Nortriptyline: Cheap and effective medication now approved for smoking cessation

Nortriptyline (fully funded as Norpress) has been gazetted for smoking cessation. (http://www.medsafe.govt.nz/Regulatory/gazette.asp).

There have been three studies of Nortriptyline.[1–3] Two versus placebo and one versus Buproprion (Zyban)[2] The dosing regime in the latest study is similar to that of Zyban where patients are started on 25mg for three days followed by 50mg for four days. Dosages are only increased to 75mg if the therapeutic level has not been achieved. In my own practice I have increased the dose over two to three days for each increase up to 75mg. In the most recent study the maximum dose was 100mg but that was based on serum levels. I keep the patient on the medication for 10 weeks (not 12 as in the study so that one prescription will cover the whole period). I then reduce the medication at the pace that I started it. I have not used serum levels as a guide and have not had any problems with it. Now that Nortriptyline is gazetted for smoking cessation there is no longer any need to inform patients that it is not gazetted for this purpose. My own experience continues to be that patients are very enthusiastic at it being fully funded and, while a few have stopped the medication due to drowsiness, a good number have made dramatic changes in their smoking.

Bruce Arroll

References

1. Hughes JR, Stead LF, Lancaster T. Antidepressants for smoking cessation (Cochrane Review). In: The Cochrane Library, Issue 2, 2002. Oxford: Update Software.
2. Prochazka AV, Weaver MJ, Keller RT, Fryer GE, Licari PA, Lofaso D. A randomized controlled trail of nortriptyline for smoking cessation. Arch Int Med 1998; 158:2035–2039.
3. Hall SM, Humfleet GL, Reus VI, Munoz RF, Hartz DT, Maude-Griffen R. Psychological intervention and antidepressant treatment in smoking cessation. Arch Gen Psych 2002; 59:930-6.

A reply to Associate Professor Janes

I was delighted to see that Associate Professor Janes had responded to my article (it's good to experience the robust debate applauded by our President), miffed not to have been given an opportunity to respond in the same issue (a courtesy I think you should extend to your primary authors, Sir) and sad to read how well he demonstrated the special pleading I provocatively chose to call rural narcissism.

In early May I was in Kaiapoi, where I read, on a blackboard outside a coffee shop, their quote of the day: *'He who falls in love with himself has no rivals'*. Apt for Narcissus: looking inward does create a kind of comfort.

Rural medicine ought not to be a religion, unassailable, intolerant of outside comment – and such an attitude is worrisome in an academic. Shibboleths can shrink to become scibboli.

He obliges me to point out the blindingly obvious: I wrote as an individual, not as a spokesperson for any of the professional bodies I am or have been associated with.

Ian St George

When appropriate, primary authors will be asked to respond to correspondence (see Readers Write this issue) but deadlines for copy may preclude this from being published in the same issue – Editor

Delayed prescriptions for viral infections

In respect of delayed prescriptions for viral infections (*NZFP* 2003; 30:30–34), I suppose we should look sympathetically at any strategy that reduces inappropriate antibiotic use, and I am all too familiar with the pressure one often feels, real or imagined, from the patient who 'thought I better come and get something for it' or doesn't 'want it to go to my chest'. BPAC has given its full support to the delayed prescription approach, and encouraged its use by GPs.

However I am uncomfortable with the inherent contradiction that providing a delayed prescription entails, i.e. that an antibiotic isn't necessary now, but it might be in a few days time. If we are trying to persuade patients that viral illnesses are self-limiting, we contradict ourselves by providing an antibiotic a few days later (without even reviewing the patient). What are the patients to make of that? Entrenched belief in the necessity of antibiotics is not going to be greatly shaken by such a mixed message. Surely the consistent message is that, for viral illnesses, antibiotics are no more likely to help in a few days time than they are now.

The article states that delayed prescribing is a means of reducing 'prescribing of unnecessary antibiotics without damaging the doctor-patient relationship'. This is a cop-out. If the said relationship is dependant upon doctors meeting the misguided expectations of their patients, it is a very unbalanced one. I currently work as a locum, and am generally quite happy to tell patients that their illness is viral and will not benefit from antibiotics (with the proviso that they come back if their condition deteriorates or persists longer than 10–14 days), and they are usually receptive to this, often delighted in fact. Some are a little sceptical, and very occasionally downright hostile; these patients have invariably received antibiotics as a routine from their usual doctor.

Medicine is fraught with uncertainty, and clinical judgements are really just informed best guesses; determining that an illness is just viral is not always straightforward. I am as concerned as the next GP about mistaking a clinically occult pneumonia for a viral bronchitis. Furthermore I think many other factors influence our decisions about prescribing (including the fact that we feel much more comfortable charging someone up to $50 if they leave with a prescription and not the 'usual advice' about viral illness). I am subject to these various influences, and don't mind admitting that I have certainly prescribed antibiotics when they were probably unnecessary, and even when I knew them to be unnecessary.

Nevertheless, I feel to provide a delayed prescription is to shoot ourselves in the foot as far as changing the mindset of patients about self-limiting illness.

Phil Dashfield, Picton

In response

Dr Dashfield is not alone in his concern about delayed prescriptions. In our studies on this topic we have found other GPs with similar concerns. The majority, however, have found them to be a very useful tool in dealing with patients who are insistent on antibiotics. A number of GPs no longer needed to prescribe antibiotics following the use of delayed prescriptions. There is evidence from the UK[1] that patients are less likely to re-attend after being given a delayed prescription for sore throat. We see them as a gentle form of education in the transition to lower use of antibiotics for 'viral' respiratory infections. The situation in which Dr Dashfield prescribed antibiotics, when he knew them to be unnecessary, would be an ideal situation in which to give a delayed prescription.

Bruce Arroll

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