Tablet Press

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

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• **Systematic review and meta-analysis: Inhaled corticosteroids in patients with stable COPD**
JAMA. 2008;300(20):2407-2416
Following conflicting results regarding survival and risk of adverse events associated with inhaled corticosteroids (ICS) for managing stable chronic obstructive pulmonary disease (COPD), the authors of this review systematically and quantitatively evaluated double-blind, randomised controlled trials comparing ICS for six or more months with non-steroid inhaled therapy in patients with COPD.
Data including study characteristics, all-cause mortality, pneumonia, and bone fractures were independently abstracted and assessed for heterogeneity. Data were pooled using a random-effects model or a fixed-effects model. The meta-analysis was powered to detect a 1.0% absolute difference in the primary outcome of all-cause mortality at 1 year.

Eleven randomised controlled trials (14,426 participants) met the inclusion criteria. In trials with mortality data, no difference was observed in the primary endpoint (128 deaths among 4636 patients in the treatment group and 148 deaths among 4597 patients in the control group; RR, 0.86; 95% CI, 0.68-1.09; P = 0.20; I2 = 0%).

In the trials with data on pneumonia, ICS were associated with a significantly higher incidence of pneumonia (777 cases among 5405 patients in the treatment group and 561 cases among 5371 patients in the control group; RR, 1.34; 95% CI, 1.03-1.75; P = 0.03; I2 = 72%).

The authors concluded that ICS therapy does not affect 1-year all-cause mortality in patients with COPD but is associated with a higher risk of pneumonia.

This review should prompt a review of ICS prescribing in COPD. Nice advises that ICS should only be used for moderate to severe disease where the FEV1 < 50% and the patient has experienced at least 2 exacerbations in a year. Patients currently on ICS with COPD should not have their treatment stopped since there is some evidence that this may cause deterioration. However, new prescribing should be in line with the NICE guidance and ICS not introduced in mild disease, given the risks versus benefit.

• **Orlistat leaflet**
A PCT patient leaflet has been produced to help ensure that orlistat is prescribed appropriately and in accordance with the NICE guidance.
It is available on the intranet at http://tinyurl.com/57whm8

• **Calceos contraindicated in patients with peanut or soya allergy**
The vitamin D3 component in Calceos™ is present as a 'colecalciferol concentrate powder' which contains a small amount of partially hydrogenated soybean oil; therefore the product should not be taken by patients who are allergic to soya or peanuts.
The current SPC on EMC does not reflect this information and is currently undergoing MHRA approval for this update.

• **MHRA Drug Safety Update**
The November edition of 'Drug Safety Update' has been published by the MHRA. It contains items on:

- Varenicline: adverse psychiatric reactions, including depression
- Ezetimibe and possible increased risk of cancer: results of SEAS study
- Rimonabant: European suspension of marketing authorisation
- Inhaled anticholinergics: recent published data for risk of death or stroke
- Paracetamol use in infancy: no strong evidence for asthma link

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

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