Tablet Press

The prescribing newsletter for GPs, nurses and pharmacists in Northamptonshire Primary Care Trust

Issue 20 **May 2008**

- **Drugs and Therapeutics Bulletin update on the glitazones**

The DTB has updated its 2001 review of the glitazones. The main points from this article are that there is no convincing evidence that glitazone monotherapy offers any benefits over metformin or a sulphonylurea in terms of improved clinical outcomes, though there is evidence to support use in combination with metformin or a sulphonylurea in patients unsuited to one or other of these drugs, although the evidence only relates to a reduction in HbA1c, not to improved macrovascular or microvascular outcomes. The evidence for use in triple therapy is also weak, and should be reserved for patients in whom insulin is contraindicated or is likely to be poorly tolerated. In terms of safety, glitazones increase weight, can cause heart failure and peripheral oedema, and increase fracture rates in women. There is also evidence to suggest that rosiglitazone increases the likelihood of MI and cardiovascular disease.

The DTB suggest that if a glitazone is being considered, pioglitazone is probably safer, but should only be used as an adjunct to other hypoglycaemic drugs where there is a contraindication or intolerance to metformin or sulphonylureas. However, it should not be used if there is any risk of heart failure and should probably be avoided in women at high risk of fracture. It also notes that the combination pioglitazone with insulin, though licensed, can lead to a higher incidence of weight gain, oedema and potentially heart failure.

- **Cochrane review of the gliptins for type 2 diabetes**

This review assessed the effects of dipeptidyl peptidase-4 (DPP-4) inhibitors (gliptins) for type 2 diabetes mellitus and concluded that “they have some theoretical advantages over existing therapies with oral antidiabetic compounds but should currently be restricted to individual patients.”

The review included 25 studies of 12 to 52 weeks duration: 11 evaluated sitagliptin (n=6743) and 14 vildagliptin treatment (n= 6121). None of them addressed mortality, diabetic complications, costs of treatment and health-related quality of life. Sitagliptin and vildagliptin vs. placebo resulted in an HbA1c reduction of approximately 0.7% and 0.6%, respectively.

The review highlights the need for long-term data, especially on cardiovascular outcomes and safety, before widespread use of these new agents can be recommended. Long-term data are also needed on patient parameters such as health-related quality of life, diabetic complications and all-cause mortality.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD006739/frame.html

- **NICE Clinical Guideline 64 – Prophylaxis against infective endocarditis**

Antibiotics have been offered routinely as a preventative measure to people at risk of infective endocarditis undergoing interventional procedures, however there is little evidence to support this practice. As a result, this guideline recommends that antibiotic prophylaxis is no longer offered routinely for defined interventional procedures. For a discussion of the evidence, see the full guideline at www.nice.org.uk/CG064

- **Meta-analysis comparing within versus across class switches of antidepressants for SSRI resistant depression**

A meta-analysis of studies was conducted to compare the following two switch strategies for SSRI resistant depression: second course of SSRI therapy or different class of antidepressants. Data from four clinical trials (n = 1496) were analysed and showed that:

• Patients randomised to switch to a non-SSRI antidepressant (bupropion, mirtazapine, venlafaxine) were more likely to experience remission than patients switched to a second SSRI (risk ratio = 1.29, p = 0.007).
• Pooled remission rates were 28% (for non-SSRIs) and 23.5% (for SSRIs).
• There was no difference in response rates between the two treatment groups.

According to the researchers, these results suggest a statistically significant but modest advantage in remission rates when switching patients with SSRI-resistant depression to a non-SSRI rather than an SSRI. They calculated that nearly 22 SSRI non-responders would need to be switched to a non-SSRI rather than a second SSRI to obtain one additional remitter.

This edition is also available on HNN (Health Network Northants)
http://nww.northants.nhs.uk/Display/Dynamic.jsp?topid=14070&lhsid=514&oid=2854&currentid=2854