covered by the PBS. This is incorrect. The drug is approved for use in colorectal cancer by the Therapeutic Goods Administration but is not subsidised by the PBS.

Ranibizumab has been listed on the PBS from 1 August 2007 for the treatment of age related macular degeneration.

Ben Stevenson, Senior Pharmacist, HPS Pharmacies, SA
Jim Siderov, Senior Pharmacist, Austin Health, Vic

Reference

1. Smith TC, Lee L. Age related macular degeneration: new developments in treatment. Aust Fam Physician 2007;36:359–61.

Healthy diet, healthy heart, healthy prostate

Dear Editor

At the recent Annual Scientific Meeting of the Urological Society of Australasia and National Prostate Cancer Symposium, there was increasing support for chemoprevention in prostate cancer, with the same strategies used to reduce cardiovascular risks such as healthy diet and lifestyle changes.

Studies have demonstrated that some food substances have a chemopreventive effect on prostate cancer. For example, lycopene, a carotenoid antioxidant, can lower serum testosterone levels without the side effects associated with androgen deprivation therapy or 5-alpha reductase inhibitors.[1] Therefore, foods such as tomato, watermelon, pink grapefruit, papaya, and apricots containing lycopene should be consumed regularly. Other micronutrients such as selenium, vitamin E, phytofluene and omega-3 fatty acids were also found to have similar effects. It is also recommended that a balanced diet consisting of a combination of fruit and vegetables in small quantities has superior effect than large quantities of a fruit or vegetable alone.[2]

Regular exercise, lipid lowering drugs, and maintaining a healthy waist-weight ratio reduces the risk of cardiovascular disease and the incidence of prostate cancer and biochemical relapse after curative treatment.[2]

David Ting-Wei Chiang
Ipswich, Qld

References

1. Kantoff P. Prevention, complementary therapies, and new scientific developments in the field of prostate cancer. Rev Urol 2006;8(Suppl 2):S9–14.
2. Canene-Adams K, Lindshield BL, Wang S, et al. Combinations of tomato and broccoli enhance antitumor activity in dunning r3327-h prostate adenocarcinomas. Cancer Res 2007;67:836–43.

ADDRESS LETTERS TO

The Editor
Australian Family Physician
1 Palmerston Crescent
South Melbourne Vic 3205
Australia
FAX 03 8699 0400
EMAIL afp@racgp.org.au

The opinions expressed by correspondents in this column are in no way endorsed by either the Editors or The Royal Australian College of General Practitioners

Erratum

Due to a production error, the letter by Mark Stein on vitamin D deficiency (*AFP* September) incorrectly stated the dosing regimen for vitamin D supplements. The correct regimen is to prescribe 1000 IU supplements three capsules, three times per day for 1 week, and thereafter continue 1 capsule per day.