

New hypertension treatment recommendations

Beta-blockers are no longer recommended as routine initial therapy for hypertension in England and Wales, say the National Institute for Health and Clinical Excellence and the British Hypertension Society in an updated guideline published this week. It recommends calcium-channel blockers, thiazide-type diuretics or angiotensin-converting enzyme inhibitors as first-line treatment depending on age and ethnic origin (see Panel).

The guideline updates recommendations for the management of hypertension published by NICE in 2004 (*PJ*, 28 August 2004, p279). The BHS also published guidelines in 2004, which differed from the recommendations made by NICE. The two organisations have now collaborated to produce the updated guideline.

NICE reviewed the 2004 guideline earlier than planned owing to the emergence of new evidence. A total of 20 studies were included in the meta-analysis, four of which (ASCOT, JMIC-B, PHYLLIS and VALUE) were new studies not included in the original guideline.

In head-to-head trials, beta-blockers were usually less effective than a comparator drug at reducing major cardiovascular events, particularly stroke, says the guideline. It adds that beta-blockers were also less effective than ACE inhibitors or calcium-channel blockers at reducing the risk of diabetes, particularly when taken with a thiazide diuretic.

"We are not saying in any way that beta-blockers are ineffective but we are saying that we now have better treatments," said Bryan Williams, member of the guideline development group and professor of medicine,



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Beta-blockers no longer recommended as first-line treatment for hypertension

University Hospitals NHS Trust, Leicester, at the launch of the guideline. He added that if people are already taking beta-blockers and their blood pressure is well controlled then they can stay on them for the time being. If, however, their blood pressure is not well controlled then their drug treatment should be reviewed at their next routine appointment. "Our aspiration is to see the majority of people in this country treated via [the guideline's] algorithm," he said. If beta-blockers are withdrawn they should be done so gradually, the guideline says.

Beta-blockers will still be appropriate for some people and should be considered for women of child-bearing age, patients with increased sympathetic drive and patients who are intolerant of, or have contraindications to,

ACE inhibitors and angiotensin-II receptor antagonists. Beta-blockers should not normally be withdrawn in those people taking them for other reasons, such as heart failure or angina, it adds.

NICE estimates that the net financial benefit of implementing this guideline in full is a saving of £192m (£58m more in drug costs offset by an expected £250m in benefits).

The guidance is on the NICE website (www.nice.org.uk) and is accessible via *PJ Online* (www.pjonline.com/links/pj).

Recommendations

- Hypertensive patients over 55-years old or black patients (those of African or Caribbean descent, not mixed race, Asian or Chinese) of any age: a calcium-channel blocker or a thiazide-type diuretic should be prescribed as first-line therapy. If a second drug is required, an angiotensin-converting enzyme inhibitor (or an angiotensin-II receptor antagonist if an ACE inhibitor is not tolerated) can be added.
- Hypertensive patients under 55-years old: an angiotensin-converting enzyme inhibitor (or an angiotensin-II receptor antagonist if an ACE inhibitor is not tolerated) should be prescribed first-line. If this does not control blood pressure, a calcium-channel blocker or a thiazide-type diuretic can be added.
- If treatment with three drugs is required in either group, a combination of ACE inhibitor, calcium-channel blocker and thiazide-type diuretic should be used.

NICE drug evaluations have not been discredited, says Prime Minister

Prime Minister Tony Blair has defended the National Institute for Health and Clinical Excellence as a way of evaluating drugs for use by the NHS. He denied that the NICE process had been discredited.

Mr Blair was speaking at a press conference organised by the British Society of Magazine Editors earlier this week and he told *The Journal*: "I think people should remember what happened before NICE."

The Prime Minister said: "The idea of having an institute that can evaluate drugs is extremely important. When NICE evaluates a drug and says that this is helpful for these categories of people, the Government has got a commitment that it will fund it. You do need that objective process."

Mr Blair conceded that when a new drug comes on to the market some people want to use it and some clinicians want to prescribe it

immediately. "We in Government — unless we are going to say we are going to write a cheque for it — have got to have some objective way of assessing whether it is sensible to fund it. But once NICE has made a recommendation we give guidance to the [primary care organisations] as to what they should do and to stop the postcode lottery of drugs. It is very difficult before NICE makes a recommendation for us to step in because we do not know what the evidence base is and what we would be basing our judgement on."

The whole reason why NICE was established, he argued, was that people complained that without the proper objective evidence base how did the NHS know whether it was the right thing to fund something or not. "And while we may be running into these issues here [such as Herceptin], people abroad are looking at it and saying this is the way we should be going. I know no better way," he added.

Scottish contract and minor ailment service start on 1 July

This weekend sees the start of Scotland's new community pharmacy contract. From 1 July, pharmacists can offer consultations through the minor ailment service.

A leaflet that advertises the minor ailment service is available on the new contract website (www.communitypharmacy.scot.nhs.uk).

In addition, the Scottish Executive published further advice — also available on the website — about operating the MAS.

Preparation has included registering over 250,000 patients for the service: the first time the public has had to register with a pharmacy to receive a national NHS service.

Controlled Drugs guidance

The Society has issued guidance on the management of Controlled Drugs (p25).

Society

Consultations on PPI and Rules

Consultation is beginning on patient and public involvement in the Society and on Rules covering registration (p23).

Examination introduced for registering in Australia

UK qualified pharmacists who want to work in Australia will soon have to take a competency examination before they can register, the Council of Pharmacy Registering Authorities (COPRA) and the Australian Pharmacy Examining Council have announced.

Pharmacists from the UK and Ireland have enjoyed long-standing reciprocal arrangements between the respective registering authorities, which make them exempt from the usual assessment process required of other overseas pharmacists wishing to register in Australia. Following the ending of reciprocal arrangements between the UK, Ireland, and Australia and New Zealand last month (*PJ*, 16 April 2005, p465), COPRA has reviewed its current recognition process for overseas-trained pharmacists.

From 1 December 2006, all overseas trained pharmacists, irrespective of their country of origin, will be required to be assessed for competency to practise in Australia. A shortened process will be used to assess pharmacists who have qualified in the UK, Ireland, the US or Canada. These pharmacists

will be required to pass an examination called the competency assessment of overseas pharmacists, which will be offered four times a year in Australia and overseas. Successful candidates will then be eligible for registration after they have satisfactorily completed a minimum period of four weeks' supervised practice in Australia and an assessment by the state registering authority. Holders of UK and Irish qualifications who wish to register in Australia under the current reciprocal arrangements need to apply to the relevant registering authority before 1 December and be registered no later than 31 January 2007.

Pharmacists who have qualified in countries other than the UK, Ireland, the US or Canada will continue to be assessed by the current processes.

The Pharmacy Council of New Zealand has announced similar proposals for the registration of UK and Irish qualified pharmacists in New Zealand.

Commenting on the announcement, Graham Phillips, chairman of the Society's education committee, told *The Journal*: "The Society is pleased that the Council of

Pharmacy Registering Authorities has agreed new procedures for recognising UK-registered pharmacists wishing to work in Australia. It is important to note they are very similar to the Society's new proposals for recognising Australian (and New Zealand) pharmacists.

"The sequencing of tests and supervised practise for UK and Australian pharmacists is based on the recognition of similar prior experience where that can be demonstrated. I think we all have to accept that in the modern regulatory environment we have to make judgements on the basis of evidence and demonstrations of competence.

"At its meeting next week the education committee will be considering COPRA's policy in detail so we can communicate the new procedures to members at the earliest opportunity. The Pharmacy Council of New Zealand has issued proposals for recognising UK-registered pharmacists, which the Society will be responding to. Again, once the policy for New Zealand is in place, the Society will pass it on to members as soon as possible."

Science funding restricts pharmacy education, warns the Society

Continued funding of pharmacy degrees as science, rather than clinical, degrees by the Higher Education Funding Council for England is likely to create a pinch point in pharmacy education, the House of Commons' Health Select Committee has been told.

Giving evidence to the committee's inquiry into workforce planning on 15 June, the Royal Pharmaceutical Society's director of corporate and strategic development, Rob Darracott, told the committee: "As pharmacists get into more clinical roles there is a question mark about how that training is funded, particularly the exposure of pharmacy students and students at the preregistration level to patients and how that is facilitated. If you just have a science funding stream, there is little provision within that for clinically based training."

Mr Darracott also told the committee that the Society was in the final stages of preparing a workforce planning model that confirmed that there was a shortfall in the provision of pharmacists. However, he warned that the model did not provide any answers to the problem. Instead, it supported the need for recently proposed legislative changes and showed that different ways of doing existing tasks needed to be found.

At an earlier stage in the committee's inquiry, the Society submitted written evidence that identified an emerging gap between demand and supply.

That evidence, prepared by Society head of research and development, Sue Ambler, said that pharmacists were coping with the gap by working extra hours beyond their contracts — the average is four hours per week — and dealing with prescriptions faster



Rob Darracott gives evidence

than set down in official safety levels. They were also cutting back non-core activities, reducing services and substituting pharmacists with pharmacy technicians and assistants.

Scottish NHS drugs inquiry

Prescribing and licensing of drugs in NHS Scotland was the topic of an inquiry by the Scottish Parliament's health committee last week. It agreed to seek more information on the cost of work performed by NHS Quality Improvement Scotland and the Scottish Medicines Consortium compared with that of England's National Institute for Health and Clinical Excellence. Evidence was heard from a variety of pharmaceutical bodies. The transcript can be accessed via *PJ Online* (www.pjonline.com/links/pj).

Pharmacists in the Irish Republic denied right to prescribe

Pharmacists in the Irish Republic have been refused the right to prescribe, even for minor ailments, despite claims that it would reduce delays for patients and ease pressure on GPs and accident and emergency departments in hospitals.

Health minister Mary Harney has rejected the case made by the Irish Pharmaceutical Union (IPU) on behalf of its 1,600 members. She cited the absence of a fitness-to-practise regime for the sector as one of the reasons for her refusal, plus the fact that a government-

appointed review group on pharmacy had recommended "there be no business interest between dispensing and prescribing".

Given that pharmacists would expect a small fee for each prescription, granting them the right to prescribe would make that recommendation "unsustainable", she said.

An IPU spokeswoman commented that giving pharmacists the right to prescribe for minor ailments would ensure medical cardholders had equal access to over-the-counter medicines.

NPA wants registration/membership link broken

Membership of the Royal Pharmaceutical Society and registration as a pharmacist should cease to be linked, the National Pharmacy Association has said.

In this respect, the NPA has taken a contrary position to the Society — which wants the link to continue — in its response to the Government's consultation on the planned Section 60 Order on future professional regulation. The NPA says that the proposed Order is about regulating pharmacy as a safe and quality service and that it cannot see how Society membership adds anything to this.

The NPA has also told the Government that it is worried about the cost to Society members of moving from a single Statutory Committee that considers disciplinary matters to six new committees with various functions.

Two of the draft Order's proposals have been identified as taking England and Wales out of line with the rest of the European Union, in one case, and Scotland, in the other. The NPA says that no other part of the EU considers the attitudes and behaviours of prospective pharmacists something that



Society membership and registration should split, says NPA

should be measured before they can be registered. If this proposal goes forward, the association says that explicit reasons for rejecting any applicant should be set out and that there should be an appeal process.

Plans to treat pharmacy technicians in England and Wales differently from those in Scotland also come in for criticism. The NPA

says that the draft Order covers pharmacists and technicians in equal measure and fails to reflect the fact that pharmacists supervise technicians' work. The association favours technician registration, but says that it should not be mandatory in England and Wales, but voluntary in Scotland.

The NPA has also identified two respects in which it believes the draft Order would give the Society too much legal power. First is the proposal to allow the Society to require people to provide information about a pharmacist's or technician's fitness to practise and to seek court orders against them if they fail to do so within 14 days. "The powers go too far," the NPA says. However, it adds that if this power is to be given, people should be allowed 28 days to respond before court action is taken.

It also says that the proposed 28 days is not long enough for people to launch appeals against being struck off and that it should remain at three months. The NPA sees no reason for shortening the appeal period, particularly given that the Society will have powers of immediate suspension.

S60 Order "a wasted opportunity" to ensure public safety, says PDA

Plans for the future regulation of pharmacy are a wasted opportunity to ensure the enhanced safety of the public, the Pharmacists' Defence Association has told the Department of Health.

Commenting on the draft Section 60 Order on the future regulation of pharmacy, the PDA says that the safest industry in the world is the airline industry, which ensures that the cause of any problem is the focus of any investigation.

"Unlike this safety orientated approach, the draft Order primarily focuses on seeking to find individuals to blame in the event that something goes wrong. Much of the draft Order is about punishment and exclusion, whereas it should have focused primarily on learning, supporting and inclusion," says the PDA.

The PDA also criticises the draft Order for proposing little power to deal with pharmacy companies, which are the organisations that dictate the working environment for many pharmacists and pharmacy technicians.

"The Order has powers to suspend registrants, but does not have the power to even temporarily close a pharmacy while the most basic safety improvements are put into place," the PDA says. "This significant omission means that the Order will fail to have an impact on the causes of many of the problems."

Like the National Pharmacy Association (see above), the PDA believes that the link between membership of the Royal Pharmaceutical Society and registration as a pharmacist should be broken. It sees no grounds for believing that a Society member who is not a registered pharmacist could mislead the public and practise as a pharmacist.

But the PDA goes further still and says that the regulator should have three registers, rather than the planned two. As well as a list of practising pharmacists whose work impacts on the public and a list of non-practising pharmacists, the PDA says there should be a third list comprising practising pharmacists whose work does not impact on the public. This

could include those involved in research, head office functions and journalism, for example.

Also, like the NPA, the PDA opposes consideration of the attitudes and behaviours of prospective registrants, because of the problem of defining what is a correct attitude or behaviour.

Although the PDA agrees that the Society should be able to seek information about a pharmacist's fitness to practise (FTP), it is concerned that the proposed power could be used by the Society for a wide trawl to see whether a potential FTP issue could be dredged up whenever it is investigating any complaint. This is a tactic that the PDA says it has already seen the Society use against FTP defendants. The PDA says that what it calls general fishing exercises should not be permitted except in the most serious cases and that the Society should not be able to seek information from professional defence services, error reporting schemes, lawyers and doctors with a confidential relationship with defendants or family members.

Pharmacy voice joins White Paper working group on ways to deliver care outside hospitals

The Royal Pharmaceutical Society has been invited to be part of a Government working group charged with demonstrating how health care can be provided closer to home.

The group was launched in February and originally comprised representatives from several royal medical colleges, the British Medical Association, the Royal College of

Nursing and the NHS Confederation. Hemant Patel, the Society's President, wrote to health minister Lord Warner requesting that the profession have an input into the project. Lord Warner has now agreed that the Society should be part of the working group.

Commenting on the Society's inclusion, Mr Patel said: "It is important that pharma-

cists are fully engaged with this process and through the Society the profession will now be able to make an important contribution to the work of the new group."

The group will define models of care in six specialties — ear, nose and throat, trauma and orthopaedics, dermatology, urology, gynaecology and general surgery.

TNF inhibitor infection risk coupled with lower CV risk

Tumour necrosis factor (TNF) inhibitors increase patients' risk of being admitted to hospital for infection, but appear to reduce their cardiovascular risk, two studies presented at the Annual European Congress of Rheumatology in Amsterdam last week suggest.

Johan Askling, from the Karolinska Institute in Stockholm, used the Swedish inpatient register to examine hospital admissions for infection and the Swedish programme that monitors biologics in rheumatoid arthritis to look at the admission rates among those taking TNF inhibitors. They found that, of 4,160 patients taking TNF inhibitors, 2,465 were admitted to hospital for infection and calculated that TNF inhibitors were associated with a 39 per cent increased risk of being admitted to hospital for infection (adjusted relative risk 1.39; 95 per cent confidence interval 1.23–1.57).

The reason for this increase was not clear, Dr Askling said. "However, since part of the drugs' action is to interfere with the body's normal defence against infections, some degree of risk increase is conceivable," he added.

William Dixon, from the University of Manchester, followed 8,076 patients who had

not previously taken TNF inhibitors and compared them with 1,351 patients taking disease-modifying anti-rheumatic drugs. TNF inhibitors appeared to reduce rates of hospital admission from cerebrovascular accidents and myocardial infarctions (odds ratios 0.50, CI 0.24–1.05, and 0.72, CI 0.30–1.77, respectively). "This study has suggested that [TNF inhibitors] specifically reduce the risk of myocardial infarction and cerebrovascular accidents, which are two of the most serious cardiovascular events, often leading to death," Dr Dixon said.

However, other results suggested that more still needs to be done to reduce mortality from cardiovascular disease in rheumatoid arthritis. Ulf Bergström, from the University of Malmö, Sweden, presented an evaluation of mortality changes in rheumatoid arthritis patients from 1978 to 1995. He studied cardiovascular morbidity and mortality in 309 patients with established rheumatoid arthritis treated at outpatient clinics in Sweden and found no change in the excess mortality from cardiovascular disease from 1978 to 2005, despite a decrease in overall mortality. "The management of the disease has changed significantly over the decades and



Simon Fraser/Science Photo Library

Cerebrovascular accidents were less common in those taking TNF inhibitors

this study gives an excellent measurement of whether this has improved cardiovascular events experienced by rheumatoid arthritis patients," Dr Bergström said. "It shows that further action is necessary in order to reduce additional mortality in rheumatoid arthritis."

Rituximab limits joint damage

Rituximab plus methotrexate is associated with significant inhibition of joint structural damage in rheumatoid arthritis patients with inadequate response to one or more tumour necrosis factor inhibitors, according to data presented at the Annual European Congress of Rheumatology in Amsterdam last week. After one year, bone erosions in the rituximab group (n=272) were reduced by over a half compared with the placebo group (n=184).

Heart attack data released

How the NHS manages heart attacks has been summarised in a new report by the Myocardial Infarction National Audit Project. The report (available via www.pjonline.com/links/pj) presents data from all hospitals and ambulance services in England and Wales that managed cases of suspected heart attack between April 2005 and March 2006.

Industry self-regulation "does not work"

Self-regulation of marketing activities by the pharmaceutical industry does not work and the industry demonstrates little corporate social responsibility (CSR), according to an international association of consumer groups.

Consumers International, which has a membership of 230 organisations from 113 countries, drew these conclusions after examining the activities of 20 pharmaceutical manufacturers in the Czech Republic, Denmark, Finland, Greece, Hungary, Portugal and Slovenia. In a report it asserted: "All relevant stakeholders, but particularly governments and the pharmaceutical industry, must act immediately to address the persistent roadblocks to consumer sensitive and socially responsible drug promotion."

Examples of CSR that the organisation wants to see include public reporting of marketing budgets, staff composition and breaches of marketing codes with their asso-

ciated sanction. It takes issue with non-specific promotional practices, such as providing health and illness information through pamphlets and magazine articles. CI calls this "nice and friendly marketing disguised as corporate social responsibility".

It expresses particular concern over the operation of self-regulation among pharmaceutical companies. "Large numbers of serious, recent and repeated breaches of marketing codes were found, especially regarding prescription drug advertising," it says. "The current regulatory framework is clearly insufficient to prevent systemic violations of marketing regulations and to ensure the highest possible level of consumer protection."

An Association of the British Pharmaceutical Industry spokesman said that the recently revised ABPI code of practice was a world standard code. "It [self regulation] certainly works in Britain," he said.

Insulin use in type 2 diabetes linked with hypertension

Patients with type 2 diabetes mellitus who take insulin may be at a higher risk of developing hypertension than those who do not, a recent study has shown (*Archives of Internal Medicine* 2006;166:1184).

Investigators in Taiwan looked at data from 87,850 patients with type 2 diabetes, 5,927 of whom were using insulin. Compared with patients who did not use insulin, hypertension was more likely in patients who had

been taking insulin for 10 years or more (adjusted odds ratio 1.46, 95 per cent confidence interval 1.24–1.74), five to nine years (1.35, CI 1.18–1.54) and less than five years (1.14, CI 1.06–1.23), after adjustment for age, sex, body mass index, duration of diabetes, smoking and family history of hypertension.

The relationship between exogenous insulin use and hypertension needs to be studied further, the authors conclude.

Twins and multiple births

3 to 8 July is Twins and Multiple Birth Association (TAMBA) Awareness Week. www.pjonline.com/diary

Checklists

This section offers checklists, fact sheets and dietary advice tips. www.pjonline.com/tips

Lung disease is latest Government priority for NSF

Management of patients with chronic obstructive pulmonary disease (COPD) is set to come under scrutiny following the announcement that a new national service framework is to be developed.

Plans for the national service framework (NSF) for COPD were set out by Secretary of State for Health Patricia Hewitt earlier this week. She said that the proposed NSF would seek to provide greater treatment choices for patients with COPD, to reduce inequalities in treatment and to improve standards of care.

An external reference group made up of health care professionals, service users, carers and health service managers will be established to develop the NSF. It will be jointly chaired by Peter Calverley, president of the British Thoracic Society, and Sue Hill, chief scientific officer at the Department of Health.

The announcement coincided with publication of a report by the Healthcare Commission calling for action to improve

services for people with chronic lung conditions. The commission says that care for people with COPD has traditionally been given a low priority and that more accurate diagnosis and a more structured approach to care is needed.

The report concludes that primary care organisations and respiratory teams in hospitals need to develop new initiatives to reduce hospital admissions. "Initiatives should be integrated across primary and secondary care to take advantage of opportunities for early intervention to prevent readmission," it states.

The British Thoracic Society has also published a report this week. Its report considers the burden of lung disease in the UK.

□ **MeReC Bulletin** The management of COPD is reviewed in the latest issue of the *MeReC Bulletin*. It recommends that long-acting bronchodilators are used when patients continue to have symptoms despite use of short-acting bronchodilators or if patients



Air Products Plc

Patients with chronic lung disease need a more structured approach to care

have at least two exacerbations of COPD each year. Inhaled corticosteroids should be reserved for patients with moderate or severe disease and use of combination inhalers should be considered on an individual basis (2006;16:17).

NSF update issued for paediatric renal care

National service frameworks (NSFs) for renal services and children's services have been brought together in a new document published by the Department of Health.

"The national service framework for renal services — working for children and young people" incorporates elements from the separate NSFs to provide health professionals and carers with accessible guidance on treatment and care of paediatric renal patients.

Steve Tomlin, principal paediatric pharmacist, Evelina Children's Hospital, Guy's & St Thomas' NHS Foundation Trust, London, said that the children's NSF medicines section of the document gives a broad view of paediatric issues, with the renal NSF section pro-

viding particulars, such as the supply of immunosuppressants and unlicensed medication, and concordance issues.

"Good communication has been highlighted as essential when dealing with medication and children with renal problems, with pharmacists being highlighted as one of the key professionals to ensure this happens appropriately from both the secondary/tertiary perspective as well as from primary care."

He added that there was a lot of good work being carried out in this specialised area. "This NSF brings a lot of that together to encourage all pharmacists, and to highlight the role of pharmacists to other professions and the public."

Continue to use caution when prescribing naproxen

Naproxen should continue to be prescribed with the same caution as for other non-steroidal anti-inflammatory drugs for patients with cardiovascular risk factors or disease, a *MeReC Rapid Review* published online last week concludes (www.npc.co.uk/merec_rapid_review.htm).

The review considers a *BMJ* paper (2006;332:1302) which suggested that naproxen may confer less cardiovascular risk than other NSAIDs (*PJ*, 10 June, p674). *MeReC* concludes that, until this suggestion is backed up by further evidence, naproxen should continue to be prescribed with the same precautions as other NSAIDs.

NICE issues recommendations for management of Parkinson's disease and prostate cancer

People with Parkinson's disease admitted to hospital or to care homes should receive their medicines at appropriate times, which may mean allowing self-medication, according to a guideline published by the National Institute for Health and Clinical Excellence this week. In addition, medication should be adjusted only by, or after consultation with, a specialist. The guideline states that it is not possible to identify a universal first-line drug therapy for Parkinson's disease. Choice will depend on clinical and lifestyle characteristics, and on patient preferences after they have been informed of the short- and long-term benefits and drawbacks of drug classes, it says.

Drugs that can be considered first for early disease include levodopa, dopamine antagonists and monoamine-oxidase-B inhibitors. For adjuvant therapy in later Parkinson's disease, NICE recommends dopamine agonists,

monoamine-oxidase-B inhibitors and catechol-*o*-methyltransferase inhibitors.

The guideline advises that, to avoid the potential for acute akinesia or neuroleptic malignant syndrome, medication should not be stopped abruptly (including for so-called drug holidays) or allowed to fail suddenly due to poor absorption.

People with suspected Parkinson's disease should be referred, untreated, to a specialist for diagnosis within six weeks, says NICE. The guideline recommends that diagnosis should be reviewed every six to 12 months and reconsidered if atypical clinical features develop. It specifies that acute levodopa and apomorphine challenge tests should not be used in the differential diagnosis of parkinsonian syndromes.

Regular access to specialist nursing care, physiotherapy, occupational therapy, speech

and language therapy and palliative care is also recommended in the guideline.

In separate guidance, NICE recommends the use of docetaxel as a treatment option for men with hormone-refractory metastatic prostate cancer, within its licensed indications. The guidance specifies that treatment should be stopped at the completion of planned treatment of up to 10 cycles, if severe adverse events occur, or in the presence of progression of disease as evidenced by clinical or laboratory criteria, or by imaging studies.

NICE has also issued guidance this week on atrial fibrillation and on improving outcomes in brain and other central nervous system cancers.

All NICE guidance documents can be accessed via the NICE website (www.nice.org.uk) and via *PJ Online* (www.pjonline.com/links/pj).

Rimonabant launched for the obese and overweight

The first drug in a new class of anti-obesity medicines has been launched this week by sanofi aventis.

Rimonabant (Acomplia) is a selective cannabinoid-1 (CB1) receptor antagonist, licensed as an adjunct to diet and exercise, for the treatment of obese patients or patients who are overweight but with an associated risk factor (such as type 2 diabetes or dyslipidaemia).

At the launch of the medicine, Julian Halcox, British Heart Foundation senior lecturer in cardiology, University College London, explained how the drug was designed to target the endocannabinoid system.

CB1 receptors, part of the endocannabinoid system, are located within the brain, liver, gastrointestinal tract, muscle and abdominal fat. According to Dr Halcox, over-activity of the endocannabinoid system —



Rimonabant (Acomplia) is launched this week by sanofi aventis

which occurs in obese patients — is associated with increased calorie intake, increased

abdominal fat, dyslipidaemia and impaired glucose metabolism.

According to John Betteridge, professor of endocrinology and metabolism, University College London, rimonabant is a “classic example of pharmaceutical drug development”, where it was proposed that blocking the CB1 receptor could tackle the underlying problem.

Professor Betteridge said that in four clinical trials patients taking rimonabant achieved significant reductions in body weight and waist circumference compared with placebo.

He also presented data showing improvements in triglycerides, high-density lipoprotein cholesterol and HbA_{1c} — “metabolic effects beyond those due to a reduction in weight”. He suggested that about half of the improvement could be attributed to a specific effect of the drug.

Notice-board p9

Accessible services will be key to helping smokers quit in wake of English smoking ban

Easily accessible and flexible smoking cessation services will be essential if smokers are to be motivated to quit in the wake of the smoking ban in bars and public houses in England, which is due to come into effect in October 2007, according to Robert West, of the Cancer Research UK Health Behaviour Unit at University College London.

Speaking ahead of the UK National Smoking Cessation Conference in Gateshead this week, Professor West told *The Journal*: “The effect of the ban on motivation to stop smoking depends to some degree on how it is handled but experience from other countries such as Norway suggests that there will be a surge in attempts to stop.

“To capitalise on this, it is imperative that there be a co-ordinated campaign advertising the stop smoking services and a simple gateway into those services,” he said. “The stop smoking services need to plan for a ‘flexible response’ so

that they can cope with whatever level of increase in demand there is. Specially trained pharmacists could play a crucial role in this.”

Andrew Hyland, associate member of the Roswell Park Cancer Institute, New York, agreed that smokers’ attempts to quit will increase if treatments are made easily accessible. He explained to *The Journal* what has been seen in the wake of smoking bans elsewhere.

“The air is cleaner and health improves, people support the regulations and support increases over time, hospitality economies are not devastated and appear to suffer no adverse consequences,” he said.

“When smokers decide they are ready to quit, a smoke-free environment makes it easier for them to stop successfully. For some people, they will decide to quit right away when the law is implemented or even beforehand, but for many others they will make that decision in the weeks, months and years ahead.”

Smoking cessation therapies need to be used in new ways

Smoking cessation medicines such as nicotine-replacement therapy and rimonabant (which was launched this week as a treatment for obesity, see above) may have to be used in new ways to help prompt smokers to quit, John Hughes, of the department of psychiatry, University of Vermont, US, has told *The Journal*.

He said that smoking cessation therapies could be used by those not currently interested in quitting to relieve withdrawal symptoms or cravings during temporary abstinence and to reduce the number of cigarettes they smoke.

They could also be used by those trying to quit, he added, to help reduce the number of cigarettes they smoke before they decide to give up completely and to prevent relapses after quit attempts.

Dr Hughes was speaking ahead of the UK National Smoking Cessation Conference in Gateshead this week.

Scottish smoking ban has 99 pc adherence

Scotland’s smoking ban is being adhered to, according to figures published this week.

Since smoking was banned in enclosed public places in March, local authorities have been inspecting public houses, hotels, restaurants and other public premises to check compliance with the new law. The figures show that of 15,540 inspections, 99 per cent — 15,452 premises — were compliant.

Health minister Andy Kerr also announced the results of a Market Research UK survey demonstrating public support for the ban. “Thirty-five per cent of smokers surveyed say the ban has helped them to reduce the amount they smoke — that is a great start for improving our health,” he commented.

In addition, a separate poll, conducted by Cancer Research UK, suggests that many people in Scotland are more likely to go out to bars and public houses than before the smoking ban was introduced.

Use minimum treatment for childhood fever

Parents should be advised to use the minimum medication necessary to treat fever in their children because of the lack of evidence to support one pharmacological regimen over another, the authors of an editorial in this week’s *BMJ* argue (2006;333:4).

The authors looked at studies comparing the effectiveness of paracetamol, ibuprofen and combinations of the two but say that inconsistent doses and thermometry methods make it difficult to collate the information.

“Given the desire among parents and clinicians to do something when faced with febrile children, it seems churlish to conclude that combined treatment should be withheld from all children. But parents should be advised to use the minimum treatment necessary,” they say.

Using two drugs always has some disadvantages, they add, including increased risks of overdosing, underdosing, adverse effects and the associated risk of exacerbating parental fever phobia.

Correction

The news item about National Institute for Health and Clinical Excellence guidance on Parkinson's disease (p7) should read dopamine agonist rather than dopamine antagonist.