

# The Prudent Prescriber

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Pharm Reps ≠ Rational Prescribing



Dear Readers, The recession has now hit the pharmaceutical education sector. Effective August 2009, The Prudent Prescriber will only be available electronically. Mesa County readers will continue to receive a hard copy in their hospital mailboxes. You can now view current & past issues at [www.prudentprescriber.com](http://www.prudentprescriber.com)! If you would like to continue your free lifetime subscription via email, please send an email to [prudent.prescriber@rmhp.org](mailto:prudent.prescriber@rmhp.org) Your email address will be protected and not shared.

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## An Aspirin for Every Diabetic? *Not so fast, Dr. Bayer!*

The ADA recommendations for aspirin therapy in diabetics have always depended on creative extrapolations from mostly non-diabetic studies. Only a small percentage of the Physicians Health Study (533 of 22,000), the Antithrombotic Trialists Collaboration (5126 of 135,000) and the HOT Trial (8% of 19,000 hypertensive men) were diabetic. In each study, primary prevention use of aspirin in the broader populations had clinically significant effects on decreasing CV events, but in the diabetic population there no CV benefits. Now, there is another new trial that further raises the controversy of efficacy of aspirin for primary prevention in diabetes.

### JPAD

- ❖ RCT, multicenter, prospective, open label (the Japanese do not allow placebos), blinded. (JAMA. 2008 Nov 12;300(18):2134-41)
- ❖ 2539 type 2 diabetic patients *without* a history of atherosclerotic disease, ages 30-85 years (mean age 65 yrs.) with a median duration of diabetes of ~7 yrs. Both groups had a HbA1c of ~7%; median follow-up: 4.37 years.
- ❖ Results: 154 atherosclerotic events: ASA group: 68 events (13.6 per 1000 person-yrs) and non-ASA: 86 events (17.0 per 1000 person-yrs) p=0.16.
- ❖ ASA group: 34 deaths; non- ASA group: 38 deaths p=0.67.
- ❖ None of the pre-specified secondary endpoints were reduced significantly in the low dose aspirin group.
- ❖ In the subgroup of patients > 65 yrs, there was a 32% relative reduction in total atherosclerotic events.

**Antibiotics do NOT**



**help acute bronchitis**

**β-blockers in post-MI save lives**

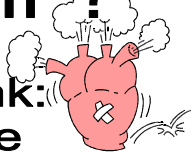


**Pill splitters save big**





## CHF?

Think:



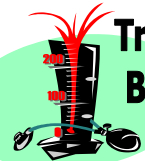
**Ace  
Aldactone  
B-blocker  
Dig  
Diuretic**

Avoid these expensive "me-too" drugs:

-  Kapidex
-  Pristiq
-  Omnisar
-  Toviaz
-  AMrix XR
-  Xyzal
-  Veramyst
-  Ambien CR



**Treat diabetics BP to 130/80**



Continued page two



**now available**  
on the  
**Generic Marquee**

**Razadyne**→galantamine  
**Topimax**→topiramate  
**Fosamax**→alendronate  
**Norvasc**→amlodipine  
**Ambien**→zolpidem  
**Flonase**→fluticasone nasal

## Not so fast, Dr. Bayer! (continued)

### 2009 ADA Recommendations:

- ❖ 75-162mg/day as primary prevention for diabetics who are at increased CV risk: >40 yrs + additional risk factors of: + FH of heart disease or hypertension or smoking or dyslipidemia or albuminuria.
- ❖ Based on the JPAD and POPADAD trials, the 2009 ADA recommendations have gone from “A” to a “C” level of evidence. The Canadian Diabetes Association now gives prophylactic ASA a “D” grade.

### My Take:

- It appears that the platelets of diabetic patients respond differently to ASA than those of non-diabetics.
- The JPAD trial included skinnier type 2 diabetics with a mean BMI of 24. Do these results apply to our typical obese type 2's in Colorado?
- It is time to look more prudently at our previous wholesale push of aspirin as primary prevention in every diabetic.
- If you do use aspirin, recall that 81mg is probably sufficient and that bleeding complications are dose-related.



## What's New with PPIs ?

- ☼ **Plavix + PPI = Trouble?** A large V.A. retrospective cohort study (JAMA 2009; 301(9):937-944) looked at 8205 patients with Acute Coronary Syndrome (ACS) who were discharged from the hospital taking clopidogrel; of these 5244 (64%) were also taking a PPI. Compared with Plavix alone, the use of a PPI was associated with an increased risk of rehospitalization and revascularization, but not all-cause mortality.
  - ♣ PPIs may reduce the inhibitory effect of clopidogrel on platelet aggregation (PPIs inhibit CYP2C19, the enzyme that converts Plavix to its active form) and thus increase the risk of adverse CV events in patients experiencing ACS. An amazing 2/3 of these patients were on a PPI.
- ☼ **PPIs and Hospital Acquired Pneumonia** This large prospective cohort study (JAMA May 27, 2009) followed 63,878 adult admissions (at least a 3 day hospital stay, no ICU) and looked at the incidence of hospital acquired pneumonia in those receiving acid –suppressive meds vs. those patients who did not.
  - ♣ The acid suppressed group had 30% more hospital acquired pneumonias. The association was only demonstrated in those patients who were receiving PPIs and was stronger for aspiration pneumonia than non-aspiration pneumonia.
- ☼ **Prevacid Goes OTC** later this year and then generic next year. Price should fall with the OTC product to compete with OTC omeprazole.

### My Take:

- ¥ Prevalence studies indicate that 40-70% of hospitalized patients receive some form of acid-suppressive medicine during their hospital stay.
- ¥ 70% of this inpatient use is for indications that have not been well investigated or supported by the literature.
- ¥ Sakar's study in Arch Int Med 2008; 149(6):391-398 demonstrated an increased risk of community acquired pneumonia in outpatients taking PPIs and H2 blockers.
- ¥ It seems prudent to relook at our PPI use in both inpatients and office practice!

## One and Two Liners

- Trying to taper a patient off a benzodiazepine? A Cochrane Review (Denis et.al 2006; (3):CD005194) found that adding carbamazepine or imipramine to a 25% weekly taper of the benzo resulted in clinically significant improvements in benzo stop rates over taper alone. Propranolol, buspirone, hydroxyzine and progesterone were not helpful.
- Three new expensive “Water Works” drugs with few if any redeeming features are hitting the market. **THINK “Me too”**.
  - For overactive bladder: **Toviaz** (fesoterodine): similar to Detrol LA (same metabolite, efficacy and side-effects and cost \$140/mo) and **Gelnique** (topical oxybutynin); fewer anticholinergic effects as avoids the first pass phenomenon like Oxytrol. Also like Oxytrol, costs \$125/month (compare generic oxybutynin at \$10-15/mo).
  - For BPH: **Rapaflo** (can't you just see the explosive spring run-off of your favorite mountain stream?) Think of it like Flomax's twin brother with less dizziness and hypotension than terazosin or doxazosin (both \$10/mo), but with a heftier price tag (\$120/mo).

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