Tablet Press

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- **Thiazide diuretics in hypertension – review of the last 50 years**

Thiazide diuretics have been used in the treatment of hypertension for over 50 years. A recent narrative review (Arch Intern Med 2009; 169: 1851-6) summarises their use and some of the major trials that provided the evidence of their efficacy.

The landmark clinical trial showing that lowering blood pressure reduced the risk of serious cardiovascular events was started in 1964: the Veterans Cooperative Study was published in 1967 and showed that lowering blood pressure in moderate to severe hypertension (diastolic >105mmHg) reduced the incidence of death, strokes, and other cardiovascular events. The authors note some of the other major trials of thiazide diuretics, including the largest hypertension trial carried out so far (ALLHAT) which showed initial treatment with a thiazide-type diuretic to be as good as, if not better than, initial treatment with an ACE inhibitor or calcium-channel blocker in terms of reducing risk of serious cardiovascular events.

Despite the trial data, and the presence of thiazides in appropriate doses as first-line recommendation for most patients in current guidelines, their use has steadily declined over the past three decades. The authors discuss possible reasons for this, including the perception, supported by repeated emphasis in the literature, that these drugs cause hypokalaemia and hyperglycaemia. They note that while these effects do occur, especially in higher doses, they do not appear to be clinically significant in most patients and the trials showed benefits in clinical outcomes despite the occurrence of these side effects. The trials also show no significant reductions in beneficial effects in diabetic patients. There have also been a number of trials indicating that the combination of a diuretic with other classes of antihypertensive drug improves response and reduces interpatient variation

- **Allopurinol and Stevens-Johnson Syndrome**

We have had a recent incident locally of a patient developing Stevens-Johnson syndrome after being prescribed allopurinol. The GP involved felt that a reminder to all prescribers of the link between allopurinol and this condition would be timely. The main issues raised are

  - allopurinol is the most common drug linked to Stevens-Johnson syndrome
  - in CKD the dose needs to be reduced and it is good practice to check both uric acid and U&Es before dose increases
  - it almost always occurs in the first 8 weeks of being prescribed

The BNF advises that treatment is withdrawn if a rash develops; if mild re-introduce cautiously but discontinue promptly if the rash recurs.
Incidence of Stevens-Johnson syndrome is rare – approximately 1-3 cases per million head of population per year and case control studies have shown that allopurinol is implicated in about 17% of those cases.
Although overall occurrence is rare, Stevens-Johnson syndrome is very severe and can be fatal. Prescribers should be alert to the occurrence of a rash, particularly in the first 8 weeks of treatment.

- **Patient Decision Aids (PDAs)**

Those of you who have attended any of the National Prescribing Centre (NPC) therapeutics workshops that we deliver locally will have seen some of the NPC PDAs that have been developed.
We have received mixed views about these at workshops – ranging from, “Incredibly helpful” to, “If I show my patient that they’ll never take their statin” – see what you think!
There are many different PDAs available for different conditions and drug interventions and they can now all be found in one place on the NPCi website at http://www.npci.org.uk/iPDAs.php

- **Silver dressings no more effective than unmedicated low-adherence dressings for treating leg ulcers**

The VULCAN study found no evidence to support the use of silver dressings under compression bandaging for the treatment of venous leg ulcers. Compared with non-silver low-adherent dressings, silver dressings were not more effective in healing ulcers, did not improve quality of life, and were not cost-effective.
See http://www.npci.org.uk/blog/?cat=25

- **Price variation of different formulations flucloxacillin 250mg/5ml**

Prescribers should be aware that the suspension costs £8.02 whereas the oral solution costs £26.70.

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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