

References

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In response

We thank Quantrill and Webbe for their response, and agree completely both that an important role of pharmacists is to educate, and that better systems are needed for providing feedback to prescribers about any errors made. We believe that feedback is complementary to pharmacist attendance on consultant ward rounds, and that both approaches are required. Pharmacists attending ward rounds are likely to be more aware of patients' current priority medical problems, and are able to discuss drug therapy with senior members of the medical team, resulting in the higher intervention rate demonstrated in our paper. Separately, better feedback on prescribing errors, particularly to junior doctors, is also needed, to facilitate learning. Several studies have shown that junior doctors get little or no feedback on their prescribing errors at present. We recently completed some exploratory work with junior doctors and pharmacists to explore these issues, and found a key barrier to be pharmacists unable to ascertain the identity of the prescriber. We are therefore considering piloting the use of name stamps, and are designing a controlled study to explore the impact of providing feedback to our junior doctors. We would encourage Quantrill and Webbe to publish their findings in more detail so that others can build on them further.

GAVIN MILLER

Lead pharmacist, clinical services,
Pharmacy Department

BRYONY DEAN FRANKLIN

Director,
Centre for Medication Safety and Service Quality

ANN JACKLIN

Chief of service pharmacy and therapies,
Imperial College Healthcare NHS Trust, London

'The tubercular diabetic'

Editor – We read with great interest the article by Bailey and colleagues (*Clin Med* August 2011 pp 344–7). Treatment of people with tuberculosis (TB) and diabetes is indeed complicated. Not only does rifampicin potentially adversely alter the pharmacokinetics of gliclazide,¹ glipizide,² pioglitazone,³ nateglinide⁴ and repaglinide,⁵ but like isoniazid, it may increase insulin requirements.⁶ Liver and nerve toxicity from anti-TB drugs may be difficult to distinguish from diabetes-associated non-alcoholic fatty liver disease and peripheral neuropathy respectively and for those with co-morbid HIV infection with access to treatment, there is the added complication of antiretroviral-associated insulin resistance.⁷ TB itself may precipitate hyperglycaemia by a stress hormone response and there is some evidence of glucose intolerance in TB patients reverting to normal in up to 75% of patients after three months of TB treatment.⁸

We wholeheartedly endorse Bailey and Grant's conclusion that TB and diabetes demand increased attention from clinicians and academics if we are to ensure that future patients receive optimal management of both conditions.

HEMANTHA CHANDRASEKARA

Specialty registrar in
endocrinology and diabetes,
Royal Liverpool University Hospital

KEVIN HARDY

Consultant in endocrinology and diabetes,
Whiston Hospital,
Prescot, Merseyside

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In response

We read with appreciation the comments of Chandrasekara and Hardy. The management of concomitant tuberculosis and diabetes mellitus remains challenging and highlights two important factors. Firstly, that our level of clinical suspicion of dual pathology here in the UK needs to be raised so that management can be optimised, including appropriate adjustment and monitoring of medication. Secondly, that as diabetes progresses in low-income countries we need to consider collectively how best to manage this chronic disease in resource-limited settings and indeed this is a focus of our ongoing research.

PAUL GRANT

Specialist registrar in diabetes
and endocrinology,
King's College Hospital, London

SARAH LOU BAILEY

Clinical lecturer in infectious diseases
and global health,
Brighton and Sussex Medical School

Oxygen therapy in acute coronary syndrome: current NICE recommendations

Editor – I read with great interest the concise guidance by O'Driscoll and colleague (*Clin Med* August 2011, pp 372–5) on emergency oxygen use in adult patients. Oxygen therapy