in two genes, CYP2C9 (which metabolises S-warfarin) and VKORC1 (pharmacological target: vitamin K epoxide reductase), account for 50% of the variance in dosage requirements.[12] Dosing algorithms incorporating genetic and clinical factors have been developed[13] but, although testing is mentioned on the label in the USA, as for irinotecan there is no dosage guidance. Routine use is not currently recommended. Randomised controlled trials are underway.

Conclusions

Genotype-guided prescribing is now routine in a few cases and should increase in coming years. It will probably be most useful for drugs with a narrow therapeutic index in the management of cancers and in drug safety. A House of Lords report has highlighted the need to develop this field.[14] It will be crucial to test the clinical validity and usefulness of any pharmacogenetic markers that are developed.

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Erratum

Fogo A, du Vivier A. The cutaneous manifestations of haematological malignancy. *Clin Med* 2009;4:366–70.

Please note figure 3 on page 368 of the August issue of *Clinical Medicine* was reproduced incorrectly. This was due to an technical error which occurred during the typesetting process.

The correct version of figure 3 is reproduced below.

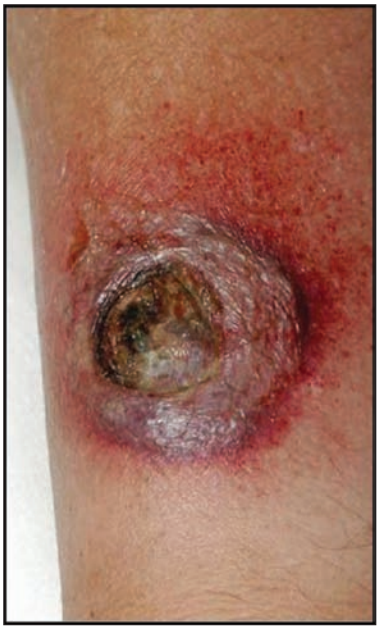

Fig 3. Pyoderma gangrenosum. An 'infection' developed at the site of the Hickman line and at other venous access sites in this patient. It was debrided until a haematologist made the correct diagnosis and a biopsy was performed. The lesions responded dramatically to steroids.