Dear Prescriber:

You’ll hear controversy about whether it makes sense to aim for a LOWER systolic blood pressure in hypertensive patients. Recent guidelines recommend aiming for more relaxed BP goals, such as a systolic < 150 mmHg in patients 60 and older instead of < 140 mmHg... due to lack of evidence that lower is better.

But the new SPRINT trial suggests that a lower systolic BP may be better for some patients...including those over age 75. For example, aiming for a systolic < 120 instead of < 140 prevents one more CV event for every 185 patients with CV risks treated/year.

But this benefit may not apply to many of your patients. For example, it’s too early to say if patients with diabetes, heart failure, or previous stroke benefit from a systolic < 120. Plus lower goals can be difficult to reach...and can lead to hypotension, electrolyte problems, and bumps in serum creatinine.

Individualize BP goals based on med tolerability, adherence, cardiovascular risk, comorbidities, shared decision making, etc.

In general, stick with current guidelines for BP goals. Aim for < 140/90 in most patients, including those with diabetes or kidney disease...or < 150/90 in those 60 and older.

But be open to a systolic goal closer to 120 in some patients. For example, consider a lower systolic goal for patients with a previous MI or chronic kidney disease...IF they can tolerate higher doses or adding meds to reach the goal.

Expect to see new hypertension guidelines from the Am Heart Assn in the next year or so...that may recommend lower BP targets.

To hear our team discuss BP goals and measurement with a SPRINT author, go to our PL Detail-Document and listen to PL VOICES.

Also see PL Algorithm, Stepwise Treatment of Hypertension, for help selecting BP meds...and our PL Patient Education Handout, Blood Pressure Meds and You, for counseling tips.

QUINOLONES

You’ll see more emphasis on limiting the use of quinolones. It’s coming from more concerns about “collateral damage” leading to resistance...and warnings of tendon rupture, peripheral neuropathy, etc. Watch for situations where you may want to bench quinolones.

Urinary tract infections. Use nitrofurantoin or trimethoprim/sulfamethoxazole (TMP/SMX) for most UNcomplicated UTIs. Nitrofurantoin used to be discouraged in renal insufficiency...but the new thinking is that it’s safe and effective if CrCl ≥ 30 mL/min.

Also consider a cephalosporin (cephalexin, etc) or Monurol (fosfomycin)...depending on the bug causing the UTI.
Prescriber’s Letter  January 2016

Save quinolones (ciprofloxacin, etc) for COMPLICATED UTIs when appropriate...such as patients with obstruction (kidney stones, etc). Acute sinusitis. Avoid antibiotics altogether if possible...since over 90% of sinusitis cases are viral.
Consider antibiotics only for patients with symptoms for at least 10 days without improvement...or severe symptoms such as fever ≥ 102°F. If antibiotics are appropriate, give amoxicillin/clavulanate in most patients...or doxycycline for patients allergic to penicillin.
Acute exacerbations of chronic bronchitis. In general, save antibiotics for COPD patients with severe exacerbations.
If an antibiotic is needed, give amoxicillin/clavulanate, azithromycin, or doxycycline in most patients.
Save respiratory quinolones (levofloxacin, moxifloxacin) for complicated patients...such as those with frequent exacerbations.
To hear our team discuss the appropriate role of fluoroquinolones, go to our PL Detail-Document and click on PL VOICES.
And get our PL Toolbox, Antimicrobial Stewardship, for handouts, posters, and other tools to increase awareness.320121

TOPICAL NSAIDS

We’re getting more questions about using TOPICAL NSAIDs for pain. NSAID safety warnings and concerns about opioid abuse and misuse leave limited options for treating pain.
Topical NSAIDs are often thought to be safer than orals...since they generally have < 10% systemic absorption compared to orals.
It’s true that topicals seem to cause fewer GI adverse effects. But it’s too soon to say they’re clearly safer from a CV or renal standpoint. They also have the same boxed warnings as orals.
Topical NSAIDs may work as well as oral NSAIDs for knee or hand osteoarthritis and acute sprains or strains. But there’s not enough evidence they work for low back pain or neuropathic pain.
Consider a topical NSAID if pain is localized and the patient can afford it. But try to avoid any NSAID in patients at high GI and CV risk.
If appropriate, consider Rx diclofenac solution (Pennsaid, etc) or gel (Voltaren) for osteoarthritis...or patch (Flect) for acute pain. The solution has dimethyl sulfoxide (DMSO) to improve penetration. But DMSO may cause more skin reactions and garlicky breath.
Expect high price tags. Pennsaid 2% costs about $1500/month for one knee...versus about $300 for the generic 1.5% solution or the gel. Some pharmacies compound topical NSAIDs...ketoprofen, piroxicam, ibuprofen, etc. Many patients swear they help.
Discourage using topical PLUS oral NSAIDs...the combo doesn’t seem to work better than orals alone and may increase the risk of side effects. Advise patients to skip applying the topical if they need to take an oral NSAID for a headache or other ailment.
Warn not to use topicals longer than needed.
See our new PL Chart, Topicals for Pain Relief, for more on the role of other topicals such as lidocaine, capsaicin, arnica, etc.320103

NALOXONE

The new Narcan nasal spray will lead to more emphasis on providing naloxone to patients at risk of opioid overdose. Over 40 Americans die from Rx opioid overdoses every day...and heroin overdose deaths have more than tripled since 2010. Having naloxone on hand can save a life in an opioid overdose. Prescribe naloxone for patients at risk. You may have more candidates for naloxone than you think.
For example, consider naloxone for opioid patients taking high doses...switching opioids...combining opioids with benzos or alcohol...or with respiratory conditions such as COPD or sleep apnea.

Include naloxone in your opioid treatment agreements, and discuss the importance of naloxone with patients AND caregivers.

Be familiar with the nuances of naloxone products. For example, explain that Narcan nasal spray does NOT need to be inhaled...and the Evzio auto-injector “talks” the user through the injection.

Or prescribe a kit with two naloxone doses. For IM use, write for naloxone 0.4 mg/mL vials plus 2 syringes. For intranasal, write for 2 mg/2 mL naloxone prefilled syringes and 2 atomizers.

A naloxone rescue kit may cost about $50...compared to $125 for Narcan nasal spray and $750 for Evzio. Most payers will cover some form of naloxone...but you may need to complete a prior authorization.

Emphasize calling 911...even if naloxone is given. Naloxone only lasts about 30 to 90 minutes...so symptoms can return after it wears off.

Collaborate with pharmacists...and know your state laws.

About 30 states, including CO, MN, RI, TN, and WA, allow pharmacists to have a standing order or other agreement with prescribers...so they can dispense naloxone in appropriate situations. Expect more states to follow.

For more ways you can reduce deaths due to opioid overdose, see our PL Detail-Document, Naloxone for Opioid Overdose: FAQs...and PL Toolbox, Appropriate Opioid Use.320122

HEPATITIS C

More hepatitis C patients will now be treated...due to updated guidelines and a push for fewer payer restrictions.

Most patients will get one or two of the new oral meds, Daklinza (daclatasvir)...Harvoni (ledipasvir/sofosbuvir)...Olysio (simeprevir)...Sovaldi (sofosbuvir)...Technivie (ombitasvir/paritaprevir/ritonavir) or Viekira Pak (ombitasvir/paritaprevir/ritonavir and dasabuvir).

Expect most patients to be treated for 12, 16, or 24 weeks...often based on whether they have cirrhosis or have been treated before.

The choice of therapy will usually come down to hep C genotype...which meds the payer prefers...and interactions.

Genotype. All of the new meds are effective for the most common genotype 1...except Technivie, which only covers genotype 4.

Combo therapy. These meds are often used with each other...or with ribavirin. For example, expect Sovaldi to usually be added if Daklinza or Olysio is used...and Sovaldi combos to sometimes include ribavirin.

Be aware that Harvoni rarely requires add-on meds.

Cost. Harvoni costs about $95,000 per 12-week course.

But the cost of therapy with combos adds up. For example, the combo of Sovaldi plus Olysio or Daklinza is around $150,000 for 12 weeks...and Viekira plus ribavirin is about $85,000 for 12 weeks.

See our PL Chart, Helping Patients Afford Meds, to help with costs.

Interactions. Watch for a plethora...especially with Technivie or Viekira. They contain ritonavir, which interacts with many drugs.

For example, avoid Technivie, Viekira, or Olysio with 3A4 INDUCERS (phenytoin, etc)...and Olysio with 3A4 INHIBITORS (clarithromycin, etc).

And avoid rosuvastatin with Harvoni...and simvastatin or lovastatin with Technivie or Viekira.

Plus acid reducers can decrease Harvoni’s absorption. If one is needed, limit doses to omeprazole 20 mg/day, famotidine 40 mg BID, etc...and suggest separating antacids from Harvoni by 4 hours.

Minimize resistance by stressing adherence...and stopping the entire regimen if a hep C drug must be discontinued due to surgery, etc.

See our PL Detail-Document for specific hep C regimens, monitoring, side effects, etc.320105
ANTIPSYCHOTICS

You may hear that aripiprazole (Abilify, etc) is associated with a higher risk of certain impulse-control behaviors.

It’s coming from a handful of reports linking aripiprazole to uncontrollable gambling or hypersexuality.

These behaviors are usually seen within days to months of starting aripiprazole...or after a dose increase.

The risk appears higher with aripiprazole than other atypicals...likely because aripiprazole is a partial dopamine agonist.

This makes sense...since we know dopamine agonists (Mirapex, Requip, Neupro, etc) are associated with compulsive gambling, shopping, sexual activity, and eating.

But impulse-control behaviors with aripiprazole are very rare.

Continue to use aripiprazole if it’s otherwise appropriate. But keep in mind when it may be inappropriate to use aripiprazole or another atypical, such as for dementia, behavior problems in kids, insomnia, etc.

If you prescribe aripiprazole, be careful using it in patients with prior gambling problems...they may be at higher risk.

If impulse-control symptoms occur, lower the aripiprazole dose...or switch to another atypical.

But lean away from the other atypicals that are partial dopamine agonists...Rexulti (brexpiprazole) or Vraylar (cariprazine). It’s too soon to know if they’re also linked to these behaviors...but another atypical may be a better choice.

See our PL Chart, Comparison of Atypical Antipsychotics, for more on side effects and approved indications to help in selecting therapy.

CARDIOLOGY

We’re getting questions about the efficacy of long-term clopidogrel (Plavix, etc)...due to a new report from FDA.

This started because of a study suggesting that coronary stent patients taking clopidogrel plus aspirin have a higher risk of death.

The good news is that this risk doesn’t pan out when data from several trials are combined.

But using clopidogrel plus aspirin for 12 months or more doesn’t reduce mortality compared to using this combo for 6 months or less.

Reassure stent patients that clopidogrel is still an important heart med...and stopping it too soon increases CV risk.

You may hear that Brilinta (ticagrelor) or EFFIENT (prasugrel) plus aspirin are more effective.

It’s true...these combos prevent one more CV event for every 50 stent patients treated for one year versus clopidogrel plus aspirin.

But don’t switch most patients on clopidogrel.

Brilinta is BID...and it may cause dyspnea in 1 in 27 patients.

And EFFIENT causes more bleeding. Avoid it in patients with a history of stroke or TIA. Also be careful using EFFIENT in those who are underweight or over age 75.

Plus Brilinta or EFFIENT costs about $300/month...compared to less than $10 for clopidogrel.

Watch for new national guidelines in the next few months that will help clarify the duration of dual antiplatelet therapy.

Ensure stent patients use low-dose aspirin indefinitely...and document aspirin use in the EHR to meet this quality measure.

To hear our team debate the pros and cons of antiplatelet combos, go to our PL Detail-Document and click on PL VOICES.

Use our PL Patient Education Handout, Why It’s Important to Take Your Blood Thinning Meds, for tips on adherence, missed doses, etc.
**VACCINES**

Patients may ask you whether statins reduce flu vaccine efficacy. This stems from new data suggesting that seniors taking a statin have a lower immune response to the inactivated trivalent flu vaccine. Plus other evidence suggests that statin patients vaccinated against flu have more respiratory illness. The theory is that statins may have anti-inflammatory and immunomodulatory effects. Blunting the response to the flu vaccine. But reassure statin users that they are still protected by the flu vaccine...and the vaccine is still the best way to avoid getting the flu. Advise patients NOT to stop the statin, even temporarily, just because they're getting the flu vaccine. Explain that it's too early to say if statins affect the immune response of nasal, quadrivalent, or high-dose vaccines. See our PL Chart, Flu Vaccines for 2015-2016, for more on vaccine formulations.

**ASTHMA**

More children will get just ONE or TWO doses of dexamethasone for asthma exacerbations.

We're seeing a shift away from the typical 3- to 5-day course of prednisone or prednisolone to a 1- to 2-day course of dexamethasone. Dexamethasone is longer acting...and may cause less vomiting. Plus new evidence suggests that a SINGLE dose of dexamethasone seems to improve acute asthma symptoms and prevent hospitalization as well as a 3-day course of prednisolone.

In kids with mild to moderate exacerbations, consider using dexamethasone...especially if adherence or tolerability is a concern.

Give 0.3 or 0.6 mg/kg orally once daily for 1 or 2 days, up to a max of 16 mg/dose...or as one IM dose.

For kids who can’t swallow tabs, recommend crushing and mixing them with chocolate pudding or applesauce to help mask the bitter taste. Or consider dexamethasone 1 mg/mL concentrated solution...but be aware it contains 30% alcohol. Try not to use the 0.5 mg/5 mL liquid...due to the large volume.

Consider stocking dexamethasone in your office...so you can start the treatment during the visit.

**CONTRACEPTION**

Women will ask you if they’re “too old” to take hormonal contraceptives...and when they should stop. We know that combo OCs can prevent pregnancy in women over 40. And they may also help with vasomotor symptoms (hot flashes, etc).

In many perimenopausal women, feel comfortable using a combo OC...and lean toward one with 20 mcg of ethinyl estradiol. If needed, use an extended- or continuous-cycle OC to limit hormone-free days.

But try not to use combo OCs, the patch, or ring in women over 35 with thrombosis risk factors...smoking, hypertension, etc. Instead, consider an IUD (Mirena, etc) or implant (Nexplanon). These are safer in most high-risk women...and have the best efficacy. Dispel myths that hormonal contraceptives speed up or slow down menopause. But be aware some may cause withdrawal bleeding or amenorrhea...making it hard to know when menopause has occurred.

In general, stop hormonal contraception by age 55...most women have gone through menopause by then.

Or advise women over 50 to switch to a NON-hormonal method...then
stop a year after their last period, when menopause can be assumed. See our PL Chart, Comparison of Contraceptives, to sort through the options...and our PL Special Report, Choosing Wisely: Contraception.320124

DIABETES

Reps will promote Tresiba (treh-SEE-bah, insulin degludec), a new once-daily ULTRA long-acting insulin. It lasts about 42 hours...compared to about 24 hours for Lantus or Levemir and a little over 24 hours for Toujeo. You may hear that Tresiba’s longer duration means it doesn’t need to be used at the same time every day. But this isn’t necessarily a benefit since it may impact adherence. Be aware that Tresiba’s long duration doesn’t seem to lead to “dose stacking” or accumulation...including in patients with renal impairment. Tresiba lowers A1C about the same as Lantus...and has a similar overall risk of hypoglycemia. Tresiba 50 units/day costs about $450/month...compared to $400 or less for Lantus, Levemir, or Toujeo...or as little as $40 for NPH. Don’t expect Tresiba to have much benefit over other longer-acting insulins...including NPH. There ISN’T a big difference in most outcomes between NPH and Lantus and Levemir in most type 2s.

Save Tresiba for when a true once-daily insulin is needed...such as patients who need over 80 units/injection of Lantus, Levemir, or Toujeo pens. The Tresiba 200 unit/mL pen delivers up to 160 units/dose. Look for Basaglar, a new, potentially less costly version of insulin glargine in late 2016. It’ll be similar to Lantus.

Get our PL Charts, How to Switch Insulin Products and Comparison of Insulins, to help select insulin.320111

Happy New Year,

Jeff M. Schiavone


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